Certification	
Questions	**Answers**
How is a CCBHC defined? Is a CCBHC a SITE or all of the sites within an agency going to be providing CCBHC services under the PPS rate during the demonstration period?	Certification will occur at the site level, as opposed to the organizational level. Therefore, only those sites that offer the core services will receive the CCBHC designation.
Can more than one provider come together to do this? Can a FQHC and a behavioral health provider merge to become a CCBHC? What if two agencies want to partner but not merge—can they share CCBHC?	The CCBHC certification will only belong to one entity. Sites who merged together prior to April 1, 2014 are eligible.
Will the CCBHCs identified for the demonstration program be chosen based on the surrounding consumer or population need?	Numerous criteria will be involved in the selection process.
What services is the CCBHC required to provide?	The CCBHC has to directly provide at least three of the nine required services— screening, assessment, and diagnosis including risk assessment, patient-centered treatment planning, and outpatient mental health and substance use services. The other six services - crisis mental health services, primary care screening and monitoring, targeted case management, psychiatric rehabilitation services, peer support and family support services, and services for members of the armed forces and veterans - can be provided by the CCBHC or by a DCO. A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC. A formal relationship is evidenced by a contract, Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU). 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. The CCBHC maintains clinical responsibility for the services provided for CCBHC consumers by the DCO. DCO-provided services for CCBHC consumers must meet the same quality standards as those provided by the CCBHC.
If one organization is able to provide all nine services, do they have to have contracts with DCOs?	If the CCBHC is able to provide all nine services at one site, then the CCBHC does not need to have any DCO contracts.
We are a non-profit entity that currently does not provide Mental Health Services through their charter. However, they have the capacity to administer and monitor a contract with a for-profit mental health provider. Will this organizational structure meet the requirements of the CCBHC?	Per SAMHSA, the CCBHC has to be an non-profit organization (with 501(c)(3) tax exemption status) and has to provide at least the three required services (screening/assessment, person-centered treatment planning and outpatient mental health and substance use services). Based on this requirement, the non-profit entity has to provide the mental health services and it cannot be done through a contract.
How is the state defining urban and rural?	The definition from the Federal Office of Management and Budget will be used. Rural is defined as “a non-metropolitan or outlaying metropolitan county. Urban is defined as a "central metropolitan county.”

Can a private, for-profit clinic or organization be a CCBHC? Are there any options for-profit organizations? Can a for profit agency switch to being a non-profit after 2014?	Criteria 6.A from the RFA: The CCBHC maintains documentation establishing the CCBHC conforms to at least one of the following statutorily established criteria: • Is a non-profit organization, exempt from tax under Section 501(c)(3) of the United States Internal Revenue Code; • Is part of a local government behavioral health authority; • Is operated under the authority of the Indian Health Service, an Indian tribe, or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.); • Is an urban Indian organization pursuant to a grant or contract with the Indian Health Service under Title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.). Private, for-profit clinics or organizations are not eligible to be a CCBHC per the statute, however "they may be a DCO working with a CCBHC." (Federal QA).
What are the guidelines regarding the requirement that CCBHCs to monitor the DCOs?	Criteria 4.a.4 from the RFA: "DCO-provided services for CCBHC consumers must meet the same quality standards as those provided by the CCBHC." (RFA, pg 37) Criteria 4.a.5 from the RFA: "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." (RFA, pg 37) Criteria from 4.b.1 from the RFA: "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, reflecting person and family-centered, recovery-oriented care, being respectful of the individual consumer's needs, preferences, and values, and ensuring both consumer involvement and self-direction of services received. Services for children and youth are family-centered, youth-guided, and developmentally appropriate. Note: See program requirement 3 regarding coordination of services and treatment planning. See criteria 4.K relating specifically to requirements for services for veterans." (RFA, pg 38)
Is there going to be a standard DCO contract for CCBHC's to use across the state?	Currently there is not a standard contract for CCBHCs to use to contract with DCOs across the state.
How are smaller providers being educated about what is a DCO and expectations of a DCO (how they are paid, monitored, etc.)?	Numerous provider and LME/MCO meetings have occurred across the state which were available and open to all providers. No information has been specifically targeted to any agency regardless of size. The Divisions have not assumed what services might be provided through a DCO arrangement.
Has the state developed the needs assessment and staffing plan as discussed in critiera 1.a.1?	The state is currently working on developing a needs assessment, based on SAMHSA's guidance, and will work with the site to complete the needs assessment. The needs assessment will include findings from the yearly LME-MCO Community Behavioral Health Service Needs, Providers and Gaps Analysis, as well as a more in-depth needs assessment that will be conducted with sites. Based on the findings of these assessments, it could be determined that additional or different services may be necessary to meet the needs of the populations to be served. The staffing plan will partly be determined by the needs assessment, as well as the expected number of individuals to be served (catchment area).
