NATIONAL COUNCIL *for* Mental Wellbeing

Building Financial Resilience: Independent Practice Associations as a Strategy for CCBHCs

SEPTEMBER 2026

CCBHC-E National Training & Technical Assistance Center

Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing

This publication was made possible by Grant Number 1H79SM085856 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views, opinions or policies of SAMHSA or the U.S. Department of Health and Human Services (HHS).

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This toolkit was developed in 2026 by Third Horizon in partnership with the National Council for Mental Wellbeing's Certified Community Behavioral Health Clinic (CCBHC)-Expansion Grantee National Training and Technical Assistance Center. It reflects the requirements outlined in SAMHSA's updated CCBHC Certification Criteria.

The National Council for Mental Wellbeing is especially grateful to the following people for their input, feedback and support in the development of this toolkit.

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Introduction

This technical assistance guide, developed by Third Horizon, examines how Independent Practice Associations (IPAs) are designed to support Certified Community Behavioral Health Clinics (CCBHCs) as they pursue long-term sustainability and a stronger payer strategy. Third Horizon conducted a literature review, researched known IPA-type structures, and completed key informant interviews with behavioral health networks in New York, Minnesota, Missouri, Kansas, and Oklahoma. The guide focuses on how these entities were formed, how they are structured and staffed, what they have accomplished to date, and what lessons they offer for CCBHCs considering a similar approach.

As clinics work to sustain the CCBHC model and adapt to changing Medicaid eligibility, financing structures, and other rule changes, many may look for ways to expand contracting opportunities, strengthen rate negotiations, and pursue alternative payment models with Medicaid managed care organizations and commercial carriers. For CCBHCs, an IPA offers one possible path to build the negotiating leverage needed to operate more effectively in a rapidly changing market.

However, IPAs must also plan for sustainability and have the necessary infrastructure to ensure success.

What is an IPA?

An IPA is a legal business entity formed by independent clinicians or provider organizations to collectively negotiate contracts with insurers, manage care, and/or share administrative resources while retaining their practices. IPAs offer a formal structure that allows provider organizations to act collectively for selected business, clinical, and operational purposes while remaining separate organizations.

An IPA is not a new concept in health care. IPA models have been used for decades in medical provider settings to help independent organizations contract collectively, share infrastructure, and strengthen their market position. According to the research,12 IPAs have supported smaller primary care practices in improving care management and outcomes for patients with chronic disease while providing a vehicle for entry into alternative payment models.

In behavioral health, guidance from New York State3 describes Behavioral Health IPAs as newer provider networks developed to help community behavioral health organizations prepare for value-based payment and use shared data to improve quality and value.

An IPA differs from a clinically integrated network (CIN). An IPA is primarily a legal and contracting vehicle that allows independent providers to negotiate with payers, share infrastructure, and preserve ownership. A CIN, by contrast, reflects deeper clinical alignment and is the specific organizing structure that providers join when they form an accountable care organization (ACO).

In the CCBHC context, IPAs can support collective payer negotiation, shared data and analytics, quality improvement, care model alignment, and network-wide infrastructure that individual clinics may struggle to build on their own. The case studies compiled for this guide vary in structure. Some are standalone nonprofits, some operate as subsidiaries of a state association, and some are joint ventures between behavioral health and primary care associations.

For CCBHCs, the strategic appeal of an IPA is scale. A single clinic may perform well clinically but still lack enough attributed lives to gain leverage with Medicaid managed care organizations or commercial plans. By aggregating attributed lives, quality performance, and infrastructure, an IPA can make behavioral health providers more visible and more credible to payers. In one New York example, leaders noted that plans often will not negotiate with organizations serving fewer than 10,000 patients, which makes coming together with other providers essential in some markets.

An IPA is more than a contracting shell. The more durable models pair contracting with shared infrastructure, especially data, quality, operations, and network management. Payers are more likely to engage when a network can demonstrate not only collective size, but also the ability to measure performance, manage populations, and improve outcomes across beneficiaries.

Potential Benefits for CCBHCs

An IPA creates greater negotiating leverage. IPAs can convert a set of smaller behavioral health providers into a network with enough patient volume and market presence to command payer attention. This may be beneficial for value-based payment arrangements, stronger rate discussions, per-member-per-month (PMPM) care coordination payments, and other hybrid payment approaches. In Kansas, for example, CCBHCs have successfully negotiated a PMPM with Medicaid Managed Care Organizations that complements the CCBHC PPS.

