CCBHC Program Implementation Additional State Guidance
Updated 02/18/2025

Document Overview
This document is intended to provide CCBHCs with timely responses to emergent program implementation questions that are applicable to many/all providers. Questions submitted to the CCBHC Readiness Inbox and raised in other forums to the Interagency Team are reflected in this document. An updated version will be circulated to all CCBHCs via email on a weekly basis at minimum. Newly added content (questions and answers) from the prior week are highlighted in YELLOW. This is an interim information sharing solution; the below guidance will be incorporated into future iterations of the CCBHC Provider Manual, Billing Manual, Quality Manual, etc. where appropriate. To help with navigation of this document, we have reorganized the questions into discrete sections (see below). For now, a word search is likely the quickest way to relocate the specific information you're looking for.

Table of Contents

- **Section I.** Certification: Program Requirements & Licensing
- **Section II.** Coordination of Care
- **Section III.** Attribution & Billing
- **Section IV.** Reporting: Program Monitoring & Quality Measures

---

Section I. Certification: Program Requirements & Licensing

1) GOP Program Requirements

Provider Question
I was reviewing the regs for CCBHC regarding pre-crisis safety plans for general outpatient programs. Traditionally, we have not completed any pre-crisis safety plans for outpatient clients and only Brown Stanley when they identify SI thoughts, intent, or plan. We are under the impression other programs need to complete pre crisis safety plans with CCBHC. Please let me know if this would apply for both our child and adult general outpatient populations.

State Response
The "Brown Stanley" can be used as a crisis safety plan for all individuals. Per the RI CCBHC Certification Standards, a crisis plan should be developed for all individuals receiving CCBHC services. If an individual refuses to complete this crisis plan, then "At minimum, people receiving services should be counseled about the use of the National Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when providers are not in their office."

2) EBP Requirements & Prescribers

Provider Question
Are prescribers required to take all CCBHC EBPs? For example, many of them have already taken MAT and prescribe it- can that course be waived for prescribers? I believe they would have to take the other EBPs like SBIRT, TIC and CBT?

State Response
No, prescribers should only take the EBPs that they will utilize in practice.

3) Seven Challenges EBP

Provider Question
Is the State requiring a specific Seven Challenges fidelity tool, or can each CCBHC select which tool they'd like to use?

State Response
The Seven Challenges trainer provides all clients with a fidelity assessment tool. You will receive this as part of your training package. This tool is accepted by the State.

4) Alcohol Use Disorder Identification Tool

Provider Question
Does the Alcohol Use Disorder Identification Tool (AUDIT) need to be completed on adults annually - regardless of ETOH (ethyl alcohol or ethanol) history or status?

State Response
The population is not limited based on current or prior alcohol use; it is designed to be inclusive of the whole adult population, and to be conducted annually.

5) PHQ Assessment

Provider Question
For 15-17 year old clients in our Healthy Transitions Program – should we administer the PHQ-9M (modified version for adolescents) assessment, or the PHQ-9 (adult) version because these clients are classified as High Acuity Adults within the CCBHC Program? Will there be any data integrity issues comparing the PHQ-9M score to the PHQ-9 score, when the client turns 18?

State Response
- CCBHCs may opt to use the PHQ-9 or PHQ-9M assessment for clients aged 15-17 years. Clinical discretion is allowed.
- With that said, the Interagency Team does encourage use of the **PHQ-9M** version as it includes some additional questions which could be of clinical valuable – e.g. "Have you EVER attempted suicide?"
- The Depression Remission at 6 Months (DEP-REM-6) quality measure allows for use of either version of the assessment; there is no impact.

6) CCBHC Case Managers – Associates Degree & Variance Request Process

Provider Question
Can CCBHCs request a variance to the Associate degree credentialing requirement for case managers who have secured a Case Management Certificate from CCRI and/or with relevant work experience?

State Response

I. Requirement for Current Variance

For all CCBHC providers with case managers currently in practice 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:

- 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.

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.

II. Requirement for Future Variance

Please be advised that from this point on, before a CCBHC hires a person who does not have an Associate degree to work as a case manager, the CCBHC is required to request a variance.
The request for variance should include information on the employee's education and experience, such as whether the employee has a pre-associate's certificate from a college in a human services field (e.g., the CCRI certificate in case management or other human service field). Other information that should be included is a current resume and the program the individual will be working in. This information must be submitted 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. Please be advised that without an approved variance, an agency that bills Medicaid for the services of a case manager without an Associate degree is non-compliant with the RI CCBHC Certification Standards.

BHDDH is in the process of drafting CCBHC licensing regulations that may allow for certain exceptions to the Associate degree requirement, which would eliminate the need for this type of variance. However, until such regulation is promulgated and finalized, CCBHCs as BHO licensed agencies are required to submit variance requests for all case managers who do not have an Associate degree (i.e., an AA or AS degree).

III. Additional Clarifications

- This guidance and the described variance request process is applicable only to CCBHCs. If a CMHC has not become a CCBHC, it does not need to request a variance as described above.
- **Case managers and Community Psychiatric Supportive Treatment Specialists (CPSTS) are separate and distinct roles per Medicaid.** This means:

- **For case managers**: CCBHCs may request a variance to the Associate degree requirement per the above guidance. We have amended the RI CCBHC Certification Standards to remove the AA or AS degree as a credentialing requirement (**Addendum 11**).
- **For CPSTS**: The State will not issue a variance for CPST Specialists, but if an employee or applicant does not have an AA or AS, they may be hired as and work as a case manager because we have amended the RI CCBHC Certification Standards to include case managers as a qualified provider type for ACT, ICTT, and Healthy Transitions (**Addendum 11**).

Follow-up Provider Question 1

Can you clarify how Medicaid distinguishes CPSTS from targeted case managers in the CCBHC program?

State Response

The main distinction is that CPSTS focus on symptom management and skill building, while case managers focus on assisting with connection and receipt of medical, social, legal, educational, housing, vocation and other services and supports.

CPSTS (per RI Medicaid State Plan)

- Ensure stability and continued community tenure via monitoring and provision of services and supports in accordance with treatment plan with a particular focus on symptom management;
- Support individuals with the development of the competencies needed to increase social support and minimize social isolation and withdrawal due to behavioral health issues.

Targeted case managers (per SAMSHA criteria and RI CCBHC certification standards)

- Assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports.
- Provide intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC.

Follow-up Provider Question 2

My understanding is that this Associate Degree variance will apply to any CCRI interns - for any current variance, where the request includes "whether the individual has successfully completed and secured a Case Management certificate from CCRI", and for a future variance, where we indicate "whether the employee has a pre-associate's certificate from a college in a human services field (e.g., the CCRI certificate in case management or other human service field)" - is such a certificate a requirement for a variance to be granted? Or is each variance considered on a case-by-case basis, where the certificate is a factor in the state's determination whether or not to grant the variance?

State Response

Yes, a certificate is a requirement (as of now) for a variance to be granted.

Follow-up Provider Question 3

To clarify, once a variance is obtained, there's no further impediment to these staff working in CCBHC programs and providing billable, qualifying case management services (separate and distinct from CPSTs as detailed in section III of the guidance)?

State Response

Correct, although it is important to note that variances are not intended to be “forever” but rather intended to be a ‘bridge’ solution, e.g., until the individual who has been granted the variance can secure their Associate Degree, or these types of credentialing requirements are formally changed via the appropriate State rules and regulations.

Follow-up Provider Question 4
Can a variance be granted for an individual who has completed the CCSP certification instead of the CCRI one? This was the legacy version. We have some staff in practice for over a decade with the CCSP certificate in hand, but not the newer CCRI one.

State Response
Please submit a formal variance request to the State and we will evaluate. Please include the following information at minimum via email to the BHDDH Office of Licensure and Standards: Gary.Amitrano@bhddh.ri.gov, Rosemary.Petteruti@bhddh.ri.gov, and lynne.m.ruelle@bhddh.ri.gov, with thomas.martin@bhddh.ri.gov and elizabeth.matthews@bhddh.ri.gov cc-ed:

- 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);
- Which specific certificate the case manager has, who it was issued by, and when;
- The regulation under which a prior variance was allowed;
- A copy of prior variance approval (if available/applicable).

Follow-up Provider Question 5
If BHDDH denies a variance request, how much time does a provider have to reassign the individual?

State Response
The individual should be reassigned as soon as possible, prioritizing continuity of care and a proper handoff for all clients currently served by the individual. If the individual does not meet the credentialing requirements, they cannot continue to bill for those specific services per Medicaid rules. The provider is to notify BHDDH Licensing of the date of reassignment.

7) Additional Credentialing Variance Questions

Provider Question
We have a Team Leader in ICTT who has a Masters degree, but not an independent license. She met the criteria for a Team Leader under the old regulations.

- **State Response:** A variance must be requested for anything outside of CCBHC required staffing/credentials.

Follow-up Provider Question 1
We have at least one staff member who was hired while pursuing their Bachelors degree but did not complete it. This person has been a case manager in ACT for decades, and has her CCSP.

- **State Response:** Please submit a variance to BHDDH Licensing for consideration.

Follow-up Provider Question 2
We have a Certified CHT worker who only has a HS diploma. Is there a waiver that we can submit to have her eligible for status as a CPST?

- **State Response**: Per State Medicaid Authority, CPSTS must have an Associates degree. No variances are allowed for CPSTS.

Follow-up Provider Question 3
How do we formally submit a variance request for these individuals (e.g., ICTT Team Leader and ACT Case Manager)?

State Response
Please submit a formal variance request to the State and we will evaluate. Please include the following information at minimum via email to the BHDDH Office of Licensure and Standards: Gary.Amitrano@bhddh.ri.gov, Rosemary.Petteruti@bhddh.ri.gov, and lynne.m.ruelle@bhddh.ri.gov, with thomas.martin@bhddh.ri.gov and elizabeth.matthews@bhddh.ri.gov cc-ed:

- A copy of the individual'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);
- A description of their years of relevant experience for/in the position (if this isn't explicitly documented in their resume);
- What specific credentials and certificate(s) the individual has, who it was issued by, and when;
- The regulation under which a prior variance was allowed;
- A copy of prior variance approval (if available/applicable).

Follow-up Provider Question 4
Vocational specialists & SUD specialists: Since we're operating the CCBHC program under the Demonstration instead of the SPA, is a variance still required for these roles?

State Response
Yes, a variance is required.

Follow-up Provider Question 5
For ICTT, there are vocational specialists with HS diplomas who received vocational certification. Can we keep them titled as vocatikateional specialists and keep them in that capacity for CCBHC

State Response
Per federal regulations (42 CFR 485.705), when no State Licensing laws or State Certification or registration requirements exist, the following requirements must be met:

"A vocational specialist is a person who has a baccalaureate degree and—

(i) Two years' experience in vocational counseling in a rehabilitation setting such as a sheltered workshop, State employment service agency, etc.; or
(ii) At least 18 semester hours in vocational rehabilitation, educational or vocational guidance, psychology, social work, special education or personnel administration, and 1 year of experience in vocational counseling in a rehabilitation setting; or
(iii) A master's degree in vocational counseling."

BHDDH is not able to offer a variance to the above qualifications per federal regulations. However, you may submit a variance to a team composition.

For example: You may request a variance to the ACT team staffing composition, with a request to replace the Vocational Specialist role with a CPST or Case Manager who is Certified in IPS to provide the Supported Employment Function.

8) Processing Timeline: High Acuity Population Exception & Staff Variance Requests

Provider Question
What's the timeline for receipt of approvals/denials from BHDDH for submitted high acuity population exception requests and staff variance requests?

State Response
The current processing timeline for submitted high acuity adult and child population exception requests is ~1 week. The current processing timeline for submitted staffing variance requests is 30 days.

If you have any pending adult services related applications from October or early November, please reach out to Beth Matthews and Tom Martin with the names of the staff/client that you submitted these variance requests for, and they will follow-up internally. If you have any pending child services related applications from October or early November, please reach out to Nicole Vadnais.

9) Peer Recovery Specialist Certification Requirements

Provider Question
Peer Recovery Specialists: Is there a pathway for individuals to practice and bill under the CCBHC program if they're **still going through** the certification process? There is a lack of timely trainings being offered. Also, there is a shortage of potential recruits with certification fully completed.

State Response
- 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:
    - "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 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".

- Based on this response, **we are unfortunately not able to allow someone who is not fully certified to either serve as or bill as a Peer Recovery Specialist**.
    - Our authority for Peer Recovery Specialists (PRS) in the 1115 Waiver has the following requirements:
        - 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:

        - 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.
        - 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."
        - 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.

Follow-up Provider Question

Does this mean we need to take these individuals out of service immediately? If no, how can they be reassigned and is there a specific way we need to flag these individuals in our monthly CCBHC Staffing Workbooks?

State Response

You can keep these individuals on for outreach and non-billable services while they complete their certification requirements. The State has no preference on what specific title you used for these individuals.

10) Changes to EBP Requirements in DY2

Provider Question

Per the Year 1 RI CCBHC Certification Standards, providers had to meet specific staff training thresholds per EBP in each program year. In the Year 2 RI CCBHC Certification Standards, these thresholds were removed (see Year 2 RI CCBHC Certification Standards, pg. 86). Can you please clarify – are we still required to have 50% of our staff trained in Motivational Interviewing (MI) by the end of Program Year 1 per the Year 1 Certification Standards?

State Response

No. We encourage all CCBHCs' continued efforts to ensure supportive training and professional development activities for their staff, however, no set thresholds regarding the % of staff trained, must be met for the following EBPs in Program Years 1 or 2: MI, CBT, DBT, FPE, Housing First, 12 Step, MAT, SBIRT, and Trauma Informed Care/Approach. The State has removed these thresholds acknowledging

that it is not clinically necessary for all staff to receive these trainings, just those providing relevant services and supports.

Provider Follow-up Question

In regards to the 'CCBHC Required Annual Trainings' (see Year 2 RI CCBHC Certification Standards, pg. 86), do our staff need to complete and retake each training annually, or are there some trainings that they can complete every other year, every two years, etc?

State Response

This will be assessed on a case-by-case basis dependent upon the specific training(s) that you implement to ensure staff education across each of the required areas (e.g., cultural competency, de-escalation training). Short, high level trainings are likely appropriate to readminister on an annual basis, while more intensive trainings are likely appropriate to readminister on a less frequent basis. The Interagency Team will be requesting further information regarding each CCBHC's training plans at future 1:1 monthly implementation check-ins to ensure compliance with this certification requirement and to offer further feedback/guidance as needed.

11) Addition of TBI Screening Requirement in DY2

Provider Question

Please provide further information regarding why the addition of OBISSS+ was made as a part of the comprehensive evaluation. We complete primary care screening and would expect that this is picked up through their medical providers. In addition, it has a cost to it and will require training and integration into our health records.

State Response

The Interagency Team determined that screening for brain injury is an important component of a comprehensive evaluation and that doing so informs behavioral health treatment and care coordination. Like other screenings that are required, the State put forth a tool to be utilized and there is work being done, led by RIDOH, to have the OBISSS as the tool used across the State for all providers. It is an assumption that brain injury is being routinely screened for all populations in all primary care settings and given both the population being served by CCBHCs, which are disproportionately individuals impacted by brain injury, and the importance of the care being delivered by CCBHCs to be informed by an individuals status as having a brain injury, it is appropriate for CCBHCs to conduct this screening as part of a comprehensive evaluation.

