Rhode Island Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria

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INTRODUCTION

Overview of Certified Community Behavioral Health Clinics (CCBHC)

The Protecting Access to Medicare Act (PAMA) § 223 laid the groundwork for the establishment of Certified Community Behavioral Health Clinics (CCBHCs). In accordance with that legislation, in 2015 the Substance Abuse and Mental Health Services Administration (SAMHSA) published Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (the Criteria) as part of the Request for Applications (RFA) for Planning Grants. Those CCBHC criteria were further amended in March of 2023. The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is designated by SAMHSA as both the State's adult mental health authority and the State's child and adult substance use disorder authority and is charged with administration and oversight of federal block grant and discretionary funding.

BHDDH received a planning grant in 2015 but was not awarded the two-year demonstration grant at the conclusion of the planning period. However, there was a continued appetite to lay the groundwork for implementation of CCBHCs as circumstances allowed. In March of 2023, Rhode Island was one of fifteen states awarded a CCBHC one year planning grant to prepare for reapplication to become a Demonstration State in 2024.

From 2018 until the present, SAMHSA has also awarded direct CCBHC expansion grants to seven community providers in Rhode Island, five of whom were Community Mental Health Centers. This helped create a critical mass of providers familiar with the CCBHC model in the State.

In 2021, the Executive Office of Health and Human Services (EOHHS) worked with BHDDH, and the Department of Children, Youth and Families (DCYF) to produce the Rhode Island Behavioral Health System Review, in partnership with Faulkner Consulting Group and Health Management Associates. As a part of that process, EOHHS requested that the consultants propose strategies to meet the identified gaps in Rhode Island's behavioral health system. Implementation plans were developed for both CCBHCs and a statewide Mobile Crisis system.

Over the next year, the State developed a CCBHC proposal with input from a group of community providers and advocates. In the State Fiscal Year 2023 Budget (passed in June 2022), the Rhode Island General Assembly authorized EOHHS, as the single state Medicaid authority, to submit a State Plan Amendment to the Centers for Medicare and Medicaid Services (CMS) to establish CCBHCs in Rhode Island, in accordance with the federal model. The General Assembly further directed BHDDH, in concert with EOHHS, to define the criteria to certify the clinics.

In 2023, Rhode Island applied to become one of ten new states to enter into the federal CCBHC Demonstration Program via a competitive process. In 2024, Rhode Island was awarded entrance into the Demonstration and went live with eight CCBHCs on October 1, 2024.

An interagency State team, hereby referred to as the 'CCBHC Interagency Team' has, and continues to work together to design, implement, and enhance Rhode Island's CCBHC program under the federal Demonstration. The CCBHC Interagency Team is comprised of staff from BHDDH as the State's adult and child substance use disorder treatment authority and adult mental health authority, DCYF as the State's child mental health authority, and EOHHS as the state's Medicaid authority and convenor of interagency State initiatives. The CCBHC Interagency Team maintains shared advisory and decision-making powers. Responsibilities include, but are not limited to, developing and updating the RI CCBHC program certification requirements, compliance and quality oversight, and program evaluation.

Together, we are pleased to share this Rhode Island State CCBHC Certification Guide.

Purpose of CCBHC State Certification Guide

This CCBHC Certification Guide is a tool used by the State's CCBHC Interagency Team, under the authority of EOHHS, to certify and/or recertify providers to deliver services as a CCBHC in the designated service areas depicted on the map on page 10. These certification standards may be updated to incorporate additional federal requirements, program refinements based on learnings to date, and/or additional application requirements for applicants proposing a new CCBHC in a service area where one or more CCBHCs are operational.

This tool is an adaptation of a template provided by SAMHSA and provides an overview of key criteria and program requirements established under PAMA § 223 to assess the qualifications of prospective CCBHCs. CCBHCs are required to meet standards in six different program areas:

1. Staffing
2. Availability and accessibility of services
3. Care coordination
4. Scope of services
5. Quality and other reporting
6. Organizational authority, governance, and accreditation

These standards shall be achieved across the nine federally required CCBHC services (listed below), as well as any additional Rhode Island required services:

1. Crisis Response
2. Screening, Evaluation, and Diagnosis
3. Person-Centered and Family-Centered Treatment Planning
4. Outpatient Mental Health and Substance Use Disorder Services
5. Primary Care Screening and Monitoring
6. Peer and Family Support
7. Psychiatric Rehabilitation
8. Targeted Case Management
9. Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans

CCBHCs are required to provide these services in a manner that is appropriate for the populations 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. CCBHCs are required to specifically address the behavioral health and related needs of the following targeted populations: Adults with severe mental illnesses, children and youth with severe emotional disorders, and individuals with substance use disorders.

CCBHCs should also be able to demonstrate 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 populations or groups: Black, Indigenous, People of Color (BIPOC); people with co-occurring Behavioral Health/Intellectual or Developmental Disabilities; older adults; transition-age youth; and people who are LGBTQ+, justice involved, unhoused, or from other under-resourced communities. The State refers to the people in these groups as our "priority consumer populations."

> The CCBHC may deliver the nine (9) federally required services and any additional Rhode Island required services, directly or through formal arrangements with Designated Collaborating Organizations (DCOs) but must directly provide services for at least 51% of all CCBHC encounters (excluding crisis services). CCBHCs shall execute a contract with all DCO partners that include provisions to ensure the required CCBHC services that DCOs provide under the CCBHC umbrella are delivered in a manner that meets the standards set forth in the RI CCBHC certification criteria. To this end, DCOs are more than care coordination or referral partners, and there is an expectation that relationships with DCOs will include more regular, intensive collaboration across organizations than would take place with care coordination partners. DCO arrangements may also include a payment element. For non-MRSS DCOs, these expenses are integrated into a CCBHC's prospective payment system (PPS) rate. For MRSS DCOs, MRSS services will be reimbursed directly by Medicaid and/or other insurers, rather than through the CCBHC PPS.

This guide describes requirements associated with each criterion, or standard, identified by SAMHSA, along with any Rhode Island enhancements or additional requirements to each criterion, or standard. The first column of the requirements table below includes the SAMHSA standard, verbatim, as it was published in the SAMHSA Certified Community Behavioral Health Clinic Certification Criteria updated in March 2023. Please note that any items denoted by a star in the first column apply only to demonstration states. Rhode Island is currently a demonstration state; thus, these items are considered a federal SAMHSA standard. The second column provides Rhode Island specific CCBHC requirements that are an enhancement to the federal criteria.

There are addenda that provide important information, e.g., criteria for the different CCBHC populations, requirements for MRSS non-financial DCOs, required services for high acuity adult and

child populations, CCBHC staffing qualifications and credential requirements, required evidence-based practices, etc. The addenda are considered a core component of the certification standards. All providers seeking certification or recertification shall demonstrate compliance with the standards contained in the body of this guide and with the additional requirements provided in the addenda.

Eligibility to Apply to be Certified as a CCBHC

All providers must submit an application for initial certification and recertification. The application is designed to minimize the burden on the applicant by providing a set of response categories for each standard that reflect the range of ways the standard may be met.

To be eligible to apply for certification as a CCBHC, the applicant must meet the following requirements:

1. Be licensed in Rhode Island (RI) as a behavioral healthcare organization (BHO) and, within the scope of its license, provide CCBHC required services; or have a pending application for BHO licensure; or have submitted a request to add service(s) at the time of request for certification as a CCBHC.
2. Be accredited by a nationally recognized accreditation body (i.e., The Joint Commission, The Commission on Accreditation of Rehabilitation Facilities, or The Council on Accreditation), or have a pending application, with standards specific to the delivery of behavioral healthcare services and substance use disorder services.
3. Have at minimum three years of demonstrated experience providing evidence-based practices for people experiencing serious and persistent mental illness (SPMI), serious mental illness (SMI), and/or serious emotional disturbance (SED) or individuals with complex or severe substance use disorders (SUD), or a track record of providing person-centered, recovery oriented, and trauma informed care.
4. Demonstrated experience with the Rhode Island targeted and priority consumer populations listed above, and ability to provide a majority of the required services and perform all required functions listed in the SAMHSA CCBHC certification criteria.

CCBHC Service Areas

CCBHCs shall be certified to serve one or more of the State's designated CCBHC service areas.

1. CCBHCs will be certified by service area.
2. Applicants shall meet all federal and state CCBHC standards in each service area for which they are applying.
3. In service areas where one or more CCBHCs are already operational, new applicants shall demonstrate that there is currently an unmet need for CCBHC services and describe how

they will meet that need.

CCBHC Service Provision

A provider must ensure the following as part of their certification and/or recertification as a CCBHC:

1. A CCBHC is responsible for ensuring access to all CCBHC required services, either directly or through a DCO agreement. CCBHCs shall ensure that comprehensive, coordinated, and age-appropriate mental health and substance use disorder treatment services and supports are accessible and available across the life span.
2. A CCBHC shall directly deliver the majority (i.e., 51% or more) of encounters across the required services, excluding crisis service encounters.
3. CCBHCs shall accept and serve involuntary clients who are subject to Civil Court Certification orders. This shall include having sufficiently qualified and available physicians and clinical staff to, as necessary, attend and testify in hearings before the Mental Health Court pursuant to Rhode Island General Laws section 40.1-5-1 et seq.
4. CCBHCs shall accept outpatient treatment individuals being discharged from inpatient psychiatric facilities with or without a civil court commitment order; individuals with co-occurring intellectual and/or developmental disabilities; all medically managed (ASAM 4.0) and medically monitored (ASAM 3.7) detoxification service discharges; individuals who are being discharged from adult and child residential programs; individuals being released from the juvenile and adult justice systems; and individuals being discharged from a state hospital.
5. Individuals seeking services are free to select a CCBHC of their choice and are not restricted to a CCBHC designated for the service area where they reside.

The goal of the CCBHC Interagency Team is to ensure that CCBHCs meet the needs of all of Rhode Islanders across the life course as indicated by community needs assessments and ongoing data evaluations.

CCBHCs must maintain all currently applicable licensure required for the operation of the CCBHC and their enrollment as a Medicaid provider. The CCBHC shall attest that it will obtain Children's Behavioral Health Organization (CBHO) licensure when available and once the State establishes the formal licensing process and timeline.

RI CCBHC Certification Process

BHDDH licensed Behavioral Health Organizations (BHOs) who wish to be certified as a CCBHC must complete an application for CCBHC certification. During the application process they must demonstrate compliance with all six program areas detailed in the PAMA 2014 (PL 113-93), the federal SAMHSA CCBHC Certification Criteria, and the RI CCBHC Certification requirements. Compliance with each standard will be reviewed after submission of the CCBHC application and

the CCBHC Criteria Compliance Checklist.

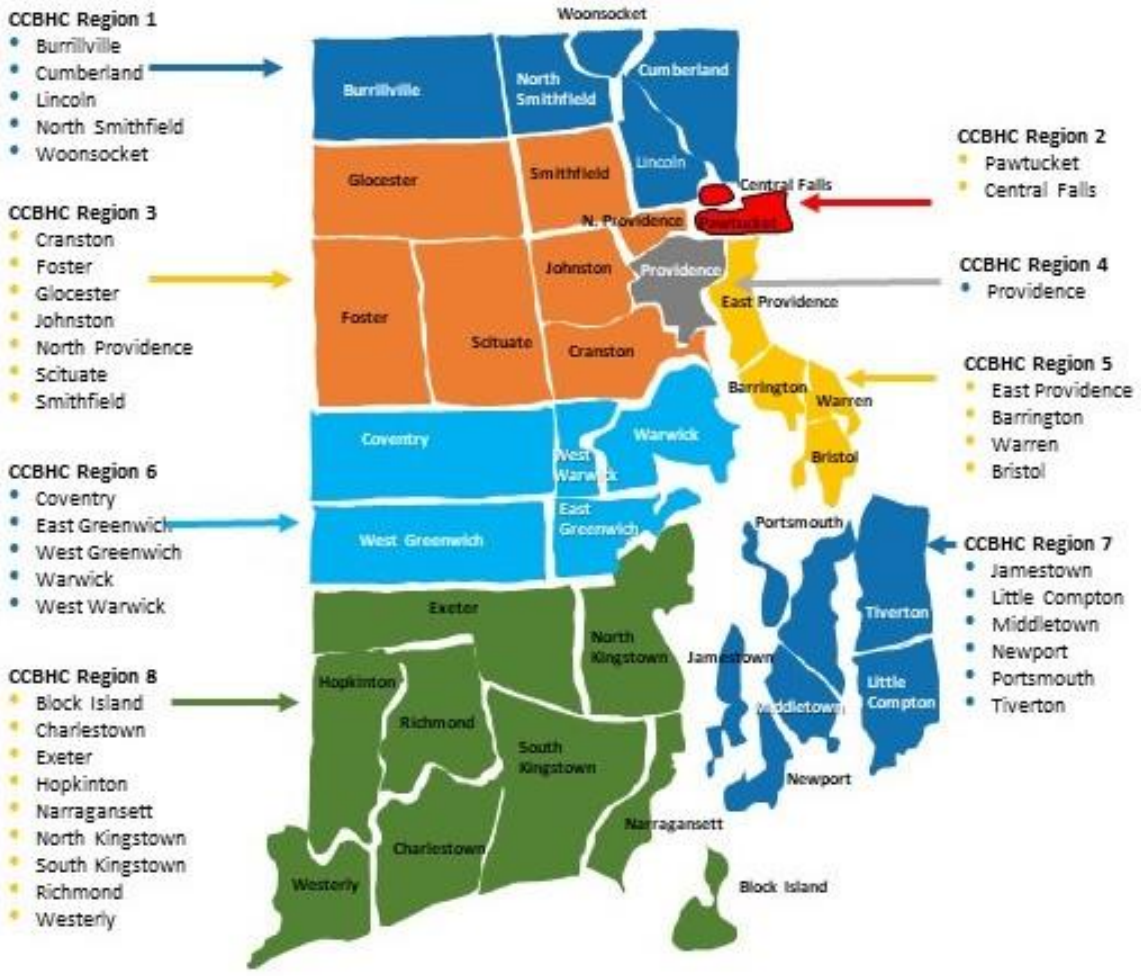
CCBHC certification applications will only be accepted during announced application periods. Upon receipt of the application and CCBHC Criteria Compliance Checklist, the CCBHC Interagency Team will conduct a preliminary review of the application and checklist and may request additional information and documents to verify compliance with criteria requirements. The Interagency Team will then conduct a full review of all submitted materials and perform an onsite assessment.

Upon review of the completed application, checklist, and completion of the site assessment, the Interagency Team will make a final determination and inform the applicant of whether they are certified as a CCBHC, or if their application for certification has been denied.

"**Certified**" means the applicant has met all of the federal and state standards to qualify as a CCBHC and has been approved to participate in the CCBHC program for a two-year period (contingent upon continued demonstrated compliance with all CCBHC certification requirements).

"**Not Certified**" means the applicant has not met all of the federal and state standards to qualify as a CCBHC.

STATE OF RHODE ISLAND CCBHC SERVICE AREA REGIONS



SECTION 1: STAFFING	
A. General Staffing Requirements	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
1.a.1 As part of the process leading to certification and recertification, and before certification or attestation, a community needs assessment (see Appendix A: Terms and Definitions for required components of the community needs assessment) and a staffing plan that is responsive to the community needs assessment are completed and documented. The needs assessment and staffing plan will be updated regularly, but no less frequently than every three years. ★ Certifying States may specify additional community needs assessment requirements.	**1.a.1** CCBHCs shall participate in the needs assessment process for the Combined Block Grant Report.
1.a.2 The staff (both clinical and non-clinical) is appropriate for the population receiving services, as determined by the community needs assessment, in terms of size and composition and providing the types of services the CCBHC is required to and proposes to offer. **Note**: *See criteria 4.k relating to required staffing of services for veterans.*	

1.a.3	1.a.3
The Chief Executive Officer (CEO) of the CCBHC, or equivalent, maintains a fully staffed management team as appropriate for the size and needs of the clinic, as determined by the current community needs assessment and staffing plan. The management team will include, at a minimum, a CEO or equivalent/Project Director and a psychiatrist as Medical Director. The Medical Director need not be a full-time employee of the CCBHC. Depending on the size of the CCBHC, both positions (CEO or equivalent and the Medical Director) may be held by the same person. The Medical Director will provide guidance regarding behavioral health clinical service delivery, ensure the quality of the medical component of care, and provide guidance to foster the integration[1] and coordination of behavioral health and primary care. **Note**: *If a CCBHC is unable, after reasonable efforts, to employ or contract with a psychiatrist as Medical Director, a medically trained behavioral health care professional with prescriptive authority and appropriate education, licensure, and experience in psychopharmacology, and who can prescribe and manage medications independently, pursuant to state law, may serve as the Medical Director. In addition, if a CCBHC is unable to hire a psychiatrist and hires another prescriber instead, psychiatric consultation will be obtained regarding behavioral health clinical service delivery, quality of the medical component of care, and integration and coordination of behavioral health and primary care.*	The CCBHC Medical Director or Chief Medical Officer, regardless of place of residence, shall maintain a physical presence on-site at the CCBHC location(s) to ensure the quality of the medical/behavioral component of care.

[1] While CCBHCs are not required to provide primary care services, they are required to provide Primary Care Screening and Monitoring (See 4.g). CCBHCs may not pay for primary care services under the Section 223 CCBHC Demonstration PPS beyond those defined under 4.g. CCBHCs should coordinate with primary care providers to support integrated provision of primary and behavioral health care.

1.a.4 The CCBHC maintains liability/malpractice insurance adequate for the staffing and scope of services provided.	

SECTION 1: STAFFING

B. Licensure and Credentialing of Providers

Federal Criteria Requirements	Rhode Island Additional Requirements
1.b.1 All CCBHC providers who furnish services directly, and any Designated Collaborating Organization (DCO) providers that furnish services under arrangement with the CCBHC, are legally authorized in accordance with federal, state, and local laws, and act only within the scope of their respective state licenses, certifications, or registrations and in accordance with all applicable laws and regulations. This includes any applicable state Medicaid billing regulations or policies. Pursuant to the requirements of the statute (PAMA § 223 (a)(2)(A)), CCBHC providers must have and maintain all necessary state-required licenses, certifications, or other credentialing. When CCBHC providers are working toward licensure, appropriate supervision must be provided in accordance with applicable state laws.	**1.b.1** All CCBHCs shall be: • Licensed as a Behavioral Health Organization (BHO) by BHDDH for the services they are required to deliver; • Accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (COA), and/or The Joint Commission (TJC) for the services they deliver; • Designated as a "Recovery Friendly Workplace" by BHDDH; • Licensed as a CCBHC provider by BHDDH once the license is available; and • Licensed as a Child Behavioral Health Organization (CBHO) by DCYF for the services they are required to deliver once the license is available. • Licensed as an Emergency Services (ES) provider by DCYF, authorizing the delivery of immediate crisis intervention. All CCBHCs shall remain in compliance with these requirements for ongoing CCBHC Certification and Re-Certification. All Designated Collaborating Organizations (DCO) shall be licensed, certified, and/or credentialed to provide a Medicaid reimbursable service.

	All DCO staff shall be appropriately licensed, certified, registered, and/or credentialed as required for the specific service they provide. Compliance with RI regulations related to licensure will be required of organizations providing behavioral healthcare services for adults, children, and families.
1.b.2 The CCBHC staffing plan meets the requirements of the state behavioral health authority and any accreditation standards required by the state. The staffing plan is informed by the community needs assessment and includes clinical, peer, and other staff. In accordance with the staffing plan, the CCBHC maintains a core workforce comprised of employed and contracted staff. Staffing shall be appropriate to address the needs of people receiving services at the CCBHC, as reflected in their treatment plans, and as required to meet program requirements of these criteria. CCBHC staff must include a medically trained behavioral health care provider, either employed or available through formal arrangement, who can prescribe and manage medications independently under state law, including buprenorphine and other FDA- approved medications used to treat opioid, alcohol, and tobacco use disorders. This would not include methadone, unless the CCBHC is also an Opioid Treatment Program (OTP). If the CCBHC does not have the ability to prescribe methadone for the treatment of opioid use disorder directly, it shall refer to an OTP (if any exist in the CCBHC service area) and provide care coordination to ensure access to methadone. The CCBHC must have staff, either employed or under contract, who are licensed or certified substance use treatment counselors or specialists. If the Medical Director is not experienced with the treatment of substance use disorders, the CCBHC must have experienced[2] addiction medicine physicians or specialists on staff, or arrangements that ensure access to consultation on addiction medicine for the Medical Director and clinical staff. The CCBHC must include staff with expertise in addressing trauma and promoting the	**1.b.2** Each CCBHC shall have an identified substance use disorder (SUD) subject matter expert who is the designated point of contact related to SUD services at the CCBHC and who oversees substance use disorder treatment services at the CCBHC. This individual will provide critical input to the community, State, and other stakeholders regarding the CCBHC's fixed point of responsibility for SUD services within the CCBHC service area.

[2] CCBHCs should seek practitioners with experience in the assessment and diagnosis of SUD, substance intoxication and withdrawal; pharmacological management of intoxication, withdrawal, and SUDs; ambulatory withdrawal management; outpatient addiction treatment; toxicology testing; and pharmacodynamics of commonly used substances.

recovery of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI). Examples of staff include a combination of the following: (1) psychiatrists (including general adult psychiatrists and subspecialists), (2) nurses, (3) licensed independent clinical social workers, (4) licensed mental health counselors, (5) licensed psychologists, (6) licensed marriage and family therapists, (7) licensed occupational therapists, (8) staff trained to provide case management, (9) certified/trained peer specialist(s)/recovery coaches, (10) licensed addiction counselors, (11) certified/trained family peer specialists, (12) medical assistants, and (13) community health workers. The CCBHC supplements its core staff as necessary in order to adhere to program requirements 3 and 4 and individual treatment plans, through arrangements with, and referrals to other providers. **Note**: *Recognizing professional shortages exist for many behavioral health providers[3]: (1) some services may be provided by contract or part-time staff as needed; (2) in CCBHC organizations comprised of multiple locations, providers may be shared across locations; and (3) the CCBHC may utilize telehealth/telemedicine, video conferencing, patient monitoring, asynchronous interventions, and other technologies, to the extent possible, to alleviate shortages, provided that these services are coordinated with other services delivered by the CCBHC. The CCBHC is not precluded by anything in this criterion from utilizing providers working towards licensure if they are working under the requisite supervision.* ★ Certifying states should specify which staff disciplines they will require as part of certification.	

