



CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS CONTRACTING AND COMMUNITY PARTNERSHIPS TOOLKIT

CCBHC DEMONSTRATION PARTICIPANT EDITION

OCTOBER 2020



DISCLAIMER

This resource was designed to provide accurate and authoritative information in regard to the subject matter covered. While based on the principles of federal law and guidance, this resource is provided with the understanding that it does not constitute, and is not a substitute for, legal, financial or other professional advice and does not take into account states' unique requirements and criteria for behavioral health providers and/or Certified Community Behavioral Health Clinics (CCBHCs).

Behavioral health providers should consult knowledgeable legal counsel and financial experts to structure and implement arrangements that are appropriate given local requirements and the particular parties' respective goals, objectives and expectations.

Please note that this document is not official Substance Abuse and Mental Health Services Administration (SAMHSA) or Centers for Medicare & Medicaid Services (CMS) guidance. Use of the materials in this Toolkit does not guarantee that grantees will be determined to be in compliance with relevant program requirements. CCBHC demonstration participants should consult with their state Medicaid agency or SAMHSA, as appropriate, with questions relating to CCBHC community partnership requirements.

This **toolkit** offers resources for CCBHCs to meet federal requirements relating to community partnerships with other service providers, through care coordination and designated collaborating organization (DCO) relationships.

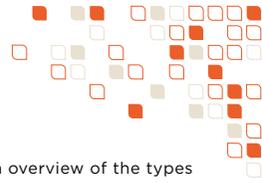
There are two main types of CCBHCs; those that participate in the CCBHC Medicaid demonstration and those that receive CCBHC Expansion Grant funding from SAMHSA to provide CCBHC services under similar program requirements to those governing the CCBHC Medicaid demonstration. **This edition of the toolkit addresses the requirements that apply to CCBHC Demonstration Participants.**

On April 1, 2014, Congress enacted the Protecting Access to Medicare Act of 2014 (PAMA)¹. Under Section 223 of PAMA, Congress required the Department of Health and Human Services (HHS) to establish a process for certification of CCBHCs as part of a two-year demonstration project under Medicaid. The law provided for an enhanced rate of federal financial participation (FFP) under the Medicaid program for services rendered under the CCBHC demonstration.² On December 21, 2016, HHS announced the eight states selected to participate in the CCBHC demonstration program: Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon and Pennsylvania. In August 2020, Kentucky and Michigan were selected as the two additional demonstration states.

¹ Protecting Access to Medicare Act (PAMA) § 223, Pub. L. No. 113-93 (Apr. 1, 2014) (42 U.S.C. § 1396a note).

² PAMA 2014, Pub. L. No. 113-93 (Apr. 1, 2014), tit. II (as amended), § 223(d)(5)(A) (42 U.S.C. § 1396a (note)).

³ Coronavirus Aid, Relief and Economic Security (CARES) Act of 2020, Pub. L. No. 116-136 (Mar. 27, 2020), tit. III, § 3814 (amending 42 U.S.C. § 1396a (note)).



The **CCBHC Contracting and Community Partnerships Toolkit** provides an overview of the types of community partnerships that are required under the CCBHC demonstration⁴ and offers resources to help clinics establish or strengthen these relationships. This **toolkit** also addresses the legal and logistical considerations that current or potential CCBHCs need to consider when forming these relationships. The two types of community partnerships contemplated in the CCBHC model are **DCO relationships** and **care coordination relationships**.

The Basic Features and Goals of the CCBHC Model

In authorizing the CCBHC demonstration program in PAMA,⁵ Congress wanted to empower providers to address behavioral health needs more holistically. Sen. Roy Blunt, who introduced the CCBHC provision with Sen. Debbie Stabenow, explained that the legislation would “create maximum flexibility and fully qualified locations” and would “allow government to begin to treat [behavioral health] challenges exactly as we treat other challenges — to have a healthy body, a healthy mind, all in one person, all in one spirit, all treatable.”⁶

Congress also wanted to ensure that behavioral health providers would be paid fairly under Medicaid for providing the comprehensive array of CCBHC services. Sen. Blunt stated that the demonstration project would give community behavioral health providers “an opportunity to increase the types of services they provide within and to their local communities by providing a similar rate under Medicaid that federally qualified [health] centers receive for primary care services.”⁷

These goals are apparent in the following three core features of the CCBHC demonstration, as set forth in the federal statute and described more fully in CMS and SAMHSA guidance.

⁴ Throughout this **toolkit**, we will refer to guidance issued by SAMHSA and CMS relating to the CCBHC program. On May 20, 2015, SAMHSA issued a request for applications that will be referred to in this **toolkit** as the 2015 Planning Grant RFA, from states to apply for CCBHC planning grants. In separate guidance documents attached to the 2015 Planning Grant RFA, SAMHSA set forth program requirements for CCBHCs and CMS described the PPS for CCBHCs. The available federal rules specifically addressing the CCBHC demonstration consist of the federal statute (PAMA § 223), the SAMHSA and CMS guidance attached to the 2015 Planning Grant RFA and numerous informal technical assistance documents published by CMS and SAMHSA. Please consult CMS’ and SAMHSA’s websites for the most up-to-date listing of CCBHC guidance at <https://www.medicaid.gov/medicaid/financial-management/section-223-demonstration-program-improve-community-mental-health-services/index.html> and www.samhsa.gov. In addition, the National Council for Mental Wellbeing maintains a useful CCBHC resource on its website at <http://www.thenationalcouncil.org/topics/certified-community-behavioral-health-clinics/>.

⁵ While the CCBHC demonstration is frequently termed a Medicaid demonstration and the changes in provider reimbursement that it authorizes apply to Medicaid, the demonstration imposes new clinical and operational requirements that extend to **all** a behavioral health provider’s consumers, not just those consumers who are Medicaid beneficiaries.

⁶ Proceedings and Debates of the 113th Congress, 160 Congressional Record S1840-02, 2014 WL 1281070 (March 31, 2014).

⁷ **Id.** Federally Qualified Health Centers (FQHCs) are reimbursed under Medicaid under a PPS methodology similar to the one CMS designed for the CCBHC demonstration.



Each CCBHC must furnish all required CCBHC services to its consumers.

Each CCBHC must be capable of “provision (in a manner reflecting person-centered care)” of all required CCBHC services to be “provided [by the CCBHC] or referred through formal relationships with other providers.”⁸ According to SAMHSA guidance on the CCBHC demonstration, the first four listed services must be furnished directly by the CCBHC.⁹ The DCO concept is discussed further in this introduction and throughout the **toolkit**.

The required services for CCBHC demonstration participants follow. Services that may be furnished via a DCO are indicated with an asterisk.

- Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization.
- Screening, assessment and diagnosis.
- Patient-centered treatment planning.
- Outpatient mental health and substance use disorder services.
- Primary care screening and monitoring.*
- Targeted case management.*
- Psychiatric rehabilitation services.*
- Peer support services and family support services.*
- Services for members of the armed services and veterans.*

CCBHCs must provide the services in every state, whether or not the services are currently covered independently under those states’ Medicaid state plan. In addition, a CCBHC must make the full array of CCBHC services available to **all its consumers**.

The CCBHC functions as a true safety-net behavioral health provider.

Each CCBHC must meet rigorous requirements for making services available and accessible to **all consumers**. For example:

- The CCBHC may not refuse services to any consumer, regardless of form of coverage or uninsured status based on inability to pay or place of residence.¹⁰
- The CCBHC must offer CCBHC services based on a sliding fee discount schedule to make the services affordable for low-income consumers.¹¹
- The CCBHC must provide each consumer a preliminary screening and risk assessment at time of first contact and develop and update a person-centered treatment plan.¹²
- The CCBHC must provide crisis management services that are accessible 24 hours a day, seven days a week.¹³



The CCBHC bills Medicaid through a prospective payment system (PPS) methodology.

States participating in the CCBHC demonstration are required to implement a PPS for Medicaid payment to CCBHCs.¹⁴ Rather than setting detailed requirements for this methodology, the federal law charged CMS with issuing guidance to states on development of the CCBHC PPS.¹⁵

Under CMS' CCBHC PPS guidance, payment to each CCBHC under Medicaid is made on a fixed per-visit rate.¹⁶ The rate is unique to each CCBHC, because each clinic's rates are based on its allowable costs per unit of CCBHC service (the "visit"), as reflected in a cost report covering a base time period.

Each CCBHC's rate per visit in Demonstration Year (DY) 1 is equal to its allowable costs per visit in the base period, trended forward by an inflationary index, the Medicare Economic Index (MEI).¹⁷ In adjusting the CCBHC PPS rate for DY 2, states have the option to either adjust the DY 1 rate by the MEI, or to "rebase" — set new rates for DY 2 based on DY 1 costs.¹⁸ This type of PPS system is sometimes referred to as a "cost-related" payment methodology. Because the rate is built from documented costs in a base period, trended forward, the provider is not guaranteed to recover its costs under a PPS, but payment is designed to bear a rational relationship to the provider's costs. This stands in contrast to "cost-based reimbursement," under which providers are reimbursed retrospectively for all allowable costs documented on a cost report.

Under the CMS guidance, states have considerable discretion in designing their PPS methodologies, including choosing between a "PPS-1" system in which the qualifying service unit is the daily encounter and a "PPS-2" system in which the qualifying service unit is the "unduplicated monthly encounter."¹⁹

¹⁴ PAMA § 223(a)(2)(D) (42 U.S.C. § 1396a (note)).

¹⁵ Department of Health and Human Services, SAMHSA, Planning Grants for Certified Community Behavioral Health Clinics, Request for Applications (RFA) No. SM-16-001, Appendix II, Criteria 4.C through 4.F (hereinafter, "the 2015 Planning Grant RFA"). In some instances, crisis behavioral health services may be furnished via a DCO. First, a "state-sanctioned alternative acting as a DCO" may furnish this service in lieu of the CCBHC providing it directly. **Id.** Criterion 4.C. Second, ambulatory and medical detoxification in ASAM categories 3.2-WM and 3.7-WM may be provided via DCO. SAMHSA Technical Assistance Clarifications (Dec. 10, 2015), #1.

¹⁶ PAMA § 223(a)(2)(B) (42 U.S.C. § 1396a (note)); 2015 Planning Grant RFA, Appendix II, Criterion 2.D.1; SAMHSA FY2020 CCBHC Expansion Grant Funding Announcement, Criteria 2.D and 2.E, p.

¹⁷ PAMA § 223(a)(2)(B) (42 U.S.C. § 1396a (note)); 2015 Planning Grant RFA, Appendix II, Criterion 2.D.2.

¹⁸ PAMA § 223(a)(2)(D)(ii) and (iii) (42 U.S.C. § 1396a (note)); 2015 Planning Grant RFA, Appendix II, Criteria 2.B, 4.D and 4.E.

¹⁹ PAMA § 223(a)(2)(B) (42 U.S.C. § 1396a (note)); 2015 Planning Grant RFA, Appendix II, Criteria 2.C, 4.C.

²⁰ Each state participating in the CCBHC demonstration is, per federal guidance, required to certify at least two providers to participate as CCBHCs. The Medicaid requirement of "statewide access" is waived for purposes of the CCBHC demonstration, meaning that states are not required to certify enough CCBHCs to make the service meaningfully accessible throughout the state. PAMA § 223(d)(6).

²¹ PAMA § 223(b) (42 U.S.C. § 1396a (note)).

²² RFA, Appendix III, pp. 3-4.

²³ RFA, Appendix III, pp. 7, 10. For purposes of DY 2, states will have the option of either applying the MEI to the Year 1 rates or conducting a "rebase" (developing a new cost-based rate built from allowable costs of furnishing CCBHC services during Demonstration Year 1).

²⁴ RFA Appendix III, p. 6.

²⁵ RFA, Appendix III, pp. 5-12.



The PPS is a "bundled" payment methodology. As Medicaid payment, each CCBHC receives the same rate for each qualifying visit, based on the average allowable per-visit cost of furnishing the entire bundle of CCBHC services, regardless of the type or intensity of clinical services provided. Importantly, for purposes of this **toolkit**, the PPS rate for any CCBHC must encompass the provider's direct and indirect costs associated with the provision of **all nine components of CCBHC services**, regardless of whether a given service is furnished directly by the CCBHC or through a DCO.²⁰

How Community Partnerships Advance the Goals of the CCBHC Program

Community partnerships are integral to the vision of holistic, person-centered care embodied by the CCBHC demonstration.

The CCBHC legislation and guidance envision two chief types of CCBHC community partnerships. The first is **care coordination relationships**. SAMHSA stated in its guidance that care coordination is the "linchpin" of the CCBHC demonstration.²¹ Care coordination relationships are typically memorialized in informal agreements between CCBHCs and other providers and social service agencies in their area. Care Coordination Agreements describe the parties' mutual expectations and responsibilities and are meant to enhance the quality of care, improve CCBHC consumers' access to services that fall outside the CCBHC benefit (for example, inpatient and specialty services) and create seamless transitions between service settings.

The benefits of a care coordination relationship are achieved primarily through referrals and the exchange of health information and information about the consumer's needs and preferences (where information exchange is contemplated in the agreement and consented to by the consumer).

In the law establishing the CCBHC demonstration, Congress described various types of providers and social service agencies with which CCBHCs are required to undertake care coordination.²² SAMHSA elaborated on these requirements in its guidance.²³

The second key type of CCBHC community partnership is the DCO relationship. In the law authorizing the CCBHC demonstration, Congress required that CCBHC services must be provided either directly or through "formal relationships."²⁴ Congress also called upon CMS to develop a

²⁰ The one potential exception to this rule is where crisis services are furnished directly by the state; the state may act as a DCO for purposes of making that portion of the CCBHC available to Medicaid beneficiaries, but the CCBHC is not required to procure the crisis services contractually from the state and the CCBHC PPS rate is not required to reflect the cost of the crisis services. CMS, **Section 223 Demonstration Programs to Improve Community Mental Health Services Qs & As - Set IV** (Sept. 28, 2016), p. 4, at <https://www.medicaid.gov/medicaid/downloads/section-223-set-4-qsandas.pdf>. Please see further discussion below at [page 24] of this **toolkit**.

²¹ 2015 Planning Grant RFA, Appendix II, p. 23.