Provider Follow-up Question 1

What are our integration options? Do we need to access the evaluation through the designated portal, or can we integrate it into our EHR? If we can integrate it into our EHR, we'll need to know ASAP and start this process in April to ensure system readiness for go-live by October 1, 2025.

State Response

The Interagency Team is consulting with RIDOH for further information. We will circle back with additional guidance ASAP.

Section II. Coordination of Care

12) Attribution and Transfers of Care

Provider Question
Do clients need to provide written consent before we attribute them as a CCBHC client?

State Response
Providers should make a full effort to inform the client about the CCBHC program, the services and supports it can provide to the client, and what this means from a care coordination and data sharing perspective. With this said, if the client wants to receive services from the provider, they do not need to provide specific and separate consent to participate in the CCBHC program. The provider can attribute the client and should bill the PPS rate for any allowable services.

Provider Follow-up Question 1
It would be helpful for the State to provide written guidance on when provider needs to secure consent prior to delivery of services for an adult or child, in context of crisis vs. ongoing services and supports (the different elements of CCBHC program), aligning with licensing, CCBHC cert. stds, and other regulations in place.

State Response
This is presently under internal discussion; we will issue further guidance ASAP.

Provider Follow-up Question 2
What do we do if a client is unable to tell us who their current CCBHC provider is, but we know they're currently attributed to someone else because we are unable to add them via the Provider Portal?

State Guidance

- **Standard Practice**:
    - Medicaid Managed Care clients should reach out to their MCO for this information. When possible, a case manager may assist the client in making this call.
    - As for Medicaid FFS clients, Gainwell's Customer Service Team is not currently permitted to release this information to either a client nor a provider.
- **Extenuating Circumstance 1:**
    - In a non-acute/non-urgent situation – if a Medicaid Managed Care client has attempted to but is unable to secure this information from their MCO, the provider may assist the client to complete, sign, and submit a release of information to BHDDH (via email to melissa.howe@bhddh.ri.gov) for this information.
- **Exentuating Circumstance 2:**
    - In an acute/urgent situation – e.g., a Medicaid Managed Care or Medicaid FFS client comes into a CCBHC in an agitated state and cannot tell the provider who their current CCBHC is and is unable to sign a release of information), the CCBHC may reach out to BHDDH (via email to melissa.howe@bhddh.ri.gov) for this information to support care coordination.

13) Dept. Of Corrections Care Coordination Agreement Template

Provider Question
Is this ready for CCBHC review and approval?

State Response
This template is currently still under review by the Dept. Of Corrections. Beth Matthews will follow-up with Chris Imbriglio. Once DOC signs off, Beth will share with all CCBHCs via email with Chris cc-ed.

Section III. Attribution & Billing

14) Attribution – Securing Client's SSN and/or MedicaidID

Provider Question
To enroll a client via the Provider Portal, we must enter in either their SSN or Medicaid ID (MID). We are often unable to secure this information in a timely manner, particularly for children because their guardian does not have this information on hand during the visit and this information is not included on all insurance cards. Can the State/Gainwell provide us with this information? Can all MCOs add this information to their insurance cards (right now only Tufts includes it)?

State Response
SSN and MID are both considered PHI. Per established data sharing policies:

- Gainwell cannot share either of these identifiers out if the provider only has the client's first name, last name, and DOB.
- Gainwell can release the MID if the provider has the client's first name, last name, DOB, and SSN. The provider must have all four identifiers.

On the MCO side, here is the assistance they're able to provide:

- NHP has a portal (Navinet) where providers can go to access a client's MID directly. All you need to input is the client first name, last name, and DOB.
- UHC offers a call line for providers.
- Tufts has this info printed on each client's insurance card.
- ***If further information/navigational assistance is required, please connect directly with your designed MCO liaison.**

15) Attribution File from BHDDH to Providers

Provider Question
Is it feasible for BHDDH to provide us with an updated attribution file every 2 weeks, instead of monthly? Over the next few months, it'd be helpful if we could check our attribution list against the State's/MCOs' lists with greater frequency so that we can resolve discrepancies quickly to mitigate against payment issues.

State Guidance
Yes! BHDDH is actually providing each CCBHC with an updated attribution file this Friday and next Friday. They will then move to a biweekly cadence, then monthly when we get to a steadier state.

16) Diagnostic Codes for High Acuity Adults and Children

Provider Question
Is there a set of defined ICD-10 codes we should use to formally attribute clients to the High Acuity Adult and High Acuity Child populations? This is a required field in the Provider Portal.

State Guidance
For **high acuity adults**: Please see attached for a list of defined ICD-10 codes that will be used by BHDDH to verify the correct attribution of adults to the High Acuity population vs. the Standard population. This list was recently shared with all CCBHCs.

For **high acuity children**: There is not a pre-defined list of ICD-10 codes. Providers should review the required set of children's diagnoses (i.e., as included in the screenshot you've provided below), then document in the Provider Portal and the 'CCBHC High Acuity Child Program Ongoing Monitoring Template (09/20/2024)', the diagnostic codes that they believe align with those diagnoses. The range of acceptable diagnostic codes for children is quite broad, e.g., many fit under the category of 'personality disorder(s)'. DCYF will review each submission. The State will inform the CCBHC if there are concerns with any of the documented diagnostic codes.

17) High Acuity Children: Eligible Age Range

Provider Question
Page 159 of the RI CCBHC Certification Standards states up to age 21 for the High Acuity Children, and page 150 states under 18. Can you please clarify the age for the High Acuity Children population?

State Response
It should say up to age 18.

18) Healthy Transitions Program: Eligible Age Range

Provider Question
What is the correct age range for Healthy Transitions?

State Response
The correct age range is 15-26 years.

19) High Acuity Adult Programs & Population Exception Request Requirements – General

Provider Question
Can you clarify when we do or do not need to submit a High Acuity Adult Population Exception Request to BHDDH?

State Response
- 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.
- A population exception request will not need to be submitted to BHDDH to formally move a client between the adult high-acuity programs, i.e., HT (individuals aged 15-26yo with typically a DLA score of 3 or below), ACT (typically those with a DLA score of 3 or below), and ICTT (typically those with a DLA score of 3.1 – 4.0). 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.

- Providers should still enter the individual into the desired "program" in BHOLD for tracking purposes. The individual's DLA score (for example, a DLA above 3 for HT) will not prevent them from entering them into this program in BHOLD.
    - For Reference in BHOLD: ACT = MTT, ICTT = CSP/GOP, and HT = Contract ID.
- We anticipate re-evaluating the DLA guidance for each team-based service for Year 2 CCBHC.

Provider Follow-up Question 1

Do we need to submit a high acuity population exception form for a kid who was in high acuity care before 10/1 and in October, but by the time they were assessed, they didn't meet the criteria for high acuity because they will be transitioning to lower acuity next month? This would be an acuity exception request for just 1 month, not 3.

State Response

Yes, you do need to submit a high acuity population exception request. Please explain these special circumstances in the request.

20) CCBHC High Acuity Children & Adult Population Exception Request Requirements – Commerical Clients

Provider Question

CCBHC high acuity children and adults – are exception requests/approvals from DCYF and BHDDH required for commercial clients?

State Response

Yes. The State is responsible for providing clinical oversight to ensure children and adults are being provided the appropriate level of services and enrolled in clinically appropriate programs given their demonstrate needs.

This has no impact on commercial billing. For commercially covered children and adults, providers will bill FFS for the individual service components that are delivered. The payer will pay the provider for the services in alignment with established fee schedules.

Provider Follow-up Question 1

What authority does the State have to require and enforce this?

State Response

The RI CCBHC Certification Standards dictate eligibility requirements for CCBHC High Acuity versus Standard populations.

DCYF holds the authority to regulate and oversee the quality, access, and appropriateness of children's BH services through various state agencies and regulations, and to help Medicaid enforce as the formal CCBHC certification agency. BHDDH holds this authority for adult BH services.

Provider Follow-up Question 2

Having to submit population exception forms for commercially insured clients adds to our administrative burden. On the children's side, can we just include information for them in the monthly High Acuity Child Monitoring Report?

State Response

Providers must submit Population Exception Requests for both Medicaid and commercially covered children, and include both in the High Acuity Child Monitoring Report. Note, we acknowledge this step requires some time, but it is necessary from a clinical oversight perspective and the volume is anticipated to be manageable.

On the adult side, we anticipate a low volume of exception requests for ACT, but potentially a higher volume for Healthy Transitions.

Provider Follow-up Question 3

If a commercial payer is willing to pay for high acuity care, why would the State ever deny this? How would you explain to a parent? This seems like an overreach and a restriction of access to services.

State Response

DCYF's review of High Acuity Population Exception Requests for commercially insured children is part of DCYF's oversight and monitoring of children's mental health services.

- If a commercial insurer has approved high-acuity services that align with the service levels and team composition for the CCBHC High Acuity Children's Program as defined in the RI CCBHC Certification Standards, that information should be included in the Population Exception Request.
- If a Population Exception Request is denied before the commercial insurer approved coverage at the service levels and team composition that align High Acuity Children's program, the Population Exception Request should be resubmitted with the additional information regarding the commercial insurer's approval.

A Population Exception Request is not needed if a commercial insurer approves a higher level of service than is standard for the Standard population (e.g., therapy twice weekly) but does not align with the team composition and service levels defined for the team-based care in the High Acuity Children's program for CCBHCs. In those cases, children can receive the higher level of service the commercial insurer approved without being placed on a high acuity children's services team.

Provider Follow-up Question 4

Are there any efficiencies that can be considered on the kids side for documentation? I.e., Does the High Acuity Child Monitoring Report not give DCYF all the info it needs to evaluate the appropriateness of care – if so, why do we also have to complete and secure an approved Population Exception Request? Is there a shorted version of the Exception Request Form that we can submit for all children under the age of 5yrs since the OHIO assessment does not apply to them?

State Response

- Providers are required to submit High Acuity Child Population Exception Request Forms and monthly High Acuity Child Ongoing Monitoring Reports to the State. The prior informs our clinical determination of appropriateness for the child to receive high acuity services when they don't meet the certification requirements for this level of care. The latter is for monitoring and compliance purposes. Both tasks are required by Medicaid.

- There is not a shortened version of the High Acuity Population Exception Request Form for children under the age of 5yrs. Please simply leave the OHIO assessment fields on the form blank as they are non-applicable, but provide the other requested information to inform our evaluation of you request.

21) Provider Portal: Client Attribution & Documentation of Assessment Data

Provider Question

As reported to Karen Murphy and Melissa Howe, we are sometimes encountering error messages on the Assessment portion of the Provider Portal and unable to proceed. Can you clarify what the root cause is and how we resolve it?

State Guidance

System configuration clarifications from Gainwell:

- There is no branching logic. All providers will see the Assessment Type, Date, and Score fields in the Provider Portal regardless of whether they check the 'Standard', 'SUD', 'High Acuity Adult', or 'High Acuity Child' population box in the prior screen/section.
- Providers cannot do the following. This will result in an 'error' message.
  - Assessment Type = N/A
  - Assessment Date = blank/skipped
  - Assessment Score = blank/skipped
- Providers must complete all fields or leave all fields blank.

As such…data entry instructions for all CCBHC providers:

- For clients being attributed to the **Standard** population, complete the Assessment fields as follows in the Provider Portal:
  - Assessment Type = leave blank
  - Assessment Date = leave blank
  - Assessment Score = leave blank
- For clients being attributed to the **High Acuity Adult** population, complete the Assessment fields as follows in the Provider Portal:
  - Assessment Type = DLA
  - Assessment Date = date assessment was administered
  - Assessment Score = assessment score
- For clients being attributed to the **High Acuity Child** population **under the age of 5 years**, complete the Assessment fields as follows in the Provider Portal:
  - Assessment Type = OHIO
  - Assessment Date = date of input of client into the Provider Portal
  - Assessment Score = 99999
- For clients being attributed to the **High Acuity Child** population **age 5 years and older**, complete the Assessment fields as follows in the Provider Portal:
  - Assessment Type = OHIO
  - Assessment Date = date assessment was administered
  - Assessment Score = assessment score

For clients being attributed to the **SUD** population, documentation of the client's ASAM assessment score via the Provider Portal is optional and strongly recommended, but not required in Program Year 1.

In Year 1, the only population criteria is an SUD as the primary diagnosis. Please note, this step will be required in Program Year 2 when the ASAM score is added as a population criterion. See **RI CCBHC Certification Requirements, Addendum 5, pg. 152** for further details.

As such, in Program Year 1, the data entry instructions for SUD clients are as follows:

- If an ASAM assessment has been administered for the client, please complete the Assessment fields in the Provider Portal as follows:
    - Assessment Type = ASAM
    - Assessment Date = date assessment was administered
    - Assessment Score = assessment score
- If an ASAM assessment has not yet been administered for the client, please complete the Assessment fields in the Provider Portal as follows:
    - Assessment Type = leave blank
    - Assessment Date = leave blank
    - Assessment Score = leave blank

Follow-up Provider Question 1

Can you provide instructions on how to enter ASAM scores into the Provider Portal?

State Guidance

The ASAM assessment produces a range of scores from 1-4, with some scores falling between whole numbers (e.g., with a decimal). In cases where there is a decimal, the decimal point should **not** be entered. You should enter the score as consecutive numbers, e.g.,

- If a client scored a total of 4, you will enter in 4.
- If a client scored a total of 2.1, you will enter in 21 without a decimal.

Follow-up Provider Question 2

For High Acuity Children under the age of 5yr – should we input their information into the Provider Portal, or submit a High Acuity Child Population Exception request to DCYF first?

State Guidance

For now, please complete both steps in parallel. Nicole Vadnais (DCYF) reviews and approves all High Acuity Child Population Exception requests from a clinical perspective. Melissa Howe (BHDDH) reviews and approves all Provider Portal entries from a systems perspective. The two are coordinating behind the scenes on formal State approvals and Nicole will inform you of any exception request denials and/or if further info is needed for approval. This approach will help us process the initial round of exception and attribution requests from all providers as quickly as possible.

Once we're at steadier state (meaning the initial round of exception requests have been submitted and processed), please submit the High Acuity Child Population Exception Request to DCYF first, then formally enroll the client via the Provider Portal once your exception request has been approved.

To reduce the risk of attribution complications, please submit your Population Exception Requests to DCYF as soon as possible to allow sufficient time for review and any follow-up that's required.

22) Children with I/DD Diagnosis

Provider Question

Our kids crisis team is contacted for crisis outreach to a child that falls on the autism spectrum. We are contacted either through the school system or a family. The crisis service might be the only CCBHC service provided in the month with only the 1 reportable diagnosis. We are aware of the V and Z codes related to child abuse/neglect for qualification, but what if these are not clinically indicated? Is the autism diagnosis allowable for Provider Portal entry? And if it is a kid served in crisis, which CCBHC population should they be attributed to?