[3] Find Shortage Areas by State & County, see HPSA Find (hrsa.gov).

SECTION 1: STAFFING	
C. Cultural Competence and Other Training	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
1.c.1 The CCBHC has a training plan for all CCBHC employed and contract staff who have direct contact with people receiving services or their families. The training plan satisfies and includes requirements of the state behavioral health authority and any accreditation standards on training required by the state. At orientation and at reasonable intervals thereafter, the CCBHC must provide training on: • Evidence-based practices • Cultural competency (described below) • Person-centered and family-centered, recovery-oriented planning and services • Trauma-informed care • The clinic's policy and procedures for continuity of operations/disasters • The clinic's policy and procedures for integration and coordination with primary care • Care for co-occurring mental health and substance use disorders. At orientation and annually thereafter, the CCBHC must provide training on risk assessment; suicide and overdose prevention and response; and the roles of family and peer staff. Trainings may be provided online.	**1.c.1** Each CCBHC shall ensure that all staff (direct care, clinical, operations, administrative, etc.) complete Community First Responder Naloxone Training (offered free online by the University of Rhode Island). Each CCBHC shall ensure that DCO staff who have contact with CCBHC clients and/or their families are subject to the same training requirements as the CCBHC staff for the service they are providing. The CCBHC shall provide culturally competent and linguistically appropriate services consistent with federal and State rules and regulations.

Training shall advance health equity, improve quality of services, and eliminate disparities. To the extent active-duty military or veterans are being served, such training must also include information related to military culture. Examples of training and materials that further the ability of the clinic to provide tailored training for a diverse population include, but are not limited to, those available through the HHS website, the SAMHSA website[4], the HHS Office of Minority Health, or through the website of the Health Resources and Services Administration. **Note**: *See criteria 4.k relating to cultural competency requirements in services for veterans.*	
1.c.2 The CCBHC regularly assesses the skills and competence of each individual furnishing services and, as necessary, provides in-service training and education programs. The CCBHC has written policies and procedures describing its method(s) of assessing competency and maintains a written accounting of the in-service training provided for the duration of employment of each employee who has direct contact with people receiving services.	
1.c.3 The CCBHC documents in the staff personnel records that the training and demonstration of competency are successfully completed. CCBHCs are encouraged to provide ongoing coaching and supervision to ensure initial and ongoing compliance with, or fidelity to, evidence-based, evidence-informed, and promising practices.	

[4] Suggested resources include the African American Behavioral Health Center of Excellence, LGBTQ+ Behavioral Health Equity Center of Excellence, Engage, Educate, Empower for Equity: E4 Center of Excellence for Behavioral Health Disparities in Aging, and Asian American, Native Hawaiian, and Pacific Islander Behavioral Health Center of Excellence.

1.c.4 Individuals providing staff training are qualified as evidenced by their education, training, and experience.	
SECTION 1: STAFFING	
D. Linguistic Competence and Confidentiality of Consumer Information	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
1.d.1 The CCBHC takes reasonable steps to provide meaningful access to services, such as language assistance, for those with Limited English Proficiency (LEP) and/or language-based disabilities.	**1.d.1** Each CCBHC is required to ensure that the DCO is providing meaningful access to services, such as language assistance, interpretation and translation services, ADA compliant auxiliary aids and services, as well as documents and information in commonly spoken languages, are available to CCBHC consumers.
1.d.2 Interpretation/translation service(s) are readily available and appropriate for the size/needs of the LEP CCBHC population (e.g., bilingual providers, onsite interpreters, language video or telephone line). To the extent interpreters are used, such translation service providers are trained to function in a medical and, preferably, a behavioral health setting.	

1.d.3 Auxiliary aids and services are readily available, Americans with Disabilities (ADA) compliant, and responsive to the needs of people receiving services with physical, cognitive, and/or developmental disabilities (e.g., sign language interpreters, teletypewriter (TTY) lines).	
1.d.4 Documents or information vital to the ability of a person receiving services to access CCBHC services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available online and in paper format, in languages commonly spoken within the community served, taking account of literacy levels and the need for alternative formats. Such materials are provided in a timely manner at intake and throughout the time a person is served by the CCBHC. Prior to certification, the needs assessment will inform which languages require language assistance, to be updated as needed.	
1.d.5 The CCBHC's policies have explicit provisions for ensuring all employees, affiliated providers, and interpreters understand and adhere to confidentiality and privacy requirements applicable to the service provider. These include, but are not limited to, the requirements of the Health Insurance Portability and Accountability Act (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.	

SECTION 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES	
A. General Requirements of Access and Availability	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
2.a.1 The CCBHC provides a safe, functional, clean, sanitary, and welcoming environment for people receiving services and staff, conducive to the provision of services identified in program requirement 4. CCBHCs are encouraged to operate tobacco-free campuses.	
2.a.2 Informed by the community needs assessment, the CCBHC ensures that services are provided during times that facilitate accessibility and meet the needs of the population served by the CCBHC, including some evening and weekend hours.	**2.a.2** Each CCBHC shall be open a minimum of 50 hours per week. Each CCBHC shall have Open Access hours: • Open access indicates availability for client walk-ins and same day appointments. • CCBHCs are required to have available designated hours at least 3 days/week for open access services. • CCBHCs are required to educate all staff about the availability of open access.
2.a.3 Informed by the community needs assessment, the CCBHC provides services at locations that ensure accessibility and meet the needs of the population to be served, such as settings in the community (e.g., schools, social service agencies, partner organizations, community centers) and, as appropriate and feasible, in the homes of people receiving services.	**2.a.3** In service areas where one or more CCBHCs are already operational, new applicants must demonstrate that there is currently an unmet need for CCBHC services in that service area and describe how they will meet that need. The Interagency Team will review and assess submitted documentation to determine if justification of need is met.

2.a.4 The CCBHC provides transportation or transportation vouchers for people receiving services to the extent possible with relevant funding or programs in order to facilitate access to services in alignment with the person-centered and family-centered treatment plan.	**2.a.4** Each CCBHC shall assist Medicaid enrolled individuals in accessing non-emergency medical transportation, as well as assist all attributed clients with community transportation resources available outside of the Medicaid non-emergency medical transportation benefit.
2.a.5 The CCBHC uses telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies, to the extent possible, in alignment with the preferences of the person receiving services to support access to all required services.	**2.a.5.** The CCBHC shall comply with all federal and State telehealth laws and regulations, and Medicaid's telehealth policies for Medicaid beneficiaries.
2.a.6. Informed by the community needs assessment, the CCBHC conducts outreach, engagement, and retention activities to support inclusion and access for underserved individuals and populations.[5]	**2.a.6.** Each CCBHC shall have staff dedicated to outreach and engagement who do not carry a caseload. Each CCBHC shall have policies and/or procedures to describe how they will conduct outreach and engagement activities to assist individuals and families to access appropriate services. Each CCBHC shall be able to document, track, and report on outreach and engagement activities to individuals and populations not currently attributed to a CCBHC.

[5] Underserved individuals and populations includes communities as defined in Federal Register: Advancing Racial Equity and Support for Underserved Communities Through the Federal Government as well as individuals or populations that have unmet needs for mental health and substance use disorder treatment and supports

2.a.7	2.a.7
Services are subject to all state standards for the provision of both voluntary and court-ordered services.	Each CCBHC shall have “Facility Status” designation by BHDDH as a requirement for certification and re-certification. Each CCBHC is required to have staff with appropriate credentials and training to provide court ordered substance use disorder treatment to individuals after a Driving Under the Influence or Refusal charge. CCBHCs are required to serve all Court-ordered clients within their designated service area. For extenuating circumstances, a CCBHC may submit a written request to BHDDH to refer a client to another agency if the CCBHC believes they are unable to serve the client. If BHDDH is of the opinion that the client should not receive services from the CCBHC responsible based on service area, the request will be approved and BHDDH will exercise their authority, as the State Mental Health Authority, and assign the client to another CCBHC. Such transfer shall be made in the sole discretion of BHDDH. BHDDH may consider closest proximity to the client’s residence, as a factor for reassignment. This request shall be made in extenuating circumstances only and not for convenience, preference, or due to a lack of existing services at the CCBHC. BHDDH shall document in writing the transfer of the client for court ordered services outside of their designated area. The documentation supporting the transfer shall be placed in the client’s chart.

2.a.8 The CCBHC has a continuity of operations/disaster plan. The plan will ensure the CCBHC is able to effectively notify staff, people receiving services, and healthcare and community partners when a disaster/emergency occurs, or services are disrupted. The CCBHC, to the extent feasible, has identified alternative locations and methods to sustain service delivery and access to behavioral health medications during emergencies and disasters. The plan also addresses health IT systems security/ransomware protection and backup and access to these IT systems, including health records, in case of disaster.	
SECTION 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES	
B. Requirements for Timely Access to Services and Comprehensive Evaluation for New Consumers	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
2.b.1 All people new to receiving services, whether requesting or being referred for behavioral health services at the CCBHC, will, at the time of first contact, whether that contact is in person, by telephone, or using other remote communication, receive a preliminary triage, including risk assessment, to determine acuity of needs. That preliminary triage may occur telephonically. If the triage identifies an emergency/crisis need, appropriate action is taken immediately (see 4.c.1 for crisis response timelines and detail about required services), including plans to reduce or remove risk of harm and to facilitate any necessary subsequent outpatient follow-up. • If the triage identifies an urgent need, clinical services are provided, including an initial evaluation within one business day of the time the request is made.	For Children age eighteen (18) years and younger: the comprehensive assessment shall be completed within thirty (30) days of the first request for services.

• If the triage identifies routine needs, services will be provided, and the initial evaluation completed within 10 business days. • For those presenting with emergency or urgent needs, the initial evaluation may be conducted by phone or through use of technologies for telehealth/telemedicine and video conferencing, but an in-person evaluation is preferred. If the initial evaluation is conducted telephonically, once the emergency is resolved, the person receiving services must be seen in person at the next subsequent encounter and the initial evaluation reviewed. The preliminary triage and risk assessment will be followed by (1) an initial evaluation and (2) a comprehensive evaluation, with the components of each specified in program requirement 4. At the CCBHC's discretion, recent information may be reviewed with the person receiving services and incorporated into the CCBHC health records from outside providers to help fulfill these requirements. Each evaluation must build upon what came before it. Subject to more stringent state, federal, or applicable accreditation standards, all new people receiving services will receive a comprehensive evaluation to be completed within 60 calendar days of the first request for services. If the state has established independent screening and assessment processes for certain child and youth populations or other populations, the CCBHC should establish partnerships to incorporate findings and avoid duplication of effort. This requirement does not preclude the initiation or completion of the comprehensive evaluation, or the provision of treatment during the 60-day period. **Note:** *Requirements for these screenings and evaluations are specified in criteria 4.d.*	
2.b.2 The person-centered and family-centered treatment plan is reviewed and updated as needed by the treatment team, in agreement with and endorsed by the person receiving services. The treatment plan will be updated when changes occur with the status of the person receiving services, based on responses to treatment or when there are changes in treatment goals. The treatment plan must be reviewed and updated no less frequently than every 6 months, unless the state, federal, or	**2.b.2** Each CCBHC shall inform the individual's identified Primary Care Physician of any changes in the comprehensive evaluation, including updates to the functional assessment. For Children age 18 years and younger: the person-centered and family-centered treatment plan shall be updated with the cooperation of the individual when changes occur with the individual's status, based on

applicable accreditation standards are more stringent.	responses to treatment or when there are changes in treatment goals or goal achievement have occurred, or every ninety (90) days, whichever is sooner.
2.b.3 People who are already receiving services from the CCBHC who are seeking routine outpatient clinical services must be provided an appointment within 10 business days of the request for an appointment, unless the state, federal, or applicable accreditation standards are more stringent. If a person receiving services presents with an emergency/crisis need, appropriate action is taken immediately based on the needs of the person receiving services, including immediate crisis response if necessary. If a person already receiving services presents with an urgent, non-emergency need, clinical services are generally provided within one business day of the time the request is made or at a later time if that is the preference of the person receiving services. Same-day and open access scheduling are encouraged.	
SECTION 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES	
C. Access To Crisis Management Services	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
2.c.1 In accordance with program requirement 4.c, the CCBHC provides crisis management services that are available and accessible 24 hours a day, seven days a week.	**2.c.1** Designated CCBHCs in Providence and Kent County shall provide at minimum, a Qualified Mental Health Professional (QMHP) located within the Courthouse at least 4 hours per day (e.g., from 9AM to 1PM), Monday through Friday, to provide onsite psychiatric evaluations and assessments.

2.c.2 A description of the methods for providing a continuum of crisis prevention, response, and postvention services shall be included in the policies and procedures of the CCBHC and made available to the public.	
2.c.3 Individuals who are served by the CCBHC are educated about crisis planning, psychiatric advanced directives, and how to access crisis services, including the 988 Suicide & Crisis Lifeline (by call, chat, or text) and other area hotlines and warmlines, and overdose prevention, if risk is indicated, at the time of the initial evaluation meeting following the preliminary triage. Please see 3.a.4. for further information on crisis planning. This includes individuals with limited English proficiency (LEP) or disabilities (i.e., CCBHC provides instructions on how to access services in the appropriate methods, language(s), and literacy levels in accordance with program requirement 1.d).	
2.c.4 In accordance with program requirement 3, the CCBHC maintains a working relationship with local hospital emergency departments (EDs). Protocols are established for CCBHC staff to address the needs of CCBHC people receiving services in psychiatric crisis who come to those E.Ds.	
2.c.5 Protocols, including those for the involvement of law enforcement, are in place to reduce delays for initiating services during and following a behavioral health crisis. Shared protocols are designed to maximize the delivery of recovery-oriented treatment and services. The protocols should minimize contact with law enforcement and the criminal justice system, while promoting individual and public safety, and complying with applicable state and local laws and regulations. **Note:** *See criterion 3.c.5 regarding specific care coordination*	

requirements related to discharge from hospital or ED following a psychiatric crisis.	
2.c.6 Following a psychiatric emergency or crisis, in conjunction with the person receiving services, the CCBHC creates, maintains, and follows a crisis plan to prevent and de-escalate future crisis situations, with the goal of preventing future crises. **Note:** *See criterion 3.a.4 where precautionary crisis planning is addressed.*	
SECTION 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES	
D. No Refusal of Services Due to Inability to Pay	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
2.d.1 The CCBHC ensures: (1) No individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services (PAMA § 223 (a)(2)(B)), and (2) Any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).	
2.d.2 The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC offers pursuant to these criteria. Such	

fee schedules will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to people receiving services and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP, literacy barriers, or disabilities.	
2.d.3 The fee schedules, to the extent relevant, conform to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics; absent applicable state or federal requirements, the schedule is based on locally prevailing rates or charges and includes reasonable costs of operation.	**2.d.3** Each CCBHC shall employ a standard means test to determine local prevailing rates.
2.d.4 The CCBHC has written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule. Those policies are applied equally to all individuals seeking services.	**2.d.4** DCOs are required to serve all individuals referred by the CCBHC, according to the eligibility guidelines established in the CCBHC/DCO contract and in compliance with the CCBHC standards on access, regardless of individual ability to pay or insurance status.
SECTION 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES	

E. Provision of Services Regardless of Residence	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
2.e.1 The CCBHC ensures no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence, homelessness, or lack of permanent address.	
2.e.2 The CCBHC has protocols addressing the needs of individuals who do not live close to the CCBHC or within the CCBHC service area. The CCBHC is responsible for providing, at a minimum, crisis response, evaluation, and stabilization services in the CCBHC service area regardless of place of residence. The required protocols should address management of the individual's on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing the CCBHC to refer and track individuals seeking non- crisis services to the CCBHC or other clinics serving the individual's area of residence. For individuals and families who live within the CCBHC's service area but live a long distance from CCBHC clinic(s), the CCBHC should consider use of technologies for telehealth/telemedicine, video conferencing, remote patient monitoring, asynchronous interventions, and other technologies in alignment with the preferences of the person receiving services, and to the extent practical. These criteria do not require the CCBHC to provide continuous services, including telehealth, to individuals who live outside of the CCBHC service area. CCBHCS may consider developing protocols for populations that may transition frequently in and out of the services area such as children who experience out-of- home placements and adults who are displaced by incarceration or housing instability.	

SECTION 3: CARE COORDINATION	
A. General Requirements of Care Coordination	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
3.a.1 Based on a person-centered and family-centered treatment plan aligned with the requirements of Section 2402(a) of the Affordable Care Act and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services. This includes access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. The CCBHC also coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare. [6] **Note:** *See criteria 4.k relating to care coordination requirements for veterans.*	**3.a.1** Each CCBHC shall work with the Continuum of Care Collaborative applicants to take referrals from the housing program(s) for eligible individuals needing Home Stabilization services in their service area.
3.a.2 The CCBHC maintains the necessary documentation to satisfy the requirements of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state privacy laws, including patient privacy requirements specific to the care of minors. To promote coordination of care, the CCBHC will obtain necessary consents for sharing information with community partners where information is not able to be shared under HIPAA and other federal and state laws and regulations. If the CCBHC is unable, after reasonable attempts, to obtain consent for any care coordination activity specified in program	

[6] For additional information on care coordination, see Care Coordination | Agency for Healthcare Research and Quality (ahrq.gov).

requirement 3, such attempts must be documented and revisited periodically. **Note:** *CCBHCs are encouraged to explore options for electronic documentation of consent where feasible and responsive to the needs and capabilities of the person receiving services. See standards within the Interoperability Standards Advisory.*[7]	
3.a.3 Consistent with requirements of privacy, confidentiality, and the preferences and needs of people receiving services, the CCBHC assists people receiving services and the families of children and youth referred to external providers or resources in obtaining an appointment and tracking participation in services to ensure coordination and receipt of supports.	
3.a.4 The CCBHC shall coordinate care in keeping with the preferences of the person receiving services and their care needs. To the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person. To identify the preferences of the person in the event of psychiatric or substance use crisis, the CCBHC develops a crisis plan with each person receiving services. At minimum, people receiving services should be counseled about the use of the National Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis, and stabilization services should a crisis arise when providers are not in their office. Crisis plans may support the development of a Psychiatric Advanced Directive, if desired by the person receiving	

[7] The Interoperability Standards Advisory (ISA) process represents the model by which the Office of the National Coordinator for Health Information Technology (ONC) will coordinate the identification, assessment, and determination of "recognized" interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs. More information can be found at Interoperability Standards Advisory (ISA) | HealthIT.gov.

services.[8] Psychiatric Advance Directives, if developed, are entered in the electronic health record of the person receiving services so that the information is available to providers in emergency care settings where those electronic health records are accessible.	
3.a.5 Appropriate care coordination requires the CCBHC to make and document reasonable attempts to determine any medications prescribed by other providers. To the extent that state laws allow, the state Prescription Drug Monitoring Program (PDMP) must be consulted before prescribing medications. The PDMP should also be consulted during the comprehensive evaluation. Upon appropriate consent to release of information, the CCBHC is also required to provide such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care.	
3.a.6 Nothing about a CCBHC's agreements for care coordination should limit the freedom of a person receiving services to choose their provider within the CCBHC, with its DCOs, or with any other provider.	**3.a.6** Each CCBHC care coordination agreement and DCO contract shall include the provision of individual freedom of choice.
3.a.7 The CCBHC assists people receiving services and families to access benefits, including Medicaid, and enroll in programs or supports that may benefit them.	**3.a.7**
SECTION 3: CARE COORDINATION	

[8] Psychiatric Advance Directives are legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric Advance Directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness. For more information visit NRC PAD | National Resource Center on Psychiatric Advance Directives (nrc-pad.org).

B. Care Coordination and Other Health Information Systems	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
3.b.1 The CCBHC establishes or maintains a health information technology (IT) system that includes, but is not limited to, electronic health records.	
3.b.2 The CCBHC uses its secure health IT system(s) and related technology tools, ensuring appropriate protections are in place, to conduct activities such as population health management, quality improvement, quality measurement and reporting, reducing disparities, outreach, and for research. When CCBHCs use federal funding to acquire, upgrade, or implement technology to support these activities, systems should utilize nationally recognized, HHS adopted standards, where available, to enable health information exchange. [9]For example, this may include simply using common terminology mapped to standards adopted by HHS to represent a concept such as race, ethnicity, or other demographic information. While this requirement does not apply to incidental use of existing IT systems to support these activities when there is no targeted use of program funding, CCBHCs are encouraged to explore ways to support alignment with standards across data-driven activities.	
3.b.3 The CCBHC uses technology that has been certified to current criteria[10] under the ONC Health IT Certification Program for the following required	

[9] Pursuant to HHS Health IT Alignment policy and Section 13112 of the HITECH Act, recipients and subrecipients of award funding which involves acquiring, upgrading and implementing health IT must utilize health IT that meets standards and implementation specifications adopted by HHS in 45 CFR part 170, Subpart B, if such standards and implementation specifications can support the award activity.

[10] As of February 2023, current criteria are the 2015 Edition of health IT certification criteria, as updated according to the 2015 Edition Cures Update

core set of certified health IT capabilities (see footnotes for citations to the required health IT certification criteria and standards) that align with key clinical practice and care delivery requirements for CCBHCs.[11] • Capture health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible). [12] • At a minimum, support care coordination by sending and receiving summary of care records.[13] • Provide people receiving services with timely electronic access to view, download, or transmit their health information or to access their health information via an API using a personal health app of their choice.[14] • Provide evidence-based clinical decision support. [15] • Conduct electronic prescribing. [16] **Note***: Under the CCBHC program, CCBHCs are not required to have all these capabilities in place when certified or when submitting their attestation but should plan to adopt and use technology meeting these requirements over time, consistent with any applicable program timeframes. In addition, CCBHCs do not need to adopt a single system that provides all these certified capabilities but can adopt either a single system or a combination of tools that provide these capabilities. Finally, CCBHC providers who successfully participate in the Promoting Interoperability Performance Category of the Quality Payment Program will already have health IT systems that successfully meet all the core certified health IT capabilities.*	

[11] Additional information about health IT products certified to these criteria is available on the Certified Health IT Product List (CHPL).

