

CCBHC Provider Questions and Answer

Note: Highlighted text reflects either new responses or updates.

#	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 Billing 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)	<p>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.</p> <p>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.</p> <p>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.</p>
4	What is the process for submitting late shadow claims, without having to hold up the claim?	<p>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]</p> <p>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.</p>

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<p>5</p> <p>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.</p> <p>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."</p> <p>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?</p>	<p>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:</p> <p>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.</p>
<p>6</p> <p>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.</p> <p>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</p>	<p>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.</p>

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	<p>allowable location, then the CCBHC should enroll the member and bill using the PPS-2 rate.</p> <ul style="list-style-type: none"> • 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? 	
<p>7</p>	<p>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.</p> <ul style="list-style-type: none"> • 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)? <p>Yes. You can provide community-based services in the service area where clients reside.</p>	<p>Yes. You can provide community-based services in the service area where clients reside.</p>
<p>8</p>	<p>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)?</p>	<p>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.</p>

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		<p>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.</p> <p>Non-CCBHC services include: MHPRR, SUD Residential, Acute/Crisis Stabilization Units, BH Link etc. Those services may be billed under the customary NPI.</p>
9	PPS T1041 modifiers - We need the modifiers	Modifiers have been finalized and are integrated into the Billing 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?	<p>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.</p> <p>If you didn't include this in your cost report, you should bill using your existing NPI and H0044 code</p>
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	<p>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.</p> <p>H2014: Treatment Consultation – Occupational, Physical, Speech and Language Therapists</p> <p>H0004 (+ modifiers): BEHAVIORAL HEALTH</p>	<p>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.</p>

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	<p>COUNSELING AND THERAPY</p> <p>H0031 (+ modifiers): MENTAL HEALTH ASSESSMENT, BY NON-PHYSICIAN</p> <p>H2016: Comprehensive community support services, per diem formerly known as Service Plan Implementation - Direct Implementation</p> <p>S9446 (+ modifier): Patient education - Social Skills Group</p> <p>T1019: Personal Care Services</p> <p>T1023: SCREENING TO DETERMINE THE APPROPRIATENESS OF CONSIDERATION OF AN INDIVIDUAL FOR PARTICIPATION IN A SPECIFIED</p> <p>T1024 (+ modifiers): Home Based Therapy – Specialized Treatment/Treatment Support</p> <p>T1027: Family Training and counseling for child development, per 15 minutes formerly known as Clinical Consultation</p>	
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	You will not need the form. We have updated the MCO ops manual to reflect the removal of a form requirement.

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	the form in Appendix C to request changes? - We will need the form in Appendix C on or before the November attribution file distribution.	
20	<p>Manual states all enrollments will be backed dated to the 1st of the month.</p> <p>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?</p>	<p>The manual has been updated. Actual dates of service and enrollment should be use for all program activities.</p> <p>There are no changes to BHOLD reporting.</p>
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	Providers should ensure all steps are taken to comply with federal and state confidentiality and privacy requirements. The state recommends providers obtain written consent to keep on record for auditing purposes.
22	<p>"EOHHS may add additional billing requirements or modifiers to capture..."</p> <p>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)</p>	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	<p>Further clarification around claim submission for all expected denied charges.</p> <p>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.</p> <p>Inclusion of a list of all reasons for denial, possibly categorizing within "expected" denials and denials that need attention for resubmission</p>	The State is unable provide a list of all denial reasons. In the event of a denial, the CCBHC should ensure the claim submitted was a clean claim to enable successful processing. If a CCBHC believes the denial is inappropriate, the CCBHC should pursue grievance and appeals rights pursuant to their payer agreement. There are certain appropriate denials that will occur (i.e., client is already enrolled and receiving services through another CCBHC, client is in a hospital). In these events the CCBHC would not be reimbursed.
24	The following questions/comments remain from previous comment periods:	The two-day timeframe is no longer relevant and the updated MCO Ops Manual will reflect this change.

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	<p>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?</p>	
25	<p>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?</p>	<p>Yes, you can bill back to the date of initial service as long as they are not attributed to another CCBHC for that month.</p>
26	<p>BHDDH responded to a question from a group participant about who is helping the DCO's be able to capture shadow billing.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	<p>The code list is final for Year 1, reflecting feedback received from providers. If there are any ongoing issues, please let us know.</p>

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	<p>for the code list to be updated with the comments made at this session.</p> <p>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.</p>	
<p>27</p>	<p>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.</p> <ol style="list-style-type: none"> 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) 	<p>See response to Question #5</p>

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	<p>4. If yes, can the triggering service be provided on day of admission or discharge from the nursing home?</p>	
28	<p>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.</p> <p>Can we receive an 824 file electronically that could be pulled into our system?</p> <p>How do we account for clients transferring from a non-CCBHC IHH/ACT provider, including OTP IHH?</p>	<p>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.</p> <p>Can you please clarify what file and purpose you're referring to? We do not currently generate an 824 file.</p> <p>Providers will be receiving a monthly attribution file, as occurs today with IHH/ACT.</p>
29	<p>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.</p> <p>Will this be an excel file so we can import into our systems for easy comparison?</p>	<p>Each payer will determine a format for conducting reconciliation. CCBHCs should consult with MCOs to determine how the reconciliation report will be shared.</p>
30	<p>Transfer of the full client record including DCO services, within 10 business days.</p> <p>Please explain what is required for DCO services (just date of service or progress notes)—Can we keep our current records transfer process?</p> <p>If not:</p> <ol style="list-style-type: none"> 1. How will 42 CFR Part 2 rule (re-disclosure of SUD data) be handled? 	<p>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.</p>

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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	<p>MCO Manual states High Acuity people need to be reassessed every 90 days.</p> <ul style="list-style-type: none"> • 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? 	<p>Transition time for clients who are grandfathered into the high acuity population</p> <ol style="list-style-type: none"> 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). <p>We would recommend having a staggered process beginning in July.</p>
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	<p>CCBHC are entitled to 5% QBP:</p> <ul style="list-style-type: none"> 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	<p>Federal QM & QBP</p> <ul style="list-style-type: none"> 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	<p>Quality Measures</p> <ul style="list-style-type: none"> 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? 	<p>The list of measures is not finalized. The measures will be updated based on final measure set when it is provided by CMS.</p> <p>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</p>
37	<p>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.</p> <ul style="list-style-type: none"> Clinical responsibility for the CCBHC over the DCO was removed in the new SAMHSA regulations. Will it be removed here too? 	The language has been updated in the Certification Standards to read as follows: "DCOs shall meet the same quality standards as CCBHCs and CCBHCs have responsibility for the services provided by a DCO."
38	<p>Outlier threshold</p> <ul style="list-style-type: none"> 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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	<p>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.</p>	
40	<p>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).</p> <ul style="list-style-type: none"> • 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? <p>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.</p> <p>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.</p>	<p>When a new member is enrolled on 9/10, it is okay to both enroll in the provider portal on 9/10 and date span the claim from 9/10-9/30, for example.</p>
41	<p>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).</p>	<p>Yes, the Medicaid billing system will be configured to ensure no inappropriate denial of services.</p>

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42	<p>Reconciliation and Settlement holds MCOs accountable to only a report on/by July 15th, 2024, for services rendered in February or March.</p> <p>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.</p>	<p>MCOs are contractually obligated to pay for CCBHC services.</p>
43	<p>With traditional Medicaid, we were able to retroactively bill back one year. MCO's has always had a shorter window.</p> <p>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?</p>	<p>We encourage providers to submit claims timely. Timely filing rules will not be changed for the CCBHC programs.</p>
44	<p>Under "Non-Qualifying Service"</p> <ul style="list-style-type: none"> • 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. <ol style="list-style-type: none"> 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, 	<p>#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.</p> <p>#3: A triggering event delivered via telehealth is allowed in keeping with clinical best practices and billing requirements for Medicaid.</p>

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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?	Duplicate. See Q20
48	Is the state going to update B HOLD 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?	Duplicate. See Q20.
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	See question 21.
50	Transfer of the full client record including DCO services, within 10 business days: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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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	<p>allowable location, these services will be paid at the provider’s standard billing (e.g., fee-for service) rate.”</p> <p>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.</p>	<p>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.</p> <p>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.</p>
53	<p>The MCO gets 90 days to do quarterly attribution reconciliation and the provider gets 15 days to respond to it for changes?</p> <ul style="list-style-type: none"> • 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? 	<p>Thank you for clarifying. See #138.</p>
54	<p>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?</p>	<p>Yes. See response to question 40 for further clarification.</p>
55	<p>Adults with serious mental illness - Someone over the age of 18</p> <ul style="list-style-type: none"> • Replace with 18 years or older 	<p>Corrected.</p>
56	<p>Care Coordination Agreement: To have agreements.</p> <ul style="list-style-type: none"> • 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” 	<p>Corrected.</p>

