Evidence shows integrating physical and behavioral health care may improve chronic health outcomes. State and local public health and behavioral health departments administer a range of programs to address physical and mental health conditions, as well as substance misuse, but the types and quality of services can vary across and within state agencies. To address gaps, coordinate care and streamline physical and behavioral health services, some state lawmakers are pursuing a new model of care known as a Certified Community Behavioral Health Clinic, or CCBHC.

Certified Community Behavioral Health Clinic Model

CCBHCs integrate behavioral health with physical health care by connecting behavioral health clinics to local primary care and hospital partners, and building coalitions with criminal justice entities, health advocates and others. CCBHCs are nonprofit organizations, local government behavioral health agencies or tribal organizations offering a wide range of mental health and substance use disorder services for people with complex health needs.

Signed into law in 2014 as part of the Protecting Access to Medicare Act, Section 223 created the Community Behavioral Health Clinics Demonstration Program to pilot this framework and evaluate its success. Eight states started the demonstration in 2017 and another 16 states were awarded CCBHC planning grants through the Substance Abuse and Mental Health Services Administration, also known as SAMHSA. Today, about 430 CCBHCs operate in over 40 states, Washington, D.C., and Guam.

CCBHCs developed under SAMSHA and those created through Medicaid have different funding mechanisms. Medicaid funds the demonstration, and participating states receive enhanced reimbursements to support their CCBHCs. States that have been awarded grant funding through SAMSHA receive $2 million per year paid directly to clinics. States that receive funding through the Medicaid demonstration may not apply for grant funding through SAMSHA.

Currently, 10 states participate in the Medicaid demonstration and, in 2021, SAMHSA awarded 100 grants totaling $250 million. An important note is that the grant funding comprised $115 million in COVID-19 relief funds, $77 million allocated from the American Rescue Plan Act and $58 million in annual appropriations. Without further congressional appropriations, CCBHCs funded through SAMSHA grants may need state support. The Medicaid demonstration will end in 2023.
States that do not participate in the demonstration or receive SAMHSA grant funding can implement CCBHCs by submitting a Medicaid 1115 waiver or state plan amendment to the Center for Medicare and Medicaid Services.

The demonstration program emphasizes that CCBHCs must provide high-quality care using evidence-based practices. Qualified CCBHCs provide nine types of services, either directly or by contracting with partner organizations: outpatient mental health and substance use treatment, primary care screening and monitoring, and behavioral health crisis resources. CCBHCs aim to improve the availability of and access to these services, as well as coordinate care across them, without increasing federal spending.

For an organization to participate as a CCBHC, it must meet program requirements under six categories: staffing; availability and accessibility of services; care coordination; scope of services; quality reporting; and organizational authority. CCBHC certification standards within these criteria are primarily determined by states, but states might need to submit a plan amendment for CMS approval.

CCBHCs are required to provide nine types of services:

- Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization.
- Screening, assessment and diagnosis.
- Patient-centered treatment planning.
- Outpatient mental health and substance use disorder services.
- Primary care screening and monitoring.
- Targeted case management.
- Psychiatric rehabilitation services.
- Peer support services and family support services.
- Services for members of the armed services and veterans.

**Status of Participation in the CCBHC Model**

There are over 430 CCBHCs in the U.S., across 42 states, Guam and Washington, D.C.

- States where clinics have received expansion grants
- States selected for the CCBHC demonstration
- Independent statewide implementation
- No CCBHCs

Source: National Council for Mental Wellbeing
Some states report that coordinating services across CCBHCs has saved money while helping patients achieve better outcomes. For example, research has shown that people living with mental health or substance use disorders typically have higher rates of emergency department usage and hospitalizations. The CCBHC model reduces use of those high-cost services. One CCBHC in Missouri indicated a 66% decrease in requests for crisis intervention services, while 85% of those referred for inpatient hospitalization were diverted to community care options. In Oregon, a CCBHC partnership with a local jail estimated a savings of $2.5 million in prison costs. Furthermore, connecting 988—the national suicide prevention and mental health crisis call number—to CCBHCs could be vital to ensuring continuity of care, as well as demonstrating return on investment.

To help states and the federal government assess the impact of the CCBHC program, state agencies and CCBHCs involved in the demonstration must annually report to the U.S. Department of Health and Human Services on 21 separate quality measures. However, one analysis cited limitations to this data, including a lack of baseline information, making evaluation of the CCBHC model difficult for now.

State Actions: Funding Mechanisms and Implementation Models

CCBHC funding and implementation can look different from state to state. For instance, Texas developed a CCBHC framework with SAMSHA grant funding in 2015. The state continues to support the CCBHC model through an approved 1115 Medicaid waiver and general fund allocations.

While some states, including Minnesota, Missouri, Nevada and Oklahoma, pursued CCBHC models through an approved SPA, other states have addressed CCBHCs via legislation. For example, Kansas enacted a law to establish a new CCBHC program, and measures passed in Indiana and West Virginia will continue or expand efforts in those states. In Illinois, the CCBHC program received funding, and Maine provided funding to hire staff to explore the plan amendment process. Idaho, one of the states without a CCBHC framework, will use $12 million of ARPA funds to develop a CCBHC model.

State lawmakers who wish to pursue a CCBHC model may want to start by engaging local public health and behavioral health officials to find out more about behavioral health services in their state and how they are accessed. Legislators might also consider which funding mechanism and policy process makes the most sense for their state.

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Additional Resources

- Behavioral Health Overview, NCSL
- State Actions on Coronavirus Relief Funds, NCSL
- Certified Community Behavioral Health Clinics and Federally Qualified Health Centers: Opportunities for Collaboration, NCSL webinar