

RI CCBHC Billing Manual



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I. Introduction

Document History

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

Version Number	Date	Summary of Changes
1.0	May 10, 2024	CCBHC Billing Manual for Program Year 1.
1.1	May 21, 2024	Integration of updated resource links.
2.0	September 19, 2025	Insertion of updates for Program Year 2.

Purpose of this Document

This Certified Community Behavioral Health (CCBHC) Billing Manual is intended to support CCBHC billing in Rhode Island. It should be used in concert with the following guidance documents:

- (1) [RI CCBHC Certification Standards](#), which provide a comprehensive description of the programmatic and operational requirements of the CCBHC model;
- (2) [RI Medicaid Managed Care Manual](#), which provides general managed care program requirements and processes;

- (3) [RI CCBHC MCO Operations Manual](#), which supports Managed Care contracting with the CCBHCs in Rhode Island;
- (4) [RI CCBHC Provider Manual](#), which provides programmatic guidance for providers; and
- (5) [RI CCBHC Quality Manual](#), which provides quality reporting and quality bonus payment (QBP) guidance for MCOs and providers.

I. Program Scope

CCBHCs shall provide the full array of outpatient mental health and substance use treatment services specified within the RI CCBHC Certification Standards. CCBHCs shall provide these services in a manner that is appropriate for the population in their service area, for people with illnesses of every severity including people with serious emotional disturbance (SED), serious mental illness (SMI), and significant substance use disorders (SUD), and to all Rhode Islanders regardless of their age, race, ethnicity, disability, sexual orientation, gender expression, developmental ability, justice system involvement, housing status, or ability to pay.

Qualifying CCBHC services will be reimbursed in accordance with the monthly Prospective Payment System (PPS) model by which a clinic's rates are set, i.e., by dividing its allowable costs by the number of monthly qualifying encounters in a year. There will be one rate established per CCBHC for each of the following defined populations: i) high acuity adults; ii) high acuity children and youth; iii) substance use disorder (SUD) treatment; and iv) standard (this includes all individuals who do not meet the criteria for the other three populations).

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

- Qualified Medicare Beneficiary (QMB)-only individuals will 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 are not eligible for cost-sharing.
- SLMB+/QMB+ individuals will be paid the PPS-2 rate and will follow established third-party liability (TPL) processes.
- Individuals in the Ryan White program 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 their other insurer. Regardless of insurer, clients receiving behavioral health services need to be entered into BHOLD for data collection compliance.
- Children enrolled in Katie Beckett (KB) program can be attributed to a CCBHC.
 - 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 Case Management Only, the MCOs are only involved on a case management level. All other services are reimbursed Medicaid FFS (i.e., through Gainwell) or via the standard TPL process. This

represents the majority of the KB population. If the member is enrolled in KB CM Only, you should bill the commercial carrier and Medicaid FFS concurrently, per the established TPL process.

CCBHC is an 'in plan' Medicaid benefit, except for Dual Eligibles (defined here as Medicare and Medicaid eligible individuals), for whom CCBHC services are provided out of plan (also referred to as Fee for Service, or FFS). As of January 1, 2026, CCBHC services are an 'in plan' benefit for Dual Eligibles enrolled in Neighborhood Health Plan (NHP)'s FIDE SNP product. Other Dual Eligibles will continue to receive CCBHC services as FFS Medicaid benefits.

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

II. Attribution

A. Introduction to Attribution

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

The CCBHC program attribution process will be managed by BHDDH's Research, Data Evaluation, and Compliance team (the 'data unit') via the Gainwell eligibility system portal (also commonly referred to as the 'Provider Portal'). The Provider Portal will be the repository for collecting and monitoring CCBHC attribution and will serve as the single source of truth for purposes of determining program attribution.

The attribution will identify the specific CCBHC who is clinically responsible for the individual and the appropriate level of care and population designation for the individual (i.e., high acuity adult, high acuity child or youth, SUD, standard). Member attribution is used as the basis for PPS rate eligibility, program quality measurement, and data collection.

See the [RI CCBHC Certification Standards](#) for additional information on the diagnostic and assessment criteria for each of the four CCBHC populations.

See the [RI CCBHC Provider Manual](#) for additional information on how to submit a High Acuity Population Exception Request to BHDDH or DCYF for any individual who does not meet the established diagnostic and assessment criteria for the High Acuity Adult population, or the High Acuity Child and Youth population, but for whom a CCBHC believes requires a high (rather than a standard) level of care due to other clinical and/or social factors.

B. Initial Program Attribution File

BHDDH's Data Unit will develop an initial CCBHC program attribution file that reflects all of the individuals who the State expects to be reasonably attributed to each CCBHC upon initial go-

live. This initial attribution file will be developed and confirmed as described below. A detailed timeline will be provided based on each provider's specific slated go-live date.

