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Designated Collaborating Organizations (DCOs): A Deeper Look

Presenter



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Learning Objectives

- Understand how DCOs can support your CCBHC – and how they differ from care coordination partners
- Review important requirements for DCOs related to service provision, data reporting/exchange, and billing
- Discuss considerations when evaluating potential DCO relationships, including financial considerations
- Review best practice components of a DCO agreement
- Explain steps that CCBHCs and DCOs can take to create a more seamless experience for the person served
- Discuss best practices to improve communication and care planning between CCBHCs and DCOs
- Understand how Health IT systems can be leveraged to support quality, coordination, and reporting
- Describe accountability mechanisms that CCBHCs can use to help manage DCOs

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What is a DCO?

What is a DCO?

DCO

An entity that is not under the direct supervision of the CCBHC but is engaged in a **formal relationship** with the CCBHC and delivers one or more of the core CCBHC services under the same requirements as the CCBHC (i.e., in alignment with the CCBHC certification criteria).

- The CCBHC maintains programmatic, clinical, and regulatory responsibility for the services provided by the DCO to CCBHC clients.
- Payment for DCO services is included within the scope of the CCBHC PPS.
- DCO encounters will be treated as CCBHC encounters for purposes of the PPS.
- The DCO must have the necessary certifications, licenses, and/or enrollments to provide the specified Medicaid covered services.
- Performance of the CCBHC and its DCOs will be considered during re-certification.

CCBHC Criteria Relevant to DCOs



Requirements for CCBHC core services are applicable to DCOs providing that service

Also important to consider:

Information from the DCO that the CCBHC will need for PPS billing

DE Criteria Overview

Section	Criteria	Content Overview
1.B Licensing 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 Care Coordination Requirements	3.a.3	Requires DCOs to be a member of and participate in DTRN360.
	3.a.6	Requires client freedom of choice/conflict-free care coordination at the CCBHC, DCO, or another organization.
3.B Care Coordination & Other Health Information Requirements	3.b.4	CCBHC accountability to ensure DCO complies with relevant privacy and confidentiality requirements, include obtaining consent and complying with HIPAA.
	3.b.5	Create and implement a plan within two years of certification to improve care coordination through a health IT system and integrate DCO clinical records into the CCBHC health record, and make relevant CCBHC clinical records available to the DCO.
3.D Care Coordination & Other Health Information Requirements	3.d.3	CCBHC accountability to coordinate services provided by DCO in accordance with client's treatment plan.

DE Criteria Overview (continued)

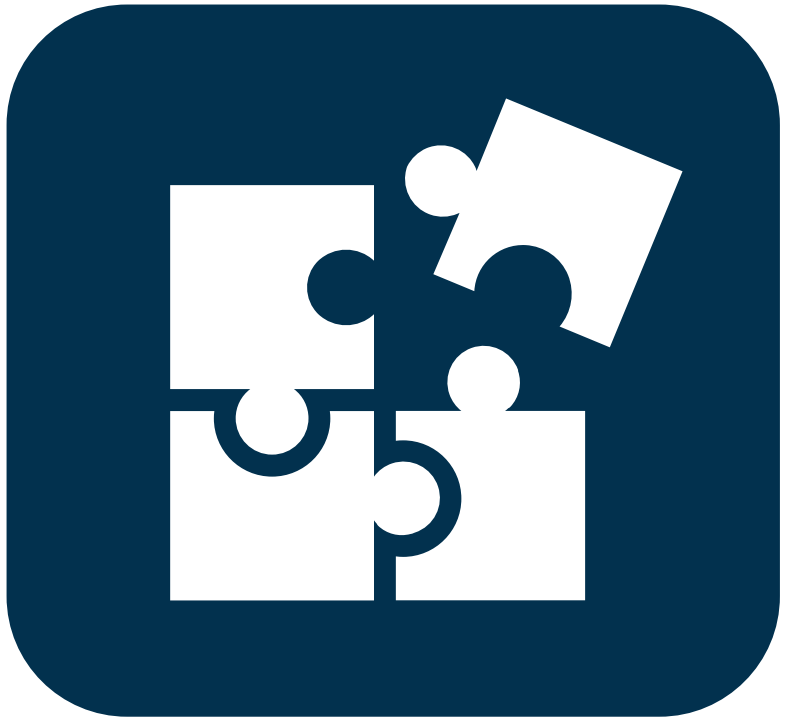
Section	Criteria	Content Overview
4.A General Service Provisions	4.a.1	CCBHC responsibility to provide all required services, directly or through DCO agreement. CCBHC must directly deliver 51%+ of all encounters across all services except crisis services.
	4.a.4	DCO services must meet CCBHC quality standards 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	CCBHC ensures that the DCO provides person-centered and family-centered treatment planning including risk assessment and crisis planning.
	4.e.6, 4.e.7	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		Definition of Designated Collaborating Organization (DCO). Includes expectations of seamless client experience, formal agreement, regular coordination.

