NATIONAL COUNCIL *for* Mental Wellbeing

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS CONTRACTING AND COMMUNITY PARTNERSHIPS TOOLKIT

CCBHC EXPANSION GRANTEE EDITION

OCTOBER 2020

DISCLAIMER

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

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

Please note that this document is not official Substance Abuse and Mental Health Services Administration (SAMHSA) guidance. Use of the materials in this Toolkit does not guarantee that grantees will be determined to be in compliance with grant requirements. Grantees should consult with their SAMHSA project officers on how they plan to structure a designated collaborating organization (DCO) and Care Coordination Agreements.

This **toolkit** offers resources for CCBHCs to meet federal requirements relating to community partnerships with other service providers, through care coordination and DCO relationships. There are two main types of CCBHCs; those that participate in the CCBHC Medicaid demonstration and those that receive CCBHC Expansion Grant funding from SAMHSA to provide CCBHC services under similar program requirements to those governing the CCBHC Medicaid demonstration. **This edition of the toolkit addresses the requirements that apply to CCBHC Expansion Grantees.**

CCBHC Expansion Grants are awarded to providers that demonstrate compliance with the CCBHC program requirements and meet other funding criteria. Notably, the SAMHSA CCBHC Expansion Grant Funding Announcements align the grant program criteria with the Centers for Medicare and Medicaid Services (CMS)/SAMHSA CCBHC Demonstration Criteria. While grantees under the CCBHC expansion program use grant funds to fulfill the CCBHC program requirements, grantees are not eligible for the unique CCBHC Medicaid payment methodology that applies to demonstration participants. As a result, the nature of grantees' partnerships may look somewhat different than that of their peers participating in the CCBHC Medicaid demonstration.

The **CCBHC Contracting and Community Partnerships Toolkit** provides an overview of the types of community partnerships that are required under the CCBHC demonstration[1] and offers resources to help clinics establish or strengthen these relationships. In this **toolkit**, we will address the legal and logistical considerations that current or potential CCBHCs need to consider when forming these relationships. The two types of community partnerships contemplated in the CCBHC model are **DCO relationships** and **care coordination relationships**.

The Basic Features and Goals of the CCBHC Model

In authorizing the CCBHC demonstration program in the Protecting Access to Medicare Act of 2014 (PAMA),[2] Congress wanted to empower providers to address behavioral health needs more holistically. Sen. Roy Blunt, who introduced the CCBHC provision with Sen. Debbie Stabenow, explained that the legislation would "create maximum flexibility and fully qualified locations" and would "allow government to begin to treat [behavioral health] challenges exactly as we treat other challenges — to have a healthy body, a healthy mind, all in one person, all in one spirit, all treatable."[3]

The goal of advancing "person- and family-centered, integrated services" is also a key goal of the CCBHC Expansion Grants, as stated by SAMHSA.[4]

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

Unless otherwise expressly indicated, each requirement applies to both CCBHC Expansion Grantees and to CCBHC demonstration participants.

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

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

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

[4] HHS, **SAMHSA Awards Grants Expanding Community-Based Behavioral Health Services, Strengthens COVID-19 Response** (April 27, 2020) at https://www.hhs.gov/about/news/2020/04/27/samhsa-awards-grants-expanding-community-based-behavioral-health-services-strengthens-covid-19.html.

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

Each CCBHC must be capable of "provision (in a manner reflecting person-centered care)" of all required CCBHC services to be "provided [by the CCBHC] or referred through formal relationships with other providers."[5] According to SAMHSA guidance on the CCBHC demonstration, the first four listed services below must be furnished directly by the CCBHC.[6]

The required services for both CCBHC demonstration participants and Expansion Grantees follow. Services that may be furnished via a DCO are indicated with an asterisk. The DCO concept is discussed further in this introduction and throughout the **toolkit**.

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

Additional required services for SAMHSA CCBHC Expansion Grantees include the following services. Services that may be furnished via DCO are indicated with an asterisk.

- Screening for HIV and viral hepatitis (A, B and C).
- Clinical monitoring for adverse effects of medications including monitoring for metabolic syndrome consistent with published guidelines.*
- Social support opportunities through established models such as clubhouses that provide therapeutic individual and group interactions, assistance with employment, housing and other community recovery supports.*
- Assertive community treatment.*[7]

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

[5] PAMA § 223(a)(2)(D) (42 U.S.C. § 1396a (note)).

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

[7] SAMHSA FY2020 CCBHC Expansion Grant Funding Announcement, pp. 8-9.

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

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

- The CCBHC may not refuse services to any consumer, regardless of form of coverage or uninsured status, based on inability to pay or place of residence.[8]
- The CCBHC must offer CCBHC services based on a sliding fee discount schedule to make the services affordable for low-income consumers.[9]
- The CCBHC must provide each consumer a preliminary screening and risk assessment at time of first contact and develop and update a person- centered treatment plan.[10] The CCBHC must provide crisis management services that are accessible 24 hours a day, seven days a week.[11]

In addition, a basic premise of the legislation governing the CCBHC demonstration program is that each CCBHC must bill Medicaid through a cost-related prospective payment system (PPS) methodology; however, this requirement does not apply to CCBHC Expansion Grantees.

How Community Partnerships Advance the Goals of the CCBHC Program

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

The CCBHC legislation and guidance envision two chief types of CCBHC community partnerships. The first is **care coordination relationships**. SAMHSA stated in its guidance that care coordination is the "linchpin" of the CCBHC demonstration.[12] Care coordination relationships are typically memorialized in informal agreements between CCBHCs and other providers and social service agencies in their area. Care coordination agreements describe the parties' mutual expectations and responsibilities and are meant to enhance the quality of care, improve CCBHC consumers' access to services that fall outside the CCBHC benefit (for example, inpatient and specialty services) and create seamless transitions between service settings.

[8] PAMA § 223(a)(2)(B) (42 U.S.C. § 1396a (note)); 2015 Planning Grant RFA, Appendix II, Criterion 2.D.1; SAMHSA FY2020 CCBHC Expansion Grant Funding Announcement, Criteria 2.D and 2.E, p.
[9] PAMA § 223(a)(2)(B) (42 U.S.C. § 1396a (note)); 2015 Planning Grant RFA, Appendix II, Criterion 2.D.2.
[10] PAMA § 223(a)(2)(D)(ii) and (iii) (42 U.S.C. § 1396a (note)); 2015 Planning Grant RFA, Appendix II, Criteria 2.B, 4.D and 4.E.
[11] PAMA § 223(a)(2)(B) (42 U.S.C. § 1396a (note)); 2015 Planning Grant RFA, Appendix II, Criteria 2.C, 4.C.
[12] 2015 Planning Grant RFA, Appendix II, p. 23.

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

In the law establishing the CCBHC demonstration, Congress described various types of providers and social service agencies with which CCBHCs are required to undertake care coordination.[13] SAMHSA elaborated on these requirements in its guidance.[14]

The second key type of CCBHC community partnership is the **DCO relationship**. In the law authorizing the CCBHC demonstration, Congress required that CCBHC services must be provided either directly or through "formal relationships."[15] DCO relationships satisfy the "formal relationship" requirement. The CCBHC must require the DCO to furnish services in a manner consistent with the CCBHC program requirements. The CCBHC must maintain clinical responsibility for provision of the services.[16]

For CCBHC demonstration participants, the CCBHC must be both clinically and financially responsible for the provision of CCBHC services provided via a DCO. Moreover, in general, under the CCBHC Medicaid demonstration, the costs associated with all CCBHC services, even those furnished via DCO, must be incorporated in the individualized, cost-related PPS rate. Therefore, for CCBHC demonstration participants, the DCO relationship should be structured as a purchase of services arrangement. Those requirements do not apply under the CCBHC Medicaid Expansion Grant, since CCBHC Expansion Grantees are not eligible for the Medicaid PPS methodology. While the CCBHC Expansion Grantee may compensate the DCO for services furnished to uninsured persons, in order to advance the CCBHC program goals, the DCO agreement is not required to be structured as a purchase of services for CCBHC Expansion Grantees.

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

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

[13] PAMA § 223(a)(2)(C) (42 U.S.C. § 1396a (note).
[14] 2015 Planning Grant RFA, Appendix II, Criterion 3.C.
[15] PAMA § 223(a)(2)(D) (42 U.S.C. § 1396a (note).
[16] 2015 Planning Grant RFA, Appendix II, p. 35; SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 4.a, p. 94.

