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ASSISTANT SECRETARY FOR
PLANNING AND EVALUATION

Certified Community Behavioral Health Clinic Demonstration Program: Report to Congress, 2025

Prepared for

**The Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S.
Department of Health & Human Services**

by

Mathematica

RAND Corporation

Advocates for Human Potential

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**CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC DEMONSTRATION
PROGRAM: REPORT TO CONGRESS, 2025**

Authors

Allison Wishon, Rachel Miller, Colleen Staats, Will Suh, Lyra Cooper, and Jonathan Brown

Mathematica

Courtney Kase, Joshua Breslau, and Michael Dunbar

RAND Corporation

Molly Anderson and Jennifer Thompson

Advocates for Human Potential

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Abstract

Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA; Public Law 113-93) authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration, which allows states to test an innovative and evidence-based strategy for delivering and reimbursing a comprehensive array of services provided in community behavioral health clinics. The demonstration aims to improve the availability, quality, and outcomes of outpatient services provided in these clinics. The demonstration requires participating states to reimburse CCBHC services through a Medicaid prospective payment system (PPS) intended to cover the expected costs of CCBHC services for Medicaid beneficiaries. In 2016, the U.S. Department of Health and Human Services (HHS) selected 8 states to participate in the demonstration (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania). The demonstration was originally authorized for two years, but Congress has extended it multiple times and it is currently authorized in the original states through September 2025. In August 2020, HHS announced that Kentucky and Michigan would begin participating in the demonstration as a result of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; Public Law 116-136), which allowed HHS to add two states from among the original 24 states that had received planning grants under PAMA. The Bipartisan Safer Communities Act (BSCA; Public Law 117-159), enacted in June 2022, extended the demonstration period for Michigan and Kentucky through September and December 2027, respectively. It also funded additional planning grants and authorized any state that received a planning grant (either under PAMA or BSCA) to apply to participate in the demonstration beginning in 2024. Starting July 1, 2024, and every two years thereafter, HHS may select up to 10 additional states to participate in the demonstration for a period of four years. In 2024, HHS welcomed 10 new states into the demonstration.

PAMA mandates that the HHS Secretary submit an annual report to Congress that assesses: (1) access to community-based mental health services under Medicaid; (2) the quality and scope of services provided by CCBHCs; and (3) the impact of the demonstration on federal and state costs of a full range of mental health services. PAMA, as amended by the BSCA, also requires HHS to submit to Congress recommendations concerning the continuation of the demonstration. This report describes findings related to the PAMA topics from 18 states participating in the demonstration as of August 2025 and includes the required recommendations. The report draws on interviews with state officials and CCBHCs, quality measure data, and a survey of CCBHCs in the original PAMA and CARES Act states.

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Executive Summary

Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA; Public Law 113-93) authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration, which allows states to test an innovative evidence-based strategy for delivering and reimbursing a comprehensive array of services provided in community behavioral health clinics. The demonstration aims to improve the availability, quality, and outcomes of outpatient services provided in these clinics. CCBHCs must offer nine types of services¹ to all people who seek care, including people with serious mental illness, serious emotional disturbance, substance use disorders including opioid use disorder (SUDs), or experiencing a behavioral health crisis. Demonstration states have some flexibility, however, to tailor these services to align with their Medicaid state plans and other regulations and to meet the needs of the communities they serve based, in part, on community needs assessments. Services must be person- and family- centered, trauma informed, and recovery oriented. CCBHCs can have formal signed agreements with Designated Collaborating Organizations (DCOs) to provide demonstration services to CCBHC clients, but services provided through a DCO must meet CCBHC standards in accordance with such agreements. Even if CCBHCs do not engage DCOs, the CCBHCs must maintain relationships with a range of health and social service providers to facilitate referrals and coordinate care. They must also offer services during accessible hours (including evenings and weekends) and in convenient locations (for example, by providing services in clients' homes and elsewhere in the community) and ensure timely access to crisis services 24 hours a day and seven days a week. Services may be delivered through telehealth and telemedicine.

The demonstration requires participating states to reimburse CCBHC services through a Medicaid prospective payment system (PPS). The PPS is intended to cover the expected costs of CCBHC services for Medicaid beneficiaries and provide CCBHCs with a flexible and stable source of funding. States select one of four PPS models to reimburse all demonstration CCBHCs in the state. Two options offer a fixed daily payment for each day a Medicaid beneficiary receives demonstration services (PPS-1 and PPS-3), and two offer a fixed monthly payment for each month in which a Medicaid beneficiary receives demonstration services (PPS-2 and PPS-4). After each demonstration year (DY), states must report measures that assess the quality of care provided to CCBHC clients.

In October 2015, the U.S. Department of Health and Human Services (HHS) awarded planning grants to 24 states to begin certifying clinics to become CCBHCs, establish their PPS, and develop the infrastructure to support the demonstration. To support the first phase of the demonstration, HHS developed criteria (as required by PAMA) for certifying CCBHCs in six areas (SAMHSA 2023). The criteria provide a framework for certifying CCBHCs, but states can exercise some discretion in applying the criteria to support implementation of the CCBHC model in their local context. The certification criteria require CCBHCs to

¹ The CCBHC criteria describe nine services CCBHCs must provide either directly or through a DCO arrangement: 1) Crisis Behavioral Health Services; 2) Screening, Assessment, and Diagnosis; 3) Person-Centered and Family-Centered Treatment Planning; 4) Outpatient Mental Health and Substance Use Services; 5) Outpatient Clinic Primary Care Screening and Monitoring; 6) Targeted Case Management Services; 7) Psychiatric Rehabilitation Services; 8) Peer Supports, Peer Counseling, and Family/Caregiver Supports; and 9) Intensive, Community-Based Mental Health Care for Members of the Armed Forces and Veterans. Additional details on service definitions and certification requirements can be found in the CCBHC certification criteria, available at: <https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf>.

provide accessible care, including 24-hour crisis management services; engage people quickly through prompt intake services; and provide treatment for all adults, children, and adolescents regardless of their ability to pay or place of residence.

In December 2016, HHS selected eight of the 24 planning grant states to participate in the demonstration. The demonstration was originally authorized for two years and scheduled to end in July 2019, but Congress has extended it multiple times (Stewart 2024). It was authorized through September 2025 for the original states. In August 2020, HHS announced that Kentucky and Michigan would begin participating in the demonstration as a result of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; Public Law 116-136) which allowed HHS to add two states from among the original 24 planning grant states. The Bipartisan Safer Communities Act (BSCA; Public Law 117-159), enacted in June 2022, extended the initial two-year demonstration period for Michigan and Kentucky by four years, for a total of six years.² It also funded additional planning grants and authorized any state that received a planning grant (either under PAMA or BSCA) to apply to participate in the demonstration beginning in 2024. Beginning July 1, 2024, and every two years thereafter, HHS may select up to 10 additional states to participate in the demonstration for a period of four years. In March 2023, HHS awarded planning grants to 15 states and in December 2024, HHS awarded planning grants to 14 states and the District of Columbia to develop proposals to participate in the demonstration. In June 2024, HHS approved 10 additional states to implement demonstration programs and as of August 2025, 18 states were participating in the demonstration, including these states, six of the eight original demonstration states (Minnesota, Missouri, New Jersey, New York, Oklahoma, and Oregon), and Kentucky and Michigan.³ HHS plans to approve 10 additional states to join the Demonstration in June of 2026.

Section 223(d)(7)(A) of PAMA mandates that HHS submit annual reports to Congress that assess: (1) access to community-based mental health services under Medicaid in the area or areas of a state targeted by a demonstration program as compared to other areas of the state, (2) the quality and scope of services provided by CCBHCs as compared to community-based mental health services provided in states not participating in a demonstration program and in areas of a demonstration state that are not participating in the demonstration, and (3) the impact of the demonstration on the federal and state costs of a full range of mental health services (including inpatient, emergency, and ambulatory services). Section 223(d)(7)(B) of PAMA, as amended by BSCA, requires HHS to submit to Congress “recommendations concerning whether the demonstration programs under this section should be continued, expanded, modified, or terminated.” ASPE contracted with Mathematica, the RAND Corporation, and Advocates for Human Potential to evaluate the demonstration. Drawing on interviews with state officials and CCBHCs, quality measure data, and surveys of CCBHCs, this report presents findings from the eighteen active demonstration states on the required PAMA evaluation areas. The level of discussion for these areas varies based on the data available for this year’s analysis, and some topics may be covered more extensively in other annual reports. The report also includes HHS’s recommendations regarding the future of the demonstration.

² Demonstrations in Michigan and Kentucky are expected to end in September and December 2027, respectively.

³ This includes Alabama, Illinois, Indiana, Iowa, Kansas, Maine, New Hampshire, New Mexico, Rhode Island and Vermont.

A. Status of demonstration implementation

As of March 2025, the CCBHC demonstration included 206 clinics across 18 states, representing an increase from 106 in May 2024. This growth was primarily due to the addition of 84 clinics in newly participating BSCA states. The number of clinics in the original PAMA and CARES Act states increased modestly from 106 to 122, with Michigan and New York accounting for most of the growth.⁴ Among the 78 CCBHCs participating in the 2024 survey, CCBHCs delivered demonstration-supported services at 730 physical clinic locations, with an average of 10 clinic locations per CCBHC and wide variation across states (ranging from an average of 3 clinic locations per CCBHC in New Jersey and Oregon to 18 in Missouri).

Newly participating BSCA states were in the early stages of implementation or preparing to launch their demonstrations. Before joining the demonstration, CCBHCs operated in all ten BSCA states; these clinics primarily became CCBHCs through SAMHSA CCBHC Expansion grants. In describing their motivations for joining the demonstration, these states universally cited the opportunity to improve access to behavioral health care, especially among populations historically facing access barriers, supported by a stable and sustainable funding mechanism. BSCA states have focused on key infrastructure activities during early implementation, such as establishing and refining certification and monitoring processes, and deploying Medicaid billing and quality reporting systems. Some states reported early successes in establishing these systems, while others encountered challenges related to technology updates and billing complexity.

At the same time, the six remaining original demonstration states were preparing for the end of the demonstration in their states in September 2025. All six states planned to sustain the model through Medicaid state plan amendments, and nearly all clinics in these states intended to continue implementing the model after the demonstration ends. States emphasized that their plans to continue the CCBHC model through Medicaid state plan authority reflect the model's perceived value and its importance to broader state behavioral health system reforms. While most states expect to retain the core elements of the CCBHC program as implemented under the demonstration when transitioning to state plan authority, some may make targeted adjustments to reduce administrative burden or better align with state priorities. These changes could include simplifying payment systems or revising quality bonus payment structures.

B. Access to care in demonstration states

The number of people served by demonstration CCBHCs increased steadily over time, suggesting CCBHCs have expanded their reach and capacity. The number of people served across the original demonstration states increased from 286,089 in 2018 to 383,816 in 2023. The CARES Act states also experienced growth, from 133,269 people served in 2022 to 149,989 in 2023. The average number of people served by each CCBHC has also increased consistently over time in almost all states, suggesting individual CCBHCs have increased their capacity. Demographic characteristics and insurance status of CCBHC clients have generally been similar across demonstration years.

⁴ In February 2023, HHS released guidance allowing existing demonstration states to add new CCBHCs to their program for the first time since the start of the demonstration (HHS 2023).

Demonstration CCBHCs continue to implement a range of activities and strategies to expand and maintain access to care. Almost all (97% in 2024) offered open access scheduling or same-day appointments. Clinics also conducted community outreach, including street outreach to people with serious mental illness or SUDs, and engagement with veterans' groups. Some developed tailored resources for specific populations, such as a call line for farmers and ranchers in Oregon or dedicated veteran peer support roles. Demonstration CCBHCs also worked to increase service delivery in community settings; for example, the percentage of CCBHCs providing services in homeless shelters increased from 9% in 2018 to 74% in 2024, and those providing services in schools increased from 51% to 88%. Telehealth use also expanded, with 100% of demonstration CCBHCs offering telehealth services by 2024. Clinics used telehealth to increase accessibility, especially in rural communities, and some deployed tools such as iPads to ensure 24/7 access in homes and public locations. CCBHCs expanded their reach by deploying vehicles to deliver mobile services throughout rural areas and increased capacity by expanding the physical space of facilities to meet growing demand.

Clinics and state officials perceived that CCBHCs provided better access to care relative to other behavioral health clinics in their communities. Becoming a CCBHC has enabled clinics to reduce wait times and keep clients engaged in care. For example, one clinic noted clients previously faced wait times of 2–3 weeks but now receive services from the clinic within 24 to 48 hours. States also highlighted that CCBHCs serve broader populations than many community mental health centers, which may limit services to adults or those with specific diagnoses. CCBHCs and states often reported national behavioral health workforce shortages as a barrier to serving their communities. Recruiting and retaining staff, particularly for child and youth services, crisis services, and bilingual providers, was sometimes challenging. To address these challenges, CCBHCs responded by offering higher salaries, adding benefits like wellness days, and adjusting roles to improve staff satisfaction; changes they noted they could accomplish because of the stable funding offered by the demonstration's PPS.

C. Quality and scope of services

Almost all CCBHCs in original and CARES Act states provided all nine required CCBHC service types, with minimal changes over time. All or nearly all CCBHCs provided crisis services; screening, assessment, and diagnosis services; person- and family-centered treatment planning services; outpatient mental health and SUD services; psychiatric rehabilitation services; peer support services; primary care screening and monitoring, and targeted case management either directly or through DCOs.⁵ The percentage of CCBHCs offering community care for uniformed service members and veterans was lower than the other eight required service types but has increased from 72 percent in 2018 to 78 percent in 2024. Within the CCBHC service categories, CCBHCs provided a wide range of individual services and treatments directly or by DCO, such as various evidence-based practices, with some growth over time.

Most demonstration CCBHCs provided services directly rather than rely on DCOs. In 2024, 31 percent of CCBHCs used DCOs to deliver crisis services, 18 percent for primary care screening and monitoring, and fewer than 10 percent for most other services. Clinics cited a preference for maintaining control over service quality and integrating care in a single location and some states have also discouraged use of

⁵ Additional details on service definitions and certification requirements can be found in the CCBHC certification criteria, available at: <https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf>.

DCOs. In some states, such as Michigan, state policy changes have facilitated innovative DCO partnerships; for example, allowing CCBHCs to serve as DCOs for rural CCBHCs with limited workforce capacity to fill service gaps.

Demonstration CCBHCs have expanded their scope of services in response to community needs and increased demand. In 2024, half of the surveyed CCBHCs reported expanding services in the prior year. Many of these clinics expanded SUD services, including medications for opioid and alcohol use disorders. Others enhanced services for children and youth, such as psychiatric rehabilitation services, and school-based care for this population. Clinics have also broadened care coordination capabilities and physical health integration, with about half offering on-site primary care in addition to required primary care screening and monitoring. States and clinics consistently reported that CCBHCs offer a broader and more integrated scope of services than other providers, with co-location of services in a single setting and care coordination cited as key strengths supporting improved service delivery under the model.

CCBHCs have generally sustained required services over time, with many attributing this to the demonstration's PPS enabling them to hire and retain staff necessary to maintain service delivery. While most CCBHCs maintained the required services, some reported challenges delivering specific services due to workforce shortages, staff turnover, and the complexity of implementing evidence-based practices. Many CCBHCs addressed these hurdles by fostering supportive work environments and internal training strategies.

D. Prospective payment systems: Selection and contributions

Most BSCA states selected a PPS model based on familiarity with similar payment systems, aiming to simplify early implementation and limit complexity. Most adopted PPS-1, which offers a fixed daily rate. Two states, Maine and Rhode Island, chose PPS-2, which uses a fixed monthly rate. Only New Hampshire selected PPS-3, which includes a special crisis services rate. Most new states opted not to include optional components of the PPS, such as quality bonus payments or special population rates, prioritizing minimizing additional complexity during initial implementation of a new model. BSCA states often hired contractors to help with initial rate setting, as was the case with the original states. In some cases, contractors may also provide other support to help states implement the PPS.

The demonstration PPS supported the expansion and sustainability of a broader scope of services than CCBHCs were providing before. The flexibility of the bundled payment has allowed CCBHCs to expand their service offerings to include care coordination, crisis services, peer supports, and other essential services that are not fully reimbursed or difficult to sustain under traditional Medicaid payment models. Almost three-quarters of CCBHCs reported the PPS has allowed them to cover services that were not previously reimbursed under the Medicaid state plan (71 percent), often referencing case management, care coordination, crisis services, and peer services and supports in their responses. CCBHCs also credited the PPS with enabling them to introduce innovative service offerings and fully support evidence-based, team-based care. By covering costs of both direct client interaction and indirect components of team-based care such as provider-to-provider consultation, the PPS has made it possible for CCBHCs to offer the collaborative, wraparound services envisioned under the model.

The PPS has strengthened CCBHCs' workforce capacity and supported staff development. Over three-quarters of CCBHCs reported the PPS has allowed them to support staff or staff types not previously reimbursed by traditional Medicaid or other reimbursement mechanisms, often mentioning staff such as peers, care coordinators, case managers, administrative support staff, and outreach and engagement staff. Demonstration CCBHCs widely reported that the PPS enabled them to offer more competitive salaries, hire staff, and retain personnel critical to service delivery. Many clinics expanded employee benefits and invested in professional development with the support of demonstration funding, offering regular trainings in evidence-based practices and culturally responsive care. State officials emphasized that these investments are key to recruiting and retaining staff and would not have been feasible under traditional reimbursement systems, with one New York official calling the PPS the "most effective factor" in allowing clinics to grow and sustain their workforce.

Improved financial stability under the PPS has allowed CCBHCs to enhance access, improve efficiency, and innovate in care delivery. A more predictable and reliable source of funding has allowed clinics to plan and budget more effectively, freeing up resources to experiment with more efficient care models, such as same-day scheduling, and to invest in outreach and engagement efforts. Some clinics hired dedicated staff for these functions, relieving clinical staff of non-clinical duties and making more efficient use of their time to perform clinical functions. However, some clinics and states continue to face challenges funding uncompensated care and are exploring mechanisms such as Medicaid uncompensated care pools to sustain gains in access for uninsured populations during the demonstration.

E. Recommendations

Section 223(d)(7)(B) of PAMA as amended by the BSCA requires HHS to submit to Congress "recommendations concerning whether the demonstration programs under this section should be continued, expanded, modified, or terminated," noting "such recommendations shall include data collected after 2019, where feasible." Since its launch eight years ago, the demonstration has driven substantial changes in the delivery of behavioral health care among participating clinics and states. Demonstration CCBHCs and states have widely viewed the demonstration as a catalyst for positive organizational transformation, enabling clinics to expand services, strengthen infrastructure, and enhance efficiency of care delivery. These changes required considerable effort. States and clinics implemented changes to data and billing systems, redesigned workflows, and put into place new partnerships and processes to improve access to and quality of care. With the support of the demonstration PPS, many clinics hired staff across a range of disciplines and invested in training and technology to support more integrated and efficient care.

CCBHCs have reported improved access to care during the demonstration, driven by both expanded service availability and strengthened care coordination. CCBHCs have substantially increased the number of people they serve over time, and clinics have reported reduced wait times, increased same-day and walk-in appointments, and extended hours to make services easier to access. CCBHCs have also expanded the range of services they offer to better meet community needs; for instance, many clinics are now providing services such as medications for opioid use disorder and have extended the reach of mobile crisis services. Many CCBHCs have also brought services into the community to reach people with limited transportation options or who face other barriers to obtaining clinic-based care. These changes have been

facilitated and reinforced by a strong emphasis on care coordination, helping people not only enter care more easily but also receive more ongoing and connected support. Clinics have built stronger relationships with external partners and implemented formal protocols to manage transitions of care, particularly after hospitalizations or crises. Dedicated care coordination staff and shared care plans have helped maintain treatment continuity during transitions in care. While some CCBHCs continue to work through data sharing challenges with other health care and social service providers, many clinics report improved communication and information sharing with partners, which are critical for delivering timely, coordinated care.

Although states and CCBHCs have effectively implemented the model and reshaped service delivery, the demonstration's long-term impacts on Medicaid costs, quality, and service use outcomes are currently less clear. The introduction of the CCBHC model affected the use of Medicaid services differently across states during the first four demonstration years. Although some states experienced reductions in costly emergency department visits and hospitalizations, others had different results, such as minimal or no observable change. In addition, although the demonstration decreased inpatient costs for some populations, these reductions did not offset an increase in ambulatory behavioral health costs in the few states with available cost data. However, these costs might not be unexpected. The demonstration did not have cost neutrality requirements, and most states did not anticipate immediate cost savings, instead viewing the demonstration as an opportunity to address longstanding underinvestment in intensive, community-based behavioral health services. There was some evidence of improved quality of care in the first four demonstration years, performance was comparable to or exceeded available Medicaid Core Set state median data, and performance on most measures remained stable or improved over time. Performance on some measures, however, indicated opportunities for strengthening care coordination and data sharing.

The demonstration has also highlighted persistent challenges in the broader behavioral health care system, including ongoing behavioral health workforce shortages and differences in access between urban and rural communities. Even so, the demonstration has helped clinics address these challenges through sustainable and flexible funding, and many clinics have used the model as a platform for continuous quality improvement, investing in staff development, adopting evidence-based practices informed by performance on quality measures and outcomes, and strengthening their ability to track and respond to the needs of people receiving care.

The demonstration has generated strong and sustained interest nationwide. Participation has grown significantly, with 18 states and more than 200 CCBHCs currently operating under the demonstration, and additional states pursuing state-level CCBHC implementation through demonstration planning grants. To date, all but seven states have taken steps toward adopting the CCBHC model at the state level, either through the demonstration itself or by exploring Medicaid waivers or state plan amendments. The federal government has made significant and sustained investments to develop and refine the CCBHC model, including designing and updating robust payment methodologies, comprehensive quality metrics, and delivering technical assistance to ensure effective implementation and continuous improvement. Notably, even states pursuing alternative Medicaid pathways for implementing the CCBHC model have often used the demonstration as a foundation, drawing on its structure, lessons, and momentum to guide implementation efforts.

Successful implementation of the CCBHC model and evidence of its positive benefits to communities provides strong justification for continuing the demonstration, opening it to all states as currently enacted in its authorizing legislation.

The demonstration has shown positive impacts across some outcomes, and implementation experiences point to its potential. Based on the available evidence, we recommend Congress continue to support CCBHCs through the demonstration as currently enacted and look for opportunities to support the growth of the CCBHC model. Continued federal support for the demonstration as planned would equip existing and new CCBHCs with essential resources to deliver consistent access to comprehensive, evidence-based services, such as psychiatric rehabilitation and job training through supported employment, that promote stability, independence, and improved health outcomes. Ending the demonstration before its scheduled conclusion would risk the elimination of some existing CCBHCs and give states less flexibility and incentives to enhance behavioral health services.

Implementing the CCBHC model represents a fundamental transformation of outpatient behavioral health service delivery and a significant evolution of traditional practice that requires different financing structures, expanded clinical and operational capacity, and strengthened state oversight. Although some states are working to expand CCBHCs under Medicaid state plan authority, others may lack the state legislative or administrative support, internal capacity, or technical expertise needed to independently establish a CCBHC program. These states may benefit from the demonstration's financial supports and incentives to implement the model prior to making changes to their Medicaid program. The federal supports available under the demonstration, including planning grants, an enhanced FMAP, and a structured technical assistance framework that fosters peer learning among states, have been essential in helping states and their clinics build infrastructure and capabilities needed for model implementation. These resources provide up-front funding to make needed changes, and ongoing support as states assess program costs and benefits. They serve as strong incentives for states to take on the financial and operational risk associated with implementing and refining changes to enhance their behavioral health delivery system.

Moreover, the demonstration facilitates continued collaboration among federal and state agencies and participating clinics to further refine and develop the model as an integral element of the broader behavioral health system. Sustaining the demonstration will preserve the progress made to date and strengthen states' efforts to build stable, sustainable behavioral health systems that respond effectively to local needs.

The needs of states and clinics as the demonstration matures and states graduate from the demonstration, along with opportunities for alignment across broader CCBHC initiatives, should also be considered.

In addition to the demonstration, the CCBHC initiative has grown substantially, with SAMHSA expansion grants awarded to clinics in 46 states, the District of Columbia, and Puerto Rico. Many states are also launching CCBHC programs through Medicaid state plan authorities outside of the demonstration. This growth is expected to continue as states transition from the CCBHC demonstration to programs supported under alternative Medicaid authorities. As the model continues to mature and longstanding underinvestment in behavioral health services begins to be addressed, states and the federal government will need to maintain strong oversight to monitor progress, assess efficiency, and ensure that the model continues to deliver high-quality, sustainable care. Recognizing this evolving landscape, a

federal strategy could promote a more coordinated and consistent approach that supports alignment across all CCBHC funding mechanisms and efforts.

To advance a more comprehensive strategy, the Department of Health and Human Services may consider options to better support collective understanding and oversight across the CCBHC initiative, including exploring how different funding mechanisms and program structures such as SAMHSA grants, the Medicaid demonstration, and state plan amendments interact, complement one another, or leave gaps that could be addressed through more coordinated design. For example, policymakers could consider whether SAMHSA's expansion grant funding might be deployed more strategically to support the uncompensated care needs of CCBHCs that operate under state Medicaid authorities or assess whether formula-based funding approaches, subject to appropriations/authority, would provide a more stable and predictable source of supplemental funding for these clinics than competitive expansion grants. These strategies may help address persistent challenges identified by demonstration states and clinics and enhance the long-term sustainability of state CCBHC programs.

Strengthening federal capacity for consistent data collection, analysis, and reporting across all CCBHC programs could also lay the groundwork for improved coordination and alignment across the CCBHC initiative. A robust national data infrastructure with standardized performance measures and reporting, regardless of funding source or program structure, could enable an integrated view of how the model functions and inform improvements across funding streams. Timely sharing of data with states and individual clinics could promote evidence-based decision-making and better facilitate learning and accountability across the broader CCBHC initiative. Federal agencies may also wish to explore opportunities to build on existing technical assistance structures and offer more unified and consistent technical assistance to states participating across funding mechanisms in key operational areas, such as cost reporting and quality monitoring.

F. Future evaluation activities

In each year of the evaluation, we will submit an annual report synthesizing findings related to changes in demonstration implementation and answering additional evaluation questions related to the PAMA topics. In future evaluation reports, we will incorporate findings from additional interviews with state officials, clinic-level surveys, cost reports and quality measures submitted by states and CCBHCs, and interviews with leaders at CCBHCs. We also will present data from CCBHC client focus groups to better understand the experiences of people receiving care at CCBHCs.

I. Introduction

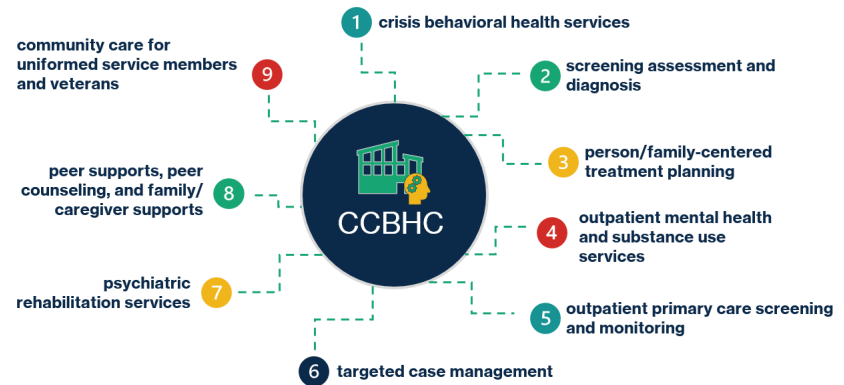
A. Demonstration overview

Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA; Public Law 113-93) authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration, which allows states to test an innovative evidence-based strategy for delivering and reimbursing a comprehensive array of services provided in community behavioral health clinics. The demonstration aims to improve the availability, quality, and outcomes of

outpatient services provided in these clinics. CCBHCs must offer nine types of services (Exhibit I.1) to all people who seek care, including people with serious mental illness, serious emotional disturbance, and substance use disorder (SUD).

Demonstration states have some flexibility, however, to tailor these services to align with their Medicaid state plans and other regulations and to meet the needs of the communities they serve based, in part, on community needs assessments.

Exhibit I.1. Required CCBHC service types



Source: CCBHC certification criteria.
CCBHC = Certified Community Behavioral Health Clinic.

Services must be person- and family-centered, trauma-informed, and recovery oriented. CCBHCs can have formal signed agreements with Designated Collaborating Organizations (DCOs) to provide demonstration services to CCBHC clients, but services provided through a DCO must meet CCBHC standards in accordance with such agreements. Even if CCBHCs do not engage DCOs, the CCBHCs must maintain relationships with a range of health and social service providers to facilitate referrals and coordinate care. They must also offer services during accessible hours (including evenings and weekends) and in convenient locations (for example, by providing services in clients' homes and elsewhere in the community) and ensure timely access to crisis services 24 hours a day and seven days a week.

