2024

CCBHC IMPACT REPORT

NATIONAL COUNCIL *for* Mental Wellbeing

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IMPACT HIGHLIGHTS

Expanding timely access to care

CCBHCs continue to close the treatment gap that leaves millions of people in the US unable to access lifesaving mental health and substance use care.

- Today, CCBHCs serve an estimated **3 million people**, representing continued yearly growth since the inception of the model.
- Access gains were particularly pronounced among Medicaid CCBHCs, which expanded their number of people served by an average of **33%**.
- The most commonly reported access expansions were among children/youth, uninsured people and those without a prior source of outpatient care.

Expanding access to substance use care

CCBHCs are addressing the nation's opioid crisis and surging demand for substance use care by expanding access to a wide range of services, such as medication-assisted treatment (MAT).

- **87%** of Medicaid CCBHCs and established grantees offer one or more forms of MAT for opioid use disorder, compared to **64%** of substance use treatment facilities nationwide.
- **68%** of CCBHCs reported that their number of clients engaged in MAT for opioid use disorder has increased since becoming a CCBHC, with **29%** reporting increases of **20%** or higher.

Investing in the workforce

The CCBHC model is alleviating the impact of the behavioral health workforce shortage by enabling clinics to increase hiring.

- Medicaid CCBHCs and established grantees hired **11,292** new staff positions, or a median of **15** new positions per clinic.
- Hiring was greatest among Medicaid CCBHCs, which reported a median of **22** new positions per clinic.
- Licensed clinicians, peer support specialists, care coordinators and nurses were among the most commonly hired staff.

Coordination and integration with primary care

CCBHCs work closely with primary care partners, using multiple strategies to coordinate and integrate care — with the result that access to primary care is increasing among individuals served.

- Half of CCBHCs exceed minimum requirements by making comprehensive primary care available on-site.
- **76%** of CCBHCs reported that referrals to primary care have increased since becoming a CCBHC, including 30% reporting that referrals have increased by **20%** or more.

Making crisis services and supports available to all

CCBHCs are expanding the availability of services across the crisis continuum directly and through partnerships with 988 call centers, mobile crisis response providers and state-sanctioned crisis systems.

- More than **80%** of CCBHCs were already working in partnership with 988 Suicide and Crisis Lifeline call centers as of March 2024, well ahead of their July 2024 deadline.
- **29%** of CCBHCs were able to add mobile crisis response as a result of certification, an indication of the expansion of mobile crisis availability in their communities. The greatest gains in mobile crisis availability were found among Medicaid CCBHCs and rural CCBHCs.

Improving collaboration with criminal justice agencies

CCBHCs and grantees work with law enforcement agencies and other partners to improve outcomes for people who are involved or at risk of involvement with the criminal justice system.

- Nearly all CCBHCs and grantees (**98%**) are actively engaged in one or more innovative activities in partnership with criminal justice agencies, such as providing services in partnership with courts (**86%**), increasing outreach to people with criminal legal system involvement (**63%**), or training law enforcement officers in Mental Health First Aid or other awareness training (**59%**).

Meeting children, youth and families where they are

CCBHCs are increasing access for children and youth through an expanded workforce, targeted services and community partnerships.

- **68%** of Medicaid CCBHCs and established grantees reported the number of children/youth they serve has increased, including **24%** that indicated the increases to their number of child/youth clients were substantial.
- The vast majority of CCBHCs (**83%**) provide services on-site in one or more schools, childcare or other youth-serving settings.

Addressing social and environmental factors that affect health

CCBHCs and grantees reported that the model has helped them engage in targeted access expansions for people with long-standing unmet needs and address social and environmental factors that affect health in their communities.

- CCBHCs engaged in a wide array of strategies to address health discrepancies, including increasing screening for unmet social needs that affect health (**81%**), increasing outreach to individuals who have long-standing unmet needs (**75%**), and hiring staff who are demographically representative of the population they serve (**75%**).
- CCBHCs are making particularly focused efforts to support access among veterans, people experiencing homelessness and those who are involved or at risk of involvement with the criminal justice system.
- The vast majority of CCBHCs (**91%**) proactively assist clients with finding or maintaining stable housing.

INTRODUCTION

The Certified Community Behavioral Health Clinic (CCBHC) model is delivering the resources our nation needs to transform our communities' access to care for mental health and substance use challenges.

CCBHCs are clinics — either recipients of a federal CCBHC grant or certified by their states as CCBHCs within Medicaid — that receive flexible funding to support their costs of expanding the scope of mental health and substance use care and serving new people in their community. They tailor their services to meet the individual needs of their communities and serve anyone who walks through the door, regardless of ability to pay.

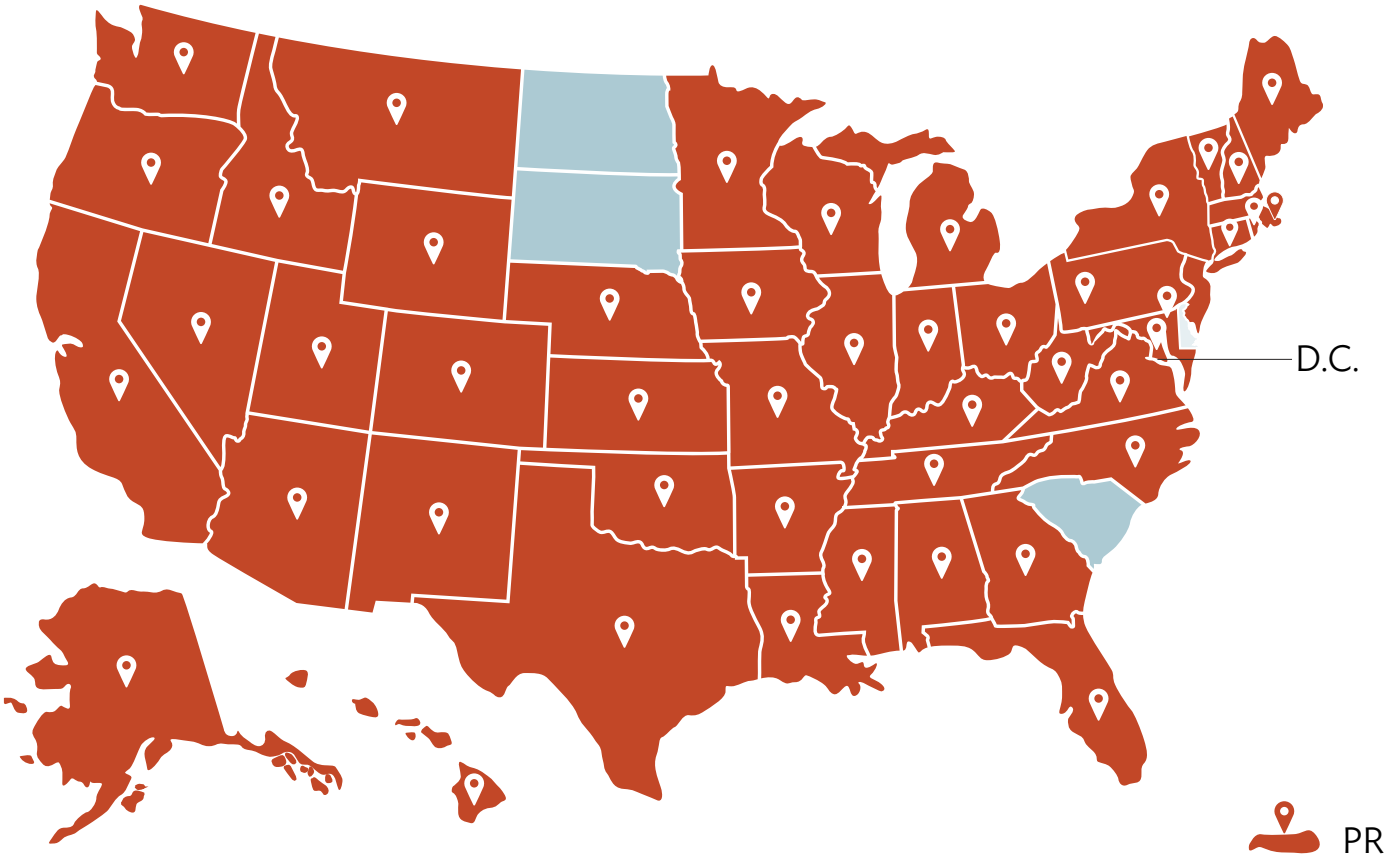
In the past 10 years, clinics, states and allied organizations seized the opportunity to expand access to high-quality mental health and substance use care through CCBHCs. The results have been transformative: CCBHCs have significantly expanded access to mental health and substance use disorder (SUD) treatment, reduced wait times and enabled organizations to hire more staff.

Our 2024 CCBHC Impact Report offers the most up-to-date data on CCBHCs and the vital role they play in their communities. Our snapshot of CCBHCs this year shows a continued trend — when evidence-based clinical care is supported with effective financing, clinics can dramatically increase access to care and provide comprehensive, lifesaving services to people whose needs were often previously unmet.

The CCBHC model was originally implemented at 66 clinics in eight states through a Medicaid demonstration that began in 2017. The model has grown steadily over time, through multiple extensions and expansions of the demonstration (now available to all states on a phased timeline through 2030), establishment of a federal CCBHC grant fund beginning in 2018, and most recently the addition of CCBHC services as a state option within Medicaid — a move that will ensure permanence and sustainability for the model beyond the end of the demonstration.

Today, there are **495 CCBHCs** in **46 states**, plus Washington, D.C. and Puerto Rico.

These organizations operate more than **600 CCBHC programs** — currently offering services in **40% of all U.S. counties** (Mauri, 2024), covering **62%** of the nation's population.



Our vision is that one day, every person in the U.S. will be able to access comprehensive, high-quality care delivered by a CCBHC and its community partners.

A note on terminology

- **Medicaid CCBHC** is used to describe CCBHCs that are participating in the Section 223 Medicaid demonstration,[1] a CCBHC Medicaid State Plan Amendment, or other Medicaid authority. These clinics have been certified by their states as meeting all CCBHC requirements and receive a Medicaid payment rate based on reasonable estimates of their cost of doing business. Some of these state-certified sites have also received a CCBHC Expansion Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). At the time of the 2024 CCBHC Impact Survey (January-March 2024), Medicaid CCBHCs were active in Kansas, Kentucky, Michigan, Minnesota, Missouri, Nevada, New York, New Jersey, Oklahoma, Oregon, Pennsylvania[2] and Texas.

- **Grantee** refers to clinics with an active SAMHSA CCBHC grant[3] that are not certified as CCBHCs by their states. These clinics do not receive the special CCBHC Medicaid payment rate and instead rely on federal grant funding to implement the CCBHC model of care.

  - **Established grantees** are those that have been through the SAMHSA attestation process and are operating in compliance with CCBHC criteria; this group includes clinics that received their grants in 2022 as well as those that received an Improvement and Advancement (IA) grant from SAMHSA in 2023 to expand upon previously funded CCBHC activities.

  - **New grantees** are those that received a Planning, Development and Implementation (PDI) grant from SAMHSA in 2023 and are still in the launch phase of their CCBHC activities, with a deadline to complete their attestation to compliance with the criteria by the end of their first grant year (September 2024).

While Medicaid CCBHCs and grantees reported broadly similar experiences, the survey data reveals some differences between the two types of clinics, providing insights as to how implementation of the model through Medicaid can further scale innovations and improvements initiated under the grant program.

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1 *Named after the section of the Protecting Access to Medicare Act that established the demonstration. (Publ. L. No. 113-93 [2014].https://www.congress.gov/113/plaws/publ93/PLAW-113publ93.pdf)*

2 *Pennsylvania's Integrated Community Wellness Centers (ICWCs) began as CCBHCs in 2017 and transitioned to ICWC status when Pennsylvania moved out of the demonstration in 2019. ICWCs continue to meet CCBHC criteria and are considered CCBHCs for the purposes of this report.*

3 *Clinics whose grant term has expired and who did not receive a new grant in either 2022 or 2023 are not included in the survey, although many have managed to continue substantial elements of the CCBHC model through other temporary funding sources.*

TYPES OF CCBHCS IN THIS ANALYSIS		
Medicaid CCBHCs	***Established grantees***	***New grantees***
Active in **12 states** as of March 2024; includes CCBHCs participating in the federal demonstration, a Medicaid State Plan Amendment, or other Medicaid authority. Some clinics in this group have also received a SAMHSA CCBHC grant.	Active in **47 states**; includes clinics that received a SAMHSA CCBHC-PDI or CCBHC-IA grant in 2022 and those that received a SAMHSA CCBHC-IA grant in 2023.	Active in **31 states**; includes clinics that received a SAMHSA CCBHC-PDI grant in 2023.
Have been certified by states as meeting CCBHC criteria.	Have completed attestation to SAMHSA that they meet CCBHC criteria.	Currently working on attesting to SAMHSA that they meet CCBHC criteria.
Receive special Medicaid payment known as PPS (or similar payment model).	Receive up to **$4M** for a four-year grant term and continue to bill Medicaid and other payers as usual.	Receive up to **$4M** for a four-year grant term and continue to bill Medicaid and other payers as usual.
Administered by state Medicaid and behavioral health authorities within guidelines set by SAMHSA and CMS.	Administered by SAMHSA.	Administered by SAMHSA.

