

The National Council for Mental Wellbeing and the National Association of Community Health Centers Joint Policy Scan

In Partnership with the Delta Center Initiative



Overview

This policy scan was developed jointly by the National Council for Mental Wellbeing (NCMW) and the National Association of Community Health Centers (NACHC) in an effort to summarize and identify current legislation, grant programs, and other policy initiatives that are relevant or could impact state primary care and behavioral health associations and their memberships.

As Medicaid and the Children's Health Insurance Program (CHIP) are key insurance providers for both association types, this scan synthesizes publicly available documents, recent legislative or regulatory developments, and notable trends to items that may have joint relevance and/or impact for both association types. **The purpose of this scan is to provide information for our shared memberships that could assist in identifying areas for future strategic or collaborative alignment, opportunities, risks, and serve as a foundation for deeper policy analysis as needed.** While not exhaustive, the information presented here reflects the most recent and credible sources available at the time of review.



Assessment of Key Policy Changes or Potential Legislation

One Big, Beautiful Bill Act (H.R. 1)

H.R. 1, the One Big Beautiful Bill Act (OBBBA), partially offsets the cost of tax cuts and other spending items included in the bill through new restrictions on Medicaid.¹ The new law will result in significant funding reductions to the program, in many cases phased in over the next decade.² Some of the key provisions impacting Medicaid include new work/community engagement requirements, cost-sharing requirements, restrictions on provider tax arrangements and state-directed payments, address verification, and more frequent eligibility redeterminations for certain enrollees.³ The Congressional Budget Office (CBO) estimates that Medicaid provisions could lead to approximately 11.8 million people losing access to insurance by 2034.⁴

Both behavioral health and primary care providers and associations are likely to experience significant impacts. Medicaid funding reductions and eligibility restrictions could lead to more barriers to accessing care and difficult financial circumstances for providers and the states in which they operate. This may include an increase in uninsured patients served and uncompensated care, greater workforce challenges, and reduced reimbursements as states struggle to backfill lost federal revenue. While the bill will present many new challenges, it also contains certain exemptions recognizing the value of community-based providers. Specifically, all services provided at certain Certified Community Behavioral Health Clinics (CCBHCs) and Community Health Centers (CHCs) are exempt from the bill's cost-sharing requirements for patients, and certain CCBHCs and CHCs (as well as community mental health centers) are among the provider types eligible for relief funding through the Rural Health Transformation Program (discussed in greater detail below).⁵

COMPLETE Care Act (H.R. 2509/S. 931):

This COMPLETE Care Act⁶ seeks to broaden access to mental health and substance use disorder treatment by supporting clinicians and healthcare systems in adopting and advancing innovative integrated care models, including the Primary Care Behavioral Health Model⁷ and the Collaborative Care Model (CoCM).⁸ These team-based, interdisciplinary approaches promote close coordination between behavioral health and primary care providers within primary care settings. By fostering holistic, collaborative care, these models have the potential to improve access, shorten wait times, enhance patient outcomes and experiences, and lower overall healthcare costs.

Use of the CoCM can help BHAs expand their network of providers into primary care settings and help PCAs enhance the behavioral health services their members offer. CoCM naturally fosters collaboration at the provider level, and thus presents an opportunity for BHAs and PCAs to explore collaboration as well, such as strengthening member engagement, supporting joint training programs, and promoting shared learning initiatives.

Consolidation of Certain Federal Agencies into the Administration for a Healthy America

The proposal to consolidate several federal health agencies into a new “Administration for a Healthy America” (AHA) is part of a broader effort by the Trump Administration to streamline and modernize the federal public health infrastructure. While this consolidation is conceptual at this point (as of late 2025) and subject to ongoing litigation, there are several potential considerations to bear in mind should this proposal be implemented.

The proposal would combine multiple agencies — the Office of the Assistant Secretary for Health (OASH), Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Agency for Toxic Substances and Disease Registry (ATSDR), and National Institute for Occupational Safety and Health (NIOSH) — into a new, unified entity. While specific details of the proposal are still coming into focus, this could present several opportunities and potential implications for behavioral health and primary care associations. Potential opportunities include improved alignment of behavioral health and primary care initiatives under a single umbrella, which could support integrated care models. This could also lead to greater policy coherence and coordination, particularly for initiatives involving workforce, health for all, and community-based prevention. Potential challenges include uncertainty around the future of legacy programs and how funding streams might be restructured. Behavioral health and primary care associations will likely need to monitor the development of this proposal closely, engage in stakeholder feedback opportunities, and ensure that the unique needs of their members are reflected in the new structure, particularly around funding, flexibility, and infrastructure support.