A second major benefit is a shared data and analytics infrastructure. Across the case studies, shared data capacity emerged as one of the strongest reasons to form an IPA. New York-based Value Network built dashboards using multiple external and partner data sources. Convergence Integrated Care developed a shared data warehouse and reporting groups aligned to electronic medical record platforms. Missouri Health Plus relied on recurring scorecards and payer-supplied reports that helped clinics identify care gaps and improve performance. In Oklahoma, participants described data and technology as a core benefit.

IPAs can also provide a stronger platform for quality improvement and clinical integration. This is a natural fit for CCBHCs because they already operate with stronger reporting, quality, and accountability requirements than many other behavioral health providers. Minnesota participants described CCBHCs as especially strong IPA participants for that reason. A network can build on that base by aligning measures, standardizing workflows, and making a credible case to payers that behavioral health providers can succeed in alternative payment arrangements by providing outcomes data. CCBHCs also serve patients with complex needs, requiring clinics to have strong care management capabilities.

Another benefit is operational or "back office" support. In the examples reviewed, IPA participation helped members address credentialing and payment issues, receive technical assistance, access shared tools, and participate in more structured payer-provider communication. In some models, the most important financial value accrued at the network level and was reinvested in the IPA shared infrastructure (e.g., data systems, staffing) rather than paid directly to member clinics. That may still be a meaningful advantage for CCBHCs if the network strengthens payer readiness and operational performance over time.

The Kansas case study shows that IPAs can benefit providers, but they also benefit payers by simplifying contracting, supporting network adequacy, and providing a vehicle for care coordination and quality reporting.

Finally, some IPAs can diversify revenue and partnership opportunities. For example, Value Network combined value-based contracts, dues, grants, and other contracts to support staffing and infrastructure. It created a separate 501(c)(3) entity, Value Network Inc. (VN), to complement VN IPA's work and make it eligible to apply for grants to support regional efforts that benefit its members and partners through training, data analytics, and other services.

Implementation Considerations

While an IPA structure has the potential to benefit CCBHCs, there are also important considerations, particularly the need for real infrastructure before they can deliver value. Successful models required staffing, governance, legal agreements, data-sharing capacity, and sustained operational attention. Missouri's experience suggests that this work cannot be managed as a side project; dedicated staffing is required to accomplish it. Oklahoma's earlier effort struggled because behavioral health organizations lacked the capital, back-end systems, and payer experience needed to establish the model on their own.

For CCBHCs, the Medicaid PPS creates both opportunity and complexity. Some IPA arrangements can result in payments that are separate and in addition to PPS, as both Kansas and Missouri examples suggest. In other settings, the practical value may be less about direct contract revenue and more about shared infrastructure, quality support, and improved negotiating position. According to Value Network, one of the Medicaid MCOs does not include CCBHCs in its value-based payment arrangement because it does not have CCBHC data in its system, as the state pays the CCBHC PPS directly. Value Network continues to advocate for a focus on the benefits CCBHCs offer since they save on the MCO's total cost of care.

Membership requirements can also limit participation. Minnesota's IPA required active data-sharing, accountability for network objectives, and participation in shared tools and workflows. Some organizations dropped out because they could not consistently submit data. In Oklahoma, some organizations left because they could not afford dues. Omnes, a New York-based IPA, raised a related concern that dues structures can unintentionally disadvantage smaller organizations if they are not carefully designed to ensure appropriate return on investment.

Governance design matters as well. Missouri and Oklahoma show that representation can shape whether behavioral health organizations feel adequately represented. Oklahoma's tiered structure gave behavioral health organizations one collective board seat, while FQHCs held the majority because of their greater size and billing volume. That arrangement created access to stronger infrastructure, but it also limited behavioral health influence over the network.

A final consideration is sustainability. Several interviewees emphasized that value-based payment is only one possible revenue lane. Omnes described value-based contracting as necessary, but not sufficient on its own. The broader lesson is that an IPA may need to show value through data, operational support, and payer relationships before direct contract revenue becomes significant.

Case Study Findings

Value Network, Western New York

Value Network was founded in 2017 by the CEOs of four large behavioral health agencies in Western New York: BestSelf Behavioral Health, Endeavor Health Services, Horizon Health Services, and Spectrum Health and Human Services. All four founding agencies are CCBHCs. The network grew from New York State's behavioral health value-based payment readiness initiative, which funded behavioral health collaboratives and IPA-type entities to help organizations build infrastructure and prepare for value-based payment.