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DCOs: Key Requirements

Designated Collaborating Organization (DCO)

Not under direct supervision of the CCBHC but affiliated through formal relationship to deliver at least one core CCBHC service.



DCO-provided services must conform to the relevant CCBHC criteria including accessibility timeframes, care coordination participation, quality, and data reporting.

DCO must seamlessly integrate the core service(s) they provide under the umbrella of the CCBHC - which must go beyond care coordination participation.

Person receiving services, and their family members, should experience services through a DCO as a part of a coordinated package with other CCBHC services.

"DCOs are **more than care coordination or referral partners**, and there is **an expectation** that relationships with DCOs will include **more regular, intensive collaboration across organizations** than would take place with other types of care coordination partners."

- 2023 CCBHC Criteria (Appendix, Definition of DCO)

Designated Collaborating Organization (DCO)

DCOs must be licensed, certified and/or credentialed, and enrolled as a Medicaid provider

CCBHCs are paid a PPS rate inclusive of all CCBHC services provided by the CCBHC and its DCOs.

The CCBHC determines and negotiates the payment to the DCO	The DCO payment is **NOT** a PPS pass-through	The CCBHC payment to the DCO should reflect an objective estimation of fair market value of the specific service(s) provided by the DCO	DCOs shall not FFS bill for CCBHC services provided to CCBHC members	CCBHCs retain responsibility for claims submission and must collect from DCOs all documentation necessary for CCBHC data collection and billing

DCO vs. Care Coordination Relationships

	DCO	Care Coordination
Scope	DCO provides designated core CCBHC services and participates in CCBHC's care coordination activities	CCBHC has relationships with various entities to provide services outside of the CCBHC scope of services; CCBHC staff coordinate care with these external partners
Type of Agreement	Purchase of services agreement	Referral agreement
Responsibility	DCO is responsible for delivery of the agreed-upon service element, but CCBHC is responsible for ensuring services delivered are aligned with CCBHC care and quality expectations	Other entity is autonomous and responsible for services provided
Billing Provider	CCBHC is responsible for billing all CCBHC services provided by the DCO under agreement	Other entity bills payers for services it provides
Consideration	CCBHC compensates DCO for services provided	CCBHC does not exchange funds with or otherwise compensate other entity
Schedule of Fees/ Discounts	CCBHC and DCO have written P&P outlining agreed-upon schedule of fees and discounts	Other entity develops and uses its own fee and discount schedules
Mandatory/ Optional	Optional	Mandatory

Care Coordination Within DCO Relationships

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

DCO provides additional services that are outside CCBHC scope

- CCBHC engages entity in care coordination agreement to address referral and coordination needs.

DCO provides additional services that are within the CCBHC scope

- In accordance with criteria, support individual served to select which entity will provide service based on goodness of fit.
  - If DCO, follow standard care coordination protocols.
  - If CCBHC, follow standard CCBHC protocols.

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DCO Payment and Information Exchange

DCO Payment

- DCOs are paid by the CCBHC - and not Medicaid FFS - for services rendered to CCBHC clients that are covered under their DCO agreement.
- DCOs may not bill Medicaid directly for CCBHC services covered under their DCO agreement.
- CCBHCs should include the costs related to compensating and administering a DCO in their cost report to determine the appropriate PPS.

- For *Medicare and commercial clients*, the CCBHC and DCO should determine billing processes and note them in their agreement.

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DCO Payment

Costs associated with DCO services covered by the DCO agreement are built into the CCBHC PPS rate, including:

- Payment to DCO for services rendered
- Staff costs associated with developing and maintaining the relationship
- Technology needs associated with meeting DCO requirements

