CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

Contracting And Community Partnerships Toolkit

Section 223 CCBHC Demonstration Participant Edition

UPDATED MAY 2025

NATIONAL COUNCIL for Mental Wellbeing

FELDESMAN

AUTHORS

- **Susannah Vance Gopalan**
  Partner, Feldesman Leifer LLP
- **Carrie Bill Riley**
  Partner, Feldesman Leifer LLP

CONTRIBUTING PROJECT TEAM

- **Rebecca Farley David**
  Sr. Advisor, Public Policy and Special Initiatives, National Council for Mental Wellbeing
- **Samantha Holcombe**
  Sr. Director, Practice Improvement and Consulting, National Council for Mental Wellbeing

DISCLAIMER

This resource was designed to provide accurate and authoritative information on the subject matter covered. While based on the principles of federal law and guidance, this resource does not constitute, and is not a substitute for, legal, financial or other professional advice and does not consider 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 to local requirements and the involved parties' respective goals, objectives and expectations.

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

CONTENTS

INTRODUCTION

About this toolkit

This toolkit offers resources for CCBHCs to meet federal requirements relating to community partnerships with other provider organizations, 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 SAMHSA to provide CCBHC services under similar program requirements (Protecting Access to Medicare Act [PAMA], 2014; SAMHSA, 2023).[1] Additionally, federal law now provides an option for states to operate a CCBHC program under the Medicaid state plan (Consolidated Appropriations Act, 2024). This toolkit addresses the requirements that apply to CCBHC Demonstration participants. It may also be a helpful reference in states that have implemented CCBHCs through a state plan amendment or waiver modeled after the 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 Demonstration sites must consider when forming these relationships.

The basic features and goals of the CCBHC model

In authorizing the Section 223 CCBHC Demonstration program in the Protecting Access to Medicare Act of 2014 (PAMA), 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 accessibility and fully qualified locations" and 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" (160 Cong. Rec. S1852–S1853, 2014).

Congress also wanted to ensure that behavioral health provider organizations would be paid fairly under Medicaid for providing the comprehensive array of CCBHC services. Sen. Blunt stated that the Demonstration project would give community behavioral health organizations "an opportunity to increase the types of services they provide within and to their local communities by providing a similar rate under Medicaid that Federally Qualified [Health] Centers receive for primary care services" (160 Cong. Rec. S1852–S1853, 2014).

These goals are apparent in the core features of the Section 223 CCBHC Demonstration, as set forth in the federal statute and described more fully in CMS and SAMHSA guidance. The guidance is key in defining the operation and goals of both the Section 223 CCBHC Demonstration program and CCBHC Expansion grants. Congress 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 Section 223 CCBHC Demonstration (PAMA, 2014, pp. 1078–1079).

SAMHSA updated its CCBHC Certification Criteria in March 2023, and CMS updated its guidance to states on the development of the CCBHC prospective payment system (PPS) in February 2024. For Section 223 CCBHC Demonstration participants, each participating state certifies organizations as CCBHCs using SAMHSA's criteria.[2]

Each CCBHC must furnish all required CCBHC services to the people it serves

Each CCBHC must be capable of "provision (in a manner reflecting person-centered care)" of all required CCBHC services that, "if not available directly through the [CCBHC], are provided or referred through formal relationships with other providers" (PAMA, 2014, p. 1078).

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 provider organizations working with CCBHCs — referred to in the criteria as DCOs — may furnish some CCBHC services on behalf of the CCBHC, but the CCBHC itself should bear a primary responsibility for service delivery.

Under the current criteria, the CCBHC must directly deliver "the majority (51% or more) of encounters across the required services (excluding crisis services)" (SAMHSA, 2023, p. 26). Any service may be furnished via a DCO, so long as this requirement is met.

Section 223 CCBHC Demonstration participants must provide the following CCBHC services (SAMHSA, 2023):

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization.
- Screening, assessment and diagnosis.
- Patient- and family-centered treatment planning.
- Outpatient mental health and substance use disorder 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 people using CCBHC services.[3]

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

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

- The CCBHC may not refuse services to anyone, regardless of form of coverage or uninsured status, 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 individuals.
- The CCBHC must provide each person receiving services with 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.

The CCBHC bills Medicaid through a PPS methodology

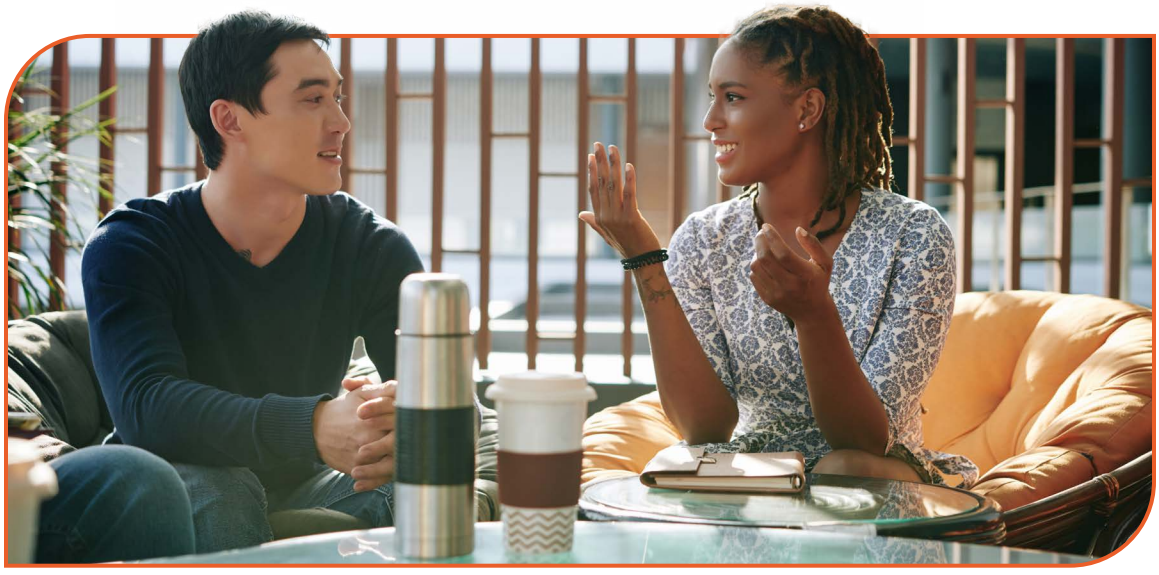
States participating in the Section 223 CCBHC Demonstration are required to implement a PPS for Medicaid payment to CCBHCs (PAMA, 2014). Rather than setting detailed requirements for this methodology, the federal law required CMS to issue guidance to states on development of the CCBHC PPS. CMS issued initial guidance in 2015, updated in February 2024. Under this guidance, payment to each CCBHC under Medicaid is made on a fixed per-unit rate (CMS, 2024a). The rate is unique to each CCBHC, because each clinic's rates are based on its allowable costs per unit of CCBHC service (the "visit" or "unduplicated monthly visit"), as reflected in a cost report covering a base time period.

Each CCBHC's rate per unit of service in Demonstration Year (DY) 1 is equal to its allowable costs per visit in the base period, trended forward by the Medicare Economic Index (CMS, 2024a). Thereafter, in adjusting the PPS rate for subsequent Demonstration years, states have the option to either adjust each year's rate by the Medicare Economic Index or to "rebase" (i.e., set new rates for the subsequent year based on the CCBHC's actual costs, as reported on its cost report). The CMS guidance provides that, at minimum, states are required to rebase the PPS rates for DY3 using DY2 cost and visit data, and that states must rebase the PPS rates at least every three years thereafter (CMS, 2024a).

PPS methodologies are sometimes referred to as cost-related payment methodologies. Because the rate is built from documented costs in a base period trended forward, the provider organization is not guaranteed to recover its costs under a PPS, but payment is nonetheless designed to bear a rational relationship to the provider organization's costs. This stands in contrast to cost-based reimbursement, under which provider organizations are reimbursed retrospectively for all allowable costs documented on a cost report.

Under the CMS guidance, states have considerable discretion to design their PPS methodologies, including choosing among four PPS systems. Under the PPS-1 and PPS-3 methodologies, the qualifying service unit is the daily encounter (CMS, 2024a). The main difference between these two methodologies is that the CCBHC is required to create two PPS rates: 1) a standard daily PPS rate for all CCBHC services except crisis services, and 2) one or more separate daily "special crisis services" PPS rates.[4]

Under the PPS-2 and PPS-4 methodologies, the qualifying service unit is the "unduplicated monthly encounter" (CMS, 2024a).[5] Similar to PPS-1 and PPS-3, the chief difference between PPS-2 and PPS-4 is the requirement under PPS-4 to create two or more separate PPS-4 rates.



The PPS is a "bundled" payment methodology. Each CCBHC receives the same rate for each qualifying unit of service, based on the average allowable cost per service unit to furnish the entire bundle of CCBHC services, regardless of the type or intensity of clinical services provided. The PPS rate for any CCBHC considers the provider organization's direct and indirect costs associated with the provision of CCBHC services. The PPS provides the opportunity for the CCBHC to: 1) include costs related to care coordination activities within its PPS rate, and 2) incorporate costs related to the provision of CCBHC services by DCOs, which would flow through to the DCO.

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: care coordination relationships and DCO 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" (PAMA, 2014, p. 1078).

The CCBHC must conduct care coordination in keeping with the preferences and care needs of the person receiving services. In addition, as appropriate and to the extent possible, a CCBHC should provide care coordination 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 (SAMHSA, 2023).

In the law establishing the Section 223 CCBHC Demonstration, Congress described various types of provider organizations and social service agencies with which CCBHCs are required to undertake care coordination (PAMA, 2014). SAMHSA elaborated on these requirements in its criteria (SAMHSA, 2023).

Many community behavioral health organizations have developed strong ties with other providers and agencies in their communities to ensure that people seeking services 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.

In the law authorizing the Section 223 CCBHC Demonstration, Congress required that CCBHC services be provided either directly or through "formal relationships" (i.e., **DCOs**) (PAMA, 2014).

According to the criteria:

> *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) of the required CCBHC services. 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. The formal relationship between CCBHCs and DCOs creates the platform for seamlessly integrated services delivered across providers under the umbrella of a CCBHC.* (SAMHSA, 2023, p. 53)

Each DCO must meet the same quality standards as the CCBHC and otherwise agree to furnish services in a manner consistent with the applicable CCBHC criteria.