The Contents of This Toolkit

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

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

CONTENTS

DISTINGUISHING DCO RELATIONSHIPS FROM CARE COORDINATION RELATIONSHIPS

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

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

1. **Formal Relationships with DCOs**

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

2. **Care Coordination**

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

Key Differences Distinguishing DCOs from Care Coordination		
	DCO	**CARE COORDINATION**
Scope	A DCO provides some of the required CCBHC services (may include primary care screening and monitoring, targeted case management, psychiatric rehabilitation services, peer support services and family support services, services for members of the armed services and veterans, clinical monitoring for adverse effects of medications, social support opportunities (such as through clubhouse model), assertive community treatment and, in some situations, crisis services).	Care coordination is regarded as an activity rather than a service. CCBHCs must maintain care coordination relationships with various entities and social service agencies. In general, the services provided by the care coordination partner do not fall within the scope of CCBHC services.
Type of Agreement	Structured (with limited exceptions) as a referral agreement, a subrecipient agreement or a purchase of services agreement.	Structured as a referral agreement.
Responsibility	CCBHC Expansion Grantee is clinically responsible for the DCO's provision of CCBHC services on the CCBHC's behalf.	CCBHC does not assume responsibility for services provided by the other entity or social service agency. The organizations maintain autonomous operations.
Billing Provider	The CCBHC Expansion Grantee and DCO are each the billing provider for the services that they furnish.	Each care coordination partner is the billing provider for the services that it furnishes.
Consideration	Depending on structure of DCO arrangement, CCBHC may compensate the DCO providing CCBHC services on the CCBHC's behalf.	No consideration (money or anything else of value) is exchanged between the CCBHC and the other entity or social service agency.
Schedule of Fees and Discounts	DCOs furnish CCBHC services in accordance with a schedule of fees, schedule of discounts and corresponding written policies and procedures.	The entity or social service agency bills consumers and/or payors for the services it provides, as applicable, independent of the CCBHC and in accordance with its own schedule of fees and schedule of discounts.
Mandatory or Optional	DCO arrangements are optional. If a CCBHC is able to furnish all CCBHC services directly, it need not contract with a DCO.	Care coordination arrangements with other providers in the community are a mandatory component of the demonstration and Expansion Grants.

CARE COORDINATION AGREEMENTS

Overview of Legal Requirements and Checklist of Recommended Terms

Coordinating care across a spectrum of services,[17] including physical health, behavioral health, social services, housing, educational systems and employment opportunities,[18] is central to the SAMHSA CCBHC Expansion Grant.

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

> *deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate and effective care to the patient*.[19]

This person-centered and family-centered approach is essential to furnishing care that addresses the well-being of the whole person.[20] In coordinating care, providers must keep in mind the consumer's preferences and needs and, to the extent possible, the preferences of the consumer's family/caregivers.[21] Additionally, as appropriate for the consumer's needs, the CCBHC should designate an interdisciplinary treatment team that is responsible for directing, coordinating and managing care and services for the consumer.[22] The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic and recovery support needs of CCBHC consumers, including, as appropriate, traditional approaches to care for consumers who may be American Indian or Alaska Native.[23]

Care coordination links CCBHC consumers with access to certain providers and social service agencies, as set forth here, through a referral process. The referral process under the care coordination model is not passive. Rather, the CCBHC and the other entity must work collaboratively to share information regarding consumers' needs and preferences, with the ultimate goal of improving health outcomes and consumer satisfaction.

SAMHSA has specified that CCBHCs must have an agreement in place with each of the entities with which the CCBHC coordinates care.[24] If the CCBHC cannot establish an agreement by the

[17] **See** Protecting Access to Medicare Act (PAMA) § 223(a)(2)(C) (42 U.S.C. § 1396a (note)), Pub. L. No. 113-93 (Apr. 1, 2014); SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, p. 71.
[18] RFA for SAMHSA Planning Grants for CCBHC, Appendix II – Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (2015 Planning Grant RFA, Appendix II), Criterion 3.c.3.
[19] **Id**.
[20] 2015 Planning Grant RFA, Appendix II, Criterion 3.a.1.
[21] **Id**. Criterion 3.a.4; SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 4.E, p. 97.
[22] **Id**. Criterion 3.d.2; SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 3.D, p. 93.
[23] 2015 Planning Grant RFA, Appendix II, Criterion 3.d.2.
[24] **Id**., Appendix II, Definitions: "Agreement"; SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 3.C, p. 91.

start of the demonstration project, it must work toward formal agreements.[25] The agreement may be structured as a contract, memorandum of agreement, memorandum of understanding, letter of support, letter of agreement or letter of commitment.[26] For purposes of this **toolkit**, the agreements are referred to as Care Coordination Agreements.

Regardless of its form, the Care Coordination Agreement must describe the parties' mutual expectations and responsibilities related to care coordination.[27] For example, consistent with requirements of privacy, confidentiality and consumer preference and need, the CCBHC must assist consumers who are referred to external providers or resources in obtaining an appointment and confirming the appointment was kept.[28]

Under care collaboration relationships, unlike the DCO relationships discussed elsewhere in this toolkit, the CCBHC does not assume responsibility for services provided by the other entity or social service agency. Both the CCBHC and the care coordination partner retain their own separate and distinct corporate structures, patient care delivery systems and locations and each is accountable and legally and financially responsible only for those services that it directly furnishes to consumers. The consumers served under the care coordination arrangement are considered consumers of the entity/agency to which the consumers are referred. The referral provider is responsible for billing and collecting payments from third-party payors and consumers for the services rendered, to the extent that services furnished by the entity/agency are billable. There is no exchange of funds or other remuneration between the CCBHC and the other party. Additionally, nothing about a CCBHC's agreements for care coordination should limit a consumer's freedom to choose his or her provider.[29]

Scope of Care Coordination: Providers and Social Service Entities

In the spirit of promoting access to services that is both integrated and comprehensive, SAMHSA requires, as part of the CCBHC Expansion Grant program, that CCBHCs maintain care coordination relationships with the following providers and social service entities:

- Federally Qualified Health Centers (and as applicable, rural health clinics).
- Inpatient psychiatric facilities, including substance use disorder facilities and residential programs.
- Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers and other facilities of the Department as defined in section 1801 of title 38, United States Code.
- Inpatient acute care hospitals and hospital outpatient clinics.[30]

[25] **Id**.
[26] **Id**.
[27] **Id**.
[28] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 3.C, p. 91.
[29] 2015 Planning Grant RFA, Appendix II, Criterion 3.a.6.
[30] PAMA § 223(a)(2)(C) (42 U.S.C. § 1396a (note)); SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 3.C, pp. 91-92.

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[31]

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

- Specialty providers of medications for treatment of opioid and alcohol dependence
- Suicide/crisis hotlines and warmlines
- Indian Health Service or other tribal programs
- Homeless shelters
- Housing agencies
- Employment services systems
- Services for older adults, such as aging and disability resource centers
- Other social and human services (e.g., domestic violence centers, pastoral services, grief counseling, Affordable Care Act navigators, food and transportation programs)[32]

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

Care Coordination Agreements with Certain Provider Types

In general, the federal agencies' guidance provides CCBHCs with flexibility in how they achieve care coordination, provided that the Care Coordination Agreement establishes expectations and protocols to ensure adequate care coordination.[33] However, for certain provider types, the SAMHSA guidance identifies specific issues for Care Coordination Agreements to address.