The demonstration requires participating states to reimburse CCBHC services through a Medicaid prospective payment system (PPS). The PPS is "cost-based", meaning payment rates are intended to cover the expected costs of required CCBHC services for Medicaid beneficiaries and provide CCBHCs with a flexible and stable source of funding. Prospective rates are developed using standardized cost reports that document both historic and projected costs associated with delivering the full scope of CCBHC services, including direct and indirect costs such as staffing, administrative support, facility, and overhead. During rate development, states may include reasonable projections for anticipated costs of new demonstration services not yet provided, consistent with CMS guidance (CMS 2024). States select one of

four PPS models to reimburse all demonstration CCBHCs in the state. Two options offer a fixed daily payment for each day a Medicaid beneficiary receives demonstration services (PPS-1 and PPS-3), and two offer a fixed monthly payment for each month in which a Medicaid beneficiary receives demonstration services (PPS-2 and PPS-4).⁶ PPS-3 and PPS-4 include the option of setting a separate special crisis services rate for several categories of crisis services. After each demonstration year (DY), states must report measures that assess the quality of care provided to CCBHC clients. Quality measure reporting provides CCBHCs and state officials with standardized metrics to monitor the quality of care and inform quality improvement efforts. PPS-1 and PPS-3 states have the option to provide CCBHCs with quality bonus payments (QBPs) based on their performance on quality measures. PPS-2 and PPS-4 states must provide QBPs.

B. Demonstration roll-out

In October 2015, the U.S. Department of Health and Human Services (HHS) awarded planning grants to 24 states to begin certifying clinics to become CCBHCs, establish their PPS, and develop the infrastructure to support the demonstration. To support the first phase of the demonstration, HHS developed criteria (as required by PAMA) for certifying CCBHCs in six areas: (1) staffing, (2) availability and accessibility of services, (3) care coordination, (4) scope of services, (5) quality and reporting, and (6) organizational authority (SAMHSA 2023).⁷ The criteria provide a framework for certifying CCBHCs, but states can exercise some discretion in applying the criteria to support implementation of the CCBHC model in their local context. The certification criteria require CCBHCs to provide accessible care, including 24-hour crisis management services; engage people quickly through prompt intake services; and provide treatment for all adults, children, and adolescents regardless of their ability to pay.⁸

In December 2016, HHS selected eight of the 24 planning grant states to participate in the demonstration (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania). The demonstration was authorized for two years at first and scheduled to end in July 2019, but Congress has extended it multiple times (Stewart et al. 2024). It is currently authorized through September 2025 for the original states.

In August 2020, HHS announced that Kentucky and Michigan would begin participating in the demonstration as a result of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; Public Law 116-136), which allowed HHS to add two states from among the original 24 planning grant states. The Bipartisan Safer Communities Act (BSCA; Public Law No. 117-159), enacted in June 2022, extended the initial two-year demonstration period for Michigan and Kentucky by four years, for a total of six years.⁹ It also authorized all states that have received a SAMHSA CCBHC planning grant to apply to participate in

⁶ PPS-3 and PPS-4 were introduced as options for demonstration states to use starting in 2024. Before this, states could only select PPS-1 or PPS-2.

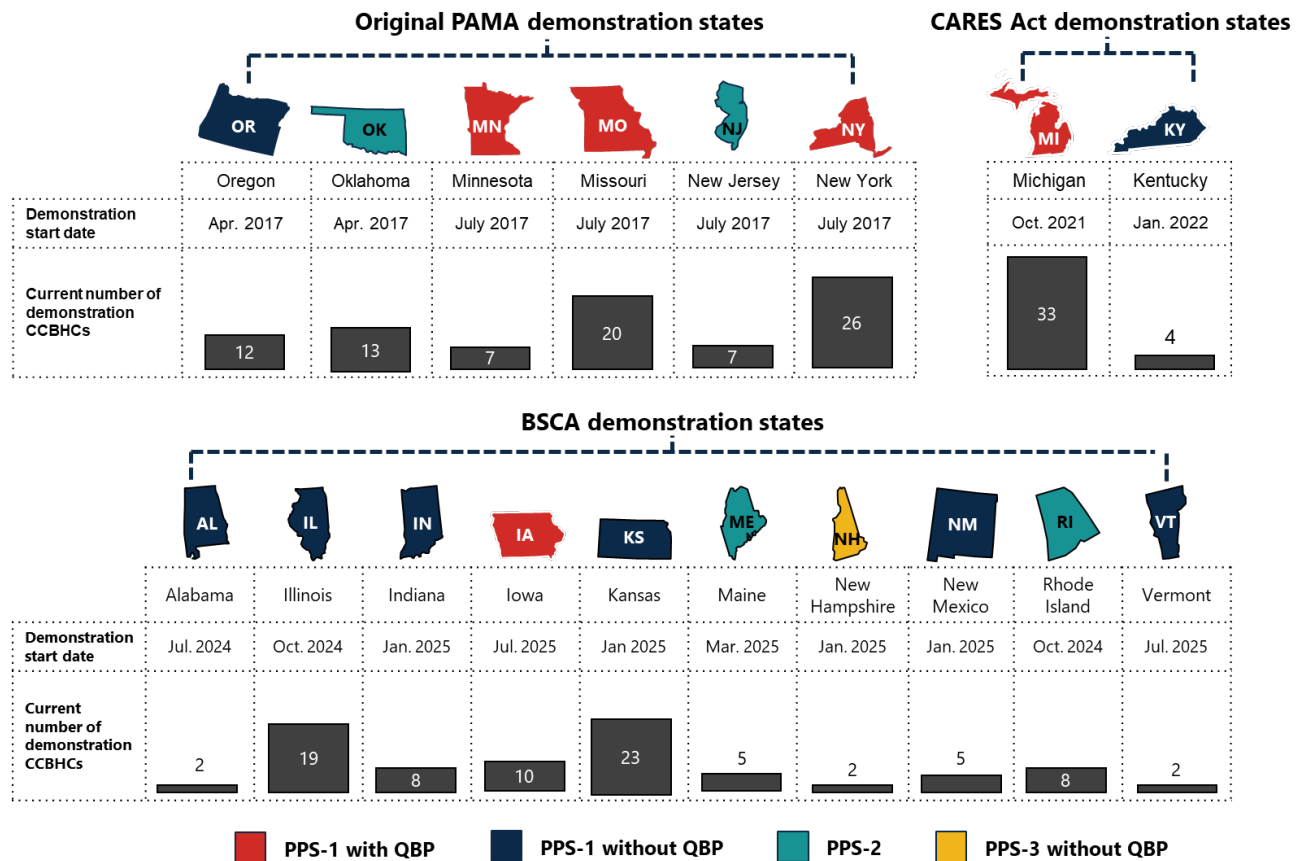
⁷ HHS published updated certification criteria in March 2023 (SAMHSA 2023; <https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf>).

⁸ Public Law 117-159 creates requirements regarding the availability and accessibility of services, including crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence. These form the basis of accessibility and availability requirements in the CCBHC certification criteria.

⁹ Demonstrations in Michigan and Kentucky are expected to end in September and December 2027, respectively.

the demonstration beginning in 2024.¹⁰ Beginning July 1, 2024, and every two years thereafter, HHS may select up to 10 additional states to participate in the demonstration for a period of four years. In March 2023, HHS awarded planning grants to 15 states to develop proposals to participate in the demonstration. In June 2024, HHS announced it would welcome 10 new states into the demonstration.¹¹ In December 2024, HHS awarded planning grants to an additional 14 states and the District of Columbia to develop proposals to participate in the demonstration. As of August 2025, 18 states participate in the demonstration, including six of the eight original demonstration states (Minnesota, Missouri, New Jersey, New York, Oklahoma, and Oregon), Kentucky and Michigan, and the first 10 states added under the BSCA in June 2024 (Exhibit I.2).¹²

Exhibit I.2. Characteristics of current demonstration states



Source: Interviews with state officials in fall 2024 and winter 2025.

¹⁰ States must have received a planning grant at any time since 2015 in order to apply to participate in the demonstration.

¹¹ This includes Alabama, Illinois, Indiana, Iowa, Kansas, Maine, New Hampshire, New Mexico, Rhode Island, and Vermont.

¹² Since the launch of the demonstration in 2017, two of the original states ended their participation. Pennsylvania chose not to continue participating after the first two years. Nevada ended its participation in the demonstration on July 1, 2023. Both states are continuing to fund CCBHCs under separate Medicaid authorities. Additionally, Minnesota briefly ended its participation on December 31, 2022, but rejoined the demonstration on July 1, 2023.

BSCA = Bipartisan Safer Communities Act of 2022; CARES = Coronavirus Aid, Relief, and Economic Security Act of 2020; CCBHC = Certified Community Behavioral Health Clinic; PAMA = Protecting Access to Medicare Act of 2014; PPS = prospective payment system; QBP = quality bonus payment.

In addition to the demonstration, the Substance Abuse and Mental Health Services Administration (SAMHSA) supports implementation of the CCBHC model through the CCBHC Expansion (CCBHC-E) grant program. CCBHC-E grants provide funding directly to clinics but do not change Medicaid payment or require states to certify clinics or oversee the grants.¹³ To date, SAMHSA has awarded seven cohorts of CCBHC-E grants. Demonstration CCBHCs can participate in the demonstration and CCBHC-E grant program. In 2024, at least one demonstration CCBHC in all demonstration states had received a SAMHSA CCBHC-E grant since 2018, and, in some states, all demonstration CCBHCs had received a CCBHC-E grant (Exhibit I.3).

Exhibit I.3. Demonstration CCBHCs with CCBHC-E grants, 2024

State	CCBHCs that have also received expansion grants, 2024	
	N	%
Kentucky	4	100
Michigan	8	62
Minnesota	10	17
Missouri	1	50
New Jersey	6	86
New York	10	77
Oklahoma	3	100
Oregon	5	42

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year.

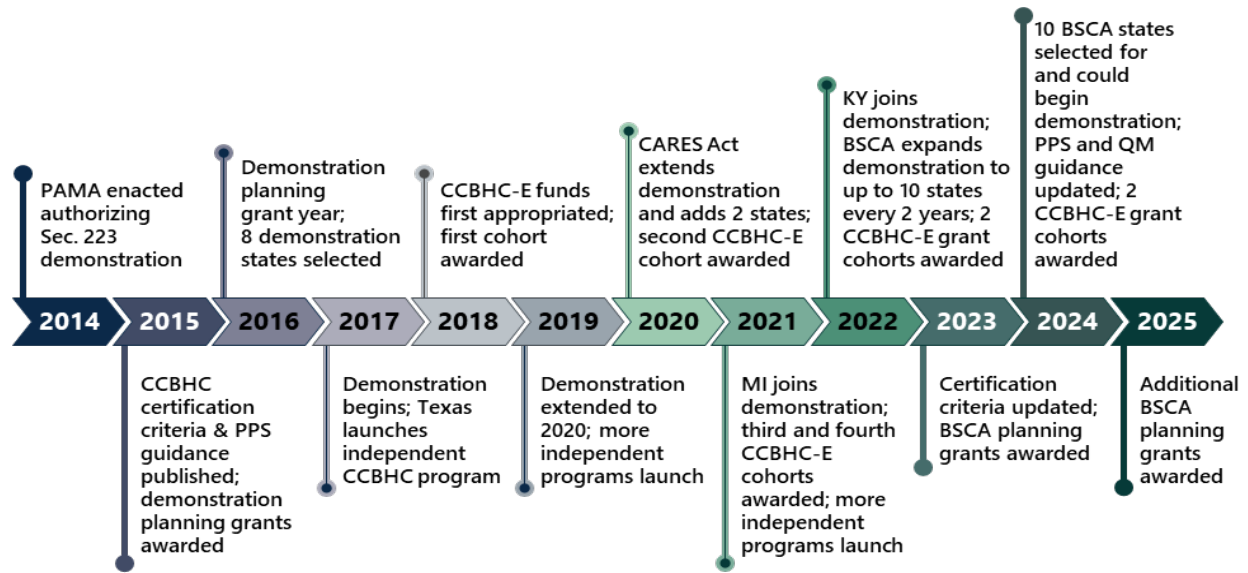
Notes: The denominators for the state percentage calculations are the total number of CCBHCs responding to the survey in each state in 2024 (see Appendix Exhibit A.1). The denominator for the total percentage calculation is the total number of CCBHCs responding to the survey in 2024: 78.

CCBHC = Certified Community Behavioral Health Clinic; CCBHC-E = Certified Community Behavioral Health Clinic-Expansion.

Demonstration CCBHCs use CCBHC-E grants to cover the costs of services for people who are uninsured and underinsured, to help launch the model in new clinic locations, or provide start-up and infrastructure costs to launch additional services. Some demonstration states and non-demonstration states have independently expanded the model beyond the CCBHC demonstration and CCBHC-E grants through other Medicaid authorities, including state plan amendments (SPAs) and section 1115 demonstration waivers (Brown et al. 2021; Stewart et al. 2024). Exhibit I.4 shows how the model has expanded over time.

¹³ CCBHC-E grantees that are not certified by their states must submit an attestation describing how they meet the CCBHC certification criteria.

Exhibit I.4. CCBHC model expansion timeline



BSCA = Bipartisan Safer Communities Act of 2022; CARES = Coronavirus Aid, Relief, and Economic Security Act of 2020; CCBHC = Certified Community Behavioral Health Clinic; CCBHC-E = Certified Community Behavioral Health Clinic-Expansion; PAMA = Protecting Access to Medicare Act of 2014; PPS = prospective payment system; QM = quality measure.

C. Evaluation description and goals

PAMA requires HHS to submit annual reports to Congress that assess the following:

1. Access to community-based mental health services under Medicaid in the area or areas of a state targeted by a demonstration program as compared to other areas of the state
2. The quality and scope of services provided by certified community behavioral health clinics as compared to community-based mental health services provided in states not participating in a demonstration program and in areas of a demonstration state that are not participating in the demonstration
3. The impact of the demonstration on the federal and state costs of a full range of mental health services (including inpatient, emergency, and ambulatory services)

In September 2016, the Office of the Assistant Secretary for Planning and Evaluation contracted with Mathematica and its subcontractor, RAND, to evaluate the demonstration’s implementation and impacts and to provide information for HHS’s Reports to Congress. The evaluation included the eight original demonstration states and covered the two-year period for which the demonstration was initially authorized (Brown et al. 2021).

Exhibit I.5. Key findings from prior evaluation reports

1. In early demonstration years, states and CCBHCs implemented activities to improve access, increased the number of clients served, expanded types of services and service capacity, hired and trained staff, developed partnerships with external providers, and changed many of their care processes. States and clinics were mostly able to overcome initial implementation challenges but cited workforce shortages and the possibility of the end of the demonstration as key challenges to sustaining the model.

2. The original demonstration states have generally been able to maintain CCBHC services and other certification requirements over time. CCBHCs have maintained and expanded activities to improve access to care and care coordination.
3. The number of people that CCBHCs care for has increased steadily, and the characteristics of CCBHC clients have generally remained consistent over time. The number of people served by the six original PAMA states remaining in the demonstration increased from 286,089 to 340,334 from the first to the fifth demonstration year.
4. In some states, introduction of the CCBHC model was associated with reduced emergency department visits, and there was some evidence of positive impacts on hospitalization rates. For example, among all Medicaid beneficiaries included in the analysis in Nevada, there was a 23 percent decrease in hospitalizations (an average reduction of 75 all-cause hospitalizations per 1,000 beneficiaries per year) for people who received care from CCBHCs relative to the comparison group ($p = 0.02$), which was primarily driven by behavioral health-related hospitalizations. The demonstration was associated with increased behavioral health-related ambulatory visits. For example, in Minnesota, the demonstration was associated with an average increase of 1,225 behavioral health-related ambulatory visits per 1,000 beneficiaries per year among people who received care from CCBHC relative to the comparison group. Although the demonstration decreased inpatient costs for some populations in some states, these decreases did not offset an increase in ambulatory behavioral health costs driven by increased behavioral health-related ambulatory visits.
5. Quality of care in the first four demonstration years was comparable to or exceeded available Medicaid Core Set state median data, and performance on most measures remained stable or improved over time. Performance on some measures indicated opportunities to strengthen care coordination and data sharing.

Sources: See [Stewart et al. 2024](#); [Wishon et al. 2024](#); [Brown et al. 2021](#) for additional findings.

CCBHC = Certified Community Behavioral Health Clinic.

As the demonstration continued in the original states and expanded to others, the Office of the Assistant Secretary for Planning and Evaluation contracted with Mathematica and the RAND Corporation in 2021 and again with Mathematica, the RAND Corporation, and Advocates for Human Potential in late 2023 to further evaluate the demonstration (Exhibit I.5).

This report describes findings related to the PAMA topics of access to care, quality of care, and the demonstration's impact on costs from 18 active demonstration states. The report also includes HHS's recommendations regarding the future of the demonstration. Findings draw on interviews with state officials and CCBHCs, quality measure data, and a survey of CCBHCs in original and CARES Act states. The report describes the quantitative and qualitative methods and then summarizes findings related to each area of the PAMA evaluation requirements.

Consistent with the statutory reporting requirements, the report addresses all required PAMA evaluation topics. However, the depth of discussion of each topic varies, reflecting differences in the maturity of available data and the evaluation's ongoing analysis. Some topics may be covered more extensively in past or future annual reports as additional data become available or as specific areas of inquiry are emphasized at different stages of the evaluation.

II. Methods

A. Qualitative

1. Clinic and state official interviews

From November 2024 to January 2025, we conducted semistructured telephone interviews with state Medicaid or behavioral health agency officials knowledgeable about CCBHC demonstration implementation in each of the states participating in the demonstration or preparing to participate in the demonstration at the time of interviews. These included interviews across the three active demonstration state cohorts: the original PAMA demonstration states (six states), the CARES Act states (two states), and the 2024 BSCA states (10 states). At the time of interviews, seven of the 10 BSCA states HHS selected to join the demonstration in 2024 were in the initial weeks or months of implementing the demonstration, and three were in the final stages of preparing for the demonstration. State interview topics included demonstration oversight, efforts to increase access to care, expanding and maintaining the scope of services, quality measurement, state PPS experiences, sustainability planning, and experiences serving children and adolescents with behavioral health needs.

In addition to interviewing state officials, we also interviewed clinic leaders from CCBHCs in each of the original and CARES Act states from October to December 2024. We conducted 15 CCBHC interviews, including one to three CCBHCs per state. Clinic interviews covered access to care, service scope, impacts on quality and cost, and overall experiences with model implementation. Interviews lasted 60 to 90 minutes. One researcher led the interview, and we asked interviewees for permission to audio-record the discussions to allow for interviews to be professionally transcribed. We systematically abstracted information from clinic and state official interview notes and transcripts, identifying compelling examples and illustrative quotes. We then conducted thematic analysis to identify high-level themes.

2. BSCA state documents

We reviewed and systematically abstracted information from planning grant materials and demonstration applications for the 10 new demonstration states and conducted targeted searches of demonstration states' websites as needed to inform other analyses. Our review of state documents helped us better understand BSCA states' early implementation plans and experiences, state characteristics, and the context in which each state implements the demonstration. We focused our review of applications and planning documents on the new states because we gathered information from these documents to answer many of the evaluation questions for the original PAMA and CARES Act demonstration states when evaluating earlier years of the demonstration (Brown et al. 2021; Wishon et al. 2023).

B. Quantitative

1. Clinic survey

In August and September 2024, all 78 CCBHCs with at least one year of participation in the demonstration across eight states (Kentucky, Michigan, Minnesota, Missouri, New Jersey, New York, Oklahoma, and Oregon) completed a survey of structured information on CCBHC characteristics, activities CCBHCs engaged in to increase access to care, scope of services, quality improvement activities and costs, and

other topics related to the certification criteria. To analyze the survey data, we computed descriptive statistics (for example, frequencies and percentages) using Excel and SAS. We summarized findings across all clinics that responded and also included findings from select open-ended survey questions. To provide context to the 2024 survey findings, we included complementary data from the 2018 and 2023 CCBHC surveys when available. The 2018 survey included 67 participating demonstration clinics, and the 2023 survey included 72 participating demonstration clinics.¹⁴ Select state-level findings are available in Appendix A, and state-level denominators for all exhibits with survey data are available in Appendix Exhibit A.1.

2. Quality measure reports

SAMHSA provided states and CCBHCs with the technical specifications and a standard reporting template for the required demonstration quality measures (SAMHSA 2016). In addition to the quality measures, the reporting template captures data on the unduplicated number of people CCBHCs served and their characteristics. States submit completed quality measure reports to SAMHSA within a year following each DY's end. We obtained the quality measure reports for the first six DYs for the original states and two DYs for the CARES Act states submitted to SAMHSA by March 2025. Our analyses included 70 to 74 clinics, depending on DY. We used the quality measure reports to examine demographic characteristics and insurance status of people who received CCBHC services each year DY. We report aggregate findings across all CCBHCs in a state and describe overall trends and variability across states. Appendix B includes detailed findings for each state.

C. Limitations of data sources and methods

Findings in this report should be interpreted in the context of several limitations of the available data. State interview data generally reflect the perspective of a few state officials, and, in some cases, state officials were relatively new to the state or to the CCBHC demonstration. Similarly, clinic interviews reflect the perspectives and experiences of a subset of clinics and do not necessarily reflect perspectives of all demonstration clinics. The information reported in interviews reflects the status of implementation when we collected the data, and states and CCBHCs might have continued to change and implement new activities and services after our interviews. In addition, certain documents we reviewed were outdated (for example, the demonstration planning grant application for one BSCA state was submitted in 2015), and the state plans and other information they include could have changed. Because the original and CARES Act states started their implementation activities at different times, the survey responses likely reflect differences in implementation progress across cohorts. Some survey questions changed across CCBHC surveys over time, so we could not compare some responses across multiple survey years. Additionally, the data available for this report do not support quantitative assessment of the quality of services provided by CCBHCs.

¹⁴ See Wishon Siegwarth et al. 2020 and Wishon et al. 2024 for more on the methods used to conduct these surveys.

III. Status of Demonstration Implementation

The CCBHC demonstration has progressed in phases, with states entering the program at different times. The original demonstration states authorized under PAMA began implementation in 2017, and a second cohort joined under the CARES Act in 2021–2022. At the time of this report, a new cohort of states (the 2024 BSCA states) had just launched their demonstrations or were preparing to begin. These newer states are navigating initial implementation and addressing early challenges...This chapter provides an overview of the current number and distribution of CCBHCs across states, examines the initial characteristics and experiences of the newest demonstration states, and explores the sustainability strategies the original cohort members are pursuing as they prepare to exit the demonstration.

A. Number of CCBHCs participating in the demonstration

As of March 2025, the CCBHC demonstration included 206 clinics across 18 states, an increase of 100 clinics from the 106 reported in May 2024 (Exhibit III.1). This increase was primarily driven by new BSCA states joining the demonstration. Among the BSCA states, the number of participating or expected clinics ranged from two (in Alabama and Vermont) to 23 (in Kansas), totaling 84 clinics across these states. The number of clinics in the original and CARES Act states increased modestly from 106 to 122, with only Michigan and New York expanding their clinic counts over the past year, adding three and 13 clinics, respectively. Both states plan further expansion: Michigan expected to add three more clinics by January 2025 (for 36 total), and New York planned to add 13 more by July 2025 (for 39 total).¹⁵

Exhibit III.1. Number of demonstration clinics, 2024 to 2025

State	2024	2025	State	2024	2025
Kentucky	4	4	Illinois	n/a	+ 19
Michigan	30	+ 33	Indiana	n/a	+ 8
Minnesota	7	7	Iowa	n/a	+ 10*
Missouri	20	20	Kansas	n/a	+ 23
New Jersey	7	7	Maine	n/a	+ 5*
New York	13	+ 26	New Hampshire	n/a	+ 2
Oklahoma	13	13	New Mexico	n/a	+ 5
Oregon	12	12	Rhode Island	n/a	+ 8
Alabama	n/a	2	Vermont	n/a	+ 2*
Total				106	206

Source: State official interviews.

*State had not launched its demonstration at the time of interview; reflects the expected number of clinics at demonstration start.

¹⁵ These clinics had not yet been certified at the time we interviewed the state.

CCBHCs reported significant variation in the number of physical CCBHC clinic locations¹⁶ out of which they provide demonstration services, with some CCBHCs only offering services in one clinic location and one Missouri CCBHC offering services in 56. On average, CCBHCs participating in the survey offered demonstration services in 10 clinic locations (Exhibit III.2).¹⁷

B. New state characteristics and activities to prepare for demonstration implementation

Before joining the demonstration, CCBHCs operated in all 10 of the new BSCA states; these clinics primarily became CCBHCs through SAMHSA CCBHC-E grants (Exhibit III.3). At the time of applying for the demonstration, each state had at least three CCBHC-E grantees, and some states anticipated that these grantees would join the demonstration. In addition, Kansas has operated an independent CCBHC program under the Medicaid State Plan authority, reimbursing CCBHCs through a PPS using a daily bundled rate, since 2022. The state had fully certified 11 CCBHCs through this program at the time of the state’s demonstration application.

Exhibit III.2. Number of physical clinic locations offering CCBHC services supported by the demonstration in original and CARES Act states, 2024

State	Number of CCBHCs	Number of CCBHC clinic locations	Average number of clinic locations per CCBHC
Kentucky	4	56	14
Michigan	13	70	5
Minnesota	6	45	8
Missouri	20	350	18
New Jersey	7	20	3
New York	13	104	8
Oklahoma	3	48	16
Oregon	11 ^a	37 ^a	3 ^a
Total	78	730	10

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year.

Notes: The denominators for the state percentage calculations are the total number of CCBHCs responding to the survey in each state in 2024 (see Appendix Exhibit A.1). The denominator for the total percentage calculation is the total number of CCBHCs responding to the survey in 2024: 78. Differences in average numbers of physical clinic locations may in part reflect differences in geographic areas served by CCBHCs. For example, some CCBHCs serve a subsection of a city or county and others serve multiple counties.

^a One Oregon CCBHC did not respond to this survey question, so this table reflects responses from 11 of 12 CCBHCs in Oregon.

CARES = Coronavirus Aid, Relief, and Economic Security Act of 2020; CCBHC = Certified Community Behavioral Health Clinic.

Exhibit III.3. Number of CCBHCs in operation prior to joining the demonstration through the BSCA expansion

	AL	IL	IN	IA	KS	ME	NH	NM	RI	VT
Number of CCBHCs	4	20	19	15	22	6	3	3	8	5

Source: BSCA state demonstration applications.

¹⁶ The term physical clinic location refers to offices or other clinic facilities where CCBHCs provide demonstration services. Many CCBHCs also provide demonstration services in locations in the community; we report on these community service locations separately and use different terminology.

¹⁷ Differences in numbers of physical clinic locations may be due in part to differing geographic areas being served by CCBHCs, as some CCBHCs serve a subsection of a city or county and others serve multi-county areas.

III. Status of Demonstration Implementation

Notes: CCBHCs in operation before the demonstration primarily became CCBHCs through CCBHC-E grants. Of Kansas's 22 CCBHCs with CCBHC-E grants, 11 had also achieved full state certification and were funded through the state's existing Medicaid CCBHC program.

BSCA = Bipartisan Safer Communities Act of 2022; CCBHC = Certified Community Behavioral Health Clinic; CCBHC-E = Certified Community Behavioral Health Clinic-Expansion.

In describing motivations for joining the demonstration, the 2024 BSCA states universally cited the opportunity to improve access to behavioral healthcare, especially among populations historically facing access barriers, supported by a stable and sustainable funding mechanism. For example, Iowa pursued the demonstration in hopes of expanding care to groups who have struggled to reach care, including veterans and military personnel. States were also motivated by the ability to provide comprehensive evidence-based services and better integrate behavioral health services with other services and supports, thereby addressing service fragmentation. In their applications, a few states discussed a desire to improve their behavioral health workforce, noting they expected the demonstration to allow CCBHCs to offer competitive salaries, which would help retain high-quality behavioral health providers. These states also noted that by improving their behavioral health workforce, they expected to improve the provision of timely services and quality of care.

Beyond these direct service improvements, states emphasized that participation in the demonstration offers benefits to states wishing to implement the model that are not available under other avenues, such as enhanced federal funding, robust technical assistance, and opportunities for collaboration with other implementing states. Collaboration between federal and state officials and implementing clinics under the demonstration fosters shared learning, problem-solving, and the exchange of best practices, helping states more effectively navigate implementation challenges. Additionally, states noted the demonstration enables states to build from a national model with established program and payment rules, reducing burden on states and allowing them to focus their efforts on aligning the state's requirements to meet the unique needs of their communities and populations of focus.

Medicaid covered most CCBHC service types before the demonstration, but a few states updated their Medicaid plan to align with the service requirements of the CCBHC demonstration. States most commonly mentioned not covering outpatient primary care screening and monitoring, peer support, and community care for uniformed service members and veterans. Alabama, New Mexico, and Vermont noted submitting or planning to submit a Medicaid SPA to authorize or expand coverage for one or more of the nine required CCBHC service types in their demonstration application.¹⁸ In an interview, New Hampshire officials noted the state was expanding peer services covered under their Medicaid state plan, a key component of the CCBHC model which the state had already been aiming to support.

BSCA states worked in early months of the demonstration to establish and augment processes for monitoring the demonstration and clinics' adherence to the certification criteria. Expected time frames and procedures for conducting recertifications vary by state. For example, New Mexico plans to recertify CCBHCs yearly, and Alabama expects to recertify every two years. Indiana, Maine, and New Hampshire will follow the minimum three-year schedule for recertification required by the criteria.

¹⁸ Indiana's demonstration application includes reference to the development of an SPA as part of its planning process but did not indicate for what service or whether an SPA was submitted.

Recertifications will often include reviewing quality data and site visits, with at least four states expecting to conduct on-site reviews.

