2026

CCBHC IMPACT REPORT

NATIONAL COUNCIL *for* Mental Wellbeing

TABLE OF CONTENTS

IMPACT HIGHLIGHTS

Certified Community Behavioral Health Clinics (CCBHCs) provide comprehensive mental health and substance use care in communities across the country. Their work includes 24/7 mobile crisis response, specialized care for veterans, and structured collaboration with community partners to ease the pressure on emergency departments (EDs) and law enforcement. CCBHCs are required to serve anyone with a need for mental health and substance use care, regardless of age, ability to pay or place of residence.

Expanding timely access to care

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

- In 2025, CCBHCs served an estimated **3.4 million** people, a nearly 13% increase since January 2024 that reflects continued yearly growth since the inception of the model.
- Nearly **54%** of CCBHC clients have serious mental illness or serious emotional disturbance.
- On average, CCBHCs reported a **42%** increase in the number of clients served since becoming a CCBHC.
- The most commonly reported expansions in access 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 continued high demand for substance use care by expanding access to comprehensive substance use treatment, including recovery supports and medications for substance use disorders.

- Half of CCBHC clients with opioid use disorder receive medication-assisted treatment, nearly three times the national average.
- Nearly **two-thirds** of CCBHCs reported an increase in the number of people receiving medications for opioid use disorder served, with **30%** reporting increases of 20% or more.

Meeting children, youth and families where they are

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

- **57%** of CCBHCs reported an increase in the number of children and youth served, including **22%** that indicated a substantial increase of 20% or more.
- Nearly all CCBHCs (**96%**) partner with youth-serving organizations, with **73%** providing on-site services in schools.

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.

- **41%** of CCBHCs were able to add mobile crisis response because of certification, expanding mobile crisis availability in their communities.
- CCBHCs coordinate with crisis, health care and public safety systems to dispatch mobile crisis teams through multiple access points, including direct calls, 988 or 911 calls, provider referrals, and other emergency or community response pathways.

Improving collaboration with criminal justice entities

CCBHCs 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 (**98%**) are actively engaged in one or more innovative activities in partnership with criminal justice agencies, including providing services in partnerships with courts (**82%**), increasing outreach and service delivery to people with criminal justice system involvement (**76%**), and providing behavioral health awareness training to law enforcement officers (**65%**).
- **76%** of CCBHCs report positive outcomes from these efforts, such as improved diversion from arrest to treatment, increased joint response or co-responder activities, and reduced law enforcement time spent responding to behavioral health crises.

Addressing homelessness and unemployment among CCBHC clients

CCBHCs are providing targeted services to address homelessness and unemployment in their communities.

- **94%** of CCBHCs have partnerships with housing entities, such as supportive housing providers, emergency shelters, transitional housing providers and public housing agencies.
- **73%** of CCBHCs report positive housing outcomes among their clients, including reduced homelessness and increased housing retention.
- **65%** of CCBHCs report positive employment outcomes among their clients, including increased employment, work readiness and job retention.

Coordination and integration with primary care

CCBHCs work closely with primary care partners, using multiple strategies to coordinate and integrate care. As a result, access to primary care is increasing among CCBHC clients.

- Nearly half of CCBHCs (**49%**) exceed minimum care coordination requirements by making comprehensive primary care available on-site.
- **76%** reported that referrals to primary care have increased since becoming a CCBHC, including **35%** reporting that referrals have increased by 20% or more.

Investing in the workforce

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

- Since becoming a CCBHC, respondents reported creating **32,086** new staff positions, or a median of **31** new positions per clinic.
- Hiring was greatest among Medicaid CCBHCs, which reported a median of **81** new positions per clinic.
- The most commonly hired staff positions include care coordinators, data managers or analysts, licensed behavioral health clinicians (including those with a substance use focus), nurses and peer support specialists.

OVERVIEW OF THE CCBHC MODEL

Since launching in 2017, the Certified Community Behavioral Health Clinic (CCBHC) model has transformed community behavioral health systems by advancing the delivery of comprehensive, integrated mental health and substance use care throughout the country. CCBHCs are clinics — either recipients of a federal CCBHC grant or certified by their states as CCBHCs through 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.

CCBHCs must deliver services aligned to their local communities' needs, incorporate evidence-based practices (EBPs) and establish care coordination as a central part of service delivery. They are required to serve anyone with a need for behavioral health care in the community, regardless of age, ability to pay or place of residence. These populations include people with serious or complex mental or substance use conditions, veterans and members of the armed services, and children and youth.

Since its inception, the model has experienced significant growth. What began as a Medicaid demonstration program with 66 clinics across eight states has expanded to hundreds of organizations across nearly every state. This growth is driven by successive federal actions, including demonstration program expansions, state legislative and administrative policymaking, and the establishment of a federal CCBHC Expansion (CCBHC-E) grant program. As of June 2026, 33 states have implemented or are working to implement the model through the federal Medicaid demonstration or an independent Medicaid authority.

The 2026 CCBHC Impact Survey provided an opportunity for CCBHCs nationwide to share current data on their operations, successes and challenges. This report offers insights into how the CCBHC model continues to expand access to care, strengthen service delivery systems and improve outcomes for individuals across the nation.

SURVEY METHODOLOGY

The 2026 CCBHC Impact Survey was conducted by the National Council for Mental Wellbeing from January to April 2026. The survey was disseminated to 539 unique organizations that were certified as a CCBHC by their state or had an active Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC-E grant as of December 31, 2025. This survey was administered at the organizational level, rather than the clinic site level. Organizations with multiple CCBHC programs in place (e.g., multiple CCBHC-E grants serving different regions, multiple state CCBHC certifications for different service areas, or both state certification and a CCBHC-E grant) were counted once in both the survey distribution and analysis. Of the organizations contacted, 414 clinics submitted responses, resulting in an overall 76.8% response rate.

Survey data was self-reported and were not weighted; therefore, findings reflect the experiences and perspectives of organizations that completed the survey. Where relevant, CCBHC-E grantees were analyzed separately from Medicaid CCBHCs.

A Note on Terminology

For the purposes of this report:

Medicaid CCBHC includes CCBHCs that are participating in the Section 223 Medicaid Demonstration[1] and those that are certified by their states under an independent state implementation effort, such as a Medicaid State Plan Amendment or waiver. Medicaid CCBHCs receive payment through Medicaid that is designed to cover their costs of delivering services aligned with CCBHC criteria. Some of these state-certified sites have also received one or more CCBHC-E grants from the SAMHSA, but these organizations are categorized as "Medicaid CCBHCs" in the analysis because of their access to the special CCBHC Medicaid payment methodology.[2]

CCBHC-E grantee refers to clinics with an active SAMHSA CCBHC-E grant *that are not certified as CCBHCs by their states* — in other words, they are grantees only. 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 during the period of their grant.

1 Named after the section of the Protecting Access to Medicare Act of 2014 that established the demonstration.

2 Medicaid CCBHCs include Texas' T-CCBHC providers, Pennsylvania's Integrated Community Wellness Centers and Missouri's Certified Community Behavioral Health Organizations (CCBHOs).

CCBHC Type	Geographic Reach	Funding Mechanism	Number of Survey Respondents
Medicaid CCBHCs	292 Medicaid CCBHCs were active in 22 states as of December 2025. 23 Medicaid CCBHCs also had an active CCBHC-E grant as of December 2025.	Receive a special Medicaid CCBHC Prospective Payment System (PPS)[3] under the Section 223 Demonstration or similar payment model under an independent state Medicaid CCBHC initiative	238 of 414 survey respondents (57.5%) were Medicaid CCBHCs, representing 81.5% of all Medicaid CCBHCs in the country.
CCBHC-E grantees only	247 grantee-only CCBHCs were active in 26 states and territories as of December 2025.	Receive up to $4 million for a four-year grant term under SAMHSA's CCBHC-E grant program	176 of 414 respondents are solely CCBHC-E grantees (42.5%), representing 71.3% of grantee-only CCBHCs throughout the country.

While Medicaid CCBHCs and grantees reported broadly similar experiences, the survey data reveals some differences between the two types of clinics. These findings provide insight into how implementation of the model through Medicaid can further scale innovations and improvements initiated under the grant program.

New Areas of Analysis

The 2026 survey expanded on prior years by including new sections that capture emerging areas of CCBHC impact, including:

- Efforts to address employment needs among CCBHC clients
- Impact of CCBHCs' efforts to prevent and/or address housing needs among CCBHC clients
- CCBHCs' partnerships with Federally Qualified Health Centers (FQHCs)
- Adoption of value-based payment arrangements
- Use of technology and artificial intelligence (AI) in service delivery and operations

3 The CCBHC PPS is a Medicaid reimbursement model that provides CCBHCs with a bundled payment rate based on anticipated costs of delivering services.

