

NATIONAL
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TRANSFORMING STATE BEHAVIORAL HEALTH SYSTEMS:

FINDINGS FROM STATES ON THE
IMPACT OF CCBHC IMPLEMENTATION



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Acknowledgments



The National Council for Mental Wellbeing developed much of this paper based on interviews with state officials and review of supporting documents they shared. These individuals include:

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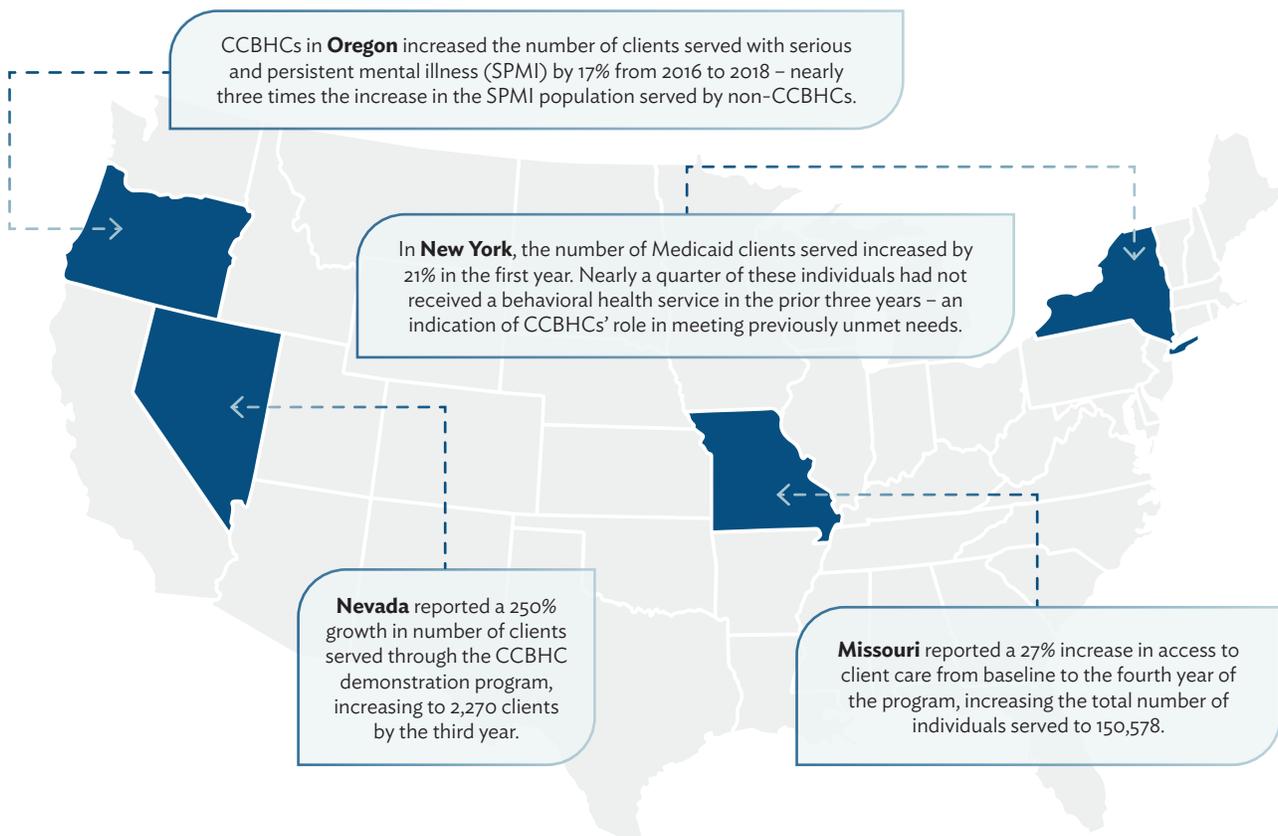
Summary and Data Highlights

With the Certified Community Behavioral Health Clinic (CCBHC) demonstration in its fifth year, a growing number of states are exploring implementing the model to address complex challenges, from rising levels of drug overdoses and suicide to longstanding issues with fragmentation of mental health and substance use from primary care systems. Concurrently, Congress is considering bipartisan legislation to further expand the demonstration.¹ As policymakers contemplate expanding the model, what can they learn about its impact in demonstration states to date?

In the summer of 2021, the National Council for Mental Wellbeing conducted surveys and interviews with state CCBHC program directors in each of the eight original demonstration states to explore how states' behavioral health systems have transformed with the advent of the CCBHC model. State officials reported that over the full lifespan of the program, the CCBHC model has lowered costs, improved outcomes, contributed to building critical mental health and substance use care system capacity and infrastructure required to meet rising levels of need and integrated services with the rest of the health care system. State officials credit the CCBHC prospective payment system (PPS) as instrumental to the success of their CCBHC programs.

HIGHLIGHTS FROM THE REPORT:

The CCBHC demonstration increased access to mental health and substance use care, largely due to increased availability of same-day appointments, expanded hours of operation facilitated by increased hiring and concerted efforts to conduct outreach to underserved groups.





States reported reductions in emergency department and hospital visits among CCBHC clients, leading to cost offsets.



Oklahoma's three CCBHCs reduced the proportion of their clients seen in emergency departments by 18–47% (rates varied by clinic) and those admitted to inpatient care by 20–69% over the first four years of the program, compared to baseline.



In its first year, **New York** reported a 54% decrease in the number of CCBHC clients using behavioral health inpatient care, which translated to a 27% decrease in associated monthly costs. Similarly, the state reported a 46% decrease in the number of clients using the emergency department, leading to a 26% reduction in monthly costs. New York also saw a 61% decrease in the number of clients using general hospital inpatient services and a 54% decrease in all-cause readmissions.



New Jersey reported a decline in all-cause readmission rates from the first to second demonstration year.



Missouri reported that among clients with a prior emergency department visit engaged in outpatient care at a CCBHC, 76% experienced reduced emergency department visits and hospitalizations. Of those engaged in care who had some type of prior law enforcement involvement, nearly 70% had no further law enforcement involvement at six months.

The CCBHC demonstration helped states mitigate the effects of the mental health and substance use service workforce shortage by enabling clinics to hire and retain vital staff.



Prior research has found that CCBHCs participating in the demonstration program hired an average of 117 new staff positions each, with a median of 43.² The most added staff include adult and child psychiatrists, licensed clinical social workers, nurses, counselors, case managers and peer specialists/recovery coaches.³ State officials cited expansion of staff as one of the biggest system improvements resulting from the CCBHC demonstration.



In **Nevada**, areas that rarely had access to psychiatrists prior to the demonstration now have an onsite psychiatrist and/or psychiatric advanced practice registered nurse, as well as providers that can offer medication-assisted treatment (MAT) for individuals with certain types of substance use disorders. Nevada referred to CCBHCs' ability to hire additional staff as “one big win for the [CCBHC prospective payment] rate.”



Multiple states, including **Minnesota, Missouri, New Jersey, Nevada and Oregon**, reported that the CCBHC program led to a significant expansion of peer workers and family support specialists, individuals with lived experience of mental health or substance use conditions who support coordination and understanding of services for new clients.

Rates of initiation, engagement and follow-up for mental health and substance use care tended to improve under the CCBHC demonstration program, with CCBHCs reporting higher performance than non-CCBHCs on key metrics.



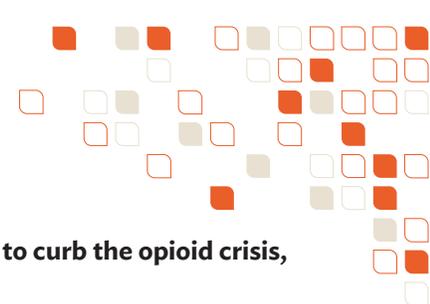
In **New Jersey**, the rate of follow-up after hospitalization for mental illness nearly doubled in the second year of the demonstration. New Jersey also reported that treatment initiation and engagement rates for alcohol and other drug use in adults increased from the first to the second demonstration year. CCBHCs far outperformed statewide averages on these measures.



New York CCBHCs outperformed other provider types in the state on numerous quality measures, including initiation and engagement of alcohol and other drug treatment and seven day follow-up after hospitalization.



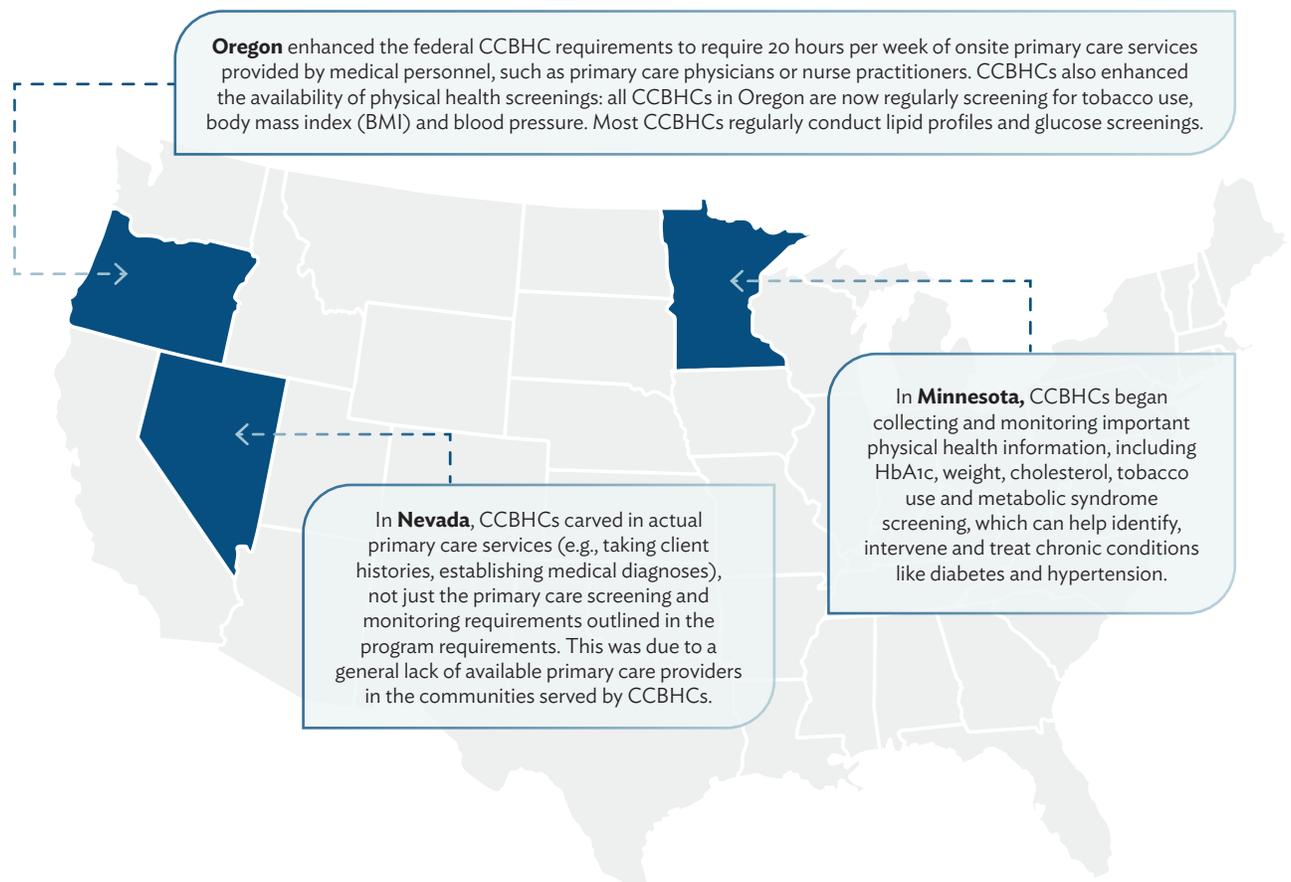
In **Missouri**, by the third demonstration year, CCBHCs had a 75% rate of 30-day post-hospitalization follow-up for adults hospitalized with mental illness, compared to a statewide average of just 33% for Medicaid providers.