[12] United States Core Data for Interoperability (USCDI) standard at 45 CFR 170.213 and "Demographics" criterion at § CFR 170.315(a)(5).

[13] "Transitions of care" criterion at § 170.315(b)(1))

[14] "Application access – patient selection" criterion at § 170.315(g)(7); "Application access – all data request" criterion at § 170.315(g)(9) and "Standardized API for patient and population services" criterion at § 170.315(g)(10).

[15] "Clinical decision support" criterion at § 170.315(a)(9)

[16] "Electronic prescribing" criterion at § 170.215(b)(3).

3.b.4 The CCBHC will work with DCOs to ensure all steps are taken, including obtaining consent from people receiving services, to comply with privacy and confidentiality requirements. These include, but are not limited to, those of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.	
3.b.5 The CCBHC develops and implements a plan within two-years from CCBHC certification or submission of attestation to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system. This plan includes information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care. To support integrated evaluation planning, treatment, and care coordination, the CCBHC works with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record. Further, all clinically relevant treatment records maintained by the CCBHC are available to DCOs within the confines of federal and/or state laws governing sharing of health records.	Providers are required to participate in the statewide Health Information Exchange (HIE) to support data sharing, care coordination, and quality reporting for the CCBHC program. Providers shall work to establish the requisite interfaces to contribute data and the client consent processes to enable this exchange in Demonstration Year 2 and fully participate in the HIE in Demonstration Year 3. Full participation in the HIE is defined as: (1) real-time or near-real-time submission of a standardized CCDA or outbound FHIR connection; (2) inclusive of all USCDI elements currently supported by the EHR; (3) for all clinical programs and services, including those covered by 42 CFR Part 2. Any necessary Part 2 consent processes shall be conducted within the HIE system as part of a Qualified Service Organization Agreement (QSOA) with the CCBHC.
SECTION 3: CARE COORDINATION	
C. Care Coordination Agreements	
Federal Criteria Requirements	**Rhode Island Additional Requirements**

3.c.1 The CCBHC has a partnership establishing care coordination expectations with Federally Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics (RHCs)) to provide health care services, to the extent the services are not provided directly through the CCBHC. For people receiving services who are served by other primary care providers, including but not limited to FQHC Look-Alikes and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination. **Note**: *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.*	**3.c.1** Each CCBHC shall inquire whether the consumer has a Primary Care Provider (PCP), assist individuals who do not have a PCP to acquire one, and establish policies and procedures that promote and describe the coordination of care with each individual's PCP.
3.c.2 The CCBHC has partnerships that establish care coordination expectations with programs that can provide inpatient psychiatric treatment, OTP services, medical withdrawal management facilities, and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs (if any exist within the CCBHC service area). These include tribally operated mental health and substance use services including crisis services that are in the service area. The clinic tracks when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric programs, medically monitored withdrawal management services, and residential or inpatient facilities that serve	

children and youth such as Psychiatric Residential Treatment Facilities and other residential treatment facilities, to a safe community setting. This includes transfer of health records of services received (e.g., prescriptions), active follow-up after discharge, and, as appropriate, a plan for suicide prevention and safety, overdose prevention, and provision for peer services. **Note**: *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.* ★ Certifying states are encouraged to find ways to incentivize inpatient treatment facilities to partner with CCBHCs to establish protocols and procedures for transitioning individuals, including real time notification of discharge and record transfers that support the seamless delivery of care, maintain recovery, and reduce the risk of relapse and injury during transitions.	
3.c.3 The CCBHC has partnerships with a variety of community or regional services, supports, and providers. Partnerships support joint planning for care and services, provide opportunities to identify individuals in need of services, enable the CCBHC to provide services in community settings, enable the CCBHC to provide support and consultation with a community partner, and support CCBHC outreach and engagement efforts. CCBHCs are required by statute to develop partnerships with the following organizations that operate within the service area: • Schools • Child welfare agencies • Juvenile and criminal justice agencies and facilities (including	**3.c.3** RI requires Care Coordination Agreements with: • Service area hospital/ Emergency Department, • Service area Urgent Care, • Service area FQHC, • Service area Primary Care Providers (adult and pediatric), • Service area court, • Service area Community Action Program (CAP) Agencies, • Department of Children, Youth, and Families (DCYF), including the Division of Family Services and Division of Youth Development. • Butler Hospital,

drug, mental health, veterans and other specialty crisis) • Indian Health Service youth[17] regional treatment centers • State licensed and nationally accredited child placing agencies for therapeutic foster care service • Other social and human services. CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people receiving services, and/or needs identified in the community needs assessment. Examples of such partnerships include (but are not limited to) the following: • Specialty providers including those who prescribe medications for the treatment of opioid and alcohol use disorders. • Suicide and crisis hotlines and warmlines • Indian Health Service or other tribal programs • Homeless shelters • Housing agencies • Employment services systems • Peer-operated programs • Services for older adults, such as Area Agencies on Aging • Aging and Disability Resource Centers • State and local health departments and behavioral health and developmental disabilities agencies • Substance use prevention and harm reduction programs • Criminal and juvenile justice, including law enforcement, courts, jails, prisons, and detention centers • Legal aid • Immigrant and refugee services • SUD Recovery/Transitional housing • Programs and services for families with young children, including Infants & Toddlers, WIC, Home Visiting Programs, Early Head Start/Head Start, and Infant and Early Childhood Mental Health Consultation programs • Coordinated Specialty Care programs for first episode psychosis	• Bradley Hospital, • Hasbro Children's Hospital, • Service area Police/Emergency Medical Services (EMS), • Veterans Administration, • BH Link, • 988, • Service area Family Care Community Partnerships (FCCP) providers, • Accountable Entities (AE), • Department of Corrections, • Opioid Treatment Provider (OTP/Methadone), • Home Stabilization Service provider, • Eleanor Slater Hospital, • Rhode Island State Psychiatric Hospital, • Providers specialized in support and services for adults and children with I/DD, • Agency with SOAR-trained individuals who can support SSI and SSDI applications (unless they have an existing person trained in this in-house), **AND** • All state-licensed MRSS providers with whom the CCBHC does not have a non-financial DCO contract.

[17] The Indian Health Service is an Operating Division within HHS, responsible for providing federal health services to American Indians and Alaska Natives.

• Other social and human services (e.g., intimate partner violence centers, religious services and supports, grief counseling, Affordable Care Act Navigators, food, and transportation programs) In addition, the CCBHC has a care coordination partnership with the 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located. **Note**: *These partnerships should be supported by a formal, signed agreement detailing the roles of each party or unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.* ★ Certifying states may require CCBHCs to establish additional partnerships.	
3.c.4 The CCBHC has partnerships with the nearest Department of Veterans Affairs' medical center, independent clinic, drop-in center, or other facility of the Department. To the extent multiple Department facilities of different types are located nearby, the CCBHC should work to establish care coordination agreements with facilities of each type. **Note***: These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be*	

developed. All partnership activities should be documented to support partnerships independent of any staff turnover.	
3.c.5 The CCBHC has care coordination partnerships establishing expectations with inpatient acute-care hospitals in the area served by the CCBHC and their associated services/facilities, including emergency departments, hospital outpatient clinics, urgent care centers, and residential crisis settings. This includes procedures and services, such as peer recovery specialist/coaches, to help individuals successfully transition from ED or hospital to CCBHC and community care to ensure continuity of services and to minimize the time between discharge and follow up. Ideally, the CCBHC should work with the discharging facility ahead of discharge to assure a seamless transition. These partnerships shall support tracking when people receiving CCBHC services are admitted to facilities providing the services listed above, as well as when they are discharged. The partnerships shall also support the transfer of health records of services received (e.g., prescriptions) and active follow-up after discharge. CCBHCs should request of relevant inpatient and outpatient facilities, for people receiving CCBHC services, that notification be provided through the Admission, Discharge, and Transfer (ADT) system. The CCBHC will make and document reasonable attempts to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge. For all people receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, the care coordination agreement between these facilities and the CCBHC includes a requirement to coordinate consent and follow-up services with the person receiving services within 24 hours of discharge and continues until the individual is linked to services or assessed to be no longer at risk. **Note**: *These partnerships should be supported by a formal, signed agreement detailing the roles of each party. If the partnering entity is unable to enter into a formal agreement, the CCBHC may work with the*	

partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination. At a minimum, the CCBHC will develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed. All partnership activities should be documented to support partnerships independent of any staff turnover.	
SECTION 3: CARE COORDINATION	
D. Treatment Team, Treatment Planning, and Care Coordination Activities	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
3.d.1 The CCBHC treatment team includes the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, and any other people the person receiving services desires to be involved in their care. All treatment planning and care coordination activities are person- and family-centered and align with the requirements of Section 2402(a) of the Affordable Care Act. All treatment planning and care coordination activities are subject to HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.	

3.d.2 The CCBHC designates an interdisciplinary treatment team that is responsible, with the person receiving services and their family/caregivers, to the extent the person receiving services desires their involvement or when they are legal guardians, for directing, coordinating, and managing care and services. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic, and recovery support needs of the people receiving services, including, as appropriate and desired by the person receiving services, traditional approaches to care for people receiving services who are American Indian or Alaska Native or from other cultural and ethnic groups. **Note**: *See criteria 4.k relating to required treatment planning services for veterans*.	
3.d.3 The CCBHC coordinates care and services provided by DCOs in accordance with the current treatment plan. **Note**: *See program requirement 4 related to scope of service and person-centered and family-centered treatment planning*.	

SECTION 4: SCOPE OF SERVICES	
A. General Service Provisions	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
4.a.1 Whether delivered directly or through a DCO agreement, the CCBHC is responsible for ensuring access to all care specified in PAMA. This includes, as more explicitly provided and more clearly defined below in criteria 4.c through 4.k the following required services: crisis services; screening, assessment and diagnosis; person-centered and family-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans. The CCBHC organization will deliver directly the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs.	**4.a.1** The following service enhancements will also be required in Rhode Island: Assertive Community Treatment, i.e., • ACT (Adults) • ACT YA (Young Adults)
4.a.2 The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the freedom of the person receiving services to choose providers within the CCBHC and its DCOs. This requirement does not preclude the use of referrals outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities.	**4.a.2** Each CCBHC shall have the capacity to directly provide mental health and substance use disorder treatment services to people with serious mental illness and serious emotional disorders, as well as developmentally appropriate mental health and substance use care for children and youth, separate from any DCO relationship.

4.a.3 With regard to either CCBHC or DCO services, people receiving services will be informed of and have access to the CCBHC's existing grievance procedures, which must satisfy the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities or state authorities.	
4.a.4 DCO-provided services for people receiving CCBHC services must meet the same quality standards as those provided by the CCBHC. The entities with which the CCBHC coordinates care and all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.	
SECTION 4: SCOPE OF SERVICES	
B. Person-Centered and Family-Centered Care	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
4.b.1 The CCBHC ensures all CCBHC services, including those supplied by its DCOs, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act. These reflect person-centered and family-centered, recovery-oriented care; being respectful of the needs, preferences, and values of the person receiving services; and ensuring both involvement of the person receiving services and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. A shared decision-making model for engagement is the recommended approach.	

Note: *See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.k relating specifically to requirements for services for veterans.*	
4.b.2 Person-centered and family-centered care is responsive to the race, ethnicity, sexual orientation, and gender identity of the person receiving services and includes care which recognizes the particular cultural and other needs of the individual. This includes, but is not limited to, services for people who are American Indian or Alaska Native (AI/AN) or other cultural or ethnic groups, for whom access to traditional approaches or medicines may be part of CCBHC services. For people receiving services who are AI/AN, these services may be provided either directly or by arrangement with tribal organizations.	

SECTION 4: SCOPE OF SERVICES

C. Crisis Behavioral Health Services

Federal Criteria Requirements	Rhode Island Additional Requirements

4.c.1
 	
The CCBHC shall provide crisis services directly or through a DCO agreement with existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. HHS recognizes that state sanctioned crisis systems may operate under different standards than those identified in these criteria. If a CCBHC would like to have a DCO relationship with a state-sanctioned crisis system that operates under less stringent standards, they must request approval from HHS to do so.[18]
	4.c.1
	
	The CCBHC shall provide:
	• 24-hour staffed hotline;
	• 24-hour mobile crisis teams
	• A 2-person mobile crisis team to provide clinic-based and mobile crisis intervention services.
	  ○ At least one (1) member of the mobile crisis team shall be a Qualified Mental Health Professional (QMHP).
	  ○ For MRSS responses for children or youth, it is strongly encouraged that the clinician serving on the two-person

[18] For questions about this process, please email ccbhc@samhsa.hhs.gov

★ Certifying states must request approval from HHS to certify CCBHCs in their states that have or seek to have a DCO relationship with a state-sanctioned crisis system with less stringent standards than those included in these criteria.[19]

PAMA requires provision of these three crisis behavioral health services, whether provided directly by the CCBHC or by a DCO:

- **Emergency crisis intervention services**: The CCBHC provides or coordinates with telephonic, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards for risk assessment and engagement of individuals at imminent risk of suicide. The CCBHC should participate in any state, regional, or local air traffic control (ATC)[20] systems which provide quality coordination of crisis care in real-time as well as any service capacity registries as appropriate. Quality coordination means that protocols have been established to track referrals made from the call center to the CCBHC or its DCO crisis care provider to ensure the timely delivery of mobile crisis team response, crisis stabilization, and post crisis follow-up care.

- **24-hour mobile crisis teams:** The CCBHC provides community-based behavioral health crisis intervention services using mobile crisis teams twenty-four hours per day, seven days per week to adults, children, youth, and families anywhere within the service area including at home, work, or anywhere else where the crisis is experienced. Mobile crisis teams are expected to arrive in-person within one hour (2 hours in rural and frontier settings) from the time that they are dispatched, with response time not to exceed 3 hours. Telehealth/telemedicine may be used to connect individuals in crisis to qualified mental health providers during the interim travel time. Technologies also may be used to provide crisis care to individuals when remote travel distances make the 2-mobile crisis team is a QMHP. If a QMHP is not part of the responding team, the provider must ensure that the team has timely and ready access to a QMHP for consultation and clinical support.

- The CCBHC is <u>required</u> to provide clinic-based crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care. In all cases, emergency and crisis stabilization shall include care coordination for up to (30) days subsequent to the crisis response.

In Rhode Island, Mobile Response and Stabilization Services (MRSS) is the required model for **24-hour mobile crisis services** for children 0-18 and may be appropriate for youth 18-21. CCBHCs shall ensure MRSS is available and provided when clinically appropriate and/or upon client request. To ensure 24/7 access to MRSS within each CCBHC service area, each CCBHC shall:

Enter into at least one (1) non-financial DCO contract with an MRSS provider that is licensed by the RI Department of Children, Youth, and Families (DCYF) in accordance with the Regulations for Mental Health Emergency Service Interventions for Children, Youth and Families Regulations for Licensure (214-RICR-40-00-6)

1) If a CCBHC has a non-financial DCO contract with an MRSS provider, the CCBHC is responsible for ensuring a warm handoff to that MRSS provider for any calls that come to the CCBHC for which an MRSS response is requested by the caller and/or clinically appropriate.

In alignment with CMS rules, client choice will be honored. Individuals not currently attributed to a CCBHC who receive MRSS services, shall

[19] For questions about this process, please email ccbhc@samhsa.hhs.gov

[20] Air traffic control (ATC) serves as a conceptual model for real-time coordination of crisis care and linkage to crisis response services. It may involve real-time connection to GPS-enabled mobile teams, true system-wide access to available beds, and outpatient appointment scheduling through the integrated crisis call center. For more information see National Guidelines for Behavioral Health Crisis Care | SAMHSA.

hour response time unachievable, but the ability to provide an in-person response must be available when it is necessary to assure safety. The CCBHC should consider aligning their programs with the **CMS Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services** if they are in a state that includes this option in their Medicaid state plan.[21] • **Crisis receiving/stabilization:** The CCBHC provides crisis receiving/stabilization services that must include at minimum, urgent care/walk-in mental health and substance use disorder services for voluntary individuals. Urgent care/walk-in services that identify the individual's immediate needs, de-escalate the crisis, and connect them to a safe and least-restrictive setting for ongoing care (including care provided by the CCBHC). Walk-in hours are informed by the community needs assessment and include evening hours that are publicly posted. The CCBHC should have a goal of expanding the hours of operation as much as possible. Ideally, these services are available to individuals of any level of acuity; however, the facility need not manage the highest acuity individuals in this ambulatory setting. Crisis stabilization services should ideally be available 24 hours per day, 7 days a week, whether individuals present on their own, with a concerned individual, such as a family member, or with a human service worker, and/or law enforcement, in accordance with state and local laws. In addition to these activities, the CCBHC may consider supporting or coordinating with peer-run crisis respite programs. The CCBHC is encouraged to provide crisis receiving/stabilization services in accordance with the SAMHSA National Guidelines for Behavioral Health Crisis Care. Services provided must include suicide prevention and intervention, and services capable of addressing crises related to substance use including the risk of drug and alcohol related overdose and support following a non-fatal overdose after the individual is medically stable. Overdose	not automatically become enrolled with a CCBHC. CCBHCs should rely on clinical discretion and caregiver and youth choice. There are a few scenarios in which it may be appropriate for the CCBHC ES staff and/or the client's current CCBHC treatment team to provide the initial crisis response instead of an MRSS provider, for example: • A child or youth presents physically at a CCBHC site. • A call is received by the CCBHC for a child or youth who is already a client of the CCBHC (e.g., a child/youth in an intensive/high acuity program), and the CCBHC is able to respond to the client in the community within the required timeframes. • A call is received by the CCBHC from a youth aged 18-21 who is experiencing a crisis, and an adult mobile crisis response is determined to be more clinically appropriate than an MRSS initial crisis response. See Addendum 4 for requirements for DCO agreements between CCBHCs and MRSS providers. CCBHCs' failure to comply with the requirements of Addendum 4 may result in state licensing or Medicaid certification action.

[21] For information on crisis services for children and youth, please see National Guidelines for Child and Youth Behavioral Health Crisis Care (samhsa.gov) and A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth (samhsa.gov)

prevention activities must include ensuring access to naloxone for overdose reversal to individuals who are at risk of opioid overdose, and as appropriate, to their family members. The CCBHC or its DCO crisis care provider should offer developmentally appropriate responses, sensitive de-escalation supports, and connections to ongoing care, when needed. The CCBHC will have an established protocol specifying the role of law enforcement during the provision of crisis services. As a part of the requirement to provide training related to trauma-informed care, the CCBHC shall specifically focus on the application of trauma-informed approaches during crises. **Note**: *See program requirement 2.c regarding access to crisis services and criterion 3.c.5 regarding coordination of services and treatment planning, including after discharge from a hospital inpatient or emergency department following a behavioral health crisis.*	
SECTION 4: SCOPE OF SERVICES	
D. Screening, Assessment, and Diagnosis	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
4.d.1 The CCBHC directly, or through a DCO, provides screening, assessment, and diagnosis, including risk assessment for behavioral health conditions. In the event specialized services outside the expertise of the CCBHC are required for purposes of screening, assessment, or diagnosis (e.g., neuropsychological testing or developmental testing and assessment), the CCBHC refers the person to an appropriate provider. When necessary and appropriate screening, assessment and diagnosis can be provided through telehealth/telemedicine services. **Note**: *See program requirement 3 regarding coordination of services and treatment planning.*	

4.d.2 Screening, assessment, and diagnosis are conducted in a time frame responsive to the needs and preferences of the person receiving services and are of sufficient scope to assess the need for all services required to be provided by the CCBHC.	
4.d.3 The initial evaluation (including information gathered as part of the preliminary triage and risk assessment, with information releases obtained as needed), as required in program requirement 2, includes at a minimum: 1. Preliminary diagnoses. 2. The source of referral. 3. The reason for seeking care, as stated by the person receiving services or other individuals who are significantly involved. 4. Identification of the immediate clinical care needs related to the diagnosis for mental and substance use disorders of the person receiving services. 5. A list of all current prescriptions and over-the counter medications, herbal remedies, and dietary supplements and the indication for any medications. 6. A summary of previous mental health and substance use disorder treatments with a focus on which treatments helped and were not helpful. 7. The use of any alcohol and/or other drugs the person receiving services may be taking and indication for any current medications. 8. An assessment of whether the person receiving services is a risk to self or to others, including suicide risk factors. 9. An assessment of whether the person receiving services has other concerns for their safety, such as intimate partner violence. 10. Assessment of need for medical care (with referral and follow-up as required).	

11. A determination of whether the person presently is, or ever has been, a member of the U.S. Armed Services. 12. For children and youth, whether they have system involvement (such as child welfare and juvenile justice).	
4.d.4 A comprehensive evaluation is required for all people receiving CCBHC services. Subject to applicable state, federal, or other accreditation standards, clinicians should use their clinical judgment with respect to the depth of questioning within the assessment so that the assessment actively engages the person receiving services around their presenting concern(s). The evaluation should gather the amount of information that is commensurate with the complexity of their specific needs and prioritize preferences of people receiving services with respect to the depth of evaluation and their treatment goals. The evaluation shall include: 1. Reasons for seeking services at the CCBHC, including information regarding onset of symptoms, severity of symptoms, and circumstances leading to the presentation to the CCBHC of the person receiving services. 2. An overview of relevant social supports; social determinants of health; and health- related social needs such as housing, vocational, and educational status; family/caregiver and social support; legal issues; and insurance status. 3. A description of cultural and environmental factors that may affect the treatment plan of the person receiving services, including the need for linguistic services or supports for people with LEP. 4. Pregnancy and/or parenting status. 5. Behavioral health history, including trauma history and previous therapeutic interventions and hospitalizations with a focus on what was helpful and what was not helpful in past treatments.	

