RI CCBHC
Managed Care Organization (MCO) Operations 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 this document will be updated and refined over the course of the CCBHC program to incorporate feedback and learnings from program participants, and to accommodate any program modifications required by the Centers of Medicare and Medicaid Services (CMS), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the State. The table below will be updated accordingly.

This document is considered final for year 2 of the CCBHC program.

Version Number	Date	Summary of Changes
1.0	October 3, 2023	Initial Final CCBHC MCO Operations Manual. QBP measures included are based on SAMHSA proposed measures and will be updated once final guidance is published.
1.1	December 1, 2023	Updates incorporated based on final decisions for billing and MCO and provider feedback.
1.2	May 10, 2024	Updates to remove sections being incorporated into other manuals; updates based on revised program implementation timeline; updates based on provider Q&As; updates based on MCO Q&As; and other refined implementation guidance.
2.0	August 31, 2025	Updates for Demonstration Year (DY) 2; updated timelines; updates regarding individuals enrolled as dual eligibles in the Medicare Medicaid Plan (MMP) demonstration.
2.1	November 18, 2025	Update to remove the CCBHC Cost Utilization Report requirement.

Purpose of this Document

This Managed Care Organization (MCO) operations manual is intended to support Managed Care contracting with the Certified Community Behavioral Health Clinics (CCBHCs) in Rhode Island. It should be used in concert with:

(1) Rhode Island's CCBHC Certification Standards, which provide a comprehensive description of the programmatic and operational requirements of the CCBHC model;
(2) The Medicaid Managed Care Manual, which provides general managed care program requirements and processes

(3) the CCBHC Billing Manual, which provides program service codes, billing, and payment instructions;
(4) the CCBHC Provider Manual, which provides programmatic guidance for providers; and
(5) The Quality Manual, which provides quality reporting and quality bonus payment (QBP) guidance for MCOs and providers.

Purpose of Certified Community Behavioral Health Clinics (CCBHCs)

The CCBHC model is designed to ensure access to coordinated, comprehensive behavioral health services and supports for all Rhode Islanders. CCBHCs are required to serve all individuals who request care for mental health or substance use, regardless of their ability to pay, place of residence, illness severity, or age; this includes providing developmentally appropriate care for children and youth.

CCBHCs must meet all established standards for the range of services they provide. CCBHCs are required to provide: i) timely care; ii) crisis services that are available 24 hours a day, 7 days a week; and iii) a comprehensive array of behavioral healthcare services to alleviate the need for people to seek care across multiple providers. Additionally, CCBHCs are responsible for providing care coordination to help people navigate behavioral healthcare, physical healthcare, social services, and other systems they may be involved in.

The adoption of the federal CCBHC model in Rhode Island is intended to:

- Expand community-based services for all Rhode Islanders, regardless of their ability to pay;
- Improve integration of behavioral healthcare with medical care for physical concerns;
- Expand the use of Evidence Based Practices (EBPs);
- Improve access to high quality care;
- Improve data collection; and
- Serve anyone in the community with any level of need for behavioral healthcare services, with a specific focus on serving people with Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and significant Substance Use Disorder (SUD).

II. Key Terms and Definitions

- **Adults with serious mental illness -** Anyone 18 years of age or older with (within the past year) a diagnosable mental, behavioral, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major daily life activities.

- **Care Coordination Agreement -** Agreement between providers to collaborate in the development and execution of a treatment and service plan for the patient, required health information exchange, and care transitions. Certified community behavioral health clinics (CCBHCs) are required to have formal care coordination agreements with certain entities,[1] e.g. federally qualified health centers (FQHCs), the Veteran's Administration (VA), 988, Accountable Entities (AEs), and Family Care Coordination Partnerships (FCCPs). When formal agreements cannot be reached, then informal agreements with written procedures are acceptable.

- **Care Transition -** When a client transfers from a treatment program or facility to a CCBHC. This may also include the transition of a client from one CCBHC to another CCBHC.

- **CCBHC -** A Certified Community Behavioral Health Clinic is a specially designated clinic that complies with all certification standards as issued by SAMHSA and the State. A CCBHC provides coordinated, comprehensive behavioral healthcare to anyone seeking help for a mental health and/or substance use condition, regardless of their place of residence, ability to pay, age, or the severity of their condition. CCBHCs provide:
  - Mental health and substance use services appropriate for individuals across the lifespan.
  - Increased access to high-quality community mental health and substance use care, including crisis care.
  - Integrated person- and family-centered services, driven by the needs and preferences of the people receiving services and their caregivers.
  - A range of evidence-based practices, services, and supports to meet the needs of the people within their communities.
  - Services provided in homes and communities, rather than inpatient or non-community-based residential settings.