²² PAMA § 223(a)(2)(C) (42 U.S.C. § 1396a (note)).

²³ 2015 Planning Grant RFA, Appendix II, Criterion 3.C.

²⁴ PAMA § 223(a)(2)(D) (42 U.S.C. § 1396a (note)).



PPS methodology, which Congress contemplated and CMS implemented as a bundled methodology incorporating the allowable costs to the CCBHC of furnishing all nine (9) CCBHC services. In order to ensure that CCBHCs could maintain clinical and financial responsibility for the entire bundle of CCBHC services and document the associated costs on their cost reports, SAMHSA created the concept of a “designated collaborating organization.”²⁵ DCO relationships are contractual arrangements under which the CCBHC purchases the services of another provider, the DCO. The CCBHC retains responsibility for the provision of the purchased CCBHC service rendered by the DCO and the CCBHC serves as the billing provider for the service.²⁶

CMS has made clear in guidance that Medicaid agencies pay via the CCBHC PPS rate only for those CCBHC services furnished by CCBHCs, or by the DCOs with which CCBHCs contract.²⁷ In other words, DCOs represent the only mechanism whereby CCBHCs can outsource the provision of CCBHC services to a vendor.

DCO relationships, unlike care coordination relationships, **are not required** under the CCBHC demonstration. If a CCBHC is able to provide all CCBHC services on its own, it does not need DCOs. DCOs are simply a mechanism a CCBHC may use to make a CCBHC service available to its consumers that it does not provide directly.

Many community behavioral health providers today have developed strong ties with other providers and agencies in their areas to ensure that consumers are cared for promptly and effectively. For some aspiring CCBHCs, meeting the community partnership requirements of the CCBHC demonstration will be more a matter of strengthening or formalizing existing relationships than forging new ones.

The Contents of This Toolkit

This **toolkit** focuses primarily on requirements, as set forth by CMS and SAMHSA, applicable to CCBHCs in contracting with DCOs and establishing Care Coordination Agreements. It is intended as a resource for community behavioral health organizations pursuing designation as CCBHCs in Medicaid or for existing CCBHCs seeking to strengthen their compliance with the community partnership and for other organizations in the community consideration working with CCBHCs as DCOs or as care coordination partners.

We hope the **toolkit** provides useful information for you as you navigate the transition to CCBHC status and negotiate mutually beneficial community partnerships that promote the goals of the CCBHC Expansion Grant program.

²⁵ In Appendix II, the RFA specifically lists which services can be provided by DCOs and which services must be provided directly by the CCBHC.
²⁶ RFA, Appendix II, p. 35.
²⁷ CMS, **Section 223 Demonstration Programs to Improve Community Mental Health Services Qs & As - Set III**, (June 1, 2016), p. 4, at <https://www.medicaid.gov/medicaid/downloads/section-223-set-3.pdf>.



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DISTINGUISHING DCO RELATIONSHIPS FROM CARE COORDINATION RELATIONSHIPS



Collaboration among providers and safety-net organizations is central to CCBHC model. Two distinct types of collaborations are addressed – DCOs and care coordination.

Understanding the difference between DCOs and care coordination and their associated requirements is critical.

1. Formal Relationships with DCOs

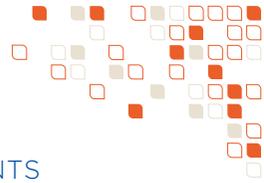
CCBHCs must provide consumers with access to all required CCBHC services; however, they are not required to furnish all CCBHC services directly. A subset of the required CCBHC services may be provided through formal relationships with other providers known as DCOs. Under this relationship, the DCO furnishes a required CCBHC service or services on behalf of the CCBHC and is subject to various CCBHC requirements.

2. Care Coordination

In addition to furnishing CCBHC services, either directly or through DCOs, CCBHCs must coordinate care across a specific spectrum of safety-net services, including services like inpatient care, primary care and housing access.

Key Differences Distinguishing DCOs from Care Coordination

	DCO	CARE COORDINATION
Scope	A DCO provides some of the required CCBHC services and may include outpatient primary care screening and monitoring, targeted case management, psychiatric rehabilitation, peer and family supports, intensive community-based outpatient behavior health care for veterans and members of the U.S. armed forces and, in some situations, crisis behavioral health services.	Care coordination is regarded as an activity rather than a service. CCBHCs must maintain care coordination relationships with various entities and social service agencies. In general, the services provided by the care coordination partner do not fall within the scope of CCBHC services.
Type of Agreement	Structured (with limited exceptions) as a purchase of services agreement.	Structured as a referral agreement.
Responsibility	CCBHC is clinically and financially responsible for the DCO's provision of CCBHC services on the CCBHC's behalf.	CCBHC does not assume responsibility for services provided by the other entity or social service agency. The organizations maintain autonomous operations.
Billing Provider	CCBHC is the billing provider for CCBHC services provided by the DCO.	Each care coordination partner is the billing provider for the services that it furnishes.
Consideration	CCBHC, with limited exceptions, compensates the DCO providing CCBHC services on the CCBHC's behalf.	No consideration, money or anything else of value is exchanged between the CCBHC and the other entity or social service agency.
Schedule of Fees and Discounts	DCOs furnish CCBHC services in accordance with the CCBHC's schedule of fees, schedule of discounts and corresponding written policies and procedures.	The entity or social service agency bills consumers and/or payors for the services it provides, as applicable, independent of the CCBHC and in accordance with its own schedule of fees and schedule of discounts.
Mandatory or Optional	DCO contracting are optional. If a CCBHC is able to furnish all CCBHC services directly, it need not contract with a DCO.	Care coordination arrangements with other providers in the community are a mandatory component of the demonstration.



CARE COORDINATION AGREEMENTS

Overview of Legal Requirements and Checklist of Recommended Terms

Coordinating care across a spectrum of services,²⁸ including physical health, behavioral health, social services, housing, educational systems and employment opportunities,²⁹ is central to the CCBHC demonstration project.

The Agency for Healthcare Research and Quality (AHRQ) defines care coordination as:

*deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient'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.*³⁰

This person-centered and family-centered approach is essential to furnishing care that addresses the well-being of the whole person.³¹ 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.³² 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.³³ 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.³⁴

Care coordination is regarded as an activity rather than a service.³⁵ A patient encounter consisting of care coordination activities alone would not trigger payment under CCBHC prospective payment system (PPS).³⁶ However, most clinical, administrative and technology costs

²⁸ See Protecting Access to Medicare Act (PAMA) § 223(a)(2)(C) (42 U.S.C. § 1396a (note)), Pub. L. No. 113-93 (Apr. 1, 2014); SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, p. 71.

²⁹ RFA for SA MHSa 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 (2015 Planning Grant RFA, Appendix II), Criterion 3.c.3.

³⁰ *Id.*

³¹ 2015 Planning Grant RFA, Appendix II, Criterion 3.a.1.

³² *Id.* Criterion 3.a.4; SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 4.E, p. 97.

³³ *Id.* Criterion 3.d.2; SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 3.D, p. 93.

³⁴ 2015 Planning Grant RFA, Appendix II, Criterion 3.d.2.

³⁵ *Id.*, Appendix II, Definitions: "Care Coordination."

³⁶ 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.



associated with care coordination activities will be considered allowable costs on states' CCBHC cost reports.³⁷ Care coordination links CCBHC consumers with access to certain providers and social service agencies, as set forth below, through a referral process.

The referral process under the care coordination model is not passive. 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.

Federal law requires that CCBHCs enter "partnerships or formal contracts" with a variety of organizations in the community.³⁸ CMS and SAMHSA specified that CCBHCs must have an agreement in place with each of the entities with which the CCBHC coordinates care.³⁹ If the CCBHC cannot establish an agreement by the start of the demonstration project, it must work toward formal agreements.⁴⁰ The agreement may be structured as a contract, memorandum of agreement, memorandum of understanding, letter of support, letter of agreement or letter of commitment.⁴¹ 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.⁴² 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.⁴³ 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.⁴⁴

Under care collaboration relationships, unlike the [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

³⁷ 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 regarding 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.

³⁸ PAMA § 223(a)(2)(C) (42 U.S.C. § 1396a (note)).

³⁹ *Id.*, Appendix II, Definitions: "Agreement"; SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 3.C, p. 91.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

⁴³ SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 3.C, p. 91.

⁴⁴ *Id.*, Appendix II, Criterion 3.a.5.



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.⁴⁵

Scope of Care Coordination: Providers and Social Service Entities

In the spirit of promoting access to services that is both integrated and comprehensive, PAMA requires that CCBHCs maintain care coordination relationships⁴⁶ with the following providers and social service entities:

- Federally Qualified Health Centers (and as applicable, rural health clinics).
- Inpatient psychiatric facilities, including substance use disorder facilities 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.
- Inpatient acute care hospitals and hospital outpatient clinics.⁴⁷

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
- Other social and human services⁴⁸

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

⁴⁵ 2015 Planning Grant RFA, Appendix II, Criterion 3.a.6.

⁴⁶ 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.

⁴⁷ PAMA § 223(a)(2)(C) (42 U.S.C. § 1396a (note)); SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 3.C, pp. 91-92.

⁴⁸ SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 3.C, p. 92.



- Housing agencies
- Employment services systems
- Services for older adults, such as aging and disability resource centers
- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs)⁴⁹

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.

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.⁵⁰ However, for certain 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.⁵¹ Unless there is a formal transfer of care from the CCBHC 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.⁵² 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 24 hours of discharge. Those obligations must continue until the consumer is linked to services or assessed to be no longer be at risk.⁵³ Additionally, the CCBHC must ensure that it can make and document reasonable attempts to contact all CCBHC consumers discharged from these settings within 24 hours of discharge.⁵⁴

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.⁵⁵ The CCBHC must establish protocols and procedures for transitioning individuals from

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*, p. 93.

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*



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.⁵⁶

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.

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. The documentation must satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 CFR Part 2 and other federal and state privacy laws.⁵⁷ 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.⁵⁸

If CCBHCs are unable, after reasonable attempts, to obtain consent for care coordination activities, such attempts must be documented and revisited periodically.⁵⁹ 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.

⁵⁶ *Id.*
⁵⁷ *Id.* p. 90.
⁵⁸ *Id.*



CARE COORDINATION AGREEMENT CHECKLIST

Note: 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?
- 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?
- Developed a crisis plan with each consumer to ascertain in advance the consumer's preferences in the event of a psychiatric or substance use crisis so the crisis plan can be shared with the other party?
- 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?
- 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?
- Drafted an agreement written in clear and unambiguous language?

⁵⁹ *Id.*



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?
- Describe the process by which the parties will share medical notes/records regarding diagnosis and treatment, including prescriptions?
- 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:

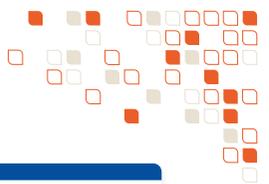
- For Care Coordination Agreements applicable to inpatient psychiatric treatment with ambulatory and medical detoxification, post-detoxification step-down services and residential programs:
 - o Establish that the CCBHC is able to track when consumers are admitted to facilities providing such services, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity?
 - o 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?
- For Care Coordination Agreements applicable to inpatient acute care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers:
 - o Describe how the CCBHC tracks when its consumers are admitted to facilities providing the previously listed services, 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?
 - o Establish that the CCBHC will make and document reasonable attempts to contact all CCBHC consumers who are discharged from these settings within 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 24 hours of discharge, which shall continue until the individual is linked to services or assessed to be no longer at risk?



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?
 - o **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?



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?
- 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?
- Specify that the parties will request consumers' consent for the disclosure of their health information, in accordance with state and federal laws and regulations?
- Specify that the parties will follow consumers' preferences for shared consumer health information, consistent with the philosophy of person- and family-related consent?

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:

- 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?



SAMPLE CARE COORDINATION AGREEMENT

*This sample Care Coordination Agreement is between a fictional CCBHC, **Behavioral Health Clinic**, and a fictional hospital, **Community Hospital**, for the provision of inpatient psychiatric treatment. Note that this sample Care Coordination Agreement is not a template, but is provided as an example. All questions regarding SAMHSA requirements for the care coordination relationship should be directed to SAMHSA. CCBHCs must maintain Care Coordination Agreements⁶⁰ with a range of other providers and social support organizations and each such agreement must be drafted to reflect the unique characteristics of each care coordination relationship.*

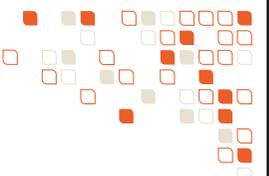
This Care Coordination Agreement (the “Agreement”) serves to confirm the mutual understandings of Behavioral Health Clinic, a Certified Community Behavioral Health Clinic (“CCBHC”), and Community Hospital, an acute care hospital, to coordinate inpatient acute care and hospital outpatient services (collectively, the “Services”) for those individuals who receive community-based mental health and substance use disorder services from Behavioral Health Clinic, in accordance with the terms set forth below. The purpose of this Agreement is to set forth the parties’ understanding regarding their collaborative treatment planning and care coordination activities.

I. Provision of Services

1. Behavioral Health Clinic is committed to providing integrated and coordinated care across a spectrum of services in a manner that is both person-centered and family-centered, consistent with Section 2402(a) of the Patient Protection and Affordable Care Act (“ACA”), and with the requirements of the CCBHC demonstration, as implemented by the United States Department of Health and Human Services (“HHS”).
2. Community Hospital agrees to furnish Services to consumers referred to Community Hospital by Behavioral Health Clinic, regardless of the individual’s ability to pay, payor source, insurance status or place of residence, subject to capacity limitations, as determined in Community Hospital’s sole discretion. Community Hospital agrees to promptly inform Behavioral Health Clinic when Community Hospital no longer has capacity to accept additional consumers from Behavioral Health Clinic.

Note: The PAMA does not require that the Care Coordination Agreement include a representation that the Community Hospital will furnish services to all CCBHC consumers, regardless of their ability to pay. However, we recommend including this provision.

⁶⁰ The SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement states that CCBHCs are expected to “work toward” formal agreements during the two year grant period, but should at least have some informal agreement (e.g., letter of support, letter of agreement, or letter of commitment) with each entity at certification.

