DRAFT CCBHC Certification Standards
Public Feedback/Questions & CCBHC Interagency Team Responses
Updated: 01/31/2023

No.	Public Comment / Question	State Response
1	Will an MOU/BAA agreements suffice for DCO's inclusion in the CCBHC Application or does there need to be more specificity?	The application will request a list of the proposed DCOs and services they will provide. The state does not expect formal agreements to be executed prior to the application due date. Formal agreements will be necessary prior to finalizing contingent or full certification status.
2	The Evidence Based Practices (EBP) mentioned do not include some of the DCYF contracted programs that are recognized by the Families First Clearinghouse. a. Is it allowable to use these other Evidence Based Practices not listed? Are the EBP listed in the Standards the minimum requirement or suggestions?	CCBHC Applicants, or their DCOs may propose any additional EBP that is appropriate to the need of the population served by the CCBHC. The EBPs listed represent the minimum requirement.
3	In 4.a.1 it describes the services that must be done by a CCBHC. Are DCO's also allowed to do some of those activities based on 4.a.2. Example Substance Use counseling, Individual Counseling, Peer support, Intensive Home-Based Services?	CCBHC must provide the first four services however you can also use a DCO to enhance access and availability: 1. **Crisis Mental Health Services** 2. **Screening, assessment, and diagnosis including risk assessment** 3. **Patient-centered treatment including risk assessment and crisis planning** 4. **Outpatient mental health and substance use services** The following services described may be delivered by a DCO: 5. Primary Care Screening and Monitoring 6. Peer and Family Support 7. Psychiatric Rehabilitation 8. Targeted Case Management Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans
4	What is the intersection of DCYF and BHDDH/EOHHS on this effort? Will DCYF funded programs and Children's Behavioral Health be part of this system?	There is an Interagency Executive Team comprised of EOHHS, BHDDH and DCYF staff that meet weekly to focus specifically on the intersection the CCBHC children's services and the children's system of care, including on-going work. It is the intention that there be alignment with programs administered and funded by DCYF. Please note that High Acuity Children and Youth are included as part of the system and need to be included in the cost report.

5	The standards and the model suggest that CCBHCs need to utilize DCOs. How will this be operationalized and reinforced?	CCBHCs serve as the fixed point of contact for clinical care and responsible for ensuring that consumers/clients served by the CCBHC receive the clinical services needed. This means that specialized or population specific services/interventions may be needed which are outside the scope of the CCBHC's clinical expertise. In these circumstances, a formal DCO arrangement may be required. **CCBHC's are required to hold DCOs to the same standards of clinical care as the CCBHC**. The CCBHC is responsible for assuring that the contracted DCO services and supports comply with all of the SAMHSA certification criteria and CMS requirements (4.a.1) Other more highly specialized services/interventions may be better served by a formalized referral arrangement. Information pertaining to the use of DCOs is asked in the CCBHC application. This would include listing the DCO arrangements that have been finalized and those that are still pending or in negotiation. Responses to this will be scored in the evaluation of the applications. The use of DCO's will be further addressed in the issuance any certification.
6	Wraparound is mentioned as a model in Mental Health and Substance Use treatment section and Care Coordination is mentioned in other places. Is Wraparound a required model for the CCBHC model	BHDDH/DCYF are currently working on guidance for the utilization of wraparound facilitation in Rhode Island as a recommended practice. We expect such guidance to be issued shortly.
7	The draft certification standards state" DCO staff must also be appropriately licensed, certified, registered and credentialed as required for the specific service they provide. DCO organizations do not have to accredited but must be licensed as a BHO to provide clinical services. " If an organization is currently providing case management and evidenced -based clinical behavioral health treatment services to a specific population but is not licensed as a BHO, is there an ability to waive the licensing requirement?	**The licensing requirement cannot be waived**, **unless the DCO is applying for a license and the application is pending during the CCBHC application period and review**. The DCO cannot provide clinical services until the license is approved. The DCO's attainment of licensure as a BHO may be one of the elements that need to be fulfilled as part of the CCBHC's contingent certification. In order for a CCHBHC or DCO to participate in the CCBHC program they must be a Medicaid Provider. For instructions on the process to become a Medicaid provider please refer to HCP Provider Portal > Home (riproviderportal.org) . *212-RICR-10-10-1.1.3.3 Licensing and Statutory Designations* *A. No person or governmental unit, acting separately or jointly with any other person or governmental unit, shall establish, conduct, or maintain a facility, program, or organization as defined in this Part without a license, pursuant to R.I. Gen. Laws § 40.1-24-3.* *B. An organization that wishes to provide clinical behavioral healthcare services shall apply for a BHO License in accordance with Subchapter 00 Part 1 of this Chapter, Licensed Organizations (212-RICR-10-00-1)*

8	If a DCO organization serves primarily children and youth, and is currently contracted with DCYF, will DCYF serve as the BHO licensing and/ or certification organization? How will these services interface with the DCYF service array?	See above. In this instance, if the DCO is proposed for clinical services for adults or children, they should be licensed as BHO. DCYF will continue to fund the DCYF-contracted, home-based service array.
