Certified Community Behavioral Health Clinics (CCBHC) Managed Care Organizations Operations Manual

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I. Introduction

Document History

The State CCBHC Interagency Team, comprised of the Rhode Island Executive Office of Health and Human Services (EOHHS)/RI Medicaid, the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), and the Department of Children, Youth, and Families (DCYF), anticipates that this document will be updated and refined over the course of the CCBHC program to incorporate feedback and learnings from program participants, and to accommodate any program modifications required by the Centers of Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). The table below will be updated accordingly.

Version Number	Date	Summary of Changes
1.0	October 3, 2023	Initial Final CCBHC MCO Operations Manual. QBP measures included are based on SAMHSA proposed measures and will be updated once final guidance is published.
1.1	December 1, 2023	Updates incorporated based on final decisions for billing and MCO and provider feedback.

Purpose of this Document

This operations manual is intended to support Managed Care contracting with the Certified Community Behavioral Health Clinics (CCBHCs) in Rhode Island. It should be used in concert with both: (1) Rhode Island's CCBHC Certification Standards[1], which provide a comprehensive description of the programmatic and operational requirements of the CCBHC model; and (2) the Medicaid Managed Care Manual [2], which provides general managed care program requirements and processes.

Purpose of Certified Community Behavioral Health Clinics (CCBHCs)

The CCBHC model is designed to ensure access to coordinated, comprehensive behavioral health care for all Rhode Islanders. CCBHCs are required to serve any individual who requests

[1] State of Rhode Island Certification Guide- CCBHCs
[2] Rhode Island Medicaid Managed Care Manual

care for mental health or substance use, regardless of their ability to pay, place of residence, or age. This includes developmentally appropriate care for children and youth.

CCBHCs must meet all established standards for the range of services they provide. CCBHCs are required to provide: i) care to those in need quickly; ii) crisis services that are available 24 hours a day, 7 days a week; and iii) a comprehensive array of behavioral healthcare services to alleviate the need for people to have to seek care across multiple different providers. Additionally, CCBHCs are responsible for providing care coordination to help people navigate behavioral healthcare, physical healthcare, social services, and the other systems they are involved in.[3]

The adoption of the CCBHC model in Rhode Island is intended to:

- Expand community-based services for the people of Rhode Island, regardless of their ability to pay;
- Improve integration with medical care for physical concerns;
- Expand the use of Evidence Based Practices (EBPs);
- Improve access to high quality care;
- Improve data collection; and
- Serve anyone in the community with any level of need for behavioral healthcare services, with an added focus on serving people with Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and significant Substance Use Disorder (SUD).

II. Key Terms and Definitions

- **Adults with serious mental illness-** Someone over the age of 18 having (within the past year) a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.

- **Care Coordination Agreement-** Care coordinate agreements across services and providers defining accountable treatment team, health information technology, and care transitions. Certified community behavioral health clinics (CCBHCs) are required to have agreements establishing care coordination expectations with certain entities[4], e.g. federally qualified health centers (FQHCs), the Veteran's Administration (VA), 988, Accountable Entities (AEs), and Family Care Coordination Partnerships (FCCPs).

- **Care Transition-** When a client transfers from a treatment program or facility to a CCBHC. This may also include a transition from one CCBHC to another CCBHC.

[3] https://www.samhsa.gov/certified-community-behavioral-health-clinics
[4] RI CCBHC Certification Application, page 20

- **CCBHC-** A Certified Community Behavioral Health Clinic is a specially designated clinic that complies with all certification standards as issued by SAMHSA and is certified by BHDDH. This clinic provides coordinated comprehensive behavioral healthcare to anyone seeking help for a mental health or substance use condition, regardless of their place of residence, ability to pay, age, or the severity of their condition.

  CCBHCs provide:
  - Mental health and substance use services appropriate for individuals across the lifespan.
  - Increased access to high-quality community mental health and substance use care, including crisis care.
  - Integrated person- and family-centered services, driven by the needs and preferences of the people receiving services and their families.
  - A range of evidence-based practices, services, and supports to meet the needs of their communities.
  - Services provided in homes and communities rather than in inpatient or non-community-based residential settings.

- **CCBHC Payment/Utilization Report-** A report generated by RI Medicaid Finance, in collaboration with the Managed Care Organizations (MCOs), which specifies for a given month on a member basis (a) the CCBHC with which the member is enrolled and (b) whether the member received at least one qualifying service, or a "billable event" in that month from the CCBHC that they are enrolled with, or from one of the CCBHC's Designated Collaborative Organizations (DCOs).

- **CCBHC Contract/Payment Year (CY)-** Refers to the 12-month period in which each Rhode Island CCBHC program's contract is active and to which PPS rates apply. This follows the state fiscal year (July 1-June 30 of the following year). The first CY may be less than 1 year, depending upon the start date.
- **CCBHC Demonstration Year (DY):** Refers to the 12-month period covering the SAMHSA and CMS CCBHC Demonstration Program (pending approval). The first DY may be less than one year, depending upon the start date.

- **CCBHC Program/Performance Year (PPY):** Refers to the 12-month period when CCBHCs are responsible for performing against quality benchmarks for purposes of measuring quality performance and calculating eligibility for the Quality Bonus Payment. The timeframe for performance year follows the calendar year. The first PPY may be less than 12 months, depending upon the program start date.

- **CCBHC Program Attribution-** A member is attributed to the CCBHC program by the BHDDH Data Unit via the Gainwell eligibility system portal. The member is attributed to a particular participating CCBHC and a particular population rate category. Member attribution is the basis for quality measurement and reporting.

- **Children, adolescents, and adults with substance use disorder (SUD)-** Substance use disorder occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. This can be categorized as mild, moderate, or severe, based on a combination of diagnostic criteria.

- **Children and adolescents with Serious Emotional Disturbance (SED)-** For people under the age of 18, the term Serious Emotional Disturbance refers to a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

- **Collaborative Agreement-** A legally binding document establishing the terms and responsibilities of parties engaging in a collaborative business endeavor. In addition, these agreements summarize the scope of the collaboration, the objectives achieved, and each participant's distinctive roles and contributions.

- **Designated Collaborating Organization (DCO)-** A Designated Collaborating Organization is an agency that is contracted with the CCBHC to offer required CCBHC services to the clients being served. Additional requirements are articulated in the CCBHC certification criteria issued by SAMHSA and BHDDH.

- **Discharge-** When a client leaves an agency's CCBHC services. An individual may be discharged from the CCBHC program when treatment is complete, or due to the client's choice to transfer providers or discontinue services. If a client discontinues services unexpectedly, the CCBHC should make an effort to reengage the client in clinically appropriate care.

- **Dually Eligible Individual-** An individual who is eligible for both Medicaid and Medicare.

- **Encounters-** Documented provision of services to a client.

- **Federally Qualified Health Center (FQHC)-** Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations, providing primary care services regardless of a person's ability to pay.

- **General outpatient populations-** Those in need of standard outpatient behavioral health treatment who often have a mental illness that does not rise to the level of a serious mental illness (SMI) or have an SMI that is well managed. This level of care is lower in acuity than Intensive Outpatient, Residential, and Inpatient services.

- **Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Program (IHH/ACT)-** This refers to the Integrated Health Homes and Assertive Community Treatment programs in Rhode Island. These programs provide coordinated care that treats the whole person by including primary care, specialist care, and behavioral health together.

- **Members of the Armed Forces and Veterans-** Those who have served or are serving in the United States Armed Forces regardless of active duty or discharge status.

- **Non-Qualifying Service-** A service that does not qualify as a billable event but is factored into the CCBHC's operating costs. The expense of Non-Qualifying Service encounters is an allowable cost in the cost report, but when delivered alone the service does not count as a visit for the purpose of monthly billing and will not trigger payment of the PPS rate. The following are examples of non-qualifying services:
  - A collateral encounter (i.e., one that occurs between a CCBHC staff member and a person 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).
  - A care coordination encounter.
  - An outreach encounter.
  - A primary care screening encounter.

- **National Provider Identifier (NPI)** – This is a unique identification number for covered health care providers to use when billing.

- **Outlier Payment-** The PPS2 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.

- **PPS2 rates-** A monthly Prospective Payment System (PPS) model in which a clinic's rate is set by dividing its allowable costs by the number of monthly encounters in a year. Monthly encounters are calculated as the number of months in which a client has at least one

encounter, regardless of the number of days or quantity of services received within a given month.

- **Qualifying Service-** An allowable service under the CCBHC program that is eligible for the monthly PPS2 rate.

- **Quality Bonus Payment (QBP)-** The QBP is an additional incentive payment made to CCBHCs who report and meet required quality performance thresholds for members attributed to their CCBHC.

- **Quality Bonus Program-** A financial incentive provided for achieving certain quality outcomes.

- **Serious and Persistent Mental Illness (SPMI)-** To be considered as an individual with SPMI, a person will be required to have a qualifying diagnosis, demonstrated extended significant impairment in functioning due to their mental illness, and a documented psychiatric treatment history that indicates the need for community supportive treatment or services of a long-term or indefinite duration. Provisional SPMI eligibility determinations may be granted if the person meets the state's identified qualifying circumstances.

- **The Substance Abuse and Mental Health Services Administration (SAMHSA)-** A federal agency that leads public health efforts to improve the behavioral health of the United States. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on American communities. SAMHSA was established by Congress in 1992.

III. Background

Federal CCBHC History

The Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93), Section 223, directed the Department of Health and Human Services (HHS) to publish criteria for clinics to be certified as Certified Community Behavioral Health Clinics (CCBHCs). In 2015, HHS issued the original CCBHC certification criteria. The criteria established a set of uniform standards that providers must meet to be a CCBHC. By meeting these criteria, CCBHCs across the country are transforming systems by providing comprehensive, coordinated, trauma-informed, and recovery-oriented care for mental health and substance use conditions.

In 2016, the standards were used by eight initial states participating in the Section 223 CCBHC Demonstration program to certify 67 CCBHCs. Since then, the CCBHC Section 223 CCBHC Demonstration has expanded to include two additional states. HHS has supported the

development of CCBHCs through the SAMHSA CCBHC Expansion Grant Program, which was established in 2018. States have supported the development of CCBHCs separate from the Section 223 CCBHC Demonstration. Today, there are over 500 CCBHCs across 48 U.S. states, territories, and the District of Columbia.[5]

CCBHCs in Rhode Island

The RI Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is designated by SAMHSA as both the state mental health authority and the state substance abuse authority and is charged with administration and oversight of federal block grant and discretionary funding. BHDDH is also charged with the certification of select programs and services that are reimbursed by Medicaid, including CCBHCs.

BHDDH received a SAMHSA CCBHC planning grant in 2015 but was not awarded the two-year demonstration grant at the conclusion of the planning period. However, there was a continued appetite to lay the groundwork for implementation of CCBHCs as circumstances allowed.

SAMHSA subsequently awarded CCBHC expansion grants directly to community providers and four of the organizations designated by the Director of BHDDH as community mental health centers (CMHC) have received these awards, creating a critical mass of providers familiar with the CCBHC model.

In 2021, a review of the Rhode Island Behavioral Health System[6] was conducted by the Executive Office of Health and Human Services (EOHHS)/RI Medicaid, in conjunction with BHDDH, and the Department of Children, Youth, and Families (DCYF). The project included the identification of the gaps in the RI behavioral health system and proposed solutions to address these gaps. This resulted in the development of implementation plans for both CCBHCs and Mobile Crisis.

Over the subsequent year, the CCBHC Interagency Team (comprised of EOHHS/RI Medicaid, BHDDH, and DCYF) worked with input from a group of community providers and advocates to build a CCBHC proposal. In the State Fiscal Year (SFY) 2023 Budget (passed in June 2022), the Rhode Island General Assembly authorized EOHHS to submit a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) to establish CCBHCs in Rhode Island, according to the federal model. It also directed BHDDH to define the criteria to certify the clinics and, working in concert with the other CCBHC Interagency Team partners, to determine how many CCBHCs to certify in SFY 2024 and the costs for each CCBHC.