- **CCBHC Contract/Payment Year -** Refers to the time period in which each Rhode Island CCBHC's MCO contract is active and to which established PPS rates apply. A Contract/Payment Year is typically 12 months in duration.

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[1] RI CCBHC Certification Application, page 20

- **CCBHC Demonstration Year (DY) –** The State has applied to participate in the SAMHSA CCBHC Demonstration Program. It offers RI Medicaid enhanced federal match for CCBHC services. If selected, this is the authority we will operate our CCBHC program under. The Demonstration Program is four years in duration. DY1 refers to the first year of the program, DY2 to the second year, etc. The State started DY1 on October 1, 2024.

- **CCBHC Populations –** There are four designated RI CCBHC populations: High Acuity Adults, High Acuity Children and Youth, Substance Use Disorder (SUD), and Standard. Detailed descriptions of each population are found in the [RI CCBHC Certification Standards](). Each CCBHC will receive a PPS rate per population, as established by the Cost Report process.

- **CCBHC Program/Performance Year (PPY) -** Refers to the 12-month period when CCBHCs are responsible for performing against quality benchmarks for purposes of measuring quality performance and calculating eligibility for the Quality Bonus Payment. The timeframe for program/performance year follows the calendar year.

- **CCBHC Program Attribution -** A Medicaid member is attributed to the CCBHC program by the BHDDH Data Unit via the Gainwell eligibility system portal. The member is attributed to a particular participating CCBHC and a particular population rate category (i.e. High Acuity Adults, High Acuity Children and Youth, SUD, or Standard). Member attribution is the basis for payment, quality measurement, and reporting.

- **Children, adolescents, and adults with substance use disorder (SUD) -** Substance Use Disorder occurs when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. This can be categorized as mild, moderate, or severe, based on a combination of diagnostic criteria.

- **Children and adolescents with serious emotional disturbance (SED) -** For people under the age of 18, the term Serious Emotional Disturbance refers to a diagnosable mental, behavioral, and/or emotional disorder in the past year, which results in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

- **Collaborative Agreement -** A legally binding document establishing the terms and responsibilities of parties engaging in a collaborative business endeavor. In addition, these agreements summarize the scope of the collaboration, the objectives achieved, and each participant's distinctive roles and contributions.

- **Designated Collaborating Organization (DCO) -** A Designated Collaborating Organization is an agency that is contracted with the CCBHC to offer required core CCBHC services to the clients being served. Additional requirements are articulated in the CCBHC certification criteria issued by SAMHSA and the State.

- **Discharge -** When a client leaves an agency's CCBHC services. An individual may be discharged from the CCBHC program when treatment is complete, or due to the client's choice to transfer providers or discontinue services. If a client discontinues services unexpectedly, the CCBHC should make an effort to reengage the client in clinically appropriate care.

- **Dually Eligible Individual -** An individual who is eligible for both Medicaid and Medicare.

- **Encounters -** Documented provision of services to a client.

- **Federally Qualified Health Center (FQHC) –** Health Resources and Services Administration (HRSA) designated federally funded nonprofit health centers or clinics that serve medically underserved areas and populations, which provide primary care services regardless of a person's ability to pay.

- **Gainwell** – RI State's Medicaid Management Information System (MMIS) vendor.

- **Healthcare portal** - Providers must use the Healthcare Portal for access to information, including eligibility verification, remittance advice, prior authorization, claim status. Providers must enroll as a Trading Partner and then register to use the Healthcare Portal. For further information, see here.

- **Integrated Health Home (IHH) and Assertive Community Treatment (ACT) Program (IHH/ACT) -** These programs provide coordinated care that treats the whole person by including primary care, specialist care, and behavioral health together.

- **Members of the Armed Forces and Veterans -** Those who have served or are serving in the United States Armed Forces regardless of active duty or discharge status.

- **Medicaid Management Information Systems (MMIS)** – An integrated group of procedures and computer processing operations (subsystems) developed at the general design level to meet principal objectives. For Title XIX purposes, "systems mechanization" and "mechanized claims processing and information retrieval systems" is identified in section 1903(a)(3) of the Act and defined in regulation at 42 CFR 433.111. The objectives of this system and its enhancements include the Title XIX program control and

administrative costs; service to recipients, providers, and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.

- **National Provider Identifier (NPI) -** This is a unique identification number for covered healthcare providers to use when billing.

