

90-MINUTE WORKING SESSION

NATIONAL
COUNCIL
for Mental
Wellbeing®

Sustaining Virginia Behavioral Health

Building forward through the CCBHC model amid Medicaid change

VACSB Public Policy Conference
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A Virginia case grounded in policy and evidence

Four sections connect policy analysis, strategic value, system design and advocacy execution.

1

POLICY LANDSCAPE

Identify policy triggers and system vulnerabilities.

2

BUILD THE STRATEGIC CASE

Translate the CCBHC model into public and fiscal value.

3

SYSTEM ALIGNMENT

Define the operating, financing and accountability mechanisms.

4

ADVOCACY EXECUTION

Build, tailor and rehearse a decision-maker case.

Protect Coverage Continuity

Sustain Crisis Investment

Build Workforce Capacity

A credible case connects evidence to an audience-specific ask and a next step.



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CCBHC is a certified operating model

The model combines defined standards for access, staffing, services, coordination and quality with state certification, financing and oversight.



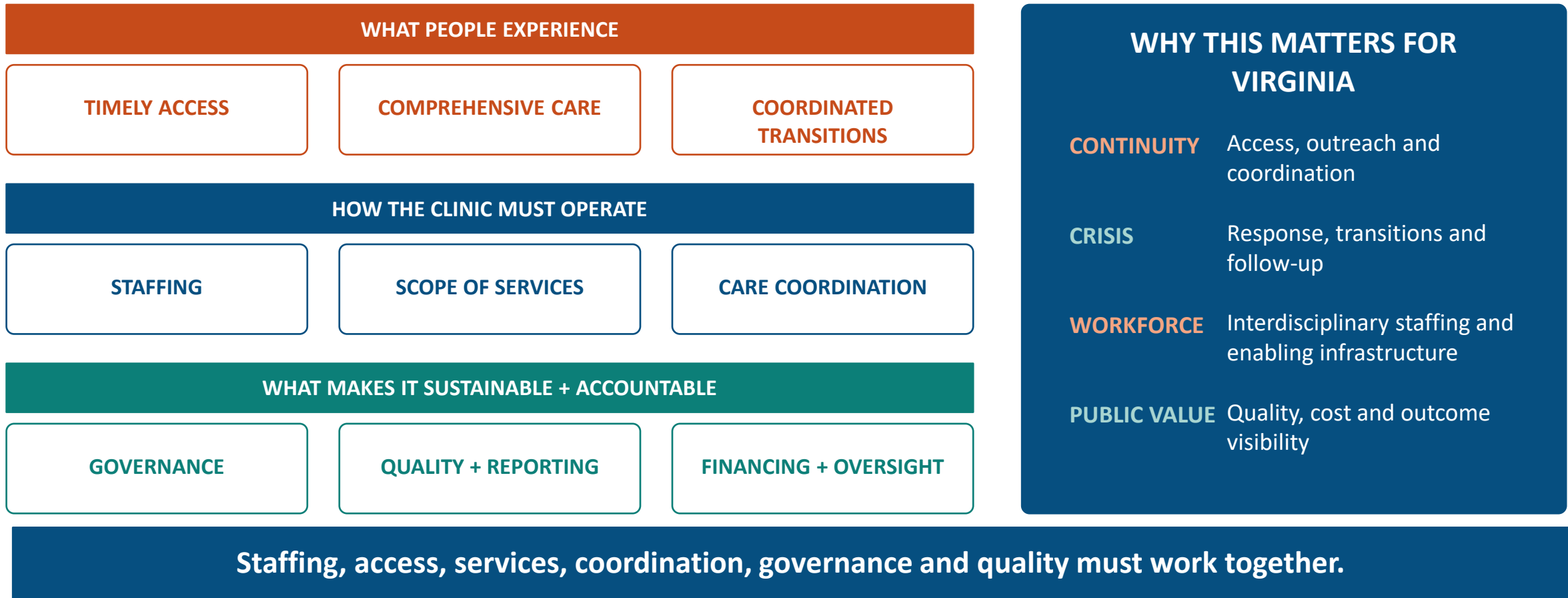
Certification connects care standards with payment and measurable accountability.



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Six operating requirements work as one model

The required services are only one layer. The clinic must also sustain staffing, access, coordination, governance and measurable quality.



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Nine required services form one coordinated system

CCBHC connects services people otherwise may have to assemble across separate providers, programs and systems.

1 24/7 CRISIS Response and stabilization	2 OUTPATIENT MH + SUD Integrated treatment	3 PERSON + FAMILY PLANNING Goals and shared decisions
4 VETERAN-FOCUSED CARE Military-informed access	5 PEER + FAMILY SUPPORT Engagement and recovery	6 TARGETED CARE MANAGEMENT Navigation across systems
7 PRIMARY CARE SCREENING Whole-person monitoring	8 PSYCHIATRIC REHABILITATION Skills and functioning	9 SCREENING + DIAGNOSIS Rapid assessment and risk

The nine services form a coordinated standard of care.