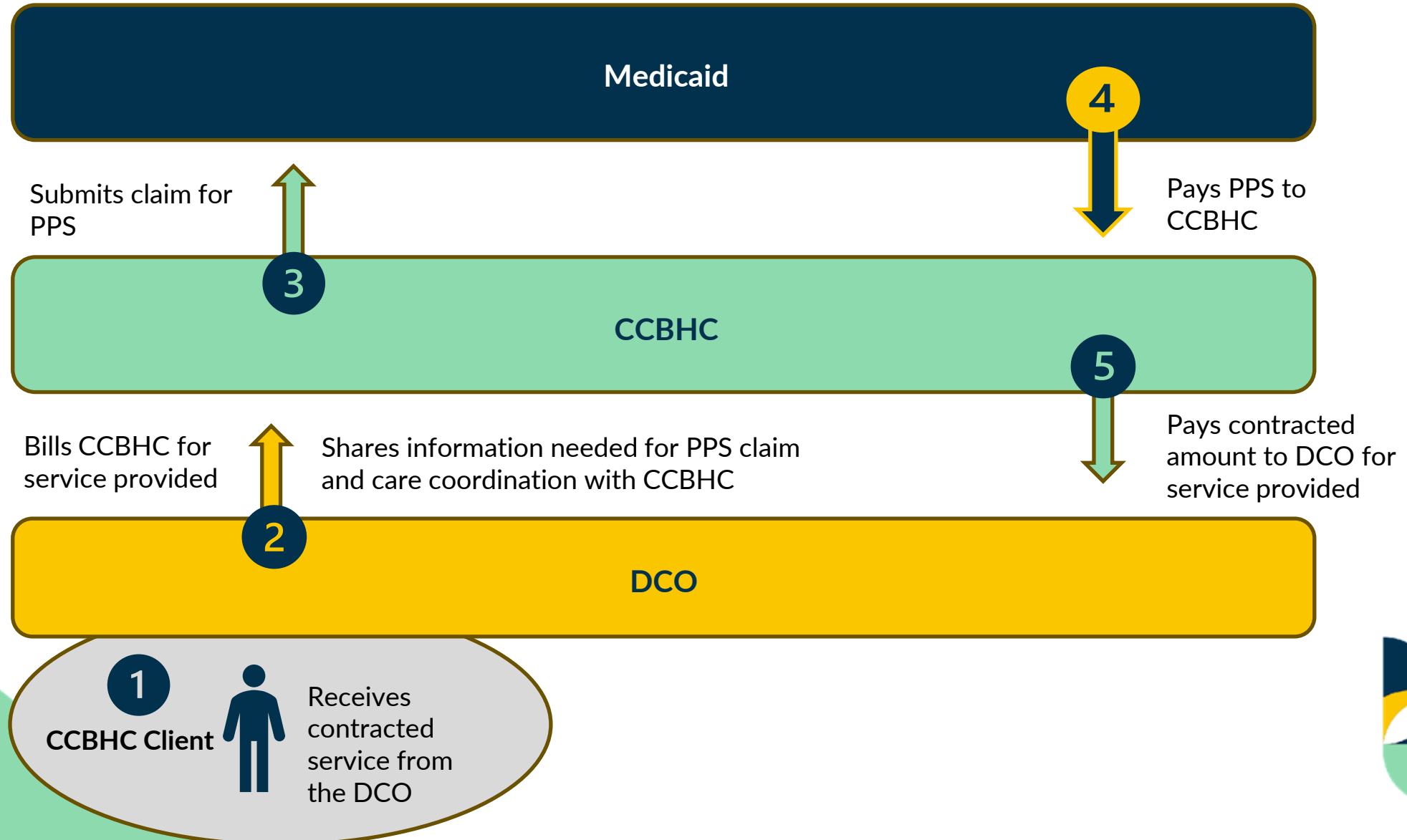
DCO services that meet the definition of an encounter are included as encounters in the cost report.

Adapted from the National Council for Mental Wellbeing, 2025

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DCO relationships are required to be structured as *contractual purchases of services* under the CCBHC. The CCBHC acts as the billing provider for services furnished by the DCO. The CCBHC compensates the DCO for delivering the agreed-upon service on behalf of the CCBHC.



Basic Flow of Payment

1. The DCO provides the CCBHC service outlined in their DCO agreement
2. The DCO bills the CCBHC in accordance with its agreement
3. The CCBHC bills Medicaid the PPS rate for the DCO service. In some states, a modifier is used to identify services performed by the DCO
4. Medicaid pays the CCBHC the PPS rate
5. The CCBHC pays the DCO the negotiated rate (DCO payment may come before Medicaid payment to CCBHC, depending on the DCO contract)

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Non-Fiscal DCOs

- When the DCO receives its own exclusive funding for the services being rendered payment to the DCO may not be allowed or appropriate.
- If a non-fiscal DCO will be used to provide CCBHC services, this must be reflected accurately in the cost report.

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Managing Clients Shared Between CCBHC & DCO

Scenario: A CCBHC contracts with a DCO for a specific service. The DCO also provides other services that are part of the CCBHC scope of services; however, these are not included in the DCO agreement.

A client goes to the DCO for the agreed-upon service and identifies the need for additional services. Can she receive services from the DCO beyond the scope of the DCO agreement? Is she still considered a CCBHC client when receiving these additional services? How are they paid for?



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Considerations

- The priority is client choice – who does she want to receive services from?
- Engage the client in a discussion about the various services in her treatment plan and the options of who can provide those services.
- Communicate clearly with the DCO about care coordination expectations.
- Anticipate and plan for the possibility that clients may change providers during treatment.
- Plan ahead for challenges that may arise.

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To Be or Not To Be a CCBHC Client

- ☑ If the client is still receiving CCBHC services from the CCBHC then yes, they are still a CCBHC client!
- ☑ If the DCO is providing the service for which they are under agreement with the CCBHC, then they are a CCBHC client.
- ☒ If the DCO is providing a service for which they are NOT under agreement with the CCBHC, the DCO should bill their normal funding source for that service.
- ⊟ Crisis as a DCO service can create additional challenges. Further discussion about how it is being provided in a specific catchment area should be discussed in an individual TA session.

*Client **choice** is key but so is **coordination and communication** between all involved.*

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CCBHC-DCO Information Exchange

- CCBHC Criteria 3.B and 5.A describe expectations related to data exchange shared across the CCBHC and DCO.

