COMMONWEALTH of VIRGINIA

Office of the Governor

Janet Vestal Kelly
Secretary of Health and Human Resources

December 9, 2024

To: The Honorable L. Louise Lucas, Chair, Senate Finance & Appropriations Committee
The Honorable Luke E. Torian, Chair, House Appropriations Committee
The Honorable R. Creigh Deeds, Chair, Behavioral Health Commission

From: Janet V. Kelly, Secretary of Health and Human Resources

RE: Item 267.D, 2024 Special Session I Appropriations Act

Item 267.D of the 2024 Special Session I Appropriations Act directs the Secretary of Health and Human Resources to provide a report on plans to implement the Certified Community Behavioral Health Clinic model in the Commonwealth. The language states:

> *D. The Secretary of Health and Human Resources shall report to the Chairs of the House Appropriations and Senate Finance and Appropriations Committees and to the Behavioral Health Commission by December 1, 2024, on plans to implement the Certified Community Behavioral Health Clinic (CCBHC) model in the Commonwealth, how adopting the CCBHC model could improve access to community-based behavioral health services and their quality, and barriers to implementation of the CCBHC model in the Commonwealth.*

In accordance with this item, please find enclosed the report for Item 267 D. Staff are available should you wish to discuss this request.

Cc: DBHDS Commissioner Nelson Smith
DMAS Director Cheryl Roberts

Report on the Implementation of the Certified Community Behavioral Health Clinic (CCBHC) Model

(Item 267. D, 2024 Special Session I Appropriations Act)

December 1, 2024

1111 EAST BROAD STREET • P.O. BOX 1475 • RICHMOND, VIRGINIA 23218 • PHONE: (804) 786-7765 • FAX: (804) 786-3389 • WEB SITE: WWW.HHR.VIRGINIA.GOV

Item 267.D CCBHC Implementation

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Introduction

The Certified Community Behavioral Health Clinic (CCBHC) model is a national best practice model for improving access to quality community behavioral health services. The CCBHC model creates a specialty provider type within Medicaid with an emphasis on access and care coordination. States are selected through applications to participate in a CCBHC demonstration operated by the US Substance Abuse and Mental Health Services Administration. Medicaid agencies share oversight and governance of CCBHCs. Selected states are responsible for establishing a certification process and associated criteria and quality indicators tied to a prospective payment system in accordance with SAMHSA and CMS requirements.

Goals of the model for individuals include increasing individuals served targeting underserved populations, providing universal care (regardless of ability to pay), expanding operating hours, decreasing wait-times, expanding the range of services provided, providing culturally sensitive services, and improving screening. Goals of the model for providers include providing high-quality evidence-based treatment, strengthening infrastructure to better monitor individuals and coordinate care, increased rates of hiring and retaining staff, and strengthening relationships with local community partners. Goals of the model for the state include increasing accountability and governance of providers, decreasing utilization of emergency and inpatient care, and supporting diversion of individuals from the criminal justice system.

Virginia applied for and received a CCBHC Planning Grant in 2015. However, after receiving the planning grant, the state did not apply for the CCBHC Demonstration Grant in 2017. Instead, Virginia developed a model to improve community services based on the CCBHC model, called System Transformation, Excellence and Performance (STEP-VA). Virginia again applied for a CCBHC Planning Grant in 2022 as part of Governor Youngkin's *Right Help, Right Now* plan; however, the application was denied, likely because the Commonwealth had already received a grant in the past. SAMHSA has confirmed that Virginia remains eligible to apply for the CCBHC demonstration despite not having received a second round of planning grant funding.

Congress also appropriates yearly funds for CCBHC Expansion Grants to be awarded directly to individual clinics through SAMHSA. There are currently four community services boards (CSBs) that are operating as CCBHCs under a SAMHSA Expansion Grant. However, all expansion grant funded CCBHCs are potentially at risk of losing their ability to function as CCBHCs when their grants end as they do not operate on a prospective payment system as would be required under the demonstration.

Enhancing STEP-VA

STEP-VA focuses on improving access, quality, consistency, and accountability in public mental health services across Virginia. Mirroring the CCBHC model, STEP-VA requires CSBs to provide a minimum of nine core services, including (same day access, primary care screening, outpatient services for mental health and substance use disorders, crisis services, peer and family support services, veteran, military, and service member services, case management services, psychiatric rehabilitation services, and care coordination services).

Prior to STEP-VA, CSBs were mandated to provide two services (emergency services and case management); STEP-VA requires all CSBs to provide nine core services (same day access, primary care screening, outpatient services for mental health and substance use disorders, crisis services, peer and family support services, veteran, military, and service member services, case management services, psychiatric rehabilitation services, and care coordination services). Approximately one year after the launch of STEP-VA implementation, Medicaid was expanded in Virginia and behavioral health services were (over time) largely carved into managed care.

