

CCBHC CARE COORDINATION AGREEMENTS: OVERVIEW OF LEGAL REQUIREMENTS AND CHECKLIST OF RECOMMENDED TERMS

Coordinating care across a spectrum of services,²⁹ including physical health, behavioral health, social services, housing, educational systems and employment opportunities,³⁰ is central to Congress' vision for the Certified Community Behavioral Health Clinics (CCBHC) demonstration project.

CCBHCs are instructed to follow the Agency for Healthcare Research and Quality (AHRQ) definition of care coordination as they provide integrated and coordinated care to address all aspects of a person's health.³¹ AHRQ defines care coordination as:

"deliberately organizing consumer care activities and sharing information among all of the participants concerned with a consumer's care to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate and effective care to the patient."³²

This person-centered and family-centered approach is essential to furnishing care that addresses the well-being of the whole person.³³ In coordinating care, providers must keep in mind the consumer's preferences and needs and, to the extent possible, the preferences of the consumer's family/caregivers.³⁴ To ascertain in advance the consumer's preferences in the event of psychiatric or substance use crisis, CCBHCs must develop a crisis plan with

²⁹ See Protecting Access to Medicare Act (PAMA) § 223(a)(2)(C), Pub. L. No. 113-93 (Apr. 1, 2014).

³⁰ RFA for SAMHSA Planning Grants for CCBHC, Appendix II – Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (RFA, Appendix II), Criterion 3.c.3.

³¹ RFA, Appendix II, Introduction to Program Requirement 3: Care Coordination.

³² *Id.*

³³ RFA, Appendix II, Criterion 3.a.1.

³⁴ *Id.* Criterion 3.a.4.



each consumer.³⁵ Additionally, as appropriate for the consumer's needs, the CCBHC should designate an interdisciplinary treatment team that is responsible for directing, coordinating and managing care and services for the consumer.³⁶ The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic and recovery support needs of CCBHC consumers, including, as appropriate, traditional approaches to care for consumers who may be American Indian or Alaska Native.³⁷

Care coordination is regarded as an activity rather than a service.³⁸ A patient encounter consisting of care coordination activities alone would not trigger payment under CCBHC prospective payment system (PPS).³⁹ However, most clinical, administrative and technology costs associated with care coordination activities will be considered allowable costs on states' CCBHC cost reports.⁴⁰ Care coordination links CCBHC consumers with access to certain providers and social service agencies, as set forth below, through a referral process.

³⁵ *Id.* Criterion 3.a.4.

³⁶ *Id.* Criterion 3.d.2.

³⁷ RFA, Appendix II, Criterion 3.d.2.

³⁸ *Id.*, Appendix II, Definitions: "Care Coordination."

³⁹ While states have discretion to define a CCBHC "visit," CMS has indicated in informal guidance that it expects that consumer encounters in which only care coordination occurs would not qualify as CCBHC visits.

⁴⁰ The model cost report and instructions released by CMS in January 2016 (<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/223-demonstration-for-ccbhc.html>) did not address with specificity how care coordination costs would be included on the CCBHC cost report. For example, the instructions do not specify whether new expenditures on electronic practice management systems would qualify as allowable administrative costs. Therefore, prospective CCBHCs should consult their own state's instructions as to the scope of allowable care coordination costs. States may also have unique cost reporting requirements in order to ensure that the costs of care coordination activities associated with other payment streams (such as the ACA § 2703 Health Home program, if applicable) are excluded from the CCBHC cost report.

The referral process under the care coordination model is not passive. Rather, the CCBHC and the other entity must work collaboratively to share information regarding consumers' needs and preferences, with the ultimate goal of improving health outcomes and consumer satisfaction.

The federal law requires that CCBHCs enter “partnerships or formal contracts” with a variety of organizations in the community.⁴¹ The Centers for Medicaid Services (CMS) and Substance Abuse and Mental Health Services Administration (SAMHSA) specified in guidance accompanying the Request for Applications (RFA) associated with the SAMHSA Planning Grants that CCBHCs must have an agreement in place with each of the entities with which the CCBHC coordinates care.⁴² If the CCBHC cannot establish an agreement by the start of the demonstration project, it must work toward formal agreements.⁴³ The agreement may be structured as a contract, memorandum of agreement, memorandum of understanding, letter of support, letter of agreement or letter of commitment.⁴⁴ For purposes of this *Toolkit*, the agreements are referred to as “care coordination agreements.”