- **Non-Qualifying Service -** A service that does not qualify as a CCBHC billable event, but is factored into the CCBHC's operating costs. The expense of non-qualifying services is an allowable cost in the cost report, but when delivered alone the service does not count as a visit for the purpose of monthly billing and will not trigger payment of the PPS rate. The following are examples of non-qualifying services:
    - A collateral encounter (i.e., one that occurs between a CCBHC staff member and a person other than the identified client, with the client's permission, and involves the sharing of information in support of the client's treatment or service plan).
    - A care coordination encounter.
    - An outreach encounter.
    - A primary care screening encounter.

- **Outlier Payment -** 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.

- **PPS2 rate -** A monthly reimbursement rate for the CCBHC program as determined through CMS' Prospective Payment System (PPS) model. A clinic's PPS2 rate is set by dividing its total allowable costs within the rating period by the expected number of qualifying monthly encounters within that year. Monthly qualifying encounters are calculated as the number of months in which a client has at least one qualifying encounter, regardless of the number of daily visits or the quantity of services received within a given month.

- **Qualifying Service -** An allowable service under the CCBHC program that is eligible for the monthly PPS2 rate.

- **Quality Bonus Payment (QBP) -** An incentive payment made to CCBHCs who report and meet required quality performance thresholds for members attributed to their CCBHC.

- **Quality Bonus Program -** A set of financial incentives designed to reward providers for achieving specific quality measure targets.

- **Serious and Persistent Mental Illness (SPMI) -** To be considered as an individual with SPMI, a person is required to have a qualifying diagnosis, demonstrated extended significant impairment in functioning due to their mental illness, and a documented psychiatric treatment history that indicates the need for community supportive treatment or services of a long-term or indefinite duration. Provisional SPMI eligibility determinations may be granted if the person meets the State's identified qualifying circumstances.

- **Standard Population –** Individuals in need of standard outpatient behavioral health treatment who often have a mental illness that does not rise to the level of a serious mental illness (SMI) or have an SMI that is well managed. This level of care is lower in acuity than Intensive Outpatient, Residential, and Inpatient services.

- **The Substance Abuse and Mental Health Services Administration (SAMHSA) -** A federal agency that leads public health efforts to improve behavioral health nationwide. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on American communities. SAMHSA was established by Congress in 1992.

III. Background

Federal CCBHC Program History

The Protecting Access to Medicare Act of 2014 (PAMA, P.L. 113-93), Section 223, directed the Department of Health and Human Services (HHS) to publish criteria for clinics to be certified as Certified Community Behavioral Health Clinics (CCBHCs). In 2015, HHS issued the original CCBHC certification criteria. The criteria established a set of uniform standards that providers must meet to be a CCBHC. By meeting these criteria, CCBHCs across the country are transforming systems by providing comprehensive, coordinated, trauma-informed, and recovery-oriented care for mental health and substance use conditions.

In 2016, the standards were used by eight initial States participating in the Section 223 CCBHC Demonstration Program to certify 67 CCBHCs. Since then, the Section 223 CCBHC Demonstration has expanded to include two additional states. In 2018, HHS established the SAMHSA CCBHC Expansion Grant Program to support the development of additional CCBHCs. States have made significant investments with other funding to support these efforts in tandem. Today, there are over 500 CCBHCs across 46 States, territories, and the District of Columbia.[2]

[2] https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-locator/

In June 2022, the CCBHC Demonstration Program was extended and expanded under Section 11001 of the Bipartisan Safer Communities Act (P.L. 117-159, BSCA) to include up to an additional ten States starting in 2024, and every two years thereafter. A State must have received at least one planning grant since 2015 to be an eligible applicant. Since the passage of this legislation, CMS and SAMHSA have been developing new and updated guidance to govern the CCBHC program. Notable federal guidance includes:

- SAMHSA Quality Guidance
- SAMHSA State Discretion Guidance
- SAMHSA Guidance on Addition of new CCBHCs
- CMS PPS Guidance

The timing of the release of these documents has significantly challenged Rhode Island's implementation plan and schedule.

CCBHCs in Rhode Island

The RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) is designated by SAMHSA as both the State's mental health authority and the State's substance use authority and is charged with the administration and oversight of federal block grants and discretionary funding. BHDDH received a SAMHSA CCBHC Planning Grant in 2015.

In 2018, SAMHSA awarded CCBHC Expansion Grants directly to community providers. Four of the organizations designated by the Director of BHDDH as community mental health centers (CMHC) have received these awards, creating a critical mass of providers familiar with the CCBHC model.