9	The draft certification standards state" CCBHCs shall be selected to serve eight (8) designated service areas as provided under Rhode Island General Laws section 40.1-8.5-1 et seq. that are currently the eight (8) service areas designated by BHDDH to the private nonprofit CMHCs." If a potential DCO organization is located in one catchment area, serves a specific /specialized population and its catchment area is statewide, should the DCO be reaching out and attempting to develop relationships with all CCBHC's or can DCO's be approved as statewide DCO's and affiliate later in the CCBHC structure process? Our services are currently statewide.	Given the circumstances described, it would be recommended that a provider who currently has a statewide footprint would attempt to develop DCO relationships with all CCBHCs. Please note that there are implications of DCO relationships for the purpose of creating the cost reports. There is no formal state approval of DCO relationship per se and CCBHCs may choose to change DCOs at any point based on performance or emerging need within the catchment or service area.
10	The draft certification standards state" A CCBHC can partner with a DCO that is licensed or certified to provide a 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. " If a DCO is not licensed, certified, or currently billing Medicaid, but is providing services that are Medicaid reimbursable, how will the DCO become certified? Will the DCO need to bill Medicaid directly or will the CCBHC bill Medicaid for the DCO?	The process for certification to become a Medicaid provider would vary based on the service. If, in this instance, the service is providing peer and family supports, a required CCBHC non-clinical service, the DCO would need to submit an application to become a certified Provider of Peer Based Recovery Support Services.
11	While the standards state that there is additional guidance coming regarding how the children's mobile crisis system will align CCBHC mobile crisis services, will this guidance also clarify the statement made on Page 86, Addendum 3, 4.f, a DCO provides mobile crisis services must include QMHP staff - Does this include an organization providing children's mobile crisis services?	Yes. A QMHP would be required for crisis response, even for children's mobile crisis.
12	Page 62, 4.f.2. and Page 93 states DCYF must review and approve children's EBP's. Does this mean anything in addition to the required list of EBP's? Please describe the process for achieving this review and approval.	Yes, it does. The applicant should describe all EBPs that it intends to provide in the application, this will be reviewed by CCBHC application review team in context of the application. The CCBHC application review team will review all proposed EBP's for suitability for the intended populations.

13	Page 62 and Page 93 says DCYF will not be involved in approving Teen ACT EBP, but Page 96 says DCYF will be involved in approving Teen ACT. Which is it?	Teen Act has been removed from the list of the EBPs based on feedback from the public meeting on January 18, 2023. The Certification Standards Guide will be updated to reflect this decision from the CCBHC Interagency Executive Committee.
14	Is it necessary to have a DCO relationship with Tides for the provision of mobile crisis services, or will an MOU suffice? Same thing with BHLink? CCA was considering a DCO relationship with Tides, but we see criteria around coordination with BH Link and 988 is more of a collaboration agreement, vs. a DCO arrangement. Do we treat these 2 entities similarly?	For Year 1 of CCBHCs, formal DCO relationships would be required for the hours 7a.m-11p.m for children's and adult crisis services. If the CCBHC cannot provide it themselves in accordance with the RI CCBHC Certification Standards, MOUs will suffice. MOUs must meet all the qualifications in Addendum 3 – "Requirements of Designated Collaborating Organizations". Additional guidance for Year 2 will be forthcoming. Note, all mobile crisis for adults and children must have a QMHP as a minimum requirement. Care coordination agreements with BH Link and 9-8-8 are required. Formal DCO arrangements would be permitted for overnight, weekend, and holiday coverage if the applicant were to propose such an arrangement.