- The CCBHC criteria does not address the exchange of data needed for billing and claiming, but obviously this is also very important.

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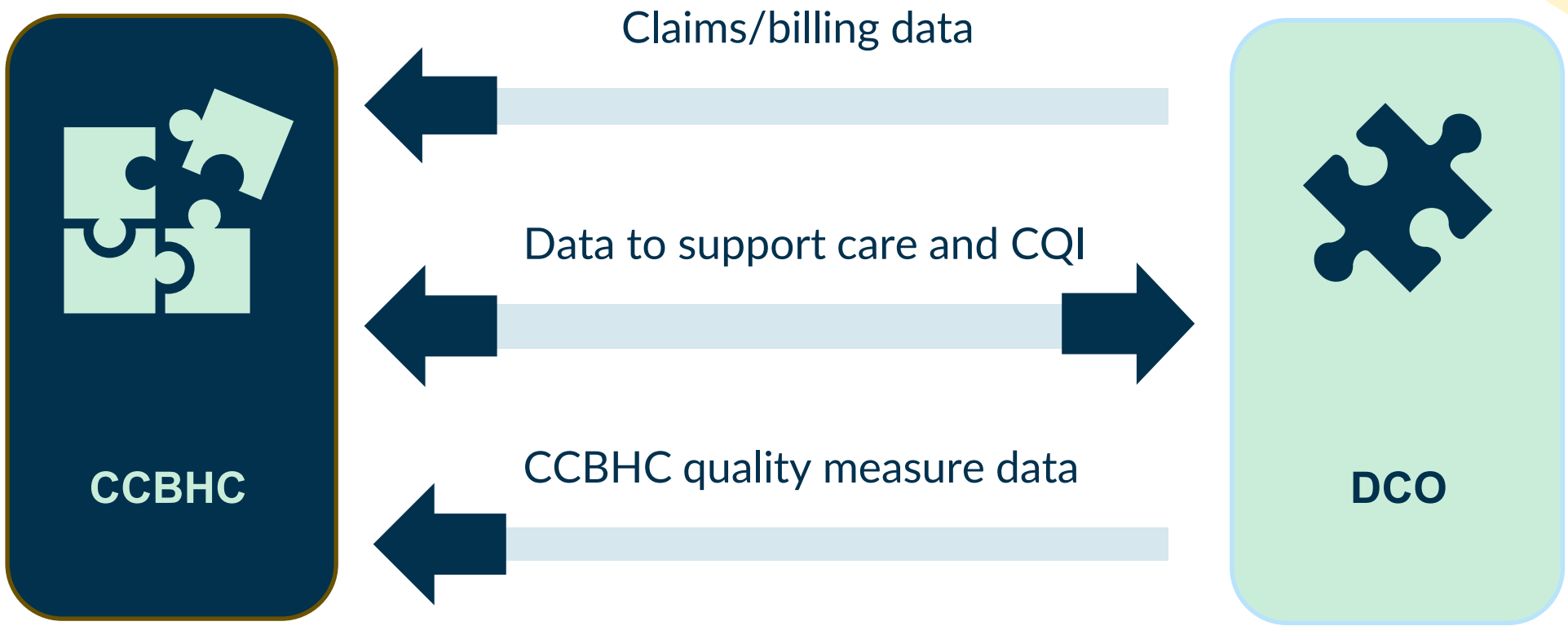
CCBHC-DCO Information Exchange

Criteria 3.B and 5.A - Highlights
The CCBHC **develops and implements a plan within two years** from CCBHC certification **to focus on ways to improve care coordination** between the CCBHC and all DCOs **using** a **health IT** system.
This **plan includes** information on how the CCBHC can support **electronic health information exchange** to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care.
CCBHCs should **ensure that consent is obtained and documented** as appropriate, and that releases of information are obtained for each affected person.

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Information Exchange



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Does a DCO Make Sense for Your CCBHC?

Considerations for the DCO Relationship

When might a DCO be beneficial?

- Specialized nature of services
- Level of need within the community
- Workforce realities
- Make vs. buy calculations
- Pre-existing strength of relationships
- Reinforce diversity of provider landscape by supporting, rather than competing, with partners.

