



EMORY | ROLLINS SCHOOL OF PUBLIC HEALTH

Community Service Board Research Project: CCBHC Model

Literature Review

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Introduction

In recent years, the importance of accessible, high-quality mental health care has taken on new urgency. The COVID-19 pandemic exposed and exacerbated long-standing gaps in behavioral health systems, leading to an increased demand amid a shrinking workforce. Additionally, recent political administration policies and priorities pose a large threat to the longevity of behavioral health care systems. To navigate these administrative shifts and sustain access to behavioral health services, it is essential to explore the evolving landscape of mental health service models, payment systems, and policy initiatives. Doing so can inform strategies for having a more resilient, equitable, and responsive behavioral health infrastructure. One model that has emerged as a central strategy in addressing these systematic gaps is the Certified Community Behavioral Health Clinic (CCBHC) model. To understand its relevance today, it is important to examine the origins and the evolution of CCBHCs as a federally supported initiative.

National History of CCBHC Model

In 2014, the Protecting Access to Medicare Act (PAMA) authorized the creation of CCBHC Certification Criteria and established the CCBHC Medicaid Demonstration to improve access to comprehensive and coordinated mental health and substance use care.¹ PAMA provided guidelines for program requirements, scope of services, quality and reporting, and organizational authority.² In 2015, SAMHSA and the Centers for Medicare and Medical Services (CMS) released the CCBHC Certification Criteria and the Prospective Payment System (PPS) guidance for CCBHCs, launching planning grants to 24 states.¹ The following year (2016), SAMHSA selected eight states to participate in the CCBHC Medicaid Demonstration (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania), while Texas pursued its own state-led initiative to establish CCBHCs.^{1,3} The demonstration officially launched in 2017, with the selected states establishing a total of 67 CCBHCs.⁴ During this time, the U.S Department of Health & Human Services (HHS) Office of the Assistant Secretary for Planning & Evaluation (ASPE) began evaluating implementation and impact.¹

In 2019, ASPE published the first federal annual evaluation report on the CCBHC Medicaid Demonstration.¹ Congress subsequently expanded the time frame of the original 8-state demonstration, allocating \$150 million to support additional CCBHC expansion grants and continue funding to four years.¹ SAMHSA created two grant tracks: 1) Planning, Development and Implementation (PDI) for new CCBHCs, and 2) Improvement and Advancement (IA) for expanding existing CCBHCs.⁵ By 2022, the bipartisan Safer Communities Act had facilitated the model's expansion to additional states. In 2024, Congress made CCBHC services a permanent Medicaid option through the Consolidated Appropriations Act along with updated payment guidance.¹

The CCBHC model is jointly overseen by SAMHSA, CMS, and ASPE.¹ SAMHSA leads administration of planning grants, certification criteria, and quality measures; CMS handles PPS, cost reporting, and Medicaid reimbursements; and ASPE evaluates the

implementation, develops annual reports to Congress, and conducts ongoing analysis to assess the program's impact.¹ As the CCBHC model expands across states, a standardized structure of the model is followed.

The CCBHCs model stands out as a premier example of integrated care, combining health, mental health, and social services to improve access for vulnerable populations.⁶ This model incorporates the latest advancements in chronic care management to provide a broad spectrum of evidence-based treatments and recovery supports, regardless of an individual's financial situation.⁷ Many states have turned to this model in recent years, and early results are promising. CCBHCs are specially designated clinics that provide a comprehensive range of mental health and substance use services across the life span. To meet the criteria, they must provide nine essential services either directly or through formal partnerships including. See **Figure 1**.^{2,3,8} Today, there are 495 CCBHCs across 46 states offering services in 40% of all counties throughout the nation.⁹