In addition to required recertifications, most states plan to monitor their CCBHCs through a mix of regular meetings and site visits. States generally meet with clinics at least monthly to discuss implementation progress and provide proactive support or identify areas for future technical assistance (TA). For example, Iowa plans to hold monthly calls with CCBHC providers and weekly office hours. Most states plan to have their CCBHCs self-monitor to some extent using tools such as data dashboards. These dashboards are being developed at the state level, but, in some cases, the data will be shared with CCBHCs to allow them to monitor their own progress. For example, New Mexico has contracted with its Health Information Exchange vendor to develop a data dashboard for quality reporting.

In the early months of the demonstration, BSCA states focused heavily on setting up, testing, and refining Medicaid billing and quality reporting systems. States reported early successes and challenges associated with this work. For example, Rhode Island, which began the demonstration in October 2024, reported that the state reimbursed 90 percent of PPS claims submitted by CCBHCs for people not enrolled in managed care within the first month of the demonstration, and managed care plans had been successfully reimbursing CCBHC PPS claims as well. The state was encouraged that clinics had been able to successfully submit approvable claims despite the complexity of shifting to the demonstration's PPS bundled payment with different rate categories for special populations and service-level detail required on claims.¹⁹ A few states, however, highlighted challenges in their billing system work, including the substantial time needed to set up billing systems, challenges determining the appropriate level of detail to include in claims without overburdening providers, and technological challenges associated with implementing a bundled payment system (PPS).

In parallel, states also worked to develop and align quality reporting systems. Some partnered with external organizations, such as New Mexico's collaboration with its Health Information Exchange to support data sharing and reporting. Others, like Vermont, took steps to align quality measures across programs. Vermont revised its alternative payment model measure set to match CCBHC quality measures, requiring even non-CCBHC sites to report on the same metrics. This alignment enables more consistent, statewide comparisons of behavioral health providers. As one state official explained, this approach allows for "apples-to-apples" comparisons between CCBHCs and other providers and supports broader quality improvement efforts.

C. Plans to sustain the CCBHC model in original states

The CCBHC demonstration was authorized through September 30, 2025, for the remaining six original states. With the demonstration's end approaching, planning for model sustainability has been a primary focus for state and clinic demonstration teams in these states in the most recent demonstration year. All six states plan to sustain the model through existing Medicaid SPAs or are in the process of drafting SPAs, which underscores the value that states perceive in the model and its ongoing importance to their delivery system reforms. States have aligned or aim to align the service delivery, payment structures, and

¹⁹ States participating in the CCBHC demonstration must have a mechanism for identifying claims attributable to the CCBHC demonstration and service-level detail of the CCBHC-covered services provided during the encounter.

other requirements in their SPAs with those of the demonstration to the extent permitted under their respective authorities. Although most states intend to retain most of CCBHC program elements as

implemented under the demonstration when they transition their CCBHCs to state plan authority, a few are considering changes to payment systems, quality reporting requirements, or QBP systems. These adjustments aim to reduce administrative burden and better align with state priorities.

- Minnesota** has had a SPA including the CCBHC model in effect since October 2020.²⁰ When the demonstration ends, the state expects a seamless transition for the seven demonstration CCBHCs to the state plan authority, joining 14 other CCBHCs currently operating under the state plan. The state intends to continue using the PPS-1 payment methodology with QBPs and anticipates updating its QBP program to more effectively encourage and reward meaningful improvements in quality.
- Missouri** also plans to sustain the model through its approved CCBHC SPA, which has been in place since 2019. To prepare for the end of the demonstration, the state legislature has allocated state general revenue funds to support CCBHC services and offset the loss of the demonstration’s enhanced Federal Medical Assistance Percentage. Missouri expects its core service and program requirements to remain aligned with the demonstration, but the state may revise its QBP structure and measures to better reflect priorities and outcomes valued by the state and its CCBHCs.
- New Jersey** is developing a SPA, and state officials hope to be able to enshrine the CCBHC program in the Medicaid state plan. The state does not expect to substantially change services or other requirements for CCBHCs, but it is considering altering the structure of its payment rates under an SPA. The state currently uses the PPS-2 option with diagnosis-based special population rates but is considering shifting to age-, utilization-, and risk-based rates to better align payments with service needs.
- New York** is drafting a SPA to continue to expand the CCBHC model. The state expects to retain its current payment system (PPS-1 with QBPs), and many of the demonstration’s financial and other requirements. The state is, however, exploring an uncompensated care pool to help offset the costs of CCBHC services provided to people without insurance through the demonstration program or a

Exhibit III.4. CCBHCs planning to sustain the CCBHC model after demonstration end, 2024

State	CCBHCs planning to sustain the model	
	N	%
Minnesota	6	100
Missouri	19	95
New Jersey	7	100
New York	12	92
Oklahoma	3	100
Oregon	12	100
Total	59	97

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year.

Notes: This table reflects CCBHCs in states where the demonstration is expected to end in September 2025. The denominators for the state percentage calculations are the total number of CCBHCs responding to the survey in relevant states in 2024 (see Appendix Exhibit A.1). The denominator for the total percentage calculation is the total number of CCBHCs responding to the survey in relevant states in 2024: 61.

CCBHC = Certified Community Behavioral Health Clinic.

²⁰ Congress has extended the demonstration multiple times beyond its original two-year period. During times when the demonstration was expected to end, several original states adopted SPAs to continue the CCBHC model before subsequent extensions were enacted.

separate SPA. The state also plans to update its QBP program to make receiving payments more attainable while still promoting improved quality, as clinics have struggled to meet thresholds for receipt of QBP payments in the past.

- **Oklahoma** plans to continue its CCBHC program under its existing CCBHC SPA, which went into effect in 2019. The state noted several expected financial challenges for sustainability, however, such as covering the increased state share of costs after the enhanced demonstration Federal Medical Assistance Percentage ends and reductions in state Medicaid coverage from Medicaid unwinding.²¹
- **Oregon's** legislature authorized pursuing an SPA to bring the CCBHC program into the state's Medicaid plan, and funding for CCBHC was recently included in the governor's approved budget. The state is considering a few changes to its requirements for CCBHCs, such as potentially conducting rate rebasing every two years. In addition, the state has required CCBHCs to provide on-site primary care services under the demonstration but may remove this requirement under the SPA.

At the clinic level, nearly all CCBHCs in the six remaining original demonstration states plan to sustain the model after demonstration funding ends (Exhibit III.4). Most plan to sustain CCBHC implementation through state-established funding mechanisms when possible, such as through a CCBHC SPA if the state pursues one. In cases in which state funding is not continued, or to fund services for people not covered by Medicaid, CCBHCs plan to draw on other sources, including CCBHC-E grants; federal, state, or county grants; and private or commercial insurance billing to support continued delivery of CCBHC services.

Most CCBHCs plan to retain their current service offerings and activities after the demonstration ends or were still deciding their plans. A few clinics expressed hesitation about continuing certain aspects of the model, such as quality measures, if not required after the demonstration ends. These clinics emphasized the effort required to calculate certain measures and the desire to align measures with CCBHC-specific business practices and populations served. Still, clinics will continue reporting any measures required by the state.

²¹ "Medicaid unwinding" refers to the process of states resuming regular Medicaid eligibility reviews and disenrollments, which were paused during the COVID-19 public health emergency.

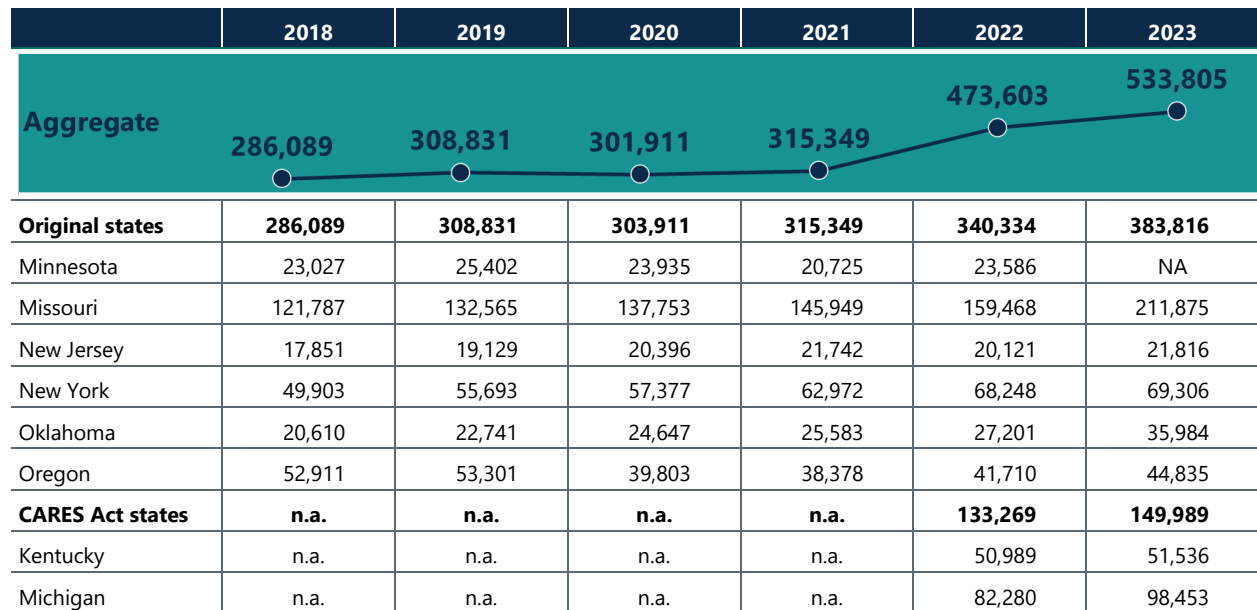
IV. Access to Care in Demonstration States

The CCBHC model is intended to expand access to high-quality care in the communities that clinics serve and engage new clients in care. The certification criteria specify that CCBHCs must provide accessible care, including 24-hour crisis management services; engage people quickly through prompt and thorough intake services; and treat all who seek services regardless of their ability to pay. To address the PAMA requirements on access, we first examine changes in the number and characteristics of people CCBHCs served and then explore activities reported by states and CCBHCs meant to improve access to care. Finally, we describe the initial successes and challenges states new to the demonstration have experienced in early demonstration months.

A. Changes in number and characteristics of people served by CCBHCs

The overall number of people the demonstration served has increased steadily over time and grown in almost all states. Across original demonstration states, the number of people CCBHCs served increased from **286,089** in 2018 to **383,816** in 2023 (Exhibit IV.1). The most significant growth occurred in Missouri (121,787 to 211,875 from 2018 to 2023), which was driven by existing CCBHCs expanding the number of people served and the addition of new clinics to the demonstration. Most states experienced consistent increases over time, except Minnesota and Oregon.²² CCBHCs in the CARES Act states have also increased the number of people served, growing from **133,269** to **149,989** from 2022 to 2023.

Exhibit IV.1. Number of people CCBHCs served, by state and year



Source: State quality measure reports.

Notes: Numbers are unduplicated counts of CCBHC clients. Years reflect the end of each annual demonstration year measurement period. Minnesota data are not available for 2023 because of a temporary pause in activity and reporting in the state. Missouri counts include data on all CCBHCs in the state each year, which includes 15 clinics in 2018–2022. The count

²² In Oregon, the decline was largely from the decertification of three clinics in 2019 during a period of funding instability. Although these clinics were recertified in 2021–2023, the number of clients served by these clinics did not immediately rebound to previous levels.

includes 21 clinics in 2023, reflecting an administrative merger of two of the 15 original clinics and the addition of seven clinics. Oregon counts include data on all CCBHCs in the state each year: 12 clinics in 2018–2019, nine clinics in 2020–2021, 10 clinics in 2022, and 12 clinics in 2023. Although the three clinics were recertified between 2021–2023, they did not immediately return to their initial numbers served. In the original states, 2018 = DY1, 2019 = DY2, 2020 = DY3, 2021 = DY4, 2022 = DY5, and 2023 = DY6. In the CARES Act cohort, 2022 = DY1 and 2023 = DY2. DYs do not perfectly align with calendar years, as the month of DY start and end dates varied by state (see Exhibit I.4).

CARES = Coronavirus Aid, Relief, and Economic Security Act of 2020; CCBHC = Certified Community Behavioral Health Clinic; DY = demonstration year; n.a. = not applicable; NA = not available.

Across original and CARES Act cohorts, demographic characteristics of CCBHC clients generally remained consistent over time, with some differences between cohorts and states. States and CCBHCs report on the age, sex, race and ethnicity, and insurance status of the people they serve each year. With few exceptions, characteristics of clients generally remained stable across years (see Appendix B for detailed findings). For example, the following characteristics were stable across states:

- **Age.** In both cohorts, most people served were adults. About three-quarters of the people served in the original cohort were adults age 18 or older, and about one-quarter were children or adolescents. The CARES Act cohort showed a similar distribution, with 72 percent adults and 28 percent children, although Kentucky stood out with a higher proportion of children served (34 percent). States either held steady or experienced a slight increase (2 to 3 percent) in the percentage of children served, except for New Jersey, for which the share of children declined by about 5 percent.²³
- **Sex and race and ethnicity.** Distribution by sex was relatively stable across states and time, with CCBHCs serving slightly more females than males. The proportion of female clients ranged from 51 to 53 percent across all states, with New Jersey showing a higher share, between 55 and 59 percent. Racial and ethnic composition also remained fairly consistent in the original cohort, with 70 to 73 percent of people served identifying as White, 11 to 12 percent as Black or African American, and 8 to 15 percent as Hispanic or Latino. The CARES Act cohort had a slightly different racial composition, with 67 percent White, 20 percent Black or African American, and 6 percent Hispanic or Latino.
- **Insurance coverage.** The proportion of people served who were uninsured in the original states declined, dropping from 15 percent in 2018 to 9 percent in 2023. This shift was largely driven by increased Medicaid coverage in Oklahoma, Oregon, and to a lesser extent in Missouri.²⁴ The CARES Act cohort had a higher rate of Medicaid coverage than the original states, with about 78 percent of clients covered by Medicaid, Children’s Health Insurance Program, or dually enrolled in Medicaid and Medicare in the CARES Act cohort versus 63 percent of the original states cohort in 2023. Medicaid coverage was highest in Michigan at about 83 percent per year, compared with 69 percent in Kentucky and 63 percent in the original cohort. Commercial insurance covered 6 percent of people served in the CARES Act cohort, while 11 percent were uninsured.

In the past year, CCBHCs worked to expand access for specific populations, responding to increased demand and aiming to better reach underserved groups. Many CCBHCs described efforts to improve access for people with SUD, especially those with opioid use disorder, citing vastly increased

²³ This decrease was primarily driven by an increase in adult clients, with a modest decrease in the number of children served.

²⁴ In Oklahoma, the proportion of people served who were uninsured decreased as the proportion covered by Medicaid increased, which reflects the state’s expansion of Medicaid to new populations in July 2021.

demand for SUD treatment and increases in fentanyl use and overdoses in the community. Several CCBHCs focused on access improvements for people experiencing homelessness because of the high needs of this group and the importance of addressing health-related social needs. A few CCBHCs described working to improve access for people involved with or at risk of involvement with the justice system. For example, one CCBHC noted efforts to *“divert or reduce involvement with the criminal justice system due to an increase in those identified as having mental illness coming into that system.”* A few CCBHCs described specific efforts to better serve veterans (see the Spotlight box below).



Spotlight: Tailored efforts to increase access for special populations

Some CCBHCs have developed specific resources or services tailored to special populations that may have been hesitant to access services in the past. For example:

- A CCBHC in Oregon identified behavioral health service needs among **farmers and ranchers** in its service area. To better engage this population, the CCBHC launched a dedicated call line for farmers and ranchers. It also recruited a rancher to join its board and advise on strategies and opportunities to reach and support this community.
- To reach **veterans** more successfully, all four CCBHCs in Kentucky hired dedicated veterans coordinators, and some have therapists who are specially trained to provide services to veterans. All four CCBHCs employ veteran-specific peer support specialists. State officials explained that, by offering tailored staff for veterans, CCBHCs in the state have significantly improved their outreach and engagement with this population compared with previous efforts. Two other states, Maine and Vermont, adopted a more standardized, statewide approach to partnering with Veterans Affairs agencies to better support CCBHCs in serving this population by developing a formal memorandum of understanding in partnership with the states' Veterans Affairs agencies. This standardized process has improved CCBHCs' ability to establish successful partnerships with individual Veterans Affairs facilities.

B. Activities CCBHCs implemented to improve and maintain access to care

The increase in the number of unique people served by demonstration CCBHCs and the average number of people each CCBHC served suggests that efforts to increase access to care might have been successful at bringing more people into services. CCBHCs have implemented a wide range of activities to increase access to services during the demonstrations (Brown et al. 2021; Stewart et al. 2024). Consistent with evaluation findings from previous demonstration years, CCBHCs and state officials described a range of strategies to increase access to care and maintain those increases in the most recent demonstration year. Respondents emphasized a few key approaches, such as implementing open access scheduling and intake improvements, conducting external outreach efforts, and establishing partnerships and referral pathways to make people aware of their services and engage them in care. Adding staff to increase capacity, providing services in more locations outside the clinic, and expanding and remodeling clinic space made it easier for people to access services once they were engaged.

CCBHCs continued implementing open access scheduling and other intake improvements to reduce service wait times and increase ease of accessing services. Many CCBHCs in the first two cohorts of demonstration states provided open access or same-day scheduling, which in some cases represents a fundamental shift from the way the clinics served clients before the CCBHC demonstration. This approach allows clinics to offer services on the same day people request them, reducing wait times for appointments and improving service attendance. In 2023, 94 percent of CCBHCs reported offering open

access scheduling, increasing to 97 percent in 2024. A clinic in New Jersey cited this as a key success in its implementation of the CCBHC model, explaining that *“prior to CCBHC, you could still get a scheduled appointment, but it [was] harder... Now, it's much easier because we're walk-in each day of the week. And folks can just walk into our clinic and get services for behavioral health. That is one thing that I think was a huge success for us because I think that really opened up the doors.”* Some clinics not yet providing same-day access cited doing so as an important goal for the future. Clinics also described improving efficiency by implementing new scheduling practices for making and helping clients keep appointments and monitoring and evaluating intake capacity when needed. One Oklahoma CCBHC reported purposefully overbooking clinicians to minimize the impact of no-shows and maximize provider capacity, as part of their strategy to improve same-day access for screening, intake, and treatment planning.

Clinics provided in-person community outreach and other efforts to increase awareness of services and bring more people into care. For example, a CCBHC in Oklahoma conducted field outreach along a specified route with 40 stops, including neighborhood storefronts where people with untreated mental illness or substance use may congregate. The clinic reported that, through this street outreach, it has brought in up to 100 new clients. Similarly, a CCBHC in Oregon sent staff members to attend local veterans' groups to conduct outreach and engagement. A representative from this CCBHC believes that it has been helpful to *“meet [veterans] where they are”* in the community because this population has historically been hesitant to seek out behavioral healthcare at the CCBHC on-site. CCBHCs also commonly described publicizing their services directly to potential clients via billboards, radio ads, and social media to reach new clients with behavioral health needs.

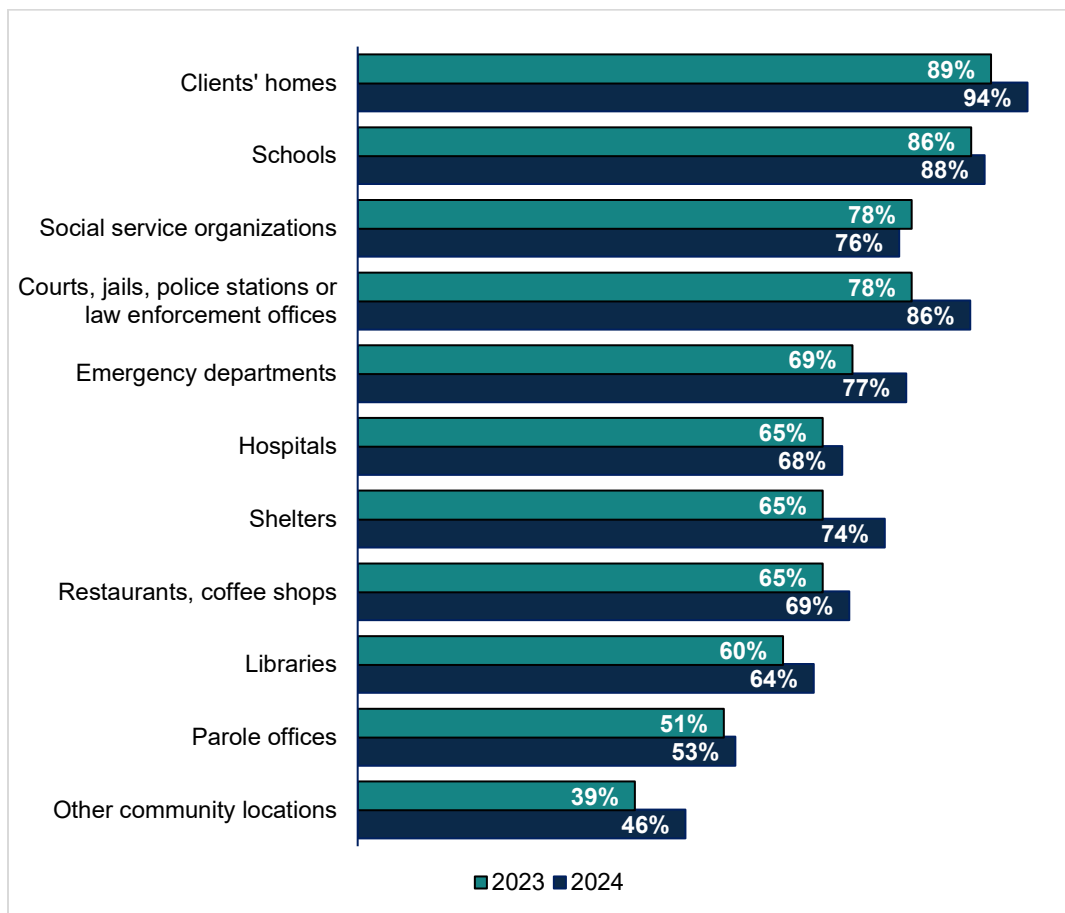
CCBHCs fostered partnerships and referral pathways with external entities to increase access to and bring people into CCBHC services. The CCBHC model's required partnerships with community organizations have allowed them to develop strong referral pathways, particularly for specific populations such as children, youth, and families; people who are incarcerated; people experiencing homelessness; and veterans. In some cases, CCBHCs co-located staff at some of their partner organizations to enhance referral pathways and allow for warm handoffs. Working to raise awareness of the services CCBHCs provide with these partners has helped increase CCBHCs' visibility among potential clients. As a representative from a CCBHC in Michigan explained, *“You have to have relationships with your community partners. We have not really had to advertise at all. I think it's word of mouth in the community...It's your relationships.”* Community partner organizations in which CCBHCs conduct outreach or co-locate staff include local jails, shelters, hospitals and emergency departments, and schools.

CCBHCs hired new staff to expand outreach, reduce wait times, and engage people in services more quickly. Many CCBHCs have hired outreach-focused staff, such as engagement specialists and care navigators, to connect community members to CCBHC services. Others have expanded their clinical teams, hiring additional psychiatrists, therapists, case managers, and peer support specialists to boost clinical capacity and increase timely access. Several CCBHCs credited the demonstration's PPS with making these staffing improvements possible. For example, one CCBHC reported that the PPS allows them to pay competitive salaries and create new positions such as a psychiatric nurse practitioner, which decreased wait times and supported engagement and access. A CCBHC in Kentucky created a new position, an engagement specialist, who connects with people in the community with care needs, helping them overcome potential barriers to accessing care such as lack of transportation. The engagement specialist

also follows up with those who miss appointments to encourage their return to care. Hiring new staff roles has also allowed CCBHCs to use clinical staff more efficiently, thereby increasing staff members' availability to serve more people. As a respondent from a CCBHC in New York explained, *"By having a [newly hired] counsellor assistant, counsellors [don't have] some of those administrative burdens. That's cleared up their schedule [for] providing supports to our clients."*

CCBHCs have expanded their services in community settings over time to make care more accessible and convenient for people when and where they need it. In 2024, 95 percent of CCBHCs provided services in locations outside the clinic space. They provided services in a wide range of community settings to reduce barriers to access and meet people in a space of their choosing. The percentage of clinics providing services in certain community settings has increased over time, growing for most locations from 2023 to 2024 (Exhibit IV.3).

Exhibit IV.2. CCBHCs providing services outside the physical clinic space, 2023 and 2024



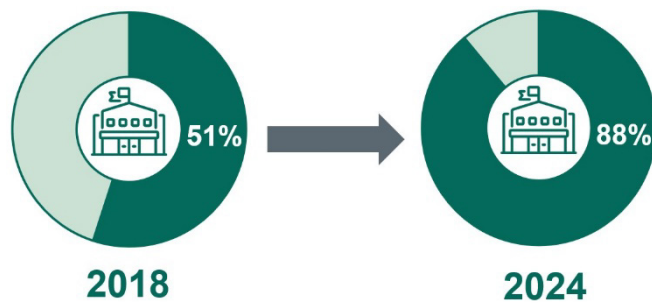
Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, and 2023 CCBHC survey.

Notes: See Appendix Exhibit A.2 for the full table including denominators. "Other community locations" reported by clinics in write-in responses included service provision on the street, in parks, and in homeless camps; through mobile crisis services; in doctors' and pediatricians' offices; in transitional living facilities; and in community venues such as senior centers and churches. We used 2023 survey data for this table because the earlier CCBHC survey years collected data on only a few community locations and some categories were combined, preventing comparisons with 2024.

CCBHC = Certified Community Behavioral Health Clinic.

CCBHCs have dramatically increased provision of services in a few particular locations since the early years of the demonstration, especially homeless shelters and schools.²⁵ In 2018, only 9 percent of clinics provided services in homeless shelters (data not shown) and 51 percent in schools (Exhibit IV.4). By 2024, those numbers had grown to 74 percent and 88 percent, respectively. For example, a clinic in Minnesota described sending peers to local shelters to engage with people needing services and connect them to the CCBHC via telehealth, facilitating comprehensive evaluations and care coordination directly in the environments where people are. Similarly, states and CCBHCs shared that school-based initiatives have made services easier for families to access and allowed CCBHCs to identify and serve children in need of behavioral health services whom they would not have otherwise reached.

Exhibit IV.3. Percentage of demonstration CCBHCs providing services in schools, 2018 and 2024



Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, and 2018 CCBHC Annual Progress Report Demonstration Year 1.

Note: Denominators are 67 CCBHCs for the 2018 survey and 78 CCBHCs for the 2024 survey. The 2018 percentage represents 34 CCBHCs; the 2024 percentage represents 69 CCBHCs.

CCBHC = Certified Community Behavioral Health Clinic.



Spotlight: Meeting access needs in rural communities

Clinics worked to improve access to care for rural communities in several ways:

- **Expanding clinic facilities.** CCBHCs in Kentucky, Missouri, and Oregon described purposefully expanding their locations in rural areas to meet the demand for services in these communities. For example, a clinic in Oregon remodeled a new and larger building in one of its rural locations and embedded services and a youth drop-in center.
- **Mobile clinics in community settings.** In addition to expanding or remodeling existing locations, some clinics implemented mobile services that use vehicles that travel throughout rural areas. Several clinics in Kentucky have recreational vehicles that provide comprehensive mobile screening and monitoring of health needs. Similarly, a clinic in Oklahoma deploys what it calls a “caravan” to rural areas, setting up temporary clinics and offering screening services.
- **Using telehealth.** Clinics also expanded access to care for those in rural areas without access to transportation by continuing to expand the use of telehealth. In the 2024 clinic survey, 100 percent of CCBHCs in all demonstration and CARES Act states reported providing services through telehealth (see Appendix A for full data). A clinic in Oklahoma has increased immediate access to behavioral health support by distributing iPads throughout its service area, including in rural communities. These devices provide direct 24/7 access to a provider in one of the CCBHC’s crisis centers. iPads are strategically placed in law enforcement vehicles, schools, libraries, museums, and other public places with high foot traffic as well as in people’s homes to ensure people can access help.

²⁵ The CCBHC survey in the early years of the demonstration included a limited set of service locations outside the clinic, so comparison of all locations across time was not possible.

CCBHCs have expanded and remodeled their physical space to meet growing community needs, particularly for crisis and urgent behavioral health services. CCBHCs remodeled and expanded their facilities in rural (see the Spotlight box above) and non-rural areas to provide more treatment space, increase capacity to see more clients, create dedicated space for intake processes, and open new spaces for crisis services and behavioral health urgent care, which is something communities increasingly need. A few CCBHCs mentioned encountering challenges, however, with inadequate space and inability to expand to meet increased demand for services from the community, expressing concern with their ability to meet demand without additional space.

Clinics and state officials perceived that CCBHCs provided better access to care relative to other behavioral health clinics in their communities. In implementing the CCBHC model, clinics have been able to provide assessments and services more quickly, primarily through the ability to hire new staff funded through the PPS. These staff members conduct outreach and reduce barriers to access (including for specific populations) and schedule care promptly, ensuring clients receive timely treatment. For example, a CCBHC in Oklahoma explained that, before the demonstration, people in need of care in their area had to wait two to three weeks for services. Since the demonstration, the CCBHC can now provide transportation and get people into treatment within 24 to 48 hours. The CCBHC's respondent highlighted the dramatic improvement, noting that the difference is *"night and day...as a CCBHC, because we have immediate access, people aren't waiting for an appointment...It's just the ability for us to provide services at so many different levels and not just at a therapist level."* State officials echoed the perception that CCBHCs provide better access to care relative to non-CCBHC behavioral health organizations, partly because the CCBHC model connects people seeking services and clinicians quicker through strategies such as offering same-day access. CCBHCs noted that they served a broader population than community mental health centers do, which often serve more specialized populations or only serve adults.

