Certified Community Behavioral Health Clinics

What they are | How they work | Where Montana stands

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DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

What is a CCBHC?

A Certified Community Behavioral Health Clinic (CCBHC) is a federally-designated clinic model that provides a comprehensive, integrated array of outpatient mental health and substance use disorder services regardless of ability to pay or insurance status.

Created by the Excellence in Mental Health Act (2014), CCBHCs must meet SAMHSA certification criteria across six domains and nine required service types. They operate as a new provider type under a daily Prospective Payment System (PPS) in Medicaid.

SAMHSA'S 6 CERTIFICATION CRITERIA

1. Organizational Authority & Governance
2. Needs Assessment and Staffing
3. Availability & Accessibility of Services
4. Care Coordination
5. Person & Family- Centered Care Plans
6. Quality Improvement & Data Reporting

Source: SAMHSA CCBHC Certification Criteria · Excellence in Mental Health Act (2014)

9 Required CCBHC Service types

Crisis Mental Health Services
24/7 crisis intervention, Mobile Crisis, Crisis receiving (walk-in facilities)

Outpatient Mental Health and SUD
Core Therapy and Counseling

Psychiatric Rehabilitation Services
Skills, employment, housing support
For community integration

Screening, Assessment & Diagnosis
For MH and SUD conditions- including risk assessment

Outpatient Primary Care Screening & Monitoring
Physical health integration

Peer & Family Support Services
Lived- experience peer specialists

Patient Centered Treatment Planning
Whole-person, individualized plans for Youth And adults

Targeted Case Management
Direct support for service access

Intensive Community- Based MH & Recovery Support
Housing, social, follow-up care
For members of the armed forces And Veterans

Source: SAMHSA CCBHC Certification Criteria (2023)

Designated Collaborating Organizations and how they fit into the CCBHC model.

- CCBHC's must provide the 9 required behavioral health services, either directly or through formal partners. DCO's exist to help clinics meet those requirements while maintaining a unified standard of care.
- Designated Collaborating Organizations (DCO's) deliver specific CCBHC services under the same quality, licensure, cultural competency, and compliance standards as the CCBHC.



Why CCBHC's use DCO's?

Expand the clinic's ability to offer the full continuum of required services.

Leverage community partners with specialized expertise (e.g., primary care screening, Veteran services, Mobile crisis).

Ensure consistent access across all service categories without having everything "in house".

CCBHC pays DCOs fair-market-value reimbursement for the service (not necessarily the PPS rate)

Seems a lot like services we already have…what is the difference?

CCBHCs are required to…

- Provide **comprehensive, high-quality, community-based behavioral health** (BH) care.
- **Serve anyone** who requests care for mental health or substance use regardless of their ability to pay, place of residence, or age –this includes developmentally appropriate care for children and youth.
- **Get people into care quickly** with the services they need, when they need it -including providing crisis services 24 hours a day, 7 days a week.
- Meet people where they are, with a range of comprehensive BH services and supports. **Providing access to a continuum of care** so people who need care do not have to piece together behavioral support they need across multiple providers.

CCBHCs are required to…(cont.)

- Provide **care coordination and other enabling services** to help people navigate BH care, physical health care, social services and other systems individuals are involved in to ensure access to care and services
- Employ **interdisciplinary teams** (medical and BH) and patient-centric approaches
- Be **community-based and collaborate** with other services, providers, and programs to improve access to care and community resources

Quality measures and outcomes

CCBHCs are required to collect and report key data on who they serve, how quickly people get care, and the outcomes of that care. This information helps track access, quality, and coordination across the clinic.

Clinics report core measures like time to services, depression and alcohol screening, follow-up care, and social needs screening. The state also tracks experience-of-care surveys, medication management, readmissions, follow-up after a crisis, ED visits, and other health outcomes.

All of this feeds into continuous quality improvement. Clinics review their performance, look at major events, use data to guide changes, and work to reduce disparities. The goal is simple: better access, better quality, and better outcomes.