Segmentation of respondents for this analysis

This report contains data collected from Medicaid CCBHCs and grantees that were active as of March 2024, with responses received from 380 of 495 organizations, representing a 77% overall response rate. Respondents included 155 of the 192 Medicaid CCBHCs (an 81% response rate) and 196 of the 303 established grantees (a 65% response rate).

For the purposes of this report, new grantees were analyzed separately from Medicaid CCBHCs and established grantees. New grantees are still in the first-year launch period of building out their CCBHC services; while many of them have already taken on new services, staffing and operations aligned with the SAMHSA CCBHC Certification Criteria, they are at different stages of implementation and have not yet completed attestation of their full compliance with the CCBHC model. **Except where otherwise noted, the data that follows reflects only Medicaid CCBHCs and established grantees, whose experiences reflect the impact of the model when fully implemented.** New grantees' experiences to date provide a helpful reference point in comparison with their longer-tenured peers, allowing us to better understand how organizations' services, staffing and other activities expand as a direct result of CCBHC implementation.

CCBHCs' REACH ACROSS THE NATION

The number of people served by all CCBHCs across the U.S. continues to grow. The 380 Medicaid CCBHCs, established grantees and new grantees responding to this year's survey reported serving 2,259,715 clients. Based on this finding, the National Council for Mental Wellbeing estimates that all 495 CCBHCs across the U.S. serve **3,000,000 clients** as of March 2024. CCBHCs are currently active in **46 states plus Washington, D.C. and Puerto Rico**, with 125 CCBHCs (25%) operating in rural areas.

The CCBHC model will continue to expand with the anticipated addition of 10 states to the Section 223 Medicaid Demonstration in July 2024 and the award of a new round of up to 15 state demonstration planning grants in the fall of 2024. For the most up-to-date information on the current status of states' CCBHC implementation efforts, please visit the National Council's **Find a CCBHC** webpage.

EXPANDING TIMELY ACCESS TO CARE

Despite ongoing high levels of need for mental health and substance use services, a large majority of people in the U.S. are unable to access the services they need. There remains an urgent need to reduce barriers to access. According to SAMHSA's 2022 National Survey on Drug Use and Health (NSDUH), only 1 in 4 (24%) adults with an SUD and 51% of adults with any mental illness received treatment in the last year. Access to services among young people is similarly lacking.

Medicaid CCBHCs and established grantees are filling this gap in care access. The majority of this group (79%) reported that the number of people their organization serves has increased since becoming a CCBHC. These increases have resulted in respondents serving more than 243,000 additional individuals.

2.3 million

people served by 380 respondents.

Estimated

3 million

served by all 495 active Medicaid CCBHCs and grantees.

79%

serve more people since becoming a CCBHC.

More than **243,000** total **new people** served

Medicaid CCBHCs experienced greater than average increases: Medicaid CCBHCs reported average client increases of 33%, substantially greater than the average of 13% across all CCBHCs. This difference is likely attributable to the different financing mechanisms available to each group: Medicaid CCBHCs participate in a Medicaid payment model, in which funding can flex according to the number of clients, which supports clinics in their staffing and costs associated with assertive outreach efforts to bring clients into care. These differences suggest that states implementing the CCBHC model through Medicaid (with Medicaid's prospective payment system [PPS]) may expect to build upon grantees' initial successes with further increases to the number of people served.

> *"We are most excited about the opportunity CCBHC has given us to expand services in our extremely rural areas. Geographically, our coverage area is quite large, and to travel to a larger site to access services is not a possibility for many. Since becoming a CCBHC, we have been able to open clinics in each county we serve and hire additional staff to meet the overwhelming behavioral health needs. Although small sites, these clinics continue to grow (so much so that we have had to add on to existing sites and purchase larger locations). For the first time ever, individuals living in these extremely rural areas have access to quality behavioral health services. Many lives have been changed/saved because of access. We are very thankful to be a CCBHC."*
>
> **— FCC Behavioral Health, Missouri (Medicaid CCBHC)**

Access expansions among key groups include children/youth, uninsured people and those without a prior source of outpatient care: New this year, the National Council surveyed CCBHCs about changes among specific client subgroups. The most frequently reported client increases were among children/youth: 68% of Medicaid CCBHCs and established grantees reported the number of children/youth they serve has increased, including 24% who indicated the increases to their number of child and youth clients were substantial. In light of the surging need for services and support among young people in the U.S. (SAMHSA, 2023b), the CCBHC model may provide an important strategy for increasing their access to care, along with improved coordination across organizations serving children, youth and families. (See further discussion in "Meeting Children, Youth and Families Where They Are.")

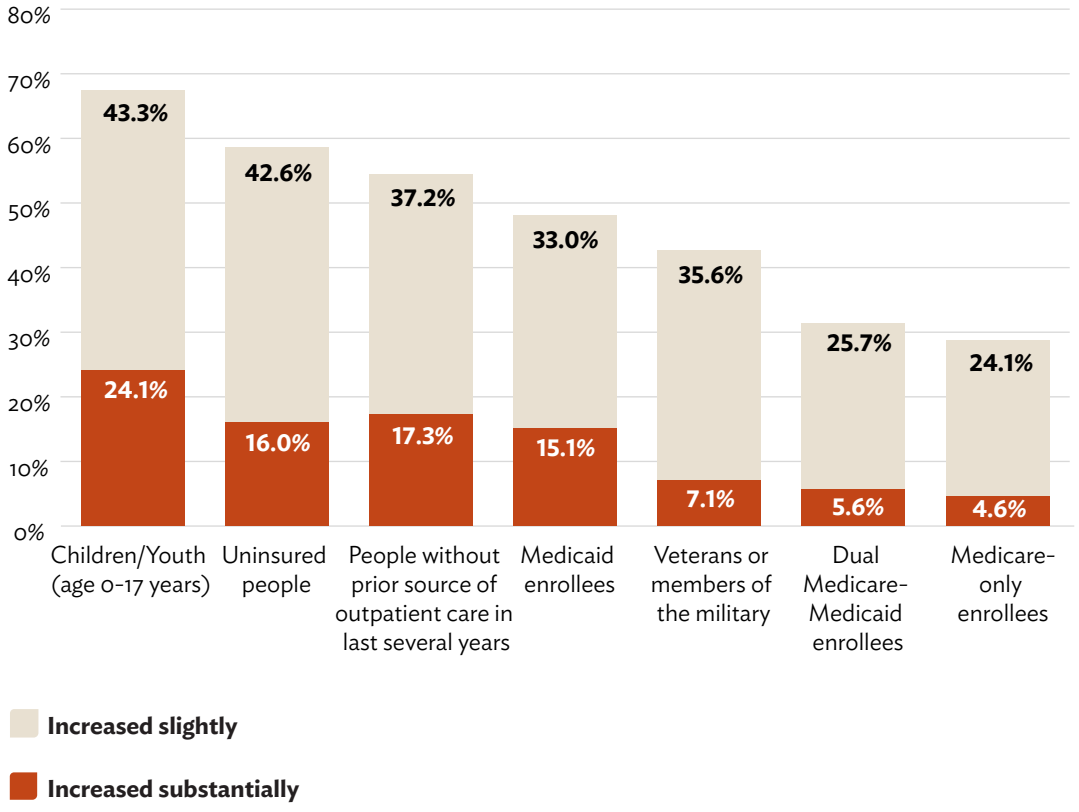
Uninsured people were the second-most commonly expanded group. Almost two-thirds (59%) of Medicaid CCBHCs and established grantees indicated their number of uninsured clients had increased, with 43% reporting the increases were substantial. Growth in the number of uninsured clients likely indicates the model's focus on ensuring access to care for all people within the CCBHCs' service areas, its ability to support flexible outreach and engagement strategies, and its focus on developing partnerships that help CCBHCs reach people who previously may have rotated through emergency departments, hospitals, jails or other settings without access to routine outpatient care. Expanded access to care for uninsured community members is a major success of the CCBHC model and produces savings in hospitals, emergency departments, jails/prisons, schools and more; yet, because CCBHCs cannot receive payment through the Medicaid PPS for services provided to uninsured clients, they may experience increasing financial strain in sustaining the full scope of services for all people as their uninsured populations grow. Further attention is needed to understand how this trend will impact CCBHCs and what supplemental funding strategies will most effectively support CCBHCs in serving this population.

More than half of Medicaid CCBHCs and established grantees (55%) reported increases to the number of clients they serve who had not received regular outpatient behavioral health care in the last several years, with 17% reporting that the increases within this group were substantial. This suggests that the growth in CCBHCs' clients served is driven in part by those who did not have a prior source of treatment, an important indicator of how CCBHCs are helping to close the mental health and substance use treatment gap. Several

elements of the model are likely responsible for improved access among this group, including partnerships between CCBHCs and hospitals, emergency departments and law enforcement agencies, which connect people to outpatient services, improve transitions of care and ensure individuals don't fall through the cracks upon reentry into the community.

Notably, service expansions were least frequently reported among Medicare enrollees (with only 29% of Medicaid CCBHCs and established grantees reporting increases within this group) and dual Medicare-Medicaid enrollees (with 31% reporting increases within this group). This may in part reflect Medicare's narrow coverage of the required CCBHC services and activities — suggesting that establishing CCBHCs as a provider type in Medicare, with access to a Medicare PPS for the full CCBHC scope of services, could expand access to CCBHC services and support among older adults, people with disabilities and other Medicare enrollees.

CCBHCs reporting access expansions among key groups



The model's flexibility supports a multitude of access points and strategies: In comments about changes to their client caseloads and access, survey respondents shared numerous insights on the factors driving these changes. Many noted that improved staffing has enabled CCBHCs to serve more people. (See further discussion in "Investing in the Workforce.") Several respondents shared that they have worked to open more flexible pathways to access through partnerships in their communities.

> *"We have more nontraditional ways to get into services. Crisis programs, mobile response, school-based services, etc. have opened more avenues for clients."*
>
> **— Bert Nash Community Mental Health Center, Kansas (Medicaid CCBHC)**

Others described how the model's flexibility in supporting a wide array of staff positions has allowed them to offer immediate support and improve engagement with clients between appointments, keeping more people engaged in care. The following were all mentioned as being critical to improving access: peer support specialists; care navigators providing immediate assistance with housing, food and other social and environmental factors that affect health; care coordinators assisting people with accessing services for other health conditions; and community health workers facilitating telehealth encounters in the community.

Several respondents mentioned they have improved access by integrating intake protocols for multiple service lines into a single streamlined entry point. This change was highlighted as being particularly helpful for people who frequently receive care in hospitals or emergency departments (ED) and forgo routine outpatient care, which has led to improved health outcomes and reduced hospital/ED use among this population.

CCBHCs are ensuring quick access to care, including access to MAT: Medicaid CCBHCs and established grantees are also improving access by reducing wait times. More than 8 in 10 (81%) reported seeing patients for routine needs within 10 days of the initial call or referral, 65% offer access within one week or less, and 21% offer same-day access to routine services. This is in contrast to the national average of 48 days between an individual's first outreach/referral and their first appointment.[4]

[4] *As determined from an MTM Services analysis of 10,000 care access protocol flowcharts that were collected from 1,000 community mental health centers engaged in initiatives to measure and reduce wait times for care in 47 U.S. states (A. Jensen, sr. consultant, MTM Services, personal communication, April 4, 2019).*

"Since we are considered a frontier community, it has decreased waiting times, allowed same-day crisis interventions, and provided community-based support as in ACT for the severely mentally ill. It has provided the spectrum of complete behavioral health in a frontier rural community."

— Vitality Unlimited, Nevada (Medicaid CCBHC)

The data reveals that CCBHCs are prioritizing speedy access to MAT for opioid use disorder (OUD), such as buprenorphine, methadone and naltrexone. Sixteen percent of Medicaid CCBHCs and established grantees indicated they offer same-day access to MAT, with an additional 53% able to provide access to MAT for OUD within one to seven days.

"Our previous model did not allow adults seeking services to receive access to medications at the intake appointment. We have been able to alter this process to where those seeking services' initial visit is with a psychiatrist and they are able to receive prescriptions the same day."