With regard to **inpatient acute hospitals** (including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities

[31] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 3.C, p. 92.
[32] **Id**.
[33] **Id**.

and ambulatory detoxification providers), the Care Coordination Agreement must address the needs of consumers, including procedures and services to help transition individuals and shorten time lag between assessment and treatment.[34] Unless there is a formal transfer of care from the CCBHC to another entity, the Care Coordination Agreement must enable the CCBHC to track when consumers are admitted and discharged and allow for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge.[35] For all CCBHC consumers discharged from such facilities who presented to the facilities as a potential suicide risk, the Care Coordination Agreement must include a requirement to coordinate consent and follow-up services with the consumer within 24 hours of discharge. Those obligations must continue until the consumer is linked to services or assessed to be no longer be at risk.[36] Additionally, the CCBHC must ensure that it can make and document reasonable attempts to contact all CCBHC consumers discharged from these settings within 24 hours of discharge.[37]

With regard to facilities providing **inpatient psychiatric treatment with ambulatory and medical detoxification, post-detoxification step-down services and residential programs**, the Care Coordination Agreement must enable the CCBHC to track when consumers are admitted to the facilities as well as discharged, unless there is a formal transfer of care to a non-CCBHC entity.[38] The CCBHC must establish protocols and procedures for transitioning individuals from emergency departments, inpatient psychiatric treatment, detoxification and residential settings to safe community settings, including transfer of medical records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety and provision of peer services.[39]

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

Privacy and Data Sharing Requirements for Care Coordination Agreements

The CCBHC must obtain all necessary consents from consumers for the release of information for facilitating care coordination, including for care coordination activities with other entities. The documentation must satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 CFR Part 2 and other federal and state privacy laws.[40] The CCBHC also must ensure consumers' preferences and those of their families are adequately documented in clinical records, consistent with the philosophy of person and family-centered care.[41] Policies and procedures related to consumer consent requirements and data sharing with care coordination partners should be incorporated into Care Coordination Agreements.

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[34] **Id**. p. 93
[35] **Id**.
[36] **Id**.
[37] **Id**.
[38] **Id**.
[39] **Id**.
[40] **Id**. p. 90.
[41] **Id**.

CARE COORDINATION AGREEMENT CHECKLIST

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

Pre-contracting Activities:

Has the CCBHC:

- ☐ Evaluated whether the other party has sufficient personnel and facility space to see additional consumers?
- ☐ Explored establishing Care Coordination Agreements with each type of facility regarding establishing care coordination expectations with the nearest Department of Veterans Affairs facilities, to the extent multiple department facilities of different types are located nearby?
- ☐ Ascertained consumers' preferences and needs for care and adequately documented those needs and preferences in clinical records such that the preferences can be shared with the other party?
- ☐ Developed a crisis plan with each consumer to ascertain in advance the consumer's preferences in the event of a psychiatric or substance abuse crisis so the crisis plan can be shared with the other party?
- ☐ Made and documented reasonable attempts to determine any medications prescribed by other providers for CCBHC consumers and obtained appropriate consent to release of information to allow the CCBHC to provide such information to the other party?
- ☐ Identified how the CCBHC will assist consumers (and their families, as applicable) in obtaining an appointment with the other party and will confirm that the appointment was kept?
- ☐ Drafted an agreement written in clear and unambiguous language?

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?[42]
- ☐ Include as attachments all applicable care coordination protocols (such protocols should be incorporated by reference into the Agreement)?

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

- ☐ For Care Coordination Agreements applicable to inpatient psychiatric treatment with ambulatory and medical detoxification, post-detoxification step-down services and residential programs:
  - o Establish that the CCBHC is able to track when consumers are admitted to facilities providing such services, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity?
  - o Attach protocols and procedures developed by the CCBHC for transitioning individuals to a safe community setting, including the transfer of medical records of services received (e.g., prescriptions), active follow-up after discharge and, as appropriate, a plan for suicide prevention and safety and provision for peer services?
- ☐ For Care Coordination Agreements applicable to inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities and ambulatory detoxification providers:
  - o Describe how the CCBHC tracks when its consumers are admitted to facilities providing the previously listed services, as well as when they are discharged, unless there is a formal transfer of care to an other entity, and provide for transfer of medical records of services received (e.g., prescriptions) and active follow-up after discharge?
  - o Establish that the CCBHC will make and document reasonable attempts to contact all CCBHC consumers who are discharged from these settings within 24 hours of discharge? For all CCBHC consumers discharged from such facilities who presented to the facilities as a potential suicide risk, include a requirement to coordinate consent and follow-up services with the consumer within 24 hours of discharge, which shall continue until the individual is linked to services or assessed to be no longer at risk?

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

Does the Care Coordination Agreement:

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

[42] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 3.C, p. 92.

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

Does the Care Coordination Agreement:

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

Provisions in the Care Coordination Agreement Relating to Standards of Care

Does the agreement contain assurances that the other party and each of its professionals providing services pursuant to the Care Coordination Agreement:

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

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

Does the Care Coordination Agreement:

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

Autonomy and Compliance with State and Federal Law

Does the Care Coordination Agreement:

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

SAMPLE CARE COORDINATION AGREEMENT

*This sample Care Coordination Agreement is between a fictional CCBHC, **Behavioral Health Clinic**, and a fictional hospital, **Community Hospital**, for the provision of inpatient psychiatric treatment. Note that this sample Care Coordination Agreement is not a template, but is provided as an example. All questions regarding SAMHSA requirements for the care coordination relationship should be directed to SAMHSA. CCBHCs must maintain Care Coordination Agreements[43] with a range of other providers and social support organizations and each such agreement must be drafted to reflect the unique characteristics of each care coordination relationship.*

This Care Coordination Agreement (the "Agreement") serves to confirm the mutual understandings of Behavioral Health Clinic, which receives a Certified Community Behavioral Health Clinic ("CCBHC") Expansion Grant from the Substance Abuse and Mental Health Services Administration ("SAMHSA"), and Community Hospital, an acute care hospital, to coordinate inpatient psychiatric treatment and other substance use disorder services (collectively, the "Inpatient Psychiatric Treatment Services") for those consumers 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 hereinafter be referred to individually as a "Party" and collectively as the "Parties". The purpose of this Agreement is to set forth the Parties' understanding regarding their collaborative care coordination activities.

I. Referral Process

1. Behavioral Health Clinic is committed to providing integrated and coordinated care across a spectrum of services in a manner that is both person-centered and family-centered.

2. Behavioral Health Clinic agrees to provide intake, initial screening, and appropriate treatment to consumers presenting at Behavioral Health Clinic for the provision of community-based mental health and substance use disorder services, and to establish and maintain records for the Behavioral Health Clinic's consumers.

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

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

4. If Behavioral Health Clinic's screening and/or treatment indicate the need for Inpatient Psychiatric Treatment Services, as determined in the sole discretion of the Behavioral Health Clinic provider, consistent with requirements of privacy, confidentiality, and consumer preference and need, Behavioral Health Clinic will assist the consumer and/or their families to obtain an appointment with Community Hospital.

   Note: The Funding Announcement states that the CCBHC must have policies and procedures to "**assist consumers and families of children and adolescents in obtaining appointments and keeping the appointment when there is a referral to an outside provider, subject to privacy and confidentiality requirements and consistent with consumer preference and need**."

5. Community Hospital agrees to furnish Inpatient Psychiatric Treatment Services at the clinically appropriate level to consumers referred to Community Hospital by Behavioral Health Clinic, in accordance with Community Hospital's policies and procedures.

6. Community Hospital shall have sole authority to bill consumers and payors for Community Hospital's provision of Inpatient Psychiatric Treatment Services in accordance with Community Hospital's policies and procedures applicable to fees, ,discounts, and collections, with the understanding that no consumer shall be denied Inpatient Psychiatric Treatment Services based on his/her inability to pay.

   Note: The Funding Announcement does not require that the Care Coordination Agreement explicitly include a representation that Community Hospital will furnish services to all CCBHC consumers, regardless of their ability to pay or in accordance with a particular discount schedule. However, the Parties may opt to include applicable provisions in the Agreement.

II. Care Coordination Processes

1. The Parties will collaborate to conduct treatment planning and care coordination activities in a manner that is person and family-centered.

2. Behavioral Health Clinic will track consumers admitted and discharged from Community Hospital in accordance with CCBHC's applicable procedures.

> **Note**: For Care Coordination Agreements, the CCBHC may wish to include that the parties will jointly develop a Care Coordination Protocol and that the protocol will address, as applicable: (i) how Behavioral Health Clinic tracks its consumers when admitted to, and discharged from, Community Hospital; (ii) how Behavioral Health Clinic and Community Hospital will coordinate the transfer of medical records 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) consumer preferences and needs for care, to the extent possible in accordance with consumer's expressed preferences; and (vii) any other expectations necessary to effectively manage care transitions. Alternatively, these details may be set forth in the body of the Care Coordination Agreement.