CCBHCs must submit data on time, follow reporting standards, and take action when the numbers show an opportunity to improve.

The PPS-1 Model: Montana's Choice

Prospective Payment System (PPS)

A cost-based Medicaid reimbursement mode that pays clinics based on the actual cost of delivering the full scope of required CCBHC services.

Why PPS exists: Traditional Fee for service doesn't cover comprehensive Behavioral Health care. PPS ensures clients can sustainably expand access, hire needed staff and deliver integrated services.

What PPS funding covers: Supports all nine required services areas, to deliver a full continuum of care ensuring faster access, fewer gaps and community level impact.

PPS- 1

PPS-1 uses a daily, per-client rate for any day a person receives a qualifying CCBHC service.

Provides predictable funding to support rapid access, crisis care, and care coordination.

DY2 is rebased by applying the MEI to the cost report, DY 3 is reconciled within 60 days

Montana's Path to CCBHC Implementation

Legislative foundation:

- HB 574 (2025 session)- Directed DPHHS to apply for CMS CCBHC demo; mandates launch Oct. 1, 2026.
- Application submitted April 1, 2026- And May 2026 Application was approved with 100% rating! Montana awarded the Federal Demonstration opportunity.
- PPS-1 (Daily rate) was selected; biennial rebasing after DY2 cost report.
- 100% state share from BHSFG special revenue- No general fund.
- 2027 legislative session- DPHHS proposes CCBHC into Medicaid base budget.

Flow of funds

BHSFG special Revenue appropriated to DPHHS under HB 2

DPHHS draws federal Medicaid match (FMAP)- no General funds used. Enhanced FMAP is paid during the demonstration years.

Combined State + federal funds flow to CCBHC's as PPS-1 Daily rate payments

Annual MEI update adjusts cost report in DY2 rebases DY3 rate with 60-day reconciliation.

Period	State (BHSFG)	Federal	Total
SFY 2027	$8.5M	$32.0M	$40.5 M
SFY 2027-31	>$13.5M	>$41.5 M	>$55M

Source: HB 574 (2025 Montana Legislature) · Montana SAMHSA Application (April 2026)

Service Eligibility & Non-duplication Care Requirements

CCBHC's may serve individuals in these situations if they do not duplicate services already provided by another program:

- Individuals enrolled in Medicaid Waiver Programs
- Individuals living in Assisted Living Facilities not covered by a waiver
- Individuals in Partial Hospitalization Programs (PHP)
- Individuals participating in ASAM Level 2.5 SUD programs
- Youth receiving Comprehensive School & Community Treatment (CSCT)
- Youth in Therapeutic Foster Care
- Adults in Adult Foster Care settings

**If another program is already providing a service as part of its own package or rate, CCBHCs cannot provide the same service at the same time. Organizations must collaborate to avoid duplication.

CCBHC's must pause services when someone is in a higher level, facility-based program that assumes full responsibility for treatment.

- Individuals admitted to an inpatient medical or psychiatric hospital
- Individuals in a 72+ hour crisis stabilization program
- Individuals in ASAM 3.1 – 3.7 residential SUD treatment
- Individuals in psychiatric residential treatment programs
- Youth in therapeutic group homes
- Adults in behavioral health group homes
- Individuals living in nursing homes or skilled nursing facilities

CCBHCs must not provide services during the stay — but should stay involved in care transitions, including; help with discharge planning, Coordination between providers, Supporting re-engagement once the person returns to the community

Montana's CCBHC Crisis Model

Mobile Crisis Requirements determined by County Population :

Tier 1: **Crisis De-Escalation (Frontier <10,000)**
• 24/7 crisis access via shared/contracted models
• Coordination with 988 for calls & follow-up
• First responders provide in-person response when needed
• Licensed BH clinician available via telehealth for real-time consults