— Starcare Specialty Health System, Texas (Medicaid CCBHC)

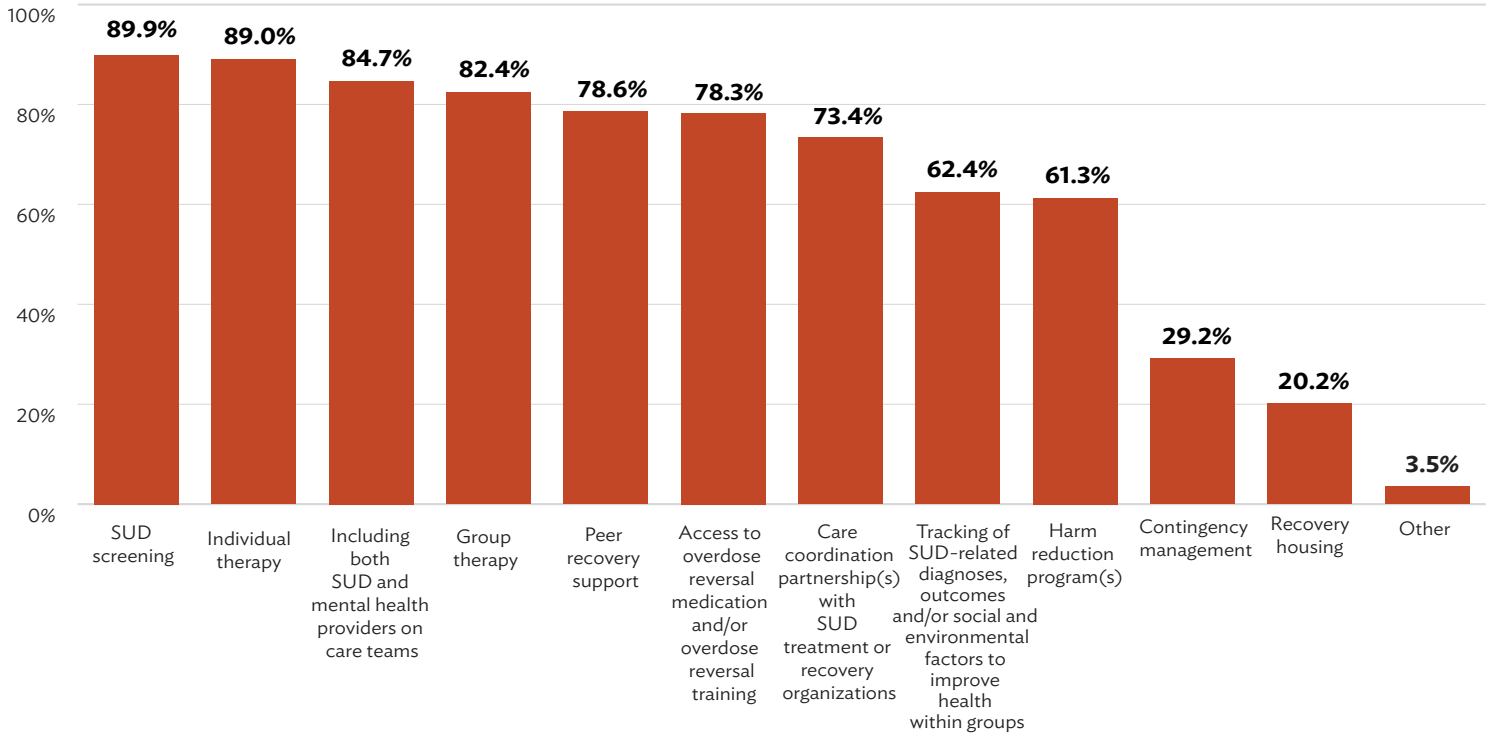
EXPANDING ACCESS TO SUBSTANCE USE CARE

The most recent data from NSDUH shows that 3 in 4 people aged 12 or older who needed substance use treatment in the past year did not receive it (SAMHSA, 2023b). Amid this gap in access — and the ongoing overdose crisis that resulted in over 105,000 deaths in the last 12 months (Ahmad et al., 2024) — CCBHCs are making a difference by improving access to substance use treatment and care nationwide.

Substance use treatment and partnerships are core components of CCBHCs' service array: Medicaid CCBHCs and established grantees currently serve more than 373,000 people with an SUD diagnosis. Ninety-one percent of CCBHCs directly provide one or more SUD-related services, with 9% offering access to SUD care through a Designated Collaborating Organization (DCO).

> The SAMHSA CCBHC Certification Criteria permit CCBHCs to contract with partners known as Designated Collaborating Organizations (DCOs) to deliver services that the CCBHC does not provide directly. CCBHCs may use a DCO for any of the nine required services but must ensure that most encounters are provided directly by the CCBHC. As described in the SAMHSA criteria, "DCOs are more than care coordination or referral partners, and there is an expectation that relationships with DCOs will include more regular, intensive collaboration across organizations than would take place with other types of care coordination partners" (SAMHSA, 2023a).

SUD services and supports provided directly by CCBHCs



"We have been able to provide immediate services to help our clients manage their addiction."

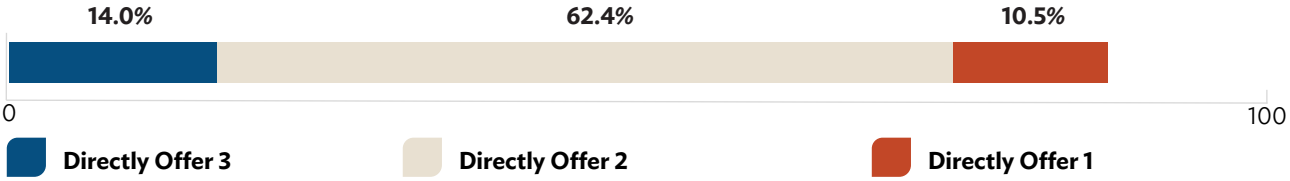
— BestSelf Behavioral Health, New York (Medicaid CCBHC)

In addition to the services noted above, most CCBHCs provide additional services or supports targeted toward people living with SUDs, who experience disproportionate involvement with the criminal justice system. Among their activities, half of Medicaid CCBHCs and established grantees (n=171, 49%) provide reentry support, conduct prerelease screening/referrals or engage in related activities to ensure continuity of care on reentry to the community from jail. Half (n=171, 49%) engage peers as community navigators or reentry specialists, offer peer-provided career or legal support or use other strategies.

Medicaid CCBHCs and established grantees are also working to provide overdose prevention and support: 60% have already implemented the new SAMHSA CCBHC certification requirement of ensuring that individuals and/or families have access to naloxone for overdose reversal, ahead of the July 2024 deadline, and 56% provide support following a nonfatal overdose after the individual is medically stable.

CCBHCs are expanding access to MAT for OUD: Of the 314 Medicaid CCBHCs and established grantees that provided information about their MAT offerings for OUD (MOUD), 87% (n=273) reported that they directly offer at least one type of MOUD, compared to 64% of substance use treatment facilities nationwide. Sixty-two percent (n=196) offer two forms of MOUD, compared to 49% nationwide. Fourteen percent (n=44) of CCBHCs directly offer all three forms, compared to 4% nationwide.[5] As a result of these access expansions, **two-thirds of CCBHCs (n=213, 68%) reported that the number of people engaged in MOUD has increased since becoming a CCBHC, with 29% reporting increases of 20% or higher.**

Number of MAT options CCBHCS offer for OUD



As noted above, 16% of CCBHCs indicated they offer same-day access to MOUD, with an additional 53% able to provide access to MOUD within one to seven days.

"MOUD is part of the culture, and all prescribers utilize this treatment throughout the agency."

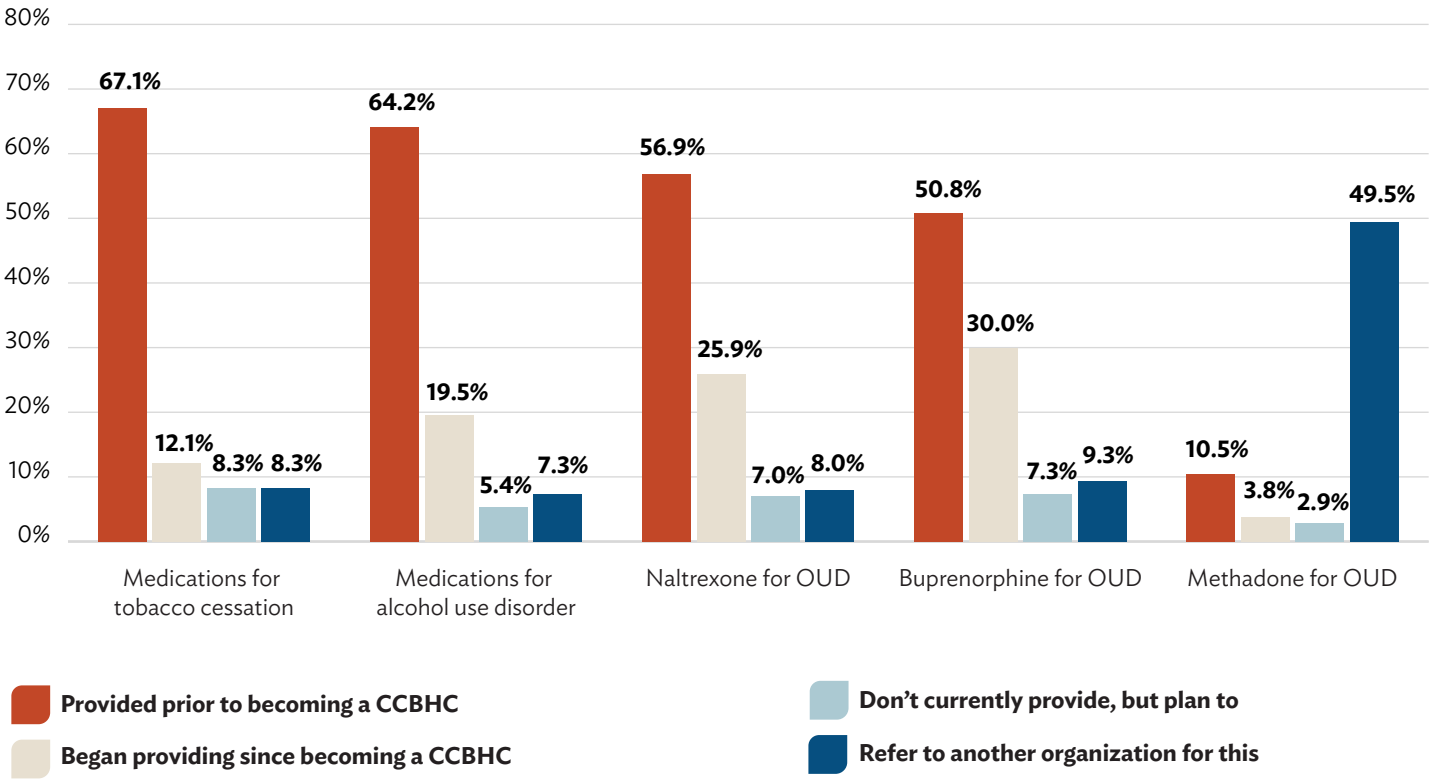
— CPC Integrated Health, New Jersey (Medicaid CCBHC)

[5] *Nationwide percentages were calculated from dashboards provided by amfAR, using data drawn from the National Survey of Substance Abuse Treatment Facilities. The dataset indicates there are 14,144 facilities providing substance use treatment, with 9,036 offering any type of MAT, 6,973 offering two or more forms of MAT and 603 offering all three forms of MAT.* https://ehe.amfar.org/data/SA_fac

> *"Being able to provide MAT has promoted access and success for those we serve. The program has improved communication about individuals transferring from jails and other programs to promote a seamless transition to therapy and MAT care. Peer recovery coaches play an integral role in increasing access as well, by providing supportive transportation alongside support and guidance."*
>
> **— Community Mental Health Authority of Clinton-Eaton-Ingham, Michigan (Medicaid CCBHC)**

Most Medicaid CCBHCs and grantees also offer medications for alcohol use disorder (n=262, 76%) and tobacco cessation (n=248, 72%). For many CCBHCs, MAT services were added as a result of becoming a CCBHC, an indication of the model's potential for expanding access to this important type of SUD treatment.

Medication-assisted treatments offered by CCBHCs



CCBHCs are integrating SUD and mental health care through an expanded workforce: 67% of Medicaid CCBHCs and established grantees hired staff with a substance use focus. This includes 35% that have hired addiction specialty psychiatrists, 63% that have hired other professional levels of substance use clinicians, and 61% that have hired peer support specialists with an SUD focus. The workforce shortage continues to affect hiring of SUD-focused providers, with 38% of respondents reporting they have created new positions for SUD providers that have not yet been filled.

67%
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"The expansion of our recovery support team in both our integrated outpatient and crisis services has positively supported client engagement in MOUD. Staff have received training to effectively screen and educate clients and individuals in the community about MOUD and related services. Since we have become a CCBHC, additional walk-in hours were added to improve access to services."

— Chestnut Health Systems Inc., Illinois (established grantee)

INVESTING IN THE WORKFORCE

As of March 2024, 122 million people live in areas with mental health professional shortages, and the Health Resources and Services Administration estimates that thousands more professionals are needed to meet the demand for care (HRSA, 2024). Recent polling of the behavioral health workforce indicates that increased caseload and case severity is contributing to severe burnout, with the vast majority of the workforce concerned about the shortage's negative impact on society (National Council, 2023).

CCBHC status supports enhanced hiring, particularly among Medicaid CCBHCs: CCBHC status — particularly for Medicaid CCBHCs that receive payment through PPS — has allowed organizations to hire more staff and fill long-vacant positions to better meet the needs of their communities. Ninety-eight percent of Medicaid CCBHCs and established grantees reported an increase in the number of staff positions since becoming a CCBHC, **for a total of 11,292 newly created staff positions** across 346 respondents. This includes 3,267 staff positions added among rural respondents.

CCBHCs reported **a median staff increase of 15 new positions per clinic.** Significantly more staff positions were created by Medicaid CCBHCs, with a median of 22 new positions per clinic, than by established grantees, with a median of 12 new positions per clinic. These differences are likely attributable to the different funding mechanisms for each clinic type: While both types of CCBHCs have enhanced financial resources to support workforce investment, the Medicaid payment available to Medicaid CCBHCs is expressly designed to support the costs of bringing on new staff to meet their communities' needs; it also supports clinic-driven staff retention efforts. Many established grantees commented that transitioning to Medicaid CCBHC status and payment would enable them to further increase hiring.