Acknowledgment

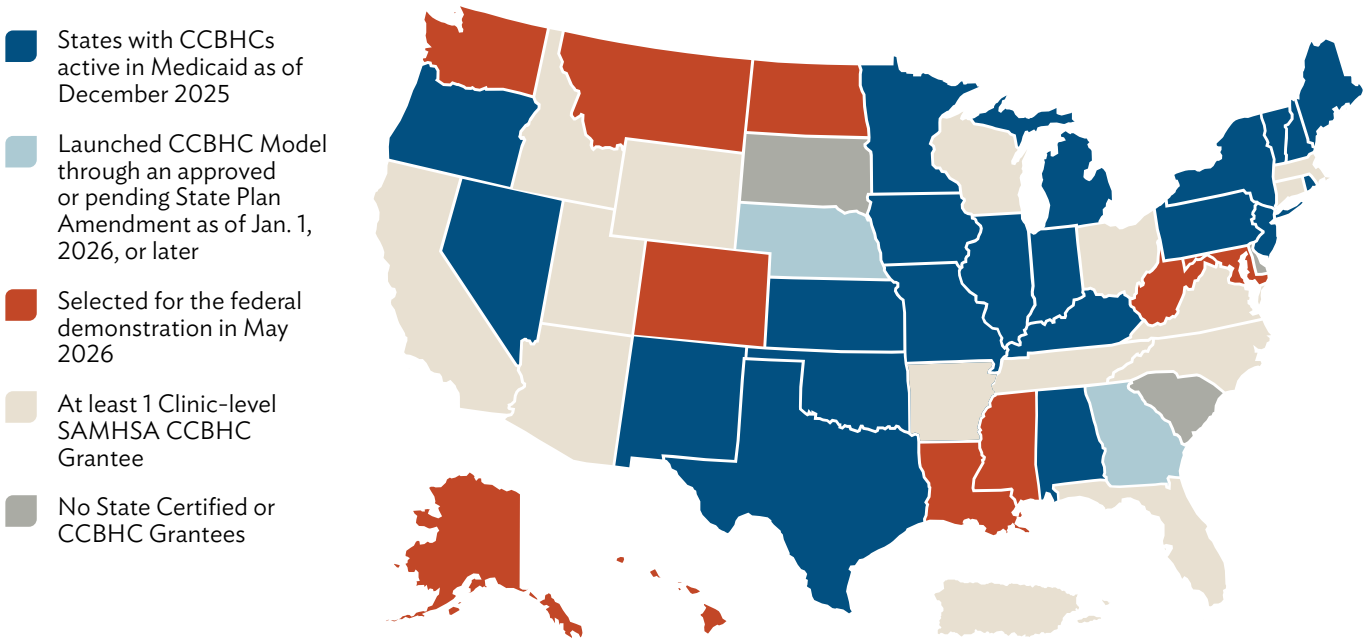
The National Council extends its sincere appreciation to the individuals who completed the survey on behalf of their organizations. We also thank state officials and state behavioral health provider associations for their partnership in supporting survey outreach and encouraging clinic participation, which was critical to achieving a strong response rate.

CCBHCs' REACH ACROSS THE NATION

As of December 31, 2025, there were 539 CCBHCs in 48 states and territories, including Washington D.C. and Puerto Rico, representing an 8.9% increase in the number of CCBHCs since the previous CCBHC Impact Survey was conducted in January 2024. This increase is attributable to new SAMHSA CCBHC-E grants awarded in late 2024 and the expansion of the CCBHC demonstration program to 10 new states in mid-2024 to 2025.

The 414 CCBHCs that responded to this year's survey reported serving 2,582,687 clients in calendar year 2025. Based on this data, the National Council estimates that all 539 CCBHCs across the U.S. serve approximately 3.4 million clients as of December 2025 — a 12.9% increase since January 2024.

CCBHC Implementation Status



The CCBHC model will continue to expand with the May 2026 selection of 10 new states for the Section 223 Medicaid Demonstration (with demonstration start dates ranging from July 2026 to July 2027) and the award of up to 12 CCBHC state planning grants expected in the fall of 2026. At the same time, the number of CCBHC-E grantees may decline in 2026 as numerous grants supported through supplemental COVID-era appropriations come to an end. Some clinics may receive renewed awards in 2026, while others may transition into state Medicaid demonstration programs where opportunities are available. The anticipated transition in CCBHC participation highlights the need for continued federal and state investment in supporting long-term sustainability and stable financing pathways for the model.

ACCESS EXPANSIONS: 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 care they need. According to SAMHSA's 2024 National Survey on Drug Use and Health (NSDUH), only 1 in 5 (20%) adults with a substance use disorder (SUD) and 52% of adults with any mental illness received treatment in the last year (SAMHSA, 2025). There remains an urgent need to reduce barriers to access.

CCBHCs are addressing longstanding gaps by increasing access to care. The majority of CCBHCs (86.2%) reported that the number of people their organization serves has increased since becoming a CCBHC. Survey respondents reported serving a total of 1,814,158 unduplicated clients in the year prior to becoming a CCBHC. Following certification and implementation of the model, these same clinics reported serving 2,582,687 unduplicated clients in calendar year 2025, reflecting a 42.4% increase in the number of individuals receiving CCBHC services. This growth highlights the CCBHC model's ability to expand service capacity and access.[4]

2,582,687
people served by 414 CCBHC respondents

Estimated
3.4 million
served by all 539 Medicaid CCBHCs and grantees across the U.S.

86.2%
of CCBHCs serve more people since becoming a CCBHC

More than **768,529** total **new people** served

CCBHCs are expanding access to rural areas. Rural CCBHCs reported that they served 377,846 individuals in the year prior to becoming a CCBHC. In calendar year 2025, rural CCBHCs reported serving 552,214 individuals, making a 46.2% increase in the number of CCBHC clients since becoming a CCBHC.

4 It is important to note that clinics became CCBHCs at different points in time; therefore, this increase reflects aggregate growth across respondents rather than a uniform year-over-year change for all clinics.

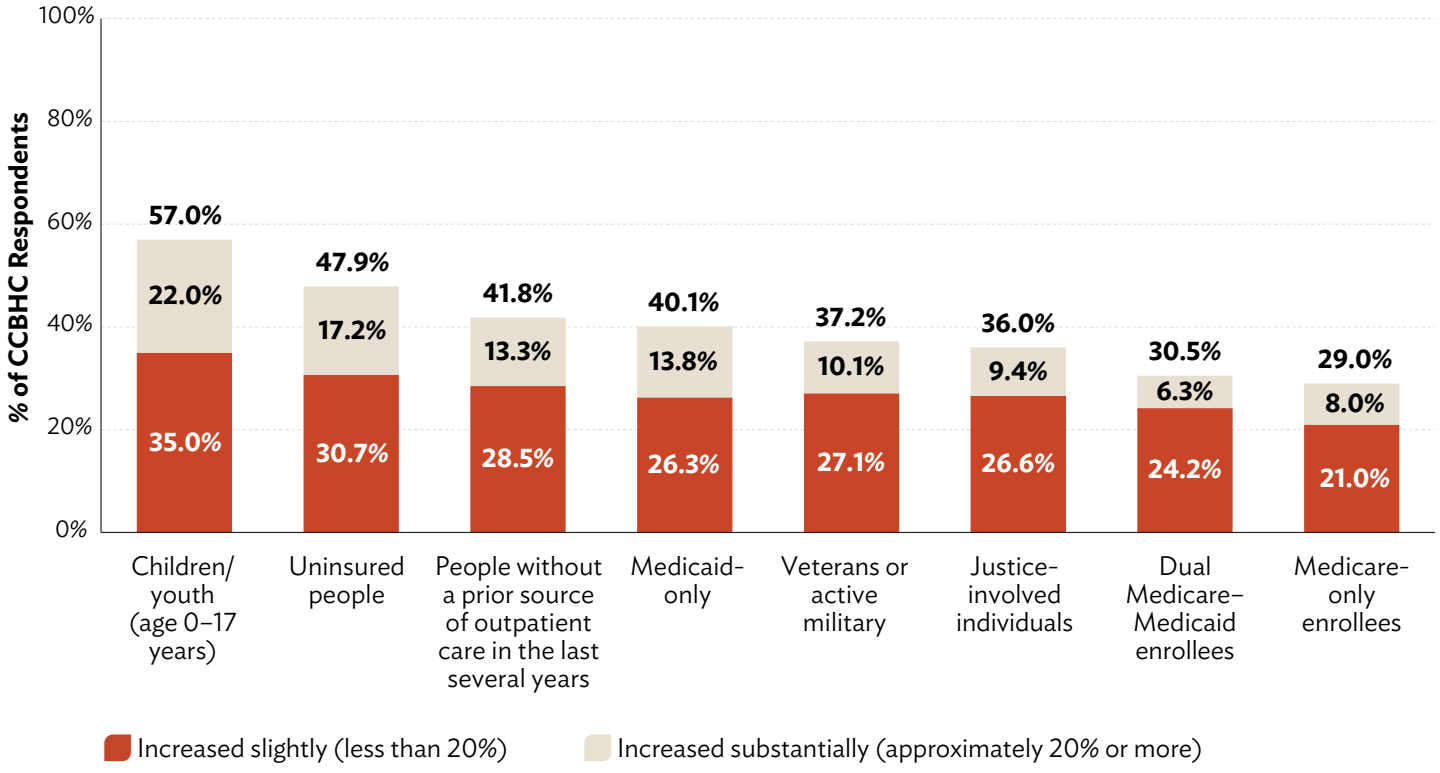
CCBHCs also play a critical role in serving people with serious mental illness (SMI) and serious emotional disturbance (SED). In 2025, CCBHCs served 1,012,564 individuals with SMI (39.2% of all CCBHC clients) and 373,134 individuals with SED (14.4% of all CCBHC clients). In total, more than half (53.7%) of all CCBHC clients have either SMI or SED.

> *"CCBHC grant funding has allowed our clinic to care for clients with a holistic lens, as we are able to provide services through a multitude of different access points such as: primary care services, reentry services, mental health treatment court, and juvenile justice."*
>
> **— The Guidance Center, Arkansas (CCBHC-E grantee)**

Medicaid CCBHCs had greater increases in service capacity compared to CCBHC-E grantees. Medicaid CCBHCs reported an average 43.6% increase in the number of clients served since the year before becoming a CCBHC, compared to an average 39.7% increase in clients served by CCBHC-E grantees.