Tier 2: On-Call Co-Response (10,001–50,000)
• 24/7 on-call paraprofessional co-responders
• Licensed therapist always on-call (in-person or telehealth)
• Integrated with 988, EMS, and local first responders

Tier 3: Full Mobile Crisis (>50,001)
• 24/7 mobile crisis program
• Two-person mobile team for 16 hours/day
• At least one qualified responder available during remaining hours
• Includes licensed therapist + clinical supervision

All Counties
• CCBHCs encouraged to form DCO partnerships with state-sanctioned mobile crisis providers
• Enhances capacity and leverages existing infrastructure

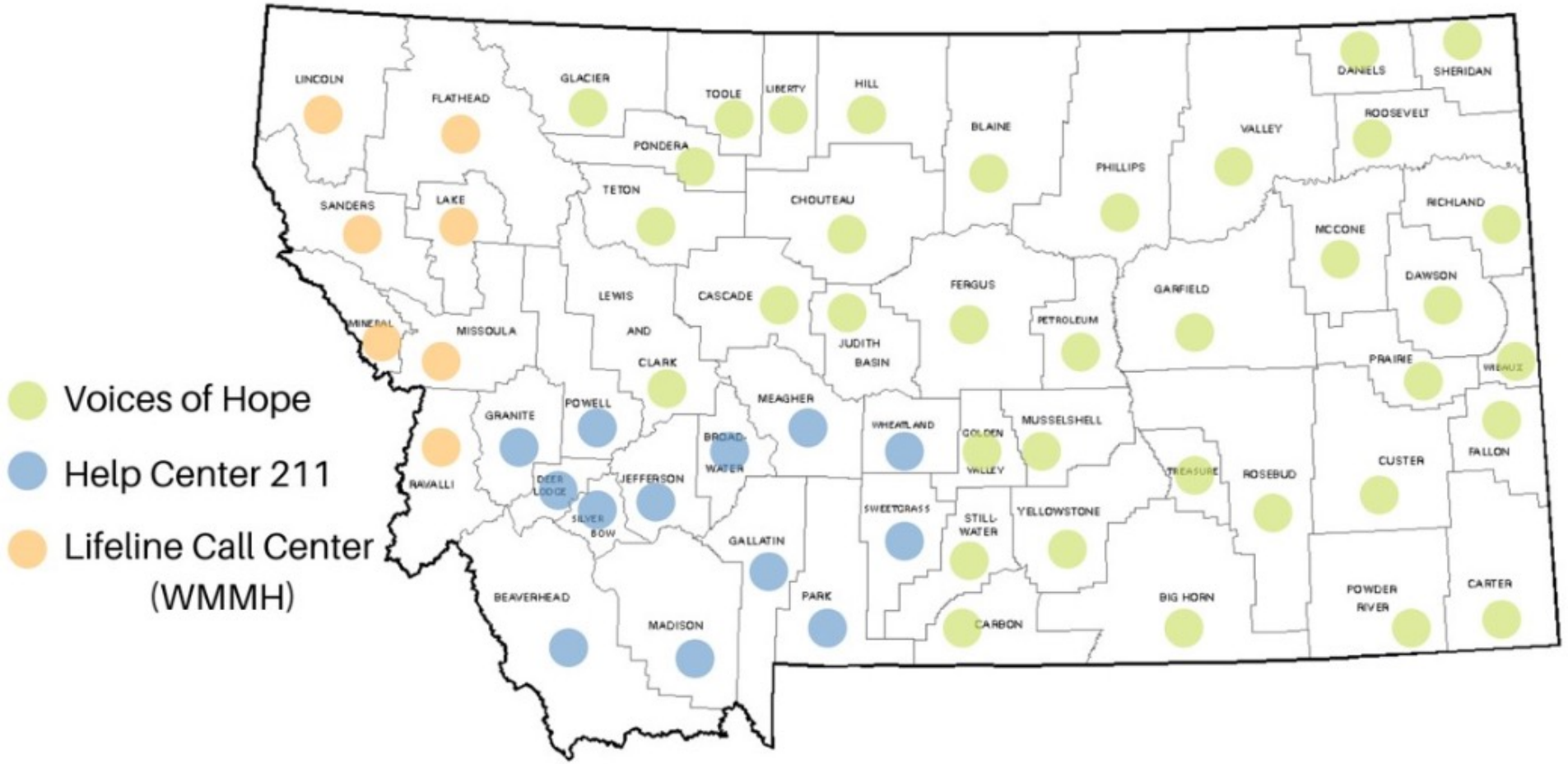
Current Model: Crisis Receiving Structure

