CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS CONTRACTING AND COMMUNITY PARTNERSHIPS TOOLKIT

CCBHC Expansion Grantee Edition

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NATIONAL COUNCIL *for* Mental Wellbeing

FELDESMAN

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DISCLAIMER

This resource was designed to provide accurate and authoritative information regarding 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) guidance. Use of the materials in this Toolkit does not guarantee that grantees will be determined to be in compliance with grant requirements. Grantees that have questions about how to structure community partnerships under their CCBHC Expansion Grants should consult with their SAMHSA project officers.

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.

The two main types of CCBHCs are those that participate in the Section 223 CCBHC Demonstration and those that receive CCBHC Expansion grant funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide CCBHC services under program requirements (referred to here as the "Criteria") similar to those governing the Section 223 CCBHC Demonstration.[1] This edition of the Toolkit addresses the requirements that apply to CCBHC Expansion Grantees.

Since fiscal year (FY) 2018, Congress has appropriated funds enabling SAMHSA to award CCBHC Expansion Grants to organizations that comply with the CCBHC program requirements and meet other funding criteria. Although grantees under the CCBHC Expansion program use grant funds to fulfill the CCBHC Criteria, grantees are not eligible for the unique CCBHC Medicaid prospective payment system (PPS) methodology that applies to demonstration participants. As a result, the nature of grantees' partnerships may look somewhat different than that of their peers participating in the Section 223 CCBHC Demonstration.

The two types of community partnerships contemplated in the CCBHC model are care coordination relationships and DCO relationships. In this Toolkit, we address the legal and logistical matters that current or potential CCBHC Expansion Grantees need to consider when forming these relationships.

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[1] Throughout this Toolkit, we refer to guidance issued by SAMHSA and CMS relating to the CCBHC program. In March 2023, SAMHSA issued an updated guidance document: Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria. The updated Criteria, which reflect the outcome of a public comment period, include various programmatic changes and revisions to reflect changes in the law since SAMHSA issued its initial Criteria as part of the Department of Health and Human Services' 2015 Request for Applications for States to submit planning grants for the CCBHC Demonstration. The changes also reflect various new policy developments and best practices. The available federal rules that specifically address the CCBHC Demonstration consist of the federal statute (Social Security Act § 1902 [Note]) reflecting the text of the Protecting Access to Medicare Act of 2014 (PAMA) § 223 and subsequent amendments thereto, the SAMHSA and CMS guidance referred to in this Toolkit, 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 https://www.samhsa.gov. In addition, the National Council for Mental Wellbeing maintains a CCBHC resource on its website: http://www.thenationalcouncil.org/topics/certified-community-behavioral-health-clinics/.

BASIC FEATURES AND GOALS OF THE CCBHC MODEL

In authorizing the CCBHC Demonstration program in the Protecting Access to Medicare Act of 2014 (PAMA),[2] 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."[3]

The goal of advancing "programs, practices and policies that are recovery-oriented, trauma-informed and equity-based as a means of improving behavioral health" is also a key goal of the CCBHC Expansion Grants, as stated by SAMHSA.[4]

These goals are apparent in the following core features of the CCBHC Demonstration, as set forth in the federal statute and described more fully in SAMHSA and CMS guidance. The guidance is key in defining the operation and goals of both the Section 223 CCBHC Demonstration program and CCBHC Expansion Grants, because Congress, via PAMA 2014, required the Department of Health and Human Services (HHS) to "publish criteria for a clinic to be certified by a State as a certified community behavioral health clinic" (an obligation that HHS delegated to SAMHSA), and required HHS (via CMS) to "issue guidance for the establishment of a prospective payment system" for purposes of the Medicaid CCBHC Demonstration.[5]

For CCBHC Demonstration participants, the state certifies organizations as CCBHCs using the Criteria. For SAMHSA CCBHC Expansion Grantees, depending on the terms of the grant award, the grantee either must attest to meeting the Criteria when it applies for grant funding or use the grant award to work toward meeting the Criteria.[6]

In recent years, SAMHSA has issued two types of CCBHC Expansion Grants: CCBHC Improvement and Advancement (CCBHC-IA) grants and CCBHC Planning, Development, and Implementation Grants (CCBHC-PDI). CCBHC-PDI Grants are intended to provide funding to assist with CCBHC implementation at clinic sites that have not previously benefited from a CCBHC Expansion Grant or been certified by a state to participate in a CCBHC Demonstration; CCBHC-IA grants are intended to assist organizations that have already received CCBHC Expansion Grants or have already been certified by a state to participate in a CCBHC Medicaid demonstration, in improving or expanding their CCBHC programs.

EACH CCBHC MUST FURNISH ALL REQUIRED CCBHC SERVICES TO ITS CLIENTS

Each CCBHC must be capable of "provision (in a manner reflecting person-centered care)" of all required CCBHC services, which, "if not available directly through the [CCBHC], are provided or referred through formal relationships with other providers."[7]

SAMHSA's Criteria convey an expectation that the CCBHC is responsible for directly furnishing a significant portion of the full scope of CCBHC services. Other providers working with CCBHCs – referred to in the Criteria as "designated collaborating organizations" (DCOs) – may furnish some CCBHC services on behalf of the CCBHC, but the CCBHC itself should bear a primary responsibility for service delivery.

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2 PAMA 2014 (PAMA) § 223, Pub. L. No. 113-93, § 223(a)(1), (b)(1).

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

4 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 4; HHS/SAMHSA, FY 2023 Certified Community Behavioral Health Clinic Planning, Development and Implementation Grant (CCBHC-PDI) Notice of Funding Opportunity, page 16 (Funding Opportunity SM-23-024).

5 PAMA 2014 § 223(a)(1), (b)(1).

6 Notice of Funding Opportunity (NOFO) No. SM-23-016 (FY 2023 CCBHC Improvement and Advancement (CCBHC-IA) Funding Announcement); NOFO No. SM-23-024 (CCBHC Planning, Development, and Implementation (CCBHC-PDI) Grant).

7 PAMA § 223(a)(2)(D).

In the recently updated CCBHC Criteria, SAMHSA shifted its manner of implementing this expectation. The initial Criteria, published in 2015, indicated that CCBHCs must directly furnish four specific services included in the CCBHC benefit. Those services are indicated by asterisks in the following list. Under the 2015 Criteria, CCBHCs could elect to provide the other five services directly or provide one or more of them in whole or in part via a DCO.

The updated Criteria (March 2023) require, instead, that the CCBHC directly deliver the majority (51% or more) of encounters across the required services (excluding crisis services).[8] Any service may be furnished via a DCO if this requirement is met.

The required CCBHC services include:

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

The required services must be provided by CCBHCs in every state, regardless of whether the services are independently covered under those states' Medicaid state plans. In addition, a CCBHC must make the full array of CCBHC services available to all persons using CCBHC services.

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 clients. For example:

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

[8] SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 4.

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 Section 223 CCBHC Demonstration. The CCBHC legislation and guidance envision two main types of CCBHC community partnerships.

The first is **care coordination relationships**. Care coordination requires the harmonization of "care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services including acute, chronic and behavioral health needs."[9]

The CCBHC must conduct care coordination in keeping with the preferences of the those individuals receiving services and their care needs. In addition, to the extent possible, a CCBHC should deliver care coordination, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by that person.

Care coordination partnerships should be supported by a formal, signed agreement detailing the roles of each party, although joint protocols may suffice as an alternative, as described in this Toolkit.[10]

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.[11] SAMHSA elaborated on these requirements in its Criteria.[12]

Many community behavioral health providers today have developed strong ties with other providers and agencies in their communities to ensure that clients 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 second is the **DCO relationship**. In the law authorizing the CCBHC Demonstration, Congress required that CCBHC services be provided either directly or through "formal relationships."[13] DCO relationships satisfy the "formal relationship" requirement.

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 to deliver one or more (or elements) of the required services.[14] The formal relationship is evidenced by a contract; memorandum of agreement (MOA); memorandum of understanding (MOU); or such other formal, legal arrangements describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized.[15]

SAMHSA's Criteria explain, "The formal relationship between CCBHCs and DCOs creates the platform for seamlessly integrated services delivered across providers under the umbrella of a CCBHC."[16] Each DCO must meet the same quality standards as those provided by the CCBHC and otherwise agree to furnish services in a manner consistent with the applicable CCBHC Criteria.[17]

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9 PAMA § 223(a)(2)(C).

10 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.C, pages 20–23.

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

12 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3, pages 16–24.

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

14 SAMHSA, CCBHC Certification Criteria (updated March 2023), page 53.

15 Ibid.

16 Ibid.

17 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 4.a.4, page 26.

Notably, DCO relationships, unlike care coordination relationships, are not required under either the CCBHC Demonstration or the Expansion Grant. If a CCBHC can provide all CCBHC services on its own, it does not need a DCO. DCOs are simply a mechanism a CCBHC may use to make a CCBHC service available to its clients that it does not provide directly.[18]

CONTENTS OF THIS TOOLKIT

This Toolkit focuses primarily on requirements, as set forth by SAMHSA, applicable to CCBHC Expansion Grantees in contracting with DCOs and establishing Care Coordination Agreements. It is intended as a resource for current Expansion Grantees and for other community organizations considering working with CCBHC Expansion Grantees as DCOs or as care coordination partners.

The Toolkit contains information for those navigating the transition to CCBHC status and negotiating mutually beneficial community partnerships that promote the goals of the CCBHC Expansion Grant program.

