CCBHC Designated Collaborating Organizations: Frequently Asked Questions

January 2025

Overview

Federal certification criteria for Certified Community Behavioral Health Clinics (CCBHCs) allow CCBHCs to enter a formal relationship with a designated collaborating organization (DCO) to deliver required services on the CCBHC's behalf. DCOs may provide any of the required services described in the Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC Certification Criteria under Program Requirement 4, Scope of Services.

This document answers questions the National Council for Mental Wellbeing receives frequently about the DCO model. Information in this document is current as of January 2025 and will be updated should additional guidance on DCOs be published by the SAMHSA or the Centers for Medicare and Medicaid Services (CMS).

If you have a question about DCOs that is not answered here, email our team: CCBHC@TheNationalCouncil.org.

Disclaimer: *This FAQ document is a product of the National Council for Mental Wellbeing. It provides information summarized from federal guidance and offers recommended practices drawn from our team's experience with the CCBHC model, but it does not constitute official guidance from SAMHSA or CMS. States participating in the demonstration or adopting the CCBHC model under other Medicaid authority may impose requirements or expectations for DCO arrangements that build on the federal guidance. Questions about specific DCO relationship and payment arrangements should be directed to SAMHSA, CMS or state Medicaid and behavioral health agencies, as appropriate. Guidance from any of these entities supersedes any information found in this document.*

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Federal and State Guidance on DCOs

Where can I find federal demonstration guidance and reference documents?

SAMHSA definitions and requirements pertaining to DCOs can be found in the CCBHC Certification Criteria, Section 4.A and Appendix A: Terms and Definitions. States, clinics and prospective DCOs should read these sections of the criteria closely to understand DCOs' roles and obligations. CMS guidance on payment to DCOs can be found in Section 5.1a of the CMS CCBHC Demonstration Prospective Payment System (PPS) Guidance. For any questions not addressed in the federal demonstration guidance, states and clinics should reach out directly to SAMHSA[1] and CMS[2]).

What role do states have in setting additional standards for the DCO relationship?

Beyond the minimum requirements outlined in the federal criteria and payment guidance, states may want to establish additional expectations or requirements for DCO relationships in their CCBHC Medicaid demonstration or CCBHC state plan amendment (SPA) modeled after the demonstration (states do not have oversight over CCBHC expansion grants). This could include determining the types of services for which CCBHCs either must use DCOs or are not permitted to use DCOs, expectations regarding reasonable cost principles CCBHCs must follow when contracting for DCO services, expectations regarding the types of collaborative activities in which CCBHCs and DCOs will engage, and any processes or documentation by which compliance with state and federal criteria will be demonstrated. The National Council recommends that any state-specific guidance on DCOs balance local flexibility with state oversight needs. One-size-fits-all approaches to DCOs may not reflect the unique relationship opportunities and constraints within each community.

What guidance applies to SAMHSA CCBHC expansion grant (PDI and IA) recipients?

Organizations that have received a SAMHSA CCBHC expansion grant are subject to the same federal certification criteria as CCBHCs participating in the Medicaid demonstration, including provisions that govern DCOs. However, grant recipients are not subject to CMS PPS guidance unless they are also participating in their state's CCBHC demonstration.

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[1] CCBHC@samhsa.hhs.gov

[2] CCBHC-Demonstration@cms.hhs.gov

All CCBHC expansion grant recipients are subject to federal requirements regarding the use of grant funds, along with any other program requirements conveyed in the Notice of Funding Opportunity and Notice of Award. Grant recipients should consult these documents to understand any expectations related to DCO relationships and payment, in addition to the DCO guidance found in the CCBHC Certification Criteria. Additionally, SAMHSA has provided a DCO checklist for grant recipients. CCBHC expansion grant recipients may also reference the National Council's CCBHC Contracting and Partnerships Toolkit for Expansion Grantees.

Grant recipients that also participate in their state's demonstration or a SPA are subject to CCBHC certification and payment guidance from SAMHSA, CMS and their state, including guidance related to the use and payment of DCOs.

For any questions about the use of DCOs in the CCBHC expansion grant program, grant recipients should consult their SAMHSA project officer.