Provisions in the CY2026 Medicare Physician Fee Schedule

As part of the proposed CY2026 Medicare Physician Fee Schedule (PFS) rule, CMS is proposing new optional add-on codes for Advanced Primary Care Management (APCM)

services to aid in the provision of complementary behavioral health integration (BHI) services and reduce the burden on practitioners by removing the time-based requirements of the existing BHI and CoCM codes. These codes would be billed as add-on services when the APCM base code is reported by the same practitioner in the same month. CMS is also currently soliciting comments from stakeholders on how cost-sharing should be applied for APCM services, particularly if preventative services are included in the APCM bundles.

The CY 2026 PFS also clarifies that Marriage and Family Therapists and Mental Health Counselors can bill Medicare directly for Community Health Integration (CHI) and Principal Illness Navigation services they personally perform for the diagnosis or treatment of mental illness. CMS is soliciting comments on the CY2026 PFS through September 12, 2025, and the final PFS rule would be effective January 1, 2026.

Additionally, in the CY2025 PFS, there was a request for comment on CCBHCs' considerations for service payments. Like CHCs, CCBHCs are safety-net providers that provide care to individuals regardless of their ability to pay, offer services in a defined service area, and have consumer majority boards and data reporting requirements, among other similarities.



Potential Funding Opportunities

Grant/Funding Item	Description	Future Opportunities
<u>Promoting the Integration of Primary and Behavioral Health Care (PIPBHC)</u>	Administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), PIPBHC grants enable states to integrate behavioral health into primary care settings, targeting populations like adults with serious mental illness (SMI), children with serious emotional disturbance (SED), and those with co-occurring physical health conditions. The goal of the program is to improve health outcomes through evidence-based, bidirectional care—screening, diagnosis, treatment, recovery support across mental, SUD, and physical health domains. These grants encourage state health agencies and associations to formally collaborate with CHCs, CCBHCs, and rural clinics, in an effort to eliminate silos and improve care coordination.	Future funding for the program beyond FY25 will be contingent upon action by Congress. Both the House and Senate FY26 budget proposals included funding for the program, however FY25 appropriations have not yet been finalized.

<p><u>CMMI Behavioral Health Integration Model</u></p>	<p>Administered by the Centers for Medicare and Medicaid Innovation (CMMI), part of the Center for Medicare and Medicaid Services (CMS), the Innovation in Behavioral Health (IBH) Model is a new valued-based payment model focused on patients with moderate to severe mental illness. The program’s objective is to improve the ability of community-based outpatient mental health and substance use treatment providers to deliver integrated care to patients with multiple medical/ surgical chronic conditions, prioritizing closer collaboration with primary care and medical specialty facilities.</p>	<p>In late 2024, CMS announced four state Medicaid agencies selected to participate in the program: Michigan, New York, Oklahoma, and South Carolina. Oklahoma is implementing the IBH model statewide, and Michigan, New York, and South Carolina are implementing the model in designated sub-state geographic service areas. Based upon the original CMS released the Cohort II Recipients NOFO on October 16, 2025. Applications are due June 3, 2026.</p>
<p><u>Rural Health Transformation Program</u></p>	<p>In response to concerns regarding the negative impacts of H.R. 1, the “One Big Beautiful Bill Act,” on rural community-based providers, hospitals, and other clinics, Congress included a \$50 billion fund within the bill titled the “Rural Health Transformation Program.” The program provides \$10 billion annually to states from FY 2026 through FY 2030. Half of the funds will be evenly distributed among states with approved applications, and half will be allocated by CMS based on each state’s rural population and demonstrated need. Only states (with the exception of Washington, D.C.) can submit applications. Certain CCBHCs, CHCs, and CMHCs are among the provider types eligible for awards, though geographic restrictions apply.</p>	<p>CMS opened the application for the program on September 15, 2025. The application will close by November 5, 2025 and decisions on approval or denial will be made by December 31, 2025.</p>