Although access has expanded, workforce shortages still pose a significant challenge to meeting growing demand. Consistent with previous years, behavioral health workforce shortages continue to present a key challenge to CCBHCs that wish to implement some of the activities to increase access mentioned above. For example, hiring new staff to conduct outreach or reduce barriers to care is more challenging in areas with more pronounced staffing shortages, such as rural areas, which often lack housing for staff as well. A Michigan CCBHC described how *"our entire [community mental health] network is experiencing the same challenge in finding staff to meet the needs of our community. Child psychiatric prescribers are particularly difficult to find."* Several other CCBHCs across states also described difficulties recruiting clinicians who can provide care to children. The intense nature and long hours of clinical work at CCBHCs also present a challenge to hiring staff. For example, state officials in Oregon reported that some CCBHCs have struggled to find staff to provide crisis services because many potential clinicians do not want to work overnight hours or find the nature of the role too demanding. CCBHCs have addressed staffing shortages primarily by increasing salaries and other benefits to attract staff. Other strategies include using clinicians from other sites to provide telehealth services when there are staffing shortages and accommodating clinicians' preference in terms of their required duties. For example, a clinic in Oregon reported that some clinicians disliked providing crisis services; the clinic responded by creating a dedicated crisis team to allow other clinicians to focus on providing non-crisis services. A few CCBHCs also reported challenges providing culturally and linguistically appropriate care to certain populations, partially

because of challenges recruiting bilingual and bicultural staff. To address these needs, clinics have sought to hire translators.

C. Access to care in new demonstration states

The BSCA states are just beginning demonstration implementation, but they shared early insight into their progress, successes, and challenges with implementing the model. These states' early successes and challenges increasing access to care generally echoed those in the original demonstration states.

The BSCA states reported developing community partnerships with non-DCO external providers to help improve referrals and coordination and increase access to care. As expected in this phase of the demonstration, these partnerships were in the early stages. In some cases, CCBHCs simply formalized existing partnerships. For example, Rhode Island noted that many of the state's CCBHCs already had informal partnerships with external partners, making the formalization process fairly easy. Some BSCA states are in the early phases of planning how to publicize their CCBHC services, but most have not implemented large-scale external communications campaigns. For example, Rhode Island has prepared a large campaign to raise awareness of CCBHCs, but it was not rolling the campaign out until the state was confident the CCBHCs could handle their current volume of patient admissions. The state plans to roll out the campaign in a phased approach and slowly ramp it up.

As is the case with the initial demonstration states, most BSCA states noted staffing shortages as a major challenge to increasing access to care and to providing high-quality care and offering the full scope of services. Staffing shortages were sometimes exacerbated by a lack of available housing in rural states. A respondent in Vermont explained, "*Workforce shortage...is a real challenge, but that also interrelates with our housing shortage as well. We have a severe housing shortage in Vermont. Some of our community partner [organizations] have actually housed prospective staff for a short period of time like three months in order to at least get them here. Get them on staff and then we'll figure out the housing thing later.*"

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V. Quality and Scope of Services in Demonstration States

CCBHCs must provide a broad set of services that include the nine service types listed in the authorizing legislation. PAMA and the certification criteria set the minimum scope of service requirements for CCBHCs but also afford states flexibility in establishing those requirements, thereby ensuring the scope of services align with states’ respective Medicaid State Plans and other state regulations and goals. For example, in addition to federal requirements for screening and monitoring of key health indicators, Oregon required its clinics to provide 20 hours of on-site primary care services per week. Because providing the full scope of services might challenge many community behavioral health providers, the certification criteria allow CCBHCs to provide services either directly or through a relationship with an external provider known under the demonstration as a DCO—an entity engaged in a formal financial relationship with a CCBHC to deliver some of the nine required services under the same requirements. The CCBHC must, however, assure that the services provided by DCOs meet CCBHC standards through a formal signed agreement. This section summarizes (1) the types of services that CCBHCs in the original and CARES Act states provide and changes in the provision of those services over time and (2) characteristics of services provided by new demonstration states.

A. Services offered by CCBHCs over time

CCBHCs across original and CARES Act states provide a diverse array of behavioral health services, consistent with the federal CCBHC criteria. Almost all CCBHCs provided all nine required CCBHC service types, with minimal changes over time.²⁶ All or nearly all clinics provided crisis behavioral health services; screening, assessment, and diagnosis services; person- and family-centered treatment planning services; outpatient mental health, SUD services, or both; psychiatric rehabilitation services; peer support services; primary care screening and monitoring, and targeted case management directly or through DCOs (Exhibit V.1).

Exhibit V.1. CCBHCs providing required CCBHC service types directly or by DCO, 2018 and 2024

Service	Provided directly or by DCO			
	2018		2024	
	N	%	N	%
Crisis behavioral health services	67	100	78	100
Screening, assessment, and diagnosis	67	100	78	100
Person- and family-centered treatment planning services	66	99	76	97
Outpatient mental health and SUD services	67	100	78	100
Psychiatric rehabilitation services	67	100	76	97
Peer support services	67	100	78	100
Targeted case management	63	94	69 ^a	88
Primary care screening and monitoring	65	97	76	97
Community care for uniformed service members and veterans	48	72	61	78

²⁶ Small fluctuations in response rates for these services over time could be because of response error rather than true changes in service provision.

V. Quality and Scope of Services in Demonstration States

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, and 2018 CCBHC Annual Progress Report Demonstration Year 1.

Notes: The service categories illustrated in this figure correspond to most of the service categories described in the CCBHC certification criteria. The denominator for each category is the total number of survey respondents in that year (n = 67 in 2018; n = 78 in 2024). Small fluctuations in response rates for these services over time may be because of response error rather than true changes in service provision.

^a Seven of the nine CCBHCs that reported not providing targeted case management in 2024 were located in Missouri, but it is unclear whether there is a state-specific service definition or reason that could explain this finding.

CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization; SUD = substance use disorder.

Consistent with previous demonstration years, a smaller percentage of CCBHCs provided community care for uniformed service members and veterans directly or by DCO than other required CCBHC service types. The percentage providing these services has improved over time, however, increasing from 72 percent in 2018 to 78 percent in 2024 (Exhibit V.2). CCBHCs and state officials offered some explanations for why these services were not offered more frequently, often saying that these services have been among the most challenging for CCBHCs to provide. Some respondents perceived that CCBHCs were not located in communities in which a large number of uniformed service members or veterans sought services from community behavioral health providers. For example, two clinics reported that they are located very close to Veterans Affairs health facilities and that veterans may prefer to receive services from those facilities. One explained, *"The challenge that we have is [Veterans Affairs] is a mile-and-a-quarter from here, which is the ultimate one-stop-shop for all veterans."* Yet clinics and state officials also reported that some CCBHCs struggled to engage these populations and to develop referral relationships with agencies that serve veterans and military members. One CCBHC explained, *"We do have a veteran navigator on staff and a peer with lived experience as a veteran, but that has not increased the penetration for that population. So, that's one area that I think we struggle a little bit with...I don't know that veterans in our area is such a big need. And to put all that weight on having a specific signed agreement with [Veterans Affairs], that should be maybe more of a suggestion based on your community needs."*

Exhibit V.2. CCBHCs providing community care for uniformed service members and veterans directly or by DCO, 2018 and 2024



Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, and 2018 CCBHC Annual Progress Report Demonstration Year 1.

Notes: The denominator for this graphic is the total number of survey respondents in that year (n = 67 in 2018; n = 78 in 2024). The 2018 percentage represents 48 CCBHCs, and the 2024 percentage represents 61 CCBHCs.

CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization.

Within the CCBHC service categories, CCBHCs provided a wide range of individual services and treatments directly or by DCO, including different outpatient mental health and SUD services and evidence-based practices (EBPs); psychiatric rehabilitation services such as supported employment; and several types of crisis behavioral health services, peer support services, and primary care screening and monitoring services. We explore a few services in spotlights throughout this section and report full data on all individual services and treatments in Appendix Exhibit A.7.

Most CCBHCs delivered required CCBHC services directly, with DCO use remaining limited and changing only modestly over time. In 2024, most CCBHCs continued to provide required services themselves, though some partnered with DCOs, most commonly for the following service categories: crisis services; primary care screening and monitoring; and screening, assessment, and diagnosis (Exhibit V.3). Six percent of CCBHCs or less used DCOs to deliver other categories of CCBHC services in 2024.

Exhibit V.3. CCBHCs providing the nine required CCBHC services by DCO, 2023 and 2024

Service	2023		2024	
	N	%	N	%
Crisis behavioral health services	19	26	24	31
Screening, assessment, and diagnosis	3	4	7	9
Person- and family-centered treatment planning services	5	7	5	6
Outpatient mental health and SUD services, or both	6	8	5	6
Psychiatric rehabilitation services	5	7	5	6
Peer support services	6	8	4	5
Targeted case management	4	6	3	4
Primary care screening and monitoring	8	11	14	18
Community care for uniformed service members and veterans	2	3	3	4

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, and 2023 CCBHC survey.

Notes: The denominator for each service is the total number of survey respondents in that year (n = 72 in 2023; n = 78 in 2024). Services are not mutually exclusive. CCBHCs can report that they both offer a service and contract with a DCO for the same service. The percentages above reflect CCBHCs with a DCO relationship for each respective service regardless of whether the CCBHC also provides the service. We used 2023 survey data for this table because the earlier CCBHC survey years only collected DCO service provision data at the level of individual services and treatments, and not the nine required CCBHC services.

CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization; SUD = substance use disorder.

Among individual services and treatments (that is, services and supports within required broader CCBHC service categories), various types of crisis services, methadone, and certain primary care screening and monitoring services were the services most commonly delivered by DCOs (Exhibit V.4). Otherwise, DCO use was infrequent, with less than 10 percent of CCBHCs reporting that DCOs provided those services for them. The percentage of clinics using DCOs to provide individual services remained steady or showed slight increases over time for most service types, except for individual crisis services, which decreased from 2018 to 2024 (see Appendix Exhibit A.7 for full data).²⁷

²⁷ The increase in overall crisis behavioral health service provision by DCO from 2023 to 2024 shown in Exhibit V.3 suggests that, as CCBHCs have built up their capacity to provide crisis services directly and as the 988 Lifeline is implemented, CCBHCs may be using DCOs to provide more targeted, complementary crisis services to fill out the continuum of crisis options emphasized by 988 implementation efforts.

Exhibit V.4. Individual services and treatments most commonly delivered by DCOs, 2018 and 2024

Service	Provided by DCO			
	2018		2024	
	N	%	N	%
Crisis behavioral health services				
24-hour mobile crisis teams	23	34	18	23
Emergency crisis intervention	20	30	19	24
Crisis stabilization	14	21	11	14
Suicide prevention and intervention	n.a.	n.a.	15	19
Services capable of addressing crises related to substance use, including overdose prevention	n.a.	n.a.	15	19
Outpatient mental health and SUD services				
Methadone ^a	n.a. ^a	n.a. ^a	13	17
Primary care screening and monitoring^b				
Testing for hepatitis	n.a.	n.a.	12	15
Tuberculosis screening	n.a.	n.a.	8	10
HIV screening	n.a.	n.a.	12	15
Cholesterol screening	n.a.	n.a.	10	13
Triglyceride testing	n.a.	n.a.	9	12

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, and 2018 CCBHC Annual Progress Report Demonstration Year 1.

Notes: This table includes services that at least 10 percent of CCBHCs reported DCOs provide. See Appendix Exhibit A.7 for full data. The denominator for each service is the total number of survey respondents in that year (n = 67 in 2018; n = 78 in 2024). We did not populate the gold-shaded overall service rows because they may include additional services not listed in this table, for which there were not at least 10 percent of CCBHCs reporting DCO use. Services with n.a. were not included in the 2018 CCBHC survey.

^a The 2018 CCBHC survey included a single category: Medication-assisted treatment for alcohol and opioid use. The 2024 CCBHC survey broke this broad category into specific medications, including methadone, so it is not directly comparable with 2018.

^b The 2018 survey did not include specific primary care screenings, instead asking about the overall category.

CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization; HIV = human immunodeficiency virus; n.a. = not applicable; SUD = substance use disorder.

Variation across states in the percentage of CCBHCs engaging DCOs in 2024 was notable (see Appendix Exhibit A.9 for full data). None of Kentucky’s CCBHCs had DCO relationships in 2024, but CCBHCs in Michigan reported DCOs were providing all of the nine required CCBHC service types (see the box called Michigan’s approach to DCOs below). New Jersey had the highest percentage of CCBHCs using DCOs for community care for uniformed service members and veterans at 29 percent, which is considerably higher than all other states (which ranged from 0 to 8 percent).

CCBHCs preferred to provide services directly rather than through DCOs to fully embrace the model and to retain control over service delivery. For example, state officials perceived clinics wished to embrace the model fully and were reluctant to assume oversight for another provider’s services.

Clinics also expressed a preference for providing required services on-site (which clients may prefer) and, in some cases, noted a lack of suitable organizations in their area to serve as DCOs. Among clinics that were using DCOs, they often expressed a desire not to duplicate services already existing and delivered

effectively in the community. As one clinic in New York with a DCO for crisis services explained, *“You can’t be everything to everyone. At least with the crisis service component, [the DCO provider] did that so long and have done it so well that why would we try to do something in addition to what others are doing?”*

Nearly all CCBHCs reported efforts to expand existing services, add new services, and offer services to more people and new populations because of the demonstration, with many doing so in the past year. In 2024, half of CCBHCs reported expanding services over the last 12 months, particularly for SUD and child and youth mental health, to meet growing demand and align with updates to the CCBHC criteria. Clinics

commonly added or expanded SUD services; for example, a Missouri CCBHC significantly expanded its SUD program, with a CCBHC leader saying, *“I believe the requirement to [offer medications for opioid and alcohol use disorder] in the CCBHC program pushed us to do better than we would have done otherwise...over 15 providers have become certified in addiction medicine because we pushed to be a better co-occurring treatment provider because of CCBHC.”* Similarly, two Oregon described clinics increased provision of medications for opioid use disorder in response to rising fentanyl use and overdoses, with one saying, *“We have a huge need for this lifesaving service!”*

Several clinics expanded services for children and youth, introducing new programs such as intensive outpatient and psychiatric rehabilitation for this population because of the demonstration. A New York CCBHC, for instance, added psychiatric rehabilitation and case management services and began offering behavioral health services to children and adolescents for the first time because it became a CCBHC. A Missouri clinic identified the need for expanded youth services through its annual CCBHC community needs assessment, and a New Jersey CCBHC reported adding child and youth services because it saw *“an increase in very high-risk/high-need youth.”* In response to identifying increased need, some clinics added or expanded family peer services and school-based programming.

CCBHCs also bolstered their care management and coordination services because of the demonstration, adopting team-based models of care that involve multidisciplinary staff members and dedicated coordinators to meet the behavioral, physical, and health-related social needs of the people they serve. Some CCBHCs also have coordination staff that work with external entities, such as law enforcement and jails, primary care providers, hospitals, and schools. For example, a Kentucky CCBHC has co-located coordination staff to provide targeted case management in local jails across four of the six primary

Michigan’s approach to DCOs

Michigan recently updated its DCO policy to allow CCBHCs to serve as DCOs for other CCBHCs. This change helped fill service gaps by leveraging the strengths of clinics already proficient in delivering certain services, particularly in rural areas in which alternative behavioral health providers are limited. Over the past year, Michigan CCBHCs have added a range of new DCO partnerships under this model, such as for provision of outpatient SUD treatment and therapy for clients with mild-to-moderate mental health needs. A state official explained, *“The [clinics] that are doing an evidence-based practice quite well can help support other [CCBHCs] as they’re building and growing... It takes time to get to full capacity, so it’s nice that the CCBHCs can help one another to be able to get there.”*

counties in their services area. These staff provide targeted case management directly to people in jail, working to help prepare them to reenter the community. Beyond behavioral health, several CCBHCs broadened their scope to address physical health and social needs in the last 12 months. For example, a New Jersey clinic adopted more comprehensive primary care and trauma screenings, enhancing its ability to identify and respond to clients' health needs.



Spotlight on CCBHC service types: Crisis services

- Nearly all CCBHCs provided crisis behavioral health services required in the criteria, directly or through DCOs (Exhibit V.5).** Although DCO use for crisis services was relatively high, direct provision of these services by the CCBHCs increased, and reliance on DCOs declined over time. Despite this shift, DCO engagement for crisis services remained common, indicating that many CCBHCs continued to partner with external providers to support their crisis response capacity. Although high percentages of CCBHCs reported delivering each crisis service directly, a substantial share also reported using DCOs for the same services. This suggests that CCBHCs may engage with DCOs to supplement the services they offer directly with specialized services that complement their internal capabilities. For example, one CCBHC in New York has an internal after-hours crisis line for adults but has a DCO arrangement with another agency to provide after-hours crisis care for youth and for mobile crisis services.
- In all, 15 percent of CCBHCs reported expanding their crisis services in the past year.** These clinics cited increased demand for crisis services and the need to divert people from emergency departments and hospitals. Common enhancements included the addition of behavioral health urgent care and the expansion of youth-focused crisis services. For example, a Missouri CCBHC said, *“While we have maintained a continuum of crisis response services for many years, predating CCBHC, in the past few years we have added and expanded Behavioral Crisis Center [BCC] services to provide appropriate crisis services and screening, assessment, and diagnostic services to meet community needs and defer [a]way from [the emergency department] and hospitalizations. More recently, we have been expanding the services and hours available in these centers to further meet community and client needs and are in the process of developing BCC services for youth in crisis.”*

Exhibit V.5. CCBHCs providing crisis behavioral health services, 2018 and 2024

Service	Provided directly				Provided by DCO				Provided directly or by DCO			
	2018		2024		2018		2024		2018		2024	
	N	%	N	%	N	%	N	%	N	%	N	%
Crisis behavioral health services	n.a.	n.a.	74	95	n.a.	n.a.	24	31	67	100	78	100
24-hour mobile crisis teams	49	73	66	85	23	34	18	23	65	97	76	97
Emergency crisis intervention	59	88	73	94	20	30	19	24	67	100	77	99
Crisis stabilization	60	90	67	86	14	21	11	14	66	99	70	90
Suicide prevention and intervention	n.a.	n.a.	76	97	n.a.	n.a.	15	19	n.a.	n.a.	78	100
Services capable of addressing crises related to substance use, including overdose prevention	n.a.	n.a.	76	97	n.a.	n.a.	15	19	n.a.	n.a.	78	100

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, and 2018 CCBHC Annual Progress Report Demonstration Year 1.

Notes: The denominator for each service is the total number of survey respondents in that year (n = 67 in 2018; n = 78 in 2024). Services are not mutually exclusive. Services with n.a. were not included in the 2018 CCBHC survey.

CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization; n.a. = not applicable.

CCBHCs have generally maintained delivery of required services over time, with many attributing this continued capacity to the support provided by the demonstration. Respondents highlighted several key ways the demonstration enabled CCBHCs to maintain delivery of services:

- **Allowing clinics to hire new staff and improve staff retainment and satisfaction.** A few CCBHCs credited their ability to maintain core services to hiring new staff, retaining existing staff, and achieving high staff satisfaction. They attributed this success to the staff trainings and supportive benefits made possible because of the demonstration's PPS. In Missouri, a CCBHC has sustained a 95 percent staff satisfaction rate because of its strong employee engagement efforts, which include comprehensive staff training that supports meaningful involvement in the organization's work. Furthermore, an Oklahoma CCBHC has successfully maintained services by retaining and supporting staff through an increase in the number of wellness days it provided to frontline staff. A representative for the CCBHC said, *"For years as an executive team, we've heard [staff] need mental health days...[we've implemented] 26 wellness days a year. It's been extremely helpful in recruiting and retaining staff."*
- **Leveraging demonstration funding to sustain and expand existing services.** A few CCBHCs said that they were already providing most required service types before joining the demonstration, which provided a foundation for them to maintain and build on without needing to expand entirely new service lines. These clinics often described being able to add or grow individual services as a result of the stability of the demonstration's funding mechanism. For instance, a Minnesota CCBHC noted that the demonstration allowed it to maintain services by providing a reimbursement that fully covers the cost of services. A representative from the CCBHC shared, *"...we were already doing most, if not all, of the services. We had been doing that for many years. CCBHC, just in that platform and the reimbursement model, and being able to build in anticipated cost, being able to really cover the cost of providing the services, has been able to sustain us..."*

Most CCBHCs in the original and CARES Act states successfully met demonstration service requirements and sustained services over time, but a few faced challenges delivering certain types of care. These challenges were often compounded by behavioral health workforce shortages, particularly of experienced providers and higher-level clinicians such as psychiatrists and psychologists as well as staff turnover at participating clinics, which made it difficult to meet service demand.

Some CCBHCs reported difficulties implementing demonstration requirements for screening, assessment, and treatment planning, noting that lengthy assessments could be burdensome for providers, difficult for clients, and could delay timely care. Others struggled to provide certain SUD services; for example, one clinic experienced challenges providing American Society for Addiction Medicine–level Intensive Outpatient (IOP) services. As this clinic explained, it is difficult to project demand for and appropriately staff IOP services because client attendance often falls short of the required intensity to meet the level of care, even when IOP is clinically appropriate.

CCBHCs also encountered challenges implementing EBPs, which often require costly and time-intensive staff training. In Michigan, clinics had difficulty recruiting clinicians interested in EBP implementation and retaining them once trained, as EBP certification increased their marketability. One clinic described the implementation of the Parent Management Training – Oregon Model as a year-long process followed by

ongoing supervision, with staff often leaving for higher-paying opportunities once trained, forcing clinics to restart the process. In addition, some CCBHCs struggled to provide family therapy services, such as in-home family therapy and Parent-Child Interaction Therapy, because of a shortage of providers willing to deliver this care and the challenges of delivering such care, especially in rural areas. A few also reported difficulties offering psychiatric rehabilitation services and metacognitive therapy, citing the complexity of training clinicians in these specialized approaches.

Despite these challenges, many CCBHCs took proactive steps to adapt and improve service delivery. For example, a New York CCBHC addressed providers' discomfort with prescribing medications for opioid use disorder by bringing in other licensed providers to train their psychiatrists. The clinic also focused on building rapport with patients to encourage them to seek services in-house rather than through external SUD providers. Similarly, some clinics have worked to strengthen staff retention by fostering supportive work environments and offering professional development opportunities to sustain EBP delivery over time.



Spotlight on CCBHC service types: Outpatient mental health and SUD services

CCBHCs deliver a broad range of outpatient mental health and SUD services, with modest growth in the provision of some service types over time (Exhibit V.6). Nearly all CCBHCs consistently offered outpatient mental health counseling, SUD treatment, motivational interviewing, and individual cognitive behavioral therapy, with many also providing additional services. Online cognitive behavioral therapy, which was rare at the start of the demonstration, saw substantial growth by 2024, likely reflecting increased telehealth adoption during the COVID-19 pandemic. Provision of certain EBPs also increased over time, including Assertive Community Treatment, Dialectical Behavioral Therapy, and evidence-based medication evaluation and management, driven in part by an increase in provision of services through DCOs.²⁸ Some CCBHCs that previously offered EBPs expanded them to additional populations. For example, a CCBHC in Michigan that already offered Dialectical Behavioral Therapy for adults reported adding this service for adolescents.

Almost all CCBHCs provided medications to treat substance use, with high percentages offering buprenorphine and other FDA-approved medications (excluding methadone). Some CCBHCs cited their expansion of SUD treatment and specifically access to medications to treat SUD as a key demonstration success. For example, a CCBHC in a rural area of New Jersey noted that it has enhanced access to medications in an area that previously had limited access. As one clinic leader said, *"We are a rurally designated CCBHC in our location, and there wasn't a lot of access for those sorts of meds...when we started this project...I think that's one of the other things that we've been able to be successful at, is just continuing to grow that part of the model."*

Direct provision of methadone by CCBHCs was reported less commonly than other FDA-approved medications, and methadone was commonly provided by DCOs (17 percent of CCBHCs in 2024), which some state officials suggested reflect more stringent federal and state requirements associated with prescribing and dispensing methadone than other medications. Nonetheless, CCBHCs frequently partnered formally or informally with opioid treatment programs to ensure clients can access methadone when needed (Wishon et al. 2023). DCOs providing several other outpatient mental health and SUD services increased from 2018 to 2024 as well, though use of DCOs never became common. These services include: outpatient mental health counseling, outpatient SUD treatment, motivational interviewing, and individual and group cognitive behavioral therapy.

²⁸ At the beginning of the demonstration, the criteria required CCBHCs to deliver outpatient mental health and SUD services directly. Updates to the criteria in 2023 expanded the CCBHC services that could be delivered by DCOs to all required services, likely contributing to the increase in DCO use for some outpatient mental health and SUD services.

Exhibit V.6. CCBHCs providing outpatient mental health and SUD services, 2018 and 2024

Service	Provided directly				Provided by DCO				Provided directly or by DCO			
	2018		2024		2018		2024		2018		2024	
	N	%	N	%	N	%	N	%	N	%	N	%
Outpatient mental health and SUD services	n.a.	n.a.	77	99	n.a.	n.a.	5	6	67	100	78	100
Outpatient mental health counseling	67	100	77	99	0	0	6	8	67	100	78	100
Outpatient SUD treatment	67	100	75	96	0	0	5	6	67	100	77	99
Motivational interviewing ^a	67	100	77	99	2	3	7	9	67	100	77	99
Individual CBT ^a	67	100	76	97	0	0	5	6	67	100	76	97
Group CBT ^a	56	84	66	85	0	0	2	3	56	84	66	85
Online CBT ^a	7	10	39	50	0	0	0	0	7	10	39	50
Trauma-focused CBT ^a	n.a.	n.a.	70	90	n.a.	n.a.	5	6	n.a.	n.a.	70	90
Dialectical behavioral therapy ^a	49	73	67	86	0	0	4	5	49	73	67	86
Coordinated specialty care for first episode psychosis ^{ab}	n.a.	n.a.	42	54	n.a.	n.a.	2	3	n.a.	n.a.	42	54
Multi-systemic therapy ^a	27	40	35	45	0	0	1	1	27	40	35	45
Assertive Community Treatment ^a	30	45	40	51	1	1	5	6	31	46	44	56
Forensic ACT ^a	6	9	9	12	0	0	0	0	6	9	9	12
Evidence-based medication evaluation and management ^a	58	87	72	92	0	0	3	4	58	87	73	94
Methadone ^c	n.a.	n.a.	10	13	n.a.	n.a.	13	17	n.a.	n.a.	22	28
Buprenorphine ^c	n.a.	n.a.	67	86	n.a.	n.a.	5	6	n.a.	n.a.	71	91
Other FDA-approved medications for opioid, alcohol, and tobacco use disorders ^c	n.a.	n.a.	69	88	n.a.	n.a.	5	6	n.a.	n.a.	72	92
Therapeutic foster care ^a	4	6	5	6	1	1	2	3	5	7	7	9
Community wraparound services for youth and children ^a	50	75	59	76	2	3	3	4	51	76	60	77
Specialty mental health/ SUD services for children and youth	58	87	61	78	0	0	4	5	58	87	62	79
Seeking safety ^{a,d}	n.a.	n.a.	41	53	n.a.	n.a.	4	5	n.a.	n.a.	42	54

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, and 2018 CCBHC Annual Progress Report Demonstration Year 1.

Notes: The denominator for each service is the total number of survey respondents in that year (n = 67 in 2018; n = 78 in 2024). Services with n.a. were not included in the 2018 CCBHC survey.

^a Evidence-based practice referenced in the criteria.

^b The 2018 CCBHC survey included a broader category, First episode/early intervention for psychosis, which is not directly comparable with this specific EBP.

^c The 2018 CCBHC survey included a single category: Medication-assisted treatment for alcohol and opioid use. The 2024 CCBHC survey broke this broad category into specific medications so it is not directly comparable with 2018.

^d Seeking Safety is an evidence-based treatment that helps people with trauma, post-traumatic stress disorder, and substance use. ACT = assertive community treatment; CBT = cognitive behavioral therapy; CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization; FDA = Food and Drug Administration; n.a. = not applicable; SUD = substance use disorder.

Clinics and states universally reported CCBHCs provide a much broader, more integrated, and more accessible scope of services than other behavioral health clinics in their communities. Clinics often described their ability to integrate service lines and provide a broad array of services in a single location as a hallmark of the CCBHC model. In describing services that CCBHCs offer more commonly than other providers, respondents often highlighted services that can be challenging for behavioral health providers to fund and sustain under traditional payment mechanisms, such as the robust care coordination and management, peer support, psychiatric rehabilitation, and primary care screening and monitoring offered by CCBHCs. In Michigan, for example, state officials emphasized the wider scope of services their CCBHCs can offer and noted the demonstration has driven improvements in non-CCBHC behavioral health clinics. They shared, *"I would say it's really hard to compare [CCBHCs and non-CCBHCs], quite frankly, because the CCBHC is just able to provide such a vast amount of services. From the [EBPs] to the 24-hour mobile crisis service delivery, across-the-lifespan services as well. Certainly the focus on veteran service delivery is at the forefront of the CCBHC. The way that they're able to utilize peer support specialists and youth peer supports and parent support partners is definitely another area where they're able to stand out, as far as scope of services, against a non-CCBHC provider. And I think that statewide, we're moving toward making the rest of the state catch up to CCBHC requirements, which is neat too."*

Combining services in a single location makes it not only easier for different types of providers to collaborate but also more likely people receiving services will be able use the behavioral health services they need. For instance, a New York CCBHC shared how its co-location of services has helped it build relationships with clients and improve care experiences. One clinic in Oregon described having 17 different programs in a single location, including specialized EBPs, making it unique in its county.