Adapted from the National Council for Mental Wellbeing, 2025

DCO Trade-Offs: Service Delivery

Pros	Cons
External organization may be uniquely well-suited to provide a required service (e.g., a peer-led support organization)	Requires clients to go to and be familiar with a new provider/site
Increases access by accelerating start-up period	Increases complexity of care coordination
Increases service capacity	
DCO provides highly specialized approach to the service	

DCO Trade-Offs: Administrative

Pros	Cons
Allows for other provider organizations to remain viable and strong partners, rather than in competition with the CCBHC.	Redirects resources to an external organization that the CCBHC could use to build service capacity in-house
Can be used as a bridge to in-house program development	Requires CCBHC to allocate staff to manage DCO relationship and performance
Helps retain culture and diversity of community continuum of care	Increases complexity for billing, reporting, data management, and associated policies and procedures

DCO Trade-Offs: Legal & Fiscal

Pros	Cons
Potential fiscal benefits associated with contracted personnel (as opposed to staff FTEs)	Contracting may require engagement of legal counsel
DCO payments are not a pass-through of the PPS, enabling the CCBHC to retain a margin to support management costs	As CCBHC is accountable for DCO compliance with CCBHC requirements, requires close monitoring
	Need to ensure all required consent and confidentiality policies, forms and workflows are in place and aligned across organizations
	The cost of DCO services needs to be incorporated into CCBHC cost-reporting, which can be challenging given the cost-reporting process and timelines (especially for the first year)

DCO Compatibility Questions

What is their staff's capacity for participating in treatment planning and care coordination?

What rate would they need?

Do they serve all ages? (or at least all ages you need for the DCO)

What EHR do they use? (Ask your EHR vendor about compatibility for an API)

Are they able to collect and report to you on all necessary metrics and demographics?

More DCO Compatibility Questions

Do they have a reputation of agility and flexibility?

Is it cheaper than building in-house?

Does the leadership team have capacity to engage in the partnership?

Do their services complement or compete with yours in any way?

Do they have a proven track record for providing quality services in alignment with your philosophy of care?

If Not a DCO…Then What?



- CCBHCs were designed to promote access to a full continuum of core services.
- As part of the “make vs. buy” assessment, consider whether you can meet this intent through a generalist lens by developing a service that meets the key requirements but does not go beyond them.
- Should a person served need more specialized services, the CCBHC can leverage its strong care coordination agreements to connect the individual with an organization that specializes in more complex or acute presentations of a particular need.

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DCO Agreements

"Regardless of DCO relationships entered into, **the CCBHC maintains responsibility** for assuring that people receiving services from the CCBHC receive all nine services as needed in a manner **that meets the requirements of the CCBHC certification criteria**."

- 2023 CCBHC Criteria (Appendix, Definition of DCO)

Key Points

- Formal, legal agreement
- Describes each party's mutual expectations and deliverables regarding the services to be provided
- Documents the purchase of required CCBHC services from the DCO
- Provides an accountability framework and mitigates risk for your CCBHC if there are performance or legal issues at the DCO

We are not providing legal advice.

You are strongly encouraged to consult with your own attorneys to ensure legal compliance and protect your agency's interests.

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Helpful Resources

National Council Contracting and Community Partnerships Toolkit (2025) – "Demonstration Edition"

- *Newly Updated!*
- *Includes model* ***DCO agreement language*** *and* ***Care Coordination partner agreement language***

CCBHC-DCO Oversight Checklist Guidance for Year 1 (2024)

- *Note: This was developed by the State of Rhode Island for its CCBHCs entering the Demonstration. It includes some RI-specific requirements, but overall it is a robust resource applicable to CCBHCs in all states.*

Considerations for the Agreement

- Services
- Policies & Procedures
- Qualifications
- Quality
- Billing & Payment
- Accountability & Oversight
- Data Sharing & Reporting
- Care Coordination

Adapted from State of Rhode Island, 2024

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Planning for DCO Relationships – In Review

- The CCBHC retains responsibility for care provided by DCOs
- The goal is a seamless integration of care across the two entities
- CCBHC and DCO staff will need to work together to provide the best care to clients
- The negotiated payment for DCO services is not a PPS passthrough, and the CCBHC should maintain a margin to cover the care coordination and other responsibilities you retain
- You have some latitude to pilot information sharing systems in the first two years of the partnership, but ultimately you are seeking to integrate DCO data into your CCBHC EHR

Engaging a DCO is a strategic decision for your CCBHC. Consider the short-term and long-term benefits and trade-offs.

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Sequencing Planning Tasks

Identify Gaps

Review your current services to identify gaps. Do you provide all required services across the full lifespan?

Assess Capacity

Determine your organization's capacity and interest in providing the service in-house.

Assess the costs of providing the service in-house.

Environmental Scan

Scan care environment to identify organization(s) providing services that meet your gaps.

Complete review of these organizations to assess mission alignment, reputation, and other factors.

High-Level Discussion

Approach the organization(s) to assess its high-level capacity and interest in serving as DCO

Determine a high-level cost estimate

Cost/Benefit

Begin to work through elements of the DCO agreement to assess capacity and compatibility

Complete make vs. buy analysis

Formalize

Finalize DCO agreement

Ensure costs are captured in cost report

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Partnering to Provide Person-Centered Care

A Seamless Experience for the Person Served

The CCBHC and DCO should work to reduce administrative burden on people receiving services and their family members.

Examples of suggested collaborative activities from the criteria:

- Coordinating intake processes
- Engaging in coordinated treatment planning
- Information sharing
- Direct communication between the CCBHC and DCO to prevent the person receiving services or their family from having to relay information between the CCBHC and DCO
- Including DCO providers on CCBHC treatment teams
- Co-locating services

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Finding the Balance

When systems and processes are aligned, we reduce administrative burden and improve immediate experience of people served.