The CCBHC demonstration increased access to a comprehensive, evidence-based services to curb the opioid crisis, including MAT.

-  In **New Jersey**, CCBHCs nearly doubled the number of clients receiving MAT from the first to the second demonstration year.
-  **Missouri** reported a 122% increase in MAT from baseline to the third demonstration year, increasing the number individuals receiving MAT from 3,128 at baseline to 6,929 by the third demonstration year.
-  **Oklahoma** had very few individuals receiving MAT prior to the CCBHC demonstration. State officials reported a 700% growth in this service from the year prior to the CCBHC demonstration to the fourth demonstration year.

The CCBHC demonstration resulted in improved integration of physical care with mental health and substance use care, with CCBHC sites in some states exceeding program requirements to offer onsite primary care services.



The CCBHC program contributed to building vital mental health and substance use service capacity and infrastructure required to meet rising levels of need for care while integrating services with the rest of the health care system. Other accomplishments included: increased utilization of evidence-based practices; expanded use of electronic health records (EHRs) and health information exchange; improved capacity to engage in care coordination with health system partners, law enforcement and other public service sectors; and more.



Introduction

Mental health and substance use challenges affect millions of Americans;⁴ yet, they have historically been undertreated in the United States.⁵ Section 223 of the Protecting Access to Medicare Act of 2014 authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration, which aims to improve the availability, accessibility, quality and outcomes of outpatient mental health and substance use services by establishing a standard definition and criteria for CCBHCs and prospective payment systems (PPS) that provide adequate financial support for clinics providing comprehensive services to all individuals who seek care. The Centers for Medicare and Medicaid Services (CMS) provides an enhanced match for CCBHC services to states that are included in the CCBHC Demonstration. In 2017, the Substance Abuse and Mental Health Agency (SAMHSA) selected eight states to participate in the CCBHC demonstration: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon and Pennsylvania. These states designated a total of 66 CCBHCs, which began providing services in 2017 (see Appendix 1). To implement the demonstration, SAMHSA developed criteria⁶ for states to certify community mental health centers or other behavioral health facilities as CCBHCs. The criteria provided flexibility for states to implement activities that aligned with their respective Medicaid programs and community needs.

While the CCBHC demonstration was initially established for a two-year period, it has been extended by law numerous times, most recently through September 30, 2023.⁷ Two states, Kentucky and Michigan, were added to the demonstration in 2020 and are currently in the planning stages of implementation. Driven by early successes from the demonstration, Congress also began appropriating yearly funds for CCBHC Expansion Grants in 2018 to individual clinics, distributed through SAMHSA. As of the publication of this report, there are more than 430 CCBHCs operating in 42 states, the District of Columbia and Guam. The majority of these CCBHCs are grant-funded and risk losing the ability to function as CCBHCs when their grants end. States also have the authority to implement the CCBHC model in their state Medicaid programs, bringing permanent sustainability to Congress' more than \$1.97 billion investment in CCBHC grants. While several states have actively begun CCBHC implementation in Medicaid, others have expressed a desire to understand more about the benefits of the model.^{8,9,10}

The U.S. Department of Health and Human Services (HHS) has issued several interim reports on the original two-year CCBHC demonstration, but little information has been published about states' experiences over the entire course of the program, now in its fifth year. This report highlights the impact of the CCBHC demonstration from the perspectives of the eight original participating states. The findings presented here go beyond the two-year federal evaluation to further articulate how state officials perceive the effect that the CCBHC model – when funded through a Medicaid PPS – has had on their delivery systems over the entire course of the program to date.



Scope and Methodology

The findings in this report were primarily based on semi-structured interviews with state officials from the eight states participating in the CCBHC demonstration; review of reports, program data and other documents shared by state officials; and review of other publicly available evaluation reports on the CCBHC program. Throughout the report, there are references to behavioral health services and providers. This language is used in line with individual state references and definitions but is generally inclusive of mental health and substance use services. In addition, any data analysis of the CCBHC program must include several caveats.

First, it is still relatively early in the CCBHC program's inception and states are still working to collect and process data – particularly claims data, which often requires a significant lag time for analysis – that would allow policymakers to understand the full impact of the program to date.

Second, the initial two-year limitation on the demonstration period may have impacted longer-term results; for example, while Congress has repeatedly extended the original demonstration program and associated funding, states and CCBHCs experienced a lack of certainty around sustained programming that held clinics back from long-term planning and hiring in certain cases.

Third, the overall impact of the CCBHC demonstration program may vary across states for several reasons, including:

1. Implementation of other payment and delivery system reform initiatives (e.g., Medicaid health home programs) and
2. How robust the behavioral health delivery system was prior to CCBHC implementation.

Appendix 1 includes selected information regarding CCBHC demonstration states, their CCBHC programs and other delivery system characteristics. Other factors that limit direct comparability across CCBHC programs include state flexibility to implement additional guidelines or parameters for their own programs and state-submitted data that varied across timeframes and levels of aggregation. Given the variation in CCBHC programs and data submitted by the states, this report generally highlights CCBHC program data, where available, from individual states, rather than aggregating or comparing data for similar metrics across states.

Finally, the fifth report to Congress by HHS, due December 2021, will assess the preliminary impact of the demonstration on care utilization using Medicaid claims and encounter data, but only for the first two years of the program.¹¹ Given that CCBHCs spent most of the first demonstration year making necessary operational and structural changes needed to meet certification standards – such as adopting or upgrading EHRs, hiring and training staff or reviewing and cleaning data – an evaluation of quality improvement over a two-year timeframe will not be long enough to measure the true impact of the demonstration. As a result, more than two years' worth of the CCBHC demonstration program results will not be included in the forthcoming study. While the intent of this report was to collect comprehensive data on service delivery, costs and outcomes for the entire duration of the CCBHC demonstration program, some states were unable to share more current CCBHC program data due to time and resource constraints.



CCBHC Impact on Costs and Outcomes

This section offers data, as reported by states, that demonstrates the positive impact of the CCBHC demonstration on care processes, access to care, costs and beneficiary outcomes.¹² Overall, the major findings include:

1. A substantial increase in the number of individuals accessing care through CCBHCs, particularly for historically underserved groups, as well as improved timeliness of care;
2. Increased provision of a comprehensive range of services, including physical, mental health and substance use screenings, peer services and medication-assisted treatment (MAT); and
3. Improved rates of follow-up during transitions of care.

States also reported positive outcomes for CCBHC clients, including reductions in emergency department visits, hospital inpatient visits and readmission rates, which suggests that CCBHC services and supports generated cost offsets by reducing use of more expensive care settings.

The CCBHC demonstration increased access to care, largely due to increased availability of same-day appointments and concerted efforts to conduct outreach to underserved groups.

Although the growth rate varied by state, across the seven states with available data, the total number of individuals receiving care increased nearly 10%, from 284,919 in the first demonstration year to 312,196 in the third (see Appendix I). At the same time, clinics increased the total number of individuals served and substantially reduces how long it takes to receive services – in some cases eliminating wait lists completely – a noteworthy finding given that the average wait time for mental health and substance use services across the United States is 48 days.¹³

New York officials reported that the demonstration enabled CCBHCs to hire additional staff to accommodate open access and demand for clinic and medication management appointments, making it possible to expand access by increasing days and hours of operation to eliminate wait lists; as a result, the number of Medicaid individuals served increased by 21% in the first year of operation. Outreach and engagement of unserved or underserved populations increased as nearly one quarter of individuals receiving services at CCBHCs had not received a behavioral health service in the previous three years. In New York, all 13 CCBHCs reported that they have no wait lists and individuals can receive services when they want an appointment. New York also reported a 24% increase in providing children and adolescent services, noting that this was possible, in part, because the PPS allowed CCBHCs to hire more child psychiatrists.

Missouri reported a 27% increase in access to client care from baseline to the fourth year of the program, primarily because of adopting same day/next day access (see Figure 1). Missouri also reported growth in the number of armed forces and veterans served by almost 41% from baseline (2,524) to Year 4 (3,562).