3. Behavioral Health Clinic will make and document reasonable attempts to contact all Behavioral Health Clinic consumers who are discharged from Community Hospital within 24 hours of discharge. For all Behavioral Health Clinic consumers who present to the Community Hospital as a potential suicide risk, Behavioral Health Clinic will provide targeted case management services, emphasizing smooth transitions to and from emergency department care or psychiatric hospitalization. A Behavioral Health Clinic will coordinate consent and follow-up services with the consumer within 24 hours of discharge, which shall continue until the individual is linked to services or assessed to be no longer at risk.

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

III. Insurance and Liability

> **Note**: The Parties may wish to include a section that sets forth their mutual understandings and obligations related to insurance and liability. The Funding Announcement does not require such provision be in the Care Coordination Agreement. We nonetheless recommend including such representations to ensure that the care coordination entity is adequately insured.

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

IV. Assurance of Consumer and Clinician Choice

1. Behavioral Health Clinic and Community Hospital acknowledge and agree that all consumer referrals shall be subject to patient freedom of choice and the health and health-related professionals' independent clinical judgment.

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

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

V. Term and Termination

Note: Care coordination agreements are customarily non-binding on the Parties. Accordingly, it is unnecessary to set forth a term and causes for termination, although such provisions are recommended.

1. The term of this Agreement shall commence on _____ , 20___ (the "Effective Date"), and shall terminate on _____ , 20___ , unless terminated at an earlier date in accordance with Section V. This Agreement will automatically renew for additional one (1) year terms unless written notice of intent not to renew is provided by one Party to the other Party no less than thirty (30) days prior to the expiration of the 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 at any time by either Party upon providing the other Party with written notice, with the understanding that if a Party seeks to terminate this Agreement, it shall make reasonable efforts to provide the other Party with sixty (60) days' prior notice.

VI. Privacy and Confidentiality of Consumer Information

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

SIGNATURE PAGE TO FOLLOW.

Behavioral Health Clinic	**Community Hospital**
Signature: _____	Signature: _____
Date: _____	Date: _____

DCO ARRANGEMENTS

Overview of Legal Requirements and Checklist of Recommended Terms

The 2014 law authorizing the CCBHC demonstration program required the Department of Health and Human Services (HHS) to establish criteria for a clinic to be certified by a state as a CCBHC in Medicaid. PAMA requires that CCBHCs provide an array of required services that must either be provided directly by the CCBHC or "through formal relationships with other providers."[44]

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

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

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

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

CCBHC Services and DCO Scope of Services

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

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

Additional SAMHSA CCBHC Expansion Grantees required services include the following services. Those marked with an asterisk may be provided via DCO.

- Screening for HIV and viral hepatitis (A, B and C).
- Clinical monitoring for adverse effects of medications including monitoring for metabolic syndrome consistent with published guidelines.*
- Social support opportunities through established models such as clubhouses that provide therapeutic individual and group interactions, assistance with employment, housing and other community recovery supports.*
- Assertive community treatment.*[45]

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

[45] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, pp. 8-9.

The DCO relationship, as described in the SAMHSA and CMS guidance, is an agreement between the CCBHC and the DCO. The CCBHC assumes clinical responsibility for the provision of the service furnished by the DCO.[46]

Under the Medicaid CCBHC demonstration, there is also a requirement that the CCBHC be financially responsible for services furnished by the DCO and a requirement that the DCO relationship be structured as a contractual procurement by the CCBHC of all CCBHC services furnished by the DCO. Importantly, those requirements do not apply to CCBHC Expansion Grantees.

The DCO arrangements of CCBHC Expansion Grantees may, however, include the procurement of services furnished to uninsured individuals by the CCBHC, for which the DCO will be assuming an obligation. The purpose of the CCBHC Expansion Grant is to support grantees in fulfilling the program requirements. One of the key objectives of the program is for CCBHCs to make services accessible to all consumers by not refusing services to consumers based on their ability to pay and by offering a sliding fee discount schedule for low-income individuals.[47] In most instances, health care providers do not have such obligations and may choose not to serve consumers based on their uninsured status or inability to pay the provider's fees. Since the DCO would assume this new care obligation as a result of its DCO status, the CCBHC could use its Expansion Grant funding, or associated program income, to procure contractually the services the DCO furnishes to uninsured, low-income consumers; alternatively, it could choose to delegate this responsibility to the DCO as a subrecipient of the CCBHC Expansion Grant.

More broadly, however, unlike the DCO arrangements formed by Medicaid CCBHC demonstration participants, DCO arrangements of Expansion Grantees should not be structured as a purchase by the CCBHC of all CCBHC services furnished by the DCO. The SAMHSA Fiscal Year 2020 CCBHC Expansion Grant Funding Announcement provides generally that the grant funds are intended to be used to supplement existing activities and not "to supplant current funding of existing activities."[48] If a CCBHC contracted to procure the services of a DCO, such that the remuneration from the CCBHC stood in the place of payor payment for which the DCO would otherwise submit claims, then arguably, such a procurement relationship could run afoul of the "supplement, not supplant" guidance.

CMS has recognized that in CCBHC demonstration states where a state-sanctioned, certified or licensed system is in place to cover crisis services, the state as DCO may furnish the crisis services, rather than the CCBHC providing them directly. Where a CCBHC Expansion Grantee works with a state to provide crisis services as DCO through a state-sanctioned program, it is up to the state to determine whether this arrangement needs to be codified formally in a DCO agreement with the CCBHC or not.

[46] 2015 Planning Grant RFA, Appendix II, p. 35; SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 4.a, p. 94.
[47] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 4.a, p. 94.
[48] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, p. 60.

Typically, the CCBHC and DCO would be entirely distinct organizations, but SAMHSA guidance has indicated that in some instances, a CCBHC and a DCO may be related entities. For example, the DCO and CCHBC may be separate clinics within a larger, non-profit organization.[49] Or, similarly, a DCO may be a subsidiary of the CCBHC as a stand-alone site or subsidiary.[50]

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

Structuring DCO Agreements

The DCO-CCBHC relationship must be documented in a written agreement. The CCBHC is obligated to structure its DCO agreement in compliance with the CCBHC's obligations as a federal grantee, under 45 CFR Part 75. The CCBHC is responsible for ensuring that CCBHC services furnished through the DCO are compliant with all relevant CCBHC program requirements, including those relating to access to services for all consumers.

DCO agreements could be structured merely as referral agreements — statements of commitment between two parties concerning their intentions to work together to furnish CCBHC services, without the exchange of remuneration. However, if a DCO agreement involves remuneration by the CCBHC to the DCO, then this portion of the agreement should be structured either as a contract (with the DCO as a "vendor" or "contractor") or as a subrecipient agreement (with the funds dispersed to the DCO functioning as a subaward of the CCBHC Expansion Grant). Grantees have different obligations with respect to third parties involved in carrying out a grant award, depending on whether those third parties are characterized as vendors or subrecipients (or neither).

A subrecipient is a non-federal entity that receives a subaward from a "pass-through entity" (i.e., the prime grantee).[51] The prime grantee delegates responsibility to subrecipients to carry out some portion of the grant project. A vendor, or contractor, on the other hand, is an entity from which a grant recipient procures items or services and is not viewed as directly carrying out or being bound by the terms of award of a grant.

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

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[49] **See** SAMHSA, Planning Grants for Certified Community Behavioral Health Clinics, 2015 Planning Grant RFA No. SM-16- 001, **Frequently Asked Questions, available at** www.samhsa.gov/sites/default/files/grants/pdf/faq/sm-16- 001-faq_1.pdf, p. 5 (Question 18).
[50] If the CCBHC plans to compensate the DCO for services furnished to the uninsured, then A CCBHC would be unable to apply the principles of commercially reasonable contracting that would normally govern a purchase of services arrangement, where its DCO is its own subsidiary or a component of the organization. "Arm's length" negotiation would be impossible in this context. Prospective CCBHCs that intend to use a subsidiary or portion of their organization as a DCO should consult legal counsel concerning the structuring of the arrangement.
[51] 45 CFR § 75.2.