CCBHC Provider Questions and Answer

57	<p>Under “Discharge”</p> <ul style="list-style-type: none"> 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 best practice for engagement. If this remains in place, how does it convey with GOP population. 	<p>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.</p>
58	<p>Under “PPS-2 Rates”</p> <ul style="list-style-type: none"> Is an encounter the same as a qualifying service? This needs to be clarified if both terms are to be used. 	<p>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.</p>
59	<p>Under “PPS-2 Rates”</p> <ul style="list-style-type: none"> Who sets the thresholds for the bonus payments? Are they annual? 	<p>CMS sets annual thresholds for performance for the Quality Bonus Payment (QBP) program.</p>
60	<p>Important timeline please over emphasize:</p> <p>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.</p>	<p>Communications have been and will continue to be actively shared with providers as this process happens.</p>
61	<p>January 15, 2024 - Is this enough time to prepare for February billing?</p>	<p>Timelines have been updated and shared with providers and MCOs.</p>
62	<p>How is the system going to handle continuing IHH and ACT attribution and implementing CCBHC attribution.</p>	<p>All IHH/ACT members of CCBHCs will be end-dated for the IHH/ACT program and auto-enrolled in CCBHC when that CCBHC goes live. Under CCBHC, members will receive ICTT and ACT services as an attributed member to a CCBHC. The IHH/ACT program will continue to operate as usual for non-CCBHC CMHCs, with the current enrollment process.</p>

CCBHC Provider Questions and Answer

63	What is the process for new enrollments?	Providers should assess individual's needs and eligibility criteria to determine program enrollment.
64	Will BHDDH identify a process for instance when a client consents to treatment from a CCBHC but is unable or unwilling to sign an enrollment form.	See question 21.
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	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

	may also affect client choice for services in these situations.	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	<p>When someone is leaving a hospital inpatient or ED, they will be attributed to a CCBHC based on geographic proximity to their home address.</p> <p>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.</p>	See response to Question #70.
72	<p>MCO Manual states High Acuity people need to be reassessed every 90 days.</p> <ul style="list-style-type: none"> • 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?	<p>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.</p> <p>See #97 for further detail about enrolling as a Trading Partner.</p>
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

CCBHC Provider Questions and Answer

		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	<p>Integrated Dual Diagnosis Treatment (IDDT)--This is required of all ACT & ICTT Co-Occurring Clinicians and SUD Specialists. We looked into the training and it is very expensive. It is a 3-day training and costs \$3,500 per day (\$10,500 total, plus possible travel expenses for the facilitator). Do you have any suggestions of a less costly option that we would be able to sustain over time?</p> <p>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.</p>	Zero suicide and IDDT - the state is working on compiling resources in regards to these trainings. EBP requirements for these two trainings have been updated (as of 4.18.24) to year 2: training, year 3: implementation, to allow for more time to align training for providers.
77	<p>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.</p> <p>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?</p>	This EBP has been updated as of 4.18.24 to require that 50% of clinical staff are trained by the end of year 1, 75% are trained by the end of year 2, and then 75% trained must be maintained. The fidelity requirement has been removed.
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 has softened requirements for year 1. As of 4.18.24, fidelity will be required and monitored in year 3.
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.

CCBHC Provider Questions and Answer

		<p>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.</p> <p>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.</p>
80	<p>No TPL pays for MRSS</p> <ul style="list-style-type: none"> • If insurance does not pay for this service the claim will be denied • Can we waive the TPL and bill directly to Medicaid? 	<p>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.</p> <p>Concurrently, the CCBHC program billing guidelines indicate that the provider should bill the state using the T1041 code with their new NPI.</p> <p>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.</p> <p>Providers will need to explore the way to bill this through their commercial insurers.</p> <p>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.</p>
81	<ol style="list-style-type: none"> 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? 	<p>#1 Individuals enrolled in OTP HH can also be enrolled in CCBHC.</p> <p>#2 Yes, individuals in Center of Excellence can also be enrolled in CCBHC. This decision may be revisited for year 2.</p>
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?	<p>A urine screen alone is not a qualifying event.</p> <p>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.</p>

CCBHC Provider Questions and Answer

		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. <ul style="list-style-type: none"> 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? 	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.
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?	If this question is in reference to a CCBHC consent form, see question 21. If this questions is in reference to the population exception process waiver, see question 116.
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)

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93	Can you provide clarification around outreach guidelines?	<ul style="list-style-type: none"> • 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. • 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. <ul style="list-style-type: none"> • 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?	<ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> ○ 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?	<p>NOTE: Guidance has now been updated more recently. Please refer to 4.18.24 updates regarding EBPs.</p> <ul style="list-style-type: none"> • Fidelity Tools for required EBPs <ul style="list-style-type: none"> ○ We have taken out the fidelity column on the EBP table in the updated Certification Standards.

CCBHC Provider Questions and Answer

		<ul style="list-style-type: none"> ○ 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 <ul style="list-style-type: none"> ○ 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 <ul style="list-style-type: none"> ○ 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 <ul style="list-style-type: none"> ○ 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?	<p>NOTE: Staffing requirements have been further updated in the 4/18/24 communication (and please note the state CCBHC go-live date is now 10/1).</p> <ul style="list-style-type: none"> ● ICCT Rehab Specialist/Occupational Therapist (OT)

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		<ul style="list-style-type: none"> ○ 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 <ul style="list-style-type: none"> ○ The SOAR workers can be included in your Cost Report and Staffing Workbooks. ○ 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. <ul style="list-style-type: none"> ○ 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 <ul style="list-style-type: none"> ○ We have confirmed that Community Mental Health Workers/Community Health Workers are <u>not</u> included in the SPA or updated Certification Standards. ○ Therefore, Community Mental Health Workers/Community Health Workers should <u>not</u> be included in your Cost report or Staffing Workbook. ● SOR/Co-Responder <ul style="list-style-type: none"> ○ 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. <ul style="list-style-type: none"> ○ The SOR clinicians can be included in your Cost Report and Staffing Workbook.
97	How do I enroll/register as a Trading Partner?	<ul style="list-style-type: none"> ● Here is the link to enroll as a Trading Partner: https://www.riproviderportal.org/hcp/provider/Home/TradingPartnerEnrollment/tabid/931/Default.aspx

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		<ul style="list-style-type: none"> • 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. • 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	<p>Is the state willing to rethink children’s treatment plan frequency. We currently require this 3 months for all children under CCBHC.</p> <p>Providers are requesting:</p> <ol style="list-style-type: none"> 1. Treatment plan - high acuity KIDS should be done every 3 months. 2. Treatment plan – general population KIDS should be done every 6 months. 	<p>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.</p>
99	<p>Are mobile crisis services provided in the ED setting qualifying services?</p>	<p>See questions 156 and 157</p>
100	<p>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.</p>	<p>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.</p>

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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
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.

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107	<p>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?</p>	<p>This can be contractual agreement. A DCO agreement is not required.</p>
108	<p>To account for staff ramp-up throughout SFY 2025, costs included in the Cost Report should reflect an “average FTE” volume for SFY 2025. Can you clarify the “average FTE” and what this means for the CCBHC?</p>	<p>Example: If you’re expecting to hire someone April 1st, that person should account for 0.5 FTE in your Cost Report.</p> <ul style="list-style-type: none"> • April – September: 6 months (hence 0.5 FTE) • Cost reporting is completed on a 12 month basis. This is based off of the RI Demonstration Year (October 1 – September 30), not the calendar year or your go-live date.
109	<p>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?</p>	<p>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.</p>
110	<p>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?</p>	<p>How providers will be paid for Dual-eligible clients:</p> <ul style="list-style-type: none"> • 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. <p>How providers should bill for duals:</p> <ul style="list-style-type: none"> • Duals with full Medicaid benefits:

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- 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.
- 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.