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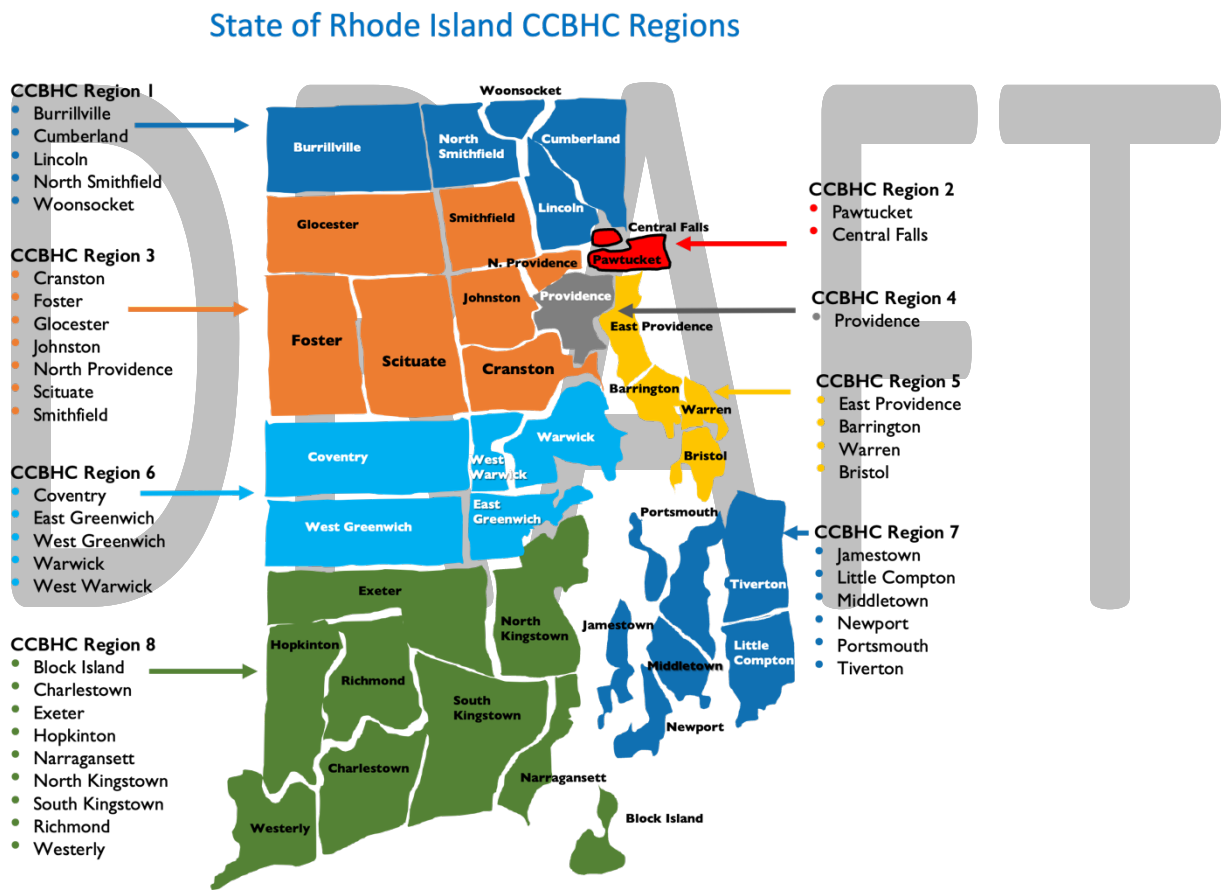
[5] Substance Abuse and Mental Health Services Administration (March 2023). *Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria*. Retrieved from: https://www.samhsa.gov/sites/default/files/ccbhc-compliance-checklist.pdf

[6] Faulkner Consulting Group and Health Management Associates (July 2021). *Rhode Island Behavioral Health System Review Technical Assistance*. Retrieved from: https://eohhs.ri.gov/initiatives/behavioral-health-system-review

The State intends to certify CCBHCs to serve specific designated service areas as defined under Rhode Island General Laws section 40.1-8.5-1 et seq. [7] (see Figure 1 below). As such, a CCBHC will be certified for a particular service area, and thereby eligible to receive a PPS2 rate for services provided *in that service area.* CCBHCs cannot establish a new physical location or brick and mortar clinic for CCBHC service delivery outside their catchment area. CCBHCs can provide services outside their designated areas if the care modalities do not require the establishment of a clinic outside their catchment area (i.e. mobile crisis services). Services provided by certified or contingently certified CCBHCs in other service areas will continue to be billed and paid in accordance with existing (non-CCBHC) billing and payment rules.

Figure 1: Rhode Island CCBHC Service Areas



[7] State of Rhode Island General Laws (2022). *Title 40.1 - Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1-8.5 - Community Mental Health Services, Section 40.1-8.5-1- Policy and Purpose.* Retrieved from https://law.justia.com/codes/rhode-island/2022/title-40-1/chapter-40-1-8-5/section-40-1-8-5-1/:

Core CCBHC Functions and Responsibilities

The RI CCBHC Certification Criteria, which establish a basic level of service and quality at which a CCBHC must operate, fall into six key program areas:

1. **Staffing** – Staffing plan driven by local needs assessment, licensing, and training to support service delivery.
2. **Availability and Accessibility of Services** – Standards for timely and meaningful access to services, outreach and engagement, 24/7 access to crisis services, treatment planning, and acceptance of all patients regardless of ability to pay or place of residence.
3. **Care Coordination** – Care coordination agreements across services and providers (e.g., Federally Qualified Health Centers, inpatient and acute care) defining the accountable treatment team, health information technology, and care transitions.
4. **Scope of Services** – Nine core required services, as well as person-centered, family-centered, and recovery-oriented care.
5. **Quality and Other Reporting** – Required quality measures, a plan for quality improvement, and tracking of other program requirements.
6. **Organizational Authority and Governance** – Consumer representation in governance, appropriate state accreditation.

CCBHC Alignment with Rhode Island Executive Office of Health and Human Services' Priorities

The CCBHC model directly supports RI EOHHS' five strategic priorities as depicted in Table 1[8]:

Table 1: Rhode Island's Five Strategic Priorities and Corresponding CCBHC Requirements

Strategic Priority		Complementary CCBHC Area
1	Focus on the Root Causes and the Socioeconomic and Environmental Determinants of Health That Ensure Individuals Can Achieve Their Full Potential.	CCBHCs serve all people regardless of ability to pay. Practices are informed by needs assessments and training which identify community disparities and guide provision of culturally appropriate and accessible care.
2	Promote Continuums of Care That Can Deliver Efficient, Effective, and Equitable Services Across the Life Course.	CCBHCs are required to effectively serve all people across the lifespan.
3	Address Addiction, Improve the Behavioral Health System, and Combat Stigma, Bias, and Discrimination.	CCBHCs are designed to serve anyone in the community in need of services, with a focus on serving people with Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and significant Substance Use Disorder (SUD).

[8] Rhode Island Strategic Goals and Priorities

4	Develop and Support a Robust and Diverse Health and Human Services Workforce to Meet the Need of Every Rhode Islander.	CCBHCs maintain teams that are well-trained in meeting the complex needs of those seeking behavioral health (BH) treatment.
5	Modernize, Integrate, and Transform Health Information Technology, Data Systems, and Overall Operations to Support Value-Based Systems of Care.	The CCBHC model promotes consistent, efficient data sharing between providers to support care coordination for all clients.

IV. General Program Requirements

Program Overview

MCOs will contract with all CCBHCs that are fully or contingently certified by BHDDH to provide the array of CCBHC services (as defined within the RI CCBHC Certification Standards) and reimburse for those services in accordance with state defined PPS2 rates.

Program Scope

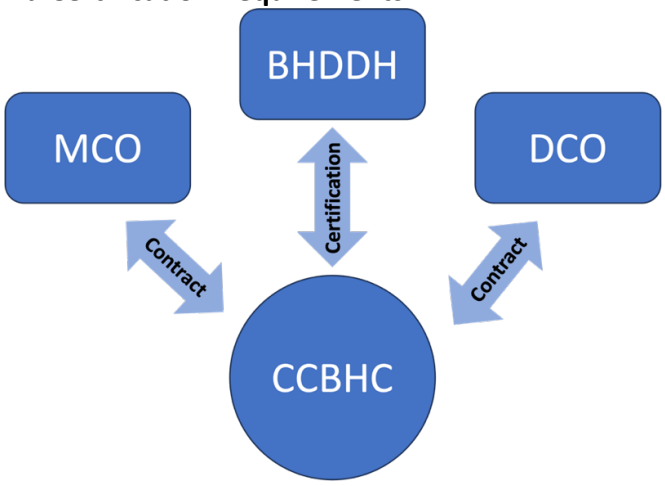
The CCBHC program will include all Full-Medicaid Individuals with CCBHC services provided in plan and Dual Eligibles (defined as Medicare and Medicaid eligible individuals) with CCBHC services provided out of plan.

Contractual Guidelines and Timelines

In addition to being certified by BHDDH, each CCBHC will be required to have contracts, at minimum, with the following entities:

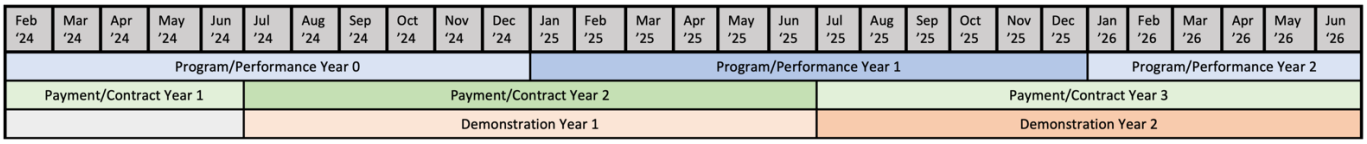
- Managed Care Organizations (MCOs), and
- Designated Collaborating Organizations (DCOs) (if applicable).

Figure 2: Contractual and Certification Requirements



MCOs must contract with all BHDDH-certified CCBHCs fully or contingently certified by BHDDH, to provide a state-specified array of expanded services to eligible Medicaid beneficiaries and reimburse for those services in accordance with state defined PPS2 rates for an attributed population, inclusive of a state defined Quality Bonus Payment Program, as specified in Section X of this document.

Figure 3: Timelines for Program/Performance Years, Payment/Contract Years, and Demonstration Years



Note – please refer to the Key Terms section of this manual for details about program/performance year, payment/contract year, and demonstration year.

There are three distinct timelines for this program:

1. **Payment/Contract Timelines:** MCO and CCBHC contracts must be executed in advance of the slated CCBHC program start date (pending CMS approval of the SPA) and will be aligned with the state fiscal year.
    a. Pending CMS approval of the SPA, the initial round of MCO contracts with eligible CCBHCs will be effective from the program start date (targeting February 1st, 2024) until June 30th, 2024 (Contract Year 1). New contracts for Contract Year 2 must be issued and effective by July 1, 2024, and end June 30, 2025.
    b. MCOs must provide evidence of such contracts to EOHHS via submission of:
        - A signed copy of the contract, indicating that an MCO/CCBHC contract has been executed, the date of execution, and the period of the contract, signed by both parties.
        - MCO contracts with CCBHCs need to specify the CCBHC specific participating DCOs and specify the service agreements with those DCOs in accordance with the requirements specified in Section VI of this document.

2. **Program/Performance Timelines:** Performance measurement and Quality Bonus Program implementation must be aligned with the calendar year. CCBHC Program/Performance Year 0 will begin with the program start date (targeting February 1, 2024) pending federal approval of the RI State Plan Amendment (SPA)) and will be calendar year based, ending December 31, 2024. While performance measurement will begin with Program/Performance Year 0, the Quality Bonus Program (QBP) will begin with Program/Performance Year 1 (1/1/25 – 12/31/25).

3. **CCBHC Demonstration Timelines:** Rhode Island is also seeking to participate in the Federal CCBHC Demonstration (if selected by SAMHSA), which is targeted to begin July 1, 2024 (pending approval) and run through June 30, 2025, coinciding with SFY 2025, and will align with the state fiscal year upon approval.

Additional Agreements

All CCBHCs are required to have care coordination agreements that meet the definitional requirements as specified in Table 2 below and are required to demonstrate to the MCO that they have these agreements in place. When those entities include inpatient psychiatric facilities, ambulatory and medical detoxification facilities, post-detoxification step-down services, residential programs, inpatient acute-care hospitals, emergency departments, hospital outpatient clinics, urgent care centers, or residential crisis settings, the agreement must provide for:

- Transfer of medical records of services received from those providers, including prescriptions.
- Tracking of admission and discharge.
- Active follow-up after discharge.
- Coordination of specific services if the consumer presented as a potential suicide risk.
- To the extent necessary, agreements should also include any other expectations necessary to carry out the other requirements related to care transitions.