6. Relevant medical history and major health conditions that impact current psychological status. 7. A medication list including prescriptions, over-the counter medications, herbal remedies, dietary supplements, and other treatments or medications of the person receiving services. Include those identified in a Prescription Drug Monitoring Program (PDMP) that could affect their clinical presentation and/or pharmacotherapy, as well as information on allergies including medication allergies. 8. An examination that includes current mental status, mental health (including depression screening, and other tools that may be used in ongoing measurement- based care) and substance use disorders (including tobacco, alcohol, and other drugs). 9. Basic cognitive screening for cognitive impairment. 10. Assessment of imminent risk, including suicide risk, withdrawal and overdose risk, danger to self or others, urgent or critical medical conditions, and other immediate risks including threats from another person. 11. The strengths, goals, preferences, and other factors to be considered in treatment and recovery planning of the person receiving services. 12. Assessment of the need for other services required by the statute (i.e., peer and family/caregiver support services, targeted case management, psychiatric rehabilitation services). 13. Assessment of any relevant social service needs of the person receiving services, with necessary referrals made to social services. For children and youth receiving services, assessment of systems involvement such as child welfare and juvenile justice and referral to child welfare agencies as appropriate. 14. An assessment of need for a physical exam or further evaluation by appropriate health care professionals, including the primary care provider (with appropriate referral and follow-up) of the person receiving services.	

15. The preferences of the person receiving services regarding the use technologies such as telehealth/telemedicine, video conferencing, remote patient monitoring, and asynchronous interventions.	
4.d.5 Screening and assessment conducted by the CCBHC related to behavioral health include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix B of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix B as a reason not to provide clinically indicated behavioral health screening or assessment. ★ The state may elect to require specific other screening and monitoring to be provided by the CCBHCs beyond those listed in criterion 4.d.4 or Appendix B.	**4.d.5** Each CCBHC shall provide a Traumatic Brain Injury (TBI) Screening using: • The comprehensive OBISSS+ tool; or • The 3-question Brief ABI Screen tool, and for individuals who respond YES to Question 1 and/or 2, complete the full OSU TBI-ID structured interview (which is an extended form of the screen). The screening shall be conducted with all CCBHC clients ages 10 years and older as part of the comprehensive evaluation, unless: • The client has an active TBI diagnosis on record; and/or • A TBI screening was completed for the client by a DCO, care coordination partner, or health care provider (e.g., a local hospital or primary care provider) within the past 12 months prior to the client's transfer of care to the CCBHC, and those screening results are documented within the client's CCBHC record. An initial TBI screening should be conducted with a new CCBHC client at any time during the clinical assessment period, and not necessarily at intake. The screening should be reconducted outside of the clinical assessment period with a client based upon demonstrated need and/or a report of a potential incident which could result in a brain injury, e.g., an accident, assault, or fall. Each CCBHC shall utilize the PHQ-9 assessment to screen all adults, and the PHQ-9M to screen all adolescents (age 12-18 years of age) for depression. For clients in the Healthy Transitions Program, providers may opt to use either version – clinical discretion is allowed. With that said, the State does encourage use of the PHQ-9M as it includes some additional questions which could be of clinical value.

4.d.6 The CCBHC uses standardized and validated and developmentally appropriate screening and assessment tools appropriate for the person and, where warranted, brief motivational interviewing techniques to facilitate engagement.	
4.d.7 The CCBHC uses culturally and linguistically appropriate screening tools and approaches that accommodate all literacy levels and disabilities (e.g., hearing disability, cognitive limitations), when appropriate.	
4.d.8 If screening identifies unsafe substance use including problematic alcohol or other substance use, the CCBHC conducts a brief intervention and the person receiving services is provided a full assessment and treatment, if appropriate within the level of care of the CCBHC or referred to a more appropriate level of care. If the screening identifies more immediate threats to the safety of the person receiving services, the CCBHC will take appropriate action as described in 2.b.1.	
SECTION 4: SCOPE OF SERVICES	

E. Person-Centered and Family-Centered Treatment Planning	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
4.e.1 The CCBHC directly, or through a DCO, provides person centered and family-centered treatment planning, including but not limited to, risk assessment and crisis planning (CCBHCs may work collaboratively with DCOs to complete these activities). Person centered and family-centered treatment planning satisfies the requirements of criteria 4.e.2 – 4.e.8 below and is aligned with the requirements of Section 2402(a) of the Affordable Care Act, including person receiving services involvement and self-direction. **Note**: *See program requirement 3 related to coordination of care and treatment planning*.	
4.e.2 The CCBHC develops an individualized treatment plan based on information obtained through the comprehensive evaluation and the person receiving services' goals and preferences. The plan shall address the person's prevention, medical, and behavioral health needs. The plan shall be developed in collaboration with and be endorsed by the person receiving services; their family (to the extent the person receiving services so wishes); and family/caregivers of youth and children or legal guardians. Treatment plan development shall be coordinated with staff or programs necessary to carry out the plan. The plan shall support care in the least restrictive setting possible. Shared decision making is the preferred model for the establishment of treatment planning goals. All necessary releases of information shall be obtained and included in the health record as a part of the development of the initial treatment plan.	

4.e.3 The CCBHC uses the initial evaluation, comprehensive evaluation, and ongoing screening and assessment of the person receiving services to inform the treatment plan and services provided.	
4.e.4 Treatment planning includes needs, strengths, abilities, preferences, and goals, expressed in a manner capturing the words or ideas of the person receiving services and, when appropriate, those of the family/caregiver of the person receiving services.	Each CCBHC shall develop an initial care plan for children within 30 days of intake and review the care plan every 90 days thereafter.
4.e.5 The treatment plan is comprehensive, addressing all services required, including recovery supports, with provision for monitoring of progress towards goals. The treatment plan is built upon a shared decision-making approach.	
4.e.6 Where appropriate, consultation is sought during treatment planning as needed (e.g., eating disorders, traumatic brain injury, intellectual and developmental disabilities (I/DD), interpersonal violence and human trafficking).	
4.e.7 The person's health record documents any advance directives related to treatment and crisis planning. If the person receiving services does not wish to share their preferences, that decision is documented. Please see 3.a.4., requiring the development of a crisis plan with each person receiving services. ★ Consistent with the criteria in 4.e.1 through 4.e.7, certifying states should specify other aspects of person-centered and family-centered treatment planning they will require based upon the needs	

of the population served. Treatment planning components that certifying states might consider include: prevention; community inclusion and support (housing, employment, social supports); involvement of family/caregiver and other supports; recovery planning; and the need for specific services required by the statute (i.e., care coordination, physical health services, peer and family support services, targeted case management, psychiatric rehabilitation services, tailored treatment to ensure cultural and linguistically appropriate services).	

SECTION 4: SCOPE OF SERVICES

F. Outpatient Mental Health and Substance Use Services

Federal Criteria Requirements	Rhode Island Additional Requirements
4.f.1 The CCBHC directly, or through a DCO, provides outpatient behavioral health care, including psychopharmacological treatment. The CCBHC or the DCO must provide evidence-based services using best practices for treating mental health and substance use disorders across the lifespan with tailored approaches for adults, children, and families. SUD treatment and services shall be provided as described in the American Society for Addiction Medicine Levels 1 and 2.1 and include treatment of tobacco use disorders. In the event specialized or more intensive services outside the expertise of the CCBHC or DCO are required for purposes of outpatient mental and substance use disorder treatment the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine, in alignment with state and federal laws and regulations. The CCBHC also provides or makes available through a formal arrangement traditional practices/treatment as appropriate for the people receiving services served in the CCBHC	**4.f.1** See Addendum 6 for a full list of Rhode Island required Evidence Based Practices (EBPs). CCBHCs shall provide ASAM Level 1 and Level 2 Withdrawal Management services either directly or through a Designated Collaborating Organization (DCO) partner. These services need to be made available and accessible to individuals who need to withdraw from substances and can be treated on an outpatient basis. However, referral and admission to these ASAM services is based on the CCBHC's clinical judgement to ensure appropriate and safe medical care. There is no requirement or expectation that CCBHCs provide everyone who needs withdrawal services (e.g., alcohol withdrawal management) these services in an outpatient setting only. The appropriate setting should be determined by the provider on a case by-case basis taking the individual's condition including their medical risk

area. Where specialist providers are not available to provide direct care to a particular person receiving CCBHC services, or specialist care is not practically available, the CCBHC professional staff may consult with specialized services providers for highly specialized treatment needs. For people receiving services with potentially harmful substance use, the CCBHC is strongly encouraged to engage the person receiving services with motivational techniques and harm reduction strategies to promote safety and/or reduce substance use. **Note**: *See also program requirement 3 regarding coordination of services and treatment planning.* ★ Based upon the findings of the community needs assessment as required in program requirement 1, certifying states must establish a minimum set of evidence-based practices required of the CCBHCs. Among those evidence based practices states might consider are the following: Motivational Interviewing; Cognitive Behavioral Therapy (CBT); Dialectical Behavior Therapy (DBT); Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP); Seeking Safety; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (FACT); Long acting injectable medications to treat both mental and substance use disorders; Multi-Systemic Therapy; Trauma Focused Cognitive Behavioral Therapy (TF-CBT); Cognitive Behavioral Therapy for psychosis (CBTp); High-Fidelity Wraparound; Parent Management Training; Effective but underutilized medications such as clozapine and FDA approved medications for substance use disorders including smoking cessation. This list is not intended to be all inclusive. Certifying states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification.	factors, comorbid substance use issues, and the person's support system, into consideration. Each CCBHC's evaluation criteria and treatment protocols should be developed with input from their Medical Director and formally documented.
4.f.2 Treatments are provided that are appropriate for the phase of life and development of the person receiving services, specifically considering what is appropriate for children, adolescents, transition-age youth, and older adults, as distinct groups for whom life stage and functioning may affect treatment. When treating children and adolescents, CCBHCs	

must provide evidenced-based services that are developmentally appropriate, youth- guided, and family/caregiver-driven. When treating older adults, the desires and functioning of the individual person receiving services are considered, and appropriate evidence-based treatments are provided. When treating individuals with developmental or other cognitive disabilities, level of functioning is considered, and appropriate evidence-based treatments are provided. These treatments are delivered by staff with specific training in treating the segment of the population being served. CCBHCs are encouraged to use evidence-based strategies such as measurement-based care (MBC) [22]to improve service outcomes.	
4.f.3 Supports for children and adolescents must comprehensively address family/caregiver, school, medical, mental health, substance use, psychosocial, and environmental issues.	

SECTION 4: SCOPE OF SERVICES

G. Outpatient Clinic Primary Care Screening and Monitoring

Federal Criteria Requirements	Rhode Island Additional Requirements
4.g.1 The CCBHC is responsible for outpatient primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for	**4.g.1** Rhode Island enhanced screening requirement includes: • Tobacco Use

[22] Measurement-based care (MBC) is the systematic use of patient-reported information to inform clinical care and shared decision-making among clinicians and patients and to individualize ongoing treatment plans: Measurement-Based Mental Health Care (va.gov).

ensuring these services are received in a timely fashion. Prevention is a key component of primary care screening and monitoring services provided by the CCBHC. The Medical Director establishes protocols that conform to screening recommendations with scores of A and B, of the United States Preventive Services Task Force Recommendations (these recommendations specify for which populations screening is appropriate) for the following conditions: • HIV and viral hepatitis • Primary care screening pursuant to CCBHC Program Requirement 5 Quality and other Reporting and Appendix B • Other clinically indicated primary care key health indicators of children, adults, and older adults receiving services, as determined by the CCBHC Medical Director, and based on environmental factors, social determinants of health, and common physical health conditions experienced by the CCBHC person receiving services population.	
4.g.2 The Medical Director will develop organizational protocols to ensure that screening for people receiving services who are at risk for common physical health conditions experienced by CCBHC populations across the lifespan. Protocols will include: • Identifying people receiving services with chronic diseases. • Ensuring that people receiving services are asked about physical health symptoms; and • Establishing systems for collection and analysis of laboratory samples, fulfilling the requirements of 4.g In order to fulfill the requirements under 4.g.1 and 4.g.2 the CCBHC should have the ability to collect biologic samples directly, through a DCO, or through protocols with an independent clinical lab organization. Laboratory analyses can be done directly or through another arrangement with an organization separate from the CCBHC. The CCBHC must also coordinate with the primary care provider to ensure	

that screenings occur for the identified conditions. If the person receiving services' primary care provider conducts the necessary screening and monitoring, the CCBHC is not required to do so as long as it has a record of the screening and monitoring and the results of any tests that address the health conditions included in the CCBHCs screening and monitoring protocols developed under 4.g.	
4.g.3 The CCBHC will provide ongoing primary care monitoring of health conditions as identified in 4.g.1 and 4.g.2., and as clinically indicated for the individual. Monitoring includes the following: 1. Ensuring individuals have access to primary care services. 2. Ensuring ongoing periodic laboratory testing and physical measurement of health status indicators and changes in the status of chronic health conditions. 3. Coordinating care with primary care and specialty health providers including tracking attendance at needed physical health care appointments; and 4. Promoting a healthy behavior lifestyle. **Note**: *The provision of primary care services, outside of primary care screening and monitoring as defined in 4.g., is not within the scope of the nine required CCBHC services. CCBHC organizations may provide primary care services outside the nine required services, but these primary care services cannot be reimbursed through the Section 223 CCBHC demonstration PPS.* **Note**: *See also program requirement 3 regarding coordination of services and treatment planning.* ★ Certifying states may elect to require specific other screening and monitoring to be provided by the CCBHCs in addition to the those described in 4.g.	

SECTION 4: SCOPE OF SERVICES	
H. Targeted Case Management Services[23]	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
4.h.1 The CCBHC is responsible for providing directly, or through a DCO, targeted case management services that will assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports. CCBHC targeted case management provides an intensive level of support that goes beyond the care coordination that is a basic expectation for all people served by the CCBHC. CCBHC targeted case management should include supports for people deemed at high risk of suicide or overdose, particularly during times of transitions such as from a residential treatment, hospital emergency department, or psychiatric hospitalization. CCBHC targeted case management should also be used accessible during other critical periods, such as episodes of homelessness or transitions to the community from jails or prisons. CCBHC targeted case management should be used for individual with complex or serious mental health or substance use conditions and for individuals who have a short-term need for support in a critical period, such as an acute episode or care transition. Intensive case management and team-based intensive services such as through Assertive Community Treatment are strongly encouraged but not required as a component of CCBHC services. ★ Based upon the needs of the population served, states should specify the scope of other CCBHC targeted case management services that will be required, and the specific populations for which they are intended.	**4.h.1** Each CCBHC is required to provide, either directly or via a DCO, ACT services to high acuity adults and transition aged youth (ACT-YA).

[23] CCBHC targeted case management services are separate from and do not follow state targeted case management rules under the Medicaid state plan or waivers.

SECTION 4: SCOPE OF SERVICES	
I. Psychiatric Rehabilitation Services	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
4.i.1 The CCBHC is responsible for providing directly, or through a DCO, evidence-based rehabilitation services for both mental health and substance use disorders. Rehabilitative services include services and recovery support that help individuals develop skills and functioning to facilitate community living; support positive social, emotional, and educational development; facilitate inclusion and integration; and support pursuit of their goals in the community. These skills are important to addressing social determinants of health and navigating the complexity of finding housing or employment, filling out paperwork, securing identification documents, developing social networks, negotiating with property owners or property managers, paying bills, and interacting with neighbors or coworkers.[24] Psychiatric rehabilitation services must include supported employment programs designed to provide those receiving services with ongoing support to obtain and maintain competitive, integrated employment (e.g., evidence-based supported employment, customized employment programs, or employment supports run in coordination with Vocational Rehabilitation or Career One-Stop services). Psychiatric rehabilitation services must also support people receiving services to: • Participate in supported education and other educational	

[24] For more information, see Social Determinants of Health (SDOH) State Health Official (SHO) Letter (medicaid.gov).

services; • Achieve social inclusion and community connectedness; • Participate in medication education, self-management, and/or individual and family/caregiver psychoeducation; and • Find and maintain safe and stable housing. Other psychiatric rehabilitation services that might be considered include training in personal care skills; community integration services; cognitive remediation; facilitated engagement in substance use disorder mutual help groups and community supports; assistance for navigating healthcare systems; and other recovery support services including Illness Management & Recovery, financial management, and dietary and wellness education. These services may be provided or enhanced by peer providers. **Note:** *See program requirement 3 regarding coordination of services and treatment planning* ★ Certifying states should specify which evidence-based and other psychiatric rehabilitation services they will require based upon the needs of the population served above the minimum requirements described in 4.i.	

SECTION 4: SCOPE OF SERVICES

J. Peer Supports, Peer Counseling, and Family/Caregiver Supports

Federal Criteria Requirements	Rhode Island Additional Requirements
4.j.1 The CCBHC is responsible for directly providing, or through a DCO, peer supports, including peer specialist and recovery coaches, peer counseling, and family/caregiver supports. Peer services may include	**4.j.1** Each CCBHC shall be Certified by BHDDH to provide Peer Based Recovery Support Services (PBRSS).

peer-run wellness and recovery centers; youth/young adult peer support; recovery coaching; peer-run crisis respites[25]; warmlines; peer-led crisis planning; peer navigators to assist individuals transitioning between different treatment programs and especially between different levels of care; mutual support and self-help groups; peer support for older adults; peer education and leadership development; and peer recovery services. Potential family/caregiver support services that might be considered include community resources education; navigation support; behavioral health and crisis support; parent/caregiver training and education; and family-to-family caregiver support. **Note:** *See program requirement 3 regarding coordination of services and treatment planning.* ★ Certifying states should specify the scope of peer and family services they will require based upon the needs of the population served.	

SECTION 4: SCOPE OF SERVICES

K. Intensive, Community-Based Mental Health Care for Members of The Armed Forces and Veterans

Federal Criteria Requirements	Rhode Island Additional Requirements
4.k.1 The CCBHC is responsible for providing directly, or through a DCO, intensive, community- based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more	

[25] For more information, see National Guidelines for Behavioral Health Crisis Care

(driving distance) from a VA medical facility, or as otherwise required by federal law. Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. The provisions of these criteria in general and, specifically in criteria 4.k, are designed to assist the CCBHC in providing quality clinical behavioral health services consistent with the Uniform Mental Health Services Handbook **Note**: *See program requirement 3 regarding coordination of services and treatment planning*.	
4.k.2. All individuals inquiring about services are asked whether they have ever served in the U.S. military. **Current Military Personnel**: Persons affirming current military service will be offered assistance in the following manner: 1. Active-Duty Service Members (ADSM) must use their servicing MTF, and their MTF Primary Care Managers (PCMs) are contacted by the CCBHC regarding referrals outside the MTF. 2. ADSMs and activated Reserve Component (Guard/Reserve) members who reside more than 50 miles (or one hour's drive time) from a military hospital or military clinic enroll in TRICARE PRIME Remote and use the network PCM or select any other authorized TRICARE provider as the PCM. The PCM refers the member to specialists for care he or she cannot provide and works with the regional managed care support contractor for referrals/authorizations. 3. Members of the Selected Reserves, not on Active Duty (AD) orders, are eligible for TRICARE Reserve Select and can schedule an appointment with any TRICARE- authorized provider, network or nonnetwork. **Veterans**: Persons affirming former military service (veterans) are	

offered assistance to enroll in VHA for the delivery of health and behavioral health services. Veterans who decline or are ineligible for VHA services will be served by the CCBHC consistent with minimum clinical mental health guidelines promulgated by the VHA. These include clinical guidelines contained in the Uniform Mental Health Services Handbook as excerpted below (from VHA Handbook 1160.01, Principles of Care found in the Uniform Mental Health Services in VA Centers and Clinics). **Note**: *See also program requirement 3 requiring coordination of care across settings and providers, including facilities of the Department of Veterans Affairs.*	
4.k.3 The CCBHC ensures there is integration or coordination between the care of substance use disorders and other mental health conditions for those veterans who experience both, and for integration or coordination between care for behavioral health conditions and other components of health care for all veterans.	**4.k.3** Each CCBHC shall have an identified Veterans Coordinator role who is trained as a Veterans Service Officer.
4.k.4. Every veteran seen for behavioral health services is assigned a Principal Behavioral Health Provider. When veterans are seeing more than one behavioral health provider and when they are involved in more than one program, the identity of the Principal Behavioral Health Provider is made clear to the veteran and identified in the health record. The Principal Behavioral Health Provider is identified on a tracking database for those veterans who need case management. The Principal Behavioral Health Provider ensures the following requirements are fulfilled: 1. Regular contact is maintained with the veteran as clinically indicated if ongoing care is required. 2. A psychiatrist or such other independent prescriber as satisfies the current requirements of the VHA Uniform Mental Health Services Handbook reviews and reconciles each veteran's psychiatric medications on a regular basis.	

3. Coordination and development of the veteran's treatment plan incorporates input from the veteran (and, when appropriate, the family with the veteran's consent when the veteran possesses adequate decision-making capacity or with the veteran's surrogate decision maker's consent when the veteran does not have adequate decision-making capacity). 4. Implementation of the treatment plan is monitored and documented. This must include tracking progress in the care delivered, the outcomes achieved, and the goals attained. 5. The treatment plan is revised, when necessary.[26] 6. The principal therapist or Principal Behavioral Health Provider communicates with the veteran (and the veteran's authorized surrogate or family or friends when appropriate and when veterans with adequate decision-making capacity consent) about the treatment plan, and for addressing any of the veteran's problems or concerns about their care. For veterans who are at high risk of losing decision making capacity, such as those with a diagnosis of schizophrenia or schizoaffective disorder, such communications need to include discussions regarding future behavioral health care treatment (see information regarding Advance Care Planning Documents in VHA Handbook 1004.2). 7. The treatment plan reflects the veteran's goals and preferences for care and that the veteran verbally consents to the treatment plan in accordance with VHA Handbook 1004.1, Informed Consent for Clinical Treatments and Procedures. If the Principal Behavioral Health Provider suspects the veteran lacks the capacity to make a decision about the mental health treatment plan, the provider must ensure the veteran's decision-making capacity is formally assessed and documented. For veterans who are determined to lack capacity, the provider must identify the authorized surrogate and document the surrogate's verbal consent to the treatment	

[26] These services must still meet the basic CCBHC requirements to review and update every 6 months in criterion 2.b.2.

plan.	
4.k.5 Behavioral health services are recovery - oriented. The VHA adopted the National Consensus Statement on Mental Health Recovery in its Uniform Mental Health Services Handbook. SAMHSA has since developed a working definition and set of principles for recovery updating the Consensus Statement. Recovery is defined as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." The following are the 10 guiding principles of recovery: • Hope • Person-driven • Many pathways • Holistic • Peer support • Relational • Culture • Addresses trauma • Strengths/responsibility • Respect[27] As implemented in VHA recovery, the recovery principles also include the following: • Privacy • Security • Honor Care for veterans must conform to that definition and to those principles in order to satisfy the statutory requirement that care for veterans	

[27] See SAMHSA's Working Definition of Recovery.

adheres to guidelines promulgated by the VHA.	
4.k.6 All behavioral health care is provided with cultural competence. 1. Any staff who is not a veteran has training about military and veterans' culture in order to be able to understand the unique experiences and contributions of those who have served their country. 2. All staff receive cultural competency training on issues of race, ethnicity, age, sexual orientation, and gender identity.	
4.k.7 There is a behavioral health treatment plan for all veterans receiving behavioral health services. 1. The treatment plan[28] includes the veteran's diagnosis or diagnoses and documents consideration of each type of evidence-based intervention for each diagnosis. 2. The treatment plan includes approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care, and milestones for reevaluation of interventions and of the plan itself. 3. As appropriate, the plan considers interventions intended to reduce/manage symptoms, improve functioning, and prevent relapses or recurrences of episodes of illness. 4. The plan is recovery oriented, attentive to the veteran's values and preferences, and evidence-based regarding what constitutes effective and safe treatments. The treatment plan is developed with input from the veteran and, when	

[28] If the treatment plan section of the electronic health record does not include fields for capturing diagnosis, it shall be captured in other areas of the electronic health record.

the veteran consents, appropriate family members. The veteran's verbal consent to the treatment plan is required pursuant to VHA Handbook 1004.1.	