Value Network was formed because the founders believed behavioral health organizations lacked negotiating power in a market dominated by hospitals and primary care. The IPA gave them enough scale to approach payers as a serious network rather than as separate agencies. It also created a platform for shared data, quality infrastructure, and business development. The founding agencies recruited more than 55 partners and affiliates, which expanded the network's reach and made the model more compelling to payers.

The network's staffing model is well developed. It operates with 6.2 full-time equivalents, including a chief executive officer, a director of clinical quality, a director of data analytics and infrastructure, and a director of operations, along with additional part-time support for population health work and partner relations. Its membership model has three tiers: four lead partners, network partner members, and affiliate members. Network partners are behavioral health organizations with billable services, including peer-run agencies. Affiliate members include housing agencies, hospitals, primary care IPAs, prevention agencies, and perinatal service organizations. Members pay dues, and dues are one of four stated revenue streams, alongside value-based contracts, grants, and other contracts.

Outcomes to date are notable. Value Network secured a flagship contract with Highmark Blue Cross Blue Shield of Western New York for Medicare Advantage and commercial populations. The arrangement includes pay-for-performance HEDIS measures, utilization metrics, and a high-risk management program. The organization also reported four value-based contracts overall and highlighted measurable savings in emergency department use and inpatient hospitalization for the Highmark program. At the same time, its strongest success has come in Medicare Advantage and commercial business rather than Medicaid.

Value Network's challenges are also instructive. Leaders described ongoing difficulty in including CCBHC patients in Medicaid value-based contracts due to data flow issues and payer concerns about PPS. Those barriers have not been fully resolved. The case nonetheless offers several lessons for other communities. A behavioral health IPA needs scale, but scale without infrastructure will not be enough. IPAs should provide sophisticated data management and leadership to help organizations demonstrate their value proposition, report on quality measures, and improve performance. Payer engagement requires persistence, and diversified revenue is more durable than reliance on a single contract.

Missouri Health Plus, Missouri

Missouri Health Plus reflects a different model. Around 2021, the Missouri Behavioral Health Council (MOBHC) and the Missouri Primary Care Association developed a joint IPA to support CCBHCs and FQHCs in pursuing value-based arrangements with managed care organizations. The IPA is a separately incorporated nonprofit, but it operates with oversight from both sponsoring associations rather than as a fully independent subsidiary. That structure grew from a long-standing relationship between the two associations, rooted in behavioral health and primary care integration work.

This case shows how much existing trust can matter. Missouri Health Plus did not emerge from a newly assembled coalition. It grew from a partnership that already existed and already had a reason to work together. That foundation appears to have helped the organizations develop a workable operating model and sustain it with relatively lean staffing. The IPA is staffed primarily by one dedicated payer-relations staff person, employed by the primary care association, with additional leadership and support provided in kind by both associations.

Its membership includes both CCBHCs and FQHCs under one umbrella, although the behavioral health and primary care payer arrangements are separate due to the complexities of their respective PPS payment models.

According to Natalie Cook, Senior Vice President for Health Technology for MOBHC, the primary VBP arrangement Missouri Health Plus has in place is with UnitedHealthcare and Optum, and it focuses on Medicaid managed care. Importantly, the arrangement sits atop PPS for CCBHCs. The payment model is primarily pay-for-performance, with one incentive tied to follow-up after hospitalization that functions more like a fixed payment per qualifying individual than a traditional shared-savings arrangement. Organizations receive scorecards and reports, participate in quarterly review meetings, and use the data to identify care gaps and improve performance. Cook emphasized that timely access to payer-supplied data was a major factor in the model's success.

Reported outcomes are meaningful. Missouri Health Plus created a recurring structure for payer-organization dialogue. Organizations reportedly became more comfortable with the data, improved selected measures, and benefited from stronger communication with the payer. The case suggests that a clear payer-facing lead, disciplined data-review routines, and sufficient institutional support from sponsoring organizations are essential to the success of an IPA.

Wheat State Healthcare Inc. IPA, Formed by the Kansas Association of Community Mental Health Centers

Kansas Association of Community Mental Health Centers leaders formed the IPA as a result of a state change to managed care that carved all populations into much larger Medicaid managed care contracts. They saw managed care organizations retaining a significant administrative fee for care coordination. Community mental health centers and CCBHCs believed they could perform that function more directly, at lower administrative cost, and with stronger clinical accountability.

