Certified Community Behavioral Health Clinics (CCBHC) Billing Manual

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I. Introduction

Document History

The State CCBHC Interagency Team, comprised of the Rhode Island Executive Office of Health and Human Services (EOHHS)/RI Medicaid, the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), and the Department of Children, Youth, and Families (DCYF), anticipates that this document will be updated and refined over the course of the CCBHC program to incorporate feedback and learnings from program participants, and to accommodate any program modifications required by the Centers of Medicare and Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the State. The table below will be updated accordingly.
This document is considered final for year 1 of the CCBHC program.

Version Number	Date	Summary of Changes
1.0	May 10, 2024	Initial Final CCBHC Billing Manual.

Purpose of this Document

This Certified Community Behavioral Health (CCBHC) Billing Manual is intended to support CCBHC billing in Rhode Island. It should be used in concert with:
(1) Rhode Island's CCBHC Certification Standards, which provide a comprehensive description of the programmatic and operational requirements of the CCBHC model;
(2) the Medicaid Managed Care Manual, which provides general managed care program requirements and processes;
(3) the CCBHC MCO Operations Manual, which is intended to support Managed Care contracting with the CCBHCs in Rhode Island
(4) the CCBHC Provider Manual, which provides programmatic guidance for providers;

(5) the CCBHC Quality Manual, which provides quality reporting and quality bonus payment (QBP) guidance for MCOs and providers; and
(6) CCBHC regulations, which define EOHHS, BHDDH, and DCYF regulatory requirements pertinent to the CCBHC program, e.g. licensing.

I. Program Scope

CCBHCs are required to provide the full array of outpatient mental health and substance use treatment services specified within the RI CCBHC Certification Standards, to all Rhode Islanders seeking behavioral healthcare regardless of their diagnosis, symptom severity, age, race, ethnicity, disability, sexual orientation, gender expression, developmental ability, justice system involvement, housing status, or ability to pay.

These CCBHC services will be reimbursed in accordance with the monthly Prospective Payment System (PPS) model by which a clinic's rates are set by dividing its allowable costs by the number of monthly qualifying encounters in a year. There will be one rate established per CCBHC for each of the following populations: high acuity adult, high acuity children and youth, substance use disorder (SUD), and standard.

This PPS payment model applies to all Medicaid eligible populations with the following clarifications:

- Qualified Medicare Beneficiary (QMB)-only individuals would be paid through cost-sharing up to the Medicare reimbursement rate or the PPS-2 rate if lesser.
- Specified Low-Income Medicare Beneficiary (SLMB)-only individuals would not be eligible for cost-sharing.
- SLMB+/QMB+ would be paid the PPS-2 Rate and would follow established third-party liability (TPL) processes.

CCBHC is an 'in plan' Medicaid benefit except for Dual Eligibles (defined here as Medicare and Medicaid eligible individuals) with CCBHC services provided out of plan (also referred to as Fee For Service).

The monthly PPS model includes an outlier payment mechanism (performed by EOHHS) and an additional Quality Bonus Payment (calculated and paid directly by EOHHS to eligible CCBHCs).

II. Attribution

A. Introduction to Attribution

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

The CCBHC program attribution process will be managed by BHDDH's Data Unit via the Gainwell eligibility system portal. The eligibility portal will be the repository for collecting and monitoring

CCBHC attribution and will serve as the single source of truth for purposes of determining program attribution.

The attribution will identify the specific CCBHC and the population rate category for each member (i.e., high acuity adult, high acuity children and youth, SUD, standard). Member attribution is used as the basis for PPS rate eligibility, program quality measurement, and data collection.

B. Initial Program Attribution File

BHDDH's Data Unit will develop an initial CCBHC program attribution file. This initial attribution file will be developed and confirmed as below. A detailed timeline will be provided based on a providers go live date.