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

- They determine who is eligible to receive what federal assistance.
- They have their performance measured in relation to whether objectives of a federal program are met.
- They have responsibility for programmatic decision-making.
- They are responsible for adherence to applicable federal program requirements.
- They, in accordance with their agreement with the grantee, use federal funds to carry out a program for a public purpose.[52]

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

- They provide goods and services within normal business operations.
- They provide similar goods or services to many different purchasers.
- They normally operate in a competitive environment.
- They provide goods or services that are ancillary to the operation of the federal program.
- They are not subject to compliance requirements of the federal grant program as a result of the agreement with the grantee.[53]

Whether a given CCBHC Expansion Grantee's DCO is a vendor or a subrecipient may depend in large part on how the CCBHC Expansion Grantee has structured the DCO's obligations in the agreement, as well as how the DCO's role was described in the grant application. A key area of DCO obligation for this purpose is the financing by the CCBHC of the discounts offered by the DCO on services furnished by the DCO to low-income uninsured consumers. If the DCO is simply furnishing such services as directed by the CCBHC, the DCO arrangement would more likely resemble a purchase of services and the DCO, a "vendor." On the other hand, if the CCBHC vests more discretion in the DCO (for example, if the agreement charges the DCO with screening of consumers for eligibility for sliding fee discounts or allows the DCO to establish and implement its own schedule of discounts rather than using the CCBHC's schedule of discounts), this would suggest a degree of programmatic autonomy more on the part of the DCO consistent with a subrecipient designation and the funds conveyed by the CCBHC to the DCO would be viewed as a pass-through of federal grant dollars.

CCBHCs were required to list subrecipients (as well as budgets associated with each subrecipient) in their FY 2020 CCBHC Expansion Grant applications and subrecipients are

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[52] 45 CFR § 75.351(a).
[53] 45 CFR § 75.351(b).

independently required to meet numerous requirements relating to the federal award.

It is important for CCBHCs to be aware how they characterized the DCO in their funding applications and to conform with the legal requirements relating to subrecipients or to vendors, as applicable. If the DCO is a vendor, the CCBHC must ensure that the procurement of the DCO's services is consistent with the grant management regulations.[54] For example, the CCBHC must have established written procurement policies and all procurement transactions should be conducted in a manner to provide open and free competition to the extent practical.[55] To the extent the DCO agreement includes the purchase of clinical services (for example, services rendered to low-income uninsured individuals), the consideration paid by the CCBHC to the DCO should reflect an objective estimation of fair market value (FMV).[56]

To the extent that the DCO functions as a subrecipient under the DCO agreement, then the CCBHC and DCO must ensure compliance with all requirements in the Funding Announcement concerning subawards.

Under the terms of the SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, the CCBHC is **clinically responsible** for the services rendered by DCOs to CCBHC consumers pursuant to the DCO agreement. This means that the CCBHC must ensure that those services:

- Meet cultural competency standards set by SAMHSA and/or the CCBHC.[57]
- Are reflected in the data the CCBHC furnishes in furtherance of its reporting obligations under the CCBHC Expansion Grant (appropriate consents must be obtained necessary to satisfy HIPAA, 42 CFR Part 2 and other requirements).[58]
- Meet SAMHSA CCBHC standards for accessibility of services (e.g., application of sliding fee scale, no limitation or denial of services based on ability to pay or residence, regardless of insurance status),
- For more information on sliding fee discount policy, see CCBHC Fee Schedule and Sliding Fee Discount Schedule.

[54] 45 CFR §§ 75.326-75.335. The regulations require that if the amount of the contract exceeds a simplified acquisition threshold (currently, $150,000), then the procurement must conform to one of three procedures set forth in the regulations. A grantee may use a noncompetitive or "sole source" procurement if, among other conditions, the item or service is available only from a single source. 45 CFR § 75.329(f).
[55] **Id.**; SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, p. 71.
[56] 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 historic costs to the DCO of furnishing the type of services rendered under the contract. For more information, see Determining Fair Market Value.
[57] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 1.C, p. 85.
[58] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 1.C, p. 100.

- Are rendered within specified time period after appointment request.
    - For example, established consumers must be provided an appointment within 10 business days of the requested date for services, unless the state, the federal government or accreditation standards are more stringent. If a consumer presents with an emergency or crisis need, the DCO must take immediate action, including any necessary outpatient follow-up care and ensure clinical services are provided within one business day of the request.
- Meet all relevant SAMHSA program requirements applicable to the specific contracted service.

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

The CCBHC is required to have a plan in place to improve care coordination between the CCBHC and DCO using health information technology (HIT). The plan should explain how the CCBHC can support electronic health information exchange to improve care transitions to and from the CCBHC using the HIT system the CCBHC has (or is developing) related to transitions of care.[59]

In addition, with respect to CCBHC grantees, CCBHCs must require the DCO to attest through the agreement that the DCO:

- Has two years of relevant experience, as of the due date of the application, providing relevant services.
- Complies with all applicable local and state licensing, accreditation and certification requirements.[60]

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

[59] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 3.B, p. 91.
[60] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, pp. 12-13.

DCO AGREEMENT CHECKLIST

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

- ☐ If DCO is vendor, does the contract set forth compensation to the DCO at FMV for a defined scope of services?
  - o Has the CCBHC otherwise ensured that the procurement meets the standards described in 45 CFR §§ 75.326-75.335?
- ☐ If DCO is subrecipient, does the DCO Agreement meet all requirements stated in the CCBHC Expansion Grant Funding Announcement for subawards?

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

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

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

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

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

- ☐ Provide that DCO and CCBHC will seek to improve care coordination using health information systems including, but not limited to, electronic health records, practice management systems and billing systems?

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

- ☐ Require the DCO to furnish to the CCBHC programmatic and/or financial reports pertaining to the services provided under the agreement, as deemed necessary by the CCBHC for monitoring and oversight?
- ☐ Require the DCO to retain and provide access to such records and reports?

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

- ☐ Prohibit disclosure of any business, financial or other proprietary information, which is directly or indirectly related to the CCBHC and obtained as a result of services performed under the agreement, unless the CCBHC gives prior written authorization for the disclosure or the disclosure is required by law (consistent with all applicable state and federal laws and regulations, as well as the CCBHC's policies, regarding the use and disclosure of confidential and proprietary information)?
- ☐ Prohibit the unauthorized use or disclosure of consumers' protected health information consistent with all applicable federal and state laws, including the requirements of HIPAA, as well as the CCBHC's policies regarding the confidentiality and privacy of consumer information?

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

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

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

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

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

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

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

- ☐ Require the DCO to comply with all applicable state and federal laws and guidance, including but not limited to Appendix M (CCBHC Criteria Compliance Checklist) of the SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement?
- ☐ Provide for penalties for failure to comply with applicable state and federal laws and guidance, including but not limited to Appendix M of the Funding Announcement?

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

- ☐ Identify the independent contractor relationship of the parties and appropriately allocate the parties' obligations with respect to insurance 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 Agreement is between a fictional CCBHC, **Behavioral Health Clinic**, and a fictional **DCO** called DCO for the DCO's provision of psychiatric rehabilitation services in furtherance of the CCHBC's SAMHSA Expansion Grant. Note that this sample DCO Agreement is not a template. Certain provisions set forth are not required under the SAMHSA Expansion Grant, but are provided as an example. This sample agreement is designed as a template for those engaging their DCOs as a vendor, rather than a subrecipient.*

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

This document should be reviewed in tandem with the summary of DCO requirements. In addition, prior to executing a DCO Agreement, it is suggested that the CCBHC and DCO collaboratively review the Funding Announcement (in particular, Appendix M) to ensure that the parties jointly satisfy the applicable requirements. As applicable, the parties' respective obligations to satisfy the aforementioned requirements applicable to the DCO relationship should be set forth in the DCO Agreement. …" CCBHCs are encouraged to consult legal counsel for purposes of drafting the DCO Agreement.

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

WITNESSETH

WHEREAS, Behavioral Health Clinic is a organized and existing under the laws of the State of [insert] and receives a Certified Community Behavioral Health Clinic ("CCBHC") Expansion Grant from the Substance Abuse and Mental Health Services Administration ("SAMHSA") within the Department of Health and Human Services ("HHS") (hereinafter, the "CCBHC Expansion Grant");

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

WHEREAS, DCO furnishes psychiatric rehabilitation services ;

WHEREAS, as a CCBHC, Behavioral Health Clinic is committed to furnishing integrated and coordinated care that addresses all aspects of a person's health, consistent with the terms and conditions of its CCBHC Expansion Grant;

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

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

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

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

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

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

SECTION 1. OVERVIEW.

1.1 Scope of Services. DCO shall provide psychiatric rehabilitation services, as set forth in Exhibit A, attached hereto and incorporated by reference herein (collectively the "Psychiatric Rehabilitation Services") consumers referred to DCO from CCBHC (the "Consumers").