Has the state defined the staffing pattern and who can provide what services?	The state has not defined the staffing pattern. This will in part be determined by the results of the needs assessment, as well as the proposed geographic area to be served and expected number of participants.
What type of catchment area will the CCBHCs cover? How far reaching will catchment areas be from clinic site?	The geographic coverage area has yet to be determined.

Criteria 1.d.3 requires auxiliary aids for services; will the state be looking for more than language/sign language interpreters and documents in additional languages?	Decisions regarding the need for these services will be considered after reviewing the results of the needs assessment.
What is the expectation of the CCBHC regarding increasing access to transportation for consumers?	As per Criteria 2.a.4 from the RFA: "To the extent possible within the state Medicaid program or other funding or programs, the CCBHC provides transportation or transportation vouchers for consumers." (RFA). As well, sites are encouraged to develop care coordination agreements with transportation programs as necessary given the needs of the consumer population." The state has not determined the specifics regarding this criteria.
What are the guidelines regarding telehealth and in-home services?	Criteria 2.a.5 from the RFA: "To the extent possible within the state Medicaid program and as allowed by state law, CCBHCs utilize mobile in-home, telehealth/telemedicine, and on-line treatment services to ensure consumers have access to all required services." The state is reviewing the current state Medicaid plan and discussing the scope of telehealth services that CCBHC will be able to provide. Information specific to Telemedicine and Telepsychiatry is described in Clinical Coverage Policy 1H.
What are the requirements regarding the CCBHC engaging "in outreach and engagementactivities to assist consumers and families to access benefits, and formal or informal services to address behavioral health conditions and needs (criteria 2.a.6)?"	The requirements regarding outreach and engagement have not been determined yet.
What is the guidance regarding services for undocumented individuals?	Criteria 2.D from the RFA: No Refusal of Services due to Inability to Pay"2.d.1 - The CCBHC ensures: (1) no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services (PAMA § 223 (a)(2)(B)), and (2) any fees or payments required by the clinic for such services will be reduced or waived to enable the clinic to fulfill the assurance described in clause (1).2.d.2 - The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC proposes to offer pursuant to these criteria. Such fee schedule will be included on the CCBHC website, posted in the CCBHC waiting room and readily accessible to consumers and families. The sliding fee discount schedule is communicated in languages/formats appropriate for individuals seeking services who have LEP or disabilities."
What is guidance regarding providing services to individuals that live in other states?	Criteria 2.E from the RFA: "2.e.1 - The CCBHC ensures no individual is denied behavioral health care services, including but not limited to crisis management services, because of place of residence or homelessness or lack of a permanent address. 2.e.2 - CCBHCs have protocols addressing the needs of consumers who do not live close to a CCBHC or within the CCBHC catchment area as established by the state. CCBHCs are responsible for providing, at a minimum, crisis response, evaluation, and stabilization services regardless of place of residence. The required protocols should address management of the individual's on-going treatment needs beyond that. Protocols may provide for agreements with clinics in other localities, allowing CCBHCs to refer and track consumers seeking non-crisis services to the CCBHC or other clinic serving the consumer's county of residence. For distant consumers within the CCBHC's catchment area, CCBHCs should consider use of telehealth/telemedicine to the extent practicable. In no circumstances (and in accordance with PAMA § 223 (a)(2)(B)), may any consumer be refused services because of place of residence."

Who is responsible for care coordination? Are the sites responsible for care coordination or can LME/MCOs continue to manage care coordination? What if another agency has the person for one service that has some targeted case management in the definition and the person also is seen at the CCBHC? Or someone seen at a DCO; who is the main responsible party for coordination; especially when one doesn't have authority?	Critieria 3.a.1 from the RFA: "Based on a person and family-centered plan of care aligned with the requirements of Section 2402(a) of the ACA and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person." (RFA) This is an ongoing conversation with LME/MCOs to develop the best way of providing comprehensive care coordination at the CCBHC without duplicating services.
Regarding DCO and care coordination agreements, what is the leverage if the community partner does not want to partner?	In order to operate as a CCBHC, agencies and DCO(s) will be required to have adequate working agreements which cover all necessary CCBHC components.
Has the state decided which entities the CCBHC need to have relationships with (FQHC, inpatient psych, child welfare, etc.) – per the National Council conference, the state is supposed to define who the partnership agreements need to be with.	Please refer to the RFA for guidance regarding entities with which the CCBHC is required to have partnership agreements. 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."