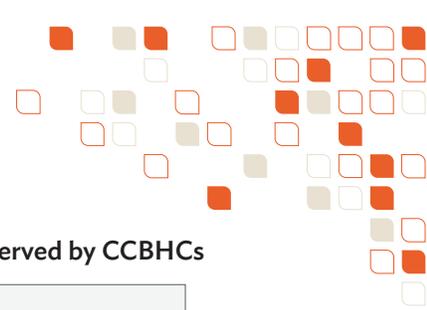
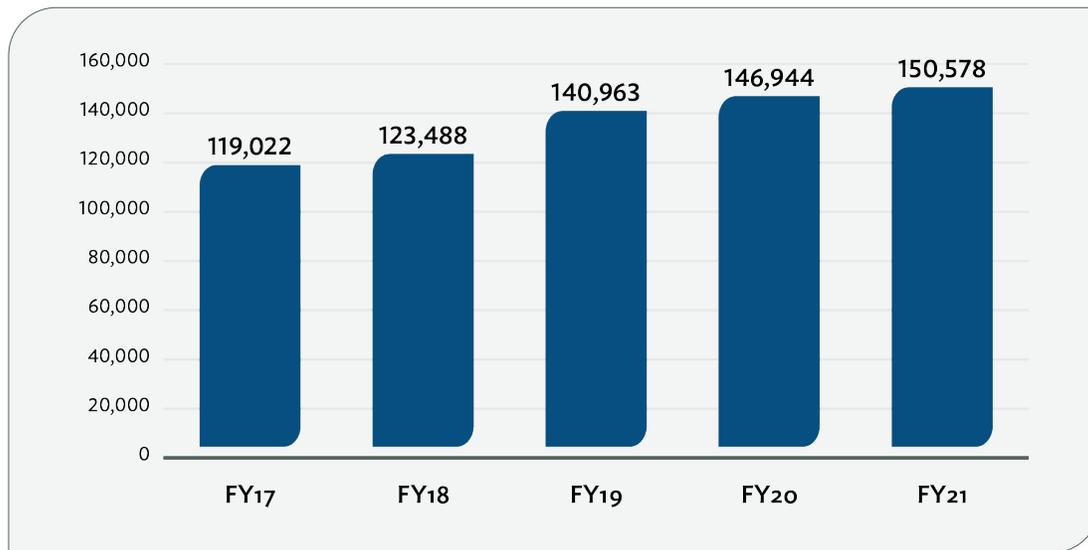


FIGURE 1: Missouri Data Snapshot: Increased Access in Number of Individuals Served by CCBHCs



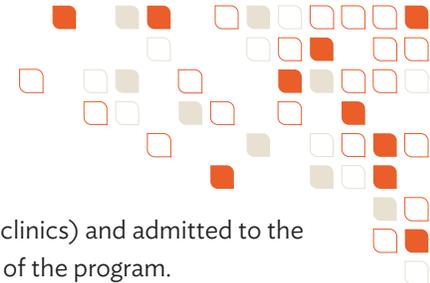
In Oregon, increased collaboration and outreach efforts enabled CCBHCs to deliver services to populations that would have otherwise been underserved. For example, CCBHCs in Oregon increased the number of individuals with serious and persistent mental illness served by nearly three times that of non-CCBHCs, with a 17% increase from 2016 to 2018, compared to 6% increase for non-CCBHCs during the same time frame. In 2018, CCBHCs in Oregon saw 61,881 Medicaid clients, and 25,503 (41%) of them had a serious and persistent mental illness diagnosis. Oregon reported that the populations that have benefited most from the CCBHC demonstration include those that are typically hard to engage or otherwise underserved, including: justice-involved, veterans, older adults, youth and homeless.

The CCBHC demonstration had timely access requirements that included completion of an initial evaluation within 10 business days. Most states highlighted that CCBHCs improved and/or met the 10-day access goal. One of the most common strategies used by CCBHCs to increase access to care was to introduce open access, a method of scheduling in which individuals can receive an appointment slot on the same day they call. New Jersey reported that all CCBHCs offer at least some open access hours to the community, with 78% of new clients having had initial evaluations within 10 business days of the first contact and an average of 7.2 days from first contact to the initial evaluation. Open access hours in New Jersey helped facilitate a 14% increase in the number of individuals served between the first and third demonstration years. Missouri also shared data indicating that in the third year of the demonstration, 81% of all new clients and 83% of all new Medicaid clients had an initial evaluation within 10 business days. In New York, CCBHCs improved upon already strong performance this measure, decreasing time to initial evaluation from 7.3 days on average in the first demonstration year, to 5.8 days in the second and 4.9 in the third year of the demonstration.

Minnesota reported that prior to CCBHC implementation, it took approximately 20 days on average to get access to behavioral health services; this was reduced to an average of 13 days during the demonstration. While this is still short of the 10-day access goal, Minnesota reported that some clients, families in particular, were often unable to come into a CCBHC that quickly, even if an appointment was available within the 10-day standard.

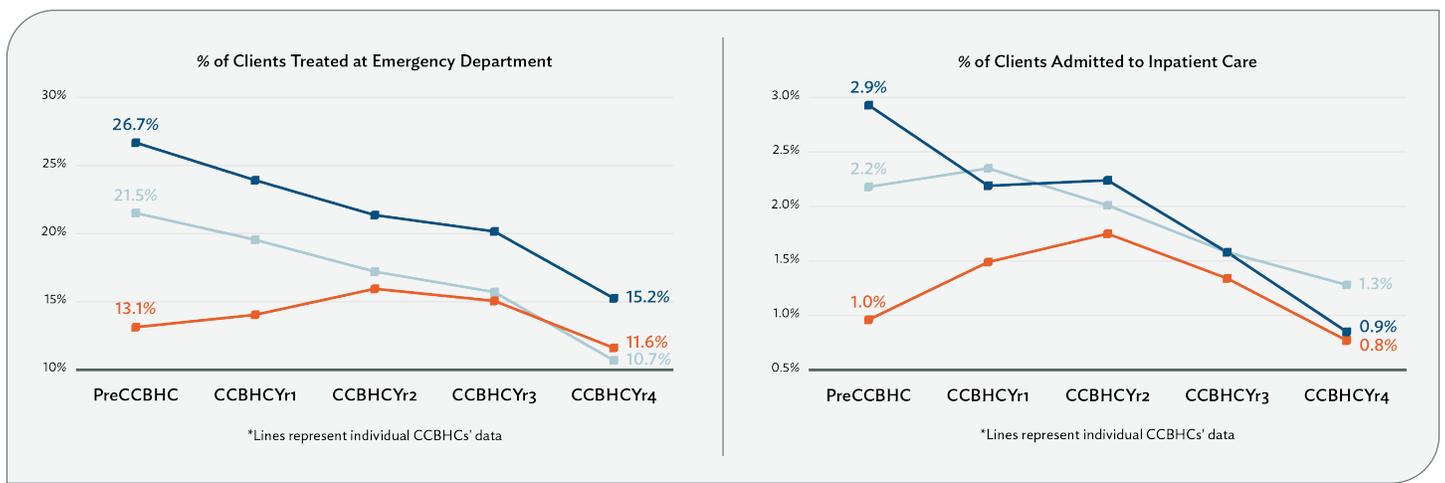
States reported reductions in emergency department visits and inpatient visits among CCBHC demonstration sites, leading to cost offsets.

Four states provided data that demonstrated a reduction in utilization of higher levels of care through the CCBHC program, including emergency departments visits and hospital inpatient admissions. Remarkably, states reported the reductions even as they substantially increased the number of people served, many of whom had prior unmet needs and often had more complex mental health, substance use and/or physical health needs. Oklahoma reported notable decreases in the percent of individuals admitted to inpatient care and treated in an emergency department (see Figures 2). The three CCBHCs generally showed a decline in the



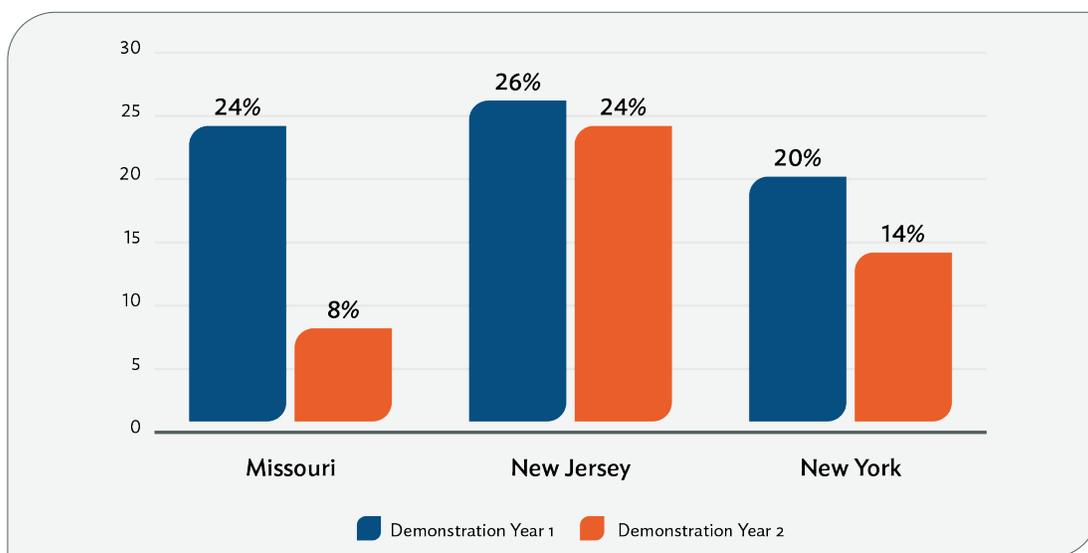
percentage of clients treated at the emergency department (an 18-47% reduction across the three clinics) and admitted to the hospital (a 20-69% reduction) from the period prior to CCBHC implementation to the fourth year of the program.

FIGURE 2: Oklahoma Data Snapshot: Percent of CCBHC Clients Treated at Emergency Department and/or Hospital Inpatient Setting, By Program Year



Over the first year of CCBHC operations, New York reported individuals receiving CCHBC services showed a reduction in the utilization of more costly inpatient and emergency services. This included a 54% decrease in the number of CCBHC clients using behavioral health inpatient care, a 61% decrease in the number of clients using general hospital inpatient services and a 46% decrease in the number of clients using the emergency department. Three states also reported declines in all-cause readmissions rates ranging from 7% to 67% (see Figure 3).

FIGURE 3: Decline in All-cause Readmission Rates from Demonstration Year 1 to Demonstration Year 2: Missouri, New Jersey and New York CCBHC Programs. Note: Lower rates are better for this metric.





Most state officials reported that it is too early in the CCBHC demonstration program to assess for cost reductions. Minnesota advocated to its legislature that a key goal of the CCBHC program should not be obtaining cost savings but increasing access to care and addressing unmet need. Despite those caveats, two states reported that reductions in utilization of higher levels of care translated into decreased costs. New York reported that reductions in the utilization of more costly inpatient and emergency services resulted in a 27% decrease in associated monthly behavioral health inpatient costs and a 26% reduction in monthly costs associated with use of the emergency department for behavioral health related conditions.

According to Missouri, the multitude of outreach and engagement efforts to get individuals engaged in care through CCBHCs had a “big impact” on reducing costs; this included CCBHCs’ collaborations with emergency departments, law enforcement, crisis teams and proactive outreach to individuals with high utilization of Medicaid resources.

Based on an analysis completed in July 2020, Missouri CCBHCs reported:

- 2,600 people engaged in emergency departments.
 - » 76% of them followed up with recommended mental health or substance use services.
- Of the 1,976 who engaged in care:
 - » 40% were initially homeless — at six months, 76% of them had obtained housing.
 - » 19% had some type of law enforcement involvement — at six months, nearly 70% of them had no further law enforcement involvement.
- 76% reduced emergency department visits and hospitalizations.

Requirements placed on CCBHCs to provide primary care screening and monitoring, and follow-up on hospitalizations and emergency department visits are similar to – but exceed – the expectations established for Medicaid health homes. CCBHCs are subject to a wider range of coordination, monitoring and follow-up activities and must extend those supports to all clients, not just those with designated diagnoses as in the health homes program.