Defining a DCO

What types of relationships are envisioned under the CCBHC model?

Broadly speaking, the CCBHC model references three types of relationships: DCOs, care coordination partners and referral partners. All CCBHCs will have multiple care coordination and referral partners, but only some will have DCOs.

What is a DCO?

A DCO is an organization that provides required services on the CCBHC's behalf, through a formal relationship defined in a signed legal document. With limited exceptions, CCBHCs pay their DCOs for services rendered to CCBHC clients. DCOs deliver one or more of the nine required services (or elements of the required services) as described in CCBHC Certification Criteria under Program Requirement 4, Scope of Services. The full DCO definition can be found in Appendix A: Terms and Definitions.

When might a DCO relationship be beneficial?

While the CCBHC model and PPS are well-positioned to support CCBHCs expanding their capacity for direct service delivery, there may be situations in which CCBHCs prefer to establish a relationship with a DCO. Based on experiences CCBHCs have shared with the National Council over the years, considerations that may influence a CCBHC's choice to work with an existing community provider as a DCO include (but are not limited to):

- **Specialized nature of services:** The CCBHC historically has not provided a required service that is being delivered effectively by a specialty provider within the community, and the CCBHC would not be able to readily match the level of expertise offered by the specialty provider.[3]
- **Level of need within the community**: Based on the community needs assessment, the CCBHC (and its state, if applicable) have determined the anticipated level of need for a particular service (e.g., mobile crisis, crisis stabilization) among the population served does not justify adding capacity at the CCBHC when another provider in the community already offers this service and can be engaged as a DCO. When conducting this assessment, states and clinics should carefully consider projected future levels of need within the community, including needs that are currently unmet, rather than looking only at historic service utilization, as the CCBHC model may provide an ideal opportunity

[3] States and clinics must ensure they remain in compliance with federal requirements related to serving individuals across the lifespan and serving people with serious mental illness, substance use challenges, serious emotional disturbance, and more.

to invest in critically needed capacity expansions. Conversely, a CCBHC may wish to work with a DCO if very high levels of anticipated need within the community exceed the CCBHCs' ability to directly deliver services or build out new service capacity within the timeframe for becoming certified.

- **Workforce realities:** Workforce recruitment for a service line that is already offered by another organization in the community may pose a challenge or introduce competitive dynamics that negatively impact access.
- **Pre-existing strength of relationships:** A CCBHC and prospective DCO have already been working effectively together to ensure access to comprehensive care and wish to take their relationship to a new level of integration.
- **Reach within underserved communities:** A CCBHC working to expand its engagement with a community that has historically been underserved by the CCBHC may want to partner with another organization that has strong ties to and history with that community.

When considering any of these scenarios, states and clinics must always ensure they remain in compliance with federal requirements related to serving individuals across the lifespan and serving people with serious mental illness, substance use challenges, serious emotional disturbance, and more.

Feedback the National Council has received from current and prospective CCBHCs indicates DCO relationships may be an important option in rural communities where staffing shortages, geography and low population density may limit the feasibility or desirability of CCBHCs adding new direct services. They may also be preferred in instances where an existing provider that has historically provided a limited array of services has no interest in becoming a CCBHC itself, but has served a limited function or population very effectively. Rather than trying to expand its own capacity to meet the needs that have been met by that provider, the CCBHC could develop a DCO agreement with that provider.

In short, there is no one-size-fits-all approach to DCOs. Some CCBHCs may choose to partner with DCOs, while others may be well positioned to provide all the required services directly. States and clinics maintain flexibility to determine the approach that best meets the needs of their own communities.

What are the defining characteristics of a DCO?

Based on the definition and requirements in the CCBHC Certification Criteria for the demonstration,[4] a DCO must:

[4] Additional requirements for DCOs may apply to CCBHC-PDI and CCBHC-IA grants. Grant recipients and applicants should review the Notice of Funding Opportunity (NOFO) and their Notice of Award (NOA) for any further requirements that may pertain to DCOs under the grant program. See also the CCBHC Contracting and Community Partnerships Toolkit for Expansion Grantees.

