CCBHC Provider Questions and Answer

#	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 the CCBHC? (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.	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.

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	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?	
6	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?" 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	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. Language in

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	• 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 (i.e. CPRS accompanying to a doctor appointment in another service area)?	the final MCO operations manual will be revised to reflect this clarification. Note that if RI becomes a demonstration state, SAMHSA/CMS will review and may provide updated guidance that differs from this direction.
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 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 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	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.

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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.

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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.
19	Attribution file: We all submit BHOLD admissions, discharges, and changes every month. After 11/30 do we have to use the form in Appendix C to request changes? - We will need the form in Appendix C on or before the November attribution file distribution.	You will not need the form. We have updated the MCO ops manual.
20	Manual states all enrollments will be backed dated to the 1st of the month. Is the state going to update BHOLD policies requiring face-to-face contact when enrollment starts since now all enrollment will start on the 1st even if the first contact was not until later in the month?	Back dating is going to be necessary only in the event of a correction. Otherwise, actual dates of service and enrollments should be used for all program activities.
21	Manual states 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. We will need this process	CCBHCs do not need to obtain consent from each client. Rather, CCBHCs must provide notice to all clients about the nature of the CCBHC program, privacy and treatment considerations, and that clients always have the right to choose the best provider to meet their needs.
22	"EOHHS may add additional billing requirements or modifiers to capture…" Is this expected to be a part of completed Appendix F? This would be core to all billing setup impacted, and may result in a major vendor change (i.e., 4 modifiers)	EOHHS will make sure adequate notice is provided in advance of any additional billing requirements or modifiers to ensure time for appropriate setup and vendor changes.

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23	Further clarification around claim submission for all expected denied charges. Clients not attributed due to another attribution, Clients services that pre-date an attribution, Clients services that co-exist with hospital placements that would not allow for reimbursement. Inclusion of a list of all reasons for denial, possibly categorizing within "expected" denials and denials that need attention for resubmission	The State is unable provide a list of all denial reasons. In the event of a denial, the CCBHC should ensure the claim submitted was a clean claim to enable successful processing. If a CCBHC believes the denial is inappropriate, the CCBHC should pursue grievance and appeals rights pursuant to their payer agreement. There are certain appropriate denials that will occur (i.e., client is already enrolled and receiving services through another CCBHC, client is in a hospital). In these events the CCBHC would not be reimbursed.
24	The following questions/comments remain from previous comment periods: If we do not get the person in the Gainwell system by 2 days before the end of the month for the following month, you cannot bill for that month?	The two-day timeframe is no longer relevant and the updated MCO Ops Manual will reflect this change.
25	Can you back bill if you get the person in on the last day of the month? Or somehow missed getting the person in the system to the following month?	Yes, you can bill back to the date of initial service as long as they are not attributed to another CCBHC for that month.
26	BHDDH responded to a question from a group participant about who is helping the DCO's be able to capture shadow billing. In the BHDDH (paraphrased) response, it was indicated that in guidance seen the DCO's should be documenting in the CCBHC record, using the CCBHC treatment plan, etc. so therefore, the CCBHC should be all set with capturing the shadow billing. CCBHC Standard 3.b.5. requires a plan to improve care coordination between the CCBHC and the DCO using the health IT system within 2 years. While this level of care coordination and using one record to document all services is certainly aspirational, we have not interpreted this to mean the DCO will be using the EHR of the CCBHC directly.	The code list is final for Year 1, reflecting feedback received from providers. If there are any ongoing issues, please let us know.