Prior to participating in the Demonstration, Missouri had established behavioral health homes and made the choice to embed these activities within the CCBHC program, essentially establishing health homes as a foundation on which CCBHCs were required to build. From 2012 through 2018, more than \$377 million in savings have been attributed to the Missouri Community Mental Health Center (CMHC) Healthcare Homes as a result of diverting individuals from unnecessary trips to the hospital or emergency departments. While cost data is not yet available for the full range of coordination, monitoring and follow-up activities conducted by Missouri’s CCBHCs, at a minimum, it would be expected to exceed the cost savings achieved by the health homes program. Other states opting to build on their health homes initiatives through the CCBHC model could reasonably expect to see similar savings.

The CCBHC demonstration increased access to a comprehensive range of services, including physical, mental health and substance use screenings, crisis response, peer services and MAT.

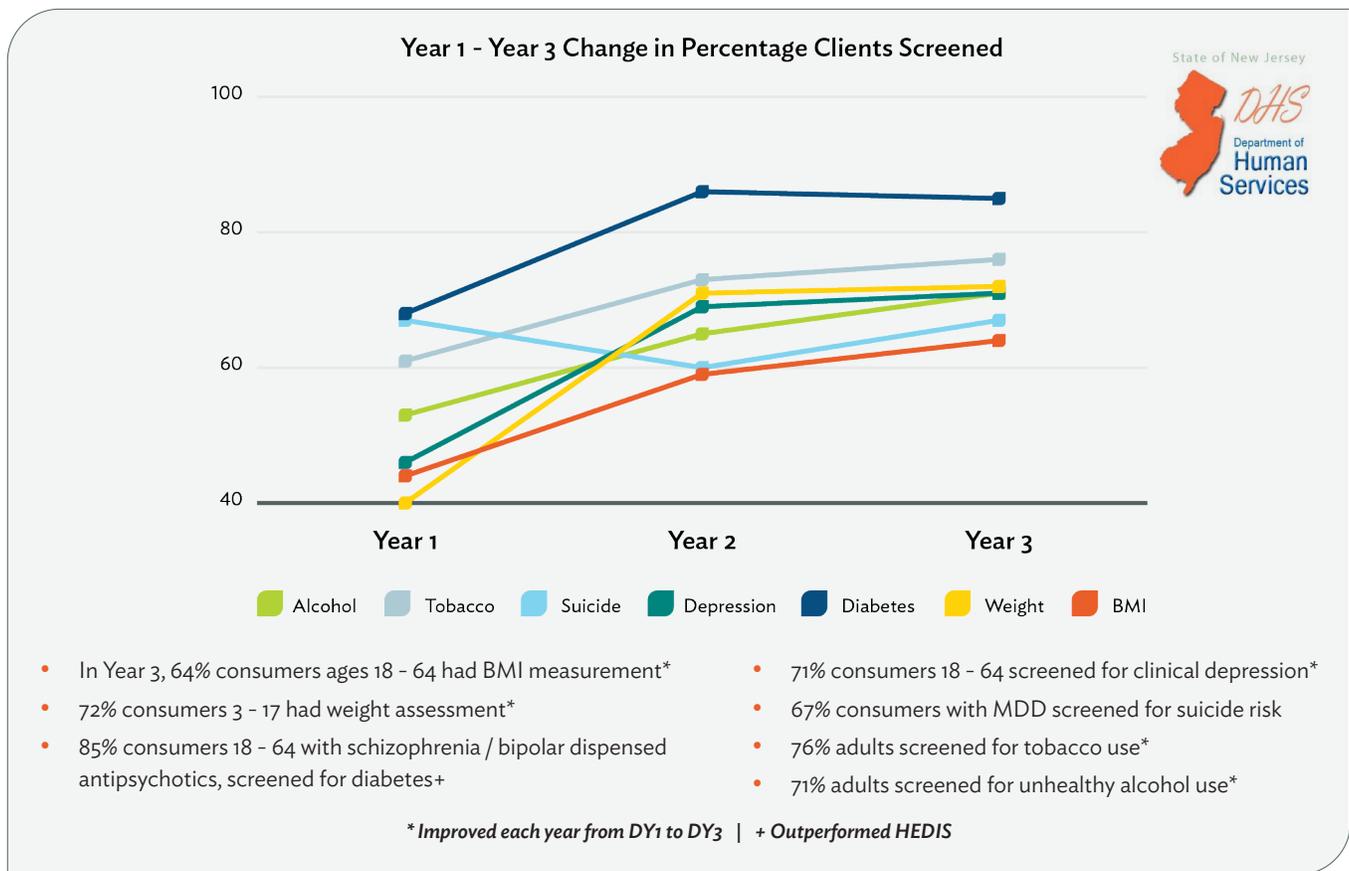
States reported a general increase in access to a comprehensive range of services under the CCBHC program, such as physical, mental health and substance use screenings; peer services; and MAT. These service expansions indicate an improved spectrum of care available in many communities, filling gaps where all services were not available previously. Most states reported that increased screenings was one of the big impacts of the CCBHC program, with many clinics adopting standardized tools to assess specific health conditions, such as the Patient Health Questionnaire-9 (PHQ-9) to assess the 12-month depression remission.¹⁴

Minnesota, New York and Oregon reported a substantial increase in primary care screening and monitoring under the CCBHC demonstration. In Minnesota, CCBHCs began collecting and monitoring important physical health information, including HbA1c, weight, cholesterol, tobacco use and metabolic syndrome screening. In New York, primary care screening and monitoring tasks were billable services for behavioral health providers prior to the CCBHC demonstration, but the CCBHC model reinforced the importance of these functions and state certification and compliance monitoring site visits ensured they were happening.



Missouri also highlighted the importance of expanding certain screenings, such as suicide risk assessments, to a statewide level under the CCBHC program. By the third demonstration year, CCBHCs in Missouri conducted suicide risk assessments for children and adults with major depressive disorder nearly 91% and 94% of the time, respectively. Pennsylvania increased the number of standardized depression screenings administered by CCBHCs for individuals age 18 and older by more than 30% from the first (4,021) to the second demonstration year (5,369), doubling the state’s goal of a 15% increase over this period. In addition, CCBHCs in Pennsylvania more than doubled the number of individuals who had a depression screen with a positive finding and a follow-up plan documented the same day from the first (1,464) to the second demonstration year (2,978), improving performance on this measure from 77% to 91%. New Jersey also shared data demonstrating the growth in percentage of individuals screened across various physical, mental health and substance use indicators from the first to the third demonstration year, including diabetes screenings for individuals with schizophrenia or bipolar disorder taking antipsychotics, screenings for clinical depression, tobacco and unhealthy alcohol use and weight/BMI assessments (see Figure 4).

FIGURE 4: New Jersey Data Snapshot: Changes in Percentage of Individuals Screened for Selected Health Conditions via CCBHCs



According to New Jersey officials, the integrated care treatment model embodied in the CCBHC program has promoted greater access to integrated care. One of the most notable highlights of CCBHC performance related to improving the delivery of integrated care for co-occurring mental health and substance use disorders. Through the increased screenings provided by CCBHCs, many clients with substance use challenges were identified and engaged in care. New Jersey officials reported that 53% of the 2,354 CCBHC clients identified as unhealthy drug users did not previously have an identified substance use disorder. Through the CCBHC program, individuals with co-occurring mental health and substance use disorders in New Jersey received integrated care for secondary conditions that they may not have received otherwise.

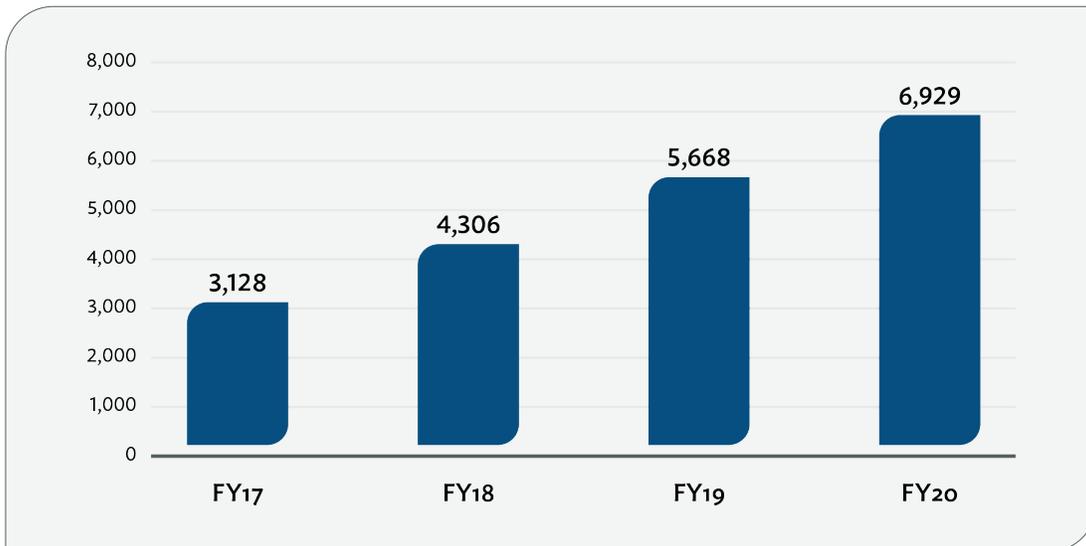


EXHIBIT 1: Addressing the Opioid Epidemic via the CCBHC Program

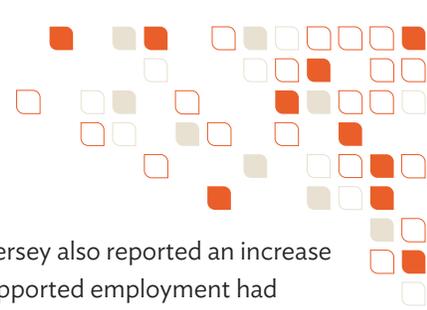
Despite the ongoing opioid crisis, which has only worsened due to the COVID-19 pandemic, only one in 10 Americans with a substance use disorder receives treatment in a given year.¹⁵ The CCBHC program has played a crucial role in helping to mitigate the opioid epidemic. First, participating clinics have implemented major expansions in addiction treatment services and increased the number of individuals with substance use challenges they serve, either by taking on new clients, improving screening protocols to identify at-risk use and substance use disorders among existing clients or both.¹⁶ Second, most CCBHCs have adopted MAT, an evidence-based substance use treatment method, considered the gold standard for opioid use disorder treatment. Third, CCBHCs' innovative partnerships with law enforcement, hospitals and jails/prisons and effective use of health information technology have generally resulted in higher rates of care initiation, engagement and follow-up for individuals with substance use disorder, most of whom historically went without treatment.