- The initial attribution file will specify the individuals who the State believes should be attributed to the CCBHC. The file will also specify which population and rate category each individual has been enrolled into (i.e., High Acuity Adult, High Acuity Child and Youth, SUD, or Standard Population) in accordance with the specifications in the RI CCBHC Certification Standards.
 - Note, initial enrollment is based on the current IHH/ACT provider on record for an individual (if there is one), rather than the individual's place of residence.
- BHDDH will electronically share a DRAFT initial attribution file with each CCBHC for their review.
- Each CCBHC will have the opportunity to propose updates and corrections to this DRAFT attribution file. Requested changes may include observed errors, duplications in client enrollment across CCBHCs, incorporation of individuals served by a DCO partner who would benefit from the full suite of CCBHC services, and corrections of any other noted discrepancies.
- Each CCBHC will submit their requested changes in writing and supporting documentation to BHDDH's Data Unit.
- BHDDH will review all attribution change requests and make final determinations to approve or deny each request. Once this task is complete, BHDDH will send a FINAL initial attribution file to Gainwell.
- Gainwell will upload the file to the Medicaid Management Information System (MMIS) and auto-enroll individuals into the CCBHC program, under the appropriate CCBHC provider and population designation.
- Gainwell will identify any individuals who were included in the FINAL initial attribution file but are not ultimately enrolled into the CCBHC program based on identified non-compliance with all program eligibility criteria (e.g., individual was not Medicaid eligible at the time of the file upload) and will share that list with BHDDH.
- BHDDH will share the final list of successfully attributed clients with each CCBHC.
- Between the date of the initial attribution file pull and the CCBHC's designated go-live date, the provider may need to manually track new enrollments and discharges. Once the provider has been successfully enrolled in MMIS as a certified CCBHC provider, the provider will be able to, and responsible for entering these updates into the Provider Portal.
 - Providers should enroll clients into the CCBHC program with a start date that corresponds with the CCBHC's certification effective date.

C. Ongoing Attribution

- **New Enrollments:**
 - The provider must submit a CCBHC enrollment request to BHDDH via the Provider Portal. The client's eligibility category (i.e., High Acuity Adult, High Acuity Child and

Youth, SUD, Standard Population) and supporting diagnosis/assessment scores must be entered in the portal. Functional assessment scores must also be submitted directly to the State via BHOLD and direct report to DCYF. See **Appendix A** for instructions.

- An individual can be enrolled at any time prior to a claims submission for payment.
 - For example, if an individual receives their first qualifying encounter on March 22, 2025, the provider should enter that date into the portal. The attribution for that individual will be for the full month of March and the provider will receive the full PPS payment (i.e., monthly rate).
 - Staff at BHDDH will review and either approve or deny enrollment requests within two business days.
 - Any CCBHC service provided to a non-attributed CCBHC client should prompt the CCBHC to initiate/complete a new enrollment to ensure appropriate attribution and payment for all CCBHC services.
- **Client Discharges:**
 - The provider must enter the discharge date for any clients who leave their agency's care. An individual may be discharged from the CCBHC program when treatment is complete or if and when the individual chooses to seek care from another CCBHC, consistent with BHDDH guidance.
 - **Attribution Transfers and Care Transitions:**
 - As noted above, individuals 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. Providers shall collaborate in the best interest of the client to ensure a timely transfer of care and to ensure the client receives all clinically appropriate services during the transfer process. It is expected that the client will be attributed to the CCBHC providing the majority of the services to the client within a given month.
 - An individual may only be enrolled with **one CCBHC per month**. CCBHC attribution dates in the provider 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 must add a discharge date in the provider 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 must 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 in a given month will be the provider who is clinically responsible for the individual and that is eligible to receive PPS payment. There will not be partial month payments.
 - The cost of the provision of all allowable, anticipated services (including instances in which services provided in the transitional period are not directly billable and compensated) are included in the cost report and therefore in the calculation of rates for each CCBHC.
 - CCBHCs and DCOs should develop data sharing arrangements, including EHR access, to facilitate care coordination and required reporting activities in the instances of a client transferring from one provider to another. If the current records transfer process is sufficient, that can be employed in this model. For further details regarding data sharing requirements, please refer to SAMHSA's CCBHC criteria for care coordination.
- **Population Transfers:**
 - **From a clinical perspective:** CCBHCs 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 necessary.
 - **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.

D. Ongoing Attribution and Reconciliation

- Provider attribution file and reconciliation:
 - The BHDDH Data Unit will update the ongoing attribution file on a monthly basis based on the prior month's attribution. The updates will show adjustments for new client enrollments, discharges, transfers, prospective member assignments, and population changes, as described above. BHDDH will send the ongoing attribution file reflecting the attributions as they appear in MMIS the last week of the month so providers can verify against their own Electronic Health Records (EHRs).
 - Gainwell will maintain ongoing up-to-date attribution, which can be checked by providers at any point via the Provider Portal.
 - If needed, BHDDH will work with CCBHCs to review any errors on the ongoing attribution file and make any required updates in MMIS. In the event there are

discrepancies that cannot be immediately resolved, the affected client will remain assigned to the CCBHC and population category they were attributed to on the earlier date, pending resolution.

