NATIONAL COUNCIL *for* Mental Wellbeing

CCBHC & Managed Care Collaboration: **A Guidebook for State & Managed Care Leaders**

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Executive Summary

Since the Certified Community Behavioral Health Clinic (CCBHC) demonstration began in 2017, CCBHCs have been improving care access and outcomes for people with mental health and substance use challenges. As states seek opportunities to optimize their CCBHC programs, they are discovering the importance of more strategically engaging with state-contracted Medicaid managed care organizations (MCOs) throughout CCBHC implementation efforts so that each party can be leveraged to their full potential. A lack of collaboration can lead to uncertainty for beneficiaries/clients and their families when navigating behavioral health crises, inefficient use of services across the care continuum, denials of payments to providers, and resources being directed toward conflicting objectives.

This guidebook is developed for state and MCO leaders based on the significant roles both play in setting policy, determining resource allocation and helping beneficiaries access the services they need. State governments hold contractual relationships with both MCOs and CCBHCs and are accountable to both the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). As such, they are ideally positioned to directly influence these issues. Health plans can help by taking a proactive approach to understanding the CCBHC model, engaging thoughtfully with the state and leading cultural, operational and technical changes within their organizations.

The following recommendations and considerations draw on insights shared by MCO, state and CCBHC stakeholders, as well as people with lived and living experience.

LESSON 1
Embrace leadership responsibilities to drive alignment

State CCBHC leaders note that states should embrace their leadership role in defining the vision, tone and strategic direction of CCBHC programs by convening stakeholders, defining what "good" looks like, defining state-specific certification criteria and payment approaches, creating certification and decertification processes, and adapting MCO contracts. The CCBHC model affects multiple MCO functions, including member services, provider relations, claims processing, contracting and care coordination. It also presents meaningful opportunities for MCOs. By aligning internal operations, strengthening collaboration with providers and supporting the model's implementation, MCO leaders can also advance core business objectives.

LESSON 2
Bring stakeholders together early and often

Strong partnerships require a deliberate blend of structure, goodwill, trust and shared accountability for clearly defined outcomes. Effective collaboration also depends on understanding each partner's needs, pressures and pain points. Stakeholder engagement also must extend beyond agencies, plans and providers to meaningfully include people with lived and living experience.

Executive Summary

LESSON 3
Facilitate education and capacity building for state and MCO staff on how CCBHCs change business as usual

Clear, shared understanding is the foundation for both effective collaboration and complex program planning and execution. CCBHCs change "business as usual" for many functions in MCO and state operations. It is a manageable change but requires adapting and/or creating new individual policies, processes and procedures. To do this, staff need practical, role focused knowledge about how CCBHCs operate (including the prospective payment system) and the rules that govern them.

LESSON 4
Create clear roles and responsibilities across states, MCOs and CCBHCs

Overlapping responsibilities between states, health plans and CCBHCs — in areas such as care coordination, data reporting, risk assessment and population health management — create real potential for confusion and duplication of efforts. Clear, concise guidance documents for fiscal, clinical and compliance tasks reduce redundancy, align expectations and create consistent messaging about program benefits and challenges, which helps protect clinic bandwidth for direct care. This clarity strengthens partnerships and improves operational performance.

LESSON 5
Invest in data quality and data sharing between states, MCOs and CCBHCs

Access to high quality, timely data is foundational to improving care. States and MCOs must prioritize four linked areas: data quality, type, exchange and collection. Clear governance, shared standards and role based expectations help ensure that data-related work supports operational needs rather than creating extra burden, and will pay dividends in care quality and system efficiency.

LESSON 6
Employ strategies to address uncompensated care at CCBHCs

States are uniquely positioned to mitigate uncompensated care pressures through targeted policy levers and program design choices. Health plans and CCBHCs will both be significantly impacted by the drop in Medicaid enrollment due to H.R.1 regulations. MCOs can help themselves while also supporting CCBHC stability by partnering with CCBHCs on beneficiary enrollment and re-enrollment efforts and employing targeted community reinvestment strategies.

Ultimately, the full value of the CCBHC model will be realized when there is stronger alignment across states, MCOs and CCBHCs. Clearer expectations, shared data and coordinated priorities will support smoother implementation and ensure beneficiaries experience the seamless, high-quality care the model is designed to deliver.

INTRODUCTION

Opportunity and Roles of States and Health Plans in Advancing the CCBHC Service Delivery Model

Opportunities for stronger collaboration

Since the Certified Community Behavioral Health Clinic (CCBHC) demonstration began in 2017, CCBHCs have been improving care access and outcomes for people with mental health and substance use challenges. High certification and quality standards, along with a payment model that more closely reflects the true cost of services, have contributed to the successful implementation of this model nationwide. CCBHCs have made important investments in clinical interventions, workforce recruitment and retention, and technologies that enhance the ability to provide timely and high-quality care with robust service coordination (Assistant Secretary for Planning and Evaluation, 2020).[1]

As states seek opportunities to optimize their CCBHC programs, they are uncovering the importance of more strategically engaging with state-contracted Medicaid managed care organizations (MCOs) throughout CCBHC implementation efforts. MCOs have benefited from the clinics' intensive outreach and engagement efforts aimed at bringing more people (often those with unmet needs) into care. CCBHCs also reduce the use of higher-cost settings like hospitals, integrate behavioral health services with primary care, and enable workforce development efforts because they are large enough and have the flexible funding needed to support training programs and staff development.

But missed opportunities for collaboration across states, MCOs and CCBHCs have held each party back from leveraging its full potential. MCOs have faced challenges as they work to identify how to best fit CCBHCs into their provider panels and delivery networks, and how to develop or establish effective models for CCBHCs and MCO care coordinators to work together. States do not always address MCO contract requirements and goals as a discrete component of CCBHC implementation (nor are they always clear to CCBHCs). Gaps in data collection, reporting and aggregation across CCBHCs, MCOs and states have limited stakeholders' ability to fully leverage systemwide data for powerful population health and quality improvement activities and quality-based performance incentives.

A lack of collaboration can have concrete effects on beneficiaries and other stakeholders:

- If care coordination responsibilities are not clear across all parties, clients/beneficiaries and their families may be uncertain who is their primary point of contact when navigating a behavioral health crisis, and there may be duplication of efforts across the MCOs and CCBHCs.
- If MCO customer service representatives do not understand how CCBHCs differ from other providers, they will not be able to guide beneficiaries on how to most efficiently and effectively use CCBHC services alongside other available supports across the care continuum.
- Not involving MCOs in early discussions about procedure codes that trigger a Prospective Payment System (PPS) payment can result in inefficiency during implementation or denials of payment that are disruptive for providers.[2]
- Quality measures that lack consistent prioritization or specifications across all system partners may result in resources being directed toward conflicting objectives.

Ultimately, the full value of the CCBHC model will be realized when there is stronger alignment across states, MCOs and CCBHCs. Clearer expectations, shared data and coordinated priorities will reduce friction, support smoother implementation and ensure beneficiaries experience the seamless, high-quality care the model is designed to deliver.

1 A full history of the CCBHC program and evaluation can be accessed on the Substance Abuse and Mental Health Services Administration's CCBHC webpage.

2 The PPS rate for CCBHCs is a calculation of the total cost of providing CCBHC services over a year and the number of eligible service events over the same period. It is a bundled rate reflecting a group of services and additional costs that are part of service delivery, such as care coordination and technology. It is paid as either a daily or a monthly rate, and payment is prompted (or "triggered") only when specific services take place that have been defined by the state as part of its payment methodology.

Roles of states and health plans in advancing CCBHCs

State governments, as the entities that hold contractual relationships with both MCOs and CCBHCs and are accountable to both the Centers for Medicare and Medicaid Services (CMS) and Substance Abuse and Mental Health Services Administration (SAMHSA), are ideally positioned to directly influence these issues, and at times pull partners together for vital strategic conversations. States can set clear expectations for how MCOs and CCBHCs work together, as well as set the overall vision for how CCBHC programs will most positively impact state communities.

Health plans have a responsibility to take a proactive approach to understanding the CCBHC model, engaging thoughtfully during the state's many decisions about the program, and leading cultural, operational and technical changes within their organizations. This engagement will improve each MCO's own performance, as well as the experiences of both beneficiaries and providers.

This guidebook is developed for state and MCO leaders based on the significant roles both play in setting policy, determining resource allocation and helping beneficiaries access the services they need. Successful implementation of the CCBHC model, with its potential to transform behavioral health access and outcomes, requires robust and ongoing collaboration between states, MCOs and CCBHCs.

This venture cannot succeed if undertaken in isolation. Throughout this guidebook, there is a repeated emphasis on: (1) seeking first to understand, (2) bringing all critical stakeholders to the table, and (3) equipping participants with the knowledge and skills to meaningfully engage in planning and/or executing the vision for CCBHCs.