Unique considerations arise with respect to DCO arrangements under the Section 223 Demonstration, in which CCBHC services are paid for under a PPS. Because the PPS rate reflects the clinic's per-unit costs of furnishing those services, the CCBHC's DCO agreements are structured as contractual procurements of services, with the CCBHC's contracting costs built into the PPS rate, and with the CCBHC functioning as billing provider organization for CCBHC services rendered by DCOs to Medicaid beneficiaries. CMS has made clear in guidance that DCOs represent the only mechanism whereby CCBHCs can outsource the provision of CCBHC services to another organization (CMS, 2016).

DCO relationships, unlike care coordination relationships, are not required under the Section 223 CCBHC Demonstration. If a CCBHC can provide all CCBHC services on its own, it does not need to use DCOs. DCOs are simply a mechanism a CCBHC may use to make available a CCBHC service that the clinic does not provide directly (or cannot provide directly in sufficient volume to meet the needs of all people who need the service).

The contents of this toolkit

This toolkit focuses primarily on requirements, as set forth by CMS and SAMHSA, applicable to CCBHCs certified under the Section 223 Demonstration when forming agreements with DCOs and establishing care coordination agreements. It is intended as a resource for community behavioral health organizations pursuing certification as CCBHCs within the Demonstration or for existing CCBHCs seeking to strengthen their compliance with the community partnership requirement, and for other community organizations considering working with CCBHCs as DCOs or care coordination partners.

We hope the toolkit provides useful information for those navigating the transition to CCBHC status, as they seek to negotiate mutually beneficial community partnerships that promote the goals of the CCBHC Demonstration.

DISTINGUISHING DCO RELATIONSHIPS FROM CARE COORDINATION RELATIONSHIPS

Collaboration among provider organizations and safety net organizations is central to Certified Community Behavioral Health Clinic (CCBHC) model. Two distinct types of collaborations are addressed — Designated Collaborating Organizations (DCOs) and care coordination. Understanding the difference between DCOs and care coordination and their associated requirements is critical.

1. Formal relationships with DCOs

According to the Substance Abuse and Mental Health Services Administration (SAMHSA)'s CCBHC Criteria (2023), "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) of the required CCBHC services" (p. 53), with the understanding that the CCBHC must directly deliver "the majority (51% or more) of encounters across the required services (excluding crisis services)" (p. 26). A DCO furnishing services on behalf of the CCBHC agrees to provide care in a manner consistent with CCBHC program criteria. SAMHSA states that "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" (p. 53).

The Centers for Medicare and Medicaid Services (CMS) clarifies how relationships with DCOs are handled under the CCBHC prospective payment system (PPS): "The applicable cost of DCO services is included within the scope of the CCBHC PPS, and these included DCO encounters will be treated as CCBHC encounters for purposes of the PPS" (CMS, 2024a, p. 42).

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 inpatient care, primary care and housing access. These care coordination activities should promote clear and timely communication, deliberate coordination and seamless transition between service settings (SAMHSA, 2023). SAMHSA (2023) notes that "care coordination is regarded as an activity rather than a service" (p. 50).

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" (SAMHSA, 2023, p. 50). CCBHCs must maintain care coordination relationships with various health care and social service entities and agencies. In general, the services provided by the care coordination partner do not fall within the scope of CCBHC services.
Type of Agreement	These are typically structured as a contractual purchase of services agreement; they may be memorialized in a memorandum of understanding (MOU) or memorandum of agreement (MOA).	These are typically 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" (SAMHSA, 2023, p. 20).
Responsibility	The DCO agrees to provide services that meet the same requirements as if services were directly furnished by the CCBHC.	The CCBHC does not assume responsibility for services provided by the care coordination partner. The organizations maintain autonomous operations.
Billing Provider Organization	For CCBHC Demonstration sites, the CCBHC is typically the billing provider organization for CCBHC services provided by the DCO.	Each care coordination partner is the billing provider organization for the services that it furnishes.
Consideration	The CCBHC generally compensates the DCO providing CCBHC services on its behalf.	No consideration (money or anything else of value) is exchanged between the CCBHC and the other entity or social service agency.
Schedule of Fees and Discounts	DCOs generally furnish CCBHC services in accordance with the CCBHC's schedule of fees, schedule of discounts and corresponding written policies and procedures.	The care coordination partner bills people receiving services 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, it need not contract with a DCO.	Care coordination arrangements with other provider organizations in the community are a mandatory component of the Demonstration.

CARE COORDINATION AGREEMENTS

Overview of legal requirements and checklist of recommended terms

Care coordination is central to the CCBHC model, as reflected in the Protecting Access to Medicare Act of 2014 (PAMA), which established the CCBHC Demonstration.

The Agency for Healthcare Research and Quality offers the following definition (2022):

> *Care coordination, a key element for delivery of quality primary care, involves 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 across units or sites of care to provide safe, appropriate and effective care to the patient.*

The SAMHSA CCBHC Criteria (2023) set forth that the CCBHC is specifically charged with coordinating "access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems and employment opportunities as necessary to facilitate wellness and recovery of the whole person. The CCBHC also coordinates with other systems to meet the needs of the people they serve, including criminal and juvenile justice and child welfare" (p. 17).

In coordinating care, provider organizations must keep in mind the person's preferences. In addition, "to the extent possible, care coordination should be provided, as appropriate, in collaboration with the family/caregiver of the person receiving services and other supports identified by the person" (SAMHSA, 2023, p. 17).

The criteria also require the CCBHC to designate an interdisciplinary treatment team that is responsible for directing, coordinating and managing care and services for the person. "The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychiatric, psychosocial, emotional, therapeutic and recovery support needs of the people receiving CCBHC services, including, as appropriate, traditional approaches to care for people receiving services who are American Indian or Alaska Native" (SAMHSA, 2023, p. 24).

As SAMHSA (2023) notes, "Care coordination is regarded as an activity, rather than a service" (p. 50). A patient encounter consisting of care coordination activities alone would typically not trigger payment under CCBHC PPS. However, most clinical, administrative and technology costs associated with care coordination activities will be considered allowable costs on states' CCBHC cost reports.[6]

Care coordination links people receiving CCBHC services 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 care coordination partner must work collaboratively to share information regarding the person's needs and preferences.

SAMHSA (2023) has specified that care coordination "partnerships should be supported by a formal, signed agreement detailing the roles of each party" (p. 20). "Such an agreement is evidenced by a contract, Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU) with the other entity, or by a letter of support, letter of agreement or letter of commitment. The agreement describes the parties' mutual expectations and responsibilities related to care coordination" (p. 49).

"If 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 and roles in care coordination. At a minimum, the CCBHC [must] develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time, so that jointly developed protocols or formal agreements can be developed" (SAMHSA, 2023, p. 20).

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" (SAMHSA, 2023, p. 49). For example, "consistent with requirements of privacy, confidentiality, and preference and need, the CCBHC [must assist] people [who are] referred to external providers or resources in obtaining an appointment and tracking participation in services to ensure coordination and receipt of supports" (SAMHSA, 2023, p. 17).

Under care coordination relationships, unlike the DCO relationships discussed elsewhere in this toolkit, the care coordination partner is not required to comply with the CCBHC Certification 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, and each is accountable only for those services that it directly furnishes. The care coordination partner is responsible for billing and collecting payments from third-party payors and, where appropriate, individuals for the services rendered. There is no exchange of funds or other remuneration between the CCBHC and the care coordination partner. Additionally, nothing about a CCBHC's care coordination agreements should limit a person's freedom to choose their provider.

SCOPE OF CARE COORDINATION: PROVIDERS AND SOCIAL SERVICE ENTITIES

In the spirit of promoting integrated and comprehensive access to services, SAMHSA's 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 such services are not provided directly through the [CCBHC]" (p. 16).
- Inpatient and residential psychiatric facilities, including programs that can provide opioid treatment program services and programs/facilities that provide medical withdrawal management and overdose prevention, including the use of naloxone. (These 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" (p. 16).
- Emergency departments, "inpatient acute care hospitals and hospital outpatient clinics" (p. 16).

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

- "Schools
- "Child welfare agencies
- "Juvenile and criminal justice agencies and facilities (including drug, mental health, veterans and other specialty courts)
- "Indian Health Service youth regional treatment centers
- "State-licensed and nationally accredited child-placing agencies for therapeutic foster care service
- "Other social and human services" (SAMHSA, 2023, p. 21)
- "The 988 Suicide & Crisis Lifeline call center serving the area in which the CCBHC is located" (SAMHSA, 2023, p. 22)

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 needs identified in the community needs assessment" (p. 21–22). (For a comprehensive list of suggestions, see the revised CCBHC Certification Criteria.) Examples include:

- "Specialty providers including those who prescribe medications for treatment of opioid and alcohol use disorders
- "Suicide and crisis hotlines and warmlines
- "Indian Health Service or other tribal programs
- "Homeless shelters
- "Housing agencies
- Employment services systems ...
- "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)" (SAMHSA, 2023, p. 22)

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 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. Generally, CCBHCs should use care coordination arrangements to assist people receiving services and their families by referring them to external providers or resources. CCBHCs are required to identify each client's preferences when facilitating care coordination and assisting people receiving services in obtaining appointments or tracking their participation in referred services or activities (SAMHSA, 2023). CCBHCs should determine the person's preferences in the event of a psychiatric or substance use crisis and, working with them, develop a crisis plan, including counseling the client about "the use of the [988] Suicide & Crisis Lifeline, local hotlines, warmlines, mobile crisis and stabilization services should a crisis arise when providers are not in their office" (SAMHSA, 2023, p. 17–18).

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 they are incorporated within care coordination agreements and protocols.