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How Medicaid PPS supports the CCBHC model

Medicaid's Prospective Payment System (PPS) uses a cost-related rate to support eligible services and the capacity needed to deliver the certified model.

MEDICAID PPS

Cost-related reimbursement for CCBHC services for Medicaid-enrolled clients.

Clinic reports costs.
State selects methodology.
Rate targets expected costs of the certified model.

REQUIRED CARE

Nine services, crisis, integrated MH/SUD care, peers and screening

ENABLING CAPACITY

Outreach, coordination, data, quality, technology and training

CRISIS DESIGN

Base-rate costs, separate crisis rates and other funding authorities

OVERSIGHT

Allowable costs, quality, rebasing, outliers and accountability

Source: 2026 CCBHC Impact Report, pp. 13, 39 and 44.

Uninsured care needs supplemental funding alongside Medicaid PPS.



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Virginia’s STEP-VA and crisis investments provide a foundation for CCBHC

These investments offer capabilities to build on. Access, implementation and performance still vary.

ACCESS	STEP-VA: Same Day Access and Outpatient Services	Required CSB services under STEP-VA.
CRISIS CONTINUUM	STEP-VA Crisis Services and Virginia’s 988 crisis system	988, mobile crisis response and stabilization services.
WHOLE-PERSON CARE	STEP-VA: Primary Care Screening and Care Coordination	A service foundation for connecting behavioral and physical health.
RECOVERY SUPPORTS	STEP-VA recovery services	Peer and Family Support, Psychiatric Rehabilitation and Case Management.
INFRASTRUCTURE	STEP-VA quality measures and CSB performance contracts	Oversight structures exist. Performance measurement still has gaps.
USE THIS FOUNDATION	Which capability should Virginia protect, connect or strengthen?	

Virginia’s existing capabilities are the starting point for the CCBHC case.

Name the beneficiary, the value already produced and the sustainability gap.

Sources: DBHDS STEP-VA, Jan. 2026. Virginia 988. BHC STEP-VA, Oct. 2025.

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Which Virginia capability needs strengthening?

STEP-VA, crisis transformation and local innovation have established a base CCBHC can connect, standardize and sustain.

USE THIS FOUNDATION

**Which capability should
Virginia protect, connect
or strengthen?**

**Name the beneficiary,
value and sustainability
gap.**

ACCESS

Same-day access and community pathways

CRISIS CONTINUUM

988, mobile response and stabilization

WHOLE-PERSON CARE

Primary-care screening and coordination

RECOVERY SUPPORTS

Peers, rehabilitation and case management

INFRASTRUCTURE

Partnerships, performance expectations and data

Name the capability, who benefits and the gap that threatens its value.



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CCBHC strengthens Virginia’s existing capabilities

The value is connecting, standardizing, financing and measuring capabilities already underway.

WHAT VIRGINIA HAS BUILT	WHAT CCBHC ADDS	STRATEGIC PRESSURE
Same-day access and community pathways	A consistent access standard, outreach and follow-through	PROTECT COVERAGE CONTINUITY
988, mobile response and stabilization	Required crisis access plus dependable transitions	SUSTAIN CRISIS INVESTMENT
Peers, care managers, clinicians and partnerships	Needs-based staffing supported by infrastructure	BUILD WORKFORCE CAPACITY
Quality, reporting and funding streams	A common certification, payment and performance framework	MAKE PUBLIC VALUE VISIBLE

CCBHC connects Virginia’s assets to continuity, crisis and workforce goals.

CCBHC benefits extend beyond today’s three priorities

3.4 million people served in 2025, nearly 13% more than January 2024.¹

PEOPLE AND FAMILIES

- 50% of clients with opioid use disorder receive medication-assisted treatment¹
- 73% of clinics provide care in schools or childcare settings¹
- 1 in 2 clinics offer primary care at the same location¹

COMMUNITIES AND SYSTEMS

- 76% of clinics report positive criminal justice outcomes¹
- 73% report improved housing outcomes, including stability and retention¹
- 65% report improved employment outcomes, including work readiness and retention¹

CLINIC CAPACITY

- 57% median staff growth among Medicaid CCBHCs²
- 86% of clinics hired data and analytics staff²
- 97.8% of clinics report a hospital or emergency department partnership²

National estimates and clinic self-reports. Capacity measures differ from outcomes and do not predict Virginia results.

Today’s focus: coverage continuity, crisis sustainability and workforce capacity.
These priorities represent only part of CCBHC’s broader value.

