NATIONAL COUNCIL for Mental Wellbeing

HEALTHY MINDS STRONG COMMUNITIES

CCBHCs: A Conversation with VACSB

October 1, 2025

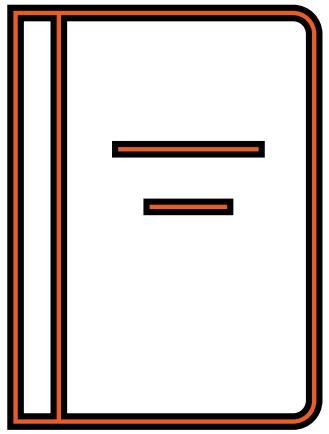
Our vision is that one day, every person in the U.S. will be able to access comprehensive, high-quality care delivered by a CCBHC and its community partners.

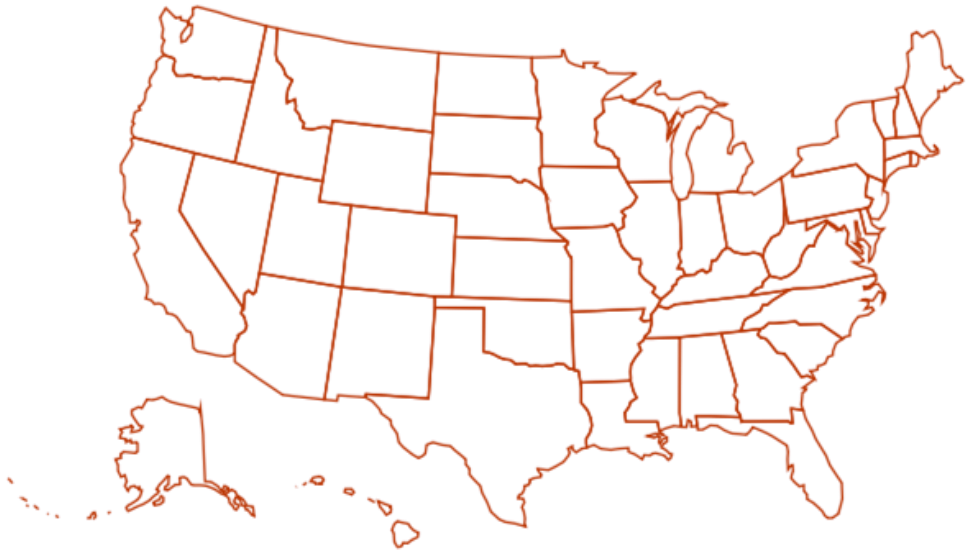
Agenda

Time	Activity	Objective
12:00-12:05p	**Introductions**	
12:05-12:15p	**CCBHC Overview**	• Confirm shared understanding of CCBHC Criteria • Review CCBHC-PPS and other payment structures
12:15-12:25p	**CCBHC Outcome Data**	• National Impact Survey data • Statewide CCBHC data • Individual clinic outcome data
12:25-12:40p	**Statewide CCBHC Implementation**	• Year-long implementation process as outlined by SAMHSA • Recommendations and considerations when implementing CCBHC • State examples to tailor the model • Importance of the **Community Needs Assessment!**
12:40-12:45p	**CCBHC Medicaid Demonstration**	• Review CCBHC demonstration requirements • Understand FMAP implications
	CCBHC SPA Options	• Discuss SPA. Waiver, and other options • Share strategies for this approach
12:45-12:50p	**Legislative Approaches**	• Impacts of HR 1 Medicaid changes • Create shared understanding around state legislation examples and options
12:50-1:00p	**Questions**	

CCBHC Overview

The CCBHC model **turns "bright spots"** into a **national and statewide standard of care**… transforming access and outcomes for the communities CCBHCs serve.





Federally Defined

State Driven

Locally Achieved

Inconsistent access & quality

Workforce shortages

Burden falls on other systems

Inconsistent availability of evidence-based practices (EBPs)

Losing staff to other industries

Service gaps

People can’t get the right service at the right time

Inability to do engagement with people in need of services

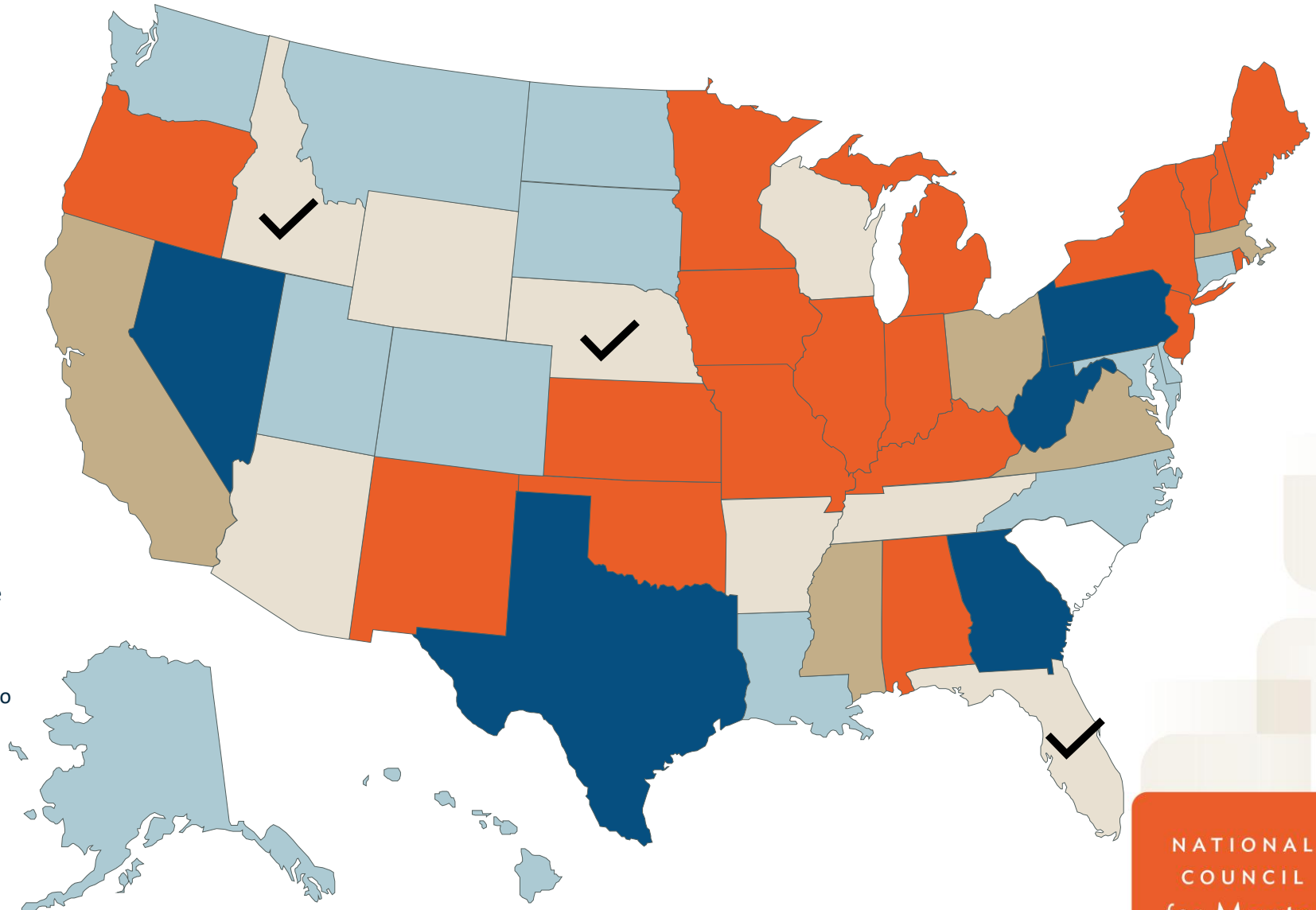
Persistent, high levels of unmet need

Lack of understanding of local, statewide needs

Inadequate data/technology infrastructure

Too few incentives to collaborative with partner entities

Federal & State CCBHC Actions Across the Country



18 States

Active CCBHC demonstration states

5 States*

CCBHC Model approved under an independent Medicaid pathway

15 States^*

2025 State Planning Grant Recipient^

13 States

At least 1 Clinic-level SAMHSA CCBHC Grantee

5 States

2016 or 2024 Planning Grant, Eligible for Demo

1 State

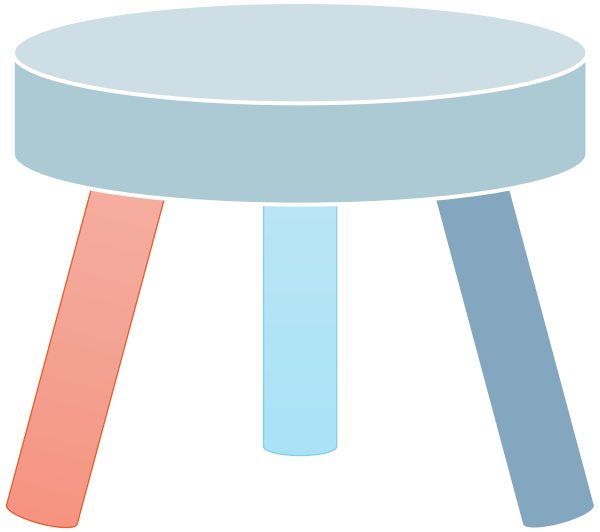
No State Certified or CCBHC Grantees

3 States

State legislation to pursue CCBHC, but no planning grant or approved SPA by CMS

Foundation of the CCBHC Model

CLINICAL MODEL:
Integrated mental health and substance use treatment, including care coordination.