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		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?	<ul style="list-style-type: none"> • 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 Billing Manual
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.
113	For MRSS, do our staff need to be trained for MRSS or just the DCO we have providing this service?	<p>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.</p> <p>The CCBHC is responsible for ensuring that the provider they have DCO'd to has the appropriate certifications.</p>
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?	BHDDH will discuss staffing ratios during scheduled 1:1s with providers. This will be a continuous conversation. Appropriate ratios are determined by anticipated client load and providers' current staffing, hiring up plans, and the community needs assessment.
116	Can you provide more detail about the exception process for designating an adult as high acuity?	The exception process will be assessed on a case-by-case basis (by BHDDH and DCYF). The state will provide a more detailed process.
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?	See question #156 and 157

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118	<p>What provider code should we use for DCOs in BHOLD? Should each DCO have a different provider code specific to the DCO CCBHC partnership?</p>	<p>The CCBHC is responsible for reporting, including BHOLD, so there is no need to designate a DCO for BHOLD.</p>
119	<p>In reviewing the most recent FAQ, more information was requested regarding:</p> <p>82 Does TBH need access to the SUD section in BHOLD due to partnership with CODAC? Request for provider clarification: Can you provide more detail on your question?</p> <p>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?</p>	<p>All providers who have access to BHOLD are asked to report on the same set of questions; there are no differences.</p> <p>Providers should follow the standard process in which the CCBHC is required to report.</p>
120	<p>What are the updated (as of 3/4/24) staffing requirements for MRSS and Adult Mobile Crisis?</p>	<p>NOTE: Staffing requirements have been further updated in the 4/18/24 communication.</p> <p>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”.</p> <p>Please see the qualifications for these specific “unlicensed CCBHC personnel” below:</p> <ul style="list-style-type: none"> • Unlicensed CCBHC personnel must work under the direct supervision of a licensed professional or QMHP. Unlicensed staff must meet these qualifications: <ul style="list-style-type: none"> ○ 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

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		<ul style="list-style-type: none"> ○ A minimum of four (4) years employment in the human services field may be substituted for a bachelor’s degree. <p>We expect that providers will review their staffing proposals to confirm alignment with this guidance.</p> <p>*Please note this guidance is subject to change pending any changes to federal authority or requirements.</p> <p>*Please note children’s mobile crisis requires child competent clinicians</p>
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.

CCBHC Provider Questions and Answer

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.
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?	Although a Prior Authorization is not required for Home Stabilization Services provided by a CCBHC (either by the CCBHC itself or via a DCO agreement), a request form will be required to ensure that the CCBHC member meets eligibility criteria for the service and for tracking, monitoring and compliance purposes. This form is available on the CCBHC website (“Additional State Guidance and Reference Materials” → “Home Stabilization Request Form for CCBHCs (06/17/2024)”). A housing plan is required in keeping with the certification standards for Home Stabilization Services.
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.

CCBHC Provider Questions and Answer

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	We have updated the billing and shadow codes list to reflect this edit. We have disseminated this updated version.
133	What is the billing process for Blue Cross and United DSNP Programs?	The CCBHC billing process for D-SNP clients should follow the one for Medicare Advantage clients. Please refer to the CCBHC Billing Manual for further details.
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.	This is not a CCBHC service for Year 1. The state may reconsider for Year 2.
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?	<ol style="list-style-type: none"> 1. H2011 is specific to crisis intervention services as a stand-alone service, whereas MRSS billing codes should be applied when that specific EBP is being delivered. 2. MRSS codes should be applied only when the EBP is being delivered to fidelity. It is only an EBP for children and youth ages birth through seventeen (17) and youth ages eighteen (18) through twenty (20) who are involved with child welfare or still in secondary school. It does not include adults. 3. MRSS codes should be applied only when the EBP is being delivered to fidelity.

CCBHC Provider Questions and Answer

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.	See 150.
137	Enrollment Form – are providers expected to create their own, or will a specific one be given by the State?	See question 21.

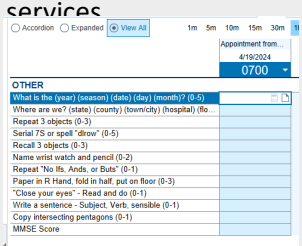
CCBHC Provider Questions and Answer

<p>138</p>	<p>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.</p> <p>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.</p> <p>It's just not enough time. It can lead to unnecessary denials to the agencies for services that actually were provided.</p> <p>Page 33 of the MCO Manual: Financial Reconciliation and Settlement</p>	<p>This process will be updated in the final version of the Billing/Ops Manual, as follows.</p> <p>“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).</p> <p>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.</p> <p>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.”</p>
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CCBHC Provider Questions and Answer

	<ul style="list-style-type: none"> •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. <ul style="list-style-type: none"> 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. <ul style="list-style-type: none"> • 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. 	
<p>139</p>	<p>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?</p>	<p>CCBHCs must have sufficient Care Coordination agreements with an AE to provide care in their service area.</p>

CCBHC Provider Questions and Answer

<p>140</p>	<p>We currently have a Ph.D. level occupational therapist on staff and are wondering how we might be able to utilize this staff person for supervision and/or billing under CCBHC. Could you please provide guidance as to which CCBHC staff types an OT can supervise and what services if any, an OT could provide under CCBHC?</p>	<p>This type of question will be evaluated on a case by case basis, with consideration not only towards the individual’s credentials but whether or not they have the required skills and knowledge to support the IPS EBP to fidelity.</p>
<p>141</p>	<p>Under the Comprehensive Assessment this is written: An overview of relevant social supports; social determinants of health; and health- related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status. How do you want this documented on the Comprehensive Assessment or just that it is part of their record. We need this information so we can put this in EPIC.</p>	<p>Yes, this type of information should be captured and included as part of the Comprehensive Assessment. Please note there may be elements of SDOH information that you may be required to report to the state for quality monitoring purposes.</p>
<p>142</p>	<p>We are looking to complete the Mini Mental Status exam at the Initial Intake assessment. Does this satisfy the requirement to complete the cognitive assessment in the first 60 days of their first request of services</p> 	<p>Criteria 4.d.4 states the need for a "Basic cognitive screening for cognitive impairment." A Mini Mental Status exam does satisfy the requirement for criteria.</p>
<p>143</p>	<p>For ASAM Level 1 is the expectation that it is offered 7 days a week during business hours?</p>	<p>This service should be available during normal substance use outpatient business hours.</p>

CCBHC Provider Questions and Answer

<p>144</p>	<p>We received previous guidance from DOH that (Principal) Counselors are only licensed to provide treatment for adults, not children. In the new staffing guidance from BHDDH, a (Principal) Counselor is a member of the healthy transitions team and would be treating children. Does the DOH guidance still apply? Or can we have a (Principal) Counselor on our Health Transitions team treating children?</p>	<p>A Principal Counselor was a designation for clinicians with a masters degree and experience but who did not have a license. Principal Counselors were a role specific to CMHCs or similar entities. There’s nothing in RIDOH regulations pertaining to non-licensed clinicians (RIDOH only regulates licenses) and RIDOH has recently promulgated regulations relating to associate level licensures (counselors and social workers). Medicaid allows counselors with a masters degree to provide services to any Medicaid member under supervisory protocol, so there are no restrictions in Medicaid, RIDOH, BHDDH, or DCYF which limits Medicaid unlicensed clinicians to serve children. Commercial payors may only allow for a licensed clinician, but that would be on the commercial side.</p> <p>A CCBHC counts as an entity that could utilize a Principal Counselor and there are no limitations in a counselor being able to work with children.</p> <p>Principal counselors can also work with adults.</p>
<p>145</p>	<p>Will the state be providing the Seven Challenges training?</p>	<p>The state will be providing this training, and more details will be shared soon (as of 4.26.24).</p> <p>The training will include: training for one or two representatives from each agency (with the possibility to add more), it includes supplies and the cost of the year 1 fidelity assessment by seven challenges. There is no cost to the CCBHCs for year 1, but supplemental supplies and fidelity for year 2 and on should be included in year 2 cost reports.</p>
<p>146</p>	<p>What is the process for providers when there is an attribution conflict?</p>	<p>The Interagency Team is working to develop a set protocol to resolve attribution conflicts between CCBHCs. Further guidance will be issued ASAP.</p>

CCBHC Provider Questions and Answer

147	Date of Service Requirements for T1041 Code: Does the DOS on the charge need to match the CCBHC Attribution date on the monthly files? Will the MCO/State be doing any matching on these two data points to ensure correct payment? In my opinion, this is the rationale behind Q40. Whoever entered this request knows the attribution date/payment DOS causes issues in the existing programs. I am just not sure the answer covers that item specifically.	Yes, the dates should match. A couple scenarios: 1) Client is admitted on the 15th of July, then both the portal enrollment and the claim should show a start date of July 15th. 2) Client transfers from Provider A to Provider B. Provider A discharges the portal enrollment during the month of transition (e.g., June 30th) and the new provider adds a new admission for July 1st. In both cases, the claims should match the respective dates for each provider.
148	Monthly encounters are calculated as the number of months in which a patient has at least one encounter, regardless of the number of days or quantity of services received in any given month. Are we correct in our understanding that the date of the first qualifying encounter in a month will be the first date on the claim and the last qualifying encounter in a month will be the last date on the claim, neither of which may be the 1st or last day of the month?	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.
149	Can you confirm that when nurses administer an injection, they should use the 99211 for "Office or other outpatient visit for the evaluation and management of established patient?"	Yes.
150	#136 is not yet answered regarding individuals with a behavioral health diagnosis on the I/DD Waiver and eligibility for high-acuity adult services. Likewise, if they are on the I/DD Waiver, are they eligible for CCBHC General Outpatient Services under the T1041 U6 procedure code?	Individuals on the IDD waiver are eligible for any CCBHC service as long as it is not duplicative of a service they can receive on the waiver. Anyone on the I/DD waiver (which is visible to all providers in the Health Care Portal) is eligible for the CCBHC 'high acuity adult' group.
151	Can you provide details about DCO licensure requirements?	Per Standard 1.b.1 of the RI CCBHC Certification Standards (see pgs. 15-16, Column 3):

