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?	The expectation is that the claim will include all shadow claims for that month. If you find that there was a service that was missed, the assumption is that any corrections will be submitted using an electronic process. Within the electronic process an adjustment is called a replacement claim (replacing an original paid claim) and a recoupment is called a void. Here are instructions that outline the process if the provider is using Medicaid's software: RI Provider Electronic Solutions Software (PES). replacements_voids.pdf (ri.gov) [linkprotect.cudasvc.com] Replacement involves adding missing services provided in the month (i.e., shadow claims). Recoupment would be to void the claim all together. If the provider is using their own billing software, then their software vendor would need to configure their software to submit these types of transactions.

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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 original language on this topic was based on specific federal guidance for CCBHC sites of service. The state has continued to engage with federal partners on this issue and has recently received updated federal guidance that permits CCBHC service delivery in nursing facility settings under the following specific guidelines: If CCBHC staff provide services as part of in-reach (care coordination) for the purpose of transition out of nursing facility, that can be an allowable activity, so long as the services are (1) furnished pursuant to a written plan of care (2) considered outside the scope of both NF and specialized services (3) for non-recurring set-up expenses for people transitioning from an institution (4) and are provided on or after the start of the discharge planning process. Allowable services would include those in alignment with the nine required CCBHC demonstration services that are also necessary to enable a person to transition into their own household such as assessing needs after discharge, working to identify and set up behavioral health services the person will need after discharge, accessing community services, non-medical transportation, and related services and supports.
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	For nursing facilities, please see response to question 5. Residential facilities and inpatient hospitals would follow the guidance provided to nursing facilities in the response to question 5. Correctional facilities are excluded from Medicaid coverage due to a provision in the Social Security Act Amendments of 1965 known as the Medicaid Inmate Exclusion Policy ("MIEP"). There are currently no IMDs in Rhode Island.

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	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?	
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. • 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)? Yes. You can provide community-based services in the service area where clients reside.	Yes. You can provide community-based services in the service area where clients reside.
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.

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		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, and include it in your cost report.
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,	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.**

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	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	
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?	IOP SUD is required, but the others 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	You will not need the form. We have updated the MCO ops manual.

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	need the form in Appendix C on or before the November attribution file distribution.	
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.
23	Further clarification around claim submission for all expected denied charges.	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.
	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	
24	The following questions/comments remain from previous comment periods:	The two-day timeframe is no longer relevant and the updated MCO Ops Manual will reflect this change.

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	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?	
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. 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	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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	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)	See response to Question #5

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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. Can you please clarify what file and purpose you're referring to? We do not currently generate an 824 file. Providers will be receiving a monthly attribution file, as occurs today with IHH/ACT.
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?	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.

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	2. How will HIPAA Minimum necessary rule be handled?	
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 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.	This process will be defined and implemented at a later date.
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?	Transition time for clients who are grandfathered into the high acuity population 1. <u>For Cohort 1</u>: 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. 2. <u>For Cohort 2</u>: as of 10/1/2024, 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. 3. 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. 4. Any exceptions that were granted prior to 7/1/24 (Cohort 1) or 10/1/24 (Cohort 2) 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.
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.

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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.	See Q121 and Q126
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. Update: A final measure set has been posted; we are in the process of creating a Quality Manual with updated guidance. The updated guidance posted by SAMHSA can be found here: https://www.samhsa.gov/sites/default/files/ccbhc-quality-measures-technical-specifications-manual.pdf
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. • Clinical responsibility for the CCBHC over the DCO was removed in the new SAMHSA regulations. Will it be removed here too?	The standards are being updated and the manual will be updated when it is shared publicly.
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?	No, CCBHCs do not need to report or map service categories.

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	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.	
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 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).	Yes, the Medicaid billing system will be configured to ensure no inappropriate denial of services.

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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,	#1 and 2: Outreach and care coordination (which could include collateral contacts) are a required and allowable CCBHC activity. It alone does not trigger payment of the PPS rate. However, it is a cost that's integrated and accounted for in the Cost Reporting process, and thus built into the PPS rate. #3: A triggering event delivered via telehealth is allowed in keeping with clinical best practices and billing requirements for Medicaid.