- The initial attribution file will specify which population rate category an individual has been enrolled into (i.e., High Acuity Adult, High Acuity Children and Youth, High Acuity Substance Use Disorder, Standard Population) in accordance with the specifications in the Provider Manual. The file will also specify the CCBHC to which the client is enrolled.
    - Initial attribution file enrollment will be based on current IHH/ACT provider of record rather than their area of residence.
- BHDDH will electronically distribute a DRAFT initial attribution file to CCBHCs for their review.
- CCBHCs will have the opportunity to propose changes to this DRAFT attribution file. Requested changes may include errors/duplications between participating CCBHCs, incorporation of members served by DCO partners, and any other discrepancies.
- CCBHCs will submit their requested changes and supporting documentation to BHDDH's Data Unit.
- BHDDH will review all attribution change requests and make final determinations to approve or deny each request. Once complete, BHDDH will send the updated file to Gainwell.
- At this time, Gainwell will upload the file to MMIS and auto enroll recipients in the correct program and CCBHC provider in the Medicaid Management Information System (MMIS).
- Gainwell will identify any members who were included on the initial attribution file but did not end up being enrolled into the CCBHC based on eligibility criteria (e.g., they are not Medicaid eligibile at the time of the file upload) and will share that list with the BHDDH team
- BHDDH will share the final list with providers.
- Between the date of the initial attribution file and the go live date, providers may need to track enrollments and discharges while awaiting enrollment in MMIS as a CCBHC provider. Once providers are enrolled in MMIS as a certified CCBHC, they will be responsible for entering these updates into the provider portal.
    - Providers should enroll their members into the CCBHC program with a start date that corresponds with the CCBHC's full certification go live date

C. Ongoing Attribution

- **New Enrollments:**
    - The provider must submit a BHDDH CCBHC admission request via the healthcare portal. The client's eligibility category (i.e., High Acuity Adult, High Acuity Children and Youth, High Acuity Substance Use Disorder, Standard Population) and supporting diagnosis/assessment scores must be entered in the portal.
    - A member can be enrolled any time prior to payment submission.
        - For example, if a member receives their first qualifying encounter on 3/22/25, the provider should enter that date into the portal. The attribution for that member will be for the full month of March and the provider will receive the full PPS payment.
    - Staff at BHDDH will review and either approve or deny requests within two business days.
    - Any CCBHC service provided to a non-attributed CCBHC member should prompt the CCBHC to initiate/complete a new enrollment to ensure appropriate attribution and payment for all CCBHC services.
    - For individuals already enrolled/attributed to another CCBHC, the provider must provide services to the client but will not be eligible to receive payment for these services. The cost of the provision of all allowable, anticipated services are included in the cost report and therefore in the calculation of rates for each CCBHC.

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

- **Attribution Transfers and Care Transitions:**
    - Members may choose to change CCBHC service providers at any time. Support for this change request must occur expeditiously to reduce disruption to care, which may exacerbate symptoms and increase risk to the member.
    - A client may only be enrolled with **one CCBHC per month**. CCBHC attribution dates in the web portal cannot overlap. If a client is already attributed to a CCBHC, it is up to the receiving provider to coordinate transfer with the client's current CCBHC.
        - The CCBHC from which an attributed client is transferring should add a discharge date in the healthcare portal for the end of the current month. That CCBHC will be eligible to receive the PPS payment through the end of that month, consistent with any qualifying service provision.
        - The CCBHC admitting a client into their CCBHC should put an admission date in the healthcare portal for the 1st of the following month. The admitting

CCBHC will be eligible to begin receiving CCBHC payments the following month, consistent with any qualifying service provision.

- The CCBHC to whom the client is attributed to in a given month will be the provider that is eligible to receive PPS payment. There will not be partial month payments.
- CCBHCs and DCOs should develop data sharing arrangements, including EHR access, to facilitate care coordination and required reporting activities in the instances of a client transferring from one provider to another. If the current records transfer process is sufficient, that can be employed in this model. For further details regarding data sharing requirements please refer to SAMSHA's CCBHC criteria for care coordination.

D. Program Ongoing Attribution File and Reconciliation

- Provider attribution file and reconciliation:
  - The BHDDH Data unit will update the ongoing attribution file on a monthly basis before the 10th of each month based on the prior months attribution. The updates will show adjustments for new client enrollments, discharges, transfers, prospective member assignments, and population changes as described above. BHDDH will send the ongoing attribution file reflecting the attributions as they appear in MMIS so providers can verify against their own Electronic Health Records (EHRs).
  - Gainwell will maintain ongoing, up-to-date attribution, which can be checked by providers at any point for the most recent attribution information for members.
  - If needed, BHDDH will work with a CCBHC to review any errors on the ongoing attribution file and make any required updates in MMIS. In the event there are discrepancies that cannot be immediately resolved, the affected client will remain assigned to the CCBHC and population category they were attributed to on the earlier date, pending resolution.
- MCO Weekly Extract file and reconciliation:
  - Gainwell will submit the MCO Weekly Extract file (see sample file in Appendix A) to the MCOs on a weekly basis which will include the CCBHC attribution details, including a 24-month look-back period.
  - For the purposes of program integrity, all MCOs are required to, at a minimum, utilize the MCO Weekly Extract file provided by the state to retroactively audit CCBHC payments, in accordance with the specifications defined in the MCO Operations Manual.