In 2021, a review of the Rhode Island Behavioral Health System was conducted by the Executive Office of Health and Human Services (EOHHS), in conjunction with BHDDH, and the Department of Children, Youth, and Families (DCYF).[3] The project included the identification of substantive gaps in the RI behavioral health system and proposed solutions to address these gaps. This resulted in the development of implementation plans for both CCBHCs and Mobile Crisis services.

Over the subsequent year, the CCBHC Interagency Team (comprised of EOHHS/RI Medicaid, BHDDH, and DCYF) worked with input from a group of community providers and advocates to build a CCBHC proposal. In the State Fiscal Year (SFY) 2023 Budget (passed in June 2022), the Rhode Island General Assembly authorized EOHHS to submit a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) to establish CCBHCs in Rhode Island,

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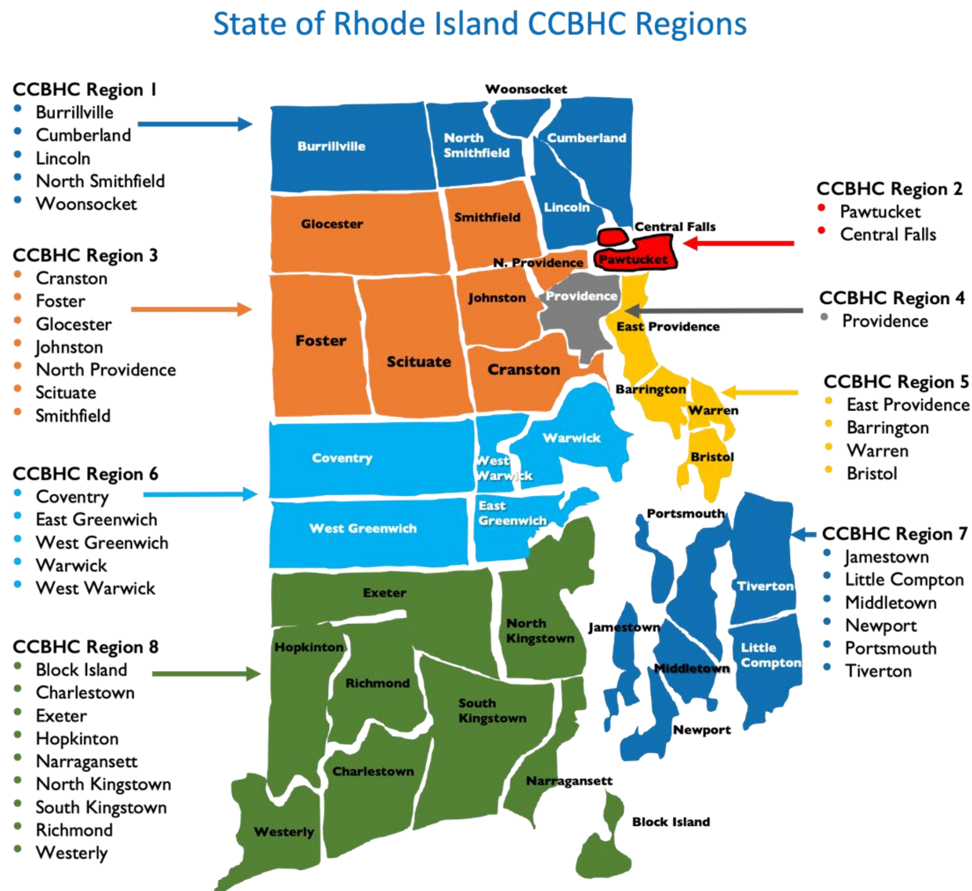
[3] Faulkner Consulting Group and Health Management Associates (July 2021). *Rhode Island Behavioral Health System Review Technical Assistance*. Retrieved from: https://eohhs.ri.gov/initiatives/behavioral-health-system-review

according to the federal model. It also directed BHDDH to define the criteria to certify the clinics and, working in concert with the other CCBHC Interagency Team partners, to determine how many CCBHCs to certify and the costs for each CCBHC.

The State has certified CCBHCs to serve specific designated service areas as defined under Rhode Island General Laws section 40.1-8.5-1 et seq. (see Figure 1 below).[4] As such, a CCBHC is certified for a particular service area, and thereby eligible to receive a PPS2 rate for services provided *in that service area.* CCBHCs may provide community-based services in the service area where attributed clients reside, as appropriate.