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	That being said, we do understand it is the CCBHC responsibility to capture shadow billing information from the DCO and will work with the DCO to capture this information. It may be necessary to provide the code list to the DCO prior to finalization to ensure all codes they use are present and accounted for. It may be best to wait for the code list to be updated with the comments made at this session. Once we receive the updated code lists, we will send it to the DCO's for review and would like the opportunity to send additional comments back to the Department.	
27	Per CMS guidelines, CCBHC services cannot be billed for services provided in residential settings. This includes: Correctional facilities, Nursing homes, Inpatient hospitals, Institutes of Mental Disease (IMD), Non-community based residential facilities. 1. 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. 2. CCBHC Certification Standards state repeatably 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. 3. If Thrive provides a triggering service outside the above stay, are we allowed to bill for the month? (Ex. client 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)	#1: See above (Question #6) regarding allowable settings. For #3 and #4: Response being developed.

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	4. If yes, can the triggering service be provided on day of admission or discharge from the nursing home?	
28	Haven't heard of this process yet. Assuming it's like our current waiver process. This needs clarification. We cannot count on a current process as we cannot count on a set schedule for receiving our attribution file. We need this to be on a reliable schedule for CCBHC. Can we receive an 824 file electronically that could be pulled into our system? How do we account for clients transferring from a non-CCBHC IHH/ACT provider, including OTP IHH?	We will follow the same exception process for IHH/ACT. Process is being updated for CCBHC. Providers will be notified when this process is final. There cannot be overlap in patients who enroll in IHH/ACT and CCBHC. The system will not allow a member to be enrolled in both programs. OTP IHH members can overlap with CCBHC.
29	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. Will this be an excel file so we can import into our systems for easy comparison?	Each payer will determine a format for conducting reconciliation. CCBHCs should consult with MCOs to determine how the reconciliation report will be shared.
30	Transfer of the full client record including DCO services, within 10 business days. Please explain what is required for DCO services (just date of service or progress notes)—Can we keep our current records transfer process? If not: 1. How will 42 CFR Part 2 rule (re-disclosure of SUD data) be handled? 2. How will HIPAA Minimum necessary rule be handled?	Consistent with SAMHSA criteria, data sharing in support of care coordination must comply with 42 CFR Part 2 and HIPAA. CCBHCs and DCOs should develop data sharing arrangements, including EHR access, to facilitate care coordination and required reporting activities. If the current records transfer process is sufficient, that can be employed in this model. For further detail on what data sharing is required for DCO services, please consult with SAMSHA's CCBHC criteria for care coordination.
31	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. BHDDH is	This process will be defined and implemented at a later date.

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	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). We need the process.	
32	MCO Manual states High Acuity people need to be reassessed every 90 days. • When does the 90-day reevaluation requirement start? • Will every existing client be on the same 90-day rotation? • Will you consider extending the amount of time between re-evaluations or doing them on an as-needed basis? • How long are grandfathered people grandfathered in? • Is there a transition process for people who move to lower acuity levels so they don't lose services?	The 90-day reevaluation requirement is applicable only to level of care and related scores determination. The timeframe should run from the time of the last completed assessment. Assessment scores are one factor in determining an individual's acuity. The State, in partnership with providers, will monitor this carefully so individuals do not lose clinically appropriate services.
33	BHDDH will identify a process for CCBHCs to submit exception requests for clients who they feel should be categorized for payment purposes based on the clinician's professional judgment. We need this process	This process will be defined and implemented at a later date.
34	CCBHC are entitled to 5% QBP: • Will this payment be done using a withhold from the clinic's monthly payments? Where does this pool come from?	No, this payment will be in addition to the CCBHC's full PPS rate and will be determined on an annual basis based on the CCBHC's attainment of benchmarks for quality measures.
35	Federal QM & QBP • We were previously told that the state was not going to require any optional measures (although, you reserve the right to change that decision). Is this still the direction that the state is going in? • When will we have to start collecting and reporting on the Federal QM? SAMHSA is not requiring this until CY 2025.	The State at this time is only intending to include required measures. The State has included a timeframe for quality data collection and reporting in the MCO Manual. We want to begin collecting measures as soon as feasible to allow for testing of systems and ensure accuracy before CCBHCs will be held accountable for performance. We are waiting for the full measures set.
36	Quality Measures • There are 7 extra measures listed in the MCO Manual that are not listed in the new QM distributed by SAMHSA. Are we going to be required to report these?	The list of measures is not finalized. The measures will be updated based on final measure set when it is provided by CMS.
37	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 standards are being updated and the manual will be updated when it is shared publicly.