"We're able to provide everything in one location. A lot of the clients that have transferred from...another clinic, have felt scattered because they must go to so many different places to get the support that they need. [A single location] helps [clients] build a rapport with the staff here, starting from our security guard downstairs to our front desk staff. They're able to build a community with us here well."

— New York clinic leadership, 2024

B. Scope of services in new demonstration states

As new participants in the CCBHC demonstration, BSCA states focused their initial efforts on defining the scope of required services and laying the groundwork for service delivery. State officials generally expressed optimism that CCBHCs would be able to offer a broader and more integrated array of services than traditional behavioral health clinics, thanks in part to the financial stability the demonstration's PPS provided. For example, Indiana reported that the reliable funding provided through the demonstration's PPS enabled CCBHCs to strengthen their crisis response infrastructure. Although many of the state's CCBHCs were already offering some crisis services, the demonstration has led to more consistent and widespread availability of mobile crisis teams, crisis receiving centers, and stabilization services. In this

early phase, states have worked to ensure that CCBHCs are equipped to deliver the full range of required services, either directly or through partnerships with DCOs, and to embed EBPs that align with the needs of their populations.

All BSCA states have established a minimum set of required services and EBPs aligned with demonstration requirements. Several EBPs are mandated by multiple states, reflecting their perceived value in addressing the needs of CCBHC populations. For instance, nearly all states require CCBHCs to implement Motivational Interviewing and Cognitive Behavioral Therapy. About half of the BSCA states also require Assertive Community Treatment, Individual Placement and Support or Individual Placement and Support-Supported Employment, and Trauma-Informed Cognitive Behavioral Therapy. Substance use treatment combined with medication is another common requirement, although states vary in the terminology they use to describe these services. Illinois requires CCBHCs to offer Medication-Assisted Recovery, while Iowa, Kansas, and New Mexico require Medication-Assisted Treatment. Three states, Maine, New Mexico, and Vermont, require CCBHCs to offer Medications for Opioid Use Disorder, and Vermont further mandates Medications for Alcohol Use Disorder and Nicotine Replacement Therapy., (See Appendix C for a summary of required EBPs by state.)

CCBHCs in seven BSCA states plan to partner with DCOs to provide required CCBHC services. DCOs are most commonly expected to provide crisis services, including mobile crisis response, as well as primary care screening and monitoring. The number of DCOs anticipated at the time of application ranged from three in Maine to 26 in New Mexico. The specific services DCOs provide vary by state and may include any of the nine required CCBHC service types (Exhibit V.7). Vermont and New Hampshire do not plan to use DCOs. In Kansas, two CCBHCs in the same county serving different age groups (one serving youth and the other adults) have entered into DCO agreements with each other to provide services for the population they do not already serve. As a state official explained, “If a youth comes into the adult facility, there’s a DCO agreement to get them over to the youth specialist [the other CCBHC] and vice versa.” Although Alabama does not anticipate DCO partnerships at the outset of the demonstration, the state noted that agencies may choose to use DCOs in future years to deliver mobile crisis services, 24/7 crisis stabilization, and medications to treat opioid use disorder.

Exhibit V.7. Planned DCO services in BSCA states

Service type	IL	IN	IA	ME	KS	NM	RI
Required CCBHC service types							
Crisis services (including mobile crisis services)	X	X	X	X		X	X
Behavioral health screening, assessment, and diagnosis		X	X				
Person-centered and family-centered treatment planning		X	X				X
Outpatient mental health and substance use services	X	X	X		X	X	
Primary care screening and monitoring	X	X	X			X	X
Targeted case management	X	X	X			X	X
Psychiatric rehabilitation services	X	X				X	
Peer supports, peer counseling, and family/caregiver supports	X	X				X	
Community care for uniformed service members and veterans	X	X	X			X	

Source: BSCA state demonstration applications.

Notes: Kansas also has a CCBHC that only serves youth, and a CCBHC that only serves adults will serve as DCOs for one other. It is unclear whether the DCOs will provide all nine services or only specific types.

BSCA = Bipartisan Safer Communities Act of 2022; CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization.

Although BSCA states were optimistic that CCBHCs would be able to deliver the full scope of required services, they also reported several early implementation challenges. These challenges centered on the time and training needed for clinics to adapt to providing services they had not previously offered. For example, two states reported that primary care screening and monitoring was a particularly challenging service for their clinics to add because some clinics without previous experience offering this service had difficulty understanding this requirement. Similarly, a few states also reported challenges providing mobile crisis services among clinics that had not previously provided those services. For example, Kansas reported that mobile crisis services did not yet have 24/7 operation across CCBHCs but that the state is working on this. A respondent in Maine, which anticipated challenges offering youth SUD treatment and psychiatric rehabilitation services, in addition to crisis services, explained, *“I think implementation of a new [EBP] can require a lot of time to do and do it well. I think it's going to take some time for providers [in clinics without previous organizational experience] to feel comfortable in providing these services to the individuals that need them.”* Finally, staffing shortages were a commonly cited barrier to providing the full scope of services, although respondents hoped that the PPS would help clinics be able to attract and retain staff.



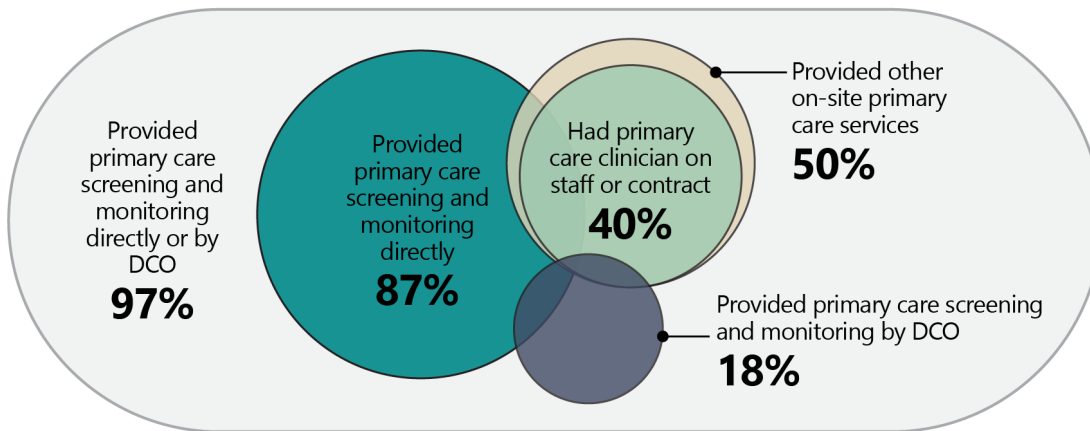
Spotlight on CCBHC service types: Outpatient primary care

Nearly all CCBHCs provided required primary care screening and monitoring, and about half of CCBHCs also provided primary care services on-site. CCBHCs must screen for and monitor key health indicators and health risks, such as body mass index, blood pressure, cholesterol, tobacco use, and certain infectious diseases.²⁹ In 2024, 97 percent of CCBHCs provided primary care screening and monitoring, with 87 percent of CCBHCs providing these services directly and 18 percent by DCO (Exhibit V.8). Some CCBHCs reported providing primary care screening and monitoring services directly while also partnering with DCOs to deliver these services. This suggests that CCBHCs may use DCOs to complement and expand their in-house capabilities, similar to crisis services.

Although the certification criteria do not require delivery of primary care services (beyond screening), half of CCBHCs also provided on-site primary care services, and slightly less than half had a primary care clinician on staff or under contract; most clinics providing on-site primary care also had a primary care clinician on staff or under contract. Some CCBHCs have implemented models of on-site primary care in collaboration with partner organizations. For example, a CCBHC in Oregon partnered with its local Federally Qualified Health Center to build a joint facility that offers integrated behavioral health, primary care, dental, and other services. The percentages of CCBHCs providing primary care screening and monitoring and delivering primary care on-site have remained fairly steady over time (see Appendix Exhibit A.12).

²⁹ The CCBHC medical director establishes protocols for screenings that conform to screening recommendations with scores of A and B of the United States Preventive Services Task Force Recommendations (these recommendations specify which populations screening is appropriate for).

Exhibit V.8. CCBHCs providing primary care screening and monitoring and on-site primary care, 2024



Source: Mathematica’s analyses of data from a fall 2024 survey of CCBHCs that had participated in the demonstration for at least a year.

Notes: See Appendix Exhibit A.12 for full data, including denominators.

CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization.

CCBHCs supported delivery of primary care screening and monitoring services and on-site primary care in various ways, including modifying physical spaces to better accommodate physical health service delivery, hiring staff such as health liaisons and certified medical assistants to conduct primary care screenings and coordinate physical healthcare, and enhancing collaboration with primary care partners. For example, one Missouri clinic trained case managers to support clients with chronic physical conditions and partnered with a Federally Qualified Health Center to deliver on-site care. Similarly, one New York CCBHC described a strong bidirectional integration with primary care, including embedding primary care providers within behavioral health sites and placing behavioral health staff in primary care settings to support holistic treatment. The clinic also enhanced screening and monitoring through nursing-led health assessments, on-site blood draws, and coordination with primary care providers. A family nurse practitioner on staff conducts limited physical assessments and refers clients to appropriate primary care services, helping ensure continuity of care and alignment with psychiatric treatment. In addition to these structural and staffing strategies, some CCBHCs emphasized how their primary care services fit within the broader framework of CCBHC implementation and complement other CCBHC requirements, such as care coordination, outreach, and partnerships with external entities. One New Jersey CCBHC described its efforts this way:

“At the primary level, we are prioritizing health education and awareness campaigns to prevent the onset of health issues, particularly around topics like chronic disease management, mental health awareness, and substance abuse prevention. We are working closely with local organizations and community leaders to ensure that these preventive measures reach at-risk populations early, improving overall community health outcomes. At the secondary level, we are intensifying efforts to identify and address health issues in their early stages through screenings, early interventions, and targeted health services. These initiatives include programs like early detection for diabetes, hypertension management, and mental health screenings, ensuring timely treatment to prevent further complications.”

Clinics and states reported barriers that might limit the feasibility of offering on-site primary care beyond screening and monitoring, including high costs, regulatory differences between primary care and behavioral health settings, and challenges partnering with primary care providers. In Oregon, where demonstration CCBHCs must provide 20 hours of on-site primary care per week, a state official noted that clinics struggled to deliver this service and that the requirement became a barrier to expanding the CCBHC model. Indeed, some Oregon CCBHCs reported planning to maintain required care coordination with external primary care providers after the demonstration ends but also to discontinue on-site primary care beyond screening and monitoring. Recognizing the importance of integration, however, the state plans to work with clinics to identify new processes and ideas to support primary care linkages and integration in lieu of requirements for on-site delivery. Similarly, CCBHCs in New Jersey and Minnesota suggested that an integrated CCBHC license would be more practical than obtaining a separate license for on-site primary care as is currently required, highlighting regulatory barriers that may impede clinics' ability to offer these services when desired.

VI. PPS: Selection and Contributions

Medicaid programs typically use fee-for-service or managed care arrangements to reimburse community behavioral health organizations, and some evidence suggests that these arrangements have not historically covered the full cost of the services these clinics provide to Medicaid beneficiaries (Scharf et al. 2015). The demonstration addresses this problem by establishing Medicaid payment rates on the basis of projected costs of delivering a full CCBHC scope of services. Prospective rates are developed using standardized cost reports that document both historic and anticipated costs of delivering CCBHC services. The demonstration's PPS options (Exhibit VI.1) were designed to improve the alignment of financial incentives with provision of high-quality, patient-centered care. These payment models enable CCBHCs to exercise considerable flexibility in tailoring services to the needs of their clients without being concerned about the financial impact of each service decision or procedure.

The PPS models include incentives that could lead to either over- or under-provision of care, but they also contain mechanisms to mitigate these risks. For example, ideally, in contrast with FFS systems where each additional service brings an additional payment, the PPS should not incentivize providing high volumes of care. Rather, the amount that clinics are paid is determined by the average cost of care, regardless of the quantity of services provided on a given day or month. While there is an incentive for clinics to have more frequent visits with clients, particularly under PPS-1 and 3, this incentive only operates over the short term because states have the option to adjust the payment rates based on the cost data from the previous year (a process known as re-basing). At the same time, because clinics receive a fixed payment for each day or month in which a client has an encounter, regardless of the specific services provided, there is a potential incentive to withhold care. To address this concern, states can award quality bonus payments based on performance on quality measures, encouraging clinics to deliver high-quality care. Ongoing state oversight plays a critical role in monitoring service patterns and cost data, ensuring payment structures support appropriate and effective care delivery.

In this chapter, we describe the characteristics of the PPS established by new demonstration states as they begin their demonstration, including the structure of their PPS and rationale for selecting specific PPS

Exhibit VI.1. CCBHC demonstration PPS overview

- **Payment frequency:** PPS-1 and PPS-3 offer a fixed *daily* payment for each day a Medicaid beneficiary receives demonstration services. PPS-2 and PPS-4 offer a fixed *monthly* payment for each month in which a Medicaid beneficiary receives demonstration services.
- **Population categories:** PPS-1 and PPS-3 offer a uniform rate for all populations. PPS-2 and PPS-4 include a “standard” population rate and additional rates for special populations with certain conditions expected to have different average costs.
- **Special crisis service rates:** PPS-3 and PPS-4 include the option of setting a separate special crisis services rate for several categories of crisis services.
- **Outlier payments:** PPS-2 and PPS-4 include separate supplemental payments to cover costs of extremely high-cost Medicaid beneficiaries above a state-defined threshold.
- **Quality bonus payments:** PPS-1 and PPS-3 states *can* provide CCBHCs with QBPs based on their performance on quality measures at state option. PPS-2 and PPS-4 states *must* provide QBPs.

options. We then briefly describe changes in the PPS rates in original states over time and ways the Medicaid PPS has supported states' and CCBHCs' efforts to improve access, quality of care, and scope of services.

A. PPS in new demonstration states

States select one of four PPS methodologies to reimburse all demonstration CCBHCs in the state, numbered PPS-1 through PPS-4. Most new states (seven of the 10) selected PPS-1, offering a fixed daily rate (Exhibit VI.1). Maine and Rhode Island selected the PPS-2 monthly rate option, and New Hampshire selected the PPS-3 daily rate with special crisis service rates. New Hampshire is the only demonstration state to select PPS-3 or 4 to date, but several states are interested in exploring these special crisis service rate options further in future demonstration years.

In reflecting on their decisions to pursue specific PPS models, BSCA states primarily chose their PPS because of prior experience using similar payment systems. Illinois, Indiana, and New Mexico chose the PPS-1 because of its similarity to the Federally Qualified Health Center daily encounter rate, which these states had significant familiarity and experience with. Although Rhode Island also had experience with a daily rate through reimbursing Federally Qualified Health Centers, the state legislature instructed the state to use PPS-2 in part to align with the monthly payment model the state uses in its Medicaid Health Home program. Similarly, Kansas selected PPS-1 because it was most similar to fee for service, and the state believed it would be easier for providers to implement. Meanwhile, Maine chose PPS-2 because the state's CCBHC providers were already familiar with a per-member-per-month model through the state's Behavioral Health Homes and Opioid Health Homes.

Vermont chose PPS-1 because of concerns about changes in service utilization under a different state program. Since 2019, the state has implemented a monthly case rate for children's and adult's mental health, through which CCBHCs gained experience with bundled rates. Yet the state observed a decrease in the amount of services provided with the switch from fee for service to a monthly rate. Thus, the state decided to select a daily rate (PPS-1) for the CCBHC demonstration, hoping to avoid a similar service-drop-off, but might consider a different PPS in the future.

Most new states have opted not to include optional components of the PPS, such as QBPs or special population rates, prioritizing instead minimizing additional complexity during initial implementation. States' decisions reflect a recognition that transitioning to a PPS is already a complex and resource-intensive undertaking. States have also drawn on lessons from earlier demonstration cohorts, which emphasized the significant challenges involved in implementing these optional elements. Although these components are not part of initial plans, many states intend to explore them in the future. For example, of the seven PPS-1 states (for which offering QBPs is optional), only Iowa plans to offer QBPs at the outset. A few states are considering implementing QBP programs in the future after gaining more experience with cost and quality reporting. In addition, only one PPS-2 state, Rhode Island, chose to include special population rates, including different rates for high-acuity adults, children, and people with SUD.

BSCA states often hired contractors to help with initial rate setting, as was the case with the original states. In some cases, contractors might also provide other support to help states implement the PPS. For example, Maine’s rate-setting vendor is teaching the state team how to set rates in the future and supporting the state in its cost-reporting process. Partnerships with contractors and other state agencies were especially helpful with states that had limited previous experience with a PPS, such as Alabama, which explained that, to set rates, *“we worked with a national consultant actuarial firm. And then we worked with the Alabama Medicaid Agency and their actuaries...We were very green and new to this process, so a lot of stuff was way above our heads. But we leaned heavily on the Alabama Medicaid Agency and their actuaries to assist us in the rate setting.”*

To support their application for the demonstration and test rate-setting processes, states developed sample PPS rates, illustrating rates for a prospective clinic (Exhibit VI.2). Sample rates varied considerably by state. In future evaluation years, we will examine clinic-specific PPS rates in new demonstration states, assess how they compare with rates in the original and CARES Act states, and assess changes over time.

B. PPS support of states’ and CCBHCs’ efforts to improve access, quality of care, and scope of services

States and CCBHCs consistently reported that the PPS has played a critical role in expanding access, enhancing quality of care, and broadening the scope of services. Described as a transformative funding model, the PPS provides the stability and flexibility of a prospective bundled payment, enabling clinics to deliver the right set of services at the right time and place.

As reported in previous evaluation years, PPS rates have varied over the course of the demonstration within and across states (Exhibit VI.3). By the fourth demonstration year, PPS-1 daily rates ranged from approximately \$188 to \$389, and PPS-2 monthly rates ranged from \$706 to more than \$872, depending on the state and clinic. These increases were not uniform: some states saw relatively modest adjustments, but others experienced more substantial growth in rates because of changes in average costs per client driven by increases in the average number of visits per client. Rate changes were expected as part of the demonstration PPS to align rates with actual costs.

Exhibit VI.2. Sample BSCA state PPS rates

State	Sample adjusted rate
PPS-1 states	
Alabama	\$342.68
Illinois	\$267.21
Indiana	\$227.70
Iowa	\$264.86
Kansas	\$335.00
New Mexico	\$335.45
Vermont	\$194.00
PPS-2 states	
Maine	\$738.00
Rhode Island	\$1,166.00
PPS-3 state	
New Hampshire	Standard: \$316.90 (standard) Mobile crisis (consistent with section 9813 of the ARP): \$2,082.98

Source: State demonstration applications.
ARP = American Rescue Plan Act; BSCA = Bipartisan Safer Communities Act of 2022;
PPS = prospective payment system.

CCBHCs and states reported that PPS rates that are based on actual costs and the bundled nature of the PPS have supported strategic investments in workforce development, infrastructure, and more responsive client-centered care delivery in the following ways.

The PPS has enabled CCBHCs to fund a variety of services and activities critical to expanding capacity and infrastructure. More than three-quarters of CCBHCs reported the PPS has allowed them to support staff or staff types not previously reimbursed by traditional Medicaid or other reimbursement mechanisms (79 percent), often mentioning staff such as peers, care coordinators, case managers, administrative support staff, and outreach and engagement staff. For example, one CCBHC reported the PPS allowed it to fund “emergency room enhancement staff, [a] Veteran’s liaison, intake coordinator, billing, medical records [staff], support and administrative [staff], crisis staff.” Almost as many reported the PPS has allowed them to cover services that were not previously reimbursed under the Medicaid state plan (71 percent), often referencing case management, care coordination, crisis services, and peer services and supports in their responses. In addition, many CCBHCs used the PPS to support access improvements, such as implementing open access scheduling or providing transportation (65 percent), and to support data collection and quality improvement activities such as dashboards and hiring data-focused staff (62 percent). Many also reported the PPS supported other activities essential to the CCBHC model, including staff training and other professional development activities, and employee supports and benefits (63 percent) (Exhibit VI.4).

Exhibit VI.3. Average PPS rates in demonstration states, by year

State	DY1 (2017–2018)	DY2 (2018–2019)	DY3 (2019–2020)	DY4 (2020–2021)
PPS-1 states				
Minnesota	\$433	\$383	\$387	\$389
Missouri	\$241	\$238	\$243	\$248
Nevada	\$225	\$187	\$187	\$188
New York	\$318	\$271	\$265	NA
Oregon	\$288	\$288	\$286	\$285
PPS-2 states				
New Jersey	\$716	\$706	\$712	\$708
Oklahoma	\$726	\$844	\$846	\$872

Source: CCBHC PPS rates. See Wishon et al. 2023 for full findings.

Notes: We inflated rates for each DY to 2022 dollars using the MEI to facilitate year-to-year comparisons.

CCBHC = Certified Community Behavioral Health Clinic; DY = demonstration year; MEI = Medicare Economic Index; PPS = prospective payment system; NA = not available.

Exhibit VI.4. CCBHCs reporting services and activities supported by the PPS, 2024

Services and activities supported by the PPS	2024	
	N	%
Services not previously reimbursed under Medicaid state plan	55	71
Staff or staff types not previously supported by traditional Medicaid or other reimbursement mechanisms	62	79
Access improvements (such as open access scheduling and transportation)	51	65
Data collection or quality improvement activities (such as data dashboards)	48	62
Other activities to support the CCBHC model (such as training and staff meetings)	49	63

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year.

Notes: The denominator for each category is the total number of survey respondents in 2024 (n = 78). Categories are not mutually exclusive.

CCBHC = Certified Community Behavioral Health Clinic; PPS = prospective payment system.

Consistent with survey findings, the CCBHCs interviewed credited the PPS with supporting the expansion and sustainability of a broader scope of services than they were providing before. The PPS provided flexibility to fund services that are typically not reimbursed under traditional payment models, allowing clinics to introduce innovative offerings and fully support EBP, often involving team-based care. Clinics and state officials frequently emphasized that the PPS has been instrumental in supporting comprehensive care coordination and management, which are often unreimbursed outside the demonstration but essential to achieving its goals of accessible, coordinated, and high-quality care. Care coordination often includes activities that do not involve direct client contact, such as outreach to external providers and tracking referrals to ensure clients receive needed specialty services. Similarly, team-based care involves coordination, consultation, and planning that occur outside of face-to-face client sessions. These indirect but critical activities have been difficult for some clinics to sustain as a result. The PPS, however, allows CCBHCs to cover the anticipated cost of these services, making it possible to deliver the kind of collaborative wraparound care envisioned under the CCBHC model.

Clinics have also used the flexibility of the PPS to introduce new and innovative services. For example, an Oklahoma clinic said, *"We've incorporated some types of treatments that have never been available...because if there's not a specific reimbursement for it, [they are] too expensive to provide. [But] on a cost reimbursement basis, we're able to... It's things as innovative as ketamine treatment...we have seen benefits of people having ketamine infusions for long, hard-to-treat depressive and suicidal symptoms. We've never been able to take that treatment to [the Medicaid] population, but [because of the PPS] we can."* Other clinics cited peer services and supports, as well as crisis services including behavioral health urgent care, as important services not previously reimbursable outside the PPS.

The PPS has strengthened CCBHCs' workforce capacity and supported staff development. CCBHCs widely credited the PPS with enabling them to offer more competitive salaries, hire new staff, and retain personnel essential to delivering an expanded array of services. As New York state officials explained, "The PPS has long been shown to be the most effective factor as a clinic transitions into a CCBHC and is able to offer more competitive salaries to staff, for example, or extend the hours accordingly, and then receive reimbursement based on the cost of doing those more innovative things." Clinics reported the PPS supported a wide range of roles needed to provide the full array of CCBHC services, but that may be difficult to sustain under traditional payment structures, such as peers, care coordinators, case managers, outreach and intake staff, and administrative positions such as data analysts, human resources managers, information technology staff, and quality improvement personnel. In addition to hiring, many CCBHCs used the PPS to invest in staff development, offering regular trainings on EBPs such as Motivational Interviewing, Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing, and culturally responsive care. Some clinics hired training coordinators or hosted speaker series and all-staff meetings. Others used PPS flexibility to support staff wellness and expand employee benefits, with one New Jersey CCBHC highlighting its focus on staff health and well-being as part of its broader workforce strategy.

Improved financial stability under the PPS has allowed CCBHCs to enhance access, become more efficient, and innovate in care delivery. The predictable and reliable funding stream has allowed clinics to plan and budget more effectively, freeing up resources to experiment with more efficient care models,

such as same-day scheduling, and to invest in outreach and engagement efforts. Some clinics hired dedicated staff for these functions, relieving clinical staff of non-clinical duties and making more efficient use of their time to perform clinical functions. Although clinics are reimbursed at the PPS rate for Medicaid beneficiaries, many clinics noted that the financial stability it provides has strengthened their ability to provide a comprehensive array of services to all who seek care by allowing them to maintain staffing and infrastructure that benefit all clients. Some clinics and states, however, continue to face challenges funding uncompensated care and are exploring mechanisms such as Medicaid uncompensated care pools and CCBHC expansion grants to sustain gains in access for uninsured populations during the demonstration. The PPS also enabled clinics to offer multiple services in a single visit, which some were previously unable to do because of same-day billing restrictions or cost barriers. A New York CCBHC described this shift as a culture change, noting that the bundled rate has allowed the clinic to deliver more comprehensive care during each visit.

The PPS has supported a shift toward quality-focused team-based care. Clinics often described the PPS as a paradigm shift away from prioritizing service billability and toward emphasizing provision of appropriate services in ways that improve clients' outcomes. As one Oklahoma CCBHC explained, *"We're able to focus more on what the client needs and less about managing every single second that our clinician is billing."* Clinics used the PPS to support quality improvement initiatives, including hiring data-focused staff, enhancing electronic health record systems, and developing dashboards to monitor key metrics such as suicide risk, caseloads, staff productivity, and client outcomes. They also used the PPS to support other improvements in transportation services, extend clinic hours beyond the traditional workday, and invest in infrastructure improvements such as phone systems, electronic medical records, and intake scheduling platforms; enhancements that contributed to more coordinated, accessible, and efficient care.

Although they are still early in their demonstrations, BSCA states reported a few initial or anticipated successes with the PPS that mirror those observed in original and CARES Act states, including the following:

- **Funding services that were not previously reimbursable.** States reported that the PPS has helped CCBHCs deliver new services or receive reimbursement for services that were previously not covered. These include services such as comprehensive care coordination, navigation, outreach to unhoused populations, primary care screening and monitoring, and translation services. A state official in Maine reported excitement about the opportunities the PPS provides, saying, *"I think [the PPS] takes down all those silos and barriers that are pretty artificial to the billing system... and [allows you] to just put together a clinic that meets the need of your population."*
- **Better ability to recruit and retain clinicians.** BSCA states reported or anticipated that the higher reimbursement rates that CCBHCs receive under the PPS will help them recruit new staff and increase staff salaries. Because of the pervasiveness of behavioral health workforce shortages, one BSCA state felt having the ability to offer higher salaries is "a really huge opportunity for these providers," Rhode Island identified a potential unanticipated challenge, however, noting that CCBHCs reimbursing staff at higher rates could attract staff away from other behavioral health providers, potentially exacerbating staffing shortages for non-CCBHCs.

VII. Conclusions and Recommendations

Section 223(d)(7)(A) of PAMA mandates that HHS' reports to Congress include (1) an assessment of access to community-based mental health services, (2) an assessment of the quality and scope of services provided by CCBHCs, and (3) an assessment of the impact of the demonstration on the federal and state costs. Here we summarize the status of the demonstration and main findings in each of the PAMA topic areas, provide a recommendation regarding the future of the demonstration, and describe future evaluation activities that will shed further light on how the demonstration influences access, services and quality, and costs over time.

A. Status of demonstration implementation

As of March 2025, the CCBHC demonstration included 206 clinics across 18 states, representing an increase from 106 in May 2024. This growth was primarily due to the addition of 84 clinics in newly participating BSCA states. The number of clinics in original and CARES Act states increased modestly from 106 to 122, with Michigan and New York accounting for most of the growth. Among the 78 CCBHCs participating in the 2024 survey, CCBHCs delivered demonstration-supported services at 730 clinic locations, with an average of 10 locations per CCBHC and wide variation across states (ranging from an average of 3 clinic locations per CCBHC in New Jersey and Oregon to 18 in Missouri).

Newly participating BSCA states were in the early stages of implementation or preparing to launch their demonstrations. Before joining the demonstration, CCBHCs operated in all ten BSCA demonstration states; these clinics primarily became CCBHCs through SAMHSA CCBHC-E grants. In describing their motivations for joining the demonstration, 2024 BSCA states universally cited the opportunity to improve access to behavioral health care, especially among populations historically facing access barriers, supported by a stable and sustainable funding mechanism. These states have focused on key infrastructure activities during early implementation, such as establishing and refining certification and monitoring processes, and deploying Medicaid billing and quality reporting systems. Some states reported early successes in establishing these systems, while others encountered challenges related to technology updates and billing complexity.