PRIVACY AND DATA SHARING REQUIREMENTS FOR CARE COORDINATION AGREEMENTS

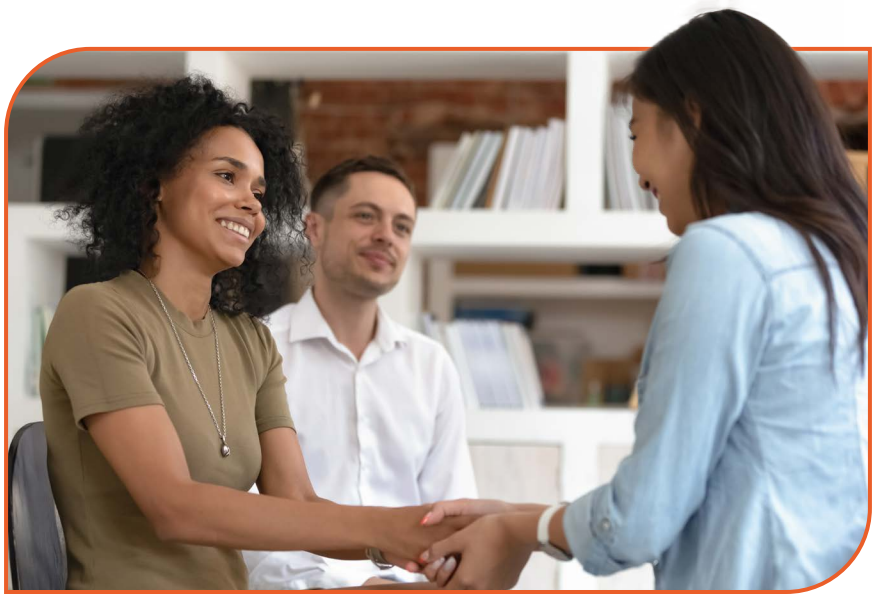
The CCBHC must obtain consent, as necessary, from the people it serves for the release of information to facilitate care coordination, including care coordination activities with other entities. The documentation must satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 CFR Part 2 and other federal and state privacy laws (SAMHSA, 2023). "If the CCBHC is unable, after reasonable attempts, to obtain required consent for any care coordination activity … such attempts must be documented and revisited periodically" (SAMHSA, 2023, p. 17). It is best practice to incorporate policies and procedures related to client consent requirements and data sharing with care coordination partners into care coordination agreements.

To both enhance the experiences of people receiving services from CCBHCs and facilitate care coordination partnerships, CCBHCs must use technology that meets the requirements of the Department of Health and Human Services (HHS) Office of the National Coordinator for Health Information Technology for various health information technology (HIT) capabilities, including to:

- "Capture health information, including demographic information …
- "Support care coordination by sending and receiving summary of care records" to care coordination partners.
- "Provide people receiving services with timely electronic access to view, download or transmit their health information or to access their health information via an API using a personal health app of their choice.
- "Provide evidence-based clinical decision support.
- "Conduct electronic prescribing" (SAMHSA, 2023, p. 19).

SAMHSA recognizes that CCBHCs may not have all these capabilities in place when certified. However, they "should plan to adopt and use technology meeting these requirements over time, consistent with applicable program timeframes" under the CCBHC Demonstration (p. 19).

Additionally, enhanced care coordination expectations apply to CCBHCs' care coordination partnerships with DCOs. In particular, within two years of their certification, CCBHCs are required to develop and implement a plan "to focus on ways to improve care coordination between the CCBHC and all DCOs using a health IT system" (SAMHSA, 2023, p. 20).



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

Precontracting activities (for consideration before executing agreements)

Has the CCBHC:

- ☐ Evaluated whether the other party has sufficient personnel and facility space to serve additional referred 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 needs identified in the community needs assessment?
- ☐ Ascertained individuals' preferences and needs for care and established the care coordination relationship in a manner that aligns with such preferences?
- ☐ Developed a crisis plan with each person receiving services to ascertain in advance their preferences in the event of a psychiatric or substance use crisis, so the crisis plan can be shared with the care coordination partner, subject to the person's consent?
- ☐ Made and documented reasonable attempts to determine any medications prescribed by other providers for people using CCBHC services, 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 help clients (and the families of children and youth, as applicable) obtain an appointment with the care coordination partner and track participation to ensure receipt of services?
- ☐ Discussed with the partnering entity the importance of 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" [SAMHSA, 2023, p. 21].)

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?
- ☐ Include (at the parties' option) references to any applicable jointly developed care coordination protocols?
- ☐ *For care coordination agreements applicable to inpatient psychiatric treatment, opioid treatment program services, medical withdrawal management facilities and ambulatory medical withdrawal management providers for substance use disorders, and residential substance use disorder treatment programs:*
  - » Does the agreement 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?

- Does the agreement attach or otherwise reference protocols and procedures developed by the CCBHC for transitioning individuals to a safe community setting, including "the transfer of health records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety, overdose prevention and provision for peer services" (SAMHSA, 2023, p. 21)?

☐ *For care coordination agreements applicable to inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers and residential crisis settings:*

- Does the agreement 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?
- Does the agreement establish that the CCBHC will "make and document reasonable attempts to contact all people receiving CCBHC services who are discharged from these settings within 24 hours of discharge? For all people receiving CCBHC services being discharged from such facilities who are at risk for suicide or overdose, the care coordination agreement [should include] a requirement to coordinate consent and follow-up services with the person receiving services within 24 hours of discharge, [which shall continue] until the individual is linked to services or assessed to be no longer at risk" (SAMHSA, 2023, p. 23).

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 individuals referred to it by the CCBHC, subject to capacity limitations?

☐ Specify whether the other party will make services available to people regardless of their ability to pay?

> **Please note** *that the criteria do not require that services accessed through a CCBHC 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 for its services?

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

Does the care coordination agreement:

☐ Contain a provision stating each party agrees to comply with any federal or state law governing the privacy and confidentiality of the individually identifiable health information of clients originating with either party?

☐ Specify that the parties will provide treatment planning and care coordination activities, as set forth in the care coordination agreement, in compliance with HIPAA, 42 CFR Part 2 and other applicable federal and state laws, "including patient privacy requirements specific to the care of minors" (SAMHSA, 2023, p. 10)?

- ☐ Specify that the parties will request clients' consent for the disclosure of their health information, if required by state and federal laws and regulations?
- ☐ Specify that the parties will follow clients' preferences for shared consumer health information, consistent with the philosophy of person- and family-centered care?

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 professional judgment?
- ☐ Specify that nothing in the arrangement will, or is intended to, prevent clients served by each party from exercising freedom of choice of provider?

Provisions in the Care Coordination Agreement Relating to 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 and that neither party has offered or received any inducement or other consideration in exchange for entering into the agreement, and that nothing in the agreement requires, is intended to require, or provides payment or benefit of any kind (directly or indirectly) for the referral of individuals or business to either party by the other party?

Sample care coordination agreement

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

The criteria set forth that, "if 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 and roles in care coordination. At a minimum, the CCBHC [must] develop written protocols for supporting coordinated care undertaken by the CCBHC and efforts to deepen the partnership over time so that jointly developed protocols or formal agreements can be developed" (SAMHSA, 2023, p. 20). This sample care coordination agreement contemplates that the parties maintain a joint protocol, in addition to the underlying care coordination agreement. This sample agreement should be adapted to reflect the specific elements of each unique care coordination relationship.

This care coordination agreement (the "Agreement") serves to confirm the mutual understandings of Behavioral Health Clinic, a Certified Community Behavioral Health Clinic ("CCBHC"), and Community Hospital, an acute care hospital, to coordinate inpatient acute care and hospital outpatient services (collectively, the "Services") for those individuals who receive community-based mental health and substance use disorder services from Behavioral Health Clinic, in accordance with the terms set forth below. Behavioral Health Clinic and Community Hospital shall be referred to herein 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. PROVISION OF SERVICES

1. Behavioral Health Clinic is committed to providing integrated and coordinated care across a spectrum of services in a manner that is both person- and family-centered, consistent with Section 2402(a) of the Patient Protection and Affordable Care Act ("ACA"), and with the requirements of the Protecting Access to Medicare Act of 2014 ("PAMA") Section 223 CCBHC Demonstration, as implemented by the Department of Health and Human Services ("HHS").

2. Community Hospital agrees to furnish Services to people referred to Community Hospital by Behavioral Health Clinic, regardless of the individual's ability to pay, payor source, insurance status or place of residence, subject to capacity limitations, as determined at Community Hospital's sole discretion. Community Hospital agrees to promptly inform Behavioral Health Clinic when Community Hospital no longer has capacity to accept additional clients from Behavioral Health Clinic.

> **Note:** *PAMA § 223 does not require that the care coordination agreement include a representation that Community Hospital will furnish services to all CCBHC clients, regardless of their ability to pay. However, we recommend including this provision, if possible.*

II. CARE COORDINATION PROCESSES

1. The Parties will collaborate to conduct treatment planning and care coordination activities in keeping with the preferences of the individual client and their person- and family-centered treatment plan.

2. Behavioral Health Clinic agrees to provide intake, initial screening and appropriate treatment to people presenting at Behavioral Health Clinic for the provision of community-based mental health and substance use disorder services, and to establish and maintain health records for such people. If Behavioral Health Clinic's screening and/or treatment indicate the need for Services, as determined in the sole discretion of the Behavioral Health Clinic provider, consistent with requirements of privacy, confidentiality and personal preference and need, Behavioral Health Clinic will assist such people (and the families of children and youth, as applicable) to obtain an appointment with Community Hospital. Behavioral Health Clinic will track their receipt of Services from Community Hospital, consistent with the Referral and Communication Protocol described in Section II.5.

3. Behavioral Health Clinic will ensure that people's preferences and those of their families, as applicable, for shared information will be adequately documented in the health records, consistent with the philosophy of person- and family-centered care. Behavioral Health Clinic will make reasonable efforts to obtain the necessary consent for release of information.

4. Behavioral Health Clinic and Community Hospital agree to jointly develop a care coordination protocol. Such protocol shall describe: (i) how Behavioral Health Clinic tracks its clients when admitted to, and discharged from, Community Hospital; (ii) how Behavioral Health Clinic and Community Hospital will coordinate the transfer of health records regarding diagnosis, treatment, prescriptions and specific recommendations for appropriate follow-up care; (iii) the process for coordinating Behavioral Health Clinic's active follow-up after discharge; (iv) how timely and orderly referrals will be made; (v) individual preferences and needs for care, to the extent possible in accordance with the person's expressed preferences; and (vii) any other expectations necessary to effectively manage care transitions.