- Be an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC.
- Provide at least one CCBHC-required service or an element of a required service described in Program Requirement 4 or state-specific CCBHC requirements.
- Enter a formal agreement with the CCBHC to deliver service(s) to CCBHC clients on behalf of the CCBHC.
- Meet all CCBHC criteria applicable to the selected service(s), including any state-determined requirements for DCOs.
- Receive payment from the CCBHC for applicable services rendered to CCBHC clients (with limited exceptions).
- Submit information to the CCBHC that enables the CCBHC to bill for encounters if applicable, report on quality metrics and meet other requirements.
- Engage with the CCBHC in the required collaborative activities outlined in Section 4.A and Appendix A of the CCBHC Certification Criteria.
- Provide 49% or less of the total number of CCBHC encounters during a year, excluding crisis services. If a CCBHC has more than one DCO, the total number of DCO encounters must be less than 49% of the total CCBHC encounters.

The CCBHC Certification Criteria neither address the nonprofit/for-profit status of DCOs nor specify that DCOs be Medicaid-enrolled providers. Therefore, states in the demonstration have discretion to determine whether for-profit providers and non-Medicaid-enrolled providers may qualify as DCOs.

When is a partnership not a DCO arrangement?

Not all partnerships under the CCBHC model are DCOs. A partnership is not a DCO arrangement when:

- The services delivered by the partner to CCBHC clients fall outside the nine required services described in the CCBHC Certification Criteria Program Requirement 4: Scope of Services (e.g., residential treatment, comprehensive primary care).
- The partner organization does provide one or more of the nine required services to CCBHC clients, but the CCBHC also delivers these services directly (i.e., it does not rely on a DCO to meet certification standards), and the partners have opted to engage in a care coordination agreement rather than a DCO arrangement.[5]
- The partner's staff do not meet state or federal qualifications to deliver a CCBHC-required service (e.g., the staff do not have state licensure).

[5] As noted in Section 3.a.6 of the CCBHC Certification Criteria: "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."

- The partnership is limited to care coordination activities involving non-health care providers (e.g., coordination with schools or law enforcement).

How is a DCO different from a care coordination partner?

Program Requirement 3 of the SAMHSA Certification Criteria describes care coordination partnerships and activities that are required of all CCBHCs. Care coordination partners include health care providers such as primary care clinics, hospitals and opioid treatment programs; they also include non-health system entities such as schools, courts and law enforcement agencies. The intent of the care coordination requirements is to ensure the CCBHC will be equipped to "coordinate care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic and behavioral health needs."[6]

DCO relationships, unlike care coordination relationships, are not required under the CCBHC demonstration. The intent of the DCO option is to offer a mechanism by which a CCBHC may use another provider to deliver required services on its behalf. If a CCBHC provides all required services directly, it does not need to establish a DCO. While DCOs are expected to coordinate and collaborate with the CCBHC as outlined in Appendix A of the CCBHC Certification Criteria, CCBHCs remain responsible for directly leading the full range of care coordination activities described in Program Requirement 3 and may not use a DCO to fulfill these requirements.

Is it a DCO?

The following scenarios are based on questions commonly received by the National Council, with rationales reflecting the general requirements and parameters outlined in the SAMHSA CCBHC Certification Criteria. **There are many situation-specific variables that will dictate whether an entity may function as a DCO. Those listed here are merely examples of how the federal DCO definition may be applied, and do not constitute official guidance on the permissibility of any particular scenario.** Bear in mind that states may adopt additional requirements or limitations for DCO services. CCBHCs and prospective DCOs participating in a state CCBHC initiative should always refer to applicable state guidance in determining whether specific proposed DCO relationships are permitted.

Scenario	Is it a DCO?	Why or why not?
CCBHC provides substance use screening and counseling on-site, but contracts with a specialty substance use disorder (SUD) organization to deliver other	Yes	Federal criteria do not prevent CCBHCs from directly delivering some services within one of the nine categories and contracting with a DCO for others. States may have

[6] See CCBHC Certification Criteria, introduction to Program Requirement 3.