E. Dual Eligible (MMP) Attribution

For dual eligible individuals enrolled in the Medicare-Medicaid Plan (MMP), the MMP participating health plan must review the MCO Weekly Extract file and identify any MCO enrolled dual eligible individuals attributed to CCBHCs (and therefore eligible to be paid a PPS2 rate directly by the state). For those identified dual eligible individuals attributed to CCBHCs, MMP participating health plans must monitor for and must not pay for any duplication of

services as specified in the MCO Ops Manual. For clients identified as Dual eligible and attributed to a CCBHC, the MMP should reimburse the CCBHC (using the provider's pre-existing non-CCBHC NPI) for any Medicare-covered services according to their existing contracted rates. The State will reduce its PPS2 payments to CCBHC by the amount paid by the MMP plan.

F. Grievance/Errors in CCBHC Attribution Report

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

III. Billing Requirements

A. Introduction to PPS2 Methodology for CCBHC Billing and Payment

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

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

Rhode Island elected to implement PPS2, which is a monthly PPS.

- In the monthly PPS, a clinic's rate is set by dividing its allowable costs by the number of monthly qualifying/billable encounters in a year. Monthly qualifying encounters are calculated as the number of months in which a patient has at least one qualifying encounter, regardless of the number of days or quantity of services received in any given month.
- Monthly PPS is similar to per-member-per-month capitated payment, **except** that clinics do not receive payment in a month in which a patient did not receive a qualifying service, so it is a per-served-member-per-month methodology.
- Under the monthly PPS option, states define "special populations" of patients based on level of complexity or need and set different rates for the Standard Population and each special population.
- States must implement quality bonus payments (QBP) in accordance with SAMHSA defined parameters, based on state-defined metrics, and include a process for addressing outlier costs.[1] The QBP will be calculated by EOHHS and paid directly by the state to eligible CCBHCs. For additional details about QBP payments, please see the CCBHC Quality Manual.
- Providers are required to submit one claim that will include all shadow claims for that month.
- Individuals may **not** be enrolled in both IHH/ACT and CCBHC. Individuals **may** be enrolled in OTP Health Home and CCBHC or Centers of Excellence and CCBHC for year 1.

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

B. CCBHC Population Rate Categories

The Rhode Island PPS2 rate structure will include four population rate categories:

1. High Acuity Adult
2. High Acuity Children and Youth
3. Substance Use Disorder
4. Standard Population (Adults and Children/Youth)

Eligibility criteria for each population are specified in CCBHC RI Certification Standards.

C. Qualifying and Non-Qualifying Services

There are two primary categories of CCBHC Services. Services that must be provided by the CCBHC directly, or in partnership with their DCO(s):

- **Qualifying Services** – an allowable service under the CCBHC program that when provided, will trigger the monthly PPS payment. PPS payment can be triggered only once monthly, per member.
- **Non-Qualifying Services** – an allowable service under the CCBHC program that does not trigger a PPS monthly payment. The expense of non-qualifying service encounters is an allowable cost in the cost report and therefore the expense is built into the PPS rate. However, these services, when delivered alone, do not qualify as a visit for the purpose of monthly billing. This means the delivery of these services by themselves will not trigger a payment of the PPS rate.

The current list of billing codes for qualifying and non-qualifying CCBHC services applicable to all MCOs in Rhode Island can be found here.

D. Dual Eligible and Third-Party Liability (TPL) Billing

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

- As certain services included in the PPS2 are covered by Medicare, EOHHS expects that there will be a meaningful volume of Medicare duals/TPL reimbursement (an estimated 40% of high acuity member visits). As described in Section A, CCBHC services for dual eligible populations are an out of plan benefit; therefore, this process will be handled through FFS.
- EOHHS estimates that there will be a much smaller amount of commercial TPL (<~2% of visits). This TPL process will generally be handled by the Medicaid Managed Care Organizations given that CCBHC services are an in-plan benefit for the majority of Medicaid individuals.

