



SMD # 26-004

**RE: New State Plan Option to
Cover Certified Community
Behavioral Health Clinic Services**

October 6, 2026

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is issuing the following guidance on a new state option to add Certified Community Behavioral Health Clinic (CCBHC) services to Medicaid state plans. This option was authorized by section 209 in Title I of Division G of the Consolidated Appropriations Act, 2024 (CAA, 2024) (Pub. L. 118-42) enacted on March 9, 2024. This new state plan benefit is based on a preexisting demonstration program that covers services provided to Medicaid beneficiaries by clinics that are certified by their states as meeting specific CCBHC criteria.¹ CMS encourages states to support comprehensive services, including crisis intervention services, for individuals with serious mental illness and substance use disorders (SUD), and this CCBHC state plan benefit provides states with another option to do so.²

I. Background

While the CAA, 2024 enacted the new CCBHC state plan benefit, states have long had the option to apply to participate in a CCBHC Demonstration program and to use existing Medicaid authorities to implement the CCBHC model.^{3,4} The CCBHC Demonstration program was established over ten years ago, in 2014, under section 223 of the Protecting Access to Medicare

¹ The CCBHC Demonstration was established under section 223 of the Protecting Access to Medicare Act of 2014, Pub. L. 113-93 (enacted April 1, 2014).

² Please note that as of October 13, 2026, Federal Financial Participation is no longer available for sex-rejecting procedures for individuals under the age of 18 in Medicaid and under 19 in the Children's Health Insurance Program (CHIP) pursuant to CMS 2451-F, titled "Medicaid Program; Prohibition on Federal Medicaid and Children's Health Insurance Program Funding for Sex-Rejecting Procedures Furnished to Children." This prohibition applies to sex-rejecting procedures furnished under the CCBHC state plan option. For more information, please see: <https://www.federalregister.gov/documents/2026/08/13/2026-16508/medicaid-program-prohibition-on-federal-medicaid-and-childrens-health-insurance-program-funding-for>.

³ For more information on the ways states can cover the CCBHC model of care, including the CCBHC Demonstration program, see *Appendix A: Other Options for Covering the CCBHC Model of Care*.

⁴ For more information on the CCBHC model of care, see: <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria>.

Act of 2014 (PAMA) (Pub. L. 113-93) to provide and coordinate comprehensive mental health and SUD treatment and support services. Under PAMA section 223(d)(3), up to eight states could participate in the CCBHC Demonstration program, and eight states were originally selected for the Demonstration.⁵

CMS, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) (collectively, the tri-agency group) share joint responsibility for operating the CCBHC Demonstration, with SAMHSA developing the CCBHC Certification Criteria⁶ that participating states use to certify clinics. The framework for these criteria, based on six program areas identified in PAMA, is as follows⁷:

1. *Staffing*—Staffing plan driven by local needs assessment, licensing, and training to support service delivery.
2. *Availability and accessibility of services*—Standards for timely and meaningful access to services, outreach and engagement, 24/7 access to crisis services, treatment planning, and acceptance of all patients regardless of ability to pay or place of residence.
3. *Care coordination*—Care coordination agreements across services and providers (e.g., Federally Qualified Health Centers (FQHC) (and, as applicable, Rural Health Clinics [RHC]), inpatient and acute care) defining accountable treatment team, health information technology, and care transitions.
4. *Scope of services*—Nine required services, as well as person-centered, family-centered, and recovery-oriented care.
5. *Quality and other reporting*—Required quality measures, a plan for quality improvement, and tracking of other program requirements.
6. *Organizational authority and governance*—Consumer representation in governance, appropriate state accreditation.

As part of the CCBHC Certification Criteria, CCBHCs must meet uniform standards for the range of services they provide, including the nine required CCBHC services,⁸ and are required to serve anyone requesting mental health or substance use care, regardless of the individual's ability to pay, or place of residence. This includes developmentally appropriate care for children and youth.

To participate in the CCBHC Demonstration, states must first apply for a one-year planning grant overseen by SAMHSA and, if awarded a grant, subsequently apply to participate in the CCBHC Demonstration through a competitive application process. Selection to participate in the Demonstration entitles states to receive an enhanced federal Medicaid match (generally

⁵ In December 2014, SAMHSA announced the eight states selected for the section 223 CCBHC Medicaid Demonstration: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania.

⁶ For more details on the CCBHC Certification Criteria, see *Appendix A: Other Options for Covering the CCBHC Model of Care*.

⁷ For more information, see: <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria>.

⁸ For more information about the nine required CCBHC services, see *II. New CCBHC Medicaid State Plan Benefit, 4. Scope of Services* below.

equivalent to their match rate for the Children’s Health Insurance Program (CHIP)) for CCBHC services provided to Medicaid beneficiaries.

Over the last decade, Congress appropriated additional funds to extend and expand the CCBHC Demonstration⁹ and to establish a separate SAMHSA CCBHC Expansion (CCBHC-E) Grant Program¹⁰ that supports providers in adhering to the CCBHC criteria, among other things. CMS also made states aware of the availability of various Medicaid authorities, such as rehabilitative services under Medicaid state plan authority at section 1905(a) of the Social Security Act (the Act) and Medicaid demonstration authority at section 1115 of the Act, to cover CCBHC services.¹¹ The CAA, 2024 created a state plan option at section 1905(a)(31) for Medicaid agencies to cover CCBHCs under their Medicaid state plans through a single authority.¹²

II. New CCBHC Medicaid State Plan Benefit

The CAA, 2024 amended section 1905 of the Act to establish a new, optional CCBHC state plan benefit at section 1905(a)(31), as defined in section 1905(jj) of the Act. CCBHCs are defined at section 1905(jj)(2) as organizations that: 1) have been certified by the state as meeting the most recent version of the CCBHC Certification Criteria (“the Certification Criteria”);^{13,14,15} 2) provide the nine services^{16,17} defined at section 1905(jj)(1) (see the “4. *Scope of Services*”

⁹ In addition to the original 8 states, the following 12 states were later approved to participate in a CCBHC Demonstration: Alabama, Illinois, Iowa, Indiana, Kansas, Kentucky, Maine, Michigan, New Hampshire, New Mexico, Rhode Island, and Vermont. For more information about the extension and expansion of the CCBHC Demonstrations, see: <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/history-background>.

¹⁰ For more information about the CCBHC-E Grant Program—including the interaction between the Grant Program, CCBHC Demonstrations, and Medicaid payment—see *B. CCBHC Expansion Grant Program* in *Appendix A: Other Options for Covering the CCBHC Model of Care*.

¹¹ For more information on the various options for covering CCBHC services, see *Appendix A: Other Options for Covering the CCBHC Model of Care*.