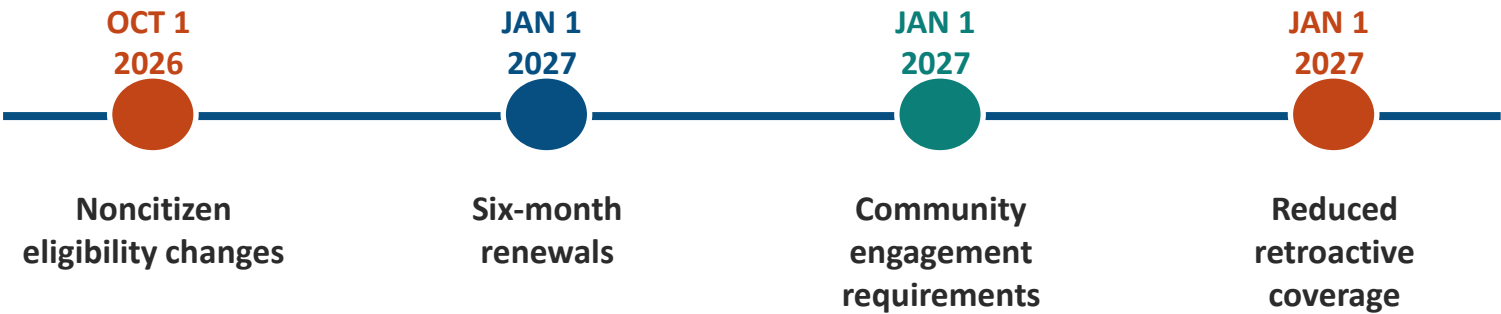
Sources: 2026 CCBHC Impact Report and release. ¹2025 activity. ²Report findings. Details in notes.



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H.R.1 increases coverage-continuity pressures

New eligibility and enrollment requirements increase coverage risk and operating burden.



ABOUT 550,000

Virginians enrolled in Medicaid expansion

Enrollment, not projected coverage losses. Work-requirement exemptions apply.

Virginia can influence notices, verification, data exchange, navigator roles and escalation.

SYSTEM VULNERABILITIES

Administrative load

Renewals, notices and documentation

Continuity risk

Medication and services during gaps

Infrastructure demand

Alerts, worklists, outreach and escalation

January 2027 brings a major increase in coverage-continuity work.

Source: Virginia DMAS, Federal Medicaid Work Requirement FAQs, July 2026.

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H.R.1 coverage risks differ by population

The population affected and the type of risk differ; the CCBHC response is to protect access and continuity, not determine eligibility.

WHO MAY BE AFFECTED

COVERAGE OR CONTINUITY RISK

HOW CCBHC ADDRESSES H.R.1 RISKS

NONCITIZEN ADULTS

Eligibility narrows for some nonpregnant adults beginning Oct. 1, 2026.
About 5,800 VA members received potential-impact notices in Aug. 2026. This is not a confirmed coverage-loss count.

Rapid access regardless of ability to pay; outreach and referral to available coverage and community resources.

MEDICAID EXPANSION ADULTS

Six-month renewals and community-engagement requirements begin Jan. 1, 2027.

Care coordination, benefits-navigation workflows, status monitoring and support for documentation or escalation.

PEOPLE WITH COMPLEX BH NEEDS

Behavioral health conditions, functional limitations, unstable work or housing may complicate notices, reporting and exception documentation.

Needs-based teams, peers, outreach, medical-frailty coordination and continuity planning.

PEOPLE ENTERING CARE AFTER A GAP

Retroactive coverage narrows to one month for Expansion and two months for other Medicaid groups.

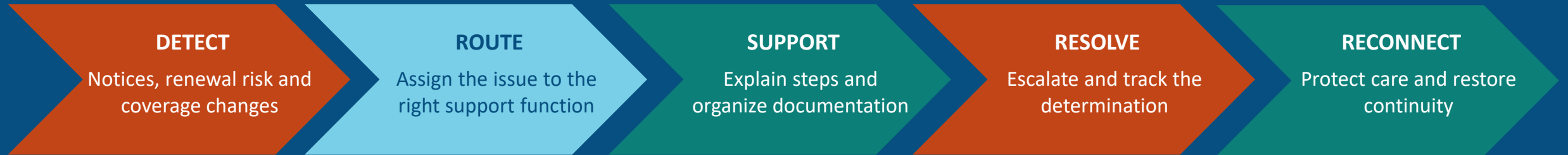
Same-day access, crisis response and rapid reconnection to treatment. Maintain access during coverage gaps and identify financing for uninsured care.

Virginia can define who supports coverage navigation, who tracks coverage gaps, and how care during gaps is financed.

Sources: DMAS, JCHC briefing, Sept. 23, 2026 (notices); 2026 CCBHC Impact Report, p. 13 (financing).

Coverage continuity requires a shared provider workflow

More frequent reviews and documentation requirements create work across intake, registration, treatment, care coordination and benefits support.



CAPACITY TEST

Where does risk surface?
Who owns the next action?
Could the current team absorb twice the volume?

VIRGINIA DESIGN MECHANISMS

Data from Medicaid and MCOs
Defined navigator and provider roles
Allowable costs, privacy and escalation

Clear workflow ownership protects clinical teams from diffuse administrative burden.



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Three pressures, one CCBHC strategy

CCBHC connects an operating model with financing and accountability to address these pressures.