QUALITY MEASUREMENT MODEL:
Data-driven programming, including Continuous Quality Improvement (CQI).

SUSTAINABLE FUNDING MODEL:
Clinic-specific cost-based Prospective Payment System (PPS) Medicaid rate.

CCBHC criteria

Criteria span six domains, with significant state discretion in establishing standards and expectations under each:

1. Staffing
2. Availability and Accessibility of Services
3. Care Coordination
4. Scope of Services
5. Quality and Other Reporting
6. Organizational Authority

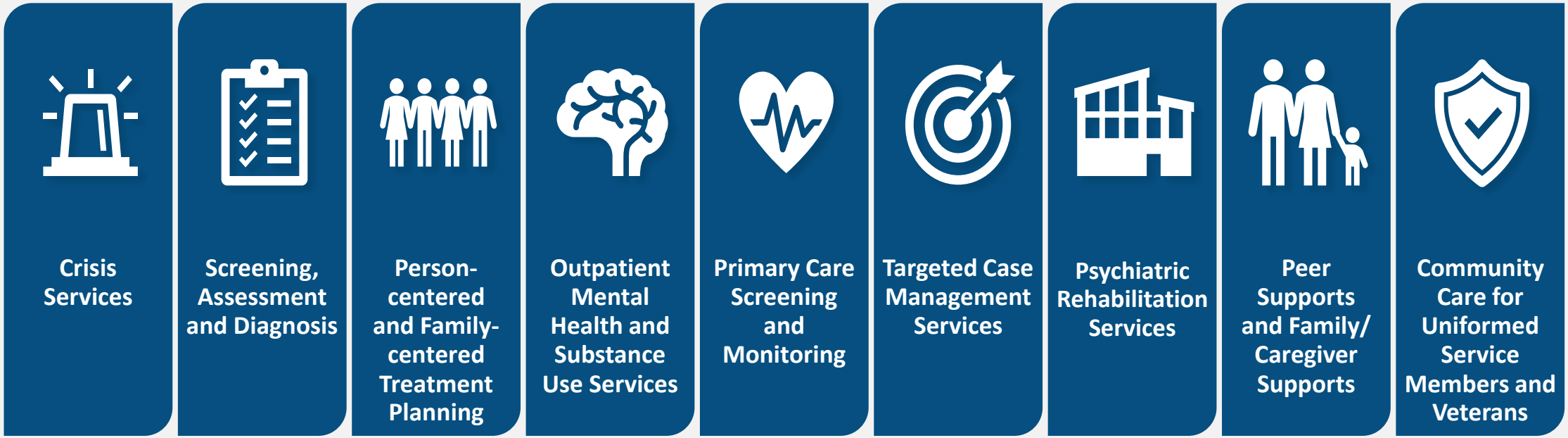
Throughout the criteria, emphasis on:

- Designing requirements to meet state/local needs
- Person- and family-centered care
- Delivery of services outside the clinic
- Innovative partnerships
- Reaching individuals not currently in care
- Measurement-based or data-informed care

To view the full criteria: https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf

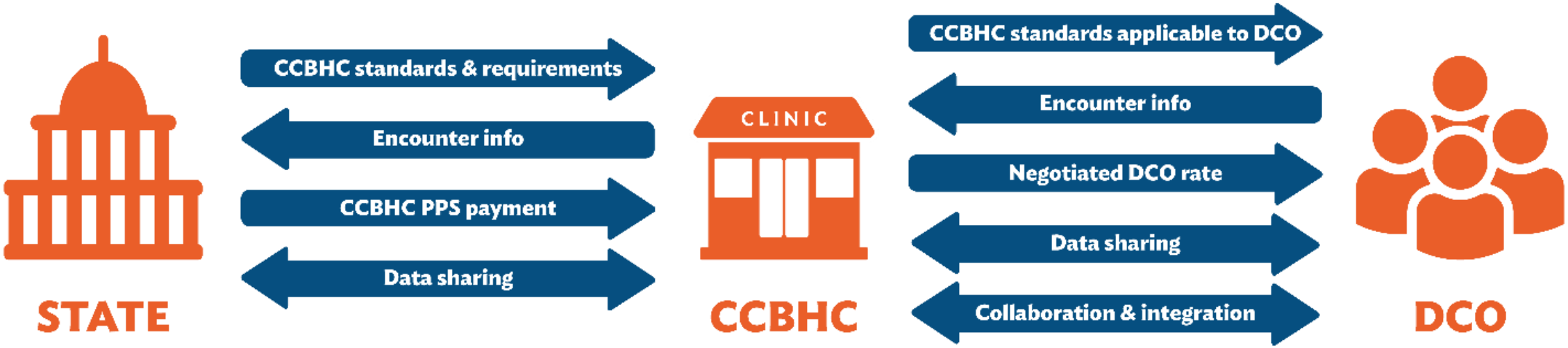
CCBHC

*The CCBHC organization will deliver the **majority of services** under the CCBHC umbrella directly rather than through DCOs (i.e., a majority of total service volume delivered across the nine required services).*



The primary goal of the CCBHC program is to increase access to mental health and substance use care for everyone.

The State-CCBHC-DCO Relationship



Non-DCO Partnership Examples

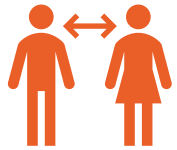
Create staff sharing agreements with partners

CCBHC hires school counselors part-time to support youth in care after hours/over the summer

Create data sharing/use agreements with partners

CCBHC provides financial support for monthly data aggregation and sharing to the CCBHC for joint CQI efforts

Embed CCBHC staff into a partner organization



CCBHC embeds behavioral health staff into a hospital to deflect and divert to the CCBHC as appropriate

Embed CCBHC technology into a partner organization

CCBHC allows for partners to have access to technologies (iPads, hotspots) or trainings to strengthen connectivity

PPS Guidelines (Daily/Monthly Encounter Payment)

- CCBHCs receive **a fixed daily or monthly reimbursement per visit**
  - Based on the FQHC PPS approach used nationally, but different!
- Payment is the same regardless of intensity of services

$$\frac{\text{Total allowable costs of providing services per year}}{\text{Total number of daily visits per year}} = \text{Daily/Monthly per-visit rate}$$

What Goes Into the Numerator?

$$\frac{\text{Total allowable costs of providing services to all patients each year}}{\text{Total number of daily or monthly visits each year}} = \text{Payment rate for each daily or monthly visit}$$

- "**Allowable costs**" for the entire year
  - Direct costs related to anticipated CCBHC services **and activities** (e.g. staff salaries, care coordination activities, costs of services provided under agreement/contract, medical supplies, professional liability insurance, etc.)
    - Including "incident to" costs
  - Allocation of overhead, indirect costs
  - Does NOT include non-CCBHC services

Steps to Calculating Allowable Costs

1. **Understand CCBHC services**
   - Review CCBHC core required services.
2. **Compare existing services versus CCBHC services to identify gaps**
   - How will gaps be covered – internal staff/resources versus an outside organization?
   - These become your anticipated costs.
3. **Calculate direct CCBHC service costs**
   - Direct CCBHC service costs – personnel/other then personnel services
   - Anticipated Costs
4. **Allocate overhead costs (agency-wide)**
   - Overhead costs that benefit both CCBHC and non-CCBHC services which are allocated per the CCBHC cost report methodology

Source: CohnReznick

PPS-Special Crisis Service Rates

Under PPS-3 and PPS-4, the **special crisis service (SCS)** rates allow states to set at least one of three separate monthly rates for CCBHCs providing crisis services.

The three categories of crisis services for which SCS rates can be set are:

1. Mobile crisis services as outlined under section 9813 of (American Rescue Plan) ARP,
2. CCBHC mobile crisis services that do not meet the criteria above but meet criteria described in section 4.C of the updated SAMHSA CCBHC Criteria (CCBHC Demo Mobile Crisis services)
3. On-site CCBHC crisis stabilization services.

CCBHC Outcome Data

77%

CCBHCs & GRANTEES

say their caseload has increased since becoming a CCBHC

Nearly

180,000

total new clients served by these clinics

This represents a 23% increase since becoming a CCBHC

- **30%** average increase for state-certified sites vs. **18%** for grantee-only sites*

6,220

STAFF HIRED

Across the 249 responding CCBHCs and grantees as a result of becoming a CCBHC

Estimated

11,240

STAFF HIRED

across all 450 active CCBHCs as of August 2022

27

NEW POSITIONS PER CLINIC

on average since becoming a CCBHC

(82% of organizations have created at least 10 new staff positions)

These workforce expansions represent a 13% increase compared to prior to becoming a CCBHC.