[18] Please note that SAMHSA, in its 2023 edition of the Criteria, has used the term "person receiving CCBHC services" to identify individuals served by the CCBHC. We have endeavored to match SAMHSA's wording where possible; however, where the use of one word rather than a phrase is necessary for concision, we use the word "client" to refer to persons using CCBHC services.

CONTENTS

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 in this Toolkit: DCOs and care coordination.

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

1. Formal Relationships with DCOs

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 to deliver one or more (or elements) of the required CCBHC services, with the understanding that the CCBHC must directly deliver the majority (51% or more) of encounters across the required services (excluding crisis services). [19] A DCO furnishing services on behalf of the CCBHC agrees to provide care in a manner consistent with CCBHC program criteria. DCOs "are more than care coordination or referral partners, and there is an expectation that relationships with DCOs will include more regular, intensive collaboration across organizations than would take place with other types of care coordination partners."[20] CCBHC services provided through a DCO must conform to the relevant applicable CCBHC Criteria.[21]

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 but not limited to inpatient care, primary care and housing access. These care coordination activities should promote clear and timely communication, deliberate coordination and seamless transition.[22] Care coordination is regarded as an activity rather than a service.

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19 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 4.a.1, page 26.

20 SAMHSA, CCBHC Certification Criteria (updated March 2023), page 53.

21 Ibid.

22 SAMHSA, CCBHC Certification Criteria (updated March 2023), page 49.

Key Differences Distinguishing DCOs from Care Coordination		
	DCO	**CARE COORDINATION**
Scope	A DCO may provide one or more CCBHC services on behalf of the CCBHC, but the CCBHC itself must directly provide at least 51% of all CCBHC encounters.	Care coordination is regarded as an activity rather than a service. CCBHCs must maintain care coordination relationships with various health care and social service agencies. In general, the services provided by the care coordination partner do not fall within the scope of CCBHC services.
Type ofAgreement	Structured as a MOU, MOA, referral agreement, subrecipient agreement or purchase of services agreement.	Structured as a referral agreement. If the partnering entity is unable to enter into a formal agreement, then the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together and roles in care coordination.
Responsibility	The DCO agrees to provide services under the same CCBHC program requirements as those that would be in place if the services were directly furnished by the CCBHC Expansion Grantee.	CCBHC does not assume responsibility for services provided by the care coordination partner. The organizations maintain autonomous operations.
Billing Provider	Both the CCBHC Expansion Grantee and the DCO are the billing providers for the services that they furnish. **Please note that in this regard, the CCBHC Expansion Grant and Section 223 Demonstration differ. For purposes of the demonstration, DCO relationships are required to be structured as contractual purchases of services under which the CCBHC acts as the billing provider for CCBHC services furnished by DCO.**	Each care coordination partner is the billing provider for the services that it furnishes.
Consideration	Depending on the structure of the DCO arrangement, the CCBHC may compensate the DCO for delivering certain CCBHC services on the CCBHC's behalf.	No consideration (money or anything else of value) is exchanged between the CCBHC and the care coordination partner.

Key Differences Distinguishing DCOs from Care Coordination		
Schedule of Fees and Discounts	DCOs furnish CCBHC services in accordance with a schedule of fees, schedule of discounts, and corresponding written policies and procedures.	The care coordination partner bills clients 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 arrangements are optional. If a CCBHC can furnish all CCBHC services directly, then it need not contract with a DCO.	Care coordination arrangements with other organizations in the community are a mandatory component of the demonstration and Expansion Grants.

CARE COORDINATION AGREEMENTS

Overview of Legal Requirements and Checklist of Recommended Terms

Care coordination is central to the CCBHC concept as reflected in PAMA, the 2014 law establishing the CCBHC Demonstration.[23]

The Agency for Healthcare Research and Quality defines the term "care coordination" as follows:

> *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.*[19]

The Criteria set forth that the CCBHC is specifically charged with coordinating access to high-quality physical health care (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems and employment opportunities as necessary to facilitate wellness and recovery of the whole person.[24] The CCBHC also coordinates with other systems — including criminal and juvenile justice and child welfare — to meet the needs of the people they serve.[25]

In coordinating care, providers must keep in mind the client's preferences.[26] In addition, to the extent possible, care coordination should be given, as appropriate, in collaboration with the client's family/caregivers.[27]

The Criteria also set forth that the CCBHC should designate an interdisciplinary treatment team that is responsible for directing, coordinating and managing care and services for the client.[28] The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic and recovery support needs of CCBHC clients, including, as appropriate, traditional approaches to care for clients who may be American Indian or Alaska Native.[29]

Care coordination links CCBHC clients with access to certain providers and social service agencies through a referral process. The referral process under the care coordination model is not passive; rather, the CCBHC and the other entity must work together to share information regarding clients' needs and preferences.

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23 See Protecting Access to Medicare Act (PAMA) § 223(a)(2)(C) (42 U.S.C. § 1396a (note); SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.a.1, page 17.

24 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.a.1.

25 Ibid.

26 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.a.4, page 17.

27 Ibid.

28 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.d.2, page 24.

29 Ibid.

SAMHSA has specified that care coordination partnerships should be supported by a formal, signed agreement detailing the roles of each party.[30] Such an agreement is evidenced by a contract, MOA or MOU with the other entity, or by a letter of support, letter of agreement or letter of commitment from the other entity. [31] The agreement should describe the parties' mutual expectations and responsibilities related to care coordination. [32]

If, however, the partnering entity is unable to enter into a formal care coordination agreement, the CCBHC may work with the partner to develop unsigned joint protocols that describe procedures for working together as well as roles in care coordination. [33] At a minimum, the CCBHC must create written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time, so that jointly developed protocols or formal agreements can be made.

For purposes of this Toolkit, the agreements to memorialize care coordination partnerships 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.[34] For example, consistent with requirements of privacy, confidentiality, and client preference and need, the CCBHC must assist clients who are referred to external providers or resources in obtaining an appointment and tracking participation in services to ensure coordination and receipt of support.[35]

Under care collaboration relationships, unlike the DCO relationships discussed elsewhere in this Toolkit, the care coordination partner is not required to comply with the CCBHC Criteria in furnishing services. Both the CCBHC and the care coordination partner retain their own separate and distinct corporate structures, patient care delivery systems and locations; each is accountable and legally and financially responsible only for those services that it directly furnishes to clients. The care coordination partner is responsible for billing and collecting payments from third-party payors and clients 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 care coordination partner.

SCOPE OF CARE COORDINATION: PROVIDERS AND SOCIAL SERVICE ENTITIES

In the spirit of promoting access to services that are both integrated and comprehensive, the Criteria require that CCBHCs maintain care coordination relationships with the following providers and social service entities:

- Federally qualified health centers (and, as applicable, rural health clinics), to the extent that federally qualified health center services (and, as applicable, rural health clinic services) are not provided directly through the CCBHC.
- Inpatient and residential psychiatric and substance use treatment programs, including programs that can provide opioid treatment program (OTP) services and programs/facilities that provide medical withdrawal management and overdose prevention, including the use of naloxone (must include any tribally operated facilities within the service area).
- 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.
- Emergency departments, inpatient acute care hospitals and hospital outpatient clinics.[36]

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30 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.C, pages 20–23.

31 SAMHSA, CCBHC Certification Criteria (updated March 2023), page 49.

32 Ibid.

33 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.C, pages 20–23.

34 SAMHSA, CCBHC Certification Criteria (updated March 2023), page 49.

35 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.A.3, page 17.

36 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirements 3.a.3 and 3.c.3.

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

- Schools
- Child welfare agencies
- The 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located
- 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 services
- Other social and human services [37]

The SAMHSA CCBHC Certification Criteria further state that CCBHCs may develop partnerships with the following entities based on the population served, the needs and preferences of people receiving services and/or the needs identified in the community needs assessment. Examples of such partnerships include but are not limited to those listed here. (For a comprehensive list of suggestions, see the revised CCBHC Certification Criteria.)

- Specialty providers of medications for treatment of opioid and alcohol dependence
- Suicide and crisis hotlines and warmlines
- Indian Health Service or other tribal programs
- Homeless shelters
- Housing agencies
- Employment services systems
- Aging and disability resource centers
- Other social and human services (e.g., intimate partner violence centers, religious services and supports, grief counseling, Affordable Care Act navigators, food and transportation programs)[38]

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 SAMHSA CCBHC Certification Criteria give CCBHCs flexibility in how they achieve care coordination, provided that the CCBHC and care coordination partner set forth their mutual expectations and responsibilities related to care coordination. Generally, CCBHCs should use care coordination arrangements to assist clients and families by referring them to external providers or resources. CCBHCs are required to identify each client's preferences in facilitating care coordination and assisting people receiving services in obtaining appointments or tracking their participation in referred services or activities.[39] CCBHCs should determine the person's preferences in the event of a psychiatric or substance use crisis and, working with the person, develop a crisis plan, including counseling the client about the use of the National Suicide & Crisis Lifeline (988), local hotlines, warmlines and stabilization services should a crisis arise when providers are not in the office.[40]

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37 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.C.3, page 21.

38 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.C.3, page 22.

39 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.a.3. and 3.a.4.

40 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.a.4.

For certain provider types, the Criteria identify specific issues for Care Coordination Agreements to address. CCBHCs should review these specified requirements, outlined in Criteria 3.c.1-5, and ensure that they are incorporated within Care Coordination Agreements and protocols.