   Note: *The criteria set forth that, for the purposes of care coordination partnerships, the CCBHC "should request of relevant inpatient and outpatient facilities, for people receiving CCBHC services, that notification be provided through the Admission-Discharge Transfer (ADT) system" (SAMHSA, 2023, p. 23). For care coordination agreements applicable to inpatient psychiatric treatment, with ambulatory and medical detoxification, post-detoxification step-down services and residential programs, the care coordination agreement or protocol should address:*

   - *How the CCBHC will track "when people receiving CCBHC services 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" (SAMHSA, 2023, p. 20).*
   - *Procedures for assisting individuals with the transition to a safe community setting, including the "transfer of health records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety, overdose prevention and provision for peer services" (SAMHSA, 2023, p. 21).*

5. 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, which shall continue until the individual is linked to 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).*

6. Behavioral Health Clinic and Community Hospital agree that, to the extent that people receive care from either Party pursuant to this Agreement, such individuals are considered clients or patients of the Party furnishing the services. Accordingly, each Party agrees to be solely responsible for billing and collecting all payments for such services from appropriate third-party payors, funding sources and, as applicable, people receiving services, observing the Party's customary billing, collection and discount/charity care policies.

7. The Parties are implementing this care coordination relationship to enhance continuity of care. As set forth herein, 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.

III. INSURANCE

Note: *The Parties may wish to include a section that sets forth their mutual understandings and obligations related to insurance and liability. PAMA § 223 does not require such provision be in the care coordination agreement. We nonetheless recommend including such representation. As applicable, it is recommended that provisions describing mandated insurance (and indemnification, as applicable) are reviewed and expanded upon with support from counsel.*

Behavioral Health Clinic and Community Hospital represent and warrant that each Party and its clinicians providing Services hereunder are covered by a professional liability insurance policy (malpractice, errors and omissions) in amounts consistent with applicable law.

IV. ASSURANCE OF CONSUMER AND CLINICIAN CHOICE

1. Behavioral Health Clinic and Community Hospital acknowledge and agree that all health and health-related professionals employed by or under contract with either Behavioral Health Clinic or Community Hospital retain sole and complete discretion, subject to any valid restriction(s) imposed by participation in a managed care plan and consistent with Section II above, to refer people to any and all providers who best meet the clients' medical needs.

2. Behavioral Health Clinic and Community Hospital acknowledge that all people have the freedom to choose (and/or request referral to) any provider of services, and Behavioral Health Clinic and Community Hospital will advise people of such right, subject to any valid restriction(s) imposed by participation in a managed care plan.

3. Behavioral Health Clinic and Community Hospital acknowledge and agree that they have freely negotiated the terms of this Agreement and that neither Party has offered or received any inducement or other consideration in exchange for entering into this Agreement. Nothing in this Agreement requires, is intended to require or provides payment or benefit of any kind (directly or indirectly) for the referral of individuals or business to either Party by the other Party.

4. Behavioral Health Clinic and Community Hospital remain separate and independent entities. No provision of this Agreement is intended, nor shall any provision be deemed or construed, to create a relationship between the Parties other than that of independent contractors. Behavioral Health Clinic and Community Hospital retain the authority to contract or affiliate with, or otherwise obtain services from, other parties on either a limited or a general basis.

V. TERM AND TERMINATION

1. The term of this Agreement shall commence on _____, 20_____, and continue until _____, 20_____, unless terminated at an earlier date in accordance with Section V. This Agreement will automatically renew for additional one-year terms unless written notice of intent not to renew is provided by one Party to the other Party no less than 30 days prior to the expiration of the then-current Agreement.

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

2. This Agreement may be terminated in whole or in part at any time upon the mutual agreement of Behavioral Health Clinic and Community Hospital.

3. Either Behavioral Health Clinic or Community Hospital may terminate this Agreement without cause upon 90 days' prior written notice to the other Party.

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

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

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

VI. PRIVACY AND CONFIDENTIALITY OF CONSUMER INFORMATION

1. Behavioral Health Clinic and Community Hospital will coordinate care, as set forth in this Agreement, in a manner that complies with privacy and confidentiality requirements, including but not limited to those of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2 and other applicable federal and state laws, including privacy requirements specific to the care of minors.

SIGNATURE PAGE TO FOLLOW.

Behavioral Health Clinic	**Community Hospital**
Signature: _____	Signature: _____
[Insert Name/Title]	[Insert Name/Title]
Date: _____	Date: _____

DCO ARRANGEMENTS

Overview of legal requirements and checklist of recommended terms

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

PAMA required that CCBHCs provide an array of required services either directly or "through formal relationships with other providers" (p. 1078). SAMHSA's CCBHC Certification Criteria clarify the requirements for the formal relationships 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 DCO. This requirement applies both to participants in the CCBHC Medicaid Demonstration and to CCBHC Expansion grantees.

The DCO concept

According to the criteria, "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 under the same requirements as the CCBHC]. … The formal relationship between CCBHCs and DCOs creates the platform for seamlessly integrated services delivered across providers under the umbrella of a CCBHC" (SAMHSA, 2023, p. 53).

"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" (SAMHSA, 2023, p. 49); the person using CCBHC services should encounter a seamless interface rather than simply accessing services through another provider organization.

CCBHC services provided through a DCO must conform to the relevant 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 one is denied services because of inability to pay.

CCBHC SERVICES AND DCO SCOPE OF SERVICES

Under SAMHSA's current criteria, CCBHCs may delegate to a DCO the provision of any CCBHC service. This represents a change from the prior criteria, which specified that only certain services could be provided by DCO. Nonetheless, the CCBHC must directly provide at least 51% of all CCBHC encounters across all CCBHC services (excluding crisis services).

DCO eligibility

Health care provider organizations may function as a DCO whether they are a nonprofit, for-profit or governmental entity. CCBHCs, on the other hand, must be nonprofit, tribal or governmental entities. Typically, the CCBHC and DCO would be entirely distinct organizations, but in some instances a CCBHC and a DCO may be related entities. For example, the DCO and CCHBC may be separate clinics within a larger nonprofit organization.

CCBHC PAYMENT TO DCOS FOR SERVICES, AND POTENTIAL EXCEPTIONS

Typically, CCBHCs contract with DCOs to procure CCBHC services from the DCOs. As CMS (2024a) notes, "The applicable cost of DCO services is included within the scope of the CCBHC PPS, and these included DCO encounters will be treated as CCBHC encounters for purposes of the PPS" (p. 42). The "applicable cost of DCO services" corresponds to the costs incurred by the CCBHC in purchasing services from the DCO under a contractual model. These costs are included within the PPS to the extent that CCBHC's costs of purchasing CCBHC services from DCOs constitute allowable costs on the cost reports used to develop the CCBHC's PPS rates.

Please note that prior CMS CCBHC guidance expressly noted that, when CCBHCs partner with a state-sanctioned crisis services provider organization as a DCO, the CCBHC would not be required to procure the DCO's services through a formal contract. It is our understanding that this still is the case.

Under the typical DCO contracting model, the CCBHC is responsible for billing third-party payors, including Medicare, Medicaid and private insurers, for services rendered under contract by the DCO. To do so, the CCBHC must obtain adequate records and documentation of services rendered from the DCO. Additionally, according to a model cost report and instructions that CMS has made available for the benefit of Demonstration states, the costs associated with procuring services via DCO would be included as service costs to the CCBHC on its cost report (CMS, 2024b).

Under a DCO contracting relationship, the CCBHC must pay a fee to the DCO for services purchased under the agreement. Note that the consideration paid by the CCBHC to the DCO under the contract should not reflect a "pass-through" of the PPS rate. Instead, the consideration should reflect an objective estimation of fair market value (FMV). Documentation of the FMV basis for the consideration should be retained in the CCBHC's files. The estimation of FMV could be based on salary surveys, fee schedules or the DCO's historic costs to furnish the type of services rendered under the contract. (For more information, see Determining Fair Market Value on Page 46.)

Generally, when purchasing the DCO's service under such an arrangement, the CCBHC:

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

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

KEY TERMS FOR DCO AGREEMENTS

CCBHC Criteria

DCOs, while not under the direct supervision of the CCBHC, are expected to deliver services under the same requirements as the CCBHC (CMS, 2024a).

As one key example, the CCBHC should ensure, through the document governing its relationship with the DCO, that fees and cost-sharing for services rendered by the DCO under the contract are collected and discounts are provided under a sliding fee schedule, as required in the criteria. This can be achieved through a variety of approaches, including contractually delegating collection of fees and cost-sharing at the point of service to the DCO.

For more information on sliding fee discount policy, see CCBHC Fee Schedule and Sliding Fee Discount Schedule on Page 49.

More broadly, the CCBHC must ensure that DCO-furnished services:

- Meet standards set by SAMHSA and/or the CCBHC.
  - For example, the CCBHC must have a staff and DCO training plan in place that addresses person- and family-centered, recovery-oriented, evidence-based, trauma-informed care.
  - CCBHC staff must be "culturally and linguistically trained to serve the needs of the clinic's patient population" (PAMA, 2014, p. 1078).
- Are reflected (where required) in the data reported by the CCBHC to the state or, as applicable, SAMHSA.
- Are rendered within a specified period after the appointment request.
  - For example, established clients "must be provided an appointment within 10 business days of the request for an appointment, unless the state, federal or applicable accreditation standards are more stringent. If a person receiving services presents with an emergency/crisis need, [the DCO must take immediate action] based on the needs of the person receiving services, including immediate crisis response if necessary. If a person already receiving services presents with an urgent, nonemergency need, clinical services … generally [should be] provided within one business day of the time the request is made or at a later time if that is the preference of the person receiving services" (SAMHSA, 2023, p. 13).
- Meet all relevant SAMHSA program requirements applicable to the specific service that is being made available via a DCO.
  - For example, targeted case management services must include the appropriate scope of services for the specific population, as specified by the state, such as "supports for people deemed at high risk of suicide or overdose, particularly during times of transitions such as from a residential treatment, hospital emergency department or psychiatric hospitalization" (SAMHSA, 2023, p. 36).
- Are rendered in keeping with state law (e.g., each clinician is acting within the scope of their license/certification, and applicable supervision requirements are met).

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

These applicable criteria should be incorporated into the body of the DCO agreement.

DCO relationships and HIT

Within two years of CCBHC certification, the CCBHC is required to develop and implement a plan to use an HIT system to improve care coordination with all DCOs. This plan should include "information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system … for transitions of care. 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 them 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" (SAMHSA, 2023, p. 20).

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

Structuring a DCO relationship

Under the Section 223 Demonstration, DCO arrangements are usually structured as contractual procurements of services. A contract is distinguished from other forms of agreement in that there is "consideration" (i.e., payment for services). Under such a contract, the CCBHC typically pays an FMV amount to the DCO in exchange for the provision of CCBHC services. The CCBHC's contractual costs of procuring the services are included as service costs on the CCBHC cost report, and the CCBHC bills the Medicaid program, where appropriate, for DCO-furnished services. The CCBHC in turn serves as provider organization of record and is effectively financially responsible for services furnished by the DCO.