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	• Clinical responsibility for the CCBHC over the DCO was removed in the new SAMHSA regulations. Will it be removed here too?	
38	Outlier threshold • Could you provide more information on the outlier process? • Will shadow billing be used? • What is the threshold?	Outlier thresholds were provided with Cost Report instructions. Shadow billing is not part of the process.
39	Is it required to report all 11 CCBHC services as being provided by the agency via claims or other reporting? A previous Medicaid rate schedule had a mapping inclusive of some of these 11 services, but not all. If we will need to account for the category of CCBHC delivered services through any reporting mechanism that would force us to create a link between our services delivered and its associated category.	No, CCBHCs do not need to report or map service categories.
40	EHR's are designed to acknowledge a start date of services and the related components. Backdating the claim would be new. (It is our understanding that 1/1-1/31 is submitted parent claim T code, with child/shadow services within that date range). • Can we maintain actual start dates and those processes by submitting a CCBHC claim (i.e., 9/10-9/30) for a full month's reimbursement? While we understand partial month billing to not be allowable, we are asking in attempt to minimize vendor ask with new client enrollments, maintaining core components to EHRs. If a MCO was only setup to pay a full month's rate, partial month billing could still be disallowed. This would not impact 1st of the month attribution in Gainwell and should not be confused with transfer clients as a reason for the mid-month enrollment.	All dates submitted should represent actual dates of service and claiming. Backdating should only be done in the event of a correction.
41	Confirming "CCBHC qualifying services provided by other providers (i.e., non-CCBHCs) for an attributed member should be	Yes, the Medicaid billing system will be configured to ensure no inappropriate denial of services.

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	billed and paid at the provider's standard billing rate" provides enough of language to ensure that our agency's non-CCBHC services will not be denied due to enrollment denial reasons (i.e., Crisis Stabilization code will not deny due to CCBHC enrollment).	
42	Reconciliation and Settlement holds MCOs accountable to only a report on/by July 15th, 2024, for services rendered in February or March. Without a plan to further hold MCOs accountable for payment, we are unclear about what reporting may be needed in the interim to preserve financial stability.	MCOs are contractually obligated to pay for CCBHC services.
43	With traditional Medicaid, we were able to retroactively bill back one year. MCO's has always had a shorter window. What is the window with CCBHC billing? In addition to reiterating the request to put a hold on the MCO timely filing denial rule, can the length be extended to traditional Medicaid rules?	We encourage providers to submit claims timely. Timely filing rules will not be changed for the CCBHC programs.
44	Under "Non-Qualifying Service" • This language is confusing and needs more detail. For example: the collateral encounter without client present. Care Coordination without client present. An outreach encounter that does not meet the threshold. A primary care screening encounter that does not include supportive CM. 1. Why isn't face-to-face outreach a CCBHC billable/qualifying service? 2. All current collateral contracts should count towards billing if they are in support of the client's recovery plan and meet the normal criteria for a billable service under Medicaid. 3. Telehealth should be billable if it meets the billing requirements for Medicaid. 4. Fidelity is a quality measure and should not be conflated with billing. There should be clear guidelines developed for fidelity monitoring, related corrective action and if necessary	**Request for provider clarification:** Can you provide more detail to help clarify your 4th question?