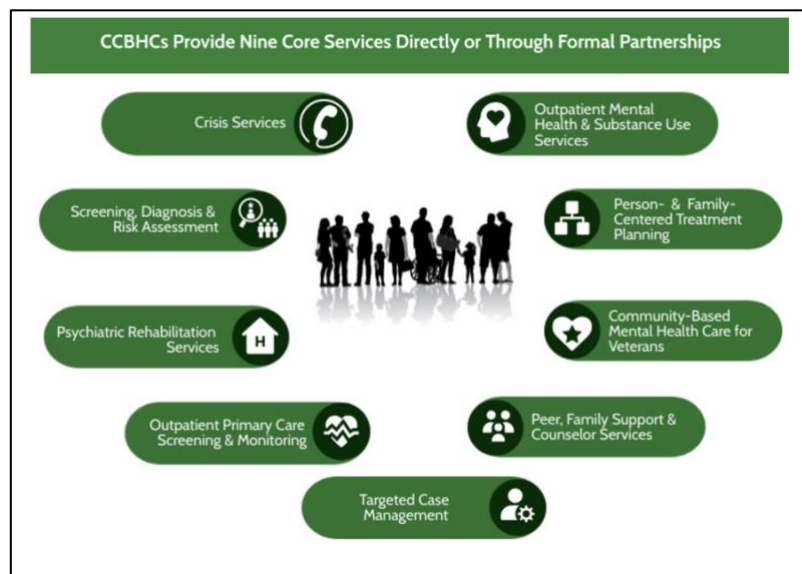


Figure 1: Retrieved from Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria- March 2023

Evidence of Impact: Six key benefits and outcomes of the CCBHC Model

Beyond simply meeting service requirements, CCBHCs have demonstrated at least six measurable improvements in access, outcomes, and operational capacity. *First*, organizations with existing CCBHC designations have enhanced their operational capacity and are more likely to offer integrated services such as Assertive Case Management (ACT), peer coaching, psychiatric crisis services and primary care coordination compared to Community Mental Health Clinics (CMHCs).⁶ *Second*, CCBHCs also report increased patient volume and improved access among youth, individuals without insurance, and

those without prior outpatient care⁹. *Third*, becoming a CCBHC also enables an entity to expand the crisis continuum directly or through partnerships with the 988-crisis hotline and mobile crisis response teams, especially in rural areas.⁹ *Fourth*, clinics report increased patient volume due to access gains among Medicaid CCBHCs, alleviating the behavioral workforce shortage, better collaboration with criminal justice agencies, and providing services on site like schools, and reductions in Emergency Department and law enforcement usage⁹. *Fifth*, this model incorporates financial sustainability through Enhanced Federal Medical Assistance Percentage (E-FMAP)¹⁰ reimbursement and cost-based Prospective Payment Systems (PPS) to support clinics' broader service needs.³ With this new payment system, CCBHCs have more resources to reinvest in their workforce, increase salaries, and expand services.⁹ Nationwide, there has been a long-running shortage of mental health professionals. However, using the PPS system enables CCBHCs to invest money into building a stronger workforce to recruit highly qualified staff and create new positions. *Lastly*, expanded access to substance use care has shown improved SUD engagement and outcomes.⁹

Georgia's Transition from CSBs to CCBHCs

Georgia is currently in the early stages of transitioning from its current Community Service Board (CSB) model to the CCBHC model. This presents a valuable opportunity to apply lessons learned from other states and examine how this transformation could strengthen Georgia's behavioral health infrastructure.

Georgia CSBs were established in 1994 to provide services for individuals with serious mental illness, intellectual/developmental disabilities, and/or substance use disorders.¹¹ There are 21 CSBs across the state, serving all 159 counties.¹¹ Together, they form Georgia's behavioral health safety net, delivering services across the lifespan from birth to death, regardless of ability to pay. The CSBs in Georgia provide a comprehensive continuum of behavioral health services ranging from intensive crisis stabilization and detoxification to less-intensive outpatient counseling, residential treatment, peer support services, and more.¹¹ CSBs also can assist with psychosocial services such as, supported employment, day programs, and supportive housing.¹¹ With the rising mental health needs and recent policy changes, these services are more essential than ever.

In 2023, Georgia was awarded a SAMHSA Planning Grant to begin its transition to the CCBHC model.¹² While there are no fully certified CCBHCs in Georgia yet, twelve CSBs are participating in the three-phase transition. Seven CSBs are in Phase 1 and five are in Phase 2. Phase 1 focuses on certification planning, allocating resources to develop a work plan, and conducting a community needs assessment to guide service delivery.¹³ Phase 2 involves implementation, including the integration of physical healthcare services, revising policies and procedures to align with the model, and hiring staff to increase organizational capacity.¹³ Phase 3 reflects the final certification phase through the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD).¹³ DBHDD and the Georgia Association of Community Service Boards (GACSB) are working to transition all CSBs into fully designated CCBHCs over the next several years.