Regardless of how a state designs its CCBHC program (e.g., which services or populations to include or carve out of managed care, which PPS payment methodology to use, whether to include a quality bonus payment model), there are concrete mechanisms that support greater collaboration among MCOs, CCBHCs and states. This guidebook explores recommendations and considerations for state health policy and MCO leadership. The following lessons are drawn from insights shared by MCO, state and clinic stakeholders, as well as people with lived and living experience who work as peers in CCBHCs, as they reflected on their CCBHC implementation experiences, challenges and successes.

Note

- This guidebook focuses specifically on what state agencies and Medicaid MCOs can do to better align managed care with the CCBHC model. While clients, beneficiaries and providers are essential voices in designing and implementing effective CCBHC programs, this guide does not attempt to cover the full breadth of stakeholder engagement practices. The absence of detailed discussion about provider and client roles should not be interpreted as minimizing their importance, implying they do not bear responsibility for effective care management in an MCO environment, or suggesting they be excluded from program planning or decision-making.
- Changes in federal and state policies, practices and financing can all affect the opportunities and approaches for states, MCOs and CCBHCs.

LESSON 1

Embrace leadership responsibilities to drive alignment

This guidebook focuses on state agencies and MCOs because of their decisive influence on the success of CCBHCs. Through policymaking, operational choices and priority setting, states and MCOs may enable strong implementation or create barriers to success. This holds true for states just launching CCBHCs and for those with more mature programs.

Reflections from state CCBHC leaders point to the importance of states explicitly embracing their leadership role in defining the vision, tone and strategic direction of CCBHC programs. States have practical levers to do this: convening stakeholders, defining what "good" looks like, defining state-specific certification criteria and payment approaches, creating certification and decertification processes, and adapting MCO contracts. A broader list of strategic decisions and ongoing management interventions is included in Figure 1.

Besides setting policy guidance for contractors and service providers, state leaders also are responsible for ensuring that the executive branch (e.g., state Medicaid program, state behavioral health agencies, state child welfare program) and its myriad parts are moving in lockstep.

MCOs, likewise, can advance their own goals and the broader system by approaching their support role with intention and clarity as they help shape the success of the CCBHC model and its intended outcomes. This requires active participation in local system design discussions and concrete internal operational changes to integrate this new behavioral health model into their networks. Underestimating the scope of change is a common cause of delays and frustration.

The introduction of CCBHCs affects multiple MCO functions, including member services, provider relations, claims processing, contracting and care coordination (see Figure 2). These operational shifts are further complicated by the matrixed structures common in many health plans, in which some functions are controlled locally and others centrally. Given the far reaching nature of CCBHCs, MCO leaders must dedicate the time and resources needed to enable this level of system change.

At the same time, CCBHCs present meaningful opportunities for MCOs. By aligning internal operations, strengthening collaboration with providers and supporting the model's implementation, MCO leaders can also advance core business objectives: improving Healthcare Effectiveness Data and Information Set (HEDIS) measures and Medicare Advantage Star Ratings, meeting Medicaid and Medicare targets, and enhancing access and quality of care. In this way, the work required to adapt to the CCBHC model directly supports the outcomes MCOs are already striving to achieve.

Figure 1
Critical state decisions for CCBHC programs

- What are the state's principal goals and priorities, and how will implementation of the CCBHC program help to support and advance them (e.g., increase access to care and/or quality of services for populations with significant unmet needs, move toward a value-based versus fee-for-service model of care for behavioral health)?
- How will CCBHCs fit into the state's broader behavioral health service continuum?
- Which CCBHC services and/or populations, if any, will be carved in or carved out from managed care? (These choices trigger a cascade of downstream policy and operational decisions.)
- Which PPS model and methodology will be used (PPS-1, PPS-2, PPS-3 or PPS-4)?
- If CCBHC services are covered by the MCOs, will the state pay a wraparound payment to CCBHCs or include the full PPS in the MCOs' capitation rates (and, when included, what will be the cadence of actuarially sound rate adjustments)?
- What evidence-based practices will be included in the state's certification criteria?
- What are the Alternative Payment Model (APM) expectations of CCBHCs and MCOs (e.g., use of the CCBHC quality bonus payment and/or targets for contracts in specific levels of the Health Care Payment Learning and Action Network APM Framework)?[1]
- What are the certification, evaluation, quality monitoring/improvement and decertification processes?
- What are the data reporting requirements, and how will information flow from and between CCBHCs, MCOs and the state?
- What is the role of clients, providers, MCOs, sister state agencies and other stakeholders in program governance and oversight?

1 This guidebook uses the term *Alternative Payment Model* to align with the Health Care Payment Learning and Action Network's framework (HCP-LAN) for quality-based payment models. It is meant to encompass other commonly used terms such as value-based payment or value-based care. The HCP-LAN APM framework is federally endorsed and categorizes quality-based payment models, including pay-for-performance, shared savings and risk-based models. It is used nationally to track APM adoption in and outside of Medicaid and Medicare.

The CCBHC model cannot function well as a passive add-on; it requires active involvement, management, collaboration, adequate resources and oversight from both state agencies and their contracted MCOs to realize its promise.

Considerations for both states and MCOs

- Embed change management strategies — meaning the structured preparation of people, processes and systems for upcoming shifts — into planning and execution during both early development and later modifications. Look across internal and external stakeholders: Who must be involved in planning? Which roles will be affected and how? What resources, training, skills or guidance will they need to navigate the transition successfully? What IT updates are required? What is a reasonable timeline for each component? Communicate a clear vision with audience-specific messaging that supports the transition.
- When contracted health plans have a national presence, encourage national company leadership engagement and/or education on CCBHCs to garner sufficient access to national infrastructure.
- Dedicate adequate staff time and expertise for achieving active involvement, management, collaboration and oversight.
- Be prepared to adapt. Even the most mature CCBHC programs are still learning where changes are needed, and state and federal policy are always in flux.

Figure 2
MCO and state roles/functions impacted by CCBHCs

Numerous roles and functions across states' executive health and human services branches agencies and at MCOs may be impacted by CCBHCs, including:

- Member customer service
- Provider customer service
- Care management and outreach
- Network management
- Clinical strategy and specific benefit groups (e.g., behavioral health, primary care, pharmacy)
- Regulatory affairs
- Medicaid Management Information Systems and other state- and MCO-specific data-management-platform managers
- Claims processing and payment, including third-party liability coordination and out-of-network provider policies
- Financial analyses and related functions, actuarial and financial modeling, and rate setting
- Informatics and data analytics
- Provider contracting
- Provider licensing, credentialing and/or certification
- Groups charged with advancing APMs
- Waiver programs
- MCO oversight and state-MCO contract compliance
- Utilization management
- Provider oversight
- Beneficiary grievance processes
- Ombudspersons
- Training and HR
- Community and community-based organization engagement and reinvestment

Considerations for states

- Designate a formal state convener to bring key Medicaid, mental health, substance use and other agencies together. Because authority is often split across departments, states need a structured forum where CCBHC and MCO experts can jointly shape decisions and guide implementation.
- Be explicit about which problems the CCBHC model is meant to solve, for which populations and how outcomes will improve. Show how CCBHCs align with the state's quality strategy and MCO contract expectations. Clarify when goals extend beyond Medicaid (e.g., uninsured populations) and when they apply only to Medicaid beneficiaries, so MCOs can plan accordingly.

Considerations for MCOs

- Educate MCO staff from a wide range of functional areas about the CCBHC model, its requirements and its implementation considerations (see Figure 2).
- When developing communication for MCO staff, name the benefits CCBHCs can bring to the specific health plan. Has the health plan faced a particular challenge that CCBHCs could help solve? Where MCOs are held to reporting or certification requirements from the National Committee for Quality Assurance (NCQA) or other accrediting bodies, do CCBHCs directly or indirectly support these criteria? (For more messaging considerations, see Figure 3.)

Figure 3
Messaging elements to include when introducing CCBHCs to MCOs

- **What is the CCBHC service model?** How does it differ from prior models (e.g., Community Mental Health Centers or Health Homes)? What is the CCBHC financial model?
- **What is the big picture?** How do CCBHCs best complement other providers/supports along the state's medical and behavioral health continuum of care? What are the goals of the CCBHC program, on what time horizon and using what theory of change?
- **Why is the state invested in CCBHCs?** What are the benefits to clients, providers, health plans, hospitals, the state and local communities?
- **How can CCBHCs align, advance or further MCO priorities and requirements within the state?** How do they help MCOs achieve network adequacy, meet quality measure minimums and/or earn performance incentives? How do CCBHC certification and cost reporting requirements improve state oversight and allow for increased transparency into service delivery and costs? How can CCBHCs help MCOs ensure effective care coordination delivery for beneficiaries with especially complex health needs? How can CCBHCs help reduce the use of emergency department and inpatient services?
- **How are health plans protected financially, given that PPS rates are higher than typically paid to behavioral health providers?** After the initial actuarially based MCO rate adjustments required by CMS, how often can MCOs expect rates to be revisited (especially during start-up)? How often will the states rebase clinic PPS rates and, consequently, MCO rates? Does the PMPM percentage load for MCO administrative costs differ based on whether CCBHC services are included in MCO benefits and/or if the PPS is paid via wraparound?
- **How will this work in practice?** What are the service navigation pathways for clients, other referring providers, health plans and other potential referral sources, such as police department, schools and community-based organizations?