Following the news from SAMHSA that Virginia would not receive a second planning grant, the Administration considered whether to take the next opportunity to apply for a CCBHC demonstration grant in March 2024. Several important factors were considered:

- Capacity and resources: Implementation of CCBHC requires significant resources and effort from both the Department of Medical Assistance Services and the Department of Behavioral Health and Developmental Services.
    - Medicaid Unwinding – Significant resources were needed to prioritize resuming the annual eligibility evaluation of individuals covered by Medicaid, which was paused during the COVID-19 pandemic, allowing for continuous coverage. The end of the federal public health emergency on May 11, 2023, meant that throughout the following 12 months, Medicaid would revert to pre-pandemic operations, anticipating that 14 percent of Medicaid enrollees may lose coverage yet still have a need for their health care needs to be met.
    - Reprocurement of the Medicaid Managed Care Organizations – In order to prioritize and further support behavioral health, maternal health, and youth in foster care, Medicaid announced rebidding of the Managed Care Contracts on August 31, 2023. A Notice of Intent to Award (NOIA) was issued in February 2024 and while these contracts have not yet been finalized due to administrative barriers, Medicaid members would need to undergo a process of reassignment to new MCO plans through Medicaid as a priority for ensuring there are no gaps in care.
    - Consideration of multiple federal innovation opportunities related to mental health – Virginia has been in discussion with the Centers for Medicare and Medicaid (CMS) to consider several federal innovation opportunities that serve high priority mental health populations, including the CCBHC demonstration, the Serious Mental Illness (SMI) 1115 Waiver, and the Re-entry 1115 Waiver (Carceral In-reach). Each of these are large scale initiatives requiring funding and additional resources for implementation, and it is not feasible to pursue all of them simultaneously. At this time, Virginia is in the process of preparing an application for the SMI 1115 Waiver which would strengthen the quality and capability of the comprehensive crisis system and inpatient treatment facilities.
- Holding for a potential application for CCBHCs in the future gives DMAS, in collaboration with DBHDS, capacity to pursue federal waiver programs for individuals with serious mental illness, which builds on the success of the Addiction Recovery Treatment Services (ARTS) 1115 waiver.
- STEP-VA has not fully reached its potential, according to a 2023 Behavioral Health Commission report. DBHDS will continue to support any CSB that pursues CCBHC independently through direct federal grants.

Since STEP-VA remains at a high priority for the state with respect to strengthening the public community behavioral health system, the decision was made to focus on enhancing STEP-VA and continue other CCBHC planning activities including evaluating the options for long term financial sustainability of the program and authority for the oversight at the state level. DBHDS has been working with the CSBs to make plans in areas such as building quality and accountability throughout STEP-VA, determining the true costs of services, and bolstering workforce and data reporting. Part of the STEP-VA enhancement will be looking for ways to transform the system to increase quality and accountability, while maximizing state and federal funding streams. These activities will prepare Virginia for future CCBHC opportunities.

DBHDS is working in collaboration with the CSBs to identify ways to better define each step, refine the requirements outlined in the performance contracts, and improve methods for measuring success and service efficacy. Of note, DBHDS will be working to employ a funding formula method to the STEP-VA funding allocation to ensure that funds are fairly distributed across the 40 CSBs based on data informed determination of needs using the most up-to-date data. In 2024, DBHDS completed STEP-VA site visits with 20 of the 40 CSBs and launched multiple collaborative workgroups, meetings, and listening sessions to ensure that the experience, feedback, and successful strategies from our CSB partners are taken into consideration throughout the process of examining and re-aligning the initiative. Please reference the DBHDS Annual STEP-VA Report to the General Assembly[1] for more information on recent enhancements to the STEP-VA Program.

A major area where progress is needed, is related to the integration of a Medicaid payment structure. STEP-VA does not integrate a Medicaid payment structure such as the Prospective Payment System (PPS) required under the CCBHC Demonstration program. CSBs rely on state general fund allocations from the General Assembly to cover costs of serving those who are uninsured and to meet service needs of the community not met by standard Medicaid rates. Since STEP-VA does not integrate a Medicaid payment structure such as the PPS, some of the areas below are outside of the scope of STEP-VA in its current structure and funding:

1. Supported Employment Services, to include supported educational services and housing services.
2. Designated Collaborating Organization relationships to serve specific populations if not offered at a specific CSB, particularly regarding Outpatient Services. More robust physical health screening and monitoring (to include collection and analysis of lab results).
3. Agreements and infrastructure to support data sharing across multiple public and private entities (i.e.. Social Determinants of Health (SDOH) information, confirmation of receipt of services).
4. Specific federal requirements (Veterans Health Administration) around the Veteran population.