15	Please clarify this statement: "Any CCBHC serving a geographic area with fewer than 200,000 people must form a partnership with another CCBHC and establish a primary mobile crisis team (MCT) for that combined region overnight." CCA does provide mobile crisis services and plans to coordinate with BH Link and Tides for enhancement. Would doing so therefore eliminate the need for CCA to form a partnership with another CCBHC then?	See answer to Question 14. For overnight mobile crisis (coverage from 11 PM – 7 AM), holidays, and weekends, any CCBHC serving a geography with fewer than 200,000 people may form a partnership with another CCBHC and establish a primary mobile crisis provider for the combined region overnight. CCBHCs partnering together for after-hours mobile crisis coverage may utilize DCOs in addition to this partnership to enhance capacity.
16	How will the state align and support CCBHCs in aligning mobile crisis adult with 988? Is the expectation for each CCBHC provider to fund a mobile crisis team for their catchment area? Standards also speak to existing state-sanctioned, certified, or licensed system or network for crisis behavioral health service, does BH Link and 988 qualify to meet the needs of 24 -hour response, and ASU for crisis stabilization if these are outside of catchment area? What part of the 24-hour staffing, mobile crisis, and stabilization would be expected from CCBHCs directly?	Please refer to responses to questions 14 and 15. Partnerships with 988 are required to provide a care coordination agreement. This requirement will be reflected in the application.

17	Clarify where/when you see a CCBHC implementing SBIRT. As part of the comprehensive biopsychosocial assessment, a more intensive substance use assessment is conducted, including an assessment of ASAM placement criteria.	Based on the standards from SAMHSA, the expectation is that SBIRT would be used during screening, assessment and as an intervention, when clinically appropriate and indicated. The intent of the standard to ensure that if problematic use of a substance is identified, the consumer/client is immediately referred to appropriate treatment. (4.f.2, 4.d.6). The standards do not mandate specific models for conducting the screening but leaves it to the CCBHC to organize and describe those functions in meeting the standard.
18	We see URI is noted as a resource for 7 of the EBP tools. How will these tools be obtained? Has an arrangement been worked out by the State with URI for fidelity scoring, analysis and reporting? If so, at what cost, and should this be included in the Cost Report, or will the cost be assumed by the state?	It is the expectation that the applicant will describe how they will assess and monitor fidelity to the evidence-based practices proposed in their application. Members of the CCBHC Interagency Team were provided information on the availability of fidelity tools/processes developed for current CCBHC Expansion Grant awarded and recognized the value of including them as one way of monitoring fidelity. The team member who had the initial communication with URI identified a set of tools that were completed and were in various stages of implementation by expansion grants. There were others that were still under development and to our knowledge, Med Team was one of those, but may now be completed. URI expressed a willingness to work with the CCBHC awardees. These costs should be included in the cost report as the state is not able to contract for this service with URI directly. Applicants may propose other methods of assessing fidelity but must include the process in their application.
19	The revised ASAM criteria lists five levels of Withdrawal Management for Adults. It is a SAMHSA requirement that the CCBHC will have the first four available and accessible to the person experiencing a crisis at the time of the crisis. Within the scope of services at CCA there is capacity for all levels-ES, IOP, ASU, and Residential SU. Some of these services fall outside of the catchment area. Is it allowable to count those resources for certification standards?	Yes. Please refer to Criteria (4.c.1)/Standard 4. This standard, and Addendum 7 – Scope of Services/Ambulatory and Medical Detoxification Table 1, describe which ASAM levels must be provided by the CCBHC (Level 1-WM, 2-WM). and which can be a referral relationship. Any other Withdrawal Management can be a referral relationship and may be provided outside of the catchment area.
20	1.a.1 references state providing needs assessment and staffing plan. When will that be provided?	The state completed a needs assessment for our CCBHC Demonstration Grant Application in 2016, but it does not meet the criteria set out by SAMHSA of being less than three years old. The state recognizes that the Block Grant Needs Assessment does not have the necessary level of detail for an applicant to support a fully developed staffing plan because the data is reporting at the aggregate level for the state and does not break data down to a service or catchment area level. The state will accept a proposed staffing plan based on other sources of data and information

		currently available to the applicant. Considering the turnaround time for the application, it would **not** be possible for an applicant without a current (defined as less than three years old) to complete one. Applicants may attest that they will complete a needs assessment by end of the first year and the state will accept the attestation if the proposed staffing plan appears to be appropriate for the services required of the CCBHC within the service or catchment area. Please note that the state has provided a required staffing plan for four services provided to high acuity populations. Those staffing plans are described in Addendum 7 on Tables 2 and 3 of the Certification Standards. It is the expectation that the applicant will follow the required minimum staffing patterns for those specific services and propose an appropriate pattern for others based on the projected service needs of the service or catchment area.