Grantee sites had a **10%** increase in staff; state-certified sites had a **16%** increase in staff.*

*Difference is statistically significant

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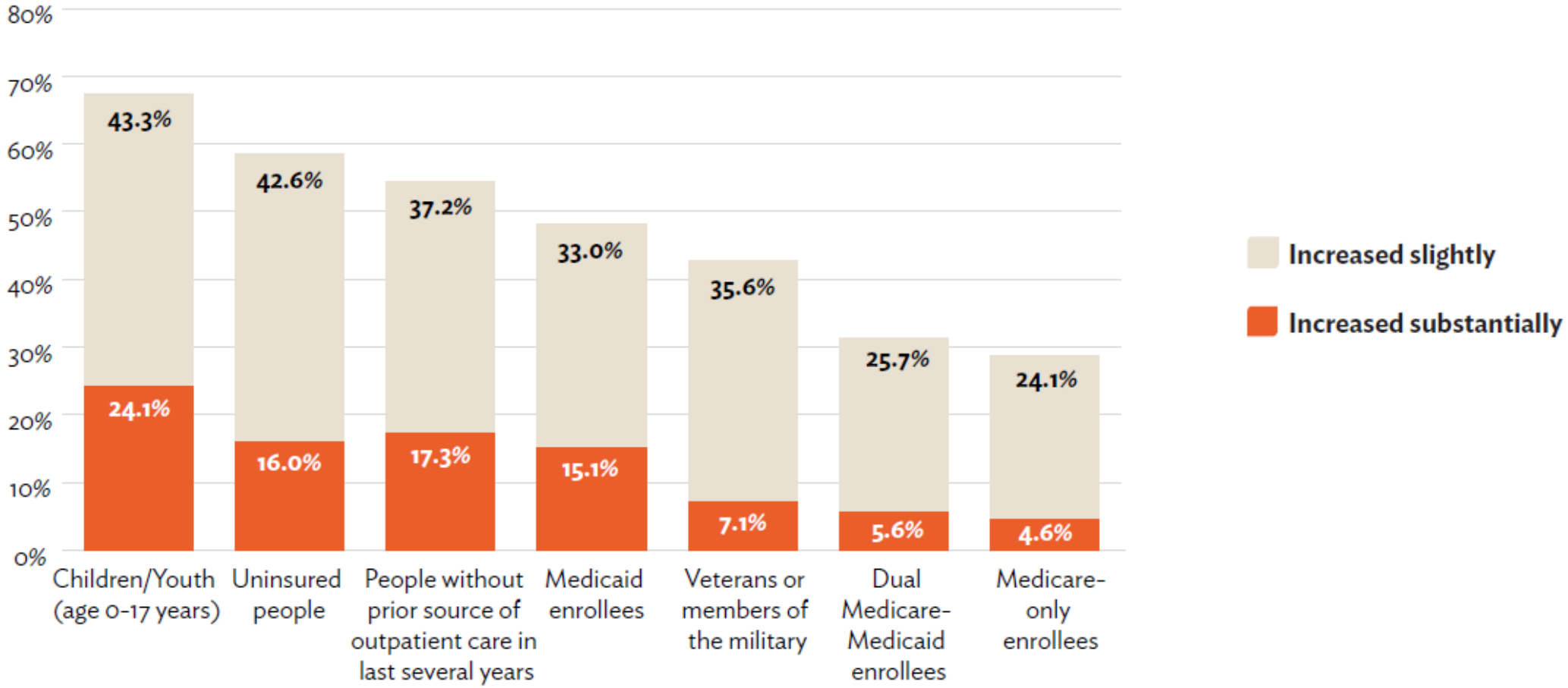
Percent of CCBHCs Reporting Increases in Clients Served, by Group



Reduced Wait Times for Care

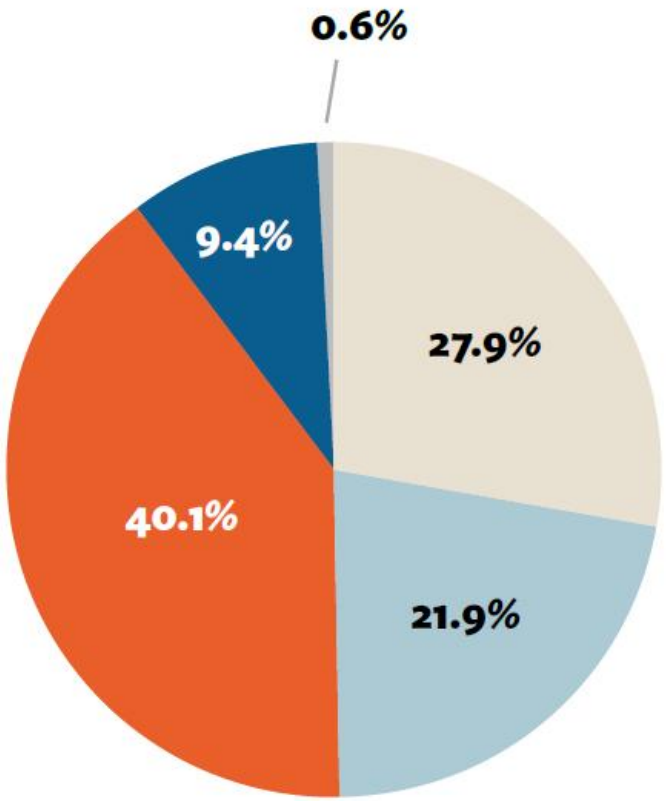
More than 8 in 10 Medicaid CCBHCs and established grantees report seeing patients for routine needs **within 10 days** of the initial call or referral.

65% offer access within **one week or less**.

21% offer **same-day access** to routine services.

The national average between an individual's first outreach/referral until their first appointment is **48 days.**

CCBHCs Exceeding Minimum Integration/Coordination Requirements



Fully integrated provider: Our CCBHC is also a comprehensive primary care provider, and services are available in the same location(s).

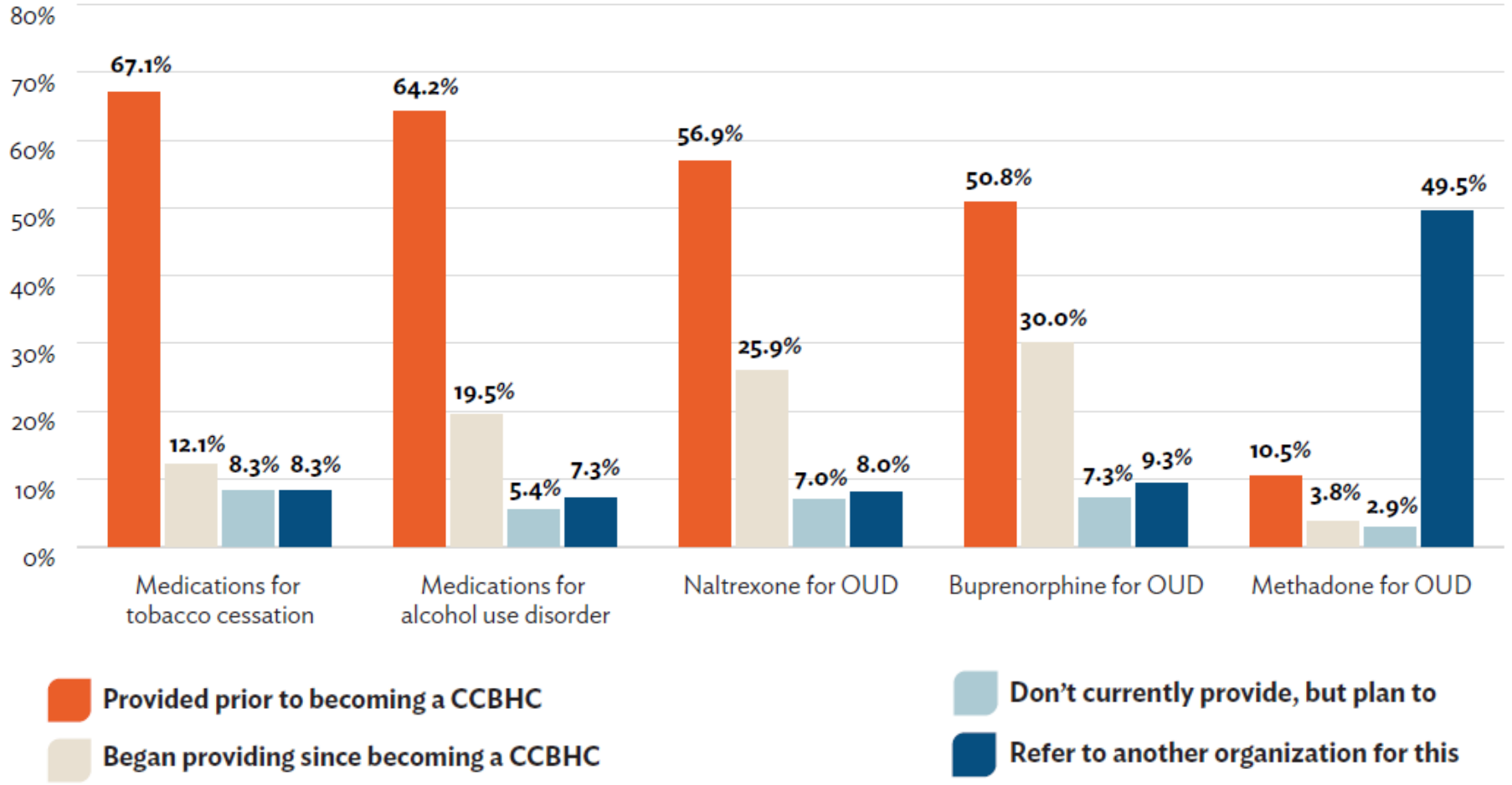
Co-location arrangement: Our primary care partner provides services on-site at our CCBHC location, we provide services on-site at the prima care location or both..

Care coordination: We provide referrals to our primary care partner(s), track follow-up and proactively coordinate care.

Referrals only: We provide referrals to primary care organizations but do not actively track or coordinate care at this time.

None.