The CCBHC model can potentially help address persistent challenges facing Georgia's CSBs, such as workforce shortages, limited transportation access, and funding constraints. However, the transition process is lengthy and complex, involving planning, development, and implementation. Given the complexity and potential of this transition, it is essential to draw from national evidence and lessons learned. In response, a team from Emory University's Rollins School of Public Health conducted a literature review to support Georgia's planning efforts.

Purpose and Scope of Literature Review

At the request of DBHDD and GACSB, this literature review aims to provide a clear summary of CCBHC model, review evidence of its impact across the U.S., highlight lessons learned from other states, and guide Georgia through the implementing process. These findings are intended to support Georgia's transition while informing broader efforts to establish a more equitable, accessible, and sustainable.

Comparison of Behavioral Health Facility Models

Several models exist for delivering behavioral health services, each with varying scopes, access requirements, and funding structures. **Table 1** highlights how CCBHCs compare to more traditional facility-based models like Community Mental Health Centers (CMHC), Federally Qualified Health Centers (FQHC), Community Service Boards (CSB), and Integrated Behavioral Health (IBH) programs.

Table 1: Comparison of Behavioral Health Facility-based Models					
Category	CCBHC^{5, 6, 14-17}	CMHC^{8, 16, 17}	FQHC¹⁴	CSB¹¹	IBH^{16,18}
Scope of Services	Offer 9 core behavioral health services, including 24/7 crisis care, mobile crisis care, MAT, primary care screening, care coordination, and peer/family support.	Outpatient mental health services, case management	Preventive health, dental, mental health and substance abuse, transportation services as needed, hospital and specialty care	Varies; often includes outpatient therapy, case management, and crisis intervention but not always all CCBHC-required services.	Usually provides select services (e.g., therapy, SUD treatment); often narrower in scope.
Access Requirements	Must offer same-day access and serve anyone regardless of ability to pay.	None	Must serve all, sliding scale required	Often prioritizes Medicaid/uninsured; waitlists are common.	Medicaid/Medicare
Crisis Services	24/7 mobile crisis and walk-in crisis response required.	Some have crisis services, but not all.	Sometimes, may refer out.	Often provides crisis services, but not 24/7 or not mobile.	Not typically required or available.
Funding Model	Uses a Prospective Payment System (PPS) cost-based per-day or per-month Medicaid payments.	Fee-for-service and grants.	PPS (Medicare/Medicaid) based on visits	Mainly fee-for-service, supplemented by state/county contracts and grants.	Usually fee-for-service and grant funded.
Certification/Oversight	Must meet federal SAMHSA standards and undergo regular certification.	State licensed	HRSA certified, annual site visits	Licensed and overseen by state agencies or local governments.	Licensed by state; less standardized oversight nationally.
Quality Reporting	Required to report standardized quality and performance metrics.	Varies by state and funding requirements.	Uniform Data System through HRSA	Some reporting required but depends on state or contract.	Reporting usually linked to insurance or grant requirements.
Target Population	Open to all, including uninsured	Low-income, public insurance	Rural/low-income populations	Primarily serves low-income or Medicaid populations.	Medicaid/Medicare recipients with moderate to severe mental health conditions and SUD

Alternative Models to CCBHCs

Several alternative models of care delivery for behavioral health have been developed to prioritize flexibility, integration with physical health services, and innovative care coordination strategies. Examples include the use of Section 1115 Medicaid waivers, behavioral health homes, and integrated care pilots within primary care settings. The 1115 Medicaid Waiver allows states to experiment with customized care and payment model, such as California's CalAIM Initiative.¹⁹ Behavioral health homes emphasize the coordination of behavioral, physical, and social services for high-need individuals, often under a designated provider or a team of health providers.²⁰ Integrated care programs, such as the Collaborative Care Model, aim to integrate mental health into primary care settings through co-location or coordinated care structures.²¹ While these models represent promising steps toward more holistic and accessible behavioral health care, they typically lack the comprehensive service requirements that define the CCBHC model.¹⁷ As a result, CCBHCs have been increasing nationally with the support of federal funding.