Additionally, if the MCO has a separate contractual agreement with any of the entities listed below, these MCO/provider agreements must acknowledge the CCBHC partnership and function.

Table 2: Required Care Coordination Agreements

SAMHSA-Required CCBHC Care Coordination Agreements
Federally Qualified Health Center (FQHCs) or Rural Health Clinics (RHCs) serving CCBHC consumers
Other primary care providers
Inpatient psychiatric treatment programs
Ambulatory and medical detoxification
Post-detoxification step-down services
Key community and regional services, supports and providers
Veteran's Administration and other veteran serving organizations
Inpatient acute-care hospitals, including emergency departments
Hospital outpatient clinics
Urgent care centers
Residential crisis settings
State-Required CCBHC Care Coordination Agreements
9-8-8 provider

Family Care Community Partnerships (FCCPs)
Accountable Entities (AEs)

V. Core CCBHC Service Descriptions and Requirements

Contract Requirements

CCBHCs are required to provide mental health and substance use treatment services, listed as the Core Services in Table 3, to all Rhode Islanders seeking behavioral healthcare regardless of their diagnosis, symptom severity, age, race, ethnicity, disability, sexual orientation, gender expression, developmental ability, justice system involvement, housing status, or ability to pay.

Services must be provided in a manner that is appropriate for individuals across the lifespan. Additionally, the CCBHC must be able to provide services for people with illnesses of every severity including:

1. People with serious mental illness (SMI)
2. People with substance use disorder (SUD), including opioid use disorder (OUD)
3. Children and youth with serious emotional disturbances (SED)
4. Individuals with co-occurring disorders (COD)
5. People experiencing a mental health or substance use-related crisis
6. Members of the armed forces and veterans
7. General outpatient populations

CCBHCs should also be able to demonstrate the capacity to promote equity by identifying and addressing barriers to effective behavioral healthcare services that may be associated with access issues and health disparities identified by the state among the following state-defined *priority consumer populations*:

1. Black, Indigenous, and People of Color (BIPOC)
2. People with co-occurring Behavioral Health needs and Intellectual/Development disabilities (I/DD)
3. Older adults
4. Transition-age youth
5. People who identify as LGBTQ+
6. People who are justice-involved
7. People without stable housing
8. People from under-resourced communities

CCBHC Core Services are defined in Table 3:

Table 3: Core Services

1	Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
2	Screening, assessment, and diagnosis, including risk assessment.
3	Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
4	Outpatient mental health and substance use services.
5	Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
6	Targeted case management.
7	Psychiatric rehabilitation services.
8	Peer support and counselor services and family supports.
9	Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.
10	Screening for Hepatitis A, B and C and HIV for populations at risk as defined by the US Preventive Services Task Force.
11	Assertive Community Treatment (ACT).

A CCBHC may choose to use a Designated Collaborative Organization (DCO) to provide some of the core services; however, the CCBHC is ultimately responsible for the delivery of all core services to all populations. Therefore, the CCBHC will provide the needed services directly to the client on an ongoing basis, or until that service can be initiated by the DCO. While waiting for DCO service initiation, the client must be engaged in clinically appropriate, stabilizing care with the CCBHC.

All CCBHCs will be required, via certification, to have "collaborative arrangements" for 988 services. Currently 988 provides 24/7/365-day coverage of the suicide lifeline and behavioral health crisis and information response line, which all fall under 988. RI 988 has the highest local response rates across the country. It also provides limited local text and chat responses; coverage is expected to improve with the implementation of the federal 988 formula grant coming in the Fall of 2023.

Pending approval, from February 1, 2024 - June 30, 2024, CCBHCs are required to directly provide Core Services 1 through 4, with the exception that mobile crisis services may be provided by a DCO.

- Per the updated SAMHSA CCBHC Certification Criteria, from July 1, 2024 onwards, the category-specific service directives required in Year 1 are discontinued.
- The directive for year 2 allows for the DCO to provide any of the services so long as the CCBHC provides ***at least 51% of all encounters for adults, and 51% of encounters for children*** during the fiscal year, excluding crisis service delivery, directly. This is aggregate across all encounters and not client specific.

VI. Participating Entities: Certified CCBHCs

Background: CCBHC Certification Process

The established certification standards, criteria, and application evaluation process reflect the State's mission and priority to ensure access to high quality services to all Rhode Islanders. The main components of the Rhode Island CCBHC certification process are:

- All CCBHC applicants are evaluated based on their demonstrated ability to meet the established certification requirements. This determination is informed by both the contents of each provider's written application for certification and an onsite assessment by the CCBHC Certification Team.
- Applicants will receive one of four designations based on their demonstrated level of readiness to meet all core and minimum CCBHC certification requirements, by the anticipated go-live date of February 1, 2024, for Year 1 of the CCBHC program in Rhode Island:
    1a) **Not Certified – Application Closed**;
    1b**) Not Certified – Application Remains Open**;
    2) **Contingently Certified**; OR
    3) **Fully Certified**.
- Applicants who are designated 'contingently certified' or 'fully certified' are eligible to execute an MCO contract and to receive the CCBHC PPS rate for as long as they maintain either of these statuses.
- Please see below for additional details on all the certification designations.

More information regarding the certification process can be found at:
https://eohhs.ri.gov/initiatives/behavioral-health-system-review

CCBHC Certification Designation Details

1a) Not Certified – Application Closed

Based on information provided through the certification application process, the State has determined the CCBHC applicant to be "Not Certified" because: i) their application received **a score of under 60%,** AND/OR ii) they are **unable** to meet the Minimum CCBHC Certification Requirements to begin services. (See **Appendix H**)

- Providers in this category are NOT eligible to execute an MCO contract and receive the PPS rate.

- All providers in this category are invited to reapply for CCBHC certification. To do so, they will need to submit a new application. Applications will be accepted on a rolling basis; the process for this will be further defined soon.

1b) Not Certified – Application Remains Open
Based on information provided through the certification application process, the State has determined the CCBHC applicant to be "Not Certified" because: i) their application received **a score of 60-84%,** AND/OR ii) they are **unable** to meet the Minimum CCBHC Certification Requirements (See **Appendix H**) to begin services.

- Providers in this category are NOT eligible to execute an MCO contract and receive the PPS rate.
- All providers in this category are invited to submit additional application materials towards CCBHC certification. Their application will stay open and valid for another 12 months.
- Providers are encouraged to work to address key deficits identified in initial application review and can request a reevaluation at prescribed intervals to demonstrate progress towards satisfying key deficits identified in the initial application review.

2) Contingently Certified
Based on information provided through the certification application process, the State has determined the CCBHC applicant to be "Contingently Certified" because: i) their application received **a score of 85-94%,** AND ii) they are **able** to meet the Minimum CCBHC Certification Requirements (See **Appendix H**) to begin services.

- All providers in this category are eligible to execute an MCO contract and receive the PPS rate.
- The State will prioritize work with Contingently Certified providers to:
    - Finalize their cost report and staffing plan.
    - Support the establishment of necessary DCO partnerships and required care coordination agreements.
    - Support execution of an MCO contract.
- Once Contingently Certified, providers must work to meet additional requirements for Full Certification.

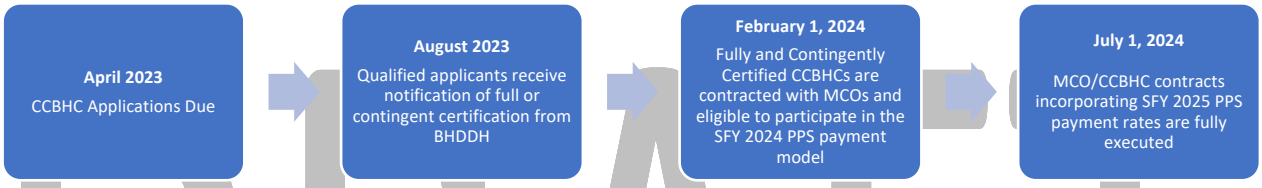
3) Fully Certified
Based on information provided through the certification application process, the State has determined the CCBHC applicant to be "Certified" because: i) their application received **a score of 95 - 100%,** AND ii) they are **able** to meet the Minimum CCBHC Certification Requirements (See **Appendix H**) **AND** the remaining certification requirements that are laid out in the RI CCBHC Certification Standards to ensure full compliance with the CCBHC model.

- Providers in this category are eligible to execute an MCO contract and receive the PPS rate.
- Certification status is active for two years, contingent on continued demonstration of ability to meet the State's certification requirements and quality standards.

CCBHC Certification Timeline

The launch of CCBHCs in Rhode Island will consist of two components: (1) Initial Contracting (Figure 4), and (2) Ongoing Certification Verification and Contracting

Figure 4: Initial Contracting Timeline
Initial Contracting



- A list of 'Contingently' and 'Fully Certified' CCBHCs is posted to the EOHHS CCBHC webpage. This information is also shared with the MCOs to enable initiation of the MCO/CCBHC contracting process.
- MCO/CCBHC Contracts will be renewed on an annual basis according to the State Fiscal Year (SFY).

BHDDH will continue to work with providers towards contingent or full certification on a rolling basis. As such, BHDDH expects that there will be some CCBHCs who may not qualify for the initial go live but become certified over the course of the first or second contract year. CCBHCs who are certified or contingently certified through this rolling approval process and have a completed/State approved cost report to support their PPS2 rate will be eligible to immediately start the MCO contract process. This contracting process must be completed within 90 days of BHDDH certification.

Ongoing CCBHC Certification Verification and Contracting

After the initial phase of contracting, MCOs can verify an agency's ongoing certification status by requesting a copy of an updated certification letter from the provider. Agency certification status will be provided annually on/before October 1 of each year and should be verified at the time of contracting with the MCO as well as on an annual basis to ensure that the agency has maintained its BHDDH-granted CCBHC certification.

Participating Designated Collaborating Organizations (DCOs)

The CCBHC criteria require that CCBHCs provide a range of services, either directly or by establishing a formal relationship with other providers. These other providers are known as designated collaborating organizations (DCOs). DCOs must be licensed or certified to provide the associated Medicaid reimbursable service (except for outreach and engagement).

In support of these DCO arrangements, CCBHCs must provide confirmation to the MCO that there is a legally binding contractual agreement, that has been reviewed by BHDDH and meets the requirements listed in addendum 3 of the CCBHC State of RI Certification Guide, between each participating CCBHC and each of its DCOs. This agreement must outline the DCOs requirements to:

- Comply with payment rules.
- Comply with shadow claim submission requirements.
- Adhere to payment arrangements between the CCBHC and DCO for services rendered by the DCO on behalf of the CCBHC.
- Collect and maintain all documentation necessary for CCBHC data collection and reporting as required by the MCO, RI Medicaid, BHDDH, and CMS/SAMHSA.

If a CCBHC and DCO relationship is materially altered throughout the course of a CCBHC program year (i.e., an arrangement is terminated) the State must be notified as this has oversight and compliance implications. The State is developing safeguards to mitigate against the risk of double-billing if a CCBHC and DCO relationship is terminated mid-year.

New DCO relationships can only go into effect with the start of each new program year. This will be in alignment with each annual CCBHC and MCO contracting cycle.

VII. CCBHC Attribution

Overview

CCBHC encounter based attribution methodology drives reimbursement and is critical to the functioning of the CCBHC program.

The CCBHC program attribution process will be managed by BHDDH's Data Unit via the Gainwell eligibility system portal. This eligibility portal will be the repository for collecting and monitoring CCBHC attribution and will provide the single source of truth for purposes of determining program attribution.

A member is attributed in the CCBHC program by the BHDDH Data Unit via the Gainwell eligibility system portal. The attribution will identify the specific CCBHC and the population rate category for each member. Member attribution is used as the basis for program quality measurement and data collection.

Initial Program Attribution File

BHDDH's Data Unit will develop an initial CCBHC program attribution file. This initial attribution file will be developed and confirmed as follows:

- The initial attribution file will specify to which population rate category an individual has been enrolled (i.e., High Acuity Adult, High Acuity Children/Youth, High Acuity Substance Use Disorder, General Population) in accordance with the specifications in **Appendix B**. The attribution file will also specify the CCBHC to which the client is enrolled.
- BHDDH will electronically distribute a DRAFT initial attribution file to all participating CCBHCs on December 14, 2023 or 2 months ahead of go live.
- CCBHCs will have the opportunity to propose changes to this DRAFT attribution file. Requested changes may include errors/duplications between participating CCBHCs, incorporation of members served by DCO partners, and any other discrepancies.
- CCBHCs will submit their requested changes to BHDDH's Data Unit by December 22, 2023.
- All attribution change requests will be reviewed, and final determinations (approval or denial) will be made prior to sharing the final initial attribution file with both CCBHCs and MCOs at least two weeks ahead of go live.
- At this time, Gainwell will auto enroll recipients in the correct program and CCBHC provider in Medicaid Management Information System (MMIS).
    - Providers will be responsible for tracking enrollments and discharges between the date of the initial attribution file and the go live date. Once the Provider Portal updates have gone into production, providers will be responsible for entering these updates into the provider portal.