When we provide autonomy for the DCO to meet the requirements and coordinate care in the way that makes the most sense for them, we help maintain the cultural fabric of the community.

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Best Practices for DCO Partnerships

CCBHC-DCO Information Exchange

Select Criteria	
CRITERIA 3.B	The CCBHC develops and **implements a plan within two years** from CCBHC certification to focus on ways **to improve care coordination** between the CCBHC and all DCOs **using a health IT system**
	This plan **includes** information on how the CCBHC can support **electronic health information exchange** to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care
CRITERIA 5.A	CCBHCs should **ensure that consent** is obtained and documented as appropriate, **and** that **releases of information are obtained** for each affected person.

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Bidirectional Data Exchange

Interim Plan

Excel billing and reporting workbook shared via secure email or shared folder on a weekly basis. Clinical chart data shared via secure e-fax based on pre-determined notification triggers.

Goal State (2 yrs)

Billing, reporting, and clinical data transmitted across EHRs via API on a daily basis.

Bidirectional data exchange requires the CCBHC to send data to the DCO as well. CCBHCs and DCOs should negotiate what data the DCO needs from the CCBHC to provide integrated services.

BIDIRECTIONAL DATA EXCHANGE

Direct Scheduling: Limited key staff at each organization have access to the other organization's scheduling systems and can directly schedule appointments.

Intentional Information Exchange: At first appointment, FQHC (with signed consent), requests documentation of last three visits plus any recent assessment. This limited data helps improve client care without high burden to either organization.

Regular Reporting: Use Report Writer function in EHR to run reports which capture agreed upon relationship indicators and CCBHC measures at set intervals.

Shared Treatment Planning

Good

Clinically relevant treatment records generated by each entity are e-faxed or scanned into the other's chart.

Shared care planning meetings to discuss treatment needs and progress.

CCBHC care plan incorporates services provided by DCO.

Better

Separate treatment plans that incorporate relevant information from the other entity.

Shared lists of care team members and other supports.

Shared care registries.

Best

Shared care plan that collates all diagnoses and symptoms being treated, services and interventions provided, and care team members.

Shared ROIs.

API feed that automatically shares clinical data.

Co-located services.

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Streamlined Service Delivery

- Define pathways for warm handoffs across service lines
- Clarify roles in assessment, treatment planning, and treatment team meetings
- Align evidence-based treatment modalities
- Standardize screening & symptom measurement tools (e.g., PHQ-9, Columbia, etc.)
- Coordinate training & professional development
- Establish shared supervision frameworks for embedded staff
- Provide cross training across teams
- Address workforce shortages collaboratively

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Collaborative Policies & Procedures

- Billing and payment processes
- Intake process
- Treatment planning process
- Inter-agency communication strategy
- Clinical documentation and metric reporting process
- Complaints and grievances
- Quality improvement

Co-development of policies and procedures can facilitate the DCO partnership.

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EARLY PARTNERSHIP CONSIDERATIONS

Identify communication leads

- Name the individuals and/or roles that will serve as point of contact for each entity.

Establish communication protocol

- Outline the cadence, modality, structure, escalation process, and other expectations for communication.

Set goals

- Identify 2-3 mutually agreed upon goals aligned with CCBHC criteria and requirements.

Create simple metrics

- Establish metrics that align with the goals such as number referred, number served, or services delivered.

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DCO Management and Accountability

DCO Management Tools & Strategies

- Compliance checklists for the DCO
- Chart audits for CCBHC services
- Performance Improvement Plans as needed
- Regular review of CQI data with the DCO
- Regular meetings with cross-agency leadership
- Invite relevant DCO staff to participate in CCBHC staff trainings
- Ongoing opportunities for cross-agency teaming

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DCO Pitfalls

- Insufficient resources or planning to support oversight of the DCO
- Unclear expectations across parties – at the leadership and/or staff level
- Lack of vision for the relationship
- Siloed staff and/or systems across the entities
- DCO costs not fully/accurately considered in cost-reporting process
- Clunky data sharing across entities

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DCO PITFALLS

In the absence of clear, written protocols for communication and escalation, problems may get bigger, leading to poor client outcomes and ruptures in the relationship.

Sample Escalation Plan:

- **Tier 1:** Staff member A attempts to address the problem with their counterpart at the other entity, Staff member B.
- **Tier 2:** Supervisor of Staff A attempts to address the problem with Supervisor of Staff B.
- **Tier 3:** Director of Staff A attempts to address the problem with Director of Staff B.
- **Tier 4:** CEO of Staff A attempts to address the problem with CEO of Staff B.

Optimizing DCO Relationships – In Review

- Aligned systems and processes reduces administrative burden and improves the experience of people served.
- Providing space for flexibility helps preserve the culture of the DCO organization.
- There is a range of approaches to coordination, from low resource to high resource. CCBHCs should meet immediate needs while working towards streamlined processes.
- Outlining shared expectations, values, and goals up front can help avoid and mitigate downstream risk.