State Behavioral Health Models and the National Expansion of CCBHCs

Across the nation, states have adopted varied approaches to organizing and financing behavioral health systems. Each state employs a unique combination of models, evidence-based practices, and oversight structures to address the mental health and substance use needs of its population. For example, states like Washington transitioned to integrated care models early on merging physical, mental health, and substance use disorder services under managed care through state legislation in 2014 due to Senate Bill 6312.²² Other states, including Oregon, Montana, Delaware, and Mississippi have followed similar paths toward integrated behavioral health systems.²³⁻²⁶ In contrast, states such as Arizona and Nebraska use regional behavioral health agreements,^{27, 28} while Idaho has granted centralized contracts to specific health systems to manage behavioral health services from inpatient to outpatient.²⁹ Persistent challenges such as provider shortages, service fragmentation, and rising demand have led many states to explore new models. However, these varying models reflect a shared goal: delivering accessible, coordinated care that improves outcomes and reduces costs.

The CCBHC model is now being expanded nationally as one of the most significant and fast-growing behavioral health models. Clinics operating under a Medicaid demonstration project, a CCBHC State Plan Amendment, or another form of Medicaid authority are officially certified by their states as meeting all federal CCBHC standards.^{4,9} In return, these clinics receive Medicaid reimbursement rates that more accurately reflect the true cost of care. Others are in the early stages of development, supported by SAMHSA expansion grants or state funding to begin planning for CCBHC.⁹ This means that clinics are grantees and not certified by their state, so they do not receive special CCBHC Medicaid payment rates and only have funding to implement the CCBHC model of care.⁹

As of the 2024 CCBHC Impact Survey (conducted between January and March 2024), the following states had active Medicaid CCBHCs programs: Kansas, Kentucky, Michigan, Minnesota, Missouri, Nevada, New York, New Jersey, Oklahoma, Oregon, Pennsylvania, and Texas.⁹ States that opt in often do so to address gaps in behavioral health access, reduce strain on emergency systems, expand the workforce, and leverage enhanced federal Medicaid funding and grant support.

In 2023, Georgia was among 14 new states awarded a SAMHSA CCBHC Planning Grant, signaling its intent to transition to the model.³⁰ Three clinics are on target to begin Medicaid for CCBHC services in January 2026 according to the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD). Georgia’s approach is focused on preparing for a Medicaid reimbursement rate and statewide certification. However, implementation does not need to be uniform across a state. Some states apply the model only to designated regions, such as counties or tribal areas, or at specific clinics.³¹

Together, these developments underscore the nationwide momentum toward adopting CCBHCs while highlighting examples of some state variations in behavioral health infrastructure. **Table 2** provides an overview of CCBHC status and federal grant funding. CCBHC grants refers to the number of active SAMSHA grants awarded.¹² New grantees were last awarded in 2023 and expected to receive up to \$4 million for a four-year grant term and continue to bill Medicaid and other payers.¹²

Table 2: List of CCBHCs Activities By State (Jan 2024) ¹²			
State	Summary of State Certified CCBHC Activity	CCBHC Grants	State-Certified or Demonstration CCBHCs
Alabama	Received CCBHC Planning Grant (2023)	2	0
Alaska	Received CCBHC Planning Grant (2016)	4	0
Arizona	Clinic Grantees Only	4	0
Arkansas	Clinic Grantees Only	5	0
California	Received CCBHC Planning Grant (2016)	22	0
Colorado	Received CCBHC Planning Grant (2016)	7	0
Connecticut	Received CCBHC Planning Grant (2016)	10	0
Delaware	Received CCBHC Planning Grant (2023)	0	0
Florida	State legislation establishing a CCBHC implementation effort	23	0
Georgia	Received CCBHC Planning Grant (2023)	9	0
Hawaii	Clinic Grantees Only	1	0
Idaho	State legislation establishing a CCBHC implementation effort	4	0
Illinois	Received CCBHC Planning Grant (2016)	23	0
Indiana	Received CCBHC Planning Grant (2016)	11	0
Iowa	Received CCBHC Planning Grant (2016) and (2023)	8	0