PRIVACY AND DATA SHARING REQUIREMENTS FOR CARE COORDINATION AGREEMENTS

The CCBHC must obtain consents, as necessary, from clients 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.[41] If the CCBHC is unable, after reasonable attempts, to obtain consent for any care coordination activity, such attempts must be documented and revisited periodically.[42] It is best practice to incorporate policies and procedures related to client consent requirements and data sharing with care coordination into Care Coordination Agreements.

To both enhance the experiences of people receiving services from CCBHCs and facilitate care coordination partnerships, CCBHCs – under the Criteria – must use technology that meets the requirements of the HHS Office of the National Coordinator for Health Information Technology for various health IT (HIT) capabilities, including the following:

- Capturing health information, including demographic information such as race, ethnicity, preferred language, sexual and gender identity, and disability status (as feasible).
- Supporting care coordination by sending and receiving summaries of care records to care coordination partners.
- Providing people receiving services with timely electronic access to view, download or transmit their health information, or to access their health information via an application programming interfaces (APIs) using a personal health app of their choice.
- Providing evidence-based clinical decision support.
- Conducting electronic prescribing. [43]

SAMHSA recognizes that CCBHCs may not have all these capabilities in place at the time they submit the attestation required as part of the CCBHC Expansion Grant application. However, CCBHCs should plan to adopt and use technology meeting these requirements over time.

Additionally, as described further in the following section, enhanced care coordination expectations apply to CCBHCs' partnerships with DCOs. In particular, CCBHCs are required to develop and implement, within two years of their certification (for demonstration participants) or submission of attestation (for CCBHC Expansion Grantees), a plan to focus on ways to improve care coordination between the CCBHC and DCOs using a HIT system.[44]

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41 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.A.2.

42 Ibid.

43 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.b.3.

44 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.b.5.

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 client diagnosis and treatment information, including medications. Accordingly, it is important that CCBHCs apply the checklist to the facts and circumstances specific to each individual care coordination relationship.*

Pre-contracting Activities for Consideration in Advance of Executing Agreements:

Has the CCBHC:

- ☐ Evaluated whether the other party has sufficient personnel and facility space to see additional clients?
- ☐ Explored establishing Care Coordination Agreements with each type of required care coordination partner as well as other entities, based on the population served, the needs and preferences of people receiving services, and/or the need identified in the community needs assessment?
- ☐ Ascertained clients' preferences and needs for care as well as established the care coordination relationship in a manner that aligns with such preferences?
- ☐ Developed a crisis plan with each client to ascertain in advance the client's preferences in the event of a psychiatric or substance abuse crisis so the crisis plan can be shared with the other party, subject to the client's consent?
- ☐ Made and documented reasonable attempts to determine any medications prescribed by other providers for CCBHC clients and obtained appropriate consent to release such information to other providers not affiliated with the CCBHC to the extent necessary for safe and quality care?
- ☐ Identified how the CCBHC will assist clients and the families of children and youth in obtaining an appointment with the care coordination partner and tracking participation in services to ensure receipt of services?
- ☐ Discussed with the partnering entity the importance of memorializing a formal, signed agreement detailing the roles of each party vis-à-vis the care coordination relationship? (If the partnering entity is unable to enter into a formal agreement, then the CCBHC and the partnering entity must develop unsigned joint protocols that describe procedures for working together and roles in care coordination.)

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?[45]
- ☐ Include (at the parties' option) references to any applicable care coordination protocols jointly developed by the parties?

[45] SAMHSA, CCBHC Certification Criteria (updated March 2023), Appendix A, page 49.

As applicable for certain provider types, does the Care Coordination Agreement:

- ☐ For Care Coordination Agreements applicable to inpatient psychiatric treatment, OTP services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs:
  - » Establish that the CCBHC can track when clients 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?
  - » Attach or otherwise reference 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, overdose prevention and provision for peer services?
- ☐ For Care Coordination Agreements applicable to inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers and residential crisis settings:
  - » Describe how the CCBHC tracks when its clients 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?
  - » Establish that the CCBHC will make and document reasonable attempts to contact all CCBHC clients who are discharged from these settings within 24 hours of discharge. For all CCBHC clients discharged from such facilities who are at risk for suicide or overdose, include a requirement to coordinate consent and follow-up services with the client 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 clients receive services from the other party, such individuals are considered clients of the other party?
- ☐ Specify that the other party agrees to accept all clients referred to it by the CCBHC, subject to capacity limitations?
- ☐ Specify whether the other party will make services available to clients regardless of their ability to pay?
  - » **Please note** that the Criteria do not require that services a CCBHC client 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 responsible for billing and collecting all payments from appropriate third-party payors, funding sources and, as applicable, clients?

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

Does the Care Coordination Agreement:

- ☐ Specify that the parties will provide treatment planning and care coordination activities in compliance with HIPAA, 42 CFR Part 2, and other applicable federal and state laws, including client privacy requirements specific to the care of minors?
- ☐ Specify that the parties will request clients' consent for the disclosure of their health information, where necessary, in accordance with state and federal laws and regulations?
- ☐ Specify that the parties will follow clients' preferences for shared client health information, consistent with the philosophy of person- and family-related consent?

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 providers' exercise of independent professional judgment?
- ☐ Specify that nothing in the arrangement will, or is intended to, impair the exercise of freedom of choice of provider by any and all clients served by each party?

No Inducement of Referrals

Does the Care Coordination Agreement:

- ☐ Specify that the parties acknowledge and agree that they have freely negotiated the terms of the agreement; 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; it is an example. All questions regarding SAMHSA requirements for the care coordination relationship should be directed to SAMHSA. CCBHCs must maintain care coordination relationships with a range of other providers and social support organizations, and each such agreement/protocol 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, which receives a Certified Community Behavioral Health Clinic ("CCBHC") Expansion Grant from the Substance Abuse and Mental Health Services Administration ("SAMHSA"), and Community Hospital, an acute care hospital, to coordinate inpatient psychiatric treatment and other substance use disorder services (collectively, the "Inpatient Psychiatric Treatment Services") for those clients who receive community-based behavioral health services from Behavioral Health Clinic, in accordance with the terms set forth as follows. Behavioral Health Clinic and Community Hospital shall hereinafter be referred to individually as a "Party" and collectively as the "Parties." The purpose of this Agreement is to set forth the understanding of the Parties regarding their collaborative care coordination activities.

I. REFERRAL PROCESS

1. Behavioral Health Clinic is committed to providing integrated and coordinated care across a spectrum of services in a manner that is person- and family-centered.
2. Behavioral Health Clinic agrees to provide intake, initial screening and appropriate treatment to clients presenting at Behavioral Health Clinic for the provision of community-based mental health and substance use disorder services and to establish and maintain records for the Behavioral Health Clinic's clients.
3. Behavioral Health Clinic will coordinate care in keeping with the preferences of individual clients and their person- and family-centered treatment plans.
4. Behavioral Health Clinic will make reasonable efforts to obtain necessary consent for the release of information from clients.
5. If Behavioral Health Clinic's screening and/or treatment indicates the need for inpatient psychiatric treatment services, as determined in the sole discretion of the Behavioral Health Clinic provider, consistent with requirements of privacy, confidentiality, and client preference and need, Behavioral Health Clinic will assist the client and the families of children and youth in obtaining an appointment with Community Hospital and will track their receipt of services.
6. Community Hospital agrees to furnish Inpatient Psychiatric Treatment Services at the clinically appropriate level to clients referred to Community Hospital by Behavioral Health Clinic, in accordance with Community Hospital's policies and procedures.
7. Community Hospital shall have sole authority to bill clients and payors for Community Hospital's provision of Inpatient Psychiatric Treatment Services, in accordance with Community Hospital's policies and procedures applicable to fees, discounts and collections, with the understanding that no client shall be denied inpatient psychiatric treatment services based on ability to pay.

Note: *The Criteria do not require that the Care Coordination Agreement explicitly include a representation that*

Community Hospital will furnish services to all CCBHC clients, regardless of their ability to pay or in accordance with a particular discount schedule. However, the Parties may opt to include applicable provisions in the Agreement.

8. The Parties are implementing this care coordination relationship to enhance continuity of care. Consideration is not exchanged between the Parties pursuant to this Agreement, nor is either Party rendering services on behalf of the other. Each Party shall remain clinically, financially and legally responsible for its provision of services, and neither Party shall assume liabilities associated with the other Party's provision of services.

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 will track clients admitted and discharged from Community Hospital in accordance with CCBHC's applicable procedures.

   Note: *For Care Coordination Agreements, the CCBHC may wish to include that the Parties will jointly develop a care coordination protocol and that the protocol will address, as applicable (1) how Behavioral Health Clinic tracks its clients when admitted to and discharged from Community Hospital; (2) how Behavioral Health Clinic and Community Hospital will coordinate the transfer of medical records regarding diagnosis, treatment, prescriptions and specific recommendations for appropriate follow-up care; (3) the process for coordinating Behavioral Health Clinic's active follow-up after discharge; (4) how timely and orderly referrals will be made; (5) any client preferences and needs for care, to the extent possible in accordance with client's expressed preferences; and (6) any other expectations necessary to effectively manage care transitions. Alternatively, these details may be set forth in the body of the Care Coordination Agreement.*

3. Behavioral Health Clinic will make and document reasonable attempts to contact all Behavioral Health Clinic clients who are discharged from Community Hospital within 24 hours of discharge. For all Behavioral Health Clinic clients 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. Behavioral Health Clinic will coordinate consent and follow-up services with the client within 24 hours of discharge; such services shall continue until the individual is linked to additional services or assessed to be no longer at risk.