SAMHSA's CCBHC Certification Criteria (2023) indicate some flexibility regarding the expected form of the document memorializing the DCO relationship, noting that the DCO arrangement must be a "formal relationship [that] 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" (p. 53).

It is recommended that organizations seek clarity from their state Medicaid agency as to forms of accepted DCO arrangements (as well as for clarification as to how DCO-related costs will be handled on CCBHC cost reports).

DCO agreement checklist

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

- ☐ Specify the services to be provided to the CCBHC?
- ☐ Provide that all people receiving services from the DCO under the agreement are considered clients 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 people retain the freedom to see whatever provider they choose)?
- ☐ Require the DCO to furnish services consistent with CCBHC's applicable health care and personnel policies, procedures, standards and protocols?
- ☐ Require the DCO and its clinicians to satisfy the CCBHC's professional standards and qualifications, including licensure, credentialing and privileging?
- ☐ Require the DCO and its personnel to cooperate in the CCBHC's clinical quality and compliance activities?

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

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

Where the agreement is structured as a contractual procurement, does the agreement contain provisions related to billing by the CCBHC and payment to the DCO, such as those that:

- ☐ Provide terms and mechanisms for billing and payment, such as invoice procedures and deadlines?
- ☐ Specify in advance the compensation for the services or a fixed methodology by which the compensation will be established?
- ☐ Set the compensation at a commercially reasonable amount that is consistent with FMV and does not vary based on the volume or value of referrals or business generated, directly or indirectly, between the parties?
- ☐ Allow the CCBHC to withhold or deny payment for services rendered in breach of a material term of the agreement, including all statutes, rules, regulations and standards of any governmental authorities and regulatory and accreditation bodies relating to the provision of services?

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

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

  (CCBHCs and DCOs are encouraged to include provisions specifically detailing how they will use HIT systems 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 prepare medical records consistent with the CCBHC's standards?
- ☐ Require the DCO to furnish the CCBHC with programmatic and/or financial reports pertaining to the services provided under the agreement, as deemed necessary by the CCBHC for monitoring, oversight and compliance with reporting requirements imposed by the state or SAMHSA?
- ☐ Require the DCO to retain and provide access to such records and reports?

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

- ☐ Prohibit disclosure of any business, financial or other proprietary information that is directly or indirectly related to the CCBHC and obtained as a result of services performed under the agreement, unless the CCBHC gives prior written authorization for the disclosure or the disclosure is required by law, consistent with all applicable state and federal laws and regulations and CCBHC 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?

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

- ☐ Identify the term of the agreement, which should be at least one year?
- ☐ Provide that any option to renew is conditioned on:
  - » The CCBHC's satisfaction with the 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 HHS Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) and/or applicable state exclusion lists?
- ☐ The CCBHC:
  - » Determines that continuation could jeopardize the health, safety and/or welfare of the CCBHC's clients?

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 arises 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 regularly attest to the CCBHC 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 PAMA § 223 and implementation guidance and all requirements of Medicaid, Medicare or any other applicable federal or state health care programs?
- ☐ Provide penalties for failure to comply with applicable state and federal laws and guidance, including but not limited to PAMA and implementation guidance and all requirements of Medicaid, Medicare or any other applicable federal or state health care programs?

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

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

Sample DCO Agreement

This sample DCO purchase of services agreement is between a fictional CCBHC, "Behavioral Health Clinic," and a fictional entity, "Vendor," for the purchase of psychiatric rehabilitation services under the CCBHC Demonstration. Note that this sample DCO agreement is not a template. Certain provisions set forth below are not required under the Demonstration but are provided as an example. Purchase of services agreements must be drafted to reflect the unique characteristics of each DCO relationship and must satisfy the applicable state's requirements, in addition to federal law. This document should be reviewed in tandem with the summary of DCO requirements (National Council for Mental Wellbeing, 2025). CCBHCs are encouraged to consult legal counsel for 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 "Vendor" will be replaced throughout.]*

WITNESSETH

WHEREAS, Behavioral Health Clinic is a *[insert appropriate description (e.g., nonprofit corporation, governmental entity)]* organized and existing under the laws of the state of [insert state] and is certified as a CCBHC under Medicaid by the state of *[insert state]* pursuant to Protecting Access to Medicare Act of 2014 ("PAMA") Section 223 CCBHC Demonstration, as implemented by the Department of Health and Human Services ("HHS");

WHEREAS, Vendor is a *[insert appropriate description (e.g., nonprofit corporation)]* organized and existing under the laws of the state of *[insert state]* that furnishes psychiatric rehabilitation services;

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

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

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

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

SECTION 1. OVERVIEW.

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

Note: *The body of the agreement or an attached exhibit should set forth the specific DCO services being procured pursuant to the agreement. The description of the DCO services should align with the applicable CCBHC requirements. For example, for purposes of psychiatric rehabilitation services, the description should align with Criteria 4.I: Psychiatric Rehabilitation Services.*

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

1.3 Quality Standards. Vendor represents that its provision of Psychiatric Rehabilitation Services to individuals who receive CCBHC services from Behavioral Health Clinic (hereinafter, the "People") shall meet the same quality standards as equivalent services provided by Behavioral Health Clinic, and shall meet all standards specified by the state of *[insert state]* based upon the needs of the population served.

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

1.5 Billing. Behavioral Health Clinic shall be clinically and financially responsible for Vendor's provision of the Psychiatric Rehabilitation Services. Behavioral Health Clinic shall accordingly be responsible for billing people receiving services and/or third-party payors for all Psychiatric Rehabilitation Services rendered by Vendor hereunder, in accordance with Behavioral Health Clinic's schedule of charges and discounts, and Behavioral Health Clinic shall retain all payments so collected. Except as provided in Paragraph 1.6, Vendor shall not seek reimbursement from people receiving services or from any third-party health care payor, including Medicaid or Medicare, for Psychiatric Rehabilitation Services rendered by Vendor pursuant to this Agreement. Vendor agrees to comply with any reasonable third-party requirements, including but not limited to participation in any credentialing process imposed by a managed care entity, in order for the Behavioral Health Clinic to be eligible to bill for Psychiatric Rehabilitation Services. Vendor shall provide such data necessary, in the appropriate format, to enable Behavioral Health Clinic to bill any third-party health care payor, including Medicaid or Medicare, for Psychiatric Rehabilitation Services. If a third-party payor requires Vendor to bill directly for any Psychiatric Rehabilitation Services that Vendor furnishes on behalf of Behavioral Health Clinic pursuant to this Agreement, Vendor shall assign any payments to Behavioral Health Clinic.

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

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

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

1.9 Data Tracking. At regular intervals, but at least monthly, Vendor shall provide Behavioral Health Clinic with the necessary information in the appropriate form for Behavioral Health Clinic to collect, report and track encounter, outcome and quality data, including but not limited to data that captures: characteristics of people receiving services; staffing; access to Psychiatric Rehabilitation Services; use of Psychiatric Rehabilitation Services; screening, prevention and treatment; care coordination; other processes of care; and individual outcomes.

1.10 Consents. Behavioral Health Clinic shall work with Vendor to ensure all steps are taken, including obtaining consent from people receiving services, to comply with privacy and confidentiality requirements. These include, but are not limited to, those of HIPAA, 42 CFR Part 2 and other federal and state laws, including patient privacy requirements specific to the care of minors.

1.11 Coordinated Care. Behavioral Health Clinic and Vendor shall take steps to reduce the administrative burden on people receiving services and their family members when accessing Psychiatric Rehabilitation Services, through measures such as coordinated intake process, coordinated treatment planning, information sharing and direct communication between Behavioral Health Clinic and Vendor, to prevent the person receiving services or their family from having to relay information between Behavioral Health Clinic and Vendor.

SECTION 2. DCO REQUIREMENTS.

2.1 Vendor shall provide Psychiatric Rehabilitation Services on behalf of Behavioral Health Clinic in accordance with licensure and scope of practice laws in the state of [insert state] and in accordance with generally recognized standards of care.

2.2 Vendor represents that, during the term of this Agreement, Vendor and its clinicians providing Psychiatric Rehabilitation Services pursuant to this Agreement shall:

2.2.1 Be and remain licensed [insert licensure/title, as applicable (e.g., psychiatrist, licensed, addiction counselor, etc.)] legally authorized to furnish Psychiatric Rehabilitation Services [insert description of service] in accordance with federal, state and local laws.

2.2.2 Have expertise in [insert area of focus (e.g., addressing trauma and promoting the recovery of children and adolescents with serious emotional disturbance and adults with serious mental illness and those with substance use disorders)].

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

2.2.3 Act only within the scope of their respective [insert state] license, certifications, credentials or registrations and in accordance with all applicable laws and regulations, including any applicable state Medicaid billing regulations or policies.

2.2.4 Have customary narcotics and controlled substance authorizations.

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

2.2.5 Be and remain eligible to participate in Medicaid, Medicare and any other third-party health care payor with which Behavioral Health Clinic participates.

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

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

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

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

2.2.9 Establish and maintain medical records in accordance with standards prescribed by Behavioral Health Clinic, using Behavioral Health Clinic's electronic medical records system in compliance with Behavioral Health Clinic's privacy and security policies.

2.2.10 Render services in accordance with an individual's diagnostic and treatment planning evaluation.

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

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

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

2.5 Vendor represents that neither Vendor nor its employed or contracted clinicians providing Psychiatric Rehabilitation Services pursuant to this Agreement are an "excluded entity/individual," which is defined for purposes of this Agreement as an individual or entity that: (1) is currently listed on the government-wide Excluded Parties List System in the SAM, in accordance with the Office of Management and Budget guidelines at 2 CFR 180 that implement Executive Orders 12549 and 12689; (2) is currently excluded, debarred or otherwise ineligible

to participate in the federal health care programs as defined in 42 U.S.C. § 1320a-7b(f) (the "Federal Health Care Programs"); (3) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred or otherwise declared ineligible to participate in the Federal Health Care Programs; or (4) is under investigation or otherwise aware of any circumstances which may result in such entity or person being excluded from participation in the Federal Health Care Programs. On a monthly basis, Vendor shall check of the organization and each clinician providing Psychiatric Rehabilitation Services pursuant to this Agreement against the System for Award Management exclusion database, the HHS Office of Inspector General (OIG)'s exclusion database and any other relevant source of information, and provide Behavioral Health Clinic with an updated attestation regarding such information. If the condition described in Clause 4 above applies to any of Vendor's clinicians, Vendor shall, upon Behavioral Health Clinic's request, remove the clinician from providing Psychiatric Rehabilitation Services pursuant to this Agreement until a final determination is made regarding the aforesaid alleged action, event, claim, proceeding or investigation.