¹² Section 209, Title I, Division G, Consolidated Appropriations Act, 2024, Pub. L. 118-42 (enacted March 9, 2024). See: <https://www.congress.gov/118/bills/hr4366/BILLS-118hr4366enr.pdf>. Section 209 adds “certified community behavioral health clinic services” to the list of optional benefits in section 1905 of the Social Security Act (the Act) with the addition of a new section 1905(a)(31).

¹³ For more details on the CCBHC Certification Criteria, see *Appendix A: Other Options for Covering the CCBHC Model of Care*.

¹⁴ States are responsible for certifying that CCBHCs meet the most recent version of the Certification Criteria and may rely on recognized accrediting organizations that have specific accreditation programs for CCBHCs as part of their certification process.

¹⁵ At the time of publication of this guidance, the most recent version of the Certification Criteria was published in March 2023.

¹⁶ For more information about the service requirements for the new CCBHC state plan benefit, including the list of the nine services identified in statute, as well as the services required by the CCBHC Certification Criteria within those nine services, see the “4. *Scope of Services*” subsection below.

¹⁷ With one exception, the services required for the CCBHC Demonstration, as defined at section 223 of PAMA, are the same as the services required for the new Medicaid CCBHC state plan benefit, as identified at section 1905(jj) of the Act. The “Targeted Case Management” (TCM) service required under the CCBHC Demonstration was replaced with “Intensive Case Management” under the new CCBHC state plan benefit. As noted in the 2023 CCBHC Certification Criteria, TCM under the CCBHC Demonstration does not fully align with the mandatory components of TCM outlined in 42 C.F.R. § 440.169 that are required under the TCM Medicaid state plan. Given that, CMS interprets replacement of the “Targeted Case Management” service with “Intensive Case Management” in 1905(jj)

subsection below for the complete list of services) and do so in a manner that reflects person-centered care; and 3) submit ongoing data on the provision of services, such as data on service encounters and clinical outcomes, to the state or Secretary.

The Certification Criteria that states use to certify CCBHCs establish a baseline of operations. These Criteria are organized into the six program areas previously identified in the *I. Background* section above, with each of the areas including a number of related criteria.¹⁸ In addition to the nine broad services defined at section 1905(jj)(1), the Certification Criteria also specify certain services that an organization must provide to be certified as a CCBHC. Because section 1905(jj) requires that CCBHCs meet the most recent Certification Criteria, the new state plan benefit includes coverage of the nine services identified in statute, as well as any specific services that the Certification Criteria require to be covered under one of those nine services. Similarly, if a service is identified as optional under the Certification Criteria, coverage for that service is also optional under the new state plan benefit. Services provided under the state plan benefit must be delivered directly by a certified CCBHC or by another provider that has a formal relationship with the certified CCBHC.

Prior to being certified, a CCBHC must conduct a Community Needs Assessment,¹⁹ using data and input from key interested parties to determine, for example, the prevalence of mental health and substance use conditions in the community and the factors affecting the community's access to health services. CCBHCs then use this information to inform a number of the Certification Criteria, such as the necessary clinical and non-clinical providers to serve the individuals in the community who are receiving services.

This section provides information on the new CCBHC state plan benefit and is organized in subsections that correspond to the Certification Criteria's six overarching program areas. Each subsection provides general information about the program area and related criteria and identifies specific topics relevant for the new CCBHC state plan benefit. For complete and current information on the Certification Criteria, please see SAMHSA's website on the Certification Criteria.²⁰

1. Staffing

The *staffing* program requirement includes criteria regarding the CCBHC's staffing plan, the licensing and credentialing of providers, training needs, and linguistic competence. Prior to being

to signify that the TCM Medicaid state plan authority requirements do not apply to the new state plan benefit. However, the service requirement is functionally the same. For more information on the CCBHC Certification Criteria, see: <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria>.

¹⁸ For more information on the CCBHC Certification Criteria program requirement, see *Appendix A: Other Options for Covering the CCBHC Model of Care* and <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria>.

¹⁹ For more information on the Community Needs Assessment, see *Appendix A: Other Options for Covering the CCBHC Model of Care*.

²⁰ See <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria>.

certified or recertified, CCBHCs must develop a staffing plan that is responsive to the Community Needs Assessment.

In accordance with the staffing plan, CCBHCs must maintain a core workforce comprised of employed and contracted staff. To ensure staffing meets the needs of the community, CCBHCs can provide services directly or establish formal agreements with a Designated Collaborating Organization (DCO) to furnish one or more of the required CCBHC services. Under these agreements, DCOs are legally authorized to provide services and act within their scope of state licensing and certification. The formal relationship between CCBHCs and DCOs creates the platform for seamlessly integrated services delivered across providers under the umbrella of a CCBHC. DCOs must ensure that the services provided under this CCBHC umbrella are delivered in a manner that meets the standards set in the CCBHC Certification Criteria.²¹

2. Availability and Accessibility of Services

The *availability and accessibility of services* program requirement includes criteria on the standards for outreach and engagement, timely access to services and assessment, and 24-hour access to crisis services. The criteria also require CCBHCs to accept all patients regardless of ability to pay or place of residence. Thus, CCBHCs must be able to serve anyone seeking help for a mental health or substance use condition, including individuals with serious mental illness, and/or SUDs, co-occurring conditions, and children and adolescents with serious emotional disturbance. Furthermore, CCBHCs are required to use a sliding scale for payment.

States implementing the new Medicaid CCBHC state plan option should note that, under the *availability and accessibility of services* program requirement, CCBHCs must provide “transportation or transportation vouchers for people receiving services to the extent possible with relevant funding or programs in order to facilitate access to services in alignment with the person-centered and family-centered treatment plan.”²² These states should also be mindful of the preexisting statutory requirement that state Medicaid agencies ensure necessary transportation for Medicaid enrollees to and from providers.^{23,24} Under sections 1902(a)(4) and 1902(a)(30)(A) of the Act, states are required to describe the methods the agency uses to meet this Medicaid requirement and the methods and procedures used to ensure payment for such services is consistent with efficiency, economy, and quality of care. In general, states may pay for

²¹ Only a single payment may be issued for the same service rendered by a CCBHC or DCO to prevent duplicate payments. In order to satisfy CCBHC certification criteria, all required services must be billed by and paid to an eligible CCBHC provider.

²² CCBHC Certification Criteria, available at: <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria>.

²³ Section 1902(a)(4) of the Act and 42 C.F.R. § 431.53.