[1] Chapter 683, 2017 Acts of Assembly

CCBHC Certification

SAMHSA establishes basic criteria that all participating states must include in their CCBHC program criteria[2]. These criteria establish a basic level of service at which a CCBHC should operate, and fall into six key program areas:

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

Each state can tailor requirements within these areas to meet the specific state needs. The Commonwealth could work towards identifying specific operational requirements and targeted populations in the state's CCBHC certification. Additionally, the state certification process includes identification of specific benchmarks and performance measures that each site must hit to retain its CCBHC certification.

In a similar fashion, STEP-VA has created performance measures and benchmarks. Please reference the DBHDS December report on the changes to STEP-VA performance measures[3] and benchmarks which will provide detailed information on how current and planned performance measures and benchmarks align with the CCBHC model.

Options for CCBHC Implementation

Table 1, below, shows a comparison on how the Commonwealth could proceed towards implementing CCBHC by either applying to the federal demonstration program or applying for a waiver and submitting a state plan amendment to include CCBHCs as a Medicaid service.

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[2] **Source:** https://www.samhsa.gov/certified-community-behavioral-health-clinics/ccbhc-certification-criteria

[3] Item 295 NN. (Special Session I Appropriations Act, 2024)

Table 1.

Approaches	1: Federal demonstration program	2: Independent statewide implementation
Process	-States apply for a planning grant from HHS/ SAMHSA -Following the planning stage, states may apply to participate in the CCBHC Medicaid demonstration program	-States legislatures enact legislation to independently implement the CCBHC model -States can receive a 1115 waiver or amend their State Plan Amendment (SPA) to include CCBHCs as a Medicaid service
Degree of state control	-Low -State may not receive a planning grant or approval to participate in demonstration program	-High -States have flexibility in how and when they implement CCBHCs
Governance authority	-Substance Abuse and Mental Health Services Administration (SAMHSA) -Centers for Medicare and Medicaid Services (CMS) -State mental health authority -State Medicaid authority	-Centers for Medicare and Medicaid Services (CMS) -State legislative authority -State mental health authority -State Medicaid authority
Certification requirements	-Providers are required to meet federal standards around certification -States may add their own certification requirements	-State mental health authority determines certification requirements
Medicaid FMAP rate	-States receive **enhanced Federal Medical Assistance Percentage (**FMAP) for CCBHC-services (65%) for 4 years	States receive **baseline** (around 50%) FMAP Medicaid reimbursement for CCBHC-services

CCBHC Prospective Payment System (PPS)

CCBHC allows for two types of Medicaid per encounter rates: monthly and daily. CCBHC recently added a third and fourth type of payment model. They are specifically centered around crisis services but still follow a monthly or daily rate setup.

A Medicaid per-encounter rate is set based on a cost report that documents a clinic's allowable costs and qualifying patient encounters (either on a monthly or daily basis) over a year. The costs are divided by the number of qualifying encounters to arrive at a single rate which is paid to the clinic each time a monthly or daily encounter occurs, regardless of the number or intensity of services provided. In places with Medicaid managed care, states may either make up the difference between managed care payments and PPS through a periodic reconciliation process or require managed care organizations to pay the PPS rate.

The CCBHC Medicaid demonstration is governed primarily at the state level within a framework set by SAMHSA and CMS. The CCBHC initiative requires the active involvement of Medicaid agencies to tailor payment and scope of services to their own states' needs. Additional clarification on these requirements can be found in Appendix B. Key points to be considered:

- CCBHCs are certified by states, not by a federal agency. Beyond a floor set by SAMHSA, states define CCBHC requirements and may require CCBHCs to prioritize

specific difficult-to-serve populations, such as those with a history of emergency department use or on parole.
- CCBHC rates are set by state Medicaid agencies through a cost reporting process that provides opportunities for Medicaid Directors to benchmark clinics' anticipated costs against one another.
- The CCBHC PPS methodology explicitly permits and encourages options aligned with states' movement toward value-based purchasing, such as a monthly (instead of daily) PPS that allows stratified payment rates for patient subgroups with varying levels of need.

Many of the states that have participated in the demonstration or state plan amendments have included the payment as part of the Medicaid MCO capitation payments. Some states tried making the CCBHC payment a wraparound payment, but eventually diverted back to MCO payments, as wrap around payments proved cumbersome.

Virginia Stakeholder Impact Analysis

The CCBHC model would enable the Commonwealth to create a sustainable, accountable and efficient payment model by utilizing the strengths of current organizations and systems in the Commonwealth.

Commonwealth's Citizens – The CCBHC model has established requirements and outcomes which help to drive service provider accountability. National evidence has shown decreases in emergency department visits, and less law enforcement involvement after interaction and services at CCBHCs.