All Types of MAT Offered by CCBHCs



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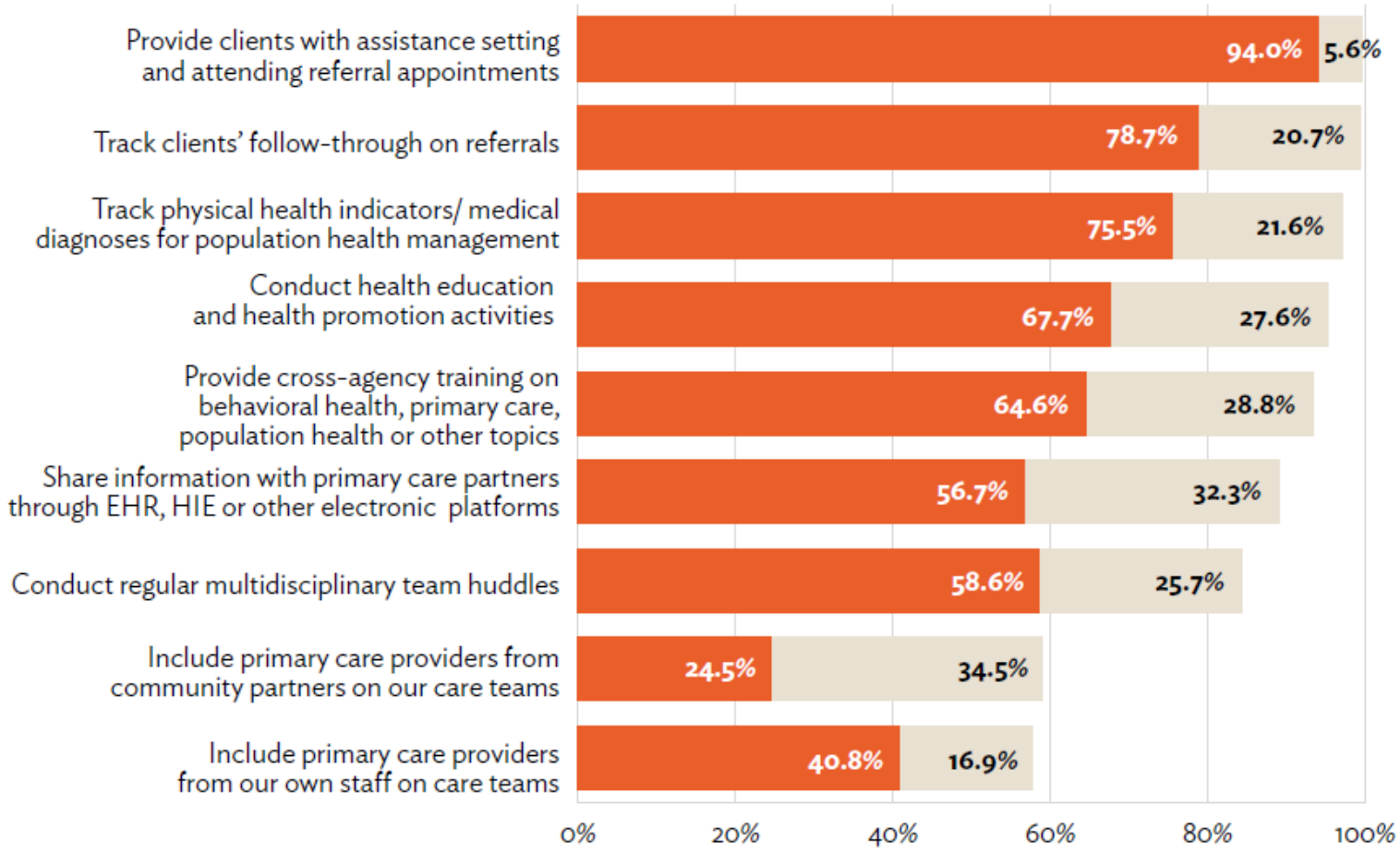
CCBHCs' Integration/Coordination Activities



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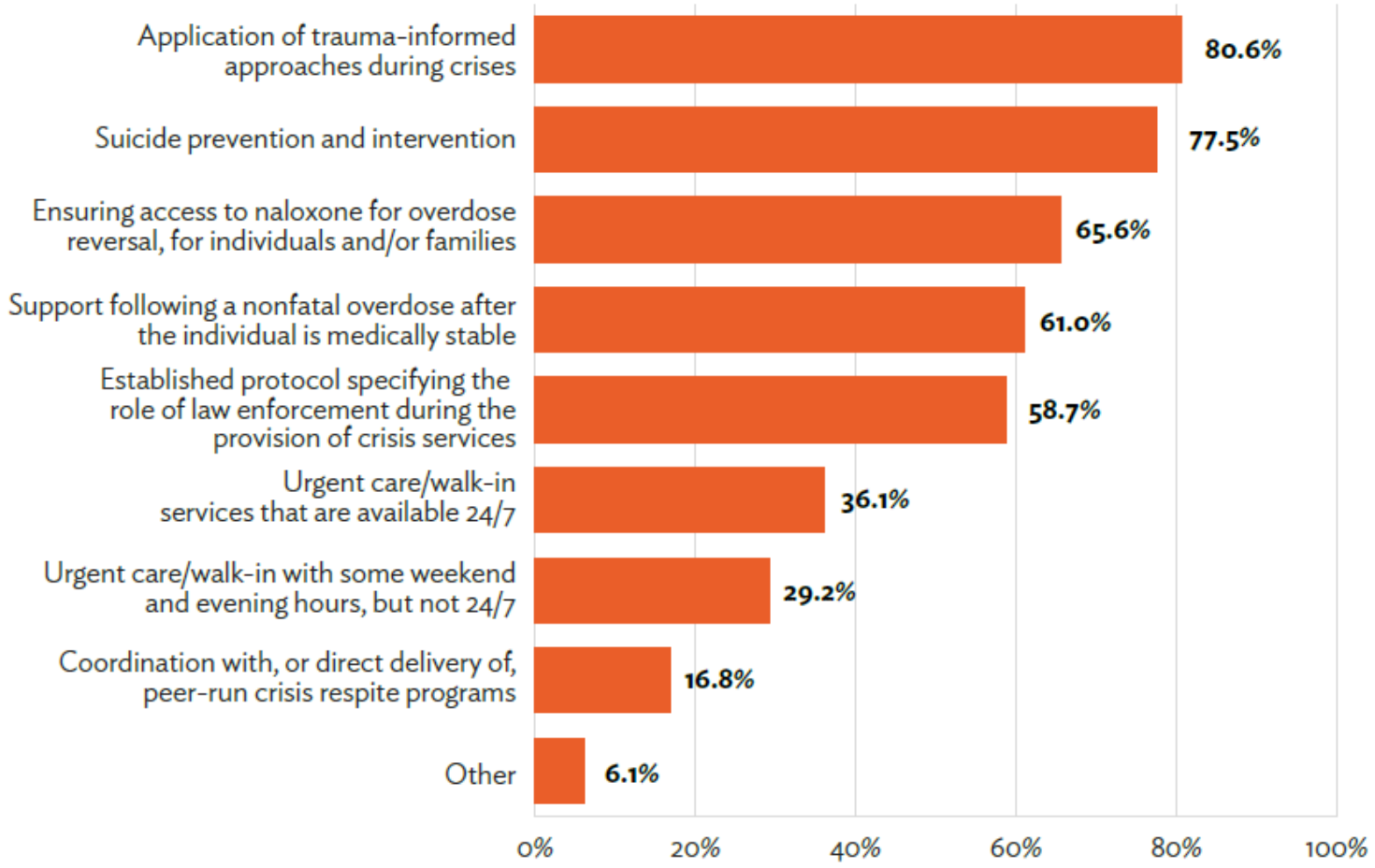
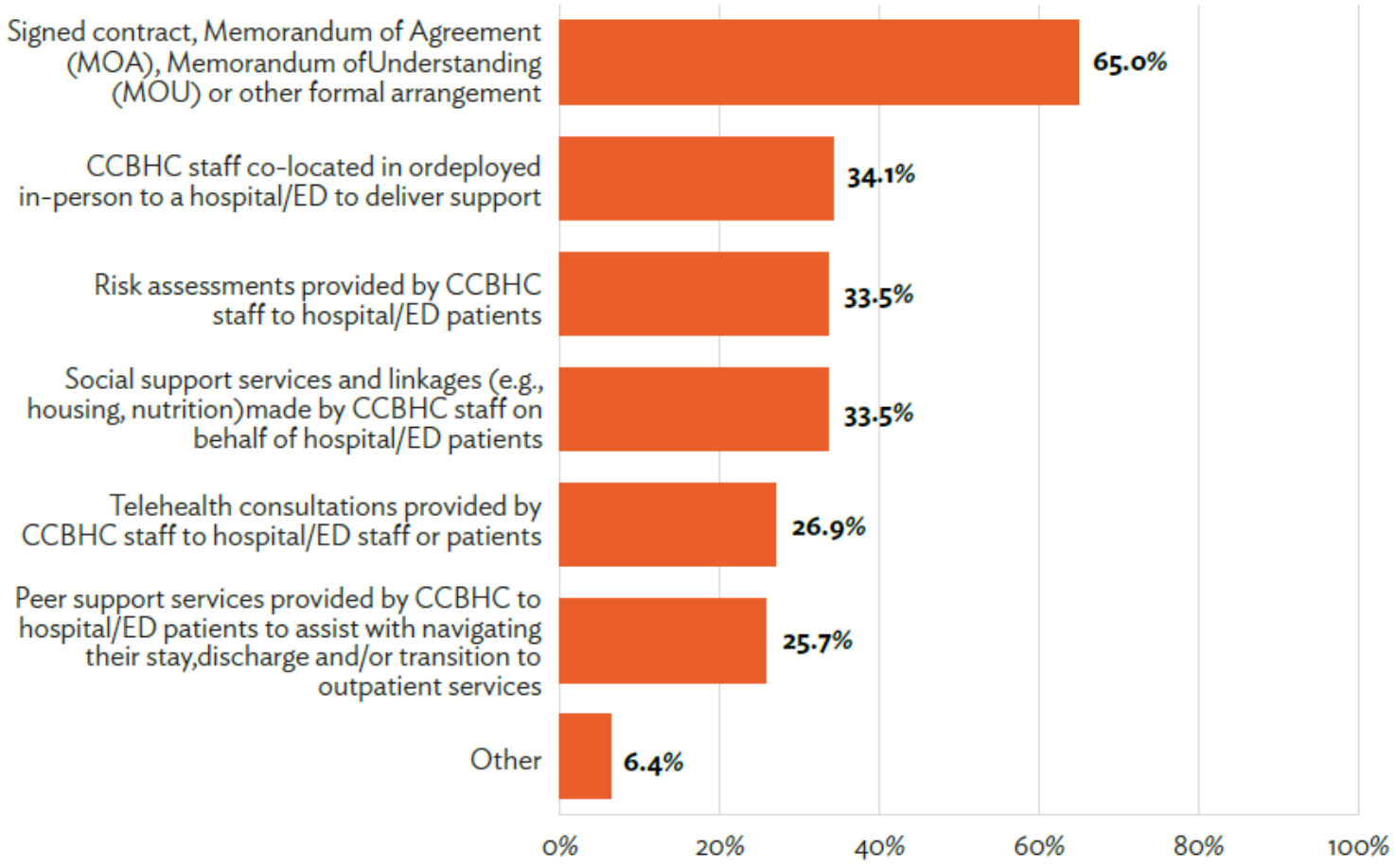
CCBHCs' Crisis Stabilization Services & Supports



