

Becoming a Certified
Community Behavioral
Health Clinic: Strategies
for a Smooth Transition

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Power of One is One for All – System and Vendor

For many years, community behavioral health providers have seen sustained growth in the need for their services. But the resources they need to provide these services have become harder to secure. It's now become common knowledge that physical and behavioral providers can increase the quality of care and improve outcomes by sharing patient and client information. Today, the act of sharing information has simultaneously become less difficult to do but much more expensive to accomplish with the advent and widespread adoption of Electronic Health Records (EHRs).

Incentive programs began in January 2011 aimed at organizations that deliver services on the physical medicine side of healthcare. These programs were aimed at encouraging healthcare organizations to "adopt, implement, or upgrade" EHRs and demonstrate "Meaningful Use" of EHR technology procured from certified vendors; those whose products had passed the rigorous standards established by the Centers for Medicare & Medicaid Services (CMS). However, during the intervening years, no such program was established for behavioral health, and this has had a deleterious effect on access to services, as well as groups' ability to provide services or share information.

On March 31, 2014, Congress laid the foundation for changing these dynamics when it passed H.R. 4302, the Protecting Access to Medicare Act (PAMA). PAMA included a two-year demonstration program based on the Excellence in Mental Health Act that will inject a total of \$1.1 billion into the expansion of community mental health services by the time it is fully enacted. This represents the largest behavioral health program in generations, both in terms of sheer dollars invested and in terms of the expansion of services.

The program creates a new type of behavioral health (BH) organization called a Certified Community Behavioral Health Clinic (CCBHC). It stipulates nine broad categories of services these organizations must provide – either directly or through tight relationships with partner organizations known as Designated Collaborating Organizations (DCOs). Most significantly, it creates a new federal reimbursement methodology based on a Prospective Payment System (PPS). PPS will ensure that organizations are compensated for the actual cost of providing high-quality care to individuals in their service area.

While the demonstration program is currently underway, organizations that intend to become a CCBHC or even a DCO need to begin planning for the transition now to be successful when the program begins across the country. Going forward, these changes will fundamentally alter the methodology for delivering BH care and being reimbursed.

Services

Summary of S. 264 Services

S. 264 makes for nine broad service areas. Of these nine, the CCBHC must provide four, and the remaining five may be provided either by the CCBHC or through tight contractual relationships with DCOs. (See subsequent section of this paper for a more in-depth discussion of DCOs.)

The four required service categories that the CCBHC must provide are:

- 1 Crisis services
- 2 Screening, diagnosis, and risk assessment
- 3 Person-centered, family-centered treatment planning
- 4 Outpatient mental health and substance use services

The five required service categories that can be provided either directly by the CCBHC or through contractual relationship with one or more DCOs are:

- 1 Outpatient primary care screening and monitoring
- 2 Targeted case management
- 3 Psychiatric rehab services
- 4 Peer, family support, and counseling services
- 5 Community-based mental health care for veterans

Service Transition

Many groups are not large enough or diverse enough to provide the services required by the four core service categories set forth in S. 264. However, the majority will want to grow sufficiently to become a CCBHC due to the enhanced CMS payments. To meet these four service requirements, organizations may need to expand their operations or acquire or merge with other organizations to augment their service offerings. Memorandums of Understanding (MOUs) will not be sufficient, as S. 264 requires a single governance structure for the CCBHC. This will cause a significant amount of consolidation among the many community behavioral health groups that exist today.

Because S. 264 holds the CCBHC “clinically responsible” for all nine services, and pays the CCBHC for them regardless of whether they are provided directly or through a DCO, it is preferable to be in a position to provide all nine services directly. To the extent a CCBHC leverages DCOs to provide one or more services, it will require tight contractual and procedural relationships with the DCO(s) in order to ensure quality of care and documentation.