Providers – Providers would benefit from a rate that is based on costs during a particular period, and to have that rate reviewed each year. However, states have the flexibility to decide whether or not to cost settle each year. This model has been proven to help providers expand and retain their workforce by having a prospective payment that matches their operating expenses for the Medicaid population. However, there would be immense reporting requirements needed to ensure compliance with CCBHC certification requirements. Start-up funding would be needed to support provider administrative capacity to creating their initial cost report. Administrative resource needs to support ongoing reporting would be built into the prospective payment rate after initial implementation.

Medicaid MCO Considerations – Payment for individuals under a Medicaid MCO would allow for the same type of assessment and treatment requirements for current billing practices (authorizations, peer reviews etc.). Additionally, Medicaid MCOs will already have relationships and contracts with many organizations including CSBs that could be considered a CCBHC. The MCO contracts would need to be modified to allow for this. MCOs would need to adapt their systems to allow for these payments. This has proven to be a challenge in some states that have adopted CCBHC.

DMAS – The state Medicaid agency would need to work with the MCOs and providers to review cost reports and do audits of the cost reports. This would require additional administrative resources at the state Medicaid agency.

DBHDS – DBHDS could be the certification entity and would certify CCBHCs according to the standards set by the agency and agreed to by DMAS and HHR. This would require additional administrative resources to support enhanced federal reporting and oversight requirements.

General Assembly – It is expected that this model would result in increased Medicaid expenditures. States that have gone through CCBHC have seen between 15-30 percent increase in Medicaid expenditures at the sites providing these services. Additional appropriation would be needed for these services. States have referenced cost savings in emergency rooms, hospitalizations, and jails, however this report does not have a quantified offset to be considered.

Benefits Observed Nationally – After SAMHSA's initial 8 state trial it reported the success of these programs consistently providing positive client outcomes across multiple hospital settings in the following ways (National Council for Mental Wellbeing, 2021):

- Oklahoma's, New York's, and Missouri's CCBHCs each saw reduced emergency department visits by 18–46%.
- In Oklahoma and New York, the number subsequently admitted to inpatient care declined by 20–69% across a 4-year implementation window.
- Readmissions dropped in both New York and New Jersey, and Missouri reported that of those with prior law enforcement involvement, 70% had no further involvement at 6 months.
- Six states emphasized that their involvement with the CCBHC program increased staffing and reduced long-standing workforce shortages, with particular emphasis on the increase in access to psychiatry, medication for opioid use disorder (MOUD), and peer support workers.
- In New Jersey alone, the number of clients receiving MOUD doubled, Missouri saw a 122% increase, and Oklahoma saw a 700% growth in clients served.
- States also reported substantially higher rates of follow-up care after hospitalization, outperforming statewide averages and other provider types on these and other quality measures.[4]

Next Steps and Conclusion

The CCBHC model is a national best practice model for improving access to quality community behavioral health services. STEP-VA was originally designed to emulate CCBHC, and the Administration and General Assembly have supported DBHDS in their work to enhance STEP-VA including identifying ways to better define each step, refining the requirements outlined in the performance contracts, and improving methods for measuring success and service efficacy. Enhancements to STEP-VA continue to improve access and quality of essential services and are essential to positioning the state to be prepared to adopt additional components of the CCBHC model such as state certification and the prospective payment system. This work has better positioned Virginia for a future CCBHC application.

[4] Source: https://psycnet.apa.org/fulltext/2024-47772-001.html

There are multiple options for supporting implementation of the CCBHC model in Virginia that the General Assembly may consider. Implementation would require legislative authority and budgetary support. Additional resources would also be needed to support expansion of administrative capacity of state agencies and CSBs to fulfill oversight and reporting requirements.

Importantly, the Medicaid Behavioral Health Redesign authorized in the FY 2024 – FY 2026 biennial budget has significant implications for the implementation of the CCBHC model. Any amendments to the Behavioral Health service array under the Medicaid State Plan and associated regulatory amendments to licensing of behavioral health services must be finalized prior to the state beginning the process for implementation of the CCBHC model. Scope of service and quality requirements defined in the state CCBHC Certification Criteria, and the Prospective Payment rate are all informed by the current state regulatory requirements for licensing and service definitions, rates, and associated requirements defined under the Medicaid State Plan.

Appendices

Appendix A – Comparison of current state requirements for STEP-VA and the most recent federal requirements for CCBHC.