CCBHC Provider Questions and Answer

		<ul style="list-style-type: none"> • A CCBHC may partner with a DCO that is licensed, certified and/or credentialed to provide a Medicaid reimbursable service. • DCO staff shall be appropriately licensed, certified, registered and credentialed as required for the specific service they provide.
152	<ol style="list-style-type: none"> 1. Is principal counselor a position available for DCOs as well, whether they have a BHO license or not? 2. What are the rules for principal counselor for Medicare? 	<ol style="list-style-type: none"> 1. Yes. 2. Principal Counselors have not been reimbursed by Medicare. You can reach out to Medicare Advantage plans to confirm credentialing requirements. <p>The May Medicaid provider update with instructions about updating staff can be found on page 16 here.</p>
153	<ol style="list-style-type: none"> 1. Can you describe the rationale for a 25 day length of stay for MRSS? We are concerned that this is not realistic. Warm hand-offs sometimes take 39-40 days. 	<p>In States with no waitlists and better access the average length of stay for MRSS is 17 days. We believe an average length of stay of 20 – 25 days is a reasonable projection for Year 1 of the CCBHC program, given that the CCBHCs will be taking on a good portion of the stabilization responsibilities. Upon go-live, CCBHCs are expected to have sufficient staffing to support warm hand-offs to ensure stabilization does not exceed 30 days. While we understand that some children, may need up to 30 days, the expectation is that not all will.</p>
154	Can you provide guidance on how agencies can get individuals credentialed as principal counselors?	Agencies can reach out to Rosemary.Petteruti@bhddh.ri.gov and she can provide you the application.
155	Can the state please look into a train the trainer course for the DLA-20 for the CCBHCs? The last one I know of was held about 3 years ago by MTM Services.	6/3: The State is unable to provide additional funding or training coordination support for this EBP, at this time. A subset of the CCBHC grantees organized a group training with MTM, using a portion of their Infrastructure Grant dollars, over recent months. We encourage all other grantees in need of this training to consider a similar approach. You may also consider connecting with the providers who have already completed this training for assistance, as this is truly a ‘train the trainer’ model.
156	Can we include clinicians (existing staff and vacancies) based in hospitals located outside of our designated catchment area in our Cost Report?	<p>You must remove hospital-based clinicians located outside your catchment areas from your Cost Reports.</p> <p>Exceptions may be further discussed and considered on a case-by-case basis with the State.</p>

CCBHC Provider Questions and Answer

157	Should we bill FFS for services provided by hospital-based clinicians?	<p>Yes. There is no CCBHC-related barrier to fee-for-service billing for these non-CCBHC services. Services provided by hospital-based clinicians who work in hospitals outside the CCBHC catchment area are <u>not</u> CCBHC services; therefore, there is no barrier to fee-for-service billing for those services.</p> <p>Exceptions may be further discussed and considered on a case-by-case basis with the State.</p>
158	What is the state’s role in provider-MCO contracts?	The state approves MCO base contracts based on a checklist the MCOs need to comply with, see here , under “Additional State Guidance and Reference Materials” → “CCBHC-MCO Base Contract Checklist V2”. MCOs are also required to pay the state-determined provider-specific PPS rates. Other amendments may be negotiated directly between MCOs and providers.
159	What is the timeline for DCO agreement finalization?	Once the scope of work and DCO rate are approved by the state, those can be inserted into the DCO agreements, which can then be signed by the DCO and CCBHC. The state is working with each CCBHC to finalize these details.
160	Where will the final state PPS rates be documented in writing for each provider? Not all payors will be MCO. We would like a binding document that references the rates we will receive.	<p>Final rates will be documented and shared in the following ways:</p> <ul style="list-style-type: none"> • Providers will receive a formal memo with their rates. • The rates will be communicated to the MCOs in writing and they will be required to pay those rates. • The rates will be included in the Gainwell FFS pay schedule. • The rates will also be posted to the RI EOHHS website.
161	<p>“Crisis visits with police (H2011) is a qualifying service but it does not match the service settings listed – or it is mobile site? (page 47)</p> <ul style="list-style-type: none"> • These patients are emergent crisis services and could often not be in the Provider Portal under our CCBHC. • If the patient is not enrolled, we have to work on enrollment subsequent of crisis visit and will not be reimbursed.” 	<p>CCBHC staff responding to a community-based crisis event with police within their catchment area is a qualifying event.</p> <p>A crisis visit that involves a CCBHC crisis response (with or without police) is considered a CCBHC qualifying event, as this is a community-based response. In order to be reimbursed the PPS rate, the CCBHC will need to enroll AND attribute the client to their CCBHC.</p>

CCBHC Provider Questions and Answer

162	Is there is a way to contract with the DCO and pay the DCO per client over technical integration?	The State and MCOs have no formal relationship with the DCOs. CCBHCs must develop direct contracts with DCOs. All payment flows from the CCBHC directly to the DCO. The terms of your contract are to be determined by the two of you.
163	What is the expected turnaround time for DCO billing? There will be a delay if a manual process is needed, due to lack of technical capabilities on other EMRs, and it will need to be manually processed and backdated.	See answer above. The State’s and MCOs’ expectation are that all payment triggering and shadow claims (regardless of whether the service was directly provided by the CCBHCs, or by their partner DCO) are appropriately submitted in a timely manner – per the requirements laid out in the CCBHC Billing Manual.
164	Does the state have minimum requirements for clinical documentation supporting billing within an EMR?	There are no changes to current State requirements for clinical documentation. Refer to existing guidelines.
165	How to resolve these billing and reporting issues Example: PHP service at Butler. Butler now bills CCBHC instead of NHP Rite Care. CCBHC bills monthly claim to NHP Rite Care (Optum) with a UB Modifier. This will all be manual. Further discussion remains needed.	Clarification needed on issue of concern. If there is no current DCO relationship with Butler, Butler would continue to bill as they currently do.
166	What is the billing process for Blue Cross and United DSNP Programs?	The CCBHC billing process for D-SNP clients should follow the one for Medicare Advantage clients. Please refer to the CCBHC Billing Manual (disseminated on Fri, 5/10) for further details.
167	Per the manual = Reconciliation on claims will be done every 3 months for previous quarter. CCBHC must reply within one week of the reconciliation file <ul style="list-style-type: none"> • (page 33) Who will review and validate MCO quarterly report? There is only a one-week turnaround on the reconciliation. • (page 34) Outlier threshold appears to be another validation of EOHHS calculations – who will validate? 	Please refer to the CCBHC Billing Manual and updated CCBHC Operations Manual disseminated on Fri, 5/10 for relevant updates related to these two concerns.

CCBHC Provider Questions and Answer

168	Our EMR is stating that they cannot officially test billing until they get our finalized rates, this is in conflict with the timeline that we have gotten around testing. Please advise.	It's our understanding that each provider's EMR should be able to handle testing with test/placeholder rates. Please help us understand the technical barrier that you are encountering.
169	What are the testing requirements? i.e. do we export sample claims only or are other pieces of build required for satisfactory testing? What build is expected to be tested on 7/1?	Please contact Karen Murphy (the designated Gainwell representative for providers) for further info.
170	How are DCOs expected to distinguish between owning organizations for patients?	<p>Clients are attributed to specific CCBHCs. Each CCBHC is responsible for informing their partner DCO which clients they share. This is crucial to care coordination.</p> <p>The CCBHC is responsible for claims and data reporting to the State (e.g., through BHOLD) for all clients attributed to them.</p>
171	Could we speak to Cohort 1 and inquire about the current processes? Or could the state provide more information on the cohort 1 billing?	The Cohorts 1 and 2 providers are currently in a similar place with their systems testing. Cohort 1 is only further along on refining their Cost Reports (based on progress made to-date prior to the merger of both cohorts with the adjusted go-live date of 10/1).
172	If a DCO chart was audited, what would you expect to see in the CCBHCs record vs the DCOs record for the same client?	<p>DCOs will not be audited by the State or MCOs. The CCBHC will be audited, as this is the entity that the State/MCOs have a direct contract with.</p> <p>Records should align as is clinically appropriate for care coordination purposes.</p>
173	What are the BHOLD timeline/expectations with CCBHC? Reporting will be delayed without defined requirements.	There are no changes to existing BHOLD data submission requirements.
174	Are CCBHCs expected to distinguish between CCBHC clients and DCO clients when reporting on required clinical measures?	The CCBHC is responsible for submitting all required clinical measures data to the State or MCOs. The CCBHC must collect all necessary data from their DCO to support this requirement; there is no need to distinguish between CCBHC sand DCO provided services.
175	Is the State able to provide any supports for the Seven Challenges, IDDT, and Zero Suicide EBP trainings?	<ul style="list-style-type: none"> ○ Seven Challenges: See response to Q145. The State is able to provide supports for the 1st year of training. All current CCBHC grantees are eligible to participate. For additional information, contact Beth Matthews: elizabeth.matthews@bhddh.ri.gov.