SECTION 3. LINGUISTIC AND CULTURAL APPROPRIATENESS; TRAINING.

3.1 If, pursuant to this Agreement, Vendor serves people with LEP or language-based disabilities, Vendor shall take reasonable steps to provide meaningful access to Vendor's Psychiatric Rehabilitation Services.

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

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

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

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

SECTION 4. INDEMNIFICATION.

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

- Acts or omissions by Vendor or its employees, agents and/or subcontractors, including any provider rendering Psychiatric Rehabilitation Services.
- Vendor's breach of any representation, warranty or obligation under this Agreement, including but not limited to failure to comply with applicable laws or standards.

SECTION 5. PAYMENT.

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

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

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

5.3 All payments to Vendor 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.

5.4 Nothing in this Agreement requires, is intended to require or provides payment or benefit of any kind (directly or indirectly) for the referral of individuals or business to either Party by the other Party. Neither Party shall: (1) require its employed and/or contracted professionals to refer individuals to one another (or to any other entity or person); or (2) track referrals for purposes relating to setting the compensation of its employed and/or contracted professionals or influencing their referral choice.

5.5 Behavioral Health Clinic may withhold or deny payment for any Psychiatric Rehabilitation Services furnished by Vendor in material breach of a term of this Agreement or statutes, rules, regulations and standards of any and all governmental authorities and regulatory and accreditation bodies relating to the provision of Psychiatric Rehabilitation Services provided pursuant to this Agreement, including without limitation PAMA and implementation guidance and all requirements of Medicaid, Medicare or any other applicable federal or state health care programs.

SECTION 6. INSURANCE OBLIGATION.

Note: *The Parties should include provisions that address mandatory insurance coverage, including workers' compensation, professional liability and comprehensive general liability. Note that the customary professional liability insurance coverage is at least $1,000,000 per incident and $3,000,000 in the aggregate. It is recommended that the CCBHC consult with its counsel and insurance broker regarding appropriate types of coverage given the nature of the DCO service.*

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

SECTION 7. INDIVIDUAL AND PROVIDER FREEDOM OF 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 individuals to any and all provider(s) who best meet the clinical needs of the individual.

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

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

Note: *The CCBHC may wish to include additional provisions addressing the CCBHC's oversight vis-à-vis the DCO's activities pursuant to the Agreement, particularly if the CCBHC compensates the DCO.*

8.1 Vendor agrees to permit Behavioral Health Clinic, HHS and the state [insert relevant state agencies] to evaluate, through inspection or other means, the quality, appropriateness and timeliness of services delivered under this Agreement.

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

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

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

8.5 Behavioral Health Clinic shall retain exclusive ownership of all information contained in the medical records for the people receiving services pursuant to this Agreement, regardless of whether such data and information is in paper or electronic format.

Note: *Modify the description of health records to reflect the specific transaction. Note that the criteria state that, "to support integrated evaluation planning, treatment and care coordination, the CCBHC [must work] with its DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record. Further, all clinically relevant treatment records maintained by the CCBHC [must be] available to DCOs within the confines of federal and/or state laws governing sharing of health records" (SAMSHA, 2023, p. 20).*

8.6 On a monthly basis, Vendor shall provide Behavioral Health Clinic with all data elements necessary to comply with requirements for reporting related to the SAMHSA Uniform Reporting System.

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

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

SECTION 9. COMPLIANCE WITH APPLICABLE LAW.

Vendor shall comply fully with all applicable statutes, rules, regulations and standards of any and all governmental authorities and regulatory and accreditation bodies relating to the provision of Psychiatric Rehabilitation Services provided pursuant to this Agreement, including without limitation PAMA and implementation guidance and all requirements of Medicaid, Medicare and any other applicable federal or state health care programs.

SECTION 10. TERM.

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

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

SECTION 11. TERMINATION.

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

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

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

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

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

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

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

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

SECTION 12. CONFIDENTIALITY OF HEALTH INFORMATION.

Note: *The Parties may wish to expand this section to include more detail regarding health record 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 a person's privacy rights relevant to the Parties' use of HIT to share clinically relevant treatment records and information.*

12.1 Behavioral Health Clinic shall ensure that the person's preferences, and those of their family, for shared information are adequately documented in clinical records, consistent with the philosophy of person- and family-centered care. Vendor agrees to furnish Psychiatric Rehabilitation Services in accordance with such documented preferences.

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

12.3 Vendor shall ensure that its employed and contracted clinicians furnishing services under this Agreement and any directors, officers, employees, agents and contractors of Vendor who have access to the health information for the people receiving services are aware of and comply with the obligations set forth in 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 email and fax number if included as an acceptable form for notice, as specified above)]

If to Vendor:

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

The foregoing addresses may be changed and/or additional people may be added 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, coventurer, 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 informal dispute resolution and/or binding arbitration.*

Any dispute arising under this Agreement shall first be resolved by informal discussions between the Parties, subject to good-cause exceptions, including but not limited to disputes determined by either Party to require immediate relief (e.g., circumstances under which an extended resolution procedure may result in a violation of law). Any dispute that has failed to be resolved by informal discussions between the Parties within a reasonable period after the commencement of such discussions (not to exceed 30 days, unless the Parties otherwise agree) 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 [insert state].

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 people 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 entity other than the Parties hereto. This Agreement is not intended to create any third-party beneficiary right for any other person or entity.

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 assignees.

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, including the Exhibits, shall be in writing and signed by both Parties.

SECTION 22. HEADINGS AND CONSTRUCTION.

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

SECTION 23. AUTHORITY.

Each signatory to this Agreement represents and warrants that they possess all necessary capacity and authority to act for, sign and bind the respective entity on whose behalf they are 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	**Vendor**
Signature: _____	Signature: _____
[Insert Name/Title]	[Insert Name/Title]
Date: _____	Date: _____

What you need to know about acting as a DCO

In the Protecting Access to Medicare Act of 2014 (PAMA), Congress authorized the Certified Community Behavioral Health Clinic (CCBHC) Demonstration. The Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services (HHS), in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA) within HHS, administer the Demonstration program on the federal side, in partnership with state Medicaid agencies.

WHAT IS A CCBHC?

The CCBHC serves as a hub for comprehensive safety-net behavioral health services for the people in its service area seeking care. States participating in the CCBHC Demonstration "certify" community behavioral health provider organizations within the state which have demonstrated that they can carry out the following functions of a CCBHC during the Demonstration period.

1. CCBHCs provide a comprehensive array of services. Each provider organization certified as a CCBHC must demonstrate that it can (on its own or through Designated Collaborating Organization [DCO] arrangements, if it so chooses) furnish the full set of required CCBHC services, which include:
    - Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization.
    - Screening, assessment and diagnosis, including risk assessment.
    - Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
    - Outpatient mental health and substance use disorder services.
    - Outpatient clinic primary care screening and monitoring of key health indicators and health risks (e.g., BMI, blood pressure, tobacco use, HIV/viral hepatitis).
    - Targeted case management.
    - Psychiatric rehabilitation services.
    - Peer support, counselor services and family supports.
    - Services for members of the armed services and veterans.
2. A CCBHC functions as a true safety net behavioral health provider organization. To make their required services available and accessible to all clients, CCBHCs must:
    - Not refuse services to any person, 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 individuals.
    - Provide each person seeking CCBHC services with a preliminary screening and risk assessment at time of first contact and develop and update a person-centered treatment plan.
    - Provide crisis management services that are accessible 24/7.
3. CCBHCs bill Medicaid through a prospective payment system (PPS) methodology. For CCBHC services provided to Medicaid beneficiaries, the CCBHC bills Medicaid based on a PPS. A PPS methodology includes the following features:
    - Payment is made according to a fixed rate per visit. The details of what types of visits are billable vary by state.
    - The per-visit payment rate is related to the CCBHC's costs of furnishing the full scope of CCBHC services in a base time period, as documented in a cost report and in line with guidance on the details of the CCBHC PPS (CMS, 2024a).

WHERE DO DCOS FIT IN?

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

1. The CCBHC must ensure (through 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. In addition to furnishing the contracted CCBHC services under all the same quality, accessibility and clinical requirements that apply to the CCBHC, the DCO must convey data to the CCBHC to enable the CCBHC to bill Medicaid and other payors for CCBHC services and to fulfill relevant state Medicaid and/or SAMHSA quality reporting requirements.
3. Where CCBHCs furnish some services via a DCO, the CCBHC must ensure that it directly provides at least 51% of total CCBHC encounters (excluding crisis services).
4. The DCO relationship is structured either as a contract providing for payment by the CCBHC to the DCO for the covered services or as a memorandum of agreement (MOA), memorandum of understanding (MOU) or similar instrument indicating the parties' intention for the DCO to furnish CCBHC services that conform to the requirements in SAMHSA's CCBHC Certification Criteria.
5. The CCBHC must ensure, via the instrument memorializing the DCO relationship, that the DCO is held accountable to furnish CCBHC services under the same clinical standards as the CCBHC.
6. Under a contractual DCO arrangement:
    - The CCBHC pays the DCO to furnish CCBHC services to CCBHC clients. The contract must provide for reimbursement at a fair market value (FMV) rate. The consideration paid by the CCBHC to the DCO should not reflect a pass-through of the CCBHC's PPS rate.
    - The CCBHC presents itself to CCBHC clients as the provider of the service rendered by the DCO.
    - The CCBHC bills Medicaid for services furnished via DCOs. The costs to the CCBHC of purchasing services from the DCO are included on the CCBHC's Medicaid cost report. When the DCO renders a CCBHC service that qualifies as a billable CCBHC "visit," the CCBHC bills and receives reimbursement from Medicaid for the visit.

WHAT ARE THE ADVANTAGES OF ACTING AS A DCO?