- MCO Weekly Extract file and reconciliation:
 - Gainwell will submit an updated attribution file to each MCO each week via SFTP. This file is commonly referred to as the ‘MCO weekly extract file’ (see sample file in **Appendix B**). The file includes a 24-month rolling look-back period. Each MCO will only receive member data for the specific month(s) in which an individual was actively enrolled with them.
 - For the purposes of program integrity, all MCOs are required to, at a minimum, utilize the MCO Weekly Extract file provided by the state to retroactively audit CCBHC payments in accordance with the specifications defined in the [RI CCBHC MCO Operations Manual](#).

E. Dual Eligible (MMP/FIDE SNP) Attribution

Health plans participating in the Medicare-Medicaid Plan (MMP) or the Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) must review the MCO Weekly Extract file and identify any MCO enrolled dual eligible individuals attributed to CCBHCs (and therefore eligible to be paid a PPS2 rate).

Prior to January 1, 2026, MMP participating health plans must continue to pay for behavioral health services covered under their Medicare Coverage of Benefits (COB) as specified in the [RI CCBHC MCO Operations Manual](#). The MMP should reimburse the CCBHC (using the provider’s pre-existing non-CCBHC NPI) for any Medicare-covered services according to their existing contracted rates. The State will reduce its PPS2 payments to CCBHC by the amount paid by the MMP plan through December 31, 2025.

Beginning January 1, 2026, health plans participating in FIDE SNP will pay the full PPS2 rate for dual eligible individuals. It will be the responsibility of the FIDE SNP participating health plan to appropriately allocate its payments to Medicare and Medicaid.

F. Grievances/Errors in CCBHC Attribution Report

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

III. Billing Requirements

A. Introduction to PPS2 Methodology for CCBHC Billing and Payment

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

- CCBHCs receive a single payment each month a client receives a qualifying service, set at a level calculated to cover the clinic’s anticipated costs of delivering care throughout the year.
- A unique set of PPS rates are established per CCBHC which reflects the specific population the serve and array of services they provide.

Rhode Island currently utilizes the PPS2 payment model, which is a monthly PPS rate.

- In the monthly PPS, a clinic’s rate is set by dividing its allowable costs by the number of anticipated monthly qualifying encounters in a year. Monthly qualifying encounters are calculated as the number of months in which a patient has at least one qualifying encounter, regardless of the number of days or quantity of services received in any given month.
- Monthly PPS is similar to per-member-per-month capitated payment, **except** that clinics do not receive a payment in a month in which a patient did not receive a qualifying service. In other words, it is a per-served-member-per-month methodology.
- Under the monthly PPS option, states define “special” populations of patients based on level of complexity or need and set different rates for the “standard” population and each special population.
- States must implement quality bonus payments (QBPs) in accordance with SAMHSA defined parameters, based on state-defined metrics, and include a process for addressing outlier costs.¹ The QBPs will be calculated by EOHHS and paid directly by the state to eligible CCBHCs. For additional details about QBP payments, please see the [RI CCBHC Quality Manual](#).
- While the delivery of one qualifying service is sufficient to trigger payment of the full monthly PPS rate, providers must document and share information on all CCBHC services delivered to a client within a given month via the submission of shadow claims.
- Individuals may **not** be enrolled in both a IHH/ACT and CCBHC program. The individual can only be enrolled in one program per month. A determination should be made based upon clinical need and client choice. The CCBHC program offers individuals access to more extensive wraparound supports than the IHH/ACT program.
- Individuals **may** be enrolled in a OTP Health Home and a CCBHC, or a Center of Excellence and a CCBHC simultaneously.

B. CCBHC Population Rate Categories

The Rhode Island CCBHC rate structure includes four distinct populations, or PPS rate categories:

1. High Acuity Adults;
2. High Acuity Children and Youth;
3. Substance Use Disorder (SUD); and
4. Standard Population (which is inclusive of all individuals who do not meet the criteria for the above “special” populations)

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

Eligibility criteria for each population are specified in [CCBHC RI Certification Standards](#).

C. Qualifying and Non-Qualifying Services

There are two primary categories of CCBHC Services. These services must be provided directly by the CCBHC, or through a DCO partner. They include:

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

RI has defined a set of billing codes for qualifying and non-qualifying CCBHC services. It can be found [here](#). This code list is used by all CCBHCs, the State (Gainwell), and MCOs to process CCBHC claims for Medicaid members.

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

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

Please note that billing code ‘S9986’ is used to alert FFS that there is a qualifying service to be paid, because providers 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.

For behavioral health services, Neighborhood Health Plan (NHP) Integrity is the primary payor, and they pay Medicare for CCBHC enrolled clients. The state will later recoup the payment received by Medicare. Providers should bill RI Medicaid FFS the T1041 for the PPS rate, and if needed (see instructions above) the S9986, to identify that there is a qualifying service.

- As certain services included in the PPS2 are covered by Medicare, EOHHS expects that there will be a meaningful volume of Medicare duals/TPL reimbursement (i.e., an estimated 40% of high acuity member visits). Such services may include, but are not limited to: psychotherapy and psychiatry beginning January 1, 2025; intensive outpatient (IOP) services; and substance use disorder (SUD) treatment. As described above, CCBHC services for dual eligible populations are an out-of-plan benefit; therefore, this process

will be handled through FFS, with the exception of those enrolled in the FIDE SNP product, beginning January 1, 2026.