Same Day Access	STEP VA status	CCBHC status
Assessment	**	Required
Diagnosis	**	Required
BH risk assessment	**	Required
Same day screening/triage	*	Required
SDOH screening using standardized tool		Required
Depression screening (CDF) using standardized tool		Required
Comprehensive evaluation within 30 days	*	Required
Same day comprehensive assessment with diagnosis	Required	
Assessment with diagnosis in 1-10 business days based on triage	*	Required
Person-Centered treatment plan	Required	Required
Service initiation within 30 calendar days	Required	Required
DLA-20	Required	
Policy that no one can be refused service based on residency or address	***	Required

** To be reflected in FY 2026 Performance Contracts*

*** Reflected in Comprehensive Needs Assessment and other requirements outside of STEP*

**** Crisis only*

Primary Care	STEP VA status	CCBHC status
HIV and Hepatitis Screening		Required
Primary Care Screening	Required	Required
Referral/follow-up services for accessing primary health services	Required	Required
Identifying individuals with chronic disease		Required
Physical health symptoms screening		Required
Systems for collecting and analyzing lab results		Required
Periodic lab and physical measurements to monitor health indicators over time		Required
Metabolic screening for individuals prescribed antipsychotics	Required	Required
Ensuring individuals have access to primary care provider	*	Required

** Required in other avenues (ie., performance contract)*

Outpatient	STEP VA status	CCBHC status
Evidence-based behavioral health care for mental health and substance use, including psychopharmacological treatment	Required	Required
OP services for children and families (developmentally appropriate)	Required	Required
OP services for geriatrics (developmentally appropriate)	*	Required
OP services for dev and cog disabilities (developmentally appropriate)	*	Required
ASAM levels 1 and 2.1	*	Required
Treatment of tobacco use disorders	*	Required
Suicide Risk Assessment (state to select tool)	Required	Required
PHQ9 for dx of depressive d/o (DEP REM 6)		Required
DLA-20	Required	
Harm reduction strategies	*	Strongly recommended
Cultural competence training on race, ethnicity, age, sexual orientation, and gender identity (all clinical staff)	**	Required
Trauma-informed care training (all clinical staff)	Required	Required
Risk assessment, suicide and o/d prevention training annually (all clinical staff)		Required
EBPs selected by the state based on Community Needs Assessment	****	Required

** CSBs may offer but not necessarily required in-house at each CSB*

*** Cultural competency training is required by not necessarily covering all listed topics as per CCBHC*

*****EBPs selected based on CSB informal report on community need conducted in 2024, to be required in FY 2026*

CCBHC recommended EBPs listed below:	STEP VA status	CCBHC status
Motivational Interviewing	Required ****	Recommended
Cognitive Behavioral Therapy	Required ****	Recommended
`Dialectical Behavioral Therapy	Optional	Recommended
`Coordinated Specialty Care	Optional	Recommended
`Seeking Safety	Optional	Recommended
`Assertive Community Treatment	Optional	Recommended
`Forensic Assertive Community Treatment	Optional	Recommended
`Long-Acting Injectible Medications	Required ****	Recommended
`Multi-Systemic Therapy	Optional	Recommended
`Trauma-Focused CBT	Optional	Recommended
CBT for psychosis	Optional	Recommended

Hi-Fidelity WrapAround	Optional	Recommended
Parent Management Training	Optional	Recommended
Effective but underutilized meds for SUD treatment	Optional	Recommended
Other EBPs identified by CSBs for use in STEP VA as of 2025	**STEP VA status**	**CCBHC status**
Solution Focused Brief Therapy	Optional	
ASAM levels of care	Optional	
Acceptance and Commitment Therapy	Optional	
Collaborative Assessment and Management of Suicidality	Optional	
Cognitive Behavioral Intervention for Trauma in Schools	Optional	
Dialectical Behavioral Therapy	Optional	
EMDR	Optional	
Functional Family Therapy	Optional	
Hi-Fidelity WrapAround	Optional	
Integrated Treatment for Co-Occurring Disorders	Optional	
Living in Balance	Optional	
MAT	Optional	
Moral Reconation Therapy	Optional	
Motivational Enhancement Therapy	Optional	
Multi-Systemic Therapy	Optional	
Parent Child Interaction Therapy	Optional	
SBIRT	Optional	
Seeking Safety	Optional	
Trauma-Focused CBT	Optional	
Effective but underutilized meds for SUD treatment	Optional	

*****EBP's selected based on CSB informal report on community need conducted in 2024, to be required in FY 2026*

Crisis	STEP VA status	CCBHC status
24/7 access to crisis management services	Required	Required
crisis continuum services for prevention, response, and postvention	Optional	Required
crisis planning and advance psychiatric directives for all individuals served	Optional	Required
crisis planning for all individuals who experienced a crisis	*	Required
mobile crisis services (1-2 hour response time limit)	Required	Required
Overdose prevention including naloxone	*	Required