System spotlights for Lesson 1

- Since 2015, Missouri has taken an unusually open and collaborative approach to developing its CCBHC program — an approach that continued as MCOs became central partners. The state recognized that a statewide program as complex as CCBHCs required transparency and shared problem-solving, not guarded decision-making. During the 2015-2017 demonstration planning period, the Missouri Behavioral Health Council participated in weekly high-level meetings with the state. As implementation neared, the state launched weekly calls staffed by policy, fiscal, billing and certification experts, at which any provider could raise questions. If answers weren't available, the state committed to resolving them by the next call and circulated FAQs to ensure consistent communication. This direct communication continued well into implementation. MCOs were brought more fully into planning once the demonstration was extended beyond its initial two years, though stakeholders noted that earlier MCO involvement would have reduced confusion and friction. Today, monthly CCBHC leadership meetings continue, with the Missouri Behavioral Health Council helping shape the agenda and the state's Medicaid MCO leadership in attendance.
- In 2018, Washington implemented its Wraparound with Intensive Services (WISe) program, a high-intensity behavioral health service model designed for Medicaid-eligible children and youth with serious emotional disturbances who are involved in multiple systems. This required creating new policies, codes and payment models, as does CCBHC implementation. An MCO operating in the state became a core partner, offering leadership, convening cross-system stakeholders, driving shared problem-solving across all five MCOs in Washington and providing high-touch technical assistance for providers. It worked with the state to develop new solutions to capacity challenges, rural access barriers and long waitlists. At the same time, the MCO supported internal change through specialized staffing, cross functional quality improvement structures and the creation of subject matter expert roles dedicated to wraparound and children's behavioral health. This combination of convening, policy alignment, training and ongoing technical assistance established a unified direction for the system while giving providers the support they needed to succeed. Adopting this type of robust state/MCO partnership may be helpful for other states as they work to implement or refine their CCBHC initiatives.

LESSON 2

Bring stakeholders together early and often

Strong partnerships require a deliberate blend of structure, goodwill, trust and shared accountability to clearly defined outcomes. The success of the partnership itself requires almost as much discussion and ongoing attention as the actual work the partners do together. Convening the right people early — and sustaining predictable, purposeful engagement throughout exploration, planning and implementation — helps align expectations, reduce confusion and create a foundation for timely decision making and constructive problem solving. States lead planning and are accountable to CMS and SAMHSA, so they are often best positioned to convene stakeholders, set expectations for good faith participation and ensure that engagement is consistent rather than episodic.

Because early engagement might be sensitive, discussions with stakeholders are often held separately rather than in an open forum, but these practices can erode trust and slow progress. States can mitigate this by being explicit about roles and nonnegotiables, and by setting the expectation that all parties participate constructively.

Effective collaboration also depends on understanding each partner's needs, pressures and pain points. For example, states operate on long program horizons and external mandates. MCOs face shorter commercial cycles and acute pressures related to utilization, quality and service gaps. CCBHCs navigate operational barriers such as payment delays and intake burdens stemming from onerous state requirements. Creating structured spaces to name these tensions allows solutions to be both contractual and motivational.

Finally, stakeholder engagement must extend beyond agencies, plans and providers to meaningfully include people with lived and living experience. Long standing frustrations with access barriers, confusing coverage rules and fragmented care erode trust — especially for populations with unmet needs. Introducing CCBHCs will not resolve these frustrations overnight. Existing guidance, such as recommendations from the National Council for Mental Wellbeing's CCBHC Living Experience Advisory Council, offers practical approaches for centering lived experience (National Council, 2023; Williams et al., 2023; Barth, 2007). States and MCOs can leverage advisory committees and member feedback structures to ensure community voices shape program design and implementation.

Considerations for both states and MCOs

- Engage as early as possible, and keep engagement consistent throughout exploration, planning and implementation.
- Clarify the ideal division of responsibilities between the state and local health plans, playing to each entity's strengths and authority.
- Invest time in building shared understanding of each partner's needs, constraints and values, and develop a clear and cohesive definition of program success.
- Establish nonnegotiables up front to avoid unproductive conflict; for example, be transparent about contractual, IT and policy limitations that shape what is feasible.
- Consider hiring staff with MCO or provider experience to strengthen cross-sector understanding and trust.
- Leverage advisory committees and member feedback structures to ensure community voices shape program design and implementation.
- Prioritize training so all participants understand the CCBHC clinical and financial model. (For more on this, see Lesson 3.)

Considerations for states

- Engage stakeholders, including MCOs, at every stage of program development, from early exploration through planning grants and ongoing program refinement. Giving stakeholders a voice and a meaningful role in design strengthens their commitment to seeing the initiative succeed.
- Be explicit about what is federally required versus what is within state discretion, and impose additional state requirements only when necessary and manageable.
- Maintain frequent, transparent communication and a predictable convening schedule to support continuous quality improvement and timely issue resolution.
- Ensure MCOs, CCBHCs, clients and other key stakeholders have a role in program oversight and governance.
- Involve MCOs in any needs assessments that the state undertakes as part of its planning.
- Provide CCBHCs with clear information about MCO expectations (e.g., quality priorities, populations of focus) to support their own assessments without duplicative outreach.
- Align MCO performance measures with CCBHC measures where possible, and use shared pain points (e.g., emergency department utilization, readmissions) to guide incentives and requirements.
- Consult MCOs early when establishing or revising payment models, so state decisions are well informed and implementation timelines are realistic.
- Involve both decision-makers and operational staff in planning and governance to ensure policy and practice stay connected.
- Strengthen interagency alignment (e.g., Medicaid and behavioral health authorities), and embed that coordination into the program's governance structure. The extent and composition of interagency coordination will vary by state context.

Considerations for MCOs

- Recognize that each state's CCBHC program will differ; draw on lessons from other markets, and leverage national and state health plan associations to support consistent, efficient implementation.
- Use regional associations not only for shared learning, but also for ongoing operational coordination, policy development and potential strategic community investments.
- Identify for states where policy or operational decisions affect alignment with other frameworks (e.g., NCQA), such as role delineation for care coordination.
- Bring a cross functional team to planning discussions — behavioral health subject matter experts in clinical strategy and provider relations, member services, contracting, enrollment, data systems and analytics, community outreach, business intelligence, payment, quality and APM design — rather than relying solely on contracting management.

System spotlights for Lesson 2

- During its planning period, the state of Kansas held weekly meetings between the state, MCOs, Community Mental Health Centers, advisors and the Kansas Department of Health and Environment (which houses the state's Medicaid agency) to discuss state options in certification criteria.
- The state of Illinois began meeting with MCOs at the outset of its implementation phase. While many program decisions had already been made as part of the planning period, the state provided guidance to MCOs regarding provider enrollment system changes, statewide CCBHC contracting requirements, and billing and payment. The state has continued to hold regular CCBHC-focused meetings with the MCOs.

LESSON 3

Facilitate education and capacity building for state and MCO staff on how CCBHCs change business as usual

Clear, shared understanding is the foundation for both effective collaboration and complex program planning and execution. States and MCOs benefit from conducting widespread education to ensure state agency and health plan staff have a baseline understanding of the CCBHC model, how it operates, the payment methodology, flexibility in state requirements, and shared measures of success across staff directly and indirectly involved with the program. This alignment reduces miscommunication and creates a common foundation for training, policy and operational decisions across partners.

CCBHCs change "business as usual" for many functions in MCO and state operations. It is a manageable change but requires many functions to adapt and/or create new individual policies, processes and procedures.

Targeted upskilling is essential across specific state *and* MCO roles in clinical, operational, payment and fiscal-management domains. Training should emphasize concrete implications for day to day tasks, not just high level theory, so staff can adapt policies and processes. It should be provided on a regular basis to ensure continuity of technical knowledge over time.

Training and capacity building: Clinical care and operations

In clinical and operational domains, staff should understand how CCBHCs change both the services that are available and how they are delivered, as well as how federal and state CCBHC reporting and other requirements extend to MCOs and state agencies. Among other criteria, CCBHCs are required to:

- Deliver a comprehensive array of services, including mental health and substance use treatment, peer services, health risk assessments, preventive care, and primary care screening and monitoring.
- Serve clients across the lifespan.
- Provide 24/7 access to crisis services.
- Use evidence based practices that meet state criteria.
- Ensure prompt access to care for new and established clients, and provide crisis response, evaluation and stabilization even for individuals outside the clinic's immediate service area.
- Coordinate care with primary care providers, emergency departments, hospitals, law enforcement, schools, child welfare, social services and other required partners.
- Maintain an electronic health record system.
- Collect, report and track data according to federal and state guidelines.
- Engage in continuous quality improvement.

These requirements have implications for a variety of state and health plan functions, from technical and operational functions to external-facing customer service and strategic planning. (See Figure 2 for a partial list of likely functions impacted.)

