CCBHC DESIGNATED COLLABORATING ORGANIZATIONS (DCO) GUIDANCE

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Definitions & Core Concepts

A Designated Collaborating Organization (DCO) is an entity that is engaged in a formal relationship with the CCBHC to deliver one or more of the core CCBHC services under the same requirements as the CCBHC, in exchange for payment. A CCBHC might choose to engage a DCO if the CCBHC does not yet provide a core service and a partner organization does. In this situation, the CCBHC must consider whether to implement the service themselves or engage a DCO. CCBHCs do not have to engage a DCO, if they provide all core services in-house.

DCOs must meet the same standards as CCBHCs for the services that they provide, as described throughout the DE CCBHC Criteria. The Criteria does include a number of items that uniquely pertain to DCOs, as shown below.

Table 1. DCO-specific DE Criteria

Section	Criteria	Content Overview
1.B Licensure and Credentialing of Providers	1.b.1	DCO providers that provide CCBHC services must be licensed and credentialed to provide such services. Requires DCOs to be certified as relevant provider type.
3.A General Requirement of Care Coordination	3.a.3, 3.a.6	Requires DCOs to be a member of and participate in DTRN360. Requires client freedom of choice/conflict-free care coordination at the CCBHC, DCO, or another organization.
3.B Care Coordination & Other Health Information Systems	3.b.4, 3.b.5	CCBHC accountability to ensure DCO complies with relevant privacy and confidentiality requirements, include obtaining consent and complying with HIPAA. Create and implement a plan within two years of certification to improve care coordination through a health IT (HIT) system and integrate DCO clinical records into the CCBHC health record, and make relevant CCBHC clinical records available to the DCO.
3.D Care Treatment Team, Treatment Planning, and Care Coordination Requirements	3.d.3	CCBHC accountability to coordinate services provided by DCO in accordance with client's treatment plan.
4.A General Service Provisions	4.a.1, 4.a.4	CCBHC responsibility to provide all required services, directly or through DCO agreement. CCBHC must directly deliver 51%+ of all encounters across all services except crisis services. DCO services must meet CCBHC quality

		standards and taken together, the CCBHC and DCO must meet all requirements.
4.B Requirement of Person-Centered and Family-Centered Care	4.b.1	CCBHC ensures that the DCO provides services that are person/family/youth centered; developmentally appropriate; recovery-oriented; incorporate shared decision making.
4.E: Person-Centered and Family Centered Treatment Planning	4.e.1, 4.e.6, 4.e.7	CCBHC ensures that the DCO provides person-centered and family-centered treatment planning including risk assessment and crisis planning. Treatment plan references when recommended services are referred to DCO, or other service provider and when recommended services are deferred or not otherwise provided by CCBHC or DCO and the reason why.
Appendix	N/A	Definition of Designated Collaborating Organization (DCO). Includes expectations of seamless client experience, formal agreement, regular coordination.

Coordination of Care

DCOs are expected to seamlessly integrate the core service(s) they provide under the umbrella of the CCBHC such that the person receiving services, and their family members, experience services provided through a DCO as part of a coordinated CCBHC package. This collaboration should go beyond traditional care coordination relationships. For example, DCOs and CCBHCs must leverage HIT to share relevant information (see Criterion 3.5, above), reducing the administrative burden on people receiving services associated with relaying information. Other examples of collaboration include merging documentation or processes (e.g. intake paperwork, treatment plans, screening processes) and co-locating services. The DCO is an extension of the care team; information must flow often and in a timely manner to ensure all team members have the information they need. In the back-office, it is critical that the two organizations have shared data dictionaries, complementary reporting processes, and coordinated processes for billing and payment, complaints and grievances, and quality improvement.

Billing & Payment

The CCBHC is paid a Prospective Payment System (PPS) rate inclusive of all CCBHC services provided by the CCBHC and its DCOs. CCBHCs must take care to incorporate the costs associated with DCOs into their cost report including payment for the services rendered, staff costs associated with developing and managing the relationship with the DCO, and technology needs associated with meeting DCO requirements. The cadence of the payment depends on the methodology used, but the PPS is paid when a “triggering” service is billed by the CCBHC on an outgoing claim.

DCO relationships are required to be structured as contractual purchases of services under the CCBHC. This means that when a service is provided by the DCO, the CCBHC

acts as the billing provider for services furnished by the DCO; however, payment to the DCO is not simply a pass through of the PPS. Instead, the CCBHC must negotiate a payment to the DCO that reflects an objective estimation of fair market value of the specific service. The billing and payment process is described below:

1. CCBHC client receives contracted service from the DCO
2. DCO bills the CCBHC for service rendered, sharing all information needed to support the PPS claim and care coordination
3. CCBHC submits claim for PPS
4. Medicaid pays PPS to CCBHC
5. CCBHC pays contracted amount to DCO for service rendered

In order to facilitate billing and payment, DCOs must be licensed, certified, and/or credentialed, and enrolled as a Medicaid provider.