Care Coordination

Section 223 (a)(2)(C) of PAMA: “Care coordination, including requirements 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. Care coordination requirements shall include partnerships or formal contracts with the following:

- I. Federally-qualified health centers (and as applicable, rural health clinics) to provide Federally-qualified health center services (and as applicable, rural health clinic services) to the extent such services are not provided directly through the certified community behavioral health clinic.
- II. Inpatient psychiatric facilities and substance use detoxification, post-detoxification step-down services, and residential programs

- III. Other community or regional services, supports, and providers, including schools, child welfare agencies, and juvenile and criminal justice agencies and facilities, Indian Health Service youth regional treatment centers, State licensed and nationally accredited child placing agencies for therapeutic foster care service, and other social and human services
- IV. Department of Veterans Affairs medical centers, independent outpatient clinics, drop-in centers, and other facilities of the Department as defined in section 1801 of title 38, United States Code
- V. Inpatient acute care hospitals and hospital outpatient clinics”

While many describe care coordination as the “linchpin” of care coordination, it is really the fulcrum. It is the thing that allows the physical and behavioral care to balance and thus provide the best outcomes. Care coordination is achieved through sharing of comprehensive healthcare information. This will be much easier to accomplish if the CCBHC is providing all nine of the mandatory services. The reality is, however, that many organizations will simply not be able to gain sufficient size to provide all nine services, so many will rely on DCO relationships. Coordinating care among these organizations will take significant planning.

EHR products have been maturing over the years, and much of this has been driven by Meaningful Use (MU, now rebranded as “Advancing Care Information” by ONC under MACRA) and its continuing certifications. However, the ability to share information easily is rare in EHRs. In addition, a high number of EHR vendors that service the Behavioral Health market specialize in only BH. This means, while many groups will have an EHR, it may not accommodate activities in the physical health space – and CCBHCs that develop a DCO relationship may use a different EHR than their DCO(s).

For care coordination to work, groups must include their EHRs, and possibly their EHR vendors, in planning sessions to lay out the level of information sharing necessary to support truly serviceable care coordination. CCBHC staff will need easily available healthcare information and it should flow back and forth between the CCBHC and any DCOs seamlessly.

This information flow must include the consumers' needs and preferences. Regarding the information sharing necessary to help provide effective care coordination, the AHRQ states: "This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and this information is used to provide safe, appropriate, and effective care to the patient." Agencies will have to examine information flows and make significant changes to ensure they meet goals.

Staffing

Initially, the CCBHC will be required to staff to a level consistent with their State's assessment of the CCBHC's community needs. The State will assess the treatment needs, as well as the cultural and linguistic needs of the community. Once the clinic has been certified, it must solicit the input of its consumers and family/caregivers to determine the best staffing to meet their needs. This feedback will be used to update the staffing assessment at least every three years that the clinic is certified. But clinics will want to perform this analysis more often than every three years because changes will need to be factored into the Prospective Payment System (PPS) cost report. This ensures the PPS rates are sufficient to cover the cost of care provided.

The clinic must maintain several positions including a CEO, Medical Director, and appropriate levels of management for the clinic's size. Clinics also will need sufficient clinical staff to cover the mix of services they offer. In addition to proper certification and licensure needs, there are cultural and linguistic needs that must be taken into consideration when determining staffing needs. In addition to linguistic, cultural, and credentialing requirements that apply to the clinical and management staff, the clinic must determine current and additional accreditation standards that will apply to any new or augmented services they will be offering.

Reporting

CCBHCs have a high level of reporting requirements due to two areas; quality metrics and cost metrics. Clinics will have to generate cost information to support their Prospective Payment System (PPS) calculations in order for their revenue to cover their costs. Quality metrics will be required to justify the CCBHC certification, and needed to get recertified every five years. They will also be necessary to qualify for the quality bonus payments from CMS.

Encounter information data collection will be modeled after the FQHC Uniform Data System (UDS) reporting standards. These standards have been in place for many years and collect significant amounts of information that is reported to CMS.

Data collection for quality measures and clinical outcomes will also be a significant requirement for all CCBHCs. It will take advance planning to ensure the clinic knows what data points must be captured to measure clinical outcomes accurately. Also, the clinic must perform the analysis to determine the treatment plan variables that encourage better outcomes.

The biggest change for many behavioral health groups will be the need for clinics to capture much more information as discrete data versus free-form text. Discrete information is individual data points that can be tallied and manipulated. Most behavioral health clinicians are accustomed to writing encounter information in a free-form text format, whether electronically or on paper. It takes additional time to break out and enter discrete information rather than free-form text. But this transition must occur to collect and report the data required to become and remain a CCBHC.

Clinics will need to analyze and determine what data points they need for quality improvement initiatives, outcomes analysis, cost reporting, service usage, UDS reporting, and more. They will need to put a committee and process in place to ensure this analysis is done each year so they can note changes to their EHR. As they evaluate Health IT products, clinics should select those that are flexible; easy and inexpensive to change. Change will also be driven by the evolution of the services and programs the clinic offers.

