NATIONAL ASSOCIATION OF Community Health Centers®

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The table below provides a high-level overview of program similarities and differences between Federally Qualified Health Centers (FQHC) and Certified Community Behavioral Health Clinics (CCBHC). For more information, please email federalpolicy@nachc.org.

Federally Qualified Health Center (FQHC) & Certified Community Behavioral Health Clinic (CCBHC):			
Topic Area:	**Subtopic Area:**	**Federal Qualified Health Centers (FQHC)**	**Certified Community Behavioral Health Clinic (CCBHC)**
Overview	*# of States*	50 states and US Territories	34 States with at least one local CCBHC grantee
	# of provider sites	1,373 Federally Qualified Health Centers. ▪ 14,276 service delivery sites. 108 FQHC Look-Alikes ▪ 399 service delivery sites.	450 CCBHCs operating across the country. 9 Federal CCBHC Medicaid Demonstration (and SAMHSA Expansion Grants). 6 States with CMS-approved payment method via SPA or 1115 wavier
	# of patients	Health centers serve over **30 million patients** (2021).	**2.1 million clients** are served nationwide. ▪ By all 450 CCBHCs and grantees (August 2022).
	Patient Demographics	1 in 11 US Residents 1 in 6 Medicaid beneficiaries 1 in 5 uninsured persons 1 in 3 people in poverty 1 in 7 racial/ethnic minorities 1 in 5 rural Americans 1 in 8 children 1 million migrant agricultural workers	150 clients (at each CCBHC), on average, are currently engaged in Medication Assisted Treatment. 69,400 (estimated) total CCBHC clients with SUD currently engaged in MAT. ▪ Across all 450 CCBHCs and grantees (August 2022). 80% of CCBHCs report directly offering MAT for alcohol use disorder. 76% of CCBHCs report directly offering MAT for tobacco cessation.

Oversight	*Federal Agency*	Health Resources & Services Administration	**Medicaid CCBHC Demonstration** Administered by state Medicaid and Behavioral Health Authorities. Within guidelines set by SAMHSA and the Centers for Medicare and Medicaid Services (CMS). **SAMHSA CCBHC Expansion Grants** Administered by SAMHSA.
	Site Certifications	**Federally Qualified Health Centers (FQHC)** Private non-profit entities. Must demonstrate that they are eligible organizations under the Health Center Program statute and regulations. **FQHC Look-Alikes** Look-alikes must meet the Health Center Program requirements. ▪ Look-alikes do not receive Federal funding under section 330 of the PHS Act.	**Medicaid CCBHC Demonstration** CCBHCs are certified by their states. States determine certification criteria using SAMHSA guidance as a baseline. **SAMHSA CCBHC Expansion Grants** Grantees must meet SAMHSA baseline CCBHC certification criteria. CCBHCs are funded by SAMHSA and do not receive state certification.
	Medical Malpractice	Covered under the Federal Tort and Claims Act as covered entities. ▪ Treated as PHS employees for purposes of medical malpractice liability coverage.	Maintains malpractice insurance adequate for the staffing and scope of services provided.
	Data Reporting	Required to report a core set of information as part of the Uniform Data System (Annually). ▪ Includes patient characteristics, services provided, clinical processes and health outcomes, patients' use of services, staffing, costs, and revenues.	The CCBHC criteria specify 22 quality measures that clinics and states were required to report for the demonstration.