²⁴ For more information about Medicaid transportation requirements, as well as information on states’ oversight and accountability responsibilities for Medicaid transportation, see *Assurance of Transportation: A Medicaid Transportation Coverage Guide*, available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd23006.pdf>; and CMS’s *Assurance of Transportation* website, available at: <https://www.medicaid.gov/medicaid/benefits/assurance-of-transportation>.

transportation services as an administrative expense or as an optional medical service under 42 C.F.R. § 440.170(a) or some combination of these methods.²⁵

3. Care Coordination

The *care coordination* program requirement includes criteria on care coordination agreements across settings and providers (e.g., FQHCs and, as applicable, RHCs, inpatient and acute care, etc.), health information technology (IT), treatment planning, and care transitions.²⁶ Below, we discuss requirements regarding partnerships with organizations operating within the CCBHC's service area and health IT for states to consider when implementing the new CCBHC state plan benefit.

Partnerships with Organizations Operating within the CCBHC's Service Area

CCBHCs are required by statute to develop partnerships or formal contracts with Indian Health Service (IHS) youth regional treatment centers, the nearest Department of Veterans Affairs' (VA) medical center, schools, child welfare settings, and criminal and juvenile facilities, among others. In addition to partnering with the IHS youth regional treatment centers (which provide federal health services to individuals, including Medicaid beneficiaries, who are American Indians and Alaska Natives (AI/AN)), states implementing the new CCBHC state plan benefit should verify that their CCBHCs have the necessary resources and connections to effectively address the needs of AI/AN individuals. States must also consult with the Tribes, IHS, and Tribal and Urban Indian organizations to ensure AI/AN Medicaid beneficiaries are aware of, and have access to, the services available at CCBHCs.²⁷ This includes support services, such as assistance with transportation that may be needed to access medically necessary services at the CCBHCs.

Similarly, in addition to partnering with VA medical centers, states implementing the new CCBHC state plan benefit should ensure their CCBHCs provide outreach to veterans and military service personnel regarding the availability of CCBHC services. Veterans and military service personnel have faced unique stressors and may have different service needs than the general population and, as a result, this outreach should be a priority, in particular to individuals living in rural areas where military and VA health facilities are usually less available.²⁸

States should also encourage their CCBHCs to partner with other community organizations and entities based on the needs of the populations in the service area, particularly populations with increasing rates of mental health and/or substance use conditions or higher rates of these conditions compared to the general population.

²⁵ Note, when the state claims FFP for necessary transportation as an optional medical service, the state must not also claim the same transportation expenditures as an administrative activity, which would result in duplicative payment. For more information about avoiding duplication of payment, see "Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming, 2023," available at: <https://www.medicaid.gov/medicaid/financial-management/downloads/sbs-guide-medicaid-services-administrative-claiming.pdf>.

²⁶ For more information, see the CCBHC Certification Criteria, available at:

<https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria>.

²⁷ States also must consult with and support IHS, tribal, and urban Indian health providers to qualify as CCBHCs.

²⁸ <https://www.samhsa.gov/data/sites/default/files/reports/rpt44472/2022-nsduh-pop-slides-veterans.pdf>.

Health Information Technology

States that implement the new CCBHC state plan benefit should be mindful of the health IT systems requirement when determining payment rates.²⁹ Under this requirement, CCBHCs must establish and maintain IT systems, including electronic health records (EHR), that are certified by the Office of the National Coordinator Health IT Certification Program. Many community-based mental health and SUD treatment providers that are likely to qualify as CCBHCs do not have IT systems or EHRs and these systems can be very expensive to implement.³⁰

States should also consider supporting the development of IT systems that can be accessed by CCBHCs for some aspects of care coordination and that can interface with or substitute for provider-owned or -operated EHR systems. Enhanced federal match may be available for some state expenses for developing and operating these types of state IT systems, but federal match is not available for costs associated with provider-owned or -operated EHR systems.³¹

4. Scope of Services

The *scope of services* program requirement includes criteria on the nine services that CCBHCs must deliver either directly or through a formal relationship with a DCO³² in a manner that reflects person-centered and family-centered care. States generally have the flexibility to determine the specific services that CCBHCs must cover within these statutorily mandated services, with some exceptions noted in this subsection. The nine services include the following:^{33,34}

²⁹ For more information about payment rates and the availability of claiming administrative expenses for health IT related to the new CCBHC state plan benefit, see *IV. FFS Payment Considerations for the New Medicaid State Plan Benefit* below.

³⁰ Medicaid and CHIP Payment and Access Commission. Report to Congress on Medicaid and CHIP Chapter Four: Integrating Clinical Care through Greater Use of Electronic Health Records for Behavioral Health. June 2021. See: <https://www.macpac.gov/wp-content/uploads/2021/06/June-2021-Report-to-Congress-on-Medicaid-and-CHIP.pdf>.

³¹ For additional information on this topic, see the CMCS Informational Bulletin on “Accessing Enhanced Federal Medicaid Matching Rates for State Information Technology Expenditures to Improve Access to Mental Health and Substance Use Disorder Treatment and Care Coordination,” available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib06142024.pdf>, as well as subsection *D. Administrative Claiming for Information Technology Systems that Support the CCBHC State Plan Benefit* in section *IV. FFS Payment Considerations for the New Medicaid State Plan Benefit* below.

³² 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.

³³ Section 1905(jj) of the Act.

³⁴ The Certification Criteria identify these nine services using shortened titles as follows: 1. Crisis Services; 2. Screening, Assessment, and Diagnosis; 3. Person-Centered and Family-Centered Treatment Planning; 4. Outpatient Mental Health and Substance Use Services; 5. Primary Care Screening and Monitoring; 6. Targeted Case Management Services; 7. Psychiatric Rehabilitation Services; 8. Peer Supports and Family/Caregiver Supports; and 9. Community Care for Uniformed Service. For service 6, the CAA, 2024 replaces “Targeted Case Management” with “Intensive Case Management Services.”

1. Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization;³⁵
2. Screening, assessment, and diagnosis, including risk assessment;
3. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning;
4. Outpatient mental health and substance use services;
5. Outpatient clinic primary care screening and monitoring of key health indicators and health risk;
6. Intensive case management services;³⁶
7. Psychiatric rehabilitation services;
8. Peer supports and counselor services and family supports; and
9. Intensive, community-based mental health care for members of the armed forces and veterans who are eligible for medical assistance, particularly such members and veterans located in rural areas, provided the care is consistent with minimum clinical mental health guidelines promulgated by the Veterans Health Administration, including clinical guidelines contained in the Uniform Mental Health Services Handbook of such Administration.

For psychiatric rehabilitative services, the Certification Criteria specify that CCBHCs must provide supported employment services, as well as educational and housing support services. As a result, states implementing the new CCBHC state plan option must cover supported employment, as well as services that support people with participating in supported education and finding and maintaining housing, as part of the benefit.