Kansas IPA

The Kansas Association of Community Mental Health Centers owns the IPA. All members of the association agreed to participate and made a financial commitment. The model allows organizations to retain local ownership and governance while creating a shared platform for collective contracting, data and quality infrastructure. The IPA structure simplifies payer and partner engagement.

The primary value-based arrangement for the Kansas IPA is with Medicaid managed care organizations. Wheat State Healthcare has used a variety of value-based payment methodologies, including per-member-per-month payments, post-hospital discharge follow-up, data reporting and quality measurement. The arrangement is separate from the CCBHC PPS and separate from any previous FFS arrangements prior to CCBHC. Financial incentives accrue first to the IPA, which then distributes funds proportionally to the members. Models have focused on upside opportunity rather than downside risk-bearing contracts.

The arrangement also changed how members think about their role in the market. Participation shifted organizations from a primarily mission-driven to a more performance-driven posture. The IPA gave payers a single contracting counterpart rather than requiring contracts with 25 separate entities. When the State of Kansas needed a network of behavioral health organizations to quickly and effectively respond to settlement agreements, the IPA offered that cohort.

The Kansas model offers a clear payer value proposition. For health plans, the IPA creates access to a turnkey behavioral health network, supports network adequacy, enables care coordination through clinically aligned programs and simplifies contracting and administration.

While maintaining organizational autonomy makes the model attractive to members, it also creates some implementation challenges. Members use different data systems, electronic health records, IT tools and protocols. Data integration, therefore, required more time and planning than participants initially expected. The Kansas lesson is practical. Start small, pilot the model, show results, build trusted payer relationships and then expand the arrangement.

For CCBHCs, the IPA has proven beneficial in providing advanced collective data infrastructure, securing Medicaid MCO value-based contracts, contracting with the State and providing opportunities for joint contracting with vendors. It also suggests a future commercial opportunity. Kansas leaders are interested in offering commercial plans access to CCBHC services that commercial members may not currently receive, such as peer support, while using CCBHC quality measurement findings to demonstrate value.

Convergence Integrated Care, Minnesota

Convergence Integrated Care, or CIC, is the IPA subsidiary of the Minnesota Association of Community Mental Health Programs. It was created so that like-minded organizations could negotiate together for more favorable rates, and its first contract was with Minnesota's Integrated Health Partnerships, a state-based Accountable Care Organization model4. CIC operates as a subsidiary under the umbrella association while continuing to function distinctly.

The network's members are 14 independent nonprofit community behavioral health agencies across Minnesota, a subset of MACMHP's 36 association members. Participation requires member agreements, governance documents, data-sharing and privacy expectations, accountability for value-based arrangement requirements, use of shared Health-Related Social Needs approaches and active data submission.

CIC's staffing model is lean and shared. Gladys Chuy, Chief Operating Officer for MACMHP, leads the work for CIC. She and Parker Lewis, Population Health Director, split time across MACMHP and CIC, and an intern also supports both entities. This staffing structure reflects CIC's broader model. The organization uses an innovative approach to support members. It grouped participating organizations by readiness, staffing capacity and systems. It also created reporting groups aligned with the main electronic medical record platforms, ensuring operations and reporting remained aligned.

Outcomes to date are more operational than financial. The main secured arrangement is the Integrated Health Partnership with the state. Under that arrangement, CIC receives claims data; Admission, Discharge, and Transfer (ADT) data access; and Healthcare Effectiveness Data and Information Set (HEDIS)-related information that can be used to generate clinic-level and network-level insights. The financial benefit to member clinics is largely indirect. CIC explained that IHP-related funds remain with the IPA to support shared infrastructure and services, such as the data warehouse, health-related social needs tools, technical assistance and data insights, rather than flowing directly to clinics.

The strongest lesson from Minnesota is that readiness varies widely, and IPA leadership must plan for that from the start. Some organizations dropped out because they lacked the infrastructure to consistently submit data. CIC responded by using readiness-based cohorts, engaging staff involved in quality improvement and reporting, and defining clear accountability expectations. For other communities, CIC shows that an IPA can create meaningful value for CCBHCs even before major external payment gains emerge, if it builds shared infrastructure that improves performance and prepares members for future contracting.