SECTION 5: QUALITY AND OTHER REPORTING

A. Data Collection, Reporting and Tracking

Federal Criteria Requirements	Rhode Island Additional Requirements
5.a.1 The CCBHC has the capacity to collect, report, and track encounter, outcome, and quality data, including, but not limited to, data capturing: 1. characteristics of people receiving services; 2. staffing; 3. access to services; 4. use of services 5. screening, prevention and treatment 6. care coordination; 7. other processes of care; 8. costs; and 9. outcomes of people receiving services. Data collection and reporting requirements are elaborated below and in Appendix B. Where feasible, information about people receiving services and care delivery should be captured electronically, using widely available standards. **Note**: *See criteria 3.b for requirements regarding health information systems.*	**5.a.1** As part of the reporting requirements for Rhode Island, CCBHCs shall complete and submit the following reports at a regular cadence to the State Interagency Team for program monitoring and oversight purposes: • CCBHC Staffing Template (monthly); • High Acuity Child Program Monitoring Report (monthly); • Mobile Crisis Services Report (monthly); • CCBHC Shadow Claims Report (monthly); • BHOLD Reporting (monthly); • Outreach Activities Monitoring Report (quarterly); • Quality Measures Report (quarterly); • CBHC-DCO TPL Payment Report (quarterly); • CCBHC All Payor Utilization Report (quarterly); and • CCBHC Year-End Cost Report (annual).

5.a.2 Both Section 223 Demonstration CCBHCs, and CCBHC-Es awarded SAMHSA discretionary CCBHC-Expansion grants beginning in 2022, must collect and report the Clinic-Collected quality measures identified as required in Appendix B. Reporting is annual and, for Clinic- Collected quality measures, reporting is required for all people receiving CCBHC services. CCBHCs are to report quality measures nine (9) months after the end of the measurement year as that term is defined in the technical specifications. Section 223 Demonstration CCBHCs report the data to their states and CCBHC-Es that are required to report quality measure data report it directly to SAMHSA. ★ States participating in the Section 223 Demonstration must report State-Collected quality measures identified as required in Appendix B. The State-Collected measures are to be reported for all Medicaid enrollees in the CCBHCs, as further defined in the technical specifications. Certifying states also may require certified CCBHCs to collect and report any of the optional Clinic-Collected measures identified in Appendix B. Section 223 Demonstration program states must advise SAMHSA and its CCBHCs which, if any, of the listed optional measures it will require (either State Collected or Clinic-Collected). Whether the measures are State- or Clinic-Collected, all must be reported to SAMHSA annually via a single submission from the state twelve (12 months after the end of the measurement year, as that term is defined in the technical specifications. States participating in the Section 223 Demonstration program are expected to share the results from the State-Collected measures with their Section 223 Demonstration program CCBHCs in a timely fashion. For this reason, Section 223 Demonstration program states may elect to calculate their State-Collected measures more frequently to share with their Section 223 Demonstration program CCBHCs, to facilitate quality improvement at the clinic level. Quality measures to be reported for the Section 223 Demonstration program may relate to services individuals receive through DCOs. It is the responsibility of the CCBHC to arrange for access to such data	

as legally permissible upon creation of the relationship with DCOs. CCBHCs should ensure that consent is obtained and documented as appropriate, and that releases of information are obtained for each affected person. CCBHCs that are not part of the Section 223 Demonstration are not required to include data from DCOs into the quality measure data that they report. **Note**: *CCBHCs may be required to report on quality measures through DCOs as a result of participating in a state CCBHC program separate from the Section 223 Demonstration, such as a program to support the CCBHC model through the state Medicaid plan*.	
5.a.3 ★ In addition to the State- and Clinic-Collected quality measures described above, Section 223 Demonstration program states may be requested to provide CCBHC identifiable Medicaid claims or encounter data to the evaluators of the Section 223 Demonstration program annually for evaluation purposes. These data also must be submitted to CMS through T-MSIS in order to support the state's claim for enhanced federal matching funds made available through the Section 223 Demonstration program. At a minimum, Medicaid claims and encounter data provided by the state to the national evaluation team, and to CMS through T-MSIS, should include a unique identifier for each person receiving services, unique clinic identifier, date of service, CCBHC-covered service provided, units of service provided and diagnosis. Clinic site identifiers are very strongly preferred. In addition to data specified in this program requirement and in Appendix B that the Section 223 Demonstration state is to provide, the state will provide other data as may be required for the evaluation to HHS and the national evaluation contractor annually. To the extent CCBHCs participating in the Section 223 Demonstration program are responsible for the provision of data, the data will be provided to the state and as may be required, to HHS and the evaluator. CCBHC states are required to submit cost reports	

to CMS annually including years where the state's rates are trended only and not rebased. CCBHCs participating in the Section 223 Demonstration program will participate in discussions with the national evaluation team and participate in other evaluation-related data collection activities as requested.	
5.a.4 ★ CCBHCs participating in the Section 223 Demonstration program annually submit a cost report with supporting data within six months after the end of each Section 223 Demonstration year to the state. The Section 223 Demonstration state will review the submission for completeness and submit the report and any additional clarifying information within nine months after the end of each Section 223 Demonstration year to CMS. **Note**: *In order for a clinic participating in the Section 223 Demonstration Program to receive payment using the CCBHC PPS, it must be certified by a Section 223 Demonstration state as a CCBHC*.	
SECTION 5: QUALITY AND OTHER REPORTING	
B. Continuous Quality Improvement	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
5.b.1 In order to maintain a continuous focus on quality improvement, the CCBHC develops, implements, and maintains an effective, CCBHC-wide continuous quality improvement (CQI) plan for the services provided. The CCBHC establishes a critical review process to review CQI outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services. The CQI plan focuses on indicators related to improved behavioral and physical health	

outcomes and takes actions to demonstrate improvement in CCBHC performance. The CQI plan should also focus on improved patterns of care delivery, such as reductions in emergency department use, rehospitalization, and repeated crisis episodes. The Medical Director is involved in the aspects of the CQI plan that apply to the quality of the medical components of care, including coordination and integration with primary care.	
5.b.2 The CQI plan is to be developed by the CCBHC and addresses how the CCBHC will review known significant events including, at a minimum: (1) deaths by suicide or suicide attempts of people receiving services; (2) fatal and non-fatal overdoses; (3) all-cause mortality among people receiving CCBHC services; (4) 30 day hospital readmissions for psychiatric or substance use reasons; and (5) such other events the state or applicable accreditation bodies may deem appropriate for examination and remediation as part of a CQI plan	
5.b.3 The CQI plan is data-driven and the CCBHC considers use of quantitative and qualitative data in their CQI activities. At a minimum, the plan addresses the data resulting from the CCBHC-collected and, as applicable for the Section 223 Demonstration, State-Collected, quality measures that may be required as part of the Demonstration. The CQI plan includes an explicit focus on populations experiencing health disparities (including racial and ethnic groups and sexual and gender minorities) and addresses how the CCBHC will use disaggregated data from the quality measures and, as available, other data to track and improve outcomes for populations facing health disparities.	

SECTION 6: ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION	
A. General Requirements of Organizational Authority and Finances	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
6.a.1. The CCBHC maintains documentation establishing the CCBHC conforms to at least one of the following statutorily established criteria: • Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code • Is part of a local government behavioral health authority • Is operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.) • Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). **Note**: *A CCBHC is considered part of a local government behavioral health authority when a locality, county, region or state maintains authority to oversee behavioral health services at the local level and utilizes the clinic to provide those services.*	
6.a.2 To the extent CCBHCs are not operated under the authority of the Indian Health Service, an Indian tribe, or tribal or urban Indian organization, CCBHCs shall reach out to such entities within their geographic service area and enter into arrangements with those entities to assist in the	

provision of services to tribal members and to inform the provision of services to tribal members. To the extent the CCBHC and such entities jointly provide services, the CCBHC and those collaborating entities shall, as a whole, satisfy the requirements of these criteria.	
6.a.3 An independent financial audit is performed annually for the duration that the clinic is designated as a CCBHC in accordance with federal audit requirements, and, where indicated, a corrective action plan (CAP) is submitted addressing all findings, questioned costs, reportable conditions, and material weakness cited in the Audit Report.	

SECTION 6: ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION

B. Governance

Federal Criteria Requirements	Rhode Island Additional Requirements
6.b.1 CCBHC governance must be informed by representatives of the individuals being served by the CCBHC in terms of demographic factors such as geographic area, race, ethnicity, sex, gender identity, disability, age, sexual orientation, and in terms of health and behavioral health needs. The CCBHC will incorporate meaningful participation from individuals with lived experience of mental and/or substance use disorders and their families, including youth. This participation is designed to assure that the perspectives of people receiving services, families, and people with lived experience of mental health and substance use conditions are integrated in leadership and decision-making. Meaningful participation means involving a substantial number of people with lived experience and family members of people receiving	**6.b.1** CCBHCs shall adopt one of the following approaches to secure meaningful participation in the CCBHCs policies, processes, and services by individuals and families receiving services from CCBHCs: **Option 1**: At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental health and/or substance use disorders, and their family members. This governing board can function as the Advisory Council as described in Addendum 8. **Option 2**: Development of an Advisory Council that reports to the board, as described in Addendum 8.

services or individuals with lived experience in developing initiatives; identifying community needs, goals, and objectives; providing input on service development and CQI processes; and budget development and fiscal decision making.[29] CCBHCs reflect substantial participation by one of two options: **Option 1**: At least fifty-one percent of the CCBHC governing board is comprised of individuals with lived experience of mental and/or substance use disorders and families. **Option 2**: Other means are established to demonstrate meaningful participation in board governance involving people with lived experience (such as creating an advisory committee that reports to the board). The CCBHC provides staff support to the individuals involved in any alternate approach that are equivalent to the support given to the governing board. Under option 2, individuals with lived experience of mental and/or substance use disorders and family members of people receiving services must have representation in governance that assures input into: 1. Identifying community needs and goals and objectives of the CCBHC 2. Service development, quality improvement, and the activities of the CCBHC 3. Fiscal and budgetary decisions 4. Governance (human resource planning, leadership recruitment and selection, etc.) Under option 2, the governing board must establish protocols for incorporating input from individuals with lived experience and family members. Board meeting summaries are shared with those participating in the alternate arrangement and recommendations from the alternate arrangement shall be entered into the formal board record; a member or members of the arrangement established under option 2 must be invited to board meetings; and representatives of the alternate arrangement must have the opportunity to regularly address the board directly, share	

[29] For more information regarding meaningful participation, see Participation Guidelines for Individuals with Lived Experience and Family | SAMHSA.

recommendations directly with the board, and have their comments and recommendations recorded in the board minutes. The CCBHC shall provide staff support for posting an annual summary of the recommendations from the alternate arrangement under option 2 on the CCBHC website.	
6.b.2 If option 1 is chosen, the CCBHC must describe how it meets this requirement, or provide a transition plan with a timeline that indicates how it will do so. If option 2 is chosen, for CCBHCs not certified by the state, the federal grant funding agency will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes. ★ For certifying states, if option 2 is chosen then states will determine if this approach is acceptable, and, if not, require additional mechanisms that are acceptable. The CCBHC must make available the results of its efforts in terms of outcomes and resulting changes.	
6.b.3 To the extent the CCBHC is comprised of a governmental or tribal organization, subsidiary, or part of a larger corporate organization that cannot meet these requirements for board membership, the CCBHC will specify the reasons why it cannot meet these requirements. The CCBHC will have or develop an advisory structure and describe other methods for individuals with lived experience and families to provide meaningful participation as defined in 6. b.1.	
6.b.4 Members of the governing or advisory boards will be representative of the communities in which the CCBHC's service area is located and will be selected for their expertise in health services, community affairs,	

local government, finance and accounting, legal affairs, trade unions, faith communities, commercial and industrial concerns, or social service agencies within the communities served. No more than one half (50 percent) of the governing board members may derive more than 10 percent of their annual income from the health care industry.	
SECTION 6: ORGANIZATIONAL AUTHORITY, GOVERNANCE AND ACCREDITATION	
C. Accreditation	
Federal Criteria Requirements	**Rhode Island Additional Requirements**
6.c.1 The CCBHC enrolled as a Medicaid provider and licensed, certified, or accredited provider of both mental health and substance use disorder services including developmentally appropriate services to children, youth, and their families, unless there is a state or federal administrative, statutory, or regulatory framework that substantially prevents the CCBHC organization provider type from obtaining the necessary licensure, certification, or accreditation to provide these services. The CCBHC will adhere to any applicable state accreditation, certification, and/or licensing requirements. Further, the CCBHC is required to participate in SAMHSA Behavioral Health Treatment Locator.	
6.c.2 CCBHCs must be certified by their state as a CCBHC or have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program. Clinics that have submitted an attestation to SAMHSA as a part of participation in the SAMHSA CCBHC Expansion grant program are designated as CCBHCs only during the period for which they are authorized to receive federal funding to provide CCBHC services. CCBHC expansion grant recipients are encouraged to seek state certification if they are in a state that certifies CCBHCs.	**6.c.2** EOHHS will determine the recertification timeline in compliance with SAMSHA standards that recertification occurs no more than every three years. CCBHC certification is valid for a period of three years from the date of issuance, contingent upon continued provider compliance with all RI CCBHC certification requirements. Providers who wish to retain their certification status beyond three years shall undergo a reapplication process before their current certification expires.

★ State-certified clinics are designated as CCBHCs for a period of time determined by the state but not longer than three years before recertification. States may decertify CCBHCs if they fail to meet the criteria, if there are changes in the state CCBHC program, or for other reasons identified by the state. Certifying states may use an independent accrediting body as a part of their certification process as long as it meets state standards for the certification process and assures adherence to the CCBHC Certification Criteria.	
6.c.3 States are encouraged to require accreditation of the CCBHCs by an appropriate independent accrediting body (e.g., the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities [CARF], the Council on Accreditation [COA], the Accreditation Association for Ambulatory Health Care [AAAHC]). Accreditation does not mean "deemed" status.	

ADDENDA

ADDENDUM 1: Special Population Rate Eligibility Criteria

Rhode Island has selected the PPS2 rate structure and has identified two (2) distinct "Special Population" rates. Each rate has its own eligibility criteria which is noted below. The three "Special Population" rates are:

A. High Acuity Adults
B. High Acuity Children

A. High Acuity Adults

An individual may be attributed to the CCBHC 'High Acuity Adult' population if they meet the following eligibility criteria:

Age 18 Years or Older	**WITH** a Qualifying MH Diagnosis[30]	**AND** a DLA score of Four (4) or less **OR** on an I/DD waiver	**AND** meets the ACT Service Thresholds[31]
Age 15–26 Years (Transition Aged Youth)	**WITH** a Qualifying MH Diagnosis[31]	**AND** a DLA score of Four (4) or less	**AND** meets the ACT-YA Service Thresholds[32]

Exception Request:

For any individual who may require High Acuity Adult services but does not meet the above eligibility criteria: Please complete a 'CCBHC High Acuity Adult Population Exception Request Form' and submit to BHDDH for review. The individual may only be attributed to the High Acuity Adult population and enrolled in ACT services if the request is approved in writing by BHDDH. The exception shall be placed in the patient's chart.

Re-evaluation Requirements:

All individuals who are attributed to the High Acuity Adult population must be re-evaluated at minimum every ninety (90) days, if not sooner based on change(s) in the patient's health status. The DLA is the level of care instrument required as part of the re-evaluation and must be completed by a staff member certified to administer the DLA and the DLA form itself must be signed by the certified staff member who completed the DLA for that individual. CCBHCs must provide to EOHHS and BHDDH a list of all DLA certified staff upon request.

[30] Please see Table 1 for State Approved Mental Health Diagnoses for CCBHC High Acuity Adult Population

[31] Please see Table 2 for required Service Thresholds for CCBHC High Acuity Adult Population

Continued Eligibility Requirements:

Continued eligibility for individual attribution to the High Acuity Adult population requires:

- Reassessment of each individual's eligibility (per the above criteria) **OR** an approved and valid 'High Acuity Adult Population Exception Request Form' approved in writing by BHDDH; **AND**
- Review of each individual's service utilization to ensure compliance with the minimum ACT service threshold requirements. This is to ensure that the patient receives the approved level of care services.

A 'High Acuity Adult Population Exception Request Form' shall only be submitted for individuals who do not meet the minimum ACT service threshold requirements due to hospitalization, incarceration, and/or being out of State for a significant period of time.

Table 1: State Approved ICD-10 Diagnoses for CCBHC High Acuity Adult Population

ICD-10 Code	Code Description
F06.2	Psychosis
F20.0	Schizophrenia
F20.1	Schizophrenia
F20.2	Schizophrenia
F20.3	Schizophrenia
F20.5	Schizophrenia
F20.8	Schizophrenia
F20.9	Schizophrenia
F22	Delusional Disorders
F23	Psychosis
F25.0	Schizoaffective Disorder
F25.1	Schizoaffective Disorder
F25.8	Schizoaffective Disorder
F25.9	Schizoaffective Disorder
F28	Psychosis
F29	Psychosis
F31.0	Bipolar
F31.1	Bipolar
F31.2	Bipolar
F31.3	Bipolar
F31.4	Bipolar
F31.5	Bipolar

F31.6	Bipolar
F31.7	Bipolar
F31.8	Bipolar
F31.9	Bipolar
F32.0	Major Depression
F32.1	Major Depression
F32.2	Major Depression
F32.3	Major Depression
F32.9	Major Depression
F33	Major Depression
F33.0	Major Depression
F33.1	Major Depression
F33.2	Major Depression
F33.3	Major Depression
F33.4	Major Depression
F33.8	Major Depression
F33.9	Major Depression
F41.0	Severe Panic Disorder
F42.2	Severe OCD
F42.3	Severe OCD
F42.4	Severe OCD
F42.8	Severe OCD
F42.9	Severe OCD
F43.1	PTSD
F53	Psychosis
F60.1	Schizoid Personality Disorder
F60.3	Borderline Personality Disorder

Note: The following diagnoses may be identified as co-morbidities for any client attributed to the CCBHC High Acuity Adult population. However, these clinical diagnoses by themselves, are not sufficient for attribution to the High Acuity Adult population.

- F32.5 – Major Depressive Disorder
- F41.1 – Generalized Anxiety Disorder
- F43.2 – Adjustment Disorder

Table 2: High Acuity Adult Service Threshold Requirements

The below minimum service thresholds are established per client, per month. Only services that are a qualifying event per the PPS Billing Codes for DY3 can be considered qualifying services to be counted as part of the minimum services requirement for ACT and ACT YA.

Program	Minimum # of TOTAL Qualifying Services (HOURS)
ACT	Four (4) *At least four (2) of these must be provided in-person
ACT-YA	Four (4) *At least four (2) of these must be provided in-person

- High Acuity Adult required treatment model are detailed in Addendum 2: Required Treatment Models for Special Populations.
- In order to continue to bill for High Acuity Adult for a member, a minimum of twelve (12) service hours of qualifying events must be provided per ninety (90) days to each high acuity adult. Six (6) of the service hours within the 90-day period, must be delivered in-person. Exceptions to the six hour in-person requirement may be permitted for documented, extenuating circumstances (e.g., relocation or health-related barriers), provided the total 12 service hour per 90-day requirement is met via telehealth, and the exception is clearly justified in the patient's clinical record.

B. High Acuity Child

An individual may be attributed to the CCBHC 'High Acuity Child' population if they meet the following eligibility criteria:

Age 18 years or under[32]	**AND** meet at least one of the below criteria: • At least 1 inpatient psychiatric admission within 1 year • A history of at least 1 suicide attempt within 2 years • Have engaged in self-harm or have had suicidal and/or homicidal ideation within the past year • At least 2 emergency department visits within the past 6 months putting them at risk of psychiatric hospitalization or out-of-home placement • Are being referred for treatment as a transition from a higher level of care within the past 30 days, such as inpatient hospitalization, a partial hospitalization program, or a congregate care setting • Within the past six months, have gone through an acute crisis (e.g. a home fire, a school shooting, or exposure to community violence) that has greatly affected their ability to function across multiple environments including home, school, and community • Have a co-occurring moderate or severe substance use disorder, as defined by the DSM-5 or ASAM criteria • Have experienced trauma (including but not limited to physical, sexual, or emotional abuse; neglect; exposure to domestic or community violence; natural disasters; or acts of terrorism) • Involvement with multiple systems, such as child welfare, juvenile justice,	**AND** Received <u>CANS Child Risk Behavior Domain of at least:</u> • One score of 3 **OR** • Two scores of 2 **OR** <u>CANS Child Behavioral/Emotional Needs Domain of at least:</u> • One score of 3 **OR** • Two scores of 2	**AND** meets the Child High Acuity Service Threshold

[32] Children aged 0-4 will require an approved exception form by DCYF until the appropriate CANS assessment tool is available

	or special education currently or within the past year • Are currently unhoused or have been unhoused in the last 90 days		

High Acuity Child Eligibility Guidance:

- Individuals who are eligible for the High Acuity Child population attribution must be re-evaluated every ninety (90) days.
- Individuals who do not meet the required eligibility criteria but assessed to be clinically appropriate must submit a "High Acuity Child" population exception request form for approval by DCYF to successfully attribute this individual to the High Acuity Child population.
- A minimum of twenty-four (24) service hours must be provided per ninety (90) days to each high acuity child. Twelve (12) of the service hours must be delivered in-person to the child. Exceptions to the 12-hour in-person requirement may be permitted for documented, extenuating circumstances (e.g., relocation or health-related barriers), provided the total 24-hour service hour requirement is met via telehealth and the exception is clearly justified in the child's record.