Cross-agency collaboration is essential to creating a seamless experience for the person served.

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Questions?

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Appendix: Considerations for the DCO-CCBHC Written Agreement

Services

- Defines the scope of services to be provided by the DCO.
- Details referral pathways between DCO and CCBHC.
- Requires that DCO services are trauma-informed, person-centered, recovery-based and culturally appropriate.
- Ensures the DCO provides translation, interpretation, auxiliary aids and meaningful access to services for individuals with Limited English Proficiency.
- Requires DCO to serve all individuals referred by the CCBHC, according to the eligibility guidelines established in the agreement and in compliance with all CCBHC quality standards pertaining to access requirements, use of evidence-based practices, care coordination, outcomes, and provision of services regardless of place of residence and ability to pay.

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Policies & Procedures

- Provides that all individuals receiving services under the agreement are considered clients of the CCBHC.
- Requires the DCO to furnish services consistent with the CCBHC's applicable clinical and personnel policies, procedures, standards, and protocols, including (a) timeframes for assessment, screening and treatment and (b) serving all consumers regardless of age, race, ethnicity, disability, sexual orientation, gender expression, developmental ability, correctional system involvement, housing status, or ability to pay.
- Includes a provision regarding the consumer's freedom to choose their provider.
- Ensures individuals receiving services from DCOs have access to CCBHC grievance procedures.

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Qualifications

- Requires the DCO staff is appropriately licensed, certified, registered, and/or credentialed as required by state and federal statute and regulations.

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Quality

- Requires that the DCO provide services that meet the same quality and clinical standards as CCBHC requirements.
- Requires the DCO and its personnel to cooperate in the CCBHC's clinical quality and compliance activities, and specify the required activities for the services they are providing (e.g., frequency of chart audits, participation in CQI meetings).
- Requires DCO clinical staff to be trained in relevant Evidence Based Practices (EBPs) and that the CCBHC monitors DCO's use of EBPs including training, coaching and fidelity compliance.

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Billing & Payment

- Specifies in advance the compensation the CCBHC will provide for services delivered by the DCO.
- Provides terms and mechanisms for billing and payment between the DCO and the CCBHC, such as invoice procedures and deadlines.
- Describes how the CCBHC's policies and procedures related to billing of third parties will apply to the DCO.
- Describes how fees and cost-sharing for non-Medicaid beneficiaries (including commercial and Medicare clients) will be collected.
- Details methods to ensure the DCO bills the CCBHC for attributed and referred clients appropriately, such as a description of CCBHC referral procedures and how the CCBHC will communicate attribution to the DCO.

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Accountability & Oversight

- States that the CCBHC provides oversight of all services performed by the DCO, consistent with the requirements of the CCBHC Certification Criteria.
- Includes language allowing the CCBHC to withhold or deny payment for services rendered in breach of a material term of the agreement.
- Requires full DCO participation in and timely delivery of any supporting materials upon request related to any state or federal audits or corrective action plans (CAPs).
- Requires the DCO to furnish to the CCBHC programmatic, staffing and/or financial reports pertaining to the services provided under the agreement, as deemed necessary by the CCBHC for monitoring, oversight and compliance.
- Describes performance management and monitoring processes that the CCBHC will use with the DCO.

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Data Sharing & Reporting

- Requires the DCO to collect and maintain all documentation necessary for CCBHC data collection and reporting.
- Requires the DCO to prepare health records consistent with CCBHC's standards.
- For each service provided by the DCO, specifies the following about the bidirectional data exchange: method (e.g., SFTP, email); frequency; responsible parties (e.g., IT contact, invoice contact); regular auditing activities for quality; limitations and legal framework; and content. Data exchange must support billing, clinical, and quality needs.

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Care Coordination

- Indicate that the CCBHC retains care coordination responsibility.
- The CCBHC and DCO lists specific steps that are implemented to take active steps to reduce administrative burden on people receiving services when accessing DCO services. This includes expectations regarding coordination of intake systems, regular team huddles for care coordination, and direct communication between the CCBHC and DCO.
- Articulates clearly the role and function of the CCBHC and DCO in developing treatment plans, care coordination, and ensuring CCBHC coordinates DCO care/services in accordance with the current treatment plan.
- Describes the processes for ensuring that releases of information are obtained for each affected person.

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Appendix: Relevant CCBHC Certification Criteria

Criteria 1.B: Licensure and Credentialing of Providers

1.b.1 All CCBHC providers who furnish services directly, ***and any Designated Collaborating Organization (DCO) providers that furnish services under arrangement with the CCBHC***, are legally authorized in accordance with federal, state, and local laws, and act only within the scope of their respective state licenses, certifications, or registrations and in accordance with all applicable laws and regulations. This includes any applicable state Medicaid billing regulations or policies. Pursuant to the requirements of the statute (PAMA § 223 (a)(2)(A)), CCBHC providers must have and maintain all necessary state-required licenses, certifications, or other credentialing. When CCBHC providers are working toward licensure, appropriate supervision must be provided in accordance with applicable state laws.