CCBHC Provider Questions and Answer

		<p>IDDT: The State is able to provide supports for training. Funding and training logistics are currently being sorted by the State; additional details will be forthcoming.</p> <ul style="list-style-type: none"> ○ Zero Suicide: The State is unable to provide additional funding or training coordination support for this EBP, at this time. CCBHC grantees have the option of leveraging a portion of their Phase 2 or 3 grant dollars to cover this expense, if desired. Providers can also consider integrating a portion of these training costs into their Year 2 Cost Report.
<p>176</p>	<p>In regards to compliance with criteria 2.c.3. “Individuals who are served by the CCBHCs are required to be educated about Psychiatric Advance Directives at the time of the initial evaluation.”</p>	<p>To comply with 2.c.3, all clients are to be educated on the option to identify a Durable Power of Attorney for healthcare reasons and are to be asked if they have a DPOA or Guardian at the time of evaluation. Education will be ongoing with every client about their options for treatment. Although clients may have a DPOA on file, if deemed at risk to themselves or others, they are to be aware that under Rhode Island Mental Health Law, they can be involuntarily hospitalized and even court ordered for treatment by a qualified medical healthcare provider. The RI Mental Health Law is to be posted and accessible to all clients, and the Mental Health Advocate number is to be posted and given freely to any consumer who requests this. Documentation of this education is to be evident in the treatment records.</p>
<p>177</p>	<p>Question is regarding the Place of Service (POS) of the 1500 Claim Form for PPS2 Claims. The T1041 is billed with POS 53. If shadow services are rendered via telehealth, or the client’s home, should we be reporting the appropriate POS codes or should we list POS 53 on all claim lines.</p> <ul style="list-style-type: none"> • Telehealth 02/10, • In Home Visit (12) <p>Claims are typically split place of service to ensure the charges match the service location reported in Box 32. Loop 2310C on the electronic claim file.</p>	<p>The specific place of service should be listed for each shadow claim encounter. The first shadow claim line can be 53 but each additional detail should be whatever place of service is appropriate.</p> <p>The following is the link for POS codes: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets</p>

CCBHC Provider Questions and Answer

178	We heard there is a new contract with DCYF and additional funding for MRSS. What impact should we expect that to have on MRSS capacity?	Specific details are being finalized with the state team and appropriate entities and will be shared with impacted stakeholders once finalized.
179	Will the first CCBHC year be 12 months or 9 months to align with the state fiscal year? Will this be a problem to have it continue unaligned with the state fiscal year?	Our current plan is to continue a 12-month year. See question #88.
180	What will be the impact to CCBHC of the new BHOLD system implementation?	For providers who complete bulk uploads, you will continue to report data to BHOLD as you typically do. The BHOLD implementation team will continue to be in contact with you as implementation approaches. The implementation date is being finalized.
181	<p>Follow-up to question #176.</p> <ol style="list-style-type: none"> 1. Exactly what education should we be providing to members to comply with the criteria in 2.c.3? 2. Are we required to inform clients of the RI mental health law which prohibits advanced directives? 	<p>Clients and prospective clients should be advised of their rights pursuant to the Mental Health Law (see 40.1-5-5), their options regarding advanced directives and crisis planning and how to access crisis management services.</p> <p>RI law does not prohibit advanced directives. A bill was proposed to codify psychiatric advanced directives which did not pass. Psychiatric advanced directives were not prohibited when the bill failed to pass, they simply were not codified into RI Law. Clients should be informed of their right to an advanced directive, and should be encouraged to have a medical advanced directive. If they wish to include psychiatric advanced directives, they should be advised that under specific circumstances the RI Mental Health Law may allow for the court to intervene in decisions regarding behavioral health treatment regardless of their psychiatric advanced directives.</p>
182	<ol style="list-style-type: none"> 1. Do we remain on the same documentation timelines if clients move across levels of acuity (for example from Healthy Transitions to general population)? 2. In addition, does another initial comprehensive assessment need to be completed? 	<ol style="list-style-type: none"> 1. Yes, the assessment can move with the client to a new program as long as it has been updated to reflect why the client has moved. 2. No.

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183	Do we no longer need to add clinicians to their current behavioral health billing group (provider type 066) once the CCBHC is billing?	<p>New providers will still need to be added to group 066 if they are billing under that provider type for any services that are outside of the CCBHC (for example, psychological testing).</p> <p>All new providers, including those solely providing CCBHC services, need to be screened by Medicaid per the Cures Act. To have a new provider screened, please go to the RI Medicaid Health Care Portal [linkprotect.cudasvc.com].</p>
184	What should CCBHC-DCO contracts include?	A “CCBHC- Oversight Checklist Guidance for Year 1” document was shared with providers on 7/2/24 as part of the readiness packet and is posted on the EOHHS website (Additional State Guidance and Reference Materials→Implementation) for guidance purposes only.
185	We are wondering if you or anyone else on the State's team has any guidance to share relating to documenting outreach and engagement activities. As part of our CCBHC implementation efforts so far, we are running into privacy and corporate compliance concerns about documenting outreach activities in electronic health records in cases where the person has not yet agreed to engage in treatment. Are there expectations for how these encounters might be tracked and recorded for reporting and for care coordination purposes?	Additional guidance is forthcoming in the provider manual regarding the documentation requirements and oversight standards for outreach activities that can't be collected in a patient record.
186	Can we stagger 90-day DLA re-evaluations and begin in September?	Providers must reevaluate a client’s level of need every 90 days from the date of their last assessment, OR sooner if a change in acuity is observed (e.g., with a new hospital admission or transfer of program) within the 90 days, to determine the appropriate level of service intensity (i.e., Standard vs. High Acuity) for the client. Shifts in acuity level are anticipated over time for most clients. As such, we anticipate an organic staggering of all DLA evaluations across your client census.
187	Is the state planning to rebase or just use the MEI adjustment for year 2. We did not include year 2 hires in our cost report and therefore costs are expected to increase beyond MEI adjustment.	The CCBHC PPS is a cost-based reimbursement model, and the state’s goal is to pay CCBHCs for their actual costs. The expectation is that the current cost reports reflect actual costs in Year 1. We will monitor staffing, service delivery volume, and payment levels throughout Year 1 (anticipated versus actuals) and based on the data, determine if we need rebase to get appropriate rates in Year 2 or if an MEI adjustment is sufficient. The State aims to make this determination by April/May 2025.

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188	Do telehealth visits (i.e. via a phone or video call) count as an ‘encounter’ for CCBHC billing purposes?	Telehealth visits can be considered Face to Face visits and are counted as direct contacts. The minimum time required to bill for a 15-minute unit is 8 minutes. Community based programs may require a minimum number of contacts to be in person/in the community .
189	<p>Below are the required qualifications for ‘unlicensed CCBHC personnel’. We have a question about the ‘Community Responder’ component of this. What are the certification requirements for a ‘Community Responder’?</p> <ul style="list-style-type: none"> · “Unlicensed CCBHC personnel must work under the direct supervision of a licensed professional or QMHP. Unlicensed staff must meet these qualifications: <ul style="list-style-type: none"> o 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; o Certified in First Aid/CPR and as a <u>Community Responder</u>; o A minimum of four (4) years of employment in the human services field may be substituted for a bachelor’s degree.” 	An unlicensed CCBHC personnel who provides crisis services must be able to administer naloxone. They must be trained (for example, using the following training: https://web.uri.edu/cfrp/ [web.uri.edu]). Note, the training is completed online, is free, and can be completed in about 10 minutes.)
190	Is there additional information on the TPL reconciliation process? Will the state be working on a fully automated system to eliminate the manualized steps required for TPL reconciliation.	The process for TPL reconciliation will not be fully automated. The process is described in detail in “Appendix B: Duals and Third Party Liability (TPL) Billing Processes” of the CCBHC Billing Manual . The state is working to operationalize the information provided in the Billing Manual, developing reconciliation and audit business processes. Providers will be asked to submit a quarterly CCBHC/DCO TPL Payment Report with the amount they and their DCO have received in TPL payments for reconciliation. The state will run a parallel report as well, for comparison. The provider report template will be shared with providers as soon as it is finalized.