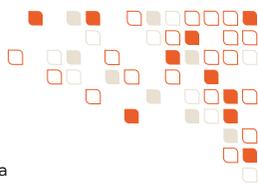


II. Care Coordination Processes

1. The parties will collaborate to conduct treatment planning and care coordination activities in a manner that is person- and family-centered.
2. Behavioral Health Clinic agrees to provide intake, initial screening, and appropriate treatment to consumers presenting at Behavioral Health Clinic for the provision of community-based mental health and substance use disorder services, and to establish and maintain records of such individuals’ healthcare.
3. If such screening and/or treatment indicate the need for Services, as determined in the sole discretion of the Behavioral Health Clinic provider, consistent with requirements of privacy, confidentiality, and consumer preference and need, Behavioral Health Clinic will assist consumers and/or their families to obtain an appointment with Community Hospital. Behavioral Health Clinic will confirm with Community Hospital that the appointment was kept, consistent with the Referral and Communication Protocol described below in Section II.5.
4. Behavioral Health Clinic will ensure that consumers’ preferences and those of their families, as applicable, for shared information will be adequately documented in the applicable clinical records, consistent with the philosophy of person- and family-centered care. Behavioral Health Clinic will make reasonable efforts to obtain necessary consent for release of information from consumers of Behavioral Health Clinic.
5. Behavioral Health Clinic and Community Hospital agree to jointly develop a Care Coordination Protocol. Such protocol shall describe: (i) how Behavioral Health Clinic tracks its consumers when admitted to and discharged from, Community Hospital; (ii) how Behavioral Health Clinic and Community Hospital will coordinate the transfer of medical records for Services received at Community Hospital (e.g., prescriptions) by consumers of the Behavioral Health Clinic; (iii) the process for coordinating Behavioral Health Clinic’s active follow-up after discharge; (iv) how timely and orderly referrals will be made; (v) how the Parties will track referred consumers and the Services they receive, including prescriptions, admission, and discharge, as applicable; (vi) consumer preferences and needs for care, including psychiatric or substance use crises, and to the extent possible and in accordance with consumer’s expressed preferences with consumer’s family or caregiver and other supports identified by consumer; (vii) any other expectations necessary to effectively manage care transitions; and (viii) as applicable, the sharing of medical notes and records regarding diagnosis, treatment, prescriptions, and specific recommendations for appropriate follow-up care.

Please note: For Care Coordination Agreements applicable to inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services and residential programs, the Care Coordination Protocol should address:

- How the CCBHC will 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.

- Procedures for assisting individuals with the transition 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.
6. Behavioral Health Clinic will make and document reasonable attempts to contact all Behavioral Health Clinic consumers who are discharged from Community Hospital within twenty-four (24) hours of discharge. For all Behavioral Health Clinic consumers who present to the Community Hospital as a potential suicide risk, Behavioral Health Clinic will provide targeted case management services, emphasizing smooth transitions to and from emergency department care or psychiatric hospitalization. A Behavioral Health Clinic will 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.
 7. Behavioral Health Clinic and Community Hospital agree that, to the extent that consumers receive care from either Party pursuant to this Agreement, such individuals are considered consumers of the Party furnishing the services. Accordingly, each Party agrees to be solely responsible for billing and collecting all payments for such services from appropriate third party payors, funding sources, and, as applicable, consumers, observing the Party's customary billing, collection, and discount/charity care policies.

III. Insurance and Liability

Note: The Parties may wish to include a section that sets forth their mutual understandings and obligations related to insurance and liability. PAMA does not require such provision be in the Care Coordination Agreement. We nonetheless recommend including such representation.

1. Behavioral Health Clinic and Community Hospital represent and warrant that each Party and its clinicians providing Services hereunder are covered by a professional liability insurance policy (malpractice, errors, and omissions) that provides sufficient coverage against professional liabilities that may arise from acts or omissions in connection with or related to the Services that the Party furnishes under this Agreement.
2. Behavioral Health Clinic and Community Hospital understand and agree that the provider of record of services, Behavioral Health Clinic, is solely liable for all such services, and that the Party which is not the provider of record of the services will not be liable, whether by



way of contribution or otherwise, for any damages incurred by consumers or arising from any acts or omissions in connection with or related to the provision of such Services.

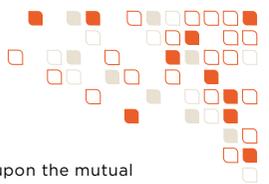
IV. Assurance of Consumer and Clinician Choice

1. Behavioral Health Clinic and Community Hospital acknowledge and agree that all health and health-related professionals employed by or under contract with either Behavioral Health Clinic or Community Hospital retain sole and complete discretion, subject to any valid restriction(s) imposed by participation in a managed care plan and consistent with Section II above, to refer consumers to any and all providers who best meet the medical needs of such consumers.
2. Behavioral Health Clinic and Community Hospital acknowledge that all consumers have the freedom to choose (and/or request referral to) any provider of services, and Behavioral Health Clinic and Community Hospital will advise consumers of such right, subject to any valid restriction(s) imposed by participation in a managed care plan.
3. Behavioral Health Clinic and Community Hospital acknowledge and agree that they have freely negotiated the terms of this Agreement and that neither Party has offered or received any inducement or other consideration in exchange for entering into this Agreement. Nothing in this 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, subject to Section II above.
4. Behavioral Health Clinic and Community Hospital remain separate and independent entities. No provision of this Agreement is intended to create, nor shall any provision be deemed or construed to create, a relationship between the parties other than that of independent contractors. Behavioral Health Clinic and Community Hospital retain the authority to contract or affiliate with, or otherwise obtain services from, other parties, on either a limited or a general basis.

V. Term and Termination

1. The term of this Agreement shall commence on January 1, 2017, and continue until January 1, 2019, unless terminated at an earlier date in accordance with Section V. This Agreement will automatically renew for additional one (1) year terms unless written notice of intent not to renew is provided by one Party to the other Party no less than thirty (30) days prior to the expiration of the then-current Agreement.

Note: The parties should identify an appropriate term, which may include provisions for the automatic renewal for subsequent terms, absent a Party's election to terminate the Agreement.



- 2. This Agreement may be terminated, in whole or in part, at any time upon the mutual agreement of Behavioral Health Clinic and Community Hospital.
- 3. Either Behavioral Health Clinic or Community Hospital may terminate this Agreement without cause upon ninety (90) days prior written notice to the other Party.

Note: The Parties should identify the number of days' notice one Party must provide the other Party in the event a Party seeks to terminate this Agreement without cause.

- 4. This Agreement may be terminated for cause upon written notice by either Behavioral Health Clinic or Community Hospital. "Cause" shall include, but is not limited to:

Note: The Parties should identify appropriate causes for termination under the Agreement, which may vary with the Services being coordinated by the Parties and the specific terms of the Agreement.

VI. Privacy and Confidentiality of Consumer Information

- 1. Behavioral Health Clinic and Community Hospital will coordinate care, as set forth in this Agreement, in a manner that complies with privacy and confidentiality requirements, including but not limited to those of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including privacy requirements specific to the care of minors.
- 2. Each Party agrees it shall request consumers' consent for disclosure of their health information, in accordance with state and federal law and regulations. Each Party shall follow consumers' preferences for shared protected health information, consistent with the philosophy of person- and family-related consent.
- 3. This Section VI shall survive termination of this Agreement.

SIGNATURE PAGE TO FOLLOW.

Behavioral Health Clinic

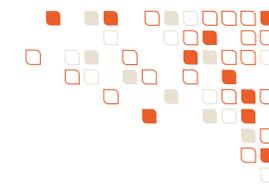
Community Hospital

Signature: _____

Signature: _____

Date: _____

Date: _____



DCO ARRANGEMENTS

Overview of Legal Requirements and Checklist of Recommended Terms

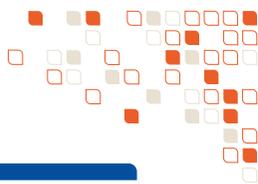
The 2014 law authorizing the CCBHC demonstration program required HHS to establish criteria for a clinic to be certified by a state as a CCBHC in Medicaid. PAMA requires that CCBHCs provide an array of required services that must either be provided directly by the CCBHC or "through formal relationships with other providers."⁶¹

SAMHSA guidance on the CCBHC demonstration narrowed the requirements for the "formal relationships" with other providers that a CCBHC may use to make required services available to the CCBHC's consumers. SAMHSA advised that if a CCBHC is not able to provide a required service directly, the service must be provided through a relationship with what SAMHSA termed a "designated collaborating organization" or DCO.

A DCO is an entity that is not under the direct supervision of the CCBHC, but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC.

In addition, SAMHSA advised that of the required CCBHC services, only a portion may be provided via DCOs. The remainder must be furnished directly by the CCBHC.

⁶¹ Protecting Access to Medicare Act, Pub. L. No. 113-93 (Apr. 1, 2014) § 223(a)(1)(D) (42 U.S.C. § 1396a (note)), 128 Stat. 1079.



CCBHC Services and DCO Scope of Services

The CCBHC services that demonstration participants are required to provide are the following. Those marked with an asterisk may be provided via DCO.

- Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization.
- Screening, assessment and diagnosis.
- Patient-centered treatment planning.
- Outpatient mental health and substance use disorder services.
- Primary care screening and monitoring.*
- Targeted case management.*
- Psychiatric rehabilitation services.*
- Peer support services and family support services.*
- Services for members of the armed services and veterans.*

The required services must be provided by CCBHCs in every state, whether or not the services are independently covered under those states' Medicaid state plan currently. In addition, a CCBHC must make the full array of CCBHC services available to **all of its consumers**.

The DCO relationship, as described in the SAMHSA and CMS guidance, is an agreement between the CCBHC and the DCO. The CCBHC assumes clinical responsibility for the provision of the service furnished by the DCO and serves as the billing provider for the service.⁶²

As noted previously, CMS has recognized that in CCBHC demonstration states where a state-sanctioned, certified or licensed system is in place to cover crisis services, the state as DCO may furnish the crisis services, rather than the CCBHC providing them directly. In addition, CMS clarified in the guidance, where the CCBHC does not incur any contractual cost in association with the state-sanctioned crisis services, the PPS rate is not required to include any costs associated with that service.⁶³ It, therefore, appears (while CMS did not state this explicitly) that, unless the state determines this is necessary, CCBHCs do not need to enter a purchase of service agreement with the state as a provider of crisis services. In effect, the state as a provider of crisis services may be deemed a DCO.

⁶² RFA, Appendix II, p. 35.

⁶³ CMS, **Section 223 Demonstration Programs to Improve Community Mental Health Services Qs & As - Set IV** (Sept. 28, 2016), p. 4, at <https://www.medicaid.gov/medicaid/downloads/section-223-set-4-qsandas.pdf>.



Because the CCBHC is financially responsible for the provision of the CCBHC services rendered via DCO, the CCBHC's contracting costs associated with those services are (with the exception noted above regarding crisis services) included on the cost report that the CCBHC is required to submit to support its PPS rate.⁶⁴ CMS noted in guidance that during the planning phase of the demonstration, since specific DCO contractual arrangements may not yet be in place, CCBHCs may rely on reasonable estimates of DCO contracting costs in the materials they submit to states and states may rely on these estimates in setting CCBHC PPS rates.⁶⁵

Typically, the CCBHC and DCO would be entirely distinct organizations, but SAMHSA guidance has indicated that in some instances, a CCBHC and a DCO may be related entities. For example, the DCO and CCBHC may be separate clinics within a larger, non-profit organization.⁶⁶ Or, similarly, a DCO may be a subsidiary of the CCBHC as a stand-alone site or subsidiary.⁶⁷

Health care providers may function as a DCO whether they are a nonprofit, for-profit or governmental entity. CCBHCs, on the other hand, must be non-profit or governmental entities.

CCBHC Clinical and Financial Responsibility for DCOs

The purchase of required CCBHC services from DCOs must be documented in a written agreement. Consumers receiving CCBHC services from DCO personnel under the contract are considered to be CCBHC's consumers. The CCBHC is responsible for billing third-party payors, including Medicare, Medicaid and private insurers for services rendered under contract by the DCO. As a result, the CCBHC must obtain adequate records and documentation of services rendered for billing third parties from the DCO.

Additionally, the CCBHC is responsible for ensuring that consumer fees and cost-sharing for services rendered by the DCO under the contract are collected. This can be achieved through a variety of approaches, including contractually delegating collection of consumer fees and cost-sharing at the point of service to the DCO.⁶⁸

Finally, with the narrow exception noted regarding crisis services, the CCBHC must pay a fee to the DCO for services purchased under the agreement. Please note that the consideration paid by the CCBHC to the DCO under the contract should not reflect a "pass-through" of the PPS rate. Instead, the consideration should reflect an objective estimation of fair market value.

⁶⁴ RFA, Appendix III, pp. 7, 11.

⁶⁵ CMS, **Section 223 Demonstration Programs to Improve Community Mental Health Services Qs & As - Set II** (updated May 26, 2016), p. 2, at <https://www.medicaid.gov/medicaid/downloads/section-223-set-2.pdf>.

⁶⁶ See SAMHSA, Planning Grants for Certified Community Behavioral Health Clinics, RFA No. SM-16-001, **Frequently Asked Questions, available at** www.samhsa.gov/sites/default/files/grants/pdf/faq/sm-16-001-faq_1.pdf, p. 5 (Question 18).

⁶⁷ A CCBHC would be unable to apply the principles of commercially reasonable contracting that would normally govern a purchase of services arrangement, where its DCO is its own subsidiary or a component of the organization. "Arm's length" negotiation would be impossible in this context. Prospective CCBHCs that intend to use a subsidiary or portion of their organization as a DCO should consult legal counsel concerning the structuring of the arrangement.

⁶⁸ SAMHSA has stated in guidance that a CCBHC may contractually delegate the collection of consumer fees to the DCO, without compromising its financial responsibility for the service rendered by the DCO. See Project 223 Clarification to Guidance - Set 1 Distributed to Project Directors on March 21, 2016 (available at <http://www.samhsa.gov/section-223/clarifications>), at 4.



Documentation of the fair market value basis for the consideration should be retained in the CCBHC's files. The estimation of fair market value could be based on salary surveys, fee schedules or the historic costs to the DCO of furnishing the type of services rendered under the contract. For more information, see [Determining Fair Market Value](#).