- EOHHS estimates that there will be a much smaller amount of commercial TPL (i.e., approximately less than 2% of visits). This TPL process will generally be handled by the Medicaid Managed Care Organizations (MCOs) because CCBHC services are an in-plan benefit for the majority of Medicaid individuals.

There are several potential scenarios where a member has dual or TPL coverage. Those scenarios are:

1. Dual eligible Medicaid members with Medicare FFS (i.e., Part B)
2. Dual eligible Medicaid members with CCBHC out-of-plan
 - a. Medicaid members in FFS with Commercial TPL (including Medicare Part C/Medicare Advantage)
 - b. Dual eligible individuals in Neighborhood Integrity, where the CCBHC services are out-of-plan through the existence of NHP Integrity, which will sunset December 31, 2025. Note, dual eligible individuals in NHP FIDE SNP will have CCBHC services in plan, beginning January 1, 2026.
3. Dual eligible Medicaid members in managed care with Commercial TPL

Details for the processes to follow for each of these scenarios can be found in **Appendix C**.

Note: MCO Financial Data Cost reporting (FDCR) will include CCBHC TPL collections.

E. Billable Events and Payment

Member Attribution and CCBHC Service Utilization are the basis for CCBHC billing and payment.

A CCBHC receives a PPS2 monthly payment if a client:

- Is attributed to the CCBHC; and
- Had at least one qualifying service among their claim details in that month from the CCBHC where they are enrolled or its Designated Collaborating Organization (DCO).
 - A visit is defined as a qualifying “billable event,” when a client receives at least one face-to-face encounter or telehealth visit, with a qualifying CCBHC staff person in a qualifying setting, during which qualifying CCBHC services are provided and documented, consistent with the Attribution guidance provided in this manual.
 - Please note that in order to bill for a fifteen minute service, a minimum of eight consecutive minutes of time must be provided. Staff cannot add up separate visits of less than eight minutes to qualify for a fifteen minute service.
- The T1041 (always the first detail on the claim) should include the date span of the entire month. If a provider’s billing system does not allow for this, use the first date of service through the end of the month. Each subsequent claim detail should be the actual date of service.

- A CCBHC can bill back to the date of the initial service as long as the member is not attributed to another CCBHC for that month.

F. Billing Restrictions

Please note the following billing restrictions:

- Correctional facilities are a disallowed setting for Medicaid billing under federal law.
- CCBHC services cannot be reimbursed if they are provided in a setting or as part of a service in which behavioral health care is already part of a bundled payment.
- CCBHCs cannot bill for services provided in schools for which they are contracted by the Local Education Agency (LEA) or school to provide.
- CCBHC services are and are not allowed in the following settings, as described below:

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.

Emergency Room: CCBHC staff who are located on site at a hospital outside of a provider’s catchment area may not bill FFS for emergency services provided to clients attributed to another CCBHC. To do so, a provider would need a DCO arrangement with the attributed CCBHC and directly bill the CCBHC responsible for delivery of emergency services.

G. CCBHC Specific National Provider Identifier (NPI)

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

H. Provisions for Payment – PPS Codes and Modifiers

EOHHS has established T1041 as the PPS2 rate code to be utilized for all CCBHC PPS billing.

To trigger a PPS payment, providers must:

- Submit a claim using their CCBHC specific NPI, with the T1041 code on the first claim, and the appropriate designated population rate modifier in the MOD1 position.
- A list of the required T1041 modifiers (i.e., MOD1) can be found in **Appendix E**.

Of note:

- EOHHS requires this specific billing code and population modifier to be used across all MCOs and FFS Medicaid.
- Providers should list the primary diagnosis first. For individuals with comorbid conditions (e.g. a mental health and a SUD diagnosis), the primary diagnosis should reflect their most acute and/or priority clinical treatment need.
- EOHHS has added a modifier to distinguish services provided by a DCO.
- The EOHHS approved CCBHC PPS2 rates will be posted [here](#). As mentioned above, each CCBHC will receive a clinic-specific set of rates – one per designated CCBHC population. EOHHS will update these PPS rates in accordance with CMS rules, e.g. on an annual basis through an federal Medicare Economic Index (MEI) rate adjustment or rebasing process. These rates apply across all participating RI Medicaid MCOs and Medicaid FFS.

I. Provisions for Payment – Qualifying Service Codes

- A list of standardized qualifying service codes can be accessed via the [EOHHS CCBHC Resource](#) webpage for providers and MCOs.
- This billing code list will be evaluated on a continual basis and updated at least annually to reflect and accommodate any substantive changes at the federal or state program level (e.g. updates to qualified provider credentials, changes to allowed services, release of new procedure codes, etc.). The CCBHC Interagency Team will modify the billing code list in consultation with its clinical, billing, and policy subject matter experts, as well as with provider and plan representatives. Note, all requested updates will be critically evaluated. It is the State’s intention to keep the billing code list simple and focused so that it can be efficiently, consistently, and accurately leveraged by all for billing, payment processing, and reporting purposes.