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	for programs who are audited and found out of compliance with Medicaid regs.	
45	The new CCHBC criteria is 6 months, not 90 days for updating the CANS or DLA, recovery plans, etc. the standard should be every 6 months or as clinically indicated – not every 90 days.	See above (Question #32)
46	**Outlier payments** – is this calculated by the MCO's based on shadow billing. This needs further clarification. Do we have a state defined threshold? If all our services are 0 billed, how will we know what the cost is above the threshold?	Outlier thresholds were provided with Cost Report instructions. Shadow billing is not part of the process.
47	All enrollments will be backed dated to the 1st of the month?	Enrollment should not be back dated.
48	Is the state going to update BHOLD policies requiring fact-to-face contact when enrollment starts since now all enrollment will start on the 1st even if the first contact was not until later in the month?	This will not be required. See question 20 for further clarification.
49	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. We will need this process	CCBHCs do not need to obtain consent from each client. Rather, CCBHCs must provide notice to all clients about the nature of the CCBHC program, privacy and treatment considerations, and that clients always have the right to choose the best provider to meet their needs.
50	Transfer of the full client record including DCO services, within 10 business days: • Please explain what is required for DCO services (just date of service or progress notes)?	Manual has been clarified to emphasize that a full client file is not required to facilitate transfer. Relevant clinical data necessary to support coordination of care is required to facilitate transfer.
51	Transfer of the full client record including DCO services, within 10 business days: • What about 42 CFR Part 2 rule (re-disclosure of SUD data)? • HIPPA Minimum necessary rule?	CCBHCs and DCOs have contracts. Providers are required to follow all applicable laws.
52	"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." This needs more clarity. How will we set this up for Medicaid and Duals? "Not allowable location" is bed-type settings like an ED or	As noted in Question #6: 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.

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	hospital, so this needs further clarification as well. This needs a drill down on these issues for us to be able to set up the billing.	Our understanding is that billing system should already be designed to capture this type of billing so would not need to be "set up". Please provide additional clarification if this is not accurate.
53	The MCO gets 90 days to do quarterly attribution reconciliation and the provider gets 15 days to respond to it for changes? • Can this timeframe be reviewed? The provider may need more time. • Will this be a reason for denial if we find someone missing after the 15-day period? • Can we retroactively bill? How far back can we retroactively bill?	Response being developed
54	The transfer process seems to rely on the sending CCBHC to discharge in BHOLD, among other things that out of our control. Can we retroactively bill to straighten out issues?	Yes. See response to question 40 for further clarification.
55	Adults with serious mental illness - Someone over the age of 18 • Replace with 18 years or older	Corrected.
56	Care Coordination Agreement: To have agreements. • Replace with to have formal agreements, and when formal agreements are not in place, then informal agreements with written procedures are acceptable (per new CCBHC certification standards) • "Meframe"; Replace with "timeframe"	Corrected.
57	Under "Discharge" • Do we need to keep our three-month protocol as is, or can we revisit what this outreach attempt means for folks who drop out? is this a beast practice for engagement. If this remains in place, how does it convey with GOP population.	Response being developed
58	Under "PPS-2 Rates" • Is an encounter the same as a qualifying service? This needs to be clarified if both terms are to be used.	Response being developed
59	Under "PPS-2 Rates" • Who sets the thresholds for the bonus payments? Are they annual?	CMS sets annual thresholds for performance for the Quality Bonus Payment (QBP) program.

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60	Important timeline please over emphasize: BHDDH will electronically distribute a DRAFT initial attribution on file to all participating CCBHCs no later than November 15, 2023. 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 service by DCO partners and any other Discrepancies. CCHBCs will submit their requested changes to BHDDH's Data Unity no later than November 30, 2023, with a justification on using the prescribed form included as Appendix C.	Communications have been and will continue to be actively shared with providers as this process happens.
61	January 15, 2024 - Is this enough time to prepare for February billing?	Timelines have been updated and shared with providers and MCOs.
62	How is the system going to handle continuing IHH and ACT attribution and implementing CCBHC attribution.	IHH/ACT will continue to operate alongside the CCBHC program. Individuals enrolled in IHH/ACT are not eligible to be enrolled in a CCBHC.
63	What is the process for new enrollments?	Providers should assess individual's needs and eligibility criteria to determine program enrollment.
64	Will BHDDH identify a process for instance when a client consents to treatment from a CCBHC but is unable or unwilling to sign an enrollment form.	See response to question 49 for clarification.
65	The receiving CCBHC will not be reimbursed during the provision of their most expensive services. Intake biopsychosocial assessment and initial psychiatric evaluation in the current set up. Churn is not in the cost report. We were instructed to put our churn in our staff report but not in the cost report.	Response being developed
66	Clients often do not know they are attributed, especially years into the program. This has led to many unbillable IHH/ACT clients since 2016. The state needs to support and coordinate transfers when a client request services at a new CCBHC.	Providers are expected to work together to facilitate transfer of clients. When necessary, the state will help with this process if there are discrepancies.
67	Why aren't these 2 days like a new client?	This requirement has been removed. The MCO operations manual has been updated.