1 COVERAGE CONTINUITY

PRESSURE

H.R.1 increases eligibility activity and coverage risk.

VULNERABILITY

Care disruption and administrative burden.

CCBHC RESPONSE

Access, outreach, navigation and follow-through.

2 CRISIS SUSTAINABILITY

PRESSURE

Virginia has invested in response and stabilization.

VULNERABILITY

Transitions to ongoing care remain disconnected.

CCBHC RESPONSE

Formal handoffs, follow-up and continuing care.

3 WORKFORCE CAPACITY

PRESSURE

Staff shortages intersect with rising demand.

VULNERABILITY

Scarce clinicians absorb broader work.

CCBHC RESPONSE

Finance teams, retain staff and build workforce pipelines.

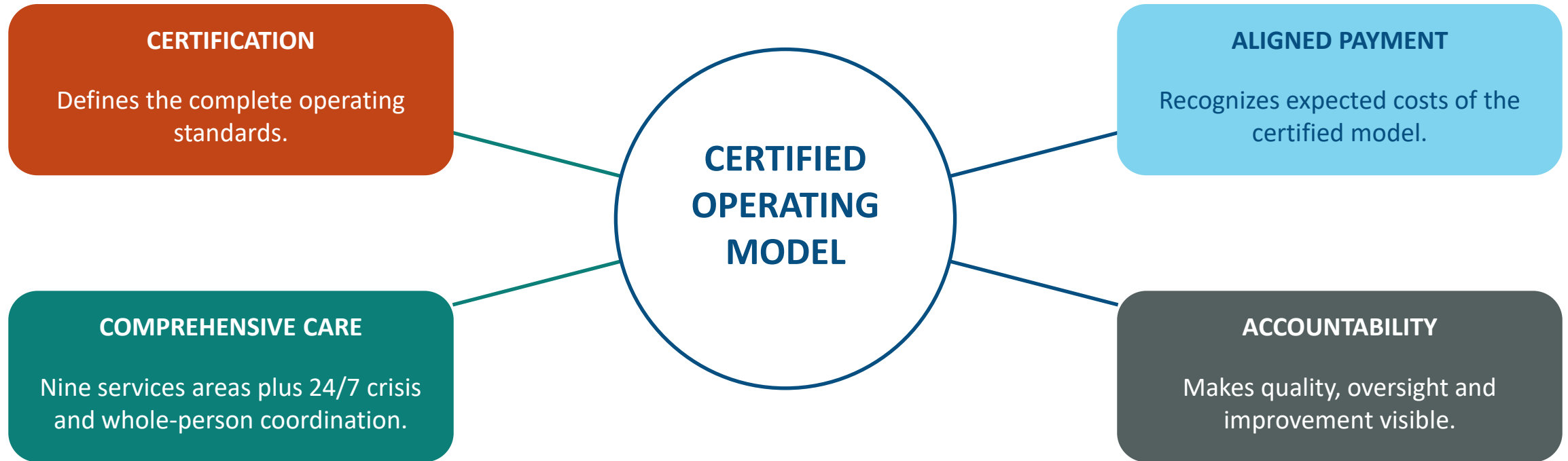
One CCBHC strategy can address continuity, crisis and workforce pressures.



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CCBHC aligns services, payment and accountability

The model aligns standards, comprehensive care, payment and accountability so capabilities function together.



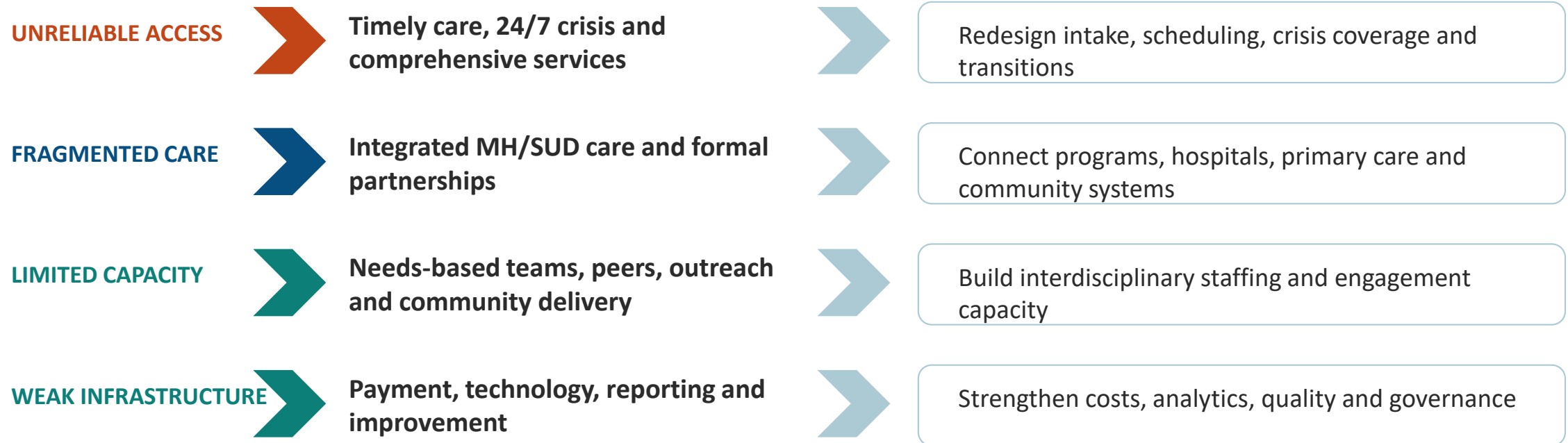
CCBHC certification defines how the complete clinic model operates.