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

1. Dual eligible Medicaid members with Medicare FFS (i.e., Part B)
2. Dual eligible Medicaid members with CCBHC out of plan
    a. Medicaid members in FFS with Commercial TPL (including Medicare Part C/Medicare Advantage)
    b. Dual eligible individuals in Neighborhood Integrity, where the CCBHC services are out of plan
3. Dual eligible Medicaid members in managed care with Commercial TPL

Details for the processes to follow for each of these scenarios can be found in Appendix B.
Note: MCO Financial Data Cost reporting (FDCR) will include CCBHC TPL collections.

E. Billable Events and Payment

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

- A client is attributed to the CCBHC; and
- Had at least one qualifying service among their claim details (shadow claim) in that month from the CCBHC where they are enrolled or its Designated Collaborating Organization (DCO).
    - A visit is defined as qualifying "billable event," when a client receives at least one face-to-face encounter or telehealth visit with a CCBHC qualifying staff person in a qualifying setting during which qualifying CCBHC services are provided and documented, consistent with the Attribution Guidance in section II of this manual.

- The T1041 (always the first detail on the claim) should have the date span of the entire month. If a provider's billing system does not allow for this, use the first date of service through the end of the month. Each subsequent claim detail should be the actual date of service.
- A CCBHC can bill back to the date of the initial service as long as the member is not attributed to another CCBHC for that month.

F. Billing Restrictions

Please note the following billing restrictions:

- Correctional facilities are a disallowed setting for Medicaid billing under federal law.
- CCBHC services cannot be reimbursed if they are provided in a setting or as part of a service in which behavioral health care is already part of a bundled payment.
- Service provision is limited to discharge planning activities in the following settings, as described in further detail below:
    - Nursing homes
    - Inpatient hospitals

- Institutes of Mental Disease (IMD)
- Non-community based residential facilities
- Intermediate Care Facilities

The following information provides further guidance on billing in these non-carceral institutional settings:

- If CCBHC staff provide services as part of in-reach (care coordination) for the purpose of transition out of these non-carceral institutional settings, 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 the institutional setting 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.

G. CCBHC Specific National Provider Identifier (NPI)

- Participating CCBHC providers will be responsible for obtaining a unique, CCBHC specific NPI upon certification, using the taxonomy provided in **Appendix E.** Providers should enroll as a Medicaid provider using that NPI. The NPI will represent the billing provider.
- Providers should bill all CCBHC qualified services provided to CCBHC attributed members using this NPI.
- Non-CCBHC services including, but not limited to: MHPRR, SUD Residential, Acute/Crisis Stabilization Units, BH Link, children's home-based services referred and authorized by the DCYF Central Referral Unit (CRU), early intervention, infant/early childhood home visiting programs, etc. should be billed under the existing, non CCBHC NPI.

H. Provisions for Payment – PPS Codes and Modifiers

EOHHS has established T1041 as the PPS2 rate code to be utilized for all PPS billing. Participating CCBHC providers are required to submit a claim using their CCBHC specific NPI for T1041 with a modifier to determine the appropriate population consistent with the population definitions specified in **Appendix C** (in the MOD1 position) to trigger a PPS payment. A list of the required T1041 modifiers (MOD1) can also be found in **Appendix C**.

- EOHHS requires this specific billing code and population modifier to be used across all MCOs and FFS Medicaid.

- Providers should list the primary diagnosis first. A SUD diagnosis should be listed first if appropriate.
- EOHHS has added a modifier to distinguish services provided by a DCO.
- Final approved EOHHS PPS2 rates for T1041 and each of the modifiers will be posted here. EOHHS will update and rebase these PPS rates in accordance with CMS rules. These rates must apply across all participating RI Medicaid managed care providers and Medicaid FFS.

I. Provisions for Payment – Qualifying Service Codes

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

J. Responsibility for Payment

For all populations and services specified in Section I - Program Scope, the MCO is responsible for paying the established provider and population-specific PPS rate per T1041 claim. This payment is directly paid by the MCO to the CCBHC.

- No fee is paid on shadow claims.
- MCOs must ensure that the professional claim that triggers payment of the PPS rate, includes the T1041 code + population modifier + at least one qualifying code. Shadow claims can include qualifying and non-qualifying CCBHC services.
- MCOs are required to implement a process to ensure CCBHC payments are exclusively made to the appropriate CCBHC attributed members; this process must, at a minimum, include retroactively auditing CCBHC payments on a monthly basis.
- MCOs are required to confirm that the member population category matches their enrollment at the time of the DOS, based on the Weekly MCO Extract File.