21	Pg. 100, Lead Rehab Voc specialist notes EBP of Permanent Supported Housing but should this be Individualized Placement Service (IPS)?	The team will review the information contained in Addendum 7 related to High Acuity Adult populations to make sure that the staffing patterns in Tables 2 & 3 are accurate as to the EBPs identified.
22	Pg. 99 in ACT staffing, there is no Voc position and instead a Permanent Supportive Housing specialist. Is this an oversight or intentional given ACT level of care?	See above.
23	There is a discrepancy with density requirements for ACT. There are no specific density requirements in the certification standards, but technical guidance refers to TMACT (at 3 hrs) and also refers to state guidelines. Please clarify.	The guidance refers to TMACT as the state's preferred fidelity model. The state understands that there is potential conflict between the density requirement in the preferred fidelity model, current state guidelines (IHH and ACT Medicaid Program Manuals) the CCBHC Model. Please review Addendum 7 for CCBHC requirements. That is the model that the Interagency CCBHC Team believes can be accomplished with current workforce shortages. Applicants can propose enhanced staffing patterns as what is presented is considered the minimum staffing pattern for the services. Average of 6 hours per month per ACT client. Average of 3 hours per month per ICTT client.
24	LPN is not listed under the staffing models, this had been recently approved, but no mention here. Will these standards be reflective of the new regulations of 12/27/22.	Please refer Addendum 4 which references Staffing Requirements necessary to meet the needs of the populations served by a CCBHC. LPNs are referenced as part of Primary Care Screening Monitoring. Use of LPNs consistent with existing regulation is allowable and be reviewed as part of the application process.
25	For the 2.b.2 standard for treatment plan assessment every 90 days, the state is requiring attestation for DLA for SPMI and CANs for child every 90 days. Requesting removal of this state requirement as this is too frequent and excessive for this population for reassessing level of	The state is unable to revise the requirement that the treatment plan assessment be conducted every 90 days as that what is a SAMHSA requirement. As noted, current state regulation requires the treatment plan to be reviewed every six (6) months. The frequency of assessment should be factored into the

	functioning and consistency with licensing regulations of treatment plans every 6 months. DLA and CAN assessments especially for the use of placement for these clients should not be more frequent than 6 months as these higher acuity and need clients do not demonstrate change that quickly nor can be predictive of sustained functioning without the needed supports in a short 3 month period.	cost report and staffing plan. While the proposed revision to the SAMHSA CCBHC Criteria would align with the 6 months' time, frame, they have not been formally adopted yet and until that time we have to observe the criteria or standard as currently written. DCYF continues to utilize clinical best practice of the CANs assessment every 90 days.
26	DLA scores have been made more concrete, 3 and under for ACT; 3.1 -4 for ICTT in these standards. Language should allow for individuals to be served by ICCT if under 3. Some clients are not agreeable to ACT level of care or have supports in place that would not require ACT level of care (i.e. MHPRR clients should be ICCT but DLA scores would put them under 3, clients living in Assisted living, or with family or other support person).	This is an existing exception process used by BHDDH if a provider believes that a consumer/client's DLA score is not truly reflective of the actual functional level. Typically, that exception process is used with consumers/clients whose DLA score suggests a higher level of functioning than that which is exhibited by the individual. However, the exception process can be used for the example provided.
27	ICTT only has 4 CMs for a population of 200, that's a caseload of 50. That is a high caseload given the acuity and severity of need of population. While the thinking may be that specialists (similar to ACT) can assist with caseload requirements, this will make it more challenging to deliver the MH and SU therapy that is needed for this population. All record documentation, treatment planning, etc. adds to the burden of the high caseloads and takes away from direct care. It is also the number 1 complaint right now of these licensed staff in these types of roles on ACT team. This ICTT team should include 2 more CMs for balancing the needs of the caseloads.	The applicant may propose staffing to address CM needs described within the minimum staffing requirements. The proposed staffing does not indicate that the 4 CMs are responsible for treatment planning etc. The required staffing ratio is 1:14, staff can be assigned as primary for the purposes of treatment planning.