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	related corrective action and if necessary 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 response to 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	As noted in Question #6: Per Medicaid requirements, services (regardless of whether they are CCBHC or non CCBHC services) cannot be billed/reimbursed if

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	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 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.	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. 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?	Provider clarified in #137
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.

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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.	A provider's responsibility to meet regulatory requirements related to outreach attempts are still in place. The CCBHC model does not circumvent or change existing program requirements tied to regulations.
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.	Encounters refer to all reportable shadow encounters/claims. Billable or qualifying event/service refers to services that meet criteria to bill the PPS rate for the month. Not all encounters are qualifying/billable services.
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.
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.

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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.	As a reminder, the PPS rate is a loaded, monthly, cost-based rate, which will include these costs and will be billed each time a Medicaid eligible member is served for a threshold CCBHC service, regardless of the type of encounter.
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.
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.

CCBHC Provider Questions and Answer

		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.	See response to Question #32.
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?	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	Response being developed

CCBHC Provider Questions and Answer

	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? 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	This EBP, along with Seven Challenges and IDDT, has softened requirements for year 1. CCBHCs will be required to train indicated staffing (per certification standards) in each model for year 1 with a plan to implement to fidelity in Year 2.
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.

CCBHC Provider Questions and Answer

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. 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. Providers will need to explore the way to bill this through their commercial insurers. MRSS, like any bundled service that is comprised of other services, those services (as a group or individually) will be billed to the primary payer for CCBHC services.
81	1. Can someone be in OTP HH and also enrolled in CCBHC? 2. Can someone be in Center of Excellence and also enrolled in CCBHC?	#1 Individuals enrolled in OTP HH can also be enrolled in CCBHC. #2 Yes, individuals in Center of Excellence can also be enrolled in CCBHC. This decision may be revisited for year 2.
82	Does TBH need access to the SUD section in BHOLD due to partnership with CODAC?	See Q119, which included provider clarification.
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.	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.

CCBHC Provider Questions and Answer

	• 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?	
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?	Yes, we will remove these restrictions so you can bill MRSS for the SUD population.
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: Oct 1, 2024 – September 30, 2025
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?	Response being developed
90	Please confirm, how long will be IHH clients be grandfathered into the high acuity ICTT group?	See response to Question #32
91	What is the definition of a biologic sample?	A biologic sample is a material that originates from a living organism that which can be analyzed in a lab. Examples of biologic samples include Blood, Plasma, Urine, Feces, and Human Tissue.
92	What is the Definition of a "Satellite Facility"?	See from SAMHSA: Definitions of Satellite and Other Facilities Under the Section 223 Demonstration Program for CCBHCs (Updated March 15, 2023)
93	Can you provide clarification around outreach guidelines?	• If the focus is to engage hard to serve populations, this should be provided through a separate and dedicated team. • If the outreach/engagement activities focus on existing clients who have disengaged, the preference is to have this outreach activity performed by an existing team member known to the client.

CCBHC Provider Questions and Answer

		• Per SAMHSA, outreach and engagement includes outreach to underserved populations as well as engagement with difficult to engage clients. • BHDDH views outreach and engagement as not only outreach to existing clients but to those who are not currently enrolled in services. • Outreach can include street outreach, homeless outreach, and recovery/harm reduction. • Anyone providing outreach services that require specific certification/training (e.g., naloxone treatment) should adhere to all relevant state laws and regulations.