1. Participating in a collaborative effort to advance access to care: As a DCO, your organization will play a critical role in providing a comprehensive array of behavioral health services for CCBHC clients. You will learn more about the services furnished by the CCBHC in this process, and you may choose to refer the people you routinely serve to the CCBHC for services that your organization does not provide.
2. Getting paid for services that your organization might otherwise provide free of charge: Some of the services included in the CCBHC benefit are not otherwise covered under Medicaid in most states and are not commonly reimbursed by Medicare or third-party payors. Instead, your organization may receive federal, state or local grant funds to defray some of the uncompensated costs of providing these services. By serving as a DCO, your organization will have the opportunity to be reimbursed at FMV for providing these critical behavioral health services.

3. Being reimbursed by one payor (the CCBHC) for the purchased service(s): Because the CCBHC will be responsible for billing various payors for the service(s) furnished via DCO, the DCO's responsibility is only to deliver the service(s) in keeping with the contract and to bill the CCBHC as provided in the contract. The DCO will not be required to meet the requirements of numerous payors beyond furnishing requested information to the CCBHC.

4. The possibility that CCBHC clients who receive CCBHC services via DCO will come to you for other services: As a DCO, your organization will serve CCBHC clients under an agreement with the CCBHC. In the process of receiving CCBHC services, people may learn about other services furnished by your organization and seek other types of care from you.

HOW CAN ORGANIZATIONS INTERESTED IN BECOMING A DCO PREPARE?

In addition to learning more about the requirements of the Section 223 CCBHC Demonstration, potential DCOs may wish to consider the following key questions:

- With what organizations in your service area does your organization collaborate?
- What organizations in your service area are best situated to become CCBHCs, and are any of these organizations current partners?
- How will your organization identify and approach potential CCBHC partners?
- What is your organization's capacity to take on additional clients?
- Can your organization implement the clinical and financial requirements of the Section 223 CCBHC Demonstration, including 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 (e.g., timely access, assessment processes, cost and location), and is your organization able to adopt them?
- Does your organization have the necessary staff capacity 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 you would provide?
- What constitutes adequate payment for CCBHC services to ensure your organization's capacity to serve people who need those services?
- How will your organization electronically exchange clinically relevant treatment records and other information with a CCBHC?

For more information about the Section 223 CCBHC Demonstration program, please consult the CMS website and the SAMHSA website.

DCO questions and answers

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

   The DCO relationship typically involves a referral element, but it is more broadly intended 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 but is engaged in a formal [contractual] relationship with the CCBHC" and delivers services under the same requirements as the CCBHC (SAMHSA, 2023, p. 53). Under a DCO agreement, the parties should describe their mutual expectations and establish accountability for services provided and funding sought and used. Payment for DCO services is included within the scope of the CCBHC PPS per-visit rate.

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

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, on the other hand, is required to be a nonprofit, tribal or governmental entity.

3. **How is a DCO paid for services provided on behalf of the CCBHC?**

   Typically, the CCBHC is responsible for ensuring that DCO-related costs are included in the CCBHC's Medicaid base period cost report, which determines the CCBHC's PPS rate. The CCBHC will pay the DCO a contracted per-visit rate for services provided. The rate should represent FMV for the services purchased (see Page 46).

   Under such a contractual arrangement, it is the CCBHC, rather than the DCO, that bills Medicaid for CCBHC services furnished via a DCO.

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

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

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

   Similarly, to fulfill the clinical and quality reporting requirements imposed by state Medicaid agencies or SAMHSA, CCBHCs will in some instances be required to provide information concerning all CCBHC services, including those furnished via a DCO; therefore, the CCBHC needs access to wide-ranging data from the DCO.

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

Tips for Negotiating with DCOs

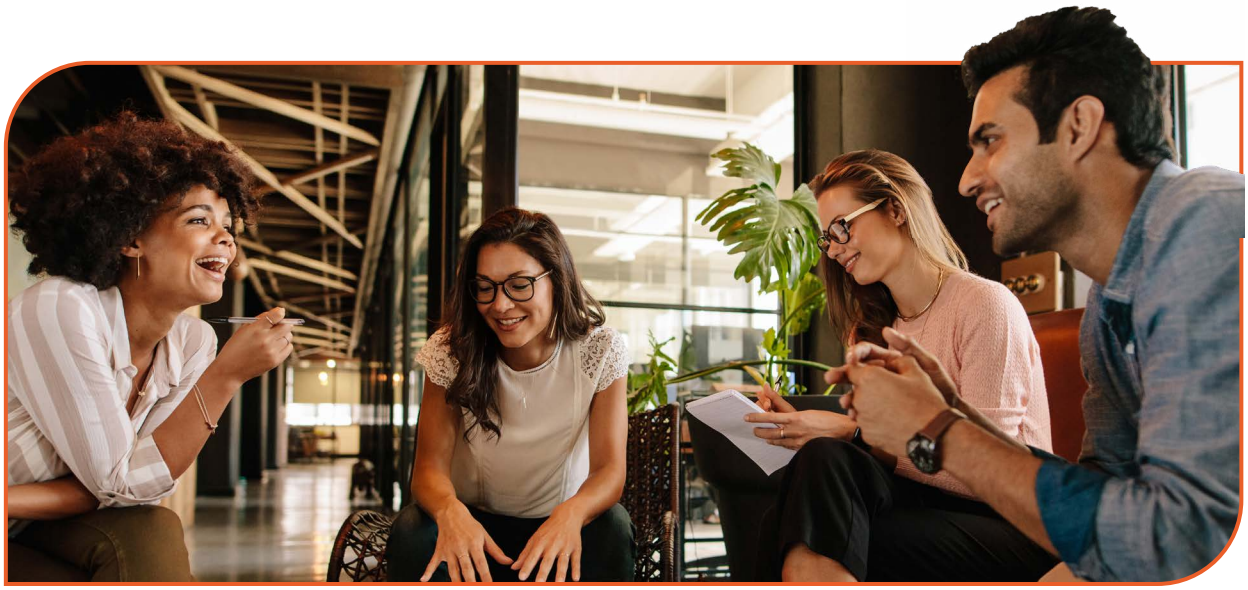
THE P.E.N. STRATEGY: PREPARE, EDUCATE, NEGOTIATE!

PREPARE

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

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

- With respect to the CCBHC, answer the following general questions:
  - What geographic areas does it serve?
  - What organizations furnish similar services in the same geographic area?
  - What organizations furnish services to the Medicaid population in the same area?
  - For each of the CCBHC's services, what percentage of the market does the CCBHC serve compared to other organizations?
- With respect to the CCBHC service that the DCO would provide through a potential DCO relationship:
  - Is the service reimbursed under the Medicaid state plan outside the context of the Section 223 CCBHC Demonstration? If so, what is the reimbursement methodology for the service?
  - Is the service commonly reimbursed by payors other than Medicaid (e.g., Medicare, private health insurers)?
  - Is the service otherwise supported by federal, state or local grant funding?
  - Does the DCO incur uncompensated care costs in furnishing the service to uninsured individuals?



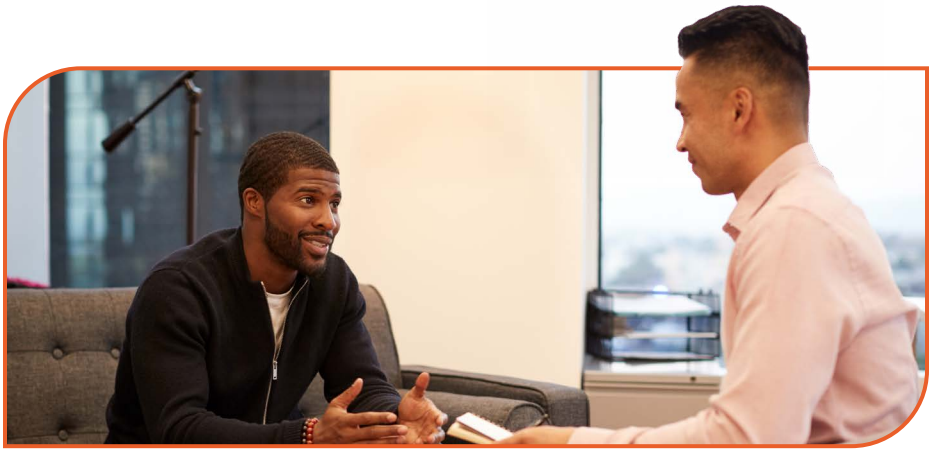
Identify and assess potential partners based on your market analysis.

- Does the potential DCO currently provide the service the CCBHC seeks to purchase? If so:
  - Is the service provided under clinical conditions that largely conform to the program requirements in the SAMHSA CCBHC Certification Criteria, so major changes in service delivery would not be required for the service to be furnished as a CCBHC service?
  - How does the DCO currently reimburse or finance provision of the service?
  - Would contractual consideration from the CCBHC supplement the potential DCO's income stream relating to the service by covering otherwise uncompensated costs associated with furnishing the service to low-income uninsured individuals? (Please note that the CCBHC Expansion grant is intended to supplement, not supplant, other sources of funding with respect to the CCBHC services within the CCBHC's scope.)
- Is the potential DCO otherwise capable of meeting the clinical requirements for carrying out CCBHC services on behalf of the CCBHC (e.g., cultural and linguistic appropriateness, providing services 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:
  - Sharing health record information with the CCBHC to communicate encounter data and justify billing a CCBHC "visit."
  - Sharing clinical and quality data with the CCBHC to enable the CCBHC to meet SAMHSA Uniform Reporting System requirements.
  - The provider organization or its individual employed or contracted clinicians undergoing credentialing with managed care plans, where necessary, to enable the CCBHC to bill plans for services furnished by the DCO.
  - Collecting fees and cost-sharing based on requirements in the CCBHC's sliding fee discount schedule (if the CCBHC seeks to delegate this collection function contractually).

Assess the FMV of any services that the CCBHC may purchase from the potential DCO.

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



EDUCATE

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

Communicate the value of the CCBHC model.

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

Identify and explain requirements unique to CCBHCs and the Demonstration.

- For more concise information geared toward potential partners, see What You Need to Know About Acting as a DCO and the DCO Questions and Answers sections of this toolkit.

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

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

Provide draft contracts to potential partners.

- Establish a point person to work with the other entity and answer questions during the contracting process.

NEGOTIATE

Discuss all parties' concerns with the goal of reaching an agreement that works for everyone.

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 their position wins, regardless of whether the overall goal is attained.
- Parties take extreme positions in the expectation that they'll 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 — it includes.

This is particularly true in health care, an industry that is highly regulated with numerous legal rules addressing the exchange of money or items of value between health care provider organizations. 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.

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" (SAMHSA, 2023, p. 53).