28	4.a.1 states that all core services except mobile crisis must be performed directly by the CCBHC. It has been stated in the past that only the 4 services that SAMHSA requires must be provided by the CCBHC and the other core services can be provided by a DCO. Please clarify which services need to be provided directly by the CCBHC and cannot only be provided by a DCO.	The following services must be delivered by the CCBHC: 1. Crisis Response 2. Screening, Evaluation and Diagnosis 3. Person-Centered and Family-Centered Treatment Planning 4. Outpatient Mental Health and Substance Use Disorder Services Any of the other services may be provided by the CCBHC or a DCO.
29	Please clarify the mobile crisis services requirements. a. 4.a.1 states that mobile crisis must be provided by a DCO. b. 4.c.1 states that ambulatory and medical detox (ASAM Level 1 & 2) must be provided directly by the CCBHC and also states it can be through a DCO. Addendum 7 states CCBHC must directly provide ASAM Level 1 and 2.	Item a. 4.a.1 – After hours mobile crisis services (defined as overnight 11pm - 7 am; weekend and holidays) may be provided through a DCO. If the CCBHC does not propose to provide 24 hour/day, 7 days a week, 365 days a year mobile crisis, then they must form a partnership with another CCBHC and establish a primary mobile crisis team (MCT) for after-hours crisis response. Please also see

		Addendum 7 – Scope of Services. Language related to criteria/standard 4.a.1 in column 2 "Explanation/Interpretation" and column 3 "Documenting Compliance" pages 46-47 will be revised and updated to reflect this clarification. Items b. & c. 4.c.1-Please refer to column 3 "Documenting Compliance" 4.A-D, which describes use of an attestation related to the provision of withdrawal management services required of a CCBHC. ASAM Levels 1-WM & 2-WM must be directly provided by the CCBHC, levels 3.2 and 3.7 may be through a referral relationship and not a DCO relationship. Addendum 7 – Please refer to Table 1, Addendum 7 which also described the requirements in the same way described above.
30	Implementing all 18 EBPs in year 1, even partially, is a big uplift when also trying to operationalize core CCBHC services up to the level that is needed to serve our communities along with all other CCBHC requirements (services, recruitment, hiring, systems, reporting, mandates, etc.). I recommend allowing the providers to lay out their 3-5 year plan for implementing these EBPs. This will allow more time to hire the staff that is needed, handle the increase in clients and, become better educated in implementing and operationalizing these EBPs.	The CCBHC Interagency Team is cognizant of the many challenges that face the CCBHCs in the first year of operation and the points are well taken. The clinical practices identified in Addendum 6 reflect the required practices and programs to meet the needs for the population and services for the CCBHC. Additional clarity has been provided for the positions where training in the EBP is required, especially for ACT and ICCT. Please note there are modifications to the timelines in Addendum 6 for EBP implementation. Providers are encouraged to utilize DCOs to increase access and availability to EBPs for populations served. Additional or alternative EBPs may be proposed. A justification or rationale must be provided of the efficacy of proposed EBP's.
31	4.f.2 requires for applicants to provide a list of names of staff who are trained in each EBP, names of those who need to be trained and a plan for training each staff who is not trained. Since staff will be changing a lot between now and implementation, is this information necessary for the certification application?	Yes. This information is requested in the application. The state needs to assess compliance to the criteria and standard. The criteria and standards address properly trained and credentialed staff who have the requisite skills to provide the clinical and program services of the CCBHC, including the use of evidence-based practices. The state is very much aware of the critical shortages in the behavioral health workforce and of the fluidity in staffing patterns that come from the critical shortages. We fully understand that staff will change, even from the time of initial application to certification/contingent certification but need to have some baseline to work with.

32	Will CCBHCs be able to use their own methods of assessing fidelity?	CCBHCs will be asked to address how they propose to assess fidelity as part of the application. If the CCBHC wishes to propose their own method, it will be evaluated as part of the application. Additional guidance will be provided in the future.
33	In the quality measures, BMI is required. There is movement across the nation away from collecting BMI because it is not an accurate predictor of health for certain demographics and races. I suggest removing this from the quality measures.	We are unable to change the quality measures at this time because it is required by SAMHSA. However, there have been proposed changes to Quality Measures which may be adopted in the future. Once those changes are adopted, the state will revise the quality measures to reflect those changes.
34	Will there be further guidance on what tools should be used for certain quality measures?	Please see Addendum 8 which describe the quality measures, how they will be reported and by whom. Further guidance will be provided post application to those entities who receive contingent or full certification.