Regardless of its form, the care coordination agreement must describe the parties' mutual expectations and responsibilities related to care coordination.⁴⁵ For example, consistent with requirements of privacy, confidentiality and consumer preference and need, the CCBHC must assist consumers who are referred to external providers or resources in obtaining an appointment and confirming the appointment was kept.⁴⁶ Additionally, the CCBHC must make and document reasonable attempts to determine any medications prescribed by other providers for CCBHC consumers and, upon appropriate consent to release of information, provide such information to other providers not affiliated with the CCBHC.⁴⁷

⁴¹ PAMA § 223(a)(2)(C).

⁴² *Id.*, Appendix II, Definitions: “Agreement.”

⁴³ *Id.*, Appendix II, Criterion 3.c.1.

⁴⁴ *Id.*, Appendix II, Definitions: “Agreement.”

⁴⁵ *Id.*, Appendix II, Definitions: “Agreement.”

⁴⁶ *Id.*, Appendix II, Criterion 3.a.3.

⁴⁷ *Id.*, Appendix II, Criterion 3.a.5.



Under care collaboration relationships, unlike the [designated collaborating organization \(DCO\) relationships discussed elsewhere in this Toolkit](#), the CCBHC does not assume responsibility for services provided by the other entity or social service agency. Both the CCBHC and the care coordination partner retain their own separate and distinct corporate structures, patient care delivery systems and locations, and each is accountable and legally and financially responsible only for those services that it directly furnishes to consumers. The consumers served under the care coordination arrangement are considered consumers of the entity/agency to which the consumers are referred. The referral provider is responsible for billing and collecting payments from third-party payors and consumers for the services rendered, to the extent that services furnished by the entity/agency are billable. There is no exchange of funds or other remuneration between the CCBHC and the other party. Additionally, nothing about a CCBHC's agreements for care coordination should limit a consumer's freedom to choose his or her provider.⁴⁸

Scope of Care Coordination: Providers and Social Service Entities

In the spirit of promoting access to services that is both integrated and comprehensive, the Protecting Access to Medicare Act of 2014 (PAMA) requires that CCBHCs maintain care coordination relationships⁴⁹ with the following providers and social service entities:

- Federally qualified health centers (and as applicable, rural health clinics);
- Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services and residential programs;
- Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers and other facilities of the Department as defined in section 1801 of title 38, United States Code and
- Inpatient acute care hospitals and hospital outpatient clinics.⁵⁰

⁴⁸ RFA, Appendix II, Criterion 3.a.6.

⁴⁹ If an agreement cannot be established with any of the provider/social service organizations set forth in PAMA or the RFA, or cannot be established within the timeframe of the demonstration project, justification must be provided to the certifying body and contingency plans must be established. The state will make a determination whether the contingency plans are sufficient to require further efforts. See RFA, Appendix II, Criterion 3.c.3.

⁵⁰ PAMA § 223(a)(2)(C).

CCBHCs must also have agreements establishing care coordination expectations with a variety of community or regional services, supports and providers, including:

- Schools,
- Child welfare agencies,
- Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts),
- Indian Health Service youth regional treatment centers,
- State licensed and nationally accredited child placing agencies for therapeutic foster care service and
- Other social and human services.⁵¹

SAMHSA's guidance accompanying the RFA states that, to the extent necessary given the population served and the needs of individual consumers, CCBHCs also should have agreements with:

- Specialty providers of medications for treatment of opioid and alcohol dependence;
- Suicide/crisis hotlines and warmlines;
- Indian Health Service or other tribal programs;
- Homeless shelters;
- Housing agencies;
- Employment services systems;
- Services for older adults, such as Aging and Disability Resource Centers, and
- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs).⁵²

Each state has discretion to decide, based on the community needs assessment, which of these additional providers and social service entities are required care coordination partners.

⁵¹ RFA, Appendix II, Criterion 3.c.3.

⁵² *Id.*



Care Coordination Agreements with Certain Provider Types

In general, the federal agencies' guidance provides CCBHCs with flexibility in how they achieve care coordination, provided that the care coordination agreement establishes expectations and protocols to ensure adequate care coordination.⁵³ However, provider types, the SAMHSA guidance identifies specific issues for care coordination agreements to address.