Ongoing Attribution

- **New Enrollments:**
    - The provider must submit a BHDDH CCBHC admission request via the healthcare portal. The client's eligibility category (i.e., High Acuity Adult, High Acuity Children/Youth, High Acuity Substance Use Disorder, General Population) and supporting diagnosis/assessment scores must be entered in the portal. Ideally, new enrollment requests should be submitted two business days prior to the end of the month to be effective for the following month. However, a member can be enrolled any time prior to payment submission. For example, if a member is enrolled on 3/22/24 with a backdated admission date of 3/1/24, the member will be eligible for

full PPS payment for March (assuming they are not attributed to another CCBHC and that there is a qualifying encounter) when the billing occurs in April. BHDDH will identify a process for instances when a client consents to treatment from a CCBHC but is unable or unwilling to sign an enrollment form. Providers should enter the actual date of admission in the portal and utilize the start date on the claim should also be the actual date.

- Staff at BHDDH will review and either approve or deny requests within two business days.
- When enrolling a new client, the CCBHC must include an admission date that coincides with the first of the appropriate month and will be effective immediately.
- Any CCBHC service provided to a non-attributed CCBHC member should prompt the CCBHC to initiate/complete the CCBHC new enrollment or transfer process to ensure appropriate payment for all CCBHC services. For example, if a new client receives a mobile crisis service from a CCBHC, that service should be a triggering event for the client to be enrolled and therefore attributed to the CCBHC.
- For individuals already enrolled/attributed to another CCBHC, the cost of the provision of all allowable, anticipated services (and other crisis services) are included in the cost report and therefore in the calculation of rates for CCBHC. Crisis services provided to an already enrolled/attributed individual cannot be billed separately from the CCBHC rate.

- **Client Discharges:**
  - The provider must enter the discharge date for any clients who leave the agency's CCBHC. An individual may be discharged from the CCBHC program when treatment is complete, consistent with BHDDH guidance.

- **Attribution Transfers and Care Transitions:**
  - Honoring client choice in care is a non-negotiable Medicaid requirement. Members may choose to change CCBHC service providers at any time. Support for this change request must occur expeditiously to reduce disruption to care, which may exacerbate symptoms and increase risk to the member.
  - A client may only be enrolled with **one CCBHC per month**. CCBHC attribution dates in the web portal cannot overlap. If a client is already attributed to a CCBHC, it is up to the receiving Provider to coordinate transfer with the client's current CCBHC.
    - The CCBHC from which an attributed client is transferring should add a discharge date in the healthcare portal for the end of the current month. That CCBHC will be eligible to receive the PPS payment through the end of that month, consistent with any qualifying service provision (**see Appendix D**).

- The CCBHC admitting a client into their CCBHC should put an admission date in the healthcare portal for the 1st of the following month. The admitting CCBHC will be eligible to begin receiving CCBHC payments the following month, consistent with any qualifying service provision (see **Appendix D**).

- The CCBHC to whom the client is attributed on the 1st day of the month will be the provider that is eligible to receive PPS payment. There will not be partial month payments.
- CCBHCs and DCOs should develop data sharing arrangements, including EHR access, to facilitate care coordination and required reporting activities in the instances of a client transferring from one provider to another. If the current records transfer process is sufficient, that can be employed in this model. For further details regarding data sharing requirements please refer to SAMSHA's CCBHC criteria for care coordination.
- BHDDH expects that providers will work together to place clients in the most appropriate CCBHC, with client choice being the deciding.

Prospective Member Attribution

An unenrolled member is a Medicaid recipient who previously was not assigned to a CCBHC through BHDDH's initial attribution process or by a provider requesting a new attribution. Unattributed Medicaid members who meet defined criteria may be assigned and attributed to a CCBHC by BHDDH based on geographic proximity to the member's residence.

- A provider referral and/or the following events may trigger BHDDH prospective attribution to a CCBHC:
  - Discharge from Eleanor Slater Hospital
  - Utilization of mobile crisis team service
  - Mental Health Court civil outpatient commitment
  - Discharge from an inpatient stay or an emergency department visit for mental health or substance use disorders
  - Utilization of BH Link
  - Release from incarceration

BHDDH is identifying a process to inform CCBHCs when a member is prospectively attributed based on a triggering event to facilitate coordination, follow-up, and discharge planning (as applicable). When a CCBHC is informed of a prospective attribution, they should follow the admission process outlined above when the necessary information is received from the client directly or from the discharging facility.

Population Changes

We recognize a client's condition may change over time, necessitating their attribution to a different population category based on assessment results (e.g., Daily Living Assessment or DLA; Child and Adolescent Needs and Strengths Assessment or CANS) and clinical judgment.

- BHDDH will monitor these assessment results and other clinical factors.
- Similar to IHH/ACT, BHDDH may make population adjustments based on their consideration of these factors (e.g., a consistent change in DLA scores; CANS).
- Additionally, individuals in the high acuity group must be re-evaluated by their CCBHC every 90 days to determine if they continue to need this level of service intensity. CCBHCs should be prepared to provide proof that they have conducted a re-evaluation of their client's population category every 90 days to BHDDH.

To request a population change, providers must initiate a new admission or discharge. An admission or discharge request should be submitted with accompanying diagnosis and DLA scores when appropriate. BHDDH will review and approve these requests using the same process as other CCBHC discharges and admissions. For payment purposes, the discharge date should be set as the end of the affected month and the admission date should be the first of the following month.

Population Exception Process

There may be times when, despite assessment results and other documentation, clinical judgment supports an individual being attributed to a different population category. BHDDH will identify a process for CCBHCs to submit exception requests for clients who they feel should be "recategorized" for payment purposes based on the clinician's professional judgment.

Program Attribution File and Reconciliation

- The BHDDH Data unit will update the attribution file on a monthly basis before the 10th of each month based on the prior months attribution. The updates will show adjustments for new client enrollments, discharges, transfers, prospective member assignments, and population changes as described above. BHDDH will send the attributions as they appear in MMIS so providers can verify against their own Electronic Health Records (EHRs).
- Gainwell will maintain ongoing, up-to-date attribution, which can be checked at any point for the most recent attribution information for members.
- Gainwell will submit an MCO Extract file (see sample file in Appendix A) to the MCOs on a weekly basis which will include the CCBHC attribution details. The CCBHC attribution will be included in the file.

BHDDH will facilitate an attribution reconciliation process with each participating CCBHC on a monthly basis. In the event there are discrepancies that cannot be immediately resolved, the affected client will remain assigned to the CCBHC and population category they were attributed to on the earlier date, pending resolution.

Dual Eligible (MMP) Attribution

For dual eligible individuals enrolled in the Medicare-Medicaid Plan (MMP), the MMP participating health plan must review the monthly BHDDH/Gainwell attribution report and identify any MCO enrolled dual eligible individuals attributed to CCBHCs (and therefore eligible to be paid a PPS2 rate directly by the state). For those participating CCBHCs serving dual eligible members who are also CMHOs participating in the IHH and/or ACT programs, CCBHC attributed members should not also be attributed to any IHH or ACT programs.

Grievance/Errors in CCBHC Attribution Report

Any grievance or errors identified in the CCBHC enrollment file should be sent to the Data Unit at BHDDH. Grievances and errors will be reviewed, and a final determination will be shared within two business days.

VIII. Billing and Payment Requirements

Introduction to PPS2 Methodology for CCBHC Billing and Payment

CCBHCs in the Medicaid demonstration are paid using a Prospective Payment System, or PPS. PPS supports clinics' costs of expanding services and increasing the number of clients they serve, while improving their flexibility to deliver client-centered care.

- CCBHCs receive a single payment each month a client receives qualifying services, set at a level calculated to cover the clinic's anticipated costs of delivering care throughout the year.
- Each CCBHC has unique payment rates based on its own care delivery and population served.

At this time, Rhode Island has elected to implement PPS2, which is a monthly PPS.

- In the monthly PPS, a clinic's rate is set by dividing its allowable costs by the number of monthly encounters in a year. Monthly encounters are calculated as the number of months in which a patient has at least one encounter, regardless of the number of days or quantity of services received in any given month.
- Monthly PPS is similar to per-member-per-month capitated payment, except that clinics do not receive payment in a month in which a patient did not access qualifying services.
- Under the monthly PPS option, states define "special populations" of patients based on level of complexity or need and set different rates for the general population and each special population.

- States must implement quality bonus payments in accordance with SAMHSA defined parameters, based on state-defined metrics, and include a process for addressing outlier costs.[9]

CCBHC Population Rate Categories

The Rhode Island PPS2 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 (Adults and Children/Youth)

Eligibility criteria for each population are specified in **Appendix B**.

Qualifying and Non-Qualifying Services

There are two primary categories of CCBHC Services:

- **Qualifying Services** – services that must be provided by the CCBHC directly, or in partnership with their DCO(s). This category includes nine core services required by the Protecting Access to Medicare Act (PAMA), and two additional RI specific required services, as specified in **Appendix H**. These services may qualify as a billable event in accordance with the Attribution Guidance in **Appendix D**.
- **Non-Qualifying Services** – services that do not qualify as a billable event but are factored into the CCBHC's cost. The expense of non-qualifying service encounters is an allowable cost in the cost report. However, these services, when delivered alone, do not qualify as a visit for the purpose of monthly billing. This means the delivery of these services by themselves will not trigger a payment of the PPS rate. The following are non-qualifying services:
    - 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)
    - A care coordination encounter
    - An outreach encounter
    - Primary care screening encounter

A list of billing codes for qualifying and non-qualifying CCBHC services applicable to all MCOs in Rhode Island is provided in **Appendix E**.

FQHC Services

If an FQHC is also a CCBHC, and a Primary Care service is performed during the visit, the agency should bill toward the FQHC PPS. If the services provided are not Primary Care and are

[9] https://www.thenationalcouncil.org/wp-content/uploads/2022/06/CCBHCs_A_New_Type_of_PPS_3-2-20.pdf

allowable CCBHC services, the services should be billed toward the CCBHC PPS. Whether the non-Primary Care CCBHC service is a Qualifying Event is determined by the Qualifying Event list provided by the state.

Dual Eligible and Third-Party Liability (TPL) Billing

For all Medicare or commercial covered services, the CCBHC must bill CMS, Part C plan or commercial plan for reimbursement. Per federal regulations Medicaid is the payer of last resort so this is an essential task for the CCBHC.

- As certain services included in the PPS2 are covered by Medicare, EOHHS expects that there will be a meaningful volume of Medicare duals/TPL reimbursement (40% of high acuity member visits). EOHHS sought a solution to ensure adequate provider cash flow is serving dual Medicare/Medicaid CCBHC enrollees, and this will be handled through FFS.
- EOHHS estimates that there will be a much smaller amount of commercial TPL (~<2% of visits). This TPL process will be handled by the health plans.

There are three potential scenarios that will arise for situations where a member has dual or TPL coverage. Those scenarios are:

1. Members who have dual Medicare and Medicaid coverage through the MMP program
2. Members who have Medicaid and Commercial TPL coverage including Medicare Part C
3. Members who have Medicaid through managed care and Commercial TPL.

Details for the processes to follow for each of these scenarios can be found in Appendix J.

Note: EOHHS will update MCO's FDCR reporting to include CCBHC TPL collections.

Billable Events and Payment

Member Attribution and CCBHC Service Utilization are the basis for CCBHC billing and payment. A CCBHC receives a PPS2 monthly payment if:

- A client is attributed to the CCBHC; and
- Had at least one qualifying service, or "billable event" included in their claim detail (shadow claim) in that month from the CCBHC they are enrolled at or its Designated Collaborative Organization (DCO).
    - A visit is defined as a "billable event," when a client receives at least one face-to-face encounter or telehealth visit with a CCBHC qualifying staff person at a qualifying setting during which qualifying CCBHC services are provided and documented, consistent with the Attribution Guidance in **Appendix D**.