Training and capacity building: Payment policy and fiscal oversight

Payment reform is a major operational shift for many health plans. Paying behavioral health providers a PPS rate is still uncommon, and even where analogs exist (e.g., Federally Qualified Health Centers (FQHCs), Rural Health Centers, Diagnosis Related Groups), those analogs have significant differences from the CCBHC PPS, and health plans may lack established processes for PPS-based contracting, payment and analytics for behavioral health services.

Training for state and MCO staff could include topics such as the methodology behind the specific cost-based PPS rate selected by that state (including rebasing), the importance of correctly programming and tracking shadow encounters, what is included in CCBHC cost reports, how use of a bundled PPS payment changes common fiscal analyses based on a fee-for-service architecture, and how PPS standards intersect with APMs.[1],[2] For states whose CCBHC program is still in an early design stage, training can explore the operational implications to states, providers and MCOs when states choose to pay clinics their PPS via a wraparound payment instead of through the managed care capitation rates.[3]

Training must also surface common misunderstandings about the PPS model, such as:

- Misinterpreting a CCBHC trigger procedure code as a single high-priced service rather than a bundled payment covering many services. This has implications for common fee-for-service analyses and comparisons across providers and, for MCOs, across markets.
- Believing that CCBHCs develop a significant financial margin when they provide PPS trigger-eligible services at a higher frequency than originally forecast. Training should help staff understand how regular rate rebasing aligns the PPS rate with any variations in service frequency, cost, program model or payer mix that have occurred since the PPS rate was last rebased.
- Assuming that, when full PPS rates are being paid by the MCO, the MCO is newly bearing that cost. In fact, CMS policy requires that managed care capitation rates paid by the state Medicaid program be adjusted through actuarial certification processes to fully incorporate the full PPS rate, which may even extend to CMS review.

It is important that MCO executives and state health care leaders understand the nature of the PPS, so they can explain any anomalies that stand out when comparing service lines of CCBHCs versus clinics that use other payment methodologies, particularly fee-for-service. By understanding how the PPS works, leaders are also better positioned to ask for reports and comparative analyses that appropriately and accurately account for the CCBHC clinical and payment model.

Another intricacy for state and MCO staff to understand about the PPS is its intersection with APMs. At its core, the PPS rate reflects the average expected costs for delivery of CCBHC services to clients served by the CCBHC. Payments are then made to the clinics as they provide services to Medicaid beneficiaries, and over the course of a year the total amount of Medicaid funding paid to the clinic should be roughly equivalent to their actual costs of delivering care to Medicaid enrollees.

See Appendix A, Common Prospective Payment System Questions and Appendix B, MCO Finances Under a PPS Model for more detailed explanations of PPS rates, methodologies, why comparing fee-for-service rates to PPS rates is often misleading, and how MCO margins can be impacted by decisions made at the state level during planning and implementation.

CCBHC cost reports

The CCBHC cost report is the foundation for each clinic's PPS rate, capturing staffing levels, utilization assumptions, allowable anticipated costs, IT investments, DCO arrangements and other administrative expenses. MCOs do not have direct control over the clinic-specific PPS rate; it is developed by the clinic and the state. However, becoming more familiar with cost report components and how the inputs are used in the state's PPS rate methodology can help MCOs understand what they are paying for with the PPS rate.

1 If in early CCBHC planning, include the full spectrum of PPS options for CCBHCs (PPS-1, PPS-2, PPS-3 and PPS-4).

2 Under the PPS model, certain procedure codes are identified as eligible for prompting (or "triggering") payment of the PPS bundled payment. Other CCBHC services must also be recorded on claims/encounters, but they are coded as "shadow" claims with zero dollars paid to the clinic. State and MCO data analyses need to factor this in when comparing service costs.

3 A wraparound payment is an intermittent, supplemental payment the state makes to the CCBHC to reconcile the difference between managed care payments to CCBHCs and the full PPS rate for covered services. These occur in instances when the state has chosen not to require the MCOs to pay CCBHCs the full PPS.

For CCBHCs outside of the demonstration program, federal policy does not require that clinics be paid exclusively via a PPS model; rather, just as with FQHCs paid by Medicaid, it requires that CCBHCs be paid *at least what they would have been paid* under a PPS model. This gives MCOs the opportunity to develop APMs such as shared savings and population-based payment models, so long as CCBHCs are paid at least what they would have been paid if they had stayed under a PPS structure (Centers for Medicare and Medicaid Services, 2024).[4]

A common misconception regarding APMs and CCBHCs pertains to what quality measures may be used. APMs with incentive payments are not limited to the CCBHC measures required by SAMHSA. States and MCOs can set quality measure targets outside of the mandated measures for additional priorities, such as outreach to clients who are unengaged in regular care or clients involved with the justice system.[5]

Understanding federal policy in this area is important for both state and MCO payment policy staff, so they can design CCBHC and MCO payment and contracting requirements to cultivate more advanced APMs (see Figure 4).

Figure 4
MCO Approaches to Building Effective APM Pathways with CCBHCs

- **Understanding PPS structure and state flexibilities:** Health plans are encouraged to analyze state-specific PPS methodologies (e.g., daily versus monthly rates, special crisis service add-ons) to understand any areas of overlap or intersection with APMs, and then act accordingly to align, differentiate or otherwise layer APMs on top of the PPS. Align incentives with state-structured/demonstration quality bonus payments and rebasing schedules to avoid state prohibitions around duplication of services and double-counting outcomes.
- **Glidepaths to increasing accountability:** Codevelop glidepath models for clinics to move from PPS-only to pay-for-performance and shared savings or population-based payment models. Use HCP-LAN frameworks to guide parameters for quality gates, and eventually for cost benchmarks. Risk-based contracts (HCP-LAN Category 3B APMs) are possible as systems mature and grow, but payment rates must be high enough that losses would not push payments below the PPS floor. Alternatively, CCBHCs can work together to spread the financial risk. Look for opportunities to work with clinically integrated networks.
- **Provider readiness assessment:** Evaluate CCBHC infrastructure and performance on quality and cost metrics before onboarding providers to APM arrangements. This is of mutual benefit to MCOs and providers and helps them understand how implementation is best phased.
- **Operational levers for success:** Standardize best-practice contract templates for markets while allowing flexibility for state-specific compliance. Include provisions for data exchange, attribution models and actuarial benchmarks to streamline negotiations.

4 This assumes that the state's Medicaid State Plan, waiver and/or demonstration agreement supports APMs. Depending on each state's circumstances, there may need to be additional CMS approval.

5 This assumes that the state plan, waiver demonstration agreement or own state policy does not limit additional quality measures.

Considerations for both states and MCOs

- Leverage existing guidance documents and resources from SAMHSA, CMS and CCBHC-focused national technical assistance centers, such as the SAMHSA-funded State Technical Assistance Center (S-TAC) and the National Council for Mental Wellbeing's CCBHC Success Center. Many of these resources can be used for stakeholder education on certification criteria and PPS rate development, how to identify meaningful process and impact measures to drive quality improvement, and how to facilitate peer-to-peer learning.
- Develop a plan for training state and MCO staff on CCBHCs, as well as an onboarding plan for new staff who join after the initial wave. Consolidate resources for efficiency and to ensure all staff receive the same message.
- Identify a CCBHC/Medicaid policy lead at both the MCO and the state to help partners and internal staff understand minimum requirements and where there is flexibility.
- As much as possible, partner with each other in the development of actuarially sound capitation rates for MCOs when CCBHCs are introduced. MCO (and CCBHC) input can help ensure the final capitation rates reflect all reasonable, appropriate and attainable costs, and that updated rates reflect the addition of the CCBHC program and any changes in benefits, populations or trends (Actuarial Standards Board, 2015).

Considerations for states

- Develop state-level policies and procedures for ongoing education about CCBHCs for staff across different parts of the executive branch, especially those staff responsible for developing state guidance documents and policies that require MCO implementation.
- Require that MCOs have policies and procedures for educating their staff about CCBHCs.
- Provide technical assistance and training to MCO staff who are directly and indirectly impacted by the CCBHC program. Host and maintain office hours or FAQ documents for MCOs, particularly in early years of implementation.
- Help health plans understand PPS rate/cost report and rebasing procedures. Include executive team members as well as network management, clinical and financial staff so that:
  - Health plan staff can build fluency in describing what the PPS rate does or does not represent (e.g., the payment for a single triggering procedure code represents a bundle of services and not that single procedure alone).
  - There is transparency and opportunity for awareness/engagement as the model is either being built out or being updated during rebasing.
- Maintain clear guidance documents on billing practices for both providers and MCOs, including instructions for procedure codes that trigger a PPS payment, encounter or shadow claims, and third-party liability. Each participating MCO should participate in building out these protocols, to reconcile any differences in their internal systems.
- Develop policy or guidance on how or whether MCO APMs can mix with state quality bonus program payments.
- Undertake robust planning, training and testing for billing systems prior to the go-live date. There often are significant payment delays when the PPS is introduced, which hurts clinic cash flow. Two critical steps to mitigate this problem are:
  - Testing billing systems ahead of time. CCBHCs should submit test claims and payers should process them to ensure everything works as anticipated.
  - States and MCOs should track claim submission and denial rates monthly, to identify and solve emergent billing, processing or payment issues in a timely manner.
- As a last resort, consider setting targets for how long a CCBHC payment can be delayed before the MCO makes an estimated interim payment to the provider. The interim payment can be reconciled back to the correct amount after the claims/encounters have been successfully processed.
- Establish standardized processes and protocols for the state to inform MCOs regarding which clinics and site locations are CCBHCs and which members/beneficiaries are attributed to the CCBHCs (in cases where the state program has attribution).
- Plan for extra rate amendments for MCOs when including PPS in capitation payments, especially early in implementation when all parties are learning more about beneficiary utilization patterns and CCBHC costs. See Appendix B, MCO Finances Under a PPS Model for further discussion.