35	2.a.2 The CCBHC provides outpatient clinical services during times that ensure accessibility and meet the needs of the consumer population to be served, including some nights and weekend hours. NMH currently provides evening OP hours. Would we need to provide weekend hours, or could this be covered by utilizing Emergency Service staff and other weekend staff?	Yes, use of weekend staff to provide services during weekend hours would be permissible and would be consistent with the intention of the criteria/standard established by SAMHSA. General hours of operation for certain services such as ACT, ICTT and CSC are indicated in the standards. Aside from what is already detailed in the standards, the hours that specific services are provided are left to the CCBHC to determine in order to meet the accessibility standard. Difficulty for any CCBHCs in meeting response, evaluation and treatment needs of the community would require the CCBHCs to reexamine their hours of availability as part of CQI process however, the use of DCOs is encouraged to expand capacity, availability and accessibility.
36	2.b.1 Requirements for Timely Access to Services and Comprehensive Evaluation for New Consumers If the initial evaluation is conducted telephonically, once the emergency is resolved the consumer must be seen in person at the next subsequent encounter and the initial evaluation reviewed. In part the intent of this criterion seems to be that when a crisis has been resolved without a face-to-face encounter then next contact with the individual involved should be face-to-face and the individual's need for services and level of risk assessed. There may be individuals who utilize ES phone triage that may not be seen on the next visit in person currently. When they say once the crisis is resolved does this mean it is ok to have several calls with clients in crisis?	No. SAMHSA criteria/standard 2.b.1 in the far-left hand column, fourth bullet, specifically requires that the next encounter MUST be in person and that the initial evaluation reviewed.

37	2.b.2. The organization attests that each individual's comprehensive evaluation is updated with the cooperation of the consumer when changes in the consumer's status, responses to treatment, or goal achievement have occurred, and at least every 90 days for individuals with moderate or more serious impairment as determined by an approved functional assessment (e.g. DLA 20 for adults and CANs for children/adolescents and ASAM for individuals with substance use disorder) SAMHSA has indicated that they are moving to a 6 month plan review, will RI include this change? Currently DLA-20 is only required every 6 months.	Not at this time, as this is a SAMHSA prescribed requirement. See response to comment 25 for additional detail.
38	2.c.3 Individuals who are served by the CCBHC are educated about crisis management services and Psychiatric Advanced Directives (PAD) and how to access crisis services, including suicide or crisis hotlines and warmlines, at the time of the initial evaluation. This includes individuals with LEP or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1). There is no RI law allowing PAD.	The language contained in the first column is the SAMHSA's language verbatim and does not always accurately reflect RI statute or regulation or other contextual factors. Please refer instead to the second column "Explanation/Interpretation" and the third column "Documenting Compliance" for information relevant to how the applicant will need to address the criteria in RI. In this case, the use of Psychiatric Directives is not indicated for compliance but rather the provision of lists of collaborating EDs and titles of existing policies related to accessing crisis management services.
39	3.c.5 The organization provides policy or procedure number, title, issuance or revision date or page numbers relating to efforts to make and document, reasonable attempts to follow up within 24 hours following hospital discharge. Need greater definition of accepted follow-up contact, and 'reasonable attempts'.	For the purpose of application, please provide the policy or procedure. SAMHSA did not provide specific guidance on what constitutes "reasonable attempts". That is left up to the CCBHC to define. The CCBHC review team will need to review the policies or procedure to determine adequacy/compliance and judge each on a case-by-case basis.
40	High Acuity Adult A DLA score of four or less Is the DLA-20 score 4.0 or less, or 4.99 or less?	It is a DLA-20 score of 4.0 or less. Please note that there is an exception process identified in Addendum 5.
41	High Acuity Adult Staffing Models The staffing models greatly reduce the number of CPST Case managers. We would request flexibility on staffing. model based on specific team population.	See response to comment 27. The proposed staffing for high acuity adult services is a minimum required staffing pattern. The applicant may propose additional staffing to address the population needs.
42	Requirement for ICCT and HT to provide. These Teams currently do not work weekends and holidays, although some of the IHH do operate 10 hours a day. These expanded hours would need to be financially incentivized in the current workforce crisis.	Please be sure to include any costs associated with the expanded hours in the cost report.
43	Eligibility Criteria. Would it be okay to split those 4 qualifications with a DCO based on specialty and population?	Please refer to answers from questions 3.