Access expansions were most prevalent among children and youth, uninsured people, and people without a prior source of outpatient care. CCBHCs report notable increases in the number of CCBHC clients across a range of priority populations and those with unmet needs. The most frequently reported growth was observed among children and youth (ages 0–17), with 22.0% of respondents reporting a substantial increase (approximately 20% or more) and an additional 35.0% reporting a slight increase.

CCBHCs Reporting Access Expansions Among Key Groups



Similarly, half of CCBHCs (47.9%) reported increases in uninsured CCBHC clients. Growth in the number of uninsured clients likely reflects 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 to extend their reach into the community. Expanded access to care for uninsured people is a major success of the CCBHC model and will become particularly important in the coming years, as new federal Medicaid eligibility and enrollment requirements enacted in 2025 take effect (An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, 2025). The Congressional Budget Office estimates that provisions enacted through law will result in millions of individuals losing Medicaid coverage over the next decade, with coverage losses beginning as early as 2027 and increasing over time (Congressional Budget Office, 2025).

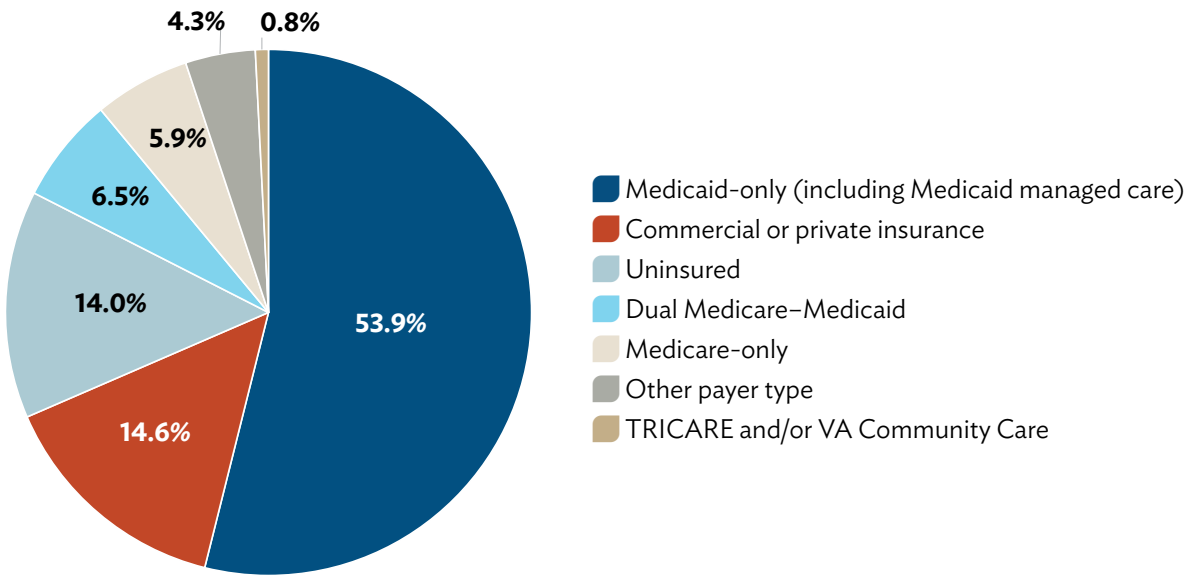
At the same time, CCBHCs face a unique challenge in serving uninsured populations. While CCBHCs are required to provide care regardless of an individual's ability to pay, they cannot receive Medicaid PPS reimbursement for services delivered to uninsured clients. As a result, growth in the uninsured population could increase uncompensated care costs and place additional financial strain on clinics seeking to maintain comprehensive behavioral health services. Further attention is needed to understand how coverage losses and rising uninsured rates may affect CCBHC operations and what supplemental funding strategies (e.g., federal grants, state investments and other financing mechanisms) may be needed to support continued access to care for uninsured individuals.

CCBHCs also reported meaningful increases in the number of people served who did not have a prior source of outpatient care in the last several years (41.8%), indicating that CCBHCs are increasing access to behavioral health care for those with unmet needs. When behavioral health needs are unmet, individuals are more likely to seek care through hospital EDs, experience psychiatric hospitalization, encounter law enforcement during behavioral health crises, or become involved with other costly crisis response systems (Mongelli et al., 2020). By expanding access to timely outpatient mental health and substance use treatment, CCBHCs help connect individuals to appropriate levels of care earlier, reducing reliance on emergency and public safety systems while improving health outcomes.

While CCBHCs reported increased access across a wide range of populations, some groups were less commonly reported as experiencing access expansions. The least commonly reported increases were among Medicare-only beneficiaries (29.0%) and dually eligible Medicare-Medicaid beneficiaries (30.5%). 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 supports among older adults, people with disabilities and other Medicare enrollees.

CCBHCs serve individuals with various types of health insurance coverage, with the largest share enrolled in Medicaid. Aligned with their requirement to provide care to all individuals regardless of ability to pay, CCBHC survey respondents reported serving individuals with different types of health insurance coverage, as well as individuals without coverage. Medicaid enrollees (including those enrolled in Medicaid managed care) made up the greatest share of CCBHC clients, representing 53.9% of people served, on average. An additional 6.5% of CCBHC clients are dually eligible for Medicaid and Medicare.

Average Percentage of CCBHC Clients by Payer Type

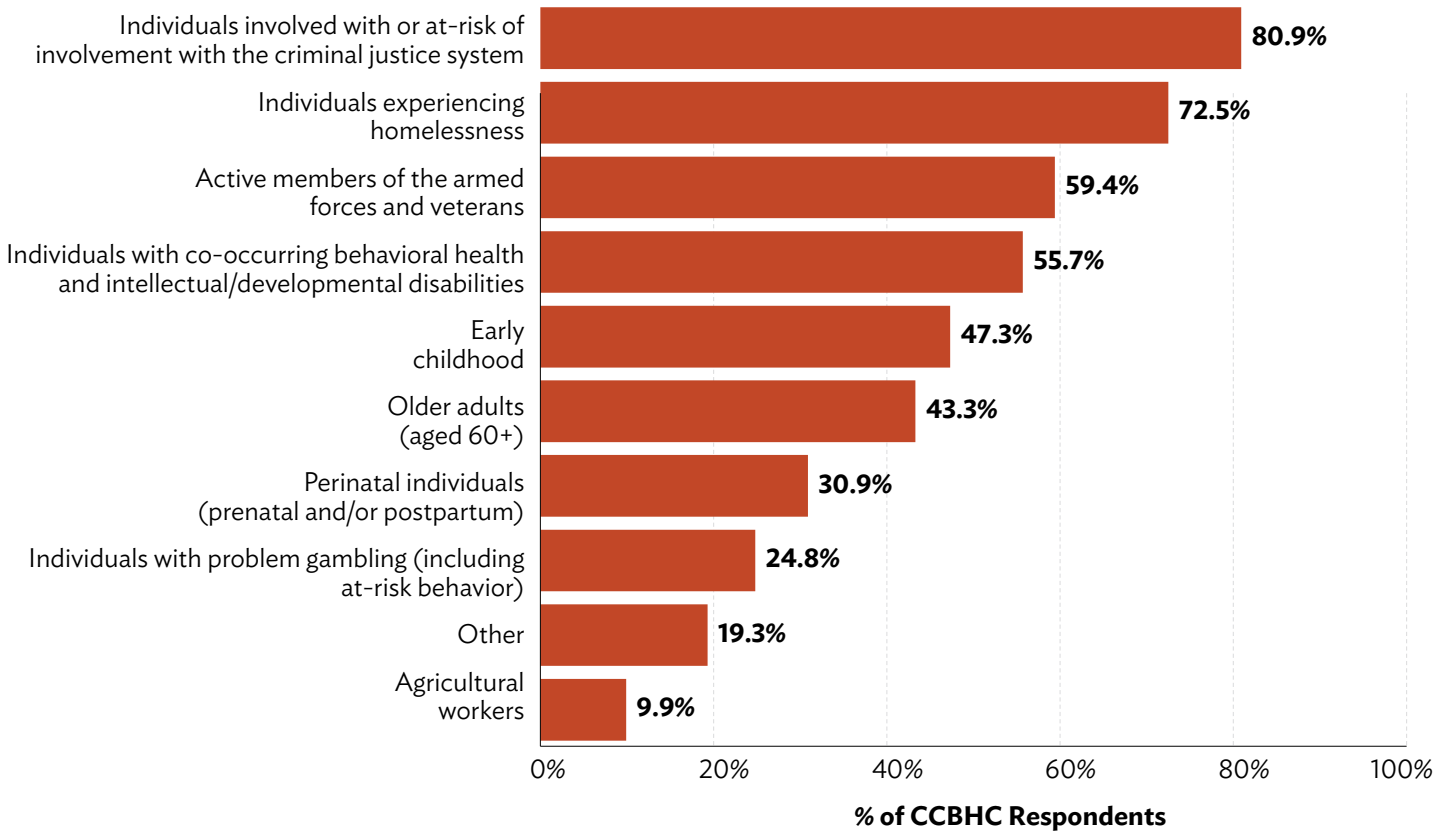


With more than three-quarters of their clients enrolled in Medicaid (including dual Medicaid-Medicare enrollees) or uninsured, CCBHCs play a critical role in ensuring access to care for populations that, on average, have a higher need for behavioral health care than the general population. Expansion of the model to areas that are not yet served by a CCBHC holds potential to close remaining access gaps for these populations.