[4] State of Rhode Island General Laws (2022). *Title 40.1 - Behavioral Healthcare, Developmental Disabilities and Hospitals, Chapter 40.1-8.5 - Community Mental Health Services, Section 40.1-8.5-1- Policy and Purpose.* Retrieved from https://law.justia.com/codes/rhode-island/2022/title-40-1/chapter-40-1-8-5/section-40-1-8-5-1/:

Figure 1: Rhode Island CCBHC Service Areas



Core CCBHC Functions and Responsibilities

The RI CCBHC Certification Criteria, which establish the basic level of service and quality at which a CCBHC must operate, fall into six key program areas. CCBHCs must meet the following criteria:

1. **Staffing** – Have a staffing plan driven by local needs assessment and secure the appropriate licenses and training to support service delivery.
2. **Availability and Accessibility of Services** – Meet standards for timely and meaningful access to services, outreach and engagement, 24/7 access to crisis services, treatment planning, and accept all patients regardless of ability to pay or place of residence.
3. **Care Coordination** – Establish care coordination agreements across services and providers (e.g., Federally Qualified Health Centers, inpatient and acute care) defining the accountable treatment team, required health information exchange, and care transitions protocols.
4. **Scope of Services** – Offer all nine core required services, as well as person-centered, family-centered, and recovery-oriented care.

5. **Quality and Other Reporting** – Meet all required quality measures, and establish a plan for quality improvement and tracking of program requirements.
6. **Organizational Authority and Governance** – Ensure consumer representation in governance of CCBHC and secure all appropriate State accreditations.

CCBHC Alignment with Rhode Island Executive Office of Health and Human Services' Priorities

The CCBHC model directly supports RI EOHHS' five strategic priorities as depicted in Table 1.[5]

Table 1: Rhode Island's Five Strategic Priorities and Corresponding CCBHC Requirements

	Strategic Priority	Complementary CCBHC Area
1	Focus on the Root Causes and the Socioeconomic and Environmental Determinants of Health That Ensure Individuals Can Achieve Their Full Potential.	CCBHCs serve all people regardless of ability to pay. Practices are informed by needs assessments and training which identify community disparities and guide provision of culturally appropriate and accessible care.
2	Promote Continuums of Care That Can Deliver Efficient, Effective, and Equitable Services Across the Life Course.	CCBHCs are required to effectively serve all people across the lifespan.
3	Address Addiction, Improve the Behavioral Health System, and Combat Stigma, Bias, and Discrimination.	CCBHCs are designed to serve anyone in the community in need of services, with a focus on serving people with Serious Mental Illness (SMI), Serious Emotional Disturbance (SED), and significant Substance Use Disorder (SUD).
4	Develop and Support a Robust and Diverse Health and Human Services Workforce to Meet the Need of Every Rhode Islander.	CCBHCs maintain teams that are well-trained in meeting the complex needs of those seeking behavioral health (BH) treatment.
5	Modernize, Integrate, and Transform Health Information Technology, Data Systems, and Overall Operations to Support Value-Based Systems of Care.	The CCBHC model promotes consistent, efficient data sharing between providers to support care coordination for all clients.

[5] Rhode Island Strategic Goals and Priorities

IV. General Program Information

Program Overview

MCOs will contract with all certified CCBHCs and reimburse for those services in accordance with state-defined PPS2 rates.

Program Scope

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

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

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

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

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

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

Core Services

Services must be provided in a manner that is appropriate for individuals across the lifespan. Additionally, the CCBHC must be able to provide services for people with illnesses of every severity including:

1. People with serious mental illness (SMI),
2. People with substance use disorder (SUD), including opioid use disorder (OUD),

3. Children and youth with serious emotional disturbances (SED),
4. Individuals with co-occurring disorders (COD),
5. People experiencing a mental health or substance use-related crisis,
6. Members of the armed forces and veterans, and
7. Standard outpatient populations.

CCBHCs must also be able to demonstrate the capacity to promote equity by identifying and addressing barriers to effective behavioral healthcare services that may be associated with access issues and health disparities identified by the State among the following State-defined *priority consumer populations*. This includes:

1. Black, Indigenous, and People of Color (BIPOC),
2. People with co-occurring Behavioral Health needs and Intellectual/Development disabilities (I/DD),
3. Older adults,
4. Transition-age youth,
5. People who identify as LGBTQ+,
6. People who are justice-involved,
7. People without stable housing, and
8. People from under-resourced communities.

1	Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
2	Screening, assessment, and diagnosis, including risk assessment
3	Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
4	Outpatient mental health and substance use services.
5	Outpatient clinic primary care screening and monitoring of key health indicators and health risk, including screening for HIV and Viral Hepatitis
6	Targeted case management.
7	Psychiatric rehabilitation services.
8	Peer support and counselor services and family supports.
9	Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

A CCBHC may choose to partner with a Designated Collaborating Organization (DCO) to deliver core services; however, the CCBHC is ultimately responsible and must ensure that all attributed members receive all core services in a timely manner per the CCBHC certification criteria.