J. Responsibility for Payment

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

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

CCBHC services for dual eligible populations are an out-of-plan benefit for all individuals through January 1, 2026; therefore, the State is responsible for paying the established provider and population specific PPS rate per T1041 claim through that time. As of January 1, 2026, CCBHC services are an ‘in plan’ benefit for Dual Eligibles enrolled in Neighborhood Health Plan (NHP)’s FIDE SNP product, and NHP will be responsible for paying the established PPS rate from that point onward. Other Dual Eligibles will continue to receive CCBHC services as Fee for Service Medicaid benefits. In such cases, the payment process and confirmations described in Section D. Dual Eligible and Third-Party Liability (TPL) Billing will be performed by the state.

K. Duplication: Non-CCBHC Service Monitoring and Reporting

- There will not be partial month payments. The CCBHC to whom a client is attributed on the 1st day of the month will be the provider eligible for the PPS2 payment, except for extenuating circumstances due to retrospective Provider Portal updates.

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

L. Detailed Claims and Shadow Billing

In addition to billing the PPS rate code and modifier, SAMHSA requires CCBHCs to submit claims for all individual qualifying and nonqualifying CCBHC services found in the [RI CCBHC PPS and Shadow Billing Code List](#) that were provided during a CCBHC Visit.

Purpose

- EOHHS uses the detailed claims to monitor the cost and utilization of services provided by CCBHCs. Underlying encounters will also be used to validate services provided to CCBHC attributed populations and their assignment to the appropriate population category.
- These detail claims or encounter data – sometimes referred to as “shadow data” or “shadow services” – are needed to track important performance measures that can only be appropriately measured based on details submitted for purposes of calculating the Quality Bonus Payment program.
 - For example, follow-up after an emergency department (ED) visit can only be appropriately measured if all shadow claims are reported; otherwise, it may appear as if the follow-up never occurred, even if it did.

- Detailed claims or encounter data are also critical to successful PPS rate setting and rebasing. CCBHCs that under-report these shadow data will risk substantive reductions in future PPS rates that may be tested and justified against these claims.

Shadow Billing Process

- Providers are required to include all shadow claim data on the submitted claim.
- All providers should be bundling same-day services in their shadow claims submission where appropriate. For example: If a CCBHC provided two separate, one-hour case management sessions to a client within one day:
 - The provider should submit one 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 two separate claims with code H0036 of 4 units each (15 min x 4 = 1 hour).
- While it should be rare, if a provider identifies that there was a service that was missed, any corrections should be submitted using an electronic process. Within the electronic process an adjustment is called a replacement claim (replacing an original paid claim) and a recoupment is called a void.
 - If the provider is using their own billing software, then their software vendor would need to configure their software to submit these types of transactions.
 - Alternatively, Providers will use the Medicaid software: RI Provider Electronic Solutions Software (PES) for the replacement claims. Instructions for submitting a replacement claim can be found [here](#).
- The PPS rate code and modifier should be bundled with the corresponding qualifying and non-qualifying services provided to the attributed member for that month, including all relevant billing codes as specified in **Appendix E**.
- Please note, providers must update date span to include dates of all services. If a new shadow claim falls outside of the previously paid claim date span, providers must update the date span in the replacement claim.
- EOHHS will monitor these claims to ensure that adequate and appropriate shadow claims are included with submitted claims. Failure to submit adequate and appropriate shadow claims may trigger a Medicaid Financial Audit and further penalties in accordance with Program Integrity processes as specified in Section Q. Medicaid Financial Auditing, Corrective Action, and Decertification Standards and Processes.
- Providers should submit claims in a timely manner. General timely filing rules apply.

M. Financial Reconciliation and Settlement

- MCOs are required to complete a Cost and Utilization Report as specified in the [RI CCBHC MCO Operations Manual](#) and **Appendix F**. This report will specify paid and denied claims (with and without TPL) by population, by CCBHC, by month.

- This report will be used by all parties to identify any claims discrepancies and to support the determination of any required adjustments, financial reconciliation and/or settlement.
- Each MCO will determine a format for conducting reconciliations based (at a minimum) on this report. CCBHCs should consult with MCOs to determine how any required adjustments, financial reconciliation and/or settlement will be handled.

N. Utilization Review & Management

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

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

O. Outlier Thresholds and Allocation Guidance

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

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

P. Quality Bonus Program (QBP)

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

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

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

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

R. Billable Events Description

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

- **A face-to-face encounter** is a visit that takes place in person (i.e., with the staff person and the client in the same room or via telephone or videoconference). A face-to-face encounter is provided in one of the following contexts:
 - With only the client and staff person present;