> *"Unlike previous grants, CCBHC status allows us to serve everyone, eliminating gaps in service eligibility."*
>
> **— United Services Inc., Connecticut (CCBHC-E grantee)**

CCBHCs provide focused services to a variety of populations with significant unmet needs. More than 95% of CCBHCs provide targeted programming, dedicated service lines and/or intensive outreach to groups with high levels of unmet need for care. As seen below, the most common populations targeted through specialized outreach and programming include individuals involved with or at risk of involvement in the criminal justice system (80.9%) and individuals experiencing homelessness (72.5%), reflecting the model's focus on addressing social factors that affect health and reducing barriers. The high prevalence of targeted efforts aimed at increasing access for people with criminal justice system involvement (or at risk of involvement) indicates that CCBHCs recognize the significant behavioral health needs of this population and are intentionally investing in strategies to improve access, reduce barriers to care, and strengthen connections to treatment and recovery supports.

Targeted Efforts to Serve High-need Populations



CCBHCs are also implementing targeted efforts for active members of the armed forces and veterans (59.4%) and individuals with co-occurring behavioral health and intellectual and developmental disabilities (55.7%), underscoring their role in serving individuals with complex needs. Additional targeted efforts aim to address early childhood populations (47.3%), adults aged 60 and over (43.3%) and perinatal individuals (30.9%), highlighting the model's commitment to delivering age-appropriate and life-stage-specific care. Nearly 20% of CCBHCs reported focusing on additional populations based on community-specific needs, such as school-aged youth, those involved in child welfare or foster care, and transition-age youth and young adults. Other populations mentioned were individuals experiencing early or first episode psychosis, individuals with co-occurring mental health and substance use disorders, individuals who have experienced trauma or domestic violence, and individuals who frequently use emergency or crisis services.

CCBHCs are reducing wait times for routine care. CCBHCs must ensure timely access to care for routine needs. Nearly 80% of all CCBHCs surveyed reported seeing CCBHC clients for routine needs within 10 days of the initial call or referral, and approximately 65% offer access within one week. CCBHCs have expanded same-day access to care, with almost 25% offering same-day access to routine services, compared to 21% of CCBHCs offering same-day access in 2024. These average wait times are significantly shorter than the national average of 31-48 days between an individual's first outreach/referral and their first appointment (S. Lloyd, president, MTM Services, personal communication, May 19, 2026).[5]

5 This average is based on an MTM Services analysis of 25,000 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 49 U.S. states and two U.S. territories. The lower number ties to individuals seeking therapy while the higher number ties to psychiatric evaluation for medication services.

> *"Community partners have shared that they are 'blown away' that a referred patient was able to be seen the very next day. Some patients and their families shared that they had been unable to find behavioral health care elsewhere for years, and were emotional and relieved to finally be seen."*
>
> **— CHAS Health, Washington (CCBHC-E grantee)**

Expanding Access to Substance Use Care

The 2024 NSDUH data shows that about 4 in 5 individuals aged 12 or older who needed substance use treatment in the past year did not receive it in 2024 (SAMHSA, 2025). Faced with this gap in access, CCBHCs are making a difference by improving access to substance use treatment and recovery supports nationwide. Substance use treatment and partnerships are core components of CCBHCs' service array: CCBHCs are required to provide, either directly or through a designated collaborating organization (DCO), evidence-based services for treating SUD across the lifespan, and they must partner with a variety of health and community-based partners to address clients' substance use and related needs.

CCBHCs are expanding substance use treatment and connecting more individuals to evidence-based care. CCBHC respondents reported serving over 501,720 individuals with an SUD, representing one-fifth (19.4%) of all CCBHC clients. A quarter of this population has an opioid use disorder (OUD). Among CCBHC clients with OUD, half (50.1%) received medications for opioid use disorder (MOUD) — almost three times the national rate of 17.0% (SAMHSA, 2025).

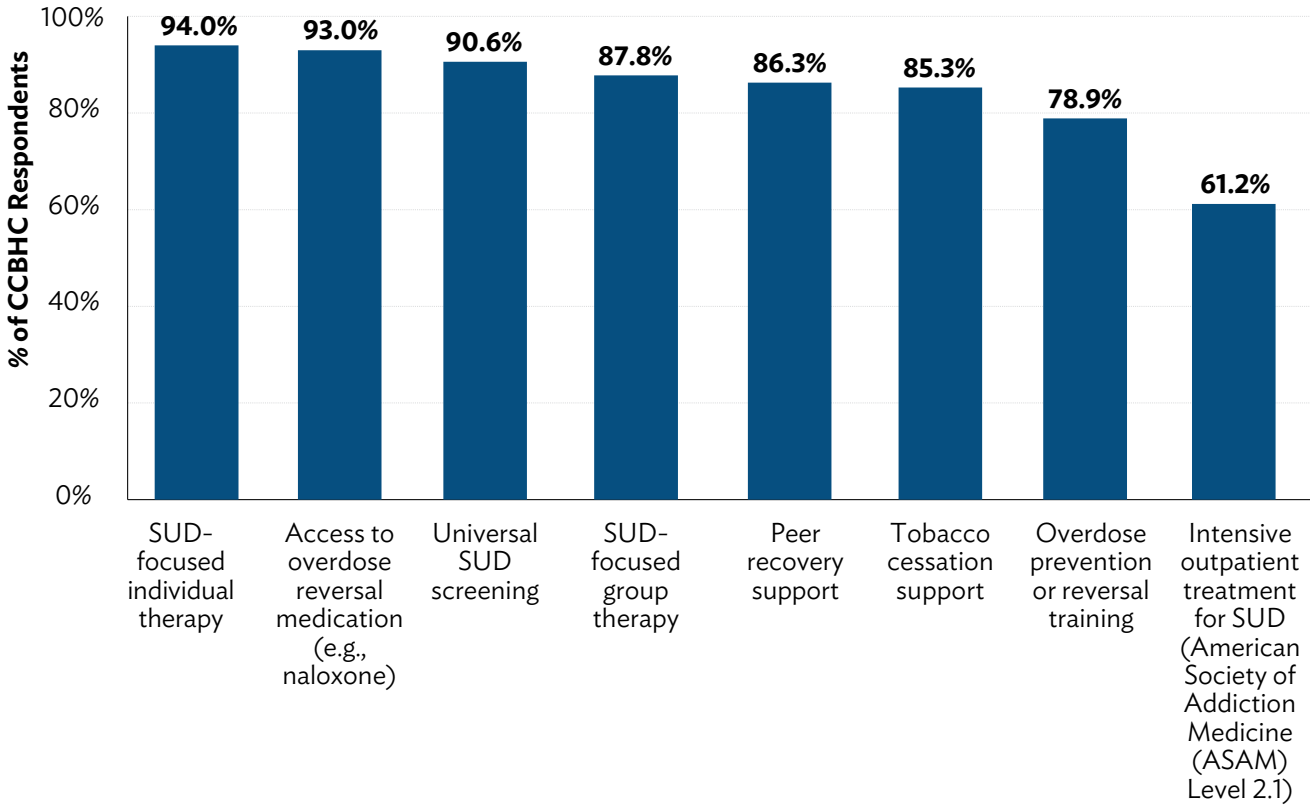
CCBHCs are ensuring access to comprehensive SUD services by providing services directly or through formal partnerships with DCOs.[6] Nearly all CCBHCs (96.1%) provide SUD services and/or supports directly, while 7.0% report they use a DCO. Ninety-one percent of CCBHCs are leveraging universal SUD screening to identify substance use needs that might otherwise be missed. Screening is a critical step toward identifying individuals with unmet SUD care needs and engaging them in the appropriate services and supports. Nearly four-fifths of CCBHCs (78.9%) directly provide overdose prevention or reversal training, helping equip community members with the knowledge and skills needed to recognize and response to opioid overdoses.

6 A DCO is an organization that provides required services on the CCBHC's behalf, through a formal relationship defined in a signed legal document. With limited exceptions, CCBHCs pay their DCOs for services rendered to CCBHC clients. DCOs deliver one or more of the nine required services (or elements of the required services) as described in CCBHC Certification Criteria. CCBHCs may provide services directly or partner with a DCO to supplement care available through the CCBHC. Informal partnerships are not considered DCO relationships, nor are partnerships for services outside of the nine required CCBHC services.