94	Can you clarify the new federal Intensive Outpatient Program (IOP) requirement for 7/1/24?	• SAMHSA criteria 4.f.1 states that "The CCBHC or the DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailor approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine (ASAM) level 1 and 2.1 including treatment of tobacco use disorders."
		• The IOP should focus on SUD but does not prohibit co-occurring MH and SUD.
		• CCBHCs will be required to provide IOP services for adults in Year 1. They may provide these services directly, or through a DCO agreement.
		• CCBHCs will be required to identify and have a referral arrangement with an IOP that serves youth in Year 1 to ensure appropriate access if a CCBHC member requires this level of care.
		  ○ Bradley Hospital has a co-occurring youth IOP.
		  ○ Your Care Coordination Agreement should identify your referral relationship with this program

95	Can you clarify updates to EBP requirements as of 2/2/24?	• **Fidelity Tools for required EBPs**
		  ○ We have taken out the fidelity column on the EBP table in the updated Certification Standards.
		  ○ The State recognizes the need for CCBHCs to implement the fidelity model that meets its needs for each EBP.
		  ○ Brandeis is currently working on identifying best practice fidelity tools for each EBP that we will share with all providers as a reference.
		• **12-Step Facilitation Therapy/Matrix Model**

CCBHC Provider Questions and Answer

		○ **Concern:** There was a question raised about the fidelity to this model, considering CCBHCS are not required to provide 12 step facilitation directly. ○ **Plan:** Brandeis is currently reviewing fidelity models, taking this into account. The state will review provide updated fidelity guidance to CCBHCs. • **Family Psychoeducation** ○ **Concern:** CRAFT and Family to Family may not be the most appropriate EBPs under Family Psychoeducation for all providers, depending on the needs of the population. ○ **Plan:** Providers should utilize the appropriate EBP under "Family Psychoeducation" that meets the unique needs of their population. Brandeis will suggest a list of models to allow for provider flexibility. The State will review and provide updated clarification on Family Psychoeducation models. • **Seven Challenges, IDDT, Zero Suicide** ○ **Concern:** These models and EBPs have costly and timely training requirements which impact providing training to required staff, and fidelity to the model. • **Plan:** These three EBPs have softened requirements for year 1. CCBHCs will be required to train indicated staffing (per certification standards) in each model for year 1 with a plan to implement to fidelity in Year 2. BHDDH and EOHHS are currently working with Brandeis to identify training resources for CCBHCs and funding options. The State will provide updates on both training and funding options for these three EBPs.
96	Can you clarify CCBHC program staffing requirement updates for 7/1/24?	• **ICCT Rehab Specialist/Occupational Therapist (OT)** ○ Currently our ICTT team composition requires two rehab specialist positions: one bachelors level rehab and the second being a MA/OT. ○ We have decided to remove the OT option and instead require Masters level clinician with employment experience. • **SOAR Workers** ○ The SOAR workers can be included in your Cost Report and Staffing Workbooks.

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		○ The training for this SOAR work is covered by SAMHSA and should not be included in your Cost Report. • **DCO staffing in your staffing workbook.** ○ Your current addition of DCO staffing in your workbook can remain the same. ○ Please note: There may be additional needs for DCO staffing documentation for your Cost Report, however this should be addressed in your standing 1:1 staffing check-ins with BHDDH. • **Community Mental Health Workers/Community Health Workers** ○ We have confirmed that Community Mental Health Workers/Community Health Workers are not included in the SPA or updated Certification Standards. ○ Therefore, Community Mental Health Workers/Community Health Workers should not be included in your Cost report or Staffing Workbook. • **SOR/Co-Responder** ○ SOR/Co-responder contract termination letters have been sent to Cohort 1 providers with a contract end date of 6/30/24. ○ SOR/Co-responder contract termination letters have sent to Cohort 2 providers (minus FSRI!) with a contract end date of 9/30/24. ○ The SOR clinicians can be included in your Cost Report and Staffing Workbook.
97	How do I enroll/register as a Trading Partner?	• Here is the link to enroll as a Trading Partner: https://www.riproviderportal.org/hcp/provider/Home/TradingPartnerEnrollment/tabid/931/Default.aspx • This is an Enrollment Guide: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/HCP_Enrolling_as_TP.pdf • Once enrolled you will receive an email asking you to register. Here is a guide for registering: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/HCP_Registering_to_use.pdf • During the registration process you will be asked to create a User ID. You should enter the Trading Partner ID as the User ID.