Kansas	Independent State CCBHC Program Outside of Section 223 Demonstration, Received CCBHC Planning Grant (2023)	14	21
Kentucky	Established the CCBHC model through Section 223 demonstration, Received CCBHC Planning Grant (2016)	7	4
Louisiana	State Legislative or Other Action	6	0
Maine	State Legislative or Other Action, Received CCBHC Planning Grant (2023)	7	0
Maryland	State Legislative or Other Action, Received CCBHC Planning Grant (2016)	6	0
Massachusetts	Received CCBHC Planning Grant (2016)	15	0
Michigan	Established the CCBHC model through Section 223 demonstration, Received CCBHC Planning Grant (2016)	24	30
Minnesota	Established the CCBHC model through Section 223 demonstration, Received CCBHC Planning Grant (2016)	4	16
Mississippi	Received CCBHC Planning Grant (2023)	8	0
Missouri	Established the CCBHC model through Section 223 demonstration, Received CCBHC Planning Grant (2016)	3	20
Montana	Received CCBHC Planning Grant (2023)	5	0
Nebraska	State legislative or other action	5	0
Neveda	Established the CCBHC model through Section 223 demonstration, Independent State CCBHC Program Outside of Section 223 Demonstration, Received CCBHC Planning Grant (2016)	3	8
New Hampshire	Received CCBHC Planning Grant (2023)	3	0
New Jersey	Established the CCBHC model through Section 223 demonstration, Received CCBHC Planning Grant (2016)	19	7
New Mexico	Received CCBHC Planning Grant (2016) and (2023)	3	0
New York	Established the CCBHC model through Section 223 demonstration, Received CCBHC Planning Grant (2016)	60	13
North Carolina	State legislative or other action, Received CCBHC Planning Grant (2023)	2	0
North Dakota	State Legislative or Other Action	0	0
Ohio	Received CCBHC Planning Grant (2023)	17	0

Oklahoma	Established the CCBHC model through Section 223 demonstration, Received CCBHC Planning Grant (2016)	7	13
Oregon	Established the CCBHC model through Section 223 demonstration, Received CCBHC Planning Grant (2016)	2	12
Pennsylvania	Established the CCBHC model through Section 223 demonstration, Independent State CCBHC Program Outside of Section 223 Demonstration, Received CCBHC Planning Grant (2016)	8	7
Puerto Rico	Clinic Grantees Only	5	0
Rhode Island	State legislative or other action, Received CCBHC Planning Grant (2023)	6	0
Tennessee	Clinic Grantees Only	5	0
Texas	Independent State CCBHC Program Outside of Section 223 Demonstration, Received CCBHC Planning Grant (2016)	17	48
Utah	Clinic Grantees Only	3	0
Vermont	Received CCBHC Planning Grant (2023)	5	0
Virginia	Received CCBHC Planning Grant (2016)	1	0
Washington	State legislative or other action	16	0
Washington D.C.	Clinic Grantees Only	2	0
West Virginia	State legislative or other action, Received CCBHC Planning Grant (2023)	7	0
Wisconsin	Clinic Grantees Only	2	0
Wyoming	Clinic Grantees Only	2	0

Payment Models

Many states are familiar with the Prospective Payment System (PPS) through other healthcare programs. Under this model, Medicaid reimburses clinics at a per-encounter rate that is determined based on a detailed cost report, which reflects allowable clinic costs and qualifying patient encounters over a specific time (typically daily or monthly over the course of a year).⁶ CCBHCs receive a customized payment rate that reflects both the scope of services provided and the characteristics of the population served, ensuring alignment with actual care delivery costs. PPS 1 is a fixed daily rate unit composed of all the CCBHC costs and visits for services, while the PPS 2 is the fixed monthly unit composed of CCBHC costs and visits of services.⁶ The CCBHC Transformation Payment Model (also called the Startup or Transitional Payment Model), is a payment plan designed to support clinics before they are fully participating in Medicaid PPS or while ramping up service capacity. Transformation payments are time-restricted lump sum payments, usually funded through SAMHSA grants or state-based supplements. These payments help clinics build infrastructure (staffing, Electronic Health Records, crisis systems), expand

access to meet CCBHC criteria, and transition from traditional fee-for-service to value-based or PPS reimbursement.^{30, 32} FFS, or Fee-for-Service, is the traditional payment model and most used among behavioral health providers. Under this model, providers are reimbursed for each individual service delivered (e.g., such as therapy sessions, assessments, or medication management) based on a fixed fee schedule. **Table 3** evaluates the advantages and challenges of the three payment models used for CCBHCs: the PPS model, the Transformation model, and FFS.