- With the client, the staff person, and the client’s family member(s) or representative present;
 - With only the client’s family member or representative and the staff person present, subject to the client’s consent (an encounter in this context may not serve alone as a visit for the purpose of monthly billing); or
 - With two or more clients and a staff person present in a group setting.
- **Telehealth:** An encounter provided via telephone or videoconference may only be considered a visit when such event is a minimum of 15 minutes, and otherwise meets the requirements for a billable outpatient visit under the RI Medicaid program (for example, in terms of clinical necessity, and relevance to the client’s treatment plan), and it is conducted directly with the client.
- **Qualifying Service Settings:**
 - An encounter can take place in any location type, unless otherwise specified in this manual in Section F. Billing Restrictions.
 - Service location is generally restricted to the CCBHC’s approved catchment area, with the following clarifications:
 - i. Services which are appropriately billed from locations within the CCBHC service area, such as crisis services or any other CCBHC service provided in homes and/or community locations within the service area, are not considered to be outside the service area.
 - ii. CCBHCs can provide services to attributed individuals from outside the catchment area and through care delivery modalities that do not require the establishment of a brick and mortar clinic outside their catchment area (i.e., mobile crisis services).
 - iii. Attributed clients can receive services from their designated CCBHC in their homes and in community-based locations which may be outside of the service area of the CCBHC they are attributed to.
 - iv. CCBHCs cannot establish a new physical location or brick and mortar clinic for CCBHC service delivery outside their catchment area.
 - **Qualifying Staff:**
 - A CCBHC qualifying staff person is defined in the certification standards.
 - **Qualifying Service:**
 - A list of Qualified Services can be found [here](#).

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

Appendix A: How to Enroll Clients via the Gainwell Eligibility System (aka 'Provider Portal') and Submit Functional Assessment Scores to the State

Providers must submit the following data and assign clients to a specific CCBHC population as follows:

I. Provider Portal

Providers must enter the following information into the Provider Portal to formally enroll a client: (i) basic client information; (ii) program designation, i.e. CCBHC; (iii) population assignment, i.e. High Acuity Adult, High Acuity Child, SUD, or Standard; (iv) initial functional assessment score for any client being enrolled in the High Acuity Adult, High Acuity Child, or SUD population; (v) clinical diagnosis; and (vi) attestation of appropriateness of client population assignment. BHDDH and DCYF will review and approve.

1. General data entry guidance:

- The Provider Portal form does not include 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.

2. CCBHC client enrollment instructions:

- 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

Instructions for Entering DLA Scores into the Provider Portal

The provider portal allows for up to 6 characters to be entered into the Score field within the Recipient Assessment box. You should enter the DLA scores as follows:

- The DLA produces a cumulative score made up of up to 20 different elements that are each scored between 1-7 and are then divided by 20.
- Resulting scores can range from 1-7, with most 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 member scored a total of 6, you will enter 6.
 - If a member scored a total of 3.45, you will enter 345 without a decimal.

- For clients being attributed to the **High Acuity Child** population, complete the Assessment fields as follows in the Provider Portal:
 - Assessment Type = CANS
 - Assessment Date = date of input of client into the Provider Portal
 - Assessment Score = *see below*

Instructions for Entering CANS Scores into the Provider Portal

For now, the Provider Portal will only be used to attest whether a child meets the CCBHC functional assessment requirements. The Portal is not presently configured to accommodate all resultant CANS assessment scores. You should complete the assessment score field as follows:

- Enter '99' if the child meets the high acuity criteria.
- Enter '00' if the child is under 5 years of age or does not meet the criteria, but for whom a High Acuity Child and Youth Population Exception Request Form has been submitted to DCYF for review and/or has been approved.

- For clients being attributed to the **SUD** population, complete the Assessment fields as follows in the Provider Portal:
 - Assessment Type = ASAM
 - Assessment Date = date assessment was administered
 - Assessment Score = assessment score

Instructions for Entering ASAM Scores into the Provider Portal

- 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.

II. Submission of Functional Assessment Scores to the State

In addition to formally enrolling each client through the Provider Portal, providers must also submit each client's functional re-assessment scores to the State. As noted above, high acuity and SUD clients must be reevaluated **at least every 90 days** and transitioned to the 'standard' level of care population in a timely manner when clinically appropriate.

This data will be used by the State to affirm providers are attributing clients to the correct level of care and CCBHC population. The data will be used to support enrollment approval and auditing processes.

1. Submission of DLA Scores

- Providers must document each client's initial and reevaluated functional assessment scores in their electronic health record (EHR), then follow the current, established protocol with BHDDH to transfer this data to the BHOLD system via a monthly bulk upload.

2. Submission of ASAM Scores

- Providers must document each client's initial and reevaluated functional assessment score in their electronic health record (EHR) and/or the client's care plan. Additional system configurations would be required on the provider and State side to support BHOLD submission. In DY2, ASAM scores do not need to be submitted to BHOLD.

3. Submission of CANS Scores

- Providers are expected to document which functional assessment (LON vs. complete CANS) was conducted for the client, as well as the client's initial and reevaluated functional assessment score in their EHR record, e.g. via a fixed field, a progress note, and/or their treatment plan.
- Additional system development work is required before CANS scores can be submitted to the State via BHOLD. This build is underway. In the interim, providers must submit the CANS scores to the State manually using the below form and instructions:
 - Form: [CCBHC High Acuity Child Program Ongoing Monitoring Template](#)
 - Completion instructions can be found on Tab 1 of this Excel workbook.
 - Please submit the completed form via upload to the designated State SFTP (managed by the EOHHS Data and Analytics Team) by the 14th of every month. If this date should fall on a weekend or holiday, please submit it by the following business day.