Data Sharing

Information exchange will be critical to the success of any CCBHC. The services required for a CCBHC require that physical healthcare providers share information with their peers in behavioral healthcare within the clinic to ensure quality outcomes over the life of the consumer. Clinics will have to devise strategies and processes to ensure information about a consumer's healthcare is shared throughout the organization. If DCOs are used, the processes will have to include sharing that information bidirectionally with one or more external entities. Current Health IT (HIT) solutions do not excel at this level of information exchange, so clinics will need to start preparing early to meet this need.

There is not yet an easy, ubiquitous method for EHRs to exchange information.

Most EHRs share information by creating a Continuity of Care Record (CCR) and implementing a Continuity of Care Document (CCD) architecture, which is a joint venture of Health Level 7 (HL7) and American Standards for Testing and Measurement (ASTM).

According to HL7, "CCD fosters interoperability of clinical data by allowing physicians to send electronic medical information to other providers without loss of meaning and enabling improvement of patient care." This is analogous to using ASCII files to shuttle documents among word processors. It allows disparate EHRs to exchange information. However, there is no common nomenclature among EHR data elements. What one EHR calls a diagnosis field may be completely different from what another EHR calls it, or how one EHR stores the pieces of a treatment plan may be completely different from how a different EHR stores that treatment plan. The current methodology relies on mapping both EHRs' fields into sections of a common file format. This means there are always data elements that cannot be shared among EHRs.

CCBHCs, and especially those using one or more DCOs, will have to plan very carefully to ensure consumers' healthcare information is shared with different EHRs and organizations effectively – and to ensure they're providing quality care. This will entail significant use of Health IT, as well as planning and testing, to ensure data is moving properly and is available in a timely manner. Adding to the complexity, data must be transformed into the format each "side" expects to see so it can be used properly. Clinicians in physical medicine visualize and make use of information differently than clinicians in behavioral health. Simply providing a BH treatment plan to a physician will not allow the information to be used properly; the physician must be able to understand it to use it.

CCBHCs will need to bring different groups of clinicians together and discuss and document what information needs to be exchanged and what formatting changes need to be made so that each group can consume and use the information. Very few organizations have done this level of analysis, so CCBHCs will need to do this themselves. Groups that have the ability to get started on this now will find themselves in a much better position than groups that do not currently have this ability.

In addition to sharing information within the CCBHC, and among CCBHCs and any DCOs, the clinics will have to share information with external entities such as hospitals, as well as the State and Federal government.

In these cases, the entity receiving the information will establish the data elements it expects and the format of the data transfer. The clinic's EHR will need to be capable of adapting to needs. It should be expected that these data transfer needs will change over time; they always do.

Certification

Ultimately S. 264 does three things;

- › It defines a coordinated care delivery system for a national safety net
- › It creates federal status and sets forth criteria for CCBHCs
- › It creates a mechanism to pay for CCBHCs

Currently the 24 States selected for participation in the one-year planning grant are putting together their proposals. This will result in the Secretary of SAMHSA selecting eight States to participate in the demonstration program. Once the demonstration program is over, the program will go national. The current certification criteria are set forth in S. 264 and can be found in their entirety [HERE](#). It is expected that States will add additional criteria to those set forth in S. 264, so clinics will need to check with their individual States.

Criteria

The criteria set forth in S. 264 includes the following areas:

Services

Services are broken into nine broad areas including:

1. Crisis Services, 24/7, mobile
2. Screening, diagnosis and risk assessment
3. Person-centered, family-centered treatment planning
4. Outpatient mental health and substance use services
5. Outpatient primary care screening and monitoring
6. Targeted case management
7. Psychiatric rehab services
8. Peer, family support, and counseling services
9. Community-based mental health care for veterans

1 through 4 are considered mandatory for the CCBHC to provide, and 5 through 9 can be provided by the CCBHC, or by one or more DCOs.

Staffing

1. The clinic must have a single management chain (no MOUs)
2. Executive management must include CEO and Medical Director
3. Medical Director must be able to prescribe and provide substance abuse treatment
4. Clinicians must have necessary licensure and credentialing
5. Clinicians must have cultural and linguistic compliance for service area

Structure

1. Availability of services
2. Available regardless of time
 - Available at a place convenient for consumers
3. Accessibility of services
 - Access regardless of ability to pay
 - Access regardless of residency
 - Access with regard to cultural and linguistic needs of community

Consumer population

1. Must meet the needs of the community served
2. Must regularly collect community feedback regarding needed services

Payment methodology

1. Will move to a new Prospective Payment System
2. Will cover the expected cost of the services provided
3. Certification
 - Recertify every five years
4. Outside-the-box thinking
 - Person/family-centered care

Time Frames

While this program actually began with S. 264 in 2014, it still has some time remaining before it will move to a national status. Currently, States are finalizing their proposals to participate in the demonstration program. Once the demonstration program is over, CCBHCs will move to the national platform. The specific timeline is below.