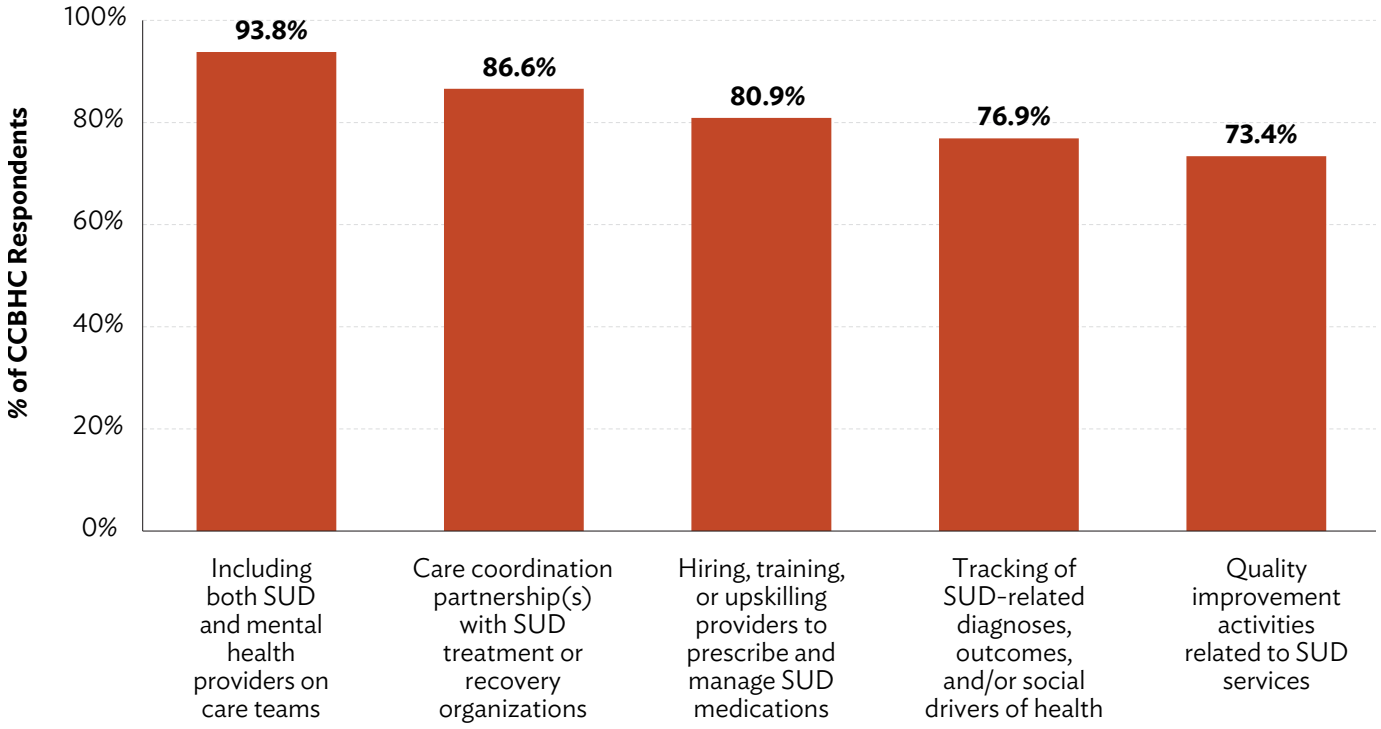
CCBHCs integrate mental health and substance use care, ensuring that individuals receive comprehensive services from providers working as one team. Nearly all respondents (93.8%) report including both SUD and mental health providers on care teams, supporting coordinated treatment for individuals with co-occurring conditions.

CCBHCs are advancing integration of SUD services within broader care delivery systems. The majority (86.6%) have established care coordination partnerships with other SUD treatment or recovery organizations that provide CCBHC clients with additional services beyond those delivered by the CCBHC. Over three-quarters (76.9%) of CCBHCs also report data-driven activities to improve SUD care quality and outcomes. Together with universal screening, these activities support a holistic approach to ensure a full continuum of substance use care.

SUD Services and Supports Provided by CCBHCs Directly



CCBHCs' SUD Activities

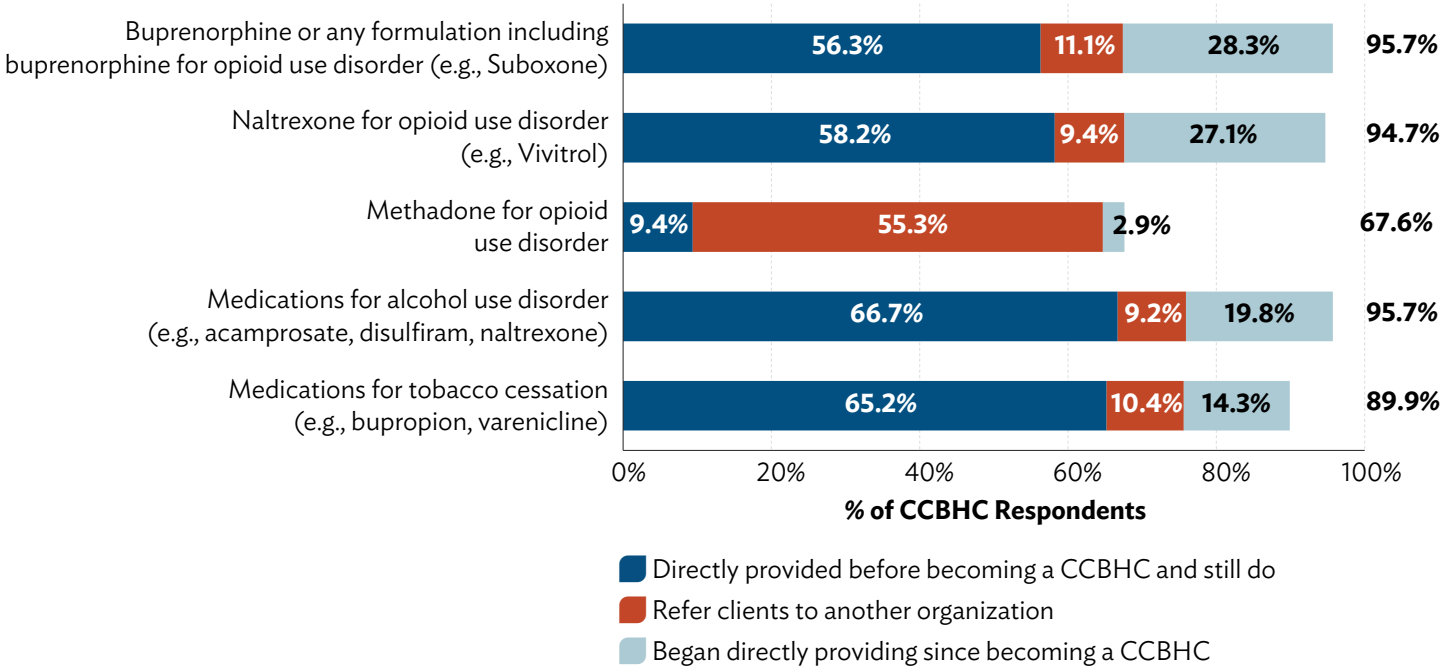


> *"Our CCBHC has made meaningful progress in integrating substance use treatment into overall behavioral health care. Co-location of behavioral health and medical services has significantly improved access to MOUD and other SUD medications. Same-day access to prescribers, warm handoffs between therapists and medical providers, and integrated treatment planning have strengthened engagement and reduced barriers to care."*
>
> **— Community Service Board of Middle Georgia (CCBHC-E grantee)**

CCBHCs have expanded their capacity to provide a range of U.S. Food and Drug Administration (FDA)-approved medications for SUD treatment, especially MOUD. Nearly 90% of CCBHCs offer one or more FDA-approved medication for the treatment of OUD. Eighty-two percent offer two or more MOUD options, and 12.2% offer three MOUD options. Nearly 6% of CCBHCs noted they are dually certified as an Opioid Treatment Program for the delivery of methadone; however, methadone remains more commonly accessed through referral, with 55.3% of CCBHCs referring clients to other providers for this service. Almost two-thirds of CCBHCs (63.8%) reported increases in the number of individuals engaged in MOUD through the CCBHC, including 29.7% reporting increases of 20% or more. Half of respondents (51.2%) report that individuals can access MOUD within 1-7 days, and 19.6% offer same-day access.

Most CCBHCs also offer medications for alcohol use disorder (86.5%) and tobacco cessation (79.5%). For many CCBHCs, medication-assisted treatment 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



Despite significant gains in expanding access to medications for SUDs, CCBHCs continue to face some barriers to delivering these services. Among the barriers described by respondents were cost and insurance limitations, workforce shortages, administrative and regulatory burdens, limited prescriber training or comfort with MOUD, patient engagement, stigma and logistical barriers (e.g., transportation and pharmacy access).

> *"Integrating same-day appointments along with telehealth appointments has allowed us to lower the barrier of entry for patients to access MOUDs, which has led to increased treatment."*
>
> **— JWCH Institute Inc., California (CCBHC-E grantee)**

MEETING CHILDREN, YOUTH AND FAMILIES WHERE THEY ARE

Children and youth continue to face significant barriers in accessing timely behavioral health services. In 2021 to 2022, approximately 19% of U.S. children ages 2-8 had one or more diagnosed mental, behavioral or developmental disorders, yet nearly half (45.8%) did not receive needed mental health services (Meng & Wiznitzer, 2024). More recently, NSDUH found that 39.4% of adolescents ages 12-17 who experienced a major depressive episode received mental health treatment in the past year (SAMHSA, 2025).

CCBHCs are working to address gaps in access to care for children and youth. The model requires CCBHCs to provide family-centered, comprehensive, developmentally appropriate services across the lifespan for children, youth and their families or caregivers. Partnerships are key to addressing the unique needs of children, youth and families, with CCBHCs required to coordinate care with schools, child welfare agencies, juvenile justice agencies and other youth-serving entities based on the results of the CCBHCs' community needs assessments.

CCBHCs are serving more children and youth. As noted above, children and youth were the group most frequently mentioned by CCBHCs as experiencing significant growth in the number of clients served since becoming a CCBHC: 57.0% of CCBHCs reported the number of children/youth they serve has increased, including 22.0% that indicated the increases to their number of child and youth clients were substantial (20% or more).