> *"Being a Demo CCBHC has, through the PPS reimbursement structure, allowed our agency to recruit and retain high-cost, high-value positions that we were unable to afford in a traditional clinic environment, including psychiatrists, child psychiatrists, RNs [registered nurses] and licensed clinical social workers. Among our existing staff, CCBHC has supported the infrastructure needed for professional development, including for nurse practitioners to prescribe MAT medications, clinicians to specialize in children's trauma work and suicide prevention, and peers to cross-certify in mental health and substance use disorders."*
>
> **— Central Nassau Guidance and Counseling Services Inc., New York (Medicaid CCBHC)**

The transition to CCBHC status has been critical in mitigating the effects of the workforce shortage: In their comments, CCBHCs — including Medicaid CCBHCs, established grantees and new grantees — noted that the national workforce shortage remains a major challenge, although many reported that they would be in a worse position were it not for being a CCBHC. Among the strategies CCBHCs reported using to mitigate the effects of the workforce shortage were increasing employee pay and benefits, enhancing career pathways and engaging in new recruitment strategies.

STRATEGIES USED BY CCBHCs TO MITIGATE THE WORKFORCE SHORTAGE

Increasing employee pay and benefits

- Increasing salaries
- Offering hiring or retention bonuses
- Providing stipends to intern-supervising clinicians
- Implementing employee wellbeing initiatives
- Offering wellness incentives.
- Increasing benefits.

Enhancing job roles and career pathways

- Partnering with universities and health systems.
- Hosting internships.
- Enhancing staff training opportunities.
- Improving career paths across service lines.

Engaging in recruitment strategies

- Working with external recruiters.
- Hiring contracted, rather than full-time, staff.
- Increasing participation in job fairs.

By providing a source of funding for critical activities such as outreach, individual engagement, care coordination and internal team consultation/support, the CCBHC model supports flexibility in how staff engage with people they serve and with one another. Several CCBHCs reported that staff find greater satisfaction in the clinical environment and culture, leading to better retention. Other CCBHCs noted they have created new types of positions to meet community needs, support clinical and quality improvement and establish career growth pathways.

> *"We've been able to offer better salary that has assisted us in hiring and retaining staff. We've had approximately 20 former staff return to our agency that had previously left due to salary."*
>
> **— Bert Nash Community Mental Health Center, Kansas (Medicaid CCBHC)**

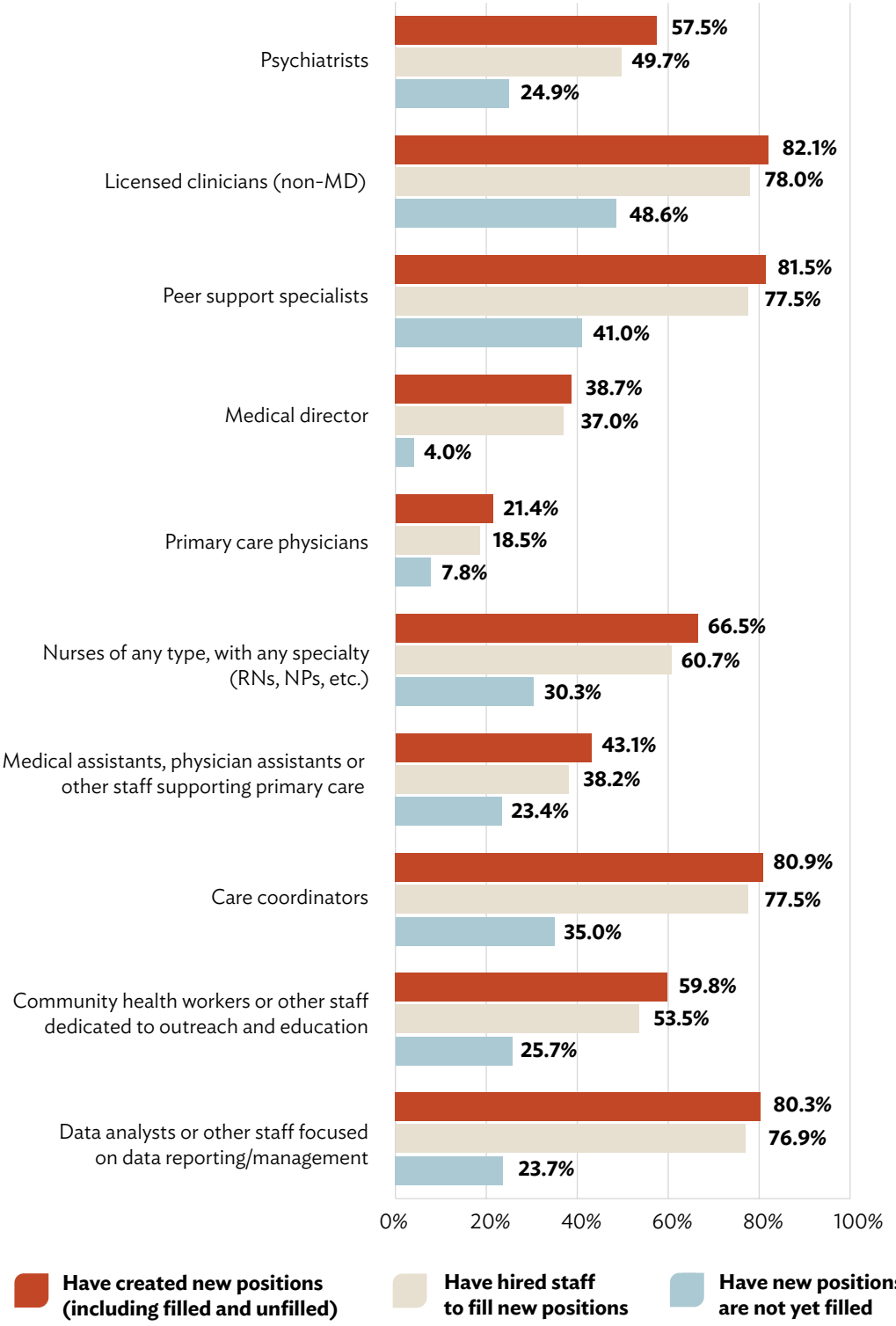
> *"Candidates were very excited to work for an organization that was able to provide flexibility in the type of services and how services were provided."*
>
> **— Pines Behavioral Health Services, Michigan (Medicaid CCBHC)**

> *"Becoming a CCBHC allowed us to increase compensation for key clinical and nonclinical positions, which helped with recruitment."*
>
> **— Beacon Mental Health, Missouri (Medicaid CCBHC)**

Care coordinators, licensed clinicians, data analysts and peers are among the most commonly hired new staff: Medicaid CCBHCs and established grantees reported hiring a wide array of staff types as a result of their transition to CCBHC status. Among the most commonly reported types of newly hired staff were care coordinators (with 85% of CCBHCs reporting they have hired care coordinators), data analysts (85%), non-MD licensed clinicians (78%), peer support specialists (77%) and nurses (67%). CCBHCs also reported having created many positions that they are still working to fill, an indicator of the ongoing workforce shortage. New grantees reported similar trends in the types of staff they have hired or are looking to hire in their launch period.

Notably, CCBHCs reported widespread hiring of staff that support integrated care delivery. (See further discussion in "Coordination and Integration With Primary Care.")

New staff positions created by CCBHCs



Note that the numbers of CCBHCs with filled and unfilled positions do not equal the total number of CCBHCs that have created positions, because many CCBHCs both have hired new staff and have remaining vacancies.

"We are happy and keenly aware of the benefit of peer involvement in service provision. Building this workforce opportunity allows for gaps in service to be addressed. It also allows individuals we serve that have been diligent in reaching their treatment goals to become the respected and productive members of society we promised they could be! Our patients have become our colleagues. The CCBHC model embraces their contribution, and supported peer employees truly make a difference."

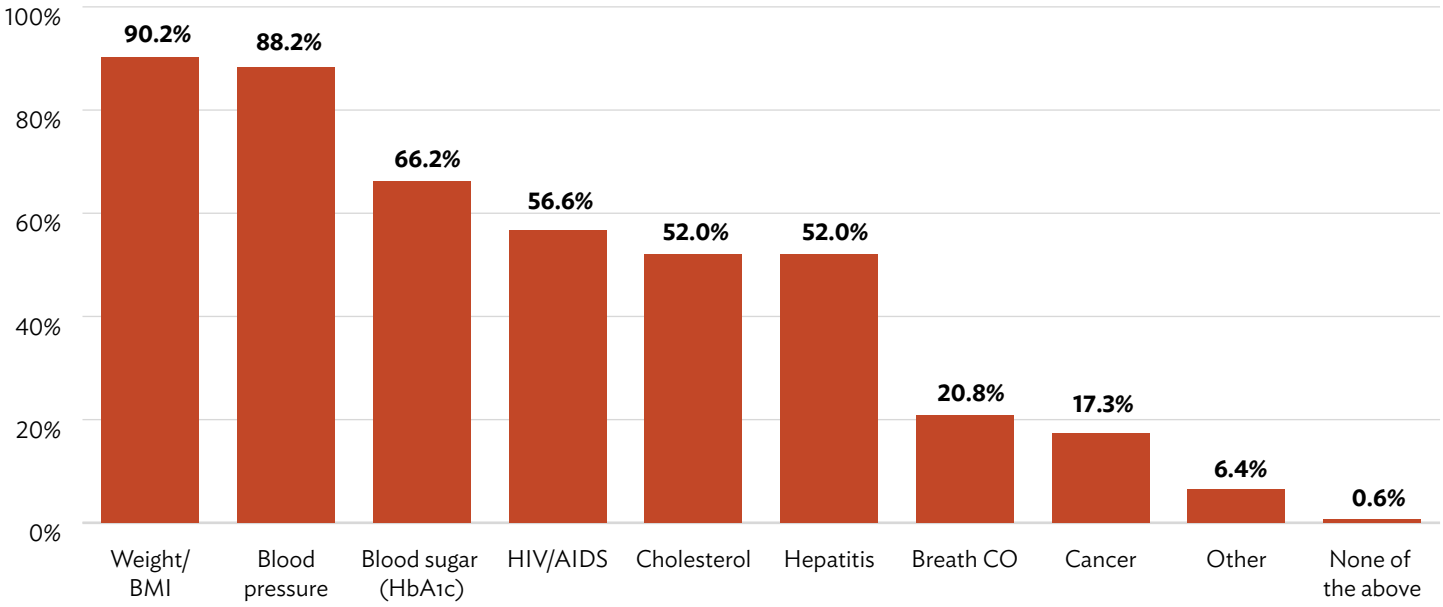
— Human Resources Development Institute, Illinois (established grantee)

COORDINATION AND INTEGRATION WITH PRIMARY CARE

Responding to a large body of literature demonstrating that people with serious mental illnesses and substance use disorders experience disproportionately high rates of chronic diseases and early mortality, the CCBHC model was designed to support improved coordination with and access to primary care services. Primary care itself is not a CCBHC required service, but CCBHCs are responsible for screening for and monitoring key health indicators and establishing strong partnerships with primary care providers to ensure clients' whole health needs are met. States may supplement these minimum requirements with additional primary care-focused criteria. For example, Oregon requires CCBHCs to make primary care available on-site a minimum of 20 hours per week.

Most CCBHCs directly deliver primary care screening and monitoring: Most Medicaid CCBHCs and expansion grantees provide primary care screening and monitoring directly; only 43 (12%) reported that they contract with a primary care provider as a DCO. CCBHCs reported screening for a wide variety of health indicators.

Health screenings conducted by CCBHCs directly or in partnership with a primary care provider

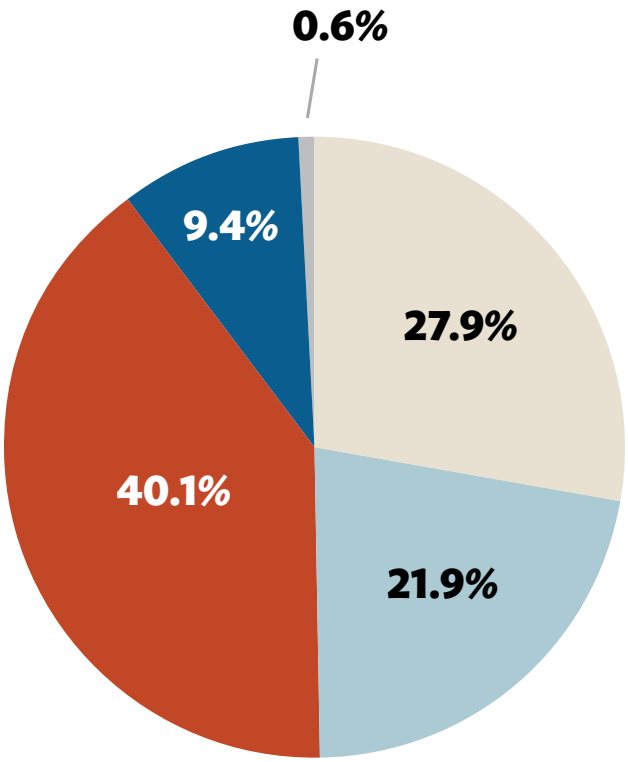


"Patients with untreated hypertension have been able to receive lifesaving treatment and, for many patients, for the first time have been able to maintain healthy blood pressure readings."

— Bridgeway Center Inc., Florida (established grantee)

Half of CCBHCs exceed minimum requirements by making comprehensive primary care available on-site: Nearly 3 in 10 (28%) Medicaid CCBHCs and established grantees reported their CCBHC is a fully integrated primary care and behavioral health provider with all services available in the same location. An additional 22% reported they have a co-location arrangement with a primary care provider, for a total of 50% that make comprehensive primary and behavioral health care available to all clients in the same location. Among the CCBHCs that shared further information on their co-location arrangements, 51 reported that their primary care partner provides services on-site at the CCBHC facility, and 15 reported that the CCBHC provides services on-site at the primary care partner's facility, including nine that reported doing both.