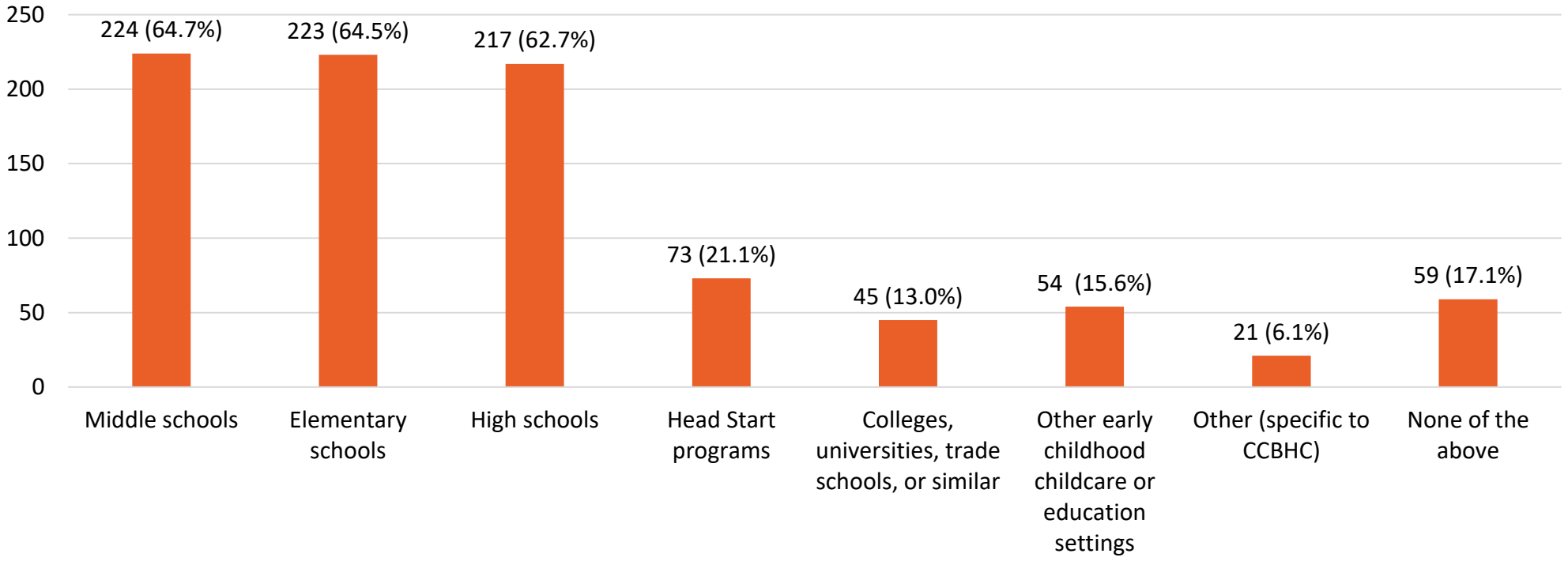
Collaborating with Hospitals and EDs



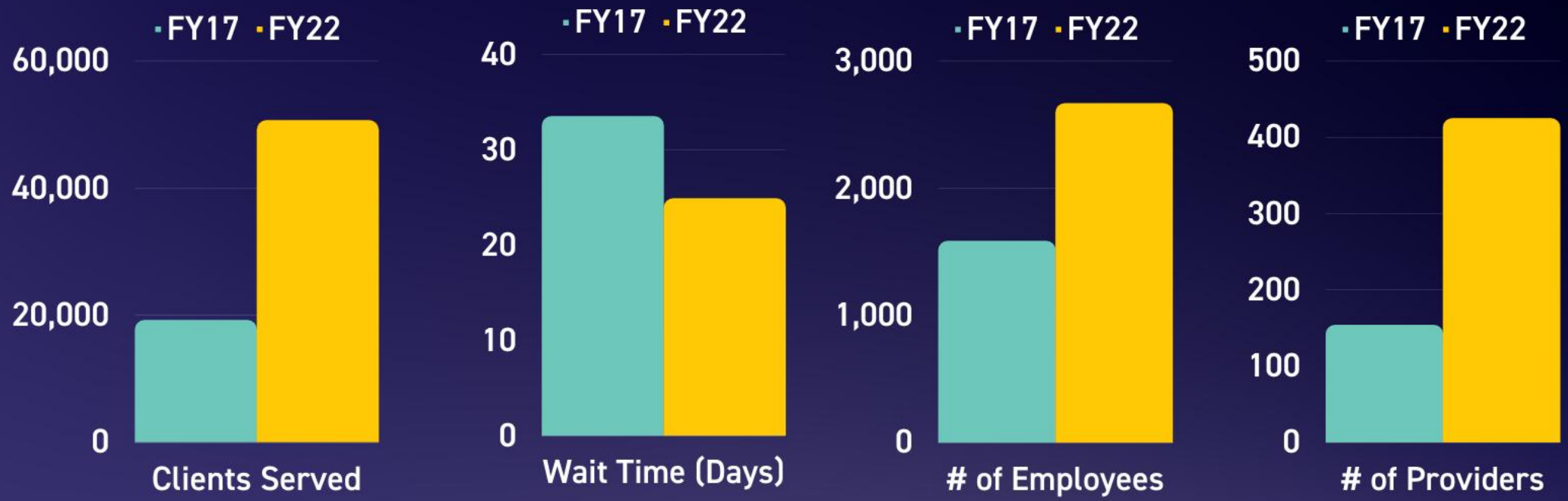
Nearly 85% of Medicaid CCBHCs and established grantees report having one or more collaborative activities in place with hospital and/or ED partners.

Collaborating with Schools

83% of Medicaid CCBHCs and established grantees provide services onsite in one or more schools, childcare, or other child-serving settings.



HIGH-LEVEL ADVANTAGES



BRIGHTLI
livebrightli.org

Comparative Data

Before CCBHC

- 2,500 clients served
- 100 employees
  - Avg MHP $55,000
  - Avg Rehab $42,000
  - Avg Peer $15.00
- Access
  - To Comp Eval 19 days
  - To Ongoing Svc 15 days
- Revenue
  - $6 million

Current

- 4,205 clients served (2022)
- 160 employees
  - Avg MHP $70,000
  - Avg Rehab $51,000
  - Avg Peer $18.25
- Access
  - To Comp Eval 7 days
  - To Ongoing Svc 12 days (covid)
- Revenue (2022)
  - $15.6 million

CCBHC

Certified Community Behavioral Health Clinics

Missouri's Impact Report | Year 5

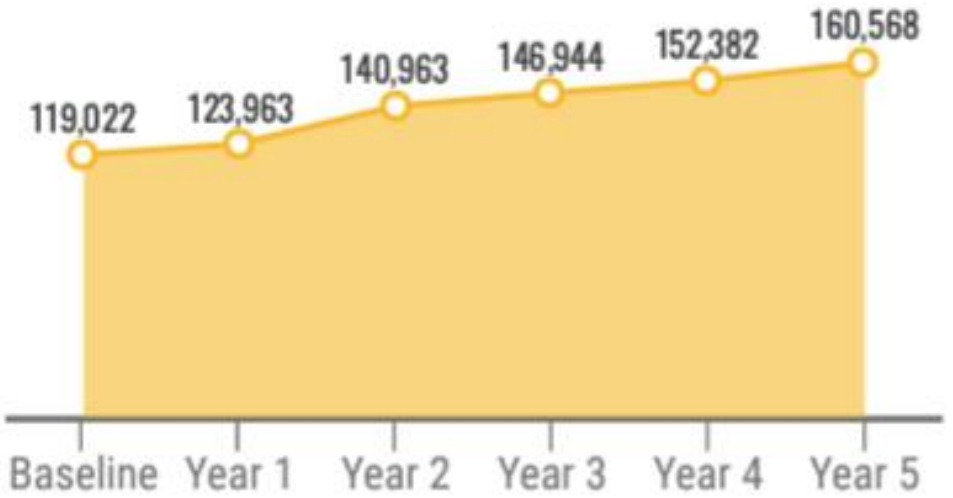
Improving Outcomes & Access to Care

35%

Increase in patient access to care

Overall increase in patients served from baseline (2017) to Year 5 (2022)