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CCBHC addresses gaps in access, capacity and coordination

Each requirement has an operational purpose: solve a system problem and make a specific capability reliable.



A credible case links a system problem to a specific CCBHC operating change.



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CCBHC can sustain Virginia's crisis investment

Virginia's crisis investment produces more durable value when 988, mobile response, stabilization, hospitals and ongoing treatment operate as one continuum.

CALL → RESPOND → STABILIZE → TRANSITION → FOLLOW UP → CONTINUING CARE

55%

of responding CCBHCs added at least one crisis service after certification

89.1%

of CCBHC mobile crisis teams could receive dispatches or referrals through 988

97.8%

of responding CCBHCs reported a hospital or emergency department partnership

MECHANISM

Sustain staffing and technology, formalize cross-system handoffs, finance follow-up and measure whether people reach continuing care.

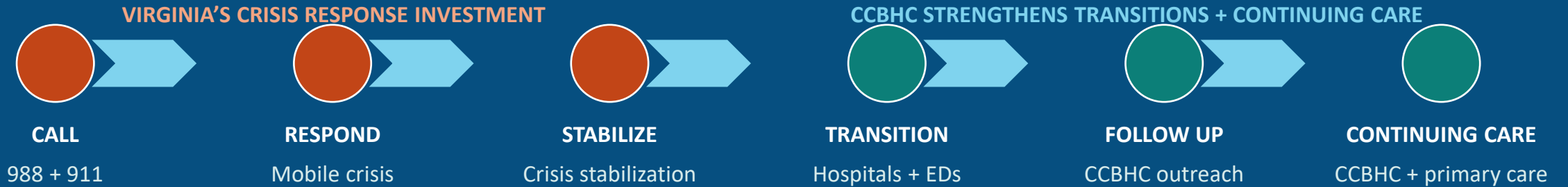
Crisis investment needs a dependable path from response to continuing care.



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CCBHC can connect crisis response to continuing care

Crisis response creates its full value when every call, response and stabilization encounter leads to a dependable next step.



41%

EXPANDED MOBILE CRISIS CAPACITY

CCBHCs reported adding mobile crisis response after CCBHC Certification.

THE CCBHC OPERATING MECHANISM

Defined roles • shared protocols • closed-loop referrals • rapid follow-up • continuing treatment • data and accountability

89.1%

CONNECTED MOBILE TEAMS TO 988

Mobile crisis teams could receive dispatches or referrals through 988.

97.8%

BUILT HOSPITAL OR ED PARTNERSHIPS

Responding CCBHCs reported at least one hospital or ED partnership.

THE VIRGINIA DESIGN QUESTION

How will Virginia organize, finance and measure the connection between crisis response and continuing care?

ROLES • FINANCING • ACCOUNTABILITY

Every crisis contact needs a financed, accountable next step in care.

Dependable crisis handoffs require clear partner roles

CCBHC does not replace Virginia’s crisis partners; it can serve as the clinical hub that connects crisis response with treatment, recovery and whole-person care.

988 + 911	Screen and route the call; initiate the appropriate behavioral health or public-safety response.	Shared routing criteria • warm transfer • mobile-team dispatch
MOBILE CRISIS + STABILIZATION	Respond in the community, stabilize and identify the next level of care.	Real-time capacity • common assessment • peer involvement
LAW ENFORCEMENT + EMS	Support safety and transport when clinically necessary; use diversion or co-response pathways.	Cross-training • referral protocols • telehealth or clinician support
HOSPITALS + EDs	Identify behavioral health needs, coordinate discharge and avoid disconnected transitions.	Notification • discharge planning • rapid follow-up appointment
CCBHC + PRIMARY CARE	Provide continuing MH/SUD treatment, care management, physical-health screening and follow-up.	Next-day access • outreach after missed handoff • shared care plan

COMMON INFRASTRUCTURE | care traffic control • shared protocols • closed-loop referrals • data exchange • performance review • financed follow-up

Dependable crisis handoffs require named partners and clear responsibilities.

SECTION 2 | BUILDING THE STRATEGIC CASE

CCBHC builds capacity by financing the full team

H.R.1 adds operational demands. Clear staff roles can help clients navigate coverage changes.

32,086

new positions created by
responding CCBHCs

57%

median staff growth among
Medicaid CCBHCs

8.9%

reported vacancy rate across
CCBHC positions

FINANCE CLINICAL AND SUPPORT CAPACITY

Cost-related payment supports clinicians and nurses
alongside care coordinators, peers, outreach, data and
quality staff that traditional billing may not sustain.