The fact that the CCBHC is **clinically responsible** for the services rendered by DCOs under the contract means that the CCBHC must ensure that those services:

- Meet cultural competency standards set by SAMHSA and/or the CCBHC.
 - For example, the CCBHC must have a training plan in place for staff and DCOs that addresses cultural competence and person-centered, family-centered, recovery-oriented, evidence-based and trauma-informed care.
- Are reflected in the data reported by the CCBHC under SAMHSA's Uniform Reporting System.
- Meet SAMHSA's CCBHC standards for accessibility of services (e.g., application of sliding fee scale, no limitation or denial of services based on ability to pay or residence regardless of insurance status).
 - For more information on sliding fee discount policy, see [CCBHC Fee Schedule and Sliding Fee Discount Schedule](#).
- Are rendered within a specified time period after appointment request.
 - For example, established consumers must be provided with an appointment within 10 business days of the requested date for services, unless the state, the federal government or accreditation standards are more stringent. If consumer presents to with an emergency or crisis need, the DCO must take immediate action, including any necessary outpatient follow-up care and ensure clinical services are provided within one business day of the request.
- Meet all relevant SAMHSA program requirements applicable to the specific contracted service.
 - For example, targeted case management services must include the appropriate scope of services for the specific population as specified by the state such as supports for people deemed high risk of suicide during care transitions.
- Are rendered in keeping with state law (e.g., each clinician is acting within the scope of their license/certification and applicable supervision requirements are met).
- The CCBHC should ensure that consumers who receive CCBHC services via DCO have access to the CCBHC's grievance procedures.



The fact that the CCBHC is **financially responsible** for the services rendered by DCOs under the contract means that the CCBHC:

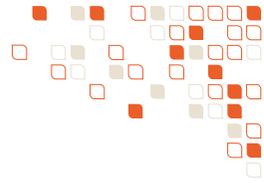
- Bears financial risk for collection of consumer out-of-pocket liability (fees and cost-sharing).
- Bears legal responsibility for coordination of benefits.
- Is responsible for ensuring that DCO-related costs are included in CCBHC Medicaid cost report.
- Is responsible for billing third party payors, including Medicaid and Medicare, for services furnished by DCOs to CCBHC consumers.⁶⁹

Please note that in November 2016, CMS published a set of Healthcare Common Procedure Coding System (HCPCS) codes for CCBHC encounter billing codes and modifiers, effective for dates of service on or after January 1, 2017.⁷⁰

These risks and responsibilities apply to all services that the CCBHC purchases under the DCO contract, not just services rendered to Medicaid beneficiaries.

⁶⁹ Notably, CMS has stated that because CCBHCs bear clinical and financial responsibility for the services furnished by DCOs, DCOs and their individual clinicians are not required to be enrolled in state Medicaid programs in order for the services they furnish to be billable under Medicaid. See CMS, FAQ Set IV, 9/28/2016, <https://www.medicaid.gov/medicaid/downloads/section-223-set-4-qsandas.pdf> ("[F]or the duration of the demonstration, the state is not required to enroll a DCO or DCO practitioners as Medicaid providers"). Since CMS issued that guidance, however, the federal law has been amended to require that rendering providers of Medicaid services, both under the Medicaid state plan and via Medicaid managed care networks, are required to be enrolled with the state Medicaid agency. See Social Security Act § 1902(a)(78) (state plan services enrollment requirement, effective Jan. 1, 2017); 1932(d)(6) (managed care network provider enrollment requirement, effective Jan. 1, 2018). Services furnished under the CCBHC demonstration are arguably exempt from these requirements, since CCBHC is a standalone demonstration project. However, since the law typically requires all rendering providers to be enrolled in Medicaid, CCBHCs should generally seek to contract with DCOs that are enrolled in Medicaid, and CCBHCs (or participating states) should consult with CMS if Medicaid enrollment is not possible for one or more DCOs in their state.

⁷⁰ CMS, CCBHC Demonstration Billing Codes (Nov. 27, 2016), at <https://www.medicaid.gov/medicaid/financial-management/section-223-demonstration-program-improve-community-mental-health-services/index.html>.



DCO AGREEMENT CHECKLIST

Does the agreement contain provisions related to the scope and provision of services, such as terms that:

- Specify all of the services to be provided to the CCBHC?
- Provide that all consumers receiving services under the agreement are considered consumers of the CCBHC?
- Describe how the CCBHC's policies and procedures related to the provision of services will apply?
- State that neither party is under obligation to refer consumers or business to the other party as a result of the agreement?
- State that the health care professionals of each party retain the ability to refer based on professional judgment (and consumers retain the freedom to see whatever provider they choose)?
- Require the DCO to furnish services consistent with CCBHC's applicable health care and personnel policies, procedures, standards and protocols?
- Require the DCO and its clinicians to satisfy the CCBHC's professional standards and qualifications, including licensure, credentialing and privileging?
- Require the DCO and its personnel to cooperate in the purchasing entity's clinical quality and compliance activities?

Does the agreement contain provisions related to the billing of third parties and collection of cost-sharing from consumers, such as terms that:

- Describe how the CCBHC's policies and procedures related to billing of third parties and consumers, including the sliding fee discount program, will apply?
- Describe how consumer fees and cost-sharing will be collected and, if the obligation for such collection is contractually delegated to the DCO, transmitted to the CCBHC?



Does the agreement contain provisions related to billing of the CCBHC and payment to the DCO, such as terms that:

- Provide terms and mechanisms for billing and payment, such as invoice procedures and deadlines?
- Specify in advance the compensation for the services or a fixed methodology by which the compensation will be established?
- Set the compensation at a commercially reasonable amount that is consistent with fair market value and does not vary based on the volume or value of referrals or business generated, directly or indirectly, between the parties?
- Allow the 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?

Does the agreement contain provisions related to recordkeeping and reporting, such as terms that:

- Require the DCO to prepare medical records consistent with CCBHC's standards?
- Require the DCO to furnish to the CCBHC programmatic 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)?
- Require the contractor to retain and provide access to such records and reports?

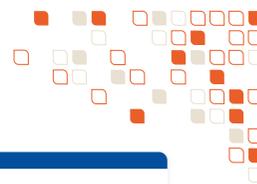


Does the agreement contain provisions related to confidentiality and consumer privacy, such as terms that:

- Prohibit disclosure of any business, financial or other proprietary information that 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 consumers' protected health information consistent with all applicable federal and state laws, including the requirements of HIPAA, as well as the CCBHC's policies regarding the confidentiality and privacy of consumer information?

Does the agreement contain reasonable and specific provisions related to the term of the agreement, such as terms that:

- Identify the term of the agreement, which should not be less than one year?
- Provide that any option to renew is conditioned on:
 - o The satisfaction of the CCBHC with the performance of services?
 - o The availability of grant funds, as applicable?
 - o The successful renegotiation of key terms?



Does the agreement contain reasonable and specific provisions related to the termination of the agreement, such as terms that give the CCBHC the right to terminate in the event that:

- The DCO:
 - o Materially breaches any of the agreement's terms and conditions?
 - o Loses its license or other certifications necessary to perform services under the agreement?
 - o Fails to maintain insurance?
 - o Is listed on, or becomes listed on, the government-wide exclusions in the System for Award Management (SAM), the Department of Health and Human Services, Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and applicable state exclusion lists?
- The CCBHC:
 - o Determines that continuation could jeopardize the health, safety and/or welfare of the CCBHC's consumers?

Does the agreement contain additional protections for the CCBHC related to "Excluded Parties," such as provisions that:

- Obligate the DCO to notify the CCBHC in the event that an action or claim has arisen that has resulted or could result in the revocation, suspension or termination of the license or necessary certification of any of its personnel performing services under the agreement? If so, does the agreement give the CCBHC the right to request removal/suspension of such individual until such action or claim has been resolved?
- Require the DCO to furnish to the CCBHC attestations on a regular basis that the DCO has checked the SAM, OIG, LEIE and applicable state exclusion lists to ensure that neither it, nor its staff furnishing services on the CCBHC's behalf, are listed?
- Require the DCO to immediately inform the CCBHC if it becomes aware that it or one of its staff furnishing services on the CCBHC's behalf is listed on an exclusions database?



Does the agreement contain additional protections for the CCBHC related to compliance with applicable laws and guidance, such as provisions that:

- Require the DCO to comply with all applicable state and federal laws and guidance, including but not limited to the Protecting Access to Medicare Act § 223, Pub. L. No. 113-93, and implementing guidance and all requirements of Medicaid, Medicare or any other applicable federal or state health care programs?
- Provide for penalties for failure to comply with applicable state and federal laws and guidance, including but not limited to the Protecting Access to Medicare Act, Pub. L. No. 113-93 and implementing guidance and all requirements of Medicaid, Medicare or any other applicable federal or state health care programs?

Does the agreement contain additional protections for the CCBHC, such as provisions that:

- Identify the independent contractor relationship of the parties and appropriately allocate the parties' obligations with respect to insurance and/or indemnification?
- Provide for adequate indemnification of the CCBHC should the DCO fail to comply with applicable laws or standards?



SAMPLE DCO AGREEMENT

This sample designated collaborating organization (DCO) Purchase of Services Agreement is between a fictional Certified Community Behavioral Health Clinic (CCBHC), Behavioral Health Clinic, and a fictional entity, Vendor, for the purchase of psychiatric rehabilitation services under the CCBHC demonstration. Note that this sample DCO Purchase of Services Agreement is not a template. Certain provisions set forth below are not required under the demonstration but are provided as an example. Purchase of Services agreements must be drafted to reflect the unique characteristics of each DCO relationship and must satisfy the applicable state's requirements. This document should be reviewed in tandem with the [summary of DCO requirements](#).

This DESIGNATED COLLABORATING ORGANIZATION AGREEMENT ("the Agreement") is entered into as of the _____ day of _____, 2020, between Behavioral Health Clinic and _____ ("DCO") (hereinafter referred to individually as a "Party" and collectively as the "Parties"). **[The agreement will include the DCO's name and "DCO" will be replaced throughout.]**

WITNESSETH

WHEREAS, Behavioral Health Clinic is a _____ organized and existing under the laws of the State of _____ and is certified as a Certified Community Behavioral Health Clinic ("CCBHC") under Medicaid by the State of _____ pursuant to the Protecting Access to Medicare Act of 2014 ("PAMA");

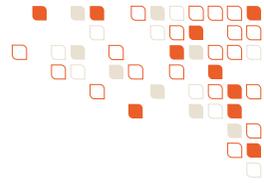
WHEREAS, Vendor is a _____ organized and existing under the laws of the State of _____ that furnishes psychiatric rehabilitation services;

WHEREAS, as a CCBHC, Behavioral Health Clinic is committed to furnishing integrated and coordinated care that addresses all aspects of a person's health, consistent with Section 2402(a) of the Affordable Care Act ("ACA");

WHEREAS, Behavioral Health Clinic seeks to have Vendor serve as a Designated Collaborating Organization ("DCO") for purposes of furnishing psychiatric rehabilitation services to Behavioral Health Clinic's consumers; and

WHEREAS, Behavioral Health Clinic seeks to purchase, and Vendor seeks to provide, psychiatric rehabilitation services;

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, and for good and valuable consideration, the sufficiency and receipt of which are hereby acknowledged, and intending to be legally bound hereby, the Parties agree as follows:



SECTION 1. OVERVIEW.

1.1 Scope of Services. Behavioral Health Clinic shall purchase psychiatric rehabilitation services, as set forth in Exhibit A, attached hereto and incorporated by reference herein (collectively the "Psychiatric Rehabilitation Services") from Vendor.

Note: The body of the agreement or an attached exhibit should set forth the specific DCO services being procured pursuant to the agreement.

1.2 Person and Family-Centered Care. Vendor shall furnish Psychiatric Rehabilitation Services and coordinate care with Behavioral Health Clinic in a manner that aligns with Section 2402(a) of the ACA, reflecting person- and family-centered, recovery-oriented care, being respectful of the individual consumer's needs, preferences, and values, and ensuring both consumer involvement and self-direction of services received. In addition, Psychiatric Rehabilitation Services furnished to children and youth shall be family-centered, youth-guided, and developmentally appropriate. Vendor shall update the Behavioral Health Clinic when changes in the consumer's status, responses to treatment, or goal achievement occur that require an update to the consumer's treatment plan.

1.3 Quality Standards. Vendor represents that its provision of Psychiatric Rehabilitation Services to Behavioral Health Clinic consumers (hereinafter, the "Consumers") shall meet the same quality standards as equivalent services provided by Behavioral Health Clinic, and shall meet all standards specified by the State of _____ based upon the needs of the population served.

1.4 Availability of Services. Vendor shall ensure that Consumers will not be denied Psychiatric Rehabilitation Services because of (i) their place of residence or homelessness or lack of a permanent address, or (ii) their inability to pay for such services. Vendor shall ensure any Consumer fees or payments required for Psychiatric Rehabilitation Services will be reduced or waived, in keeping with Behavioral Health Clinic's sliding fee discount schedule, to fulfill this assurance.

1.5 Billing Consumers/Payers. The Parties acknowledge and agree that all Consumers receiving Psychiatric Rehabilitation Services from Vendor pursuant to this Agreement shall be Behavioral Health Clinic's consumers. Accordingly, Behavioral Health Clinic shall be clinically and financially responsible for the Psychiatric Rehabilitation Services provided. Behavioral Health Clinic shall be responsible for billing Consumers and/or third party payors for all Psychiatric Rehabilitation Services rendered by the Vendor hereunder, in accordance with Behavioral Health Clinic's schedule of charges and discounts, and Behavioral Health Clinic shall retain all payments so collected. Except as provided in Paragraph 1.6, Vendor shall not seek reimbursement from Consumers or from any third party healthcare payor, including Medicaid or Medicare, for Psychiatric Rehabilitation Services rendered by Vendor pursuant to this Agreement. Vendor agrees to comply with any reasonable third-party requirements, including but not limited to participation in any credentialing process imposed by a managed care entity, in order for the



Behavioral Health Clinic to be eligible to bill for Psychiatric Rehabilitation Services. Vendor shall provide such data necessary, in the appropriate format, to enable Behavioral Health Clinic to bill any third party healthcare payor, including Medicaid or Medicare, for Psychiatric Rehabilitation Services rendered by Vendor pursuant to this Agreement. If a third-party payor requires Vendor to bill directly for any Psychiatric Rehabilitation Services that Vendor furnishes under contract on behalf of Behavioral Health Clinic pursuant to this Agreement, Vendor shall assign any payments under the contract to Behavioral Health Clinic.