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191	<p>In the Final CCBHC standards, addendum 5, page 149, we were reviewing the below criteria in the high acuity adult population. We are unclear on whether one of these items will qualify a client to be attributed to this group, or do they need to meet ALL criteria.</p> <p>“2. An individual is in the High Acuity Adult Population if they are transition aged Individuals between the ages of 15 and 26, and:</p> <p>a. Experienced first episode psychosis or early onset of serious mental illness with high prevalence of co-occurring substance use disorders.</p> <p>b. Have or at imminent risk of developing a serious mental health condition.</p> <p>c. Conditions including not employed, or in school; currently homeless or at risk; having recent contact with the juvenile or criminal justice system; at risk of hospitalization.</p> <p>d. Individuals in a residential setting are not eligible for CSC services and I</p> <p>e. Individuals with autism spectrum disorder are eligible only by exception.</p> <p>f. Request for exceptions to eligibility criteria may be made at any time in writing to BHDDH.”</p>	<p>They need to be between the ages of 15 and 26 and meet a, or b, or c - or go through the exception process. They are still required to meet the DLA requirements for high acuity and for CSC/HT it is less than 3.00.</p> <p>There was a formatting error in the Certification Standards. Below is what the guidance should read as. We will be correcting this in the next iteration of our Certification Standards:</p> <p>“An individual is in the High Acuity Adult Population if they are a transition-aged individual between the ages of 15 and 26, <u>AND</u>:</p> <p>a. Experienced first episode psychosis or early onset of serious mental illness with high prevalence of co-occurring substance use disorders; <u>OR</u></p> <p>b. Have or at imminent risk of developing a serious mental health condition; <u>OR</u></p> <p>c. Conditions including not employed, or in school; currently homeless or at risk; having recent contact with the juvenile or criminal justice system; at risk of hospitalization.</p> <p>If they do not meet this criteria, but you believe they should be in the ‘High Acuity Adult’ population instead of the ‘Standard’ population, you will have to submit a Population Exception Request to BHDDH. (We are in the process of developing a standard request form and submission process, and are working to release this to all providers ASAP.)</p> <p>Please note:</p> <ul style="list-style-type: none"> • Request for exceptions to eligibility criteria may be made at any time in writing to BHDDH. • Individuals in a residential setting are not eligible for CSC services. • Individuals with autism spectrum disorder are eligible only by exception.”
192	<p>1. I have a question about transition-aged HT/CSC clients. They are categorized as HA Adults but looking at the certification guide in Addendum 5, does the reassessment requirement under point</p>	<p>1. CSC/HT requires a DLA score less than 3.0. Please see Addendum 7 in the RI CCBHC Certification Standards under “Coordinated Specialty Care/Healthy Transitions” for more detailed information. All high acuity clients need to be reassessed every 90 days. Individuals who do not meet the requirements (e.g.,</p>

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	<p>3 apply to these clients? There is no DLA criteria for CSC/HT, so does the 90-day re-evaluation apply only for clients enrolled in HT under an exception? The program is curious to clarify whether there will be any barriers to maintaining their clients at a longer length-of-stay after their initial presentation stabilizes.</p> <p>2. I see the clear DLA score requirement in Addendum 7, but looking at Addendum 5, the DLA requirement is not listed for this group. Should the DLA requirement be added to this listing as an "and" or as an "or"? As in, to qualify, do clients need to have a requisite diagnosis AND a DLA less than 3.0?</p>	<p>DLA score, etc.) of High Acuity but may be clinically appropriate for the service, will need to go through the exception process. The Interagency Team is currently working to finalize a 'High Acuity Population Exception Request Form' and submission instructions, and will be releasing this guidance to all providers ASAP.</p> <p>2. Clients with a DLA 4.0 or under will be in the high acuity population. If the client has a greater than 4.0 DLA score, an exception form is required to be considered for high acuity.</p>
<p>193</p>	<p>In the final standards on page 41 it states the following regarding the comprehensive assessment:</p>  <p>Are we able to make our intake assessment more robust to encompass all of the required elements of the comprehensive assessment rather than ask the clients to sit for an additional assessment within 60 days?</p>	<p>It is required that a comprehensive evaluation is completed within 60 days. This comprehensive evaluation must meet the minimum requirements of Standards 4.d.3 and 4.d.4 and can be done at any point within 60 days, whether this be day 1 or 60.</p>
<p>194</p>	<p>Is there any time requirement for outreach prior to a client discharge for any of the four populations?</p>	<p>At this juncture, the state does not have established requirements regarding duration, frequency or type of outreach that must be performed prior to discharge due to voluntary disengagement from services. The state's expectation is that each provider will conduct the appropriate outreach (e.g., phone, home visit, mail) before discharging a patient, as informed by their clinical judgement based on client's last presentation when seen, client's history of treatment, and applicable</p>

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		<p>state regulations (212-RICR-10-10-01 (1.6.1 & 1.6.11)). The state does not accept a policy that supports only 2 outreach efforts before discharge.</p>
<p style="text-align: center;">195</p>	<p>In a scenario where a CCBHC/DCO sees a client (not currently attributed to a CCBHC) for Mobile Crisis and in the same month transfers the client to another CCBHC for continued care, who would bill for the client? Keep in mind that the 2nd CCBHC might see the client for longer if the client is transferred in the beginning of the month and only 1 CCBHC can be paid.</p>	<p>Please refer to the Billing Manual:</p> <p>“Attribution Transfers and Care Transitions:</p> <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> ○ 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.”
<p style="text-align: center;">196</p>	<p>For people in the SUD category, BHDDH requires that the 1st diagnosis on the claim be the SUD diagnosis; however, the MCOs require that the MH diagnosis be 1st. This is causing us to do manual corrections to satisfy both directives. Can this be changed to just have a SUD diagnosis on the claim, in any order, to enroll/bill for a client in the SUD category?</p>	<p>We believe there is a misunderstanding. To clarify:</p> <p>On the State side:</p> <ul style="list-style-type: none"> • A client must have an ‘SUD’ as their primary clinical diagnosis to be attributed to the CCBHC ‘SUD’ population. • For clients with co-occurring conditions, providers are expected to use their clinical judgement to determine whether the SUD should be documented as the primary or secondary diagnosis.

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		<ul style="list-style-type: none"> We expect this type of clinical information to be documented within the provider’s EHR/the client’s medical record. This information is typically not captured on a claim submitted for a rendered service. <p>On the MCO side:</p> <ul style="list-style-type: none"> All (UHC, NHP, and Tufts) have confirmed they do <u>not</u> have a diagnosis qualifier set up for the CCBHC codes. Testing was conducted to verify. In other words, the MCOs will default to the State’s attribution rules. The SUD PPS rate will be paid out for allowable CCBHC services provided to any client categorized within the SUD population per the established State criteria.
197	On 10/1, Thrive will be enrolling all of our CCBHC qualified clients into CCBHC. What is the expectation for DCOs? Should they also enroll all of their qualified clients? If so, will they be granted the same timeframe for completing.	Only CCBHCs can enroll. DCOs cannot. DCO must coordinate with CCBHC to have members enrolled at the CCBHC.
198	There are 3 OHIO assessments. Which set of scores need to be documented and formally shared with the State?	The worker scale.
199	In our Provider Office Hours meeting last Friday it was mentioned that OHIO is for age 5 and above. For our IOP children ages 3 and 4, will exception forms be required to assign them to high acuity child?	Yes.
200	<p>Can you provide additional clarity on when CCBHC services can be provided to individuals placed in a residential setting?</p> <p>How should we proceed with CCBHC services for clients currently enrolled in substance use residential treatment? Specifically, we are interested to know if we can bill for community-based services while the client is concurrently in SUD residential.</p>	<p>The following guidance applies to nursing facilities, intermediate care facilities, inpatient hospitals, I/DD residential, children’s residential, and Psychiatric Residential Treatment Facilities (PRTFs):</p> <ul style="list-style-type: none"> If CCBHC staff provide services as part of in-reach (care coordination) for the purpose of transition out of the 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 the facility and specialized services; (3) for nonrecurring set-up expenses for people transitioning from a facility; and (4) are provided on or after the start of the discharge planning process. <ul style="list-style-type: none"> NOTE: CCBHCs can only bill the PPS rate for the portion of in-reach activities that occur <u>after</u> the client’s discharge from the institution or

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		<p>facility (e.g. inpatient hospital, nursing facility, or correctional facility), <u>not</u> the portion that occurs <u>before</u> their formal discharge. The PPS rates cover the costs of the in-reach coordination, even if providers aren't formally billing for them until after discharge.</p> <ul style="list-style-type: none"> • 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 (or a community-based setting) 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. • CCBHC services are allowable for group homes (children's, MHPRR, e-MHPRR and I/DD), Assisted Living Facilities, SUD residential (all levels) and all other community based congregate care settings that are not subject to the restrictions noted above for facilities and long-term residential settings. <p>EOHHS in partnership with the Interagency Team will monitor compliance with this guidance and revisit decisions that are at the State's discretion for upcoming CCBHC program years.</p>
<p style="text-align: center;">201</p>	<p>Can you please clarify for us whose financial assistance policy and sliding fee schedule applies to DCO clients? A CCBHC's eligibility rates and discounts are different from one of our DCOs. I thought that since the clients would be attributed to our CCBHC, they would fall under our policies.</p>	<p>Page 53 of the CCBHC criteria (2023) says, "CCBHC services provided through a DCO must conform to the relevant applicable CCBHC criteria." In this instance the relevant criterion is Criterion 2D, which says:</p> <p>2.d.1 The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services (PAMA § 223 (a)(2)(B)); and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).</p> <p>2.d.2. The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC offers pursuant to these criteria. Such fee schedules will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to people receiving services and families. The sliding fee discount</p>