Omnes Health IPA, New York

Omnes offers a case study in affiliation and strategic repositioning. The current organization emerged when two New York behavioral health Independent Practice Associations, Omnes and Northwinds, came together. Both began as Behavioral Health Care Collaboratives (BHCCs) in 2017, a model created by the New York State Office of Mental Health to help behavioral health organizations build the infrastructure needed to participate in value-based payment arrangements. Over time, BHCCs were restructured into Behavioral Health IPAs. Direct state funding for BH IPAs has since been discontinued, putting smaller networks in jeopardy. Of approximately 22 BHCCs formed in 2017, roughly 15 remain, and further consolidation is expected. Omnes and Northwinds responded by combining complementary strengths to build toward a more sustainable model.

The rationale was strategic. Northwinds brought depth in contracting, legal structure, quality improvement, data science and risk arrangements, along with a broad rural network. Omnes contributed

stronger technology capacity and infrastructure. The newly combined organization now operates as both a nonprofit IPA (Omnes IPA, Inc.) and a for-profit management services organization (Omnes MSO, LLC), a structure that developed out of the affiliation and reflects the dual nature of the organization's work. The network includes 36 member organizations (including eight members with CCBHC designations), across 34 New York counties from the Canadian border to Pennsylvania, serving roughly 80,000 people annually. Enrico Cullen, the CEO, describes the organization as explicitly business-focused, with core functions in clinical quality, technology and data, and negotiation and contracting strategy.

Omnes has a small permanent staff, but its operating budget — roughly $1 million annually — reflects a deliberate investment approach rather than minimal capacity. A substantial share of spending goes to contracted data science and technology experts who function as core operational capacity. Membership is tiered and composed mostly of community-based behavioral health organizations, with FQHC Look-Alike participation expanding the population served and strengthening attribution with payers. The organization has moved away from a dues-based funding model, in part out of concern that earlier structures disadvantaged smaller members, and is developing a more equitable and sustainable revenue approach.

The organization's clinical performance has been consistently strong. Member organizations have met quality metrics across initiatives, including hospital discharge planning and HEDIS measure obligations. Northwinds maintained a Level 2 risk arrangement with a managed care organization for four years, during which the network demonstrated it could manage financial risk without incurring losses — a meaningful validation of its capabilities. That contract included an interesting sub-attribution model through a primary care ACO. When Omnes and Northwinds teamed up, the combined network's size and geographic footprint made the existing contract structure no longer viable, and it is currently being restructured and renegotiated. The central challenge for Omnes, as for most BH IPAs, has not been clinical performance but financial sustainability. The organization has relied primarily on state funding, grants and modest shared savings — a foundation that is no longer reliable as direct state support ends. The strategic work ahead is building the revenue model to match the network's demonstrated capabilities.

Oklahoma Provider Network Experience

Oklahoma offers a useful counterpoint because its experience was more mixed, showing where IPA-type efforts can stall. Behavioral health providers and FQHCs initially attempted to form a provider-led managed care entity or IPA. That effort failed because the group lacked key infrastructure such as billing, credentialing, and back-end systems, faced high consultant costs, and ran out of capital. Providers later pivoted into Patient Care Network of Oklahoma, or PCNOK, which is led and staffed by the Primary Care Association (PCA).

PCNOK includes FQHCs and a small number of behavioral health and substance use disorder providers. It is not exclusively a CCBHC network. At the time of the interview, the behavioral health side had narrowed to three to four participating providers, including one standalone CCBHC and two specialty

substance use disorder providers. Another CCBHC participated through a merger with an FQHC. Some behavioral health providers had stopped participating due to a perceived insufficient return on investment. The PCA staffs the network and absorbs operational costs, rather than hiring a separate dedicated team.

Membership dues are based on organization size and billing, and the governance structure is tiered accordingly. Behavioral health providers collectively hold one board seat, while FQHCs hold the majority due to their greater scale. Several behavioral health organizations left because they could not afford dues or lacked sufficient internal capacity to benefit fully from participation.