States highlighted the increase in providing MAT under the CCBHC program as a major impact of the program. Unfortunately, most people who could benefit from MAT do not receive it, with less than 20% of individuals with an opioid use disorder receiving MAT in the past year, and less than one-third of substance use facilities offering medications to treat opioid use disorder.¹⁷ Missouri reported a 122% increase in MAT from baseline to the fourth demonstration year (see Figure 5). Oklahoma had very few individuals receiving MAT prior to the CCBHC demonstration and state officials reported nearly 700% growth in this service from the year prior to the CCBHC demonstration to the fourth demonstration year, with the number of individuals receiving MAT increasing from 124 to 988. In New Jersey, CCBHCs nearly doubled the number of clients receiving MAT for opioid use disorder from the first to the second demonstration year. While some were doing MAT prior to the CCBHC demonstration, this became a key focus of the certification process.

FIGURE 5: Missouri Data Snapshot: Number of Individuals Receiving Medication-assisted Treatment via a CCBHC Demonstration Site

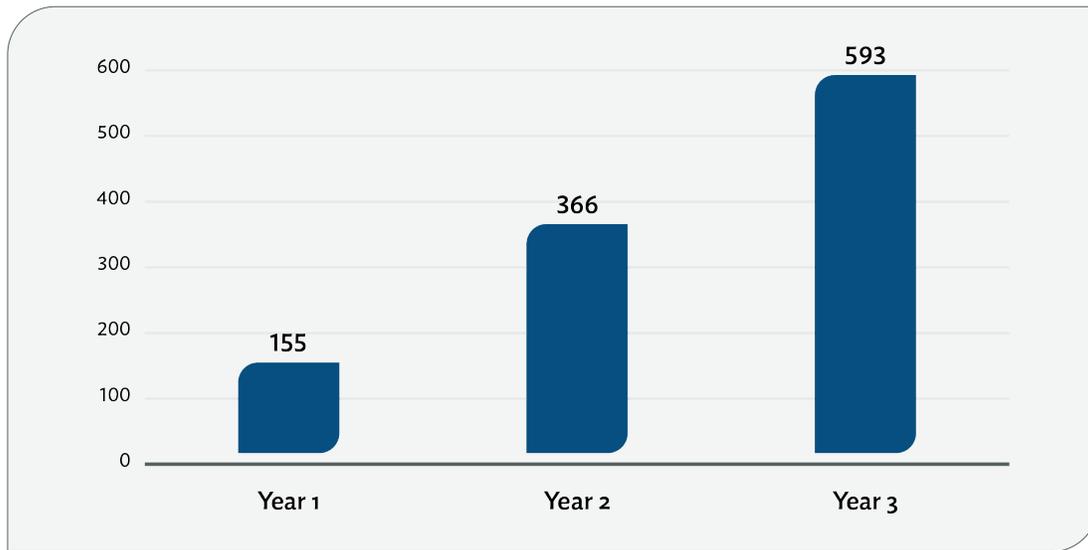


Multiple states also provided data demonstrating a substantial increase in access to peer services under the CCBHC program. For example, in Oklahoma the percentage of clients accessing peer supports increased from 40% in 2016, prior to the CCBHC demonstration, to nearly 57% by 2019. While Oklahoma reported there is not necessarily an optimal rate for use of peer services, state officials view increases in this type of service as positive and are excited to see continued growth.



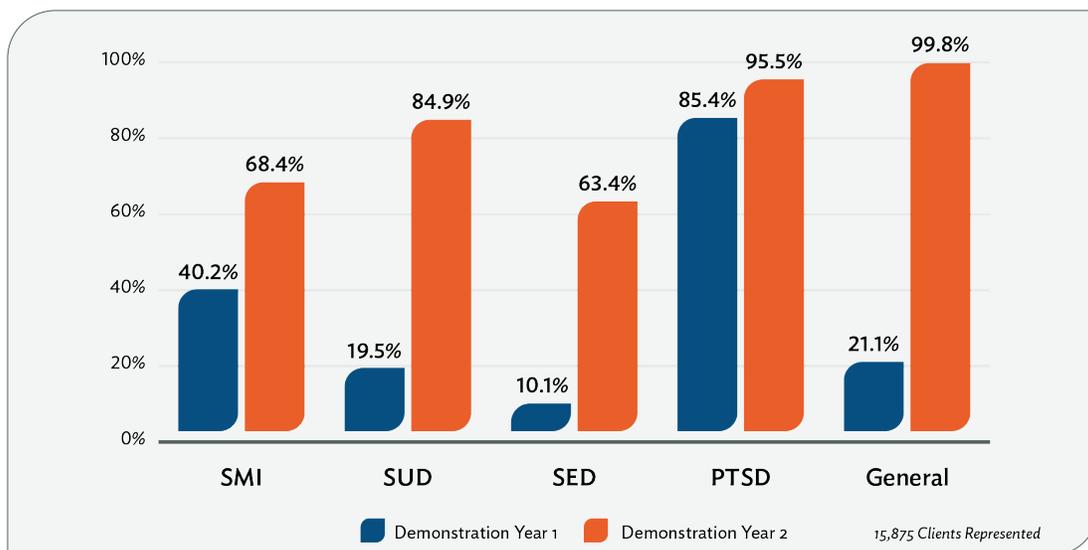
In New Jersey, use of peer services increased 21% from the first to third demonstration year. New Jersey also reported an increase in utilization of wrap-around recovery supports. For example, New Jersey officials reported that supported employment had historically been underutilized and its use increased by 282% from the first to third demonstration year (see Figure 6).

FIGURE 6: New Jersey Data Snapshot: Change in Number of CCHBC Clients Receiving Supported Employment from Demonstration Year 1 through Demonstration Year 3



Case management services nearly tripled in New Jersey, increasing from less than one-third of CCBHC clients in the first demonstration year to 83% in the second year. Use of case management increased across all primary diagnosis types, including serious mental illness (SMI), substance use disorder (SUD), serious emotional disturbance (SED) and post-traumatic stress disorder (PTSD) (see Figure 7).

FIGURE 7: New Jersey Data Snapshot: Change in Percentage of Beneficiaries Receiving Case Management Services, by Primary Diagnosis, from Demonstration Year 1 to Demonstration Year 2





Several states highlighted addition or expansion of crisis services as a major impact of the CCBHC demonstration. Oklahoma reported that one of the biggest impacts of the CCBHC program was establishment of urgent recovery centers, which operate 24 hours per day, seven days per week and function as an outpatient unit where a person can receive up to 23 hours and 59 minutes of care to stabilize an emerging crisis with no appointment needed. Two of the three CCBHCs in Oklahoma have urgent recovery centers and the third is in the process of opening one. Oklahoma also increased mobile crisis response teams through the CCBHC demonstration, as some rural areas did not have a crisis team nearby. Nevada struggled initially implementing crisis services, especially in rural areas that are “completely off the grid,” with no streetlights and no paved roads. Nevada reported that this is where CCBHCs now show their greatest value and the state is considering how to build out local crisis capacity in conjunction with the federal 988 National Suicide Prevention hotline, expected to go live July 16, 2022.¹⁸

EXHIBIT 2: Nevada’s Journey to Building a Strong Behavioral Health Care System via CCBHCs

While the other seven states participating in the CCBHC demonstration started their journey with a more robust provider network, prior to CCBHC, Nevada had “no strong community-based mental health services delivery system” and no means of ensuring that their clinics provided quality behavioral health care. Historically, Nevada had a bifurcated behavioral health system that only offered separate state-run mental health and state-run substance use treatment centers. Prior to CCBHCs, many services were either not available at all or there were long wait times to begin care. According to Stephanie Woodard, PsyD, Nevada CCBHC Program Director, “The CCBHC demonstration has moved the needle on community-based behavioral health services in Nevada by a decade or more.”

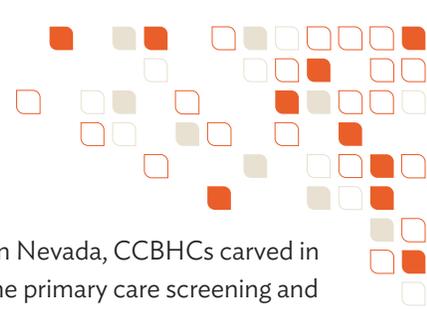
As a direct result of the demonstration, Oregon expanded access for 21 behavioral health service types, including care-coordination, veteran’s services, services for older adults, primary care, outpatient mental health and substance use disorder treatment, MAT, peer delivered services, case management, vocational skills training, wraparound services, assertive community treatment (ACT), jail-based services, jail diversion, home visits, first episode psychosis programs, rehabilitation services, screenings and assessments.

The CCBHC demonstration resulted in improved integration of physical and behavioral health care, with CCBHC sites in some states exceeding program requirements to offer onsite primary care services.

States generally reported more integrated physical and behavioral health care under the CCBHC demonstration. The reported level of impact that the CCBHC demonstration had on integration and coordination of physical and behavioral health tended to vary depending on:

1. Whether a state had previously implemented similar requirements under other payment and delivery system reforms such as a Medicaid health home program – a model intended to provide enhanced integration and coordination of primary, acute and behavioral health services for individuals with chronic illness,¹⁹ among other things, and
2. Whether a state included additional requirements related to the provision of primary care beyond the nine core CCBHC requirements.

In New York, some CCBHCs also developed better formal agreements with existing physical health providers for referrals and used medical staff hired by CCBHC program to carry out other functions, such as onsite phlebotomists to conduct blood draws for metabolic syndrome screenings or nurses to carry out screenings for diabetes, cardiovascular disease, smoking cessation programs and medication management. Others moved toward co-located models with onsite primary care providers, allowing for more direct coordination across physical and behavioral health. According to New York officials, by carrying out key primary care monitoring and screening tasks such as collecting BMIs, taking blood work and monitoring diabetes, CCBHCs helped prevent certain chronic conditions and filled an essential gap between being a primary care provider and simply filling out paperwork to refer clients out for physical health care.



CCBHCs in three states also exceeded federal requirements to offer onsite primary care services. In Nevada, CCBHCs carved in actual primary care services (e.g., taking client histories, establishing medical diagnoses), not just the primary care screening and monitoring requirements, so CCBHCs have the capability to provide primary care services as needed. This was in response to a general lack of available primary care providers and the state’s interest in pursuing a health home model for individuals with chronic health care conditions that used a “no wrong door” approach to service entry. According to Nevada, this approach was beneficial because without primary care services available onsite at the CCBHC, individuals tend to forgo needed services, including necessary primary and preventive health care.