The CCBHC and DCO typically maintain a contractual relationship, under which the CCBHC procures services from the DCO on behalf of CCBHC clients. In most such arrangements, the CCBHC presents itself as the provider of the DCO-rendered services.

FEDERAL RULES AND LIMITATIONS THAT APPLY TO DCO CONTRACT PAYMENTS

Several sets of legal rules apply to the consideration paid in a health care services contracting relationship.

I. PRINCIPLES OF REASONABLE COST

The principles of reasonable cost apply to health care provider organizations paid on a cost-related basis. Under the Section 223 CCBHC Demonstration, states are required to pay CCBHCs under a PPS. The PPS rate is a per-visit rate related to the total allowable per-visit costs of furnishing the entire bundle of CCBHC services in a base cost-reporting period.

According to a CCBHC cost report template issued by CMS, the following should be included as components of the "direct" costs of furnishing the entire bundle of CCBHC services in the base period cost report of each CCBHC (or potential CCBHC seeking state certification) (CMS, 2024b):

- The actual or anticipated costs to the CCBHC of procuring DCO services.
- Any other actual or anticipated direct costs specifically related to services performed by the DCO. For example, when a CCBHC contracts with a DCO to perform mobile crisis services, the CCBHC compensates the DCO for mileage associated with those services.

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

CMS explains that, in reporting costs, states must "use a uniform cost report Demonstration-wide to report costs. In reporting cost, state and provider organizations must adhere to 2 CFR 200 Uniform Administrative Requirements, Cost Principles, and

Audit Requirements for Federal Awards and 45 CFR 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards" (CMS, 2024a, p. 40).

- According to the HHS Uniform Administrative Requirements, when the costs of contracted services are claimed as allowable, the provider organization 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" (Uniform Administrative Requirements, 2014, § 75.404). In determining whether costs are reasonable, consideration must be given to factors including "sound business practices; arm's-length bargaining[; and] market prices for comparable goods or services for the geographic area" (Uniform Administrative Requirements, 2014, § 75.404).[7]

The HHS cost principles specifically designate certain types of "unallowable" costs, such as costs associated with entertainment and lobbying.

The main goal of the cost principles is to ensure that an entity (whether a grantee claiming funds under a federal award or a health care provider organization paid on a cost report basis) includes costs that are no higher than necessary and appropriate. Therefore, in including the payment made to a DCO on a cost report, it is important for a CCBHC or potential CCBHC to ensure that the payment reflects no more than the FMV of this type of services in the community.

II. *THE ANTI-KICKBACK STATUTE*

A second applicable set of rules relating to exchange of money under a DCO contract is a federal law referred to as the Anti-Kickback Statute. This law prohibits anyone, including health care providers, from intentionally offering, paying, soliciting or receiving anything of value (i.e., "remuneration") to induce or reward referrals involving "federal health care programs" or to generate federal health care program business (Criminal Penalties for Acts Involving Federal Health Care Programs, 1990). 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 a reduction from FMV, the discount could be interpreted as an inducement to the CCBHC to refer clients to the DCO.[8]

Documenting FMV is important for 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.[9]

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 goods being purchased. The key step in determining and documenting FMV is to identify an objective indicator of the value of the services.

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

Below are several examples of acceptable measures of FMV:

- Average hourly or annual salary costs for clinicians furnishing 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 applicable to the region should be considered.

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 considered, such as:

- The potential DCO's average charges for the type of services purchased (based on its schedule of charges).

  Note: *In general, the payment would be based on a percentage of charges, rather than the potential CCBHC's full charges, since few payors reimburse services at a rate as high as the provider organization'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 (2023), CCBHCs must maintain a published sliding fee discount schedule that conforms to "state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics" (p. 14). The sliding fee discount schedule is intended to benefit low-income individuals by providing 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.

More generally, a CCBHC's schedule of fees should be based on "locally prevailing rates or charges and includes [the CCBHC's] reasonable costs of operation" (SAMHSA, 2023, p. 15).

CCBHCs also must ensure that no one is denied CCBHC services due to their inability to pay. Notably, this requirement is separate 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. Those policies [must be] applied equally to all individuals seeking [CCBHC] services" (SAMHSA, 2023, p. 15).

Key terms that should be included in sliding fee discount policies and procedures include the following (SAMHSA, 2023):

- 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 based on inability to pay or place of residence, nor will the availability of CCBHC services be limited on those grounds.
- The CCBHC (and its DCOs, as applicable) will provide clients with information regarding the sliding fee discount schedule. Specifically, the sliding fee discount schedule will be communicated in languages and formats appropriate for people seeking services who have 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 the DCO website and in the DCO 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.
- 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 a client's eligibility for the sliding fee discount if they are unable to provide the necessary documentation/verification, such as allowing for self-declaration.
  - Provisions related to billing and collections, including 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 people seeking services, such as through any new client registration?
- ☐ Is the sliding fee discount schedule communicated in languages/formats appropriate for people 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 people using a sliding fee discount schedule?

REFERENCES

160 Cong. Rec. S1852–S1853 (daily ed. March 31, 2014) (statement of Sen. Blunt). https://www.govinfo.gov/content/pkg/CREC-2014-03-31/pdf/CREC-2014-03-31-senate.pdf

Agency for Healthcare Research and Quality. (2022, September). *Care coordination*. https://www.ahrq.gov/ncepcr/research/care-coordination/index.html

Centers for Medicare and Medicaid Services. (2016, June 1). *Section 223 Demonstration programs to improve community mental health services: Qs & As – Set III*. https://www.medicaid.gov/medicaid/downloads/section-223-set-3.pdf

Centers for Medicare and Medicaid Services. (2024, February). *Section 223 Certified Community Behavioral Health Clinic (CCBHC) Demonstration prospective payment system (PPS) guidance*. https://www.medicaid.gov/sites/default/files/2024-02/section-223-ccbh-pps-prop-updates-022024.pdf

Centers for Medicare and Medicaid Services. (2024, February 1). *Certified Community Behavioral Health Clinic cost report instructions*. https://www.medicaid.gov/media/173121

Consolidated Appropriations Act of 2024, P.L. 118-42 (2024). https://www.congress.gov/118/plaws/publ42/PLAW-118publ42.pdf

Criminal Penalties for Acts Involving Federal Health Care Programs, 42 U.S.C. § 1320a-7b(b) (1990). https://www.govinfo.gov/content/pkg/USCODE-2023-title42/pdf/USCODE-2023-title42-chap7-subchapXI-partA-sec1320a-7b.pdf

National Council for Mental Wellbeing. (2025, January). *CCBHC Designated Collaborating Organizations: Frequently asked questions*. https://www.thenationalcouncil.org/wp-content/uploads/2025/02/DCO-FAQ_25.01.06.pdf

Program Integrity — Medicare and State Health Care Programs, 42 C.F.R. § 1001.952 (1992). https://www.govinfo.gov/content/pkg/CFR-2024-title42-vol5/pdf/CFR-2024-title42-vol5-part1001.pdf

Protecting Access to Medicare Act of 2014, P.L. 113-93 (2014). https://www.congress.gov/113/statute/STATUTE-128/STATUTE-128-Pg1040.pdf

Substance Abuse and Mental Health Services Administration. (2023, March). *Certified Community Behavioral Health Clinic (CCBHC) certification criteria*. https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards, 45 C.F.R. § 75.404 (2014). https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-75/subpart-E/subject-group-ECFRffa2eaa9f93be60/section-75.404

ENDNOTES

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 specifically addressing 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 § 223 and subsequent amendments thereto) and CMS guidance. In February and March 2024, CMS issued new guidance on the CCBHC prospective payment system, as well as an updated CCBHC cost report template and instructions. (States may choose to use the template and instructions but are not required to.) Please consult CMS' website and SAMHSA's website for the most up-to-date listing of CCBHC guidance). In addition, the National Council for Mental Wellbeing maintains various CCBHC resources on its website.

2 Please note that some of the criteria apply differently to CCBHCs certified under the Section 223 Demonstration than to CCBHCs participating only in the SAMHSA grant programs. SAMHSA used a green dot to denote criteria, or parts of criteria, that apply uniquely to CCBHCs under the Demonstration.

3 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 here 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 people receiving or seeking CCBHC services.

4 One reason states might set up more than one crisis services rate relates to the interaction between CCBHC crisis services and the Medicaid state plan mobile crisis services option (authorized in Section 9813 of the American Rescue Plan legislation of 2021). The scope and requirements of the crisis services benefit under the CCBHC criteria and under the Section 9813 state plan option are different, and therefore states may create up to three special crisis services rates, for mobile crisis services that qualify under Section 9813, mobile crisis services that meet CCBHC (but not Section 9813) requirements, and on-site CCBHC crisis stabilization services.

5 In addition to the difference in unit of payment between PPS-1/PPS-3 (daily visit) versus PPS-2/PPS-4 (unduplicated monthly encounter), there are other ways the methodologies differ. For example, quality bonus payments and outlier payments are mandatory under PPS-2 and PPS-4, but optional under PPS-1 and PPS-3.

6 The model cost report and instructions released by CMS on Feb. 1, 2024, do not specifically address how care coordination costs should be included on the CCBHC cost report. For example, the instructions do not specify whether new expenditures on electronic practice management systems would qualify as allowable administrative costs or as service costs. Therefore, prospective CCBHCs should consult their own state's instructions regarding the scope of allowable care coordination costs. States may also have unique cost reporting requirements to ensure that the costs of care coordination activities associated with other payment streams (such as the ACA § 2703 Health Home program, if applicable) are excluded from the CCBHC cost report.

7 The HHS Uniform Administrative Requirements also include an extensive set of procurement standards relating to items purchased or services procured using federal grant funds or program income. This summary assumes that those procurement standards do not control DCO contracting, because the CCBHC demonstration will not involve the receipt of federal grant funds by behavioral health providers.

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

9 The Anti-Kickback Statute includes numerous statutory and regulatory "safe harbors." The safe harbors correspond to health care payment and business practices that, although they potentially implicate the federal Anti-Kickback Statute, are not treated as offenses under the statute. If a provider in the community offers to contract with the CCBHC or potential CCBHC to furnish CCBHC services on a discounted basis and the CCBHC is interested in entering such an arrangement, the CCBHC should seek legal counsel to determine whether the discounted arrangement would fall within a safe harbor.

NATIONAL COUNCIL
for Mental Wellbeing

TheNationalCouncil.org