How CCBHCs facilitate access to comprehensive primary care, beyond the required screening and monitoring



- **Fully integrated provider:** Our CCBHC is also a comprehensive primary care provider, and services are available in the same location(s).
- **Co-location arrangement:** Our primary care partner provides services on-site at our CCBHC location, we provide services on-site at the primary care location or both.
- **Care coordination:** We provide referrals to our primary care partner(s), track follow-up and proactively coordinate care.
- **Referrals only:** We provide referrals to primary care organizations but do not actively track or coordinate care at this time.
- **None.**

> *"In 2019 we were able to open an on-site primary care practice in one of our largest clinics and on the same floor as one of our opioid treatment programs. Our model is highly client centered, including harm reduction, ambulatory withdrawal management, comprehensive screenings and chronic health education and management. This resource has been of tremendous value to people we serve."*
>
> **— Community Health Resources Inc., Connecticut (established grantee)**

Access to primary care is increasing among people served by CCBHCs: The overwhelming majority of Medicaid CCBHCs and established grantees (76%) reported that referrals to primary care have increased since becoming a CCBHC, including 30% reporting that referrals have increased by 20% or more. Even among respondents that were fully integrated care providers, 69% reported increases in primary care referrals, indicating the model's ability to further improve access to whole health care when layered on top of existing integration initiatives. Referrals were also more likely to have increased among clinics that used a primary care provider as a DCO, an indication that the depth of collaboration required of CCBHCs and their DCO partners may facilitate improved integration and access to whole health care.

Organizations that had been operating as a CCBHC for one year or less were more likely to report that their referrals to primary care had remained the same compared to CCBHCs that had been operating for longer, suggesting that referrals to primary care can be expected to increase over time as the CCBHC becomes more established.

> *"Providing comprehensive integrated care — including care coordination — has had a positive effect on our client population. We see increased awareness of physical health needs as a result of added screenings, increased knowledge of resources available at Burke and outside of Burke, and improved ability to navigate the health care system. These all lead to a greater level of follow-through for addressing physical health needs and ultimately improved health for our clients."*
>
> **— Burke Center, Texas (Medicaid CCBHC)**

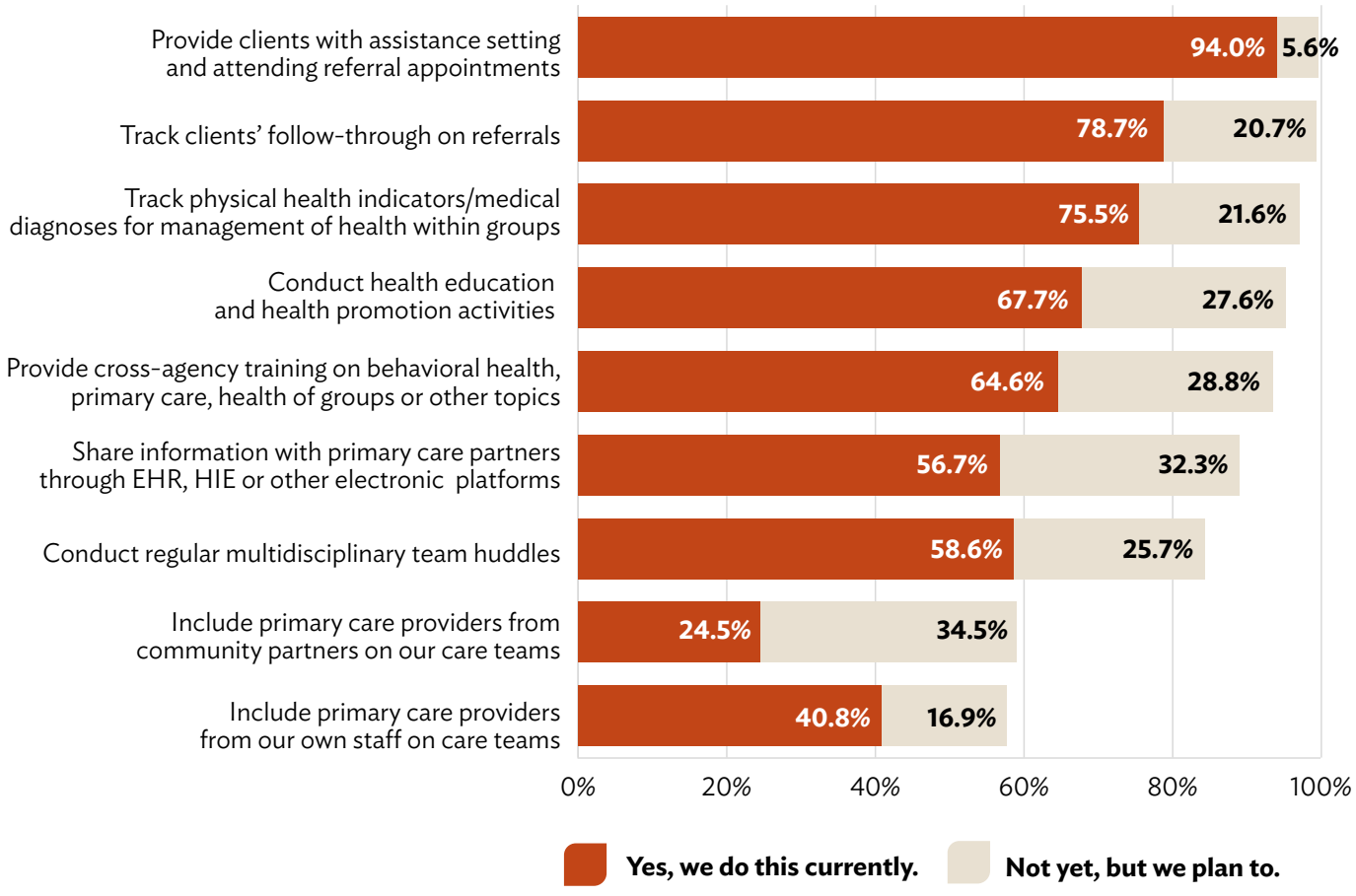
CCBHCs are partnering with FQHCs to coordinate and integrate services: Federally qualified health centers (FQHCs) emerged as common primary care partners for Medicaid CCBHCs and established grantees. Respondents reported substantial engagement with FQHCs across all levels of integrated and coordinated care arrangements. For example, among the 51 respondents who indicated that their primary care partner co-locates services on-site at the CCBHC, 25 (49%) said that their co-location partner was

an FQHC. Among the 43 respondents who used a DCO for primary care screening and monitoring, 32 (74%) reported having an FQHC as their DCO. Among the 158 respondents who reported having a care coordination or referral relationship with a primary care partner, 95 (60%) said their partner was an FQHC.

These findings indicate a strong foundation of collaboration between CCBHCs and FQHCs, with room to further advance co-location, care coordination and other collaborative arrangements between these partners across the board.

CCBHCs are engaging in a variety of strategies to advance integrated care: Nearly all (92%) Medicaid CCBHCs and established grantees reported engaging in one or more strategies to advance integrated care, in contrast to 69% of new grantees reporting they engage in one or more of these strategies at their current stage of implementation. This indicates the model's potential to help organizations grow their integrated care collaborations when the model is fully implemented.

CCBHCs' integrated care and care coordination activities with primary care partner(s)



MAKING CRISIS SERVICES AND SUPPORTS AVAILABLE TO ALL

SAMHSA's National Guidelines for Behavioral Health Crisis Care map out a crisis response continuum with three core elements: someone to talk to (crisis call services), someone to respond (mobile crisis team services) and a safe place for help (crisis receiving and stabilization services) (SAMHSA, 2020). SAMHSA's 2023 updates to the CCBHC Certification Criteria reflect CCBHCs' important role in delivering care or partnering with other crisis response providers within each of these core areas. Beginning in July 2024, CCBHCs must have care coordination partnerships in place with local 988 Suicide & Crisis Lifeline call centers and must meet an enhanced set of criteria related to mobile crisis and crisis stabilization services, with the option to partner with state-sanctioned crisis systems for these services. CCBHCs also engage in activities designed to link people to care postcrisis and prevent them from experiencing future crises.

CCBHCS' ROLE IN THE IDEAL CRISIS SYSTEM

		
Someone to talk to	***Someone to respond***	***A safe place for help***
Provides or coordinates with **988** Suicide & Crisis Lifeline.	Operates or partners with behavioral health mobile crisis teams providing **24/7 services** anywhere the crisis is experienced.	Provides or partners with crisis receiving and stabilization services like **urgent care** and **walk-in services**.

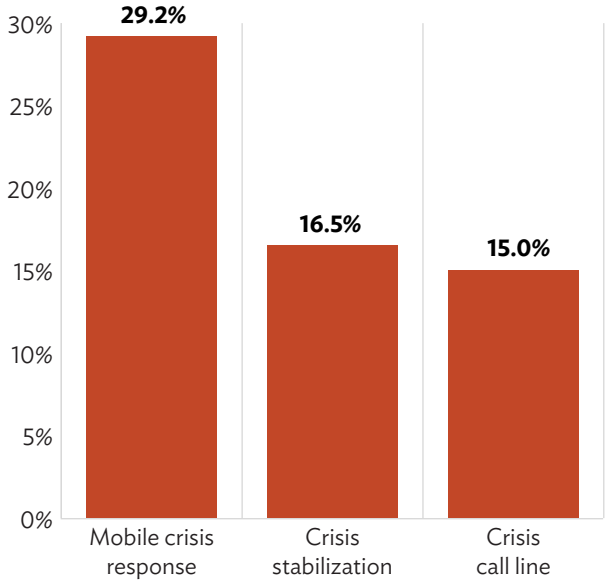
Crisis prevention

- Works with people postcrisis to create a crisis plan to prevent and de-escalate future crises.
- Provides postcrisis follow-up care to support people with managing their condition(s) and preventing future crises.

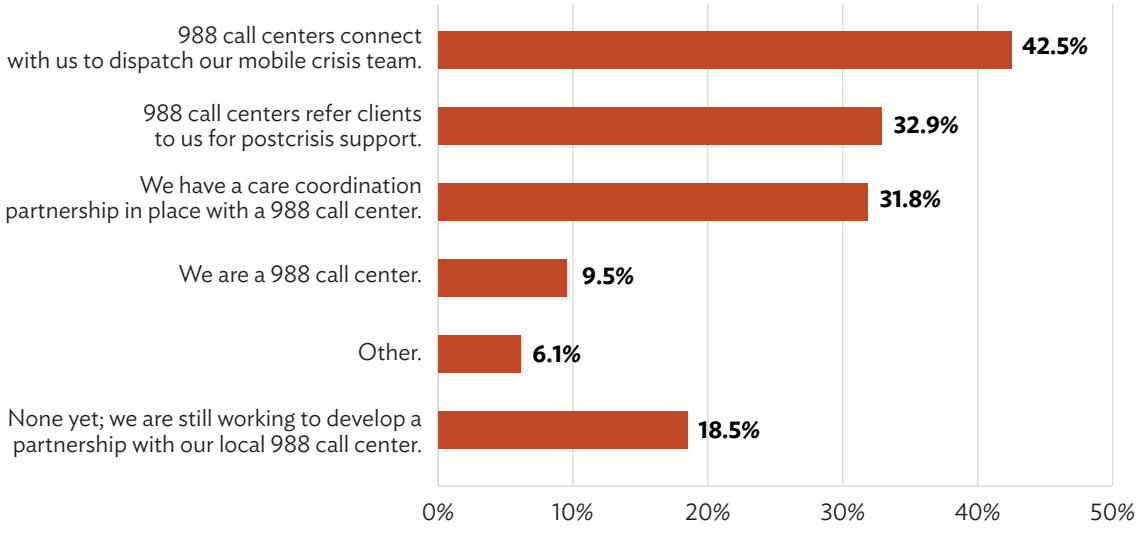
Availability of crisis services has expanded as a result of the CCBHC model: Many Medicaid CCBHCs and established grantees reported having added crisis services as a result of CCBHC implementation; others shared comments that CCBHC status has supported them in expanding their preexisting crisis response services. The addition of crisis response as a new service line generally indicates new or expanded crisis continuum capacity in CCBHCs' communities.

Someone to talk to — CCBHCs demonstrate early compliance with new 988 coordination requirements and offer additional access to crisis call lines: The 2023 updates to the CCBHC criteria established a clear role for CCBHCs in coordinating with the 988 Suicide & Crisis Lifeline. More than 80% of Medicaid CCBHCs and established grantees are already engaging in various partnership activities with 988 call centers (well ahead of the July 2024 compliance deadline for most of these CCBHCs[6]), with the remaining 19% actively working to establish 988 partnerships.

Services added to CCBHCs' scope as a result of certification



How CCBHCs engage with the 988 Suicide & Crisis Lifeline



[6] *CCBHCs in Oregon and Oklahoma will have until March 2025 to comply with the new requirements, based on the start of their demonstration years (SAMHSA, 2023c).*

In addition to their partnerships with 988 call centers, many Medicaid CCBHCs and established grantees offer additional access to crisis support through dedicated call lines, with 15% reporting they added crisis call line capacity as a result of CCBHC certification. More than half (58%) operate a 24/7 crisis call line available to anyone, 14% operate a 24/7 call line dedicated to supporting their clients, 3% operate a crisis line that is open limited hours and 6% reported offering access to a crisis call line in another way. CCBHCs' crisis call lines complement the support available through 988 call centers by providing localized support and connection points to clients' established providers.