<p><u>Behavioral Health Wellness Education and Training (BHWET) Grants</u></p>	<p>The Behavioral Health Workforce Education and Training (BHWET) program, administered by the Health Resource Services Administration (HRSA), funds clinical training for students in behavioral health professions in an effort to grow the mental health and substance use disorder treatment workforce. The Program's goal of enhancing interprofessional and integrated training can be utilized in a number of different clinical settings, including CCBHCs and community health centers.</p>	<p>Applications for the most recent funding cycle are now closed. Future funding for the program beyond FY25 will be contingent upon action by Congress. The President's Budget-in-Brief included funding for this program, as did the House and Senate FY26 budget proposals, however FY25 appropriations have not yet been finalized.</p>
<p><u>CCBHC Planning Grants</u></p>	<p>Certified Community Behavioral Health Clinics (CCBHCs) are specially designated providers that deliver comprehensive, coordinated mental health and substance use disorder services to people of all ages, regardless of their ability to pay, where they live, or their diagnosis. The CCBHC model emphasizes accessible services, often integrating with primary care and other community resources. In 2024, nearly 3 in 10 (28%) CCBHCs reported offering fully integrated behavioral health and primary care services, with all services available in the same location. SAMHSA administers state planning grants; one-year cooperative agreements which help states develop certification systems, establish Medicaid prospective payment systems, and prepare applications to join the CCBHC Medicaid demonstration program.</p>	<p>Applications for FY25 planning grants are currently closed, <u>with 14 new states and D.C. receiving awards.</u></p>

<p><u>CCBHC Expansion Grants</u></p>	<p>Since 2018, HHS has supported the development of CCBHCs through the SAMHSA CCBHC Expansion Grant Program. These grants help providers establish new CCBHC programs, strengthen and improve existing ones, and cover costs for uncompensated care. Funding comes primarily through SAMHSA, and some grants are also part of state demonstration programs. The expansion grants emphasize meeting CCBHC criteria and grant requirements, while prioritizing increased access to care for individuals with serious mental illness, serious emotional disturbance, and substance use disorders. Initially, these were two-year grants providing up to \$2 million per year. In 2022, SAMHSA extended the program to four years, with funding of up to \$1 million annually.</p>	<p>The President’s Budget-in-Brief proposed level program funding for FY26 (\$385 million), and both chambers of Congress have proposed \$385 million for FY26.</p>
<p>HRSA Behavioral Health Service Expansion</p>	<p>In 2024 a Notice of Funding Opportunity (NOFO) allowed CHCs to apply for funding under the fiscal year (FY) 2024 Behavioral Health Service Expansion (BHSE) program. BHSE will support health centers to increase access to behavioral health services through starting or expanding mental health and substance use disorder (SUD) services. One of the program’s recommendations for health centers was to consider CCBHCs and opioid treatment programs in project proposals. The performance period is for two years from September 1, 2024, through August 31, 2026.</p>	<p>Future support for this grant will depend on future appropriations and the progress in meeting the project’s objectives.</p>



State Activity for Integrating Behavioral Health Care Services and Primary Care

This section highlights actions taken across states focused on integrating behavioral health and primary care that could be of interest or relevance to BHSAs and PCAs as they work to advance joint initiatives.

State Waivers

In 2022, the Centers for Medicaid and Medicare Services (CMS) approved a Massachusetts application to extend its MassHealth Section 1115 Demonstration through 2027 to reform and invest in primary care, behavioral health, and pediatric care. The intent is to expand access to services while pivoting away from fee-for-service health care. Specifically, Massachusetts is investing \$115 million per year in primary care and requiring providers to meet clear standards for access and team-based integrated care to meet patients' health care needs. This supports Massachusetts' Roadmap for Behavioral Health Reform for expanding substance use disorder services and diversionary behavioral health services. There is \$43 million available for loan repayment and residency training programs to strengthen the primary care and behavioral health workforce. Additionally, it will address health-related social needs, such as housing, nutrition, and post-release transition supports for justice-involved individuals.

State Reimbursement

In the Medicaid program, successes and obstacles to primary care and behavioral health integration differ depending on how states choose their implementation strategies. One significant barrier is restrictive same-day billing rules. Same-day billing is the practice of health centers being reimbursed for the full cost of each Medicaid-covered service furnished by billable providers to Medicaid patients (i.e., if a patient has a primary care and behavioral health visit on the same day, then the health center can bill for both services).

Currently, six states have enacted policies that restrict health centers from receiving Medicaid reimbursement when patients receive more than one service on the same day. These same-day billing restrictions fall into two categories: "one encounter per patient per day" (Indiana, Kentucky, New York, and Utah) or "up to two encounters per patient per day" (California and Minnesota). This means that if a patient visits their health center for both medical and behavioral health needs—or medical and dental needs—on the same day, the organization may not be fully reimbursed.

Allowing same-day billing is a practical, cost-effective solution. It supports team-based care models that maximize a patient's time and reduce unnecessary barriers to access, such as decreasing transportation reliance for patients in both rural and urban communities. For states, this policy helps Medicaid dollars go further by preventing costly complications down the line. Patients would not need to return for multiple visits to have

their health needs addressed. This falls in line with health centers and other community-based behavioral health organizations' mission to provide patients with access to a comprehensive set of health services they may seek in one visit.