Scenario	Is it a DCO?	Why or why not?
required SUD services like medication-assisted treatment in alignment with applicable CCBHC criteria.		their own requirements or limitations regarding which services may be provided by a DCO; always defer to applicable state guidance.
CCBHC directly provides BMI and blood sugar screening and monitoring, but partners with a federally qualified health center (FQHC) that takes referrals and provides physical exams, nutritional counseling and other primary care services for diabetes management. FQHC coordinates care with CCBHC and participates in care team huddles. The CCBHC and FQHC have a memorandum of understanding (MOU) in place defining this collaborative relationship.	No	Although primary care screening and monitoring are required CCBHC services a DCO could deliver, in this case the CCBHC is conducting those activities directly and is working with its FQHC partner to offer supplemental chronic disease management. Primary care services such as this are not a component of the CCBHC scope of services described in Program Requirement 4. In this scenario, the FQHC is a care coordination partner, not a DCO.
CCBHC contracts with a telehealth organization to provide SUD psychiatry and medication-assisted treatment (MAT) prescribing. The remote telehealth provider functions as a member of the CCBHC's staff.	No	The remote provider functions as a contracted employee, permitted under 1.b.2 of the CCBHC criteria. The CCBHC should include costs associated with the contract in its cost report and bill qualifying telehealth encounters with the remote provider at its PPS rate.
Prospective CCBHC does not currently offer any services or supports for children and youth and wants to engage a specialty child- and youth-serving organization as a DCO to deliver all services for this population.	Allowability is contingent on modifications to meet the "lifespan requirement"	Federal criteria clearly state that CCBHCs "must have the capacity to directly provide" services to children and youth "separate from any DCO relationship." Further, CCBHCs are responsible for care coordination for their child and youth clients. Care coordination is not one of the CCBHC requirements that may be outsourced to a DCO. States may have additional requirements for child- and youth-focused services to be directly delivered by CCBHCs. **The**

Scenario	Is it a DCO?	Why or why not?
		CCBHC must satisfy all minimum federal and state requirements regarding delivery of services across the lifespan. Beyond these minimum requirements, the CCBHC has flexibility in determining whether to engage a DCO for child and youth services. A DCO could fill any remaining gaps in the CCBHC's service array for this population, could augment the CCBHC's direct services with a more comprehensive scope, or could be the provider of choice for CCBHC clients even if the CCBHC also delivers some of the same services directly.
CCBHC contracts with a for-profit service provider to deliver certain required services on its behalf.	Yes	Unless states decide otherwise, for-profit organizations may be DCOs.
CCBHC directly provides all required services, but some clients prefer receiving certain services from a different organization or provider with which they have a preexisting relationship.	Maybe	At a minimum, the CCBHC will be expected to coordinate care with other providers serving the CCBHC's clients. Unless state guidance dictates otherwise, it is up to the CCBHC and the partner whether they wish to establish a DCO relationship.

Can another CCBHC be a DCO?

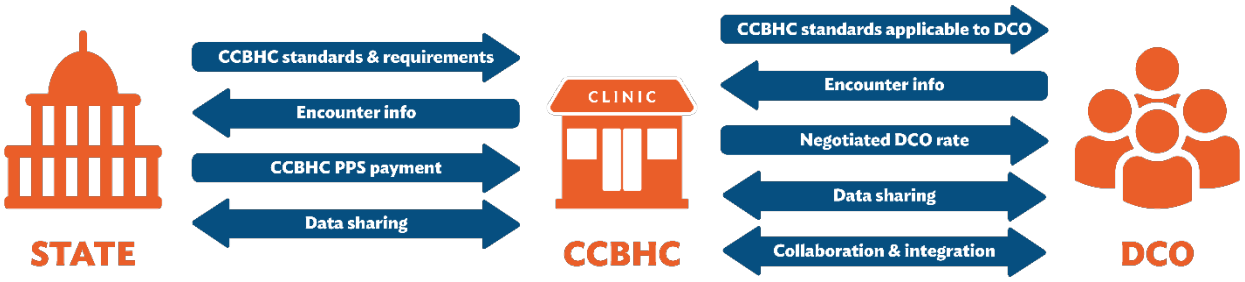
States may determine whether this is permissible in their state. Having another CCBHC as a DCO will introduce complex considerations related to attribution of clients to a "home" CCBHC, and there must be clear parameters governing when a CCBHC bills its own PPS rate rather than billing the other CCBHC for services provided on its behalf. These decisions will influence how each CCBHC's costs are represented in their cost report for the purposes of rate setting. The CCBHCs must also set clear parameters for transparency related to individual choice of providers as well as the policies, procedures and processes in place at each CCBHC.