State Response

In general, one-time assessments on not previously-attributed children should be billed under the standard population. Even if a child or youth could qualify for a high acuity program, you should not bill for the high acuity program unless the child or youth is receiving high acuity services. Providers must assess each child, including those who enter the CCBHC program due to a crisis event, to determine the appropriate level of ongoing care and assign the child to either the Standard or High Acuity Child population accordingly.

Children receiving crisis services and subsequent stabilization through MRSS who meet the high acuity criteria defined in the RI CCBHC Certification Standards should be assigned to and billed under the High Acuity Child population. The diagnosis given to a child in crisis must accurately reflect the underlying cause of the crisis. If the primary diagnosis or other criteria do not align with the High Acuity Child population requirements, a High Acuity Population Exception Request Form should be completed and submitted via email to DCYF (DCYF.CCBHC@dcyf.ri.gov) for review, including detailed clinical information justifying the need for continued stabilization services.

BHDDH will approve all children entered into the portal. DCYF is reviewing the monthly CCBHC program attribution lists and substantiating them using data from providers' submitted monthly CCBHC High Acuity Child Program Ongoing Monitoring Templates. DCYF will inform each CCBHC of any observed discrepancies for reconciliation/correction.

Moving forward, it is essential for providers to submit completed High Acuity Child Population Exception Requests to DCYF as soon as eligibility is determined. Ideally, exception requests should be approved before providers enter these children into the Provider Portal, as a denial may result in required payment adjustments.

23) Provider Portal Data Entry for High Acuity I/DD Clients

Provider Question

Per the CCBHC Provider Manual_V1, the High Acuity Adult Population criteria are as follows:

A. Overview of Populations:

There are two main categories of populations; 1) Standard Population, individuals not included in one of the High Acuity Populations and 2) High Acuity Populations (three categories):

1. **High Acuity Adult (18+):** Individuals with serious mental health conditions, high risk of hospitalization, or other significant needs such as co-occurring disorders, or who are at high risk due to other factors like homelessness or justice system involvement. This may include individuals who are eligible for IDD waiver services with co-occurring behavioral health concerns, and transition aged youth (ages 15-26).
2. **High Acuity Children and Youth (Under 18):** Children and youth with serious emotional

We have a few clients who are meeting acuity based on their IDD waiver status, but not their DLA score. The Provider Portal doesn't recognize IDD and doesn't allow us to bill high acuity. Within the Medicaid screen it says authorization is required. Is this a separate process? How do we get these in portal? Do we just enter the higher score and you will approved based on IDD?

Benefit Plan Details

Plan Name	Effective From Date	Effective To Date	Renewal Date	Base Deductible	Message
Categorically Needy Services	10/01/2024	01/01/2025	N/A	$0.00	Limitations apply to Vision and Dental services
MBH060 PROGRAM	10/01/2024	01/01/2025	N/A	$0.00	ENROLLED IN MBH060 PROGRAM
Intellectual Disability Services (BHDDH)	10/01/2024	01/01/2025	N/A	$0.00	BHDDH Auth required/ Recipient may be subject to cost for patient share

Service Type Code Details - Covered

State Response
If a client is on the IDD waiver and has a BH diagnosis, they meet the criteria for the CCBHC high acuity population. For these specific clients:

- Please input ICD-10 code **F79** (unspecified intellectual disabilities) into the field where you typically document the behavioral health or substance use disorder diagnosis for the client in the Provider Portal.
- Melissa Howe (BHDDH) will review the entry, then approve.

Note, clients without an IDD waiver do not automatically qualify for the high acuity population. Some may only qualify for the standard population. Please attribute the client based on your assessment of their level of need. A High Acuity Population Exception Request may be submitted to BHDDH if/as needed.

24) Provider Portal Data Entry for High Acuity Transition-Aged Youth

Provider Follow-up Question 1
Can you also clarify the eligibility criteria and Provider Portal documentation requirements for clients age 15-26 yrs?

State Response
Transtion aged youth (defined as those ages 15-26 yrs) qualify for the High Acuity Adult population if they have a mental health diagnosis; and/or any of the stipulations noted below (per the RI CCBHC Certification Standards); and a DLA under 4.

2. An individual is in the High Acuity Adult Population if they are transition aged Individuals between the ages of 15 and 26, and:

   a. Experienced first episode psychosis or early onset of serious mental illness with high prevalence of co-occurring substance use disorders.
   b. Have or at imminent risk of developing a serious mental health condition.
   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.
   d. Individuals in a residential setting are not eligible for CSC services and I
   e. Individuals with autism spectrum disorder are eligible only by exception.
   f. Request for exceptions to eligibility criteria may be made at any time in writing to BHDDH.

3. Individuals in the high acuity group must be re-evaluated utilizing the DLA or resubmission of an exception request with BHDDH approval every 90 days to determine if they continue to need this level of service intensity.

25) Crisis Services – Attribution & Billing

Provider Question

For individuals who: i) are not currently attributed to another CCBHC; and ii) request/want crisis service and perhaps one stabilization visit; but iii) do not want to further engage in additional CCBHC services – can we attribute them for one month to the Provider Portal under the Standard Population, receive payment for the rendered service, then discharge them the following month? Essentially, what counts as consent (parsing attribution from ongoing CCBHC treatment) and participation in CCBHC (i.e., does a crisis service in itself count)?

State Guidance

Mobile crisis is a qualifying/payment triggering service. If a CCBHC provides mobile crisis services (in the community, not in the ED as part of emergency triage) to an unattributed client, the CCBHC can attribute that client and bill for that month, regardless of the other services that the CCBHC provides to that client in that month. If the client needs or desires further care, it the CCBHC's responsibility to help them get that care in the appropriate setting.

Follow-up Provider Question 1

If a CCBHC/DCO responds to a MRSS call and the child is likely to be enrolled in stabilization or high acuity services, can we attribute them to the High Acuity Child population instead of just the Standard population? We currently conduct the OHIO Assessment at the crisis event, so this would not be an obstacle to the State defined client attribution process via the Provider Portal.

State Guidance

A CCBHC may assign any child who meets the State established criteria for the High Acuity Child population, to this population. To do so, the provider must submit all required information to the State via the Provider Portal and a monthly High Acuity Child Program Monitoring Report. For further details, see: https://eohhs.ri.gov/initiatives/certified-community-behavioral-health-clinics-ccbhc/ccbhc-info-providers-and-mcos > **Section**: Additional State Guidance and Reference Materials > **Sub-section**: Implementation > **Document**: Acuity Level Evaluation, Score Submission, and Client Population Assignment Process (09/20/2024).

26) Documentation and Billing for Crisis Co-Response (specifically 2-person response)

Provider Question

- Since we have two staff members going out to meet with the client/family for our initial crisis intervention, should both staff (example - Clinician and Case Manager) both be documenting an Initial Crisis Intervention service (S9485) within our EMR for the same date & time?
- If yes, is this also the guidance when two staff members are together, providing crisis follow up intervention service (S9484) and/or family stabilization service (S9482) during the same date/time?

State Response

- We intend for the mobile crisis data to be patient level. We would like a single record for each individual patient.
- Documentation by 2-person crisis teams (as required by CCBHC standards for adults and children) should reflect services provided but only be documented once.
- When a crisis is responded to with 2 staff from your agency, the clinician (MA, LMHC, LCSW, LICSW, etc.) should be completing the initial crisis assessment in the EHR.
- Paraprofessionals who are also present (CPST, peers, etc.) should document what their role at the time was (e.g. provided support, made phone calls, spoke with parents). This would likely be a progress note.
- In regard to follow up stabilization services, we would encourage 1 staff from the 2 person team to complete a clinical note (whomever is primary in that visit) and the secondary staff to write a progress note detailing their role in this visit as well. This detail will not be included in the Mobile Crisis Template, but we are encouraging this practice.

Follow-up Provider Question 1

If we have two staff members (for example - Clinician and CPST) going out to meet with the client/family for our Children's Intensive Services or Healthy Transitions. Should both staff be documenting a qualifying event within our EMR for the same date & time?

State Response

- **If multiple interventions were provided**: you should include both interventions on the claim.
- **If only one intervention was provided by two people**: the event should reflect the primary intervention provided. A progress note should be included to document the presence of the additional staff member.

Follow-up Provider Question 2

Are you indicating that we can use the same times for service delivery of Case Management and Therapy if they are both present and providing services?

State Response

If there are two staff performing separate activities simulanteously (e.g., Case Management and Therapy), we don't want to lose insight into either. We expect to see both activities to be documented in your EHR and resulting claims. This information is important for both the State and providers to track from a staffing and service utilization tracking perspective.

If there are two staff performing one activity (e.g., a co-visit), please also document the presence of the secondary staff member in EHR as progress notes as directed in the above response. In this situation, the secondary staff member would not be included in your resulting claims.

Follow-up Provider Question 3
How should we bill if the client has other insurance that pays for the individual services?

State Response
Please follow the established TPL processes. We understand that other insurers may only pay for a single provider. In this instance, we encourage you to follow your current protocols (e.g., include the staff member which you receive a higher reimbursement rate for on the claim).

27) Payment for Mobile Crisis Services Delivered to Non-Attributed CCBHC Clients

Provider Question
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.

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?

State Response
- 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 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.

Attribution Transfers and Care Transitions (guidance included in the **RI CCBHC Billing Manual**):

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

28) Billing for Non-Certified Peers

Provider Question

Can a non-certified peer post quick notes in an EHR if they are under 7 mins? It is my understanding that quick notes under 7 mins are not billable. One of our non-certified peers is doing outreach to clients who recently lost their peer to see if they would like to continue their peer services with another peer. Is it okay for him to post quick notes less than 7 minutes?

State Response

It is up to each provider to determine which activities are appropriate to document in their EHR as notes, even if the encounter is not billable.

Provider Follow-up Question 1

I know some doctors co-sign notes for providers who are not licensed to bill, such as Genetic Counselors and Fellows. Can non certified peers provide peer services and bill if they are actively working towards peer certification and their note is co-signed by a certified peer?

State Reponse

No. The co-signing aligns with supervisory protocols for non-licensed staff members, not with billing protocols for non-certified peers.

<u>Provider Follow-up Question 2</u>
Can the State consider allowance of payment for training and supervisory activities?

<u>State Response</u>
Under our current authority (i.e., the State Plan or the 1115 Waiver), only individuals with the required credentials can bill for direct services as a Medicaid provider. With this said, these types of cost are assumed to have been incorporated into your PPS rate as an admin cost or an implied indirect cost.

29) Billing – Nicotine Replacement Therapy (NRT)

<u>Provider Question</u>
There is not a CPT code for Nicotine Replacement Therapy on the CCBHC fee schedule. How do you want us to code this service (a quick search states 99406 & 99407 are used for NRT)?
<u>State Response</u>
Please pick a code appropriate for the person providing the service. We do not need to identify this specific service for year 1. For example, if a counseling session for 30 minutes was provided by an LICSW, use the code 90832:AJ.

<u>Provider Follow-up Question</u>
Can we bill the PPS2 rate if a client is receiving services in Ambulatory Withdrawal Management for nicotine withdrawal?

<u>State Response</u>
No. Withdrawal protocols for Alcohol and Opioids are more intense, requiring this level of care. Nicotine withdrawal can be provided at an outpatient level of care, not requiring this level of supervision.

30) CCBHC Services & Institutional Settings

<u>Provider Question</u>
Can you provide further guidance on what CCBHC services are <u>and</u> are not allowable within different institutional settings? E.g. How should we bill for community-based services delivered to clients currently enrolled in SUD residential treatment?

<u>State Response</u>
Below is the determination by EOHHS related to what is allowable for CCBHC services to be provided to individuals admitted to/placed in a facility, residential, or congregate care setting.

The following guidance applies to nursing facilities, intermediate care facilities, inpatient hospitals, I/DD residential, children's residential, and Psychiatric Residential Treatment Facilities (PRTFs):

- 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 (4) and are provided on or after the start of the discharge planning process.
    - 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 facility (e.g. inpatient hospital, nursing

facility, or correctional facility), not the portion that occurs before 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.

- 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.

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.

Follow-up Provider Question 1

Can you clarify how acute and crisis stabilization units (ASUs/CSUs) are categorized and how the released billing guidance applies to them?

State Guidance

ASU/CSU is not a restricted site for CCBHC services. A Medicaid member can receive services from an ASU/CSU and a CCBHC concurrently, and CCBHC providers can bill the CCBHC rate for attributed Medicaid members while that member is in an ASU/CSU.

Follow-up Provider Question 2

Can you clarify what types of settings fall under the umbrella of intermediate care facilities (ICFs)?

State Guidance

An Intermediate Care Facility (ICF) is a long-term care setting that provides care and support for individuals with developmental disabilities or other related conditions. ICF requires lower levels of care than at a skilled nursing facility, but more care and attention than those who live in a residential care facility. The only ICF enrolled as a Medicaid provider in Rhode Island is the Tavares Pediatric Center.

31) CCBHCs & School-based Services

Provider Question

In regard to clients who we serve through unique contracts, such as through a contracted school-based service – historically, some RI school districts have contracted with us to provide mental health services to their students. In these cases, the full cost of the clinician who provides the service may already be covered by the school. As these services are "paid for," we would assume that there would be no corresponding Medicaid billing. Does this mean that these clients should not be attributed? Are there implications of attribution/non-attribution? If the students need more services than are covered by the clinician (such as perhaps psychiatry or case management), how can we appropriately bill for this given the CCBHC PPS rate includes services that are already covered. Do we bill fee for service for the additional services? Do we bill the PPS rate less what we have been reimbursed (this seems extremely challenging administratively)? Do we take some other approach?

State Response
If the cost of your school-based clinician is already covered by the local education authority (LEA) or the State (and therefore was not included in your Cost Report), you should not bill Medicaid for the CCBHC PPS2 rate for services provided in the school. The LEA would be responsible for any Medicaid claim/reimbursement. You should not attribute or bill for those children unless the children receive additional services outside of the school contract – then those services could be billed to Medicaid through the PPS2.

Note: As the question was written, we are assuming these clinicians were not included in your Year 1 Cost Report. If the cost of your school-based clinician is not covered by the school or the State, and you are providing CCBHC services to Medicaid eligible children in the school – then those community-based services would be eligible for billing to Medicaid through the PPS 2.

Follow-up Provider Question
The positions listed in the cost report are NOT covered by the LEA or another contract. The particular situation we were thinking of is relevant to the first bullet below - at times we have entered into contracts with LEAs and those would be for people or services not already in the cost report. Within the cost report, we built up a school-based component of services, but again these would be separate and distinct from any other contract or agreement.

To provide further clarification on our original question below - if the cost of the clinician is covered (for example by a contract with the LEA) but services such as psychiatry are not, how should we handle this should that client/student need to come to us for psychiatry services? Would that be eligible for PPS2 even though some of the cost of the services are covered? Is there some other approach?

If the students need more services than are covered by the clinician (such as perhaps psychiatry or case management), how can we appropriately bill for this given the CCBHC PPS rate includes services that are already covered. Do we bill fee for service for the additional services? Do we bill the PPS rate less what we have been reimbursed (this seems extremely challenging administratively)? Do we take some other approach?