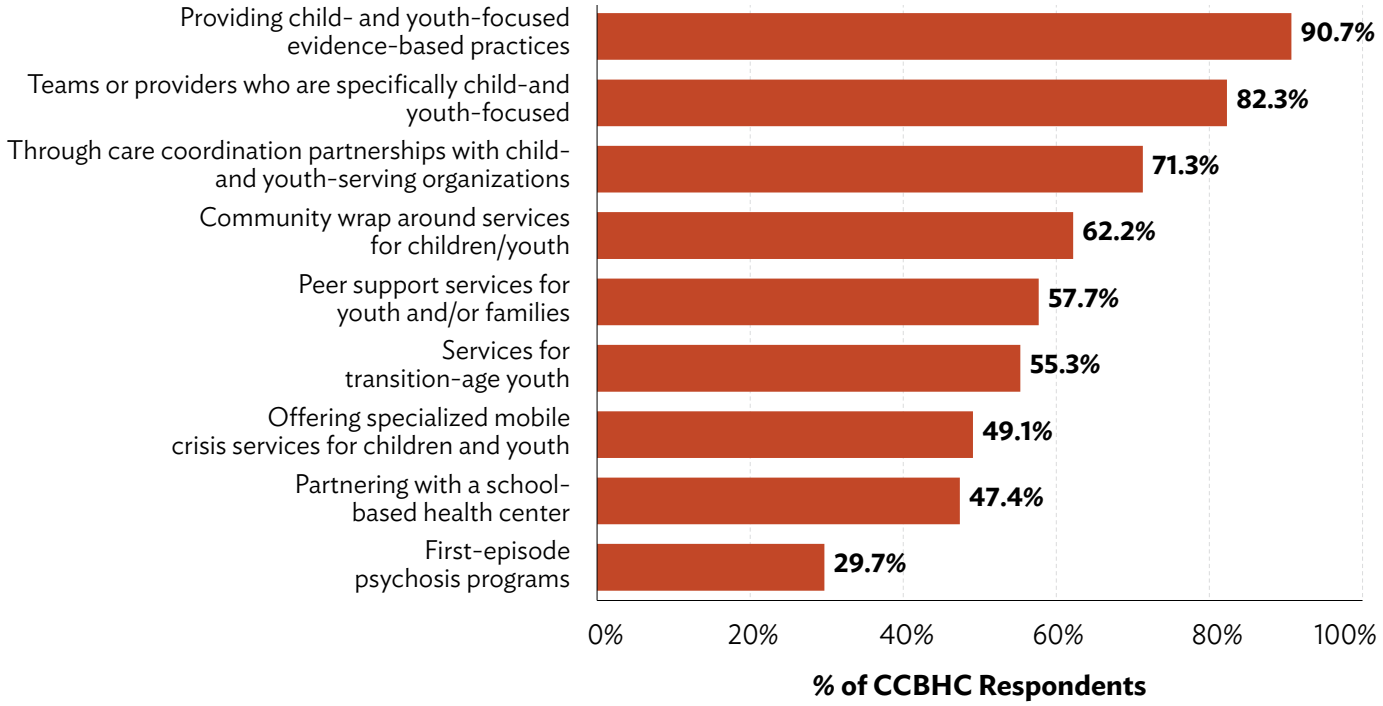
> *"Metropolitan Human Services District (MHSD) maintains active partnerships with the Louisiana State University School of Medicine and the Tulane University School of Medicine to support internships and clinical training for psychiatric fellows and residents. Through these training opportunities, MHSD has been able to expand its behavioral health workforce and increase access to psychiatric services within the child and youth program."*
>
> **— Metropolitan Human Services District, Louisiana (CCBHC-E grantee)**

CCBHCs are increasing access for children and youth through an expanded workforce. Since becoming a CCBHC, 67.6% of respondents reported hiring licensed behavioral health clinicians with a child or youth focus, and 40.3% reported hiring child and youth psychiatrists. However, workforce shortages continue to constrain these efforts: 12.6% reported unfilled child and youth psychiatrist positions, while 32.4% of CCBHCs have created positions for other licensed child/youth-specialty behavioral health clinicians that remain unfilled. Together, these findings show that CCBHCs are investing in the child and youth behavioral health workforce, but persistent shortages of professionals with relevant expertise continue to limit their ability to fully meet the demand for care.

CCBHCs engage in many strategies to reach children, youth and families with high-quality care. These include delivery of specialized EBPs along with team structures and partnerships that facilitate comprehensive support. As seen below, the vast majority of CCBHCs (90.7%) provide a broad array of child- and youth-focused EBPs. These include cognitive behavioral therapy (CBT) for children and adolescents (89.8%), trauma-focused CBT (85.9%), dialectical behavioral therapy (DBT) for adolescents (60.2%), and family-based therapy/family-systems therapy (53.6%). Some CCBHCs also reported enhancing their direct service capacity through child- and youth-serving DCO partnerships, with 5.3% working with a child or youth-serving DCO to offer additional services and supports to young CCBHC clients.

CCBHCs are also adopting specialized models to meet the needs of children, youth and families. Many reported using teams or providers specifically focused on serving young people (82.3%), offering community wraparound services (62.2%), delivering specialized mobile crisis services (49.1%) and offering youth/family peer supports (57.7%). CCBHCs are also targeting care for youth populations with specific needs, such as transition-age youth (55.3%) and people experiencing a first episode of psychosis (29.7%).

Strategies for Serving Children & Youth



CCBHCs deliver direct services in schools, offering convenient access to children and families. The vast majority of CCBHCs (95.8%) partner with schools to meet students' needs, with 72.8% delivering services on-site in one or more schools or other childcare settings. Elementary, middle and high schools were the most common settings for on-site care delivery.

Two hundred and eighty-six CCBHC respondents reported delivering services in more than 9,000 schools across the nation. These partnerships are a sign of the model's success in supporting convenient access to care for young people outside the clinic. The benefits of these school-based partnerships extend beyond increased access to care. Many CCBHCs reported that their presence in schools has contributed to improved educational outcomes for students. Commonly cited impacts included decreased suspensions, improved

school attendance, reduced behavioral problems in the classroom and greater family engagement, reflecting the value of providing behavioral health services and supports in settings that are convenient and accessible for children and their families.

> *"Recently, our CCBHC has expanded partnerships with Boys & Girls Clubs across Marion County and has also developed new collaborations with virtual education programs. These efforts help us reach youth in environments where they already learn, gather and build relationships, allowing us to provide earlier intervention and more accessible behavioral health support."*
>
> **— Adult and Child Health Inc., Indiana (Medicaid CCBHC)**

CCBHCs work with a wide range of child- and youth-serving entities across multiple systems of care to address young people's needs. The majority of CCBHCs surveyed (95.8%) reported having a partnership with at least one child- and youth-serving organization. The most frequently reported partnerships were with schools and school districts, child welfare and foster care agencies, juvenile justice and specialty child/youth behavioral health agencies. Other types of partners included early childhood programs, intellectual and developmental disability providers, youth-serving community organizations, pediatric primary care practices, and family or youth peer support organizations. These partnerships help ensure that children, youth and families experience more coordinated services across multiple systems that influence their long-term health, wellbeing and education.

> *"Our CCBHC works closely with community partners through a strong Systems of Care approach to support children, youth and families across the communities we serve. We collaborate regularly with schools, the Boys & Girls Club, Department of Social Services and other local organizations to strengthen referral pathways, improve early identification of behavioral health needs, and connect youth to services as quickly as possible."*
>
> **— Citizen Advocates Inc., New York (Medicaid CCBHC)**

COORDINATION AND INTEGRATION WITH CRISIS SERVICES

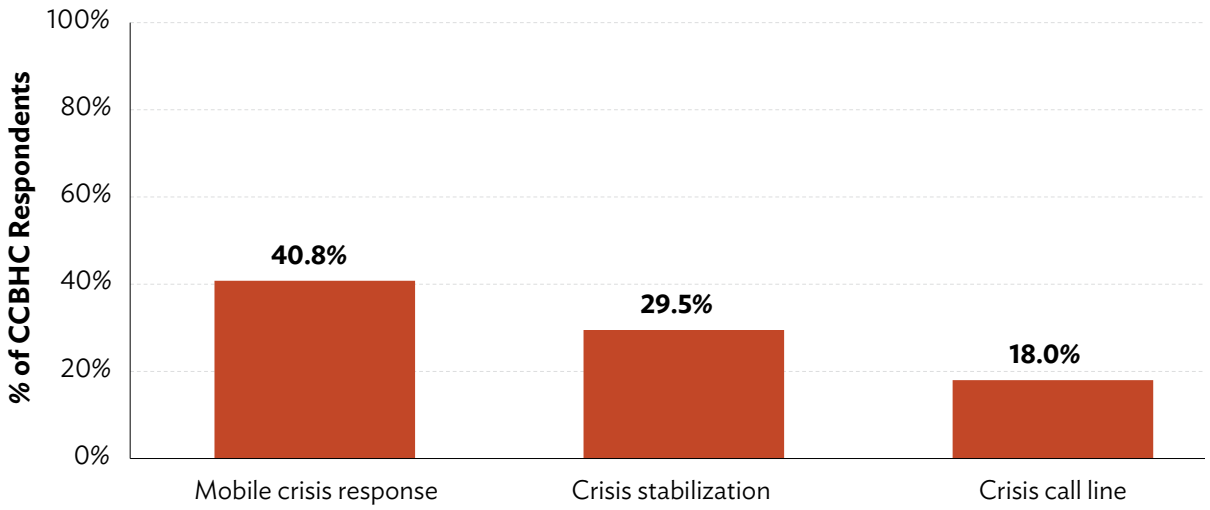
CCBHCs are strengthening and expanding crisis systems by increasing access to 24/7 services, integrating with the national 988 Suicide & Crisis Lifeline, and delivering comprehensive, community-based crisis intervention. As demand for behavioral health crisis care continues to grow, CCBHCs are playing a central role in building a more coordinated and responsive crisis continuum that prioritizes timely access, appropriate levels of care and diversion from EDs and law enforcement. CCBHCs are ensuring that individuals experiencing a crisis can access support at any time and through multiple entry points. Their partnerships with the 988 Suicide & Crisis Lifeline, along with the expansion of mobile crisis teams, stabilization services and crisis call lines, reflect a broader shift toward community-based, person-centered approaches to crisis care that improve outcomes while reducing reliance on the broader health care system.