CCBHC services for dual eligible populations are an out of plan benefit; therefore, the state is responsible for paying the established provider and population specific PPS rate per T1041 claim. In such cases, the payment process and confirmations described in Section E. Dual Eligible and Third-Party Liability (TPL) Billing will be performed by the state.

K. Duplication: Non-CCBHC Service Monitoring and Reporting

- There will not be partial month payments. The CCBHC to whom the client is attributed on the 1st day of the month will be the provider eligible for the PPS2 payment, except for extenuating circumstances due to retrospective portal updates.
    - CCBHC qualifying services provided **by a participating CCBHC to a member who is not attributed to that CCBHC** for the month of service should be billed using the qualifying service billing codes found here.

- CCBHC qualifying services provided by non-CCBHCs for an attributed member shall be billed and paid at the provider's standard billing rate.
- For those participating CCBHCs that are also CMHOs, any claims for CCBHC eligible services provided by the associated CMHO to CCBHC attributed members will be denied.
- For those participating CCBHCs that are also CMHOs participating in the IHH and/or ACT programs, CCBHC attributed members can not also be attributed to an IHH or ACT program;the CMHO IHH/ACT claims will be denied
- MMP participating health plans are responsible for monitoring for any duplication of services for individuals who are both dual eligible (MMP) and attributed to a CCBHC to ensure that they do not pay for those services. For additional details please see refer to the Program Integrity section of the CCBHC MCO Ops manual.

L. Detailed Claims and Shadow Billing

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

- **Purpose**
  - EOHHS uses the detailed claims to monitor the cost and utilization of services provided by CCBHCs. Underlying encounters will also be used to validate services provided to CCBHC attributed populations and their assignment to the appropriate population category.
  - These detail claims or encounter data – sometimes referred to as "shadow data" or "shadow services" – are needed to track important performance measures that can only be appropriately measured based on details submitted for purposes of calculating the Quality Bonus Payment program.
    - For example, follow-up after an emergency department (ED) visit can only be appropriately measured if all shadow claims are reported; otherwise, it may appear as if the follow-up never occurred, even if it did.
  - Detailed claims or encounter data are also critical to successful PPS rate setting and rebasing. CCBHCs that under-report these shadow data will risk substantive reductions in future PPS rates that may be tested and justified against these claims.
- **Shadow Billing Process**
  - Providers are required to include all shadow claim data on the submitted claim.
  - While it should be rare, if a provider identifies that there was a service that was missed, any corrections should 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.
    - 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.

        - Alternatively, Providers will use the Medicaid software: RI Provider Electronic Solutions Software (PES) for the replacement claims. Instructions for submitting a replacement claim can be found here.
    - The PPS rate code and modifier should be bundled with the corresponding qualifying and non-qualifying services provided to the attributed member for that month, including all relevant billing codes as specified in **Appendix C.**
    - Please note, providers must update date span to include dates of all services. If a new shadow claim falls outside of the previously paid claim date span, providers must update the date span in the replacement claim.
- EOHHS will monitor these claims to ensure that adequate and appropriate shadow claims are included with submitted claims. Failure to submit adequate and appropriate shadow claims may trigger a Medicaid Financial Audit and further penalties in accordance with Program Integrity processes as specified in Section Q. Medicaid Financial Auditing, Corrective Action, and Decertification Standards and Processes.
- Providers should submit claims in a timely manner. General timely filing rules apply.

M. Financial Reconciliation and Settlement

- MCOs are required to complete a Cost and Utilization Report as specified in the MCO Operations Manual and **Appendix D** of this manual. This report will specify paid and denied claims (with and without TPL) by population, by CCBHC, by month.
- This report will be used by all parties to identify any claims discrepancies and to support the determination of any required adjustments, financial reconciliation and/or settlement.
- Each MCO will determine a format for conducting reconciliations based (at a minimum) on this report. CCBHCs should consult with MCOs to determine how any required adjustments, financial reconciliation and/or settlement will be handled.