	You state in the certification standards that to be eligible a CCBHC must have the ability (not just through a DCO) to have 24/7 mobile crisis. This is different from what has been stated by EOHHS in prior meetings. Can you confirm that to be certified as a CCBHC you must have both children and adult mobile crisis that the CCBHC itself provides or can you DCO one or both of these services?	A CCBHC must be able to provide both Adult and Children mobile crisis services, you may utilize DCO to enhance your existing access and availability
44	EBPs. Based on the federal CCBHC guidelines, CCBHC had the ability to choose from a menu of EBPs that met the needs of their clientele. In this way, CCBHC had intention behind the training rather than overextending the clinical staff without demonstrated need. Is there a possibility to replicate the federal grant or divide the 18 EBP between the 10 CCBHC in an efficient way?	No. We have to certify to the existing SAMHSA Standards for the demonstration project, and not to the guidance from the expansion grants. Please refer to the answer from question 30.
45	Needs assessment. Based on the federal CCBHC guidelines, the needs assessment was the CCBHCs responsibility to determine the needs of their own community. Within the state guidelines, it seems as though the state is taking that responsibility. Is the needs assessment being completed by the state or by individual CCBHCs? How does the state needs assessment differ from the federal needs assessment guidelines? How will the outcomes of the needs assessment impact the standards? If conducted by the state, who can participate to advocate for the needs for our populations and ensure that each population is adequately represented? Will regulation around applying for QMHP status expand?	Please refer to the certification standards around the community need assessment guidelines (1.a.1). 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. Please refer to the answer from question # 20. All CCBHC must be licensed as a BHO, or in the process of becoming licensed so qualified staff can apply for QMHP.
46	Availability and Accessibility. 2.a.2- “Some weekend and evening hours.” Could you clarify if this applies to all services offered? For	Please refer to answer from question # 35.

	example, if an agency has weekend hours for outpatient counseling and emergency services but peer support only occurs during the week is that sufficient? Is it expected that all DCO's also have weekend and evening hours for all services offered as well?	
47	2.a.6- It states that "CCBHCs must have staff dedicated to outreach that do not carry a caseload." In one of the public meetings it was mentioned that Care Coordinators would be required to do care coordination and not have a caseload. Is this the same role or are CCBHCs expected to have both Outreach staff and Care coordinators? Also during the office hours for the cost report we were informed that care coordination was a service, not a position. Can you clarify? Should we have specific positions who are care coordinators who don't have a caseload or are the outreach staff the ones who should not have caseloads?	In the federal CCBHC Standard defines care coordination as an activity rather than a service. All CCBHC clients need to be provided care coordination as clinically necessary by appropriate staff. Care coordination can be performed by multiple clinical staff or direct service staff depending on their role. Yes, CCBHCs are expected to have outreach staff and provide care coordination. The CCBHC must have staff dedicated to outreach and engagement who do not carry a caseload (2.a.6)
48	2.c.1 Can you clarify if we can DCO children and/or adult mobile crisis?	Please refer to answers from questions 3. A CCBHC must be able to provide both Adult and Children mobile crisis services, you may utilize DCO to enhance your existing access and availability
49	Availability and Accessibility. 2.e.2 This standard implies that the CCBHC is responsible for crisis response outside their catchment areas- is this correct? If a CCBHC cannot respond in-person outside their catchment is telehealth acceptable?	The standard does not require crisis response outside of the CCBHC catchment area. CCBHC's are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence, when presenting to your CCBHC facility.
50	Access to Crisis Management Services. 3.a.1 Since our state is small and the CCBHC is a state-wide initiative, will EOHHS assist in collaborating to outreach to some of the entities that will be common across most if not all CCBHCs (such as the VA) to allow for a coordinated effort of collaboration?	Each CCBHC needs to enter into various care coordination and collaborative agreements with organizations that best address the needs of the populations of focus and priority consumer groups (3.a.1) The state recognizes that there may be challenges in obtaining formal agreements from important partners and we have accommodated for these circumstances in the application process.
51	Crisis Behavioral Health Services. 4.c.1 This implies that If the state creates "state-sanctioned crisis services" that the CCBHC can DCO child or adult mobile crisis services- this is different than what is outlined in the eligibility criteria for being a CCBHC. Can you clarify this? Does the state plan to have state-sanctioned crisis services such	"State Sanctioned" is SAMHSA language, however, there are various state services (BH LINK, 988) that may be utilized via a care coordination agreement to increase capacity or availability. Each CCBHC needs to be prepared to address the crisis response needs of their catchment/service area.