Considerations for MCOs

- Hire dedicated staff or leverage contracted CCBHC technical experts for health plans that are newly serving CCBHCs. This group can support education and help set up CCBHC-specific processes (e.g., claims and provider configuration, contracting requirements, data analyses, PPS payment rules).
- Ensure health plans' fiscal, actuarial and quality analysis teams are familiar with the CCBHC payment model (including the critical importance of complete shadow claims) and which providers are CCBHCs, so plans can appropriately present business, fiscal and quality reports.
- At an enterprise/corporate level, revise standard behavioral health performance reports or other metrics to account for the different billing and cost approach used by CCBHCs, to limit the need for back-end explanations.
- Clinical and compliance staff should consider how prior authorization practices may interact or conflict with CCBHC billing and program requirements. They could consider flexibilities to reduce burden in these areas, uphold parity compliance and enable CCBHCs to ensure access to the most appropriate levels of care or evidence-based treatment practices.
- Monitor expected versus actual CCBHC payments, communicate trends to CCBHCs and collaboratively explore whether any recalibrations of service delivery might be appropriate. Jointly address any issues with claims/encounter submissions.
- Where the PPS wraparound is paid by the state, ensure MCO staff involved in provider contract negotiations and rate analyses know which providers in their network are CCBHCs.

System spotlights for Lesson 3

- Kansas stakeholders held a CCBHC Summit — a large conference run by the state behavioral health provider association, with varied faculty including state officials and national subject matter experts. Sessions focused on state CCBHC policies, evidence-based practice and fidelity requirements, proper billing procedures, cost reports and rate setting.
- Missouri compared cost report variances between individual CCBHCs in group settings that included clinic CFOs and CEOs. By going through several rounds of cost report revisions, they made sure all clinics were being consistent and understood the cost reports. This ultimately prevented any outliers and reduced unnecessary variance across CCBHCs. Missouri also had the least change in clinic rates between the initial rate setting and the first rebasing (Breslau et al., 2020).
- Rhode Island gave providers grant funding to hire an actuarial partner to support them with cost reports and rate setting for Program Year 1. This proved critical in helping individual clinic CEOs and CFOs fully understand the templates and make final decisions.
- A New York CCBHC conducted audits at the onset of use of PPS, to ensure compliance and financial integrity.
- Using their independent practice association, CCBHCs in Missouri created a shared-savings contract with a Medicaid MCO, separate from the Quality Bonus Payment program with the state. Using four mutually beneficial measures (7-day follow up after hospitalization, 7- and 30-day follow up after an ER visit for mental health, and 30-day readmission rate for acute inpatient behavioral health services), the arrangement helps the plan with HEDIS-related performance and reduction of per-member-per-month spending, and it also benefits the clinics in their CCBHC-related reporting and performance. (While the state's Quality Bonus Payment program is for all Medicaid beneficiaries served by the CCBHC, this separate shared savings program with the health plan is only for that MCO's enrolled Medicaid beneficiaries.) The 10 participating clinics meet quarterly with health plan representatives to review dashboards demonstrating progress, and shared savings are calculated on the final year-end calculation. Over each of the first two years of the arrangement, several providers have experienced shared savings.
- At the outset of the COVID-19 pandemic and its necessary pivot to telehealth, a Medicaid health plan in Oregon provided interim payments to behavioral health providers while payment systems were reconfigured and providers adjusted to new billing procedures. The interim payments were based on individual providers'/clinics' historical billing patterns.

LESSON 4

Create clear roles and responsibilities across states, MCOs and CCBHCs

Overlapping responsibilities between states, health plans and CCBHCs — in areas such as care coordination, data reporting, risk assessment and population health management — create real potential for confusion and duplication of efforts. These risks are compounded when considering oversight of state-paid versus MCO-covered services. Aligning efforts requires both human-centered design focused on clients/beneficiaries and straightforward guidance that spells out who does what in routine care and in crises (see Figure 5).

States and health plans also share duties around data integrity, oversight, utilization management and monitoring of fidelity to the CCBHC model. Certification requirements and regulatory reporting add administrative burden for providers, so planning should emphasize consolidation and coordination wherever possible. It must also be sensitive to operational capacity and aim to minimize unnecessary work that diverts resources away from direct care. Clear, concise guidance documents and decision trees help reduce friction and protect clinic bandwidth for direct care. Establishing explicit ownership of specific fiscal, clinical and compliance tasks for each partner reduces redundancy, aligns expectations and creates consistent messaging about program benefits and challenges. This clarity strengthens partnerships and improves operational performance.

As highlighted previously, since MCOs and CCBHCs are both held to requirements set by state entities, the state is in the best position to create role clarity, align data requirements and assure optimal data exchange. At the same time, solutions must remain practical and achievable within existing constraints. States and clinics must be aware that MCOs are often held to NCQA (or other accrediting body) policies and standards that steer what roles the health plans can and cannot delegate. Some organizational processes cannot be fully reengineered for CCBHCs, and perfection should not block progress. Considerations should prioritize workable role definitions that balance mandates with flexibility, enabling timely implementation while preserving room for iterative improvement.

Considerations for both states and MCOs

- Clarify roles, even when CCBHCs are carved out of managed care contracts in the state. MCOs, CCBHC and state staff still need to understand, for example, referral processes, care management accountabilities, how to manage member grievances and how to access and report quality data.
- Use responsibility assignment tools to get concrete and transparent about who is responsible for different activities (e.g., care coordination, data monitoring, measure reporting, compliance oversight). Develop these collaboratively with the state, health plan and CCBHCs, and work to understand each party's constraints, priorities, pain points and areas of flexibility.

Figure 5
Areas for role and responsibility clarity between states, MCOs and CCBHCs

- **Care coordination:** Set clear expectations on fostering alignment across all partners on roles and functions to support care coordination of people served, particularly as it relates to where CCBHC requirements could overlap with MCO care coordination practices.
- **Data management and reporting:** Align on data collection, reporting and validation requirements and responsibilities across all parties, especially where there may be conflicting technical specifications or requirements.
- **Claims and billing practices:** Set expectations across all parties for how PPS is monitored (billing by clinics and rate payment by MCOs), required billing practices and responsibilities for monitoring and follow-up.
- **Quality monitoring:** Develop plans for CCBHC oversight that does not result in duplicative work for clinics; include considerations for Designated Collaborating Organizations (DCO) oversight and payment.[1]
- **Network management:** In states where CCBHCs have specific clients/beneficiaries attributed to them, ensure clarity on attribution and member assignment between MCOs and CCBHCs and how that influences their clinical and operational practices, including addressing member grievances.
- **CCBHC education and capacity building:** Determine how each party can leverage their reach to explain CCBHCs to key stakeholders; identify supports for training on the model across providers, health plans and state staff.
- **Crisis services coordination:** Map systems and data exchange to ensure alignment and clear communication across all partners, including 988, mobile crisis and emergency department diversion programs.

1 DCO are not under the CCBHC's direct supervision but are engaged in a formal relationship with the CCBHC to deliver one or more (or elements of) of the CCBHC required services. At least in Section 223 demonstration program states, DCO services are included in the scope of the CCBHC PPS, and DCO encounters are treated as CCBHC encounters for purposes of the PPS.

- Jointly create oversight protocols for adherence to CCBHC requirements such as provider enrollment, contracting, and PPS billing and payment. Ideally this would be developed as a framework during the procurement or recontracting process. While the PPS helps clinics scale services, oversight and state-level audits ensure compliance and financial integrity, especially at the outset. If CCBHCs are not diligent in their shadow billing processes, it can significantly disrupt both MCO and state documentation and reporting (as well as reporting that CCBHCs are directly responsible for).

Identify specific individuals to serve as a contact for each of the outside partners, so there is a single point of accountability to each of the other partners (e.g., a designated MCO staff member for CCBHCs and states to contact, state contacts for each CCBHC and MCO, and CCBHC contacts for states and MCOs).