N. Utilization Review & Management

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

- If an MCO delegates managed care functions to the CCBHC, the MCO remains the responsible party for adhering to its contractual obligations.
- The CCBHC must provide utilization management and oversight of all services performed by a DCO, consistent with all requirements included in the CCBHC RI Certification Standards.
- A MCO shall not require prior authorization for CCBHC or crisis services.
- MCOs will also be responsible for monitoring attributed members to ensure appropriate payment is being made to CCBHCs only for a month in which a member received at least one qualifying service, or “billable event” in that month from the CCBHC they are attributed to, or from one of the CCBHCs DCOs.

O. Outlier Thresholds and Allocation Guidance

The PPS2 rate reimbursement methodology includes an outlier payment mechanism to reimburse clinics for costs above the state-defined threshold. Federal regulation requires outlier payments to be made based upon allowable CCBHC costs for each member on either a monthly or annual basis.

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

P. Quality Bonus Program (QBP)

The QBP is an additional incentive payment made to CCBHCs that report and meet required quality performance thresholds for members attributed to their CCBHC. States who elect a PPS2 model must implement a quality bonus program in accordance with SAMHSA defined parameters, based on state-defined metrics. The QBP payments will be calculated by EOHHS and paid directly by the state to eligible CCBHCs. For additional details about QBP payments, please see the CCBHC Quality Manual.

Q. Medicaid Financial Auditing, Corrective Action, and Decertification Standards and Processes

In accordance with federal and state law, Rhode Island Medicaid has the authority to decertify an organization as a provider of CCBHC services.

- Rhode Island Medicaid (and/or its participating MCOs) will perform regular financial audits of the CCBHC's billing, cost reporting, contracting, and volume on a schedule and in a manner of Rhode Island Medicaid's choosing.
- Participating CCBHCs must make all records, audits, claims, documentation, and other materials available to Rhode Island Medicaid and participating health plans upon request in support of these audits.
- Following a Medicaid financial audit, Rhode Island Medicaid will generate a report identifying any findings and recommendations that require a response by the CCBHC site.
- Depending upon the findings and recommendations of the report, the state may (1) impose immediate penalties, fines, and restrictions up to and including decertification or exclusion from participation in the Medicaid program; or, (2) the CCBHC site may be required to provide a Financial Corrective Action Plan (FCAP) for achieving compliance within 30 days of receiving the state's report. The CCBHC site may also present new information to Rhode Island Medicaid that demonstrates it was in compliance with the questioned provisions at the time of the review.
- Rhode Island Medicaid will review the FCAP, and either seek clarification or additional information from the CCBHC site as needed or issue an approval of the FCAP within 30 days of receipt.

- Depending upon the nature and scope of the financial audit findings, the Financial Corrective Action Plan may be required to include an allowance for penalties, fines and/or restrictions in eligibility (e.g. Quality Bonus Program eligibility). These requirements will be specified in the findings.
- Failure to complete the remediation requirements and timelines specified in the Financial Corrective Action Plan may result in further penalties, fines and restrictions up to and including decertification or exclusion from participation in the Medicaid program.

R. Billable Events Description

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

- **A face-to-face encounter** is a visit that takes place in person (i.e., with the staff person and the client in the same room or via telephone or videoconference). A face-to-face encounter is provided in one of the following contexts:
    - With only the client and staff person present;
    - With the client, the staff person, and the client's family member(s) or representative present;
    - With only the client's family member or representative and the staff person present, subject to the client's consent (an encounter in this context may not serve alone as a visit for the purpose of monthly billing); or
    - With two or more clients and a staff person present in a group setting.

- **Telehealth:** An encounter provided via telephone or videoconference may only be considered a visit when such event is a minimum of 15 minutes, and otherwise meets the requirements for a billable outpatient visit under the RI Medicaid program (for example, in terms of clinical necessity, and relevance to the client's treatment plan), and it is conducted directly with the client.

- **Qualifying Service Settings:**
    - An encounter can take place in any location type, unless otherwise specified in this manual in Section F. Billing Restrictions.
    - Service location is generally restricted to the CCBHC's approved catchment area, with the following clarifications:
        i. Services which are appropriately billed from locations within the CCBHC service area, such as crisis services or any other CCBHC service provided in homes and/or community locations within the service area, are not considered to be outside the service area.
        ii. CCBHCs can provide services to attributed 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).

iii. Attributed clients can receive services from their designated CCBHC in their homes and in community-based locations which may be outside fo the service area of the CCBHC they are attributed to.

iv. CCBHCs cannot establish a new physical location or brick and mortar clinic for CCBHC service delivery outside their catchment area.