State Response
Clinicians funded by grant dollars are excluded from the CCBHC cost report and any services provided by those clinicians pursuant to the trauma-informed grant should not be treated as an eligible encounter for the PPS-2 rate. If additional services are provided through the CCBHC based on the child's needs, family/caregiver's desire to receive CCBHC services, and subsequent attribution to FSRI that meet criteria for eligible service(s), then these services can be billed for a PPS encounter. Note, only these children should be included in the denominator of the cost report. Children being exclusively treated pursuant to the grant and served by the granted-funded clinicians do not need to be included in the denominator of the cost report.

32) CCBHCs & Ryan White

Provider Question
For individuals with HIV and BH service needs – right now, these individuals are currently on our CCBHC attribution list. Should they be in the future? Which portion of services should be paid using CCBHC PPS funds vs. Ryan White ones? This has BHOLD and Ryan White/CCBHC billing implications.

State Response
Individuals in Ryan White can have full Medicaid. These clients will have an MID (not beginning with 976) and can be attributed in the provider portal and reimbursed via the PPS rate. Individuals in Ryan White Only who do not have Medicaid should not be in the provider portal and should be billed via the other insurer.

Regardless of insurer (full Medicaid, partial Medicaid, non-Medicaid, etc), clients receiving BH services need to be entered into BHOLD for data collection.

33) CCBHCs & Katie Beckett

Provider Question
Can/should children enrolled in the Katie Beckett case management (CM) program be attributed to a CCBHC?

State Response
Yes, they can be attributed to a CCBHC. However, they should not be on the MCO lists. These children receive Medicaid benefits only through Medicaid FFS, not MCOs. In other words, MCOs do not pay claims out on these members. As such, **all Katie Beckett CM Only clients should be removed from the attribution lists sent to MCOs, but should remain on CCBHC attribution lists**. It is likely that children and youth in Katie Beckett CM Only have TPL, so as applicable, CCBHCs should follow third party liability (TPL) billing processes.

Provider Follow-up Question 1
It is our experience that KB children do sometimes end up on MCO lists. They may have had Medicaid before through income eligibility, but then transitioned to KB if their family became commercially insured. They may not get dis-enrolled at that point. We do follow the TPL billing process but commercial insurance does not always cover intensive home-based services, so it reverts to the Medicaid. Are you recommending that we should ask families to disenroll in the managed care plan so that they will have access to high acuity services?

State Response
No. All KB members are enrolled in an MCO. Families are not allowed to disenroll from an MCO per the DOJ Settlement that the State is still working under.

To clarify:

- If a member is enrolled in an MCO with full coverage, they are billed to the MCO. This represents a small portion of the overall KB population.
- If a member is enrolled in an MCO for KB CM Only, the MCOs are only involved on a case management level. All other services are reimbursed Medicaid FFS (i.e., through Gainwell). This represents the majority of the KB population.

Provider Follow-up Question 2
What process should we follow for children who are partially commercially covered?

State Response

If the member is enrolled in Rite Care for full benefits (i.e., not KB Case Managed Only), bill the MCO for T1041 and they will adjudicate any TPL coverage per their usual processes. There should be few KB enrolled with full benefits who have TPL.

If the member is enrolled in KB CM Only, you should bill the commercial carrier and Medicaid FFS concurrently, per the established TPL process. In other words:

- Bill Medicaid FFS for T1041, and separately bill the commercial carrier for any covered service and submit a crossover claim to Medicaid FFS.
- Medicaid will recoup from the provider the payment from the commercial carrier and any crossover payment by Medicaid FFS. In all, the provider will be paid the full T1041 rate but no more.

Provider Follow-up Question 3

In regards to billing clients with Medicaid through Katie Beckett when it is secondary to a commercial plan – DHS currently requires that a paper authorization be submitted to them prior to CAITS services. Will this authorization still be required?

State Response

Yes, providers shall continue to follow currently established service authorization protocols, with DHS as the authorizing entity. Members of the CCBHC Interagency Team are meeting with DHS to ensure all providers receive the guidance needed to complete this step.

34) Client Transfers – Documentation in Provider Portal

Provider Question

Follow-up to guidance provided by the State regarding what CCBHCs should document as the admit and discharge dates in the Provider Portal for a client transferring from one CCBHC to another: "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."

- We cannot (and have tried) to enter a future date in the portal for the 1st of the following month, which produces an overlap error 100% of the time. Can that restriction be removed?

State Response

The overlap restriction should not be removed. It prevents enrollment in multiple programs at the same time and is for all programs not just CCBHC. The discharging provider needs to end date the enrollment before the admitting provider can add an enrollment for the next month.

35) Mid-Month Population Changes – Documentation in Provider Portal

Provider Question

If someone is general population and then mid-month has an assessment and switches to high acuity, do we enter them as high acuity beginning that date? Should we back-date them to the beginning of the month as that new population or wait until the following month to switch their population category? How does this work for FFS and for managed care?

State Response

From a clinical perspective: Providers must provide clinically appropriate services when they are needed, e.g., transition a client from a lower to higher acuity program if/when a re-evaluation of the client determines this is neccessary.

From a billing perspective: If a client switches populations mid-month (i.e., from the Standard population to High Acuity, or vice versa), we require waiting until the **beginning of the following month** to formally update their attribution, as there is no partial month billing for the CCBHC program. This approach mitigates potential billing complications. Potential payment differentials are expected to balance over time (as you will have some clients who require a step up of care, while others will require a step down of care).

This guidance applies to both FFS and managed care clients.

36) Billing Date Span – Alignment of Attribution & Billing

Provider Question

We have a client that was attributed on the 17th of the month and entered in the portal that way per Billing guidelines and then we billed 10/1-10/31 per guidelines.

We are being told by RI Medicaid that we cannot bill this way and to email you to update you billing manual as it should say that our billing should be day attributed through discharge and not 10/1-discharge.

Can you advise as I am sure this is impacting all providers.

RI CCBHC Billing Manual Updated 05.21.2024.pdf [linkprotect.cudasvc.com]

C. Ongoing Attribution

- **New Enrollments:**
  - The provider must submit a BHDDH CCBHC admission request via the healthcare portal. The client's eligibility category (i.e., High Acuity Adult, High Acuity Children and Youth, High Acuity Substance Use Disorder, Standard Population) and supporting diagnosis/assessment scores must be entered in the portal.
  - A member can be enrolled any time prior to payment submission.
    - For example, if a member receives their first qualifying encounter on 3/22/25, the provider should enter that date into the portal. The attribution for that member will be for the full month of March and the provider will receive the full PPS payment.

E. Billable Events and Payment

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

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

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

State Response

For the first month in which a client is attributed and you are billing for them, the billing date **cannot be earlier** than the initial date of attribution.

> For example: If a member receives their first qualifying encounter on 10/17/24, the provider should attribute the member in the portal with a 10/17 start date for attribution and the billing at the end of the month should reflect a date span of 10/17/24-10/31/24. While the billing span is for a partial month for the first month, you will still bill the full PPS2 rate for that month.

Note that the initial attribution date and first month billing date will be determined based on the first date of service for the member, so this will differ for each client. For ongoing members, you should bill for the entire span of the month as long as the member was attributed for the entire month.

Follow-up Provider Question 1

While we understood the attribution date needed to be entered in the portal on the actual day the client was attributed, the billing guidelines said we needed to bill first day of month through the end unless our system could not do this and then to use the first visit date. Our system allowed for the first of the month through discharge so this is what we did.

With that said we will have to go and try and obtain IT support and have this fixed once we have the exact that will be added to the manual. Can you advise if the unless our system could not do this and then to use the first visit date will it remain with the option to bill the first date of service within the month will be an option? As I do not think we can use the attribution date to pull into claims as that is being entered elsewhere so we can track the days before review

- 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.

State Response

In alignment with current Gainwell system configuration limitations…

For mid-month attribution of new FFS clients (i.e., not previously CCBHC attributed), providers should:

1. Update the claim service dates to align with the client's effective dates in the Provider Portal.
2. *Or if necessary given your current EHR/billing system configurations:* Manually update the client's effective dates in the Provider Portal to the first day of the month in which you saw the client.

For mid-month transfers of clients from one CCBHC to another, providers should:

1. **From a billing perspective**: When possible and clinically appropriate, work together and have the prior CCBHC disenroll the client at the end of the month, and have the new CCBHC enroll the client at the start of the following month. For further details, see the RI CCBHC Billing Manual pgs. 6-7.
2. **Important clarifications**:
    a. This option may not be feasible if the transfer is occuring due to a court-order, or from a non-CCBHC facility (e.g., a nursing home or group home) to a CCBHC.
    b. Providers must always work together to ensure a proper hand-off and no delay or disruption of services for the client. Pragmatically this can take some time. Clinical considerations must take priority over billing considerations.

37) 99211 Billing Code

Provider Question

Can you please confirm approved activities that a nurse would perform under this E&M Level 1 procedure code? The CCBHC Billing Code Master Sheet also indicates that the code has maximum units of 96 (it's a 5 minute code). That is a max of 8 hours. We want to make sure that this code is accepted by all the MCOs. In the past, Optum has rejected claims with this code which they consider only available for medical care.

State Guidance

As a reminder, the billing code that triggers payment is the CCBHC billing code. The code is for shadow claims, so the MCO system configuration should not affect payment. With that said, all three MCOs (with confirmation from Optum) have confirmed that billing code **99211** (with modifiers **TD** and **UB**) are configured in their systems.

38) Billing: 1500 Claim Form

Provider Question

I have searched the EOHHS CCBHC webpages, but can not locate the following information:

- On the 1500 claim form - is anything required in Box 24J as far as rendering, or in Box 31 or 32 as these are normal 1500 requirements and the billing system is asking for proof to strip?
- Optum sent the following guidance but it only talks about Box 33. Rhode Island CCBHC Provider Training

CCBHC name, billing address and phone number
P.O. Box cannot be entered on paper claim forms

CCBHC NPI#

CCBHC Taxonomy #

State Response

No rendering (Box 24J) is required on CCBHC claims. FFS service Medicaid only requires the CCBHC facility name address, NPI, taxonomy and taxonomy qualifier (ZZ) in Box 33 (name/address), 33A (NPI), and 33B (qualifier and taxonomy).

39) Billing Minutes

Provider Question

If we provide a service to a client multiple times (in person or via telehealth) within one day, can we combine those minutes and bill for the services if they total over 8 minutes? For example, if a staff person sees a client for medication for 5 minutes twice in one day, can we complete one note indicating the two 5-minute time spans and bill for the total 10-minute visit?

State Response

No. In order to bill for a 15 minute service, a minimum of 8 consecutive minutes of time must be provided.

40) Shadow Claims Submission Limitations

Provider Question

It's come to our attention that there may be a limit to how many shadow claims we can submit per client in a given month (i.e., max of 50). This is a rare occurrence but can happen for high-touch clients such as those enrolled in the ICTT program. We need to determine if this is a limitation posed by our billing system, the State/MCOs', or both. In the interim, thoughts on potential solutions forward to ensure all provided services are adequately captured?

State Response

Gainwell has confirmed there is a limitation on the Medicaid FFS billing system side of a total of 50 claim lines (first line with PPS + 49 details). This has: i) no impact upon payment (as provision of one qualifying service is sufficient to trigger payment of the CCBHC PPS rate); ii) a neglible impact on State analysis of service utilization (given the rarity of these scenarios); but iii) a potential impact upon calculation of performance against select quality measures. The Interagency Team is conducting further research into this and will issue further guidance ASAP to mitigate against this impact – e.g. clarify which services providers should prioritize including within the 50 claims lines they are able to submit per client.

In the meantime – as a gentle reminder, all providers should be bundling same-day services in their shadow claims submission where appropriate. For example: If you provided two separate, one-hour case management sessions to a client within one day…

- You should submit 1 claim for the service with code H0036 (community psychiatric supportive treatment, face-to-face, per 15 mins) with 8 units (15 min x 8 = 2 hours).
- Instead of 2 separate claims with code H0036 of 4 units each (15 min x 4 = 1 hour).

41) Billing: Copays and Deductibles

Provider Question

We need guidance on handling copays and deductibles that are transferred to Medicaid or an MCO. Previously, we submitted these charges to Medicaid and were reimbursed up to the Medicaid allowable amount. For example, a client has both Medicare and Medicaid coverage:

- We bill Medicare $100, and the client has a $20 copay.
- Medicare pays the Medicare allowable amount minus the $20 copay.
- We then bill Medicaid for the $20 copay.
- If the amount paid by Medicare is less than the Medicaid allowable, Medicaid would cover the $20 copay.

What should we do now if we bill CCBHC? Should we follow the same practice as before, with the Medicare and Medicaid copay payment being taken back in the reconciliation? Or should we write off the copay and only the amount paid by Medicare would be taken back in the reconciliation?

State Guidance

You should follow the same practice as before. Per the example provided above:

- You would not charge the client if they're full dual (Medicare/Medicaid).
- You would bill Medicare and get $100. This will generate a crossover claim to MMIS. MMIS (aka Gainwell) may pay you the $20 based on the established fee schedule.
- The State would then recup $120 during the reconciliation process. In other words, we would never recup more than you've been paid by Medicare and Gainwell.

Additional guidance:

- Bill Medicare using your non-CCBHC NPI for reimbursement.
- Bill Medicaid using your CCBHC NPI for PPS reimbursement.

42) Medicaid Spend-Down Rules

Provider Question

In the past, when a client was on a spend down payment with Medicaid, we would apply the full monthly rate for the ACT service to the spend down, which drew down relatively quickly so the client was switched to Medicaid. With the new process for "unbundling" the service to first bill Medicare/commercial payor, and billing the client for any non-covered services, it is going to take much longer to draw down on the account, delaying the client's eligibility for Medicaid by potentially several months. Can you confirm that unbundling the service is the process that we will need to follow, or will we be able to apply the full monthly rate of the service to the spend-down?

State Guidance

Medicaid doesn't advise on how providers bill patients who are not Medicaid members. The provider would bill the client following the provider's business processes and the client would present that bill/invoice to DHS as part of their eligibility processing.

43) Billing for NHP Integrity Clients

Provider Question

I'm reaching out for clarification on NHP Integrity clients. Our revenue cycle team was previously told that CCBHC services for NHP Integrity clients were excluded for Year 1. However, upon review of Scenario 2B on page 20 of the CCBHC Billing Manual, it appears they are included with separate guidance. Just looking for clarification.

State Response

Treatment of Duals in the Integrity program should be treated in the same manner as duals in any Medicare Advantage program. The CCBHC will (a) bill Medicaid FFS (i.e., Gainwell) for the full PPS-2 rate, while at the same time (b) seek primary payment from the Medicare payer (e.g., NHPRI for Integrity members, but also UHC or BCBS for DSNP providers or Medicare FFS for Part B clients). Any collections from these other payers will be "recouped" by the State against future PPS-2 payments.

Follow-up Provider Question 1

While I know NHP Rite Care (RC) is part of the CCBHC program, I am getting conflicting information on NHP Integrity. Can you advise if NHP Integrity clients are included in Year 1 of the CCBHC program, or if they are excluded?

