

Year 2 RI CCBHC Certification Standards: Addendum 10

June 9, 2025

1. The purpose of this addendum is to formally codify the following modifications and clarifications to the Year 2 RI CCBHC Certification Standards.

Criteria	Original Language (page #)	Update
CCBHC Service Areas	CCBHCs shall be certified to serve one or more of the State’s designated CCBHC service areas. The service areas currently align with the ‘catchment’ areas designated by BHDDH for community mental health centers (CMHCs) pursuant to Rhode Island General Laws section 40.1-8.5-1 et seq. (pg. 6)	<p><i>[Modification of criteria]</i></p> <p>The following language shall remain: “CCBHCs shall be certified to serve one or more of the State’s designated CCBHC service areas.”</p> <p>The following language shall be removed because it is extraneous: “The service areas currently align with the ‘catchment’ areas designated by BHDDH for community mental health centers (CMHCs) pursuant to Rhode Island General Laws section 40.1-8.5-1 et seq.”</p>
CCBHC Service Provision, Bullet 4	CCBHCs shall accept...all medically managed (ASAM 4.0) and medically monitored (ASAM 3.7) detoxification service discharges... (pg. 7)	<p><i>[Clarification of criteria]</i></p> <p>Per the federal CCBHC standards, CCBHCs shall provide ASAM Level 1 and Level 2 Withdrawal Management services either directly or through a Designated Collaborating Organization (DCO) partner. These services need to be made available and accessible to individuals who need to withdraw from substances and can be treated on an outpatient basis.</p> <p>However, referral and admission to these ASAM services is based on the CCBHC’s clinical judgement to ensure appropriate and safe medical care. There is no requirement or expectation that CCBHCs provide everyone who needs withdrawal services (e.g., alcohol withdrawal management) these services in an outpatient setting only. The appropriate setting should be determined by the provider on a case-by-case basis taking the individual’s condition including their medical risk factors, comorbid substance use issues, and the person’s support system, into consideration. Each CCBHC’s evaluation criteria and treatment protocols should be developed with input from their Medical Director and formally documented.</p>

2.a.7	Services are subject to all state standards for the provision of both voluntary and court ordered services. (pg. 20)	<p><i>[Modification of criteria]</i></p> <p>The following language shall be added: “CCBHCs are required to serve all Court-ordered clients within their designated service area. For extenuating circumstances, a CCBHC may submit a written request to BHDDH to refer a client to another agency if the CCBHC believes they are unable to serve the client. If BHDDH is of the opinion that the client should not receive services from the CCBHC responsible based on service area, the request will be approved and BHDDH will exercise their authority, as the State Mental Health Authority, and assign the client to another CCBHC. Such transfer shall be made in the sole discretion of BHDDH. BHDDH may consider closest proximity to the client’s residence, as a factor for reassignment. This request shall be made in extenuating circumstances only and not for convenience, preference, or due to a lack of existing services at the CCBHC.”</p>
2.c.1	Each CCBHC that has a courthouse within their catchment area shall provide a Qualified Mental Health Professional (QMHP) assessment onsite within 1 hour of request from the Court. (pg. 23)	<p><i>[Modification of criteria]</i></p> <p>The original language shall be supplanted with the following: “Designated CCBHCs in Providence and Kent County shall provide at minimum, a Qualified Mental Health Professional (QMHP) located within the Courthouse at least 4 hours per day (e.g., from 9AM to 1PM), Monday through Friday, to provide onsite psychiatric evaluations and assessments.”</p>
4.d.5	Each CCBHC shall provide Traumatic Brain Injury Screening using the OBISSS+ (Online Brain Injury Screening and Support System) as part of the comprehensive evaluation. (pg. 46)	<p><i>[Modification of criteria]</i></p> <p>The original language shall be supplanted with the following:</p> <p>“Each CCBHC shall provide a Traumatic Brain Injury (TBI) Screening using:</p> <ul style="list-style-type: none"> • The comprehensive OBISSS+ tool; or • The 3-question Brief ABI Screen tool, and for individuals who respond YES to Question 1 and/or 2, complete the full OSU TBI-ID structured interview (which is an extended form of the screen). <p>The screening shall be conducted with all CCBHC clients ages 10 years and older as part of the comprehensive evaluation, <u>unless</u>:</p> <ul style="list-style-type: none"> • The client has an active TBI diagnosis on record; and/or • A TBI screening was completed for the client by a DCO, care coordination partner, or health care provider (e.g., a local hospital or primary care provider)