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

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

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

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

1.4 Availability of Services. DCO shall ensure that Consumers will not be denied Psychiatric Rehabilitation Services because of (i) their place of residence, or (ii) their inability to pay for such services.

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

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

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

1.7 Data Tracking. On regular intervals, but at least monthly, DCO shall provide Behavioral Health Clinic with the necessary information in the appropriate form for Behavioral Health Clinic to collect, report, and track encounter, outcome, and quality data.

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

SECTION 2. DCO REQUIREMENTS.

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

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

2.2 DCO represents that, during the term of this Agreement, the clinicians carrying out services under this Agreement shall:

2.2.1 be and remain licensed

,

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

2.2.2 have expertise in

;

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

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

2.2.4 have customary narcotics and controlled substance authorizations;

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

2.2.5 render services in accordance with Consumers' diagnostic and treatment planning evaluation; and

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

2.3 DCO attests that neither DCO nor any its employed or contracted clinicians providing Psychiatric Rehabilitation Services pursuant to this Agreement is an "Excluded Entity/Individual," which is defined for purposes of this Agreement as an individual or entity that (1) is currently listed on the government-wide Excluded Parties List System in the System for Award Management ("SAM"), in accordance with the Office of Management and Budget ("OMB") guidelines at 2 CFR 180 that implement Executive Orders 12549 and 12689; or (2) is currently excluded, debarred, or otherwise ineligible to participate in the federal health care programs as defined in 42 U.S.C. § 1320a- 7b(f) (the "Federal Health Care Programs"). On a monthly basis, DCO shall perform a check of DCO and each clinician providing Psychiatric Rehabilitation Services pursuant to this Agreement against the SAM Exclusion Database and the Office of Inspector General's ("OIG's") Exclusion Database. If DCO becomes excluded, this Agreement shall terminate automatically. If a clinician becomes excluded, he or she shall immediately be removed from providing Psychiatric Rehabilitation Services pursuant to this Agreement.

SECTION 3. LINGUISTIC AND CULTURAL COMPETENCE; TRAINING

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

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

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

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

SECTION 4. INDEMNIFICATION.

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

SECTION 5. BILLING AND COMPENSATION.

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

For purposes of this sample, it is contemplated that the CCBHC will exclusively compensate the DCO for Psychiatric Rehabilitation Services furnished to uninsured consumers at and below 250% of the federal poverty level. Note that this is just an example. This description must be modified to reflect the parties' particular collaborative relationship and must be in alignment with the scope of activities proposed in the CCBHC's Expansion Grant application.

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

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

5.3 DCO shall provide the Behavioral Health Clinic with an invoice for Psychiatric Rehabilitation Services rendered to uninsured Consumers pursuant to this Agreement by the 15th of each month in accordance with the terms of Exhibit C.

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

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

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

SECTION 6. INSURANCE OBLIGATION.

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

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

SECTION 7. ASSURANCE OF CONSUMER AND PROVIDER CHOICE.

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

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

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

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

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

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

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

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

8.4 As applicable, DCO agrees to assist and cooperate with Behavioral Health Clinic regarding any audit (and all audit-related requirements and responsibilities) performed in connection with the activities contemplated hereunder.

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

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

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

> **Note:** The Funding Announcement provides that the CCBHC must have a plan in place to improve care coordination between the CCBHC and DCOs using HIT. The plan should include how the CCBHC can support electronic health information exchange to improve care transitions to and from the CCBHC using the HIT system they have or are developing related to transitions of care. The CCBHC may accordingly wish to include a provision describing the data elements that the DCO must submit to the CCBHC, as are necessary to comply with requirements for reporting related to the SAMHSA Uniform Reporting System (URS). In addition, the CCBHC may wish to include additional detail concerning the technology requirements associated with information sharing and/or to include a provision establishing that the Parties will work toward making their EHR systems interoperable.

SECTION 9. COMPLIANCE WITH APPLICABLE LAW.

DCO shall comply fully with all applicable statutes, rules, regulations, and standards of any and all governmental authorities and regulatory and accreditation bodies relating to the provision of psychiatric rehabilitation services.

SECTION 10. TERM.

> **Note:** As an alternative to the following, the Parties may wish to include a finite term (e.g., the project period for the SAMHSA CCBHC Expansion Grant), without automatic renewal. Regardless of whether the term allows for automatic renewals, the term of the Agreement should be at least one (1) year.

This Agreement's term shall commence on _____, 20 __ (the "Effective Date"), and shall terminate on _____, 20 __ unless terminated at an earlier date in accordance with Section 11 of this Agreement. This Agreement will automatically renew for _____ year terms unless written notice is provided from one Party to the other Party _____ days prior to the expiration of the Agreement indicating such Party's desire not to renew the Agreement.

SECTION 11. TERMINATION.

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

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

11.2 This Agreement may be terminated without cause upon [insert] ( ) 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 [insert] ( ) day opportunity to cure and a failure to cure by the end of the [insert] ( ) day period. This cure period shall be shortened if a shorter period is required by the State of [insert] Department of Health, SAMHSA, the state Medicaid agency, or any other entity by which either Party must be licensed or accredited in order to conduct regular operations;

11.3.2 termination of, or a material reduction in, Behavioral Health Clinic's CCBHC Expansion Grant;

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

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

11.3.5 either Party becomes an Excluded Entity/Individual, as set forth in Section 2.3.

SECTION 12. CONFIDENTIALITY OF CONSUMER HEALTH INFORMATION.

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

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

12.2 DCO shall ensure that it and its employed and contracted clinicians maintain the privacy and confidentiality of all information regarding the personal facts and circumstances of the Consumers in accordance with all applicable federal and state laws and regulations (including, but not limited to, the Health Insurance Portability and Accountability Act and its implementing regulations set forth at 45 CFR Part 160 and Part 164 ("HIPAA")) and 45 CFR Part 2.

12.3 DCO shall ensure that its employees, agents, contractors, and other representatives who have access to the Consumers' health information are aware of and comply with the aforementioned obligations set forth in this Section 12.

SECTION 13. NOTICES.

Any and all notices, designations, consents, offers, acceptances, or other communication required to be given under this Agreement shall be in writing, and delivered in person or sent by registered or certified mail, return receipt requested, postage prepaid, or by electronic mail or facsimile to the following addresses:

If to Behavioral Health Clinic:

If to DCO:

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

SECTION 14. INDEPENDENT CONTRACTORS.

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

SECTION 15. DISPUTE RESOLUTION.

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

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

SECTION 16. GOVERNING LAW.

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

SECTION 17. SEVERABILITY.

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

SECTION 18. THIRD PARTY BENEFICIARIES.

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

SECTION 19. ASSIGNMENT.

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

SECTION 20. ENTIRE AGREEMENT.

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

SECTION 21. AMENDMENTS.

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

SECTION 22. HEADINGS AND CONSTRUCTION.

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

SECTION 23. AUTHORITY.

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

SECTION 24. COUNTERPARTS.

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

SIGNATURE PAGE TO FOLLOW.

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

Behavioral Health Clinic	**Community Hospital**
Signature: _____	Signature: _____
Date: _____	Date: _____

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

WHAT YOU NEED TO KNOW ABOUT ACTING AS A DCO

SAMHSA has awarded CCBHC Expansion Grants to providers that demonstrate compliance with CCBHC program requirements that originated in a Medicaid demonstration program launched in eight states in 2017. The goal of both the grant program and the demonstration program is to furnish comprehensive, person-centered behavioral health services. While grantees under the CCBHC Expansion Grant program use grant funds in order to fulfill the CCBHC program requirements, grantees are not eligible for the unique CCBHC Medicaid payment methodology that applies to the demonstration participants.

What Is a CCBHC?

A CCBHC serves as a hub for comprehensive safety-net behavioral health services for its consumers. Please review the SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement for detail on CCBHCs' program requirements. Two of CCBHCs' main functions are the following:

1. **Provides a comprehensive array of services.** Each provider certified as a CCBHC must demonstrate that it can furnish the full set of required CCBHC services. For CCBHC Expansion Grantees, those services are the following. Services that may be furnished via DCO are indicated with an asterisk.

What Is a CCBHC? (cont.)

- Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization.*[61]
- Screening, assessment and diagnosis.
- Patient-centered treatment planning.
- Outpatient mental health and substance use disorder services.
- Screening for HIV and viral hepatitis (A, B and C).
- Primary care screening and monitoring.*
- Targeted case management.*
- Psychiatric rehabilitation services.*
- Peer support services and family support services.*
- Services for members of the armed services and veterans.*
- Clinical monitoring for adverse effects of medications including monitoring for metabolic syndrome consistent with published guidelines.*
- Social support opportunities through established models such as clubhouses that provide therapeutic individual and group interactions, assistance with employment, housing and other community recovery supports.*
- Assertive community treatment.*[62]

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

2. **Functions as a true safety-net behavioral health provider.** Each CCBHC must meet rigorous requirements for making the required services available and accessible to all consumers. These include:

   - Not refuse services to any consumer, regardless of form of coverage or uninsured status, based on inability to pay or place of residence.
   - Offer CCBHC services based on a sliding fee discount schedule to make the services affordable for low-income consumers.
   - Provide each CCBHC consumer with a preliminary screening and risk assessment at time of first contact and develop and update a person-centered treatment plan.
   - Provide crisis management services that are accessible 24/7.

[61] Crisis services may be furnished via DCO only in limited circumstances; see exception in Question 2 of "Where Do DCOs Fit In?" in this document.
[62] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, pp. 8-9.

Where Do DCOs Fit In?

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

The basic requirements for the DCO relationship are the following:

1. **The CCBHC is clinically responsible for services furnished via DCO.** The CCBHC must ensure (through the DCO agreement) that the DCO furnishes CCBHC services in a manner such that they are accessible to consumers and delivered consistently with all CCBHC requirements, including application of the sliding fee discount schedule to CCBHC consumers.

2. **Only certain services may be furnished via DCO.** Only eight of the 13 required CCBHC services that Expansion Grantees must furnish, can be covered via DCOs. They are primary care primary care screening and monitoring, targeted case management, psychiatric rehabilitation services, peer support services and family support services, services for members of the armed services and veterans, clinical monitoring for adverse effects of medications, social support opportunities (e.g., through clubhouse model) and community supports and assertive community treatment.

The remaining required CCBHC services must be provided directly by the CCBHC, except in special circumstances where crisis care may be provided via a state-sanctioned crisis system acting as a DCO.[63]

[63] In addition, in some circumstances, crisis behavioral health services may be furnished via DCO. **See** RFA for SAMHSA Planning Grants for CCBHC, Appendix II – Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (RFA, Appendix II), Criterion 3.c.3; SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 4.C, p. 95.

What are the Advantages of Acting as a DCO?

1. **Participating in a collaborative effort to advance access to care.** As a DCO, your organization will play a critical role in providing a comprehensive array of behavioral health services for CCBHC consumers. You will learn more about the services furnished by the CCBHC in this process and in the process, you may choose to refer the consumers you routinely serve to the CCBHC for services that your organization does not provide.

2. **Getting paid for services that your organization might otherwise provide free of charge.** Some of the services included in CCBHCs' scope of services are not otherwise covered by health care payors. Your organization, serving as a DCO, may negotiate with the CCBHC to furnish services to low-income, uninsured individuals either as a contractor (i.e., the CCBHC pays your organization FMV for procured services) or as a subrecipient of the CCBHC Expansion Grant. CCBHC Expansion Grant funds are intended to supplement, not supplant existing sources of funding for the CCBHC services, so the support provided through the grant to the DCO should be used only to cover the costs of otherwise-unreimbursed services provided to low-income, uninsured individuals.

3. **CCBHC patients who receive CCBHC services via DCO may come to you for other services.** As a DCO, your organization will serve CCBHC consumers under an agreement with the CCBHC. In the process of receiving CCBHC services, the consumer may learn about other services furnished by your organization and seek other types of care from you.

What New Responsibilities are Required of DCOs?

In addition to furnishing the contracted CCBHC services under all the same quality, accessibility and clinical requirements that apply to the CCBHC, the DCO will be required to ensure that the CCBHC services the DCO furnish are accessible to all CCBHC consumers, regardless of their ability to pay. The DCO is also required to convey data to the CCBHC to enable the CCBHC to fulfill SAMHSA quality reporting requirements and otherwise participate in care coordination efforts with the CCBHC to ensure that consumers seeking care through the DCO have seamless access to CCBHC services.

How Can Organizations Interested in Becoming A DCO Prepare?

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

- What is the capacity of your organization to take on additional consumers?
- Can your organization implement the clinical and financial requirements of the CCBHC Expansion Grant program, including but not limited to, application of the sliding fee discount schedule to CCBHC consumers and collection of cost sharing obligations from consumers?
- What CCBHC services does your organization offer that a potential CCBHC partner may not be able to provide?
- What costs are associated with the CCBHC services that you would provide?
- What constitutes adequate reimbursement for CCBHC services to ensure your organization's capacity to furnish those services to low-income uninsured consumers?
- How will your organization exchange information electronically with a CCBHC?

DCO QUESTIONS AND ANSWERS

1. What services may a CCBHC Expansion Grantee furnish to its consumers through a DCO?

Of the required CCBHC services, the CCBHC Expansion Grantee is required to furnish several directly (not via a DCO relationship). These services are comprehensive behavioral health screening, assessment and diagnosis, including risk assessment; person-centered and family-centered treatment planning; comprehensive outpatient mental health and substance use disorder services; and screening for HIV and viral hepatitis (A, B and C). In addition, in general, CCBHCs must directly provide crisis behavioral health services. However, with respect to crisis behavioral health services, a **state-sanctioned or state-licensed program** may function as a DCO.

CCBHC Expansion Grantees may furnish via DCO the remaining eight required CCBHC services: primary care screening and monitoring; targeted case management; psychiatric rehabilitation services; peer support services and family support services; services for

[64] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, pp. 8-9.

members of the armed services and veterans; clinical monitoring for adverse effects of medications including monitoring for metabolic syndrome consistent with published guidelines; social support opportunities through established models such as clubhouses that provide therapeutic individual and group interactions, assistance with employment, housing and other community recovery supports; and assertive community treatment.[65]

The CCBHC Expansion Grantee maintains clinical responsibility for services rendered to CCBHC consumers via DCO.

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

The DCO relationship typically involves a referral element, but it is more complex. A DCO is an entity that is not under the direct supervision of the CCBHC Expansion Grantee, but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. Under the written agreement, the parties should describe their mutual expectations and establish accountability for services provided and funding sought and utilized.

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

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

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

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

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

[65] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, pp. 8-9.

TIPS FOR NEGOTIATING WITH DCOs

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

PREPARE

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

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

- With respect to the CCBHC, answer the following general questions:
  - What geographical areas do I serve?
  - What organizations furnish similar services in the same geographical area?
  - What organizations in the same area furnish services to the Medicaid population?
  - For each of the CCBHC's services, what percent of the market does the CCBHC serve compared to other organizations?

- With respect to the CCBHC service that the DCO would provide through a potential DCO relationship:
  - Is the service reimbursed under the Medicaid state plan outside the context of the CCBHC demonstration? If so, what is the reimbursement methodology for the service?
  - Is the service commonly reimbursed by payors other than Medicaid (e.g., Medicare, private health insurers)?
  - Is the service otherwise supported by federal, state or local grant funding?

Identify and assess potential partners based on your market analysis.

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

- Is the potential DCO otherwise capable of meeting the clinical requirements for carrying out CCBHC services on behalf of the CCBHC (e.g., cultural and linguistic competency, requirement that services are provided on a timely basis)?

- Is the potential DCO otherwise capable of meeting the operational requirements for carrying out CCBHC services on behalf of the CCBHC?
  - Examples:
    - Sharing clinical and quality data with CCBHC sufficient to enable CCBHC to meet SAMHSA Uniform Reporting System (URS) requirements.
    - Collecting consumer fees and cost-sharing based on requirements in CCBHC's sliding fee discount schedule (if CCBHC seeks to delegate this collection function contractually).

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

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

Draft contract for relationship.

EDUCATE

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

Communicate value of the CCBHC and the demonstration.

- 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 in and outside the demonstration project.
- Attend informal networking events.
- Attend community events to showcase value to a broader audience.

Identify and explain requirements unique to CCBHCs and the demonstration.

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

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

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

Provide draft contracts to potential partners.

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

NEGOTIATE

Negotiation is discussion aimed at reaching an agreement.