This was previously shared in an email*: "Plans included: RI Medicaid, NHP RC, UHC RC, UHC Dual, NHP Integrity, Tufts Medicaid, Blue Cross Dual – Integrity is carved out in Year 1 of CCBHC program; same billing approach across all MCOs (i.e., Tufts, NHP, UHC).* But in 5/21/2024 CCBHC Billing Manual, I see this:

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

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

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

State Response

- NHP's integrity (i.e., the Dual program) is partially carved out of the CCBHC program in Year 1.
- Each CCBHC should bill Medicaid FFS (I.e., Gainwell) for the PPS2 for all clients enrolled in Integrity.
- They should also bill Integrity as a CMHO for the services provided (e.g., each 30 minute psychotherapy treatment) that Medicare would typically pay for.
- This process is the same as the CCBHC should be doing with all clients enrolled with Medicare – either Medicare FFS or a Medicare Part C (Medicare Advantage) Plan.
- So, for a period of time, the CCBHC will have been paid TWICE for certain amount of services. Once by the State through the full PPS-2 payment and partially by Medicare/Part C plan through the individual services.
- At a future date (on a quarterly basis) we will recoup against future PPS-2 payments the amount that the CCBHC collected from Medicare/Part C… or other TPL coverage (although the latter is likely minimal if any).
- The key is that CCBHCs should treat Integrity clients in the same manner as all Duals. Bill Medicaid FFS for the PPS-2 and bill some other party for the Medicare-covered services. We will then recoup the Medicare payments. This approach avoids each CCBHC having to wait potentially months before billing Medicaid for the PPS-2.

Follow-up Provider Question 2

While we bill RI Medicaid for the NHP Integrity clients as they are excluded, my question is do you need the S9986 code on these claims?

NHP Integrity is the only truly dual plan so it is one full payment and not two like the traditional plan. Adding S9986 to me does not make sense but then again setting up NHP Integrity and RI Medicaid on the same account has always been a no no and our system restricted it. Please advise if the T1041 should be billed with services as being prime or if the NHP Integrity clients need to S9986.

State Response

You should bill **RI Medicaid the PPS rate for NHP Integrity clients**. You should ALSO bill NHP Integrity for **Medicare** eligible services, as you would any Medicare Advantage plan for a dual-eligible client. These payments will be reconciled/recouped in the TPL process.

You should not bill NHP integrity the T-code or S9986 code as those are Medicaid codes, but you should bill NHP Integrity for any service components (e.g., psychotherapy) that Medicare would pay for. You should bill RI Medicaid FFS the T1041 for the PPS rate, and if needed the S9986, so there is a qualifying service.

Follow-up Provider Question 3

I need clarification on the "if needed". Is the S9986 needed on the RI Medicaid claims when client has NHP Integrity?

NHP Integrity is Medicare and Medicaid so one payment whereas all others we bill a Commercial/Medicare product prime and then bill RI Medicaid as secondary.

State Response

S9986 is used to alert FFS that there is a qualifying service to be paid for because you will not be able to bill a specific qualifying event code (e.g., for a psychotherapy visit) to both Medicare and Medicaid FFS as a shadow claim. The S code can therefore serve as a stand-in qualifying service for Medicaid FFS, if all other qualifying services were already billed to Medicare and will therefore deny.

For BH services, NHP Integrity is the primary payor, and they pay Medicare for CCBHC enrolled clients. The state will later recoup the payment received by Medicare. You should bill RI Medicaid FFS the T1041 for the PPS rate, and if needed (see instructions above) the S9986, so there is a qualifying service.

44) NHP Integrity and RIte Care

Provider Question

Can a client by covered by both Integrity and RIte Care? If yes, what is the State's expected billing procedure for these clients?

State Response

No. If a person is showing enrolled in both Rite Care and Integrity, the Rite Care coverage should be ended/terminated with the Plan. If there's a specific member case that needs to be addressed, let us know and we'll work with the appropriate team on the State side to end the Rite Care enrollment with the Plan.

45) Billing for SLMB and QMB Clients

Provider Question

My understanding of how the MMIS processes claims for SLMB/QMB is as follows:

- SLMBs are not Medicaid eligible and therefore claims submitted are denied. This would include the CCBHC PPS 2 rate.
- QMBs are only eligible for crossovers/cost sharing. If Medicare doesn't make a payment, then Medicaid denies the claim. Claims for the CCBHC PPS 2 rate will deny. Claims billed as secondary for services covered by Medicare will process accordingly.
- Based on this I think the CCBHC Provider Q&As_10.21.24_v1.21, Items 79 and 110 might need to be updated.

State Guidance

The RI CCBHC Billing Manual and the Q&A are correct. Per the Billing Manual:

- "*This PPS payment model applies to all Medicaid-eligible populations with the following clarifications:*
    - *Qualified Medicare Beneficiary (QMB)-only individuals would be paid through cost sharing up to the Medicare reimbursement rate or the PPS-2 rate if lesser.*
    - *Specified Low-Income Medicare Beneficiary (SLMB)-only individuals would not be eligible for cost-sharing.*
    - *SLMB+/QMB+ would be paid the PPS-2 Rate and would follow established third-party liability (TPL) processes.*"
- As further clarification: providers should submit for QMB through their CMHC NPI, not CCBHC NPI.

Provider Follow-up Question

Can you explain who exactly we can bill the PPS rate for?

State Response

- QMB+ And SLMB+: you can submit PPS claims via your CCBHC NPI (you should follow appropriate TPL billing processes, as you would with other TPL populations).
    - You might not know that someone is a SLMB+ or QMB+. From your perspective, the person has full Medicaid and full Medicare. You would follow the TPL process as you would with other fully Medicaid eligible duals.
- For QMB-only individuals, you can bill Medicaid via your CMHC NPI (**not** the PPS rate via your CCBHC NPI). QMB-only is only eligible for cost-sharing on the Medicare claim.
    - The Healthcare Portal Web Eligibility Message will read "Recipient eligible for Medicare Crossover Claims."
- For SLMB only, there is no Medicaid cost sharing, so do not submit any Medicaid claim.
    - The Healthcare Portal Web Eligibility Message will read "Recipient not eligible for Medicaid Benefits."

46) Billing for Clients with Private and Medicaid Coverage

Provider Question

Does a client who is dually insured Blue Cross and Medicaid have the ability to "pay" for one of the CCBHC core services (e.g. psychiatry) at one CCBHC using their Blue Cross benefit only, while seeking other CCBHC services (e.g. IOP or withdrawal management) from another CCBHC agency who bills Medicaid the PPS-2 rate?

State Response

No. A client who is dually insured cannot receive qualifying CCBHC services from more than one CCBHC agency at a time. If the client is receiving a CCBHC service from one CCBHC, any additional services would already be covered under the PPS2 bundled rate and Medicaid should receive TPL reimbursement for the Blue Cross payment. Under CCBHC contractual agreements, providers are not permitted to split and bill for CCBHC services in this manner.

The client is encouraged to secure all clinically appropriate and allowable CCBHC services from one CCBHC. If the client would like to access specific CCBHC allowable services outside of their designated CCBHC, they may do so, but would need to pay out-of-pocket for these individual services.

47) TPL Billing – EOB/COB Requirement

Provider Question

Some of the MCOs have been indicating that when Medicare or commerical is primary, we need to: i) bill Medicare or commercial first and secure an explanation of benefits (EOB) or coordination of benefits (COB) statement for the client before we are allowed to submit a claim to the MCOs for payment of the Medicaid portion of services. Without the EOB or COB, our submitted claims are being auto-denied by the MCOs; and ii) submit a claim to Medicare or commercial with the T1041 code.

This does not align with our understanding of how TPL claiming needs to/should work for the CCBHC Program. Can clarify the TPL biling process and requirements for us, and issue a similar clarification to all MCOs?

State Response

Yes, see below. This formal, written clarification will also be shared with all MCOs this week –

In a scenario where a CCBHC client is Medicare/Medicaid dual eligible or commercial/Medicaid dual eligible – Medicaid should be the payer of last resort. As such, for clients with dual coverage, Medicare and commerical *should* pay first. In alignment with this:

1. Providers should first submit a claim to Medicare or the commercial payer using their non-CCBHC NPI, for all CCBHC and Medicare/commercial allowable services. The provider should be paid by Medicare or the commercial payer for the appropriate portion of provided services.
2. **For Medicaid FFS clients**: In parallel, providers submit a claim to Gainwell.
3. **For Medicaid MCO clients:** Post adjudication or in parallel, providers submit a claim to the MCOs.
4. **When billing to Gainwell or the MCOs, the providers should include on their claims their** CCBHC NPI and the T1041 code and all other relevant CCBHC shadow claim codes. The providers should be paid by Gainwell and the MCOs for the appropriate delta (i.e., the appropriate CCBHC PPS rate minus the Medicare or commercial payment amount). This can be implemented by: i) Gainwell or the MCOs initially paying the provider the full PPS rate, and retrospectively decrementing the amount paid by Medicare or a commercial payer, or ii) the MCOs awaiting a determination of the 'paid amt' by Medicare or a commercial payer.

Clarification 1: Each MCO reserves the right to determine the specific steps and order-of-operations of their TPL processes. With this said, from RI EOHHS/Medicaid's perspective, an EOB or COB from the primary payer is not required before an MCO can process the Medicaid portion. Instead, these submissions and adjudications can happen in parallel.

Clarification 2: The CCBHC NPI and T1041 code are defined and required for Medicaid CCBHC billing only. Providers are not expected to utilize these on their claim submissions to Medicare or commercial payers.

48) Mid-Month Transfers Between Medicaid FFS and MCO Programs

Provider Question
How should we bill for the CCBHC program if a client transfers mid-month between Medicaid FFS and MCO coverge?

State Response
These should be rare occurrences. In these sitatuions, CCBHCs should bill the full amount to the MCO, and the MCO is expected to pay the PPS rate in full. This aligns with the CCBHC PPS rate-setting methodology, where this is accounted for.

49) DCO Billing

Provider Question
Does the State have a mechanism to prevent DCOs from double billing Medicaid, since the DCO claims now go under the CCBHC for the specific service they are providing? (ie. OBOT, IOP, MRSS, any DCO service)?

State Response

In regards to MRSS, double billing is not a concern. In Program Year 1, these services are only paid for via three means: 1) For CCBHCs providing these services in-house: direct payment through the PPS rate; 2) For DCOs providing these services: direct payment through their partner CCBHCs; 3) For services provided outside of the CCBHC program in East Bay: direct grant funding from the State.

For all other DCO services (e.g. OBOT, IOP, etc):
- MCOs have a responsibility to monitor potential double billing for MCO clients.
- On the Medicaid FFS side, the State will monitor via retrospective auditing of DCO billing practices for relevant services. **If providers have concerns about double-billing, you must alert the State immediately.**

50) Impacts of State's Cybersecurity Incident on CCBHC Attribution & Billing

Provider Question
We understand the State's cybersecurity incident has impacted provider and State staff access to different components of the RI Bridges and MMIS systems. What/if any impact will this have upon our ability to: i) enroll net-new CCBHC clients (i.e., those not previously attributed to any CCBHC; new Medicaid beneficiaries); ii) enroll transferring CCBHC clients (i.e., those moving from another CCBHC to ours); and iii) update a client's population designation (i.e., move them from the high acuity to standard population or vice versa). Are there any delays to the next billing cycle that we need to be aware of?

State Response

Attribution

- Enrollment of net-new CCBHC clients (i.e., those not previously attributed to a CCBHC):
    - **For existing Medicaid beneficiaries (i.e., those formally enrolled in Medicaid via the Bridges system prior to the cybersecurity incident)**: No impact. Provider access to the Provider Portal remains uninterrupted. Providers can continue to enroll existing Medicaid recipients into the CCBHC program at any time.
    - **For new Medicaid beneficiaries (i.e., those who need to be formally enrolled in Medicaid via the Bridges system)**: As a result of the cybersecurity incident, the interface between Bridges and MMIS is temporarily down. This means information regarding new Medicaid beneficiaries is not automatically being transferred from DHS to Gainwell. As such, a provider is not able to enroll the client into the CCBHC program at this time. With this said, the State and Gainwell are currently working to deploy an interim solution to address this issue, until the interface can be fully restored.
- Enrollment of transferring CCBHC clients (i.e., those moving from one CCBHC to another):
    - No impact. Provider access to the Provider Portal remains uninterrupted.
- Updates to a client's population designation (e.g., reassignment from the Standard Population to the High Acuity Adult Population):
    - Temporary delay, but no further impact. Front-end access to the Provider Portal and MMIS was restored for State staff prior to the Christmas holiday. This means Melissa Howe (BHDDH) is able to complete the steps needed on her side to allow providers to update their clients' population designations within the Provider Portal where needed.
- Monthly attribution file from BHDDH to CCBHCs:
    - Temporary delay. Back-end access to the MMIS data remains paused for State staff. BHDDH is not able to pull an updated monthly attribution file for each CCBHC until access is fully restored. We will continue to monitor the situation internally and will issue further updates ASAP.

Billing

- CCBHC claims will be denied if a client is not enrolled in the CCBHC program, and clients can be added to the Provider Portal retrospectively. As such, we advise you hold on submitting claims for a client until their attribution is sorted.

Section IV. Reporting: Program Monitoring & Quality Measures

51) CCBHC File Naming Convention for Reports

Yes! Please use the following file naming convention: **CCBHCName_ReportName _Date**

- Use the following designated name per CCBHC:
    - CCA
    - FSRI
    - Gateway Johnston
    - Gateway Pawtucket
    - Gateway South County
    - Newport

- Thrive
- TPC

- Report Names (no spaces)
  - HighAcuity
  - MobileCrisis
  - ShadowClaims
  - Staffing
  - TPLPayment
  - Quality

- Date (YYYYMMDD format)

Examples:

- "HighAcuity" (e.g., Gateway Johnston_HighAcuity_20240115)
- "MobileCrisis" (e.g., FSRI_MobileCrisis_20241212)
- "ShadowClaims" (e.g., Newport_ShadowClaims_20241212)
- "Staffing" (e.g., CCA_Staffing_20241231)
- "TPLPayment" (e.g., TPC_TPLPayment_20240215)
- "Quality" (e.g., Thrive_Quality_20241212)

52) Staffing Workbook

<u>Provider Question</u>

- Can the Staffing Workbook template be modified? The current version is administratively burdensome for us to complete on a monthly basis.

<u>State Response</u>

- Thank you for your feedback. We have looked into this extensively and appreciate those who provided samples of the staffing data they currently track in-house and how, so that we could determine if we could find a middle ground for all parties.
- Unfortunately, we <u>must</u> require all providers to continue submitting staffing data to us on a monthly basis using the current template. This is vital for the following reasons: i) Client census, staffing capacity, and time to services are critically important for us to monitor particularly at this juncture in the program. We need to ensure all clients can access the services they need in a timely manner, and all providers have sufficient staffing and cross-coverage plans in place to ensure this happens; ii) The current template provides the State with the required level of information to properly monitor these areas of concern. Alternative documentation provided to us for consideration have been evaluated and determined to be insufficient.
- Please note: There should be no further changes to the positions approved by the State through the Cost Reporting process. Rather, what we expect to see on a monthly basis are updates related to actual (vs. projected) client census, newly filled positions, and churn (any new vacancies).