At the state level, Oregon enhanced the federal CCBHC requirements to require 20 hours per week of onsite primary care services provided by medical personnel, such as primary care physicians or nurse practitioners; the state reported that this was “very new and a very heavy lift” for CCBHCs. Each CCBHC in Oregon approached these requirements differently, with some clinics sharing a nurse practitioner with a Federally Qualified Health Center (FQHC) and others hiring a primary care provider to offer services across multiple CCBHC sites. In a 2019 survey of CCBHCs, 100% of participating clinics in Oregon indicated that they had an onsite physical health care provider and offered a range of related services, such as screenings for tobacco use, BMI, blood pressure, lipid and plasma.²⁰

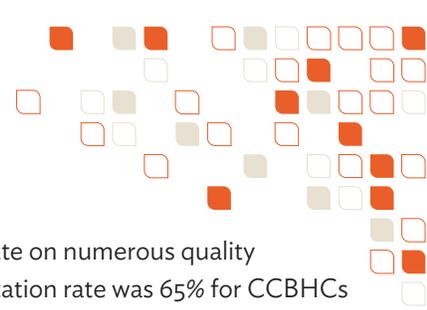
Rates of care initiation, engagement and follow-up tended to improve under the CCBHC demonstration program.

The CCBHC demonstration required measurement of seven distinct quality measures related to care initiation, engagement and/or follow-up, and several states highlighted CCBHC improvement in quality of care related to these measures.²¹ Missouri reported high rates of follow-up after hospitalization for mental illness for both children and adults. By the third demonstration year, CCBHCs had a 75% rate of follow-up for adults hospitalized with mental illness within 30 days and 77% for children ages 6 through 17. CCBHCs’ rates of initiation and engagement in treatment for alcohol or other drug use – two measures with historically low rates of performance nationwide – were relatively high, at 50% and 38%, respectively. CCBHCs in Missouri also demonstrated follow-up rates for Medicaid clients that were substantially higher than the statewide Medicaid averages (see Exhibit 3).

EXHIBIT 3: Comparison of Missouri CCBHC Follow-up Rates with Statewide Medicaid Rates

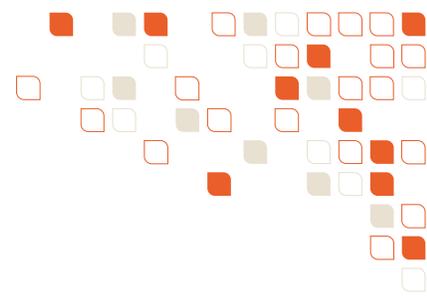
Quality Measure	CCBHC Average for Medicaid Clients, Demonstration Year 2	Missouri State Medicaid Average Reported by CMS, FY 2019
Follow-up After Emergency Department Visit for Mental Illness: Age 18 and Older – 7 Days	43%	20%
Follow-up After Hospitalization for Mental Illness: Age 18 and Older – 30 Days	76%	33%
Follow-up After Emergency Department Visit for Mental Illness: – 7 Days	43%	33%
Follow-up After Hospitalization for Mental Illness: Age 6-17 – 30 Days	78%	56%
Initiation of Treatment for Alcohol or Other Drug Abuse or Dependence within 14 Days of the Diagnosis: Ages 18 to 64	47%	47%
Engagement in Treatment for Alcohol or Other Drug Abuse or Dependence within 34 Days of the Initiation Visit: Ages 18 to 64	36%	16%

Source: Data submitted by Missouri state officials for Demonstration Year 2 (July 2018-June 2019) and compared to CMS adult and child health care quality measures from federal FY 2019.²²



New York also provided data demonstrating that CCBHCs outperformed other providers in the state on numerous quality measures. For example, in the second demonstration year, the seven-day follow-up after hospitalization rate was 65% for CCBHCs and the state Medicaid average for this metric was 58%. Similarly, CCBHCs in New York performed substantially better than the state Medicaid average on rates of follow-up after emergency department visits for mental health or alcohol or other drug dependence; CCBHCs had an average follow-up rate of 42% for individuals visiting the emergency department for alcohol or other drug dependence in the second performance year, which was double the overall state Medicaid average of 21%. CCBHCs also outperformed the Medicaid averages on the initiation and engagement of alcohol and other drug treatment measures; CCBHCs' average rate of engagement was 28%, compared to 19% for the statewide Medicaid average. The follow-up rate for children prescribed attention-deficit hyperactivity disorder medication was more than 80%.

In New Jersey, the rate of follow-up after hospitalization for mental illness nearly doubled from the first to the second demonstration year and continued to increase the third year. Additionally, New Jersey reported that 14- and 30-day initiation and engagement rates for alcohol and other drug rates for persons aged 18 to 64 increased each year from the first to the third demonstration year, and that CCBHCs far outperformed statewide Healthcare Effectiveness Data and Information set (HEDIS) averages on this measure.



CCBHC Impact on Structures, Service Design and Delivery

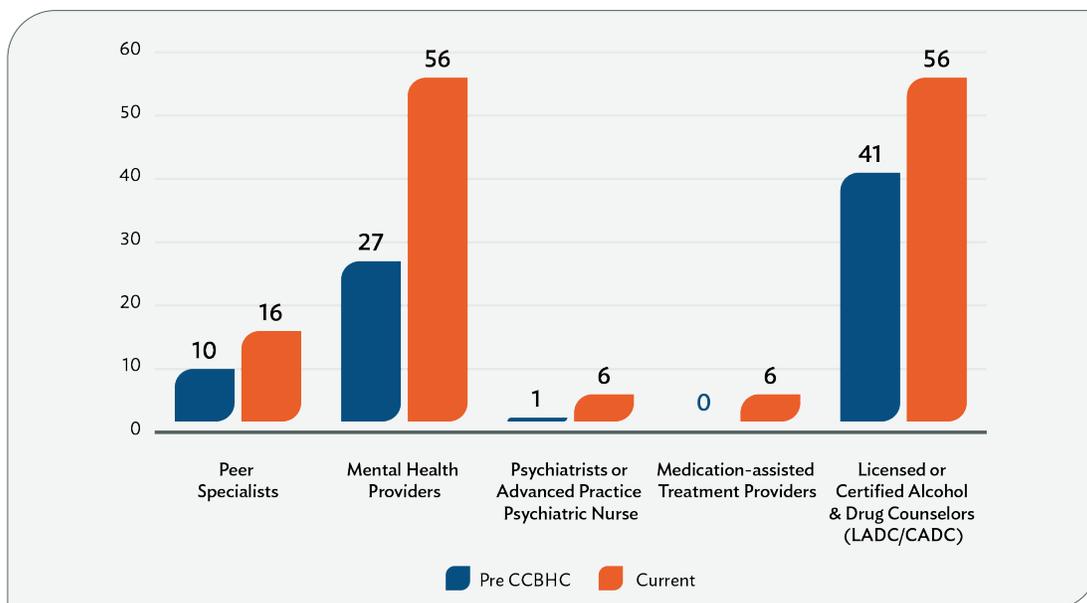
According to interviews with state officials and review of supporting documentation, implementation of the CCBHC demonstration program led to substantial improvements in key infrastructures needed to support behavioral health payment and delivery system reform under the CCBHC model. These improvements were viewed by states as key inputs that enabled CCBHCs to positively impact care processes, access to care and beneficiary outcomes.

The CCBHC demonstration enabled providers to hire and retain vital staff.

The current behavioral health care workforce is only able to meet approximately 25% of the need for services and the gaps are much higher in rural areas; if this trend is not reversed, a shortage of more than 250,000 behavioral health professionals is projected by 2025.²³ Most states cited expansion of staff as one of the biggest system improvements resulting from the CCBHC demonstration. Previous reports have demonstrated that CCBHCs hired and retained additional staff as part of the CCBHC certification, including adult and child psychiatrists, licensed clinical social workers, nurses, counselors, case managers and peer specialists/recovery coaches.²⁴ In Oregon, the most expanded workforce in CCBHCs included nurses, qualified mental health professionals, psychiatrists, primary care providers, data analysts and peers. Missouri also reported a substantial increase in the number of waived providers able to offer MAT.

Nevada referred to CCBHCs' ability to hire additional staff as "one big win for the PPS rate." Historically, Nevada's relatively low Medicaid reimbursement rates, coupled with a longstanding workforce shortage, resulted in significant understaffing and lack of availability of behavioral health professionals. As a result of the CCBHC demonstration, participating clinics in Nevada have been able to recruit and retain all types of behavioral health professionals by offering more competitive wages (see Figure 8). CCBHCs in Nevada now have a substantially enhanced workforce, which state officials acknowledged as crucial for providers in rural and frontier areas. CCBHCs in areas of Nevada that rarely had access to psychiatrists prior to the demonstration now have an onsite psychiatrist and/or psychiatric advanced practice registered nurse, as well as MAT providers to treat certain types of substance use disorders.

FIGURE 8: Nevada Data Snapshot: Increase in Number of Behavioral Health Staff Among CCBHCs

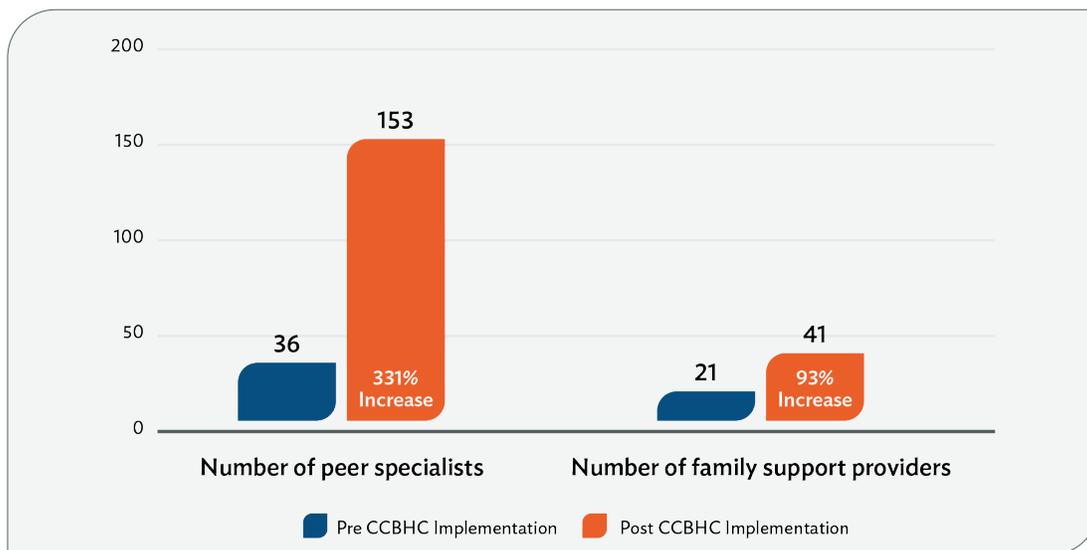




A large body of evidence has shown that services provided by peer workers are effective and associated with a range of positive outcomes, including reduced substance use, improved social supports, reduced hospitalizations and emergency department visits and decreased criminal justice involvement.²⁵ Minnesota, Missouri, New Jersey, Nevada and Oregon all reported that the CCBHC program led to a significant expansion of peer workers and in some cases, family support specialists.²⁶ In Minnesota, prior to the CCBHC demonstration, the Medicaid state plan only allowed for peer workers treating individuals with mental health conditions within a psychiatric rehabilitation setting; through the CCBHC demonstration, Minnesota expanded certified peer specialists to anyone with mental health needs receiving care through CCBHCs and also launched family peer services and peer recovery specialists for individuals with substance use disorders. Minnesota also reported success regarding use of peers in criminal justice settings as a “warm handoff” when someone with a behavioral health condition is released from jail or prison to help them enroll in Medicaid, connect with health care providers and begin a treatment plan.