If the CCBHC offers primary care services, does the site still need to have a care coordination agreement with an FQHC or rural health center?	Criteria 3.c.1 -" The CCBHC has an agreement establishing care coordination expectations with Federally-Qualified Health Centers (FQHCs) (and, as applicable, Rural Health Clinics [RHCs]) to provide health care services, to the extent the services are not provided directly through the CCBHC. For consumers who are served by other primary care providers, including but not limited to FQHC "Look-Alikes" and Community Health Centers, the CCBHC has established protocols to ensure adequate care coordination. Note: If an agreement cannot be established with a FQHC or, as applicable, an RHC (e.g., a provider does not exist in their service area), or cannot be established within the time frame of the demonstration project, justification is provided to the certifying body and contingency plans are established with other providers offering similar services (e.g., primary care, preventive services, other medical care services)."

What is the expectation with regard to formal relationships for items like neurological or developmental testing?	Criteria 3.a.1 from the RFA: "Based on a person and family-centered plan of care aligned with the requirements of Section 2402(a) of the ACA and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person."
Regarding DCO and care coordination agreements, how does this impact consumers' choice of providers? With DCOs, can they choose who is their DCO; how does choice work with having DCOs? Can people only go to the DCO that they are contracting with or can they go to anyone?	Criteria 4.a.2 from the RFA: "The CCBHC ensures all CCBHC services, if not available directly through the CCBHC, are provided through a DCO, consistent with the consumer's freedom 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." (RFA, pg 37) "Nothing about a CCBHC's agreements for care coordination should limit a consumer's freedom to choose their provider with the CCBHC or its DCOs."
The RFA notes that CCBHCs do not have to directly provide crisis behavioral health services "if there is an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services". Does North Carolina's current Mobile Crisis Management system qualify as a state-sanctioned program?	At this time, the state will likely classify the current Mobile Crisis Management service as a state-sanctioned program. CCBHCs will be required to provide the required crisis services (24 hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization) through DCO contract(s).
What crisis services are required under the CCBHC demonstration program and willl be included in the PPS? Is facility based crisis a required service?	CCBHC sites will directly or indirectly provide "24 hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization". The specific service definitions will build off the current State Medicaid Plan. Additional guidance from SAMHSA also states, that "no payments will be made under the demonstration program for inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services." (RFA)
What does it mean that the site has to provide screening, assessment, and diagnosis including risk management? What does "risk assessment" mean?	Criteria 4.d.3 from the RFA: "The initial evaluation (including information gathered as part of the preliminary screening and risk assessment), as required in program requirement 2, includes, at a minimum, (1) preliminary diagnoses; (2) the source of referral; (3) the reason for seeking care, as stated by the consumer or other individuals who are significantly involved; (4) identification of the consumer's immediate clinical care needs related to the diagnosis for mental and substance use disorders; (5) a list of current prescriptions and over-the-counter medications, as well as other substances the consumer may be taking; (6) an assessment of whether the consumer is a risk to self or to others, including suicide risk factors; (7) an assessment of whether the consumer has other concerns for their safety; (8) assessment of need for medical care (with referral and follow-up as required); and (9) a determination of whether the person presently is or ever has been a member of the U.S. Armed Services. As needed, releases of information are obtained." Specifics about "risk assessment" are yet to be determined.
How is the state defining a "comprehensive person-centered and family-centered diagnostic and treatment planning evaluation?"	Please refer to Clinical Coverage Policy 8c for guidance about a person-centered plan.

Since the CCBHC is responsiuble for the Person Centered Plan (PCP), will the CCBHC write the plan for the DCO? Is a PCP required vs a treatment plan for basic outpatient and what about if someone is medication only?	Currently, basic outpatient treatment only requires a treatment plan and not a person centered plan, however a Person Centered Treatment Plan including a risk assessment and crisis planning is a required service of the CCBHC. For patients being seen for CCBHC demonstration services, the CCBHC will complete the PCP.
What types/levels of mental health and substance use services have to be provided in-house?	Criteria 4.F from the RFA: "The CCBHC directly provides outpatient mental and substance use disorder services that are evidence-based or best practices, consistent with the needs of individual consumers as identified in their individual treatment plan. In the event specialized services outside the expertise of the CCBHC are required for purposes of outpatient mental and substance use disorder treatment (e.g., treatment of sexual trauma, eating disorders, specialized medications for substance use disorders), the CCBHC makes them available through referral or other formal arrangement with other providers or, where necessary and appropriate, through use of telehealth/telemedicine services. The CCBHC also provides or makes available through formal arrangement traditional practices/treatment as appropriate for the consumers served in the CCBHC area." Specifics about how outpatient services are defined is still to be determined.