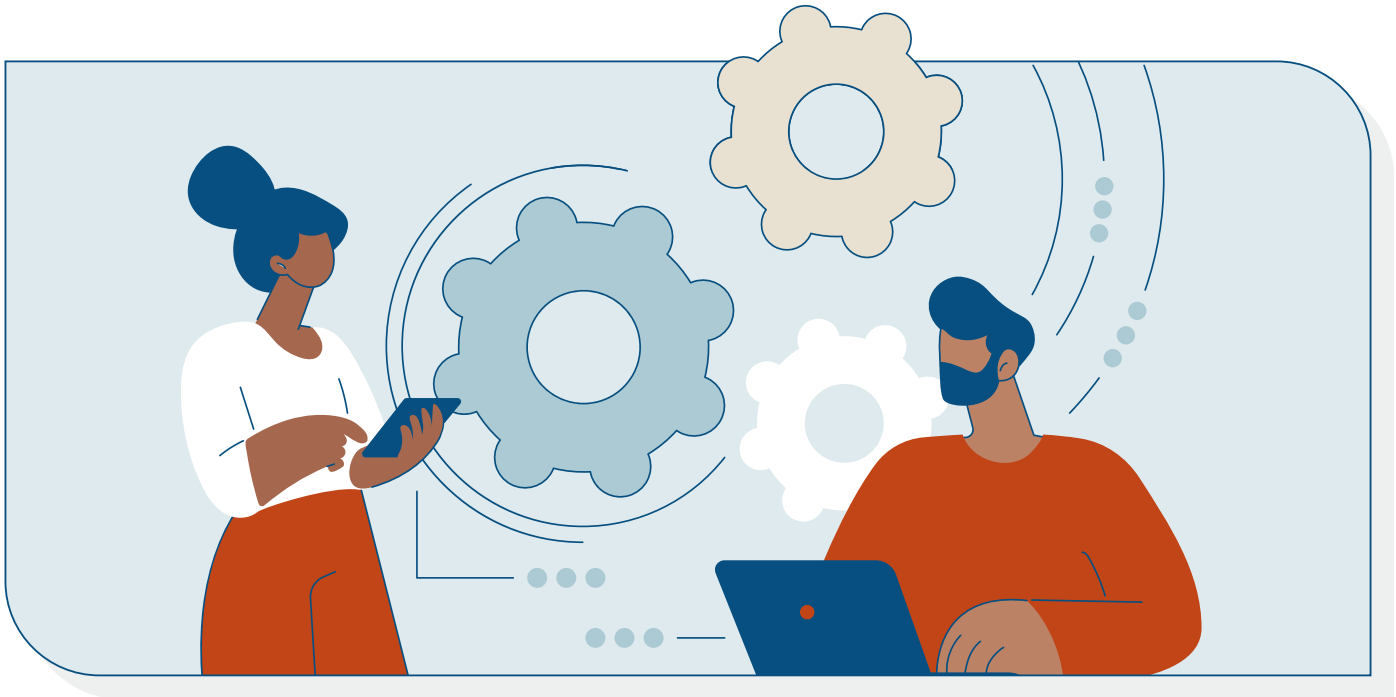
Even with those limitations, the network produced some benefits. Participating providers received some value-based payments on top of PPS, saw faster resolution of credentialing and payment issues, and gained access to a stronger network for data and technology. The most significant benefit may have been relational. Oklahoma described new partnerships between behavioral health organizations and FQHCs, including co-located services. The case suggests that for some communities, the most practical path may be a partnership with a stronger existing network rather than building a behavioral health IPA from scratch.

Conclusion

The case studies in this guide suggest that an IPA can offer CCBHCs a practical vehicle for building scale, shared infrastructure, and stronger payer engagement, but only when the model rests on a clear operational foundation. Across the examples, the most durable IPA-type structures did more than negotiate contracts. They invested in data systems, quality improvement, care model alignment, and network management. They also depended on dedicated staffing, deliberate governance, and a value proposition that members could see in day-to-day operations, not only in the possibility of future shared savings.

The broader implication is that behavioral health IPAs remain an emerging model, not a standardized one. Their usefulness will vary by state policy, PPS design, payer readiness, provider capacity, and the broader Medicaid and commercial market context. For many CCBHCs, the near-term value may lie less in immediate new revenue and more in creating the capabilities needed to negotiate effectively with Medicaid managed care organizations and commercial carriers, demonstrate performance, and adapt to a changing policy environment. Communities considering this approach should view IPA development as a strategic investment in infrastructure, alignment, and payer readiness.

The case studies demonstrate that IPAs are a promising, if not yet fully proven, strategy to support CCBHCs with sustainability. CCBHCs considering an IPA should begin with a focused pilot, prove value with data, build payer trust, and expand only when governance, staffing, and revenue models can support the network over time.



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