#	Question	Response
1	How do we bill for people who have Medicare/Medicaid or Commercial/Medicaid?	Detailed descriptions for this process can be found in MCO Ops Manual and have been shared with the providers.
2	Why would CCBHC services be provided out of plan when the MMP already knows how to separate Medicare and Medicaid claims? Could these services be left in-plan for NHP Integrity?	CCBHC services for duals will be out of plan for Year 1.
3	Do providers of DCOs have to be credentialed under Thrive? (with MCOs)	There is no explicit State or Federal requirement that DCOs be credentialed either with an MCO or lead CCBHC to provide for or bill for services. For MCO Credentialing: Contractual parties (i.e., CCBHC, DCO, & MCO) should refer to their contractual agreements to determine what type of credentialing is required for service provision and billing purposes. For Agency Credentialing: CCBHCs should refer guidance outlining what requirements are in place for monitoring DCOs. There is no State or Federal requirement for DCOs to be credentialed by the lead CCBHC agency unless that credentialing is a vehicle to satisfy requirements for monitoring DCOs under State and Federal criteria.
4	What is the process for submitting late shadow claims, without having to hold up the claim?	In Year 1, all shadow claim data should be included in the submitted claim. If shadow claimed data is incorrect or incomplete, the claim will need to be voided and resubmitted. The State will continue to explore more efficient ways to submit corrections/additions to shadow claim detail.
5	Please provide the CMS guidelines for this. It is our understanding that in other CCBHC states, BH services are provided in nursing facilities, assisted living facilities and I/DD group homes if other BH services are not already provided. We have clients who live in these facilities and we do not think it would be beneficial to stop services because the client changes a living arrangement. CCBHC Certification Standards state that services cannot be denied based on residence. In addition PAMA § 223 (a)(2)(B) states: …"no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence." If CCBHCs provide a triggering service outside the above stay are we allowed to bill for the month? (Ex: A client is in the nursing home during the month the client receives a triggering service before or after stay. Are we allowed to bill for that month?) If yes, can the triggering service be provided on day of admission or discharge from the nursing home?	The language in the operations manual is based on current guidance provided directly by SAMHSA and CMS to Rhode Island as part of its approval of the CCBHC State Plan Amendment (SPA). Documentation and background on final disallowed settings will be provided upon approval of Rhode Island's CCBHC SPA.
6	Pg. 29--CCBHC qualifying services provided by a participating CCBHC to a member who is not attribute to that CCBHC for the month of service should be billed using the qualifying service billing codes specified in Appendix F. If the member is not attributed to any CCBHC and the physical location of the providing CCBHC is not an allowable location, 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 PPS-2 rate. • What are the "not allowed locations?" o Are you referring to the residential settings: 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. It is important to emphasize that CCBHC services cannot be reimbursed if they are provided in an institutional setting or in a setting in which behavioral health care is included already as part of a bundled payment.
7	P45--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. • If clients have choice, what if they chose to go to our CCBHC but live in another service area? Can we provide community-based services in the service area they reside? What if another provider such as a doctor is in another service area? Can we provide services (ie. CPRS accompanying to a doctor appointment in another service area)?	CCBHCs **can** provide services to individuals from outside the catchment area and through care delivery modalties that do not require the establishiment 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. Language in the final MCO operations manual will be revised to reflect this clarification.
8	Providers should bill all CCBHC qualified services provided to CCBHC attributed members using this NPI. For all other services (non CCBHC services or **CCBHC services provided to Unattributed members**), CCBHC providers should use their existing, non CCBHC NPI. Does this mean if we do a 1x crisis service we would be able to bill for that service under the existing NPI (not as a CCBHC)?	**For individuals not already enrolled/attributed to a CCBHC:** 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. Enrollment can be backdated to match when initial services began. For the example of mobile crisis, if a new client receievs 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 crisis services (and other crisis services) are included cost report, and thus included in the rate buildup for CCBHC. Crisis services provided to an already enrolled/attributed individual cannot be billed separately from the CCBHC PPS rate. **Non-CCBHC services include:** MHPRR, SUD Residential, Acute/Crisis Stabilization Units, BH Link etc. Those services may be billed under the customary NPI.