State Models

North Carolina's model for care management service, the [Tailored Care Management](#) model, promotes integrated care and offers its Medicaid enrollees a choice in how to receive care management. Members have a designated Tailored Care Manager with a care team to address their care needs, including physical health, behavioral health, intellectual/developmental disabilities (I/DD), traumatic brain injuries, pharmacy, long-term services and supports, and unmet health-related resource needs. The model prioritizes frequent in-person interactions between members and their Tailored Care Managers, and it emphasizes outcomes and population health management.

New York created the [NYS Collaborative Care Medicaid Program](#) to allow primary care providers implementing the CoCM to receive a supplemental monthly case rate reimbursed by Medicaid for providing CoCM services. Provider sites must apply to be in this model, confirming team-based and evidence-based collaborative care workflows. Sites accepted into this program have access to personalized technical assistance and training on workflow development and other topics aimed at delivering high-quality, comprehensive care to patients. According to recent data, the program saw an increase in patients who received annual depression screening, and patients enrolled in CoCM for longer than 70 days showed clinical improvement.

State Agency Mergers

Arizona consolidated its Medicaid agency (Arizona Health Care Cost Containment System) and physical and behavioral health service agencies (Department of Health Services' Division of Behavioral Health Services) in 2015. As a result of this state action, the state proved that physical and behavioral health integration is a priority. There are now opportunities for strategic purchasing and managing Medicaid and non-Medicaid funds, enhanced data and information sharing through its health information exchange, and collaboration to address co-occurring disorders like serious mental illness and substance use disorder.

State Partnerships

Beginning in 2018, the New Mexico Primary Care Association and Behavioral Health Providers Association of New Mexico, as part of The Delta Center for a Thriving Safety Net's State Learning & Action Collaborative, collaborated on policy initiatives and advocacy. One significant policy change that facilitated integrated care was the implementation of reimbursement parity for behavioral health services. The two associations also gained agreement from the state to link payments to Medicare fees for behavioral health providers practicing in the community, which resulted in a 20- 30% increase for many behavioral health services. The two associations' final success has been the development of a three-year pilot project, fully funded by New Mexico's Health Services Department

and Behavioral Health Services Division, to define behavioral health-specific metrics, “Metrics that Matter.” As of 2024, 10 pilot provider teams successfully defined behavioral health quality metrics that form the basis for a payment reform initiative. The project has expanded to include 20 pilot teams.

The Alaska Behavioral Health Association and the Alaska Primary Care Association committed to a partnership to sustain collaboration between behavioral health and primary care. Together, they formed an advisory committee and met with legislators to discuss integrating behavioral health and telehealth. This partnership developed the Behavioral Health Investment for Resilient Community Health (BIRCH) Initiative for joint advocacy focused on investing in community behavioral health, adhering to parity standards, improving care coordination, and reforming school-based Medicaid services.

Starting in 2021, the Rehabilitation and Community Providers Association and the Pennsylvania Association of Community Health Centers, as part of The Delta Center for a Thriving Safety Net’s State Learning & Action Collaborative, partnered with multiple stakeholders to educate decision-makers about the impacts of current and future telehealth policy and practices on Pennsylvania’s diverse communities. The resulting policy and practice changes have significantly reduced ‘no show’ rates by removing barriers experienced in face-to-face care.

In 2021, the Louisiana Public Health Institute, the Louisiana Primary Care Association, the Community Health Center Association of Mississippi, and the Mississippi Association of Community Mental Health Centers, as part of The Delta Center for a Thriving Safety Net’s State Learning & Action Collaborative, began collaboration between the primary care and behavioral health associations. A large focus of the project was on supporting the implementation of Certified Community Behavioral Health Clinics (CCBHC) in both states. A CCBHC learning community was funded by the state of Louisiana to support CCBHC grantees in collaborative learning and inform state staff about the model. Six grantees in Louisiana and seven in Mississippi received SAMHSA CCBHC grants. Two of the Louisiana grantees are CHCs.



Recommendations for Joint Action

1. Convene recurring joint policy meetings between key stakeholders to proactively identify and address shared priorities and emerging issues:

Stakeholders should convene regular meetings to discuss emerging issues relevant to behavioral health and primary care associations. As policy challenges and opportunities continue to arise, potential meeting topics may include:

- Integrated care delivery models (e.g., CCBHC, PCMH, CoCM)
- Impacts of Medicaid reductions and grant funding fluctuations
- Joint workforce solutions (e.g., loan repayment, shared staffing models)
- Value-based care and data sharing readiness

These meetings should strengthen alignment across sectors, improve unified messaging with policymakers, and build durable coalitions to respond to emerging federal and state funding, legislative, and regulatory shifts.