Billing Restrictions

Based on the current guidance provided by SAMHSA and CMS to Rhode Island as part of the approval process for Rhode Island's CCBHC State Plan Amendment (SPA), CCBHC services cannot be billed for services provided in residential settings. The disallowed settings include:

- Correctional facilities
- Nursing homes
- Inpatient hospitals
- Institutes of Mental Disease (IMD)
- Non-community based residential facilities

Per Medicaid requirements, services (regardless of whether they are CCBHC or non CCBHC services) cannot be billed/reimbursed if they are provided in a disallowed setting. Therefore, CCBHC services cannot be reimbursed if they are provided in an institutional setting in which behavioral health care is already part of a bundled payment.

CCBHC Specific National Provider Identifier (NPI)

- Participating CCBHC providers will be responsible for obtaining a unique, CCBHC specific NPI upon certification, using the taxonomy provided in **Appendix I.** Providers should enroll as a Medicaid provider using that NPI. The NPI will represent the billing provider.
- Providers should bill all CCBHC qualified services provided to CCBHC attributed members using this NPI.
- Non-CCBHC services including: MHPRR, SUD Residential, Acute/Crisis Stabilization Units, BH Link, etc. should be billed under the existing, non CCBHC NPI.

Provisions for Payment – PPS Codes and Modifiers

EOHHS has established T1041 as the PPS2 rate code to be utilized for all PPS billing. Participating CCBHC providers are required to submit a claim for T1041 with a modifier to determine the appropriate population consistent with the population definitions specified in **Appendix B** (in the MOD1 position) to trigger a PPS payment. A list of the required T1041 modifiers (MOD1) is provided in **Appendix E**.

- EOHHS requires this specific billing code and population modifier to be used across all MCOs and FFS Medicaid.
- EOHHS has added a modifier to distinguish services provided by a DCO.
- Providers should continue to include a modifier that describes their licensure type. The licensure types will be the same as in the current FFS system.
- Final approved EOHHS PPS2 rates for T1041 and each of the modifiers will be posted here. EOHHS will update and rebase these PPS rates in accordance with CMS rules. These rates must apply across all participating RI Medicaid managed care providers and Medicaid FFS.

Provisions for Payment – Qualifying Service Codes

- A list of standardized qualifying service codes has been finalized and posted on the CCBHC page of the EOHHS website.
- BHDDH and Medicaid will establish a Clinical Review Committee, inclusive of plan and provider representatives, to support ongoing additions and modifications to the list of qualifying service codes for the CCBHC program across both managed care and FFS program delivery, as new procedure codes are created, and service delivery models evolve over time.

MCO Responsibility for Payment

- MCOs must ensure that the professional claim that triggers payment of the PPS rate, includes the T1041 code + population modifier + at least one qualifying code. Shadow claims can include qualifying and non-qualifying, CCBHC appropriate services, codes.
- MCOs are required to check that the member is attributed to the CCBHC at the time of the service.
- MCOs are required to confirm that the member population category matches their enrollment at the time of the DOS, based on the Weekly MCO Extract File.
- The MCO is responsible for paying the established provider and population specific PPS rate per T1041 claim. This payment is directly paid by the MCO to the CCBHC.
    - No fee is paid on shadow claims.

Duplication: Non-CCBHC Service Reporting

- There will not be partial month payments. The CCBHC to whom the client is attributed on the 1st day of the month will be the provider eligible for the PPS2 payment, except for extenuating circumstances due to retrospective portal updates.
    - CCBHC qualifying services provided **by a participating CCBHC to a member who is not attributed to that CCBHC** for the month of service should be billed using the qualifying service billing codes specified in **Appendix E**.
        - If the member is not attributed to any CCBHC and the physical location of the providing CCBHC is not an allowable location (see Billing Restrictions section), these services will be paid at the provider's standard billing (e.g., fee-for-service) rate.
        - If the member is not attributed to any CCBHC and the physical location of the providing CCBHC is an allowable location, then the CCBHC should enroll the member and bill using the PPS2 rate.
        - If the member is attributed to another CCBHC, these claims will be denied and these services will not be paid the PPS or standard billing rate. It is important to note that the cost of these services is accounted for in the cost report for purposes of developing the CCBHC specific PPS payment rates, and therefore should not result in undue financial burden on any provider.

- CCBHC qualifying services provided by other providers (i.e., non-CCBHCs) for an attributed member should be billed and paid at the provider's standard billing rate.
- MCOs must submit a Non-CCBHC Service Report (**Appendix C**) on a quarterly basis, documenting frequency and billed amounts for these two types of events, to support EOHHS/RI Medicaid and BHDDH in monitoring service duplication.

Detailed Claims and Shadow Billing

In addition to billing the PPS rate code and modifier, SAMHSA requires CCBHCs to submit claims for the individual qualifying and nonqualifying CCBHC services (defined in **Appendix E**) that were provided during a CCBHC Visit.

- **Purpose**
  - EOHHS uses the detailed claims to monitor the cost and utilization of services provided by CCBHCs. Underlying encounters will also be used to validate services provided to CCBHC attributed populations and their assignment to the appropriate population category.
  - These detailed claims or encounter data – sometimes referred to as "shadow data" or "shadow services" – are needed to track important performance measures that can only be appropriately measured based on details submitted for purposes of calculating the Quality Bonus Payment program. For example, follow-up after an emergency department (ED) visit can only be appropriately measured if all shadow claims are reported; otherwise, it may appear as if the follow-up never occurred, even if it did.
  - Detailed claims or encounter data are also critical to successful PPS rate setting and rebasing. CCBHCs that under-report these shadow data will risk substantive reductions in future PPS rates that may be tested and justified against these claims.
- **Shadow Billing Process**
  - All shadow claim data should be included on the submitted claim. If shadow claim data is incorrect or incomplete, the claim will need to be voided and resubmitted.
  - The PPS rate code and modifier should be bundled with the corresponding qualifying and non-qualifying services provided to the attributed member for that month, including all relevant billing codes as specified in **Appendix E.**
  - CCBHC qualifying and non-qualifying services provided to attributed members may also be reported individually, using multiple claims if needed, with individual services billed at the $0.00 or $0.01; these services will still be paid by the MCO at $0.00.
- **Payment -** These individual claims for qualifying and non-qualifying CCBHC services provided to an attributed member will be paid by the MCO at $0.00 in accordance with their general rules for shadow claiming.

- **MCO Reporting**
    - MCOs are required by Medicaid to report all paid services to RI EOHHS using encounter claims, consistent with the Medicaid Managed Care Manual.
    - CCBHC services billed through Rhode Island's CCBHC Program, but covered and paid by Rhode Island MCOs, must be sent to EOHHS.
    - MCOs are required to report encounter data consistent with requirements in the Medicaid Managed Care Manual to verify financial liability incurred for services rendered by CCBHCs.

Financial Reconciliation and Settlement

- MCOs will produce a quarterly reconciliation report that will detail the services provided and payments made to each CCBHC. The report will be shared with each CCBHC on the following schedule, incorporating a 90-day claims lag, to review and address any errors or discrepancies.
    - Q1 (Jan-Mar) – July 15th
    - Q2 (Apr-Jun) – Oct 15th
    - Q3 (Jul-Sep) – Jan 15th
    - Q4 (Oct-Dec) – Apr 15th
- Each CCBHC shall then report any errors or discrepancies within one week of receiving the MCO generated report. MCO will reconcile and settle any outstanding payments with CCBHCs based on their findings and will incorporate these refinements in future reports.
- The first quarterly report will be developed based on February and March services, to be shared with each CCBHC on/before July 15, 2024; all subsequent reports will include up to 12 months of historical monthly service utilization, incorporating any reconciliation adjustments.

Utilization Review & Management

MCOs provide access and utilization management of Medicaid-covered services, including Medicaid-covered services for individuals enrolled in CCBHC. MCOs and EOHHS use the Visit Encounter data to monitor the cost and utilization of services provided by CCBHCs.

- If a MCO delegates managed care functions to the CCBHC, the MCO remains the responsible party for adhering to its contractual obligations.
- The CCBHC must provide utilization management and oversight of all services performed by a DCO, consistent with all requirements included in updated Certification Criteria for CCBHCs published by SAMHSA in March 2023.
- An MCO shall not conduct prior authorization for CCBHC or crisis services.

Outlier Thresholds and Allocation Guidance

The PPS2 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 1, EOHHS will implement an annual basis outlier threshold.
- EOHHS will review the impact of the outlier threshold and retention percentage on the PPS2 rate development based on the CCBHC cost report submissions and may modify these values at its discretion prior to finalizing the PPS2 rate.

IX. Quality and Outcome Reporting and Measurements

Data and quality measure reporting have multiple objectives. Collection and reporting of this information offer providers, states, and other stakeholders a method for assessing the manner in which care is accessed and provided.

The data can be used for accountability to grantors or regulatory entities, for example. In general, the data collected will help states and the federal government have a better understanding of the quality of health care that consumers at CCBHCs receive. The data and measures reported may also be used to evaluate programs, such as the national evaluation of the CCBHC Demonstration Program.

Upon receipt of the final measures and QBP requirements, state, provider, and MCO responsibilities will be further refined.

Use of Quality Measures

- **State Use:** The state will use the quality measures to support oversight and monitoring of the overall program, and of each individual CCBHC. Although the federal requirement for state reporting under the program is annual, the federal guidance suggests that states collect interim measures more often, such as monthly or quarterly, and provide these measures to CCBHCs for quality plan use. The state may provide a CCBHC with their own measures, as well as a statewide average of all CCBHCs that can be used as a comparison. The state can also use the data to identify where there may be errors or omissions in reporting.
- **CCBHC Use:** The measurement information can also be used for internal quality improvement (QI) processes to determine the degree of progress achieved or to determine where new or additional improvement is needed. CCBHCs should review the data frequently and take corrective action where needed.

- **Federal Reporting:** Measurement data will be used by the state to submit required quality measures to CMS/SAMHSA annually (**Appendix F)**. The data and measures can also be used for the national evaluation of the CCBHC Demonstration Program.

Quality Measure Reporting Requirements

- CMS has defined a specific set of required CCBHC measures for reporting from CCBHC providers and Demonstration States (**Appendix F)**. Rhode Island is aligning to the current CMS measure set.[10]
- **Data sources:** Measures will be collected and calculated from several data sources, including:
    - CCBHC medical record data, as reported to BHDDH through the BHOLD system.
    - MMIS claims data.
    - CCBHC collected and reported survey data, to be collected in the REDCap system.
    - CCBHC provider collected and reported data separate from BHOLD.
- **Measure calculation and reporting:** Quality measure performance calculation will either be performed by the CCBHC or by BHDDH[11], as listed below:
    - For a subset of measures (as specified in **Appendix F**) each CCBHC must enter required data into the BHOLD system, so that BHDDH[11] can calculate these measures and provide them to each CCBHC on a quarterly and annual basis, along with a statewide average.
    - For a subset of measures (as specified in **Appendix F**) BHDDH[11] will calculate performance on a quarterly and annual basis based on claims data submissions.
    - Certain measures will be captured through surveys which will be coordinated by BHDDH[11].
    - For a subset of measures (as specified in **Appendix F**), each CCBHC must calculate its own performance and provide a separate report to BHDDH on a quarterly and annual basis.

    Note: There are currently no measures that will be provided by the MCOs[11]; however, the State reserves the right to revisit this decision as data collection efforts commence and opportunities for collaboration and data sharing are identified.
    - Notes:
        - CCBHCs are responsible for including relevant reporting data for any applicable DCO partners.

[10] CCBHCs are similarly required to submit data and report on outcomes for purposes of supporting the CCBHC program goals, consistent with guidance and rules promulgated by EOHHS, CMS, and SAMHSA

[11] Upon receipt of the final measures and QBP requirements, responsibilities of the state, the providers, and the MCOs will be further refined.

- All CCBHC performance data must be captured and reported by site (based on catchment area)**.**

- **Timing/deadlines** for submission of quarterly reports, monthly BHOLD data entry, and monthly data corrections are specified in Table 5:
  - Provider reporting will begin the first month of Program/QBP Performance Year 0 (targeting February 2024). It is the intent of the State to begin reporting as soon as possible to ensure there is time to assess and review the data submission and reporting process. This will allow for the opportunity to identify and address potential challenges prior to the Performance Year.

BHOLD Entries:

- Initial BHOLD entries are due on March 15, 2024.
- On an ongoing basis, CCBHCs who perform *manual entry* into BHOLD must complete all entries by the 15th of the month following the encounter.
- For CCBHCs who do a *bulk upload*, those uploads must be done on the 15th of the month.
- Providers can make corrections and updates to their data submission in BHOLD at any time.