**Covered in other STEPs or services.*

Peer	STEP VA status	CCBHC status
Peer Specialists, recovery coaches (peer recovery specialist), and family support partners	Required	Required
Peer run wellness and recovery centers	Optional	Optional
Youth/Young adult peer support	Optional	Optional
Recovery coaching services	Optional	Optional
Peer-run crisis respites	Optional	Optional
warmlines	Optional	Optional
peer-led crisis planning	Optional	Optional
peer navigators to assist with transitions	Optional	Optional
mutual support and self-help groups	Optional	Optional
peer support for older adults	Optional	Optional
peer education and leadership development	Optional	Optional

Veterans Care	STEP VA status	CCBHC status
Intensive, community based behavioral health for SMVF		Required
Care for veterans consistent with minimum clinical mental health guidelines promulgated by VHA		Required
Screen all individuals for SMVF status	Required	Required
Active-Duty personnel must use their servicing MTF, and MTF will be contacted by the CCBHC regarding referrals		Required
Active Duty more than 50 miles from a military hospital or clinic enroll in TRICARE PRIME remote and use the network PCM for referrals		Required
Reserves are eligible for TRICARE Select and can schedule with any eligible provider		Required
Veterans are offered assistance enrolling in VHA		Required
Veterans who decline VHA are offered CCHBC services consistent with the minimum guidelines promulgated by VHA		Required
Each veteran is assigned a Principal Behavioral Health Provider who ensures that care coordination requirements listed in CCBHC 4.k.4 are fulfilled		Required
All behavioral health services meet the VHA National Consensus Statement on Mental health Recovery (hope, person-driven, many pathways, holistic, peer support, relational, culture, address trauma, strengths, responsibilities, respect, privacy, security, honor)		Required
All behavioral health care is provided with military cultural competence	Required	Required
All staff receive cultural competence training	Required	Required

Case Management	STEP VA status	CCBHC status
Targeted Case Management that assists in sustaining recovery and gaining access to needed medical, social, legal, educational, housing, vocational, and other services and supports	Required	Required
Supports for those at high risk of suicide or overdose	Required	Required
Supports during transitions	Required	Required
Available to individuals with SMI and/or SUD and/or need short term support in a critical or acute period	Required	Required
Intensive case management	Optional	Strongly recommended
Team-based case management (such as ACT)	Optional	Strongly recommended
DLA-20	Required	

Psychiatric Rehab	STEP VA status	CCBHC status
Evidence Based rehab services for both SMI and SUD	Required	Required
Services provided must help individuals to develop skills and functioning to facilitate community living, positive development, inclusion, and integration	Required	Required
Services must develop skills that support pursuit of the individual's goals in the community	Required	Required
Services address Social Determinants of Health and navigating complex systems	Optional	Required
Supported Employment designed to provide on-going support to obtain and maintain competitive, integrated employment	Optional	Required
Supported educational services	Optional	Required
Support/skills to achieve social inclusion and community connectedness	Optional	Required
medication education, self-management, and/or psycho-education	*	Required
Support in finding and maintaining safe and stable housing	Optional	Required
States must indicate which EBPs, or other psychiatric rehab services will be required		
Proposed services for use in STEP VA as of 2025		
MH Intensive OP (IOP)	Optional	Optional
SUD Intensive OP (IOP)	Optional	Optional
Assertive Community Treatment (ACT)	Optional	Optional
MH and SU supported employment	Optional	Required
MH and SU supervised residential	Optional	Optional
MH and SU intensive residential	Optional	Optional
Intensive In-Home (IIHS)	Optional	Optional

Therapeutic Mentoring/TDT	Optional	Optional
Coordinated Specialty Care (CSC)	Optional	Optional
Mental Health Skill Building (MHSS)	Optional	Optional
Psychosocial Rehabilitation (PSR)	Optional	Optional
Clubhouse/ Fountain House Model	Optional	Optional
Permanent Supportive Housing	Optional	Optional
High Fidelity Wraparound	Optional	Optional
MH and SU Individual Peer Supports	Optional	Optional
MH and SU Group Peer Supports	Optional	Optional
Illness Management and Recovery	Optional	Optional
Social Skills Training	Optional	Optional
Cognitive Behavioral Therapy for Psychosis (CBT-P)	Optional	Optional

