CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC) DEEP DIVE *FOR DELAWARE PROVIDERS*

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I. Overview

This document translates the April 2026 CCBHC Deep Dive webinar into a guide that can be used for onboarding, planning, implementation, and compliance support. It follows the same overall flow as the presentation while expanding slide content into practical explanations.

II. A New Care Delivery Model

What is a CCBHC?

A Certified Community Behavioral Health Clinic (CCBHC) is a comprehensive care delivery model designed to ensure timely access to high-quality, integrated behavioral health services for people of all ages, regardless of ability to pay.

Key Characteristics

- Serves the full lifespan (children, adolescents, adults, older adults)
- Treats all diagnoses (mental health and substance use disorders)
- Emphasizes integration of physical and behavioral health
- Provides services regardless of insurance status or ability to pay

CCBHCs differ from traditional outpatient models by combining expanded service requirements, rigorous access standards, data reporting expectations, and a specialized reimbursement methodology.

CCBHC Core Services

CCBHCs provide nine core services directly or through formal partnerships. These are further described in Section VI

1. Outpatient Mental Health & Substance Use Services
2. Targeted Case Management
3. Peer Support Services
4. Crisis Services
5. Psychiatric Rehabilitation Services
6. Screening, Diagnosis & Risk Assessment
7. Primary Care Screening & Monitoring
8. Person- & Family-Centered Treatment Planning
9. Community-Based Mental Health Care for Veterans

CCBHC Funding Options

A key feature of the CCBHC model is the Prospective Payment System (PPS), which provides CCBHC with a more flexible payment model that allows for more creative and broad-reaching service delivery than traditional fee for service. In practice, there are several funding options for CCBHCs:

1. **Prospective Payment System (PPS):** Clinics in states participating in the Demonstration Program must use a PPS. States can also establish a PPS through a State Plan Amendment, either in lieu of participating in the Demonstration or to sustain the PPS funding model beyond the Demonstration.
2. **SAMHSA funding and traditional reimbursement:** SAMHSA provides clinic-level, time-limited funding to grantees to plan or expand their CCBHCs. Grantees would continue to bill for reimbursable services through State Plan or Managed Care payment models.
3. **SAMHSA funding and PPS:** In some cases, a CCBHC may receive a SAMHSA expansion grant and live in a state that already has an established PPS. In these cases, SAMHSA funds would be used to support costs not otherwise allowed through the PPS, and payments for services would be reimbursed through the PPS.

III. Prospective Payment System (PPS)

The Prospective Payment System (PPS) is an alternative to traditional fee-for-service billing that pays clinics a fixed daily rate for qualifying encounters, regardless of how many services are delivered on that day or how intensive those services are. The PPS rate is based on the actual allowable costs the CCBHC incurs to deliver CCBHC services (reported through a cost report to the state) divided by the number of services delivered. The PPS is calculated using one of three available methodologies known as PPS-1 (daily cost), PPS-2 (monthly cost), or PPS-3 (daily cost with special crisis services). States are responsible for determining which costs incurred by the CCBHC are allowed to be included in the cost report as well as which methodology will be used. Below, the most common methodology, PPS-1, is further described.

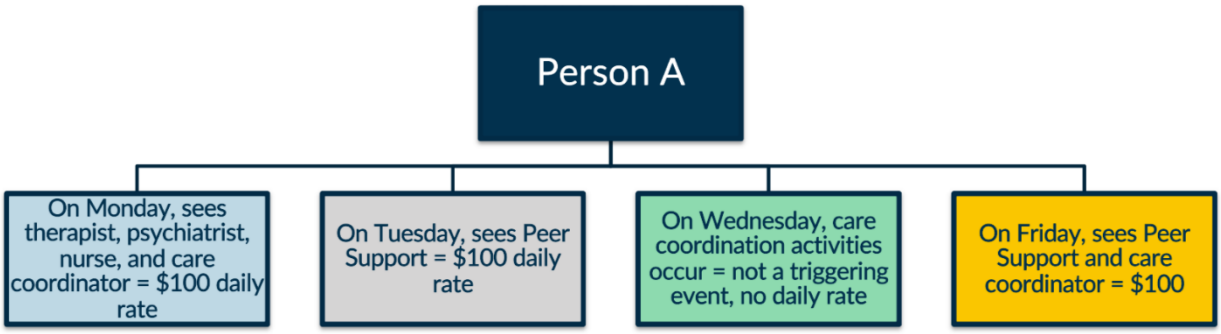
PPS-1: Expected Daily Cost

The following formula is used for calculating the standard base PPS rate for PPS-1:

$$\frac{\text{Total annual allowable CCBHC costs}^{*}}{\text{Total number of CCBHC daily visits per year}}$$

Example

If a clinic's allowable annual costs are $10,000 and total annual daily visits equal 100, the PPS-1 rate would be $100 per visit. Any qualifying visit day is paid $100, regardless of the number or type of service contacts that day. The figure below provides a visual representation.