FAQs

Q1. Do clients need to provide written consent before we attribute them as a CCBHC client?

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.

Q2. 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?

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.

Extenuating 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.

Q3. 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?

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.*

Q4. 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?

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.
- 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 Adult Population Exception Request may be submitted to BHDDH if/as needed.

Q5. CCBHC high acuity children and adults – are exception requests/approvals from DCYF and BHDDH required for commercial clients?

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.

Appendix B: Sample MCO Weekly Extract File

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

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

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

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

For QMB+ and SLMB+ members, please note the following:

- 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.”

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

Scenario 1:

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

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

1. CCBHC Action:

- Provider bills Medicaid FFS (i.e., Gainwell) using its **new Medicaid CCBHC NPI/taxonomy** specific for the PPS2 using code T1041 and the appropriate modifier as well as any claim details not submitted to primary payer.
 - To avoid denial, the provider will include on T1041 claim as the first detail and **S9986** as the second detail, for each Medicaid FFS client with TPL (Medicare Part B, Part C or other commercial).

- EOHHS acknowledges that this CPT code is being used incorrectly. However, this detail is intended to be informational to indicate that the client was provided at least one qualifying event that was billed to the primary payer.
- Provider bills Medicare for any covered services for all Dual clients under their **current NPI/taxonomy** (e.g., CMHO or other)

2. CMS Action:

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

3. Gainwell Action:

- Gainwell adjudicates the PPS2 claim and reimburses provider the full PPS2.
- Gainwell processes the separate crossover claim from CMS and reimburses provider for balance, if any, owed to provider.
- *Note that the balance owed is the difference between the Medicaid Program allowed amount and the Medicare Payment (Medicaid Program allowed minus Medicare paid); or the Medicare coinsurance and deductible up to the Medicaid Program allowed amount.*

4. EOHHS Action:

- EOHHS (or Gainwell) calculates total Medicare and Medicaid paid to the provider over the prior period (i.e., amount of TPL reported for members with a concurrent PPS2 payment since last calculation performed).
- EOHHS prepares a Fiscal Agent Control Number (FACN) request establishing a PAR against the provider's CCBHS provider ID that will auto-decrement the calculated amount against the provider's payment in the next financial cycle.
- This process will be performed on a regular schedule – either monthly or quarterly.

5. EOHHS Audit Function:

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

Scenario 2a:

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

1. CCBHC Action:

- CCBHC bills Medicaid FFS (i.e., Gainwell) using new Medicaid CCBHC NPI and taxonomy for the PPS2 using code T1041 and the appropriate modifier and with **S9986** as second detail.
- Provider bills Medicare for any covered services for all Dual clients under their **current NPI/taxonomy** (e.g., CMHO or other).

2. Commercial Plan Action:

- Commercial plan adjudicates the claim and reimburses provider.

3. CCBHC Action:

- Provider submits a secondary claim for payment to Gainwell under their **current NPI/taxonomy** (e.g., CMHO or other)

4. Gainwell Action:

- Gainwell adjudicates PPS2 claim and reimburses CCBHC the full PPS2.
- Gainwell processes Part C/commercial-adjudicated claim(s) submitted by provider as a crossover/secondary claim and reimburses provider for any balance owed.

5. EOHHS Action:

- Same as in Scenario 1.

Scenario 2b:

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.* This plan will sunset on December 31, 2025, and this guidance will no longer be relevant.

1. 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)

2. NHPRI Plan Action:

- NHPRI Integrity adjudicates the claim and reimburses provider.

3. CCBHC Action:

- Provider submits a secondary claim for payment the adjudicated claim from Gainwell under their **current NPI/taxonomy** (e.g., CMHO or other).

4. 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.

5. EOHHS Action:

- Same as in Scenario 1.

Scenario 3:

For all Medicaid members in managed care with Commercial TPL

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

FAQs

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

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

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

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

Q3. How will TPL recoupments be treated?

We do not anticipate there will be a meaningful volume of such recoupments. In the event that the CCBHC must repay a payer for claim previously submitted to Gainwell and it was already included in the auto-decrement process, any amount recouped from the CCBHC can be

excluded (i.e., returned to the CCBHC) from a subsequent PAR through a manual process. EOHHS will set up a process to review such cases.

Q4. How will Gainwell's recoupment process work?

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

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

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

Q5. How will TPL work with DCO?

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

Meanwhile, the DCO should report to the CCBHC the amount they collected from Medicare. The CCBHC may recoup the amount the DCO collected from Medicare. If a crossover claim for the DCO services was submitted to Medicaid, Medicaid will process the claim as usual and pay the DCO. The CCBHC should report the amount the DCO collected from Medicare to the state and the state will reduce their payment by this amount (similar to how the State will reduce payments by any amount directly collected by the CCBHC from Medicare).