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		• Additionally, you will need to create a password. It must be exactly 8 in length with at least one upper case, at least one lower case and at least one number. No special characters are allowed. • Finally once registered here is the guide for using the Healthcare Portal (HCP): https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/HCP_Using_the_portal.pdf • How to Managed Covered Providers: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2022-05/Managing%20Covered%20Providers%20Guide%20v1.1_0.pdf
98	Is the state willing to rethink children's treatment plan frequency. We currently require this 3 months for all children under CCBHC. Providers are requesting: 1. Treatment plan - high acuity KIDS should be done every 3 months. 2. Treatment plan – general population KIDS should be done every 6 months.	The state is maintaining the requirement for both high-acuity and standard population children to have 3-month treatment plan reviews. Given how quickly things can change with children and youth, it is important to frequently review this population's treatment plan to evaluate whether there is any improvement or decline in their functioning as this could prompt consideration for a different acuity level or even discharge/completion of treatment. A treatment plan review should not be a difficult task if you are meeting with the child regularly. Since the initial treatment plan is already in the EHR, the review would only require documentation of any significant changes or an acknowledgment that nothing has changed.
99	Are mobile crisis services provided in the ED setting qualifying services?	Response being developed
100	Will the state accept considerations for an alternative to Seven Challenges EPB for treating youth with co-occurring MH and SUD? We would prefer to use I-CBT since it has been the EBP we have used for years, have people trained in it, and have trainers in-state.	Providers are able to propose additional EBPs to use (by demonstrating its validity/improvement outcomes and explain how it is a comparable alternative). However, providers will still need to participate in the training offered by the state on Seven Challenges, as this will still be a required EBP.
101	Can the State provide guidance for how DCOs should bill for clients with Medicaid and commercial insurance?	See Q110
102	What does 3.d.3 of the DRAFT Certification Standards refer to? Cannot find this info.	3.d.3 – CCBHC coordinates and oversees services provided by the DCO. Apologies for the misalignment in reference #s; this will be fixed in the updated Certification Standards!
103	How to categorize high acuity adults in Staffing Workbook?	They should be included with the ACT/ICTT, CSP, or GOP sheets of the workbook

CCBHC Provider Questions and Answer

104	What will be the process for receiving and being notified of updated reference documents throughout the cost reporting and certification process?	The state will continue to update materials and guidance based upon feedback and follow-up questions from providers. To avoid inundating providers with several versions of the same document, we are batching updates. We are in the process of updating and reorganizing our EOHHS CCBHC webpages. We are working to post all updated reference documents to a central location, labeled with the release date: https://eohhs.ri.gov/initiatives/certified-community-behavioral-health-clinics-ccbhc/resource-documents. Older versions will be archived here: https://eohhs.ri.gov/initiatives/certified-community-behavioral-health-clinics-ccbhc/certified-community-behavioral. In tandem, we're also sending out email notices to providers with the updated document(s) attached to flag the availability of the updated guidance.
105	We see that QMHPs need to be recertified every 5 years. What does this process look like? Can you please provide specific guidance? Can they resubmit the same info as was provided the first time around?	QMHP Certification Technical Bulletin (released Jan. 30, 2024) > see instructions included on pages 8 - 9.
106	Is it permissible to incorporate additional detail as required by the updated standards as addenda to our originally drafted care coordination agreements, instead of establishing net-new agreements? For example, the VA has indicated they're unlikely to sign-off on a brand-new agreement due to administrative red tape and an Addendum would be the better path forward.	Yes, an addendum covering the new requirements is sufficient.
107	We may want to leverage the expertise of addiction medicine colleagues from another site. Providers from that site would be called upon to provide consultation service to our junior prescribers as we build our IOPs and ambulatory detox programs. Can we do this with a contractual agreement or is a DCO agreement required?	This can be contractual agreement. A DCO agreement is not required.
108	To account for staff ramp-up throughout SFY 2025, costs included in the Cost Report should reflect an	Example: If you're expecting to hire someone January 1st, that person should account for 0.5 FTE in your Cost Report.