Oregon reported an increase in the peer workforce and improvement in CCBHCs’ ability to effectively deploy peer workers through the CCBHC demonstration. Through the CCBHC program, Nevada created a clear role for peers and provided training and technical assistance on how to use the peer workforce most effectively, not just for light case management or administrative assistant work. According to Nevada, the level of client engagement is much higher when peers work alongside counselors and other behavioral health providers. In Missouri, the state developed training and certification programs for peer specialists and family support providers and conducted trainings for peer supervisors. Prior to the CCBHC demonstration, less than half of providers had peer support specialists and less than a third had family support specialists. As of May 2021, all CCBHCs in Missouri employed peer specialists and family support providers, with the number of peer specialists increasing more than 330% and the number of family support specialist increasing more than 90% (see Figure 9). A state official reported that during an onsite visit with one of the CCBHCs in Missouri, an individual receiving services from the CCBHC commented that without the intervention of a peer specialist, “I’d be dead.”

FIGURE 9: Missouri Data Snapshot: Increase in Number of Peer Specialists and Family Support Provider Prior to and Post CCBHC Implementation



The CCBHC demonstration enabled states to implement meaningful and innovative strategies to support outreach and collaboration with other community sectors

Care coordination is considered the linchpin of the CCBHC program, and CCBHCs were required to coordinate services both within and outside of the health care system.²⁷ States reported a wide range of meaningful and innovative coordination strategies that often went beyond the requirements outlined in the CCBHC certification criteria. The majority of states highlighted successful CCBHC collaborations with law enforcement. This is vital because without access to or understanding of appropriate alternatives,



police officers may leave people experiencing a mental health or substance use crisis in potentially harmful situations, bring them to a hospital emergency department or arrest them.²⁸ Missouri requires a “community mental health liaison” position for CCBHCs – individuals specifically tasked to work with law enforcement and the court system. These individuals help conduct trainings on mental health and substance use disorders for law enforcement and connect with police officers and other first responders as needed when someone is experiencing a mental health or substance use crisis. Since the beginning of the demonstration, this program has resulted in more than 54,600 referrals from law enforcement to CCBHCs.

In Oklahoma, all CCBHCs have issued electronic tablets (iPads) to law enforcement agencies. The tablets are equipped with a function that immediately connects law enforcement officers to treatment providers at local CCBHCs – 24 hours a day, seven days a week – for an assessment determining what level of care might be needed for individuals experiencing a mental health or substance use crisis. Other effective coordination and outreach strategies implemented by CCBHCs in Oklahoma include:

1. Designating liaisons who regularly visit the local crisis centers and inpatient units to engage with individuals prior to discharge, and
2. Establishing an outreach team that regularly visits the local homeless camps, day centers, etc., to connect with individuals in need.

Oregon reported that CCBHCs have coordinated most frequently with law enforcement, hospitals, schools, Veteran’s Affairs facilities and FQHCs. Oregon also highlighted the success of using peers for direct outreach to justice-involved populations, including visiting clients who were recently released from jails. New York also reported that CCBHCs have developed significant coordinated efforts with police and judicial services to engage justice-involved individuals and divert clients from emergency departments and inpatient units.²⁹

Because emergency departments are often a source of crisis care, CCBHCs were required to have clearly established relationships with local emergency departments to facilitate care coordination, discharge and follow-up. Missouri reported that while there was some outreach to emergency departments prior to the CCBHC program, the demonstration expanded these efforts to become a required component of participating clinics. A Missouri state official credited proactive outreach to emergency departments, law enforcement, crisis teams and individuals with high utilization of Medicaid resources with improving cost and quality of care, as well as increased engagement in mental health and substance use services.



“In New York, the CCBHC demonstration has proven to be an effective approach in the delivery of a comprehensive model of care that when properly resourced has the potential to deliver outstanding outcomes. The providers that participate in the demonstration all have indicated that the CCBHC model and funding provides all the needed tools to create a person-centered model of care that is flexible to meet individual’s needs. CCBHCs are resourced to hire staff at a competitive salary to meet community needs which leads to a more stable and competent workforce that is especially helpful with children’s services. CCBHCs have also developed significant coordinated efforts with police and judicial services to engage justice-involved individuals and divert clients from emergency rooms and inpatient units.”

**– Donald Zalucki, Director of Program and Policy Development,
New York Office of Mental Health**



Several states highlighted the importance of giving CCBHCs flexibility to focus care coordination and outreach strategies based on the needs and underserved groups in their local communities. For example, in Missouri, one CCBHC hired two veterans to help conduct outreach to that population, while another focused on collaborating with local schools. Minnesota reported significant and intentional effort to engage tribal nations in the CCBHC program. The state held listening sessions with the American Indian Advisory Council to seek feedback about what could be done difficultly to better engage tribal members and providers. As a result, CCBHCs started working more directly with adjacent tribes in a facilitated way; for example, CCBHCs developed processes to ensure that tribal members are referred to tribal mental health and substance use providers and traditional healing practices, when appropriate.

The CCBHC program substantially expanded use of EHRs in mental health and substance use treatment settings, a formerly underdeveloped and underfunded sector.

EHRs play a critical role in providers' efforts to improve population health, increase collaboration across the health care system, support quality reporting and tap into efficiencies in clinical care delivery. Adoption of EHRs has been slower among mental health and substance use service providers than other sectors of the health care system, in part due to lack of incentives that were historically offered to medical providers to adopt these technologies.³⁰ The CCBHC demonstration addressed this infrastructure gap by requiring participating clinics to establish or maintain health information technology systems, including EHRs, and financially supported these efforts through the PPS.

Several states cited expansion of EHRs among CCHBCs as an overlooked but significant impact of the demonstration program. Several states reported that EHR was not just implemented among participating CCBHCs; providers were using the technology more effectively to become more efficient, data-driven and outcomes-oriented. For example, in Oregon, each CCBHC used at least one EHR, and many used their EHR's analytic capabilities to develop required CCBHC reports to monitor program effectiveness.³¹ CCBHCs in Oregon also used their EHR to create intake forms, add medical profiles and implement processes to house data in the appropriate file for reporting.³²

The CCBHC demonstration promoted involvement with health information exchanges and receipt of electronic notifications of hospital admissions or emergency department visits.

Admission, discharge and transfer (ADT) notifications are widely regarded as a keystone to improving client care coordination through health information exchange. ADT notifications are sent when a client is admitted to a hospital, transferred to another facility or discharged from the hospital, thus improving post-discharge transitions, promoting follow-up, improving communication among providers and supporting clients with multiple or chronic conditions. The demonstration program promoted health information exchange by requiring CCBHCs to have:

1. Health information technology (IT) systems capable of sending and receiving summary of care data, including transitions of care, and
2. Care-coordination agreements with inpatient acute care hospitals, including emergency departments, urgent care centers, residential crisis settings and detoxification providers.

Missouri, New Jersey and Oregon reported that the CCBHC demonstration expanded health information exchanges and/or electronic notifications of emergency department visits or inpatient hospital admissions. In New Jersey, prior to the CCBHC implementation, only a few providers had some participation in health information exchange (HIE) and no clinics were fully involved in an HIE. Now, all CCBHCs in New Jersey have at least some level of participation, including receipt of ADT alerts so providers are aware of their clients' status when admitted to a hospital. According to New Jersey officials, the PPS payment structure enabled CCBHCs to include the costs of HIE participation and any associated electronic upgrades needed to enable access to the cost reporting template and eliminate much more labor-intensive means of sharing the information needed to coordinate care.



In Oregon, the state reported that CCBHCs receive notifications of emergency department visits and hospital admissions for individuals they serve. In Missouri, CCBHCs receive notification when the individuals they serve visit an emergency department and receive notification when any Medicaid enrollee is admitted to the hospital. In Nevada, CCBHCs primarily receive and refer providers using OpenBeds,³³ an electronic registry that enables users to identify, unify and track all mental health and substance use treatment services in a single network.

CCBHCs were better positioned to care for individuals during the COVID-19 pandemic due to experience with and early implementation of telehealth.

CCBHCs in the demonstration states generally made broad use of telehealth to extend the reach of services, even prior to the COVID-19 pandemic.³⁴ Nearly every state reported that CCBHCs were better positioned to care for clients during the COVID-19 pandemic, given their historical experience with use of telehealth. Minnesota reported a large growth in telehealth under the CCBHC program, noting that providers had leveraged technology to develop more integrated services for a “one stop shop.”

According to Missouri, CCBHCs fared much better than non-certified providers during the pandemic for two reasons:

1. CCBHCs were more likely to already have the technology and capacity to offer services via telehealth, and
2. The PPS rate enabled reimbursements for virtual visits, even prior to the start of COVID-19.

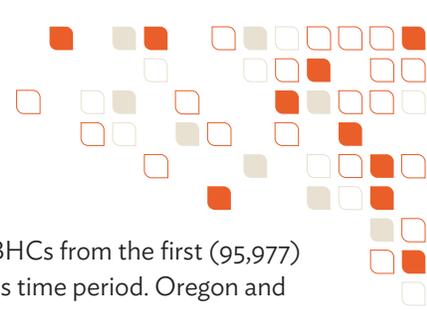
The number of telehealth services provided by CCBHCs in Pennsylvania increased 63% from the first (1,842) to second demonstration year (3,002). In Pennsylvania, behavioral health was considered a necessary service during the pandemic, so it needed to be offered in-person and via telehealth; providers who had participated in the CCBHC demonstration were reportedly better able to handle the pandemic than other mental health and substance use treatment providers in the state. New Jersey noted that its CCBHCs reported that telehealth use had substantially increased access to care and substantially reduced client “no show” rates.

Oregon, Oklahoma and Nevada also underscored the importance of telehealth in rural or frontier areas among CCBHCs. According to Oregon, CCBHCs had more “solid footing” when services shifted to a virtual setting due to the COVID-19 pandemic; rural providers offered onsite telehealth “rooms” that enabled clients to receive services via telehealth onsite, in solitary spaces that were safe from infection. Oregon also had systems in place to ensure language accessibility and translation as needed during telehealth appointments. Oklahoma highlighted the effectiveness of distributing electronic tablets to law enforcement professionals that enabled real-time connection between law enforcement and CCBHCs for individuals experiencing a mental health or substance use crisis.