   Note: *The Criteria state that the CCBHC must maintain Care Coordination Agreements that require coordination of consent and follow-up within 24 hours of discharge, continuing until the client is linked to additional services or assessed as being no longer at risk (for clients presenting to the facility at risk for suicide). The Funding Announcement further states that the CCBHC must make and document reasonable attempts to contact all clients discharged from these settings within 24 hours of discharge.*

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. The Criteria do not require such provision be in the Care Coordination Agreement. We nonetheless recommend including such representations to ensure that the care coordination entity is adequately insured.*

Behavioral Health Clinic and Community Hospital represent and warrant that each Party and its clinicians are covered by a professional liability insurance policy (malpractice, errors and omissions) that contains sufficient coverage against professional liabilities that may arise from acts or omissions in connection with a Party's provision of clinical services, as contemplated herein.

IV. ASSURANCE OF CONSUMER AND CLINICIAN CHOICE

1. Behavioral Health Clinic and Community Hospital acknowledge and agree that all client referrals shall be subject to patient freedom of choice and the health professionals' independent clinical judgment.
2. 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.
3. Nothing in this Agreement restricts the authority of either Party to refer clients to any other provider.
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 refer clients to, other parties on either a limited or a general basis.

V. TERM AND TERMINATION

Note: *Care Coordination Agreements are customarily nonbinding on the Parties. Accordingly, it is unnecessary to set forth a term and causes for termination, although such provisions are recommended.*

1. The term of this Agreement shall commence on _____, 20_____, (the "Effective Date"), and shall terminate on _____, 20_____, 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 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 at any time by either Party upon providing the other Party with written notice, with the understanding that if a Party seeks to terminate this Agreement, it shall make reasonable efforts to provide the other Party with sixty (60) days' prior notice.

VI. PRIVACY AND CONFIDENTIALITY OF CLIENT INFORMATION

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 applicable federal and state laws, including but not limited to privacy requirements specific to the care of minors.

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 Section 223 CCBHC Demonstration program, PAMA, required the HHS to establish criteria for a clinic to be certified by a state as a CCBHC in Medicaid. HHS delegated the authority to establish these criteria to SAMHSA.

PAMA required that CCBHCs provide an array of services either directly or "referred through formal relationships with other providers." SAMHSA's CCBHC Certification Criteria clarify the requirements for the "formal relationships" with other providers that a CCBHC may use to make required services available to the CCBHC's clients. Specifically, if a CCBHC cannot provide a required service directly, then the service must be made available through a relationship with what SAMHSA terms a "designated collaborating organization" (DCO). This requirement applies both to participants in the CCBHC Medicaid demonstration and to CCBHC Expansion Grantees.

THE DCO CONCEPT

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 to deliver CCBHC services. The formal relationship between CCBHCs and DCOs creates the platform for seamlessly integrated services delivered across providers under the umbrella of a CCBHC. [46]

From the perspective of the person receiving services and their family members, services received through a DCO should be part of a coordinated package with other CCBHC services; the person using CCBHC services should encounter a seamless interface rather than simply accessing services through another provider organization.[47] CCBHC services provided through a DCO must conform to the relevant applicable CCBHC Criteria. For example, a DCO must discount or waive any fees or payments for the applicable CCBHC service, as required by the sliding fee schedule policy or as necessary to ensure that no individuals are denied services because of inability to pay.

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[46] SAMHSA, CCBHC Certification Criteria (updated March 2023), page 53.

[47] Ibid.

CCBHC SERVICES AND DCO SCOPE OF SERVICES

Under SAMHSA's current Certification Criteria, CCBHCs may delegate to a DCO the provision of any CCBHC service. This represents a change from the prior Criteria, which specified that DCOs could provide only certain services. Nonetheless, the CCBHC must directly provide the majority of CCBHC services.

Under the current CCBHC Criteria, the CCBHC must directly provide at least 51% of all CCBHC encounters across all CCBHC services (excluding crisis services).[48]

Under the SAMHSA CCBHC Criteria that were in effect before March 2023, CCBHCs were required to furnish directly a certain subset of the full CCBHC scope of services. The CCBHC services that both CCBHC Demonstration participants and Expansion Grantees are required to provide are the following. Those marked with an asterisk are the services that, in the prior version of the Criteria, were permitted to be furnished via a 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.*

[48] SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 4.a.1.

DCO ELIGIBILITY

Health care providers may function as a DCO whether they are a nonprofit, a for-profit or a governmental entity. CCBHCs, however, must be nonprofits or governmental entities.

With respect to CCBHC grantees, the FY2023 CCBHC Expansion Grant Notices of Funding Opportunity require that CCBHCs submit evidence to SAMHSA that the DCO:

1. Has two years of relevant experience, as of the due date of the application, providing relevant services.
2. Complies with all applicable local and state licensing, accreditation and certification requirements.[49]

MEMORIALIZING THE DCO RELATIONSHIP

CCBHCs' agreements with DCOs should be memorialized in a written contract, a MOA, a MOU or another appropriate format describing the parties' mutual expectations and establishing accountability for services to be provided and funding to be sought and utilized.[50]

The DCO Agreement should reflect that the DCO is more than a care coordination or referral partner; rather, there is an expectation that a DCO relationship include more regular, intensive collaboration between the organizations than would take place with care coordination partners.

KEY TERMS FOR DCO AGREEMENTS

CCBHC CRITERIA

Under the terms of the SAMHSA FY2023 CCBHC Expansion Grant Funding Announcement, the CCBHC maintains ultimate responsibility for ensuring that people accessing services from the CCBHC are served in a manner consistent with the Criteria, regardless of whether a service is furnished via a DCO. This means that the CCBHC must ensure that those services:

- Meet cultural competency standards set by SAMHSA and/or the CCBHC.
- Are reflected in the data the CCBHC furnishes in furtherance of its reporting obligations under the CCBHC Expansion Grant (appropriate consents may need to be obtained to satisfy the requirements of relevant federal and state privacy laws).
- Meet SAMHSA CCBHC standards for accessibility of services (e.g., application of sliding fee scale and no limitation or denial of services based on inability to pay or residence); for more information on the sliding fee discount policy, see the CCBHC Fee Schedule and Sliding Fee Discount Schedule.
- Are rendered within a specified period after appointment request. For example, established clients must be provided 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 a client presents with an emergency or crisis need, the DCO must take immediate action, including any necessary outpatient follow-up care, and ensure that clinical services are provided within one business day of the request.
- Meet all relevant SAMHSA program requirements applicable to the specific contracted service.

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[49] SAMHSA, FY2023 CCBHC Planning, Development, and Implementation (PDI) Grant NOFO, page 22

[50] SAMHSA, CCBHC Certification Criteria (updated March 2023), page 53.

The CCBHC should ensure that people who receive CCBHC services via a DCO have access to the CCBHC's grievance procedures.[51]

It is best to incorporate these applicable criteria into the body of the DCO Agreement.

DCO RELATIONSHIPS AND HIT

The CCBHC Expansion Grantee is required to develop, and implement within two years of submitting its attestation, a plan to improve care coordination between the CCBHC and all DCOs, using a HIT system. This plan should include information on how the CCBHC can support, using the HIT system, electronic health information exchange to improve care transition to and from the CCBHC. To support integrated evaluation planning, treatment and care coordination, the CCBHC should work with DCOs to integrate clinically relevant treatment records, generated by the DCO, for people receiving CCBHC services and incorporate such data into the CCBHC health record. Further, all clinically relevant treatment records maintained by the CCBHC should be available to DCOs, within the confines of federal and/or state laws governing sharing of health records.[52]

The DCO Agreement should set forth expectations regarding the HIT plan and the exchange of health records.

STRUCTURING A DCO RELATIONSHIP

It is important to note that the nature of DCO relationships under the CCBHC Expansion Grant is different than under the Section 223 CCBHC Demonstration. Under the demonstration, the CCBHC is required to be clinically and financially responsible for services furnished by the DCO, and the relationship is typically structured as a contractual purchase of the applicable CCBHC service rendered to all clients referred from the CCBHC. Conversely, DCO arrangements of Expansion Grantees should not be structured as a purchase by the CCBHC of all CCBHC services furnished by the DCO.

The SAMHSA FY2023 CCBHC Expansion Grant Funding Announcements provide generally that the grant funds are intended to be used to supplement existing activities and sources of funding, and not "to supplant current funding of existing activities."[53] If a CCBHC contracts to procure the services of a DCO, such that the remuneration from the CCBHC stands in the place of payor payment for which the DCO would otherwise submit claims, then such a procurement relationship could run afoul of the "supplement, not supplant" guidance. This prohibition on supplanting current funding, however, does not prohibit a CCBHC from compensating a DCO for providing CCBHC services to clients who are low income and uninsured; in such a scenario, the compensation is not supplanting current funding because there is otherwise no payor for the underlying CCBHC service being rendered by the DCO.

The CCBHC must structure its DCO Agreement in compliance with the CCBHC's obligations as a federal grantee, under 45 CFR Part 75.

Although this topic is not specifically addressed in the SAMHSA FY2023 CCBHC Expansion Grant Funding Announcements, it is generally understood that a CCBHC/DCO relationship under the Expansion Grant would align with one of the following three models:

- The CCBHC compensates that DCO for CCBHC services rendered to CCBHC clients who are low income and uninsured, thereby not supplanting current funding.
- The CCBHC provides the DCO (i.e., the subrecipient) with a subaward of the CCBHC Expansion Grant funding to cover allowable costs associated with the DCO's provision of CCBHC services to CCBHC clients.

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51 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 4.a.3.

52 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 3.b.5.