With regard to **inpatient acute hospitals** (including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers), the care coordination agreement must address the needs of consumers, including procedures and services to help transition individuals and shorten time lag between assessment and treatment.⁵⁴ Unless there is a formal transfer of care to another entity, the care coordination agreement must enable the CCBHC to track when consumers are admitted and discharged and allow for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge.⁵⁵ For all CCBHC consumers discharged from such facilities who presented to the facilities as a potential suicide risk, the care coordination agreement must include a requirement to coordinate consent and follow-up services with the consumer within twenty-four (24) hours of discharge. Those obligations must continue until the consumer is linked to services or assessed to be no longer be at risk.⁵⁶ Additionally, the CCBHC must ensure that it can make and document reasonable attempts to contact all CCBHC consumers discharged from these settings within twenty-four (24) hours of discharge.⁵⁷

With regard to facilities providing **inpatient psychiatric treatment with ambulatory and medical detoxification, post-detoxification step-down services and residential programs**, the care coordination agreement must enable the CCBHC to track when consumers are admitted to the facilities as well as discharged, unless there is a formal transfer of care to a non-CCBHC entity.⁵⁸ The CCBHC must establish protocols and

⁵³ *Id.*

⁵⁴ RFA, Appendix II, Criterion 3.c.5.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ RFA, Appendix II, Criterion 3.c.2.



procedures for transitioning individuals from emergency departments, inpatient psychiatric treatment, detoxification and residential settings to safe community settings, including transfer of medical records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety and provision of peer services.⁵⁹

With regard to establishing care coordination expectations with the nearest **Department of Veterans Affairs' facilities**, to the extent multiple department facilities of different types are located nearby, the CCBHC should explore establishing care coordination agreements with facilities of each type.⁶⁰

Privacy and Data Sharing Requirements for Care Coordination Agreements

The CCBHC must obtain all necessary consents from consumers for the release of information for facilitating care coordination, including for care coordination activities with other entities.⁶¹ The documentation must satisfy the requirements of Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2, and other federal and state privacy laws, including patient privacy requirements specific to the care of minors.⁶² The CCBHC also must ensure consumers' preferences and those of their families are adequately documented in clinical records, consistent with the philosophy of person and family-centered care.⁶³

If CCBHCs are unable, after reasonable attempts, to obtain consent for care coordination activities, such attempts must be documented and revisited periodically.⁶⁴ Given these requirements, policies and procedures related to consumer consent requirements and data sharing with care coordination partners should be incorporated into care coordination agreements.

⁵⁹ *Id.*

⁶⁰ RFA, Appendix II, Criterion 3.c.4.

⁶¹ RFA, Appendix II, Criteria 3.a.2.

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

CARE COORDINATION AGREEMENT CHECKLIST

Note that some of the checklist items may be irrelevant in the context of care coordination agreements with social service agencies, such as homeless shelters and housing agencies. For example, it would be inappropriate for such care coordination agreements to set forth how the CCBHC will share certain consumer diagnosis and treatment information, including prescriptions. Accordingly, it is important that CCBHCs apply the checklist to the facts and circumstances specific to each individual care coordination relationship.

Pre-Contracting Activities:

Has the CCBHC:

- Evaluated whether the other party has sufficient personnel and facility space to see additional consumers?
- Explored establishing care coordination agreements with each type of facility regarding establishing care coordination expectations with the nearest Department of Veterans Affairs' facilities, to the extent multiple department facilities of different types are located nearby?⁶⁵
- Ascertained consumers' preferences and needs for care and adequately documented those needs and preferences in clinical records such that the preferences can be shared with the other party?⁶⁶
- Developed a crisis plan with each consumer to ascertain in advance the consumer's preferences in the event of a psychiatric or substance abuse crisis so the crisis plan can be shared with the other party?⁶⁷
- Made and documented reasonable attempts to determine any medications prescribed by other providers for CCBHC consumers and obtained appropriate consent to release of information to allow the CCBHC to provide such information to the other party?⁶⁸

⁶⁵ RFA, Appendix II, Criterion 3.c.4.

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ RFA, Appendix II, Criteria 3.a.5.



- Identified how the CCBHC will assist consumers (and their families, as applicable) in obtaining an appointment with the other party and will confirm that the appointment was kept?⁶⁹
- Drafted an agreement written in clear and unambiguous language?

Provisions in the Care Coordination Agreement Related to Coordination of Services:

Does the Care Coordination Agreement:

- Describe and establish the parties' mutual expectations and responsibilities related to care coordination?⁷⁰
- Describe the process by which the parties will share medical notes/records regarding diagnosis and treatment, including prescriptions?⁷¹
- Include as attachments all applicable care coordination protocols (such protocols should be incorporated by reference into the Agreement)?