CCBHCs successfully added a wide range of evidence-based practices – an achievement viewed by states as one of the most significant program impacts.

Nearly all states cited the addition or expansion of evidence-based practices as one of the most significant impacts of the CCBHC demonstration. Under the CCBHC demonstration, states were required to establish a minimum set of evidence-based practices for participating CCBHCs, but had flexibility to select from an initial list offered by SAMHSA or include other evidence-based treatments as a condition of certification.³⁵ States reported that the PPS reimbursement model supported CCBHCs in delivering state-required EBPs as well as implementing additional EBPs based on the needs of their population, bringing evidence-based care to more individuals.

Nevada referred to the expansion of evidence-based practices through the CCBHC demonstration as “game-changing.” New York officials cited the range of evidence-based practices added by CCBHCs as one of the most significant impacts of the demonstration. The state recently conducted a survey of CCBHCs and found that all were regularly using well-established and highly effective treatment models such as integrated treatment for co-occurring mental health and substance use conditions, cognitive behavioral therapy and motivational interviewing. New York assessed the level of care integration for co-occurring mental health and substance use disorders and reported that on a scale from 1 to 5, with 1 being siloed care with no ability to address co-occurring disorders and 5 being dual diagnosis enhanced care, the CCBHCs in New York scored an average of 4.26.



Pennsylvania reported an 85% increase in the number of evidence-based services provided by CCBHCs from the first (95,977) to the second demonstration year (177,196), far outpacing the state’s goal of a 10% increase over this time period. Oregon and Minnesota underscored how expanding evidenced-based practices improved the quality of treatment for children and youth. In Oregon, many CCBHCs started Parent-Child Interaction Therapy (PCIT), a short-term treatment designed to help young children with highly disruptive behaviors by treating the parent, the child and their interactions. In Minnesota, the state sponsored trainings in Trauma-focused Cognitive Behavioral Therapy for children and all CCBHCs were required to work with Minnesota’s early childhood expert to receive training in the DC:0-5 Assessment: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood.™

Oklahoma reported the CCBHC demonstration greatly improved treatment for suicidality; this included suicide care pathways built into CCBHCs’ EHRs and designated “touchpoints” for outreach and engagement following the Zero Suicide Framework.³⁶ CCBHCs can immediately assess in their EHRs who is at risk for suicide and whether an individual might need a more intensive level of care. CCBHCs in Oklahoma regularly use Collaborative Assessment and Management of Suicidality (CAMS) and according to state officials, it is “just what [CCBHCs] do now with a suicide screen.”

States perceived the PPS as instrumental to the success of their CCBHC programs.

The PPS reimbursement is a cost-related payment methodology intended to reimburse CCBHCs at a level that reflects the projected costs of providing comprehensive services and supports to all individuals who seek care. States perceived PPS reimbursement as instrumental to the success of their CCBHC programs for three reasons. First, behavioral health providers have historically been underpaid, often leading to an inability to recruit and retain qualified staff. Because PPS is inclusive of historic and projected staffing costs, CCBHCs – where appropriate and approved by the state – can receive a reimbursement rate that supports more competitive salaries, enabling them to recruit and retain valuable professionals.

Second, complying with the CCBHC certification criteria often required addition or expansion of new services and/or new functions. The PPS reimbursement allowed CCBHCs to build into their reimbursement rates the cost of the additional staff needed to provide the new or expanded services or functions, such as assuring same or next day access to care.

Third, and arguably most important, PPS allowed CCBHCs to receive financial support for the costs associated with the various types of activities and functions that are not direct services that have not historically reimbursed providers but are essential to meet the objectives of improving access and quality of services. This includes costs associated with adopting evidence-based practices, including staff training and monitoring fidelity; coordinating care such as tracking and follow-up of individuals discharged from hospitals and coordinating care with primary care physicians; outreach and engaging individuals not currently engaged in services who are interacting with law enforcement or schools; maintaining mobile crisis response teams; implementing new health information technology; and data collection, reporting and analysis.



“What makes prospective payment reimbursement valuable? It is what enabled key program elements including outreach and engagement and crisis response. Missouri conceptualized crisis services as a necessary capacity that CCBHCs had to have and maintain, regardless of insurance status or whether it was used or not. Because the PPS rate is cost-based, CCBHCs can also afford to hire higher-level, more expensive professionals. In Missouri, we saw a big change in the type of staff working for CCBHCs, including more psychiatrists and PhD-level staff.”

***– Dorn Schuffman, Former Director, CCBHC Demonstration Project,
Missouri Department of Mental Health***



New Jersey reported that the clinic-specific PPS has allowed each CCBHC to implement innovative programming that best meets their community's needs, such as creating 24/7 crisis call lines or implementing a "living room" crisis model, which is a home-like environment outside an emergency department for individuals who experience a mental health or substance use disorder crisis. Additionally, the PPS gave CCBHCs in New Jersey the resources needed to quickly and effectively tailor services, such as delivering meals and providing check-in visits in clients' homes in response to the COVID-19 pandemic. In Oklahoma, the state was very prescriptive about who had to be on the care team and those costs were built into the monthly PPS rates.



"On top of everything we know is great [about the CCBHC demonstration], we recently hired a new program director, who was formerly a county social services director in Olmstead County. He credited the CCBHC program with stabilizing the behavioral health system [in Olmstead County], which historically had a system that was always on the brink of insolvency but is now able to increase access to care and provide great services. Or, as another CCBHC leader recently shared in talking to a panel of legislators, 'We no longer have to do a bake sale to provide the services that people need.'"

**- Julie Pearson, CCBHC Program Manager,
Minnesota Department of Human Services, Behavioral Health Division**

The CCBHC demonstration enhanced state and provider capabilities for collecting, assessing and reporting quality and cost data.

States and CCBHCs are responsible for collecting, assessing and reporting a wide range of process, quality, outcome and cost data under the CCBHC program, an enhancement of capabilities that states viewed as a major accomplishment and system improvement. CCBHC criteria require states to report 21 total quality measures as part of their participation in the demonstration, including nine clinic-reported measures and 12 state-reported measures (see Appendix II).³⁷ States using PPS-1 also had the option to provide quality bonus payments to CCBHCs to financially incentivize the delivery of high-quality care, which was required for states using PPS-2. Though not required by the demonstration, nearly all CCBHCs (89%) used their quality reporting activities to target areas of low performance and implement data-driven approaches to continuous quality improvement.³⁸

Clinics and states also invested in IT and EHR upgrades, along with intensive staff training and continuous data reviews/compliance monitoring to support standardized data collection on required CCBHC quality measures. This is a critical advancement for a field where reporting requirements have long been fragmented and EHR products have not always supported quality data collection. Two states also developed data visualization tools to better monitor and assess CCBHC quality by provider. Pennsylvania utilized a "dashboard" that displayed CCBHC performance on quality measures and allowed individual CCBHCs to readily compare their performance against other CCBHCs in the state. Similarly, New York's Office of Mental Health developed a data visualization tool called the "CCBHC Services Dashboard," designed to pull claims data from the State's Medicaid Data Warehouse and organize the results into provider-specific tables and charts.

States used different approaches to assess quality performance for the bonus payouts, both in terms of the specific measures selected as well as the methodology used to assess quality performance. For example, CCBHCs in some states could qualify for the quality bonus in the first demonstration year by reporting the quality measures, while others had to meet specified achievement or improvement goals. While future reports will evaluate CCBHCs' performance on required quality indicators over the first two years of the demonstration, a longer timeframe is needed to measure the true impact of the program.

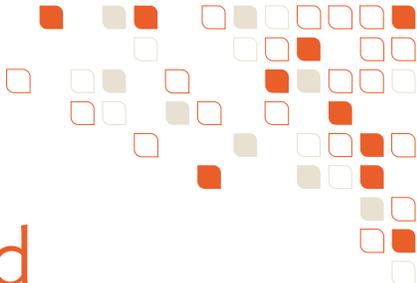


Appendix I: CCBHC Program Data and Selected Delivery System Characteristics, By State

	Minnesota	Missouri	Nevada	New Jersey	New York	Oklahoma	Oregon	Pennsylvania
CCBHC Implementation Date	7/1/2017	7/1/2017	7/1/2017	7/1/2017	7/1/2017	4/1/2017	4/1/2017	7/1/2017
Number of CCBHCs	6	15	3	7	13	3	12	7
Number of Service Locations	29	201	3	20	77	19	21	7
Number of Beneficiaries Served DY1	23,027	123,488	903	17,851	49,903	16,836	52,911	16,366
Number of Beneficiaries Served DY2	24,402	140,963	1,301	19,133	55,693	20,624	53,301	19,908
Number of Beneficiaries Served DY3	23,935	146,944	2,270	20,396	57,377	21,471	39,803*	Not available
Number of Beneficiaries Served DY4	Not available	150,578	Not available	Not available	Not available	22,981	Not available	Not available
PPS Model	PPS-1	PPS-1	PPS-1	PPS-2	PPS-1	PPS-2	PPS-1	PPS-1
Medicaid Expansion State	Yes	No	Yes	Yes	Yes	No	Yes	Yes
Medicaid Health Home State	Yes	Yes	No	Yes	Yes	Yes	No	No

Source: State officials and <https://aspe.hhs.gov/reports/certified-community-behavioral-health-clinics-demonstration-program-report-congress-2018>

*In DY3, the number of CCBHC was reduced from 12 to nine due to state budget shortfalls.



Appendix II: Required State and CCBHC Reported Quality Measures

REQUIRED STATE AND CCBHC REPORTED QUALITY MEASURES

CCBHC Measures

- Number/percent of new clients with initial evaluation provided within 10 business days and mean number of days until initial evaluation for new clients.
- Preventive care and screening: adult body mass index screening and follow-up.
- Weight assessment and counseling for nutrition and physical activity for children/adolescents.
- Preventive care and screening: tobacco use – screening and cessation intervention.
- Preventive care and screening: unhealthy alcohol use – screening and brief counseling.
- Child and adolescent major depressive disorder: suicide risk assessment.
- Adult major depressive disorder: suicide risk assessment.
- Screening for clinical depression and follow-up plan.
- Depression remission at 12 months.

State Measures

- Housing status (residential status at admission or start of the reporting period compared to residential status at discharge or end of the reporting period).
- Follow-up after emergency department for mental health.
- Follow-up after emergency department for alcohol or other dependence.
- Plan all-cause readmission rate.
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications.
- Adherence to antipsychotic medications for individuals with schizophrenia.
- Follow-up after hospitalization for mental illness, ages 21+ (adult).
- Follow-up after hospitalization for mental illness, ages 6-21 (child/adolescent).
- Follow-up care for children prescribed ADHD medication.
- Antidepressant medication management.
- Initiation and engagement of alcohol and other drug dependence treatment.
- Client experience of care survey and family experience of care survey.



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