Program Requirements		Must meet requirements within the health center program compliance manual. The manual consists of 21 chapters. (1) Eligibility, (2) Oversight, (3) Needs Assessment, (4) Required Health Services, (5) Clinical Staffing, (6) Hours of Operation, (7) Medical Emergencies (After Hours Care), (8) Continuity of Care & Hospital Admitting, (9) Sliding Fee Scale, (10) Quality Improvement, (11) Key Management Staff, (12) Contracts/Subawards, (13) Conflict of Interest, (14) Collaborative Relationships, (15) Financial Management, (16) Billing & Collections, (17) Budget (18) Data Reporting Systems, (19) Board Authority, (20) Board Composition, (21) Federal Tort Claims Act.	Requires CCBHCs not to refuse service to any individual based on either ability to pay or place of residence. Program Criteria Includes Six Areas: (1) Staffing, (2) Availability and Accessibility of Services, (3) Care Coordination, (4) Scope of Services, (5) Quality and Other Reporting, and (6) Organizational Authority.
Workforce	*Economic Impact (Number of Employees)*	**Health Centers Employed:** Over 92,000 medical professionals 18,000 dental health professionals 17,000 behavioral health specialists 25,000 enabling services professionals (2022).	**Across 249 Responding CCBHCs:** 6,220 new staff were hired. ▪ Estimated 11,240 new staff hired across all CCBHCs. 27 new positions were added on average per clinic since becoming a CCBHC (2022).
Scope of Services		Must provide a set of required primary health care services. May provide additional health services to meet the needs of its patients. Must serve a medically underserved population or one or more special medically underserved populations as their target population. Medically Underserved Populations Include:	CCBHCs are required to provide nine core services, which they can provide directly or via formal relationships with Designated Collaborating Organizations (DCOs): 1. Crisis Services 2. Treatment Planning 3. Screening, Assessment, Diagnosis & Risk Assessment 4. Outpatient Mental Health & Substance Use Services 5. Targeted Case Management 6. Outpatient Primary Care Screening and Monitoring 7. Community-Based Mental Health Care for Veterans

		▪ Migratory & seasonal agricultural workers. ▪ People experiencing homelessness. ▪ Residents of public housing.	8. Peer, Family Support & Counselor Services 9. Psychiatric Rehabilitation Services
Reimbursement		Congress created a specific payment methodology for health centers, the FQHC Prospective Payment System (PPS). • Receive a single, bundled rate for each qualifying patient visit (for Medicaid patients). • Single rate pays for all covered services and supplies provided during the visit. • States may implement an Alternative Payment Methodology (APM) to reimburse FQHCs. o Total reimbursement cannot be less than it would have been under PPS. • States and MCOs can incorporate FQHCs into value-based payment arrangements, including those involving financial risk related to quality, outcomes, and cost.	**Medicaid CCBHC Demonstration** States were able to choose between two broad PPS models developed by the HHS Centers for Medicare & Medicaid Services (CMS). First PPS Model: ▪ Like the PPS model used by Federally Qualified Health Centers. • Cost-based reimbursement that pays a fixed daily rate for all CCBHC services rendered to a Medicaid beneficiary. • Includes a state option to provide quality bonus payments (QBPs) to CCBHCs that meet defined quality metrics. Second PPS Model: • Cost-based reimbursement that pays a standard monthly rate per Medicaid beneficiary served. o With separate monthly rates that vary with beneficiaries' clinical conditions. o Includes outlier payments for costs above and beyond a specific threshold. ▪ Payment adjustments for extremely costly Medicaid beneficiaries.

			▪ Requires bonus payments for clinics that meet defined quality metrics. **<u>SAMHSA CCBHC Expansion Grants</u>** • CCBHCs under expansion grants do not have a PPS rate. • Receive up to $4M for a four-year term and continue to bill Medicaid and other payers.
	Dually Certified FQHC/CCBHC Clinics	• FQHC PPS is paid whenever at least one FQHC-covered service is provided. • Two PPS rates may be paid for the same visit. **To avoid duplication of in-state plan payments a state may modify CCBHC PPS but cannot pay less than the FQHC PPS.**	• CCBHC PPS is also paid for the same encounter when an additional service is covered only through the CCBHC rate.
Prescription Drug Purchasing Programs		340B drug pricing program provides health centers access to outpatient drugs at reduced prices. All savings from the 340B program are reinvested into ongoing operations and expanded services to patients.	CCBHCs are not considered covered entities under the 340B Drug Purchasing Program.