Quarterly Reports:

- The State will share quarterly performance reports with CCBHCs and MCOs.

Pending CMS approval, the State expects that it will refine the approach to data collection and measurement in alignment with federally released guidance. The early CCBHC-reported data will be reviewed to identify, troubleshoot, and resolve data quality and inherent definitional challenges (e.g., using shadow claiming data to support accurate measurement of follow-up care and post-discharge services), to the extent permitted by measure stewards and federal guidelines. As these learnings are identified, the state expects to engage with stakeholders where appropriate.

Table 5: Schedule for Reporting

Monthly Provider Reporting (BHOLD)		Quarter	Reporting Month	Reporting Due Date	Reporting Correction Deadline	BHDDH Report Development
For a subset of measures each CCBHC must enter required data into the BHOLD system, so that BHDDH can calculate these measures and provide them to each CCBHC on a quarterly and annual basis, along with a statewide average.	Performance Year 0	Q1	Feb 2024	Mar 15, 2024	Mar 20, 2024	
			Mar 2024	Apr 15, 2024	Apr 20, 2024	**Jul 1, 2024**
		Q2	Apr 2024	May 15, 2024	May 20, 2024	
			May 2024	Jun 15, 2024	Jun 20, 2024	
			Jun 2024	Jul 15, 2024	Jul 20, 2024	**Oct 1, 2024**
		Q3	Jul 2024	Aug 15, 2024	Aug 20, 2024	
			Aug 2024	Sep 15, 2024	Sep 20, 2024	
			Sep 2024	Oct 15, 2024	Oct 20, 2024	**Jan 1, 2025**
		Q4	Oct 2024	Nov 15, 2024	Nov 20, 2024	
			Nov 2024	Dec 15, 2024	Dec 20, 2024	
			Dec 2024	Jan 15, 2025	Jan 20, 2025	**Apr 1, 2025**

State Quarterly Claims Data Capture		Reporting Quarter	BHDDH Report Development Deadline *(180 day claims lag + 1 month report development)*
For a subset of measures BHDDH will calculate performance on a quarterly and annual basis based on claims data submissions	PY 0	Q1 2024 (Feb, Mar)	Nov 1, 2024
		Q2 2024. (Apr-Jun)	Feb 1, 2025
		Q3 2024 (Jul-Sep)	May 1, 2025
		Q4 2024 (Oct-Dec)	Aug 1, 2025

Provider Quarterly Report		Reporting Quarter	BHDDH Report Development Deadline *(180 day claims lag + 1 month report development)*
For a subset of measures each CCBHC must calculate its own performance and provide a separate report to BHDDH on a quarterly and annual basis	PY 0	Q1 2024 (Feb, Mar)	Nov 1, 2024
		Q2 2024. (Apr-Jun)	Feb 1, 2025
		Q3 2024 (Jul-Sep)	May 1, 2025
		Q4 2024 (Oct-Dec)	Aug 1, 2025

State Quarterly Reporting Publication

	Reporting Quarter	Report Publication Date
PY 0	Q1 2024 (Feb, Mar)	Dec 1, 2024
	Q2 2024	Mar 1, 2025
	Q3 2024	Jun 1, 2025
	Q4 2024	Sep 1, 2025

(Combined provider monthly BHOLD data, state quarterly claims report, and provider quarterly reported data)

Federal Quality Measure Reporting requirements for the State

The state will be responsible for reporting required quality measures to CMS/SAMHSA on an annual basis. **Appendix F** details which measures are required to be routinely reported to the federal program. The federal program may also request special reports for the purpose of program evaluation.

Whether the measures are State- or Clinic-Collected, all must be reported to SAMHSA annually via a single submission from the state twelve (12) months after the end of the measurement year.

Access Standards Compliance

One of the key objectives of the CCBHC program is to improve access to behavioral health care services. One of these measures that SAMHSA has specifically included is a new access measure: Time to Services (-SERV) – as specified **in Appendix F.** BHDDH[11] will work with providers and payors to ensure this new measure is appropriately captured, measured, and monitored in alignment with the specifications provided by SAMHSA, and to enhance and expand the measurement of access over time.

X. Quality Bonus Payment (QBP) Program

Rhode Island has elected to use the Prospective Payment System 2 (PPS2) payment model. This model must include a Quality Bonus Payment (QBP) for CCBHCs meeting CMS-defined quality benchmarks (**Appendix G**). Any applicable benchmarks will be shared in advance of the performance period for CCBHCs, upon the release of final guidance from SAMHSA and CMS.

Performance Pool and Measurement Period

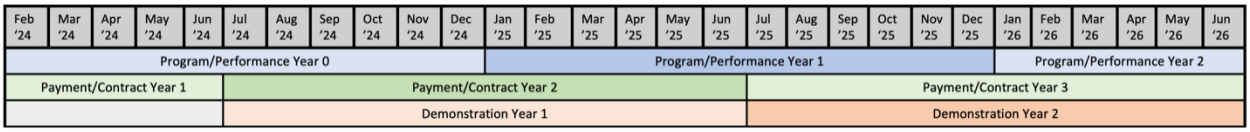
The QBP bonus pool is based on 5% of the total CCBHC Medicaid Demonstration Year Payments. CCBHCs are eligible to receive up to 5% of the clinic's annual Medicaid PPS payments for program enrollees.

- CCBHC Specific Annual Medicaid Payments are defined as the amount paid to a specific CCBHC in a given year through the PPS2 system established under the CCBHC program.
- The Medicaid Utilization and Payment report will be compiled annually by RI Medicaid Finance combining the MCO and FFS specific attribution and payment data.
- The calculation of the QBP performance pool will be based on each clinic's annual payment, as defined above, beginning with CCBHC DY 1 (currently estimated to correspond with SFY 2025, pending CMS and SAMHSA approval). Any CCBHC payments made prior to Demonstration Year 1 will not be included in the bonus pool calculation.

Quality Performance Measurement Period

Although the CCBHC Program is projected to be implemented on February 1, 2024 (pending SPA approval), CMS requires that the QBP measurement period must include a full year of performance and must be reported to SAMHSA on a calendar year basis. As such, Performance Measurement Year 1 will begin on January 1, 2025 (see Figure 5 for detailed timeline).

Figure 5: Timelines for Program/Performance Years, Payment/Contract Years, and Demonstration Years.



Note – please refer to the Key Terms section of this manual for details about program/performance year, payment/contract year, and demonstration year.

CCBHC PPS Proposed Updates

In May 2023, CMS published proposed revisions to the CCBHC Prospective Payment System, which includes updates to the required and optional measures for the Quality Bonus Program.

EOHHS will produce a final set of measures (including resources on technical specifications and definitions) upon release of final guidance from CMS. Current technical specifications and definitions on CCBHC measures can be found here. QBP performance standards and benchmarks will be finalized upon review of CMS' final guidance.

QBP Measures (Subset of Quality Measures)[12]

CMS has defined a specific set of required CCBHC measures for reporting from CCBHC providers and Demonstration States, which are currently under review. Current technical guidance and measure specifications, including reporting templates and definitions can be found on SAMHSA's website. CMS has identified a subset of the measure set for Demonstration States implementing a QBP program. EOHHS will share the final set of measures used for the QBP.

Required Quality Bonus Plan (QBP) Measures: A subset of these measures (six in total), calculated for a full year (beginning with CY25), must be used to calculate Quality Bonus Payment (QBP) eligibility (Table 6).

Table 6: Proposed Required QBP Measures

Proposed Required QBP Measures
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control for Patients with Diabetes
Depression Remission at Six Months
Time to Services
Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult)
Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (Child/Adolescent)
Initiation and Engagement of Substance Use Disorder Treatment

Optional QBP Measures: There are nine additional measures which states have the option to collect and report (Table 7). States also have the option to include one or more of these measures in the calculation of the bonus payment.

Table 7: Proposed Optional QBP Measures

Proposed Optional QBP Measures
Follow-Up After Emergency Department Visit for Substance Use
Plan All-Cause Readmissions Rate
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling

[12] The Required and Optional QBP Measures included here are proposed and will be updated once final guidance has been announced.

Screening for Depression and Follow-Up Plan
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA)
Adult Major Depressive Disorder: Suicide Risk Assessment (SRA)
Controlling High Blood Pressure
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

Calculation of Incentive Award

CMS will specify a minimum performance standard for each required and optional measure. These standards are to be used to determine if a CCBHC is eligible for a bonus payment. To receive a QBP, a CCBHC must achieve or exceed the threshold for all QBP-eligible measures as specified by CMS. Per federal guidance, all performance benchmarks must be met by a CCBHC site by demonstration year 1 for QBP to be awarded. If a CCBHC is serving as DCO to a different CCBHC in a separate catchment area, data will need to be regrouped according to the appropriate attribution for the primary CCBHC.

CCBHCs must meet the minimum denominator requirements (n=30) for the calculation of a QBP measure for it to be included in the determination. For example, a clinic meeting the minimum denominator size for five of six measures must still meet or exceed the benchmarks for the five eligible measures to qualify for payment.

Use of Performance Pool Funds

If performance benchmarks are met, EOHHS will provide the QBP payment directly to the awarded CCBHCs to be used to directly support the goals and objectives of the CCBHC program. CCBHCs should maintain a separate accounting of expenditures of these funds for state review if requested.

QBP Timelines

Table 8: Timelines for Payment

	Dates	Activity	Owner	Length of time
1	1/1/25 12/31/25	CCBHC Performance Measurement Year 1	N/A	12 months
2	1/1/26-6/30/26	Claims runout period	N/A	6 months
3	7/1/26-7/31/26	CCBHCs ensure all required performance data for PY 1 has been entered/uploaded into BHOLD	CCBHCs	1 month
4	7/1/26-7/31/26	**Bonus Pool Calculation (From QBP Calculation Timeline Below)** RI Medicaid Finance calculates total bonus pool amount for DY 1, overall and by CCBHC	RI Medicaid Finance	1 month

3	8/1/26-9/30/26	Performance Report Development – • CCBHCs develop provider calculated measures • BHDDH Data Unit develops draft state calculated measures	CCBHCs BHDDH	2 months
4	9/30/26	CCBHC Report due to the state; BHDDH shares draft state calculated measures with CCBHCs	CCBHCs BHDDH	1 day
5	10/1/26 – 10/31/26	BHDDH data unit calculates final CCBHC specific performance across QBP measures and determines QBP eligible providers (Note – since there is no partial payment it's just a yes/no) • CCBHCs confirm performance, or identifies and discusses questions with BHDDH	BHDDH CCBHCs	1 month
7	10/31/26	BHDDH Data Unit finalizes list of qualifying providers	BHDDH	1 day
8	11/1/26 – 11/30/26	RI Medicaid Finance calculates QBP payment due by CCBHC, for DY 1 (7/1/24-6/30/25)	RI Medicaid Finance	1 month
9	12/1/26-12/15/26	RI Medicaid Finance pays the QBP based on performance year 1	RI Medicaid Finance	2 weeks

Table 9: Timelines of Quality Bonus Pool Calculation

	Dates	Activity	Owner	Length of time
1	7/1/24 6/30/2025	CCBHC Demonstration Year 1 (basis for QBP bonus pool determination)	N/A	12 months
2	7/1/25-12/31/25	Claims runout period	N/A	6 months
3	1/1/26-2/28/26	CCBHC DY 1 Medicaid Utilization and Payment report (Medicaid Finance) RI Medicaid Finance calculates each CCBHC's total cost based on final attribution by PPS rate cell (combined across payors) and the applicable PPS rates	RI Medicaid Finance	2 months

4	3/1/26-3/31/26	**Bonus Pool Calculation** RI Medicaid Finance calculates total bonus pool amount, overall and by CCBHC	RI Medicaid Finance	1 month

Appendix

Appendix A: Sample MCO Extract Weekly File

MID	SSN	LNAME	FNAME	DOB	GEN	PR NAME	PR NPI	PI	PI START DATE	PI END DATE		SCORE	SCORE DATE	DX CODE	LST_CHG_DTE
Medicaid ID	Member SSN	Member last name	Member first name	Member birth date	Member gender	Provider name	Provider NPI	Program Indicator	Start date	End date	Score Type	Recipient Assessment score	Date administered	Diagnosis code	Score last change date

Appendix B: Population Definitions[13]

The PPS2 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 (Adults and Children/Youth)

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 a population assignment grid [see Cost Report Guidance] 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

[13] Cost Report Technical Guidance https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2023-01/Cost%20Report%20Technical%20Guidance_1.13.23.pdf

- Psychosis
- Bipolar
- Major Depression
- Severe Obsessive-Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)
- Borderline personality disorder, **or**
- Severe panic disorder; **and**
- A Daily Living Activities (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 criteria 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 the 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:
        i. They have utilized crisis services at least three times in a 30-day period in the past six months.
        ii. They have been homeless in the past six months.
        iii. They are at risk of homelessness (i.e., are unstably housed).
        iv. They have been charged with a crime in the past six months.
        v. They are at risk of becoming involved in the criminal justice system.
        vi. They live in a supported environment and could move to a less restrictive setting if provided with intensive services.
        vii. They are consistently unable to engage and benefit from other community-based mental health services.
        viii. They are unable to perform practical daily tasks required for adult functioning.
        ix. 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 is 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 Disorders
    - Gender Dysphoria
    - Major Depressive Disorder, recurrent
    - Obsessive-Compulsive Disorder
    - Oppositional Defiance Disorder
    - Panic Disorders
    - Personality Disorder
    - Phobic Disorders
    - Pica
    - Post-Traumatic Stress Disorder
    - Psychosis diagnosis with 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:
        i. 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**
        ii. 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 includes any individual with a primary diagnosis of a substance use disorder (SUD) 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 American Society of Addiction Medicine (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.