It is also important to note that, similar to the CCBHC Demonstration, the conflict of interest (COI) provisions described in the implementing regulations for section 1915(c) and 1915(i) home and community-based services (HCBS) do not apply to HCBS services provided under the new CCBHC state plan option as part of the nine required services.³⁷ CMS made this determination in recognition of the intent for the new state plan option to closely mirror the CCBHC Demonstration, particularly regarding how services are delivered to Medicaid enrollees. However, if a state elects not to implement the CCBHC state plan benefit and instead covers

³⁵ Section 223(b)(2)(A) of PAMA specifies that CCBHC services do not include services furnished in inpatient care, residential treatment, room and board expenses, or any other non-ambulatory services, as determined by the Secretary.

³⁶ As previously noted, the CCBHC Certification Criteria, described at section 223(a)(2) of PAMA, refer to “targeted case management services” while the new CCBHC state plan benefit language at CAA, 2024 replaces “targeted case management” with “intensive case management services.”

³⁷ In response to frequently asked questions (FAQ), the tri-agency group clarified that CCBHC Demonstrations do not need to meet the COI requirements in the 1915(c) and 1915(i) HCBS implementing regulations. See: <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-faqs>.

CCBHC-like services under section 1915(c), 1915(i), or 1115 demonstration authorities, the COI implementing regulations would still apply.^{38,39,40}

5. Quality and Other Reporting

The *quality and other reporting* program requirement includes criteria on data collection, reporting, and tracking, as well as planning for continuous quality improvement. Under this program requirement, states that elect to implement the new CCBHC state plan option must submit data to SAMHSA at CCBHCMeasuresSubmission@samhsa.hhs.gov for oversight and ongoing quality assurance in the Medicaid CCBHC program. To allow for monitoring across CCBHC programs, the data reported under the new CCBHC state plan benefit and the data reported under the CCBHC Demonstration must include the same quality measures,⁴¹ including any updates to those quality measures, and must be reported in the same manner. In order to facilitate data reporting, a number of the CCBHC quality measures are included in the Medicaid and CHIP Child Core Set and the Medicaid Adult Core Set. States were required to report on the Child Core Set and the behavioral health measures on the Adult Core Set beginning in federal fiscal year 2024.⁴² Because the new state plan option does not include a requirement that states pay CCBHCs using a prospective payment system (PPS) methodology, states will not be required to submit cost report data to CMS for CCBHCs operating outside the Demonstration.

6. Organizational Authority and Governance

The *organizational authority and governance* program requirement includes criteria on CCBHC organizational authorities, annual independent audits,⁴³ the makeup of governance or advisory boards, and appropriate accreditation and certifications. State Medicaid agencies implementing the new CCBHC state plan benefit must ensure that, among other things, their CCBHCs are a non-profit, part of a local government behavioral health authority, or operated under the

³⁸ 42 C.F.R. §§ 441.301(c)(1)(vi) and 441.730(b).

³⁹ All requirements of the Medicaid statute are applicable to expenditure authorities identified in an approved 1115 demonstration, except for those expenditure authorities that are specified in the approval as not applicable.

⁴⁰ In cases where the only willing and qualified entity to provide case management and/or develop person-centered services plans in a geographic area also provides HCBS, the state must devise COI protections, including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.

⁴¹ For more information about the CCBHC quality measures, see: <https://www.samhsa.gov/certified-community-behavioral-health-clinics/guidance-and-webinars>.

⁴² Centers for Medicare & Medicaid Services, Medicaid Program and CHIP; Mandatory Medicaid and Children's Health Insurance Program (CHIP) Core Set Reporting, Final Rule, 88 FR 60278, Publication Date Aug. 31, 2023. See: <https://www.federalregister.gov/documents/2023/08/31/2023-18669/medicaid-program-and-chip-mandatory-medicare-and-childrens-health-insurance-program-chip-core-set>. Currently, both the CCBHC quality measures and the core set measures include the following measures: screening for clinical depression and follow-up for adults and children, follow-up after hospitalization for mental illness for adults and children, follow-up after emergency department visit for mental illness or alcohol and other drug dependence for adults and children, adherence to anti-psychotic medications for individuals with schizophrenia, weight assessment and counseling for nutrition and physical activity for children/adolescents, and follow-up care for children prescribed attention-deficit hyperactivity disorder medication.

⁴³ The annual independent audit is the responsibility of the CCBHC, not the state Medicaid agency.

authority of the IHS, an Indian Tribe or tribal organization,⁴⁴ or an urban Indian organization,⁴⁵ as required under section 223(a)(2)(F) of PAMA.

III. Coverage Considerations for the New CCBHC State Plan Benefit

States interested in implementing the new CCBHC state plan benefit will need to consider a number of coverage requirements and options related to the new CCBHC state plan benefit. This section describes the general Medicaid state plan requirements applicable to this new benefit, the implications for children and youth eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and covering the new benefit under a Medicaid managed care delivery system.

A. Medicaid State Plan Coverage Considerations

States interested in implementing the new CCBHC state plan benefit must cover all of the nine services defined at section 1905(jj)(1) of the Act, as well as the services that an organization must provide to be certified as a CCBHC under the Certification Criteria. If a service is identified as optional under the Certification Criteria, coverage for that service is also optional under the new state plan benefit. As with any state plan benefit, CMS expects states to comply with all state plan requirements that are not waived or modified. This includes: general state plan regulatory requirements described at 42 C.F.R. § 430, Subpart B; comparability, which requires benefits to generally be provided in the same amount, duration, and scope to all enrollees within an eligibility group; freedom of choice, which allows beneficiaries to obtain Medicaid services from any qualified institution, agency, pharmacy, person, or organization that is willing to furnish the services;⁴⁶ and statewideness, which requires a Medicaid state plan to apply consistent standards for assistance and administration throughout the state.⁴⁷

B. Coverage Considerations for EPSDT-Eligible Children and Youth

While “behavioral health” is not an identified, stand-alone service defined within the Act, states have broad discretion to cover behavioral health services and supports under a variety of benefit categories in section 1905(a) of the Act. For EPSDT-eligible children and youth, consistent with section 1905(r)(5) of the Act, states must cover medically necessary services that could be covered under section 1905(a) of the Act, including an array of medically necessary mental health and SUD services along the care continuum, in order to meet their EPSDT obligation. States have an obligation to assess the availability of section 1905(a) services to meet EPSDT-eligible children’s individualized assessed needs, ensure coverage for an array of services to meet

⁴⁴ Specifically, section 223(a)(2)(F) of PAMA specifies “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.).”

⁴⁵ Specifically, section 223(a)(2)(F) of PAMA specifies “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.).”