1.6 Collection of Consumer Fees and Cost-Sharing; Administration of Sliding Fee Discount Policy. Notwithstanding Paragraph 1.5, Vendor shall collect, as Behavioral Health Clinic's agent, any Consumer fees, as well as any copayments, coinsurance, or deductibles that are due at the point of service from Consumers for Psychiatric Rehabilitation Services provided pursuant to this Agreement. Except as the Parties otherwise specifically agree in writing, Vendor shall waive or reduce any Consumer's fee for services, as well as any payor copayments, coinsurance, deductibles, or other cost-sharing obligation, to the extent required by Behavioral Health Clinic's schedule of discounts policy, attached hereto as Exhibit C and incorporated herein by reference. In addition, Vendor shall not withhold Psychiatric Rehabilitation Services on account of any Consumer's inability to pay the relevant fee or cost-sharing obligation. At the time of conducting the initial diagnostic and treatment planning evaluation and at regular intervals thereafter, Behavioral Health Clinic shall collect income and other information from Consumers and make a determination as to their eligibility under the sliding fee discount schedule. Behavioral Health Clinic shall furnish to Vendor on an ongoing basis each Consumer's eligibility status for the schedule of discounts policy (including the type and level of discount for which the Consumer qualifies). Vendor agrees to post Behavioral Health Clinic's schedule of discounts in Vendor's waiting room in a form readily accessible to Consumers and their families, including languages/formats appropriate for individuals seeking services who have Limited English Proficiency ("LEP") or disabilities, as set forth in Section 3.

1.7 Diagnostic and Treatment Planning Evaluation. Prior to Vendor's provision of Psychiatric Rehabilitation Services to Consumers, Behavioral Health Clinic shall ensure that Vendor has access to the applicable Consumer's comprehensive person-centered and family-centered diagnostic and treatment planning evaluation, subject to confidentiality requirements described further in Section 12. Vendor shall furnish Psychiatric Rehabilitation Services in accordance with such Consumer's comprehensive person-centered and family-centered diagnostic and treatment planning evaluation.

1.8 Timely Access to Services. Vendor shall ensure that Consumers are provided with an appointment within ten (10) business days of the requested date for Psychiatric Rehabilitation Services, unless the state, the federal government, or accreditation standards are more stringent. If a Consumer presents to Vendor with an emergency or crisis need, Vendor shall take immediate action, including any necessary outpatient follow-up care, and ensure clinical services are provided within one (1) business day of the request.



1.9 **Data Tracking.** On regular intervals, but at least monthly, Vendor shall provide Behavioral Health Clinic with the necessary information in the appropriate form for Behavioral Health Clinic to collect, report, and track encounter, outcome, and quality data, including, but not limited to data capturing: (1) Consumer characteristics; (2) staffing; (3) access to Psychiatric Rehabilitation Services; (4) use of Psychiatric Rehabilitation Services; (5) screening, prevention, and treatment; (6) care coordination; (7) other processes of care; and (8) Consumer outcomes.

SECTION 2. DCO REQUIREMENTS.

2.1 Psychiatric Rehabilitation Services on behalf of Behavioral Health Clinic shall do so in accordance with licensure and scope of practice laws in the State of _____ and in accordance with generally recognized standards of care.

2.2 Vendor represents that, during the term of this Agreement, Vendor (as applicable) and clinicians carrying out services under this Agreement shall:

2.2.1 be and remain licensed

legally authorized to furnish Psychiatric Rehabilitation Services in accordance with federal, state, and local laws;

2.2.2 have expertise in _____

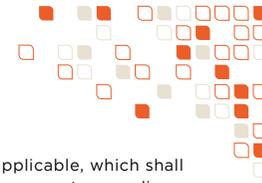
Note: The Agreement should set forth whether the DCO provider is expected to have particular professional experience and/or training. The text in this Section is included as an example.

2.2.3 act only within the scope of their respective _____ license, certifications, credentials, or registrations and in accordance with all applicable laws and regulations, including any applicable state Medicaid billing regulations or policies;

2.2.4 have customary narcotics and controlled substance authorizations;

Note: This Section should be revised to reflect your state law pertaining to narcotics and controlled substance authorizations. Maintaining such authorizations may be irrelevant for certain DCO providers, depending on their licensure/certification.

2.2.5 be and remain eligible to participate in Medicaid, Medicare, and any other third party healthcare payor with which Behavioral Health Clinic participates;



2.2.6 comply with Behavioral Health Clinic's policies and procedures, as applicable, which shall include, but not be limited to, clinical policies, procedures, and protocols; corporate compliance policies, procedures, and protocols; consumer privacy and confidentiality policies and procedures; and standards of conduct;

Note: We advise sharing the applicable policies and procedures with Vendor prior to the execution of this agreement.

2.2.7 comply with Behavioral Health Clinic's protocols pertaining to the involvement of law enforcement which are intended to reduce delays for initiating services during and following a psychiatric crisis;

2.2.8 upon request, participate in Behavioral Health Clinic's training program, as set forth in Section 3.5;

2.2.9 establish and maintain medical records in accordance with standards prescribed by Behavioral Health Clinic, utilizing Behavioral Health Clinic's electronic medical records system in compliance with Behavioral Health Clinic's consumer privacy and security policies;

2.2.10 render services in accordance with Consumers' diagnostic and treatment planning evaluation described further below; and

2.2.11 work with Behavioral Health Clinic on care coordination activities to ensure optimal access to care for each Consumer, including both CCBHC services and other primary, preventive, and specialty care services.

2.3 Vendor shall promptly inform Behavioral Health Clinic if any of the clinicians cease satisfying the requirements set forth in Section 2.2.

2.4 Vendor shall ensure that Consumers have access to Behavioral Health Clinic's grievance policies and procedures, which satisfy the minimum requirements of Medicaid and other relevant payors and accrediting entities to the extent such grievances are related to the Psychiatric Rehabilitation Services provided by the clinicians pursuant to this Agreement.

2.5 Upon execution of this Agreement and at monthly intervals thereafter, Vendor shall provide Behavioral Health Clinic with written attestation that neither Vendor nor its employed or contracted clinicians providing Psychiatric Rehabilitation Services pursuant to this Agreement are an "Excluded Entity/Individual," which is defined for purposes of this Agreement as an individual or entity that (1) is currently listed on the government-wide Excluded Parties List System in the System for Award Management ("SAM"), in accordance with the Office of Management and Budget ("OMB") guidelines at 2 CFR 180 that implement Executive Orders 12549 and 12689; (2) is currently excluded, debarred, or otherwise ineligible to participate in the federal healthcare programs as defined in 42 U.S.C. § 1320a- 7b(f) (the "Federal Health Care Programs"); (3) has been convicted of a criminal offense related to the provision of health care



items or services but has not yet been excluded, debarred, or otherwise declared ineligible to participate in the Federal Health Care Programs; (4) is under investigation or otherwise aware of any circumstances which may result in such entity or person being excluded from participation in the Federal Health Care Programs; or (5) is in receipt of any notice, whether or not official, of the existence and basis of any action, event, claim, proceeding, or investigation of a clinician providing services to Behavioral Health Clinic pursuant to this Agreement about which Vendor is informed (including, without limitation, any report to the National Practitioner Data Bank) instituted by a person, government agency, healthcare facility, peer review organization, or professional society, which involves an allegation of negligent conduct raised against the clinician and/or that could result in the revocation, termination, suspension, limitation, or restriction of the clinician's license, or authorization required to provide such Psychiatric Rehabilitation Services pursuant to this Agreement. On a monthly basis, Vendor shall perform a check of Vendor and each clinician providing Psychiatric Rehabilitation Services pursuant to this Agreement against the SAM Exclusion Database, the Office of Inspector General's ("OIG's") Exclusion Database, and any other relevant source of information and provide Behavioral Health Clinic with an updated attestation regarding such information. If the condition described in clause (4) above applies to any of Vendor's clinicians, Vendor shall, upon Behavioral Health Clinic's request, remove the clinician from providing Psychiatric Rehabilitation Services pursuant to this Agreement until a final determination is made regarding the aforesaid alleged action, event, claim, proceeding, or investigation.

SECTION 3. LINGUISTIC AND CULTURAL COMPETENCE; TRAINING

3.1 If, pursuant to this Agreement, Vendor serves Consumers with limited English proficiency ("LEP") or with language-based disabilities, Vendor shall take reasonable steps to provide meaningful access to Vendor's Psychiatric Rehabilitation Services.

3.2 Vendor shall provide interpretation/translation service(s) that are appropriate and timely for the size/needs of the LEP Behavioral Health Clinic Consumer population (e.g., bilingual providers, onsite interpreters, language telephone line). To the extent interpreters are used, such translation service providers shall be trained to function in a medical and, preferably, a behavioral health setting.

3.3 Vendor shall ensure that auxiliary aids and services for the Consumers are readily available, Americans with Disabilities Act ("ADA") compliant, and responsive to the needs of Consumers with disabilities (e.g., sign language interpreters, teletypewriter lines).

3.4 Vendor shall ensure that documents or messages vital to a Consumer's ability to access Psychiatric Rehabilitation Services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available for Consumers in languages common in the community served, taking account of literacy levels and the need for alternative formats (for Consumers with disabilities). Such materials shall be provided in a timely manner at intake. The requisite languages will be informed by the Behavioral Health Clinic's needs assessment prepared prior to Behavioral Health Clinic's CCBHC certification, and as updated.



3.5 Vendor shall ensure that all staff and clinicians furnishing services pursuant to this Agreement comply with all Behavioral Health Clinic's training requirements. Training shall address cultural competence, person-centered and family-centered, recovery-oriented, evidence-based and trauma-informed care, and primary care/behavioral health integration. Training of Vendor staff and clinicians shall occur at orientation and thereafter at reasonable intervals as may be required by the state or accrediting agencies. Training may be provided on-line and topics will include: (1) risk assessment, suicide prevention, and suicide response; (2) the roles of families and peers; and (3) such other trainings as may be required by the state or accrediting agency on an annual basis.

SECTION 4. INDEMNIFICATION.

Vendor shall defend, indemnify and hold harmless the Behavioral Health Clinic and its affiliates' officers, directors, employees, agents, successors, and assignees from and against all losses, damages, liabilities, deficiencies, actions, judgments, interest, awards, penalties, fines, costs, or expenses of whatever kind (including reasonable attorneys' fees) arising out of or resulting from:

- (a) Vendor's, or Vendor's employees, agents or subcontractors acts or omissions; and
- (b) Vendor's breach of any representation, warranty, or obligation under this Agreement, including but not limited to failure to comply with applicable laws or standards.

SECTION 5. PAYMENT.

Note: In addition to setting forth the compensation amount, the Agreement should describe the process whereby the Vendor submits an invoice to Behavioral Health Clinic. It should also set forth expectations regarding time and effort reporting, if applicable.

5.1 Behavioral Health Clinic hereby agrees to pay Vendor for the Psychiatric Rehabilitation Services furnished by clinicians in accordance with the terms set forth in Exhibit B, attached hereto and incorporated by reference herein. Vendor agrees to accept such compensation, less any copayments, coinsurance, or deductibles that are due from Consumers, per Paragraph 1.6 above, as payment in full for the Psychiatric Rehabilitation Services provided by the clinicians pursuant to this Agreement.

5.2 Vendor shall provide the Behavioral Health Clinic with an invoice for services rendered pursuant to this Agreement by the 15th of each month in accordance with the terms of Exhibit B. Vendor is solely responsible for any travel or other costs or expenses incurred by clinicians in connection with the performance of the Psychiatric Rehabilitation Services and, in no event shall the Psychiatric Rehabilitation Services reimburse Vendor for any such costs or expenses. The Psychiatric Rehabilitation Services shall reimburse Vendor within thirty (30) days of receipt of invoice.



5.3 All payments to Vendor specified in this Agreement have been determined through good-faith and arms-length bargaining and are consistent with what the Parties reasonably believe to be within fair market value for the Psychiatric Rehabilitation Services to be provided, unrelated to the volume or value of any referrals or business generated between the Parties.

5.4 Nothing in this 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. Neither Party shall (1) require its employed and/or contracted professionals to refer consumers to one another (or to any other entity or person); or (2) track referrals for purposes relating to setting the compensation of its employed and/or contracted professionals or influencing their referral choice.

5.5 Behavioral Health Clinic may withhold or deny payment for any Psychiatric Rehabilitation Services furnished by Vendor in material breach of a material term of this Agreement or statutes, rules, regulations, and standards of any and all governmental authorities and regulatory and accreditation bodies relating to the provision of Psychiatric Rehabilitation Services provided pursuant to this Agreement, including without limitation the Protecting Access to Medicare Act, Pub. L. No. 113-93 and implementing guidance and all requirements of Medicaid, Medicare, or any other applicable federal or state healthcare programs.

SECTION 6. INSURANCE OBLIGATION.

Note: The Parties should include provisions that address mandatory insurance coverage, including Worker's Compensation, professional liability insurance coverage and comprehensive general liability insurance coverage. Note that the customary professional liability insurance coverage is at least \$1,000,000 per incident and \$3,000,000 in the aggregate.

Note: CCBHCs may wish to require that the Vendor include the Behavioral Health Clinic as a named insured on the Vendor's professional liability insurance policy.

SECTION 7. ASSURANCE OF CONSUMER AND PROVIDER CHOICE.

7.1 The Parties acknowledge and agree that all health and health-related professionals employed by or under contract with either Party, retain sole and complete discretion, subject to any valid restriction(s) imposed by participation in a managed care plan, to refer consumers to any and all provider(s) that best meet the clinical needs of consumers.

7.2 The Parties acknowledge that all consumers have the freedom to choose (and/or request referral to) any provider of services, and the Parties will advise consumers of such right, subject to any valid restriction(s) imposed by participation in a managed care plan.



SECTION 8. OVERSIGHT, RECORDKEEPING, REPORTING, AND INFORMATION SHARING.