2. Engage in notice and comment processes as opportunities arise for Federal and State rulemaking

Several provisions of H.R. 1 call for rulemaking at both the federal and state levels. Provisions related to work/community engagement requirements, eligibility redeterminations, and others will require CMS and state Medicaid agencies to promulgate rules, and stakeholders will likely have opportunities to make their voices heard through the notice and comment process. Behavioral health and primary care providers and their associations should engage in this process whenever possible as it may be one avenue of mitigating the impacts of the bill's Medicaid restrictions.

3. Launch story banking campaigns as stakeholders experience the impact of policy shifts:

As the impacts of H.R. 1 and reduced federal appropriations are felt by stakeholders, both primary care and behavioral health associations may wish to collect stories concerning the impact these actions have on their members.

Story banking campaigns could include:

- Stories of lived experience, including individuals receiving services and their families (with consent)
- Provider and staff experiences (from CCBHCs, CHCS, CMHCs and other providers)
- Organizational impact (e.g., service cuts, layoffs, waitlist increases)

These stories should clearly connect funding cuts to access, outcomes, workforce strain, and public health consequences.

4. Create Joint Action Alerts

Joint action alerts issued by the NCMW and NACHC can leverage the combined advocacy power of behavioral health and primary care networks. By coordinating outreach to members, stakeholders, and policymakers, these alerts could increase the visibility and influence of key policy priorities.

This will allow both organizations to engage members across sectors for a stronger, unified message, present cohesive, evidence-backed policy priorities to lawmakers, and provide actionable steps for members, building long-term advocacy capacity.

¹ <https://www.congress.gov/bill/119th-congress/house-bill/1/text>

² <https://www.kff.org/tracking-the-medicaid-provisions-in-the-2025-budget-bill/>

³ *Id.*

⁴ <https://www.cbo.gov/system/files/2025-06/61534-hr0001-Sen-2025Recon-CLB.xlsx>

⁵ *Id.*

⁶ <https://www.congress.gov/bill/119th-congress/senate-bill/931/text>

⁷ <https://www.apa.org/health/behavioral-integration-fact-sheet>

⁸ *Id.*

About The National Council for Mental Wellbeing

The National Council for Mental Wellbeing is a membership organization that drives policy and social change. With more than 3,200+ member organizations serving millions of individuals and families nationwide, our members are at the forefront of advancing care, shaping policies, and creating meaningful change. Combined, our member organizations support more than 15 million adults, children, and families. Our members include: community-based organizations providing a comprehensive array of mental health, substance use and social services, private and state associations advocating for community-based treatment organizations, hospitals offering mental health and substance use treatment services, county behavioral health departments and regional boards, consumer-run programs empowering people with lived experience, rehabilitation programs providing recovery-focused care, residential providers supporting long-term treatment and child welfare agencies addressing the mental health needs of vulnerable youth.

We champion policies to ensure access to high-quality services. We build the capacity of mental health and substance use treatment organizations and promote greater understanding of mental wellbeing as a core component of comprehensive health and health care. Through our Mental Health First Aid (MHFA) program, we have trained over 4 million people in the U.S. to identify, understand, and respond to signs and symptoms of mental health and substance use challenges.

We work to ensure mental health and substance use treatment organizations can meet the needs of their communities now and in the future. We advocate for federal and state funding, new and innovative care delivery and payment models, and a strong mental health and substance use treatment workforce. By improving access to lifesaving services, we can make mental wellbeing — including recovery from substance use challenges — a reality for everyone.



About The National Association of Community Health Centers

The National Association of Community Health Centers (NACHC) is the leading national membership organization dedicated to promoting Community Health Centers (CHCs) (also known as Community Health Centers) as the Employer, Provider, and Partner of choice in all communities and the foundation of the primary health care system in the United States. Community Health Centers are the best and most innovative part of our nation's health system. For sixty years, health centers have provided high-quality, comprehensive, and affordable primary and preventive care, as well as dental, behavioral health, pharmacy, vision, and other essential health services to America's most vulnerable, medically underserved patients in urban, rural, suburban, frontier, and island communities. Today, health centers serve at least one in ten people and up to one in seven people at over 17,000 locations. This includes more than 6 million uninsured people, over 16 million Medicaid patients, over 3 million Medicare patients, and over 1.5 million patients experiencing homelessness.