		<p>within the past 12 months prior to the client’s transfer of care to the CCBHC, and those screening results are documented within the client’s CCBHC record.</p> <p>An initial TBI screening should be conducted with a new CCBHC client at any time during the clinical assessment period, and not necessarily at intake. The screening should be reconducted outside of the clinical assessment period with a client based upon demonstrated need and/or a report of a potential incident which could result in a brain injury, e.g., an accident, assault, or fall.”</p>
5.a.1	<p>As part of the reporting requirements for Rhode Island, CCBHCs shall submit a complete and updated CCBHC Staffing Template at a regular cadence, as determined by the CCBHC Interagency Team, to demonstrate ongoing staffing levels relative to approved staffing plans as specified in certification. (pg. 62)</p>	<p><i>[Modification of criteria]</i></p> <p>The original language will be supplanted with the following:</p> <p>“As part of the reporting requirements for Rhode Island, CCBHCs shall complete and submit the following reports at a regular cadence to the State Interagency Team for program monitoring and oversight purposes:</p> <ul style="list-style-type: none"> • CCBHC Staffing Template (monthly); • High Acuity Child Program Monitoring Report (monthly); • Mobile Crisis Services Report (monthly); • CCBHC Shadow Claims Report (monthly); • BHOLD Reporting (monthly); • Outreach Activities Monitoring Report (quarterly); • Quality Measures Report (quarterly); • CBHC-DCO TPL Payment Report (quarterly); • CCBHC All Payor Utilization Report (quarterly); and • CCBHC Year-End Cost Report (annual).” <p>The HIE participation requirement shall remain, unchanged: “Providers are required to participate in the statewide Health Information Exchange (HIE) to support data sharing, care coordination, and quality reporting for the CCBHC program. Providers shall work to establish the requisite interfaces to contribute data and the client consent processes to enable this exchange in Demonstration Year 2 and fully participate in the HIE in Demonstration Year 3.”</p>

Addendum 5, High Acuity Adults (inclusive of Transition Age Individuals)

Population criteria 3: Individuals in a residential setting are not eligible for High Acuity services. (pg. 82)

[Clarification of criteria]

CCBHC services are and are not allowable in the following settings:

Setting Type	Are CCBHC Services Allowable?
Mental Health Psychiatric Rehabilitative Residences (MHPRR) - 3 levels	Yes ¹
E-MHPRR	Yes ¹
Nursing Homes	No ²
Assisted Living	Yes ¹
Recovery Housing	Yes ¹
SUD Residential	Yes ¹
Intermediate Care Facility	No ²
Children's Residential Care (includes Group Homes and Semi-Independent Living programs)	Yes ¹
Children's Campus-Based Residential Facilities with Onsite Education	No ^{2,3}
Children's Acute Residential	No ²
Correctional Facilities (e.g., RIDOC's Adult Correctional Institutions; RI Training School)	No ²

¹In alignment with CMS rules, CCBHC services may be provided within this setting and reimbursed the PPS rate, unless the service is already being paid for via another means (e.g., via grant-funding, or an alternative Medicaid payment approach).

²If CCBHC staff provide services as part of in-reach (care coordination) for the purpose of transition out of the facility, that can be an allowable activity, so long as the services are (1) furnished pursuant to a written plan of care; (2) considered outside the scope of both the facility and specialized services; (3) for nonrecurring set-up expenses for people transitioning from a facility; and (4) are provided on or after the start of the discharge planning process. Note, CCBHCs can only bill the PPS rate for the portion of in-reach activities that occur after the client's discharge from the institution or 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.

³SUD treatment through CCBHCs may be available for youth in campus-based residential treatment facilities with DCYF approval.

<p>Addendum 5, High Acuity Children and Youth</p>	<p>Population criteria 1 (pgs. 82-83)</p>	<p><i>[Clarification of criteria; newly added language is BOLDED below]</i></p> <p>An individual is in the High Acuity Children and Youth population if they are under the age of 18 years and they meet at least one of the following criteria:</p> <ol style="list-style-type: none"> a. At least 1 inpatient psychiatric admission in the past year b. A history of at least 1 suicide attempt within the last 2 years c. Have engaged in self-harm or have had suicidal/homicidal ideation within the past year d. At least 2 emergency department visits within the past 6 months putting them at risk of psychiatric hospitalization or out-of-home placement e. Are being referred for treatment as a transition from a higher level of care within the past 30 days, such as inpatient hospitalization, a partial hospitalization program, or a congregate care setting f. Within the past six months, have gone through an acute crisis (e.g. a home fire, a school shooting, or exposure to community violence) that has greatly affected their ability to function across multiple environments including home, school, and community g. Have a co-occurring moderate or severe substance use disorder, as defined by the DSM-5 or ASAM criteria h. Have experienced trauma (including but not limited to physical, sexual, or emotional abuse; neglect; exposure to domestic or community violence; natural disasters; or acts of terrorism) i. Involvement with multiple systems, such as child welfare, juvenile justice, or special education currently or within the past year j. Are currently unhoused or have been unhoused in the last 90 days
<p>Addendum 5, High Acuity Children and Youth</p>	<p>Population criteria 3: They received at least one score of 3 or two scores of 2 within the CANS Child Risk Behavior domain or received at least one score of 3 or scores of 2 within the CANS Child Needs domain. The complete CANS is expected to be done within 30 days and updated yearly when applicable. Note: Children aged 0-4 will require exception forms until the 0-4 CANS is available. (pgs. 83)</p>	<p><i>[Modification of criteria]</i></p> <p>The original language will be supplanted with the following:</p> <p>“CCBHCs shall transition from use of the OHIO Scales to use of the following two domains of the CANS Functional Assessment to determine eligibility for child high acuity services. This change goes into effect with the start of DY2 (October 1, 2025):</p> <ol style="list-style-type: none"> 1. The Child Risk Behavior Domain; and 2. The Child Behavioral/Emotional Needs Domain. <p>Combined, these two domains of the CANS Functional Assessment are hereby designated and referred to by DCYF as the “Child and Youth Level of Need (LON) Tool”.</p>