Therefore, the CCBHC must provide the necessary services directly to the client on an ongoing

basis, or until that service can be initiated by the DCO. While waiting for DCO service initiation, the client must be engaged in clinically appropriate, stabilizing care with the CCBHC. After DCO service initiation, the CCBHC must continue to monitor the client's treatment plan and outcomes.

DCOs are allowed to provide any of the core services. However, each CCBHC must directly provide services for ***at least 51% of all encounters*** per contract year, excluding crisis services. This is in aggregate across all encounters, and not client, age, or population specific.

Timelines

Figure 2: Timelines for Program/Performance Years (PPY), Contract/Payment Years (CY), and Demonstration Years (DY)

Oct '24	Nov '24	Dec '24	Jan '25	Feb '25	Mar '25	Apr '25	May '25	Jun '25	Jul '25	Aug '25	Sep '25	Oct '25	Nov '25	Dec '25	Jan '26	Feb '26	Mar '26	Apr '26	May '26	Jun '26	Jul '26	Aug '26	Sep '26
Program/Performance Year 0			Program/Performance Year 1												Program/Performance Year 2								
Payment/Contract Year 1												Payment/Contract Year 2											
Demonstration Year 1												Demonstration Year 2											

Note – please refer to the Key Terms section of this manual for definitions of program/performance year, payment/contract year, and demonstration year.

There are three distinct timelines for this program:

1. **Contract/Payment Timelines:** MCO and CCBHC contracts must be executed in advance of the CCBHC program start date. The initial round of MCO contracts with eligible CCBHCs must be effective from the program start date of October 1, 2024 until September 30, 2025 (Contract Year 1). New contracts for Year 2 must be issued and effective by October 1, 2025, and end September 30, 2026.

2. **Program/Performance Timelines:** Performance measurement and Quality Bonus Program implementation must be aligned with the calendar year. CCBHC Program/Performance Year 0 began on October 1, 2024 and ended on December 31, 2024. CCBHC quality measurement and the Quality Bonus Program (QBP) began with Program/Performance Year 1 (i.e., January 1 – December 31, 2025). Program/Performance Year 2 will be from January 1 – December 31, 2026.

3. **CCBHC Demonstration Timelines:** Rhode Island is operating the CCBHC Program under Demonstration authority. Year 1 of the Demonstration Program is from October 1, 2024 through September 30, 2025. Year 2 of the Demonstration Program is from October 1, 2025 – September 30, 2026.

V. Contracting

Contractual Guidelines

MCOs must contract with all State certified CCBHCs to provide a State-specified array of expanded services and reimburse for those services rendered by eligible Medicaid beneficiaries in accordance with the State defined Prospective Payment System (PPS) model for an attributed population. For Contract Year 1, these contracts must be effective October 1, 2024. For Contract Year 2, these contracts must be effective October 1, 2025.

A list of certified CCBHCs is posted to the EOHHS website.

Each CCBHC will be required to have contracts, at minimum, with the following entities:

- Managed Care Organizations (MCOs), and
- Designated Collaborating Organizations (DCOs) (*if applicable*).

Contract Requirements

MCO-CCBHC Contracts must include the specific sections outlined in **the CCBHC-MCO Base Contract Checklist** posted here.

- MCOs must provide EOHHS a copy of all fully executed MCO-CCBHC contracts. The contracts must include signatures from both parties, the date of execution, and the effective dates of the contract. MCOs are not permitted to pay CCBHCs via PPS without a fully executed contract. Contracts should be submitted to EOHHS no later than 30 days prior to the effective date.
- The MCO-CCBHC contracts must specify each CCBHC's partner DCO(s) and the service agreements executed with those DCOs, in accordance with the requirements specified in **Section V. Participating Designated Collaborating Organizations (DCOs)** of this document. Participating DCOs must be screened and enrolled Medicaid providers with the contracting MCO.

The CCBHC Interagency team will continue to work with new providers to ensure their full readiness by program go-live. CCBHCs who have secured certification through the State and a State approved cost report will be eligible to start the MCO contracting process. Detailed timelines will be provided to providers and shared with the MCOs.

Ongoing CCBHC Certification Verification and Contracting

MCO-CCBHC Contracts will be renewed on an annual basis in accordance with the CCBHC contract/payment year. After the initial phase of contracting, MCOs can verify an agency's current certification status by requesting a copy of an updated certification letter from the provider. CCBHCs will be recertified by the State every two years; with compliance monitored

on an ongoing basis. Lack of compliance with the RI CCBHC Certification Standards can result in decertification. MCOs should verify each CCBHC's certification status at the time of contracting, as well as on an annual basis to ensure that the agency has maintained its CCBHC certification.