CCBHC Provider Questions and Answer

	"average FTE" volume for SFY 2025. Can you clarify the "average FTE" and what this means for the CCBHC?	• January – June: 6 months (hence 0.5 FTE) • Cost reporting is completed on a 12 month basis. This is based off of the State Fiscal Year (July 1 – June 30), not the calendar year or your go-live date.
109	The issued guidance states: 'Our expectation is that the FTEs assumed in your Cost Report reflect reasonable onboarding and vacancy assumptions.' How will you account for staff turnover with the vacancies?	The minimum staffing thresholds provided by the State are guidelines. Our primary concern is ensuring adequate staffing to provide required services. Some State discretion is allowed. All providers should continue this dialogue with the State – help us to understand where you currently are with staffing, what your ramp-up plan is, how hiring is going, and what retention challenges you're up against. The State will evaluate readiness from a staffing standpoint with all of this information in mind.
110	The issued guidance states: 'Values should reflect contracted rates and anticipated volume assumptions for each applicable DCO arrangement.' How will the qualifying service be billed if it takes place at the DCO site?	**How providers will be paid for Dual-eligible clients:** • Duals with full Medicaid benefits: the state will pay the full PPS rate to the CCBHC less what is collected from any third party (whether it be CMS or a Part C plan) for the DCO-covered service. • For QMB Only clients, the CCBHC should use their older NPI and bill CMS or the client's Part C plan. Medicaid will reimburse the crossover claim up to the Medicare reimbursement rate or the PPS-2 rate, whatever is lesser. • For SLMB-only clients, the client is not eligible for any cost-sharing from Medicaid. **How providers should bill for duals:** • Duals with full Medicaid benefits: • The DCO will bill CMS or the Part C plan for any Medicare-covered services. • The DCO will bill the CCBHC for the CCBHC-contracted amount. • The CCBHC will bill Medicaid using the Duals/TPL billing process identified in the MCO ops manual (moving to the billing manual). • Meanwhile, • The DCO will report to the CCBHC the amount they collected from Medicare. The CCBHC may recoup the amount the DCO collected from Medicare.

CCBHC Provider Questions and Answer

		• If a crossover claim for the DCO services was submitted to Medicaid, Medicaid will process the claim as usual and pay the DCO. • The CCBHC will report the amount the DCO collected from Medicare to the state and the state will reduce their payment by this amount (similar to how the State will reduce payments by any amount directly collected by the CCBHC from Medicare.) • The state is working on a formalized report and process for CCBHCs to report DCO Medicare payment received. Example: 1. DCO A is acting as a DCO for CCBHC A. 2. DCO A provides 2 psychotherapy visits to CCBHC A's attributed client with dual eligibility for Medicare and Medicaid in the month. a. The DCO should bill Medicare their contracted rate – in this example their contracted rate is $150 per psychotherapy visit, $300 in total for this month b. DCO should bill CCBHC their CCBHC contracted rate – in this example their DCO subcontracted rate is $500 c. The CCBHC bills the state the full PPS rate using the process identified in the MCO ops manual d. Medicare pays the DCO $300 (total for the month) e. CCBHC pays DCO full contracted rate- $500 f. Once payment is received from Medicare, the DCO should report the $300 payment received from Medicare to the CCBHC who will then recoup or decrease future payment by the $300. g. The CCBHC should report to the state the $300 Medicare paid to the DCO. h. The state will reduce a future payment to the CCBHC by $300. Note: these rates are just an example and do not reflect actual rates.
111	Provide supporting documentation for population allocation methodologies. Are we using our own data to create the BHOLD attribution list or is one being provided by BHDDH?	• An initial attribution list will be provided by BHDDH to each provider closer to go-live for review and feedback. • For additional information, see: CCBHC MCO Operations Manual_12.01.2023 > pages 22 – 26 for general guidance.
112	Is RIO only being rolled out in Newport?	Correct. This is a program that they already run. Other providers are not required to offer this service/program.