> *"Our Lee County CCBHC uses DCO arrangements to coordinate with the state-contracted crisis stabilization units and mobile crisis response team. This includes regular contact with their teams in addition to our crisis coordinator position that provides a direct link between their services and ours. While we have different systems and cannot share real-time data easily, collaborative efforts have resulted in rapid access to outpatient services and, in several cases, diversion from inpatient stabilization in lieu of walk-in outpatient services."*
>
> **— Centerstone, Florida (CCBHC-E grantee)**

Availability of crisis services has expanded because of the CCBHC model. Most CCBHCs provide mobile crisis response (74.6%) and crisis stabilization (86.5%) directly. A smaller portion rely on DCOs to deliver mobile crisis services (25.6%) and crisis stabilization (12.5%). Over half of CCBHCs (55.0%) reported having added one or more crisis services as a result of CCBHC implementation. Others noted that CCBHC status has supported them in expanding their preexisting crisis response services. Because mobile crisis response and crisis stabilization are high-cost services requiring substantial staffing capacity, CCBHCs typically do not establish new service lines when these services are already offered by other entities in their communities, instead opting to establish a DCO relationship with existing crisis providers. Thus, the addition of crisis response as a new service line generally indicates new or expanded crisis continuum capacity in CCBHCs' communities.

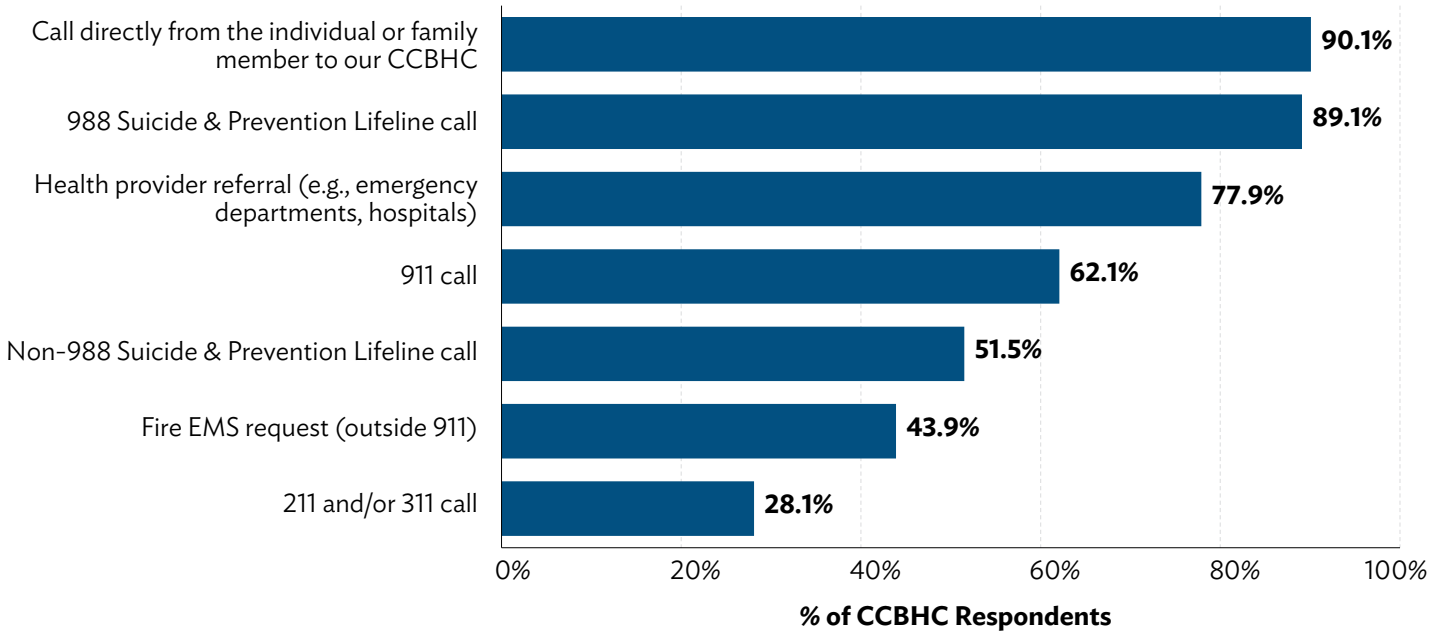
Consistent with prior research (Mauri et al., 2025), gains in crisis system capacity were particularly pronounced among Medicaid CCBHCs, which were more likely than grantees to have added mobile crisis response as a new service (52.6% compared to 24.7%). This is likely attributable to the different financing 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 prior to their grant award.

Services Added to CCBHCs' Scope As a Result of Certification



CCBHCs are coordinating across systems to dispatch mobile crisis teams through multiple access points. This multi-pathway approach reflects the integration of CCBHCs within broader crisis and emergency response systems, leading to strong coordination across behavioral health, health care and public safety systems.

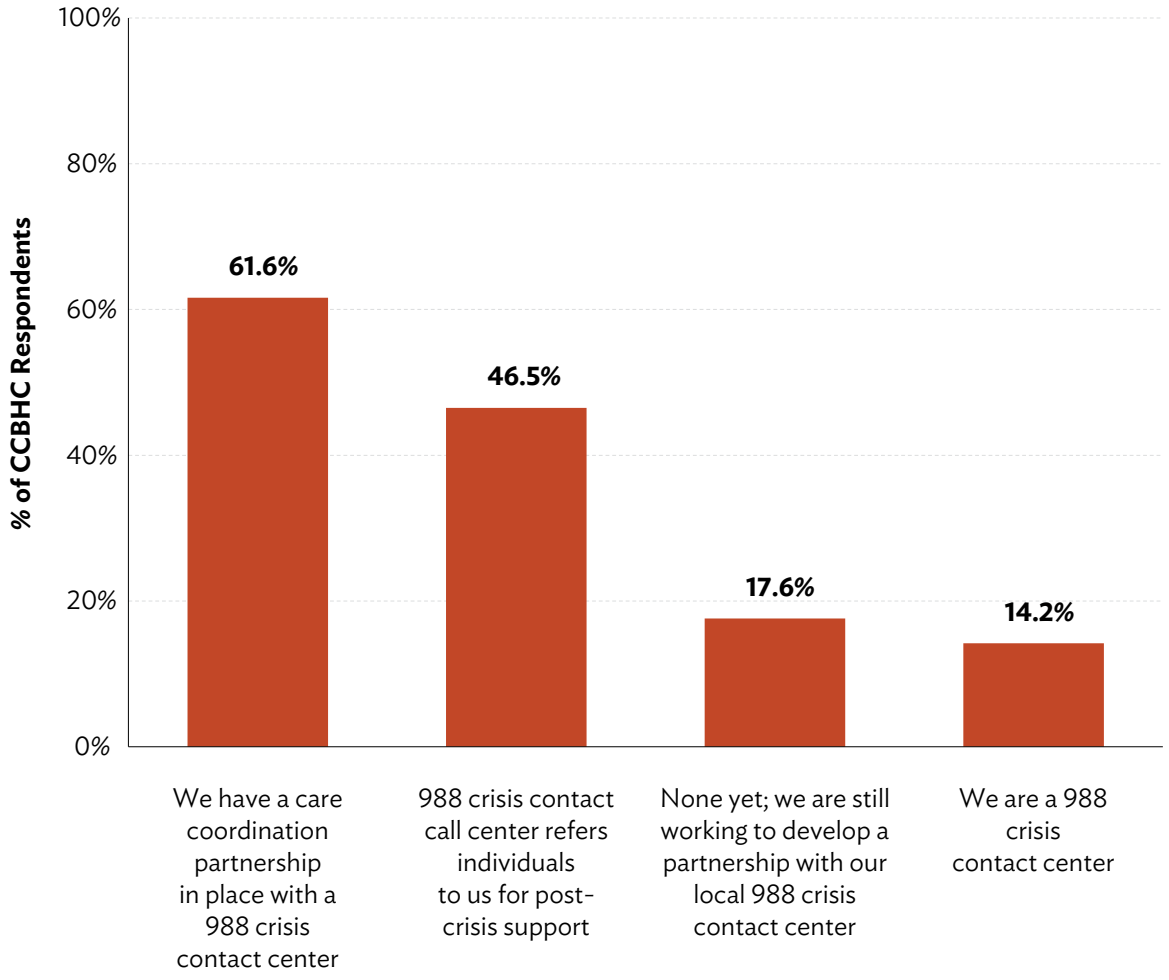
Pathways Through Which Mobile Crisis Response Teams Are Dispatched



As noted in a later section ("Improving Collaboration With Criminal Justice and Public Safety Agencies"), CCBHCs are also expanding their partnerships with first responders who frequently encounter people experiencing a mental health or substance use crisis. Nearly half of CCBHCs (48.7%) engage in a co-response model where mental health or SUD providers respond to behavioral health crisis calls alongside police and/or EMS. Roughly 28% provide telehealth support to law enforcement officers responding to behavioral health calls.