Figure 6
Delegating or coordinating care management with CCBHCs in the context of targeted care management and care coordination as core services

- **Clear roles and oversight:** Whether fully delegating or coordinating, establish explicit accountability for outreach, screening/assessments, care planning and reporting. Pay close attention to both state and health plan accrediting bodies' policies and standards on MCO delegation (and limits on further sub-delegation, to the extent DCOs are involved). Ensure all parties are using shared definitions. Include oversight mechanisms such as audits and performance reviews to maintain compliance and quality in fully delegated models, and joint training for coordinated models.
- **Integrated care planning:** Align health plan care management with CCBHC targeted case management through joint care plans, interdisciplinary care teams and closed-loop referral systems. Based on member needs/wants, operationalize team lead and potential specialist consultant roles in integrated care teams with both CCBHC and health plan participation.
- **Data sharing and technology facilitation:** Use secure platforms for real-time exchange of member-level data (e.g., risk scores, HEDIS gaps), to reduce duplication and improve outcomes.
- **Best practices for collaboration:** Schedule joint case conferences and joint training opportunities, and leverage community-based supports (e.g., housing and other social health resources) to address whole-person needs. Ensure compliance with HIPAA/42 CFR Part 2 in all communications.

Considerations for states

- Given joint oversight of the program, ensure there is internal clarity and alignment between the state's policy, finance and clinical divisions in state government (e.g., the state Medicaid and different behavioral health authorities). Work collaboratively to define parameters, develop guidance documents and determine responsibilities for clinic or MCO support or troubleshooting of operational or finance-related issues. Include county-based mental health authorities where appropriate.
- Develop detailed billing and operations manuals for both MCOs and CCBHCs. Provide training support and establish a mechanism for them to raise questions or flags early and often. Commit to revisiting and updating guidance frequently, particularly in the first years or alongside system changes.
- As much as possible within federal requirements, align state-specific CCBHC certification requirements for services, staffing, information sharing and care coordination with MCO, state and provider requirements for the same topics.
- Work with MCOs to ensure they are not implementing practices or policies that intentionally divert referrals from CCBHCs.
- Provide clear utilization review criteria expectations, and be open to discussing or revising them with CCBHCs to maintain consistency with the model.

Considerations for MCOs

- Regularly join gatherings of CCBHCs (e.g., convened by the state or by provider associations) to support open communication and to identify points of friction. If such convenings do not already exist, create one so there is an established space for collaboration.
- Hold regular (e.g., quarterly) data reviews with CCBHCs to discuss performance and areas of opportunity for collective troubleshooting and continuous quality improvement.
- Ensure internal standard operating procedures (SOPs) document mutually defined division of responsibilities between MCOs and CCBHCs. For examples of details to explore in care management, see Figure 6.
- Cross-train MCO staff on the CCBHC model and related SOPs, to ensure consistency in support and engagement with CCBHCs through health plan staffing or program transitions.
- Consider practical, day-to-day solutions for simplifying processes. For example, given MCO and provider staff turnover, consider streamlining contact information at MCOs for providers (e.g., use general email addresses such as *caremanagement@healthplan.com* or *payment@healthplan.com,* and use customer relations databases to record interactions so health plan staff can reference case history).

System spotlights for Lesson 4

- The state of Kansas built into its MCO contracts a Care Coordination Matrix that outlines care coordination responsibilities by population, delineating between MCO responsibilities and those of CCBHC, targeted case management providers and other entities with care coordination responsibilities (Kansas Department of Administration, 2024). Additionally, the state is working with its MCOs to establish an oversight approach to CCBHCs that is mindful of provider burden.
- Rhode Island has a CCBHC MCO Operations Manual that includes contracting requirements, program integrity monitoring expectations, third-party liability and system readiness testing (State of Rhode Island, 2024).
- In New York, where CCBHC services are carved out of managed care and paid directly by the Medicaid program, the state developed comprehensive resources and guidance for MCOs regarding CCBHCs to use at the start of the program. The 2017 CCBHC MCO Operations Manual included care coordination responsibilities and intersection with the state's Health Home program, how to handle grievances by members regarding CCBHC services, a list of CCBHC clinics and site locations, and how MCOs could access client-level CCBHC data for HEDIS and NCQA reporting (State of New York, 2017).
- Due to high MCO staff turnover, an MCO in Missouri has created a general email address providers can use to share information related to hospital discharges.

LESSON 5

Invest in data quality and data sharing between states, MCOs and CCBHCs

Access to high quality, timely data is foundational to improving care. Clinicians, care managers, analysts and regulators all rely on meaningful data to guide clinical decisions, run quality improvement initiatives, manage populations, demonstrate results, monitor cost trends and meet reporting requirements. When data is complete and trusted, the entire system can move from reactive troubleshooting to proactive improvement.

States and MCOs must prioritize four linked areas:

- Data quality — completeness, accuracy, timeliness
- Data type — Admission, Discharge and Transfer events; clinical measures
- Data exchange — ensuring CCBHCs and other partners see a fuller picture than just internal records
- Data collection — what to collect and review so efforts build coherent momentum
- Clear governance, shared standards and role based expectations help ensure that data work supports operational needs, rather than creating extra burden.

Data quality is fragile for many reasons, including multiple handoffs and systems that truncate or drop diagnostic codes and other claims detail, inconsistent interpretation of what to record, HIPAA and 42 CFR Part 2 confidentiality requirements that result in diagnoses or treatment data being suppressed, and claims lag. A common challenge is a lack of shared measure definitions, often because specification

changes by measure stewards are not communicated and/or implemented across all partners and technical systems at the same time. Small errors that are caught late can be time consuming or impossible to correct and can undermine confidence in performance measurement.

Data exchange faces structural barriers. Behavioral health providers were historically excluded from federal health information technology (HIT) investments that accelerated adoption of electronic health records (EHR) and health information exchange. While CCBHC PPS funding can support internal HIT upgrades, it does not automatically grant access to data generated outside the clinic, and existing statewide or regional systems may have gaps in important behavioral health fields and functionality. Costs to extract data from EHRs and variability in vendor capabilities further complicate sharing. With many competing measurement priorities — CCBHC metrics, HEDIS, state priorities, APM measures — alignment is essential to avoid diluting effort and imposing unsustainable administrative load on providers. Investing in shared standards, interoperable infrastructure and coordinated measurement priorities will pay dividends in care quality and system efficiency.

Considerations for both states and MCOs

- Establish regular working groups so all parties can review data, surface issues and solve problems together. The best way to improve data quality is by sharing data transparently across stakeholders early and often. Any data errors identified should be celebrated as opportunities for improvement. Having a wider group of stakeholders regularly scrutinizing data leads to more rapid improvement in data quality, enhances mutual understanding and builds trust.
- Promote data use for monitoring progress, with caveats for claims lag and what data does or does not represent. Transparent benchmarking that compares all CCBHCs and MCOs fosters better understanding and quicker gains. Additionally, identify other measures that can be leading indicators of performance for a measure that is otherwise incomplete.
- Build in data validation processes at different stages of data transfer. For example, periodically verify that data being collected within individual clinic EHRs aligns with what is seen at the MCO and the state. Monitor these routinely, and especially during any changes that will impact billing (e.g., new policies or EHR updates).
- Ensure that all parties meet the full requirements of Office of National Council Coordinator for Health Information Technology (ONC) and CMS interoperability and are not engaging in information blocking (ONC, 2024). Align on expectations regarding how HIPAA, 42 CFR Part 2 and ONC/CMS interoperability requirements will be operationalized, and put these details in contracts.
- Align priority quality measures at the state level, so that MCO and CCBHC quality measures and activities reinforce those priorities and incorporate existing HEDIS and CCBHC measures, when possible. Alignment helps reduce administrative burden for providers, and more attention by MCOs on CCBHC measures will likely facilitate faster sharing of data that supports the program.
- Consider creating (or requiring through contract) three-way MOUs for data sharing between the state, health plan and CCBHC, so there is no ambiguity about the permissibility of sharing data.
- Consider the reliance on CPT codes for quality measures when defining eligible encounters that trigger PPS payment.
- Create a CCBHC provider type in Medicaid Management Information Systems and managed care systems, rather than relying on specific CPT codes or provider flags.
- When possible, count HIT investments, including training and technical assistance, toward health plan medical loss ratio calculations. With some restrictions, managed care plans may include HIT expenses that are required to accomplish activities to improve health care quality (CMS, 2024).[1]

1 45 CFR §158.151 allows HIT expenses that are required to accomplish the activities allowed in 45 CFR §158.150 to improve health care quality.

Considerations for states

- Use your power as a contract holder for both CCBHCs and MCOs to require them to share information, or to require them to promptly give information to the state so it can be shared with the other partner. Be clear about who data is being shared with, for what purposes and how.
- Encourage MCOs to provide supplemental need/gap data to CCBHCs annually, so it can be incorporated into CCBHC community needs assessments and staffing plans.
- Through the MCO contract and other policymaking avenues, standardize MCO expectations of CCBHCs' billing and quality reporting, and match those to fee-for-service processes. This is essential for reliability and consistency of quality measure data and standardization of processes, so providers who work with multiple MCOs don't need a separate process for each plan.
- Create a defined set of billing codes for qualifying and nonqualifying CCBHC services, to be used by all CCBHCs, the state and MCOs when processing CCBHC claims for Medicaid members.
- Require MCOs to monitor data submissions from CCBHCs. MCOs are likely the first to notice recurrent errors, and catching these errors early can avoid perpetuating data errors and ensure CCBHC cash flow is not disrupted.
- Directly support or incentivize MCOs to invest in clinically integrated networks, data warehouses and other strategies for increasing data sharing and interoperability.
- Encourage both CCBHCs and MCOs to participate in health information exchange.