For example: DCO A is acting as a DCO for CCBHC A. DCO A provides 2 psychotherapy visits to CCBHC A's attributed client with dual eligibility for Medicare and Medicaid in the month. The DCO should bill Medicare their contracted rate – in this example their contracted rate is \$150 per psychotherapy visit, \$300 in total for this month. The DCO should bill CCBHC their CCBHC contracted rate – in this example their DCO subcontracted rate is \$500. The CCBHC bills the state the full PPS rate using the process identified above. Medicare pays the DCO \$300 (total for the month). The CCBHC pays DCO full contracted rate - \$500. Once payment is received from Medicare, the DCO should report the \$300 payment received from Medicare to the CCBHC who will then recoup or decrease future payment by the \$300. The CCBHC should report to the state the \$300 Medicare paid to the DCO. The state will reduce a future payment to the CCBHC by \$300.

Note: these rates are just an example and do not reflect actual rates.

Q6. How will EOHHS assure compliance with this guidance?

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

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

No, Medicaid is the payer of last resort and the CCBHC must bill the patient's insurance for any services rendered as detailed above, including commercial and Medicare coverage. MRSS, like any bundled service that is comprised of other services, has many component services that are billable. Providers should work with the primary insurer to understand what elements can be billed.

Appendix D: Securing and Enrolling as a Medicaid Provider with CCBHC Specific NPI

To bill as a CCBHC, all providers must:

1. Secure a **new** National Provider Identifier (NPI) that designates them as a CCBHC
2. Enroll as a Medicaid provider using the CCBHC NPI
3. Bill for all CCBHC services using the CCBHC NPI

Step 1. Securing a new CCBHC NPI

- Providers will need to apply for a new NPI via the [NPPES website](#).
- The following 'Taxonomy' should be used for the CCBHC NPI Application. Only the taxonomy identified below should be associated with this NPI.
 - **Code:** 251S00000X
 - **Type:** Community/Behavioral Health
 - **Classification:** Clinic/Center
 - **Specialization:** Public Health, State or Local
 - **Level:** Level III - Area of Specialization
- For further guidance: [NPI Application Guide](#).

Step 2. Enrolling as a Medicaid provider using the CCBHC NPI

- Providers will need to enroll as a Medicaid Provider with their CCBHC NPI via the [RI Medicaid Healthcare Provider Enrollment Portal](#).
 - *NOTE:* The Medicaid Management Information System (MMIS) is being formatted to accept Medicaid provider applications at this time. Providers can visit the NPPES website to obtain a new NPI but will then have to wait until the MMIS is ready before applying to Medicaid as a CCBHC provider. A separate notification will be sent when the MMIS is ready to accept enrollment applications [anticipated go-live date: January 10, 2024].
- CCBHC providers should have the following ready before beginning the enrollment process:
 - NPI/Taxonomy approval letter,
 - Current W-9,
 - BHDDH license, and
 - CCBHC certification approval letter.
- On the 'Request for Information' page:
 - **Type of Provider Enrollment:** choose 'MCO & RI Medicaid Provider'
 - **Provider Enrollment Type:** choose 'Facility'
 - **Provider Type:** choose 'CCBHC'
 - **Requesting Enrollment Date:** enter the effective date of your certification
- The remainder of the application will request demographic information:
 - Provider name,
 - Provider address,
 - Tax identification number, etc.

- On the Disclosure Page, providers will need to provide the following information for all Board of Directors:
 - Name and Title
 - DOB
 - Social Security Number
 - Home address
- Please note the Healthcare Portal will time out if the application is left idle for more than 30 minutes.
- The 2023 application fee is \$688. Please consult with CMS for the most up-to-date fee.
- For further information: [Provider Enrollment Guide](#)

Step 3. Billing for CCBHC Services Using the CCBHC NPI

- **Duals & Third-Party Liability:** For all Medicare-covered or commercial covered services, the CCBHC must bill CMS, Part C plan or commercial plan for reimbursement. Per federal regulations, Medicaid is the payer of last resort and so this is an essential and required task for all CCBHCs.
- Billing instructions
 - CCBHC bills Medicaid FFS (i.e., Gainwell) for PPS2 reimbursement using the **new Medicaid CCBHC NPI**.
 - For Medicaid/Medicare duals: Provider concurrently bills Medicare for any covered services for all Dual clients under their **current NPI/taxonomy** (e.g., CMHO or other). A Medicare primary does not need to be submitted because Medicare cross over claims directly to Gainwell.
 - For Medicaid/Commercial duals: Provider concurrently submits as secondary claim for payment to Gainwell for any covered services for all Dual clients under their **current NPI/taxonomy** (e.g., CMHO or other).

Appendix E: Services and Billing Codes

The full list of qualifying and non-qualifying service codes can be found [here](#).

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

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

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

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

Appendix F: CCBHC Implementation Monitoring: Cost and Utilization Report

Template sample for the MCO Cost and Utilization Report.

CCBHC Implementation Report: Cost and Utilization Report

MCO:

Report Period:

Date (Re-)Submitted:

The initial report should be submitted 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 activity for PPS-2 services incurred in October, but now with all claims submitted through December 15, 2024.

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

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