86.7% hired care-coordination staff

86.0% hired data and analytics staff

Virginia design decision: fund the full team and assign navigation work to defined roles.

Full-team financing can build capacity, while workforce shortages persist.

Sources: 2026 CCBHC Impact Report, pp. 39–43 (national findings); Workforce Solutions Jam, August 2026.



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SECTION 2 | BUILDING THE STRATEGIC CASE

Retention and workforce pipelines sustain capacity

Virginia can pair financing with supervision, career pathways and workable staff roles.

92%+ offer licensure supervision and professional development

RECRUIT AND RETAIN

Competitive salaries and benefits, supervision, professional development, flexible work and bonuses.

88.6% adjusted compensation
75.6% use flexible or hybrid scheduling

BUILD THE PIPELINE AND REDESIGN WORK

Academic partnerships, fellowships, apprenticeships and peer pathways. Team roles help clinicians work at the top of license.

74.6% participate in loan repayment
66.2% partner with academic institutions

Retention, supervision and workforce pathways help sustain team capacity.

Source: 2026 CCBHC Impact Report, pp. 39–43. National survey findings, not Virginia-specific outcomes.



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Lost community care can shift public-system costs

H.R.1-related coverage losses could increase uncompensated care even when CCBHCs keep people connected to treatment.

WHEN COVERAGE OR COMMUNITY CARE IS LOST

PROVIDERS	HOSPITALS	CRISIS + SAFETY	LOCAL GOVERNMENT
Uncompensated care + staff time	Higher-acuity ED + inpatient use	EMS + law-enforcement pressure	Justice, housing + social-service costs

VIRGINIA FINANCING OPPORTUNITY

Virginia can pair federal Medicaid matching funds for eligible CCBHC services with dedicated state and allowable grant funding for uninsured care.

Local data can show where costs shift when community care is lost.

Sources: 2026 CCBHC Impact Report, p. 13; CMS CCBHC and Section 1115 guidance. Details in notes.

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Three pressures call for clear Virginia decisions

Section 2 recap: connect each pressure to a response and a state design choice.

PRESSURE	CCBHC RESPONSE	VIRGINIA DESIGN DECISION
Coverage continuity	Access, outreach and navigation during coverage gaps.	Define navigation roles and supplemental funding for uninsured care.
Crisis sustainability	Formal handoffs and follow-up connect crisis response to continuing care.	Define partner roles, finance transitions and measure follow-through.
Workforce capacity	Finance the full team, retain staff and build workforce pathways.	Support team costs, supervision, retention tools and training partnerships.

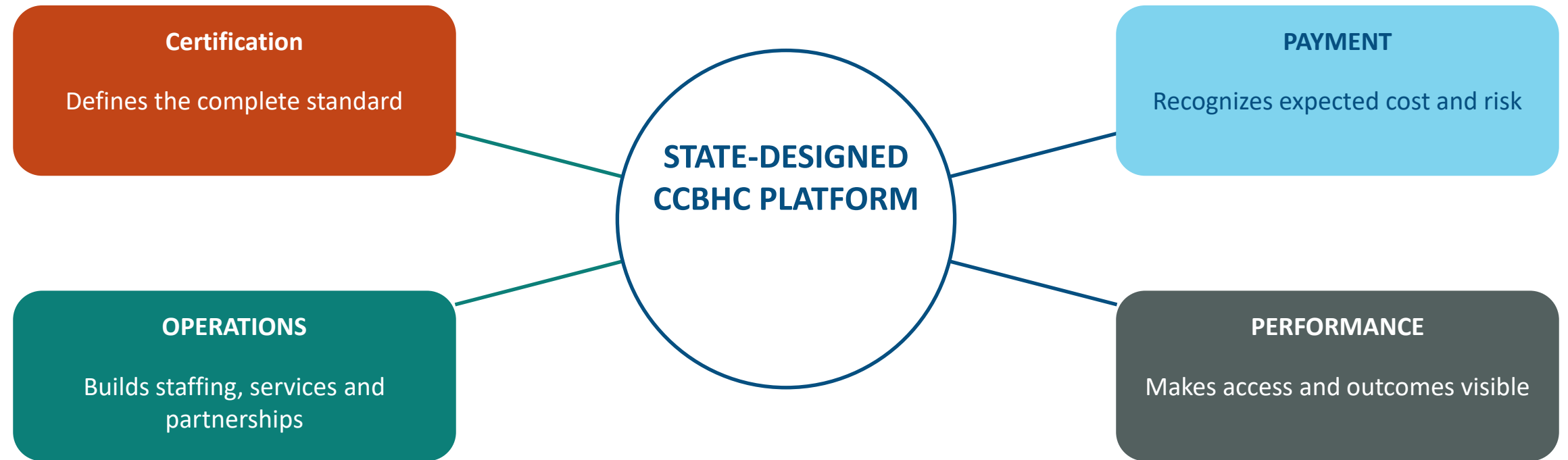
Medicaid PPS excludes uninsured care. Virginia needs supplemental financing.