By Designated Collaborating Organizations (DCOs)

The CCBHC criteria require CCBHCs to provide a range of services, either directly or by establishing a formal relationship with other providers. These other providers are known as designated collaborating organizations (DCOs). DCOs must secure the appropriate license(s) and certification(s) to provide the associated Medicaid reimbursable services.

In support of these DCO arrangements, CCBHCs must provide confirmation to the MCO that there is a legally binding contractual agreement, that has been reviewed by the State and meets the requirements listed in Addendum 3 of the CCBHC State of RI Certification Guide, between each CCBHC and each of its DCOs. This agreement should outline the services for which the DCO will have responsibility on behalf of the CCBHC. In addition, this agreement must outline the DCO's requirements to:

- Comply with payment rules.
- Comply with shadow claim submission requirements.
- Adhere to payment arrangements between the CCBHC and DCO for services rendered by the DCO on behalf of the CCBHC.
- Collect and maintain all documentation necessary for CCBHC data collection and reporting as required by the MCO, RI Medicaid, BHDDH, and CMS/SAMHSA, and consistent with the CCBHC Quality Manual.

If a CCBHC and DCO relationship is materially altered throughout the course of a CCBHC program year (i.e., an arrangement is terminated or service responsibilities changes) the State must be notified within 10 days as this has oversight and compliance implications. The CCBHC shall also inform their MCO partners of the termination of any DCO arrangements within 10 days. The State is developing safeguards to mitigate against the risk of double-billing if a CCBHC and DCO relationship is terminated mid-year. New DCO relationships can only go into effect with the start of each program year.

While there are no explicit State or Federal requirements concerning credentialing specific to a DCO designation, the MCO, CCBHC, and DCO should refer to their relevant contractual agreement and the CCBHC certification standards to determine if credentialing is required for the CCBHC related service being provided by a DCO. This may include active licensure for clinical services or certification as a specific provider type with Medicaid.

VI. Further MCO Requirements

Attribution

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

The CCBHC program attribution process will be managed by BHDDH's Data Unit via the Gainwell eligibility system portal. The eligibility portal will be the repository for collecting and monitoring CCBHC attribution and will serve as the single source of truth for purposes of determining program attribution.

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

Honoring client choice in care is a Medicaid requirement and a State priority. Members may choose to change CCBHC 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. Processed updates to a member's attribution will be reflected in the MCO Weekly Extract file provided to the MCOs by Gainwell. The file will include the details for members with an active enrollment in a relevant program that has an end date after the start of the 24-month lookback will be included on the report.

PPS-2 rates must be paid for an attributed population, consistent with the attribution methodology requirements specified in the CCBHC Billing Manual.

Individuals cannot be enrolled in the IHH/ACT and CCBHC programs simultaneously. Individuals may be enrolled in both the OTP Health Home and CCBHC programs, or Centers of Excellence and the CCBHC program in Contract/Payment Year 1.

Program Integrity

All MCOs are required to implement program integrity processes to ensure the CCBHC program is implemented in accordance with the requirements of this manual, including but not limited to the following:

- Utilize the MCO Weekly Extract file provided by the state to retroactively audit CCBHC payments. MCOs must conduct audits on a monthly basis on 10% of remitted payments. If greater than 3% of payments went to a provider to whom the member is not

attributed, MCOs must notify the State and work with them to determine a mitigation strategy.