Someone to respond — Greatest gains in mobile crisis response found among Medicaid CCBHCs and those in rural areas: When a crisis cannot be addressed fully through a call line, a mobile crisis team may be needed to respond. These teams are equipped to travel throughout the service area and provide on-location support to de-escalate crisis or, when needed, facilitate connection to a higher level of care (such as crisis stabilization or inpatient services). CCBHCs may provide 24/7 mobile crisis response directly or through a DCO partner, with 21% of Medicaid CCBHCs and grantees reporting they use a DCO for mobile crisis services.

More than 100 Medicaid CCBHCs and established grantees (29%) reported adding mobile crisis response as a result of becoming a CCBHC, an indication of the expanded availability of these important services within CCBHCs' communities. Medicaid CCBHCs were more likely to have added mobile crisis response as a new service compared to established grantees, with 35% of Medicaid CCBHCs reporting mobile crisis was a newly added service, compared to 25% of established grantees. This is likely attributable to the different financing mechanisms available to each group: While Medicaid CCBHCs have access to a payment methodology that accounts for their full cost of expanding services and reaching new populations, grantees must operate within a fixed amount of funding, making it more difficult for grantees to establish high-intensity, high-cost services such as mobile crisis response if they did not already offer this service.

Of note, rural CCBHCs were more likely to add mobile crisis teams compared to their nonrural counterparts (37% vs. 26%), suggesting that the CCBHC model may be a valuable tool in expanding the availability of crisis response in rural areas.

> ***"We expanded our mobile crisis teams and reduced our response time from hours to around 30 minutes! We have maintained this time consistently since it has originally gone down."***
>
> **— COMCARE of Sedgwick County, Kansas (Medicaid CCBHC)**

"For a small, rural community mental health agency, we have been able as a CCBHC to sustain a 24/7/365 mobile crisis team that serves all ages, regardless of insurance. As a result, we have then been able to meet the increased need for services through Same Day Access, increased MOUD services, doubled our staff to decrease wait times and provide flexible/creative services."

— Pines Behavioral Health Services, Michigan (Medicaid CCBHC)

CCBHCs' partnerships complement mobile crisis response: Partnerships are crucial to ensuring people experiencing a crisis can be met where they are and in a way that most appropriately addresses their needs. Coordination with 911, police, emergency medical services (EMS) and other community partners ensures connections across systems. Among other partnerships with first responders and public safety officers, more than 4 in 10 CCBHCs (n=143, 41%) engage in a co-response model where mental health or SUD providers co-respond to behavioral health crisis calls with police and/or EMS. A quarter (n=88, 25%) provide telehealth support to law enforcement officers responding to behavioral health calls. (See further discussion in "Improving Collaboration With Criminal Justice Agencies.")

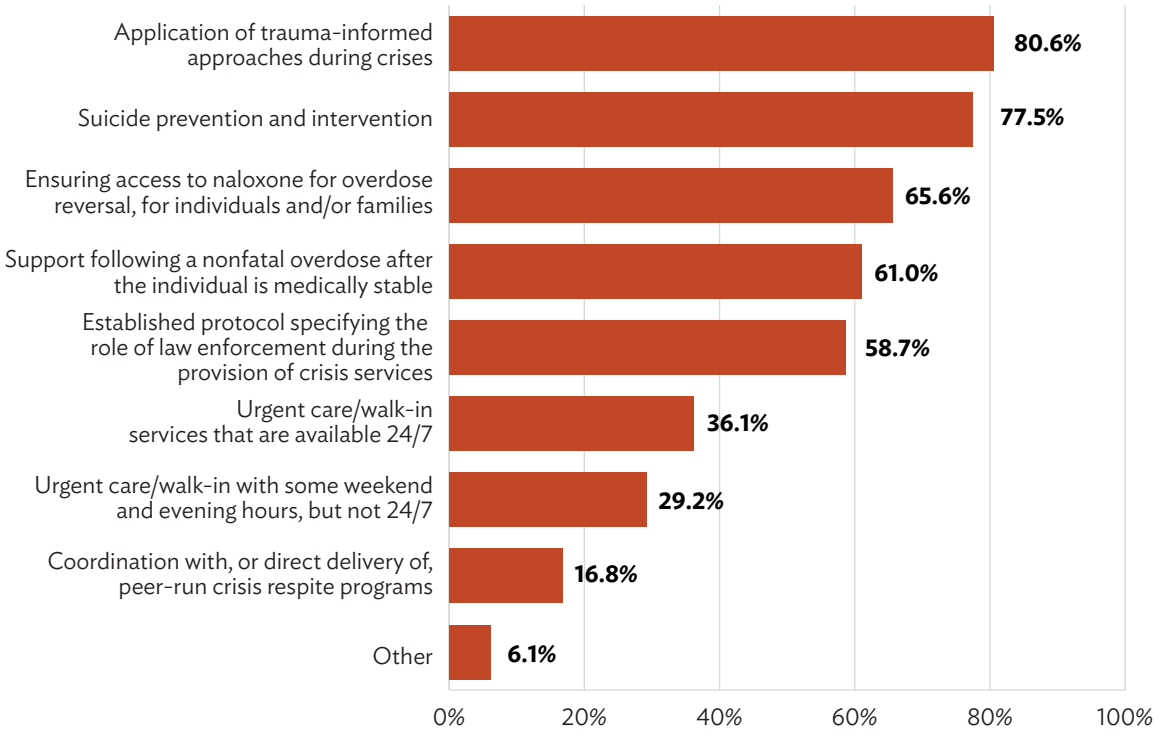
"We were the first Urgent Recovery Center in the state to provide Suboxone inductions. We are partnering with the [Oklahoma City] Fire Department to respond after a nonfatal overdose. Our peers are co-responding with them to get people into treatment after an overdose."

— HOPE Community Services, Oklahoma (Medicaid CCBHC)

A safe place for help — CCBHCs offer a wide array of crisis stabilization services: Crisis stabilization services are a critical component of the crisis response system that allows people in crisis to be seen in the least restrictive and most appropriate environment for the crisis they are experiencing. These services play an important role in relieving overburdened emergency rooms and inpatient care when a person's needs can be better addressed in a lower-intensity care setting. Through their crisis stabilization capacities, CCBHCs are meeting the critical need for a safe place for help for people experiencing a behavioral health crisis.

CCBHCs may provide crisis stabilization directly or through a DCO partner, with 15% of Medicaid CCBHCs and established grantees reporting they use a DCO for this service. CCBHCs reported offering a multitude of services and supports for people requiring crisis stabilization.

Crisis stabilization services and supports provided directly by CCBHCs



"We are incredibly proud of the success of our Zero Suicide implementation and the impact we have had on getting individuals connected to the right treatment that are in crisis. To date since we have implemented Zero Suicide, we have had zero deaths by suicide among those receiving enhanced care of our Zero Suicide clinical pathway!"

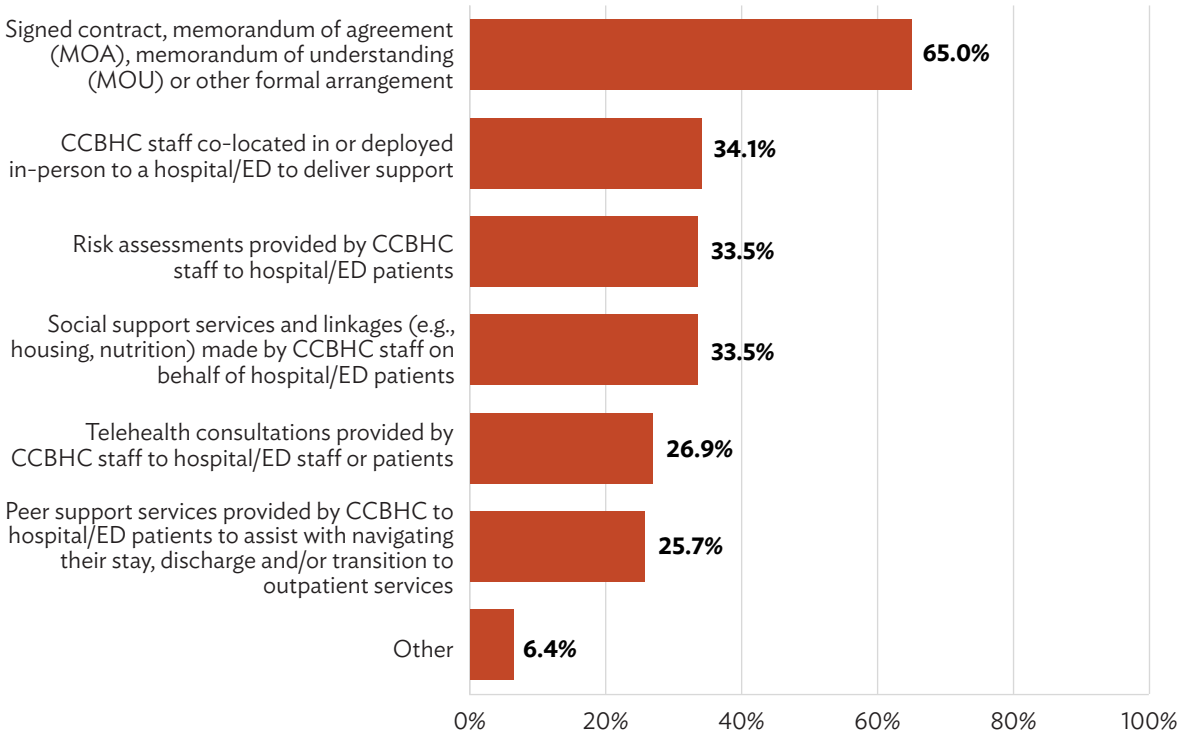
— CNS Healthcare, Michigan (Medicaid CCBHC)

WORKING WITH HOSPITALS TO IMPROVE CARE TRANSITIONS

People with serious mental illness or SUD are disproportionately likely to receive services in hospitals or EDs compared to the general population, often for complications arising from untreated chronic conditions. CCBHCs are working collaboratively with hospital and ED partners to divert individuals from higher-intensity settings and keep them from falling through the cracks upon discharge.

Nearly 85% of Medicaid CCBHCs and established grantees reported having one or more collaborative activities in place with hospital and/or ED partners, in contrast to 62% of new grantees (who are still working to build out their CCBHC services and activities) reporting one or more of the selected collaborative activities. This finding illustrates how implementation of the CCBHC model supports organizations in taking on increased collaboration with hospitals and/or EDs when it is fully implemented.

CCBHCs' activities with hospitals and/or EDs



While the majority of Medicaid CCBHCs and established grantees (n=225, 65%) have a signed agreement in place with their hospital or ED partners, many do not — an indication that collaboration can begin in practice while both parties work toward formalizing their partnership in a signed agreement.

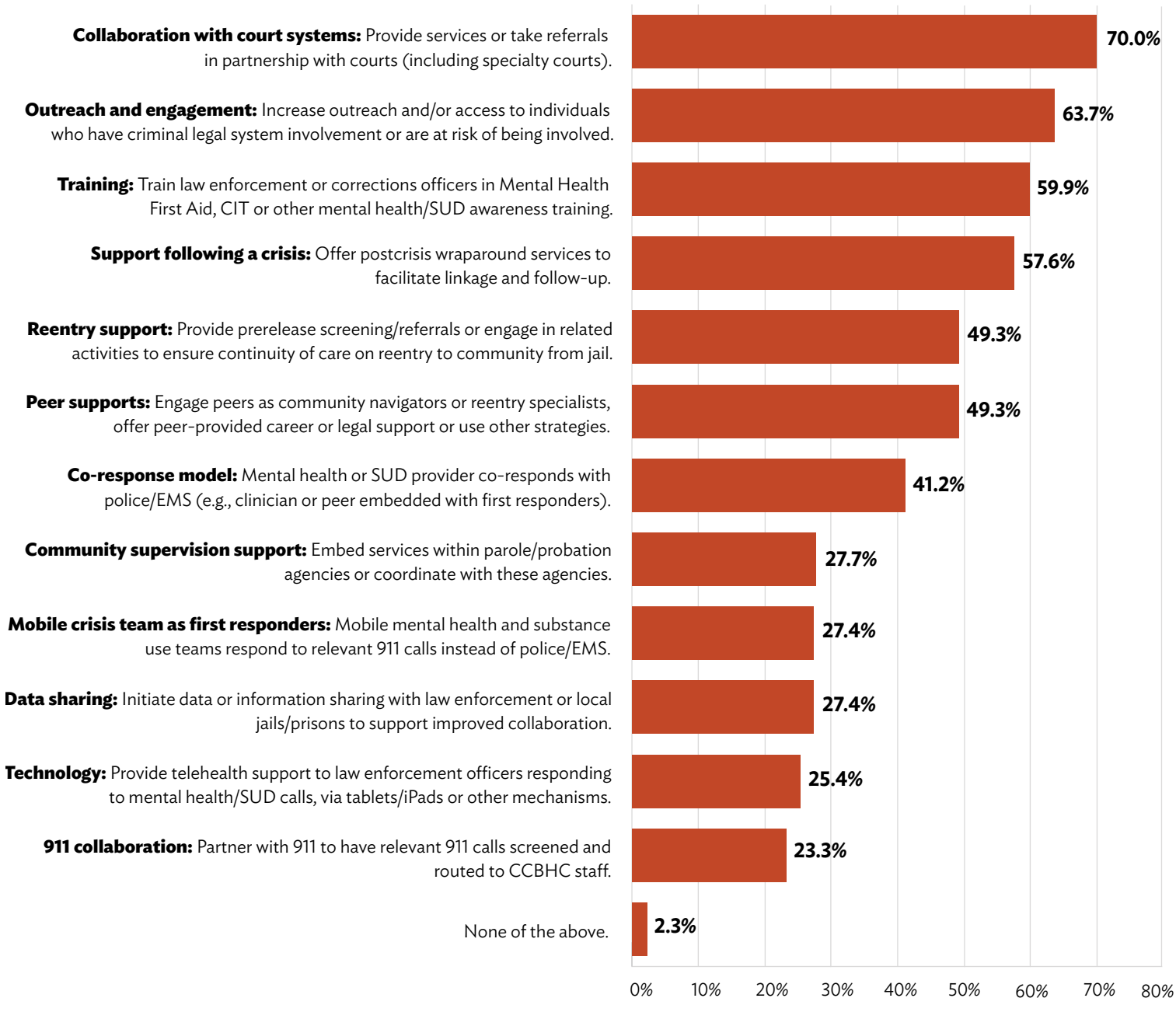
Nearly all Medicaid CCBHCs and established grantees (n=289, 91%) indicated they currently aggregate and analyze data on clients' ED and/or hospital utilization (n=164, 52%) or plan to do so (n=125, 39%). The overwhelming majority of the 164 CCBHCs that currently engage in this type of data analysis (n=119, 84.8%) reported that clients' hospital and ED utilization had decreased (n=57, 47.0%) or remained the same (n=62, 37.8%), despite large increases in overall client caseloads and particularly the increases among people without a prior source of outpatient care. These clients are more likely to have high levels of intensive unmet needs and be frequent recipients of hospital and ED services. (See "Expanding Timely Access to Care.") Steady and decreasing rates of hospital/ED utilization in the context of growing client populations with higher levels of unmet need indicate CCBHCs' ability to provide effective outpatient care that helps people manage their conditions and stay out of higher-intensity care settings.