9	pg. 28--PPS T1041 modifiers - We need the modifiers	Modifiers have been finalized and will be integrated in the next iteration of the MCO Ops Manual. The modifiers are U3 (High Acuity Adults), U4 (High Acuity Youth), U5 (SUD), and U6 (General).
10	Home Stabilization—We were told we could bill Home Stabilization outside of CCBHC. How can we bill outside CCBHC if we need to use this code as a shadow CCBHC claim? Are you planning to restrict the Home Stabilization billing?	For Year 1, this is an optional CCBHC service. You can opt to bill for it in or outside of the PPS2 rate. If you bill for it within the PPS2 rate, use **H0036 HE** for shadow billing.
11	IOP—Are we to report the per diem code or the individual services that make up the per diem?	The prior - report the per diem code.
12	Ambulatory Detox—There isn't a code for this required service on the fee schedule. Both ASAM Level 1 & 2 withdrawal management are required.	We have added **H0014** (ambulatory detox) for this purpose. The code does not have a defined unit duration. State is setting as 1 hour. This is a qualifying event.
13	T1017 Targeted case management is missing from the list and was originally a triggering event for both adults and children. This is a CCBHC required service.	Providers should use **H0036** for targeted case management (TCM). This is the CCBHC approved code. Note: TCM in CCBHCs under SAMSHA standards is not the same as the Medicaid TCM benefit.
14	The following were included as a triggering event on the Children's original but is not included in the current fee schedule. Please add to the fee schedule or explain why they are no longer part of the fee schedule. **H2014**: Treatment Consultation – Occupational, Physical, Speech and Language Therapists **H0004 (+ modifiers)** BEHAVIORAL HEALTH COUNSELING AND THERAPY **H0031 (+ modifiers)** MENTAL HEALTH ASSESSMENT, BY NON-PHYSICIAN **H2016**: Comprehensive community support services, per diem formerly known as Service Plan Implementation - Direct Implementation **S9446 (+ modifier)** Patient education - Social Skills Group **T1019**: Personal Care Services **T1023:** SCREENING TO DETERMINE THE APPROPRIATENESS OF CONSIDERATION OF AN INDIVIDUAL FORPARTICIPATION IN A SPECIFIED **T1024 (+ modifiers):** Home Based Therapy – Specialized Treatment/Treatment Support **T1027**: Family Training and counseling for child development, per 15 minutes formerly known as Clinical Consultation	Our goal is to develop a concise list of codes to lower administrative burden on providers. For the counseling and assessment codes used for children's behavioral health services, when possible, we are consolidating to utilize the related codes used in the adult system, which are more up to date with current billing practices. **If there are any services that you think are essential from an operational standpoint, which are not represented by the current billing list, let us know that they are.**
15	It is our understanding that EOHHS is trying to consolidate services under the minimal number of codes, which is why all codes currently being used are not listed. Will you please confirm that our understanding is correct?	Correct.
16	H0015 IOP MH, H0035 HF PHP SUD, H0035 PHP MH—Will these be required under CCBHC?	These are optional CCBHC services for Year 1.
17	How do we code Outreach & Engagement?	Providers should use **H0046** (mental health services, not otherwise specified) for these activities.
18	Will you please confirm that the RI CCBHC will be outcome based rather than service hour based?	The CCBHC payment model is that CCBHCs receive a bundled payment for each eligible Medicaid member served in a given month. The bundled payment is triggered by delivery and billing of a qualifying service. The rate for each CCBHC is determined using a cost-based payment method. There are services within the CCBHC program (e.g. ACT) that are service-hour based.