Figure 7
Running joint oversight committees or work groups

Creating space for stakeholders to discuss program updates, successes and challenges is key to fostering shared understanding, ensuring contract compliance and uncovering opportunities for improvement. There are benefits to holding these at multiple levels, such as (1) all MCOs with all CCBHCs, (2) one MCO with all CCBHCs in its network, and (3) one MCO with individual CCBHCs. Depending on individual state context, each type may include staff from the state — the state can even be the convener). When held at the individual payer-provider level, it is commonly referred to as a joint operating committee. Four elements help make these productive spaces:

1. Structured governance: Joint oversight groups should meet at least quarterly with clear agendas, documented action items and executive-level participation from health plan, CCBHC and state program leadership, to ensure timely decision-making and issue resolution.

2. Focus on performance and integration: Review quality metrics, utilization trends, care coordination workflows, special populations and high-needs cohorts. Incorporate behavioral health and physical health integration goals for CCBHCs that align with state objectives.

3. Transparency and accountability: Share actionable data (e.g., gaps in care, cost trends) before meetings, and track follow-up items to ensure accountability.

4. Continuous improvement loop: Include discussions on reducing administrative burden, adopting technology including telehealth and AI, and alignment with state initiatives (e.g., 1115 waivers, PPS updates).

- Only approve CCBHC certification requests and cost reports if they include adequate resourcing for IT systems and data analytics staff, so the CCBHC can successfully meet IT systems and data analytics requirements.
- Use standardized measures to reduce burden and costs for providers. Customization at the state level risks entrenching specific vendors into the state's processes and can increase EHR costs.
- Consider rewriting current state reporting requirements (e.g., for block grant funding) for more seamless integration and alignment with interoperability standards.
- Leverage policymaking processes such as contract amendments for updates to the CCBHC program and expectations of MCOs (e.g., for changes to trigger codes or quality measure reporting).

Considerations for MCOs

- Prioritize sharing member-level information and holding recurring joint oversight committee meetings with CCBHCs (see Figure 7).
- Identify gaps in performance measures, and create CCBHC action lists that identify beneficiaries who may need additional services.
- Proactively provide CCBHCs with data to help address their pain points, such as initial authorization of stay data that enables prompt follow-up at discharge.
- Regularly analyze claims and service patterns to identify outliers. CMS requires CCBHCs to submit a claim or a no-pay encounter for all services, even when the service does not trigger a PPS payment. Additionally, monitor DCO billing patterns to prevent accidental double billing.

System spotlights for Lesson 5

- In Missouri, health plans and providers meet regularly to review data as part of an APM arrangement.
- In Oklahoma, CCBHCs routinely access various data-sharing platforms that give them access to "most-in-need" lists, primary care notes, emergency department and hospital notes, incarceration status, shelter use and other data.
- In its Program Year 2 certification criteria, Rhode Island required CCBHCs to build capacity to contribute to the state health information exchange. It additionally required MCOs to develop system readiness testing plans (State of Rhode Island, 2025).
- Rhode Island convenes quarterly roundtables with MCOs and CCBHCS to review performance on quality measures and surface programmatic insights to drive continuous quality improvement opportunities.
- Oregon's health-related services benefit allows its Medicaid health plans to count HIT investments toward their medical loss ratio, and has made the criteria publicly accessible (Oregon Health Authority, 2025).

LESSON 6

Employ strategies to address uncompensated care at CCBHCs

While the CCBHC PPS is similar to the methodology used with their sister safety net, FQHCs, there are important differences in the two financing models. Unlike FQHCs, CCBHCs are not yet paid a PPS rate by Medicare. Additionally, while CCBHCs may receive state and federal grants (e.g., SAMHSA mental health and substance use block grants or discretionary funding), these are more variable and less codified than Section 330 funding to cover the cost of uncompensated care. Because CCBHCs are required to serve all individuals — including uninsured individuals and commercial MCO beneficiaries whose payers are not typically obligated to reimburse the PPS — many clinics and sponsoring agencies absorb significant losses as part of meeting access and continuity expectations.

That structural gap creates a persistent fiscal strain that can undermine program sustainability and limit clinics' ability to invest in capacity, workforce and HIT. Federal policy changes will only exacerbate this problem: The Congressional Budget Office estimates that H.R.1's Medicaid eligibility and financing provisions will result in approximately 10 million additional uninsured individuals by 2034 (Mudumala et al., 2025).

Fortunately, states are uniquely positioned to help mitigate uncompensated care pressures through targeted policy levers and program design choices. The considerations that follow outline practical ways for states to use their convening power, fiscal tools and regulatory authority to protect clinics and preserve access to behavioral health services. Health plans, too, will be significantly impacted by the predicted drop in Medicaid enrollment. They can help themselves while also supporting CCBHC stability by partnering with CCBHCs to help with beneficiary enrollment and re-enrollment efforts (to the extent permitted), as well as using targeted community reinvestment strategies that bolster services outside of health care, such as housing.

Considerations for states

- To help keep CCBHCs financially stable, monitor not just the PPS rate but also the overall financing picture, including uninsured clients, other payers, grant funding and cost shifts.
- Explore opportunities to leverage federal funding and grant dollars to support uncompensated care.
- Work with legislators to explore options for offsetting CCBHCs' costs of serving uninsured and underinsured people.
- Work with state insurance regulators to identify options for improving commercial plan coverage of and payment for CCBHC services.
- Consider a PPS rate methodology like Missouri's that accounts for the proportion of Medicaid and non-Medicaid clients being served by the CCBHCs. (See the System Spotlights description of Missouri's model as well as a more detailed explanation in Appendix A.)
- Make sure CCBHCs provide enrollment navigation support for Medicaid, Medicare and disability applications.
- Evaluate the Rural Health Transformation Program ($50 billion in federal grants to be distributed to states from 2026-2030) as a potential offset mechanism for some financial pressures, particularly for rural CCBHCs (CMS, 2026).
- Monitor Centers for Medicare and Medicaid Innovation program opportunities and resources that support initiatives for multipayer alignment.

Considerations for MCOs

- With enrollment churn likely to increase due to H.R.1, be aware of any levers to ensure continuity in care for members who often move in and out of Medicaid.
- Partner with CCBHCs on enrollment and re-enrollment by, for instance, having CCBHCs verify beneficiary contact information at each visit.
- Consider community reinvestment strategies that focus on identified community needs that align with CCBHC strategy and community needs assessments, and the role of CCBHCs as part of the behavioral health safety net.

System spotlights for Lesson 6

- Georgia, Kansas, New York, Texas and other states have uncompensated or undercompensated care pools or other financial mechanisms to mitigate the financial impacts for their CCBHCs (Georgia Department of Behavioral Health and Developmental Disability, 2026; Kansas Department for Aging and Disability Services, 2025; Sachs Policy Group, 2025; Texas Health and Human Services Commission, n.d.).
- As of Jan. 1, 2025, New York requires commercial insurers to pay CCBHCs their PPS (New York State Office of Mental Health, 2025).
- Missouri received CMS approval for a blended rate approach for its PPS in the demonstration (now sustained under its state plan). The blended rate ensures Medicaid pays its full share of certain high-cost services that are not typically covered by other insurers and are less commonly accessed by non-Medicaid enrollees (personal communication, March 19, 2026). A deeper explanation of the methodology is in Appendix A.

Conclusion

CCBHCs across the country are already demonstrating meaningful improvements in accessibility, quality and breadth of behavioral health services available to communities. States and Medicaid MCOs sit in the driver's seat for many of the policy, financing and operational decisions that shape whether CCBHCs can truly thrive. When these system partners work in concert — each leveraging its unique strengths — the potential to accelerate the success of the CCBHC model grows exponentially. The path forward depends on collaboration, coherence and a collective commitment to making the most of what each partner brings to the table.

APPENDIX A

Common Prospective Payment System Questions

1. What is the Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment System (PPS)?

The CCBHC PPS is a predetermined, cost-based, bundled payment rate that is based on each clinic's costs of delivering the CCBHC service model. The rate is paid either per day or per month when eligible CCBHC services are provided. Using methodologies that must align with Centers for Medicare and Medicaid Services (CMS) guidance, and using clinic data that is captured in a uniform, detailed cost report, each Medicaid-enrolled CCBHC has a rate certified by its state Medicaid program. That rate becomes the floor for what Medicaid must pay CCBHCs.

At its core, the PPS rate reflects the average expected costs for delivery of CCBHC services to its clients. The rate is calculated by dividing the total allowable costs (including CCBHC services, anticipated budgeted costs, direct costs and allocated overhead) by the number of expected billable visits (see Figure 8). The costs and visits included are for all services and clients, regardless of payer. Payments are then made to the clinics as they provide services to Medicaid beneficiaries. Over the course of a year, the total amount of Medicaid funding paid to the clinic should be roughly equivalent to the clinic's actual costs of delivering care to Medicaid enrollees.