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

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

Instead:

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

DETERMINING FAIR MARKET VALUE FOR SERVICES RENDERED BY A DCO

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

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

Documentation relating to the calculation of FMV for any services procured from a DCO should be retained as part of the CCBHC's files.

The DCO Agreement

According to SAMHSA, when a CCBHC furnishes services under contract with a DCO, the CCBHC is ultimately clinically responsible for all care provided.[66] In addition, the CCBHC may expend a portion of its grant funds, in the form of either a procurement or a subaward, to support the provision of discounted CCBHC services to low-income uninsured individuals by the DCO.

The relationship between the CCBHC and DCO may, therefore, contain a contractual component, under which the CCBHC procures services from the DCO on behalf of CCBHC consumers. It is important that if this is the case, the CCBHC structures the procurement in a manner that is consistent with applicable federal requirements.

[66] RFA for SAMHSA Planning Grants for CCBHC, Appendix II – Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (RFA, Appendix II), Criterion 4.a.i; SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, p. 98.

1. HHS Grant Rules

According to the Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards (45 CFR Part 75), where the costs of contracted services are claimed as allowable, the provider must document their reasonableness. A cost is reasonable if "in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost."[67] In determining whether costs are reasonable, consideration must be given to factors including "sound business practices," "arm's-length bargaining" and "market prices for comparable goods and services for the geographical area."[68]

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

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

2. The Anti-Kickback Statute

A second applicable set of rules relating to exchange of money under a DCO contract is a federal law referred to as the Anti-Kickback Statute. This law prohibits any persons, including health care providers, from intentionally offering, paying, soliciting or receiving anything of value (remuneration) to induce or reward referrals involving "federal health care programs" or to generate federal health care program business.[69] One purpose behind this law is to ensure that providers do not have an incentive to make medically unnecessary referrals, which in turn could unnecessarily increase amounts billed to federal programs for health care services.

Remuneration exchanged between health care providers can include discounts, since a discount is an item of value to the recipient of the discount. In the context of CCBHC/DCO contracting, the Anti-Kickback Statute is relevant to the extent that if a CCBHC purchased services from a DCO at a rate that reflects less than FMV, the discount could be interpreted as an inducement to the CCBHC to refer consumers to the DCO.[70]

Documenting FMV is important for purposes of the CCBHC's compliance with the Anti-Kickback Statute, chiefly from the perspective of ensuring that a CCBHC does not pay the DCO a rate below FMV.[71]

[67] 45 CFR § 75.404.
[68] 45 CFR § 75.404 (b) and (c).
[69] 42 U.S.C. §1320a-7b(b). The term "federal health care program" is defined to include both health care programs funded directly by the United States government (such as Medicare), and state health care programs, including the Medicaid and Children's Health Insurance Programs (CHIP). **Id.** §1320a-7b(f).
[70] While the contracted service itself does not constitute a referral service, other services that a CCBHC consumer accesses at a DCO could be interpreted as referral services.
[71] The Anti-Kickback Statute includes numerous statutory and regulatory "safe harbors." **See** 42 U.S.C. § 1320a-b(b)(3); 42 CFR § 1001.952. The safe harbors correspond to health care payment and business practices that, although they potentially implicate the federal anti-kickback statute, are not treated as offenses under the statute. If a provider in the community offers to contract with the CCBHC or potential CCBHC to furnish CCBHC services on a discounted basis, and the CCBHC is interested in entering such an arrangement, the CCBHC should seek legal counsel to determine whether the discounted arrangement would fall within a safe harbor.

How Is "Fair Market Value" Established?

There is no one measure for 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 has not historically been covered by private insurers or under the Medicare or Medicaid programs. The task can be yet more challenging when the provider from which the services are purchased (the potential DCO) has typically furnished the services on an uncompensated basis in the past, using grant funds to support the uncompensated costs of care.

Several examples of acceptable measures of FMV include:

- Average hourly or annual salary costs for clinicians furnishing service, based on published salary surveys applicable to the region.
    - **Note**: This measure would be most appropriate for services rendered by a single clinician.

- Fees per unit of service according to Medicare or Medicaid fee schedules, or a percentage of those fees.
    - Where FMV is based on the Medicare Part B Physician Fee Schedule, the Geographic Practice Cost Index (GPCI) applicable to the region should be taken into consideration.

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

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

- The potential DCO's historical costs of furnishing the services to be purchased.

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

FEE SCHEDULE RESOURCES

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

According to guidance issued by SAMHSA, CCBHCs must maintain a written schedule of fees for their services[72] that conforms to state statutory or administrative requirements or to federal statutory or administrative requirements that may be applicable to existing clinics. Absent applicable state or federal requirements, the fee schedule should be based on locally prevailing rates or charges and should take into account the CCBHC's reasonable costs of operation.[73]

Under the SAMHSA CCBHC Expansion Grant, CCBHCs must ensure that no individuals are denied CCBHC services due to their inability to pay.[74] Accordingly, CCBHCs are required to reduce or waive fees or payments for CCBHC services if such fee or payment presents a barrier to care. The schedule of discounts on otherwise applicable fees to make services more affordable to consumers is referred to as a "sliding fee discount schedule." CCBHCs are required to publish a written sliding fee discount schedule, by making it available on the website, posted in the waiting room and provided in a format that ensures meaningful access to the information.[75]

CCBHCs must establish and maintain written policies and procedures describing eligibility for and implementation of the sliding fee discount schedule.[76] These policies and procedures must be applied equally to all individuals seeking CCBHC services (including through DCOs).[77]

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

- The CCBHC's fee schedule has been established according to relevant state or federal statutory or administrative requirements or the fees are based on locally prevailing rates or charges and are consistent with the CCBHC's reasonable costs of operation.[78]

- The CCBHC has established a sliding fee discount schedule that is designed to assure that the CCBHC's consumers have access to all CCBHC services. Consumers will not be denied services on the basis of inability to pay or place of residence, nor will the availability of CCBHC services be limited on these grounds.[79]

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[72] Please see the Introduction to the Toolkit for a discussion of the required CCBHC services.
[73] RFA for SAMHSA Planning Grants for CCBHC, Appendix II – Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (2015 Planning Grant RFA), Criterion 2.d.3.
[74] SAMHSA FY 2020 CCBHC Expansion Grant Funding Announcement, Criterion 2.D, p. 90.
[75] **Id**.
[76] RFA for SAMHSA Planning Grants for CCBHC, Appendix II – Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (2015 Planning Grant RFA), Criterion 2.d.4.
[77] **Id**. Criterion 2.d.4.
[78] **Id**. Criterion 2.d.3.
[79] PAMA § 223(b)(2)(B) (42 U.S.C. § 1396a (note)); 2015 Planning Grant RFA, Criterion 2.d.1.

- CCBHC services furnished through a DCO will be furnished in accordance with a sliding fee discount schedule.[80]

- The CCBHC (and its DCOs, as applicable) will provide consumers with information regarding the sliding fee discount schedule. Specifically, the sliding fee discount schedule will be communicated in languages and formats appropriate for individuals seeking services who have limited English proficiency or disabilities.[81] In addition, the sliding fee discount schedule will be posted on the CCBHC website and in the CCBHC waiting room.[82] 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 consumers will have access to a sliding fee discount schedule (if they meet the eligibility criteria for the discounts), regardless whether services are furnished through the CCBHC or through a DCO.[83]

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 consumer's eligibility to obtain a fee discount under the sliding fee discount schedule.

- Alternative mechanisms to determine a consumer's eligibility for the sliding fee discount if he/she is unable to provide the necessary documentation/verification, such as through allowing for self-declaration.

- Provisions related to billing and collections including, but not limited to, payment incentives, grace periods, payment plans and refusal to pay guidelines.

[80] 2015 Planning Grant RFA, Appendix II, Criteria 2.a.3 and 4.a.5.
[81] **Id**. Criterion 2.d.2.
[82] **Id**.
[83] **Id**. Criterion 2.d.4.

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 consumers and families?
- ☐ Are the sliding fee discount schedule policies and procedures being equally applied to all individuals seeking services, such as through any new patient registration?
- ☐ Is the sliding fee discount schedule communicated in languages/formats appropriate for individuals seeking services who have limited English proficiency or disabilities?
- ☐ If the CCBHC furnishes any services through DCOs, has the CCBHC ensured through the agreement that DCOs will make services accessible to low-income, uninsured individuals using a sliding fee discount schedule?

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