- › October 31, 2016 – By this date the 24 States chosen to participate in this phase must finalize and submit their proposals to SAMHSA for review. There is currently a proposal in Congress pushing for all 24 States to be able to participate.
- › January 2017 – By this date the Secretary of SAMHSA will announce the eight States chosen to participate in the demonstration program. All State proposals will have been evaluated, and the eight selected will have until June 2017 to begin their demonstration program. SAMHSA will provide funding for these eight States for the duration of the demonstration. If the proposal in Congress goes through there will be 24 States participating in this process, rather than eight.

Prospective Payment System

One of the most significant changes being implemented by S. 264 is the provision of a methodology by which community behavioral health clinics can become permanently funded. In the current environment, behavioral health groups rely on numerous funding sources; public and private. These rates differ depending on the funding source and often don't cover the actual cost of the care provided. A significant amount of time and resources in any BH group are spent searching for new or increased funding sources rather than focusing on the quality or type of care provided. Budgets are constantly stretched thin. Frequently, for the clinic to stay afloat, decisions regarding which programs continue and which don't must be made.

The new methodology provided in S. 264 is a Prospective Payment System (PPS). This type of system has been used by Community Health Centers (CHCs) and Federally Qualified Health Centers (FQHCs) for many years. SAMHSA has created a cost spreadsheet designed to allow CCBHCs to determine the actual cost of the care they provide the population in their area. It contains 11 tabs and requires significant amounts of information to complete. Once completed clinics can choose between a daily

reimbursement rate and a monthly rate; there are significant differences between them. These options will require substantial analysis by each clinic to determine which rate is most advantageous to their specific circumstances.

Establishing Your Base Year Rate

The Cost Report is a spreadsheet provided by SAMHSA. It contains tabs for all the aspects of cost needed to determine the base year rate for the clinic. The name of the file is "CCBHC-Cost-Report.xlsx" and it is available [HERE](#). When completing the spreadsheet you will see that each cost is classified as either "allowable" or "unallowable." The most important aspect, and one the many clinics may not be accustomed to, is the importance of capturing the cost information for all encounters. The next area that will take some thought and planning will be the indirect costs of the clinic.

Because clinics are accustomed to finding creative ways to solve funding issues, they will have to think through them and ensure they leverage various creative solutions on the spreadsheet to create a true picture of their clinic's annual operation costs. It is also true that most clinics will be augmenting their service mix in order to meet the nine required service areas mandated by S. 264. In these cases, a full financial picture may not be readily evident since the services are not currently being offered. In these cases, clinics should try to put the service offering together "on paper" and diligently walk through all costs associated with the new program/service. Directors should solicit feedback from all aspects of the organization to ensure costs are not missed. Will the service require space? Will it require use of specific tools? Will it require augmenting the EHR, or a subscription to one or more assessment tools? What are the staffing implications? These and many more questions need to be answered to ensure all costs are captured and documented.

In addition to services that are currently offered within the four walls of the clinic, S. 264 envisions and encourages clinics to get out into the community and offer services at times and places that are convenient to the consumers they serve.

Another route clinics should explore is to review the “allowable costs” section and imagine what additional services they can offer, especially those which were previously unavailable or unattainable due to funding restrictions or Medicaid. Because this area has many new and enhanced items, clinics are free to pen completely new ways to bring existing or new services to their patients and clients.

Care coordination is a mandatory component of S. 264 and a function many clinics will need to add. Clinics are fully responsible for all care delivered in the nine required areas, even if that care is delivered through a DCO relationship (i.e. by an external entity). It is likely that most clinics will have to rely on at least one DCO in order to meet all nine service categories. Because of this, care coordination will take careful analysis and planning. Clinics will have to ensure that healthcare information is passed appropriately between its staff members and DCO staff members. Clinics will also have to ensure DCO staff is appropriately trained and credentialed for the services they offer. Care coordination must be aligned with the requirements in Section 2402(a) of the Affordable Care Act. This requirement includes best practices, quality measures, and other metrics designed to ensure “wellness and recovery of the whole person.” All costs associated with care coordination must be accounted for and added to the Base Year calculation.