Missourians Served by CCBHCs



3,185

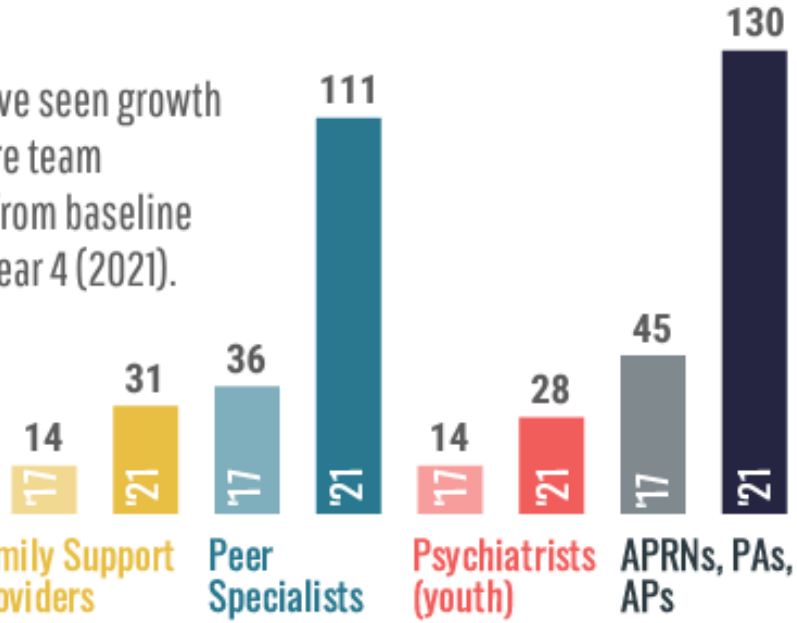
Veterans & active military served by CCBHCs

26% Overall increase in veterans and active military served from baseline to Year 5

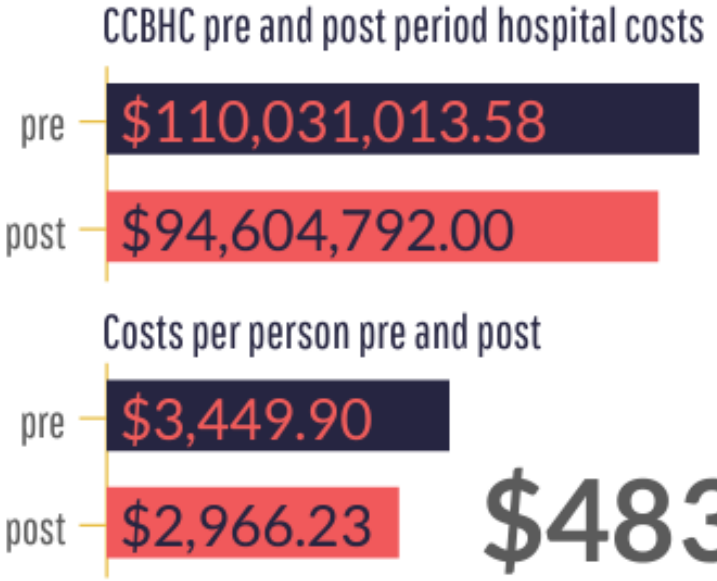
Certified Community Behavioral Health Clinics > Missouri's Impact Report | Year 5

Workforce Recruitment

CCBHCs have seen growth in their care team positions from baseline (2017) to Year 4 (2021).



Cost Savings



14%

Decrease from pre to post period hospital costs totaling

$15.4
million in savings

$483.67 savings per person

for Mental Wellbeing

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Economic Impact: Data Examples

- Number of jobs created at CCBHCs
- Estimated tax revenue associated with new jobs
- Increases in employment among CCBHC clients
- Estimated income and/or tax revenue associated with increased employment among CCBHC clients

Sample methodology for estimating police department savings

"The number of minutes and number of miles saved are calculated based on the difference between the nearest [CCBHC crisis stabilization unit] and [state psychiatric] hospital, multiplied by the number of trips. Trips are tied to specific admissions across several [admission] logs... Cost savings are based on a per mile reimbursement rate of $0.54 and an average hourly officer salary rate of $20.53.

"The estimated cost of the saved mileages was $434,710.15 and $283,970.55 in officer time, for a total savings of $718,680.70."

https://nri-inc.org/media/qa2k0wdf/grand-model-evaluation_june2022_v2.pdf

Michigan

Bringing the framework to life: Snapshot of Michigan's CCBHC program

CCBHC overall access

Total increase of 17% statewide, 18% youth, 71.5% increase in mild & moderate care needs

Same Day Access

100% of CCBHCs provide SDA, up from 5% two years prior (2023)

100% of CCBHCs provide mobile crisis response, both via DCOs and directly

Strengthening SUD care

202% increase in MAT, via DCOs and directly

Enhancing Justice Partnerships

CCBHCs are engaged in SIM mapping, publishing field guides, and embedding in specialty courts

73% provide CIT trainings

35 CCBHCs

Including 12 private providers and 23 CMHCs

~4 years

Into the demonstration (~2 years left)