CCBHC Provider Questions and Answer

113	For MRSS, do our staff need to be trained for MRSS or just the DCO we have providing this service?	Any crisis responder who is responding to children must be trained and have the ability to respond to children crisis needs, regardless if you are a specific MRSS provider, a DCO, or the CCBHC itself. All CCBHC entities will need to be certified by DCYF in emergency services. The CCBHC is responsible for ensuring that the provider they have DCO'd to has the appropriate certifications.
114	Will treatment plans be required every 90 days for all children or just high acuity children?	See response to Question #98
115	For the staffing requirements for go live, how are the staff numbers being determined for non ICTT or ACT programs? Based on our determination of need?	Response being developed
116	Can you provide more detail about the exception process for designating an adult as high acuity?	Response being developed
117	A particular CCBHC provides emergency evaluation services in EDs for hospitals across multiple catchment areas. The staffing we use to support these efforts is in addition to (not a part of) our mobile crisis response. Does the state prefer that we include these staffing costs as CCBHC staff in our cost report in anticipation of those visits triggering PPS2 payments or is it preferred that these staffing costs are reclassified in the cost report as non-CCBHC staff and we bill these services using traditional FFS billing and contractual agreements?	Response being developed
118	What provider code should we use for DCOs in BHOLD? Should each DCO have a different provider code specific to the DCO CCBHC partnership?	The CCBHC is responsible for reporting, including BHOLD, so there is no need to designate a DCO for BHOLD.
119	In reviewing the most recent FAQ, more information was requested regarding: 82 Does TBH need access to the SUD section in BHOLD due to partnership with CODAC? Request for	All providers who have access to BHOLD are asked to report on the same set of questions; there are no differences. Providers should follow the standard process in which the CCBHC is required to report.

CCBHC Provider Questions and Answer

	provider clarification: Can you provide more detail on your question? We have discovered throughout DCO meetings with CODAC that they have access to SUD questions that Thrive does not have. Since we are entering BHOLD data for CODAC, do we need the same access that they have? How do we get that access?	

120	What are the updated (as of 3/4/24) staffing requirements for MRSS and Adult Mobile Crisis?	We are requiring a 2-person response for both MRSS and adult mobile crisis. The staffing for 2-person response should include a licensed provider (Clinician, RN, QMHP) and a second responder. Second responders can include certified peer and/or an "unlicensed CCBHC personnel".
		
		Please see the qualifications for these specific "unlicensed CCBHC personnel" below:
		
		• Unlicensed CCBHC personnel must work under the direct supervision of a licensed professional or QMHP. Unlicensed staff must meet these qualifications:
		  ○ B.A. or B.S. degree in social work, psychology, or related field and have a minimum of two (2) years of experience in a human service profession;
		  ○ Certified in First Aid/CPR and as a Community Responder
		  ○ A minimum of four (4) years employment in the human services field may be substituted for a bachelor's degree.
		
		We expect that providers will review their staffing proposals to confirm alignment with this guidance.
		
		*Please note this guidance is subject to change pending any changes to federal authority or requirements.
		*Please note children's mobile crisis requires child competent clinicians

CCBHC Provider Questions and Answer

121	Are we only using federally-required measures for quality reporting?	For year 1 the state intends to use only the federally-required measures. We are in the process of developing a Quality Manual.
122	What will the Quality Manual include?	A Quality Manual is under development that will be similar to the existing quality manual for the AE program, but for CCBHC (AE quality manual linked here: https://eohhs.ri.gov/initiatives/accountable-entities/resource-documents under implementation manuals)
123	How will quality thresholds be determined? We request consideration of the amount of work we have on our plates when determining these thresholds	The state was expecting federal guidance regarding quality measure thresholds, but they ultimately left this decision to the state. The state quality team is working on setting those thresholds at ambitious but achievable targets. Currently, the quality team is using current state averages as the cutoff~~,~~ for measures for which this data is available. 2 clinic-collected measures that do not have current state performance data will be bench-marked based on other states.
124	Will we get any payment if we achieve some, but not all of the targets?	Yes, based on updated guidance.
125	Please note that if you are looking at state averages across all Medicaid managed care members, our CCBHC populations generally have greater need.	Yes, we are limited based on what baseline data we have for year 1 and benchmarks may need to be adjusted up or down to make them ambitious but achievable, as new data comes in. Once we can establish a baseline on your CCBHC, we will set CCBHC-specific improvement thresholds and a program-wide high performance threshold.
126	What is the timeline for collection and payoff?	Collection and reporting will begin ASAP. January 1, 2025 is when measurements will begin counting towards QBP thresholds. The payment will be made in fall 2026 because measurement relies on claims run-out and follow-up calculations. We will aim to provide quarterly performance reports.