Clinics will need to pay special attention to non-allowable costs, too. These costs need to be analyzed in light of what programs and services are valuable to the local community. They also will impact what services should be offered directly by the clinic and which may be offered through a DCO relationship. Costs that were previously unallowable by Medicaid, such as Health IT, health records, quality initiatives, etc., are now allowable under the CCBHC program. Only close scrutiny of non-allowable CCBHC costs will help clinics plan and budget their Base Year appropriately. Non-allowable costs are listed in full within 45 CFR §75.420-475. The URL is available at footnote “7” below.

Once the Base Year cost is established, clinics will need to determine which of the two payment options best fits their population. There is a daily rate and a monthly rate, and there are significant differences between them.

Daily Bundled Rate

To calculate the daily bundled rate, each clinic must first determine their allowable costs, non-allowable costs, and create a Base Year cost. Once this is done and the clinic is certain all costs have been included, it will need to determine the annual amount of visits it receives from consumers. Many presentations have indicated this number should be limited to Medicaid visits. However, the advice provided by SAMHSA in Appendix IV Statement of Assurance indicates this number can include the three visit types below.

1. Number of daily visits for patients receiving CCBHC services provided directly from staff
2. Number of daily visits for patients receiving CCBHC services directly from DCO (not included above)
3. Number of additional anticipated daily visits for patients receiving CCBHC services

These lines do not limit visits to only Medicaid consumers. In fact, they seem clearly designed to capture all consumers receiving services from the CCBHC and any DCO(s). Total daily visits will be divided into the total cost to determine the daily rate. The daily rate is paid for every visit regardless of the resources needed or the intensity of the visit. It is based on the payment model that has been being used in FQHCs for many years. It requires less data analysis and is less complex to implement and maintain over time.

There are drawbacks, however. If the clinic experiences a spike in acuity levels or if there are mistakes in projecting the consumer mix, this payment mechanism may not cover the full cost of providing care. This is because the payment mechanism pays a static amount for every encounter, and has no mechanism for matching payments to differing acuity levels.

Monthly Bundled Rate

The monthly bundled rate is calculated very differently than the daily rate. Clinics still determine their annual cost using the methods above, but they must divide the annual cost by 12 in order to determine an average monthly cost. Next, they must determine how many unique clients they serve each month. A client must have at least one visit in a month to count. However, they may have many visits and still count as a single client. The clinic then divides the average monthly cost by the number of unique clients seen in a month to determine the monthly rate. This rate is paid to the clinic for each unique consumer who has at least one visit in a month, but is only paid once per month regardless of how many visits the consumer has during the month (i.e. the clinic gets reimbursed the same for a consumer who comes in once as for a consumer who comes in five times).

Using the monthly rate has an additional option for the changing acuity level some consumers may experience.

The CCBHC monthly bundled rate has provisions for five specific consumer populations who have higher costs. They are:

- 1 Adults with serious mental illness (SMI)
- 2 Adults with significant substance abuse disorders (SUDs)
- 3 Adults with SMI and co-occurring substance abuse disorders (SMI/SUDs)
- 4 Children or adolescents with serious emotional disturbance (SED)
- 5 Consumers with a recent history of frequent hospitalizations related to behavioral health conditions

To determine the rate for these five distinct populations of consumers, the clinic must first determine their daily rate as described in the Daily Rate section above. Once that is done, the clinic must then determine how many visits each of these five populations has on average every month. Lastly, the clinic must determine how many consumers it has in each group. The adjusted monthly rate will be calculated by taking the daily rate for these six groups of consumers (the five outlier groups plus all other consumers as the sixth group) and multiplying each by their average visits per month and average number of consumers in the group, and then adding those six numbers to arrive at the monthly reimbursement amount.

The monthly reimbursement rate allows for different rates for five specific groups and a sixth rate for all other consumers. At first that may look like an advantage, especially for clinics that have a large number of consumers in the five specified groups. It also seems to allow payments to be more closely matched to the condition of the consumer. There are significant drawbacks to this payment methodology though. First, it is much more complex to manage than a daily rate methodology due to the increased complexity of collecting specific information on five additional groups of consumers. The cost report becomes much more complex to complete as well. The State also has significantly more work to do administratively to both make payments and to audit and validate the payment rates. That means it will take longer and require much more governmental infrastructure to manage compliance. Lastly, the clinic itself will require much more complex infrastructure to capture, make use of, and report all the additional information that goes into calculating and supporting the monthly rate figures. Many changes will likely be necessary to the EHRs and billing systems to support this data collection and analysis effort.