53 SAMHSA, FY2023 CCBHC Planning, Development, and Implementation (PDI) Grant NOFO, page 76.

- The DCO provides CCBHC services to CCBHC clients without compensation or a subaward of CCBHC Expansion Grant funding.

Under each model, the terms of the DCO Agreement should reflect the expectation that a DCO relationship include more regular, intensive collaboration between the organizations than would take place with care coordination partners.

Grantees have different obligations with respect to third parties involved in carrying out a grant award, depending on whether those third parties are characterized as vendors or subrecipients (or neither).

A subrecipient is a nonfederal entity that receives a subaward from a "pass-through entity" (i.e., the prime grantee).[54] The prime grantee delegates responsibility to subrecipients to carry out some portion of the grant project. A vendor, or contractor, however, is an entity from which a grant recipient procures items or services and is not viewed as directly carrying out or being bound by the terms of award of a grant.[55]

The SAMHSA CCBHC Expansion Grant Funding Announcement does not specify whether DCOs should be considered vendors or subrecipients. **Grantees should consult their SAMHSA project officer on any questions about the nature of the DCO relationship. In addition, grantees should refer to their CCBHC Expansion Grant applications to ensure that the DCO Agreement conforms to the description in the application.**

Key features of **subrecipients** are the following:

- They determine who is eligible to receive what federal assistance.
- They have their performance measured in relation to whether objectives of a federal program are met.
- They have responsibility for programmatic decision-making.
- They are responsible for adherence to applicable federal program requirements.
- They, in accordance with their agreement with the grantee, use federal funds to carry out a program for a public purpose.

Key features of **vendors** or **contractors** are the following:

- They provide goods and services within normal business operations.
- They provide similar goods or services to many different purchasers.
- They normally operate in a competitive environment.
- They provide goods or services that are ancillary to the operation of the federal program.
- They are not subject to compliance requirements of the federal grant program as a result of the agreement with the grantee.

Whether a given CCBHC Expansion Grantee's DCO is a vendor or a subrecipient may depend in large part on how the CCBHC Expansion Grantee has structured the DCO's obligations in the agreement – as well as how the DCO's role was described in the grant application. A key area of DCO obligation for this purpose is the CCBHC's financing of the discounts offered by the DCO on services furnished by the DCO to low-income, uninsured clients, or payment by the CCBHC to the

[54] 45 C.F.R. § 75.2.

[55] 45 C.F.R. § 75.351(a), (b).

DCO for services provided to such individuals. If the DCO is simply furnishing such services as directed by the CCBHC, then the DCO arrangement would more likely resemble a purchase of services and the DCO, a "vendor." If the DCO is a vendor, then the CCBHC must ensure that the procurement of the DCO's services is consistent with the federal grant management regulations. For example, the CCBHC must have established written procurement policies and procedures for awarding and monitoring vendor contracts.[56] To the extent the DCO Agreement includes the purchase of clinical services (such as services rendered to low-income, uninsured individuals), the consideration paid by the CCBHC to the DCO should reflect an objective estimation of fair market value (FMV).[57]

However, if the CCBHC vests more discretion in the DCO (e.g., if the agreement charges the DCO with screening individuals for eligibility for sliding fee discounts or allows the DCO to establish and implement its own schedule of discounts rather than use the CCBHC's schedule of discounts), this would suggest a degree of programmatic autonomy more on the part of the DCO, consistent with a subrecipient designation, and the funds conveyed by the CCBHC to the DCO would be viewed as a pass-through of federal grant dollars. To the extent that the DCO functions as a subrecipient under the DCO Agreement, the CCBHC and DCO must ensure compliance with all subawards requirements in the Funding Announcement. CCBHCs were required to list subrecipients (as well as budgets associated with each subrecipient) in their FY2023 CCBHC Expansion Grant applications, and subrecipients are independently required to meet numerous requirements relating to the federal award.

Applicants for the CCBHC Expansion Grant were required to include in their grant applications letters of commitment from DCOs.

[56] SAMHSA, FY2023 CCBHC Planning, Development, and Implementation (PDI) Grant NOFO, page 83.

[57] The CCBHC should document in its files the basis for its FMV analysis.

DCO Agreement Checklist

If the DCO Agreement involves remuneration paid by the CCBHC to the DCO, does the agreement specify whether the DCO is to be treated as a vendor or as a subrecipient under the CCBHC Expansion Grant?

- ☐ If DCO is vendor for purposes of certain services, does the contract set forth compensation to the DCO at FMV for a defined scope of services?
  - » Has the CCBHC otherwise ensured that the procurement meets the standards described in 45 CFR §§75.326-75.335?
- ☐ If DCO is subrecipient for purposes of certain services, does the DCO Agreement meet all relevant requirements stated in the CCBHC Expansion Grant Notice of Funding Opportunity?
  - » Has the CCBHC otherwise ensured that the subrecipient relationship meets the standards described in 45 CFR §§ 75.351 - 75.353?

Does the agreement specify how the DCO will be tasked with administering discounts for services furnished to low-income, uninsured CCBHC clients?

- ☐ Will the CCBHC's sliding fee discount schedule be used by the DCO, or is the DCO vested with discretion to use its own schedule of discounts?
- ☐ Will the CCBHC compensate the DCO fully for such services, or will the CCBHC merely subsidize the application of discounts for uninsured, low-income clients?

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

- ☐ Specify all of the services to be provided on behalf 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 clients 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 that clients retain the freedom to see whichever provider they choose)?
- ☐ Require the DCO to furnish services consistent with the CCBHC's applicable health care and personnel policies, procedures, standards and protocols?
- ☐ Require the DCO and its personnel to cooperate in CCBHC's clinical quality and compliance activities?

Does the agreement contain provisions related to care coordination between the CCBHC and DCO, such as terms that:

- ☐ Provide that DCO and CCBHC will seek to improve care coordination using HIT systems including electronic health records, practice management systems and billing systems?

  (CCBHCs and DCOs are encouraged to include provisions specifically detailing how HIT systems will be used to support integrated evaluation planning, treatment and care coordination, such as by requiring the integration of clinically relevant treatment records generated by the DCO for CCBHC clients and making clinically relevant treatment records generated by the CCBHC available to DCOs.)

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

- ☐ 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?
- ☐ Require the DCO to retain and provide access to such records and reports?

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

- ☐ Prohibit disclosure of any business, financial or other proprietary information, which is directly or indirectly related to the CCBHC and obtained as a result of services performed under the agreement, unless the CCBHC gives prior written authorization for the disclosure or the disclosure is required by law (consistent with all applicable state and federal laws and regulations, as well as the CCBHC's policies, regarding the use and disclosure of confidential and proprietary information)?
- ☐ Prohibit the unauthorized use or disclosure of clients' 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 client information?
- ☐ Ensure that, where required, each entity obtains the consent of people receiving CCBHC services before protected health information is shared between the two entities?

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:
  - » The satisfaction of the CCBHC with the DCO's performance of services?
  - » The availability of grant funds, as applicable?
  - » 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:
  - » Materially breaches any of the agreement's terms and conditions?
  - » Loses its license or other certifications necessary to perform services under the agreement?
  - » Fails to maintain insurance?
  - » 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:
  - » Is dissatisfied with the DCO's performance?

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 SAMHSA CCBHC Certification Criteria and Appendix M (CCBHC Criteria Compliance Checklist) of the SAMHSA FY2023 CCBHC Expansion Grant Funding Announcement?
- ☐ Provide for penalties for failure to comply with applicable state and federal laws and guidance, including but not limited to Appendix M of the Funding Announcement?

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?
- ☐ Provide for adequate indemnification of the CCBHC should the DCO fail to comply with applicable laws or standards?

Sample DCO Agreement

This sample DCO Agreement is between a fictional CCBHC, Behavioral Health Clinic, *and a fictional DCO called* DCO *for the DCO's provision of psychiatric rehabilitation services in furtherance of the CCHBC's SAMHSA Expansion Grant. Note that this sample DCO Agreement is not a template. Certain provisions set forth are not required under the SAMHSA Expansion Grant; they are provided as an example. This sample agreement is designed as a template for CCBHCs engaging their DCOs as a vendor rather than as a subrecipient.*

Each DCO Agreement must be drafted to reflect the unique characteristics of each DCO relationship, must align with the CCBHC's representations made in its SAMHSA Expansion Grant application (inclusive of the budget) and must comply with applicable federal and state laws. All questions regarding SAMHSA requirements for the DCO relationship should be directed to SAMHSA.

In addition, before executing a DCO Agreement, the CCBHC and DCO should collaboratively review the Funding Announcement (in particular, Appendix M) to ensure that the parties jointly satisfy the relevant requirements. The parties' respective obligations to satisfy the aforementioned requirements applicable to the DCO relationship should be set forth in the DCO Agreement. CCBHCs are encouraged to consult legal counsel for the purposes of drafting the DCO Agreement.