Sources: 2026 CCBHC Impact Report, p. 13 and pp. 39–43; existing workshop crisis and system-design sections.

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Virginia needs one aligned CCBHC system design

CCBHC creates value only when the parts of the model reinforce one another.



Certification, operations, payment and performance need one coherent design.



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A staged pathway can reduce implementation risk

A staged pathway builds authority and operating experience while preserving future federal options.

- 01** **DEFINE** Goals, certification, crisis roles and initial cohort
- 02** **AUTHORIZE** Medicaid authority, PPS, cost reporting and quality
- 03** **IMPLEMENT** Launch with ready providers and defined partnerships
- 04** **LEARN** Use cost, access and outcome data to improve design
- 05** **SCALE** Expand based on readiness and demonstrated performance

DECISION TO VERIFY

Move state implementation forward through a defined design and fiscal process rather than waiting for a future opportunity.

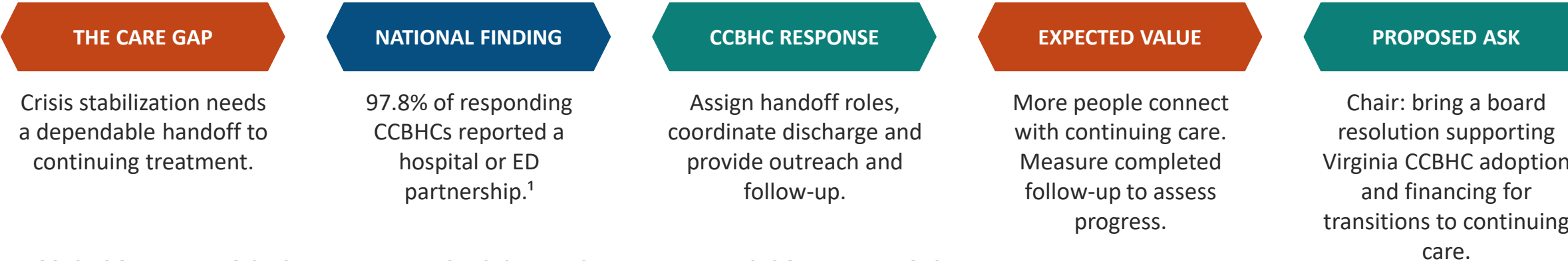
A strong initial cohort needs a clear pathway for additional providers.



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Worked example: a crisis case for a CSB board chair

Practice case: ask a CSB board chair to advance state CCBHC adoption and financing for continuing care.



60-SECOND ADVOCACY EXAMPLE: CRISIS INVESTMENT NEEDS CONTINUING CARE

Chair, crisis stabilization needs a dependable connection to continuing treatment. Nationally, 97.8% of responding CCBHCs report a hospital or ED partnership. That shows partnership capacity, not proof of better outcomes. CCBHC provides a framework for discharge coordination, outreach and follow-up. Virginia can pair Medicaid financing for eligible services with separate funding for uninsured care. Please bring a resolution to our next board meeting supporting Virginia CCBHC adoption and financing for these transitions, and communicate the board’s adopted position to state policymakers.

Local evidence note: a quality lead should verify the follow-up rate before adding a local result. No local rate is assumed.

Policy ask: support Virginia CCBHC adoption and finance transitions to continuing care.

¹ Source: 2026 CCBHC Impact Report, crisis findings. National self-report, not a Virginia forecast.

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The case and ask must fit the decision-maker

Choose the pressure your decision-maker owns, then tailor the evidence and ask to their authority.

COVERAGE CONTINUITY	Define navigation roles and supplemental financing for uninsured care.
CRISIS SUSTAINABILITY	Define partner responsibilities and finance accountable transitions to continuing care.
WORKFORCE CAPACITY	Support full-team costs, supervision, retention tools and workforce pathways.

STATE EXECUTIVE	LEGISLATOR	LOCAL OFFICIAL	CSB BOARD	MCO / HEALTH SYSTEM
System design, feasibility, fiscal impact and measurable results	Constituent access, workforce, crisis and stewardship	Hospitals, public safety, families and local cost	Readiness, staffing, data, partnerships and financial risk	Shared members, transitions, data and acute use

The strongest ask matches the decision-maker’s authority.

Medicaid FFS cannot reimburse uninsured services. Source: 2020 CCBHC Impact Report, p. 13.

Table reference: evidence for three pressures

Choose a relevant fact. A policy or financing fact can be a national proof point without being a statistic.