Conclusions

Assuming the clinic captures all allowable direct and indirect costs associated with providing the nine areas of care mandated within S. 264, the daily rate should provide sufficient reimbursement to reclaim all costs with minimum challenges. Regardless of the consumer mix and services mix being offered, this payment methodology should prove to be much easier and more reliable than all the work associated with the monthly payment methodology. This should prove true for both CCBHCs and the governments that will support them.

Quality Bonus Payments

Quality bonus payments (QBPs) are an additional layer of payments that a CCBHC can attempt to achieve. They are optional when a CCBHC chooses the Daily Rate, and mandatory when they select the Monthly Rate. There are currently 11 measures that constitute these payments. QBPs will be very difficult to achieve, but could be a significant advantage to both the CCBHC and consumers. It benefits consumers because these quality payments are all designed around actions that will encourage follow-up, preventive, and compliance services. These services will help improve outcomes and target consumers who need it most. Some examples are;

- › Follow-up after hospitalization for mental illness
- › Adherence to antipsychotics for individuals with schizophrenia
- › Adult major depressive disorder suicide risk assessment

S. 264 provides States with flexibility in determining the level of payment, but stipulates that States must follow a methodology that specifies:

1. The factors that trigger quality bonus payments
2. The methodology for making the quality bonus payment
3. The amount of the quality bonus payment

Designated Collaborating Organizations (DCOs)

A CCBHC can use a Designated Collaborating Organization to augment their service offerings. S. 264 mandates nine broad categories of services that every CCBHC must offer. Of these nine mandatory core services, four must be provided directly by the CCBHC. The remaining five services can either be offered directly by the CCBHC or they can be offered via a special relationship the CCBHC can establish with an external entity called a Designated Collaborating Organization. A CCBHC can use more than one DCO to meet the five mandatory core services, or to provide additional non-mandatory services. In all cases, however, the CCBHC retains clinical responsibility for the consumer and the outcome(s). In addition, it is the CCBHC that will receive the Daily or Monthly Rate (i.e. get paid) so the CCBHC will be responsible for paying the DCO(s).

There are many criteria surrounding the CCBHC/DCO relationship. Organizations not able or interested in becoming a CCBHC will want to look into becoming a DCO. NextGen Healthcare has created a white paper exploring aspects of the DCO including:

- › Requirements to become a DCO
- › Impact of becoming a DCO in terms of processes, services, and payments
- › How to determine if becoming a DCO make sense for your group
- › Opportunities that a DCO presents for CCBHCs
- › Health record exchange issues faced by the DCO and CCBHC
- › Data collection issues faced by DCOs
- › DCO/CCBHC relationships
- › DCO reporting responsibilities

These and several other aspects of DCOs are presented in our “To Be or Not to Be a DCO” whitepaper, Top 7 Critical Components of becoming a CCBHC

1. Understand the nine broad categories of services CCBHCs must provide – either directly, or through tight relationships with partner organizations.
2. Plan for your transition now in order to be successful when the program begins across the country – meet with your EHR vendor to lay out the level of information sharing necessary to support truly serviceable care coordination.
3. Make sure you have the right staff in place – including a CEO, Medical Director, sufficient clinical staff, and appropriate levels of management for your clinic’s size.
4. Confirm you can capture and report on the information required to become and remain a CCBHC.
5. Intelligent information exchange and use will be critical to your success as a CCBHC – devise strategies and processes to ensure you’re sharing information effectively.
6. Make sure you can conduct the substantial analysis required to determine which prospective payment system (PPS) funding rate is most advantageous for your specific circumstances.
7. Augment your service offerings, as needed, by leveraging Designated Collaborating Organizations (DCOs).

About Us

Having both BH and medical information all in one record is not common, but it's possible. It's what you get with NextGen Healthcare's comprehensive, integrated, and interoperable behavioral health EHR. You get a fully integrated EHR and PM with intuitive BH content and workflow tools. NextGen Healthcare's BH solution can help your clinic improve care outcomes, streamline data sharing and access, reduce costs, and make reporting easier. With it, you'll have the foundation you need to become a CCBHC.

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