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68	Will we be able to retroactively add someone in the portal who gets insurance?	Retroactive eligibility must conform to RI Medicaid requirements.
69	Re formal request of "full client file" This is an overly burdensome requirement. What is the definition of "full client file"? Will we be required to provide all treatment documentation or is a discharge summary with course of care sufficient? Should not be in billing regs.	Manual has been clarified to emphasize that a full client file is not required to facilitate transfer. Relevant clinical data necessary to support coordination of care is required to facilitate transfer.
70	This process [prospective attribution] may lead to attributed clients who never engage in our care. This may also affect client choice for services in these situations.	This process is not being implemented initially but will be defined and corresponding business process details will be documented and shared. Clients can choose where they receive their CCBHC services. If they choose a provider to whom they are not attributed, then the transfer process should be followed.
71	When someone is leaving a hospital inpatient or ED, they will be attributed to a CCBHC based on geographic proximity to their home address. This will create a big mess. This needs a specific workflow with the required timelines and client notification. The clients should be continuously in the current CCBHC attribution unless a full referral and warm hand off is completed post hospital ed or inpatient.	See response to Question #70.
72	MCO Manual states High Acuity people need to be reassessed every 90 days. • How long are grandfathered people grandfathered in • 50% of CSP are above 4.0 DLA. Suggestion to create an Age based & medical based DLA.	Transition time for clients who are grandfathered into the high acuity population • As of 7/1/2024, all high acuity adults will need to be reviewed every 90 days utilizing the DLA. For the first three months of operation, the DLA scores should be reviewed for all clients you have in the "high acuity" population WITHIN the 90 days. • Any client that falls outside of the DLA score for high acuity but is assessed to be clinically appropriate for these services, can have an exception form filed with BHDDH.

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		• Any exceptions that were granted prior to 7/1/24 are no longer in effect and the individual will need to reassessed utilizing the DLA within the first 90 days after CCBHC begins, and a new exception form will need to be filed with BHDDH (if clinically appropriate). We would recommend having a staggered process beginning in July.
73	Can BHDDH allow us & DCOs to see if & which CCBHC a client who comes to us is assigned to?	Federal and State healthcare privacy rules (i.e., 42 CFR Part 2 and HIPAA), make this type of data sharing difficult without violating patient confidentiality. The portal indicates if the member is assigned to the CCBHC and which program, but not the provider which they are attributed to. You will need to work with the client to identify where they are currently attributed to.
74	How can we request for more staff to have access to MMIS?	We believe you are referring to the Health Care Portal (HCP). Providers have HCP access, with a master user/account, who can add delegates from their provider's organization.
75	Will Recovery Plan requirement for 30 days be changed to line up with Comprehensive Assessment w/in 60 days required for CCBHC?	**Request for provider clarification:** Can you provide more detail on the requirement referenced in your question? We believe you may be referring to the Biopsychosocial Assessment section of BHDDH: Regulations • E. The preliminary treatment plan shall be formulated as part of the assessment and shall suffice up to thirty (30) days after the assessment unless other requirements are designated for a specific program.
76	Integrated Dual Diagnosis Treatment (IDDT)--This is required of all ACT & ICTT Co-Occurring Clinicians and SUD Specialists. We looked into the training and it is very expensive. It is a 3-day training and costs $3,500 per day ($10,500 total, plus possible travel expenses for the facilitator). Do you have any suggestions of a less costly option that we would be able to sustain over time?	Response being developed