COVERAGE CONTINUITY	CRISIS SUSTAINABILITY	WORKFORCE CAPACITY
FACT CCBHCs must provide care regardless of ability to pay. Medicaid PPS cannot reimburse uninsured services. [1] CCBHC RESPONSE Access, outreach and navigation during coverage gaps. PROPOSED VIRGINIA DECISION Define navigation roles and supplemental financing for uninsured care. LIMITATION CCBHC access does not restore insurance or guarantee payment.	FACT 97.8% of responding CCBHCs reported a hospital or ED partnership. [2] CCBHC RESPONSE Formal handoffs, outreach and follow-up connect crisis care to continuing treatment. PROPOSED VIRGINIA DECISION Define partner responsibilities and finance accountable transitions. LIMITATION National self-report shows partnerships, not completed local follow-up or savings.	FACT Medicaid CCBHCs reported 57% median staff growth. [3] CCBHC RESPONSE Finance the full team and support supervision, retention and workforce pathways. PROPOSED VIRGINIA DECISION Support team costs, retention tools and training partnerships. LIMITATION National descriptive findings do not guarantee local hiring or eliminate shortages.

Sources: 2026 CCBHC Impact Report: [1] p. 13; [2] crisis findings; [3] pp. 39–43. See earlier evidence slides.

Table Lab 1: One pressure, one capability gap

Choose one pressure and one community (a place or population), program (such as mobile crisis), or care pathway (such as crisis discharge to follow-up). In question 1, name an existing service, team, partnership or workflow within that example as your “capability.”

Keep the same example for all three labs. Select a recorder and spokesperson.

- 1 What capability has your CSB or community built?
- 2 Who benefits, and what value has it produced?
- 3 For your chosen pressure, what specific gap threatens this capability, and who would be affected?
- 4 Which staff, partners or public systems absorb the impact?
- 5 What do you know locally, how do you know it, and what still needs verification?

OUTPUT: one existing capability, one specific gap, who is affected, and one known fact or evidence need.

15 MIN: 10 min table work + 5 min report-outs. Up to three selected tables, 45 seconds each. Collect all outputs.



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Table Lab 2: An evidence-based CCBHC value case

Carry forward Lab 1’s capability and gap. Choose one decision-maker.
What can that person decide, fund, request or help advance?

01	FOUNDATION	Carry forward the existing capability from Lab 1.
02	PRESSURE + GAP	Carry forward the specific gap and who is affected.
03	CCBHC MECHANISM	Which CCBHC requirement or capacity addresses this gap?
04	PUBLIC + FISCAL VALUE	What could improve, and what indicator would show whether it did?
05	ASK	Name the decision, responsible actor and next step.

FACT MENU
Select one relevant fact
Coverage: PPS excludes uninsured care. [1]
Crisis: 97.8% report hospital/ED partnerships. [2]
Workforce: 57% median staff growth in Medicaid CCBHCs. [3]

Use a verified local fact or a clearly labeled local observation. If evidence is missing, identify what must be verified and who will obtain it. Do not invent a number.

12 minutes: a 60-second case with local evidence or a verification need, one national fact and one specific ask.

Fact menu: 2026 CCBHC Impact Report [1] p. 13; [2] crisis findings; [3] pp. 39–43. Full reference: slide 28.

Table Lab 3: Rehearsal, feedback and revision

Work in groups of three. Use the same pressure, audience and case from Lab 2.
Assign advocate, decision-maker and observer. Keep the same advocate for both rounds.

ADVOCATE

60 seconds: deliver the case.
Then 60 seconds to respond
and confirm the next step.

DECISION-MAKER

60 seconds: raise one
concern about cost, evidence,
readiness or burden.

OBSERVER

Mark the checklist yes / not
yet. Suggest one sentence to
revise.

2 MIN PREP

3 MIN ROUND 1

2 MIN REVISE

3 MIN ROUND 2

3 MIN DEBRIEF

Each round: 60 seconds case + 60 seconds concern + 60 seconds response and next step.
Use feedback to revise one sentence before round two.

13 minutes: an improved case and one remaining evidence or policy question.

Lab 3 observer checklist: yes / not yet

Keep this checklist visible during practice. Give one specific revision, then listen for it in round two.

	YES / NOT YET
1 Is the pressure and local gap clear?	Yes / Not yet
2 Does the CCBHC response address that gap?	Yes / Not yet
3 Is the evidence relevant and accurately qualified?	Yes / Not yet
4 Does the ask fit the audience’s authority?	Yes / Not yet
5 Is the next step explicit?	Yes / Not yet

Coverage caveat: Medicaid PPS does not reimburse uninsured services. National findings do not establish local outcomes.

Finish with an improved case and one remaining evidence or policy question. Source: 2026 CCBHC Impact Report, p. 13.

COMMIT TO THE NEXT MOVE

My chosen pressure point is...

My next conversation is with...

My lead message is...

My specific ask is...

My first step will occur by...

COLLECTIVE VACSB NEED

One policy clarification, data point, fiscal analysis, readiness tool or coordinated action that would strengthen member advocacy.



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THANK YOU

Questions and follow-up

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National Council H.R.1 Hub

hub.thenationalcouncil.org

National Council CCBHC resources

thenationalcouncil.org/our-work/ccbhc



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