Table 3: Strengths and Weaknesses of 3 Payment Models		
Payment Model	Strengths	Challenges
Prospective Payment System (PPS)³³	• Provides financial stability with predictable daily/monthly Medicaid rates. • Covers a wide range of services (e.g., peer support, care coordination, 24/7 crisis) not typically reimbursed under FFS. • Supports workforce investment by factoring in staffing needs. • Reduces administrative burden via simplified billing. • Encourages focus on care quality over quantity.	• Complex and labor-intensive rate setting process. • May not adjust quickly for inflation or service expansion. • Typically, only applies to Medicaid; other payers still use FFS. • Significant initial administrative burden to set up rates.
Transformation / Startup Model^{30- 32,}	• Provides upfront funding to expand capacity, hire staff, and meet CCBHC criteria. • Reduces financial risk when launching new services. • Allows clinics to test innovative care models. • Especially valuable in rural or under-resourced areas. • Helps stabilize operations before PPS adoption.	• Funding is temporary and often grant-dependent. • Often tied to strict performance benchmarks and timelines. • Requires significant reporting and compliance efforts. • Doesn't reimburse for services delivered (no per-visit payments). • Risk of long-term dependency on grants without building billing infrastructure.
Fee-for-Service (FFS)³⁴⁻³⁸	• Widely used and familiar; existing billing systems already in place. • Directly rewards high-volume service delivery. • Flexible for payers to modify coverage and reimbursement. • Easier short-term revenue gains tied to productivity.	• Does not support whole-person care; excludes peer support, care coordination, etc. • Incentivizes quantity over quality. • High administrative burden from service-level billing and documentation. • Poor reimbursement for crisis services and walk-ins. • Financially unstable; revenue depends on client volume. • Penalizes high-need populations whose services may be non-billable.

Payment Model by State

CCBHCs include three payment model options: 1) CCBHC Prospective Payment System (PPS), 2) State Plan Amendment (SPA) or Medicaid Waiver incorporating a PPS, or 3) traditional Medicaid Fee-for-Service (FFS) system.³¹ For the CCBHC PPS system, funding comes from clinic-specific daily/monthly payments from Medicaid and funding from SAMHSA expansion grants, based on service costs.³⁹ The SPA or Waiver PPS system can be put into place upon the approval of SAMHSA. The traditional FFS system is used for billing among some CCBHCs early in their transition process, supported by SAMHSA expansion grants to cover unfunded service components.^{5, 40}

Understanding how states finance CCBHCs and other behavioral health centers is critical to evaluating their sustainability, capacity, and overall impact. Payment models such as PPS, FFS, and Medicaid waivers determine the type and amount of reimbursement these clinics receive for services delivered. These models also influence clinic operations, including staffing levels, service offerings, and integration with physical health care systems. While some states have adopted standardized PPS models through Medicaid SPAs, others rely on federal grants from SAMHSA to fund expansion or planning efforts. In states with established PPS models, reimbursement is often more predictable and aligned with the actual costs of delivering care, which supports long-term program viability. However, other states remain in early stages of CCBHC implementation or use fragmented funding mechanisms, resulting in significant variability in service delivery infrastructure.

Table 4 provides a snapshot of the payment models currently in use across the United States as of July 2024. States with certified CCBHCs are highlighted in blue, indicating a more advanced stage of integration and certification under the CCBHC model.