Core Elements of the DCO Relationship

How does the DCO relationship work?

Because the DCO provides the selected services on the CCBHC's behalf, its encounters with CCBHC clients fall under the umbrella of the CCBHC model.

General Framework for the State-CCBHC-DCO Relationship as Described in Federal Guidance



Compliance with CCBHC requirements. When CCBHCs use a DCO to deliver a required service, any state or federal CCBHC requirements related to that service apply to the DCO in the same way they would apply to the CCBHC if it delivered that service directly. There are limited exceptions: For example, states may request approval if state-sanctioned crisis networks to be used as DCOs operate under guidelines other than the federal CCBHC crisis services requirements.[7]

Reporting of encounters. DCOs must inform CCBHCs about the services they deliver to CCBHC clients. At a minimum, this information must be sufficient for the CCBHC to 1) where applicable, file a Medicaid claim for any DCO services provided to Medicaid enrollees that meet the definition of a qualifying visit; and 2) engage in required reporting outlined in Program Requirement 5 and any additional state reporting requirements. This flow of encounter information may be different for CCBHC expansion grant recipients (who do not generally pay their DCOs) or if CCBHCs are using a state-sanctioned crisis network as a DCO. Demonstration and SPA CCBHCs should look to states for guidance on the reporting of encounters for their crisis provider DCOs.

Payment. The SAMHSA and CMS guidance on DCOs outline a framework for inclusion of DCO payment in the CCBHC PPS, with CCBHCs paying DCOs for services rendered to CCBHC clients. Appendix A of the CCBHC Certification Requirements notes, "Payment for DCO services is included within the scope of the CCBHC PPS, and DCO encounters will be treated as CCBHC encounters for purposes of the PPS." Section 5.a.1 of the CMS PPS guidance states, "The applicable cost of DCO services is included within the scope of the CCBHC PPS, and these included DCO encounters will be treated as CCBHC encounters for purposes of the PPS." Under

[7] See Section 4.c.1.

this framework, the state pays the CCBHC its established PPS rate for the CCBHC service rendered by the DCO. In turn, the CCBHC pays the DCO a negotiated rate for that service. There are two generally recognized exceptions to this payment framework: when the DCO is part of a state-sanctioned crisis network, and when the CCBHC is an expansion grant recipient. See further discussion on DCO payment below.

Data sharing. CCBHCs and DCOs should share information with each other to enable submission of claims (where applicable), reporting on CCBHC quality metrics, consent documentation to comply with privacy and confidentiality requirements, and tracking of service delivery to CCBHC clients. CCBHCs' and DCOs' agreements should outline these data-sharing requirements, along with any additional communication or information sharing that will be used to ensure the partners' compliance with federal and state criteria and support their collaboration and care coordination activities. See further discussion on information sharing below.

What are the collaborative components of the DCO relationship?

The CCBHC Certification Criteria describe DCOs as "more than care coordination or referral partners," citing 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." Specifically, CCBHCs and their DCO partners "shall take active steps to reduce the administrative burden on people receiving services" and "work toward inclusion of additional integrated care elements." [8] Among the suggested steps the Certification Criteria outline for CCBHCs and DCOs to meet these requirements are:

- 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

These are not the only measures CCBHCs and DCOs may implement. Partners are encouraged to think expansively about strategies for integrating care and offering a seamless experience to individuals and their families. States may also choose to require particular collaborative activities or processes.

[8] See Appendix A.

How are DCOs and CCBHCs expected to share information with one another?

Federal guidance states that CCBHCs and DCOs will share information regularly, with the expectation that they will strengthen electronic health information exchange over time. While the guidance stops short of requiring specific data-sharing processes or mechanisms, it does describe a clear vision for electronic communication between partners to advance care integration and coordination.[9] Of note, this vision includes the expectations that "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" and "all clinically relevant treatment records maintained by the CCBHC are available to DCOs."