⁴⁶ In the context of CCBHC services, an individual has the freedom to choose providers within the CCBHC, with its DCOs, or with any other provider, and does not preclude the use of referrals outside of the CCBHC or DCO if necessary.

⁴⁷ 42 C.F.R. §§ 440.240, 431.51, and 431.50.

those needs, and establish and apply medical necessity criteria, but they have flexibility in how they meet that obligation.⁴⁸ As such, under CMS’s interpretation of section 1905(r)(5) of the Act, states have various options for ensuring that EPSDT-eligible children have access to section 1905(a) services to meet their individualized assessed needs, including services that could be covered under the new CCBHC state plan benefit.

C. Covering CCBHC Services in a Medicaid Managed Care Delivery System

States can cover the new CCBHC state plan option under a fee-for-service (FFS) delivery system or a managed care delivery system. States interested in using a managed care delivery system to cover the new CCBHC benefit must have an approved managed care authority, such as a section 1932(a) state plan authority or 1915(b) waiver authority,⁴⁹ as well as the Medicaid coverage authority and a section 1905(a)(31) state plan authority. States may also utilize a section 1115(a) demonstration to implement the new CCBHC benefit using a managed care delivery system. States that want to utilize a managed care delivery system to cover state plan CCBHC services should ensure that their Medicaid managed care plans add CCBHCs to the plans’ provider networks.

Once these authorities are approved, states must also evaluate any necessary changes to their managed care contracts and work with their actuaries to evaluate any impact on the development of actuarially sound capitation rates, including any appropriate and reasonable adjustments to account for changes to the base data for programmatic changes related to CCHBC services.⁵⁰ If states wish to direct managed care expenditures related to provider payment, including how managed care plans pay providers for CCHBC services, this is considered a state directed payment and states must comply with all respective federal requirements, including any respective limit on total provider payment rates.

IV. FFS Payment Considerations for the New Medicaid State Plan Benefit

When implementing the new CCBHC state plan benefit in FFS arrangements, states must develop the related payment methodology in accordance with section 1902(a)(30)(A) of the Act. This section describes the options and requirements for developing a payment methodology, the applicable federal medical assistance percentage (FMAP), administrative claiming for services provided under the benefit, administrative claiming for IT systems that support the benefit, and, finally, third party liability for the new benefit.

⁴⁸ For more information on Medicaid EPSDT requirements, see: www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf.

⁴⁹ For more information about managed care authorities, see: <https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities>. States may request Medicaid managed care technical assistance at <https://www.medicaid.gov/medicaid/managed-care/technical-assistance/>.

⁵⁰ 42 C.F.R. §§ 438.3, 438.4, 438.5, and 438.7.

A. Payment Methodology Options and Requirements Under the CCBHC State Plan Benefit

While the CCBHC Demonstration mandated that states pay for CCBHC services using a PPS methodology, the new CCBHC state plan option does not include this requirement. Under the new CCBHC state plan authority, states have flexibility to determine the specific payment methodology used for state plan CCBHC services, as long as the methodology meets all federal Medicaid requirements. For instance, under this new benefit, states may choose to pay for CCBHC services using a fee schedule or bundled payment.

States that want to model their payment for state plan CCBHC services after one of the Demonstration PPS methodologies⁵¹ may do so using a bundled payment methodology in alignment with CMS guidance.⁵² Under this methodology, payments can be based on multiple units of a single service, multiple services within a single benefit category, or multiple services across benefit categories. States may also incorporate considerations for quality when developing payments for CCBHC services.⁵³ States may elect to utilize the federal CCBHC cost report⁵⁴ or a state-developed cost report to establish CCBHC reimbursement rates for the new state plan benefit. In determining which methodology to utilize, states should consider the administrative burden associated with reconciled cost methodologies and limits on the ability to incentivize improved quality of care through value-based payments.

States with an existing section 223 CCBHC Demonstration may, but are not required to, choose to continue their current payment methodology if transitioning coverage of CCBHC services from the Demonstration to the new state plan benefit. However, these states must submit a CCBHC state plan amendment (SPA) to CMS for review and approval prior to implementation.⁵⁵

States can find existing CMS guidance on Comprehensive State Plan Payment Methodologies on Medicaid.gov.⁵⁶

⁵¹ For additional information on the four PPS rate methodologies used to pay for Demonstration CCBHC services, see section 2.1-2.4 of the section 223 Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS) Guidance: <https://www.medicaid.gov/medicaid/financial-management/downloads/updated-ccbhc-pps-guidance-02152024.pdf>.

⁵² See CMCS guidance on bundled payments at <https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/bundled-rate-payment-methodology.pdf>.

⁵³ See CMS guidance on value based care at <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf> and quality incentive payments at <https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/qlty-pymt-state-plan.docx>.

⁵⁴ The CCBHC Cost Report and Instructions may be found at <https://www.medicaid.gov/medicaid/financial-management/certified-community-behavioral-health-clinic-ccbhc-demonstration/ccbhc-cost-reporting>.

⁵⁵ For more information on submitting a SPA for the new CCBHC state plan benefit, see *V. Medicaid State Plan Amendment Submission Requirements*.

⁵⁶ For more information on Comprehensive State Plan Payment Methodologies, see: <https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/fed-req-pymt-methodologies.docx>.

B. FMAP Rates for CCBHC State Plan Expenditures

Although an enhanced FMAP is available for expenditures under the CCBHC demonstration, the CAA, 2024 did not authorize states to receive the enhanced FMAP for CCBHC state plan expenditures. When claiming for services provided under the new CCBHC state plan benefit, CMS expects states to follow existing federal requirements regarding the applicable FMAP for a given quarter.⁵⁷ In accordance with section 1903(a)(1) of the Act and 45 C.F.R. § 95.13(b), the applicable FMAP for all state plan services expenditures, including the new CCBHC state plan option, is determined based on the quarter in which the expenditure is made, which is the date of payment and not the date of service for current quarter original expenditures. For prior period adjustments, states should use the FMAP at which the original expenditure was claimed and should report any Medicaid collections and overpayments on the Form CMS-64 series. States must return recoveries of federal financial participation (FFP) at the same FMAP rate at which they were originally claimed. If an expenditure for a CCBHC service is erroneously claimed at an increased FMAP rate, the state must document the related collection and overpayment on the Form CMS-64 NARRATIVE and return the federal share of the related recovery at the increased FMAP rate. Consistent with existing requirements, states must document all expenditures to ensure a clear audit trail, including isolating expenditures that are matched at increased FMAP rates. CMS will conduct oversight to ensure that expenditures are allowable, accurate, and are claimed at the correct FMAP rate.