High Acuity Child required treatment models are detailed in Addendum 2: Required Treatment Models for Special Populations.

C. Standard Population

- An individual is in the Standard Population if they are not eligible, or do not have an approved exception request form to be attributed to the High Acuity Adult or High Acuity Child specialty population.
- All individuals being served by a CCBHC are eligible to receive all required CCBHC services, however in order to bill special population rates, the individual must meet the special population rate eligibility criteria and programmatic requirements.

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

Setting Type	Are CCBHC Services Allowable?
Mental Health Psychiatric Rehabilitative Residences (MHPRR) – 3 levels	Yes[33]
E-MHPRR	Yes[35]
Nursing Homes	No[34]
Assisted Living	Yes[35]
Recovery Housing	Yes[35]
SUD Residential	Yes[35]
Intermediate Care Facility	No[36]
Children's Residential Care (includes Group Homes and Semi-Independent Living Programs)	Yes[35]
Children's Campus-Based Residential Facilities with Onsite Education	No[36]
Children's Acute Residential	No[36]
Correctional Facilities (e.g. RIDOC's Adult Correctional Institutions; RI Training School)	No[36]

[33] In 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).

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

ADDENDUM 2: Required Treatment Models for Special Populations

All PPS2 Rates include the required CCBHC services, however High Acuity Adult Special Population Rate and High Acuity Child Special Population rate may have required treatment models, service standards and staffing requirements.

A. High Acuity Adult Special Population

Table 1: Required Treatment Models for High Acuity Adult Special Population

Service	Description	Service Requirement
Assertive Community Treatment (ACT)	• An evidence based multidisciplinary team-based model designed for individuals with serious mental illness (SMI) who need the highest-intensity level of community-based supports	• Individual assessment, evaluation and treatment planning • Pharmacotherapy • Crisis intervention and support • Psychoeducation • Skills training and illness management • Case management • Care coordination • IPS (supported employment) • Assess housing needs and coordinate with housing resources and community partners to support housing stability • Counseling • Peer Support • Psychiatric Rehab • Substance Use Counseling • Evidenced Based Practices (e.g. DBT, CBT, MI)

Assertive Community Treatment (ACT-YA)	• An evidence based multidisciplinary team-based model designed for transition aged youth with serious mental illness (SMI), First Episode Psychosis (FEP) or who are considered at risk secondary to social/environmental circumstances	• Individual assessment, evaluation and treatment planning • Pharmacotherapy • Crisis intervention and support • Psychoeducation • Medication Education • Skills training and illness management • Case management • IPS (supported employment) • Education Assistance • Coordination with school and family • Family Counseling/ SUD Counseling • Family/Youth Support • Psychiatric Rehab • Evidenced Based Practices (e.g. DBT, CBT, MI) • Individual and group therapy

Table 2: Training for High Acuity Adult Treatment Models (ACT-I, ACT-YA)

Required Staff	Required Training	Recommended Training
All staff providing services on ACT, and/or ACT-YA teams	ACT Model (EBP)	Motivational Interviewing
		Trauma Informed Care/Approach
		Psychiatric Symptom Management & Support
		Medication Management & Support
		Psychosocial Rehabilitation
		Co-Occurring Mental Health and SUD Treatment
		Crisis Intervention & De-escalation
Team Leader	ACT Model (EBP)	TMACT Fidelity
Registered Nurse	Medication Assisted Treatment	ASAM
		DLA
Clinician	ACT Model (EBP)	CBT
		DBT
		FPE
Vocational Specialist	Individual Placement and Supports (IPS)	
SUD Specialist	SBIRT	ASAM
	Medication Assisted Treatment (MAT)[6]	
	12-STEP	
CPST and/or Case Manager	ACT Model (EBP)	Housing support, retention, and eviction prevention
		IPS

Table 3: Assertive Community Treatment (ACT) Fidelity Requirements

Fidelity is evaluated per ACT team, not at the ACT program level.

Program	Fidelity Tool	Requirements
ACT	TMACT	• **DY2**: Provider shall review the TMACT tool and use it to guide their implementation of the ACT model. • **DY3**: Provider shall conduct an initial annual fidelity assessment using the TMACT tool. • **DY4:** Provider shall use findings from their initial assessment to work towards achieving full fidelity. • **DY5**: Provider is expected to provide ACT to fidelity.
ACT-YA	Same as for ACT	Same as for ACT

ACT (High Intensity) Model

Primary Eligibility Criteria

- Adults aged 18+ who meet the current CCBHC "High Acuity Adults" eligibility criteria

Service Intensity Standards

- **Hours of Operation**: Ten (10) hours of active operation during weekday and four (4) hours per day on weekends and holidays
- **Crisis Response**: On-call capability 24/7 for individual emergencies
- **Client-to-Staff Ratio**: 1:8 ratio of client to direct service staff members
- **Contact Frequency Requirements**: Minimum of…
    - Four (4) hours of qualifying services per client, per month, at least (2) hours in-person
- **Qualifying Contacts:**
    - Contacts must be qualifying events, as defined in the RI CCBHC PPS2 Billing Code List.
    - Providers outside of the required ACT team composition (e.g. Peer Specialist, Housing Specialist) who provide a qualifying service for an individual enrolled in ACT, can be counted towards the monthly minimum contact or minimum hour requirement.
    - Requirements include daily contact capability for individuals in crisis or acute phases, and a flexible contact schedule based on individual needs and circumstances. Documentation on attempts to outreach and engage individuals who may resist team services or are unable to be located secondary to transient nature or housing, is required for continued services within this program.

Service Duration

There is no predetermined time limit for enrollment in ACT services. However, in alignment with CMS rules, each individual must be reevaluated at least every 90 days to ensure this level of service is clinically appropriate and that the individual meets the eligibility requirements for this service.

In addition to the conduction of a DLA reassessment, each individual shall be reviewed by their treatment team to determine which services, and frequency of these services, are essential and most clinically appropriate for each individual. Proactive and meaningful steps shall be taken to move each individual down to Standard Population level of care over time.
All services currently offered within the ACT model (e.g. psychosocial rehab, case management, SUD, med management) are available to individuals in Standard Population and dependent on individual needs and preferences. These service needs and preferences should be clearly documented in the individual person-centered treatment plans as required and with any change in level of care.

Exception Request Process

Individuals who do not meet the State established requirements for ACT (i.e. due to their inability to meet the CCBHC High Acuity Adult population eligibility criteria), but for whom a CCBHC believes are clinically appropriate may submit a formal Exception Request to BHDDH for review and approval.

Staffing Model

ACT (Team Census 100)		
Team Lead	1 FTE	LICSW, LCSW[35], LMHC, LMHC-A [36], LMFT, LMFT-A, LCDP, RN, Principal Counselor
Registered Nurse	3 FTE	At least two of these positions must be filled by an RN. The third positions may be filled by an LPN with appropriate RN supervision.
Clinician	1 FTE	Principal Counselor[36], LICSW, LCSW[36], LMHC, LMHC-A[36], LMFT, LMFT-A[36]
Vocational Specialist	1 FTE	BA level
SUD Specialist	1 FTE	LCDP, CADC, Principal Counselor[36], LICSW, LCSW[36], LMHC, LMHC- A[36]LMFT, LMFT-A[36], BH Level[36]
CSPT or Case Manager	3 FTE	Associates degree or BHDDH approved certification/curriculum

[35] An appropriate supervision plan shall be in place for individual without an independent license to ensure regulatory compliance
[36] Providers must request a staffing variance from BHDDH for individuals with a BA Level degree in a SUD Specialist role. Individuals must be actively pursuing licensure or certification that meets SUD Specialist requirements with documented appropriate supervision.

Flex Staff	2 FTE	These positions should be utilized to fill the specific needs of the team population. You can fill these “FLEX” positions with a Community Psychiatric Support Treatment provider (CPST), Case Manager, Clinician, Substance Use Specialist, Vocational Specialist, or a Certified Peer Recovery Specialist depending on your team needs
Prescriber	.75	Psychiatrist or APRN

ACT-YA (Young Adult) Model

Primary Eligibility Criteria

- Transition-aged individuals (age 15-26 years old) who meet the current CCBHC "High Acuity Adults" eligibility criteria

Service Intensity Standards

- **Hours of Operation**: Ten (10) hours of active operation during weekdays and four (4) hours per day on weekends and holidays.
- **Crisis Response**: On-call capability 24/7 for individual emergencies
- **Client-to-Staff Ratio**: 1:8 ratio of client to direct service staff members
- **Service Frequency Requirements**: Minimum of…
    - Four (4) hours of qualifying services per client, per month, at least (2) hours in-person

    - **Qualifying Services:**
    - Contacts must be qualifying events, as defined in the RI CCBHC PPS-2 Billing code List.
    - Providers outside of the required ACT-YA team composition (e.g. Peer Specialist, Family/Youth Support Partners) who provide a qualifying service for an individual enrolled in ACT-YA, can be counted towards the monthly minimum hour requirement.

Service Duration

There is no predetermined time limit for enrollment in ACT-YA services. However, each individual must be reevaluated at least every 90 days to ensure this level of service is clinically appropriate and that the individual meets the eligibility requirements for this service.

In addition to the conduction of a DLA reassessment, each individual shall be reviewed by their treatment team to determine which services, and frequency of these services, are essential and most clinically appropriate for each individual. Proactive and meaningful steps shall be taken to move each individual down to a Standard Population level of care over time.

All services currently offered within the ACT-YA model (e.g. psychosocial rehab, case management, SUD, med management) are available to individuals in Standard Population, dependent on individual needs and preferences. These service needs and preferences should be clearly documented in the individual person-centered treatment plans as required and with any change in level of care.

Exception Request Process

Individuals who do not meet the State established requirements for ACT-YA (i.e. due to their inability to meet the CCBHC High Acuity Adult population eligibility criteria), but for whom a CCBHC believes are clinically appropriate may submit a formal Exception Request to BHDDH for review and approval.

Staffing Model

ACT- YA (Team Census 50)		
Team Lead	1 FTE	LICSW, LCSW[36], LMHC, LMHC-A[36], LMFT, LMFT-A[36], LCDP, RN, Principal Counselor[36]
Registered Nurse	1 FTE	RN
Clinician	1 FTE	Principal Counselor[36], LICSW, LCSW[36], LMHC, LMHC-A[36], LMFT, LMFT-A[36]
Vocational Specialist	1 FTE	BA level
CPST or Case Manager	1 FTE	Associates degree or BHDDH approved certification/curriculum
Flex Staff	1 FTE	These positions should be utilized to fill the specific needs of the team population. You can fill these "FLEX" positions with a Community Psychiatric Support Treatment provider (CPST), Case Manager, Clinician, Substance Use Specialist, Vocational Specialist, or a Certified Peer Recovery Specialist depending on your team needs
Prescriber	.25	Psychiatrist or APRN

B. High Acuity Children Special Population

Required Treatment Models for High Acuity Children Special Population are inclusive of wraparound services provided in the home or other community settings.

Primary Eligibility Criteria

- Children aged 18 and under who meet the current CCBHC "High Acuity Child" eligibility criteria

Service Intensity Standards

- **Hours of Operation:** Programs should offer evening and/or weekend hours to accommodate family and school schedules
- **Client-to-Staff Ratio**: 1:10 ratio of client to clinician
- **Service Frequency Requirements:**
  - Qualifying Services are provided at minimum twice per week
  - Minimum of eight (8) hours of Qualifying service per month, or twenty-four (24) hours on average per ninety (90) days
- **Qualifying Contacts:**
  - Contacts must be qualifying events, as defined in the RI CCBHC PPS-2 Billing Code List.

Service Requirements

- **School and Community Coordination**: Coordination with schools, state agencies, and other community services (e.g., child welfare, juvenile justice, primary care/ pediatricians, childcare providers, family home visitors) ensures that the child/youth's care is holistic and extends into the environments where they live, learn, and receive other care.
- **Behavioral Interventions**: These are structured approaches designed to teach children/youth new coping strategies and ways to manage their behavior. Techniques may include reinforcement systems, skill-building activities, and social skills training.
- **Family Therapy and Support**: Given the significant role that family dynamics play in a child/youth's mental health; family therapy is often a core component. This can help families understand the child/youth's behavior, improve communication, and develop strategies to support the child/youth's treatment.
- **Group Therapy:** Group therapy for children is a therapeutic approach where children/youth participate in structured sessions led by a trained therapist in a group setting with peers facing similar challenges or issues. The goal is to provide a supportive environment where children/youth can learn social skills, improve emotional regulation, and develop coping strategies. **Group**

therapy must be offered and provided by the CCBHC to all children with a Standard or High Acuity level of need, when clinically indicated; ii) Provision of group therapy counts towards the minimum monthly service requirements for High Acuity Children.

- **Individual Therapy**: Specialized therapeutic approaches such as Cognitive Behavioral Therapy (CBT), Dialectical Behavior Therapy (DBT), or trauma-informed therapies are used to address the child/youth's specific behavioral and emotional needs. Children/youth who have experienced significant trauma, specialized services focused on trauma recovery, such as trauma-focused cognitive behavioral therapy (TF-CBT), are encouraged to be incorporated into the treatment plan.

Service Duration

There is no predetermined time limit for Child High Acuity Services; however, the average treatment duration for High Acuity services is 12-16 weeks. Each individual must be re-evaluated at minimum every ninety (90) days to ensure this level of service is clinically appropriate and that the individual meets the eligibility requirements for this service.

Exception Request Process

Individuals who do not meet the State established requirements for High Acuity Children (i.e. due to their inability to meet the CCBHC High Acuity Children population eligibility criteria), but for whom a CCBHC believes are clinically appropriate may submit a formal Exception Request to DCYF for review and approval.

Staffing Model

- Required staffing for High Acuity Children treatment models include:
    - Program Manager/Director
    - Psychiatrist and/or APRN
    - Registered Nurses
    - Licensed Clinicians and/or Psychologists
    - Case Managers and/or CPST
    - Vocational Specialist
    - Family Partners and Youth Partners
- All staff working in the High Acuity programs must have one year of direct, relevant experience with the targeted population (e.g., substance abuse, developmental disabilities, sexual abuse, and post-traumatic stress disorder).

- If a staff member does not possess the required experience, a waiver request must be submitted to DCYF and be approved to provide services.

C. Standard Population

All required CCBHC services are included within the Standard Population rate.

Primary Eligibility Criteria

- Adults who do not meet the "High Acuity Adult" special population eligibility criteria, or who do not meet service utilization requirements
- Children who do not meet the "High Acuity Children" special population eligibility criteria
- Both adults and children in this population shall receive services at the intensity and by the qualified staff as determined in their person-centered treatment plan. Services identified in the person-centered treatment plan shall be the responsibility of the CCBHC, whether the CCBHC is directly providing the service, the service is via a DCO relationship or the service is via a care coordination agreement or referral to another treatment provider, where the CCBHC is responsible for the related care coordination activities.

Service Requirements

Service Requirements and Staffing Recommendations can be seen in Table 4 below.

Table 4: CCBHC Service Requirements and Staffing Recommendations (All Populations)

Service	Requirement	Staffing Recommendation
	• 24/7 Mobile Crisis Teams *(2-person response)* • Mobile Response and Stabilization	• Qualified Mental Health Professional (QMHP) • Registered Nurses

Crisis Services	Services (MRSS) for Youth
	• Emergency Crisis Intervention Services
	  ○ Including suicide prevention and intervention
	  ○ Including Overdose prevention and access to Naloxone
	• Crisis Stabilization
		• Licensed Independent Practitioner [37]
		• Principal Counselor[38]
		• CPST
		• Certified Peer
		• Family Partner
		• Youth Partner
		• Unlicensed CCBHC Personnel[39]

Person-Centered & Family- Centered Treatment Planning	• Risk Assessment • Crisis Planning • Identification of shared goals for treatment	• Psychiatrist • APRN • Registered Nurses • LICSW • LCDP • LCSW • LMFT-A • LMHC-A • Principal Counselor • CPST • Case Manager • Certified Peer • Family Partner • Youth Partner

[37] Licensed Independent Practitioner includes Psychologist, LICSW, LMHC, LMFT
[38] Principal Counselor: Master's degree without License with 1-year post-master's degree of full time BH experience and approved designation as Principal Counselor from BHDDH
[39] Unlicensed CCBHC personnel must have B.A or B.S in social work, psychology or related field and have a minimum of 2 years of experience in human services profession. They must be certified in First Aid/CPR and as a Community Responder. A minimum of four years of employment in the human services field may be substituted for a bachelor's degree

		• Vocational Specialist
Outpatient Primary Care Screening & Monitoring	• Primary Care Provider (PCP) screening and coordination • Screening for physical health conditions and symptoms • HIV and Viral Hepatitis • A1C • Other clinically indicated primary care key health indicators of children, adults and older adults as determined by the CCBHC Medical Director and based on individual needs of the person receiving services	• Psychiatrist/APRN • Registered Nurses • LICSW • LCDP • LCSW • LMFT-A • LMHC-A • Principal Counselor • CPST • Case Manager • Certified Peer • Family Partner • Youth Partner • Care Navigators/Care Coordinators

Screening, Assessment and Diagnosis	• Risk Assessment
	  ○ Suicide Risk
	  ○ Withdrawal and Overdose Risk
	  ○ Danger to Self or Others
	  ○ Urgent or Critical medical conditions
	  ○ Other immediate risks
	• Screening, Brief Intervention and Referral to Treatment (SBIRT)
		• Psychiatrist/APRN
		• Registered Nurses
		• LICSW
		• LCDP
		• LCSW
		• LMFT-A
		• LMHC-A
		• Principal Counselor

	○ Screening for unhealthy alcohol use ○ Screening for tobacco use • Basic Cognitive Screening • Depression Screening (PHQ-9 and PHQ-9M) • Social Determinants of Health • Traumatic Brain Injury (TBI) Screen (OBISSS+) • Child and Adolescent Needs and Strengths (CANS) as indicated • Daily Living Activities (DLA) as indicated • American Society for Addition Medicine (ASAM) as indicated • Military Service screening	• CPST • Case Manager • Certified Peer • Family Partner • Youth Partner • Care Navigators/Care Coordinators • Vocational Specialist
Psychiatric Rehabilitation	• Services to develop skills and functioning to facilitate community living • Services to help educational development • Individual Placement and Supports (IPS) • Training in: ○ Personal Care Skills	• CPST • Vocational Specialist

	○ Financial Management ○ Illness Management & Recovery • Support in maintaining safe and stable housing	
Targeted Case Management	• Assistance with gaining access to supports that include but are not limited to: ○ Medical ○ Social ○ Legal ○ Educational ○ Housing ○ Vocational • Transitional Support for individuals identified as: ○ High Risk for Suicide ○ High Risk for Overdose ○ Transitioning from other levels of care (e.g. hospital, residential) ○ Unhoused ○ Previously Incarcerated	• Case Manager • Registered Nurse
Peer & Family Supports	• Peer Counseling (Individual & Group) • Recovery Coaching	• Certified Peer • Family Partner

	• Family/ Caregiver Supports	• Youth Partner
Intensive Community-Based Outpatient Behavioral Health Care for Members of the U.S Armed Forces and Veterans	• Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. • Coordination with VA Medical Facility • Assistance with enrolling in eligible benefits (VHA)	• Psychiatrist • APRN • Registered Nurses • LICSW • LCDP • LCSW • LMFT-A • LMHC-A • Principal Counselor • CPST • Case Manager • Certified Peer • Family Partner • Youth Partner • Veterans Coordinator • Vocational Specialist
	• Psychopharmacologic Treatment • Developmentally appropriate Evidenced Based Practices[40] for	• Psychiatrist/APRN • Registered Nurses • LICSW

[40] See Addendum 7 for all Rhode Island required Evidence Based Practices

Outpatient Behavioral Health Services	treating Mental Health and Substance Use Disorders across the lifespan with tailored approaches for adults, children and families. • Substance use treatment[41] • Telehealth and Telemedicine services • Referral to specialized services as indicated by individual need • Community based supports and home visits • Care Coordination with community partners • Assertive Community Treatment (ACT-I, ACT-YA)	• LCDP • LCSW • LMFT-A • LMHC-A • Principal Counselor • CPST • Case Manager • Certified Peer • Family Partner • Youth Partner • Veterans Coordinator • Vocational Specialist • Certified Alcohol and Drug Counselor (CADC)

Table 5: Required Substance Use Treatment Models

Service	Description	Components	Staffing Recommendations
ASAM Level 0.5	• Assessment and Education for individuals at risk of developing a	• Court ordered substance use education for individuals after a Driving	• LCDP • Certified Alcohol & Drug Counselor (CADC)

[41] See Table 5 for details on required Substance Use Treatment Models

	substance use disorder or	Under the Influence (DUI) or Refusal charge	

ASAM Level 1.5	• Outpatient Substance Use treatment
	  ○ less than 9 hours per week for adults
	  ○ less than 6 hours a week for adolescents
		• Direct psychosocial services
		• Individual assessment and evaluation
		• Treatment planning
		• Individual, group and/or family therapy
		• Drug Screening
		• Medication Assisted Treatment (MAT)
		• Pharmacotherapy
		• Coordination with Peer Services and Supports
		• Psychoeducational Services
		• Physical exam within 1 month of treatment
		• Coordination with medical providers
		• Recovery support services
			• Program director
			• Psychiatrist
			• APRN
			• Registered Nurses
			• LICSW
			• LCDP
			• LCSW
			• LMFT-A
			• LMHC-A
			• Principal Counselor
			• CPST
			• Case Manager
			• Certified Peer
			• CADC