Details regarding eligibility for each population can be found here.

Appendix C: Non-CCBHC Reporting Template

[To be developed]

Appendix D: Attribution Guidance

A visit is defined as a **"billable event"** when a CCBHC enrolled client receives at least one **face-to-face encounter** or **telehealth** visit with a CCBHC **qualifying staff person** at a **qualifying setting** during which **qualifying CCBHC services** (as defined in **Appendix E**) are provided **and documented**.

- **A face-to-face encounter** is a visit that takes place in person (i.e., with the staff person and the client in the same room or via telephone or videoconference). A face-to-face encounter is provided in one of the following contexts:
    - With only the client and staff person present;

- With the client, the staff person, and the client's family member(s) or representative present;
- With only the client's family member or representative and the staff person present, subject to the client's consent (an encounter in this context may not serve alone as a visit for the purpose of monthly billing); or
- With two or more clients and a staff person present in a group setting.

- **Telehealth:** 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), and it is conducted directly with the client.

- **Qualifying Service Settings:**
  - Encounters that take place in the following settings qualify as "visits":
    - A CCBHC site
    - A DCO site
    - The client's home
    - A school-based clinic or other approved school setting
    - A primary care setting such as an individual practice or an FQHC
    - A homeless shelter
    - A CCBHC mobile service site (e.g., van)
    - A Senior Center
    - Another community-based site that has been approved by the BHDDH
  - Services which are provided at clinic locations outside the CCBHC's approved service area are not eligible for PPS payment. Services which are appropriately billed from locations within the CCBHC service area, such as crisis calls, home-based services, case management follow-up and school-based services, are not considered to be outside the service area.

  - CCBHCs can provide services to individuals from outside the catchment area and through care delivery modalities that do not require the establishment of a brick and mortar clinic outside their catchment area (i.e., mobile crisis services). CCBHCs cannot establish a new physical location or brick and mortar clinic for CCBHC service delivery outside their catchment area.
- **Qualifying Staff:**
  - A CCBHC qualifying staff person is an individual who fits one of the following categories:

        - A psychiatrist
        - A clinical psychologist
        - A RIDOH licensed clinical social worker (LICSW & LCSW)
        - A RIDOH licensed professional counselor (LMHC & LMHC-A)
        - A RIDOH licensed marriage and family therapist (LMFT & LMFT-A)
        - A certified peer recovery specialist
        - An advanced practice nurse
        - An employment specialist, case manager, housing specialist, or other staff person who provides direct consumer behavioral health services approved by the BHDDH
        - Other personnel authorized to provide direct services by the BHDDH or RI Medicaid
    - Staff person's relationship to CCBHC. The individual is:
        - Employed by the CCBHC or a contractor under the direct supervision of the CCBHC; or
        - Employed by a DCO or a contractor under the direct supervision of the DCO.
    - Performing a Qualified Service (as specified in **Appendix E**).

A billable qualifying visit must be documented in the health record. Only those encounters that result in an entry in the CCBHC client's health record qualify as "visits."

Appendix E: Services and Billing Codes

The full list of qualifying and non-qualifying service codes can be found here.

To trigger payment of the PPS rate, the following will be required on the professional claim:

- **The CCBHC Billing Code:** T1041
- **One modifier field** to indicate the specific population PPS rate that applies (see the table below for the population-specific modifiers)
- A **qualifying service code**
- A modifier to distinguish services provided by a DCO.
- A modifier to indicate licensure type. The licensure types will be the same as in the current FFS system.

The following modifiers will be used to indicate the four PPS population rate categories.

CCBHC Population-Specific Modifiers		
Population	**Billing Code**	**Modifier (MOD1)**
High Acuity Adult	T1041	**U3**
High Acuity Children and Youth	T1041	**U4**
High Acuity Substance Use Disorder	T1041	**U5**
General Population (Adults and Children/Youth)	T1041	**U6**

Appendix F: CCBHC Demonstration Required Provider and State Reported Measures[14] [15]

CCBHC Reported – 9 Required Measures

Measure Name (* = required measure)	Steward	CMS Medicaid Core Set (2023)	Notes
Time to Services (I-SERV)*	SAMHSA	n/a	Will include sub-measures of average time to: Initial Evaluation, Initial Clinical Services, Crisis Services
Depression Remission at Six Months (DEP-REM-6)*	MN Community Measurement	n/a	Changed from the Twelve Month version of the measure
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)*	NCQA	n/a	n/a
Screening for Clinical Depression and Follow-Up Plan (CDF-CH and CDF-AD)*	CMS	Adult and Child	Child was added to the Medicaid Child Core Measure Set
Screening for Social Drivers of Health (SDOH)1*	Physicians Foundation	n/a	n/a
Physicians Foundation	NCQA	n/a	n/a
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-A)	Mathematica	n/a	n/a

[14] https://www.samhsa.gov/sites/default/files/revised-ccbhc-criteria-dec-2022.pdf

[15] Upon receipt of the final measures and QBP requirements, responsibilities of the state, the providers, and the MCOs will be further refined.

Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-C)	Mathematica	n/a	n/a
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	NCQA	Child	Measure modified to coincide with change in Medicaid Child Core Measure Set
Controlling High Blood Pressure (CBP-AD)	NCQA	Adult	n/a

State Reported – 12 Required Measures

Measure Name (* = required measure)	Steward	CMS Medicaid Core Set (2023)	Notes
Patient Experience of Care Survey*	SAMHSA	n/a	n/a
Youth/Family Experience of Care Survey *	SAMHSA	n/a	n/a
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)*	CMS	Adult	n/a
Follow-Up After Hospitalization for Mental Illness, ages 18+ (Adult) (FUH-AD)*	NCQA	Adult	n/a
Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (Child/Adolescent) (FUH-CH)*	NCQA	Child	n/a
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD)*	NCQA	Adult	n/a
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH and FUM-AD)*	NCQA	Adult & Child	Child was added to the Medicaid Child Core Measure Set

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA-CH and FUA-AD)*	NCQA	Adult & Child	Child was added to the Medicaid Child Core Measure Set
Plan All-Cause Readmissions Rate (PCR-AD)*	NCQA	Adult	n/a
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)*	NCQA	Child	n/a
Antidepressant Medication Management (AMM-BH)*	NCQA	Adult	n/a
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)*	NCQA	Adult	n/a
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)*	NCQA	Adult	n/a
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	NCQA	Child	n/a
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	NCQA	Child	n/a

Appendix G: QBP Proposed Required and Optional Measures[16] [17]

Required Quality Bonus Payment Measures – Proposed as of May 2023

Measure Name	Reported by	Responsible for Calculation	Steward	Notes
Comprehensive Diabetes Care: Hemoglobin A1c	State	State	NCQA	Provider collected via BHOLD

[16] The Required and Optional QBP Measures included here are proposed and will be updated once final guidance has been announced.

[17] Upon receipt of the final measures and QBP requirements, responsibilities of the state, the providers, and the MCOs will be further refined.

(HbA1c) Control for Patients with Diabetes (HBD-AD)				
Depression Remission at Six Months (DEP-REM-6)	Provider (BHOLD?)	State	MN Community Measurement	Not currently collected so may need a field added or possibly separately reported – look at specs and MN
Time to Services (-SERV)	Provider (BHOLD?)	Provider	SAMHSA	Providers – perform calculation and send to state
Follow-Up After Hospitalization for Mental Illness, ages 18+ (adult) (FUH-AD)	State	State	NCQA	Claims based
Follow-Up After Hospitalization for Mental Illness, ages 6 to 17 (Child/Adolescent) (FUH-CH)	State	State	NCQA	Claims based
Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)	State	State	NCQA	Claims based

Additional Optional Quality Bonus Payment Measures – Proposed May 2023

Measure Name	Reported By	Responsible for Calculation	Steward	Notes
Follow-Up After Emergency Department Visit for Substance Use (FUA-CH and FUA-AD)	State	State	NCQA	Claims based
Plan All-Cause Readmissions Rate (PCR-AD)	State	State	NCQA	Claims based
Follow-Up Care for Children Prescribed Attention-Deficit/ Hyperactivity Disorder (ADHD) Medication (ADD-CH)	State	State	NCQA	Claims based (part of child core set)
Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)	Provider	State	NCQA	Not clear where currently collected. Part of SBERG but unclear who is collecting. Providers- are you billing for this today?
Screening for Depression and Follow-Up Plan (CDF- CH and CDF-AD)	Provider	State	CMS	Need to review specs to understand who/how reported

Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA) (SRA-C)	Provider	State	Mathematica	Need to review specs. If needed, would need a contract with Mathematica
Adult Major Depressive Disorder: Suicide Risk Assessment (SRA) (SRA-A)	Provider	State	Mathematica	Need to review specs. If needed, would need a contract with Mathematica
Controlling High Blood Pressure (CBP-AD)	Provider	State	NCQA	Provider enters into BHOLD
Weight Assessment and Counseling for Nutrition and Physical Activity for children/Adolescents (WCC-CH)	Provider	State	NCQA	DOES BMI BHOLD field fulfill this – don't think so. Would need to review specs to understand what needs to be collected

Appendix H: Minimum CCBHC Certification Requirements

The 'Minimum CCBHC Certification Requirements' list represents a subset of the RI CCBHC Certification Standards. Providers must meet these specific criteria at minimum to demonstrate readiness to deliver quality CCBHC services by the slated program start date of 2/1/2024.