This DESIGNATED COLLABORATING ORGANIZATION AGREEMENT ("the Agreement") is entered into as of the _____ day of _____, 20____, 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 receives a Certified Community Behavioral Health Clinic ("CCBHC") Expansion Grant from the Substance Abuse and Mental Health Services Administration ("SAMHSA") within the Department of Health and Human Services ("HHS") (hereinafter, the "CCBHC Expansion Grant");

WHEREAS, DCO is a _____ organized and existing under the laws of the State of _____;

WHEREAS, DCO 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 the terms and conditions of its CCBHC Expansion Grant;

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

WHEREAS, Behavioral Health Clinic seeks to provide, psychiatric rehabilitation services in furtherance of Behavioral Health Clinic's CCBHC Expansion Grant;

WHEREAS, in recognition of DCO's limited resources and its commitment to furnish psychiatric rehabilitation services regardless of a client's ability to pay, Behavioral Health Clinic has agreed to compensate DCO for DCO's provision of psychiatric rehabilitation services to eligible CCBHC clients who are uninsured, as set forth herein; and

Note: *There is no requirement that a payment relationship exist between CCBHC Expansion Grantees and DCOs. This recital is included as an example in the event the DCO Agreement involves a purchase of services.*

WHEREAS, Behavioral Health Clinic, as the CCBHC, will coordinate care provided by DCO pursuant to this Agreement;

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. DCO shall provide psychiatric rehabilitation services, as set forth in Exhibit A, attached hereto and incorporated by reference herein (collectively the "psychiatric rehabilitation services") to individuals referred to DCO from CCBHC (the "Clients").

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

1.2 Person- and Family-Centered Care. DCO shall furnish psychiatric rehabilitation services and coordinate care with Behavioral Health Clinic in a manner consistent with person- and family-centered and recovery-oriented care, being respectful of the individual client's needs, preferences, and values, and ensuring both client 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. DCO shall update the Behavioral Health Clinic when changes in the client's status, responses to treatment or goal achievement occur that require an update to the client's treatment plan.

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

Note: *The Funding Announcement sets forth that the services provided by DCOs must meet the same quality standards as those required of the CCBHC.*

1.4 Availability of Services. DCO shall ensure that Clients will not be denied psychiatric rehabilitation services because of their inability to pay for such services. For individuals who live in CCBHC's service area but do not live close to DCO service sites, DCO shall, to the extent practical, use telehealth and other technologies to assist in the provision of services.

Note: *The CCBHC may wish to include greater detail regarding the DCO's adoption and application of policies and procedures applicable to a sliding fee schedule, as described in the Funding Announcement (i.e., policies or procedures that ensure [1] provision of services regardless of ability to pay; [2] waiver or reduction of fees for those unable to pay; [3] equitable use of a sliding fee discount schedule that conforms to the requirements in the Criteria; and [4] provision of information to clients related to the sliding fee discount schedule, available on the website, posted in the waiting room and provided in a format that ensures meaningful access to the information).*

1.5 Diagnostic and Treatment Planning Evaluation. Prior to DCO's provision of psychiatric rehabilitation services to Clients, Behavioral Health Clinic shall ensure that DCO has access to the applicable Client's comprehensive person- and family-centered diagnostic and treatment planning evaluation, subject to confidentiality requirements described further in Section 12. DCO shall furnish psychiatric rehabilitation services in accordance with such Client's comprehensive person- and family-centered diagnostic and treatment planning evaluation.

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

1.7 Data Tracking. On regular intervals, but at least monthly, DCO 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.

Note: *The CCBHC may opt to expand on the specific information that the DCO must report to the CCBHC pursuant to the agreement. Note that the Funding Announcement sets forth that the CCBHC must have the ability for, at a minimum, all Medicaid enrollees to collect, track and report data and quality metrics, as required by the statute and criteria, and must maintain formal arrangements with the DCOs to obtain access to data needed to fulfill their reporting obligations.*

SECTION 2. DCO REQUIREMENTS.

2.1 DCO represents that it has at least two (2) years' experience providing psychiatric rehabilitation services and complies with all applicable local (city, county) and state licensing, accreditation, and certification requirements. DCO shall maintain and, upon Behavioral Health Clinic's request, provide Behavioral Health Clinic with official documents reflecting that the DCO satisfies the aforementioned requirements. Official documentation shall include a copy of DCO's license, accreditation and certification; documentation of accreditation will not be accepted in lieu of a license.

Note: *For tribes and tribal organizations only, the "official documentation" previously noted may include documentation from the tribe or other tribal governmental unit establishing that licensing, accreditation and certification requirements do not exist.*

2.2 DCO represents that, during the term of this Agreement, the 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 is expected to have specific 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 DCOs, depending on their licensure/certification.*

2.2.5 Render services in accordance with Clients' diagnostic and treatment planning evaluation;

2.2.6 Collaborate with Behavioral Health Clinic on care coordination activities to ensure optimal access to care for each Client.

2.3 DCO attests that neither DCO nor any of its employed or contracted clinicians providing psychiatric rehabilitation services pursuant to this Agreement is 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; or (2) is currently excluded, debarred or otherwise ineligible to participate in the federal health care programs as defined in 42 U.S.C. § 1320a- 7b(f) (the "Federal Health Care Programs"). On a monthly basis, DCO shall perform a check of DCO and each clinician providing psychiatric rehabilitation services pursuant to this Agreement against the SAM Exclusion Database and the Office of Inspector General's ("OIG's") Exclusion Database. If DCO becomes excluded, this Agreement shall terminate automatically. If a clinician becomes excluded, that clinician shall immediately be removed from providing psychiatric rehabilitation services pursuant to this Agreement.

SECTION 3. LINGUISTIC AND CULTURAL COMPETENCE; TRAINING

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

3.2 DCO shall provide interpretation/translation service(s) that are appropriate and timely for the size/needs of the LEP Behavioral Health Clinic Client population (e.g., bilingual providers, onsite interpreters, language telephone line).

3.3 DCO shall ensure that documents or messages vital to a client's ability to access psychiatric rehabilitation services (e.g., registration forms, sliding scale fee discount schedule, after-hours coverage, signage) are available for Clients in languages common in the community served, taking account of literacy levels and the need for alternative formats (for clients with disabilities). Such materials shall be provided in a timely manner at intake.

3.4 DCO shall ensure that all staff and clinicians furnishing services pursuant to this Agreement comply with all Behavioral Health Clinic's training requirements, as applicable, in accordance with the terms of Behavioral Health Clinic's CCBHC Expansion Grant.

SECTION 4. INDEMNIFICATION.

Note: *The CCBHC may wish to include an indemnification provision.*

SECTION 5. BILLING AND COMPENSATION.

Note: *There is no requirement that a payment relationship exist between CCBHC Expansion Grantees and DCOs. If the DCO relationship includes that the CCBHC will compensate the DCO for its provision of DCO services, the DCO Agreement should set forth such compensation amount and methodology, including a description of the invoicing process. The applicable terms must align with the representations set forth in the CCBHC's SAMHSA Expansion Grant application and budget and must otherwise comply with applicable state and federal law, including but not limited to the federal Anti-Kickback Statute.*

In this sample agreement, the CCBHC will exclusively compensate the DCO for psychiatric rehabilitation services furnished to uninsured clients at and below 250% of the federal poverty level. Note that this is just an example. This description must be modified to reflect the Parties' particular collaborative relationship and must be in alignment with the scope of activities proposed in the CCBHC's Expansion Grant application.

5.1 DCO shall be responsible for billing and collecting for its provision of psychiatric rehabilitation services to Clients in accordance with DCO's policies and procedures applicable to fees, discounts and collections, regardless of the individual's ability to pay, payor source, insurance status or place of residence, with the understanding that psychiatric rehabilitation services cannot be refused because of inability to pay. DCO has specifically agreed to waive all fees for psychiatric rehabilitation services furnished to uninsured Clients with incomes at or below two hundred fifty percent (250%) of the federal poverty level.

5.2 Consistent with CCBHC's Expansion Grant, CCBHC has agreed to compensate DCO for DCO's provision of psychiatric rehabilitation services to uninsured Clients with incomes at or below two hundred fifty percent (250%) of the federal poverty level. The fees for such psychiatric rehabilitation services shall equal DCO's fee schedule, attached hereto as Exhibit B and incorporated by reference herein. DCO agrees to accept such compensation as payment in full for the Psychiatric Rehabilitation Services.

5.3 DCO shall provide the Behavioral Health Clinic with an invoice for psychiatric rehabilitation services rendered to uninsured Clients pursuant to this Agreement by the 15th of each month in accordance with the terms of Exhibit C.

Note: *The body of the agreement or an exhibit should set forth the invoicing methodology.*

5.4 All payments to DCO specified in this Agreement have been determined through good-faith and arm's-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.

5.5 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 clients 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.

SECTION 6. INSURANCE OBLIGATION.

Note: *The Parties should include provisions that address mandatory insurance coverage, including workers' 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 DCO include the Behavioral Health Clinic as a named insured on DCO's professional liability insurance policy.*

SECTION 7. ASSURANCE OF CLIENT 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 clients to any and all provider(s) that best meet the clinical needs of clients.

7.2 The Parties acknowledge that all clients have the freedom to choose (and/or request referral to) any provider of services, and the Parties will advise clients 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 DCO Agreement, particularly if the CCBHC compensates the DCO.*

8.1 DCO agrees to permit Behavioral Health Clinic to evaluate, through inspection or other means, the quality, appropriateness and timeliness of services delivered under this Agreement.

Note: *Sections 8.2 through 8.4 apply to contracts paid for with HHS grant funds and should be struck if irrelevant to the particular DCO relationship.*

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 DCO 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 DCO personnel for the purpose of interview and discussion related to such documents. DCO 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, DCO 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.

Note: *The CCBHC may opt to set forth that the DCO shall indemnify and hold harmless Behavioral Health Clinic for any liability associated with audits that result from the DCO's (or its employees', agents' or subcontractors') acts or omissions.*

8.5 In accordance with Section 4, DCO shall indemnify and hold harmless Behavioral Health Clinic for any liability associated with audits that result from the DCO's, or DCO's employees, agents or subcontractors, acts or omissions.