~65%

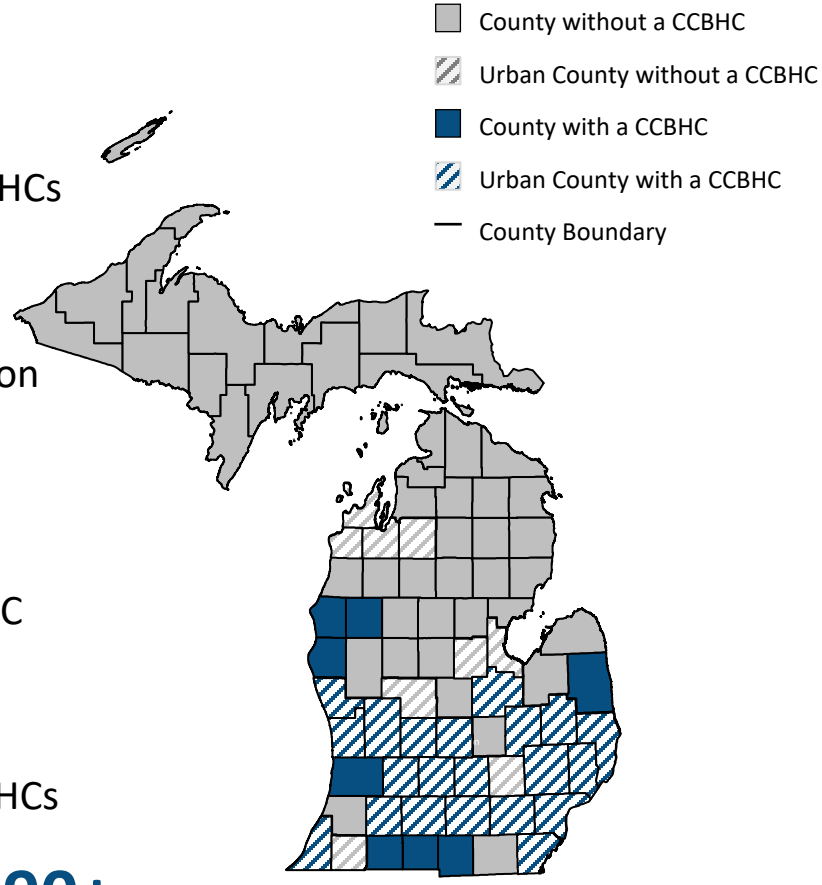
Counties lack a CCBHC

23 of 46

CMHSPs are not CCBHCs

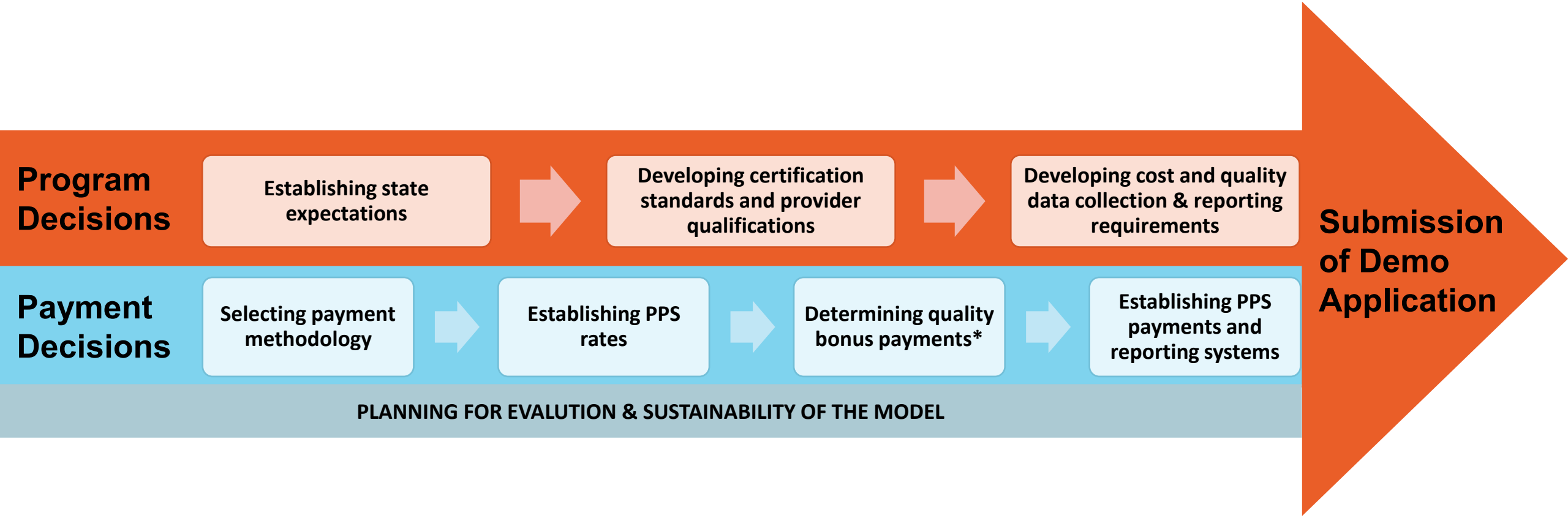
Majority of 90+

Private providers are not CCBHCs



CCBHC Statewide Implementation

Roadmap for CCBHC Planning



*Quality bonus payments (QBPs) are optional for PPS-1 and PPS-3 and are required for PPS-2 and PPS-4.

12-month Process	Planning for CCBHC Implementation (January 2025 – December 2025)											
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
Steering committee(s)	Develop committee(s)	Maintain committees, subcommittees, and partnerships (e.g., state, clinics, associations) with regular meeting cadences, notes, and deliverables to ensure stakeholder and community engagement in the CCBHC demo										
Populations & service areas		Solicit input from focus populations, identify potential CCBHCs & their service areas				Identify population health needs and secure insight from those communities, work with providers to select initial sites and regions they will serve as CCBHCs						
CCBHC training & education			Identify and provide TA needs for providers (e.g., CCBHC-PPS, billing, quality measures) as possible									
Infrastructure for data quality		Identify data collection infrastructure needs and begin processes for quality measurement				Onboard and maintain technology platforms for clinic and state efforts to ensure accurate measurement of quality measures and population health needs						
Assess clinic & community needs	Launch and complete community needs assessments and clinic readiness assessments					Assure clinics' community needs assessments and clinic readiness assessments are complete, accurate, and aligned for criteria and certification needs						
Scope of Services & Certification	Assess Scope of Services and activities that will be included in certification & PPS rate				Formalize CCBHC criteria & Create certification process			Work with clinics to meet SAMHSA and state certification criteria, certify clinics, and plan for future certifications				
Establish CCBHC-PPS					Select CCBHC PPS	Establish a CCBHC-PPS system and work with clinics to help calculate a clinic-specific rate			Establish payment operations & review cost reports			
CMS Approval for CCBHC										Prepare to apply for the Demonstration in 2026		

30-60-90 DAY PLAN FOR STATE AND COMMUNITY NEEDS ASSESSMENTS

30 DAYS

- Complete **environmental scan** using publicly-available data and state-specific literature.
- Draft a state-specific **vision** and set of **goals** based on environmental scan and possible successful through the CCBHC model
- Add data (automation) into **needs assessment module** for stakeholders

60 DAYS

- **Complete community needs assessment** with support from National Council
- **Adjust goals or vision** based off completed assessments
- **Ensure consensus** from all parties, primarily state officials, associations, and providers

90 DAYS

- Craft individualized workplans for clinics and a state workplan for CCBHC optimization
- Assist clinics and state officials as needed, ensure benchmarks are met with project timelines
- Create workplan frameworks to scale support for future states and clinics

Key Steps for Statewide CCBHC Implementation

Ex: Indiana

1. **Establish Indiana-specific Goals.** Engage stakeholders, including Indiana Medicaid, Indiana Council of Community Mental Health Centers (Indiana Council), Indiana Department of Child Service, the Indiana General Assembly, County commissioners, local service providers, Criminal Justice system stakeholders, and others in assessing and finalizing goals and objectives. CCBHC leadership and project management processes will be established by these stakeholders to ensure state staff and strategic partners are included in planning.

2. **Conduct Community Needs Assessments.** Build off the successes of local Indiana providers, (e.g., CCBHC grantees) and align with the innovations and recommendations of other Indiana-based efforts to decrease suicide and overdose. Conduct an environmental scan and surveys to identify additional needs for successful implementation of the CCBHC model to Indiana.

3. **Craft CCBHC certification criteria.** Align with the outcomes of the needs assessments and ensure Indiana's goals will be met through strict criteria to convert a current behavioral health provider to a CCBHC. These criteria may be for both CCBHCs and any designated collaborating organization (DCO) established to strengthen Indiana's care delivery system.

4. **Establish a CCBHC prospective payment methodology.** Reflect the anticipated costs of care delivery of mental health and substance use services by having behavioral health providers conduct a cost report based off Indiana's criteria and their own community needs. This payment methodology allows Indiana providers to function as a competitive business to retain and recruit a workforce. The state will also create a mechanism for quality bonus payments.

5. **Develop data collection and reporting capacities.** Streamline mental health and substance use metrics at the CCBHC level to ensure state and county officials are supported in respective efforts. Identify key health information technology needs for clinics and statewide actors to expedite quality assurance, data transparency and compliance with the CCBHC model and Indiana policies.

18 Questions for Your State to Consider with CCBHC Implementation

Identify state processes and goals

- What budgetary needs exist?
- What external supports are needed?
- What outcomes will be achieved?

Scan your systems

- How ready is your state for CCBHC?
- What needs are unmet?
- What programs work well?

Collaborate for statewide action

- How would the Demo or SPA support concurrent efforts?
- How will other clinical providers be included?
- What's your timeline?

Questions to answer now

Craft state-specific criteria

- What additional criteria are necessary?
- How will you track compliance?
- What is your plan for clinic-level support to meet criteria?

Calculate your clinic-specific rates

- Will it be a daily or monthly rate?
- Will bonus payment be included?
- When will rates be reassessed?

Develop data reporting capacities

- What additional quality measures are necessary?
- What platforms will you use?
- When will state and clinic trainings be provided?

Questions to answer in 3-6 months

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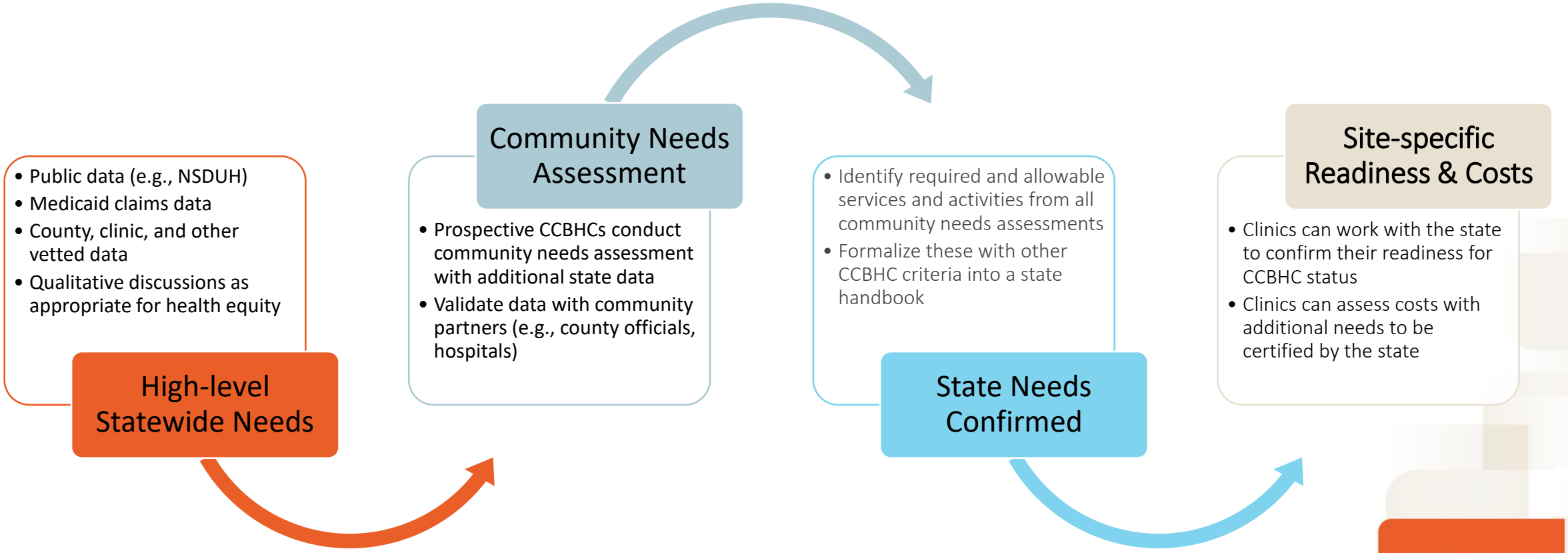
State-to-Clinic Bidirectional Efforts



SECTION 2: AVAILABILITY AND ACCESSIBILITY OF SERVICES
General Requirements of Access and Availability

Federal Criteria Requirements	Rhode Island Additional Requirements
2.a.1 The CCBHC provides a safe, functional, clean, sanitary, and welcoming environment for people receiving services and staff, conducive to the provision of services identified in program requirement 4. CCBHCs are encouraged to operate tobacco-free campuses.	
2.a.2 Informed by the community needs assessment, the CCBHC ensures that services are provided during times that facilitate accessibility and meet the needs of the population served by the CCBHC, including some evening and weekend hours.	**2.a.2** Each CCBHC shall be open a minimum of 50 hours per week. Each CCBHC shall have Open Access hours: • Open access indicates availability for client walk-ins and same day appointments. • CCBHCs are required to have available designated hours at least 3 days/week for open access services. • CCBHCs are required to educate all staff about the availability of open access.

https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2025-01/RI%20CCBHC%20Certification%20Standards%20for%20Program%20Year%202_01.28.2025.pdf

Future of the CCBHC Program

That's all 50 states!