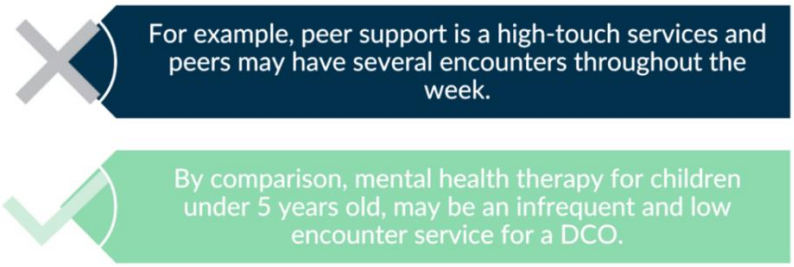
What PPS Supports

Because payment is not service-by-service, in some cases it is higher than the actual costs of providing care to a particular person, while in other cases it is lower. This flexibility supports CCBHCs to provide essential but often non-billable activities such as care coordination, transportation support, and hospital engagement and follow-up.

IV. Designated Collaborating Organizations (DCOs)

What Is a DCO?

A Designated Collaborating Organization (DCo) is an entity that a CCBHC contracts with to deliver one or more of the nine required services. CCBHCs may choose to engage a DCO if they do not have the capacity or desire to implement one of the required services; however, there are key parameters that CCBHCs must be aware of. CCBHCs must serve the full lifespan. Accordingly, they cannot DCO all services for an age group. Furthermore, the CCBHC must directly provide at least 51% of all services, by encounters.



Delaware-Specific Expectations

- DCOs must meet Delaware CCBHC certification standards for the services and populations they serve
- CCBHCs must submit DCO agreements during certification

CCBHC Responsibilities for DCO

- The CCBHC maintains programmatic, clinical, and regulatory responsibility for the services provided by the DOC to CCBHC clients.
- Payment for DCO services is included within the scope of the CCBHC PPS.
- DCO encounters will be treated as CCBHC encounters for purposes of the PPS.
- The DCO must have the necessary approvals, certifications, licenses, and/or enrollments to provide the specific Medicaid-covered services.
- Performance of the CCBHC and its DCOs will be considered during the re-certification process.

DCO Payment

DCOs are paid by the CCBHC for services rendered to CCBHC clients that are covered under their DCO agreement. This is not a pass-through of the PPS; rather, CCBHCs should develop specific payment arrangements with the DCO to cover the cost of care. DCOs may not bill Medicaid directly for CCBHC services covered under their DCO agreement. They can continue to provide and bill for services they provide outside of their DCO agreement. The costs associated with the services provided under the DCO agreement, including the costs of managing the relationship and coordinating technology and billing, should be included in the CCBHCs cost report and built into the PPS.

V. Program Requirements: Federal CCBHC Criteria

SAMHSA has established a set of federal CCBHC Certified Criteria that outline the values, expectations, and requirements of CCBHCs to maintain fidelity to the model.

Requirement 1: Staffing

- Appropriate licensure and credentialing
- Ongoing training and cultural competence
- Linguistic access for the population served

Requirement 2: Availability and Accessibility of Services

- No refusal of services due to inability to pay
- Services available regardless of residence
- Clear, enforceable access timelines based on the triaged needs of the individual seeking services:

Service	Timeframe
Crisis Management	1-2 hours from initial call
Urgent Initial Evaluation	1 business day from initial call
Routine Initial Evaluation	10 business days from initial call
Comprehensive Evaluation	60 calendar days* from initial call **45 days in Delaware*

Requirement 3: Care Coordination

- Formal care coordination agreements
- Use of health information systems
- Interdisciplinary treatment teams
- Ongoing treatment planning

Requirement 4: Scope of Services

CCBHCs must provide all nine required services across the full lifespan (*See section VI for more details*).