All counties with a mobile crisis program will have a crisis receiving location, either a Tier 1 (crisis receiving) or Tier 2 (crisis drop-in). Additional crisis drop-ins (Tier 2) are distributed across the state to support a roughly 3-hour drive time from any location.

Crisis drop-in programs: Facilities that can support a living room model, with peers or paraprofessionals providing a safe place to stabilize in a lower acuity crisis event. Staffing will be 24/7 across 8-hour shifts.

Crisis receiving: Facilities that can provide Crisis Receiving for less than 24 hours. The lowest staffing requirement is for a licensed mental health professional, 2 paraprofessional staff, and a nurse for 24/7/365.

988 Integration



All CCBHC sites must have agreements with existing 988 Suicide & Crisis Lifeline providers to ensure coordination of crisis call response and follow-up regardless of what population crisis tier.

How to become a CCBHC

Eligibility to become a CCBHC

What organizations are eligible to become or operate as a CCBHC?

Organizations must:

- Be a community-based behavioral health provider-
- Deliver (or contract/DCO for) all nine required CCBHC services

  (at least 51% of services must be provided in-house.)
- Meet Montana's staffing, access, governance, and financial standards
- Have the ability to provide 24/7 crisis services, care coordination, and outpatient behavioral health.
- Operate within a defined catchment area and accept all individuals regardless of ability to pay.

*Both nonprofit and governmental behavioral health organizations may qualify.

Will the State of Montana allow more than 1 CCBHC in a county?

The State of Montana will allow more than one CCBHC in a county. The application and selection process is still under development. As the process is finalized, the state will provide clear guidance for communities and providers. The goal is to support collaboration among local organizations and ensure that communities have expanded access to behavioral health services without duplication of services.

Timeline for expansion and New CCBHC's

Tier 1 CCBHCs provisionally certified on October 1, 2026

Site Visit with Tier 1 CCBHCs on/before April 1, 2027 resulting in full certification

One Year of Operations for all CCBHCs within the cohort– Tier 1 CCBHCs can request expanded Catchment Area (April 1, 2028 at the latest)

Expanded catchment area request reviewed within 90 days and approved/denied/ asked for more information (if approved July 1, 2028)

CAN have multiple CCBHCs in one County, provided the second CCBHC can illustrate a significant need and has a relationship with existing CCBHC(s) in the area.

Open Next Application Cycle for New CCBHCs by June 1, 2027

New Providers can apply to enter the CCBHC program with the first application round due by October 1, 2027

Certification Review done by OIG, with provisional certification in April 1, 2028

Site Visit with CCBHC on/before October 1, 2028, resulting in full certification

One Year of Operations – CCBHCs can request expanded Catchment Area (October 1, 2029 at the latest)

To be determined:

The State of Montana is working with the communications team to develop a website within DPHHS for CCBHC's
Which will provide new information as it comes out during the demonstration.

Program Contact email: CCBHC@mt.gov

Final rates for PPS-1 rate are not finalized and dependent on individual cost reports.

We are still evaluating statewide options for electronic health records connectivity and data sharing. Montana is exploring solutions that would support coordinated care across CCBHC's and community partners, but no final decision has been made

Questions?



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Thank you for supporting Behavioral Health in Montana!

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