Rates are recalculated periodically using actual cost and visit data. In years when the rates are not recalculated, they are adjusted using an inflation index.

This bundled and cost-based method allows CCBHCs to receive financial support for the costs associated with the various activities and functions not typically reimbursed under fee-for-service models, but which are nonetheless essential to improving access and quality of services. For example, the CCBHC PPS rate can include costs associated with conducting care coordination activities, IT systems and analytics, and workforce training in evidence-based practices.

2. What PPS options are available for CCBHCs?

There are currently four rate-setting methodologies available to states:

- **PPS-1:** This daily encounter rate is paid for all CCBHC services provided to a Medicaid beneficiary on any given day.
- **PPS-2:** This monthly encounter rate is paid whenever the clinic delivers at least one CCBHC service to a Medicaid beneficiary during the month.
  - Has the option of separate "special population" rates for people with certain conditions, to address their need for more costly services
  - Requires outlier payments made in addition to the PPS for participant costs above a state-defined threshold
  - Requires the state to establish a quality bonus program
- **PPS-3:** This rate is similar to PPS-1 but has at least one additional "special crisis services" PPS rate. States can develop up to three crisis service categories — definitions can be found either on CMS's website or in its 2024 PPS guidance.
- **PPS-4:** This rate is similar to PPS-2 but has at least one additional special crisis services PPS rate.

CMS's 2024 CCBHC Prospective Payment System Guidance includes a table that compares the required rate elements for the four different methodologies.

Figure 8
General PPS rate calculation

$$\frac{\text{Total Annual Allowable Costs [}\textit{Direct + Indirect + Anticipated}^{1}\text{]}}{\text{Total CCBHC Visits per Year}} = \textbf{Clinic PPS Rate}$$

1 Anticipated costs are not always included

3. PPS rates often appear extraordinarily high when compared to fee-for-service rates for the same service on the claim form. Why is that?

Several factors make it nearly impossible to compare one specific service rate to another.

First, the PPS rate is a bundled rate representing the costs of many different services, activities and components of clinic infrastructure. While a particular service may trigger the PPS payment, the rate represents more costs than just that one service.

Second, many providers see an increase in revenue when compared to their prior rates, but that is due to the insufficient rates that have long been paid to behavioral health providers. Since the PPS model is cost based, the rate reflects the actual cost of care delivery.

Third, CCBHCs typically offer an expanded set of services and take on new responsibilities required by certification or needed to improve care. The PPS rate is designed to cover the added staffing and costs associated with those functions

Fee-for-service and PPS rates are built on different assumptions and structures, so direct comparisons can create a misleading and overly simplified picture.

4. Missouri's PPS rate methodology was designed to help ensure that Medicaid covers its fair share of CCBHC Medicaid expenses. How was it developed?

- Under the typical methodology, the PPS rate is calculated by averaging all CCBHC costs across all CCBHC service visits:
  - The service costs include specialized services such as Assertive Community Treatment and peer support that are not typically a part of commercial insurance benefits, as well as more traditionally covered benefits such as counseling and medication management.
  - Since the traditional PPS rate is a simple, unadjusted average, the costs of those specialized (and often more costly) services are spread across both the Medicaid and non-Medicaid visits, regardless of which service type is provided to the beneficiary. In other words, the "rate" for both specialty and non-specialty services is the same.
  - Since only Medicaid beneficiaries typically have access to specialty services, but the costs for those services are spread to PPS rates for commercial visits, the Medicaid program is paying less for more costly services on average.
  - Since most non-Medicaid insurers do not pay the full PPS rate to CCBHCs, the clinic must absorb the difference between the PPS rate and what the non-Medicaid insurer pays.
- Missouri's blended PPS rate uses a "weighted average" or "weighted arithmetic mean" methodology.
  - After the original CMS cost report is prepared, it is then separated between what the state calls "specialty" and "non-specialty" visits. This results in a specialty services PPS rate and a non-specialty services PPS rate.
  - The cost reports include all costs and visits associated with the designated services, not just visits by Medicaid-only enrollees. The cost differentiation is based on service category and not on insurer.
  - Combined costs and visits for specialty and non-specialty services total the same as costs and services reflected in the original CMS cost report.
  - The weighted average between the specialty and non-specialty PPS rates is then calculated using a standard weighted arithmetic mean methodology. This calculation differs from ordinary arithmetic means because some data points (in this case, specialty services) are weighted more heavily than other data points (e.g., non-specialty services).
  - Weighted averages are commonly used in and outside of health care (e.g., National Committee for Quality Assurance health plan ratings weighted by measure categories, HEDIS measures weighted by population, capitation rates weighted by risk scores, and medical loss ratio calculations weighted by spending categories).
  - This weighted average becomes the CCBHC's PPS rate, before any adjustments for inflation. The weighted average PPS rate is higher than the simple average PPS rate. This approach to calculating the PPS rate ensures that Medicaid revenue can reasonably be expected to cover the cost of CCBHC specialty services provided to Medicaid enrollees.

APPENDIX B

MCO Finances Under a PPS Model

For managed care organizations (MCOs) to view Certified Community Behavioral Health Clinics (CCBHCs) as a sound business decision, they must have confidence that the model will not create unmanageable financial exposure. Many elements of this guidebook describe the operational conditions that enable CCBHCs to improve population health and reduce high-cost utilization (e.g., data sharing, clear expectations for care coordination). These benefits, however, generally accrue over the medium and long term — and some accrue primarily to states and communities rather than directly to health plans (e.g., reduced criminal justice involvement).

In contrast, the prospective payment system (PPS) model immediately increases outpatient payment rates, as PPS rates are designed to reflect the actual cost of delivering care. MCOs — nonprofit and for profit alike — therefore need assurance that the payment model is financially viable for them.

Initial capitation adjustments

The impact of CCBHC implementation on MCO revenue and risk depends on several factors:

- Whether CCBHC services are carved in or carved out of managed care
- Whether PPS payments are made directly by MCOs or through state wraparound payments
- The timing and frequency of the state's MCO capitation rate and CCBHC PPS rate adjustments
- The structure of benefits and rates prior to CCBHC implementation, including benefits the MCO otherwise manages outside of behavioral health
- Capitation rates must be reviewed and approved by the Centers for Medicare and Medicaid Services (CMS) as actuarially sound (42 CFR § 438.4). The agency's CCBHC PPS guidance reinforces this requirement by directing states to explain how CCBHC services are incorporated into MCO rates — including services already reflected in base data — and to ensure no duplication of payment (CMS, 2024).

PPS rates may be higher than MCOs' historic fee for service payments, reflecting the expanded scope of services provided by CCBHCs, the cost-based rate setting methodology and the nature of a bundled payment. If a state adjusts MCO capitation rates prior to CCBHC implementation to accommodate MCOs' obligation to pay the full PPS, the new rates will be sufficient to cover their PPS expenditures for the expected level of utilization reflected in CCBHCs' state-approved cost reports. Because risk based contracts in Medicaid programs typically include a small operating margin, this adjustment also produces a modest upward revenue effect for plans (Palmieri, 2025).

If the state does not rebase MCO capitation rates prior to CCBHC launch, three scenarios may occur:

1. MCOs pay PPS directly: MCOs might absorb any cost increases associated with paying the PPS until the next MCO capitation rate rebasing.

2. State carves CCBHC services out of managed care and pays clinics their PPS directly: MCO margins may increase temporarily by the amount they were paying to the CCBHC under fee-for-service, until the next MCO capitation rebasing.

3. MCOs pay for CCBHC services according to their prior fee schedule, while the state makes wraparound payments to bring CCBHCs up to the level of their PPS: MCOs may see little change in revenue or per-procedure payments, but they may absorb utilization driven cost increases from expanded outpatient access and the administrative costs associated with CCBHC reporting and state required collaboration.

Recalculating MCO capitation payments after initial launch

The frequency of CCBHC PPS and MCO capitation rate rebasing after CCBHC launch is a critical consideration. Because rate setting is inherently forward looking, any divergence from projected utilization, client acuity or Medicaid enrollment can create misalignment between actual costs and revenue in a given year. These variances can temporarily put either clinics or MCOs at a financial disadvantage — or advantage.

CMS requires states to update CCBHC PPS rates annually, either by applying the Medicare Economic Index or by recalculating rates using prior-year cost and visit data from CCBHC cost reports. In addition, all CCBHC PPS rates must be fully rebased using cost report data at least once every three years.

Some states have opted to rebase CCBHC PPS rates more frequently, particularly during the early years of program implementation when systems are still stabilizing. More frequent rebasing can allow states to recalibrate both PPS and managed care capitation rates in a timely manner. On the other hand, some states have chosen to refrain from rebasing until later years, noting that cost, hiring and utilization data from the early implementation years may not be representative of ongoing experiences and therefore may not result in a sustainable rate.

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