Criteria 3.A: General Requirements of Care Coordination

3.a.6 Nothing about a CCBHC's agreements for care coordination should limit the freedom of a person receiving services to choose their provider within the CCBHC, ***with its DCOs***, or with any other provider.

Criteria 3.B: Care Coordination and Other Health Information Systems

3.b.4 The CCBHC will ***work with DCOs to ensure*** all steps are taken, including obtaining consent from people receiving services, to ***comply with privacy and confidentiality requirements***. These include, but are not limited to, those of HIPAA (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), 42 CFR Part 2, and other federal and state laws, including patient privacy requirements specific to the care of minors.

Criteria 3.B: Care Coordination and Other Health Information Systems

3.b.5 The CCBHC develops and implements a plan ***within two years from CCBHC certification*** or submission of attestation to focus on ways to ***improve care coordination between the CCBHC and all DCOs using a health IT system***. This plan includes information on how the CCBHC can support electronic health information exchange to improve care transition to and from the CCBHC using the health IT system they have in place or are implementing for transitions of care. To support integrated evaluation planning, treatment, and care coordination, ***the CCBHC works with DCOs to integrate clinically relevant treatment records generated by the DCO for people receiving CCBHC services and incorporate them into the CCBHC health record***.

Further, ***all clinically relevant treatment records maintained by the CCBHC are available to DCOs*** within the confines of federal and/or state laws governing sharing of health records.

Criteria 3.D: Care Treatment Team, Treatment Planning, and Care Coordination Activities

3.d.3 The CCBHC ***coordinates care and services provided by DCOs*** in accordance with ***the current treatment plan***.

Criteria 4.A: General Service Provisions

4.a.1 Whether delivered directly or ***through a DCO agreement***, the CCBHC is responsible for ensuring access to all care specified in PAMA. This includes, as more explicitly provided and more clearly defined below in criteria 4.c through 4.k the following required services: crisis services; screening, assessment and diagnosis; person-centered and family-centered treatment planning; outpatient behavioral health services; outpatient primary care screening and monitoring; targeted case management; psychiatric rehabilitation; peer and family supports; and intensive community-based outpatient behavioral health care for members of the U.S. Armed Forces and veterans.

The CCBHC organization will deliver directly the majority (51% or more) of encounters across the required services (excluding Crisis Services) rather than through DCOs.

Criteria 4.A: General Service Provisions

4.a.2 The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, ***consistent with the freedom of the person receiving services to choose providers within the CCBHC and its DCOs***. This requirement does not preclude the use of referrals outside the CCBHC or DCO if a needed specialty service is unavailable through the CCBHC or DCO entities.

4.a.3 With regard to either CCBHC or ***DCO services***, people receiving services ***will be informed of and have access to the CCBHC's existing grievance procedures***, which must satisfy the minimum requirements of Medicaid and other grievance requirements such as those that may be mandated by relevant accrediting entities or state authorities.

Criteria 4.A: General Service Provisions

4.a.4 *DCO-provided services* for people receiving CCBHC services must ***meet the same quality standards as those provided by the CCBHC***.

The entities with which the CCBHC coordinates care and ***all DCOs, taken in conjunction with the CCBHC itself, satisfy the mandatory aspects of these criteria.***

Criteria 4.B: General Service Provisions

4.b.1 ***The CCBHC ensures all CCBHC services, including those supplied by its DCOs***, are provided in a manner aligned with the requirements of Section 2402(a) of the Affordable Care Act.

These reflect ***person-centered and family-centered, recovery-oriented care; being respectful of the needs, preferences, and values of the person receiving services; and ensuring both involvement of the person receiving services and self-direction of services received***.

Services for children and youth are ***family-centered, youth-guided, and developmentally appropriate***.

A ***shared decision-making model for engagement*** is the recommended approach.

CCBHC Service Requirements Applicable to DCOs

4.C: Crisis Services	4.D: Screening, Assessment, and Diagnosis	4.E: Person-Centered and Family Centered Treatment Planning
4.F: Outpatient Mental Health and Substance Use Services	4.G Outpatient Clinic Primary Care Screening and Monitoring	4.H Targeted Case Management Services
4.I Psychiatric Rehabilitation Services	4.J Peer/Family Services	4.K Services for Veterans and Armed Forces

Criteria 5.A: Data Collection, Reporting, and Tracking

5.a.2: […] Quality measures to be reported for the Section 223 Demonstration program may relate to **services individuals receive through DCOs**.

It is the responsibility of the CCBHC to arrange for access to such data as legally permissible upon creation of the relationship with DCOs. CCBHCs should ensure that consent is obtained and documented as appropriate, and that releases of information are obtained for each affected person. CCBHCs that are not part of the Section 223 Demonstration are not required to include data from DCOs into the quality measure data that they report.