53) Crisis Services – Reporting Requirements

Provider Question

In regards to mobile crisis 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 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.
- Currently no program seems appropriate in BHOLD options for stabilization - what should providers chose in the interim before new BHOLD system comes online?
- Are we now required to also enter DLA and Ohio Scale scores for crisis clients into BHOLD? Or is there a way to bypass these scores specifically for crisis encounters?

State Response

CCBHC crisis reporting requirements:

1. 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 [linkprotect.cudasvc.com] > Additional State Guidance and Reference Materials > Request Forms & Reporting Templates. This report must be submitted to the State every other week, beginning November 1.

2. In tandem, provider must 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.

Client attribution:

1. Providers 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).

2. As part of the attribution process in the Provider Portal, providers will have to enter a DLA and OHIO score for high acuity adults and children.
    - For further details, see: https://eohhs.ri.gov/initiatives/certified-community-behavioral-health-clinics-ccbhc/ccbhc-info-providers-and-mcos [linkprotect.cudasvc.com] > Additional State Guidance and Reference Materials > Implementation > Acuity Level Evaluation, Score Submission, and Client Population Assignment

3. State recommended attribution workflow for crisis service clients:

- Stabilize client within 24 hours
- Once stabilized, confirm with client:
    - Is the client currently attributed to another CCBHC?
        - If yes, transfer the client to the appropriate CCBHC per established protocols.
        - If no, inform client about CCBHC program and CCBHC provider choices and confirm if they want to enroll in a CCBHC.
    - If client consents to joining CCBHC program, begin enrollment process:
        - Conduct assessment to determine appropriate level of care for client.
        - Formally attribute client via the Provider Portal.
    - If client wants to be referred to another CCBHC, support referral and engagement with CCBHC provider selected by client.

Follow-up Provider Question
For MRSS for kids, do CCBHCs need to discharge them from the CONTACT program in BHOLD?

State Guidance
They can be held in CONTACT if they are receiving stabilization services. However, they must be discharged from CONTACT when they are enrolled into a new program/service.

54) CCBHC Mobile Crisis Report

Provider Question
Can the State streamline the CCBHC Mobile Crisis Reporting Template and reconsider the initial submission data and resubmission cadence? You are asking for a lot of data points in a very structured manner. We need time to build out a data collection protocol and to reconfigure our data systems to collect and submit the information you are requesting in an accurate, comprehensive, and efficient manner.

State Guidance
Thank you all for your feedback and collaboration to refine the CCBHC Mobile Crisis reporting template and process. This data is vital for us all to collect and analyze in a structured and timely manner. Our collective goal is to ensure all Rhode Islanders in need of these vital services are able to access them with ease and quickly. This data will provide us with concrete insights into how we're doing and where there may be some bumps to smooth out together.

We've adjusted the reporting template and process to address your concerns in the following ways:

- **Reporting Timeline:** We changed the submission frequency of this report to **every other week**, and delayed the initial report due date to **Friday, November 22**. The State expects your initial report to include **data on mobile crisis services provided from October 1, 2024 through November 15, 2024.**
- **Report Fields:** We shortened the report by reducing the number of questions and by simplifying some of the answer drop-down lists. We've also clarified that three of the questions are required for *MRSS cases only*. Where possible, we aligned question fields with your existing EHR fields to reduce the need/burden of further modifications to your systems.
- **Reporting Process:** We will allow EHR extracts for this report, as long as a clear data dictionary is provided in tandem to link your data to our template fields. Further instructions are included in the 'Cover' tab of the updated excel-based CCBHC Mobile Crisis Data Collection Template.

- **Updated Reporting Template:** https://eohhs.ri.gov/initiatives/certified-community-behavioral-health-clinics-ccbhc/ccbhc-info-providers-and-mcos > Section: **Additional State Guidance and Reference Materials** > Sub-Section: **Request Forms & Reporting Templates**

Given the critical need for these data insights in short order, no further modifications will be made to the template. Further questions regarding this report should be directed to the ohhs.ccbhcreadiness@ohhs.ri.gov inbox with rebecca.bucci@ohhs.ri.gov cc-ed.

Follow-up Provider Question 1

Could you please define in the data dictionary what exactly you are looking for in #19, "Was the call responded to by the co-response model?" It was not clear who the State is considering to be part of the "co-response team."

State Response

We (the State) are looking to determine if the call was responded to by the co-response team (consisting of a behavioral health clinician and law enforcement) as part of this collaborative model of crisis response. The purpose of the co-response model is to provide an integrated response to crisis situations where both mental health and public safety are a concern. In RI, this is an existing model where a clinician and a police officer respond together as part of a collaborative program between the CCBHC and the police department. We want to identify these calls to be able to differentiate between instances where this model is used, and instances where a police officer is involved in the crisis, but not as a function of the response type.

- Please select **YES** when the call was responded to by a team that included both mental health professionals and law enforcement specific to co-response.
- Please select **NO** when the co-response model was not used, even if both a law enforcement officer and clinician are at the scene.

Follow-up Provider Question 2

In regards to Item 19: "Was the call responded to by the co-response model." Should we report on both **Police** Co-Response and **EMS** Co-Response, or just one of them?

State Response

Please report on a co-response by either Police or EMS.

Follow-up Provider Question 3

#19 Co-Response: Is that referring to the 2 person co-response mobile crisis team or with police?

State Response

Co-response as referenced in the CCBHC Mobile Crisis Reporting Template refers to responses with law enforcement.

Follow-up Provider Question 4

#15 MCT Response Referral Source: We are including any requests from internal program staff reaching out to our mobile crisis team when a client is in crisis. Confirming that these requests should be included in the report? The I-SERV measure defines crisis contact as "includes instances when a client actively seeks crisis services or when others seek services on a client's behalf". We have included these internal program staff as part of those others seeking services on client's behalf but is also part of our

program risk management and crisis response protocols. In the mobile crisis report we are including them as healthcare provider, or should there be another option?

State Response
The data collected in the mobile crisis template is for State oversight of mobile crisis. It is not a direct match to oversight of crisis services, such as what is captured with the I-SERV measure. Submeasure 3 of the I-SERV is meant to measure response times for all crisis services, and is not exclusive to mobile crisis. This is different than the requirement that mobile crisis services specifically be delivered within one hour. For this reason, we are asking that the mobile crisis template be strictly limited to *mobile* crisis services.

Follow-up Provider Question 5
#22 Primary Referral Made/Given: "Specific primary referrals made (*exclude services for which the individual was directly transported)*." For clients who are transported by rescue to a hospital – should we include or exclude these? It appears that you would be referring to the MCT providing direct transportation and not rescue, but want to clarify.

State Response
Apologies for the confusion. Regardless of who provided the transport (e.g., MCT or EMS), please include the final referral type. For example, in the scenario you provided – if a client was transported to the hospital by EMS, but was referred to the hospital by your team, please select "Higher Level of Care" for this response.

Follow-up Provider Question 6
#22 Primary Referral Made/Given: To clarify, new clients that are outreached by MCT are considered new BH/SUD if we are referring to our CCBHC services – is this accurate? Or is new provider to indicate someone other than us?

State Response
The answer option of "New BH/SUD Provider – CCBHC" is to be used when a client is new to the CCBHC program (i.e., they were not previously attributed to another CCBHC).

Follow-up Provider Question 7
In data dictionary #23, line 123, what is DCR & ITA?

State Response
We will remove this response option, given that this was duplicative with the involuntary hospitalization response option. We will share a new template with this response option removed ASAP.

Follow-up Provider Question 8
For the second report submission, do you want us to submit a fresh report or a running list of clients (aka should it include cases from the prior reports)?

State Response
For year 1, please submit a running list of clients. For the second report submission, include clients from the previous report and new clients. This format will allow you to make updates to rows submitted in previous months (e.g., improvements to data quality or updated stabilization data for MRSS event that concluded after the end of the prior report submission).

Follow-up Provider Question 9

Is the intention of the report to capture all crisis services conducted within our CCBHC programs or just conducted by our mobile crisis team?

- For example, clients walk-in for assessment and are quickly determined to be in crisis and an ES clinician conducts a crisis evaluation. We had included these in the report but the report would have the same start date and time (and not necessarily inline with the data dictionary of "call") of the crisis service and there would not be a dispatch time.
- Same situation where a Child intensive clinician is at the home for a counseling service and quickly identified that the child is in crisis and a crisis evaluation is completed but these are not part of the 2 person mobile crisis response. Should these be included to capture the crisis service or excluded since it is not deemed a request for crisis service?

State Response

The intent is to capture all mobile crisis services. In regards to the provided examples, the State expects both of these scenarios to be excluded from the monthly crisis report.

Follow-up Provider Question 10

What about dispatch to an office setting? Should these be included within: i) the mobile crisis report due to the State; ii) the I-SERV measure?

State Guidance

In alignment with the State's program monitoring and oversight requirements: Dispatches to an office setting or to a home where a clinician is already onsite for a visit should be excluded from the mobile crisis report, to enable the State to determine if each provider is delivering mobile crisis services within 1 hour as required by SAMHSA.

In alignment with the I-SERV measure specifications: Dispatches to an office setting should be included as required for the measure – I-SERV pertains to all crisis services, without mobile crisis being parsed.

Follow-up Provider Question 11

Specific to MRSS, regarding *Call End Date/Time* and *Dispatch Date/Time* – these particular measurements are not relevant according to the fidelity of the MRSS model in which the most important time pieces are *Call Start Date/Time* and *Arrival Date/Time*. As such are these elements required, and if so, why?

State Response

From the Ohio State Mobile Response and Stabilization Services Practice Standards (which the RI model was based off of these):

"When a call for MRSS is received by the call center or the MRSS provider, the person receiving the call will triage the call and work with the family to determine if the mobile response is to be provided as **immediate** or **non-immediate** using their clinical judgement. Once the determination is made, the clock for the response time begins.

An immediate response involves deployment of an MRSS team member(s) to the location of the crisis **within 60 minutes of the call**. A non-immediate response involves the deployment of an MRSS team

member(s) to the site of the crisis **at a time requested by the family, but not to exceed 24 hours after the contact with the family**."

As such, Call End Date/Time and Dispatch Date/Time are **required** by the State to evaluate and track fidelity to the MRSS model.

Follow-up Provider Question 12

In an effort to provide accurate data, our MRSS DCO was wondering what they should put in as the "dispatch time" for the following types of situations:

- The caregiver calls MRSS at 10 am, MRSS calls them back at 10:05 am and the caregiver asks that MRSS come out at 3 pm because that is when the child will come back from school.
- Should they put in the time as 10:05 am? Or when they actually dispatch the staff member to the home, i.e., 2:30 pm?

State Response

This is a call that would be coded as 'non-immediate.' In this scenario…

- **Call Start Time**: 10AM
- **Call End Time**: when call back from the MRSS provider to the caregiver ends
- **Call Dispatch Time**: 2:30PM
- **Arrival Time**: 3PM

Follow-up Provider Question 13

Can we include the data of folks who are not built into the CCBHC budget? As an example, our police and EMS clinicians who are each under grants outside of CCBHC? Do you want their data included in the Crisis Services report?

State Response

Yes.

Follow-up Provider Question 14

Do you want to see ALL data, including calls that were triaged - and not exclusively assessments?

State Response

No, this data is not presently required by the State.

Follow-up Provider Question 15

In regards to Item #22 "Primary Referral Made/Given": We interpret the new definition as "if the client was involved with the CCBHC at any point, even prior to 10/01/2024," then it would count as the "Current Provider-CCBHC." Is this accurate? And would we still choose this option if the client was discharged from the CCBHC and then referred back to them?

State Response

Unless the individual is currently active (attributed) to the CCBHC, you should select "New CCBHC Provider", even if they've previously received treatment. This allows us to capture how many people become engaged (or re-engage) in treatment as a result of mobile crisis.

Follow-up Provider Question 16

In regards to "New vs. Current Provider": If the client changes programs within the same agency, is that considered "Current Provider" because it's the same agency?

State Response
Yes.

Follow-up Provider Question 17
Can we push the report submission date to more mid-month, e.g. the 15th instead of the 7th? The current deadline is tight given the heavy volume of billing and reporting all providers have to do across programs at the start of each month.

State Response
Unfortunately we are unable to push the deadline further due to: i) the current time required for State review of each submitted monthly report and back-and-forth with each provider to correct identified data quality issues; and ii) subsequent State processing and analysis of the corrected data sets. Pushing the deadline will result in a two month lag between service delivery and data insights. We collectively need the ability to monitor, evaluate, and address emergent issues with delivery of/access to mobile crisis services in a more timely manner than that.

55) Shadow Claims Report

Provider Follow-up Question 1
Should we include shadow codes that are not part of a T-Code submission (aka that do not have an associated qualifying event for that month)?

State Response
Providers should submit the Shadow Claims Report from progress notes, not claims. However, they should only submit notes associated with a billable event for that month.

Provider Follow-up Question 2
If we are only submitting shadow claims that are part of a T-Code, why wouldn't you definitely have a 100% match rate?

State Response
A less than 100% match rate could result from clinicians not signing progress notes in time, or denials from the MCO.

Provider Follow-up Question 3
We have to hold billing for some individuals as we are waiting for their High Acuity Population Exception request to be approved by BHDDH, or we are tracking down their Medicaid IDs. These will process at a later time. How do we account for later billing?

State Response
It is okay if there are a few outliers and the report is not 100% comprehensive.

Provider Follow-up Question 4

Can we push the report due date back at least for the month of October? Our billing teams are completely overwhelmed and focused on billing. Also, there have been other delays that won't affect future months but will make this difficult to complete in time for October.

State Response 4
We understand your concerns and have decided to extend the first submission date to 11/29.

56) CCBHC High Acuity Child Program Ongoing Monitoring Report

Provider Question
If we do not have full SSN, can we just provide the last 4 digits?

State Response
Please provide a full Medicaid ID and SSN when possible. If you only have a partial SSN on record, please provide at least the last 4 digits in the High Acuity Youth Report. This is necessary to sync up the attribuition data in the Provider Portal, Population Exception Requests, and High Acuity Youth Report.

Provider Follow-up Question 1
If someone has a V or Z code, do they need exception form?

State Response
No, these codes automatically qualify the child for the high acuity population and no exception form is required. We expect to see these codes in the primary diagnosis so we can ensure all criteria are met.

Provider Follow-up Question 2
Not all kids who receive MRSS are high acuity. Should we include Standard Population kids in the High Acuity Child Program Ongoing Monitoring Report?

State Response
No. Only high acuity kids need to be included in the High Acuity Youth Report.

As a reminder, providers can submit exception forms for children receiving MRSS stabilization services who do not meet criteria from CCBHC standards for high acuity services.

Provider Follow-up Question 3
We had 1 client under our Standard Population that had a qualifying event within our Standard Population at the beginning of October. This client met criteria for High Acuity Child Population as of 10/28 - 10/28 matches our portal date for High Acuity as well. However, they did not have a qualifying event/meet with our Children's Intensive Services team until November.

I uploaded our report for October include this client since they met eligibility as of 10/28/2024. Please let me know if you do not want this client to be on our report until November and I can make this adjustment.

State Response
You do not need to include this client in the October report. You should begin including clients on the date of their first qualifying encounter in the High Acuity Child Population.