2024

- Planning grant NOFO released with applications due 9/12/24
- 15 states will be awarded planning grants by 12/30/24
- Several states will be developing SPAs within the new CCBHC option

2025

- Planning states are developing their CCBHC programs in preparation for submitting an application to SAMHSA to join the demonstration in 2026
- Demonstration ends for the original 8 demo states 9/30/25

2026

- Up to 10 additional states will be selected to join the Section 223 CCBHC Demonstration.
- SAMHSA may continue to award CCBHC grants directly to clinics.

2028

- Up to 10 additional states will be selected to join the Section 223 CCBHC Demonstration
- SAMHSA may continue to award CCBHC grants directly to clinics

2030

- Up to 10 additional states will be selected to join the Section 223 CCBHC Demonstration
- SAMHSA may continue to award CCBHC grants directly to clinics

CCBHC Medicaid Options

CCBHC Funding Pathways

There are currently **three** funding pathways for CCBHCs:

1. **Section 223 CCBHC Demonstration Program:** This includes states awarded the opportunity to participate in the Section 223 CCBHC Demonstration Program established in 2017. These states establish a process for state certification for eligible clinics utilizing the federal CCBHC criteria, and clinics receive a Prospective Payment System (PPS) rate.
2. **Independent State Medicaid-funded CCBHC Programs:** This includes states that have enacted the CCBHC program through a Medicaid State Plan Amendment or Waiver with approval from The Centers for Medicare & Medicaid Services (CMS). These states establish state-specific eligibility criteria and a process for certification of eligible clinics.
3. **SAMHSA-administered CCBHC Grant Program:** SAMHSA awards grant funding directly to clinics to support adoption and implementation of the CCBHC model. Receiving grant funding is not the same as certification. Grant recipients that have not received state certification – either because the state does not certify CCBHCs or because the organization is not an entity that has received state certification – must submit an attestation to SAMHSA describing how they are meeting the federal CCBHC criteria requirements.

CCBHC Sustainability

Medicaid Waiver (e.g., 1115)	State Plan Amendment	CCBHC Demonstration	CCBHC Grants (SAMHSA funds)
Enables states to experiment with delivery system reforms	Enables states to permanently amend Medicaid plans to include CCBHC as a provider type, with scope of services, criteria and requirements, etc.	Enables states to experiment with delivery system reforms for 4 years	$4 million available for a 4-year period; Previously for a 2-year term
Requires budget neutrality	Does not require budget neutrality	Does not require budget neutrality and provides an enhanced FMAP for states	Grants are given directly to clinics with self-attestation that they meet CCBHC criteria.
Must be renewed every 5 years	With CMS approval, can continue PPS	For only 10 states every 2 years	Clinics provide all CCBHC services and activities of a CCBHC as required by SAMHSA, including basic reporting requirements.
State must be sure to specify inclusion of selected CCBHC services (some may not otherwise be included in the plan)	Cannot waive "state-wideness," may have to certify additional CCBHCs (future CCBHCs may be phased in)	State may limit the number of clinics selected to receive the PPS rate	Grant funds supplement but do not supplant other coverage sources
With CMS approval, offers opportunity to continue or establish PPS		State must be sure to follow all CCBHC criteria with ability to build onto them	

Virginia FY2026 Medicaid Match Rate: 50.39%

Virginia CHIP Rate: 65.27%

500+ in total this year

~$3.3M per year potentially saved within Virginia Medicaid budgets with the Demonstration

CCBHC Legislative Approaches

Changes ahead

HR 1 (OBBBA)

Medicaid cuts

- Beneficiary impacts: work requirements, cost-sharing
- Financing limitations: provider taxes, state directed payments
- Provisions with greatest expected impact on community BH providers start going into effect 1/1/27 (SFY27)

Rural Health Transformation Program (RHTP)

- $50B over 5 years
- Half distributed equally among states; half according to application scoring and rural factors
- Increasing MH/SUD access called out as allowable use of funds

> Considerations for CCBHCs

Strategies for maximizing enrollment

- Universal eligibility screenings
- Proactive disability determination
- Partners, technologies supporting screening & enrollment navigation

Staffing and delivery redesign

- Access redesign for greater engagement
- Clinical innovations, staffing models, or tech facilitating most efficient use of WF
- (Ensure inclusion in CCBHC cost report)

Collaboration opportunities with State

Other strategic considerations

States are entering a period of financial uncertainty, with **significant budget pressures** likely as HR 1's Medicaid cuts go into effect.

Cuts taking effect 1/1/27 fall within SFY27, starting 7/1/26… meaning **budget planning is beginning soon/now**.

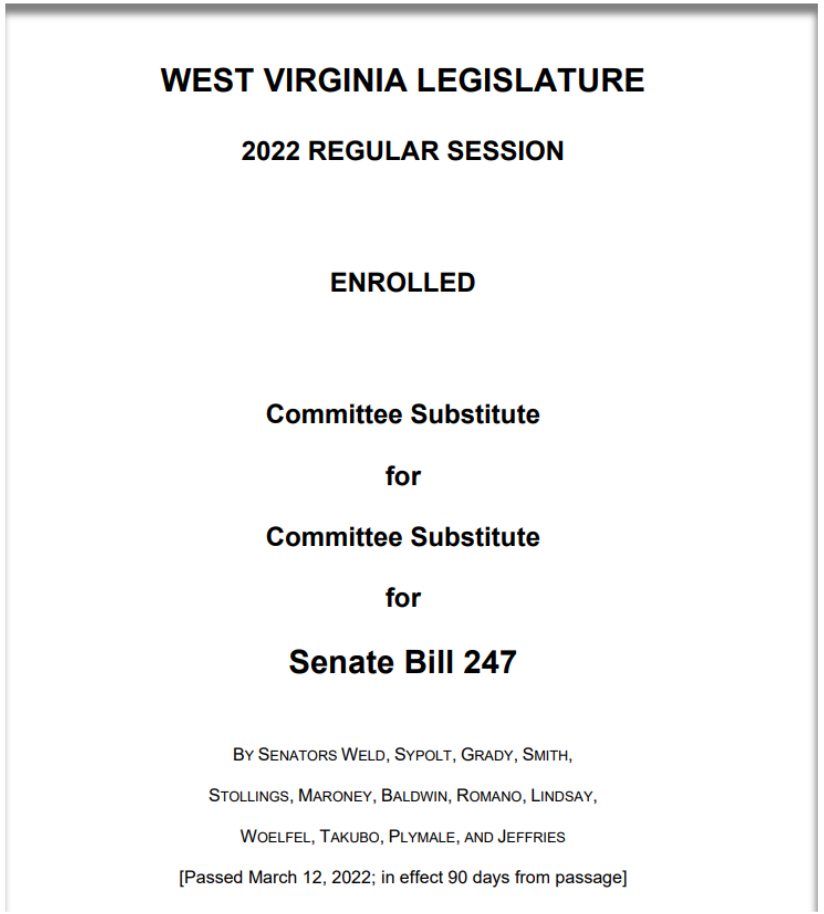
States will need **access to strong data demonstrating impact** and cost-effectiveness of key programs.

We anticipate…

- High performance paired with advocacy and collaborative state engagement is more important than ever
- Data-driven impact messaging will be critical
- CCBHCs' impact falls across many sectors, creating natural allies
- Innovative community partnerships may contribute to demonstrated efficiency or impact

CCBHC in State Legislatures

- Kansas was the first state to pass CCBHC-specific legislation
- Indiana was the first state to pass legislation linking CCBHC and 988
- West Virginia, Nebraska, and five additional states have passed legislation requiring CCBHC be a provider type in their states
- Multiple states (e.g., Georgia) have funded "bridge grants" to CCBHC-E grantees
- To date only six states have had no CCBHC legislative or executive branch efforts (AZ, AR, SC, TN, WI, WY).



WEST VIRGINIA LEGISLATURE

2022 REGULAR SESSION

ENROLLED

Committee Substitute

for

Committee Substitute

for

Senate Bill 247

BY SENATORS WELD, SYPOLT, GRADY, SMITH,

STOLLINGS, MARONEY, BALDWIN, ROMANO, LINDSAY,

WOELFEL, TAKUBO, PLYMALE, AND JEFFRIES

[Passed March 12, 2022; in effect 90 days from passage]

Questions?

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NATIONAL COUNCIL
for Mental Wellbeing

HEALTHY MINDS ▪ STRONG COMMUNITIES