	• Outpatient medically supervised evaluation, withdrawal management	• Medically supervised outpatient withdrawal management	• Psychiatrist • APRN • Registered Nurses • Certified Peer

ASAM Withdrawal Management Level 1	and referral services for adults or adolescents with *"Mild"* withdrawal symptoms	• Individual assessment and evaluation • Medical monitoring by Physician/APRN or RN • Management of signs and symptoms of intoxication and withdrawal • Pharmacotherapy • Psychoeducational Services • Verify a physical exam in the last year or refer • Referral to Counseling	• LCDP • CADC
ASAM Withdrawal Management Level 2	• Extended onsite monitoring of regularly scheduled outpatient sessions which include supervised evaluation, withdrawal management and referral services for adults or adolescents with *"Moderate"* withdrawal symptoms	• Individual assessment and evaluation • Medical monitoring by Physician/APRN or RN • Management of signs and symptoms of intoxication and withdrawal • Pharmacotherapy • Psychoeducational Services • Referral to Counseling	• Psychiatrist • APRN • Registered Nurses • Certified Peer • LCDP • CADC

ASAM Level 2.1	• Intensive Outpatient Program (IOP)
	  ○ 9-20 hours per week for adults
	  ○ 6-20 hours per week for adolescents
		• Individual assessment and evaluation
		• Structured programming for individuals with primary SUD or Co-Occurring
		• Individual, group and/or family therapy
		• Drug Screening
		• Therapeutic milieu
		• Pharmacotherapy
		• Coordination with Peer Services and Supports
		• Psychoeducational Services
		• Physical exam within 14 days of program admission
			• Program director
			• Psychiatrist/APRN
			• Registered Nurses
			• Certified Peer
			• LCDP
			• CADC
			• LICSW
			• LCSW
			• LMFT-A
			• LMHC-A
			• Principal Counselor
			• CPST
			• Case Manager

Seven Challenges (YOUTH)	• Outpatient counseling program designed for adolescents and young adults	• Individual and/or group sessions • Skill building on trauma issues such as trust, safety, boundaries and identifying threats • Psychoeducational services on co-occurring issues • Assessment and identification of life skill	• Clinical supervisors • Seven Challenges Leader • LICSW • CADC • LCDP • LCSW • Principal Counselor • CPST/Case Manager

		deficits and substance use issues	
Integrated Dual Diagnosis Team (IDDT)*	• Evidenced Based team model designed for individuals with co-occurring serious mental illness (SMI) and substance use disorders, blending both mental health and substance use services into a community-based treatment model	• Individual assessment, evaluation and treatment planning • Pharmacotherapy • Harm Reduction and Recovery Management • Substance use counseling • Psychoeducational services • Peer services • Evidenced Based Practices (e.g. DBT, CBT, MI, IPS)	• Psychiatrist • APRN • Registered Nurse • Certified Peer • LCDP • CADC • LICSW • LCDP • LCSW • LMFT-A • LMHC-A • Principal Counselor • CPST • Case Manager

***IDDT is not a REQUIRED EBP but a recommended approach for CCBHC.**

ADDENDUM 3: Required Training, Programs, Evidence-Based Clinical Practices, and Fidelity

Required Trainings

- Each CCBHC is required to provide the following training at orientation and annually thereafter to all direct care staff who work with individuals receiving CCBHC services in a clinical capacity (e.g. Case Manager, Care Coordinators, Clinicians) and any staff deemed appropriate by CCBHC leadership.
- Documentation of staff training is required to demonstrate compliance with this requirement.
-

Required Training	Required Training Topics	Recommended Training Resources
Person/Family Centered/ Recovery-Oriented Care and Treatment Planning	▪ Person-centered care ▪ Shared decision making ▪ Recovery Oriented Practice ▪ Collaborative Treatment Planning	▪ SAMHSA Person-Centered Recovery Planning (PCRP) ▪ SAMHSA Recovery to Practice Modules
Care for Co-Occurring Mental health and Substance-Use Disorders	▪ Integrated treatment for co-occurring disorders ▪ Screening, assessment and treatment approaches	▪ SAMHSA TIP 42 (Co-Occurring Disorders Training) ▪ ASAM Training on Assessment/Treatment of Co-Occurring Disorders
Risk Assessment	▪ Clinical risk identification and management ▪ Tools and evidence-based screening process	▪ Columbia Suicide Severity Rating Scale (C-SSRS) Training ▪ SAFE-T Protocol
Suicide Prevention and Response	▪ Evidence-based suicide screening, safety planning and intervention ▪ Crisis response and postvention	▪ C-SSRS Training ▪ SAFE-T Training ▪ Suicide Safety Planning (Brown and

		Stanley Model)
Overdose Prevention and Response	▪ Overdose screening, safety and intervention ▪ Crisis response and administration	▪ University of Rhode Island- Community First Responder Naloxone Training
Roles of Family and Peers	▪ Family engagement ▪ Peer support practice standards ▪ Understanding the role of Certified Peers Specialists and Family Support Partners	▪ NAMI Family-to-family
Cultural Competency	▪ Culturally Responsive Care ▪ Reducing disparities ▪ Effective communication across cultures	▪ SAMHSA Cultural Competency Curriculum for Behavioral Health Professionals ▪ Implicit Bias and Equity Training Programs
Military and Veterans Culture Training	▪ Understanding Military Culture ▪ Behavioral health considerations in Veterans ▪ Trauma, TBI, PTSD, SUD, transition stress	▪ SAMHSA "Service Members, Veterans and Their Families (SMVF) Training ▪ PSYCHARMOR- Military Culture for Behavioral Health Providers ▪ VA Community Provider Toolkit ▪ STAR Behavioral Health Provider Training
Trauma-informed care	▪ Principle of Trauma Informed Practice ▪ Screening, assessment and trauma responses ▪ Avoiding re-traumatization	▪ SAMHSA Trauma-Informed Care (TIC) Curriculum ▪ SAMHSA TIP57 (Trauma-Informed Care in Behavioral Health Services) ▪ National Center for Trauma-Informed Care (NCTIC) modules
<u>Training in CCBHC Specific Policy and Protocols for:</u> ▪ *Operation/Disaster Plan* ▪ *Primary Care Integration and Coordination*		

Required Evidenced Based Practices

- Each CCBHC is required to provide the following Evidence Based Practices throughout their CCBHC Service Array.
- Staff who are providing relevant services and support should receive training in the required Evidence Based Practices as deemed clinically appropriate by CCBHC leadership.
- Documentation of staff training is required to demonstrate compliance with this requirement.
- All EBP training should be age/developmentally appropriate related to the population being served.

Required EBP	Recommended EBP Resources
Motivational Interviewing (MI)	• Rhode Island Behavioral Health Training • Training: Motivational Interviewing | Overdose Prevention | CDC • Motivational Interviewing in Rhode Island - CODAC Behavioral Healthcare
Cognitive Behavioral Therapy (CBT)	• CADER - Boston University School of Social Work
Dialectical Behavioral Therapy (DBT)	• The Bridge of Central Massachusetts
Family Psychoeducation (FPE)	• Family-to-Family - NAMI Rhode Island
12 Step	• Twelve Step Facilitation: A Foundational Substance Use Disorder Treatment Approach - 12 Hours - Wise Communications Home Study Courses
Medication Assisted Treatment (MAT)	• NAADAC
Screening, Brief Intervention and Referral to Treatment (SBIRT)	• Products – RI SBIRT

- Each CCBHC is required to provide the following Evidence Based Practice Approach throughout their Organization and include appropriate aspects of training to all CCBHC staff as indicated within the specific EBP Approach

Required EBP	Recommended EBP Resources
Trauma Informed Care Approach	• Rhode Island Behavioral Health Training • TRAIN RI - Substance Use Mental Health Leadership

	Council of RI • Trauma Informed Care Training and Workshops - CTRI
Zero Suicide	• Zero Suicide Institute | Solutions.edc.org • Bradley Learning Exchange | Brown University Health • 2020.11.18 Suicide Care Training Options_0.pdf

- Each CCBHC is required to provide the following Evidence Based Practices and train all staff providing these services in the required EBP.
- Fidelity to each model should be available upon request by BHDDH, DCYF or EOHHS upon request

Required EBP	Recommended EBP Resource	Required Fidelity Tool
Assertive Community Treatment (ACT)	• Center for Practice Innovations > Initiatives > ACT Assertive Community Treatment > Overview • Training Frontline Staff Assertive Community Treatment	Fidelity Tool: TMACT (ACT- I and ACT- YA only)
Individual Placement and Supports (IPS)	• The IPS Employment Center – Research, Dissemination, Training, and Consultation	Fidelity Tool: IPS Fidelity Scale
Seven Challenges for Youth	• Implementation – The Seven Challenges	Fidelity Review by Seven Challenges LLC
Mobile Response and Stabilization Services (MRSS)	• Innovations Institute – Mobile Response & Stabilization Services • Mobile Response Stabilization Services Toolkit and Resource Guide	Fidelity Tool: MRSS Fidelity Tool (Versions 11/2023) and the Child and Adolescent Behavioral Health Center of Excellence/Center for Innovative Practices – Ohio

Recommended Evidence Based Practices

The following EBPs are not required but are recommended for any CCBHC:

Integrated Dual Disorder Treatment (IDDT)
Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
Parent-Child Interaction Therapy (PCIT)
Multisystemic Therapy (MST)
Functional Family Therapy (FFT)
Seeking Safety
Eye Movement Desensitization and Reprocessing (EMDR) Therapy

ADDENDUM 4: CCBHC Community/Consumer Advisory Council

Advisory Council Requirements

The requirements of the CCBHC Community/Consumer Advisory Council and/or Governing Boards serving as the CCBHC Advisory Council are as follows:

1. Each CCBHC shall develop a Community Advisory Council ("Council")
    a. For Governing Boards that meet the fifty-one percent (51%) standard in *Criteria 6.b.1, Option 1* of the RI CCBHC Certification Standards, those boards have the option of functioning as that Council or creating a separate Council(s).
        i. The bylaw of all CCBHC governing boards would be amended to reflect this requirement and the duties and responsibilities listed below.
        ii. The Governing Board would establish protocols for complying with *Criteria 6.b.1, Option 2* of the RI CCBHC Certification Standards by incorporating input and representation from the Council and from individuals with lived experience and family members into the CCCBH's governance, policies, plans, and budget.
    b. If the fifty-one percent (51%) standard in *Criteria 6.b.1* not met, the organization must create a separate Council.
2. Member or members of the Council must be invited to Board meetings with the opportunity to regularly address the Board directly, share comments and recommendations and have them reflected in the Board minutes.
3. The CCBHC will assign the necessary behavioral health planning and administrative position(s) to support and assist the functioning of the Council.
4. The Council shall:
    a. Review and assess the performance of the CCBHC including accessibility of services for all populations; staff competency and training; review of internal CQI processes and effectiveness of Designated Collaborating Organizations (DCO) and collaborative arrangements.
    b. Identify community needs and goals and objectives of the CCBHC.
    c. Perform fiscal and budgetary reviews and submit recommendations to the Governing Board.
    d. Review quality and client outcome data and identify areas for improvement.
    e. Support the creation of locally organized systems of care for persons with behavioral health issues.
    f. Help align/integrate local service delivery with statewide priorities and provide input into the statewide planning processes.
5. The Council shall meet at least six (6) times per year and comprise of at least two governing board members, with the majority consisting of consumers and family members.
6. CCBHCs must submit a quarterly report summarizing community concerns raised through CAB/CAC meetings and actions taken or planned in response.
7. The CCBHC will post an annual summary of the recommendations of the Council on the CCBHC website

Advisory Council Guidance

- CCBHC's have the option of developing separate Councils for children, youth and families, and/or adults.
- The Advisory Council goal is to form strong local partnerships within their service areas to address:
    - Local Community Needs
    - Implementation of State Behavioral Health Policies
    - Provide a forum for meaningful participation from community members, individuals receiving services and their family members into CCBHC services, policies and practices
- Advisory Councils should involve, educate and collaborate with consumer, family, advocacy and community provider groups such as NAMI, RICARES, MHARI, Local HEZ, Prevention Coalitions, Educational authorities and unhouse service providers

ADDENDUM 5: Community Needs Assessment & Response Plan Requirements

SAMHSA requires all CCBHCs complete a formal Community Needs Assessment (CNA) no less frequently than every three (3) years. The community needs assessment is a systematic approach to identify community needs and determine program capacity to address the needs of the population being served. The CNA must be thorough and reflect the treatment and recovery needs of those who reside in the service area across the lifespan, including children, youth, and families.

If a separate community needs assessment has been completed in the past year, the CCBHC may decide to augment, or build upon the information to ensure that the required CCBHC components are collected.

The CCBHC CNA must be data-driven and stakeholder-informed and utilized to determine CCBHC:

- Service Design
- Staffing
- Cultural Competency
- Outreach
- Partnerships
- Service Delivery

CCBHC Required CNA content is outlined below [42]

Description of Service Area & Population	
Geographic Service Area	• Counties, cities, ZIP codes or service areas served • Rural/Urban designation • Transportation access, community infrastructure
Demographics of the Population	• Age Distribution • Race & Ethnicity • Languages Spoken

[42] Please refer to federal SAMHSA CCBHC Certification Criteria Appendix A. for comprehensive list of elements required for CCBHC Community Needs Assessment

	• Socioeconomic indicators (poverty, unemployment, housing instability) • Populations with special health needs • Prevalence of co-occurring SUD/MH conditions • Military/Veteran population size & needs
Behavioral Health Needs of the Community[43]	
Prevalence of Mental Health Conditions	• Serious Mental Illness (SMI) • Serious Emotional Disturbance (SED) in youth • Common mental health conditions (anxiety, depression)
Substance Use Trends	• Alcohol, opioids, stimulants, polysubstance patterns • Overdose rates • ED utilization for SUD • Narcan deployment • MAT access
Co-Occurring Disorders	• Prevalence of individuals with both MH & SUD • Service gaps in integrated treatment
Suicide Risk and Crisis Trends	• Suicide Rates • Crisis call and Ed psychiatric visit data • Mobile crisis response capacity
Analysis of Health Disparities & Barriers to Care	
Health Disparities	• Racial/ethnic disparities in MH/SUD access • Difference by age, language, LGBTQ+ status, disability, socioeconomic status, rurality
Social Drivers of Health	• Housing instability • Food insecurity • Legal involvement

[43] Must include Quantitative and Qualitative Data

	• Transportation barriers • Digital access barriers
Stigma, Cultural & Linguistic Barriers	• Gaps in culturally competent care • Availability of interpreters • Cultural beliefs affecting treatment engagement
Assessment of Existing Behavioral Health System & Service Gaps	
Current Service Landscape	• Existing MH/SUD providers • Hospitals & Eds • FQHCs, primary care • Mobile crisis teams • Residential program • Criminal justice programs • Child welfare & school systems • Veteran-serving organization
System Gaps	• Long wait lists • Lack of MAT providers • Youth service gaps • Crisis service capacity gaps • Shortage of prescribers/psychiatrists • Limited evening/weekend access
Workforce Capacity	• Staffing shortages • Training needs • Specialized credential gaps (e.g. trauma, SUD, suicide prevention)
Stakeholder Engagement Requirements[44]	
	• Individuals with lived experience • Families

[44] SAMHSA requires multi-sector, collaborative input

Required Stakeholder Groups	• Peers • Community MH Providers • SUD treatment organizations • Hospitals & Eds • Criminal justice/law enforcement • Veterans' groups • School & child welfare • Local/tribal government • Social service agencies • Community advocacy groups
Methods of Engagement	• Focus groups • Surveys • Community forums • Interviews • Advisory councils
Documentation	• Meeting notes • Themes identified • How stakeholder feedback informed CCBHC decisions
Needs of Special & Priority Populations	
Required Populations	• Children & Youth (including early childhood) • Individuals with SMI/Sed • Individuals with SUD • People with co-occurring conditions • Veterans and military families • Individuals experiencing homelessness • Individuals re-entering from jail/prison • LGBTQ+ individuals • Older Adults

Required Analysis of Cultural, Linguistic & Military Competency Needs	
Cultural Competency Demands	• Languages & interpretation needs • Staff training needs • Community-specific cultural issues • Gaps in diverse workforce representation
Military Cultural Competency	• Number of Veterans & Service Members • Gaps in trauma-informed or military-informed care • Partnerships needed with VA or Vet-serving providers
Financial & Accessibility Barriers to Care	
Required Analysis	• Insurance coverage patterns • Uninsured population • Medicaid penetration • Affordability concerns • Out-of-pocket barriers • Transportation gaps • Appointment availability and wait times • Telehealth access
Summary of Priority Needs[45]	
Required Summary of Needs	• Top MH/SUD needs • Major disparities • Critical system gaps • Urgent workforce issues • Priority populations requiring new services

[45] The "Summary of Priority Needs" must directly inform the CCBHC staffing plan, service expansion, partnerships and training plan.

CCBHCs are required to provide their updated CCBHC CNA and CCBHC CNA "Response Plan" as part of their Certification or Re-Certification process. The CCBHC "Response Plan" should cover how the CCBHC will address the identified behavioral health needs, gaps, disparities, workforce shortages and access barriers identified in the Community Needs Assessment. The CCBHC CNA Response Plan must be updated to reflect new data, community trends, stakeholder input and performance outcomes with each updated CCBHC Community Needs Assessment. CCBHC "Response Plan" requirements are noted below.

CCBHC Response Plan

Summary of Priority Needs

- Each identified need must have a corresponding strategy, activity or initiative
- Rationale is provided for why specific priorities were selected
- Documented links between data findings and planned CCBHC interventions

Service Expansion

- Plan shall outline plans to strengthen or expand service needs including:
    - Behavioral health treatment capacity
    - Crisis services
    - Co-Occurring disorder services
    - Youth services
    - Veteran/military services
    - Peer and Family support services
- Plan shall identify Evidence-Based Practice (EBP) to be added or strengthened

Staffing and Workforce Development

- Plan shall summarize identified staffing gaps and staffing needs and address specific:
    - Hiring plans
    - Recruitment and retention strategies
- Plan shall address staff training needs in response to gaps or disparities identified in CNA

Access to Care

- Plan shall outline expansion of services leading to improved access such as:
    - Same-day access
    - Expanded hours
    - Telehealth improvement
    - Language access supports
    - Transportation initiatives

Care Coordination and Community Needs

- Plan shall identify new MOU's or Care Coordination Agreements in response to identified community needs or gaps in services
- Plan shall identify expanded outreach, engagement and community education activities in response to identified community needs
- Plan shall identify actions to reduce identified health disparities and improve equity and cultural responsiveness

Quality Improvement

- Plan shall include measurable goals, indicators and timelines for implementation
- Plan shall include performance metrics, expected outcomes and monitoring/reporting process
- Plan shall be integrated into overall CCBHC CQI plan

Documentation

- Plan shall be approved by CCBHC leadership and Governing Body
- Plan shall be shared with staff, advisory council and community partners as appropriate
- Plan shall be incorporated into CCBHC policies, procedures, workflows and/or strategic plan as indicated

ADDENDUM 6: CCBHC Medical Director Requirements & Responsibilities

Each CCBHC must have a Medical Director who meets the following requirements.

Required Credentials[46]

- Physician (MD or DO) with
  - Board certification or board eligibility in psychiatry
- Licensed to practice medicine in Rhode Island
- Regardless of place of residence, the Medical Director must maintain a physical presence at the CCBHC to provide appropriate clinical oversight
- Experience or training in psychiatric diagnosis, treatment and psychopharmacology
- Ability to prescribe medications including but not limited to Mental Health and Substance Use Disorders

Recommended Experience

- Experience providing behavioral health leadership in clinical or community-based settings
- Familiarity with required CCBHC EBPs
- Experience with co-occurring mental health and SUD treatment[47]
- Experience supervising or collaborating with multidisciplinary teams

Each CCBHC must have a Medical Director who provides the following:

Core Responsibilities

Clinical Leadership and Oversight	• Serve as the lead clinical authority for psychiatric and medical care across CCBHC • Ensure the clinical model of care meets CCBHC requirements • Establish and maintain clinical protocols, standing orders and medical policies[48] • Provide clinical consultation
Quality Assurance & Compliance	• Oversee clinical quality improvement programs[49] • Ensure compliance with ○ Federal and State CCBHC Criteria

[46] Please see CCBHC Certification Criteria 1.a.3
[47] Please see CCBHC Certification Criteria 1.b.2
[48] Please refer to CCBHC criteria 4.g.1 & 4.g.2 for specific policies and protocols
[49] Please refer to CCBHC criteria 5.b.1

	○ State Medicaid Requirements ○ Federal Reporting ○ HIPAA & 42 CFR Part 2 • Review and monitor medication safety, polypharmacy, adverse events and suicide risk protocols
Staff Supervision & Clinical Support	• Provide medical supervision to psychiatrists, APRNs and other prescribing clinicians • Participate in multidisciplinary team meetings across programs • Lead or contribute to clinical training
Direct Patient Care	• Conduct Psychiatric evaluations and medication management • Support high risk cases
Care Integration & Coordination	• Lead integration between behavioral health and primary care, SUD treatment and care coordination providers
Policy, Program & System Development	• Help design and oversee CCBHC workflows, protocols, treatment programs and clinical templates • Participate in CCBHC governance committees and/or advisory council
Consumer & Community Involvement	• Support inclusion of family, peers and individuals with lived experience in treatment planning and governance • Ensure clinical care reflects person-centered, recovery-oriented, culturally competent, developmentally appropriate and trauma informed practices

ADDENDUM 7: Designated Collaborating Organization (DCO) Requirement Checklist

CCBHCs are required to provide a copy of all DCO agreements to the state prior to execution for review and approval. A copy of a final signed DCO is required to be provided to the State once executed. 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) EOHHS must be notified within 10 days. The CCBHC shall also inform their MCO partners of the termination of any DCO arrangements within 10 days.