[9] See Section 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."

DCO Agreements

Note: An update to the CCBHC Contracting and Partnerships Toolkit for CCBHC Demonstration Participants *is in development. The toolkit will contain a more detailed look at the elements of DCO contracting and will be a valuable resource for teams looking for sample agreement language and considerations in developing an agreement.*

What type of agreement must be in place with a DCO?

CCBHCs and DCOs must enter into a formal, legal arrangement describing the terms of their collaboration, outlining mutual expectations and establishing accountability for the services to be delivered. If payment is involved, this will likely be a contract. However, the CCBHC Certification Criteria also allow for this agreement to be evidenced by a memorandum of agreement (MOA), MOU or other type of formal agreement. The contract or other formal legal agreement should specify what is required of the DCO, expectations around collaborative activities and other key elements of the relationship. CCBHC expansion grant recipients may consult the National Council's CCBHC Contracting and Partnerships Toolkit for Expansion Grantees for a detailed discussion of DCO agreements applicable to the grant program. An update to the *CCBHC Contracting and Partnerships Toolkit for Demonstration Participants* is underway.

What is the state's role in directing, reviewing and approving DCO relationships?

Federal CCBHC guidance does not describe specific roles or requirements for states. In general, states have discretion to establish their own state-specific criteria, which may include guiding CCBHCs toward desired DCO relationships or specifying when DCOs may not be used. States will establish their own protocols, if any, for reviewing and approving DCO arrangements. CCBHCs' staffing time and/or other costs associated with developing and maintaining DCO relationships should be incorporated into the relevant sections of the cost report, as should any payments to be made by CCBHCs to their DCOs. Cost reports are subject to review by states, and states may ask CCBHCs to provide further information about their anticipated or historical DCO costs.

Are DCOs required to comply with all CCBHC criteria?

DCOs must comply with criteria relevant to the services they provide on behalf of the CCBHC as outlined in Program Requirement 4 and any supplemental state guidance. They must also comply with any criteria that apply uniformly to all CCBHC services; for example, ensuring that services are person- and family-centered, recovery-oriented and respectful of the needs, preferences and values of the person receiving services; or applying the CCBHC sliding fee scale

to CCBHC clients.[10] In addition, CCBHCs must ensure that clients receiving services from the DCO have access to the CCBHC's grievance procedures[11] and must work with DCOs to obtain consent from people receiving services, in compliance with federal and state privacy and confidentiality laws.[12]

What are the CCBHC's responsibilities for care provided by the DCO?

The CCBHC Certification Criteria say, "DCO agreements shall include provisions that assure that the required CCBHC services that DCOs provide under the CCBHC umbrella are delivered in a manner that meets the standards set in the CCBHC certification criteria."[13] CCBHCs must also ensure that CCBHC clients who receive care at a DCO have access to the CCBHC's grievance procedures[14] and must work with the DCO to develop any processes by which the DCO will verify that it meets the same quality standards for applicable services as the CCBHC would if it delivered those services directly.[15] Any oversight or reporting processes that may be required for the CCBHC to be assured of the DCO's compliance with relevant standards should be outlined in the agreement. States may wish to take on a role in reviewing DCO agreements or may provide additional guidance on how compliance with the certification criteria will be assessed for CCBHCs using a DCO. CCBHCs' responsibilities for care delivered by a DCO will be addressed in more detail in the forthcoming updates to the *CCBHC Contracting and Partnerships Toolkit for Demonstration Participants*.

[10] See Section 4.b.1.

[11] See Section 4.a.3.

[12] See Section 3.b.4.

[13] See Appendix A. The 2023 updates to the CCBHC Certification Criteria removed language indicating that CCBHCs are "clinically responsible" for care provided by their DCOs.

[14] See Section 4.a.3.

[15] See Section 4.a.4.

DCO Encounters

What is an "encounter" in the context of DCO services?