		<p>To qualify for high acuity children services, a child shall have:</p> <ul style="list-style-type: none"> • <u>At least one score of 3 or two scores of 2</u> in the Child Risk Behavior Domain; or • <u>At least one score of 3 or two scores of 2</u> in the Child Behavioral/Emotional Needs Domain. <p>Note:</p> <ul style="list-style-type: none"> • Children aged 0-4 years will require exception forms until the 0-4 CANS is available. • In DY3, the complete CANS is expected to be done within 30 days and updated yearly when applicable.”
<p>Addendum 7, ACT-I, ACT-II, and ACT-YA Staffing Requirements</p>	<p>Allowable credentials for the Team Lead position: LICSW, LCSW, LMHC, LMFT, LCDP, and RN (pgs. 90, 92, and 94)</p>	<p><i>[Modification of criteria]</i></p> <p>The following credentials shall be added to the allowable credentials list for the ACT-I, ACT-II, and ACT-YA Team Lead position: LMHC-A and LMFT-A.</p> <p>*Note: An appropriate supervision plan shall be in place for all team members who do not have the appropriate credentials to provide supervision to individuals with a license or individuals pursuing a license. E.g., there will need to be appropriate clinical supervision for individuals in the Team Lead position with a LCSW, LMHC-A, or LMFT-A credential to ensure regulatory compliance.</p>
<p>Addendum 7, ACT-II Program Requirements</p>	<p>ACT-II teams shall provide five (5) or more contacts per month. At least three (3) contacts shall be provided in-person with the individual...</p> <p>Individuals on ACT-II receiving increased or decreased contacts for monitoring will be reviewed during the daily team meeting until the team has determined appropriate next steps for the individual. Next steps may include reducing visits in preparation for discharge...when the team is in the process of discharge planning...the</p>	<p><i>[Clarification of criteria]</i></p> <p>The ACT-II minimum contact requirements remain unchanged. Individuals who do not meet these requirements for three consecutive months (90 days) shall be reviewed by their treatment team to determine which services, and frequency of these services, are essential for success within General Outpatient Programming. All services currently offered within the ACT model (psychosocial rehab, case management, SUD, med management, etc.) are available to individuals in general outpatient programs, however to a lesser extent and dependent on individual needs and preferences. The service needs and preferences should be clearly documented in the individual Treatment plans as required and with any change in level of care.</p>

	team may conduct fewer than 80% of service contacts in the community to prepare the individual for a setting in which the individual may be required to attend office-based services such as in a clinic. (pg. 91)	*Note: Anyone receiving lesser intensity services than ACT-I, ACT-II, and ACT-YA, despite clinical eligibility (e.g., DLA, diagnosis) shall be reassigned to the “standard” population for CCBHC attribution and billing purposes.
Addendum 7, ACT-YA Staffing Requirement	Substance Use Disorder Specialist; Required FTE = 1 (pg. 94)	<i>[Modification of criteria]</i> The SUD Specialist position was erroneously included in this table and shall be removed. The ACT-YA Team does <u>not</u> require this role. The overall Team FTE count of 6 remains correct.
Addendum 7, High Acuity Children / Youth Population	Services are typically provided 2-3 times per week, with an average treatment duration of 12-16 weeks...However, services are expected to be delivered more frequently than in standard outpatient treatment, with a minimum of 10 hours per month...(pg. 95)	<i>[Clarification of criteria]</i> It is important to note that the State has not identified a maximum number of hours for high acuity services. Providers are absolutely encouraged and permitted to continue delivering 16 or more hours of care per month when the child’s treatment plan supports that level of intensity. The revised minimum simply allows for greater clinical flexibility, not a ceiling on care.

3. All other certification requirements and conditions in the [RI CCBHC Certification Standards for Program Year 2](#) issued on January 28, 2025 remain in effect.