Note: The CCBHC may wish to include additional provisions addressing the CCBHC's oversight vis-à-vis the DCO's activities pursuant to the Agreement, particularly if the CCBHC compensates the DCO. Note that the Funding Announcement states that agreements with DCOs must "make clear that the CCBHC retains ultimate clinical responsibility for CCBHC services provided by DCOs."

8.1 Vendor agrees to permit Behavioral Health Clinic, the U.S. Department of Health and Human Services ("HHS"), and the State of _____ Department of Health to evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services delivered under this Agreement.

8.2 Each Party shall maintain financial records and reports, supporting documents, statistical records, and all other books, documents, papers, or other records related and pertinent to this Agreement for four (4) years from the date of this Agreement's expiration or termination. If an audit, litigation, or other action involving these records commences during this aforesaid four (4) years, each Party shall maintain the records for four (4) years or until the audit, litigation, or other action is completed, whichever is later.

8.3 Vendor shall make available to Behavioral Health Clinic, HHS, and the Comptroller General of the United States, or any of their duly authorized representatives, upon appropriate notice, documents, papers, and other records that are pertinent to this Agreement for examination, excerpt, and transcription, for as long as such documents, papers, and other records are retained. This right also includes timely and reasonable access to Vendor personnel for the purpose of interview and discussion related to such documents. Vendor shall, upon request, transfer identified documents, papers, and records to the custody of Behavioral Health Clinic or HHS when either Behavioral Health Clinic or HHS determine that such records possess long-term retention value.

8.4 As applicable, Vendor agrees to assist and cooperate with Behavioral Health Clinic regarding any audit (and all audit-related requirements and responsibilities) performed in connection with the activities contemplated hereunder. In accordance with Section 4, Vendor shall indemnify and hold harmless Behavioral Health Clinic for any liability associated with audits that result from the Vendor's, or Vendor's employees, agents or subcontractors, acts or omissions.

8.5 Behavioral Health Clinic shall retain exclusive ownership of all information contained in the Consumers' medical records, regardless of whether such data and information is in paper or electronic format.

8.6 On a monthly basis, Vendor shall provide Behavioral Health Clinic with all data elements necessary to comply with requirements for reporting related to the Substance Abuse and Mental Health Services Administration (SAMHSA) Uniform Reporting System (URS).



8.7 Vendor and Behavioral Health Clinic shall develop and implement a plan to improve care coordination for Consumers using health information systems including, but not limited to, electronic health records, practice management systems, and billing systems.

Note: The parties should include additional detail concerning the technology requirements associated with information sharing. The CCBHC and DCO may choose to provide that DCO clinicians will chart in the electronic health record (EHR) of the CCBHC, or that the parties will work toward making their EHR systems interoperable.

SECTION 9. COMPLIANCE WITH APPLICABLE LAW.

Vendor shall comply fully with all applicable statutes, rules, regulations, and standards of any and all governmental authorities and regulatory and accreditation bodies relating to the provision of psychiatric rehabilitation services provided pursuant to this Agreement, including without limitation PAMA, Pub. L. No. 113-93 and implementing guidance and all requirements of Medicaid, Medicare, and any other applicable federal or state healthcare programs.

SECTION 10. TERM.

Note: As an alternative to the following, the Parties may wish to include a finite term, without automatic renewal. Regardless of whether the term allows for automatic renewals, the term of the Agreement should be at least one year.

This Agreement's term shall commence on _____, 20__ (the "Effective Date"), and shall terminate on _____, 20__ unless terminated at an earlier date in accordance with Section 11 of this Agreement. This Agreement will automatically renew for _____ year terms unless written notice is provided from one Party to the other Party _____ days prior to the expiration of the Agreement.

SECTION 11. TERMINATION.

Note: The Parties may wish to modify this Section to include additional causes for termination.

11.1 This Agreement may be terminated, in whole or in part, at any time upon the mutual agreement of the Parties.

11.2 This Agreement may be terminated without cause upon _____ days' written notice by either Party.

11.3 This Agreement may be terminated for cause upon written notice by either Party. "Cause" shall include, but is not limited to, the following:



11.3.1 a material breach of any term of this Agreement, subject to a _____ day opportunity to cure and a failure to cure by the end of the _____ day period. This cure period shall be shortened if a shorter period is required by the State of _____ Department of Health, HHS, the state Medicaid agency, or any other entity by which either Party must be licensed or accredited in order to conduct regular operations;

11.3.2 the loss of either Party's required insurance, as set forth in Section 6;

11.3.3 the loss or suspension of any license or other authorization to do business necessary for either Party to perform services under this Agreement; or

11.3.4 either Party becoming an Excluded Entity/Individual, as set forth in Section 2.5.

SECTION 12. CONFIDENTIALITY OF CONSUMER HEALTH INFORMATION.

Note: The Parties may wish to expand this Section to include more detail regarding consumer confidentiality expectations and/or to address confidentiality requirements applicable to their respective business and proprietary information exchanged pursuant to this Agreement.

12.1 Behavioral Health Clinic shall ensure that Consumers' preferences, and those of families of children and youth and families of adults, for shared information are adequately documented in clinical records, consistent with the philosophy of person- and family-centered care. Vendor agrees to furnish psychiatric rehabilitation services to Consumers in accordance with such documented Consumer preferences.

12.2 Vendor shall ensure that it and the clinicians maintain the privacy and confidentiality of all information regarding the personal facts and circumstances of the Consumers in accordance with all applicable federal and state laws and regulations (including, but not limited to, the Health Insurance Portability and Accountability Act and its implementing regulations set forth at 45 CFR Part 160 and Part 164 ("HIPAA")), 45 CFR Part 2, and Behavioral Health Clinic's policies and procedures regarding the privacy and confidentiality of such information. Vendor represents that, during the term of this Agreement, it shall notify Behavioral Health Clinic in the event Vendor becomes aware of any use or disclosure of Consumer information that violates the terms and conditions of this Section 12.

12.3 Vendor shall ensure that its employed and contracted clinicians furnishing services under this Agreement and any directors, officers, employees, agents, and contractors of Vendor who have access to the Consumers' health information are aware of and comply with the aforementioned obligations set forth in this Section 12.

SECTION 13. NOTICES.

Any and all notices, designations, consents, offers, acceptances, or other communication required to be given under this Agreement shall be in writing, and delivered in person or sent by



registered or certified mail, return receipt requested, postage prepaid, or by electronic mail or facsimile to the following addresses:

If to Behavioral Health Clinic:

If to Vendor:

The foregoing addresses may be changed and/or additional persons may be added thereto by notifying the other Party hereto in writing and in the manner hereinafter set forth. All notices shall be effective upon receipt.

SECTION 14. INDEPENDENT CONTRACTORS.

The Parties shall remain separate and independent entities. Neither of the Parties shall be construed to be the agent, partner, co-venturer, employee, or representative of the other Party.

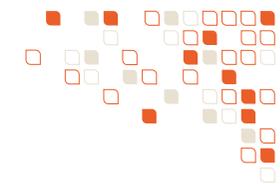
SECTION 15. DISPUTE RESOLUTION.

Note: Dispute resolution is optional. The Parties may wish to remove or revise this section to reflect their mutually agreed upon process for resolving disputes, which may include, but is not limited to, informal dispute resolution and/or binding arbitration.

Any dispute arising under this Agreement shall first be resolved by informal discussions between the Parties, subject to good cause exceptions, including, but not limited to, disputes determined by either Party to require immediate relief (e.g., circumstances under which an extended resolution procedure may endanger the health and safety of Consumers). Any dispute that has failed to be resolved by informal discussions between the Parties within a reasonable period of time of the commencement of such discussions (not to exceed thirty (30) days) may be resolved through any and all means available.

SECTION 16. GOVERNING LAW.

This Agreement shall be interpreted, construed, and governed according to the laws of the State of .



SECTION 17. SEVERABILITY.

If any term or provision of this Agreement or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Agreement or the application of such term or provision to persons or circumstances, other than those to which it is held invalid or unenforceable, shall not be affected but rather shall be valid and enforceable to the fullest extent permitted by law. In such event, the parties shall in good faith attempt to renegotiate the terms of this Agreement.

SECTION 18. THIRD PARTY BENEFICIARIES.

The Agreement is not intended to benefit, and shall not be construed to benefit, any person or entities other than the Parties hereto. This Agreement is not intended to create any third-party beneficiary right for any other person or entities.

SECTION 19. ASSIGNMENT.

Neither Party may assign or transfer this Agreement, or its rights and obligations hereunder, without the other Party's express, prior written consent. Any assignment attempted without such consent shall be void. The provisions of this Agreement shall be binding upon and shall inure to the benefit of the Parties hereto and their duly authorized transferees and assigns.

SECTION 20. ENTIRE AGREEMENT.

This Agreement represents the Parties' complete understanding regarding the subject matter herein. This Agreement supersedes any other agreements or understandings between the Parties, whether oral or written, relating to the subject matter of this Agreement. No such other agreements or understandings may be enforced by either Party nor may they be employed for interpretation purposes in any dispute involving this agreement.

SECTION 21. AMENDMENTS.

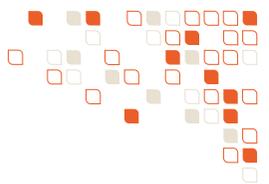
Any amendment to this Agreement, inclusive of the Exhibits, shall be in writing and signed by both Parties.

SECTION 22. HEADINGS AND CONSTRUCTION.

All headings contained in this Agreement are for reference purposes only and not intended to affect in any way the meaning or interpretation of this Agreement.

SECTION 23. AUTHORITY.

Each signatory to this Agreement represents and warrants that he or she possesses all necessary capacity and authority to act for, sign, and bind the respective entity on whose behalf he or she is signing.



SECTION 24. COUNTERPARTS.

This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, and all of which shall together be deemed to constitute one agreement.

SIGNATURE PAGE TO FOLLOW.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed as of the date set forth above by their duly authorized representatives.

Behavioral Health Clinic

Community Hospital

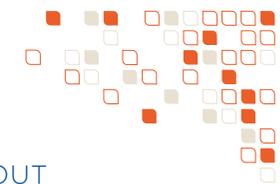
Signature: _____

Signature: _____

Date: _____

Date: _____

- Exhibit A: Scope of Services
- Exhibit B: Compensation Amount
- Exhibit C: Compensation Methodology



WHAT YOU NEED TO KNOW ABOUT ACTING AS A DCO

In the Protecting Access to Medicare Act of 2014 (PAMA), Congress authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration. Twenty-four states have received planning grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) within the federal Department of Health and Human Services (HHS) to work toward implementing the CCBHC demonstration. HHS selected eight states to carry out the two-year CCBHC demonstration, beginning in 2017. Due to various funding extensions, CCBHCs in the original eight states are still operating in 2020 under the demonstration (i.e., beyond the original two-year timeframe) and in 2020, the Centers for Medicare and Medicaid Services (CMS) is selecting two additional states to participate in the demonstration.

What is a CCBHC?

As part of the CCBHC planning grant process, the planning grant states "certified" community behavioral health providers within the state that have demonstrated they can carry out the functions of a CCBHC during the two-year demonstration. Under this demonstration, the CCBHC will serve as a hub for comprehensive safety-net behavioral health services for its consumers. Its functions include the following:

1. **Provides a comprehensive array of services.** Each provider certified as a CCBHC must demonstrate that it can furnish the full set of nine required CCBHC services. These services are required to be provided by CCBHCs in every state regardless of whether they are independently covered under the Medicaid state plan. Services marked with an asterisk (*) above may be provided via designated collaborating organization (DCO).



What Is a CCBHC? (cont.)

- Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization.
 - Screening, assessment and diagnosis.
 - Patient-centered treatment planning.
 - Outpatient mental health and substance use disorder services.
 - Primary care screening and monitoring.*
 - Targeted case management.*
 - Psychiatric rehabilitation services.*
 - Peer support services and family support services.*
 - Services for members of the armed services and veterans.*
2. **Functions as a true safety-net behavioral health provider.** Each CCBHC must meet rigorous requirements for making the required services available and accessible to all consumers. These include:
- Not refuse services to any consumer, regardless of form of coverage or uninsured status, based on inability to pay or place of residence.
 - Offer CCBHC services based on a sliding fee discount schedule to make the services affordable for low-income consumers.
 - Provide each CCBHC consumer with a preliminary screening and risk assessment at time of first contact and develop and update a person-centered treatment plan.
 - Provide crisis management services that are accessible 24/7.
3. **Billing Medicaid through a prospective payment system (PPS) methodology.** For CCBHC services provided to Medicaid beneficiaries, the CCBHC bills Medicaid based on a PPS. A PPS reimbursement methodology includes the following features:
- Payment is made according to a fixed rate per visit. The details of what types of visits are billable vary state by state.
 - The per-visit payment rate is based on the CCBHC's costs of furnishing the full scope of CCBHC services in a base time period, as documented in a cost report.

The CMS has issued [guidance on the details of the CCBHC PPS](#).



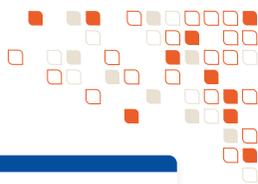
Where Do DCOs Fit In?

The federal law requires that each CCBHC make the set of nine CCBHC services available either directly or “through formal relationships with other providers.”⁷¹ SAMHSA, in conjunction with CMS, has issued guidance concerning the requirements for a CCBHC to furnish a required service through a relationship with another provider, termed a DCO. The basic requirements for the DCO relationship are the following:

1. **Only certain services may be furnished via DCO.** Only five of the required CCBHC services — primary care screening and monitoring, targeted case management, psychiatric rehabilitation services, peer support services and services for members of the armed forces and veterans) may be furnished through a DCO relationship. The remaining four CCBHC services must be provided directly by the CCBHC, except in special circumstances where crisis care may be provided via a state-sanctioned crisis system acting as a DCO.⁷²
2. **The DCO relationship is a purchase of services arrangement.** The CCBHC enters a contractual agreement with the DCO under which the CCBHC pays the DCO to furnish CCBHC services to CCBHC consumers. The contract must provide for reimbursement at a fair market value (FMV) rate. The consideration paid by the CCBHC to the DCO should not reflect a pass-through of the CCBHC's PPS rate.
3. **The CCBHC is clinically responsible for services furnished via DCO.** The CCBHC holds itself out to CCBHC consumers as the provider of the service rendered by the DCO. The CCBHC must ensure (through the contract) that the DCO furnishes CCBHC services in a manner such that they are accessible to consumers and delivered consistently with all CCBHC requirements, including application of the sliding fee discount schedule to CCBHC consumers.
4. **The CCBHC is financially responsible for services furnished via DCO.** For example, the CCBHC bears financial risk for collecting consumer out-of-pocket contributions for CCBHC services rendered by the DCO.
5. **The CCBHC bills Medicaid for services furnished via DCOs.** The costs to the CCBHC of purchasing services from the DCO are included on the CCBHC's Medicaid cost report. When the DCO renders a CCBHC service that qualifies as a billable CCBHC “visit,” the CCBHC bills and receives reimbursement from Medicaid for the visit.