The SAMHSA CCBHC Certification Criteria state that CCBHCs must "deliver directly the majority (51% or more) of encounters across the required services (excluding crisis services) rather than through DCOs."[16]

In the demonstration, "encounter," according to the CMS payment guidance, means a single day (PPS-1 and -3) or month (PPS-2 and -4) in which one or more of the CCBHC services that trigger a PPS payment are provided. The CMS payment guidance also uses the terms "daily visit" and "monthly visit" to refer to encounters. Importantly, multiple CCBHC services may be provided by the CCBHC, its DCO or both during a single encounter. In the demonstration, the 51% threshold is not calculated based on the number of discrete CCBHC services provided during an encounter. The annual number of encounters for clients across all payer types is documented in the annual cost report. Over the course of a year, at least 51% of these encounters (excluding crisis services) must be delivered directly by the CCBHC as opposed to its DCOs.

CCBHC expansion grant recipients with questions about defining or reporting encounters should contact their SAMHSA project officer.

Do DCO services always count as a CCBHC encounter?

Not necessarily. In the demonstration, whether a DCO service counts as an encounter for the purposes of triggering a CCBHC PPS payment depends on how the state has defined a qualifying visit within the parameters CMS has laid out. It is possible that DCOs may provide services that fall within the CCBHC scope but do not constitute a qualifying visit. CCBHCs and DCOs should work with their state to determine what type of information they are expected to provide regarding these nonbillable activities and any expectations for how information about these activities will be communicated from the DCO to the CCBHC, and ultimately, to the state.

CCBHC expansion grant recipients with questions about defining or reporting encounters should contact their SAMHSA project officer.

Are all DCO clients considered CCBHC clients?

Not necessarily. DCOs may serve people who do not receive other CCBHC services or who are engaged in care with other providers that are not CCBHCs. However, one advantage of the CCBHC-DCO relationship is that it may expand access to the full scope of CCBHC services to DCO clients who were not previously accessing these services. CCBHCs and DCOs should establish clear expectations regarding attribution of clients to the CCBHC in their formal agreement.

[16] See Section 4.a.1.

DCO Payment

How are DCOs paid?

CCBHC Medicaid Demonstration. SAMHSA criteria and CMS guidance describe a framework in which the CCBHC PPS includes the cost of contracting with a DCO for the delivery of required services to CCBHC clients.[17] Under this framework, the CCBHC and the DCO will negotiate a rate for services, which may be on a per-encounter, per-service, per-client, fixed-price or another basis. The CCBHC will include these costs in the cost report it uses to calculate its PPS rate and will pay the DCO according to the terms of the DCO's contract. Importantly, the DCO payment is not a pass-through of the PPS payment.

CCBHC Expansion Grants. While grants may be used in some circumstances to pay DCOs for services rendered to CCBHC clients, funding from SAMHSA CCBHC grants may not supplant other funding sources. CCBHC expansion grant recipients using DCOs should not establish a payment relationship for any service for which the DCO has access to another payment source. See the CCBHC Contracting and Partnerships Toolkit for Expansion Grantees for a discussion of DCO agreements with CCBHC expansion grant recipients.

State Plan Amendments or Other Medicaid Authorities. States determine their own payment policies. CCBHCs should consult state officials for guidance.

Can DCOs be paid for something that is not within the CCBHC scope of services?

CCBHC Medicaid Demonstration. CCBHCs' PPS may not include the costs of contracting for DCO services that are not within the CCBHC scope of services as defined by the SAMHSA CCBHC Certification Criteria and refined by states. States have substantial discretion in establishing their own state-specific scopes of services based on the results of their community needs assessments, both within the demonstration and under their CCBHC SPA. If a state has specified that a service or activity is allowable or required under its own CCBHC model — and if SAMHSA has approved that decision — CCBHCs may pay a DCO to provide it and incorporate the associated contracting costs in their CCBHC cost reports. This does not preclude CCBHCs from entering into a contract with the DCO for additional services outside the CCBHC scope. In this case, the cost of these DCO services would be included in the CCBHC cost report as a non-CCBHC service and would be excluded from the PPS rate.

CCBHC Expansion Grants. Grant recipients may not use grant funds to pay for services or activities outside the requirements of the grant.

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[17] SAMHSA criteria referencing payment to DCOs can be found in Appendix A. CMS guidance on payment to DCOs can be found in Section 5.1a of the Section 223 Certified Community Behavioral Health Clinic (CCBHC) Demonstration Prospective Payment System (PPS) Guidance.