- **Qualifying Staff:**
  - A CCBHC qualifying staff person is defined in the certification standards.
- **Qualifying Service:**
  - A list of Qualified Services can be found here.

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

Appendices

Appendix A: Sample MCO Weekly Extract File

MID	LNAME	FNAME	DOB	GEN	PR NAME	PR NPI	PI	PI START DATE	PI END DATE	TYPE	SCORE	DATE	DX CODE	LST_CHG_DTE
Medicaid ID	Member Last name	Member First name	Member Date of birth	Member Gender	Provider Name	Provider CCBHC NPI	Program Indicator	Program Start Date	Program End Date	Asssessment Type	Member Assessment Score	Date Assessment Administered	Member Diagnosis Code	Score Last Change Date

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

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

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

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

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

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

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

- CMS adjudicates claim and reimburses provider, and submits crossover claim to Gainwell.

- **Gainwell action:**
  - Gainwell adjudicates the PPS2 claim and reimburses provider the full PPS2.
  - Gainwell processes the separate crossover claim from CMS and reimburses provider for balance, if any, owed to provider.

  Note that the balance owed is the difference between the Medicaid Program allowed amount and the Medicare Payment (Medicaid Program allowed minus Medicare paid); or the Medicare coinsurance and deductible up to the Medicaid Program allowed amount.
- **EOHHS action:**
  - EOHHS (or Gainwell) calculates total Medicare and Medicaid paid to the provider over the prior period (i.e., amount of TPL reported for members with a concurrent PPS2 payment since last calculation performed).
  - EOHHS prepares a Fiscal Agent Control Number (FACN) request establishing a PAR against the provider's CCBHS provider ID that will auto-decrement the calculated amount against the provider's payment in the next financial cycle.

  This process will be performed on a regular schedule – either monthly or quarterly.
- **EOHHS audit function:**
  - EOHHS will establish an audit process/mechanism to hold CCBHC responsible for billing TPL.
  - EOHHS will review crossover and PPS2 payments for all Dual/TPL clients to assess proportion of clients with Medicare or Commercial-paid services and the volume of such services per member.
  - The expectation is that the CCBHC should have a reasonable volume of crossover activity for their Dual/TPL clients:
    - There should be a crossover claim for most Duals. If there are (a) no crossover claims within a month, and/or (b) certain codes appear on the Medicaid FFS claim (and not on a denied crossover detail) then we can assess if there is not sufficient billing to Medicare.
  - Failure to submit adequate and appropriate TPL claims may trigger a Medicaid Financial Audit and further penalties in accordance with Program Integrity processes as specified in Section Q.

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

- **CCBHC action:**

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

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

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

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

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

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

Additional Questions

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

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

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

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

Q3. How will TPL recoupments be treated?

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

Q4. How will Gainwell's recoupment process work?

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

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

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

Q5. How will TPL work with DCO?

DCOs should bill CMS or the Part C plan for any Medicare-covered services. The DCO should bill the CCBHC for the CCBHC-contracted amount. The CCBHC should bill Medicaid using the Duals/TPL billing process identified above.

Meanwhile, the DCO should report to the CCBHC the amount they collected from Medicare. The CCBHC may recoup the amount the DCO collected from Medicare. 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 should 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.

For example: DCO A is acting as a DCO for CCBHC A. DCO A provides 2 psychotherapy visits to CCBHC A's attributed client with dual eligibility for Medicare and Medicaid in the month. 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. The DCO should bill CCBHC their CCBHC contracted rate – in this example their DCO subcontracted rate is $500. The CCBHC bills the state the full PPS rate using the process identified above. Medicare pays the DCO $300 (total for the month). The CCBHC pays DCO full contracted rate - $500. 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. The CCBHC should report to the state the $300 Medicare paid to the DCO. 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.

Q6. How will EOHHS assure compliance with this guidance?

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

Q7. TPL doesn't appear for a CCBHC-included service (e.g., MRSS). Can we bill Medicaid directly and waive TPL?

No, Medicaid is the payer of last resort and the CCBHC must bill the patient's insurance for any services rendered as detailed above, including commercial and Medicare coverage. MRSS, like

any bundled service that is comprised of other services, has many component services that are billable. Providers should work with the primary insurer to understand what elements can be billed.