57) Monitoring Outreach Activities

Provider Question

Outreach is an allowable CCBHC cost (for any client), but outreach services are not a qualifying event that triggers a PPS2 payment. For non-attributed clients and clients without a qualifying encounter for that month, no shadow claim will be captured for outreach provided. Should we/do we need to track outreach activities in any other way? We were allowed to include outreach staff in our cost report, and outreach is a required CCBHC service…

State Response

Outreach is not directly billable, but the State does require providers to track this activity in some capacity (per the internal documentation protocol of their choice). This is to ensure provider activities/efforts to engage vulnerable and historically unengaged populations in alignment with the CCBHC certification requirements. The State requires providers to provide **a written narrative describing these activities on a quarterly basis** for monitoring and compliance purpose. The narrative should:

- Exclude any/all PII; and
- Include the # of outreaches conducted by the provider in the past quarter, with a description of the type of activity conducted (e.g. setting types, target populations); and
- # of hours of outreach conducted (an estimate is OK).

Provider Follow-up Question 1

Can you please clarify what types of outreach need to be tracked and shared with the State? We are being asked to report on a lot, with limited lead time. This request is administratively a heavy lift. Does a formal report need to be submitted, or can we integrate this into the current monthly 1:1 implementation check-ins with the Interagency Team as verbal updates? Alternatively, can we provide this info via other avenues, e.g. a direct output from our EHR plus supplemental information from our Marketing Teams?

State Response

In alignment with the RI CCBHC Certification Standards, CCBHCs must conduct outreach activities to be connect and engage the State's priority consumer populations in available BH support services. The priority consumer populations are as follows:

- Black, Indigenous, People of Color (BIPOC);
- People with co-occurring behavioral health/intellectual or developmental disabilities;
- Older adults;
- Transition-age youth;
- Veterans;
- LGBTQ+;
- Justice involved;
- People experiencing housing insecurity or homelessness; **AND**
- Other: additional priority population(s) identified within your completed Community Needs Assessment who are not represented above.

Outreach must be conducted to the following individuals/groups per priority consumer population:

- Direct outreach to attributed CCBHC clients
- Direct outreach to individuals not currently attributed to a CCBHC

- Direct outreach to, or through community partners associated with the priority consumer populations. Examples include:
    - Specialty providers including those who prescribe medications for the treatment of opioid and alcohol use disorders
    - Suicide and crisis hotlines and warmlines
    - Indian Health Service or other tribal programs
    - Homeless shelters
    - Housing agencies
    - Employment services systems
    - Peer-operated programs
    - Services for older adults, such as Area Agencies on Aging
    - Aging and Disability Resource Centers
    - State and local health departments and behavioral health and developmental disabilities agencies
    - Substance use prevention and harm reduction programs
    - Criminal and juvenile justice, including law enforcement, courts, jails, prisons, and detention centers.
    - Legal aid
    - Immigrant and refugee services
    - SUD Recovery/Transitional housing
    - Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation programs
    - State HEZs

Sample outreach activities that CCBHCs could conduct, and which should be documented and shared with the State for programming monitoring purposes include:

- General education and engagement in CCBHC services
- Harm reduction (e.g. street outreach, naloxone/fentanyl test strips/safe injection needle distribution, education and information)
- Recovery outreach (e.g. home-based outreach after overdose, connection to supportive services)
- ***Note, this is an non-exhaustive list. Activities should be in alignment with what's most appropriate for the specific consumer population or community partner in question.**

State Oversight Process/Provider Reporting Requirements:

I. Direct outreach to attributed CCBHC clients

- Key metrics of interest: Per priority consumer population –
    - # of clients lost to contact;
    - # of outreach attempts; **AND**
    - # of case management claims vs. service claims
- State oversight process: Type and scope of outreach activities will be primarily evaluated by the State via **shadow claims**. However, this will also be partially monitored via **discussion** at the Interagency Team's scheduled monthly 1:1 check-ins with each CCBHC.

II. Direct outreach to individuals not currently attributed to a CCBHC **AND** direct outreach to, or through community partners associated with the priority consumer populations.

- Key metrics of interest: Per priority consumer population –
  - Brief description of the type of outreach activity conducted
  - Type of staff leveraged per outreach activities (i.e., unlicensed vs. licensed staff; non-certified vs. certified staff)
  - Estimated # of staff hours spent per outreach activity
- State oversight process:
  - Each CCBHC must submit a quarterly written report to the State with the information delineated above. The metrics of interest should be clearly addressed per priority consumer population. Bullet points are sufficient. Providers may organize this data in a table format, with one row of per priority consumer population. Each report shall cover the outreach activities conducted within the prior quarter.
  - The State reserves the right to ask further probing questions (if/as needed) post receipt of each report during one of the Interagency Team's scheduled monthly 1:1 check-ins with each CCBHC.

Provider Follow-up Question 2

When is the first report due to the State? Will the State provide a report template for us to complete?

State Response

- The Interagency Team will provide a reporting template for all providers to complete.
- The first report will be due to the Interagency Team via SFTP by COB, April 15th covering all outreach activities conducted between October 1, 2024 and March 31, 2025.
  - It is the State's expectation that all providers are currently tracking these activities in some capacity, but that the initial months of data from October 1, 2024 through mid-January 2025 (when the above detailed reporting instructions were provided by the State) may not be fully complete. We do expect complete data from mid-January onwards however.
- Subsequent reports will be due the 15th of each month (or the following business day if this date falls on a holiday or weekend) after each program quarter. See below for a sample report due date calendar:

Report Due Date	Outreach Activities to be Covered
• April 15, 2025	• October 1, 2024 – March 31, 2025
• July 15, 2025	• April 1, 2025 – June 30, 2025
• October 15, 2025	• July 1, 2025 – September 30, 2025
• January 15, 2026	• October 1, 2025 – December 31, 2025

58) Implementation & Monitoring Cost and Utilization Report

Provider Question

We are in the process of building the report logic for the Implementation Monitoring Cost and Utilization report. We want to be sure we understand what each of the highlighted columns below represents.

Is the first column “Paid Amount” meant to be the total paid amount (aka Medicaid but TPL paid amount) or the non TPL paid amount (so just Medicaid)?

An example to demonstrate how to complete this report would be very helpful.

CCBHC Implementation Report: Cost and Utilization Report

MCO:

Report Period: October 2024

Date (Re-)Submitted:

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

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

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

State Response

The Cost & Utilization Report is a report generated and submitted by MCOs to the State. CCBHCs do not need to generate this report.

59) BHOLD – Documentation of DCO vs. non-DCO Clients

Provider Question

Will there be a problem when it comes to audits because our DCOs' BHOLD numbers do not match the clients they serve due to the CCBHCs entering them in BHOLD; therefore, # of clients served is being recorded under the CCBHC, not the DCO?

State Response

No, this will not be an issue for audits; the State requires this method of reporting. The CCBHC is responsible for all their clients, whether served directly by the CCBHC itself or by a partner DCO.

60) HBD-AD: Hemoglobin A1c (HbA1c) Control for Patients with Diabetes

Provider Question

HBD-AD is a quality bonus payment measure. Per State issued guidance, EHRs are listed as the data source and CCBHC as responsible of calculating this measure. It’s our understanding this is a State collected, versus a clinic collected measure. We urge the State to consider an alternate means to collect this data. MCOs collect this information now through claims and can provide these values and would have the most up to date scores. It is challenging for CCBHC providers to collect this data for various reasons:

- CCBHCS are not often the HbA1c ordering provider as that is typically managed by the PCP or specialist; thus we are not provided with the results.
- Results are not easily obtainable as CCBHCs often have to request this information or seek out lab results in Current Care if enrolled.
- Requires manual entry of values in EHR for reporting.
- While CCBHCs will need this information to support the individuals with diabetes and track for this measure, it is likely that what CCBHCs have documented will not be the most up to date or the most complete.

State Response

- We understand that CCBHCs are not typically the ordering providers for HbA1c tests. However, one purpose of this measure is to ensure coordination of care among CCBHCs, PCPs, and specialists for patients with diabetes. **Current HbA1c results for diabetic patients need to be tracked in the CCBHC EHR system. One of the 9 required CCBHC services is "Outpatient Primary Care Screening and Monitoring" (4.g.3).**
- This is a required CCBHC measure and HbA1c results need to be documented in the CCBHC EHR. Your EHR should be able to produce reports for this measure.
- The State expects that clinics will require time to build new processes and workflows during Year 1 of the quality program. We are available to provide technical assistance to clinics in meeting the quality measures and achieving the associated Quality Bonus Payments.
- The Interagency Team has evaluated the data collection methods for the HBD-AD measure. The SAMSHA specification provides three options: i) Administrative; ii) Hybrid; or iii) EHR. Unfortunately, the HbA1C level is not typically provided on administrative claims. Therefore, we do not think the Administrative option will produce accurate or reliable data. The Hybrid option would be labor intensive for both MCOs and CCBHCs, since a representative sample would need to be generated for each CCBHC, followed by a Medical Record Review in order to determine numerators. **Therefore, EOHHS has decided on the EHR data collection method as the best option currently.** Again, we are available to provide technical assistance. Further questions may be directed to the ohhs.ccbhcreadiness@ohhs.ri.gov inbox with rebecca.bucci@ohhs.ri.gov and james.brennan@ohhs.ri.gov cc-ed.

Follow-up Provider Question 1

It would be helpful for CCBHC providers to begin meeting with state leaders on these new Quality measures to help support each other on ensuring we are ready for reporting on both the clinic and state collected measures for 1/1/25.

State Response

The State's CCBHC Data & Reporting Team is meeting with all CCBHCs on 11/22 to provide a deep-dive into the CCBHC quality measures and program.

Follow-up Provider Question 2

CCBHCs understand the MCOs currently collect HbA1C results from many/all providers directly. Can the MCOs help the CCBHCs to collate this data, e.g. send the CCBHCs one collated dataset per month, quarterly, etc.?

- Is this approach acceptable per Federal and State rules considering any data collection, transfer, patient privacy, etc. restrictions?
- Is this something all the MCOs can support from a technical perspective?

State Response

No. The MCOs will not be distributing HbA1C data to the CCBHCs on a regular basis. The CCBHCs must collect this data through care coordination with PCPs, and/or through the state HIE (CurrentCare). There are other functions of CurrentCare that may be beneficial for CCBHCs as well. We can address this topic further at an upcoming CCBHC Data & Reporting Provider Reporting Office Hours and/or the Data & Reporting Deeper Dive on Nov. 22 @ 12 – 1PM.

Provider Follow-up Question 3

How will the State identify patients with diabetes when calculating this measure in BHOLD? Will the state use claims or EHR data to identify patients with diabetes? If the state uses claims, will it use any claims or just claims from the specific CCBHC?

State Response
The State will use claims data to identify the denominator (with some exceptions as specified within the SAMSHA provide technical specifications for this measure) and EHR data to identify these numerator for this measure. Per guidance issued above, CCBHCs must document the HbA1c results in their EHR.

Provider Follow-up Question 4
How will the State mitigate against providers having more clients in the denominator (e.g. non Medicaid) than the State due to inclusion of non-Medicaid CCBHC clients (e.g. duals and commercial) in their counts?

State Response
As the State is using individual data from your EHRs via BHOLD for the numerator, we will be matching these records with Medicaid records to determine who is on Medicaid and has a diagnosis of diabetes. Clients who are not on Medicaid will not be included from the denominator in the calculation for HBD for Medicaid clients.

Provider Follow-up Question 5
Will a list of the individuals the State identifies as having diabetes be sent to the CCBHCs?

State Response
No. Each CCBHC needs to report the measure using data from their EHR. Each CCBHC is responsible for knowing which clients have diabetes. Per the RI CCBHC Certification Standards (4.g.3): Primary Care Screening and Monitoring is one of the required core services.

- "The CCBHC will provide ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual. Monitoring includes the following: a) ensuring individuals have access to primary care services; b) ensuring ongoing periodic laboratory testing and physical measurement of health status indicators, and c) changes in the status of chronic health conditions; d) coordinating care with primary care and specialty health providers including tracking attendance, e) at needed physical health care appointments, and f) promoting a healthy behavior lifestyle."

Provider Follow-up Question 6
Can the State provide CCBHCs with a list of the clients who they've identified as having diabetes to: i) help the CCBHCs ensure all clients get the care they need and there are no gaps in their lists; ii) ensure the CCBHCs and State have the same denominator for this measure?

State Response
No. This quality measure is an indicator of the CCBHCs' policies and protocols for primary care screening and monitoring, which per the RI CCBHC Certification Standards, includes screening for key health indicators and chronic conditions. As such, it is the expectation for performance on this measure that CCBHCs screen all clients to determine if the client has a known diagnosis of diabetes and conduct the related care coordination to ensure that their HBA1c is being appropriately monitored.

Provider Follow-up Question 7
Does client self-report of diabetes count towards the diagnosis criterion?

State Response
No. The EHR version of the measure requires that the diagnosis be documented in the patient's medical record using the appropriate codes and that the diagnosis must be based on clinical evaluation, laboratory results, or other diagnostic criteria.

Provider Follow-up Question 8
Does documentation through CurrentCare count?

State Response
Yes; CurrentCare pulls in HbA1C results directly from each CCBHC's EHR.

Provider Follow-up Question 9
Which specific fields in BHOLD will be used to calculate performance on this measure?

State Response
The BHOLD values used to calculate performance on this measure will be the HbA1c score and the date of the assessment.

Provider Follow-up Question 10
How will the new BHOLD bulk upload format capture A1c test dates (for bulk uploads, individual values like A1c do not take specific dates of the A1c test, it uses the data submission date)?

State Response
The A1c score and date will be reported the same way it is reported today in the current BHOLD system. Providers will not have to double-document the data, i.e. input the same data into both the current and new versions of BHOLD.

Provider Follow-up Question 11
Should we be collecting A1Cs for clients with both Type 1 and Type 2 diabetes?

State Response
Yes. Both Type 1 and Type 2 diabetes clients are included in the measure.

Provider Follow-up Question 12
While the best practice and preference will be to capture HBA1C scores through Care Coordination/data integration with primary care providers or in Current Care, are values using an Hba1c analyzer (point of care) machine (taken at the CCBHC) be valid and accepted value? This would be an option for those clients who have poor follow through with obtaining labwork and as part of our metabolic syndrome screening protocol.

State Response
Yes, if you have point of care testing values in your EHR, this meets the requirement.

61) Time to Services (I-SERV)

Provider Question
Do CCBHCs need to get approval from EOHHS on their methodology for generating performance for I-SERV?

State Response
The Quality Reporting manual specifies that "CCBHS must also annually report the methodology they used to generate performance for the *Time to Services* measure, to be approved by EOHHS before performance data are reported. The methodology should specify, at a minimum, how data are collected (e.g., EHR data, clinicians reports, scheduling software), where the data are stored and what data are used to calculate measure performance." CCBHC providers should submit their methodologies to EOHHS for approval – further instructions will be provided by the State ASAP.

The State has reviewed the initial set of information shared by each providers several weeks/months ago regarding how they intend to approach this measure. We are generally comfortable with the approach described by all, but will be reaching out ASAP with some specific follow-up questions to secure any missing details that are required. In other words, more info is forthcoming from the State Team, but no need to worry!