SPA or Other Medicaid Authority. States determine their own policies related to DCO payment. CCBHCs should consult state officials for guidance.

How are DCO payments accounted for in the PPS rate?

CCBHC Medicaid Demonstration. DCO costs and visits are included in the cost report and become part of the calculation used to set the CCBHC's PPS rate. The CCBHC enters the cost of direct services to be provided under the DCO agreement and the number of anticipated DCO encounters (if applicable) in the relevant sections of the cost report:

- Payments for DCO service delivery should be included as a direct CCBHC cost and added to Part 1B of the trial balance tab on the cost report. The cost of direct services is entered in the cost report as a lump sum for the entire year.
- Unduplicated visits provided by the DCO should be included in Line 2 of the appropriate visits tab based on the PPS method used in the state.

Any other costs incurred by the CCBHC, such as staff time spent negotiating DCO contracts or managing the relationship, should be factored into the staffing and/or indirect costs sections of the cost report.

CCBHC Expansion Grants. Grant recipients do not receive PPS unless they are also participating in the demonstration or other state-led CCBHC initiative.

SPA or Other Medicaid Authority. If using PPS, states determine their own policies related to inclusion of DCO payment. CCBHCs should consult state officials for guidance.

How should DCO rates be set?

The CCBHC model offers DCOs the opportunity to negotiate reasonable, fair-market rates for their services. CCBHCs and their DCO partners should work together to establish a fair rate with a strong justification based on market value and the DCO's reasonable costs. The fair-market-value rate paid to the DCO may include compensation associated with the DCO's activities to comply with CCBHC criteria, such as administrative time spent on contracts, staff time spent on training, electronic health record (EHR) upgrades to support electronic information exchange, and more. In the demonstration, states may review payments to DCO for allowable clinical and administrative activities to ensure they are reasonable and aligned with the requirements and objectives of the model.

In what cases would a CCBHC and DCO not have a payment relationship?

Please note that this information is current as of January 2025 and may be subject to change if additional federal guidance is released. Always consult with state agency officials, SAMHSA, and/or CMS for official guidance on specific CCBHC-DCO relationships and payment scenarios.

Based on federal grants guidance and information shared by demonstration CCBHCs and states, the National Council is aware of the following scenarios in which CCBHCs might not pay a DCO for services the DCO provides to CCBHC clients:

CCBHC Medicaid Demonstration

- **When the DCO is a state-sanctioned crisis system.** Many states have statewide crisis response systems in place with well-established financing models. In these cases, it may not make sense to insert the CCBHC as the payer for crisis services that are already funded by the state through other mechanisms. Demonstration states may permit CCBHCs to enter a DCO relationship with the crisis provider that does not require the crisis provider to bill the CCBHC for services. The relationship should still meet the other requirements of a DCO as articulated in the SAMHSA Certification Criteria.

Questions about the permissibility of any other scenarios where the CCBHC and the DCO want to engage in a "non-financial" relationship should be directed to SAMHSA, CMS and state authorities. The National Council is not aware of other scenarios that have been approved within the demonstration at this time.

CCBHC Expansion Grants

- **When the CCBHC is an expansion grant recipient not participating in the demonstration, and the DCO has another payment source available for the services they are providing on the CCBHC's behalf.** Funding from SAMHSA CCBHC grants may not supplant other funding sources. Grant recipients using DCOs should not establish a payment relationship for any service for which the DCO has access to another payment source. See the CCBHC Contracting and Partnerships Toolkit for Expansion Grantees for a discussion of DCO agreements with CCBHC expansion grant recipients.

SPA or Other Medicaid Authority. States determine their own payment policies. CCBHCs in these states should consult state officials for guidance.

General Reminder Across All Scenarios. If a partner is solely providing a service to CCBHC clients that is not within the scope of required CCBHC services as outlined in Program Requirement 4 and further refined by the state (if applicable), that organization is not a DCO and cannot receive payment under the CCBHC PPS or CCBHC expansion grant for these services. Instead, they could be considered a care coordination partner.