CCBHC Provider Questions and Answer

127	Can the new CCBHC NPI be a sub-part under the provider's existing NPI, or does it have to be a completely new one?	Providers should apply for a separate NPI. The taxonomy should be 251S00000X - AGENCIES - COMMUNITY/BEHAV HLTH.
128	What should be the start date of DCO agreements?	The start date of the DCO agreement should align with the CCBHC's go-live date.
129	Housing Stabilization Services (HSS) currently requires an authorization and separate housing plan in order to be billed out separately. When including HSS in CCBHC this will no longer be a requirement, correct?	Response being developed
130	Does it matter which order the substance vs. MH diagnoses are listed on the claims from an analytic perspective?	The preference is to list the primary diagnosis first. An SUD diagnosis should be listed first if appropriate.
131	How much time is allowed for submission of replacement claims?	There are no changes to the timely filing agreements with MCOs.
132	The 90836 -Psychotherapy, 45 minute Add On Therapy code used with Evaluation and Management services is not included in CCBHC billing codes. This code is currently used, and will be used when billing TPL. This code needs to be included in order to prevent billing issues	

CCBHC Provider Questions and Answer

133	What is the billing process for Blue Cross and United DSNP Programs?	
134	Is there a CPT code we can use for running psych rehab groups under CCBHC? Other than the clubhouse code, there does not seem to be an option for outpatient except clinical groups.	
135	Could you please provide guidance as to when we should use MRSS billing codes vs H2011? Should MRSS codes be used for all age ranges or only children? Should our day ES clinicians use MRSS codes if they conduct a community-based crisis assessment?	
136	"In the High Acuity Adult Population 18 or over and…they are eligible for Rhode Island's I/DD waiver, and they have any behavioral health diagnosis." How do we know if someone is eligible for the I/DD waiver? Is there going to be a data base or some sort of way to get this information at intake. Are we relying on the client to let us know they are part of the I/DD program. I am sure I am missing something but wanted to at least have these issues addressed so we can put people in the right section of the care groupings.	
137	Enrollment Form – are providers expected to create their own, or will a specific one be given by the State?	

CCBHC Provider Questions and Answer

138	MCO Manual Question Follow-up: We asked this question a few months ago, and were asked in a recent meeting to provide a little more detail. The original question is #53. From what I can see, this specific language above is no longer there. However, I found the below information in quotes. First yellow highlight. So if I am interpreting this correct, the MCO will produce a quarterly report, with a 90-day lag and the provider will have 7 days to respond, not the original 15 (which was not much time to begin with)? I would like to posture that 7 days is not much time to respond to all attribution issues discovered in a three-month look back report. Some of the issues may be complex and involve some digging, or potentially involve other agencies. As to the second yellow highlight below, it will become even more complex to check in the 7 days, as future reports will not only have the previous 3 months to research, but will incorporate any reconciliations (that were done or not done) from the past year. It's just not enough time. It can lead to unnecessary denials to the agencies for services that actually were provided. Page 33 of the MCO Manual: Financial Reconciliation and Settlement	

CCBHC Provider Questions and Answer

	•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. o Q1 (Jan-Mar) – July 15th o Q2 (Apr-Jun) – Oct 15th o Q3 (Jul-Sep) – Jan 15th o 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.	
139	Regarding the requirement to have a Care Coordination Agreement with an AE. We are part of an AE, IHP, but the AE organization itself does not provide services, the organizations within the AE provide the services. We will have CC Agreements with 3 of the organizations in the IHP AE that provide care in our service area. Does this meet the requirement? If not, how do you want this CC Agreement structured?	