At the same time, the six remaining original Demonstration states were preparing for the end of the demonstration in their states in September 2025. All six states planned to sustain the model through Medicaid SPAs, and nearly all clinics in these states intended to continue implementing the model after the demonstration ended. States emphasized that their plans to continue the CCBHC model through Medicaid state plan authority reflect the model's perceived value and its importance to broader state behavioral health system reforms. While most states expect to retain the core elements of the CCBHC program as implemented under the demonstration when transitioning to state plan authority, some may make targeted adjustments to reduce administrative burden or better align with state priorities. These changes could include simplifying payment systems or revising quality bonus payment structures.

B. Access to care in demonstration states

The number of people served by Demonstration CCBHCs and the average number served per clinic increased steadily over time, suggesting CCBHCs have expanded their reach and capacity. The

number of people served across the original demonstration states increased from 286,089 in 2018 to 383,816 in 2023. The CARES Act states also experienced growth, from 133,269 people served in 2022 to 149,989 in 2023. The average number of people served by each CCBHC has also increased consistently over time in almost all states, suggesting individual CCBHCs have increased their capacity. Average numbers of people served varied across states; for example, Kentucky CCBHCs each served almost 13,000 people on average in 2023, while Oregon CCBHCs served 3736, likely reflecting differences in the size of states' CCBHCs and other factors. Demographic characteristics and insurance status of CCBHC clients have been similar across Demonstration years.

Demonstration CCBHCs continue to implement a range of activities and strategies to expand and maintain access to care. Almost all (97% in 2024) offered open access scheduling or same-day appointments. Clinics also conducted community outreach, including street outreach to people with serious mental illness or SUDs, and engagement with veterans' groups. Some developed tailored resources for specific populations, such as a call line for farmers and ranchers in Oregon or dedicated veteran peer support roles. Demonstration CCBHCs also worked to increase service delivery in community settings; for example, the percentage of CCBHCs providing services in homeless shelters increased from 9% in 2018 to 74% in 2024, and those providing services in schools increased from 51% to 88%. Telehealth use also expanded, with 100% of demonstration CCBHCs offering telehealth services by 2024. Clinics used telehealth to increase accessibility, especially in rural communities, and some deployed tools such as crisis iPads to ensure 24/7 access in homes and public locations. CCBHCs expanded their reach by deploying vehicles to deliver mobile services throughout rural areas and increased capacity by expanding the physical space of facilities to meet growing demand.

Clinics and state officials perceived that CCBHCs provided better access to care relative to other behavioral health clinics in their communities. Becoming a CCBHC has enabled clinics to reduce wait times and keep clients engaged in care. For example, one clinic noted clients previously faced wait times of 2–3 weeks but now receive services from the clinic within 24 to 48 hours. States also highlighted that CCBHCs serve broader populations than many community mental health centers, which may limit services to adults or those with specific diagnoses. CCBHCs and states often reported national behavioral health workforce shortages as a barrier to serving their communities. Recruiting and retaining staff, particularly for child and youth services, crisis services, and bilingual providers, was sometimes challenging. To address these challenges, CCBHCs responded by offering higher salaries, adding benefits like wellness days, and adjusting roles to improve staff satisfaction.

C. Quality and scope of services

Almost all CCBHCs in original and CARES Act states provided all nine required CCBHC service types, with minimal changes over time. All or nearly all CCBHCs provided crisis services; screening, assessment, and diagnosis services; person- and family-centered treatment planning services; outpatient mental health and/or SUD services; psychiatric rehabilitation services; peer support services; primary care screening and monitoring; and targeted case management either directly or through DCOs. The percentage of CCBHCs offering community care for uniformed service members and veterans was lower than other required services but has increased from 72 percent in 2018 to 78 percent in 2024. Within the CCBHC service categories, CCBHCs provided a wide range of individual services and treatments directly or by DCO, such

as various evidence-based practices, with some growth in delivery of individual services and treatments over time. This trend suggests that the model is dynamic, with ongoing improvements and enhancements to services occurring beyond the initial implementation period.

Most demonstration CCBHCs provided services directly rather than rely on DCOs. In 2024, 31 percent of CCBHCs used DCOs to deliver crisis services, 18 percent for primary care screening and monitoring, and fewer than 10 percent for most other services. Clinics cited a preference for maintaining control over service quality and integrating care in a single location and some states have also discouraged use of DCOs. In some states, such as Michigan, state policy changes have facilitated innovative DCO partnerships; for example, allowing CCBHCs to serve as DCOs for other CCBHCs to fill service gaps.

Clinics have expanded their scope of services in response to community needs and increased demand. In 2024, half of the surveyed CCBHCs reported expanding services in the prior year. Many of these clinics expanded SUD services, including medications for opioid and alcohol use disorders. Others enhanced services for children and youth, such as psychiatric rehabilitation services, and school-based care for this population. Clinics have also broadened care coordination capabilities and physical health integration, with about half offering on-site primary care in addition to required primary care screening and monitoring. States and clinics consistently reported that CCBHCs offer a broader and more integrated scope of services than other providers, with co-location of services in a single setting and care coordination cited as key strengths supporting improved service delivery under the model.

CCBHCs have generally sustained required services over time, with many attributing this to the demonstration's PPS enabling them to hire and retain staff necessary to maintain service delivery. While most CCBHCs maintained the required services, some reported challenges delivering specific services due to workforce shortages, staff turnover, and the complexity of implementing evidence-based practices and intensive outpatient programs. Many CCBHCs addressed these hurdles by fostering supportive work environments and internal training strategies.

D. Prospective payment systems: Selection and contributions

Most BSCA states selected a PPS model based on familiarity with similar payment systems, aiming to simplify implementation and limit complexity. Most adopted PPS-1, which offers a fixed daily rate. Two states, Maine and Rhode Island, chose PPS-2, which uses a fixed monthly rate. Only New Hampshire selected PPS-3, which includes a special crisis services rate. Most new states opted not to include optional components of the PPS, such as quality bonus payments or special population rates, prioritizing minimizing additional complexity during initial implementation of a new model. BSCA states often hired contractors to help with initial rate setting, as was the case with the original states. In some cases, contractors may also provide other support to help states implement the PPS.

The PPS supported the expansion and sustainability of a broader scope of services than CCBHCs were providing before. The flexibility of the bundled payment has allowed CCBHCs to expand their service offerings to include care coordination, crisis services, peer supports, and other essential services that are not fully reimbursed or difficult to sustain under traditional Medicaid payment models. Almost three-quarters of CCBHCs reported the PPS has allowed them to cover services that were not previously reimbursed under the Medicaid state plan (71 percent), often referencing case management, care

coordination, crisis services, and peer services and supports in their responses. CCBHCs also credited the PPS with enabling them to introduce innovative service offerings and fully support evidence-based, team-based care. By covering costs of both direct client interaction and indirect components of team-based care such as provider-to-provider consultation, the PPS has made it possible for CCBHCs to offer the collaborative, wraparound services envisioned under the model.

The PPS has strengthened CCBHCs' workforce capacity and supported staff development. Over three-quarters of CCBHCs reported the PPS has allowed them to support staff or staff types not previously reimbursed by traditional Medicaid or other reimbursement mechanisms, often mentioning staff such as peers, care coordinators, case managers, administrative support staff, and outreach and engagement staff. Demonstration CCBHCs widely reported that the PPS enabled them to offer more competitive salaries, hire staff, and retain personnel critical to service delivery. Many clinics expanded employee benefits and invested in professional development with the support of demonstration funding, offering regular trainings in evidence-based practices and culturally responsive care. State officials emphasized that these investments are key to recruiting and retaining staff and would not have been feasible under traditional reimbursement systems, with one New York official calling the PPS the "most effective factor" in allowing clinics to grow and sustain their workforce.

Improved financial stability under the PPS has allowed CCBHCs to enhance access, improve efficiency, and innovate in care delivery. A more predictable and reliable source of funding has allowed clinics to plan and budget more effectively, freeing up resources to experiment with more efficient care models, such as same-day scheduling, and to invest in outreach and engagement efforts. Some clinics hired dedicated staff for these functions, relieving clinical staff of non-clinical duties and making more efficient use of their time to perform clinical functions. However, some clinics and states continue to face challenges funding uncompensated care and are exploring mechanisms such as Medicaid uncompensated care pools to sustain gains in access for uninsured populations during the demonstration.

E. Recommendations

Section 223(d)(7)(B) of PAMA as amended by the BSCA requires HHS to submit to Congress "recommendations concerning whether the demonstration programs under this section should be continued, expanded, modified, or terminated," noting "such recommendations shall include data collected after 2019, where feasible." Since its launch eight years ago, the demonstration has driven substantial changes in the delivery of behavioral health care among participating clinics and states. Demonstration CCBHCs and states have widely viewed the demonstration as a catalyst for positive organizational transformation, enabling clinics to expand services, strengthen infrastructure, and enhance efficiency of care delivery. These changes required considerable investment. States and clinics implemented changes to data and billing systems, redesigned workflows, and put into place new partnerships and processes to improve access to and quality of care. With the support of the demonstration PPS, many clinics hired staff across a range of disciplines and invested in training and technology to support more integrated and efficient care.

CCBHCs have reported improved access to care during the demonstration, driven by both expanded service availability and strengthened care coordination. CCBHCs have substantially increased the number of people they serve over time, and clinics have reported reduced wait times, increased same-day and

walk-in appointments, and extended hours to make services easier to access. Many CCBHCs have also brought services into the community to reach people with limited transportation options or who face other barriers to obtaining clinic-based care. These changes have been facilitated and reinforced by a strong emphasis on care coordination, helping people both enter care more easily and receive more ongoing and connected support. Clinics have built stronger relationships with external partners and implemented formal protocols to manage transitions of care, particularly after hospitalizations or crises. Dedicated care coordination staff and shared care plans have helped maintain treatment continuity during transitions in care. While some CCBHCs continue to work through data sharing challenges with other health care and social service providers, many clinics report improved communication and information sharing with partners, which are critical for delivering timely, coordinated care.

Although states and CCBHCs have effectively implemented the model and reshaped service delivery, the demonstration's long-term impacts on Medicaid costs, quality, and service use outcomes are currently less clear. The introduction of the CCBHC model affected the use of Medicaid services differently across states during the first four demonstration years. Although some states experienced reductions in costly emergency department visits and hospitalizations, others had different results, such as minimal or no observable change in these outcomes. In addition, although the demonstration decreased inpatient costs for some populations, these reductions did not offset an increase in ambulatory behavioral health costs in the few states with available cost data. However, these costs might not be unexpected. The demonstration did not have cost neutrality requirements, and most states did not anticipate immediate cost savings, instead viewing the demonstration as an opportunity to address longstanding underinvestment in intensive, community-based behavioral health services. There was some evidence of improved quality of care in the first four demonstration years, performance was comparable to or exceeded available Medicaid Core Set state median data, and performance on most measures remained stable or improved over time. Performance on some measures, however, indicated opportunities for strengthening care coordination and data sharing.

The demonstration has also highlighted persistent challenges in the broader behavioral health care system, including ongoing behavioral health workforce shortages and differences in access between urban and rural communities. Even so, the demonstration has helped clinics address these challenges through sustainable and flexible funding, and many clinics have used the model as a platform for continuous quality improvement, investing in staff development, adopting evidence-based practices informed by performance on quality measures and outcomes, and strengthening their ability to track and respond to the needs of people receiving care.

The demonstration has generated strong and sustained interest nationwide. Participation has grown significantly, with 18 states and more than 200 organizations currently operating under the demonstration, and additional states pursuing state-level CCBHC implementation through demonstration planning grants. To date, all but seven states have taken steps toward adopting the CCBHC model at the state level, either through participation in the demonstration, pursuing demonstration planning grants, establishing Medicaid waivers or state plan amendments, or state legislative directives to explore the model. The federal government has made significant and sustained investments to develop and refine the CCBHC model, including designing and updating robust payment methodologies, comprehensive quality metrics, and delivering technical assistance to ensure effective implementation and continuous

improvement. Notably, even states pursuing alternative Medicaid pathways for implementing the CCBHC model have often used the demonstration as a foundation, drawing on its structure, lessons, and momentum to guide implementation efforts.

Successful implementation of the CCBHC model and evidence of its positive benefits to communities provides strong justification for continuing the demonstration and opening it to all states as currently enacted in its authorizing legislation. The demonstration has shown positive impacts across some outcomes, and implementation experiences point to its potential. Based on the available evidence, we recommend Congress continue to support CCBHCs through the demonstration and look for opportunities to support the growth of the CCBHC model. Continued federal support for the demonstration as planned would equip existing and new CCBHCs with essential resources to deliver consistent access to comprehensive, evidence-based services, such as psychiatric rehabilitation and job training through supported employment, that promote stability, independence, and improved health outcomes. Ending the demonstration before its scheduled conclusion would risk the elimination of some existing CCBHCs and give states less flexibility and incentives to enhance behavioral health services.

Implementing the CCBHC model represents a fundamental transformation of outpatient behavioral health service delivery and a significant evolution of traditional practice that requires different financing structures, expanded clinical and operational capacity, and strengthened state oversight. Although some states are working to expand CCBHCs under Medicaid state plan authority, others may lack the legislative or administrative support, internal capacity, or technical expertise needed to independently establish a CCBHC program; these states may benefit from the demonstration's financial supports and incentives to implement the model prior to making changes to their Medicaid program. The federal supports available under the demonstration, including planning grants, an enhanced FMAP, and a structured technical assistance framework that fosters peer learning among states, have been essential in helping states and their clinics build infrastructure and capabilities needed for model implementation. These resources provide up-front funding to make needed changes, and ongoing support as states assess program costs and benefits. They serve as strong incentives for states to take on the financial and operational risk associated with implementing and refining changes to enhance their behavioral health delivery system.

Moreover, the demonstration facilitates continued collaboration among federal and state agencies and participating clinics to further refine and develop the model as an integral element of the broader behavioral health system. Sustaining the demonstration as planned will preserve the progress made to date and strengthen states' efforts to build stable, sustainable behavioral health systems that respond effectively to local needs.

The needs of states and clinics as the demonstration matures and states graduate from the demonstration, along with opportunities for alignment across broader CCBHC initiatives, should also be considered. In addition to the demonstration, the CCBHC initiative has grown substantially, with SAMHSA expansion grants awarded to clinics in 46 states, the District of Columbia, and Puerto Rico. Many states are also launching CCBHC programs through Medicaid state plan authorities outside of the demonstration. This growth is expected to continue as states transition from the CCBHC demonstration to programs supported under alternative Medicaid authorities. As the model continues to mature and longstanding underinvestment in behavioral health services begins to be addressed, states and the federal

government will need to maintain strong oversight to monitor progress, assess efficiency, and ensure that the model continues to deliver high-quality, sustainable care. Recognizing this evolving landscape, a federal strategy could promote a more coordinated and consistent approach that supports alignment across all CCBHC funding mechanisms and efforts.

To advance a more comprehensive strategy, the Department of Health and Human Services may consider options to better support collective understanding and oversight across the CCBHC initiative, including exploring how different funding mechanisms and program structures such as SAMHSA grants, the Medicaid demonstration, and state plan amendments interact, complement one another, or leave gaps that could be addressed through more coordinated design. For example, policymakers could consider whether SAMHSA's expansion grant funding might be deployed more strategically to support the uncompensated care needs of CCBHCs that operate under state Medicaid authorities or assess whether formula-based funding approaches would provide a more stable and predictable source of support for these clinics than competitive expansion grants. These strategies may help address persistent challenges identified by demonstration states and clinics, and enhance the long-term sustainability of state CCBHC programs.

Strengthening federal capacity for consistent data collection, analysis, and reporting across all CCBHC programs could also lay the groundwork for improved coordination and alignment across the CCBHC initiative. CCBHCs are currently supported by the demonstration, SAMHSA expansion grants, and state Medicaid programs using authorities separate from the demonstration. A robust national data infrastructure with standardized performance measures and reporting, regardless of funding source or program structure, could enable an integrated view of how the model functions and inform improvements across funding streams. Timely sharing of data with states and individual clinics could promote evidence-based decision-making and better facilitate learning and accountability across the broader CCBHC initiative. Federal agencies may also wish to explore opportunities to build on existing technical assistance structures and offer more unified and consistent technical assistance to states participating across funding mechanisms in key operational areas, such as cost reporting and quality monitoring.

F. Future evaluation activities

In each year of the evaluation, we will submit an annual report synthesizing findings related to changes in demonstration implementation and answering additional evaluation questions related to the PAMA topics. In future evaluation reports, we will incorporate findings from additional interviews with state officials, clinic-level surveys, cost reports and quality measures submitted by states and CCBHCs, and interviews with leaders at CCBHCs. We also will present data from CCBHC client focus groups to better understand the experiences of people receiving care at CCBHCs.

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Appendices

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Appendix A. Supplemental CCBHC Survey Findings

Exhibit A.1. Number of demonstration CCBHCs included in CCBHC survey, by year

State	Number of CCBHCs included		
	2018	2023	2024
Kentucky	n.a.	4	4
Michigan	n.a.	13	13
Minnesota	6	4	6
Missouri	15	15	20
Nevada	4	3	n.a.
New Jersey	7	7	7
New York	13	13	13
Oklahoma	3	3	3
Oregon	12	10	12
Pennsylvania	7	n.a.	n.a.
Total	67	72	78

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, 2023 CCBHC survey, and 2018 CCBHC Annual Progress Report Demonstration Year 1.

Notes: Since the launch of the demonstration in 2017, two of the original states ended their participation. Pennsylvania chose not to continue participating after the first two years. Nevada ended its participation in the demonstration on July 1, 2023. Both states are continuing to fund CCBHCs under separate Medicaid authorities. Additionally, Minnesota briefly ended its participation on December 31, 2022, but rejoined the demonstration on July 1, 2023. Michigan and Kentucky joined the demonstration under the CARES Act in 2021 and 2022, respectively. See section I.B for more information.

CARES = CCBHC = Certified Community Behavioral Health Clinic; n.a. = not applicable.

A. Access to care

Exhibit A.2. CCBHCs providing services outside of the physical clinic space, 2023 and 2024

Services outside the clinic	2023		2024	
	N	%	N	%
Physically provides services in locations outside of the clinic	67	93	74	95

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, and 2023 CCBHC survey.

Notes: The denominator for CCBHC percentage calculations and each location is the total number of survey respondents in that year (n = 72 in 2023, n = 78 in 2024). Excludes telehealth services.

CCBHC = Certified Community Behavioral Health Clinic.

Exhibit A.3. CCBHCs providing services outside of the physical clinic space, by service location, 2023 and 2024

Service location	2023		2024	
	N	%	N	%
Clients' homes	64	89	73	94
Schools	62	86	69	88
Social service organizations	56	78	59	76
Courts, jails, police stations or law enforcement offices	56	78	67	86
Emergency departments	50	69	60	77
Hospitals	47	65	53	68
Restaurants, coffee shops	47	65	54	69
Shelters	47	65	58	74
Libraries	43	60	50	64
Parole offices	37	51	41	53
Other community locations	28	39	36	46

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, and 2023 CCBHC survey.

Notes: The denominator for CCBHC percentage calculations and each location is the total number of survey respondents in that year (n = 72 in 2023, n = 78 in 2024). "Other community locations" reported by clinics included service provision on the street, in parks, and in homeless camps; through mobile crisis services; in doctors' and pediatricians' offices; in transitional living facilities; and in community venues such as senior centers and churches.

CCBHC = Certified Community Behavioral Health Clinic.

Exhibit A.4. CCBHCs providing services outside of the physical clinic space, by state, 2024

Service location	State, 2024																Average percentage of CCBHCs across states, 2024
	KY		MI		MN		MO		NJ		NY		OK		OR		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Clients' homes	4	100	12	92	6	100	20	100	5	71	11	85	3	100	12	100	94
Hospitals	3	75	11	85	3	50	16	80	3	43	4	31	2	67	11	92	68
Emergency departments	3	75	11	85	3	50	18	90	3	43	7	54	3	100	12	100	77
Restaurants, coffee shops	1	25	11	85	5	83	12	60	4	57	9	69	2	67	10	83	69
Shelters	4	100	12	92	5	83	13	65	3	43	9	69	3	100	9	75	74
Social service organizations	2	50	10	77	4	67	16	80	5	71	9	69	3	100	10	83	76
Schools	4	100	12	92	6	100	20	100	5	71	7	54	3	100	12	100	88
Parole offices	1	25	8	62	3	50	12	60	3	43	4	31	1	33	9	75	53
Courts, jails, police stations or law enforcement offices	4	100	11	85	4	67	19	95	5	71	9	69	3	100	12	100	86
Libraries	2	50	10	77	6	100	16	80	4	57	4	31	2	67	6	50	64
Other community locations	2	50	5	38	3	50	11	55	1	14	6	46	3	100	5	42	46

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year.

Notes: The denominators for the state percentage calculations are the total number of CCBHCs responding to the survey in each state in 2024 (see Appendix Exhibit A.1). The denominator for the average percentage calculation is the total number of

CCBHCs responding to the survey in 2024: 78. “Other community locations” reported by clinics in write-in responses included service provision on the street, in parks, and in homeless camps; through mobile crisis services; in doctors’ and pediatricians’ offices; in transitional living facilities; and in community venues such as senior centers and churches.

CCBHC = Certified Community Behavioral Health Clinic.

Exhibit A.5. CCBHCs offering services by telehealth, by state, 2024

Type of service offered by telehealth	State, 2024																Average percentage of CCBHCs across states
	KY		MI		MN		MO		NJ		NY		OK		OR		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Crisis services	4	100	11	85	4	67	18	90	7	100	13	100	3	100	8	67	87
Screening, assessment, and diagnosis	4	100	12	92	6	100	16	80	7	100	12	92	3	100	11	92	91
Outpatient mental health	4	100	12	92	6	100	19	95	7	100	13	100	3	100	11	92	96
Outpatient SUD services	4	100	11	85	5	83	15	75	7	100	13	100	3	100	11	92	88
Targeted case management	3	75	9	69	6	100	12	60	7	100	12	92	3	100	12	100	82
Primary care screening and monitoring	3	75	4	31	4	67	8	40	5	71	12	92	2	67	7	58	58
Person- and family-centered treatment planning services	4	100	11	85	6	100	15	75	7	100	11	85	3	100	12	100	88
Psychiatric rehabilitation services	2	50	5	38	6	100	13	65	5	71	12	92	2	67	9	75	69
Peer supports, peer counseling, and family/ caregiver supports	4	100	8	62	6	100	16	80	7	100	13	100	3	100	12	100	88
Community care for uniformed service members and veterans	4	100	9	69	6	100	8	40	5	71	11	85	2	67	10	83	71

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year.

Notes: The denominators for the state percentage calculations are the total number of CCBHCs responding to the survey in each state in 2024 (see Appendix Exhibit A.1). The denominator for the average percentage calculation is the total number of CCBHCs responding to the survey in 2024: 78.

CCBHC = Certified Community Behavioral Health Clinic; SUD = substance use disorder.

B. Quality and scope of services

Exhibit A.6. CCBHCs providing services directly or by DCO, 2018 and 2024

Service	Provided directly				Provided by DCO				Provided directly or by DCO			
	2018		2024		2018		2024		2018		2024	
	N	%	N	%	N	%	N	%	N	%	N	%
Crisis behavioral health services	n.a.	n.a.	74	95	n.a.	n.a.	24	31	67	100	78	100
24-hour mobile crisis teams	49	73	66	85	23	34	18	23	65	97	76	97
Emergency crisis intervention	59	88	73	94	20	30	19	24	67	100	77	99
Crisis stabilization	60	90	67	86	14	21	11	14	66	99	70	90
Suicide prevention and intervention	n.a.	n.a.	76	97	n.a.	n.a.	15	19	n.a.	n.a.	78	100
Services capable of addressing crises related to substance use, including overdose prevention	n.a.	n.a.	76	97	n.a.	n.a.	15	19	n.a.	n.a.	78	100
Screening, assessment, and diagnosis	n.a.	n.a.	78	100	n.a.	n.a.	7	9	67	100	78	100
Mental health screening, assessment, diagnostic services	67	100	78	100	4	6	5	6	67	100	78	100
Substance use disorder screening, assessment, diagnostic services	67	100	77	99	3	4	7	9	67	100	78	100
Person- and family-centered treatment planning services	66	99	76	97	5	7	5	6	66	99	76	97
Outpatient mental health and/or SUD services	n.a.	n.a.	77	99	n.a.	n.a.	5	6	67	100	78	100
Outpatient mental health counseling	67	100	77	99	0	0	6	8	67	100	78	100
Outpatient SUD treatment	67	100	75	96	0	0	5	6	67	100	77	99
Motivational interviewing ^a	67	100	77	99	2	3	7	9	67	100	77	99
Individual CBT ^a	67	100	76	97	0	0	5	6	67	100	76	97
Group CBT ^a	56	84	66	85	0	0	2	3	56	84	66	85
Online CBT ^a	7	10	39	50	0	0	0	0	7	10	39	50
Trauma-focused CBT ^a	n.a.	n.a.	70	90	n.a.	n.a.	5	6	n.a.	n.a.	70	90
Dialectical behavioral therapy ^a	49	73	67	86	0	0	4	5	49	73	67	86
Coordinated specialty care for first episode psychosis ^{a,b}	n.a.	n.a.	42	54	n.a.	n.a.	2	3	n.a.	n.a.	42	54
Multi-systemic therapy ^a	27	40	35	45	0	0	1	1	27	40	35	45
Assertive community treatment (ACT) ^a	30	45	40	51	1	1	5	6	31	46	44	56
Forensic ACT ^a	6	9	9	12	0	0	0	0	6	9	9	12
Evidence-based medication evaluation and management ^a	58	87	72	92	0	0	3	4	58	87	73	94
Methadone ^c	n.a.	n.a.	10	13	n.a.	n.a.	13	17	n.a.	n.a.	22	28

Appendix A. Supplemental CCBHC Survey Findings

Service	Provided directly				Provided by DCO				Provided directly or by DCO			
	2018		2024		2018		2024		2018		2024	
	N	%	N	%	N	%	N	%	N	%	N	%
Buprenorphine ^c	n.a.	n.a.	67	86	n.a.	n.a.	5	6	n.a.	n.a.	71	91
Other FDA-approved medications for opioid, alcohol, and tobacco use disorders ^c	n.a.	n.a.	69	88	n.a.	n.a.	5	6	n.a.	n.a.	72	92
Therapeutic foster care ^a	4	6	5	6	1	1	2	3	5	7	7	9
Community wraparound services for youth/children ^a	50	75	59	76	2	3	3	4	51	76	60	77
Specialty mental health/SUD services for children and youth	58	87	61	78	0	0	4	5	58	87	62	79
Seeking safety ^{a,h}	n.a.	n.a.	41	53	n.a.	n.a.	4	5	n.a.	n.a.	42	54
Psychiatric rehabilitation services	n.a.	n.a.	75	96	n.a.	n.a.	5	6	67	100	76	97
Medication education	65	97	74	95	3	4	2	3	66	99	74	95
Self-management	63	94	71	91	5	7	3	4	65	97	72	92
Skills training	64	96	74	95	5	7	5	6	66	99	75	96
Psychoeducation	64	96	74	95	5	7	3	4	66	99	75	96
Community integration services	61	91	71	91	4	6	5	6	64	96	72	92
Illness management and recovery	62	93	67	86	4	6	1	1	65	97	67	86
Financial management	61	91	59	76	5	7	2	3	64	96	60	77
Wellness education services (diet, nutrition, exercise, tobacco cessation, etc.)	65	97	75	96	6	9	5	6	67	100	76	97
Supported housing	43	64	56	72	5	7	2	3	47	70	57	73
Help for clients to find and maintain safe and stable housing	n.a.	n.a.	74	95	n.a.	n.a.	3	4	n.a.	n.a.	75	96
Supported employment	45	67	64	82	5	7	5	6	50	75	68	87
Individual placement and support	n.a.	n.a.	63	81	n.a.	n.a.	1	1	n.a.	n.a.	63	81
Support for clients to participate in education ^d	n.a.	n.a.	68	87	n.a.	n.a.	3	4	n.a.	n.a.	70	90
Support for clients to achieve social inclusion and community connectedness	n.a.	n.a.	74	95	n.a.	n.a.	5	6	n.a.	n.a.	75	96
Peer support services ^e	n.a.	n.a.	78	100	n.a.	n.a.	4	5	67	100	78	100
Peer specialists	n.a.	n.a.	78	100	n.a.	n.a.	5	6	n.a.	n.a.	78	100
Peer counseling	n.a.	n.a.	66	85	n.a.	n.a.	2	3	n.a.	n.a.	66	85
Family/caregiver supports ^f	n.a.	n.a.	73	94	n.a.	n.a.	5	6	n.a.	n.a.	75	96
Targeted case management	62	93	69	88	1	1	3	4	63	94	69	88

Appendix A. Supplemental CCBHC Survey Findings

Service	Provided directly				Provided by DCO				Provided directly or by DCO			
	2018		2024		2018		2024		2018		2024	
	N	%	N	%	N	%	N	%	N	%	N	%
Primary care screening and monitoring ^g	63	94	68	87	3	4	14	18	65	97	76	97
Testing for hepatitis	n.a.	n.a.	38	49	n.a.	n.a.	12	15	n.a.	n.a.	49	63
Tuberculosis screening	n.a.	n.a.	41	53	n.a.	n.a.	8	10	n.a.	n.a.	47	60
HIV screening	n.a.	n.a.	49	63	n.a.	n.a.	12	15	n.a.	n.a.	59	76
Tobacco use screening	n.a.	n.a.	72	92	n.a.	n.a.	7	9	n.a.	n.a.	76	97
Cholesterol screening	n.a.	n.a.	46	59	n.a.	n.a.	10	13	n.a.	n.a.	54	69
Triglyceride testing	n.a.	n.a.	45	58	n.a.	n.a.	9	12	n.a.	n.a.	53	68
Waist circumference screening	n.a.	n.a.	54	69	n.a.	n.a.	6	8	n.a.	n.a.	58	74
Weight	n.a.	n.a.	74	95	n.a.	n.a.	5	6	n.a.	n.a.	76	97
Blood pressure screening	n.a.	n.a.	71	91	n.a.	n.a.	5	6	n.a.	n.a.	73	94
Blood sugar testing	n.a.	n.a.	50	64	n.a.	n.a.	6	8	n.a.	n.a.	55	71
Community care for uniformed service members and veterans	47	70	61	78	1	1	3	4	48	72	61	78

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, and 2018 CCBHC Annual Progress Report Demonstration Year 1.