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	We were told that there will be a state funded training for this? When will this training happen? We need to train our staff ASAP and implement this EBP if we need to meet fidelity in year 1.	
77	12-Step Facilitation Therapy/Matrix Model—This is required of ALL Clinical Staff. If we are interpreting this correctly as implementing an AA/NA program, we think that training our Peers and SUD staff would make more sense as our clinical staff would not be facilitating this EBP. Please advise. In addition, we are required to implement this program to fidelity but are not required to facilitate AA/NA groups. Fidelity of this EBP includes facilitating AA/NA. Do we still need to do this program to fidelity?	Response being developed
78	Zero Suicide—training 50% by end of Y1 is doable; experts state that meeting fidelity will take longer, stating that multiple years is common	Response being developed
79	Are SLMB/QMB eligible for CCBHC? Medicaid that pays only for Medicare costs	CCBHCs must serve anyone seeking services, regardless of payer, including dual-eligible members. QMB-only would be paid through cost-sharing up to the Medicare reimbursement rate or the PPS-2 rate if lesser. SLMB-only would not be eligible for cost-sharing. SLMB+/QMB+ would be paid the PPS-2 Rate and would follow the TPL process. Guidance on CCBHC billing for full dual-eligible members was shared previously.
80	No TPL pays for MRSS • If insurance does not pay for this service the claim will be denied • Can we waive the TPL and bill directly to Medicaid?	Medicaid is the payer of last resort and requires that CCBHCs must bill the patient's insurance for any services rendered, including commercial and Medicare coverage. When billing the patient's primary insurance, CCBHCs should ***not*** bill for the PPS rate using the T1041 code and instead bill as you would normally outside the CCBHC demonstration. Concurrently, the CCBHC program billing guidelines indicate that the provider ***should*** bill the state using the T1041 code with their new NPI.

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		For MRSS, many of the component services are billable and providers should work with the patient's primary insurer to understand what elements can be billed.
81	Can someone be in Center of Excellence or OTP HH and also enrolled in CCBHC?	Response being developed
82	Does TBH need access to the SUD section in BHOLD due to partnership with CODAC?	Response being developed
83	Which code should be used for urine screens?	A urine screen alone is not a qualifying event. If you are collecting the urine screening specimen as part of CCBHC activities, include this cost as part of your cost report. If you would like to capture this in the shadow claim, use shadow billing code – H0046. If you are conducting this activity outside of your function as a CCBHC, continue to bill as you have done previously.
84	In the CCBHC Billing Code List, S9986 is listed as a code that should be used when a service is not medically necessary, and the client understands that. • If this is accurate, then shouldn't this code not be used for TPL as the services are medically necessary but the insurance company will not pay for it?	Response being developed
85	This question impacts our EHR build. How do we bill for Medicaid clients who switch MCOs or move to Medicaid FFS mid-month?	Typically, members are not moved to a new MCO within the same month nor are they disenrolled partway through a month. Whichever MCO and CCBHC the member is attributed to as of the last day of PPS-2 eligible service in the month is whom should be billed for.
86	The CCBHC code guidance states that MRSS cannot be billed for the SUD population. We might have you in SUD who need MRSS. Can this restriction be removed?	Response being developed
87	What happens if a client changes insurance companies within a month - right now, clinics do split billing – first 15 days get billed to MCO 1 and second 15 days get billed to MCO 2	See response to Question #85.
88	What are the updated Year 1 dates?	Year 1: July 1, 2024 – June 30, 2025

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89	When is the expected timeline to receive the new waiver form specific for CCBHCs for attribution of clients? Do we provide these waivers at time of initial attribution prior to go-live?	
90	Please confirm, how long will be IHH clients be grandfathered into the high acuity ICTT group?	See response to Question #72