C. Administrative Claiming for Services Covered Under the CCBHC State Plan Benefit

States implementing the new CCBHC state plan benefit may claim federal match for state Medicaid agency costs associated with establishing and supporting the delivery of these new services.⁵⁸ Section 1903(a)(7) of the Act directs payment of FFP at 50% for amounts “found necessary by the Secretary for the proper and efficient administration of the State plan.” Allowable administrative activities related to the CCBHC state plan benefit could include, for example, establishing referral networks between CCBHCs and community or regional services, supports, providers, and local or state agencies to ensure the full array of CCBHCs services are available in their state. Federal administrative match may also be available for state Medicaid agency costs associated with establishing and supporting delivery of community-based mobile crisis intervention services, call centers, and other crisis stabilization services when provided as part of the CCBHC state plan benefit.⁵⁹

⁵⁷ In accordance with sections 1905(u), 2101(a)(2), and 2105(a) of the Act, states are permitted to receive enhanced FMAP funded by their title XXI CHIP allotments to provide coverage through Medicaid expansion CHIPs. Medicaid state plan rules, including those for benefits, apply to children in such Medicaid expansion CHIPs, and consequently Medicaid expansion CHIP children are eligible to receive services under the CCBHC state plan benefit. These CCBHC Medicaid expansion CHIP expenditures are reported on the CMS 64.21U series of expenditure reporting forms in the Medicaid and Children’s Health Insurance Program Budget and Expenditure System (MBES/CBES).

⁵⁸ Section 1903(a)(7) of the Act and 42 C.F.R. §§ 430.1, 433.15.

⁵⁹ See Center for Medicare & Medicaid Services State Health Official Letter on “Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services” (SHO # 21-008), Dec. 28, 2021. See: <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf>.

States interested in claiming FFP for administrative costs necessary for the proper and efficient administration of the Medicaid state plan must submit and have an approved amendment to their Public Assistance Cost Allocation Plan (PACAP), or a Medicaid Administrative Claiming (MAC) plan, whichever is applicable.⁶⁰ PACAPs are approved by the HHS Division of Cost Allocation Services (CAS) with CMS concurrence. MAC plans are approved by CMS and must be referenced in the state's PACAP. While the timeframe for SPA approvals can vary, to expedite the process, states are encouraged to submit their proposed administrative claiming methodology to CMS for review in advance of, or concurrently with, submission to CAS. CMS reviews these proposals using existing administrative claiming criteria, as well as federal cost allocation principles, to ensure the expenditures are reasonable, allowable, and allocable.⁶¹

As stated in our 1994 State Medicaid Director letter (SMDL) on administrative claiming⁶² and current CMS guidance on Medicaid.gov,⁶³ an allowable administrative cost must be supported by adequate documentation⁶⁴ and a system with the capability to isolate the costs directly related to the support of the Medicaid program from all other costs incurred by the agency. CMS is available upon request to provide technical assistance to states regarding administrative claiming.

D. Administrative Claiming for Information Technology Systems that Support the CCBHC State Plan Benefit

State Medicaid agency IT systems costs may be eligible for enhanced FFP. States may submit an Advance Planning Document (APD) requesting approval for a 90/10 enhanced FFP for the design, development, and implementation of their Medicaid Enterprise Systems (MES) initiatives that contribute to the economic and efficient operation of the program.⁶⁵ This includes technology that supports the implementation of crisis call centers, community-based mobile crisis intervention services, and crisis stabilization centers, including the maintenance and operations of these services.⁶⁶

States may also request a 75/25 enhanced FFP for the ongoing operations of CMS-approved systems.⁶⁷ Costs that may be eligible for this enhanced administrative match include, but are not limited to, systems in support of establishing and/or improving crisis call centers that can enable Medicaid beneficiaries to access mobile crisis teams, systems integration activities in support of

⁶⁰ See Subpart E of 45 C.F.R. Part 95.

⁶¹ See 2 C.F.R. Parts 200 and 300 (previously implemented by HHS in 45 C.F.R. Part 75 and formerly known as OMB Circular A-87) for accounting principles for costs claimed for federal grant awards. These principles are intended to ensure that the non-federal entity efficiently and effectively administers the federal award in a manner that complies with sound program management, program objectives, and terms and conditions of the federal award, while not engaging in any behavior that violates other applicable legal requirements.

⁶² See <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD122094.PDF>.

⁶³ See <https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming>.

⁶⁴ See 2 C.F.R. Parts 200 and 300.

⁶⁵ 42 C.F.R. § 433.112 and 433.116.

⁶⁶ States interested in pursuing approval for a 90/10 enhanced FFP should refer to 45 C.F.R. Part 95 Subpart F – Automatic Data Processing Equipment and Services-Conditions for Federal Financial Participation (FFP) for specific information on submitting an APD.

⁶⁷ States interested in pursuing approval for a 75/25 enhanced FFP should refer to 42 C.F.R. Part 433 Subpart C – Mechanized Claims Processing and Information Retrieval Systems for specific information related to approval of these systems.

the 988 activities implementing text and chat technologies that many beneficiaries, including youth, may be more comfortable using, and implementing accessible technologies to better serve individuals with disabilities.

The 90/10 and 75/25 enhanced FFP rates are not available for costs associated with provider-owned or -operated EHR systems.⁶⁸ Additionally, as noted above in *C. Administrative Claiming for Services Covered Under the CCBHC State Plan Benefit*, if these investments will benefit programs other than Medicaid, the state Medicaid agency must include a proposed cost allocation plan in their request for prior approval. If there are questions related to these topics, CMS encourages states to contact their MES State Officer.

E. Third Party Liability for CCBHC State Plan Services

Although states have flexibility to determine the structure of payment rates for CCBHC services, they are still required to seek third-party reimbursement when available and to cover any gap between the third-party rate and the CCBHC payment rate established under the state plan option.⁶⁹ Section 1902(a)(25)(A) of the Act requires state Medicaid agencies to identify third party resources (TPR), including private health insurance, TRICARE, and Medicare, that may be liable for all or part of the cost of care provided to Medicaid beneficiaries. With few exceptions, providers serving Medicaid beneficiaries are required to seek payment from TPRs before seeking payment from Medicaid. If a TPR's payment is less than the established Medicaid payment for a given service, the provider will receive a state Medicaid payment to supplement ("wrap-around") the TPRs' payment.