What evidence-based practices will be required? Will all of the CCBHCs be required to offer the same evidence-based practices?	Criteria 4.f.2 from the RFA: "Based upon the findings of the needs assessment as required in program requirement 1, states must establish a minimum set of evidence-based practices required of the CCBHCs. Among those evidence-based practices states might consider are the following: Motivational Interviewing; Cognitive Behavioral individual, group and on-line Therapies (CBT); Dialectical Behavior Therapy (DBT); addiction technologies; recovery supports; first episode early intervention for psychosis; Multi-Systemic Therapy; Assertive Community Treatment (ACT); Forensic Assertive Community Treatment (F-ACT); evidence-based medication evaluation and management (including but not limited to medications for psychiatric conditions, medication assisted treatment for alcohol and opioid substance use disorders (e.g., buprenorphine, methadone, naltrexone (injectable and oral), acamprosate, disulfiram, naloxone), prescription long-acting injectable medications for both mental and substance use disorders, and smoking cessation medications); community wrap-around services for youth and children; and specialty clinical interventions to treat mental and substance use disorders experienced by youth (including youth in therapeutic foster care). This list is not intended to be all-inclusive and the states are free to determine whether these or other evidence-based treatments may be appropriate as a condition of certification." EBPs will be selected based on the needs of the consumer population, which will be identified through the needs assessment.

What is the required scope of practice for primary care screening and monitoring of key health indicators under the CCBHC demonstration program and willl be included in the PPS? Who will be eligible to provide medical services?	Criteria 4.g.1 from the RFA: "The CCBHC is responsible for outpatient clinic primary care screening and monitoring of key health indicators and health risk. Whether directly provided by the CCBHC or through a DCO, the CCBHC is responsible for ensuring these services are received in a timely fashion. Required primary care screening and monitoring of key health indicators and health risk provided by the CCBHC include those for which the CCBHC will be accountable pursuant to program requirement 5 and Appendix A of these criteria. The CCBHC should not take non-inclusion of a specific metric in Appendix A as a reason not to provide clinically indicated primary care screening and monitoring and the state may elect to require specific other screening and monitoring to be provided by the CCBHCs. The CCBHC ensures children receive age appropriate screening and preventive interventions including, where appropriate, assessment of learning disabilities, and older adults receive age appropriate screening and preventive interventions. Prevention is a key component of primary care services provided by the CCBHC. Nothing in these criteria prevent a CCBHC from providing other primary care services." Specifics about which services and what providers are covered in this definition have not been determined yet.
How does the state define Targeted Case Management and which population does it need to be provided for? Will the current definition for Targeted Case Management continue to apply or is the state expecting to develop a new definition of targeted case management?	Critieria 4.H from the RFA: "The CCBHC is responsible for high quality targeted case management services that will assist individuals in sustaining recovery, and gaining access to needed medical, social, legal, educational, and other services and supports. Targeted case management should include supports for persons deemed at high risk of suicide, particularly during times of transitions such as from an ED or psychiatric hospitalization. Based upon the needs of the population served, states should specify the scope of other targeted case management services that will be required, and the specific populations for which they are intended." The state will review the current definition that is included in the State Medicaid Plan and with the results from the needs assessment, the state will consider how targeted care management, including qualifications, will be defined for the CCBHC demonstration program.
What psychiatric rehabilitation services will be required? How does the state define psychiatric rehabilitation?	"The CCBHC is responsible for evidence-based and other psychiatric rehabilitation services. States should specify which evidence-based and other psychiatric rehabilitation services they will require based upon the needs of the population served. Psychiatric rehabilitation services that might be considered include: medication education; self-management; training in personal care skills; individual and family/caregiver psycho-education; community integration services; recovery support services including Illness Management & Recovery; financial management; and dietary and wellness education. States also may wish to require the provision of supported services such as housing, employment, and education, the latter in collaboration with local school systems." (RFA) The state has not yet determined which psychiatric rehabilitations services will be required.
How are peer supports, peer counseling, and family/caregiver supports defined? Will the peer support services provides through IPS or ACTT qualify? Will Family Support Services be defined as more than family therapy?	Criteria 4.J: "The CCBHC is responsible for peer specialist and recovery coaches, peer counseling, and family/caregiver supports. States should specify the scope of peer and family services they will require based upon the needs of the population served. Peer services that might be considered include: peer-run drop-in centers, peer crisis support services, peer bridge services to assist individuals transitioning between residential or inpatient settings to the community, peer trauma support, peer support for older adults or youth, and other peer recovery services. Potential family/caregiver support services that might be considered include: family/caregiver psycho-education, parent training, and family-to-family/caregiver support services." The state has not yet determined which specific services will be required.