Provider Follow-up Question 1
There are some instances where new 'general population' clients with non-urgent needs, won't have an appointment within 10 days of First Contact. Meaning, we can and will offer them a next day appointment, but the client may opt for an appointment 2-3 weeks out because of their own scheduling restraints/preferences. This could negatively impact our performance for the I-SERV measure. What considerations will be made by the State/SAMHSA to mitigate against this?

State Guidance
Per page 39 of the SAMHSA Quality Measure Technical Specifications: "Per I-SERV Submeasures 1 and 2, it is likely that some New Clients will not have an appointment within 10 days because of their own schedules and/or rescheduling. This situation is a recognized limitation of this measure that will affect all clinics. Trying to adjust for New Clients who are offered, but do not accept an appointment within 10 business days complicates the calculation. The same is true for clients who are referred only for forensic evaluation or who only seek service during a crisis but may go elsewhere for additional services. We suggest that, if you see patterns over time, you report this in the space for additional notes in the bottom of the I-SERV data reporting template provided by SAMHSA."

62) Patient Experience of Care (PEC) Survey

Provider Question
Can the State clarify the: i) data collection and submission requirements; ii) implementation timeline; and iii) survey completion targets.

State Response

I. **Background:** Per SAMHSA Demonstration Program requirements, all CCBHCs must collect and submit **Patient Experience of Care Survey** and **Youth and Family Experience of Care Survey** data to the State.
    - For providers who currently collect and submit patient experience data to the State, note:
        - The State is using the **Mental Health Statistics Improvement Program (MHSIP)** survey for adults and the **Youth Service Survey for Families (YSS-F)** for children.

- Both surveys are SAMHSA recommended and nationally utilized to collect information important to consumers of publicly funded mental health services.
    - The paper-based Outcome Evaluation Instrument (OEI) that's currently in use for State reporting will be phased out.
- The new Patient Experience of Care (PEC) and Youth and Family Experience of Care (Y/FEC) surveys are to be accessed and completed electronically via the below REDCAP links:
    - **Adult survey**: https://redcap.link/ri-ccbhc-adultsurvey
    - **Child survey**: https://redcap.link/ri-ccbhc-childrensurvey

II. **Data collection**: The adult and child Patient Experience of Care surveys must be directly completed via the digital REDCAP form. Manual data collection (e.g. via completion of a paper survey and/or the current 'bubble answer sheet'), then digitalization (e.g. submission of scanned documents to the State and/or secondary data entry into REDCAP by the provider) will not be permitted. This approach ensures critical data is consistently, efficiently, and securely collected and submitted to the State. It also reduces the risk of secondary data entry errors.

- The surveys can be accessed via the above hyperlinks provided by the State, or via a QR code.
    - **Adult survey**:

    - **Child survey:**

- The surveys can be initiated by the provider or client using a computer, tablet, or personal device with connectivity.
- The surveys should ideally be completed onsite, prior, during, or after a client visit. Dissemination of the surveys via email to the client is not supported by the State.
- The following identifiers are requested within the REDCAP survey form:
    - Client First Name and Last Name (*required*)
    - Client Date of Birth (*required*)
    - BHOLD recnum (*optional; to be inputted by the Provider if they are initiating the survey for the client*)
        - **Note, the recnum is each agency's internal client ID. This is a different ID than the one that was previously used for the OEI survey.**
    - CCBHC Name(*required*)
- Parents/Guardians/Caregivers are asked to complete the survey on behalf of the child.
- Patient choice
    - If the patient agrees to take the survey, please indicate it, and choose the primary language of the client before handing them the device to complete the survey.
        - If the client is completing the survey on their own device, they will complete this step independently.

- If the patient declines to take the survey or cannot take the survey, the provider must complete the questions on the survey landing page and indicate that the survey was offered and the reason the client did not complete the survey.

- Other notes
    - The size of the font can be adjusted at the top right of the survey. We recommend making the font larger to start the survey before handing it to the client.

III. **Data submission:** Data entered via the digital REDCAP form will automatically be submitted to the State.

- Bulk import option – need further context from providers on when/why this option would be needed.
- **No longer needed**: This was only applicable if clients could continue to complete the survey via paper-form and/or if providers were somehow allowed and able to build the survey into their EHR.

IV. **Frequency and timing of survey administration:** Per federal requirements, the survey must be administered annually.

- This means every client who receives a CCBHC service from you within a given calendar year, is eligible to be given the opportunity to complete the survey within that year. We recommend that the client be offered the opportunity to complete the survey when they're in active treatment.
- There is no requirement regarding which point in treatment the survey must be administered.

V. **Survey targets per year:** Surveys do not have to be completed by all CCBHC clients you serve, but are intended to be completed by a representative sample of all the populations you serve.

- SAMHSA requires each provider to complete a minimum of 300 adult surveys and 300 child surveys.
    - Only exception granted to this rule by SAMHSA: A provider can only go below the 300 threshold if they have an adult or child client count below 300.
- The State requires the minimum sample to:
    - Include surveys completed by members of all the populations you serve; and
    - Include surveys completed by 600 unique individuals; and
    - Does not include any clients who declined to complete the survey (although this must be documented).
- The adult and child surveys will be digitally offered in English and Spanish. However, per the RI CCBHC Certification Standards, each provider will need to offer the appropriate translational services to ensure any client who wishes to complete the survey is able to do so.
    - *Citation: "The CCBHC takes reasonable steps to provide meaningful access to services, such as language assistance, for those with Limited English Proficiency (LEP) and/or language-based disabilities."*

VI. Implementation timeline:

- **October 2024**: Dissemination of State instructions and REDCAP adult and child forms. Phase out of current paper-based Outcome Evaluation Instrument (OEI) survey.
- **November 2024**: Provider testing, implementation, and transition from manual to automated data collection workflows and forms. Troubleshooting of identified technical challenges with the State.
    - **State Points of Contacts**: samantha.borden@bhddh.ri.gov and macy.daly@bhddh.ri.gov.
- **December 2024**: Full implementation of REDCAP-based Patient Experience of Care adult and child surveys.
- **January 2025:** Start of performance measurement year. Data collection via the new Patient Experience of Care and the Youth and Family Experience of Care surveys are required by CMS and SAMHSA.

Follow-up Provider Question 1
What survey completion data can/will be shared back with providers by the State? Data elements, format, frequency?

State Response

- At minimum, the State can provide: Client First Name, Client Last Name, DOB, BHOLD Recnum (if entered by provider administering survey), date of survey, whether survey was taken (Y/N), reason not taken.
- The Interagency Team will solicit additional feedback from providers re: what additional survey data points will assistance to you, and the best format and methodology for sharing this data with you.

Follow-up Provider Question 2
Can providers submit test data into the PEC survey so that they can ensure it works and scroll past page 1?

State Response
Yes, the state encourages providers to try the survey and ensure it works. Please enter '**TEST**' into the **Client First Name** and **Client Last Name** fields so the State can identify and remove this test data downstream.

Follow-up Provider Question 3
Please re-review and verify the SAMHSA requirements: Do providers need to secure a minimum of 300 completed adult surveys and 300 completed child surveys, or to demonstrate that they've offer the survey to this many clients at minimum (meaning that documented survey 'declines' count)?

State Response
For reporting for the Demonstration Program: The State requires providers to secure a minimum of 300 completed surveys for adults and 300 completed surveys for kids (or to offer the survey to all clients served by the CCBHC, if the total adult or client census is less than 300).

Note, all current Block Grant recipients (this includes all CCBHCs with the exception FSRI): Providers are required to offer the survey to all clients regardless of client census count. The State strongly recommends FSRI also offer the survey to all clients.

Follow-up Provider Question 4
We are going to start the online survey in November. The 5th question on the first page of the survey, "For staff only" - what do we enter into this field? I was told the client's agency id#, not their 9 digit number. Or is that spot for the staff 8 digit number?

State Response
It is the BHOLD "recnum" - their internal agency ID.

Follow-up Provider Question 5
It seems like we can't submit surveys if clients only start it but do not finish it. Will responses be captured for partially completed surveys? Can the staff submit their part, even if the client doesn't finish it, so that we can at least record that it was offered?

State Response
Responses are captured for partially submitted surveys and clients are able to submit partially completed surveys.

Provider Follow-up Question 6
For auditing purposes, do CCBHCs still need to document whether the survey was offered and refused?

State Response
Yes. Note, in addition to a 'declined' field, the survey also includes a drop-down field to capture why the survey was declined. This information is helpful to both the CCBHC providers and the State.

Provider Follow-up Question 7
Can CCBHCs administer the surveys on a rolling basis for CCBHC and leave CSP (aka High Acuity Adult) on the six month treatment plan?

State Response
Yes, CCBHCs can administer the surveys on a rolling basis. The intent is for CCBHCs to administer the survey to a client during or shortly after the receipt of CCBHC services, rather than the very initiation of the services or many months after. This approach yields the most accurate data about the client's experience of care. CSP clients should stay on the same schedule.

Provider Follow-up Question 8
How will CCBHCs access their performance on the survey measures?

State Response
Yes. The State will share aggregate performance data with the CCBHCs on a quarterly basis.

Provider Follow-up Question 9
We received an email from a member of the BHDDH Team stating that we needed to submit monthly PEC survey completion tracking lists. Is this a new CCBHC program requirement? Why is this being required?

State Response

- It is important to note that this was a SAMHSA Block Grant recipient specific request. We recognize that many SAMHSA Block Grant recipients are also CCBHCs which may have led to this confusion.
- CCBHCs do not need to provide monthly tracking lists to BHDDH. For CSP clients, please offer the PEC survey annually at the 6-month treatment plan review. Instead of BHDDH using the monthly tracking lists, they will be using BHDDH Data Unit audit reviews to ensure that the PEC survey is being offered to CSP clients as per federal requirements for the SAMHSA Block Grant.

Provider Follow-up Question 10
The PEC survey is really long. Can it be further consolidated/shortened?

State Response
No. The State has carefully re-reviewed the questions list. All are required.

63) FUH-CH Quality Measure

Provider Question
How will the State be identifying qualifying services?

- The measure technical specs state that 'States must develop their own methods for identifying mental health providers.' How is RI defining this? What types of providers count vs. not?
- Is th State identifying qualifying visits via a specific set of CPT codes? If yes, what are they?

State Response
FUH-CH is an MCO/EOHHS-reported measure. The value sets for qualifying follow-up services are available here [medicaid.gov [linkprotect.cudasvc.com] (the FFY 2024 Adult Core Set HEDIS Value Set Directory). **CCBHCs will receive credit for follow-up services as long as the clinic (group) NPI is entered as the rendering provider on CCBHC claims. Non-licensed providers do not count as follow-up visits for these measures.** Please note that EOHHS has requested that the MCOs work with CCBHCs during their individual meetings to review the requirements for FUH-CH, and to provide assistance on performance.

64) IET Quality Measure

Provider Question
How will the state identify a new SUD episode? Specifically, will it tie to portal attribution of SUD enrollment?

State Response
IET identifies a new substance use disorder (SUD) episode as an encounter during the intake period where the patient is diagnosed with a SUD. The date of the episode depends on the type of service. For outpatient visits, intensive outpatient programs, partial hospitalization, observation, telehealth services, or emergency department visits (not resulting in inpatient admission), the episode date is the date of service. For inpatient stays or medically managed withdrawal events (detoxification), the episode date is the discharge date. To qualify as a new episode, there must be no prior SUD diagnosis or treatment in the 194 days preceding the episode date, except for an emergency department visit or medically managed withdrawal. Additionally, any prior medication treatment for SUD within the 194 days before the episode date excludes the episode from being considered new. New SUD episode will not tie to portal attribution of SUD enrollment.

Provider Follow-up Question 1
Are there specific qualifying providers or a list of outpatient visits that will qualify?

State Response

- **Qualifying providers**: IET is an administrative only measure where compliance is measured based on codes included in the value sets. The intent is that the provider be able to legally bill the codes included in the value sets. The IET measure does not have a provider type requirement; therefore, any provider type (e.g., RNs, LCSWs, LPCs) that performs and bills the qualifying visit types meets criteria.
- **Outpatient visits**: The exact value sets for qualifying outpatient visits are available here (the FFY 2024 Adult Core Set HEDIS Value Set Directory). In general, qualifying outpatient visits include those that occur in general outpatient settings, behavioral health outpatient clinics, or community mental health centers, provided they are associated with a relevant SUD diagnosis. Intensive outpatient and partial hospitalization encounters are also included. Telehealth visits that involve real-time, synchronous communication qualify as well. Additionally, visits to non-residential substance abuse treatment facilities and those categorized under substance use disorder services are eligible. These visit types must be appropriately coded and linked to the patient's SUD treatment plan. For initiation, visits must occur within 14 days of the SUD episode date, while for engagement, two additional qualifying visits must occur within 34 days after the initiation phase.

65) CCBHC-DCO TPL Payment Report Template

Provider Question
In preparing the data for the TPL report, we encountered a problem with trying to organize it by month as stated in the directions: "(1) there is a TPL paid amount; and (2) there is a PPS2 payment for the member **in the same month**"

TPL and PPS2 payments may occur in different months for the same service dates. In the cases, we wouldn't report the payments because they weren't not received in the same month. Can you please advise on how these examples would be reported? Can the data be reported for the total quarter? Or can they be grouped according to service date (not payment date)?

State Guidance
The intent of TPL payments, reporting, and recoupment is to ensure we are not double paying for the same service for CCBHC members who have other coverage. The reason we are specifying that TPL payments and PPS-2 payments are for the same member in the same **month** is that PPS-2 rates are a monthly encounter rate model, but this is referring to the **claims date** for TPL and PPS-2 payments, not the paid date. It might be clearer to say, "This report should capture all CCBHC claims where: (1) there is a TPL paid amount; and (2) there is a PPS2 payment for the same claim or another claim for that member within the same month."

Although we are using a paid basis for this report, claims are meant to be grouped by Month of Service. What we mean by paid basis is that we **only want to see claims that have been paid out** (not all incurred or claimed) within the reporting period (October-December 2024 for this first report). Your question is still relevant when it comes to cases in which TPL and PPS-2 payments for the same claim go out across the span of multiple quarters/reporting periods. In this case, we would expect to see these captured in the report after both are paid.

Provider Follow-up Question 1
Do we need to report payments on Group Home and Crisis cases, which are separately payable above CCBHC?

State Response
No, you do not need to report these payments to us.

Provider Follow-up Question 2
Is the Report all payments received to date for Oct-Dec 2024 service dates? Or is it only payments received through 12/31/2024?

State Response
We are using a paid basis for this report, not incurred, so we are interested in claims actually paid in the period from Oct-Dec 2024. We want to see all payments in a quarter, regardless of service date, which becomes somewhat more relevant in future reports (where a payment in January may be for a service date in the prior quarter, for example—this would be picked up in the next report).

4.F.1 ambulatory withdrawal management – required or optional in DY2; Thrive notes it has been removed as requirement at federal level; n=2 right now, and Medical Directors not comfortable doing withdrawal for alcohol

Special Topic for future: available data thru Ecosystem – preview of data available to providers now vs. in pipeline, plus listening session on what other measures/metrics would be helpful to get eyes on and business use cases