8.6 DCO and Behavioral Health Clinic shall seek to improve care coordination for Clients using health information systems including, but not limited to, electronic health records, practice management systems and billing systems.

Note: *The Funding Announcement provides that the CCBHC must have a plan inplace to improve care coordination between the CCBHC and DCOs using HIT. The plan should include how the CCBHC can support electronic health information exchange to improve care transitions to and from the CCBHC using the HIT system they have or are developing related to transitions of care. The CCBHC may accordingly wish to include a provision describing the data elements that the DCO must submit to the CCBHC, as are necessary to comply with requirements for reporting related to the SAMHSA Uniform Reporting System (URS). In addition,*

the CCBHC may wish to include additional detail concerning the technology requirements associated with information sharing and/or to include a provision establishing that the Parties will work toward making their EHR systems interoperable.

SECTION 9. COMPLIANCE WITH APPLICABLE LAW.

DCO 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.

SECTION 10. TERM.

Note: *As an alternative to the following, the Parties may wish to include a finite term (e.g., the project period for the SAMHSA CCBHC Expansion Grant), without automatic renewal. Regardless of whether the term allows for automatic renewals, the term of the DCO Agreement should be at least one (1) 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 indicating such Party's desire not to renew 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, SAMHSA, 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 Termination of, or a material reduction in, Behavioral Health Clinic's CCBHC Expansion Grant.
>
> 11.3.3 The loss of either Party's required insurance, as set forth in Section 6.
>
> 11.3.4 The loss or suspension of any license or other authorization to do business necessary for either Party to perform services under this Agreement.
>
> 11.3.5 Either Party becomes an Excluded Entity/Individual, as set forth in Section 2.3.

SECTION 12. CONFIDENTIALITY OF CLIENT HEALTH INFORMATION.

Note: *The Parties may wish to expand this section to include more detail regarding client confidentiality expectations and/or to address confidentiality requirements applicable to their respective business and proprietary information exchanged pursuant to this Agreement. Further, the Parties may wish to expand this section to include protocols relating to the protection of clients' privacy rights relevant to the Parties' use of HIT to share clinically relevant treatment records and information pursuant to Section 8.6.*

12.1 Behavioral Health Clinic shall ensure that Clients' 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. DCO agrees to furnish psychiatric rehabilitation services to Clients in accordance with such documented Client preferences.

12.2 DCO shall ensure that it and its employed and contracted clinicians maintain the privacy and confidentiality of all information regarding the personal facts and circumstances of the Clients 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"]) and 45 CFR Part 2.

12.3 DCO shall ensure that its employees, agents, contractors and other representatives who have access to the Clients' 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: _____

_____

[Insert the recipient's name and address (include e-mail and fax number number if included as an acceptable form for notice, as specified previously)]

If to DCO: _____

_____

[Insert the recipient's name and address (include e-mail and fax number number if included as an acceptable form for notice, as specified previously)]

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 Party 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, mediation 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 Clients). Any dispute that has failed to be resolved by informal discussions between the Parties within a reasonable period 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 are 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 they possess 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	**DCO**
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

SAMHSA has awarded CCBHC Expansion Grants to providers that demonstrate (in the case of CCBHC-IA grants) or are making progress toward (in the case of CCBHC-PDI grants) compliance with CCBHC program requirements. The goal of both the grant program and the demonstration program is to furnish comprehensive, person-centered behavioral health services. Although grantees under the CCBHC Expansion Grant program use grant funds to fulfill the CCBHC program requirements, grantees are not eligible for the unique CCBHC Medicaid payment methodology that applies to the demonstration participants.

What Is a CCBHC?

A CCBHC serves as a hub for comprehensive safety-net behavioral health services for its clients. Please review SAMHSA's CCBHC Certification Criteria and the Notice of Funding Opportunity relevant to your organization's CCBHC Expansion Grant application for detail on program requirements. Two of CCBHCs' main functions are the following:

- CCBHCs provide a comprehensive array of services. Each provider organization certified as a CCBHC must demonstrate that it can (on its own and through DCO arrangements, if it so chooses) furnish the full set of required CCBHC services. For CCBHC Expansion Grantees, those services are:
  - 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.
  - Screening for HIV and viral hepatitis (A, B and C).
  - 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 function as a true safety-net behavioral health provider. To make their required services available and accessible to all clients, CCBHCs must:
  - Not refuse services to any client, 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 clients.
  - Provide each CCBHC client 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.

Where Do DCOs Fit In?

SAMHSA guidance associated with the Expansion Grant requires that each CCBHC make the set of CCBHC services available either directly or via formal relationships with other providers. SAMHSA, in conjunction with CMS, has issued guidance about the requirements for a CCBHC to furnish a required service through a relationship with another provider, termed a DCO. CCBHCs are not required to enter into DCO arrangements, but they may do so as a way of making the full array of CCBHC services available to clients.

The basic requirements for the DCO relationship are the following:

1. The CCBHC must ensure (via the DCO Agreement) that the DCO furnishes CCBHC services in a manner such that they are accessible to clients and delivered consistently with all CCBHC requirements, including application of the sliding fee discount schedule to CCBHC clients.
2. Where a CCBHC furnishes some services via a DCO, the CCBHC must ensure that it directly provides at least 51% of total CCBHC encounters (excluding crisis services).

How Can Organizations Interested in Becoming A DCO Prepare?

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

- What is the capacity of your organization to take on additional clients?
- Can your organization implement the clinical and financial requirements of the CCBHC Expansion Grant program, including, but not limited to, application of the sliding fee discount schedule to CCBHC clients and collection of cost-sharing obligations from clients?
- What CCBHC services does your organization offer that a potential CCBHC partner may not be able to provide?
- Does your organization understand the access and availability requirements of CCBHCs, and is your organization able to adopt them (timely access, assessment processes, cost and location)?
- Does your organization have the necessary staff to render the CCBHC service(s) as well as to coordinate and function as integrated members of care teams with the CCBHC?
- What costs are associated with the CCBHC services that your organization would provide?
- What constitutes adequate reimbursement for CCBHC services to ensure your organization's capacity to furnish those services to low-income uninsured clients?
- How will your organization exchange clinically relevant treatment records and other information electronically with a CCBHC?

DCO Questions and Answers

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

   The DCO relationship typically involves a referral element, but it is intended more broadly to ensure that people receiving CCBHC services have a seamless experience when accessing services via the DCO. A DCO is an entity that is not under the direct supervision of the CCBHC Expansion Grantee; however, the DCO is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Under a written agreement, the parties should describe their mutual expectations and establish accountability for services provided and funding sought and used. CCBHCs retain ultimate responsibility for ensuring that all CCBHC services are available and provided according to SAMHSA requirements, even where one or more services are furnished via a DCO.

   CCBHC Expansion Grantees may, through the DCO Agreement, use grant funds to compensate the DCO for discounted CCBHC services that the DCO provides to low-income, uninsured individuals, which otherwise would remain unreimbursed. Thus, the DCO relationship may involve a financial element structured either as a purchase of services or as a subaward of the CCBHC Expansion Grant. Referral agreements, in contrast to contracts, typically do not involve the exchange of financial remuneration.

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

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

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

   A CCBHC Expansion Grantee needs access to wide-ranging data from the DCO to fulfill the clinical and quality reporting requirements of the Expansion Grant, including data about those services furnished via the DCO. A CCBHC's written agreement with the DCO should require the DCO to maintain and timely submit to the CCBHC all required data, such as information on quality reporting and encounter data.

4. **Are DCOs and CCBHCs expected to share clinical information about people who access CCBHC services?**

   Yes. Under the SAMHSA CCBHC Certification Criteria, CCBHCs are required to implement plans to improve care coordination between the CCBHC and DCOs, using a HIT system, with the goal of supporting integrated evaluation planning and treatment. The ultimate goal is for the CCBHCs and DCOs to integrate clinically relevant treatment records generated by each party, incorporating them into the CCBHC health record.

Tips for Negotiating with DCOs

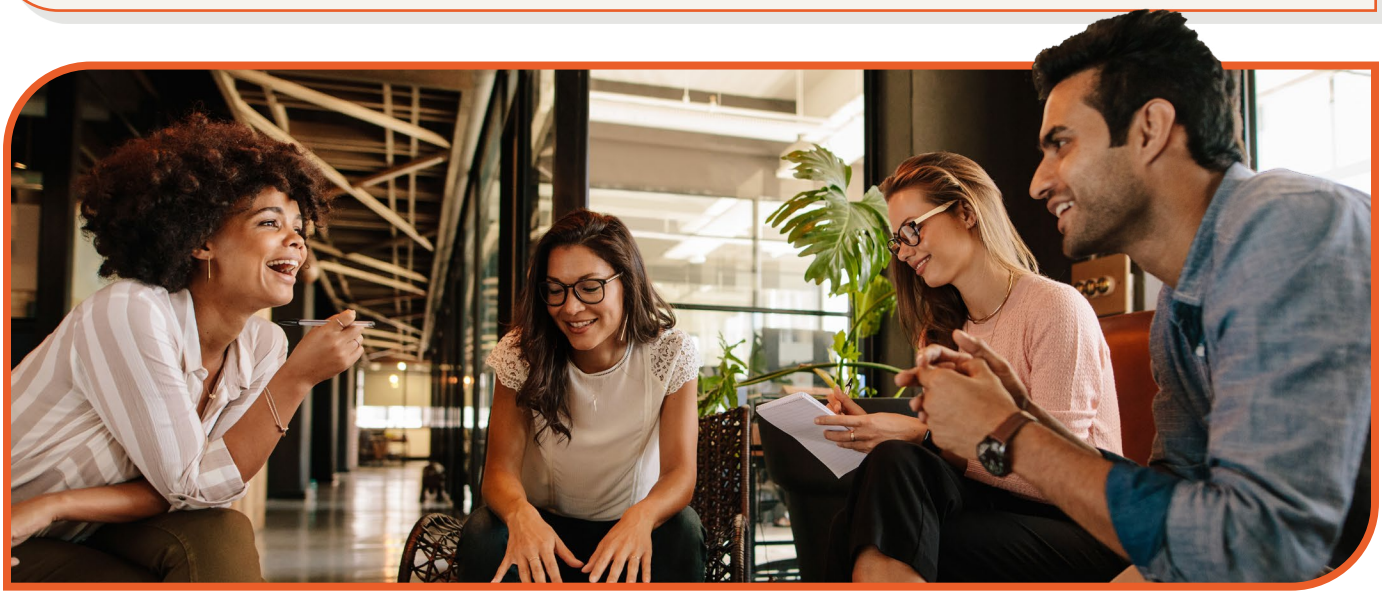
THE PEN STRATEGY: PREPARE, EDUCATE AND NEGOTIATE!