Non-Fiscal DCOs

In some situations, a DCO may not be able to accept payment for services rendered; however, a DCO relationship is still warranted if the contracted service is one of the nine core CCBHC services. This is usually related to concerns about "double dipping". For example, a DCO organization may be receiving specific grant funding for a service. In this scenario, it would not be appropriate for them to also accept payment from the CCBHC for the same service. A second example is if CCBHC A provides a core service, such as adult IOP, on behalf of CCBHC B. In this scenario, CCBHC A should ensure that these services are included in their cost report and CCBHC B should ensure that they are not. Non-Fiscal DCOs are still required to meet all CCBHC criteria including reporting, quality, and care coordination.

The DCO Agreement

The DCO agreement is a formal, legal agreement that describes each party's mutual expectations and deliverables regarding the services to be provided. It documents the purchase of the required CCBHC service(s) from the DCO and creates an accountability framework that mitigates risk for the CCBHC should there be performance or legal issues. At a high level, CCBHCs should ensure that the following topics are addressed: access and provision of services, policies and procedures, qualifications, quality, billing and payment, accountability and oversight, data sharing and reporting, and care coordination. There are a number of resources available to support organizations in developing the DCO agreement, such as the National Council Contracting and Community Partnerships Toolkit and Rhode Island's CCBHC-DCO Oversight Checklist Guidance for Year 1.

Navigating Referrals and Services Provided Outside of the Agreement

Many DCOs offer additional services beyond those for which they contracted by the CCBHC. Whether or not the services are in scope of CCBHC dictates how these

situations are managed. If the individual served requires an additional service provided by the DCO that is not within the scope of CCBHC, the CCBHC would engage the DCO in a care coordination agreement to address referral and coordination needs but would not be responsible for payment of the service. If the indicated service is within the scope of CCBHC (and the CCBHC provides the service), the CCBHC would support the individual to select which entity will provide the service in accordance with the criteria, which requires freedom to choose a provider. If the individual chooses the DCO, the CCBHC would proceed with a care coordination agreement as described above. If the individual chooses the CCBHC, the CCBHC would proceed as usual. In either case, the service is not part of the DCO agreement and therefore would not be compensated as such; rather, the service provider would bill for the service using traditional protocols.

Assessing the Cost-Benefit of a DCO

There are a number of reasons why a DCO might be beneficial to your CCBHC. In some cases, the level of need for a particular service, and associated demand, may be more than your organization can manage. A related reason is workforce; new services require new staff and it might be difficult to hire without poaching from other key resources in your community. Leveraging an existing service increases access and service capacity almost immediately. In other situations, there may be an existing organization in the community that provides effective, specialized services such that it wouldn't make sense to try to replicate (or compete). It may also mean that building a service line from scratch would be more expensive than purchasing services from the existing organization. Relational dynamics are also a key consideration; it may be strategic to build or leverage a relationship with a strong partner rather than introducing a competitive dynamic.

On the other hand, DCOs can be expensive, complicated, and labor-intensive to manage. It is difficult to project the costs associated with managing the relationship and misjudgments will negatively impact the cost report and resulting PPS. A DCO relationship increases complexity for billing, reporting, data management, and associated policies and procedures. The agreement can be complicated to execute and monitor, and not all organizations are well positioned to comply with the vast CCBHC requirements. CCBHCs are required to directly provide 51% of all services rendered, so it is critical that DCO services do not represent a significant volume of encounters. Lastly, it can be difficult for DCOs to maintain their unique culture while striving for a seamless client experience. CCBHCs might consider whether they can provide the required services in compliance with CCBHC criteria and leverage strong care coordination agreements to connect individuals served with organizations that provide more specialized services, as needed.

Table 2. Suggested Approach to DCO Decision

1. Identify Gaps: Review current services and determine whether there are gaps in populations served, EBPs offered, or services available.
2. Assess Capacity: Determine your organization's capacity and interest in address this gap in-house. What would be the costs associated?
3. Environmental Scan: Scan the care environment to identify organizations providing services that address your gaps. Assess for mission and vision alignment, reputation, and other key factors.
4. Initial Discussion: Approach the organization(s) to assess its high-level capacity and interest in serving as a DCO. Determine a high-level cost estimate.
5. Cost/Benefit Analysis: Begin to work through elements of the DCO agreement to assess capacity and compatibility. Complete a make versus buy analysis based on the projected costs associated with purchasing the services, managing the relationship, and developing coordinated processes.
6. Formalize: Finalize the DCO agreement and ensure costs are captured in the cost report.

DCO Management & Accountability

The CCBHC is accountable for ensuring that the DCO maintains compliance with all CCBHC requirements; it is advisable to consider specific tools and strategies to support them in that process. Communication is key; at minimum, the CCBHC should establish a regular meeting to discuss updates, concerns, and engage in continuous quality improvement (CQI) around shared goals. CCBHCs might also consider requiring DCOs to attend CCBHC-hosted trainings to ensure that content is being framed and communicated in the way that CCBHC expects. Other strategies include compliance checklists, chart audits, and regular review of CQI data.

Summary

Deciding whether or not to engage a DCO is a complex decision. CCBHCs must consider whether the financial and other benefits of a DCO outweigh the significant administrative burden associated with engaging and managing the relationship. To mitigate the risks associated with a DCO, CCBHCs must allocate sufficient human and financial resources to support oversight and establish clear expectations and goals across all parties.