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		<p>schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP, literacy barriers, or disabilities.</p> <p>The CCBHC is responsible for the collection of consumer fees and cost-sharing for CCBHC services furnished via DCO, but the CCBHC can delegate this responsibility to the DCO through contract. The financial assistance policy and slide fee schedule to be used, is to be determined by each CCBHC and their partner DCO(s). These terms should be included in their contractual agreement with one another.</p>
202	<p>I'm wondering if there is any insight you can share as to how ACT exceptions will be handled under CCBHC. Now that there is one single rate for ACT and ICTT services, will we still need to request an exception to move an ICCT client to ACT if their DLA is slightly above 3 but they qualify for high acuity services otherwise? These would be clients whose DLA is slightly elevated due to high score on domains such as personal hygiene and grooming but their functioning is significantly impaired in many other ways (e.g. high utilizer of hosp services, at risk of homelessness). We would be providing 4 hours of ACT time per month.</p>	<p>A population exception request must be submitted to BHDDH for any client with a DLA score of 4.0 or above, who a provider believes should be attributed to the 'High Acuity Adult' population instead of the 'Standard' population.</p> <p>A population exception request will not need to be submitted to BHDDH to formally move a client between the ACT (typically those with a DLA score of 3 or below) and ICTT (typically those with a DLA score of 3.1 – 4.0) programs. Providers can determine which program is most clinically appropriate for each high-acuity adult client. However, the State will be monitoring client census in each program to ensure providers are adequately staffed to meet service demand.</p>
203	<p>On the provider call Friday 9/6 there was mention of the CSP Determination being used for the High Acuity Adult Population. Can you please provide clarification regarding the use of the CSP determination form?</p>	<p>The CSP clients meet high acuity definition for high acuity. There was previously a CSP form. As of 10/1, providers do not need to use this CSP form. They need to verify that people are high acuity by the current high acuity definitions in the CCBHC Certification Standards.</p>
204	<p>It was also mentioned on the same call that Panic Disorder is now a eligible dx for High Acuity Adult. It was mentioned that it's for "severe" panic disorder. Please identify the F-code for this.</p>	<p>F41.0.</p>
205	<p>CODAC uses the codes below that are not on the CCBHC fee schedule. Can they be added as a triggering service or what would you like for us to use in place of these codes?</p>	<p>We haven't seen these codes in use on the FFS side, and to our knowledge we (the State) haven't instructed providers to use them. Perhaps this direction came from the MCOs?</p>

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	<p>Suboxone New patient Visit, MD-High Complexity: 99205</p> <p>Suboxone New patient Visit, MD-Moderate Complexity: 99204</p> <p>Suboxone New patient visit, MD-Low Complexity: 99203</p>	<p>In any case, there is no rate differential between new and existing patients in CCBHC, so we recommend use of codes 99212 through 99215 in Demonstration Year 1. We can consider adding these additional codes to the CCBHC Billing and Shadow Codes List down the line.</p>
206	<p>Is there any movement on implementing the Youth/Family Experience of Care Survey for CCBHC and if so, will we have for Oct 1? If no, is there a plan B?</p>	<p>The measurement year begins January 1 and this will be ready by then.</p>
207	<p>Will the state be monitoring fidelity to the MRSS model for all providers?</p>	<p>Per the RI Certification Standards, fidelity to the MRSS model is not required until year 2.</p>
208	<p>What will happen when a child/youth and their family refuse to be attributed to CCBHC contracted with DCO for MRSS service?</p>	<p>Children and their families will have choice of provider. The CCBHC/DCO should make full efforts to educate the client and their family about the CCBHC program. If they refuse to be attributed to the DCO's contracted CCBHC, efforts should be made to connect them with a CCBHC of their choice. If they chose not to work with any CCBHC, provide referrals to care in keeping with clinical best practice.</p>
209	<p>What is the age limit for MRSS?</p>	<p>MRSS is an EBP for individuals up to the age of 18. Individuals ages 18 and over should receive adult mobile crisis.</p>
210	<p>Will the state be publishing guidance on mobile crisis referral and triage pathways statewide (e.g., for CCBHCs, as well as hospital EDs, Police Departments, Children's IDD providers)?</p>	<p>The state has developed guidance specifically for referral and triage between BH Link, 988, CCBHCs and their partner DCOs. This guidance will be finalized by 10/4 and sent directly to CCBHCs. It is the State's expectation that the CCBHCs will work with their service provision partners to develop relevant protocols.</p>
211	<p>In the rare case the contracted DCO could not respond, who would be the responsible party?</p>	<p>Per the CCBHC certification standards: CCBHCs are clinically responsible for all clients. In the rare case that the contracted DCO cannot respond to a mobile crisis call, the CCBHC is the responsible party and must have staff in place to cover the required service in compliance with the established response time requirements.</p>
212	<p>Will 988, BH Link and Kids' Link be able to contact MRSS providers directly?</p>	<p>For year 1 this is allowable.</p>

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213	<p>I am looking for clarity on whether the following situations count as ‘contacts’, and if these individuals should be included within our monthly client census. If we connect with a client...</p> <ul style="list-style-type: none"> • For less than 15 mins on a video call • For more than 15 mins on a video call • For less than 15 mins on a phone call • For more than 15 mins on a phone call 	<p>Telehealth rules follow in person rules for each service. A telehealth assessment, for example, still requires 60 minutes face-to-face. CPST, which is based on 15-minute increments, does have an 8 minute minimum, but it still must comply with CPST service standards (e.g., appointment reminders are not CPST).</p>
214	<p>Is there a pathway for individuals to continue practicing/billing as case managers without an Associate’s Degree? Completion of the CCRI Certificate Program was sufficient during COVID. Is this variance being allowed post COVID due to ongoing workforce shortages?</p>	<p>For all CCBHC providers with case managers <u>currently in practice</u> who do not have an Associate degree as required by the BHO regulations – including those who have a certificate from a BHDDH-approved curriculum as described in the COVID Technical Bulletin Variance dated 10/14/21 – a request must be submitted for a variance from the credential regulation. The request must include the following information per case manager:</p> <ul style="list-style-type: none"> • A copy of the case manager’s current resume; • A description of their role within your organization (such as which program they currently support, e.g., ACT, IHH/now ICTT, or Healthy Transitions); and • Whether the individual has successfully completed and secured a Case Management certificate from CCRI. <p>The request for variance must be submitted by no later than 4 p.m. on November 1, 2024 to the BHDDH Office of Licensure and Standards via email to Gary.Amitrano@bhddh.ri.gov, Rosemary.Petteruti@bhddh.ri.gov, and lynne.m.ruelle@bhddh.ri.gov. BHDDH will review each submission and either approve or deny the request. If the request is approved, the case manager may remain in their current position and continue to bill per established Medicaid rates for their services. If the request is denied, the case manager shall be reassigned.</p>
215	<p>Is there a pathway for peers to practice and bill under CCBHC program if they’re still going through the certification process? There is a lack of timely trainings being offered. Also, a deficiency of potential recruits with certification fully completed.</p>	<p>The State has to defer to federal authority on this one. We reached out to SAMHSA to understand what (if any) flexibility is allowed under the Demonstration. Below is their response:</p> <ul style="list-style-type: none"> • “Per SMD Letter #07-011 and the related FAQs (https://www.medicaid.gov/federal-policy-guidance/downloads/faq06052024.pdf [medicaid.gov]), whether a State can