Table 4: Payment Model for Behavioral Health Centers by State (July 2024)	
State	Payment Model(s) Used
Alabama ⁴¹	PPS
Alaska ¹²	PPS
Arizona ¹²	CCBHC Expansion grant (SAMHSA)
Arkansas ¹²	Unknown
California ⁴²	CCBHC Expansion Grant (SAMHSA), PPS (FQHCs), FFS
Colorado ⁴³	CCBHC Planning Grant (SAMHSA)
Connecticut ^{12,44}	CCBHC Planning Grant (SAMHSA)
Delaware ^{12,45}	FFS; CCBHC Planning Grant (SAMHSA)
Florida ¹²	CCBHC Expansion Grant (SAMHSA)
Georgia ¹²	CCBHC Planning Grant & Expansion Grant (SAMHSA)
Hawaii ¹²	CCBHC Planning Grant (SAMHSA)
Idaho ^{12, 46}	PPS
Illinois ¹²	PPS
Indiana ¹²	PPS

Iowa ¹²	PPS
Kansas ⁴⁷	CMS-approved payment method for CCBHCs via a SPA separate from Demonstration: a PPS-1 Daily Rate
Kentucky ¹²	PPS
Louisiana ⁴⁸	FFS
Maine ¹²	PPS
Maryland ³⁰	CCBHC Planning Grant (SAMHSA)
Massachusetts ⁴⁹	State's Medicaid: Bundled FFS + pay-for-performance
Michigan ¹²	PPS
Minnesota ⁴	CMS-approved payment method for CCBHCs via a SPA separate from Demonstration: a PPS-2 Monthly Rate
Missouri ⁵⁰	CMS-approved payment method for CCBHCs via a SPA separate from Demonstration: a PPS-1 Daily Rate
Montana ⁵¹	FFS
Nebraska ¹²	PPS
Nevada ¹²	CMS-approved payment method for CCBHCs via a SPA separate from Demonstration: a PPS-1 Daily Rate
New Hampshire ¹²	PPS
New Jersey ¹²	PPS
New Mexico ¹²	PPS
New York ¹²	PPS
North Carolina ⁵²	FFS
North Dakota ⁵³	Medicaid 1915(i)
Ohio ⁵⁴	FFS – in progress to another model
Oklahoma ¹²	CMS-approved payment method for CCBHCs via a SPA separate from Demonstration: a PPS-2 Monthly Rate
Oregon ¹²	PPS
Pennsylvania ⁵⁶	PPS
Rhode Island ¹²	PPS
South Carolina ⁵⁷	FFS, Sliding Fee Scale
South Dakota	Unknown
Tennessee ⁵⁸	CCBHC Planning Grant (SAMHSA)
Texas ^{12, 59}	CMS-approved payment method for CCBHCs via a 1115 waiver separate from Demonstration
Utah ⁶⁰	Medicaid 1915(c) waiver
Vermont ¹²	PPS
Virginia ⁶¹	FFS
Washington D.C	Unknown
Washington ⁶²	CCBHC Planning Grant (SAMHSA)
West Virginia ¹²	PPS

Wisconsin ⁶³	FFS via a 1115 waiver separate from Demonstration
Wyoming ⁶⁴	FFS, Sliding Fee Scale
Note: Blue cells indicate that the state has certified CCBHCs	

Cost of Transitioning to a CCBHC

The cost of transitioning to a CCBHC varies by state, available resources, and existing programs of a behavioral health clinic. Washington state government has estimated that the state share's additional costs for one CCBHC ranges between \$0.6M to \$2.1M per clinic if selected for the Demonstration, and total costs per clinic may range between \$10.1 and \$17.3 million per clinic – with 80% of those costs expected to be reimbursed by Medicaid.⁶⁵ In 2023, New York awarded 13 agencies \$265,000 each in start-up costs to transition to CCBHCs.⁶⁶ This amount was renewed in 2024.⁶⁷ See more detailed breakdown of costs and reimbursement in Table 5.