PREPARE

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

Describe the value that an arrangement with the CCBHC Expansion Grantee can provide to a community partner in the DCO role.

- 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 with other organizations?
- With respect to the CCBHC service that the DCO would provide through a potential DCO relationship:
  - Is the service reimbursed by Medicaid or other payors?
  - Is the service otherwise supported by federal, state or local grant funding?
  - Does the DCO incur uncompensated care costs in furnishing the service to uninsured individuals?



Identify and assess potential partners based on your analysis.

- Does the potential DCO currently provide the service for which the CCBHC seeks to enter a DCO relationship? 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 or an Expansion Grant subaward 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.)
- Is the potential DCO otherwise capable of meeting the clinical requirements for carrying out CCBHC services on behalf of the CCBHC (e.g., has cultural and linguistic competency, can meet the requirement that services are provided on a timely basis)?
- Is the potential DCO otherwise capable of meeting the operational requirements for carrying out CCBHC services on behalf of the CCBHC? Examples of capability include sharing clinical and quality data with CCBHC sufficient to enable CCBHC to meet SAMHSA requirements, and collecting client fees and cost-sharing based on requirements in CCBHC's sliding fee discount schedule (if CCBHC seeks to delegate this collection function contractually).

If the DCO arrangement will involve the CCBHC procuring from the DCO services furnished to low-income uninsured individuals, assess FMV of such services.

- For more information on the FMV for DCO contracting, see Determining Fair Market Value.

EDUCATE

Explain to potential DCOs how a potential partnership aligns with each organization's goals and expectations.

Communicate the value of the CCBHC model.

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

Identify and explain requirements unique to CCBHCs.

- For more concise information geared toward potential partners, see the Fact Sheet on DCOs and the Frequently Asked DCO Questions.

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

- Examples:
  - All CCBHC services must be furnished according to the CCBHC Certification Criteria. Therefore, DCOs must be willing to provide services in a manner consistent with the access requirements in the Criteria, including making services available according to a sliding fee discount schedule for uninsured low-income individuals.

Provide draft contracts to potential partners.

- Hint: Establish a point person for the other entity to work with during the contracting process.

NEGOTIATE

Negotiation is discussion aimed at reaching an agreement.

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

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

Instead:

- Respond with questions regarding potential partners' issues rather than uncompromising statements.
- Respond specifically to potential partners' concerns.
- Develop options for mutual gain and generate a variety of possibilities before deciding what to do.
- 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. DCO relationships with CCBHC Expansion Grantees may not necessarily contain a contractual element (i.e., a purchase of services). If the agreement does contain a contractual element, then the CCBHC, as purchaser of the DCO's services, should ensure that payment for the services corresponds to FMV.

This is particularly true in the health care sphere, an industry that is highly regulated with numerous legal rules that address the exchange of money or items of value between health care providers. When a CCBHC furnishes services through a contract with a DCO and the agreement includes a contractual component, the CCBHC **must** document that the consideration paid to the DCO reflects FMV. This is especially important for CCBHC Expansion Grantees since they, as direct recipients of federal grant funds, are bound by the procurement standards in 45 CFR Part 75, Subpart D.

Documentation relating to the calculation of FMV for any services procured from a DCO 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 "maintains responsibility for assuring that people receiving services from the CCBHC receive all nine services as needed in a manner that meets the requirements of the CCBHC certification criteria."[58] 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 or to purchase those services. If the relationship between the CCBHC and the DCO contains a contractual component, it is important that the CCBHC structure the procurement in a manner that is consistent with applicable federal requirements.

[58] SAMHSA, CCBHC Certification Criteria (updated March 2023), page 53.

1. HHS Grant Rules

According to the Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards (45 CFR Part 75), where 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."[59] In determining whether costs are reasonable, Grantees must consider such factors as "sound business practices," "arm's-length bargaining" and "market prices for comparable goods and services for the geographical area."[60]

The main goal of these rules is to ensure that the costs charged to the grant are appropriate and necessary to carry out its objectives. Therefore, in charging to the CCBHC Expansion Grant a potential payment made to a DCO to furnish CCBHC services, it is important that a CCBHC Expansion Grantee ensure the payment reflects no more than the FMV of this type of service in the community.

Please refer to the regulations at 45 CFR §§ 75.326-75.335, or consult legal counsel, to ensure that all contractual procurements meet the regulatory standards and that the CCBHC has documented procurement policies and procedures that follow the standards in the regulations.

2. 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.[61] 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 health care 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 less than FMV, the discount could be interpreted as an inducement to the CCBHC to refer clients to the DCO.[62]

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. [63]

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59 45 CFR § 75.404.

60 45 CFR § 75.404 (b) and (c).

61 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).

62 While the contracted service itself does not constitute a referral service, other services that a CCBHC client accesses at a DCO could function as referral services.

63 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, then 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 FMV. The core concept is that the consideration under the contract must correspond to the market prices in the area for the services being purchased. The key step in determining and documenting FMV is to identify an objective indicator of the services' value.

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 difficult 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.

The following are examples of acceptable measures of FMV:

- Average hourly or annual salary costs for clinicians furnishing the 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 following:

- The potential DCO's average charges for the type of services purchased (based on the DCO's 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 (e.g., 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 the SAMHSA CCBHC Certification Criteria, CCBHCs must maintain a published sliding fee discount schedule(s)[64] that conforms to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics. The sliding fee discount schedule is intended to benefit low-income individuals by offering a tiered set of discounts based on income levels. CCBHCs are required to make the discount schedule available on the website, post it in the waiting room and provide it in a format that ensures meaningful access to the information.[65] More generally, CCBHCs' schedules of fees should be based on locally prevailing rates or charges and should take into account the CCBHCs' reasonable costs of operation.[66]

Under the SAMHSA CCBHC Expansion Grant, CCBHCs must ensure that no individuals are denied CCBHC services due to their inability to pay.[67] Notably, this requirement is separate and distinct from the requirement to implement a schedule of discounts for low-income individuals. Accordingly, CCBHCs are required to reduce or waive fees or payments for CCBHC services if such fee or payment presents a barrier to care.

CCBHCs must establish and maintain written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule.[68] These policies and procedures must be applied consistently to all individuals seeking CCBHC services.

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

- The CCBHC's underlying schedule of fees 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.
- The CCBHC has established a sliding fee discount schedule that is designed to ensure that the CCBHC's clients have access to all CCBHC services. Clients 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.[69]

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64 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 2.d.2.

65 Ibid.

66 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 2.d.3.

67 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 2.d.1.

68 SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 2.d.4.

69 Ibid.

- The CCBHC (and its DCOs, as applicable) will provide clients with information about 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 (LEP) or disabilities. In addition, the sliding fee discount schedule will be posted on the CCBHC website and in the CCBHC waiting room. If a CCBHC service is furnished through a DCO, then the DCO will post the sliding fee discount schedule on its website and in its waiting room.
- All CCBHC clients will have access to a sliding fee discount schedule (if they meet the eligibility criteria for the discounts), regardless of whether services are furnished through the CCBHC or through a DCO.All CCBHC consumers will have access to a sliding fee discount schedule (if they meet the eligibility criteria for the discounts), regardless whether services are furnished through the CCBHC or through a DCO.[70]
- 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) with which 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 client's eligibility to obtain a fee discount under the sliding fee discount schedule.
  - Alternative mechanisms to determine eligibility for the sliding fee discount if clients are 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.

Sliding Fee Discount Schedule Checklist

- ☐ Has the CCBHC's fee schedule been established according to relevant state or federal statutory or administrative requirements, or are the fees based on locally prevailing rates or charges and consistent with the CCBHC's reasonable costs of operation?
- ☐ Is the sliding fee discount schedule posted on the CCBHC's website?
- ☐ Is the sliding fee discount schedule posted in the CCBHC's waiting room?
- ☐ Is the sliding fee discount schedule readily accessible to clients and families?
- ☐ Are the sliding fee discount schedule policies and procedures being equally applied to all individuals seeking services, such as through any new client registration? Is the sliding fee discount schedule communicated in languages/formats appropriate for individuals seeking services who have LEP or disabilities?
- ☐ If the CCBHC furnishes any services through DCOs, has the CCBHC ensured through the agreement that DCOs will make services accessible to low-income, uninsured individuals using a sliding fee discount schedule?

[70] SAMHSA, CCBHC Certification Criteria (updated March 2023), Program Requirement 4.a.4.

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