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		<p>include costs and visits by peer support providers who are in the process of training and certification under the Demonstration will depend on the state's current Medicaid peer support provider certification criteria and billing policies. If a peer support provider does not meet the state's certification requirements, they are ineligible to render Demonstration services”.</p> <ul style="list-style-type: none">• Based on this response, we are unfortunately <u>not</u> able to allow someone who is not fully certified to either serve as or bill as a Peer Recovery Specialist.<ul style="list-style-type: none">○ Our authority for Peer Recovery Specialists (PRS) in the 1115 Waiver has the following requirements:<ul style="list-style-type: none">▪ PRS are required to work under the direction of a licensed health care professional;▪ PRS Supervisors must be certified as a PRS and have worked at least 2 years providing PRS; and▪ The State must require credentialing by the Rhode Island Certification Board as PRS (noting that the credentialing by RICB is the certification).○ The PRS Provider Billing Manual states the following:<ul style="list-style-type: none">▪ Peer Recovery Specialist (PRS) – A behavioral healthcare professional credentialed by the Rhode Island Certification Board (RICB).○ Peer Recovery Specialists must meet the qualifications in the CMS State Medicaid Director Letter, #07-011, https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD081507A.pdf.<ul style="list-style-type: none">▪ Per the SMD letter, the peer support provider “must complete training and certification as defined by the State. Training must provide peer support providers with a basic set of competencies necessary to perform the peer support function. The peer must demonstrate the ability to support the recovery of others from mental illness and/or substance use disorders. Similar to other provider types, ongoing continuing educational requirements for peer support providers must be in place.”
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		<ul style="list-style-type: none"> ▪ Individuals must acknowledge a mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD) and have received or are currently receiving treatment and/or community support for it. Or, individuals must acknowledge personal experience with a family member with a similar mental illness and/or substance use disorder. • We can continue to advocate for additional flexibility to be allowed by SAMHSA and CMS in Demonstration Year 2, and will push to make more Certification trainings available in Demonstration Year 1. However, in the interim, these are the requirements all CCBHCs must adhere to.
<p style="text-align: center;">216</p>	<p>Is it possible to reduce # of fields in the CCBHC Staffing Workbook report template and/or to reduce submission frequency? It is a heavy administrative lift to complete each month.</p>	<p>State Expectations/Requirements for October – December 2024: Providers <u>must</u> continue to submit an updated Staffing Workbook to the Interagency Team on a monthly basis.</p> <ul style="list-style-type: none"> • The following information is critical to the State – updates to each provider’s: i) team composition dashboard; ii) planned vs. vacant positions. We need this information in a timely manner to ensure all providers are scaling appropriately to delivery all required services and to meet an anticipated growth in client census over the next few months. • The administrative lift is anticipated to be manageable because: i) providers should be making no changes to their staffing plans; and ii) just providing updates on progress made towards filling planned positions at this juncture. <p>Looking Ahead: The submission cadence can be reevaluated in January. In tandem, the Interagency Team is currently reevaluating the Staffing Workbook, with the intent of: i) better aligning it to the Cost Report templates; ii) streamlining the number of requested fields/formatting to reduce administrative burden. We are aiming to release the new version in December 2024 and plan to schedule provider walk-throughs/trainings, to enable a full transition to the new Staffing Workbook template by January 2025 to inform rate setting efforts for Demonstration Year 2.</p>

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<p>217</p>	<p>Follow up to #195:</p> <p>How does a CCBHC get paid if they provide an initial mobile crisis service to a patient who ultimately does not get attributed to them? Is there a fiscal buffer integrated into each providers' PPS rate already?</p>	<ul style="list-style-type: none">• In general, the CCBHCs should try to respond with the appropriate CCBHC mobile crisis team for a CCBHC member, while ensuring timely response for an individual in crisis.• There may be instances where a member receives crisis services from one provider and follow-up services from another provider. Providers are expected to work together to ensure attribution is current and accurate (see RI CCBHC Billing Manual guidance – copied below).• Situations where one provider provides mobile crisis services to a member who is attributed to another CCBHC will likely be bi-directional and rare. There is no explicit margin for the CCBHCs to provide mobile crisis to individuals who are attributed to another CCBHC. If this is happening frequently in a single direction, providers are encouraged to work together to generate a solution. We will monitor mobile crisis volume and will work with providers to help resolve any egregious imbalance in attribution.• The PPS rate is an average monthly capitation. The structure of the rate is that a CCBHC may be over- or under-paid relative to the actual costs incurred by a client. The cost report should include all of the provider's anticipated visits and costs; discrete underpayments or overpayments are expected but should even out throughout the year.• Mobile crisis is one of the most crucial aspects of the CCBHC program. Via the mobile crisis reporting, the State is collecting data on every crisis encounter and will use this to inform problem-solving for future years. It is important that the CCBHCs collect all required mobile crisis data and report this data to the State. The State will request updates on mobile crisis service delivery during its regular meetings with CCBHCs to identify and resolve issues.• This is the first year of the program and as such the costs and visits assumptions are estimates. The CCBHCs may have higher or lower than expected costs or revenues in any given month for any program or service. Notably, hiring has been much slower than what most CCBHCs assumed would be completed as of October 1. The persistent vacancies will result in significantly lower costs and therefore overstated PPS2 rates relative to what the CCBHCs attested to in their cost report submitted to the State.• The State will review actual experience in Demonstration Year 1, including DCO contracts, as part of any rebasing for Year 2 if costs and visits are significantly
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CCBHC Provider Questions and Answer

		<p>different than anticipated. Per the instructions from the Billing Manual (see below), for an unattributed member will be attributed to the CCBHC providing the first service (i.e., CCBHC A) within the month (i.e., in this case the CCBHC providing the mobile crisis service). If a hand-off is made to a different CCBHC (i.e., CCBHC B), services should be provided in a manner that reduces disruptions to care. Attribution can be switched to CCBHC B at the start of the subsequent month – a discharge date should be added for CCBHC A at the end of the current month, and an admission date should be added for the CCBHC B for the first of the following month.</p> <p>Attribution Transfers and Care Transitions (guidance included in the RI CCBHC Billing Manual):</p> <ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> ○ 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.
218	I’m asking about MRSS clients that we will hold in stabilization until appropriate programming is available. I understand that we will assign a PPS rate of a program the client is likely to go into (high acuity	<p>To clarify –</p> <p>Under the CCBHC program, providers must:</p>

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	<p>adult, etc...) for billing purposes, however, when reporting to BHOLD, what program will we use? Currently, clients get reported to the program they're enrolled in (MTT, CSP, etc...) that correlates to the PPS rates (MTT=high acuity adult). But these clients in stabilization will not technically be enrolled in the program.</p> <p>Currently no program seems appropriate in BHOLD options for stabilization - what should providers chose in the interim before new BHOLD system comes online?</p>	<ul style="list-style-type: none"> • Formally attribute clients and designate them to a specific CCBHC Population (i.e. Standard, High Acuity Adult, High Acuity Child, SUD) via the Provider Portal (not BHOLD). • Track all mobile crisis services delivered to adults and children via the 'CCBHC Mobile Crisis Report Template' (which is excel-based). For further details, see: https://eohhs.ri.gov/initiatives/certified-community-behavioral-health-clinics-ccbhc/ccbhc-info-providers-and-mcos > Additional State Guidance and Reference Materials > Request Forms & Reporting Templates. This report must be submitted to the State every other week, beginning November 1. <p>In tandem, provider must:</p> <ul style="list-style-type: none"> • Report crisis encounters for adults and children to BHOLD. • To do so, providers should use the "CONTACT" program in BHOLD for any Adult or Child crisis encounter, and should keep the "CONTACT" open in BHOLD if they are providing stabilization services. They should "discharge" them from the "CONTACT" program if this is a one-and-done crisis evaluation. • Note: CONTACTS don't represent enrollments but emergency assessments so this would just be for the crisis encounter and stabilization services. If a program enrollment follows it should be entered under the proper program designation, not as a continuation of the CONTACT program.
<p>219</p>	<ol style="list-style-type: none"> 1. As a CCBHC is awaiting approval for an exception form can the client be placed within their population that is being requested? This is needed to meet time to serve requirements as well as to allow least disruption of services to the client. 2. What is the expected turnaround time for exception form approvals? 	<ol style="list-style-type: none"> 1. Yes, they can. 2. We are striving for a turnaround timeline of 5 business days, with the caveat that a longer duration is likely needed upon initial program go-live where we anticipate a high volume of requests to be received.
<p>220</p>	<p>Do all HT clients with Autism Spectrum Disorder require an exception form regardless of it being a primary or secondary/tertiary disorder?</p>	<p>Yes.</p>

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221	What is the Rhode Island CCBHC approved ages for Healthy Transitions? We just noticed in the RI-CCBHC Certification Manual on Page 149 and 158 the age is marked 15-26, and Pg 102 says 16-25.	The approved ages for Healthy Transitions is 15-26.
222	Will DCOs be granted the same timeframe for completing Assessments (keeping clients on the same timeframe as prior to CCBHC)?	Yes.
223	We noticed that the CCBHC population exception request process published on the State's website 9/20/24 does not outline how and on what timelines we might expect to hear back if an exception request has been granted. Can you please specify the timeline and mechanism for communicating request determinations?	<ul style="list-style-type: none"> • We are striving for a turnaround timeline of 5 business days, with the caveat that a longer duration is likely needed upon initial program go-live where we anticipate a high volume of requests to be received. It would be helpful for each provider to flag in their request whether it is for a net-new client, or for a client who an exception was previously granted for. The State will prioritize review of requests for net-new clients. • The State's decision will be communicated via email to the point-of-contact listed on each submitted population exception request. Included will be a copy of the request, inclusive of the last page of the form which lists out: i) the State's decision and rationale; ii) the specific duration of time for which the exemption is valid for.