> *"Our clients that consistently engaged in our measurement-based care approach demonstrated a 75% reduction in inpatient admissions, a 64% reduction in use of ED care and a $99 per-member per-month cost savings, compared to clients that did not consistently engage in measurement-based care. When extended to the population AMHR treats, that results in $25M overall savings."*
>
> **— Aurora Mental Health & Recovery, Colorado (established grantee)**

IMPROVING COLLABORATION WITH CRIMINAL JUSTICE AGENCIES

The vast majority of Medicaid CCBHCs and established grantees (98%) are actively engaged in one or more innovative activities with law enforcement and criminal justice agencies to improve outcomes for people who have criminal legal system involvement or are at risk of being involved with the criminal legal system.

CCBHCs' collaborative activities with criminal justice agencies



"As a result of the CCBHC and collaboration with county agencies, WellSpan is now providing substance use disorder group and peer services at the local jail."

— WellSpan Health, Pennsylvania (established grantee)

"We have expanded our community partnerships tremendously through CIT training. Currently we have trained 119 participants covering police, mental health, first responders and dispatchers. We utilize members of our [varied] populations to teach and help us shape the program. We are reaching people that we never thought we could! People are getting proper treatment instead of going to jail. We have literally helped to redefine communities. Becoming a CCBHC is only going to enhance that with financial sustainability. We are a part of a [historical] movement that will positively change behavioral health services forever! It's the greatest feeling ever."

— Southern Highlands Community Mental Health Center Inc., West Virginia (established grantee)

MEETING CHILDREN, YOUTH AND FAMILIES WHERE THEY ARE

Continued attention is needed to address the pressing behavioral health needs of children and youth in this county. In 2021, in the midst of the COVID-19 pandemic, 42% of high school students reported experiencing persistent feelings of sadness and hopelessness, and the number of young people with depression has nearly doubled in the past 10 years (CDC, 2021). Children and youth are facing urgent needs for mental health and substance use services, yet too many are left without access to care (Insel, 2023).

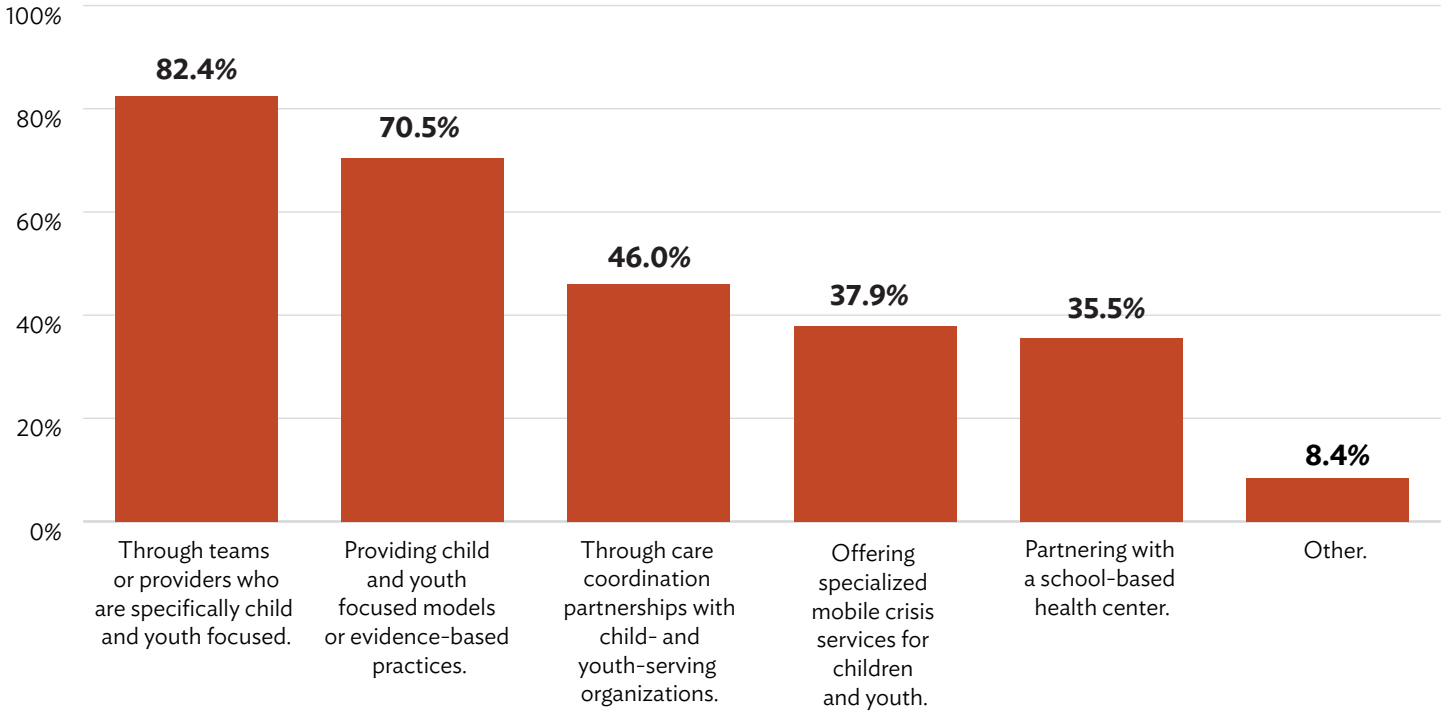
The CCBHC model offers a strategy to help address these growing needs. The model requires CCBHCs to provide comprehensive services across the lifespan for children, youth and their families or caregivers. CCBHCs must have staff trained in delivering developmentally appropriate care and meeting the unique needs of children and youth. Partnerships are key to this success, with CCBHCs required to enter partnerships with schools, child welfare agencies, juvenile justice agencies and other youth-serving entities based on the results of their community needs assessments. The model also supports clinics in providing services beyond the four walls of the clinic, a particularly important element of service delivery for young people, allowing CCBHCs to think creatively about meeting families and their children where they are.

CCBHCs are increasing the number of children and youth they serve: As noted above, children and youth were the group most frequently mentioned by CCBHCs as experiencing significant growth in the number of clients served: **68% of Medicaid CCBHCs and established grantees reported the number of children/youth they serve has increased, including 24% who indicated the increases to their number of child and youth clients were substantial.**

CCBHCs are increasing access for children and youth through an expanded workforce, targeted services and community partnerships: 60% of Medicaid CCBHCs and established grantees hired staff with a child/youth focus. This includes 36% that have hired child/youth psychiatrists and 62% that have hired other professional levels of child/youth specialty clinicians. The workforce shortage continues to affect hiring of child/youth-focused providers, with 36% of respondents reporting they have created new positions for child/youth providers that have not yet been filled.

CCBHCs engage in a variety of strategies to reach children and youth with appropriate services. For example, the majority of Medicaid CCBHCs and grantees (n=285, 82%) have established targeted teams or providers who are specifically child and youth focused. More than two-thirds (n=244, 71%) use child- and youth-focused care models or evidence-based practices. Respondents mentioned a broad variety of evidence-based models in place. As a small sampling, these included Assertive Community Treatment teams for targeted age groups, specialized mobile crisis response for youth, Parent-Child Interaction Therapy, trauma-focused cognitive behavioral therapy, and coordinated specialty care for first-episode psychosis.

How CCBHCs serve children and youth



Partnerships also emerged as a key strategy in expanding access to services. Sixteen respondents (5%) reported entering into a DCO partnership to expand access to specialty mental health or substance use services for children and youth, and nearly half (n=159, 46%) established care coordination partnerships with child- and youth-serving organizations. Among CCBHCs' care coordination partners were specialty child/youth behavioral health providers, school districts, family support centers, supportive housing providers, domestic violence centers, courts, Big Brothers/Big Sisters or Boys' and Girls' Clubs, and a vast array of other family- and child-oriented organizations.

> *"GCC has worked to increase partnerships with youth-serving organizations in order to provide early intervention to reduce the need for intensive mental health services and prevention services to reduce substance use. GCC also has partnered to provided social emotional services in the juvenile detention to reduce risk factors for those children and families."*
>
> **— Gulf Coast Center, Texas (Medicaid CCBHC)**

Partnerships with schools are a key element of CCBHCs' expanded reach: The vast majority of Medicaid CCBHCs and established grantees (83%) provide services on-site in one or more schools, childcare facilities or other youth-serving settings. Middle schools, elementary schools and high schools were the most commonly reported settings for on-site care delivery. These partnerships are a sign of the model's success in supporting convenient access to care for young people outside the clinic.

School and childcare settings in which CCBHCs provide services on-site

SETTING	NUMBER (PERCENT)
Elementary schools	223 (64.5%)
Middle schools	224 (64.7%)
High schools	217 (62.7%)
Colleges, universities, trade schools or similar	45 (13.0%)
Head Start programs	73 (21.1%)
Other early-childhood childcare or education settings	54 (15.6%)
Other	21 (6.1%)
None of the above	59 (17.1%)

"We have expanded our youth/school-based programs significantly since becoming a CCBHC — serving 1,900 kids in our school co-located programs since CCBHC. We launched our Childrens Crisis Rapid Response Team to support with stabilization and de-escalation for children/families in crisis. We have scaled up team-based care across programs, launching nine new care pathways, and staffed for interdisciplinary teaming for huddles. Staff are using dashboards and risk-stratification tools to identify their high-risk populations and aligning to the care pathway. Since FY22, we have served ~3,000 individuals on the pathways. We are on-site seven days/week with three shelters for the unhoused populations, completing intakes/peer engagement on-site. We have served ~30 underinsured/uninsured individuals to date."