Table 5: Estimate Breakdown of Cost/Revenue for Transitioning to a CCBHC			
Category	Estimated Amount	Type	Notes
Start-Up/Planning Costs^{65,66,67}	Varies	Expense	Includes staffing, training, health IT, legal, policy setup
Staffing Expansion⁶⁵	\$50,000 – \$250,000+/yr	Expense	Includes peer support, prescribers, crisis staff
SAMHSA Expansion Grant⁶⁸	\$1,000,000-\$3,000,000/yr	Restricted income	Covers implementation expenses; must be used for approved activities
Medicaid PPS Reimbursement⁶⁹	\$151 – \$667/day or \$558 – \$902/month per client	Reimbursement	Depends on state-negotiated rate, client volume, and services provided

Uncertain Future of Medicaid and its Implications for CCBHCs

As of July 4, 2025, the “One Big Beautiful Bill Act” (OBBBA) cut \$1.02 trillion from Medicaid, drastically reducing the number of people deemed eligible for Medicaid and adding increased financial strain on healthcare facilities. The Congressional Budget Office predicts that about 8.6 million people will lose their Medicaid coverage, and Medicaid will not reimburse CCBHCs for those individuals’ treatment.⁷⁰ Medicaid cuts could also impact Medicaid reimbursement rates for providers and increase uncompensated care caseloads, which would drive up operating costs for CCBHCs and potentially lead to debt.⁷⁰ Furthermore, changes in federal or state administrations often influence grant availability and prioritization, and state legislative support. Decreased grant availability and state legislative support could lead to a halt in CCBHC expansion. If expansion stalls, communities are left with their existing community behavioral health systems, but with dwindling funds and fractured infrastructure, risking a complete dismantling of behavioral health services. Vulnerable communities will not be able to mitigate these losses. This means that vulnerable communities and groups will face increased health risks including significant medical co-morbidities, lack access to continuous and preventive care, and fall into to the growing number of individuals in need of behavioral health services—ultimately

leaving millions without any access to care. In Georgia, the CCBHCs aim to service individuals across the lifespan, from birth to death.

Fortunately, core CCBHC criteria and payments currently have structural continuity under Section 223⁴, indicating that existing CCBHCs should receive the amount of funding they were awarded, despite future changes to the Medicaid budget.⁷¹ However, more needs to be done to ensure the stability of behavioral health services and reduce the impact of volatile and ever-changing systemic priorities. This should to be closely monitored and evaluated over time to understand the true impact.

Unanswered Questions

With many states in the process of transitioning to a CCBHC model, and unprecedented Medicaid cuts, there are remaining questions regarding the sustainability and future of behavioral health care in the U.S. Some of these key questions include:

- How will patient volume for CCBHCs be affected with new Medicaid eligibility requirements?
- Can CCBHCs continue to rely on Medicaid reimbursement, or do they need to find new funding sources?
- Is there a strong incoming workforce to sustain CCBHCs long-term?
- Will states in the process of transitioning to CCBHC, such as Georgia, have funding through successful implementation?
- Given various stages of readiness, how will clinics be supported to transition to CCBHCs so they can continue to serve their communities?

These questions are important to ensure people will continue to have access to critical behavioral health services. Phase 2 of the Emory CSB project aims to address these questions, among others. Phase 2 will include secondary data collection that builds on this literature review. In addition, we will attempt to address the questions above via interviews with 1) CSBs in various stages of transition and readiness toward the CCBHC model, 2) the Georgia CSB Association, and 3) Georgia DBHDD. Phase 2 will result in short term (1-2 years) and long term (3-5 years) recommendations based on findings from interviews and secondary data analysis.

Conclusion

The CCBHC model represents a significant step toward transforming the behavioral health landscape in the United States. This literature review investigated the strengths of the CCBHC model, but also uncovered some challenges and gaps:

1. CCBHCs offer a comprehensive, community-based solution to longstanding service gaps and health inequities by improving access, standardizing quality, and integrating care across mental health and substance use services.
2. The Prospective Payment System helps stabilize clinic funding and incentivize value-based care, though implementation and number of CCBHCs vary by state.

3. Adoption of the model itself can prove difficult and costly. Many behavioral health providers already face staffing shortages and heavy workloads, making the transition to a CCBHC particularly challenging.
4. While early outcomes are promising, the long-term impact of the model remains to be fully evaluated.

As states continue to adopt the CCBHC model, it is critical to monitor not only outcomes and access, but also the longevity of outcomes during uncertain times and across diverse settings. With thoughtful policy design and sustained investment, CCBHCs have the potential to drive lasting improvements in behavioral health equity, quality, and reach nationwide.

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