CCBHCs should include the following information in any DCO contract agreement. CCBHCs are solely responsible for entering into a contract with any DCO. While the state may provide the following guidance, it is advisable CCBHC & DCO partners consult with their internal attorneys to ensure legal compliance and protection.

CCBHC/DCO Contract	
Services	• Describes each party's mutual expectations, deliverables, and establishing accountability of services to be provided.
	• CCBHC assumes responsibility for provision of defined CCBHC services furnished by the DCO and serves as the billing provider.
	• The purchase of required CCBHC services from DCOs is documented.
	• Defines scope of services to be provided by the DCO.
	• Details referral pathways between DCOs and CCBHCs.
	• Requires that DCO services are trauma-informed, person-centered, recovery-based and culturally appropriate.
	• Ensures the DCO provides translation, interpretation, auxiliary aids and meaningful access to services for individuals with Limited English Proficiency.

Policies & Procedures	• Articulates the DCO requirement to serve all individuals referred by the CCBHC, according to the eligibility guidelines established in the CCBHC/DCO agreement and in compliance with all CCBHC quality standards pertaining to access requirements, use of evidence-based practices, care coordination, outcomes, and provision of services regardless of place of residence and ability to pay.
	• Attests that all consumers receiving services under the agreement are considered consumers of the CCBHC.
	• Requires the DCO to furnish services consistent with the CCBHC's applicable clinical and personnel policies, procedures, standards, and protocols, including (a) timeframes for assessment, screening and treatment and (b) serving all consumers regardless of age, race, ethnicity, disability, sexual orientation, gender expression, developmental ability, correctional system involvement, housing status, or ability to pay.
Qualifications	• Requires the DCO staff is appropriately licensed, certified, registered, and/or credentialed as required by state and federal statute and regulations. The DCO and its staff must satisfy the CCBHC's professional standards and qualifications, including licensure, credentialing, background checks and privileging, and DCO Requirements listed in addendum 3 of the Certification Standards (Requirements of a Designated Collaborating Organization)
Quality	• DCO provided services meet the same quality and clinical standards as CCBHC requirements.
Billing and Payment	• Describes how the CCBHCs policies and procedures related to billing of third parties and consumers will apply to the DCO
	• Describes how consumer fees and cost-sharing for non-Medicaid beneficiaries will be collected and (if the obligation for such collection is contractually delegated to the DCO) transmitted to the CCBHC.
	• Provides terms and mechanisms for billing and payment between DCOs and CCBHCs, such as invoice procedures and deadlines.

	• Specifies in advance the compensation for services (or a fixed methodology by which compensation will be established).
	• Allows CCBHC to withhold or deny payment for services rendered in breach of a material term of the agreement, including but not limited to all statutes, rules, regulations, and standards of any and all governmental authorities and regulatory and accreditation bodies relating to the provision of services.
	• Requires full DCO participation in and timely delivery of any supporting materials upon request related to any state or federal audits or corrective action plans (CAPs), as specified in the Billing Manual and Provider Manual. Note that the DCO may be subject to the same potential penalties for noncompliance as the CCBHC.
	• Details methods to ensure DCO bills the CCBHC for attributed and referred clients appropriately, such as description of CCBHC referral procedures and how the CCBHC will communicate attribution to the DCO. Attribution must include enrollment dates and notification of discharge from CCBHC program.
Oversight and Monitoring/ Reporting	• CCBHC provides oversight of all services performed by DCO, consistent with all requirements included in the CCBHC RI Certification Standards.
	• Requires a copy of the proposed DCO staffing pattern detailing the positions, required credentials for each position, and indicates whether the position(s) are currently filled or vacant.
	• Requires the DCO to prepare health records consistent with CCBHC's standards.
	• Requires the DCO to furnish to the CCBHC programmatic, staffing and/or financial reports pertaining to the services provided under the agreement, as deemed necessary by the CCBHC for monitoring and oversight and compliance with the requirements for reporting related to the Uniform Reporting System (URS).
	• If DCO provides a crisis service to **adults**, **children** and **youth** they shall provide: o Evidence that clinical staff include QMHPs who are available to conduct any assessment that may result in involuntary hospitalization.

	○ Copy of policies and procedures title, number and effective date that specify the role and responsibilities in working with local law enforcement and first responders upon request
	• If DCO provides a crisis service to **children and youth**, they shall provide: ○ Copy of Certification of Mental Health Emergency Service Intervention for Children, Youth and Families (Regulation 214-RICR-40-00-6) or evidence of pending certification application.
	• DCOs must collect and maintain all documentation necessary for CCBHC data collection and reporting as required by EOHHS, BHDDH, DCYF, federal partners, and CCBHC/MCO agreement.
	• Requires the DCO and its personnel to cooperate in CCBHC's clinical quality and compliance activities, and specify the required activities for the services they are providing (e.g., frequency of chart audits, participation in CQI meetings)
Data Sharing	• Describes the CCBHC and DCO agreement to take active steps to reduce administrative burden on people receiving services when accessing DCO services (ex: coordinating intake process, coordinated treatment planning, information sharing, and direct communication between providers)
	• Prohibits disclosure of any business, financial, or other proprietary information, which is directly or indirectly related to the CCBHC and obtained as a result of services performed under the agreement, unless the CCBHC gives prior written authorization for the disclosure or the disclosure is required by law (consistent with all applicable state and federal laws and regulations, as well as the CCBHC's policies, regarding the use and disclosure of confidential and proprietary information).
	• Prohibit the unauthorized use or disclosure of consumer's protected health information consistent with all applicable federal and state laws, including the requirements of the Health Insurance Portability and Accountability Act and Confidentiality Rule (210-RICR-10-05-1), as well as the CCBHC's policies regarding the confidentiality and privacy of consumer information.
	• For each service provided by the DCO, specifies the following about the bidirectional data exchange: method (e.g., SFTP, email); frequency; responsible parties (e.g., IT contact, invoice contact); regular auditing activities for quality; limitations and legal framework; and content. Data exchange must support billing, clinical, and quality needs.

	• Detail DCO and CCBHC specific responsibilities for facilitating bi-directional information exchange for cooperative treatment planning
Care Coordination	• Indicates that CCBHC retains care coordination responsibility.
	• CCBHC and DCO lists specific steps that are implemented to assure intense collaboration across the two organizations will take place.
	• Articulates clearly the role and function of the CCBHC and DCO in developing treatment plans, care coordination, and ensuring CCBHC coordinates DCO care/services in accordance with the current treatment plan.
Training	• DCO clinical staff is trained in relevant Evidence Based Practices (EBPs) and that the CCBHC monitors DCO's use of EBPs including training, coaching and fidelity compliance.
	• CCBHC training plans address training of DCO staff.
General	• Includes provisions related to the termination of the agreement.
	• Requires that any material modification in the ownership or Governance of the DCO to be communicated to the CCBHC within 2 business days of such change.
	• Includes a provision regarding the consumer's freedom to choose their provider.
	• Ensures individuals receiving services from DCOs have access to CCBHC grievance procedures.

ADDENDUM 8: Staff Qualifications for CCBHC Billing

CCBHC SERVICE	MEDICAID QUALIFIED PROVIDER (within the scope of practice)
Crisis Services	• Licensed Independent Practitioner[50] • Qualified Mental Health Professional (QMHP) • Master's Degree w/ license to provide relevant BH service. • Master's degree without license with 1 year post master's degree full-time BH experience* • Licensed RN w/ ANCC certification as a psychiatric and mental health nurse or licensed RN with 1 year post RN full-time BH experience • Clinical Interns * • Clinical Supervisors • Unlicensed CCBHC Personnel* • Certified Peer Recovery Specialist • Supervisor/manager **Note:** *Only licensed individuals listed above and QMHPs are qualified to conduct the assessment service.* * Unlicensed CCBHC personnel also must work under the direct supervision of a licensed professional. Unlicensed staff must meet these qualifications, which some or all EMTs might meet: • B.A. or B.S. degree in social work, psychology, or related field and have a minimum of two (2) years of experience in a human services profession. • Certified in First Aid/CPR and as a Community Responder • A minimum of four (4) years employment in the human services field may be substituted for a bachelor's degree.

[50] Licensed Independent Practitioner includes Psychologist, LICSW, LMHC, LMFT

Outpatient Mental Health and Substance Use Services	• Physician • Licensed Independent Practitioner • Licensed Clinical Social Worker (LCSW) • Licensed Marriage and Family Therapist - Associates (LMFT-A) • Licensed Mental Health Counselor - Associate (LMHC-A) • Master's degree without license with 1 year post master's degree full-time BH experience • Licensed RN w/ ANCC certification as a psychiatric and mental health nurse • Licensed RN with 1 year post RN full-time BH experience • Clinical Interns • Clinical Supervisors • Supervisor/manager • Licensed Drug Counselor • Certified Alcohol and Drug Counselors • Case Manager

Psychiatric Rehabilitation Services	• Clinical Interns • Clinical Supervisors • Supervisor/manager • Community Psychiatric Supports and Treatment (CPST) Specialist
Targeted Case Management	• Associates-Degree • Registered Nurse • CPST Specialist • Case Manager
Peer Support Services	• Certified Peer Recovery Specialist • Youth Partners • Family Partners
Assertive Community Treatment (ACT)	• Licensed Independent Practitioner • Registered Nurse • Licensed Clinician • Psychiatrist • Substance Use Disorder Specialist • CPST Specialist • Case Manager • Certified Peer Recovery Specialist • Vocational Specialist • Clinical Interns

	• Clinical Supervisors • Supervisor/manager
High Acuity Children Services	• Program Manager/Director • Psychiatrist • Registered Nurse • Licensed Independent Practitioner (Psychologist, LICSW, LMHC, LMFT) • Licensed Clinical Social Worker (LCSW) • Licensed Marriage and Family Therapist - Associates (LMFT-A) • Licensed Mental Health Counselor - Associate (LMHC-A) • Master's degree without license with 1 year post master's degree full-time BH experience • Case Manager • CPST Specialist • Vocational Specialist • Family Support Partner • Youth Support Partner

ADDENDUM 9: Requirements of Designated Collaborating Organizations
(DCO)

This Addendum is required by the State of Rhode Island as part of the State's limited review and approval of the DCO contract between the CCBHC for each service where a DCO service is proposed. State review and approval are limited to verification of compliance with CCBHC certification, beneficiary protection, and transition requirements. The State is not a party to the DCO contract and assumes no financial, contractual, or fiduciary obligations.

1. For Medicaid reimbursable services, a CCBHC can partner with a DCO that is licensed, certified, and/or credentialed to provide that Medicaid reimbursable service. There is no required process for State approval of the DCO itself, rather the DCO service delivery would be approved as part of the CCBHC application and certification process.

2. For the purposes of this application, a DCO will need to be an enrolled Medicaid provider to provide an applicable Medicaid covered core CCBHC service.

3. The CCBHC will attest that the DCO has at least three years' experience providing a particular service type or treatment modality unless written approval is obtained from the CCBHC Interagency Team.

4. The CCBHC will provide an attestation acknowledging and affirming responsibility for oversight and accountability of all services delivered by all contracted DCOs.

5. Prior to operating as a CCBHC, a formal written agreement (the Contract) with a DCO needs to be established that includes all elements required to comply with SAMHSA certification and state criteria reflected in the scope of work by the DCO (4.a.1). This Contract shall have provisions that ensure that the DCO services provided under the CCBHC umbrella are delivered in a manner that meets the standards set in the CCBHC certification criteria.

6. The CCBHC shall provide a written plan in sufficient detail to the CCBHC Interagency Team describing how it will monitor the DCO's compliance with its Contract and as directed by the Interagency Team, shall provide the results of such monitoring in the format and on the schedule specified by the Interagency Team. The DCO agreement shall include the following provisions:

a. Describes each party's mutual expectations, deliverables, and establishing accountability of services to be provided.

b. Describes the CCBHC and DCO agreement to take active steps to reduce administrative burden on people receiving services and their family members when accessing DCO services through measures such as coordinating intake process, coordinated treatment planning, information sharing, and direct communication between CCBHC and DCO.

c. Describes the specific steps that will be implemented by the CCBHC and DCO to ensure appropriate collaboration across the two organizations.

d. Articulates the role and function of the CCBHC and DCO in developing treatment plans, and care coordination, and that the CCBHC coordinates care and services by the DCO in accordance with the current treatment plan. (3.d.3)

e. Articulates the DCO requirement to serve all individuals referred by the CCBHC, according to the eligibility guidelines established in the CCBHC/DCO agreement and in compliance with all CCBHC quality standards pertaining to access requirements, use of evidence-based practices, care coordination, outcomes, and provision of services, regardless of place of residence and ability to pay. (4.a.4)

f. Includes provision that the CCBHC retains the responsibility for care coordination.

g. Requires a copy of the proposed DCO staffing pattern, detailing the positions, required credentials for each position, and indicates whether the position(s) are currently filled or vacant. (1.a.1 &1. a.2) and (2.a.6)

h. Articulates the individual's freedom to choose their provider (3.a.6)

i. If the DCO provides crisis services to adults, children, and youth, they shall provide:

    i. Evidence that clinical staff include QMHPs who are available to conduct any assessment that may result in involuntary hospitalization.

    ii. Copy of their policies and procedures title, number, and effective date that specify the role and responsibilities in working with local law enforcement and first responders (4.c.1).

    iii. Compliance with payment rules. iv. Compliance with shadow claim submission requirements. v. Adherence to payment arrangements between the CCBHC and DCO for services rendered by the DCO on behalf of the CCBHC.

    iv. Collection and maintenance of all documentation necessary for CCBHC data collection and reporting as required.

j. In addition, a DCO that provides crisis services to children and youth specifically shall also provide:

    i. Copy of their Certification of Mental Health Emergency Service Intervention for Children, Youth and Families (Regulation 214-RICR-40-00-6) or evidence of a pending certification application.

k. Requires CCBHC training plans address training of DCO staff.
l. Requires DCO clinical staff to be trained in relevant EBPs and that the CCBHC monitors the DCO's use of EBPs including training, coaching, and fidelity compliance.
m. Requires DCO staff to be appropriately licensed, certified, registered, and credentialed as required by state and federal statute and regulation (1.b.1)
n. Requires that the DCO service(s) be trauma-informed, person-centered, recovery based, and culturally appropriate.
o. Requires the DCO provided service(s) for CCBHC consumers meet the same quality standards as those required of the CCBHC (4.a.4).
p. Requires the persons receiving services from the DCO to have access to the CCBHC's grievance procedures. (4.a.3).
q. Requires the DCO collects and maintains all documentation necessary for CCBHC data collection and reporting as required by BHDDH, DCYF, EOHHS, and the agreement between the CCBHC and the Managed Care Organizations (MCOs). (5.a.3).
r. CCBHCs shall notify the Interagency Team, via email to the ohhs.ccbhcreadiness@ohhs.ri.gov, of any material alternations to their DCO contracts at least 20 business days in advance of its proposed effective date.
s. The parties acknowledge that the State's review and approval of the Contract is limited to verification of compliance with CCBHC certification and transition requirements. The State is not a party to the Contract and assumes no liability, obligation, or financial responsibility under the CCBHC and DCO. Contract.
t. Within seven (7) calendar days of notice, the DCO shall deliver a Termination Report to the CCBHC, containing:
    a. It's active client roster with primary contact information and primary clinician;
    b. List of open authorizations and pending claims;
    c. Summary of critical services and last service dates.
    d. The DCO shall preserve records for applicable statutory retention periods and provide the State and CCBHC access for audit and oversight consistent with HIPAA and State law.
u. The DCO shall continue to provide covered services for a minimum of thirty (30) calendar days after notice. DCO shall prioritize continuity for high-risk clients and those with active authorizations and shall coordinate directly with the CCBHC to discuss alternative arrangements.
v. The CCBHC shall lead beneficiary communications; the transitioning DCO shall not independently notify clients. The CCBHC shall notify affected clients and referral sources within seven (7) calendar days of receiving the Termination Report.
w. Abrupt Cessation: If a DCO ceases operations or abruptly discontinues services, the Contract shall provide notification from the DCO to the CCBHC within twenty-four (24) hours.

x. For all transition-related disputes, the parties shall escalate to its senior management within five (5) business days and pursue mediation at its own respective costs within fifteen (15) business days if unresolved.
y. If a CCBHC is entering into a new DCO contract, the CCBHC must submit a copy of the Contract between the CCBHC and DCO to the State for approval.
z. Assure that a new DCO relationship only goes into effect with the start of a CCBHC program year.
aa. The CCBHC must provide oversight of all services performed by a DCO, consistent with all requirements included in the RI CCBHC Certification Standards

ADDENDUM 10: Requirements of a Non-Financial Designated Collaborating Organizations (DCO) Agreement with a State-Licensed Mobile Response and Stabilization Services (MRSS) Provider

This Addendum governs the non-financial DCO agreement required for CCBHC certification purposes when a CCBHC does not directly provide MRSS. The purpose of the contract is to document mutual expectations, coordination protocols, communication, beneficiary choice, warm handoffs, data/reporting obligations, and transition responsibilities. The agreement does not place MRSS under the direction or authority of the CCBHC and does not limit access to MRSS based on CCBHC enrollment nor CCBHC designated service areas. MRSS is a DCYF-licensed, statewide children's behavioral health crisis service subject to DCYF oversight.

This Addendum is required by the State of Rhode Island as part of the State's limited review and approval of the non-financial DCO agreements between a CCBHC and a licensed MRSS provider for the provision of MRSS services. State review and approval are limited to verification of compliance with CCBHC certification, beneficiary protection, and transition requirements. The State is not a party to the DCO contract and assumes no financial, contractual, nor fiduciary obligations.

1. If a CCBHC is not a DCYF-licensed MRSS provider, the CCBHC shall establish and maintain one or more non-financial DCO agreements with qualified MRSS provider(s), consistent with applicable CCBHC certification requirements. 'Qualified' means:
    a. The licensed MRSS provider is licensed by DCYF under the authority of the Regulations for Mental Health Emergency Service Interventions for Children, Youth and Families Regulations for Licensure (214-RICR-40-00-6) to provide MRSS services.
2. The non-financial MRSS DCO agreement shall include the following provisions:
    a. Describe how MRSS services provided by the licensed MRSS provider pursuant to the non-financial DCO agreement are coordinated with the CCBHC, as applicable, and delivered in accordance with the CCBHC certification criteria, the MRSS regulations (214-RICR-40-00-6), and associated MRSS provider manual requirements.
    b. Include effective dates that align with the CCBHC program year.
    c. Describe each party's mutual expectations, deliverables, and accountability for services provided to children and families served jointly and the specific steps that will be implemented by the CCBHC and MRSS DCO to ensure appropriate collaboration across the two organizations.

d. Articulate the client's freedom to choose their provider for crisis response and stabilization services and any ongoing care. (3.a.6)
e. For children/youth already receiving CCBHC services, or who choose to engage with the CCBHC while receiving MRSS, describe the CCBHC's and MRSS provider's commitment to reduce administrative burden on children, youth, and families by supporting timely information sharing, direct communication, warm handoffs, and coordinated referrals, care planning, and transition activities, as clinically appropriate and consistent with consent, child/youth and family voice and choice, and confidentiality requirements.
f. Articulate the respective roles and responsibilities of the CCBHC and MRSS provider in care coordination, referrals, warm handoffs, transition planning, and, when applicable, coordination with an existing CCBHC treatment plan for children/youth receiving CCBHC services. (3.d.3)
g. Require the MRSS DCO to collect and maintain all documentation necessary for CCBHC data collection and reporting per state and federal CCBHC rules and the agreement between the CCBHC and the Managed Care Organizations (MCOs), for children/youth and families served jointly. (5.a.3)

3. CCBHC shall notify the Interagency Team, via email to the ohhs.ccbhcreadiness@ohhs.ri.gov, of any proposed non-financial MRSS DCO agreement, or the termination or material alteration of such an agreement prior to contract execution, termination, or material alteration.
    a. For a new MRSS DCO agreement: The CCBHC must submit to the state the following information at least 4 months prior to the anticipated contract effective date, which must align with the start of a CCBHC program year.
        i. Name of the MRSS DCO partner
        ii. Service area to be covered
        iii. Agreement start date and end date
        iv. Completed attestation that elements 2a through 2g above will be included in the DCO agreement
    b. Prior to the termination of or material alteration to an existing MRSS DCO agreement: The CCBHC shall notify the state and provide the following information at least 20 days in advance of the effective date of the change:
        i. Description of requested change (i.e., agreement amendment or termination)
        ii. Proposed effective date for change
        iii. If a termination is being requested:
            1. Explanation of which alternative DCYF licensed MRSS provider the CCBHC is entering into a non-financial DCO agreement with instead

2. Explanation of how CCBHC clients and community partners, such as 988, will be notified
3. Written transition plan for how the agency will ensure an orderly transition of services in the CCBHC's designated service area without an adverse disruption or delay to MRSS services.
4. For all transition-related disputes, the parties shall escalate to their senior management within five (5) business days and pursue mediation at its own respective costs within fifteen (15) days if unresolved.

c. Abrupt cessation: If an MRSS DCO ceases operations or abruptly discontinues services, the MRSS DCO shall notify the CCBHC within 24 hours.

4. CCBHCs must submit a copy of their fully executed MRSS non-financial DCO agreement to the CCBHC Interagency Team within 10 days of agreement execution.
5. The CCBHC shall be responsible for ensuring the MRSS provider meets the requirements of the non-financial DCO agreement. As the licensing authority for MRSS, DCYF is responsible for oversight and monitoring of MRSS providers and MRSS services delivered by MRSS DCOs, including service utilization, fidelity to the national MRSS model, staffing and training requirements, and quality of services.
6. In alignment with CMS rules, client choice will be honored. Individuals not currently attributed to a CCBHC who receive MRSS services, will not automatically become enrolled with a CCBHC. The MRSS provider shall inform the child/youth and family of available care options, including CCBHC services where appropriate, and shall support a warm referral or handoff to the CCBHC when clinically appropriate and agreed upon by the child/youth, parent, or caregiver.
7. The CCBHC's failure to comply with 1-6 of this Addendum related to non-financial DCO agreements with MRSS providers may result in state licensing or certification action.