*Medication management is required in the Outpatient STEP of STEP VA

Care Coordination	STEP VA status	CCBHC status
Individualized person or family centered treatment plan	Required	Required
Ensures access to high quality physical and behavioral health care	Optional	Required
Coordinates physical and behavioral healthcare, social services, housing, educational systems, and employment as necessary to facilitate wellness and recovery of the whole person	Required**	Required
maintains necessary documentation to satisfy HIPAA, obtains necessary consents, documents where these cannot be obtained	Required**	Required
Assists people referred to outside services with obtaining an appointment and tracking participation in services to ensure coordination and receipt of services	Required**	Required
To identify the preferences of the individual, develop a crisis plan with each person receiving services. At a minimum, this must include counseling about the use of national and local hotlines and warmlines, mobile crisis, and crisis stabilization services should a crisis arise when providers are not in their office. Crisis plans may support the development of a Psychiatric Advance Directive if the person desires.	*	Required
Document reasonable attempts to determine any medications prescribed by other providers. To the extent allowable by law, the PDMP must be consulted before prescribing medications.	Required **	Required
Provide assistance with accessing benefits, including Medicaid, and enroll in programs or supports that may benefit them.	Required **	Required
Care coordination agreements/partnerships with local agencies	Optional	Required

**Required in other STEPS or service provision*

*** Will be required as of the FY 2026 Performance Contract*

STEP	CODE	CODE DESCRIPTION
outpatient	90791	Psychiatric Diagnostic Evaluation - no medical svcs*
outpatient	90792	Psychiatric Diagnostic Evaluation - w/ medical svcs*
outpatient	99408	Alcohol/SA structured screening and brief intervention 15-30 min
outpatient	96116	Neurobehavioral status exam, by physician or other QHP, both face-to-face
outpatient	90832	Psychotherapy w/ patient, 30 min*
outpatient	90834	Psychotherapy w/ patient, 45 min*
outpatient	90837	Psychotherapy w/ patient, 60 min*
outpatient	90839	Psychotherapy for crisis, first 60 min*
outpatient	90840	Psychotherapy for crisis, additional 30 min*
outpatient	90846	Family/Couples Psychotherapy w/o patient present, 50 min*
outpatient	90847	Family/Couples Psychotherapy w/ patient present, 50 min*
outpatient	90853	Group Psychotherapy*
outpatient	90785	Interactive Complexity Add-on
outpatient	90792	Psychiatric Diagnostic Evaluation - w/ medical svcs*
outpatient	90833	Psychotherapy w/ patient, 30 min, w/ E&M svc*
outpatient	90836	Psychotherapy w/ patient, 45 min, w/ E&M svc*
outpatient	90838	Psychotherapy w/ patient, 60 min, w/ E&M svc*
outpatient	99202	Office Outpatient Visit, New patient, low to moderate severity*
outpatient	99203	Office Outpatient Visit, New patient, moderate severity*
outpatient	99204	Office Outpatient Visit, New patient, moderate to high severity*
outpatient	99205	Office Outpatient Visit, New patient, moderate to high severity*
outpatient	99211	Office Outpatient Visit, Established patient, minimal*
outpatient	99212	Office Outpatient Visit, Established patient, minor*
outpatient	99213	Office Outpatient Visit, Estbl patient, low to moderate severity*
outpatient	99214	Office Outpatient Visit, Estbl patient, moderate to high severity*
outpatient	99215	Office Outpatient Visit, Estbl patient, moderate to high severity*
outpatient	99354	Prolonged Service, in office or outpatient setting; 60 min
outpatient	99355	Prolonged Service, in office or outpatient setting; addtl 30 min
outpatient	99408	Alcohol/SA structured screening and brief intervention 15-30 min
outpatient	99409	Alcohol/SA structured screening and brief intervention > 30 min
outpatient	96121	time w/ patient & time interp & report, each addtl hr
outpatient	Q3014	Telehealth, originating site fee*
outpatient	S9480	Mental Health Program - per diem
outpatient		Mental Health Intensive Outpatient Services (MH-IOP) - per diem
outpatient	S9480	Mental Health Intensive Outpatient Services (MH-IOP) with Occupational
outpatient	H0036	Functional Family Therapy (Bachelor Established)
outpatient	H0036	Functional Family Therapy (Master Established)
outpatient	H0036	Functional Family Therapy (Bachelor New)