Under the new CCBHC state plan option, when CCBHCs provide services to individuals who are eligible for full-benefit Medicaid and Medicare (i.e., full dual eligibles), the state Medicaid agency must pay the difference between the Medicare rate and the established Medicaid rate if the Medicaid rate exceeds the amount paid by Medicare.⁷⁰ In these cases, the state must pay CCBHCs up to the Medicaid CCBHC rate after taking into account Medicare payment for services provided by the CCBHC. The CCBHCs must submit claims to any TPR, including Medicare, before submitting a claim to Medicaid. The TPR will either pay for the encounter in accordance with its approved rate or it will deny payment if the service is not within its scope of coverage. Medicaid will then pay the CCBHC an amount that, when added to the TPR's payment, equals the rate established under the CCBHC state plan option.⁷¹

⁶⁸ Per section 1903(a)(3)(A) and (B) of the Social Security Act (the Act), the 90/10 and 75/25 enhanced FFP matching rates are available for systems operated by the state Medicaid agency. For additional information on this topic, see the CMCS Informational Bulletin on "Accessing Enhanced Federal Medicaid Matching Rates for State Information Technology Expenditures to Improve Access to Mental Health and Substance Use Disorder Treatment and Care Coordination," available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib06142024.pdf>, as well as subsection *D. Administrative Claiming for Information Technology Systems that Support the CCBHC State Plan Benefit* in section *IV. FFS Payment Considerations for the New Medicaid State Plan Benefit* below.

⁶⁹ For additional information on Third Party Liability, see the "Coordination of Benefits and Third Party Liability (COB/TPL) in Medicaid 2020" handbook, available at: <https://www.medicaid.gov/medicaid/eligibility/downloads/cob-tpl-handbook.pdf>.

⁷⁰ Section 1902(n) of the Act.

⁷¹ For managed care considerations, please see subsection *C. Covering CCBHC Services in a Medicaid Managed Care Delivery System* in section *III. Coverage Considerations for the New CCBHC State Plan Benefit*, above.

For those dually eligible beneficiaries who are not eligible for full Medicaid benefits (i.e., Qualified Medicare Beneficiary (QMB) only, Specified Low-Income Beneficiary (SLMB) only, Qualifying Individuals (QI), and Qualified Disabled and Working Individuals (QDWI)), Medicaid agencies will pay some of their associated Medicare cost-sharing.⁷² Medicaid *may not* pay Medicare coinsurance, deductible, or copayment amounts for QIs, SLMB only, and QDWIs. Medicaid benefits for these dually eligible beneficiaries are limited to payment for Medicare Part B premiums (QIs and SLMB only) and for Medicare Part A premiums (QDWIs). When paying Medicare cost-sharing for QMB-only individuals who are not eligible for full Medicaid benefits, Medicaid agencies may pay providers either the Medicare rate (the Medicaid agency pays the amount Medicare has established as the Medicare cost sharing amount), the Medicaid rate (paying the difference, if any, between the Medicare payment and the Medicaid rate), or the lesser-of those rates, as the state elects in its Medicaid state plan.⁷³

V. Medicaid State Plan Amendment Submission Requirements

States electing the new CCBHC state plan benefit must submit a SPA to authorize coverage and payment for these services.⁷⁴ As with all SPAs, states should follow the submission requirements detailed at 42 C.F.R. § 430, Subpart B.

In the SPA submission, states must attest that CCBHCs are certified by the state Medicaid agency as meeting the most recent version of the Certification Criteria and covering the nine required services listed in section 1905(jj)(1) of the Act. This includes covering all mandatory services identified in the Certification Criteria that fall within the nine services identified in statute. States may cover services above and beyond these minimum requirements as long as the services are in alignment with the Certification Criteria. The SPA must also include a comprehensive description of the CCBHC services payment methodology, consistent with 42 C.F.R. § 430.10.⁷⁵ As previously mentioned, the new state plan option does not require CCBHCs to be reimbursed using the payment methodology required under the CCBHC Demonstration, so states have flexibility in determining the specific payment methodology used for these services. When setting payment rates, states may include allowable medical service costs (e.g., allowable costs for salaries, fringe benefits, supplies, and equipment) associated with furnishing the CCBHC services to Medicaid enrollees.

CMS is developing a coverage SPA template to assist states in implementing this new benefit.

⁷² Section 1902(a)(10)(E) of the Act requires state Medicaid plans to provide Medicare cost-sharing assistance to certain low-income Medicare beneficiaries.

⁷³ For more information on cost sharing and dually eligible individuals, see CMS's "Medicare Learning Network Fact Sheet: Beneficiaries Dually Eligible for Medicare & Medicaid," available at: <https://www.cms.gov/files/document/beneficiaries-dually-eligible-medicare-medicaid.pdf>.

⁷⁴ For states intending to cover the new CCBHC state plan services using a Medicaid managed care delivery system, please see subsection C. *Covering CCBHC Services in a Medicaid Managed Care Delivery System* in section III. *Coverage Considerations for the New CCBHC State Plan Benefit*, above.

⁷⁵ For more information on developing payment methodologies for Medicaid services, see CMS's "Federal Requirements for Comprehensive State Plan Payment Methodologies" guidance, available at: <https://www.medicaid.gov/resources-for-states/spa-and-1915-waiver-processing/medicaid-spa-processing-tools-for-states>.

VI. Conclusion

CMS is committed to working with state Medicaid agencies, as well as our federal partners, to increase access to comprehensive community-based care for Medicaid beneficiaries with mental health conditions and/or SUDs. We look forward to supporting state efforts to expand the availability of CCBHC services through the new Medicaid CCBHC state plan option. If you have any questions regarding this letter or would like to request technical assistance, please contact your CMS state lead.

Sincerely,

/s/

Daniel Brillman
Deputy Administrator and Director

Appendix A: Other Options for Covering the CCBHC Model of Care

Over the last decade, states have had the option to pursue a CCBHC Demonstration program or to use various Medicaid authorities, such as rehabilitative and clinic services under section 1905(a) state plan authority and the section 1115 demonstration authority, to cover CCBHC Demonstration services. This appendix includes more information about these options to cover the CCBHC Model of Care.

A. CCBHC Demonstration Program

In 2014, the CCBHC Demonstration program was authorized under section 223 of PAMA (Pub. L. 113-93) to improve the accessibility, quality, and effectiveness of comprehensive mental health and SUD treatment and support services. Participation in the Demonstration requires CCBHCs to serve anyone who requests care for mental health or substance use, regardless of the individual's ability to pay or place of residence, and allows states to claim an enhanced federal Medicaid match (generally equivalent to their match rate for CHIP) for any CCBHC services provided to Medicaid beneficiaries. CMS,⁷⁶ SAMHSA,⁷⁷ and ASPE (the tri-agency group) share joint responsibility for operating the Demonstration.

To participate in a CCBHC Demonstration, states first apply for a one-year planning grant overseen by SAMHSA and, if awarded a grant, subsequently apply to participate in the CCBHC Demonstration through a competitive application process. Selected states use the CCBHC Certification Criteria developed by SAMHSA, in close collaboration with CMS and ASPE, to certify clinics in their state as a CCBHC.