- Provide the State with a detailed process for how they will review and respond to complaints from providers who did not receive payment for attributed members 90 days ahead of the go-live date. The State will review and approve or request further clarification of the proposed MCO process. Any changes to the approved plan must be submitted to the State and approved in writing. For further details, see the **Program Attribution File and Reconciliation** section of the Billing Manual.
- Monitor attributed members to ensure appropriate payment is being made to CCBHCs only for a month in which a member received at least one qualifying service, or "billable event" in that month from the CCBHC they are attributed to, or from one of the CCBHCs DCOs.
- Perform regular financial audits of the CCBHC's billing on a schedule and in a manner of MCOs choosing. Participating CCBHCs must make all records, audits, claims, documentation, and other materials available to contracted MCOs upon request to support these audits.
- For dual eligible individuals enrolled in the Medicare-Medicaid Plan (MMP), the MMP participating health plan must review the MCO Weekly Extract file and identify any MCO enrolled dual eligible individuals attributed to CCBHCs (and therefore eligible to be paid a PPS2 rate directly by the state). MMP participating health plans are responsible for monitoring for any duplication of services for individuals who are both dual eligible (MMP) and attributed to a CCBHC to ensure that they do not pay for those services. This includes:
  - For participating CCBHCs serving dual eligible members who are also CMHOs participating in the IHH and/or ACT programs, CCBHC attributed members may not also be attributed to any IHH/ACT program, and the MMP participating health plan may not reimburse for any IHH or ACT programs for these CCBHC attributed members.
  - For MMP enrolled members who are in a CCBHC where there are CCBHC services provided out of plan, the MCO cannot pay for IHH/ACT services for any CCBHC member.
  - For participating CCBHCs serving dual eligible members who are also CMHOs, CCBHC eligible services provided to CCBHC attributed members should not also be reimbursed to the associated CMHO.
- The MMP demonstration program will be ending on December 31, 2025. The State is preparing to transition from the current MMP demonstration to a new Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) effective January 1, 2026. All provisions and MCO requirements in this MCO Operations Manual that apply to dual eligible individuals enrolled in the MMP will apply to dual eligible individuals enrolled in the new FIDE-SNP. The State may provide additional guidance for MCOs regarding FIDE-SNP members who

are receiving CCBHC services when the FIDE-SNP has been implemented.

Billing

CCBHCs are paid using a Prospective Payment System, or PPS. The PPS supports providers with increased costs as they expand services and increase the number of clients served and improve their flexibility to deliver client-centered care.

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

MCOs are required to:

- Follow relevant billing and reimbursement requirements consistent with State-defined PPS rates for an attributed population, in accordance with rules specified in the CCBHC Billing Manual.
- Follow financial reconciliation and settlement provisions in line with the CCBHC Billing Manual.
- Provide utilization management of Medicaid-covered services in line with the CCBHC Billing Manual.

MCOs shall not conduct prior authorization for CCBHC or crisis services. CCBHC qualifying services provided by non-CCBHCs for an attributed member shall be billed and paid at the provider's standard billing rate.

Reporting

MCOs are required to follow all reporting requirements established by EOHHS, including but not limited, to the below list:

- Provide encounter data consistent with requirements in the Medicaid Managed Care Manual to verify financial liability incurred for services rendered by CCBHCs.

Quality

MCOs are required to follow all MCO quality measurement and reporting requirements outlined as their responsibility in the CCBHC Quality Manual. States who elect a PPS-2 model must implement quality bonus payments (QBP) in accordance with SAMHSA defined parameters, based on State-defined metrics.[6] The QBP will be calculated by EOHHS and paid directly by the State to eligible CCBHCs. For additional details about QBP payments, please see the CCBHC Quality Manual.

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

Outlier Costs

The PPS2 rate reimbursement methodology includes an outlier payment mechanism to reimburse clinics for costs above the State-defined threshold. For Demonstration Year 1, outlier thresholds and payments will be implemented and paid directly by EOHHS to eligible providers. For additional details about outlier payments, please see the CCBHC Billing Manual.

System Readiness

System readiness, the assurance that we collectively have the appropriate IT systems and processes in place to meet all CCBHC billing and reporting requirements, is a key success factor for this program. The system readiness process is intended to ensure that each CCBHC, the MCOs, and the State have completed the necessary builds, configurations, and testing before going-live. MCOs must participate in the EOHHS system readiness process for all new contracts and agreements with CCBHCs as follows:

- MCOs are required to test system readiness with each CCBHC provider and their respective billing vendor(s). MCOs are required to provide a proposed testing plan and schedule at least 4 months before go-live. As this is an MCO oversight activity, documentation should be submitted to the MCO Oversight team (OHHS.MCOOversight@ohhs.ri.gov). The plan must:
    - Include all user testing scenarios defined by the State, as well as any additional scenarios that the MCO plans to test;
    - Include a plan to provide training to providers, as needed; and
    - Result in the following clear provider system-related documentation shared with the State, no later than 30 days before go-live: (1) provider-specific feedback and assessment of readiness for go-live, and (2) identification of any unresolved provider system defects and mitigation strategies.
    - Result in the following clear MCO system-related documentation shared with the state, no later than 30 days before go-live: (1) an MCO attestation that MCO systems are functioning as required and ready for receiving and paying claims and that the systems enable MCOs to meet all requirements specified in the CCBHC Billing and MCO Ops Manuals, (2) clear documentation that their systems have been tested in accordance with the state's required user testing scenarios and (3) identification of any unresolved MCO system defects and mitigation strategies.
- The system readiness process is required for new agreements between MCOs and CCBHCs that will be participating in the program for the first time. System readiness is not intended to be an annual process.