As applicable, for certain provider types, does the care coordination agreement:

- For care coordination agreements applicable to inpatient psychiatric treatment with ambulatory and medical detoxification, post-detoxification step-down services and residential programs:
 - Establish that the CCBHC is able to track when consumers are admitted to facilities providing such services, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity?⁷²
 - Attach protocols and procedures developed by the CCBHC for transitioning individuals to a safe community setting, including the transfer of medical records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety and provision for peer services?⁷³
- For care coordination agreements applicable to inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care

⁶⁹ *Id.*

⁷⁰ RFA, Appendix II, Definitions: "Agreement."

⁷¹ *See* RFA, Appendix II, Criterion 3.C.

⁷² RFA, Appendix II, Criterion 3.a.2.

⁷³ *Id.*

centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers:

- Describe how the CCBHC tracks when its consumers 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 another entity, and provide for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge?⁷⁴
- Establish that the CCBHC will make and document reasonable attempts to contact all CCBHC consumers who are discharged from these settings within twenty-four (24) hours of discharge? For all CCBHC consumers discharged from such facilities who presented to the facilities as a potential suicide risk, include a requirement to coordinate consent and follow-up services with the consumer within twenty-four (24) hours of discharge, which shall continue until the individual is linked to services or assessed to be no longer at risk?⁷⁵

Provisions in the Care Coordination Agreement Related to the Obligations of the Care Coordination Partner

Does the care coordination agreement:

- Contain a provision stating that to the extent that referred CCBHC consumers receive services from the other party, such individuals are considered consumers of the other party?
- Specify that the other party agrees to accept all consumers referred to it by the CCBHC, subject to capacity limitations?
- Specify whether the other party will make services available to consumers regardless of their ability to pay? [Please note that the SAMHSA guidance does not require that services a CCBHC consumer accesses through a care coordination agreement be available regardless of ability to pay, but this would be optimal.]
- Specify that the other party will be solely liable for all services provided by it and its employee/contractors?
- Specify that the other party will be responsible for billing and collecting all payments from appropriate third party payors, funding sources and, as applicable, consumers for its services?

⁷⁴ RFA, Appendix II, Criterion 3.c.5.

⁷⁵ RFA, Appendix II, Criterion 3.c.5.

Provisions in the Care Coordination Agreement Related to Patient Privacy and Data Sharing

Does the care coordination agreement:

- Contain a provision stating each party agrees to comply with any federal or state law governing the privacy and confidentiality of the individually identifiable health information of consumers originating with either party?⁷⁶
- Specify that the parties will provide treatment planning and care coordination activities, as set forth in the care coordination agreement, in compliance with HIPAA, 42 CFR Part 2, and other applicable federal and state laws, including consumer privacy requirements specific to the care of minors?⁷⁷
- Specify that the parties will request consumers' consent for the disclosure of their health information, in accordance with state and federal laws and regulations?⁷⁸
- Specify that the parties will follow consumers' preferences for shared consumer health information, consistent with the philosophy of person and family-related consent?⁷⁹

Provisions in the Care Coordination Agreement Relating to Standards of Care

Does the agreement contain assurances that the other party and each of its professionals providing services pursuant to the care coordination agreement:

- Are appropriately licensed, certified and/or otherwise qualified to furnish the services, with appropriate training, education and experience in their particular field?
- Are not excluded from participating in Medicare, Medicaid and other federal health care programs?
- Will furnish services in accordance with applicable federal, state and local laws and regulations?

Provisions in the Care Coordination Agreement Relating to Professional Judgment and Freedom of Choice

Does the care coordination agreement:

⁷⁶ RFA, Appendix II, Criterion 3.a.2.

⁷⁷ RFA, Appendix II, Criteria 3.a.2.

⁷⁸ *Id.*

⁷⁹ *Id.*

- Specify that nothing in the arrangement will, or is intended to, impair the exercise of professional judgment by any and all health care professionals employed by or contracted to either party when making referrals?
- Specify that nothing in the arrangement will, or is intended to, impair the exercise of freedom of choice of provider by any and all consumers served by each party?

Autonomy and Compliance with State and Federal Law

Does the care coordination agreement:

- State that each party maintains the right to enter into arrangements with other entities, whether for the same or for similar services, if such party deems it necessary?
- Specify that the parties acknowledge and agree that they have freely negotiated the terms of the agreement and that neither party has offered or received any inducement or other consideration in exchange for entering into the agreement, and that nothing in the agreement requires, is intended to require or provides payment or benefit of any kind (directly or indirectly) for the referral of individuals or business to either party by the other party?