⁷¹ Protecting Access to Medicare Act § 223(a)(2)(D) (42 U.S.C. § 1396a (note)).

⁷² In addition, in some circumstances, crisis behavioral health services may be furnished via DCO. See 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. [Cite discussion above re: purchase of servs.]



What are the Advantages of Acting as a DCO?

- 1. Participating in a collaborative effort to advance access to care.** As a DCO, your organization will play a critical role in providing a comprehensive array of behavioral health services for CCBHC consumers. You will learn more about the services furnished by the CCBHC in this process and in the process, you may choose to refer the consumers you routinely serve to the CCBHC for services that your organization does not provide.
- 2. Getting paid for services that your organization might otherwise provide free-of-charge.** Some of the services included in the CCBHC benefit are not otherwise covered under Medicaid in most states and are not commonly reimbursed by Medicare or third-party payors. Instead, your organization may currently receive federal, state or local grant funds to defray some of the uncompensated costs of providing these services. By serving as a DCO, your organization will have the opportunity to be reimbursed at fair market value for providing these critical behavioral health services.
- 3. Being reimbursed by one payor (the CCBHC) for the purchased service(s).** Because the CCBHC will be responsible for billing various payors for the service or services furnished via DCO, the DCO's responsibility is only to deliver the services in keeping with the contract and to bill the CCBHC as provided in the contract. The DCO will not be required to meet the requirements of numerous payors beyond furnishing requested information to the CCBHC.
- 4. CCBHC patients who receive CCBHC services via DCO may come to you for other services.** As a DCO, your organization will serve CCBHC consumers under an agreement with the CCBHC. In the process of receiving CCBHC services, the consumer may learn about other services furnished by your organization and seek other types of care from you.



What New Responsibilities are Required of DCOs?

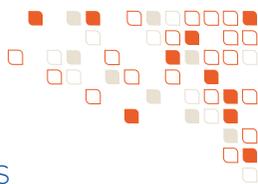
In addition to furnishing the contracted CCBHC services under all the same quality, accessibility and clinical requirements that apply to the CCBHC, the DCO will be required to convey data to the CCBHC to enable the CCBHC to bill Medicaid and other payors for CCBHC services and to fulfill SAMHSA quality reporting requirements.

How Can Organizations Interested in Becoming A DCO Prepare?

Organizations can prepare to partner with CCBHCs as DCOs in the demonstration. In addition to learning more about the requirements of the CCBHC demonstrations, potential DCOs may wish to consider the following key questions:

- With what organizations in your service area does your organization collaborate?
- What organizations in your service area are best situated to become CCBHCs and are any of these organizations current partners?
- How will your organization identify and approach potential CCBHC partners?
- What is the capacity of your organization to take on additional consumers?
- Can your organization implement the clinical and financial requirements of the CCBHC demonstration, including but not limited to, application of the sliding fee discount schedule to CCBHC consumers and collection of cost sharing obligations from consumers?
- What CCBHC services does your organization offer that a potential CCBHC partner may not be able to provide?
- What costs are associated with the CCBHC services that you would provide?
- What constitutes adequate reimbursement for CCBHC services to ensure your organization's capacity?
- How will your organization exchange information electronically with a CCBHC?

For more information about the CCBHC demonstration program, please consult the websites of CMS (www.cms.gov) and SAMHSA (www.samhsa.gov).



DCO QUESTIONS AND ANSWERS

1. What services may a Certified Community Behavioral Health Clinic (CCBHC) furnish to its consumers through a designated collaborating organization (DCO)?

Of the nine required CCBHC services, the CCBHC is required to furnish several directly and not via a DCO relationship. These services include comprehensive behavioral health screening, assessment and diagnosis, including risk assessments; person-centered and family-centered treatment planning and comprehensive outpatient mental health and substance use disorder services.

Generally, CCBHCs must directly provide crisis behavioral health services. However, the CCBHC may contract with DCO to provide crisis behavioral health services under certain conditions set forth in guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA):

- Crisis behavioral health services may be provided via a “state-sanctioned alternative” acting as a DCO.
- Ambulatory and medical detoxification in American Society of Addiction Medicine (ASAM) categories 3.2-WM and 3.7-WM may be provided via DCO.

CCBHCs may furnish via DCO the remaining five required CCBHC services, outpatient clinic primary care screening and monitoring of key health indicators and health risk, targeted case management, psychiatric rehabilitation services, peer support and counselor services and family supports and intensive community-based mental health care for members of the armed forces and veterans.

The CCBHC maintains clinical and financial responsibility for services rendered to CCBHC consumers via the DCO.

2. Are DCO services the same as referral services? If not, what is the difference between DCO services and referral services?

No. A DCO is an entity that is not under the direct supervision of the CCBHC, but is engaged in a formal contractual relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Under the written contractual agreement, the parties should describe their mutual expectations and establish accountability for services provided and funding sought and utilized. Payment for DCO services is included within the scope of the CCBHC prospective payment system (PPS) per-visit rate.



Because the CCBHC is paying the DCO to render services and the CCBHC bears financial responsibility for the services, the CCBHC/DCO relationship is necessarily contractual. Under a referral relationship, on the other hand, it is typically the referral provider that bears clinical and financial responsibility for the service. Referral agreements, in contrast to contracts, typically do not involve the exchange of financial remuneration.

3. May a private, for-profit clinic or organization function as a DCO?

Yes. A for-profit organization may function as a DCO. A CCBHC, on the other hand, is required to be a nonprofit or governmental entity.

4. How will the DCO be reimbursed for the cost of services provided on behalf of the CCBHC?

The CCBHC is responsible for ensuring that DCO-related costs are included in the CCBHC's Medicaid base period cost report that determines the CCBHC's PPS rate. The CCBHC will pay the DCO a contracted per-visit rate for services provided. The rate should represent [fair market value for the services purchased](#).

Because the CCBHC is financially responsible for DCO-provided services, it is the CCBHC, rather than the DCO, that bills Medicaid for CCBHC services furnished via DCO.

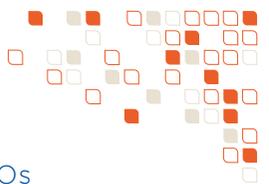
5. How do CCBHCs gather encounter and quality data from DCOs?

In order for a CCBHC to bill Medicaid for a CCBHC encounter rendered to a consumer, the encounter must be documented in the consumer's CCBHC health record. Therefore, where CCBHC service is furnished via DCO, the DCO will be required either to participate in a health information exchange through which health record entries can be shared or to transmit the encounter data to the CCBHC.

CCBHCs will also be responsible for billing Medicaid managed care entities and payors other than Medicaid for CCBHC services furnished via DCO. The encounter data reporting requirements that the CCBHC imposes on the DCO may vary according to payor.

Similarly, in order to fulfill the clinical and quality reporting requirements of SAMHSA's Uniform Reporting System concerning all CCBHC services, including those furnished via DCO, a CCBHC will need access to wide-ranging data from the DCO.

A CCBHC's written agreement with the DCO should require the DCO maintain and timely submit to the CCBHC all required data, such as information on quality reporting and encounter data.



TIPS FOR NEGOTIATING WITH DCOs

THE P.E.N. STRATEGY: PREPARE, EDUCATE AND NEGOTIATE!

PREPARE

A party that recognizes its strengths and weaknesses is better prepared to negotiate a mutually beneficial contract.

Describe the value that a contractual relationship with the CCBHC can provide to a community partner in the DCO role.

- o With respect to the CCBHC, answer the following general questions:
 - What geographical areas do I serve?
 - What organizations furnish similar services in the same geographical area?
 - What organizations in the same area furnish services to the Medicaid population?
 - For each of the CCBHC's services, what percent of the market does the CCBHC serve compared to other organizations?
- o With respect to the CCBHC service that the DCO would provide through a potential DCO relationship:
 - Is the service reimbursed under the Medicaid state plan outside the context of the CCBHC demonstration? If so, what is the reimbursement methodology for the service?
 - Is the service commonly reimbursed by payors other than Medicaid (e.g., Medicare, private health insurers)?
 - Is the service otherwise supported by federal, state or local grant funding?

Identify and assess potential partners based on your market analysis.

- o Does the potential DCO presently provide the service the CCBHC seeks to purchase? If so,
 - Is the service provided under clinical conditions that largely conform to the program requirements in the SAMHSA CCBHC guidance so major changes in services delivery would not have to be made for the service to be furnished as a CCBHC service?
 - How is provision of the service currently reimbursed or financed by the DCO?
 - Would contractual consideration from the CCBHC supplement the potential DCO's income stream relating to the service by covering otherwise uncompensated costs associated with furnishing the service to low-income uninsured individuals? (Please note that the CCBHC Expansion Grant is intended to supplement, not supplant, other sources of funding with respect to the CCBHC services within the CCBHC's scope of project.)



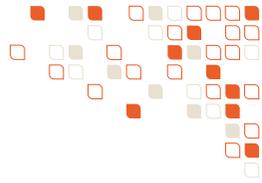
- o Is the potential DCO otherwise capable of meeting the clinical requirements for carrying out CCBHC services on behalf of the CCBHC (e.g., cultural and linguistic competency, requirement that services are provided on a timely basis)?
- o Is the potential DCO otherwise capable of meeting the operational requirements for carrying out CCBHC services on behalf of the CCBHC?
 - Examples:
 - Sharing health record information with the CCBHC sufficient to communicate encounter data to justify billing a CCBHC "visit."
 - Sharing clinical and quality data with the CCBHC sufficient to enable the CCBHC to meet SAMHSA URS requirements.
 - The provider or its individual employed or contracted clinicians undergoing credentialing with managed care plans, where necessary, to enable CCBHC to bill plans for services furnished by the DCO.
 - Collecting consumer fees and cost-sharing based on requirements in CCBHC's sliding fee discount schedule (if CCBHC seeks to delegate this collection function contractually).

Assess fair market value of any services that the CCBHC may purchase from the potential DCO.

- o For more information on the fair market valuation for DCO contracting, see [Determining Fair Market Value](#).

Draft contract for relationship.

- o For more information on DCO contracting, see the [Overview of Legal Requirements and Checklist](#).



EDUCATE

Explain to potential DCOs how a potential partnership aligns with the goals and expectations of each organization in the partnership and the demonstration project.

Communicate value of the CCBHC and the demonstration.

- o Create marketing materials that communicate the value your organization and the demonstration project can offer to a potential partner.
- o Conduct in-person meetings with potential partners.
- o Participate in conferences that highlight your organization's achievements — both in and outside the demonstration project.
- o Attend informal networking events.
- o Attend community events to showcase value to a broader audience.

Identify and explain requirements unique to CCBHCs and the demonstration.

- o For more concise information geared towards potential partners, see the [Fact Sheet on DCOs](#) and the [Frequently Asked DCO Questions](#).

Identify your most critical concerns; recognize which are flexible and which are mandatory.

- o Examples:
 - Given the legal exposure that a CCBHC faces by furnishing a service through contract with another entity, requiring the DCO to indemnify the CCBHC against potential malpractice liability associated with services furnished by the DCO might be identified as a “non-negotiable” item.
 - The CCBHC may wish to delegate some financial functions (such as collection of fees and cost-sharing for services rendered under the contract) to the DCO, but may classify this as a “flexible” item if the CCBHC is operationally capable of shouldering this responsibility.

Provide draft contracts to potential partners.

- o **Hint:** Establish a point person for the other entity to work with and answer questions during the contracting process.



NEGOTIATE

Negotiation is discussion aimed at reaching an agreement.

A common error is bargaining over positions. This results in a loss of focus on concrete concerns and occurs when:

- o One or both parties are stuck in ensuring that they win on their positions, regardless of whether the overall goal is attained.
- o Parties take extreme positions in the expectation they have room to bargain down.

Instead:

- o Respond with questions regarding potential partners' issues, rather than uncompromising statements.
- o Respond specifically to the concerns of potential partners.
- o Develop options for mutual gain and generate a variety of possibilities before deciding what to do.
- o Look for zones of agreement and areas of overlap.



DETERMINING FAIR MARKET VALUE FOR SERVICES RENDERED BY A DCO

One of the most important features of any commercial contract is the type of “consideration” — the payment made by the purchasing party to the selling party — that it includes.

This is particularly true in the health care sphere, an industry that is highly regulated with numerous legal rules addressing the exchange of money or items of value between healthcare providers. When a CCBHC furnishes services through a contract with a DCO, it is critical for the CCBHC to document that the consideration paid to the DCO reflects fair market value (FMV). This documentation should be retained as part of the CCBHC’s files.

The DCO Agreement

According to SAMHSA, when a CCBHC furnishes services under contract with a DCO, the CCBHC is ultimately clinically responsible for all care provided.⁷³ In addition, the CCBHC may expend a portion of its grant funds in the form of either a procurement or a subaward to support the provision of discounted CCBHC services to low-income uninsured individuals by the DCO.

In addition, guidance issued by the CMS makes clear that when a CCBHC provides a demonstration service to its consumer via a DCO the CCBHC must bill Medicaid for services.⁷⁴ CMS elaborated:

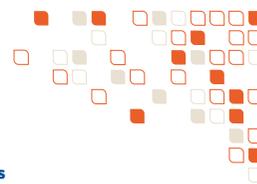
The cost of services provided on behalf of the CCBHC by DCOs will be reported in the CCBHC cost report used to determine the CCBHC prospective payment system (PPS) payment rate. The CCBHC will typically pay the DCO a contracted rate for a defined service.⁷⁵

The relationship between the CCBHC and DCO is, therefore, a contractual relationship, under which the CCBHC **procures services from the DCO** on behalf of CCBHC consumers. The CCBHC holds itself as the provider of the DCO-rendered services.