	as mobile crisis for both children and adults? This will directly impact our anticipated costs for the cost report.	
52	OP Mental Health Services. 4.f.1 This standard implies that you can refer for specialty services (ie MAT) to an agency that is not an official DCO- is this correct?	Yes, you can have a DCO relationship for specialty services that is not an "official DCO". However, MAT services (buprenorphine, naltrexone) are required of a CCBHC and must be provided by a CCBHC. In order to expand or enhance the CCBHC's MAT services, a DCO relationship is encouraged.
53	4.f.2 There appears to be a lack of EBPs listed that are appropriate for children and adolescents. Will the state be prescribing EBPs for children and adolescents? The timeframe given for agencies to implement all of these EBPs is unrealistic. There is a science behind implementing EBPs, will EOHHS reconsider the timeline for implementing all of these? You list "trauma informed care" as an EBP but do not require any specific trauma-focused EBPs to be implemented. How are you defining trauma-informed care? What standards are you using to measure that?	EBPs for children is a rapidly emerging field. We will judge any proposed EBP for children on the basis and context of the application. The preference for EBPs would be for them to be trauma informed and trauma responsive. See ADDENDUM 6 or refer to: TIP 57 Trauma-Informed Care in Behavioral Health Services (samhsa.gov)
54	DCOs. How would a CCBHC document contractually without being able to have our DCO arrangements set prior to certification? What is the guidance around managing a DCO's staffing, trainings and services without contractual agreements?	CCHBCs are responsible for assuring that the contracted DCO services and supports comply with all of the SAMHSA certification criteria and CMS requirements (4.a.1) The CCBHC application provides for listing DCO arrangements that are still being negotiated or are pending at the time of application. Final CCBHC/DCO formal agreements need to be executed prior to CCBHC operation. For additional information please refer to question 5 and 7.
55	In Rhode Island, the provision of behavioral health services for children, youth, and families is decentralized and includes DCYF, BHDDH, RIDOH, EOHHS, DHS, and RIDE/school districts. Given this, we have several questions and recommendations: The standards (3.c.3) require an agreement between DCYF and BHDDH but should have agreements with of the state agencies that may have a role in providing behavioral health services, including early childhood/family support programming, to serve the full lifespan. Infants and young children are also at risk of mental health or even substance use challenges.	The language provided in the left-hand column entitled "SAMHSA CRITERIA" is their verbatim language and not customized to the context of Rhode Island's behavioral healthcare system. This section refers to care coordination and mechanisms for both formal and informal agreements to enhance care for the population served by CCBHC. A CCBHC may propose any formal or informal care coordination agreements that enhance service provision to the populations of focus and priority consumer groups.

	The word agreements is also used in relation to other types of services including youth residential and other types of services and the nature of those agreements should be clearer**.**	
56	There have been concerns about the adequacy of CANS alone over the years. We recommend that there at least be a discussion with clinical experts as to the strengths/limitations of CANS.	The recommendation has been noted, and the state welcomes further discussion. For the purpose of the application, the state is continuing to move forward with planning for CANS implementation at this time.
57	The Section "Children and Youth with Emotional Disturbance" (p. 103) notes that all members should have access to clinical staff 24/7 via hotline or crisis response. Are these only geographically attributed clients and does it include DCO clients? Does it include youth in group care or students that do not have immediate access to clinicians?	CCBHC's are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence to anyone who presents to a CCBHC facility. CCBHCs and their contracted DCO's will have 24/7 coverage for crisis response.
58	Addendum 3.4.d: It should be stated that DCOs must receive an appropriate referral that matches program criteria if they do not have a right of refusal	We will review the addendum to determine if revision is necessary.
59	Addendum 6: Include recommended EBP's to include all currently funded by DCYF and RIDOH to encourage DCO relationships with specialty providers.	Please refer to answer to question # 12
60	Allow for master contracts between DCOs and all CCBHCs. This would be especially helpful to specialty providers that are statewide or regional to avoid having to separately contract and/or work individually with all CCBHCs, Consider whether one CCBHC could be designated as clinical lead for any master contract, so a small DCO does not have to attempt to work with all CCBHCs that might each have only a few clients with their specialty need. Is there a resolution process between CCBHCs and DCOs if there are clinical disagreements?	Please refer to answer to question # 9
61	Are the DCOs going to have contracts with each partner CCBHC, or with EOHHS as the hub?	Please refer to answer to question # 9