outpatient	H0036	Functional Family Therapy (Master New)
outpatient	99211	Office Outpatient Visit, Established patient, minimal
outpatient	99212	Office Outpatient Visit, Established patient, minor
outpatient	99213	Office Outpatient Visit, Estbl patient, low to moderate severity
outpatient	99214	Office Outpatient Visit, Estbl patient, moderate to high severity
outpatient	99215	Office Outpatient Visit, Estbl patient, moderate to high severity
outpatient	H0014	Medication Assisted Treatment (MAT) induction - Physician
CM	G9012	Substance Use Care Coordination
outpatient	H0020	Medication Administration
outpatient	H0004	Opioid treatment services - Individual
outpatient	H0005	Opioid treatment services - Group
outpatient	90832	Psychotherapy w/ patient, 30 min - ASAM level 1*
outpatient	90833	Psychotherapy w/ patient, 30 min, w/ E&M svc - ASAM level 1*
outpatient	90834	Psychotherapy w/ patient, 45 min - ASAM level 1*
outpatient	90836	Psychotherapy w/ patient, 45 min, w/ E&M svc - ASAM level 1*
outpatient	90837	Psychotherapy w/ patient, 60 min - ASAM level 1*
outpatient	90838	Psychotherapy w/ patient, 60 min, w/ E&M svc - ASAM level 1*
outpatient	90846	Family Psychotherapy w/o patient, 50 min - ASAM level 1*
outpatient	90847	Family Psychotherapy w/ patient, 50 min - ASAM level 1*
outpatient	90853	Group Psychotherapy - ASAM level 1*
crisis	H2011	Mobile Crisis (1:1 Licensed)
crisis	H2011	Mobile Crisis (1:1 Pre-screener)
crisis	H2011	Mobile Crisis (Non-Emergency 1:1 Pre-screener Licensed)
crisis	H2011	Mobile Crisis (2:1 MA/Peer)
crisis	H2011	Mobile Crisis (2:1 Licensed/Peer)
crisis	H2011	Mobile Crisis (2:1 MA/MA)
crisis	H2011	Mobile Crisis (2:1 Licensed/MA)
crisis	S9482	Community Stabilization
peer, psych rehab	T1012	Peer Support Services - Individual (Substance Use Disorder)
peer, psych rehab	S9445	Peer Support Services - Group (Substance Use Disorder)
peer, psych rehab	H0024	Peer Support Services - Individual (Mental Health)
peer, psych rehab	H0025	Peer Support Services - Group (Mental Health)
Psych Rehab	H0031	Intensive In-Home Assessment
Psych Rehab	H2012	Intensive In-Home Services, per hour
Psych Rehab	H0032	Assessment, Psychosocial Rehab*
Psych Rehab	H2017	Psychosocial Rehabilitation svcs; per unit

Psych Rehab	H0032	Assessment, Mental Health Skill Building Services
Psych Rehab	H0032	Assessment, Mental Health Skill Building Services
Psych Rehab	H0046	Mental Health Skill Building Services 1 unit = 1 to 2.99 hours per day
Psych Rehab	H0046	Mental Health Skill Building Services 2 units = 3 to 4.99 hours per day
Psych Rehab	H0040	ACT - Contracted as Base Large Team - per diem
Psych Rehab	H0040	ACT - Contracted as Base Medium Team - per diem
Psych Rehab	H0040	ACT - Contracted as Base Small Team - per diem
Psych Rehab	H0040	ACT - Contracted as High Fidelity Large Team - per diem
Psych Rehab	H0040	ACT - Contracted as High Fidelity Medium Team - per diem
Psych Rehab	H0040	ACT - Contracted as High Fidelity Small Team - per diem
CM	T1016	Case Management, Foster Care - per month
CM	H0023	Case Management, Mental Health, per month
CM	H0006	Substance Use Case Management (licensed by DBHDS)
Psych Rehab	H2015	Intensive Care Coordination/High Fidelity Wraparound/Comprehensive Community Supports

Appendix B - CCBHC PPS Requirements

Clinic Certification	CCBHCs are certified by state Medicaid agencies. Participating states may choose whether or not to certify SAMHSA CCBHC Expansion grantees
Scope of Services	Within a framework set by SAMHSA, states make final decisions about CCBHCs' scope of services and other certification criteria. Based on their own needs, states have significant authorities to require enhanced services or prioritize care delivery to targeted, difficult-to serve populations.
Authority for Coverage of Services in Medicaid	States selected to participate in the current CCBHC demonstration; states authorized to implement through waiver and/or state plan amendment.
Cost Reports and PPS Rate Setting	CCBHCs complete a cost report including both current costs and anticipated future costs associated with becoming a CCBHC. Rates are clinic-specific, but through the process of documenting anticipated costs, state Medicaid agencies have an opportunity to benchmark clinics against one another and ensure comparable services are being provided at comparable cost.
Payment on the Same Day	CCBHCs receive one PPS payment for each daily (or monthly, at state option) encounter. They cannot bill multiple PPS encounters for the same day/month.
Alternative Payment Model (APM)/Value-Based Payment (VBP) Features	States have the option to implement a monthly PPS which increases the potential downside risk for providers and captures elements of capitation, pay-for-performance, and other value-based payment (VBP) models. States can require their own performance measures as a condition of certification
Quality Bonus Payments	Quality bonus payments are mandatory under the monthly PPS and have been voluntarily adopted by nearly all states using the daily PPS.
Rebasing	States choose whether they will engage in a rebasing process at the end of the first demonstration year and with what frequency thereafter.

Source: National Council CCBHC Success Center