⁷³ 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 4.a.1; SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, p. 98.

⁷⁴ CMS, **Section 223 Demonstration Programs to Improve Community Mental Health Services Qs & As – Set III**, (June 1, 2016), p. 4, at <https://www.medicaid.gov/medicaid/downloads/section-223-set-3.pdf>, Question 6

⁷⁵ *Id.*, Question 5.



The Federal Rules and Limitations That Apply to DCO Contract Payments

Several sets of legal rules apply to the consideration paid in a CCBHC/DCO contracting relationship.

I. Principles of Reasonable Cost

The first set of legal rules is the principles of reasonable cost that apply to health care providers reimbursed on a cost-related basis. Under the CCBHC demonstration, states are required to reimburse CCBHCs under a PPS. The PPS rate is a per-visit rate reflecting the total allowable per-visit costs of furnishing the entire bundle of CCBHC services in a base cost-reporting period.

According to a CCBHC cost report template issued by CMS, each CCBHC (or potential CCBHC seeking state certification) must include in its base period cost report as components of the “direct” costs of furnishing the entire bundle of CCBHC services, (1) the actual or anticipated costs to the CCBHC of procuring DCO services and (2) any other actual or anticipated direct costs specifically related to services performed by the DCO (e.g., when a CCBHC contracts with a DCO to perform mobile crisis services, the DCO is compensated by the CCBHC for mileage associated with travel).⁷⁶

Therefore, the costs that a CCBHC incurs paying DCOs to render CCBHC services are subject to the same principles of reasonable costs as any other costs that the CCBHC documents on its cost report.

CMS explains that in reporting costs, states must require the providers to adhere to the principles of reasonable cost in both 45 CFR Part 75 (HHS Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards (the HHS Uniform Guidance) and 42 CFR Part 413 (the Medicare principles of reasonable cost).

- According to the **HHS Uniform Guidance**, when the costs of contracted services are claimed as allowable, the provider must document their reasonableness. A cost is reasonable if “in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost.”⁷⁷ In determining whether costs are reasonable, consideration must be given to factors including “sound business practices,” “arm’s-length bargaining” and “market prices for comparable goods and services for the geographical area.”⁷⁸

⁷⁶ Certified Community Behavioral Health Clinic (CCBHC) Cost Report, “Trial Balance” and “Anticipated Costs” tabs, Section 1-B); CCBHC Cost Report Instructions, OMB #0398-1148, CMS-10398 (#43) pp. 8-14.

⁷⁷ 45 CFR § 75.404.

⁷⁸ 45 CFR § 75.404 (b) and (c). The HHS Uniform Guidance also includes an extensive set of procurement standards relating to items purchased or services procured using federal grant funds or program income. *Id.* §§ 75.326-75.335. This summary assumes that the Uniform Guidance procurement standards do not control DCO contracting, because the CCBHC demonstration will not involve the receipt of federal grant funds by behavioral health providers.



- According to the **Medicare principles of reasonable cost**, providers of services are required to document on cost reports “the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider.”⁷⁹ These costs are “appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs that are common and accepted occurrences in the field of the provider’s activity.”⁸⁰

Both sets of cost principles specifically designate certain types of “unallowable” costs, such as costs associated with entertainment and lobbying. In addition, both sets of cost principles place limitations on the allowability of other types of costs, such as costs incurred in contracting with a related organization (such as a subsidiary).

The main goal of the reasonable cost principles is to ensure that a provider includes costs on its cost report that are no higher than those necessary and appropriate to furnish care. Therefore, in including the payment made to a DCO on a cost report, it is important that a CCBHC or potential CCBHC ensure that the payment reflects no more than the FMV of this type of services in the community.

II. The Anti-Kickback Statute

A second applicable set of rules relating to exchange of money under a DCO contract is a federal law referred to as the Anti-Kickback Statute. This law prohibits any persons, including health care providers, from intentionally offering, paying, soliciting or receiving anything of value (remuneration) to induce or reward referrals involving “federal health care programs” or to generate federal health care program business.⁸¹ One purpose behind this law is to ensure that providers do not have an incentive to make medically unnecessary referrals, which in turn could unnecessarily increase amounts billed to federal programs for health care services.

Remuneration exchanged between healthcare providers can include discounts, since a discount is an item of value to the recipient of the discount. In the context of CCBHC/DCO contracting, the Anti-Kickback Statute is relevant to the extent that if a CCBHC purchased services from a DCO at a rate that reflects a reduction from FMV, the discount could be interpreted as an inducement to the CCBHC to refer consumers to the DCO.⁸²

Documenting FMV is important for purposes of the CCBHC’s compliance with the Anti-Kickback Statute, chiefly from the perspective of ensuring that a CCBHC does not pay the DCO a rate below FMV.⁸³

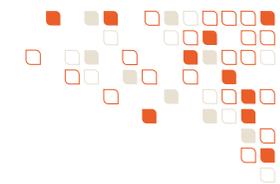
⁷⁹ 42 CFR § 413.9(c)(3).

⁸⁰ *Id.* § 413.9(b)(2).

⁸¹ 42 U.S.C. §1320a-7b(b). The term “federal health care program” is defined to include both health care programs funded directly by the United States government (such as Medicare), and state health care programs, including the Medicaid and Children’s Health Insurance Programs (CHIP). *Id.* §1320a-7b(f).

⁸² While the contracted service itself does not constitute a referral service, other services that a CCBHC consumer accesses at a DCO could be interpreted as referral services.

⁸³ The Anti-Kickback Statute includes numerous statutory and regulatory “safe harbors.” See 42 U.S.C. § 1320a-b(b)(3); 42 CFR § 1001.952. The safe harbors correspond to health care payment and business practices that, although they potentially implicate the federal anti-kickback statute, are not treated as offenses under the statute. If a provider in the community offers to contract with the CCBHC or potential CCBHC to furnish CCBHC services on a discounted basis, and the CCBHC is interested in entering such an arrangement, the CCBHC should seek legal counsel to determine whether the discounted arrangement would fall within a safe harbor.



How Is “Fair Market Value” Established?

There is no one measure for fair market value. The core concept is that the consideration under the contract must correspond to the market prices in the area for the goods being purchased. The key step in determining and documenting FMV is to identify an objective indicator of the value of the services.

Quantifying FMV can be challenging when the CCBHC is contracting for a service that has not historically been covered by private insurers or under the Medicare or Medicaid programs. The task can be yet more challenging when the provider from which the services are purchased (the potential DCO) has typically furnished the services on an uncompensated basis in the past, using grant funds to support the uncompensated costs of care.

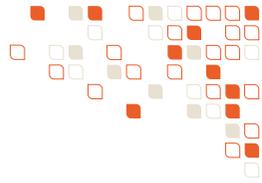
Below are several examples of acceptable measures of FMV:

- Average hourly or annual salary costs for clinicians furnishing service, based on published salary surveys applicable to the region.
 - **Note:** This measure would be most appropriate for services rendered by a single clinician.
- Fees per unit of service according to Medicare or Medicaid fee schedules, or a percentage of those fees.
 - Where FMV is based on the Medicare Part B Physician Fee Schedule, the Geographic Practice Cost Index (GPCI) applicable to the region should be taken into consideration.

Where no estimate of FMV for the services is available based on external data, such as average salaries or other payors’ fees, information unique to the DCO could be taken into consideration, such as:

- The potential DCO’s average charges for the type of services purchased (based on its schedule of charges).
 - **Note:** In general, the payment would be based on a percentage of charges, rather than the potential CCBHC’s full charges, since few payors reimburse services as high as the provider’s charges.
- The potential DCO’s historical costs of furnishing the services to be purchased.

The CCBHC’s basis for quantifying FMV (for example, salary surveys that the CCBHC located online and used in negotiating its contract rate for purchasing clinical services from the DCO) should be preserved in the CCBHC’s procurement files.



FEE SCHEDULE RESOURCES

CCBHC Fee Schedule and Sliding Fee Discount Schedule: Overview of Legal Requirements and Checklist of Recommended Terms

According to guidance issued by SAMHSA, CCBHCs must maintain a written schedule of fees for their services⁸⁴ that conforms 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 fee schedule should be based on locally prevailing rates or charges and should take into account the CCBHC's reasonable costs of operation.⁸⁵

Under the federal law governing the CCBHC demonstration, CCBHCs must ensure that no individuals are denied CCBHC services due to their inability to pay.⁸⁶ Accordingly, CCBHCs are required to reduce or waive fees or payments for CCBHC services if such fee or payment presents a barrier to care.⁸⁷ The schedule of discounts on otherwise applicable fees to make services more affordable to consumers is referred to as a "sliding fee discount schedule." CCBHCs are required to publish a written sliding fee discount schedule.⁸⁸

CCBHCs must establish and maintain written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule.⁸⁹ These policies and procedures must be applied equally to all individuals seeking CCBHC services.⁹⁰

If a CCBHC service is furnished through a DCO, the DCO must provide such CCBHC service in accordance with the CCBHC's schedule of fees, schedule of discounts and corresponding written policies and procedures. Accordingly, CCBHCs should provide each DCO with a copy of such documents. While not required by SAMHSA, it is generally recommended that the CCBHC provide each DCO with training to support the DCO in its implementation of the schedule of fees, schedule of discounts and corresponding written policies and procedures.

The DCO is not required to conduct its own discount eligibility screening. Rather, the CCBHC should inform the DCO, prior to its provision of a CCBHC service if the CCBHC has determined that the consumer is eligible for a fee discount.

⁸⁴ Please see the [Introduction to the Toolkit](#) for a discussion of the required CCBHC services.

⁸⁵ 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 (2015 Planning Grant RFA), Criterion 2.d.3.

⁸⁶ Protecting Access to Medicare Act (PAMA) § 223(b)(2)(B) (42 U.S.C. § 1396a (note)), Pub. L. No. 113-93 (Apr. 1, 2014); RFA, Appendix II, Criterion 2.d.1.

⁸⁷ *Id.*

⁸⁸ *Id.* Criterion 2.d.2.

⁸⁹ *Id.* Criterion 2.d.4.

⁹⁰ *Id.* Criterion 2.d.4.



Key terms that should be included in sliding fee discount policies and procedures include:

- The CCBHC's fee schedule has been established according to relevant state or federal statutory or administrative requirements or the fees are based on locally prevailing rates or charges and are consistent with the CCBHC's reasonable costs of operation.⁹¹
- The CCBHC has established a sliding fee discount schedule that is designed to assure that the CCBHC's consumers have access to all CCBHC services. Consumers will not be denied services on the basis of inability to pay or place of residence, nor will the availability of CCBHC services be limited on these grounds.⁹²
- CCBHC services furnished through a DCO will be furnished in accordance with a sliding fee discount schedule.⁹³
- Consumer fees and cost-sharing for CCBHC services rendered by a DCO will be collected. The CCBHC is legally responsible for the collection of consumer fees and cost-sharing (as applicable) for CCBHC services furnished via DCO, but the CCBHC may choose to delegate this duty to the DCO through the contract.⁹⁴
- The CCBHC (and its DCOs, as applicable) will provide consumers with information regarding the sliding fee discount schedule. Specifically, the sliding fee discount schedule will be communicated in languages and formats appropriate for individuals seeking services who have limited English proficiency or disabilities.⁹⁵ In addition, the sliding fee discount schedule will be posted on the CCBHC website and in the CCBHC waiting room.⁹⁶ If a CCBHC service is furnished through a DCO, then the DCO will post the sliding fee discount schedule on the DCO website and in the DCO waiting room.
- The CCBHC will assess a consumer's eligibility for the sliding fee discount schedule in accordance with the following process:⁹⁷
- The CCBHC will inform the DCO if a consumer is eligible for a fee discount under the CCBHC's sliding fee discount schedule.
- The sliding fee discount schedule policies and procedures will be applied equally to all individuals seeking services.⁹⁸

⁹¹ *Id.* Criterion 2.d.3.

⁹² PAMA § 223(b)(2)(B) (42 U.S.C. § 1396a (note)); RFA, Criterion 2.d.1.

⁹³ RFA, Appendix II, Criteria 2.a.3 and 4.a.5.

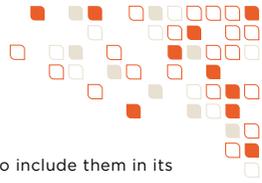
⁹⁴ SAMHSA has stated in guidance that a CCBHC may contractually delegate the collection of consumer fees to the DCO, without compromising its financial responsibility for the service rendered by the DCO. **See** Project 223 Clarification to Guidance - Set 1 Distributed to Project Directors on March 21, 2016, at 4.

⁹⁵ *Id.* Criterion 2.d.2.

⁹⁶ *Id.*

⁹⁷ Neither CMS nor SAMHSA guidance specify how CCBHCs must assess discount eligibility. Instead, the guidance specifies only that the CCBHC must have policies and procedures describing eligibility for the discounts. **See** RFA Appendix II, Criterion 2.d.3. Accordingly, CCBHCs have significant discretion in structuring their eligibility processes. At minimum, however, the policy should provide that the CCBHC will screen consumers for sliding fee discount eligibility as a preliminary measure before the consumer accesses CCBHC Services. This administrative intake process may be conducted in tandem with, or sequentially with, the preliminary screening and risk assessment that is a required CCBHC service. **See** RFA, Appendix II, Criterion 4.d.2.

⁹⁸ *Id.* Criterion 2.d.4.



Although the following terms are not required, the CCBHC may also wish to include them in its sliding fee discount policies and procedures:

- Frequency (e.g., annually) the CCBHC will review the fee schedule and discount schedule to identify whether the discounts present barriers to care based on inability to pay.
- Frequency (e.g., annually) with which the CCBHC will reassess a consumer's eligibility to obtain a fee discount under the sliding fee discount schedule.
- Alternative mechanisms to determine a consumer's eligibility for the sliding fee discount if he/she is unable to provide the necessary documentation/verification, such as through allowing for self-declaration.
- Provisions related to billing and collections including, but not limited to, payment incentives, grace periods, payment plans and refusal to pay guidelines.