Will CCBHCs have to provide intensive, community-based mental health care to members of the armed forces and veterans?	Per SAMHSA's guidelines in Criteria 4.k.1, CCBHCs, either directly, or through a DCO, are "responsible for intensive, community-based behavioral health care for certain members of the U.S. Armed Forces and veterans, particularly those Armed Forces members located 50 miles or more (or one hour's drive time) from a Military Treatment Facility (MTF) and veterans living 40 miles or more (driving distance) from a VA medical facility, or as otherwise required by federal law. Care provided to veterans is required to be consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration (VHA), including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration. The provisions of these criteria in general and, specifically, in criteria 4.K, are designed to assist CCBHCs in providing quality clinical behavioral health services consistent with the Uniform Mental Health Services Handbook." Additional guidelines are provided in Criteria 4.k.2 - 4.k.7.
To be certified, do you have to offer targeted case management and/or physical health screening to everyone, including Medicaid and non-Medicaid consumers?	"It is expected that all clinics will meet the requirements listed in the criteria, however, it is acknowledged that not all clinics will meet 100% of the criteria all the time. It is expected that all significant areas of the criteria will be met to be considered certified. The intent is to elevate service delivery in the field and for states to work with these clinics to meet the criteria. It is currently the states responsibility to track and monitor a CCBHCs compliance with the criteria and develop a process to ensure the criteria are met. The expectation is that the states will work closely with clinics to identify challenge areas and assist with process improvement in order to fully meet the criteria. Further information will be provided in the Application Guidance to apply for the Demonstration program. You may also want to consult the certification guide: http://www.samhsa.gov/section-223/certification-resource-guides/state-certification-guide." (Federal QA)
How will ancillary services such as dental care and pharmacy services be included in CCBHCs?	Ancillary services such as dental services or pharmacy services are not included by SAMHSA as one of the nine required services and thus are not eligible for payment under the PPS system. Sites are encouraged to develop working relationships with ancillary service providers as needed for their consumers.
The guidance in the RFA recommends that states only use one MCO for the demonstration program. Is North Carolina looking to do that or are they looking statewide and will use multiple MCOs?	A minimum of 2 sites will be selected and will not be required to be in the same MCO catchment area.
What specifically does the state expect the provider to have implemented when the state does the certification process at the end of the summer?	The state is in the process of reviewing the Readiness Survey to determine which specific criteria will be necessary for sites to have in place, versus those criteria that can be developed and implemented further along in the certification process. The Divisions do not expect sites to have all criteria in place at this time.
Are there any cultural competency training opportunities available?	DHHS staff are currently working on developing cultural competency training opportunities.

The certification criteria state the CCBHC will incorporate meaningful participation by adult consumers with mental illness, adults recovering from substance use disorders, and family members of CCBHC consumers, either through 51 percent of the board being families, consumers, or people in receovery from behavioral health conditions or through a substantial portion of the governing board members meeting this criteria. Are there any other options for ensuring meaningful participation of consumers and family members if it is not possible to meet these board requirements?	Criteria 6.b.1 from the RFA: "To the extent the CCBHC is comprised of a governmental or tribal entity or a subsidiary or part of a larger corporate organization that cannot meet these requirements for board membership, the state will specify the reasons why the CCBHC cannot meet these requirements and the CCBHC will have or develop an advisory structure and other specifically described methods for consumers, persons in recovery, and family members to provide meaningful input to the board about the CCBHC's policies, processes, and services."
Per North Carolina's corporate practice of medicine rules, private, for-profit, corporations many not practice medicine or employ physicians. Whether primary care services are provided by the CCBHC or by the DCO, the criteria state that "the CCBHC is ultimately clinically responsible for all care provided. The decision as to the scope of services to be provided directly by the CCBHC, as determined by the state and clinics as part of certification, reflects the CCBHC's responsibility and accountability for the clinical care of the consumers. Despite this flexibility, it is expected CCBHCs will be designed so most services are provided by the CCBHC rather than by DCOs, as this will enhance the ability of the CCBHC to coordinate services" (criteria 4.a.1). What does it mean for CCBHCs to be ultimately clinically responsible for all services provided if the CCBHC may not have the experience or staff necessary to provide medical oversight?	Additional clarification has been requested from SAMHSA.