Appendix C: Services and Billing Codes

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

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

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

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

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

Appendix D: CCBHC Implementation Monitoring: Cost and Utilization Report

In lieu of the filling out the requested template (see below for sample), the MCO may provide a CSV extract that includes the same relevant information in the following format.

The file should be named as **[MCO]_CCBHC_UTIL_RPT_[YYYYMMDD].csv**, where MCO is the name of MCO (i.e., NHP, TUFTS, UHC) and YYYYMMDD reflects date of extract (i.e., February 1, 2025, should be formatted as 20250201).

For each submission include all claims paid through date of extract for each prior reporting month. Please append the refresh of each reporting period within the same csv file. For example, the CSV submitted in February would include reporting for October, November, and December, with each reporting reflecting all claims paid or denied through January 15, 2024.

Field Name	Format and/or Allowed Input
REPORT_PERIOD	NUMBER(8) i.e., YYYYMMDD format to reflect end of reporting/incurred month
PAID_THRU	NUMBER(8) i.e., YYYYMMDD format to reflect last paid date reflected in extract
CCBHC	CCA, FSRI, GHI So County, GHI Johnston, GHI Pawtucket, NHM, Thrive, TPC
POPULATION	High Acuity Adult, High Acuity Children and Youth, SUD, Standard
PAID_AMT	NUMBER(10,2)
TPL_PAID_AMT	NUMBER(10,2)
ATTRIBUTED_CLIENTS	NUMBER(10)
SUBMITTED_CLAIMS	NUMBER(10)
PAID_CLAIMS	NUMBER(10)
PAID_CLAIMS_W_TPL	NUMBER(10)
DENIED_CLAIMS	NUMBER(10)
DENIED_CLAIMS_W_TPL	NUMBER(10)

CCBHC Implementation Report: Cost and Utilization Report

MCO:

Report Period: October 2024

Date (Re-)Submitted:

The initial report should be sumitted one month after the reporting period and reflect claims activity paid/denied through 15 days after period. For example, the initial report for October would be submitted to EOHHS Medicaid on December 1, 2024 with claims activity through November 15, 2024.
For each subsequent month, please refresh this data. For example, on January 1, 2025, please report updated claims acitivty for PPS-2 services incurred in October, but now with all claims submitted through December 15, 2024.

We are requesting that MCOs refresh this data until claims are fully adjudicated--we anticipate this to be 4 times (i.e., allowing for a total of approx. 120 days of runnout after accounting for initial lag in reporting).

Report Period	Claims Acitivity as of	CCBHC	Population	Paid Amount	TPL Paid Amount	Attributed Clients	Submitted Claims	Paid Claims	Paid Claims with TPL	Denied Claims	Denied Claims with TPL
October 2024	November 15, 2024	Community Care Alliance	High Acuity - Adult								
October 2024	November 15, 2024	Community Care Alliance	High Acuity - Youth								
October 2024	November 15, 2024	Community Care Alliance	High Acuity - Substance Use Disorder								
October 2024	November 15, 2024	Community Care Alliance	General Population								
October 2024	November 15, 2024	Community Care Alliance	Subtotal								
October 2024	November 15, 2024	Newport	High Acuity - Adult								
October 2024	November 15, 2024	Newport	High Acuity - Youth								
October 2024	November 15, 2024	Newport	High Acuity - Substance Use Disorder								
October 2024	November 15, 2024	Newport	General Population								
October 2024	November 15, 2024	Newport	Subtotal								
October 2024	November 15, 2024	Thrive	High Acuity - Adult								
October 2024	November 15, 2024	Thrive	High Acuity - Youth								
October 2024	November 15, 2024	Thrive	High Acuity - Substance Use Disorder								
October 2024	November 15, 2024	Thrive	General Population								
October 2024	November 15, 2024	Thrive	Subtotal								
October 2024	December 15, 2024	Community Care Alliance	High Acuity - Adult								
October 2024	December 15, 2024	Community Care Alliance	High Acuity - Youth								
October 2024	December 15, 2024	Community Care Alliance	High Acuity - Substance Use Disorder								
October 2024	December 15, 2024	Community Care Alliance	General Population								
October 2024	December 15, 2024	Community Care Alliance	Subtotal								

July | August | September | lookups | +

Appendix E: Taxonomy for CCBHC NPI Application

All providers will be required to:

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

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

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