Minimum Certification Criteria
1. Provide all nine core federally required CCBHC services PLUS the two State required CCBHC services: **(4.a.1)** Federally required CCBHC services: • Crisis Response • Screening, Evaluation and Diagnosis • Person-Centered and Family-Centered Treatment Planning • Outpatient Mental Health and Substance Use Disorder Services • Primary Care Screening and Monitoring • Peer and Family Support • Psychiatric Rehabilitation • Targeted Case Management • Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans RI required CCBHC services: • Screening for Hepatitis A, B, and C, and HIV • Assertive Community Treatment (ACT)
2. The CCBHC will be required to provide these services in a manner that is appropriate for the population of their service area, for people with illnesses of every severity including people with

serious emotional disturbance (SED), serious mental illness (SMI) and significant substance use disorders (SUD), 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. **(4.f.1)**
3. CCBHCs are to specifically address the behavioral health and related needs of the SAMHSA populations of focus: **(1.a.1)** • Adults with Serious Mental Illness (SPMI, SMI) • Children and Youth with Severe Emotional Disorders (SED) • Individuals with Substance Use Disorder (SUD) And provide a plan to address the needs of the following priority consumer populations: • BIPOC (Black, Indigenous, and People of Color) • People with co-occurring Behavioral Health and Intellectual/Developmental Disabilities (BH/IDD) • Members of the LGBTQ+ Community • People who are justice-involved • Older adults • People who are unhoused • Transition age youth • Members of under-resourced communities (high poverty, low-income areas) and • Other culturally diverse groups, if any
4. Capacity to comply with the following requirement: "Whether directly supplied by the CCBHC or by a DCO, the CCBHC is ultimately clinically responsible for all care provided. • The decision as to the scope of services to be provided directly by the CCBHC, as determined by the state and clinics as part of certification, reflects the CCBHC's responsibility and accountability for the clinical care of the consumers. • Despite this flexibility, it is expected CCBHCs will be designed so most services are provided by the CCBHC rather than by DCOs, as this will enhance the ability of the CCBHC to coordinate services." **(4.a.1)**
5. The CCBHC's behavioral health services and staffing are appropriate to meeting the needs of the following populations: **(1.a.2):** • Adults with severe, persistent mental illness and serious mental illness • Children and adolescents with serious emotional disorders • Children, adolescents, and adults with severe substance abuse disorders • Members of the Armed Forces and Veterans • General outpatient population
6. Directly provide ASAM level 1 Withdrawal Management **(4.c.1)**
7. Directly provide 24/7/365 Emergency Service Hotline **(4.c.1)**
8. Directly or through a DCO provide Mobile Crisis to children and adults 24/7/365 **(4.c.1)**
9. Be fully licensed as a BHO by BHDDH **(6.c.1)**
10. Be accredited by, or in the process of getting accredited by CARF, COA, or Joint Commission **(6.c.2)**

11. The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including but not limited to data capturing: (1) consumer characteristics; (2) staffing; (3) access to services; (4) use of services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; (8) costs; and (9) consumer outcomes **(5.a.1)**
12. The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records. The health IT system has the capability to capture structured information in consumer records (including demographic information, diagnoses, and medication lists), provide clinical decision support, and electronically transmit prescriptions to the pharmacy. **(3.b.1)**
13. Have a sufficient number of staff trained in EBPs as determined by BHDDH **(4.f.2, Addendum 6)**
14. Have fully executed DCO agreements in compliance with standards by 10/31/2023 to demonstrate ability to provide all required services
15. Have fully executed Care Coordination Agreements by 10/31/2023
16. Have facility status or fully executed DCO agreement (fully staffed) for court ordered individuals **(2.a.7)**
17. Have provided verification of establishment of Community/Consumer Advisory Councils by 2/1/2024 **(6.b.1, Addendum 10)**
18. Outpatient clinical services for established CCBHC consumers seeking an appointment for routine needs must be provided within 10 business days of the requested date for service. If an established consumer presents with an emergency/crisis need, appropriate action is taken immediately, including any necessary subsequent outpatient follow-up. If an established consumer presents with an urgent need, clinical services are provided within one business day of the time the request is made. **(2.b.3)** Provider must have adequate plans to address any current waitlists.
19. Management team includes a psychiatrist as Medical Director (if unable to hire psychiatrist must have provisions for psychiatric consultant) **(1.a.3)**
20. Show sliding fee scale on website, in waiting room and readily accessible, communicated in multiple languages **(1.d.4, 2.d.2)**
21. Have fully developed CQI plan approved by BHDDH by 2/1/2024 **(5.b.1)**
22. Have fully developed Emergency/Disaster Plan approved by BHDDH by 2/1/2024 **(2.a.8)**
23. Have fully developed CLAS Plan approved by BHDDH by 2/1/2024 **(1.c.1)**

Appendix I: Taxonomy for CCBHC NPI Application

All providers will be required to:

- Secure a new NPI that designates them as a CCBHC
- Enroll as a Medicaid provider using the CCBHC NPI
- Bill for all CCBHC services using the CCBHC NPI

The following taxonomy should be used for the CCBHC NPI Application and only this provider type can be assigned to this taxonomy code:

Code: 251S00000X
Type: Community/Behavioral Health
Classification: Clinic/Center
Specialization: Public Health, State or Local
Level: Level III - Area of Specialization

Appendix J: Duals and Third-Party Liability (TPL) Billing Processes

Duals Claiming Process Issue

For all Medicare-covered or commercial covered services, the CCBHC must bill CMS, Part C plan or commercial plan for reimbursement. Per federal regulations Medicaid is the payer of last resort and so this is an essential task for the CCBHC.

- As certain services included in the PPS2 are covered by Medicare, EOHHS expects that there will be a meaningful volume of Medicare duals/TPL reimbursement (40% of high acuity member visits). EOHHS is seeking a solution to ensure adequate provider cash flow is serving dual Medicare/Medicaid CCBHC enrollees, and this will be handled through FFS.
- EOHHS estimates that there will be a much smaller amount of commercial TPL among the managed care plans (approximately 2% off visits). This TPL process will be handled by the health plans.

We anticipate there to be three distinct TPL scenarios facing providers:

Scenario 1:
For all Dual eligible Medicaid members with Medicare FFS (i.e., Part B)

All CCBHC services and PPS2 payments are out of plan for Duals and will be paid through Medicaid FFS

- **CCBHC Action:**
  - Provider bills Medicaid FFS (i.e., Gainwell) using its **new Medicaid CCBHC NPI/taxonomy** specific for the PPS2 using code T1041 and the appropriate modifier as well as any claim details not submitted to primary payer.
    - To avoid denial, the provider will include on T1041 claim as the first detail and **S9986** as the second detail, for each Medicaid FFS client with TPL (Medicare Part B, Part C or other commercial).
    - EOHHS acknowledges that this CPT code is being used incorrectly. However, this detail is intended to be informational to indicate that the client was provided at least one qualifying event that was billed to the primary payer.
  - Provider bills Medicare for any covered services for all Dual clients under their **current NPI/taxonomy** (e.g., CMHO or other)

- **CMS action:**
    - CMS adjudicates claim and reimburses provider, and submits crossover claim to Gainwell.
- **Gainwell action:**
    - Gainwell adjudicates the PPS2 claim and reimburses provider the full PPS2.
    - Gainwell processes the separate crossover claim from CMS and reimburses provider for balance, if any, owed to provider.
      Note that the balance owed is the difference between the Medicaid Program allowed amount and the Medicare Payment (Medicaid Program allowed minus Medicare paid); or the Medicare coinsurance and deductible up to the Medicaid Program allowed amount.
- **EOHHS action:**
    - EOHHS (or Gainwell) calculates total Medicare and Medicaid paid to the provider over the prior period (i.e., amount of TPL reported for members with a concurrent PPS2 payment since last calculation performed).
    - EOHHS prepares a FACN establishing a PAR against the provider's CCBHS provider ID that will auto-decrement the calculated amount against the provider's payment in the next financial cycle.
      This process will be performed on a regular schedule – either monthly or quarterly.
- **EOHHS audit function:**
    - EOHHS will establish an audit process/mechanism to hold CCBHC responsible for billing TPL.
    - EOHHS will review crossover and PPS2 payments for all Dual/TPL clients to assess proportion of clients with Medicare or Commercial-paid services and the volume of such services per member.
    - The expectation is that the CCBHC should have a reasonable volume of crossover activity for their Dual/TPL clients:
        - There should be a crossover claim for most Duals. If there are (a) no crossover claims within a month, and/or (b) certain codes appear on the Medicaid FFS claim (and not on a denied crossover detail) then we can assess if there is not sufficient billing to Medicare.

Scenario 2.a:
For all Medicaid members in FFS with Commercial TPL (incl. Medicare Part C/Medicare Advantage)

- **CCBHC action:**
    - CCBHC bills Medicaid FFS (i.e., Gainwell) using new Medicaid CCBHC NPI and taxonomy for the PPS2 using code T1041 and the appropriate modifier and with **S9986** as second detail

- Provider bills Medicare for any covered services for all Dual clients under their **current NPI/taxonomy** (e.g., CMHO or other)

- **Commercial plan action:**
  - Commercial plan adjudicates the claim and reimburses provider.
- **CCBHC action:**
  - Provider submits a secondary claim for payment to Gainwell under their **current NPI/taxonomy** (e.g., CMHO or other)
- **Gainwell action:**
  - Gainwell adjudicates PPS2 claim and reimburses CCBHC the full PPS2.
  - Gainwell processes Part C/commercial-adjudicated claim(s) submitted by provider as a crossover/secondary claim and reimburses provider for any balance owed.
- **EOHHS action:**
  - Same as in Scenario 1.

Scenario 2.b:
Dual eligible individuals in <u>Neighborhood Integrity</u>, where the CCBHC services are out of plan

NHPRI's Integrity Plan is a Part C/Medicare Advantage plan. From the provider's perspective, a NHPRI Integrity member should be treated in the same manner as any Part C plan. This will be *different the CCBHC's billing practice for NHPRI's non-Integrity members. In the case of the Core Contract, the provider would directly bill NHPRI for the T1041 code (along with any shadow claim activity) using its Medicaid CCBHC NPI/taxonomy.*

- **CCBHC Action:**
  - CCBHC bills Medicaid FFS (i.e., Gainwell) using new Medicaid CCBHC NPI and taxonomy for the PPS2 using code T1041 and the appropriate modifier and with **S9986** as the second detail.
  - Provider bills NHPRI Integrity for any covered services under their **current NPI/taxonomy** (e.g., CMHO or other)
- **NHPRI plan action:**
  - NHPRI Integrity adjudicates the claim and reimburses provider.
- **CCBHC action:**
  - Provider submits a secondary claim for payment the adjudicated claim from Gainwell under their **current NPI/taxonomy** (e.g., CMHO or other)
- **Gainwell action:**
  - Gainwell adjudicates PPS2 claim and reimburses provider the full PPS2.
  - Gainwell processes Integrity- adjudicated claim submitted from provider as a crossover claim and reimburses provider for any balance owed.
- **EOHHS action:**
  - Same as in Scenario 1.

Scenario 3:
For all Medicaid members <u>in managed care</u> with Commercial TPL

- Medicaid MCO is responsible for establishing appropriate TPL processes to ensure that Medicaid payment is secondary to any existing commercial coverage.
    - Specifically, the MCO must pay the full PPS amount less any direct payment from the primary payor. There are no copays or coinsurance for Medicaid members.

Additional Questions

Q1. What if ALL allowable shadow claims are Medicare Eligible – and therefore the provider does not have a triggering event to include in the claim?

As a work-around, S9986 will be included as a qualifying event. This will be used to signify the member has TPL and can be included as a service once another qualifying non-S9986 is provided to the client. This will allow all Medicare-eligible services to be submitted to Medicare.

Q2. What if there remains a qualifying event that is not Medicare eligible. Should the S9986 still be included?

Yes. If the provider is submitting a claim for TPL please include the S9986 for informational purposes.

Q3. How will TPL recoupments be treated?

We do not anticipate there will be a meaningful volume of such recoupments. In the event that the CCBHC must repay a payer for claim previously submitted to Gainwell and it was already included in the auto-decrement process, any amount recouped from the CCBHC can be excluded (i.e., returned to the CCBHC) from a subsequent PAR through a manual process. EOHHS will set up a process to review such cases.

Q4. How will Gainwell's recoupment process work?

EOHHS will initiate a FACN to Gainwell to establish a recoupment (or provider accounts receivable (PAR) financial transaction through its. The PAR or recoupment will be associated with the provider ID assigned to the provider's CCBHC NPI. It will reduce the cash receipts paid to the CCBHC during the cycle it is applied. If the amount of the PAR exceeds the claim-based payments to the CCBHC any balance would be carried over to the following financial cycle.

The amount of the PAR will be equivalent to the amount of TPL identified by EOHHS through a review of its FFS claims data for CCBHC services paid to the provider (using their non-CCBHC NPI) for members with a concurrent T1041 claim paid to that provider (using their CCBHC NPI).

EOHHS will attempt to develop the reconciling report to mirror the 835- payment file so that the providers can employ an automated process for reconciliation.

Q5. How will TPL work with DCO?

EOHHS assumes that the CCBHC cannot bill Medicare on behalf of the DCO. If this is the case, and the DCO provides a service that is covered by Medicare, then the DCO should continue to bill Medicare or commercial TPL directly. For example, a SUD treatment provider, such as Codac, should bill Medicare for BUP services using the appropriate G code.

Then, as in Scenario 1 or Scenario 2a/b, either CMS or the provider itself, would submit the adjudicated claim to Gainwell for crossover payment. Gainwell may or may not pay any additional amount.

Any payments by Medicare/commercial TPL and by Gainwell FFS to a CCBHC's DCO for any PPS2 covered services provided to a CCBHC attributed population would be included EOHHS' recoupment amount and applied to the PAR assigned to the CCBHC.

These amounts will be separately identified in the reconciliation report and it will be responsibility of CCBHC to consider such TPL reimbursements in its payments to the DCO.

Q6. How will EOHS assure compliance with this guidance?

EOHHS will establish an audit process to review claims activity among Dual eligible members and Medicaid members with comprehensive TPL.