Notes: The denominator for each service is the total number of survey respondents in that year (n = 67 in 2018, n = 78 in 2024). CCBHCs can report they both offer a service and have a relationship with a DCO to provide the same service. Services with "n.a." were not included in the 2018 CCBHC survey.

^a EBP referenced in the criteria.

^b The 2018 CCBHC survey included a broader category "first episode/early intervention for psychosis" which is not directly comparable with this specific EBP.

^c The 2018 CCBHC survey included a single category, "Medication-assisted treatment for alcohol and opioid use;" the 2024 CCBHC survey broke this broad category into specific medications so it is not directly comparable with 2018.

^d The 2018 CCBHC survey included the specific EBP "supported education" which is not comparable with this broader set of services.

^e The 2018 CCBHC survey included a single category "peer support services for consumers/clients;" the 2024 CCBHC survey broke this broad category into specific services "peer specialists" and "peer counseling" so it is not directly comparable with 2018.

^f The 2018 CCBHC survey included "peer support services for families," which is not directly comparable with this specific service.

^g The 2018 CCBHC survey did not include specific primary care screenings, instead asking about the overall category.

^h Seeking Safety is an evidence-based treatment that helps people with trauma, posttraumatic stress disorder, and substance misuse. CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization; EBP = evidence-based practice; FDA = Food and Drug Administration; HIV = human immunodeficiency virus; n.a. = not applicable; SUD = substance use disorder.

Exhibit A.7. CCBHCs providing services directly or by DCO, by state, 2024

Service	State, 2024																Average percentage of CCBHCs across states
	KY		MI		MN		MO		NJ		NY		OK		OR		
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	
Crisis behavioral health services	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
24-hour mobile crisis teams	4	100	13	100	6	100	20	100	7	100	12	92	3	100	11	92	97
Emergency crisis intervention	4	100	13	100	6	100	19	95	7	100	13	100	3	100	12	100	99
Crisis stabilization	4	100	12	92	6	100	15	75	6	86	12	92	3	100	12	100	90
Suicide prevention and intervention	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Services capable of addressing crises related to substance use, including overdose prevention	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Screening, assessment, and diagnosis	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Mental health screening, assessment, diagnostic services	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Substance use disorder screening, assessment, diagnostic services	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Person- and family-centered treatment planning services	4	100	13	100	6	100	18	90	7	100	13	100	3	100	12	100	100
Outpatient mental health and SUD Services	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Outpatient mental health counseling	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Outpatient SUD treatment	4	100	13	100	6	100	20	100	6	86	13	100	3	100	12	100	99
Motivational interviewing ^a	4	100	13	100	6	100	19	95	7	100	13	100	3	100	12	100	99
Individual CBT ^a	4	100	13	100	6	100	18	90	7	100	13	100	3	100	12	100	97
Group CBT ^a	2	50	12	92	6	100	14	70	7	100	12	92	3	100	10	83	85
Online CBT ^a	3	75	6	46	5	83	11	55	4	57	5	38	1	33	4	33	50
Trauma-focused CBT ^a	4	100	13	100	6	100	18	90	7	100	11	85	3	100	8	67	90
Dialectical behavioral therapy ^a	4	100	13	100	5	83	14	70	7	100	10	77	3	100	11	92	86
Coordinated specialty care for first episode psychosis ^a	4	100	7	54	1	17	6	30	3	43	8	62	2	67	11	92	54

Appendix A. Supplemental CCBHC Survey Findings

Service	State, 2024																Average percentage of CCBHCs across states
	KY		MI		MN		MO		NJ		NY		OK		OR		
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	%
Multi-systemic therapy ^a	1	25	8	62	5	83	6	30	1	14	7	54	3	100	4	33	45
Assertive community treatment (ACT) ^a	4	100	13	100	2	33	6	30	2	29	3	23	3	100	11	92	56
Forensic ACT ^a	0	0	2	15	0	0	1	5	1	14	1	8	0	0	4	33	12
Evidence-based medication evaluation and management ^a	4	100	12	92	6	100	19	95	6	86	13	100	3	100	10	83	94
Methadone	1	25	3	23	1	17	6	30	3	43	7	54	0	0	1	8	28
Buprenorphine	4	100	11	85	3	50	20	100	7	100	13	100	3	100	10	83	91
Other FDA-approved medications for opioid, alcohol, and tobacco use disorders	4	100	11	85	6	100	19	95	7	100	13	100	2	67	10	83	92
Therapeutic foster care ^a	0	0	4	31	2	33	1	5	0	0	0	0	0	0	0	0	9
Community wraparound services for youth/children ^a	4	100	13	100	4	67	17	85	3	43	5	38	3	100	11	92	77
Specialty mental health/SUD services for children and youth	4	100	8	62	6	100	18	90	4	57	10	77	2	67	10	83	79
Seeking safety ^{a,b}	4	100	10	77	2	33	4	20	4	57	6	46	3	100	9	75	54
Psychiatric rehabilitation services	4	100	13	100	6	100	20	100	7	100	13	100	3	100	10	83	97
Medication education	4	100	11	85	6	100	20	100	7	100	13	100	3	100	10	83	95
Self-management	4	100	12	92	6	100	20	100	7	100	13	100	2	67	8	67	92
Skills training	4	100	13	100	6	100	20	100	6	86	13	100	3	100	10	83	96
Psychoeducation	4	100	12	92	6	100	20	100	7	100	13	100	3	100	10	83	96
Community integration services	4	100	12	92	6	100	19	95	6	86	12	92	3	100	10	83	92
Illness management and recovery	4	100	10	77	6	100	18	90	7	100	13	100	2	67	7	58	86
Financial management	3	75	9	69	4	67	17	85	5	71	11	85	3	100	8	67	77
Wellness education services (diet, nutrition, exercise, tobacco cessation, etc.)	4	100	13	100	6	100	20	100	7	100	13	100	3	100	10	83	97
Supported housing	4	100	8	62	5	83	19	95	5	71	8	62	1	33	7	58	73
Help for clients to find and maintain safe and stable housing	4	100	13	100	6	100	19	95	7	100	13	100	3	100	10	83	96
Supported employment	4	100	13	100	5	83	18	90	6	86	12	92	1	33	9	75	87

Appendix A. Supplemental CCBHC Survey Findings

Service	State, 2024																Average percentage of CCBHCs across states
	KY		MI		MN		MO		NJ		NY		OK		OR		
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	%
Individual placement and support	4	100	11	85	3	50	16	80	5	71	13	100	3	100	8	67	81
Support for clients to participate in education	4	100	10	77	6	100	18	90	7	100	12	92	3	100	10	83	90
Support for clients to achieve social inclusion and community connectedness	4	100	13	100	6	100	19	95	7	100	13	100	3	100	10	83	96
Peer support services	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Peer specialists	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Peer counseling	3	75	9	69	5	83	16	80	6	86	13	100	3	100	11	92	85
Family/caregiver supports	3	75	13	100	5	83	20	100	7	100	13	100	3	100	11	92	96
Targeted case management	4	100	13	100	6	100	13	65	7	100	13	100	3	100	10	83	88
Primary care screening and monitoring	4	100	13	100	5	83	19	95	7	100	13	100	3	100	12	100	97
Testing for hepatitis	4	100	5	38	1	17	12	60	6	86	12	92	2	67	7	58	63
Tuberculosis screening	4	100	4	31	1	17	13	65	7	100	9	69	2	67	7	58	60
HIV screening	4	100	7	54	2	33	18	90	6	86	12	92	3	100	7	58	76
Tobacco use screening	4	100	13	100	6	100	19	95	7	100	13	100	3	100	11	92	97
Cholesterol screening	4	100	7	54	1	17	16	80	6	86	10	77	2	67	8	67	69
Triglyceride testing	4	100	7	54	1	17	15	75	6	86	10	77	2	67	8	67	68
Waist circumference screening	3	75	10	77	1	17	18	90	5	71	9	69	3	100	9	75	74
Weight	4	100	13	100	6	100	19	95	7	100	13	100	3	100	11	92	97
Blood pressure screening	4	100	13	100	5	83	18	90	7	100	13	100	3	100	10	83	94
Blood sugar testing	4	100	7	54	2	33	15	75	5	71	11	85	3	100	8	67	71
Community care for uniformed service members and veterans	4	100	13	100	4	67	10	50	7	100	12	92	2	67	9	75	78

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year.

Notes: The denominators for the state percentage calculations are the total number of CCBHCs responding to the survey in each state in 2024 (see Appendix Exhibit A.1). The denominator for the average percentage calculation is the total number of CCBHCs responding to the survey in 2024: 78. Services are not mutually exclusive.

^a EBP referenced in the criteria.

^b Seeking Safety is an evidence-based treatment that helps people with trauma, posttraumatic stress disorder, and substance misuse. ACT = Assertive Community Treatment; CCBHC = Certified Community Behavioral Health Clinic; CBT = Cognitive Behavioral Therapy; DCO = designated collaborating organization; EBP = evidence-based practice; FDA = Food and Drug Administration; HIV = human immunodeficiency virus; SUD = substance use disorder.

Exhibit A.8. CCBHCs providing services by DCO, by state, 2024

Service	State, 2024																Average percentage of CCBHCs across states
	KY		MI		MN		MO		NJ		NY		OK		OR		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Crisis behavioral health services	0	0	4	31	1	17	8	40	4	57	6	46	0	0	1	8	31
24-hour mobile crisis teams	0	0	3	23	2	33	4	20	4	57	4	31	0	0	1	8	23
Emergency crisis intervention	0	0	4	31	2	33	5	25	3	43	3	23	0	0	2	17	24
Crisis stabilization	0	0	3	23	1	17	2	10	2	29	2	15	0	0	1	8	14
Suicide prevention and intervention	0	0	5	38	1	17	4	20	2	29	2	15	0	0	1	8	19
Services capable of addressing crises related to substance use, including overdose prevention	0	0	5	38	1	17	4	20	2	29	1	8	0	0	2	17	19
Screening, assessment, and diagnosis	0	0	6	46	0	0	0	0	1	14	0	0	0	0	0	0	9
Mental health screening, assessment, diagnostic services	0	0	4	31	0	0	0	0	1	14	0	0	0	0	0	0	6
Substance use disorder screening, assessment, diagnostic services	0	0	5	38	0	0	0	0	1	14	1	8	0	0	0	0	9
Person- and family-centered treatment planning services	0	0	5	38	0	0	0	0	0	0	0	0	0	0	0	0	6
Outpatient mental health and SUD services	0	0	5	38	0	0	0	0	0	0	0	0	0	0	0	0	6
Outpatient mental health counseling	0	0	6	46	0	0	0	0	0	0	0	0	0	0	0	0	8
Outpatient SUD treatment	0	0	4	31	0	0	0	0	0	0	1	8	0	0	0	0	6
Motivational interviewing ^a	0	0	6	46	0	0	0	0	0	0	1	8	0	0	0	0	9
Individual CBT ^a	0	0	5	38	0	0	0	0	0	0	0	0	0	0	0	0	6
Group CBT ^a	0	0	2	15	0	0	0	0	0	0	0	0	0	0	0	0	3
Online CBT ^a	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Trauma-focused CBT ^a	0	0	5	38	0	0	0	0	0	0	0	0	0	0	0	0	6
Dialectical behavioral therapy ^a	0	0	4	31	0	0	0	0	0	0	0	0	0	0	0	0	5
Coordinated specialty care for first episode psychosis ^a	0	0	2	15	0	0	0	0	0	0	0	0	0	0	0	0	3

Appendix A. Supplemental CCBHC Survey Findings

Service	State, 2024																Average percentage of CCBHCs across states
	KY		MI		MN		MO		NJ		NY		OK		OR		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Multi-systemic therapy ^a	0	0	1	8	0	0	0	0	0	0	0	0	0	0	0	0	1
Assertive community treatment (ACT) ^a	0	0	3	23	0	0	0	0	1	14	1	8	0	0	0	0	6
Forensic ACT ^a	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Evidence-based medication evaluation and management ^a	0	0	3	23	0	0	0	0	0	0	0	0	0	0	0	0	4
Methadone	0	0	2	15	0	0	2	10	3	43	5	38	0	0	1	8	17
Buprenorphine	0	0	3	23	0	0	1	5	0	0	0	0	0	0	1	8	6
Other FDA-approved medications for opioid, alcohol, and tobacco use disorders	0	0	3	23	0	0	1	5	0	0	0	0	0	0	1	8	6
Therapeutic foster care ^a	0	0	2	15	0	0	0	0	0	0	0	0	0	0	0	0	3
Community wraparound services for youth/children ^a	0	0	1	8	0	0	0	0	0	0	1	8	0	0	1	8	4
Specialty mental health/SUD services for children and youth	0	0	2	15	0	0	0	0	0	0	1	8	0	0	1	8	5
Seeking safety ^{a,b}	0	0	3	23	0	0	0	0	0	0	0	0	0	0	1	8	5
Psychiatric rehabilitation services	0	0	5	38	0	0	0	0	0	0	0	0	0	0	0	0	6
Medication education	0	0	2	15	0	0	0	0	0	0	0	0	0	0	0	0	3
Self-management	0	0	3	23	0	0	0	0	0	0	0	0	0	0	0	0	4
Skills training	0	0	5	38	0	0	0	0	0	0	0	0	0	0	0	0	6
Psychoeducation	0	0	3	23	0	0	0	0	0	0	0	0	0	0	0	0	4
Community integration services	0	0	4	31	0	0	0	0	1	14	0	0	0	0	0	0	6
Illness management and recovery	0	0	1	8	0	0	0	0	0	0	0	0	0	0	0	0	1
Financial management	0	0	2	15	0	0	0	0	0	0	0	0	0	0	0	0	3
Wellness education services (diet, nutrition, exercise, tobacco cessation, etc.)	0	0	5	38	0	0	0	0	0	0	0	0	0	0	0	0	6
Supported housing	0	0	1	8	0	0	0	0	1	14	0	0	0	0	0	0	3
Help for clients to find and maintain safe and stable housing	0	0	3	23	0	0	0	0	0	0	0	0	0	0	0	0	4
Supported employment	0	0	3	23	0	0	1	5	1	14	0	0	0	0	0	0	6

Appendix A. Supplemental CCBHC Survey Findings

Service	State, 2024																Average percentage of CCBHCs across states
	KY		MI		MN		MO		NJ		NY		OK		OR		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Individual placement and support	0	0	1	8	0	0	0	0	0	0	0	0	0	0	0	0	1
Support for clients to participate in education	0	0	2	15	0	0	0	0	1	14	0	0	0	0	0	0	4
Support for clients to achieve social inclusion and community connectedness	0	0	4	31	0	0	0	0	1	14	0	0	0	0	0	0	6
Peer support services	0	0	3	23	0	0	0	0	1	14	0	0	0	0	0	0	5
Peer specialists	0	0	3	23	0	0	0	0	1	14	0	0	0	0	1	8	6
Peer counseling	0	0	1	8	0	0	0	0	1	14	0	0	0	0	0	0	3
Family/caregiver supports	0	0	3	23	0	0	1	5	1	14	0	0	0	0	0	0	6
Targeted case management	0	0	3	23	0	0	0	0	0	0	0	0	0	0	0	0	4
Primary care screening and monitoring	0	0	3	23	1	17	2	10	3	43	1	8	1	33	3	25	18
Testing for hepatitis	0	0	2	15	0	0	2	10	3	43	3	23	1	33	1	8	15
Tuberculosis screening	0	0	1	8	0	0	1	5	2	29	2	15	1	33	1	8	10
HIV screening	0	0	3	23	0	0	1	5	3	43	3	23	1	33	1	8	15
Tobacco use screening	0	0	3	23	0	0	1	5	0	0	1	8	1	33	1	8	9
Cholesterol screening	0	0	1	8	0	0	1	5	3	43	2	15	1	33	2	17	13
Triglyceride testing	0	0	1	8	0	0	1	5	2	29	2	15	1	33	2	17	12
Waist circumference screening	0	0	2	15	0	0	1	5	0	0	1	8	1	33	1	8	8
Weight	0	0	2	15	0	0	1	5	0	0	1	8	0	0	1	8	6
Blood pressure screening	0	0	2	15	0	0	1	5	0	0	1	8	0	0	1	8	6
Blood sugar testing	0	0	0	0	0	0	1	5	1	14	1	8	1	33	2	17	8
Community care for uniformed service members and veterans	0	0	1	8	0	0	0	0	2	29	0	0	0	0	0	0	4

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year.

Notes: The denominators for the state percentage calculations are the total number of CCBHCs responding to the survey in each state in 2024 (see Appendix Exhibit A.1). The denominator for the average percentage calculation is the total number of CCBHCs responding to the survey in 2024: 78. Services are not mutually exclusive. CCBHCs can report they both offer a service and have a relationship with a DCO to provide the same service. The percentages above reflect CCBHCs with a DCO relationship for each respective service, regardless of whether the CCBHC also provides the service.

^a EBP referenced in the certification criteria.

^b Seeking Safety is an evidence-based treatment that helps people with trauma, posttraumatic stress disorder, and substance misuse.

CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization; EBP = evidence-based practice; FDA = Food and Drug Administration; HIV = human immunodeficiency virus; SUD = substance use disorder.

Exhibit A.9. CCBHCs providing services directly, by state, 2024

Service	State, 2024																Average percentage of CCBHCs across states
	KY		MI		MN		MO		NJ		NY		OK		OR		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Crisis behavioral health services	4	100	12	92	5	83	20	100	6	86	12	92	3	100	12	100	95
24-hour mobile crisis teams	4	100	11	85	4	67	18	90	5	71	10	77	3	100	11	92	85
Emergency crisis intervention	4	100	12	92	4	67	19	95	7	100	12	92	3	100	12	100	94
Crisis stabilization	4	100	10	77	5	83	15	75	6	86	12	92	3	100	12	100	86
Suicide prevention and intervention	4	100	12	92	5	83	20	100	7	100	13	100	3	100	12	100	97
Services capable of addressing crises related to substance use, including overdose prevention	4	100	12	92	5	83	20	100	7	100	13	100	3	100	12	100	97
Screening, assessment, and diagnosis	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Mental health screening, assessment, diagnostic services	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Substance use disorder screening, assessment, diagnostic services	4	100	12	92	6	100	20	100	7	100	13	100	3	100	12	100	99
Person- and family-centered treatment planning services	4	100	13	100	6	100	18	90	7	100	13	100	3	100	12	100	97
Outpatient mental health and SUD services	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Outpatient mental health counseling	4	100	12	92	6	100	20	100	7	100	13	100	3	100	12	100	99
Outpatient SUD treatment	4	100	11	85	6	100	20	100	6	86	13	100	3	100	12	100	96
Motivational interviewing ^a	4	100	13	100	6	100	19	95	7	100	13	100	3	100	12	100	99
Individual CBT ^a	4	100	13	100	6	100	18	90	7	100	13	100	3	100	12	100	97
Group CBT ^a	2	50	12	92	6	100	14	70	7	100	12	92	3	100	10	83	85
Online CBT ^a	3	75	6	46	5	83	11	55	4	57	5	38	1	33	4	33	50
Trauma-focused CBT ^a	4	100	13	100	6	100	18	90	7	100	11	85	3	100	8	67	90
Dialectical behavioral therapy ^a	4	100	13	100	5	83	14	70	7	100	10	77	3	100	11	92	86
Coordinated specialty care for first episode psychosis ^a	4	100	7	54	1	17	6	30	3	43	8	62	2	67	11	92	54

Appendix A. Supplemental CCBHC Survey Findings

Service	State, 2024																Average percentage of CCBHCs across states
	KY		MI		MN		MO		NJ		NY		OK		OR		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Multi-systemic therapy ^a	1	25	8	62	5	83	6	30	1	14	7	54	3	100	4	33	45
Assertive community treatment (ACT) ^a	4	100	11	85	2	33	6	30	1	14	2	15	3	100	11	92	51
Forensic ACT ^a	0	0	2	15	0	0	1	5	1	14	1	8	0	0	4	33	12
Evidence-based medication evaluation and management ^a	4	100	11	85	6	100	19	95	6	86	13	100	3	100	10	83	92
Methadone	1	25	2	15	1	17	4	20	0	0	2	15	0	0	0	0	13
Buprenorphine	4	100	9	69	3	50	19	95	7	100	13	100	3	100	9	75	86
Other FDA-approved medications for opioid, alcohol, and tobacco use disorders	4	100	10	77	6	100	18	90	7	100	13	100	2	67	9	75	88
Therapeutic foster care ^a	0	0	2	15	2	33	1	5	0	0	0	0	0	0	0	0	6
Community wraparound services for youth/children ^a	4	100	13	100	4	67	17	85	3	43	4	31	3	100	11	92	76
Specialty mental health/SUD services for children and youth	4	100	8	62	6	100	18	90	4	57	9	69	2	67	10	83	78
Seeking safety ^{a,b}	4	100	9	69	2	33	4	20	4	57	6	46	3	100	9	75	53
Psychiatric rehabilitation services	4	100	12	92	6	100	20	100	7	100	13	100	3	100	10	83	96
Medication education	4	100	11	85	6	100	20	100	7	100	13	100	3	100	10	83	95
Self-management	4	100	11	85	6	100	20	100	7	100	13	100	2	67	8	67	91
Skills training	4	100	12	92	6	100	20	100	6	86	13	100	3	100	10	83	95
Psychoeducation	4	100	11	85	6	100	20	100	7	100	13	100	3	100	10	83	95
Community integration services	4	100	11	85	6	100	19	95	6	86	12	92	3	100	10	83	91
Illness management and recovery	4	100	10	77	6	100	18	90	7	100	13	100	2	67	7	58	86
Financial management	3	75	8	62	4	67	17	85	5	71	11	85	3	100	8	67	76
Wellness education services (diet, nutrition, exercise, tobacco cessation, etc.)	4	100	12	92	6	100	20	100	7	100	13	100	3	100	10	83	96
Supported housing	4	100	8	62	5	83	19	95	4	57	8	62	1	33	7	58	72
Help for clients to find and maintain safe and stable housing	4	100	12	92	6	100	19	95	7	100	13	100	3	100	10	83	95
Supported employment	4	100	11	85	5	83	17	85	5	71	12	92	1	33	9	75	82

Appendix A. Supplemental CCBHC Survey Findings

Service	State, 2024																Average percentage of CCBHCs across states
	KY		MI		MN		MO		NJ		NY		OK		OR		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Individual placement and support	4	100	11	85	3	50	16	80	5	71	13	100	3	100	8	67	81
Support for clients to participate in education	4	100	9	69	6	100	18	90	6	86	12	92	3	100	10	83	87
Support for clients to achieve social inclusion and community connectedness	4	100	12	92	6	100	19	95	7	100	13	100	3	100	10	83	95
Peer support services	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Peer specialists	4	100	13	100	6	100	20	100	7	100	13	100	3	100	12	100	100
Peer counseling	3	75	9	69	5	83	16	80	6	86	13	100	3	100	11	92	85
Family/caregiver supports	3	75	13	100	5	83	19	95	6	86	13	100	3	100	11	92	94
Targeted case management	4	100	13	100	6	100	13	65	7	100	13	100	3	100	10	83	88
Primary care screening and monitoring	4	100	13	100	4	67	17	85	6	86	12	92	2	67	10	83	87
Testing for hepatitis	4	100	3	23	1	17	10	50	4	57	9	69	1	33	6	50	49
Tuberculosis screening	4	100	4	31	1	17	12	60	6	86	7	54	1	33	6	50	53
HIV screening	4	100	5	38	2	33	17	85	4	57	9	69	2	67	6	50	63
Tobacco use screening	4	100	13	100	6	100	18	90	7	100	12	92	2	67	10	83	92
Cholesterol screening	4	100	7	54	1	17	15	75	4	57	8	62	1	33	6	50	59
Triglyceride testing	4	100	7	54	1	17	14	70	4	57	8	62	1	33	6	50	58
Waist circumference screening	3	75	10	77	1	17	17	85	5	71	8	62	2	67	8	67	69
Weight	4	100	13	100	6	100	18	90	7	100	12	92	3	100	11	92	95
Blood pressure screening	4	100	13	100	5	83	17	85	7	100	12	92	3	100	10	83	91
Blood sugar testing	4	100	7	54	2	33	14	70	5	71	10	77	2	67	6	50	64
Community care for uniformed service members and veterans	4	100	13	100	4	67	10	50	7	100	12	92	2	67	9	75	78

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year.

Notes: The denominators for the state percentage calculations are the total number of CCBHCs responding to the survey in each state in 2024 (see Appendix Exhibit A.1). The denominator for the average percentage calculation is the total number of CCBHCs responding to the survey in 2024: 78. Services are not mutually exclusive.

^a EBP referenced in the certification criteria.

^b Seeking Safety is an evidence-based treatment that helps people with trauma, posttraumatic stress disorder, and substance misuse. CCBHC = Certified Community Behavioral Health Clinic; FDA = Food and Drug Administration; HIV = human immunodeficiency virus; SUD = substance use disorder.

Exhibit A.10. CCBHCs providing primary care screening and monitoring and on-site primary care, 2018 and 2024

Primary care service	2018		2024	
	N	%	N	%
Provided primary care screening and monitoring directly	63	94	68	87
Provided primary care screening and monitoring by DCO	3	4	14	18
Provided other on-site primary care services	37	55	39	50
Had a primary care clinician on staff or under contract	n.a.	n.a.	31	40

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year, and 2018 CCBHC Annual Progress Report Demonstration Year 1.

Notes: The denominator for each category is the total number of survey respondents in that year (n = 67 in 2018, n = 78 in 2024). Categories are not mutually exclusive. Categories with “n.a.” were not included in the 2018 CCBHC survey.

CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization; n.a. = not applicable.

Exhibit A.11. CCBHCs providing primary care screening and monitoring and on-site primary care, 2024

On-site or other primary care	State, 2024																Average percentage of CCBHCs across states
	KY		MI		MN		MO		NJ		NY		OK		OR		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Provided primary care screening and monitoring directly	4	100	13	100	4	67	17	85	6	86	12	92	2	67	10	83	87
Provided primary care screening and monitoring by DCO	0	0	3	23	1	17	2	10	3	43	1	8	1	33	3	25	18
Provided other on-site primary care services	4	100	6	46	0	0	10	50	3	43	4	31	2	67	10	83	50
Had a primary care clinician on staff or under contract	4	100	3	23	0	0	8	40	2	29	4	31	2	67	8	67	40

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year.

Notes: The denominators for the state percentage calculations are the total number of CCBHCs responding to the survey in each state in 2024 (see Appendix Exhibit A.1). The denominator for the average percentage calculation is the total number of CCBHCs responding to the survey in 2024: 78. Categories are not mutually exclusive.

CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization.

C. Costs

Exhibit A.12. CCBHCs reporting services and activities supported by the PPS, by state, 2024

Service type	State, 2024																Average percentage of CCBHCs across states
	KY		MI		MN		MO		NJ		NY		OK		OR		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	%
Services not previously reimbursed under Medicaid state plan	4	100	7	54	3	50	15	75	7	100	10	77	3	100	6	50	71
Staff or staff types not previous supported by traditional Medicaid or other reimbursement mechanisms	4	100	8	62	5	83	16	80	7	100	10	77	3	100	9	75	79
Access improvements (e.g., open access scheduling, transportation)	4	100	9	69	3	50	14	70	6	86	6	46	2	67	7	58	65
Data collection or quality improvement activities (e.g., data dashboards)	4	100	9	69	5	83	11	55	5	71	6	46	3	100	5	42	62
Other activities to support the CCBHC model (e.g., training, staff meetings)	3	75	9	69	4	67	12	60	5	71	10	77	3	100	3	25	63
Other activities not previously supported by traditional Medicaid or other reimbursement mechanisms	0	0	1	8	2	33	4	20	1	14	4	31	1	33	2	17	19

Source: 2024 survey of CCBHCs participating in the demonstration for at least one year.

Notes: The denominators for the state percentage calculations are the total number of CCBHCs responding to the survey in each state in 2024 (see Appendix Exhibit A.1). The denominator for the average percentage calculation is the total number of CCBHCs responding to the survey in 2024: 78. Categories are not mutually exclusive.