Prior to being certified for participation in the Demonstration, CCBHCs must conduct a Community Needs Assessment to identify the needs and program capacity to address the needs of the CCBHC's community. CCBHCs use this information to inform a number of the Certification Criteria, which are structured as follows using the following broad program requirements identified in the PAMA:⁷⁸

1. *Staffing*—Staffing plan driven by local needs assessment, licensing, and training to support service delivery.
2. *Availability and accessibility of services*—Standards for timely and meaningful access to services, outreach and engagement, 24/7 access to crisis services, treatment planning, and acceptance of all patients regardless of ability to pay or place of residence.
3. *Care coordination*—Care coordinate agreements across services and providers (e.g., FQHCs (and, as applicable, RHCs), inpatient and acute care), defining accountable treatment team, health information technology, and care transitions.

⁷⁶ For more information from CMS on the CCBHC Demonstration Program, see: <https://www.medicaid.gov/medicaid/financial-management/certified-community-behavioral-health-clinic-ccbhc-demonstration>.

⁷⁷ For more information from SAMHSA on the CCBHC Demonstration Program, see: <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics>.

⁷⁸ See: <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria>.

4. *Scope of services*—Nine required services, as well as person-centered, family-centered, and recovery-oriented care.
5. *Quality and other reporting*—Required quality measures, a plan for quality improvement, and tracking of other program requirements.
6. *Organizational authority and governance*—Consumer representation in governance, appropriate state accreditation.

In addition to these Certification Criteria, states participating in a CCBHC Demonstration can define additional requirements for the CCBHCs in their state, as long as the requirements are in alignment with the Certification Criteria. These additional requirements could include, for example, requirements to cover certain evidence-based programs, address specific issues identified in the CCBHCs' community, implement certain care coordination agreements, and respond to certain features of the state's CCBHC quality measurement program. Regardless of any additional requirements, states are ultimately responsible for developing a certification process and for certifying CCBHCs to be eligible providers.

Under the Demonstration, states are statutorily required to pay CCBHCs using a PPS methodology.⁷⁹ The CCBHC Demonstration PPS is a clinic-specific, cost-based rate developed using historical cost and visit data calculated via a cost report that clinics must submit to their state Medicaid agencies. States may select one of four methodologies to structure their CCBHC PPS methodology:

- PPS-1: a daily all-inclusive rate, with optional quality bonus payments (QBP)
- PPS-2: a monthly all-inclusive rate, with required outlier payments and QBPs, and separate optional special population rates.
- PPS-3: a daily rate with separate required payments for crisis services and optional QBPs.
- PPS-4: a monthly rate with separate required payments for crisis services, outlier payments, and QBPs, and separate optional special population rates.

CCBHCs participating in the Demonstration are required to submit cost reports annually to their state Medicaid agencies, and the states are required to submit these cost reports to CMS. ASPE then uses these cost reports, along with performance measure results and claims and encounter data, to conduct an evaluation of the Demonstrations and to develop annual CCBHC Demonstration Program Reports to Congress.⁸⁰

B. CCBHC Expansion Grant Program

In 2018, the Consolidated Appropriations Act, 2018 (CAA, 2018) (Pub. L. 115–141) established a separate CCBHC Expansion (CCBHC-E) Grant Program to support increased availability of CCBHCs. The grant program, overseen by SAMHSA and funded through annual appropriations, provides funds directly to clinics to assist them in meeting the CCBHC Certification Criteria,

⁷⁹ CMS, in close collaboration with SAMHSA and ASPE, issued CCBHC PPS Guidance that provides details on payment requirements for CCBHC Demonstration services. See: <https://www.medicaid.gov/medicaid/financial-management/downloads/updated-ccbhc-pps-guidance-02152024.pdf>.

⁸⁰ See: <https://aspe.hhs.gov/reports/ccbhc-demonstration-program>.

improve and enhance existing Demonstration programs, and to provide support for uncompensated care. Unlike in the Demonstration, the CAA instituting the grant does not authorize PPS payment for CCBHC services and CCBHC-E providers may self-attest to meeting the Certification Criteria. Though states are not responsible for certifying CCBHC-E's, some states have opted to formally certify them as meeting the CCBHC Certification Criteria.

CCBHC-E's are also eligible to participate as a CCBHC in a state's demonstration program. These dually certified CCBHC-E's must meet all of the Demonstration requirements outlined in the CCBHC Certification Criteria and PPS Guidance, including certification by the state as meeting the CCBHC Certification Criteria. CCBHC-E's that also hold Demonstration CCBHC certification are eligible to receive payment at the demonstration PPS rate when providing eligible demonstration services, while those with only CCBHC-E certification must be paid using existing, approved Medicaid payment mechanisms.

C. Additional Medicaid Authorities for Supporting CCBHC Services

States have the option to cover CCBHC services under various Medicaid authorities. Prior to the enactment of the new CCBHC state plan option, some states elected to sustain or newly cover certain CCBHC services under the rehabilitative services state plan authority at section 1905(a)(13) and the implementing regulations at 42 C.F.R. § 440.130(d).^{81,82} States can also cover these services under other state plan authorities, such as the section 1915(i) state plan authority, as well as the section 1115 demonstration authority.⁸³

In addition to the rehabilitative services state plan authority, states could also cover CCBHC services under the clinic services state plan authority at section 1905(a)(9) and the implementing regulations at 42 C.F.R. § 440.90.

However, not all CCBHC services outlined in the Certification Criteria qualify for Medicaid coverage under preexisting section 1905(a) benefits. For example, some components of supported employment services, which fall under psychiatric rehabilitation services in the Certification Criteria, cannot be covered under a current section 1905(a) state plan authority. States that elect to use pre-existing authorities to cover CCBHC services, as opposed to the new section 1905(a)(31) state plan benefit, must use multiple Medicaid authorities, such as the section 1115 demonstration authority and the section 1915(i) home and community-based services state plan authority, to cover the full array of CCBHC services.

⁸¹ The rehabilitative services implementing regulations at 42 C.F.R. § 440.130(d) allow states to include in their Medicaid state plan coverage of "any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level."

⁸² States that use the rehabilitative services state plan authority to cover CCBHC services include Georgia, Kansas, Missouri, Minnesota, Nevada, Oklahoma, Pennsylvania, and West Virginia.

⁸³ Expenditures for CCBHC services covered by a state under these authorities are not eligible for the enhanced federal Medicaid match available through the Demonstration and states are not required to pay the CCBHC Demonstration PPS rate for non-demonstration clinics.