— Easter Seals-Michigan Inc., Michigan (Medicaid CCBHC)

ADDRESSING SOCIAL AND ENVIRONMENTAL FACTORS THAT AFFECT HEALTH

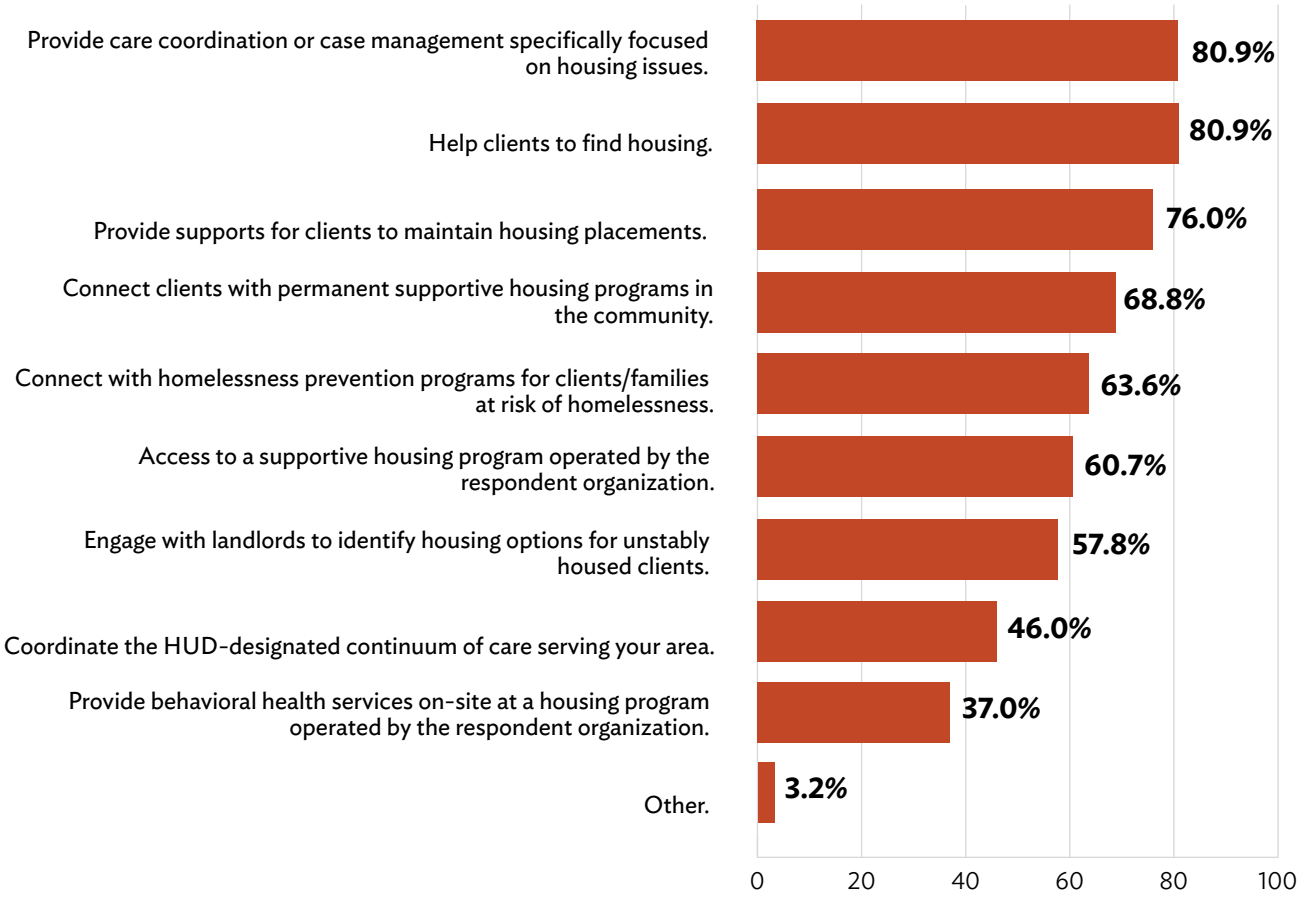
The CCBHC model supports clinics in adapting service delivery to meet the unique needs of their own communities, guided by a community needs assessment that is updated every three years.[7] CCBHCs are leveraging the model to address social and environmental factors that affect health, build partnerships across communities, connect people to care and leverage data to better understand discrepancies in service delivery and access

CCBHCs are targeting service delivery to populations with high levels of unmet need: More than 4 in 5 (n=299, 86%) Medicaid CCBHCs and established grantees have launched, expanded or sustained targeted programming, dedicated service lines and/or intensive outreach efforts to improve the accessibility of services for a wide array of populations with unmet needs. The most common populations of focus were veterans, people involved or at risk of involvement with the criminal justice system and people experiencing homelessness.

Housing is a key area of focus for many CCBHCs: Nearly all Medicaid CCBHCs and established grantees (n=294, 93%) reported universally screening CCBHC clients for their housing status, with the remainder indicating they screen some but not all clients (n=19, 6%) or don't yet screen for housing status but plan to do so (n=2, <1%). Among CCBHCs that universally screen for housing status, 13% (n=38) indicated that more than a quarter of their clients are experiencing homelessness or housing instability. An additional 34% (n=99) shared that 11%-25% of their clients experience homelessness or housing instability, and 53% (n=156) said that 1%-10% of their clients experience homelessness or housing instability. The vast majority of CCBHCs (n=315, 91%) engage in one or more activities to help clients find or maintain stable housing.

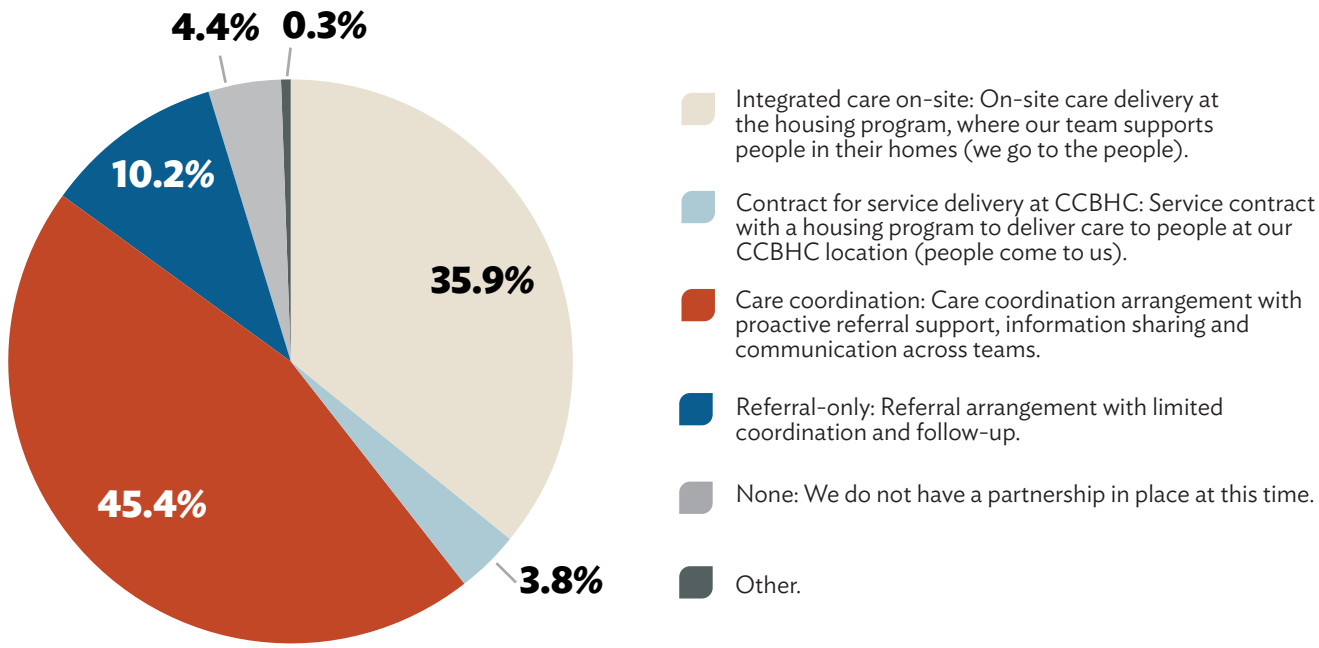
[7] *See Section 1.a.1 of the CCBHC Certification Criteria (SAMHSA, 2023a).*

CCBHCs' activities to assist clients with finding or maintaining housing



CCBHCs also reported establishing relationships with supportive housing providers to ensure access to mental health and substance use services for supportive housing clients. More than one-third (n=113, 36%) reported delivering care on-site at supportive housing facilities.

CCBHCs' partnerships with supportive housing providers



CCBHCs engaged in a wide array of strategies to address health discrepancies, driven by community need: CCBHCs engaged in many additional strategies to improve access to and quality of services for individuals from historically marginalized or underserved communities.

Among the most-used strategies were efforts to improve staff training and the responsiveness of services. Seventy-five percent of Medicaid CCBHCs and established grantees reported actively seeking input from clients about program design and direction, hiring staff who are demographically representative of the people they serve, and training staff on Culturally and Linguistically Appropriate Services (CLAS).

ACTIVITIES TO IMPROVE STAFF TRAINING AND RESPONSIVENESS OF SERVICES	NUMBER (PERCENTAGE)
Actively and consistently seeking input from clients about program design and direction, service delivery and organizational culture.	261 (75.4%)
Hiring staff who are demographically representative of population we serve.	258 (74.6%)
Training staff on CLAS.	255 (73.7%)
Initiating or expanding translation and interpretation services.	233 (67.3%)
Involving staff in strategizing to address health discrepancies.	226 (65.3%)

Many Medicaid CCBHCs and established grantees also reported working to improve access to and use of services among people from historically marginalized or underserved groups.

ACTIVITIES TO IMPROVE ACCESS TO AND USE OF SERVICES	NUMBER (PERCENTAGE)
Increasing efforts to engage and retain people already connected to services.	270 (78.0%)
Increasing outreach to people who have long-standing unmet needs.	258 (74.6%)
Hiring cultural liaisons to help us connect with populations with unmet needs.	56 (16.2%)
Other.	10 (2.9%)

> *"Our organization has created a "**CCBHC on Wheels**" to bring outreach/engagement and the CCBHC service array to [underserved] individuals and communities who experience barriers to care and would otherwise lack access. This team is staffed with peers, clinicians and an RN and can provide services (including MAT and naloxone training) in an RV, in the community and in probation/parole locations. Our agency has also created a fully mobile community-based team for chronically ill individuals who typically do not succeed in a clinic environment, to bring the CCBHC model to them and prevent hospitalization."*
>
> **— Central Nassau Guidance and Counseling Services Inc., New York (Medicaid CCBHC)**

Medicaid CCBHCs and established grantees also reported working to improve group-level health and the quality of services for underserved communities through a variety of strategies.

ACTIVITIES TO IMPROVE GROUP-LEVEL HEALTH AND CARE QUALITY	NUMBER (PERCENTAGE)
Increasing screening for unmet social and environmental factors that affect health (e.g., housing, income, insurance status, transportation).	281 (81.0%)
Regular reporting among staff on data collection and analysis.	204 (58.8%)
Establishing evaluation metrics to track progress toward eliminating health discrepancies among populations served.	178 (51.3%)
Risk stratification of subgroups based on demographics.	94 (27.1%)
Other.	5 (1.4%)

Finally, Medicaid CCBHCs and established grantees reported engaging in several strategies to develop partnerships aimed at improving the reach of their services and strengthening their connections with communities with unmet needs.

ACTIVITIES TO DEVELOP PARTNERSHIPS AND COMMUNITY CONNECTION	NUMBER (PERCENTAGE)
Establishing partnerships with community organizations that represent or serve marginalized groups.	242 (69.7%)
Establishing partnerships with religious organizations or faith communities.	139 (40.1%)
Establishing partnerships with tribal organizations.	65 (18.7%)
Other.	10 (2.9%)

CONCLUSION

Through their ability to expand access to comprehensive mental health, substance use and crisis care services, provide integrated care that focuses on the whole person, and closely partner with hospitals, law enforcement and schools, CCBHCs help ensure everyone in their communities has equitable access to high-quality care, when and where they need it.

Thanks to tremendous bipartisan support over more than a decade from members of Congress, three presidential administrations, dozens of state governors and legislatures across the country, and the tireless work of CCBHCs themselves to demonstrate the model's promise, CCBHCs have grown from a small demonstration to a nationwide movement. Most recently, the Consolidated Appropriations Act of 2024 established CCBHCs as an optional benefit in Medicaid — a crucial step toward sustaining the program beyond the demonstration. States can now swiftly take action to expand access to CCBHCs statewide, while ensuring people living in a CCBHC demonstration state can continue to access care from a CCBHC after the demonstration ends.

Despite this great progress, more work is needed to further expand the availability of CCBHC services nationwide and ensure that every person in the U.S. can access care from a CCBHC and its network of partners. States, the federal government and other stakeholders can all take action to support the continued growth and impact of this important model.

Congress can support CCBHCs' efforts by taking the next steps to secure the future of the model in the national health care landscape. These include establishing a CCBHC PPS within Medicaid, establishing CCBHCs and their PPS within Medicare, supporting continued investment in the SAMHSA CCBHC grants, and funding a national data infrastructure to advance our knowledge of CCBHCs' activities and impact.

States can work to expand or launch the CCBHC model within their state Medicaid programs, including by applying for the demonstration, expanding their existing demonstration to include new CCBHCs, and establishing permanence for the model via a Medicaid state plan amendment, waiver or other Medicaid authority.

The National Council is available as a resource to all stakeholders. Please visit **our website** to learn more and receive support with CCBHC implementation.

SURVEY METHODOLOGY

The 2024 CCBHC Impact Survey was conducted by the National Council from January to March, 2024. The survey was disseminated to 495 unique organizations certified as a CCBHC by their state or with an active SAMHSA CCBHC grant as of January 2024. Of this group, 380 organizations submitted responses, for an overall 77% response rate. Raw data was not weighted and therefore only represents those that completed the survey.

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GLOSSARY OF ABBREVIATIONS

AWD: ambulatory withdrawal management

C-SSRS: Columbia Suicide Severity Rating Scale

CCBHC: Certified Community Behavioral Health Clinic

CDC: Centers for Disease Control and Prevention

CIT: crisis intervention team

CLAS: Culturally and Linguistically Appropriate Services

CMS: Centers for Medicare and Medicaid Services

DCO: Designated Collaborating Organization

ED: emergency department

EHR: electronic health record

EMS: emergency medical services

FQHC: Federally Qualified Health Center

HRSA: Health Resources and Services Administration

IA: Improvement and Advancement [grant type]

LCSW: licensed clinical social worker

LPC: licensed professional counselor

MAT: medication-assisted treatment

MOUD: medication-assisted treatment for opioid use disorder

NSDUH: National Survey on Drug Use and Health

OTP: opioid treatment program

OUD: opioid use disorder

PDI: Planning, Development and Implementation [grant type]

PPS: Prospective Payment System

PREE: police request for emergency examination

RN: registered nurse

SAMHSA: Substance Abuse and Mental Health Services Administration

SUD: substance use disorder

VA: U.S. Department of Veterans Affairs

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