CCBHC = Certified Community Behavioral Health Clinic; PPS = prospective payment system.

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Appendix B. Characteristics of People Served by CCBHCs

Exhibit B.1. Number of CCBHCs included in analyses of people served, by state and year

State	2018	2019	2020	2021	2022	2023
Kentucky	n.a.	n.a.	n.a.	n.a.	4	4
Michigan	n.a.	n.a.	n.a.	n.a.	13	13
Minnesota	6	6	6	6	6	NA
Missouri	15	15	15	15	15	21
New Jersey	7	7	7	7	7	7
New York	13	13	13	13	13	13
Oklahoma	3	3	3	3	3	3
Oregon	12	12	9	9	10	12

Source: CCBHC quality measure reports.

Notes: One clinic in New Jersey did not provide insurance status of people served in 2021; no explanation was provided.

CCBHC = Certified Community Behavioral Health Clinic; n.a. = not applicable; NA = not available

Exhibit B.2. Age and sex of people served by original state CCBHCs, by state and year

	Number of CCBHCs	Denominator	Child/ adolescent age 0–17 years	Adult age 18+ years	Gender female	Gender male	Gender other option or not reported
DY1 Aggregate	56	286,089	24%	76%	52%	48%	0%
DY2 Aggregate	56	308,831	24%	76%	51%	48%	1%
DY3 Aggregate	53	303,911	24%	76%	52%	48%	0%
DY4 Aggregate	53	315,349	24%	76%	53%	46%	1%
DY5 Aggregate	54	340,334	25%	75%	53%	46%	1%
DY6 Aggregate	56	383,816	25%	75%	53%	46%	1%
Minnesota DY1	6	23,027	27%	73%	51%	49%	0%
Minnesota DY2	6	25,402	26%	74%	50%	49%	0%
Minnesota DY3	6	23,935	25%	75%	50%	50%	0%
Minnesota DY4	6	20,725	27%	73%	51%	47%	2%
Minnesota DY5	6	23,586	29%	71%	52%	48%	0%
Minnesota DY6	NA	NA	NA	NA	NA	NA	NA
Missouri DY1	15	121,787	24%	76%	53%	47%	0%
Missouri DY2	15	132,565	26%	74%	52%	47%	0%
Missouri DY3	15	137,753	26%	74%	53%	47%	0%
Missouri DY4	15	145,949	25%	75%	54%	45%	0%
Missouri DY5	15	159,468	26%	74%	54%	46%	0%
Missouri DY6	21	211,875	26%	74%	53%	46%	1%
New Jersey DY1	7	17,851	19%	81%	56%	44%	0%
New Jersey DY2	7	19,129	18%	82%	55%	44%	0%
New Jersey DY3	7	20,396	15%	85%	56%	44%	0%

Appendix B. Characteristics of People Served by CCBHCs

	Number of CCBHCs	Denominator	Child/ adolescent age 0–17 years	Adult age 18+ years	Gender female	Gender male	Gender other option or not reported
New Jersey DY4	7	21,742	14%	86%	57%	43%	0%
New Jersey DY5	7	20,121	14%	86%	58%	42%	0%
New Jersey DY6	7	21,816	14%	86%	59%	41%	0%
New York DY1	13	49,903	22%	78%	48%	52%	0%
New York DY2	13	55,693	22%	78%	48%	52%	0%
New York DY3	13	57,377	22%	78%	49%	51%	0%
New York DY4	13	62,972	23%	77%	52%	48%	0%
New York DY5	13	68,248	25%	75%	52%	47%	0%
New York DY6	13	69,306	25%	75%	52%	47%	1%
Oklahoma DY1	3	20,610	25%	75%	52%	48%	0%
Oklahoma DY2	3	22,741	27%	73%	52%	48%	0%
Oklahoma DY3	3	24,647	28%	70%	51%	48%	0%
Oklahoma DY4	3	25,583	28%	72%	53%	47%	0%
Oklahoma DY5	3	27,201	28%	71%	53%	47%	0%
Oklahoma DY6	3	35,984	27%	73%	53%	47%	0%
Oregon DY1	12	52,911	24%	76%	52%	48%	1%
Oregon DY2	12	53,301	24%	76%	50%	46%	3%
Oregon DY3	9	39,803	22%	78%	51%	46%	2%
Oregon DY4	9	38,378	21%	79%	52%	45%	4%
Oregon DY5	10	41,710	21%	79%	51%	45%	3%
Oregon DY6	12	44,835	25%	77%	57%	50%	3%

Source: CCBHC quality measure reports.

Notes: Denominators are the number of people CCBHCs served by state each DY. Minnesota data are not available for DY6 because of a temporary pause in activity and reporting in the state. Missouri counts include data on all CCBHCs in the state each year, which includes 15 clinics in DY 1–5. The count includes 21 clinics in DY6, reflecting an administrative merger of two of the 15 original clinics and the addition of seven clinics. Oregon counts include data on all CCBHCs in the state each year: 12 clinics in DY1–2, nine clinics in DY3–4, 10 clinics in DY5, and 12 clinics in DY6. Although the three clinics were recertified between 2021–2023, they did not immediately return to their initial numbers served. DY1 = 2017–2018, DY2 = 2018–2019, DY3 = 2019–2020, DY4 = 2020–2021, DY5 = 2021–2022, DY6 = 2022–2023.

CCBHC = Certified Community Behavioral Health Clinic; DY = demonstration year; NA = not available.

Exhibit B.3. Age and gender of people served by CARES Act state CCBHCs, by state and year

	Number of CCBHCs	Denominator	Child/ adolescent age 0–17 years	Adult age 18+ years	Gender female	Gender male	Gender other option or not reported
DY1 Aggregate	17	133,269	28%	72%	50%	49%	0%
DY2 Aggregate	17	150,249	28%	72%	50%	50%	0%
Kentucky DY1	4	50,989	34%	66%	53%	47%	0%
Kentucky DY2	4	51,536	34%	66%	52%	48%	0%
Michigan DY1	13	82,280	25%	76%	49%	51%	0%
Michigan DY2	13	98,713	25%	75%	49%	51%	0%

Source: CCBHC quality measure reports.

Notes: Denominators are the number of people CCBHCs served by state each DY. In Kentucky, DY1 includes January 2022–December 2022, and in Michigan DY1 includes October 2021–September 2022. In Kentucky, DY2 includes January 2023–December 2023, and in Michigan DY2 includes October 2022–September 2023.

CARES = Coronavirus Aid, Relief, and Economic Security Act; CCBHC = Certified Community Behavioral Health Clinic; DY = demonstration year.

Exhibit B.4. Race of people served by original state CCBHCs, by state and year

	Number of CCBHCs	Denominator	White	Black or African American	American Indian or Alaskan Native	Native Hawaiian or Pacific Islander	Asian	More than one race	Unknown
DY1 Aggregate	56	286,089	72%	12%	2%	0%	1%	5%	9%
DY2 Aggregate	56	308,831	70%	11%	2%	0%	1%	7%	8%
DY3 Aggregate	53	303,911	72%	12%	2%	0%	1%	7%	6%
DY4 Aggregate	53	315,349	73%	12%	2%	0%	1%	5%	7%
DY5 Aggregate	54	340,334	73%	11%	2%	0%	1%	5%	7%
DY6 Aggregate	56	383,816	70%	12%	2%	0%	1%	4%	11%
Minnesota DY1	6	23,027	69%	12%	2%	0%	4%	5%	8%
Minnesota DY2	6	25,402	67%	12%	2%	0%	5%	6%	7%
Minnesota DY3	6	23,935	69%	12%	3%	0%	5%	6%	6%
Minnesota DY4	6	20,725	69%	12%	3%	0%	6%	5%	5%
Minnesota DY5	6	23,586	67%	14%	3%	0%	6%	5%	5%
Minnesota DY6	NA	NA	NA	NA	NA	NA	NA	NA	NA

Appendix B. Characteristics of People Served by CCBHCs

	Number of CCBHCs	Denominator	White	Black or African American	American Indian or Alaskan Native	Native Hawaiian or Pacific Islander	Asian	More than one race	Unknown
Missouri DY1	15	121,787	80%	10%	1%	0%	0%	2%	6%
Missouri DY2	15	132,565	77%	11%	1%	0%	0%	5%	5%
Missouri DY3	15	137,753	80%	10%	1%	0%	0%	4%	5%
Missouri DY4	15	145,949	80%	10%	1%	0%	0%	3%	6%
Missouri DY5	15	159,468	81%	10%	1%	0%	0%	2%	6%
Missouri DY6	21	211,875	77%	13%	1%	0%	0%	2%	7%
New Jersey DY1	7	17,851	55%	15%	0%	0%	3%	6%	19%
New Jersey DY2	7	19,129	50%	16%	0%	0%	4%	11%	16%
New Jersey DY3	7	20,396	44%	17%	0%	0%	4%	16%	17%
New Jersey DY4	7	21,742	51%	16%	0%	0%	4%	2%	23%
New Jersey DY5	7	20,121	56%	14%	0%	0%	4%	3%	20%
New Jersey DY6	7	21,816	55%	15%	0%	0%	4%	3%	23%
New York DY1	13	49,903	62%	21%	1%	0%	1%	9%	6%
New York DY2	13	55,693	62%	19%	1%	0%	1%	13%	4%
New York DY3	13	57,377	62%	19%	1%	0%	1%	12%	4%
New York DY4	13	62,972	65%	18%	1%	0%	1%	10%	5%
New York DY5	13	68,248	66%	18%	1%	0%	1%	10%	3%
New York DY6	13	69,306	51%	15%	1%	0%	1%	8%	24% ^c
Oklahoma DY1	3	20,610	72%	13%	8%	0%	1%	5%	1%
Oklahoma DY2	3	22,741	65%	12%	7%	0%	1%	3%	14%
Oklahoma DY3	3	24,647	72%	11%	8%	0%	1%	8%	0%

Appendix B. Characteristics of People Served by CCBHCs

	Number of CCBHCs	Denominator	White	Black or African American	American Indian or Alaskan Native	Native Hawaiian or Pacific Islander	Asian	More than one race	Unknown
Oklahoma DY4	3	25,583	73%	11%	8%	0%	1%	8%	0%
Oklahoma DY5	3	27,201	72%	10%	8%	0%	0%	10%	0%
Oklahoma DY6	3	35,984	70%	10%	10%	0%	1%	8%	1%
Oregon DY1	12	52,911	71%	3%	2%	0%	1%	6%	16%
Oregon DY2	12	53,301	72%	3%	2%	0%	1%	7%	13%
Oregon DY3	9 ^d	39,803	75%	4%	3%	1%	1%	6%	11%
Oregon DY4	9	38,378	72%	4%	3%	1%	1%	5%	15%
Oregon DY5	10	41,710	71%	4%	3%	1%	1%	6%	15%
Oregon DY6	12	44,835	73%	4%	3%	1%	1%	6%	14%

Source: CCBHC quality measure reports.

Notes: Denominators are the number of people CCBHCs served by state each DY. Minnesota data are not available for DY6 because of a temporary pause in activity and reporting in the state. Missouri counts include data on all CCBHCs in the state each year, which includes 15 clinics in DY 1–5. The count includes 21 clinics in DY6, reflecting an administrative merger of two of the 15 original clinics and the addition of seven clinics. Oregon counts include data on all CCBHCs in the state each year: 12 clinics in DY1–2, nine clinics in DY3–4, 10 clinics in DY5, and 12 clinics in DY6. Although the three clinics were recertified between 2021–2023, they did not immediately return to their initial numbers served. DY1 = 2017–2018, DY2 = 2018–2019, DY3 = 2019–2020, DY4 = 2020–2021, DY5 = 2021–2022, DY6 = 2022–2023.

CCBHC = Certified Community Behavioral Health Clinic; DY = demonstration year; NA = not available.

Exhibit B.5. Race of people served by CARES Act state CCBHCs, by state and year

	Number of CCBHCs	Denominator	White	Black or African American	American Indian or Alaskan Native	Native Hawaiian or Pacific Islander	Asian	More than one race	Unknown
DY1 Aggregate	17	133,269	67%	19%	0%	0%	1%	6%	6%
DY2 Aggregate	17	150,249	67%	20%	0%	0%	1%	6%	5%
Kentucky DY1	4	50,989	76%	15%	0%	0%	0%	4%	4%
Kentucky DY2	4	51,536	77%	15%	0%	0%	0%	4%	0%
Michigan DY1	13	82,280	62%	22%	0%	0%	1%	7%	7%
Michigan DY2	13	98,713	62%	23%	0%	0%	1%	7%	7%

Source: CCBHC quality measure reports.

Notes: Denominators are the number of people CCBHCs served by state each DY. In Kentucky, DY1 includes January 2022–December 2022, and in Michigan DY1 includes October 2021–September 2022. In Kentucky, DY2 includes January 2023–December 2023, and in Michigan DY2 includes October 2022–September 2023.

CARES = Coronavirus Aid, Relief, and Economic Security Act; CCBHC = Certified Community Behavioral Health Clinic; DY = demonstration year.

Exhibit B.6. Ethnicity of people served by original state CCBHCs, by state and year

	Number of CCBHCs	Denominator	Ethnicity not Hispanic or Latino	Ethnicity Hispanic or Latino	Ethnicity unknown
DY1 Aggregate	56	286,089	76%	9%	16%
DY2 Aggregate	56	308,831	79%	10%	12%
DY3 Aggregate	53	303,911	81%	8%	11%
DY4 Aggregate	53	315,349	82%	8%	10%
DY5 Aggregate	54	340,334	81%	10%	9%
DY6 Aggregate	56	383,816	75%	15%	10%
Minnesota DY1	6	23,027	64%	5%	30%
Minnesota DY2	6	25,402	75%	6%	19%
Minnesota DY3	6	23,935	84%	6%	10%
Minnesota DY4	6	20,725	86%	7%	7%
Minnesota DY5	6	23,586	80%	7%	14%
Minnesota DY6	NA	NA	NA	NA	NA
Missouri DY1	15	121,787	75%	5%	19%
Missouri DY2	15	132,565	82%	6%	11%
Missouri DY3	15	137,753	84%	5%	11%
Missouri DY4	15	145,949	88%	4%	7%
Missouri DY5	15	159,468	86%	4%	9%
Missouri DY6	21	211,875	71%	18%	11%
New Jersey DY1	7	17,851	67%	17%	16%
New Jersey DY2	7	19,129	71%	19%	11%
New Jersey DY3	7	20,396	53%	11%	36%
New Jersey DY4	7	21,742	42%	10%	47%
New Jersey DY5	7	20,121	56%	14%	29%
New Jersey DY6	7	21,816	69%	22%	6%
New York DY1	13	49,903	78%	17%	4%
New York DY2	13	55,693	80%	17%	3%
New York DY3	13	57,377	79%	15%	6%
New York DY4	13	62,972	81%	14%	5%
New York DY5	13	68,248	73%	13%	14%
New York DY6	13	69,306	78%	11%	11%
Oklahoma DY1	3	20,610	92%	6%	2%
Oklahoma DY2	3	22,741	81%	5%	14%
Oklahoma DY3	3	24,647	92%	6%	1%
Oklahoma DY4	3	25,583	93%	7%	1%
Oklahoma DY5	3	27,201	91%	7%	2%
Oklahoma DY6	3	35,984	91%	8%	2%
Oregon DY1	12	52,911	76%	8%	16%

Appendix B. Characteristics of People Served by CCBHCs

	Number of CCBHCs	Denominator	Ethnicity not Hispanic or Latino	Ethnicity Hispanic or Latino	Ethnicity unknown
Oregon DY2	12	53,301	72%	10%	18%
Oregon DY3	9	39,803	76%	10%	14%
Oregon DY4	9	38,378	73%	11%	16%
Oregon DY5	10	41,710	74%	14%	11%
Oregon DY6	12	44,835	77%	14%	11%

Source: CCBHC quality measure reports.

Notes: Denominators are the number of people CCBHCs served by state each DY. Minnesota data are not available for DY6 because of a temporary pause in activity and reporting in the state. Missouri counts include data on all CCBHCs in the state each year, which includes 15 clinics in DY 1–5. The count includes 21 clinics in DY6, reflecting an administrative merger of two of the 15 original clinics and the addition of seven clinics. Oregon counts include data on all CCBHCs in the state each year: 12 clinics in DY1–2, nine clinics in DY3–4, 10 clinics in DY5, and 12 clinics in DY6. Although the three clinics were recertified between 2021–2023, they did not immediately return to their initial numbers served. DY1 = 2017–2018, DY2 = 2018–2019, DY3 = 2019–2020, DY4 = 2020–2021, DY5 = 2021–2022, DY6 = 2022–2023.

CCBHC = Certified Community Behavioral Health Clinic; DY = demonstration year; NA = not available.

Exhibit B.7. Ethnicity of people served by CARES Act state CCBHCs, by state and year

	Number of CCBHCs	Denominator	Ethnicity not Hispanic or Latino	Ethnicity Hispanic or Latino	Ethnicity unknown
DY1 Aggregate	17	133,269	87%	6%	7%
DY2 Aggregate	17	150,249	87%	6%	6%
Kentucky DY1	4	50,989	95%	4%	1%
Kentucky DY2	4	51,536	95%	4%	0%
Michigan DY1	13	82,280	82%	7%	11%
Michigan DY2	13	98,713	83%	7%	9%

Source: CCBHC quality measure reports.

Notes: Denominators are the number of people CCBHCs served by state each DY. In Kentucky, DY1 includes January 2022–December 2022, and in Michigan DY1 includes October 2021–September 2022. In Kentucky, DY2 includes January 2023–December 2023, and in Michigan DY2 includes October 2022–September 2023.

CARES = Coronavirus Aid, Relief, and Economic Security Act; CCBHC = Certified Community Behavioral Health Clinic; DY = demonstration year.

Exhibit B.8. Insurance status of people served by original state CCBHCs, by state and year

	Number of CCBHCs	Denominator	Medicaid + CHIP + Dual	Medicare	Commercially insured	VHA + Other	Uninsured
DY1 Aggregate	56	286,089	64%	5%	16%	4%	15%
DY2 Aggregate	56	308,831	62%	5%	16%	5%	16%
DY3 Aggregate	53	303,911	62%	5%	17%	4%	15%
DY4 Aggregate	52	307,408	62%	4%	19%	5%	14%
DY5 Aggregate	54	340,334	62%	4%	20%	5%	12%
DY6 Aggregate	56	383,816	65%	5%	18%	4%	9%
Minnesota DY1	6	23,027	59%	6%	20%	11%	5%
Minnesota DY2	6	25,402	58%	6%	22%	12%	4%
Minnesota DY3	6	23,935	58%	7%	21%	13%	2%
Minnesota DY4	6	20,725	61%	4%	20%	12%	5%
Minnesota DY5	6	23,586	59%	4%	20%	10%	5%
Minnesota DY6	NA	NA	NA	NA	NA	NA	NA
Missouri DY1	15	121,787	61%	6%	17%	4%	21%
Missouri DY2	15	132,565	56%	6%	17%	5%	24%
Missouri DY3	15	137,753	57%	6%	18%	4%	22%
Missouri DY4	15	145,949	56%	6%	21%	6%	20%
Missouri DY5	15	159,468	56%	5%	22%	6%	17%
Missouri DY6	21	211,875	61%	5%	20%	6%	11%
New Jersey DY1	7	17,851	60%	9%	23%	2%	5%
New Jersey DY2	7	19,129	61%	8%	23%	2%	6%
New Jersey DY3	7	20,396	58%	8%	25%	3%	6%
New Jersey DY4	6	13,801	65%	8%	22%	5%	7%
New Jersey DY5	7	20,121	63%	5%	24%	4%	6%
New Jersey DY6	7	21,816	64%	5%	23%	3%	5%
New York DY1	13	49,903	71%	4%	19%	2%	4%
New York DY2	13	55,693	71%	5%	18%	1%	5%
New York DY3	13	57,377	72%	3%	21%	1%	4%
New York DY4	13	62,972	70%	3%	23%	1%	3%
New York DY5	13	68,248	68%	5%	23%	1%	3%
New York DY6	13	69,306	68%	4%	21%	1%	6%
Oklahoma DY1	3	20,610	49%	4%	9%	1%	36%
Oklahoma DY2	3	22,741	48%	4%	12%	1%	36%
Oklahoma DY3	3	24,647	47%	3%	14%	1%	34%
Oklahoma DY4	3	25,583	55%	2%	15%	2%	27%
Oklahoma DY5	3	27,201	62%	5%	16%	1%	18%
Oklahoma DY6	3	35,984	69%	3%	14%	3%	11%
Oregon DY1	12	52,911	70%	3%	9%	4%	14%
Oregon DY2	12	53,301	74%	3%	10%	7%	10%

Appendix B. Characteristics of People Served by CCBHCs

	Number of CCBHCs	Denominator	Medicaid + CHIP + Dual	Medicare	Commercially insured	VHA + Other	Uninsured
Oregon DY3	9	39,803	80%	3%	7%	5%	10%
Oregon DY4	9	38,378	79%	3%	7%	3%	9%
Oregon DY5	10	41,710	81%	2%	7%	3%	7%
Oregon DY6	12	44,835	80%	4%	9%	3%	6%

Source: CCBHC quality measure reports.

Notes: Denominators are the number of people CCBHCs served by state each DY. Insurance status categories were not mutually exclusive and percentages may not add to 100% for each state each year. Denominators are the number of people CCBHCs served by state year reported in caseload of quality measure reports. Minnesota data are not available for DY6 because of a temporary pause in activity and reporting in the state. Missouri counts include data on all CCBHCs in the state each year, which includes 15 clinics in DY 1–5. The count includes 21 clinics in DY6, reflecting an administrative merger of two of the 15 original clinics and the addition of seven clinics. New Jersey data in DY4 lacked clients’ insurance status in one clinic; no explanation was provided. Oklahoma Medicaid expansion took effect July 1, 2021 and Missouri’s took effect in August 2021, which may have influenced changes in insurance status from 2021 forward. Oregon counts include data on all CCBHCs in the state each year: 12 clinics in DY1–2, nine clinics in DY3–4, 10 clinics in DY5, and 12 clinics in DY6. Oregon DY2 and DY3 is over 100% and the state possibly double counted their CHIP clients in these years. DY1 = 2017–2018, DY2 = 2018–2019, DY3 = 2019–2020, DY4 = 2020–2021, DY5 = 2021–2022, DY6 = 2022–2023.

CCBHC = Certified Community Behavioral Health Clinic; CHIP = Children’s Health Insurance Program; DY = demonstration year; VHA = Veteran’s Health Administration; NA = not available.

Exhibit B.9. Insurance status of people served by CARES Act state CCBHCs, by state and year

	Number of CCBHCs	Denominator	Medicaid + CHIP + Dual	Medicare	Commercially insured	VHA + Other	Uninsured	Unknown
DY1 Aggregate	17	133,269	78%	2%	6%	<1%	11%	4%
DY2 Aggregate	17	150,249	77%	2%	5%	<1%	11%	5%
Kentucky DY1	4	50,989	69%	3%	7%	<1%	12%	9%
Kentucky DY2	4	51,536	68%	3%	7%	<1%	12%	10%
Michigan DY1	13	82,280	83%	1%	5%	<1%	10%	1%
Michigan DY2	13	98,713	82%	1%	4%	<1%	10%	2%

Source: CCBHC quality measure reports.

Notes: Denominators are the number of people CCBHCs served by state each DY. Data submitted by Kentucky and Michigan included missing information on insurance status, resulting in up to 10% of clients being reported with an “Unknown” insurance designation. In Kentucky, DY1 includes January 2022–December 2022, and in Michigan DY1 includes October 2021–September 2022. In Kentucky, DY2 includes January 2023–December 2023, and in Michigan DY2 includes October 2022–September 2023.

CARES = Coronavirus Aid, Relief, and Economic Security Act; CCBHC = Certified Community Behavioral Health Clinic; CHIP = Children’s Health Insurance Program; DY = demonstration year; VHA = Veteran’s Health Administration.

Appendix C. Supplemental Scope of Services Findings

Exhibit C.1. Required and optional evidence-based practices in BSCA states, by state

	AL ^a	IL ^b	IN	IA ^c	KS	ME ^d	NH ^e	NM	RI	VT ^f
7 Challenges for Youth with AMI, SED, and SUD							R		R	
Acceptance and Commitment Therapy						A				
Adolescent Community Reinforcement Approach						Y				
Applied Behavior Analysis						A				
Attachment and Biobehavioral Catch-Up						F				
Attachment, Regulation and Competency										R
Assertive Community Treatment/Flexible Assertive Community Treatment	R	R ^g		R	R ^h	H	R	O	R	
Brief Strategic Family Therapy			R							
Child and Family Traumatic Stress Intervention						C				
Child-Parent Psychotherapy						C	R			
Cognitive Behavioral Intervention for Therapy in Schools			O							
Cognitive Behavioral Therapy	R	R	R		R	R	R	R	R	R
Cognitive Behavioral Therapy for Psychosis			O			R				
Cognitive Behavioral Therapy for Obsessive Compulsive Disorder			O							
Cognitive Processing Therapy						A				
Collaborative Assessment and Management of Suicidality						R				R
Community Reinforcement Approach						A		O		
Contingency Management								O		
Coordinated Specialty Care			O			A		O	R	
Critical Time Intervention for AMI and SMI							R			
Dialectical Behavior Therapy		R ^g	R			A		O	R	R
Eye Movement Desensitization and Reprocessing		R ^g				C		O		
Family Psychoeducation									R	
Functional Family Therapy			O	O		H		O		
High-Fidelity Wraparound						A				
Illness Management and Recovery			O				R			
Incredible Years						F				
Integrated Dual Diagnosis Treatment/Integrated Treatment for Co-Occurring Disorders	R		R						R	
Individual Placement and Support					R				R	
Individual Placement and Support – Supported Employment	R					R	R			R
Matrix Model			O							
Medication Assisted Treatment				R	R				R	
Medication Assisted Recovery		R								

Appendix C. Supplemental Scope of Services Findings

	AL ^a	IL ^b	IN	IA ^c	KS	ME ^d	NH ^e	NM	RI	VT ^f
Medications for Alcohol Use Disorder										R
Medications for Opioid Use Disorder						R		R		R
Mobile Response and Stabilizing Services									R	
Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems						F	R			
Motivational Interviewing	R	R	R	R		R	R	O	R	R
Multisystemic Family Therapy			O	O		H ⁱ		O		
Multisystemic Family Therapy-Problematic Sexual Behaviors (MFT-PSB)						H ⁱ				
Multidimensional Family Therapy				O		Y				
Nicotine Replacement Therapy										R
Parent-Child Interaction Therapy			O			F				
Peer and Family Support			R							
Permanent Supportive Housing/ Housing First	R						R			
Person-Centered Treatment Planning									R	
Positive Parenting Program (Triple P)										R
Prolonged Grief Disorder Treatment						F				
Research Units in Behavioral Health Intervention						A				
Seeking Safety ^j						A				
Screening, Brief Intervention, and Referral to Treatment			O			A				
Solution-Focused Brief Therapy				R		R			R	
Systemic Therapeutic Assessment Resources Treatment Model			O							
Trauma-Informed Care			O			R				
Trauma-Informed Cognitive Behavior Therapy									R	
Trauma Recovery and Empowerment Model	R	R	R	R		C	R	O		
Trauma Systems Therapy for Immigrants and Refugees						A				
Twelve-Step Affiliation Therapy						A				
Wellness Recovery Action Plan									R	
Zero Suicide Model		R				A				

Source: State demonstration applications.

^a In addition to its required EBPs, Alabama encourages CCBHCs to identify and implement other EBPs that align with their CNA, and to use other evidence-based strategies to improve service outcomes.

^b In addition to its required EBPs, Illinois plans to allow CCBHCs to adopt additional EBPs based on their CNA. Additional EBPs must first be approved by the Illinois Department of Healthcare and Family Services.

^c Iowa plans to require CCBHCs to implement all required EBPs plus one optional EBP.

^d In addition to the required EBPs (indicated by an R), Maine CCBHCs must provide at least one of four specific EBPs in the home and community (H); at least one of five EBPs focused on Family/Parents/Caregivers (F); at least one child-youth trauma-focused EBP (C); and at least one youth substance use treatment EBP (Y). EBPs marked with an "A" are allowable if justified by a CCBHC's CNA.

^e New Hampshire plans to review its required EBP list every other year to ensure it continues to match the needs of the CCBHC population and the CCBHCs CNAs.

^f Vermont recommends that CCBHCs offer additional EBPs based on the needs of children, adolescents and adults within their catchment areas, based on the CCBHCs CNAs.

^g Illinois will require these EBPs within 1 year of its demonstration start date

^h Kansas requires CCBHCs to offer either Assertive Community Treatment (ACT) or Flexible Assertive Community Treatment (F/ACT).

Appendix C. Supplemental Scope of Services Findings

ⁱ Maine CCBHCs can provide either MFT or MFT-PSB as an EBP within the home or community.

^j Seeking Safety is an evidence-based treatment that helps people with trauma, posttraumatic stress disorder, and substance misuse.

A = allowable (if justified by CNA and approved by state agency); C = at least one trauma-focused EBP required for children/youth;

F = at least one EBP required for families/parents/caregivers; H = at least one EBP in the home and community; O = optional;

R = required; Y = at least one substance use EBP required for youth.

AMI = any mental illness; BSCA = Bipartisan Safer Communities Act of 2022; SED = serious emotional disturbance; SMI = serious mental illness; SUD substance use disorder.