Requirement 5: Quality and Reporting

- Data collection and performance tracking
- A formal Continuous Quality Improvement (CQI) plan

Requirement 6: Organizational Authority

- Strong governance and fiscal oversight
- Meaningful input from people with lived experience
- Required accreditation

Delaware-Specific Service Expectations

States are required to develop their own criteria that takes into account state-specific needs and goals. State-level criteria can be more stringent than the federal criteria, but not less. The table below outlines key Delaware-specific criteria.

Service	Expectations for Delaware
Primary Care Screening	*Includes, at minimum:* • HIV and viral hepatitis screening • Blood pressure monitoring • BMI calculation • Hemoglobin A1C (when indicated)
Evidence-Based Practices	• Required trauma-specific and family-centered EBPs • MOUD, SBIRT/YSBIRT, and age-specific EBPs
Targeted Case Management Populations	*Includes individuals:* • At high risk of suicide or overdose • Transitioning from incarceration, homelessness, or higher levels of care • Transition-age youth (18–24) • Involved with child welfare or juvenile justice

Crisis System Integration	• Alignment with 988 call centers • Coordination with state mobile crisis systems • Availability of crisis receiving and stabilization services

VI. Services

The federal criteria define nine services that are required of all CCBHCs. In practice, five of these are programs and the remaining four are activities that CCBHCs must practice.



The criteria further requires that CCBHC engage in care coordination and continuous quality improvement, though they are not explicitly referenced in the nine required services messaging.

Outpatient Services for Mental Health & Substance Use Disorder: CCBHCs must provide outpatient services, using evidence-based practices, to care for people across the lifespan. Services must address mental health, substance use disorder (tobacco cessation and ASAM levels 1 and 2), and psychiatry.

Peer Support, Peer Counseling, & Family Supports: Peer supports must include peer specialists and recovery coaches, peer counseling, and family/caregiver supports. There are a number of recommended examples in the criteria, such as peer navigators to support care transitions.

Psychiatric Rehabilitation Services: Skill building and recovery supports should be available to those with social, education, medication, housing, and/or employment needs.
Targeted Case Management (TCM): Going beyond care coordination or standard case management, TCM provides intensive support to assist people receiving services in sustaining recovery and gaining access to needed medical, social, legal, education, housing, and/or vocational needs. In Delaware, the populations targeted for this service include:

- People deemed at high risk of suicide or overdose, particularly during times of transitions
- People with complex or serious mental health and/or substance use conditions
- People who have a short-term need for support in a critical period, including transitioning from higher levels of care such as the PROMISE Program
- People in other critical periods, such as episodes of homelessness and transitions to the community from correctional settings
- Transition-age youth, ages 18-24
- Children, youth, and families served by, or with prior involvement with, child welfare or juvenile justice systems.
- Special population group as identified through the CCBHC's CNA

Crisis Services: CCBHCs are expected to coordinate with 988 (someone to call)

Screening, Assessment, and Diagnosis: All individuals served by a CCBHC must first be screened for risk to determine urgency of next steps. Next, individuals receive an initial assessment, preliminary diagnosis, and treatment plan to initiate services. Once engaged, the comprehensive assessment process continues, incorporating validated screening tools and modifying the treatment plan as needed based on updated information.

Patient & Family-Centered Treatment Planning: The treatment plan should be developed in partnership with the individual served and their family and should fully integrate goals related to prevention, physical health, and behavioral health.

Primary Care Screening & Monitoring: While not responsible for the delivery of primary care services, CCBHCs are tasked with monitoring the physical health of individuals served through periodic testing and measurement of various physical health indicators and coordination with other health providers. This coordination is expected to be frequent and as needed to address areas of need including pregnancy and postnatal care, dental care, vaccination status, nutrition, cancer screening, vision, and hearing.

Services for Armed Forces, Veterans, and their Families: CCBHC staff must be culturally competent to provide all needed services to members of the armed forces, veterans, and their families.

VII. Implementation

Sequencing Matters: First This, Then That

When a clinic implements the CCBHC model, it is a transformative, complex, and comprehensive process. Successful implementation requires careful planning, integration, and continuous improvement. In the graphic below, a suggested order of operations is provided to ensure all activities have the necessary inputs they need to fully address clinic needs.



When sequencing is not taken into account, decisions may be made without the necessary inputs. For example, if a CCBHC were to submit the cost report before they determine the evidence-based practices (EBPs) they will utilize, there could be significant financial implications.

Example:

- After the CCBHC submits their cost report, they decide to offer Parent-Child Interaction Therapy (PCIT).
- To provide PCIT with fidelity, they outfit two of their offices with a two-way mirror in between and audio technology.
- These costs are not included in the cost report because it has already been submitted.

Community Needs Assessment (CNA)

CCBHCs are expected to tailor the services they deliver to the specific needs of the community; the CNA serves as the road map for service selection and expansion, workforce development, cultural and linguistic access, and location and hours of operation. As such, the CNA must be thorough and reflect the treatment and recovery needs of those who reside in the service area across the lifespan including children, youth, and families.

CCBHC Transformation

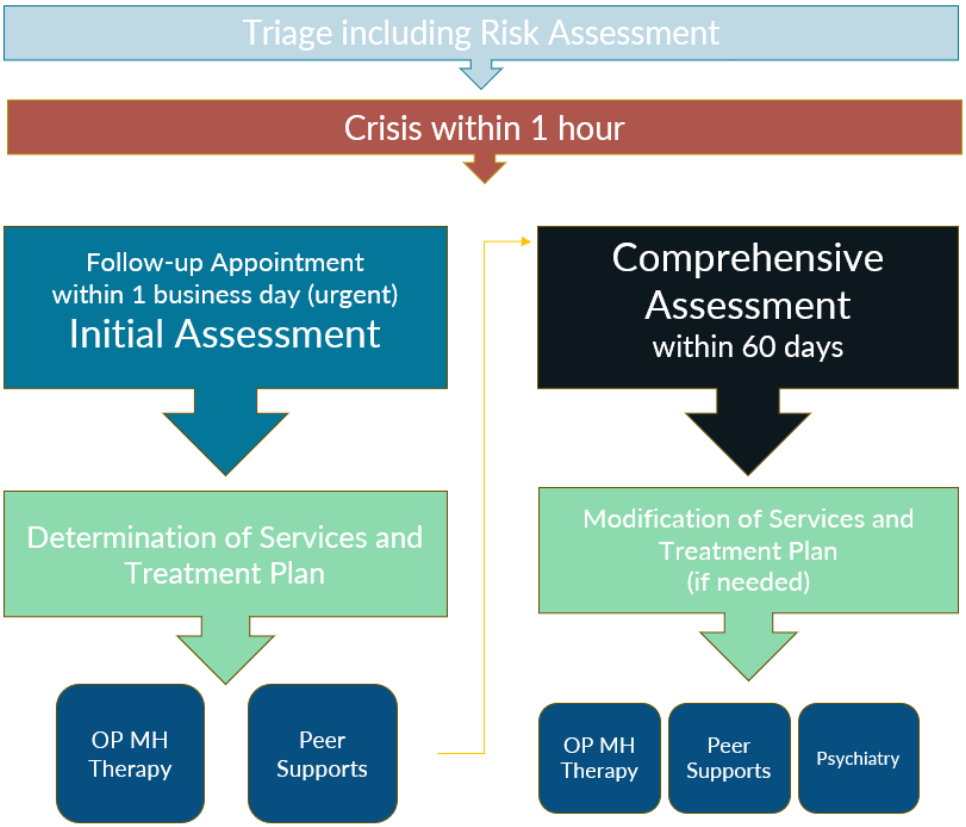
Launching a CCBHC is a system-wide transformation, not an add-on program. Clinics must ensure they have the necessary buy-in and capacity to support success.

1. *Assess the leadership team's capacity.* Launching a CCBHC is a time-sensitive transformation, not a layered-on initiative.
2. *Consider what other initiatives are underway.* Consider whether they will support the CCBHC transformation or distract from it.

3. *Strategically streamline your use of resources*. Cross walk data collection, reports, and use of staff time for committees, making use of existing resources and resolving the potential for conflicting expectations.

Beginning the User Journey at a CCBHC

Individuals seeking services at a CCBHC should expect accessible and timely initiation of services.



VII. Conclusion

The CCBHC model represents a comprehensive and transformative approach to behavioral health care, combining broad service requirements, rigorous access standards, integrated care coordination, and sustainable payment through PPS. As outlined in this guide, successful CCBHC implementation requires deliberate planning, strong partnerships, workforce readiness, and CQI, all grounded in a thorough understanding of community needs. When implemented effectively, the CCBHC framework supports timely access to care across the lifespan, improves outcomes for people with complex behavioral health needs, and strengthens accountability across the system—positioning clinics as critical access points for high-quality, person- and family-centered care.