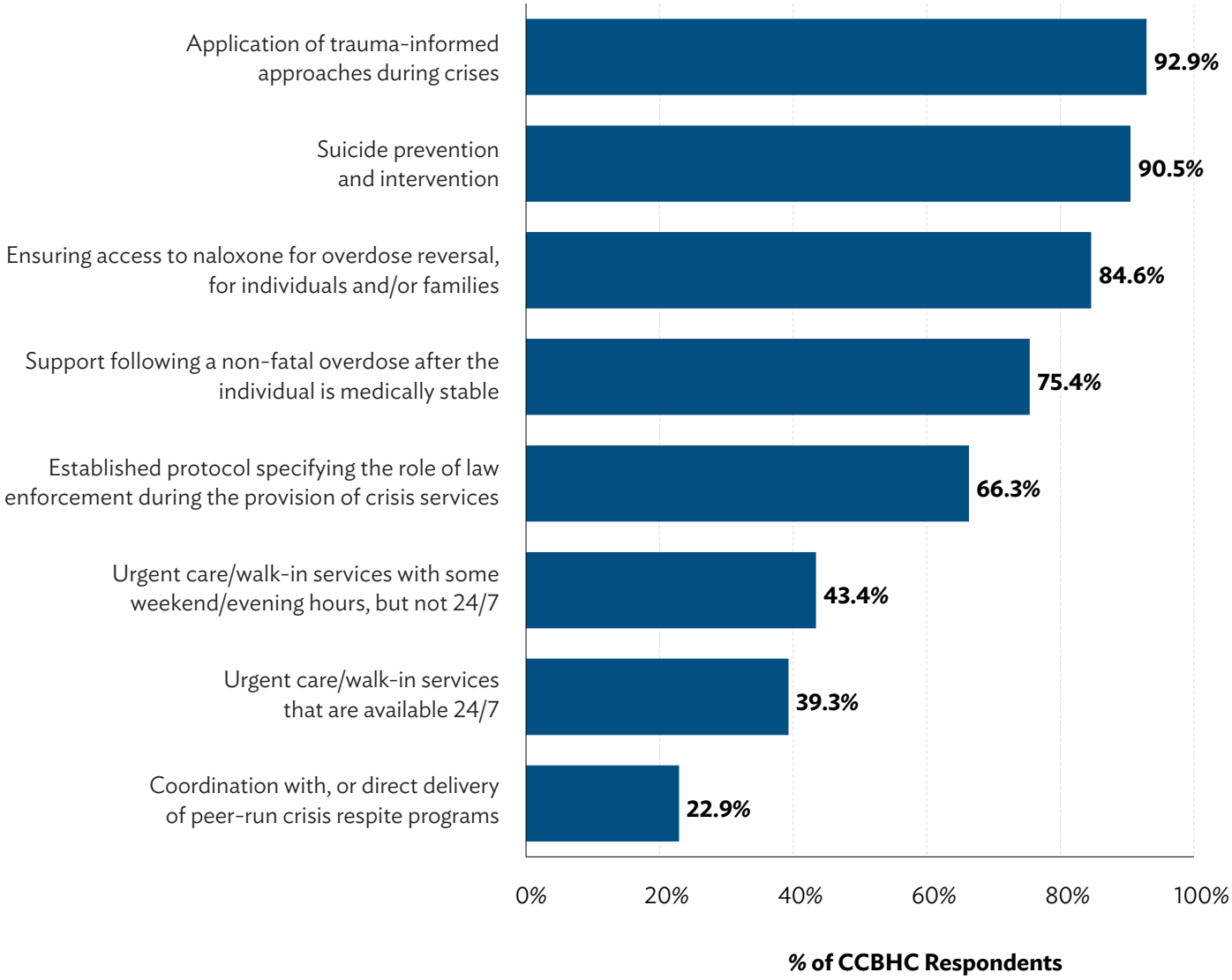
CCBHCs are partnering with the 988 Suicide & Crisis Lifeline to connect people in crisis with appropriate supports and follow-up care. In addition to the 89.1% of CCBHCs whose mobile crisis teams can be dispatched via coordination with 988, more than 80% of CCBHCs report another form of engagement with 988 call centers. These partnerships help create clearer pathways from an initial 988 contact to ongoing care — either a more intensive in-person crisis response for needs beyond what the call center can address, or connection to post-crisis follow-up care.

CCBHC Engagement with the 988 Suicide & Crisis Lifeline



For people who need more intensive support than that offered by a crisis call line or mobile crisis response, CCBHCs provide a wide range of crisis stabilization services. 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.

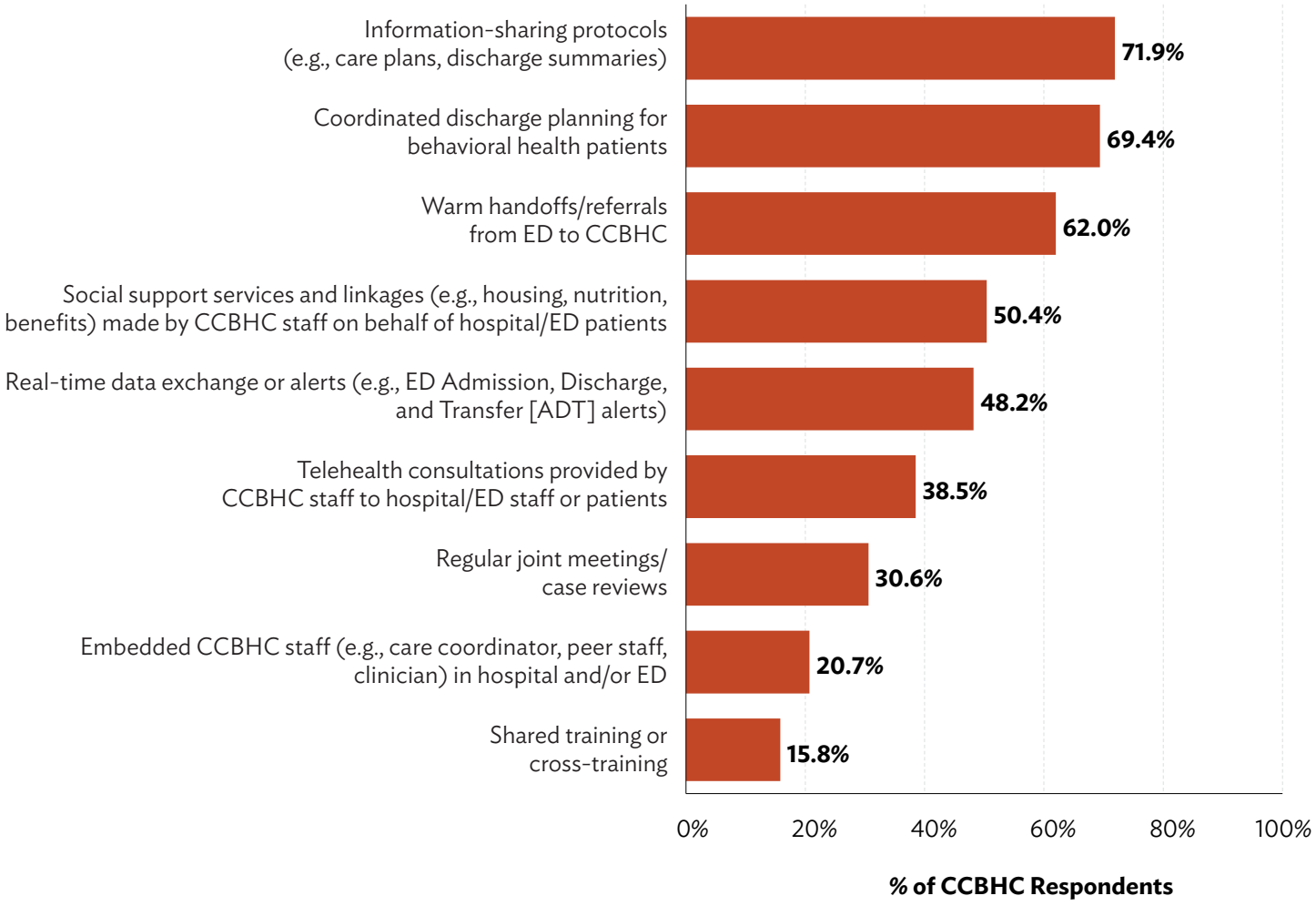
Crisis Stabilization Services & Activities Provided by CCBHCs



HOSPITAL AND EMERGENCY DEPARTMENT PARTNERSHIPS

In comparison to the general population, individuals with SMI and SUD have significantly higher rates of ED visits, hospital admissions and overall health service utilization, resulting in substantially higher health care costs (Launders et al., 2023; Spencer et al., 2023). In an effort to reduce ED visits and hospital admissions, CCBHCs are working collaboratively with EDs and hospitals to strengthen care coordination and divert individuals to more appropriate and cost-effective levels of care. Nearly all (97.8%) CCBHCs reported having one or more collaborative activities in place with local ED and/or hospital partners.

CCBHC Activities with Emergency Departments and Hospitals



Hospital and ED utilization has decreased among CCBHCs clients. Nearly all CCBHCs (55.4%) indicated they currently aggregate and analyze data on clients' ED and hospital utilization or plan to do so (37.8%) in the future. Of the CCBHCs that currently engage in this type of data analysis, the majority reported that clients' hospital and ED utilization had decreased (40.0%) or remained steady (23.5%), despite large increases in overall client caseloads and particular increases among people without a prior source

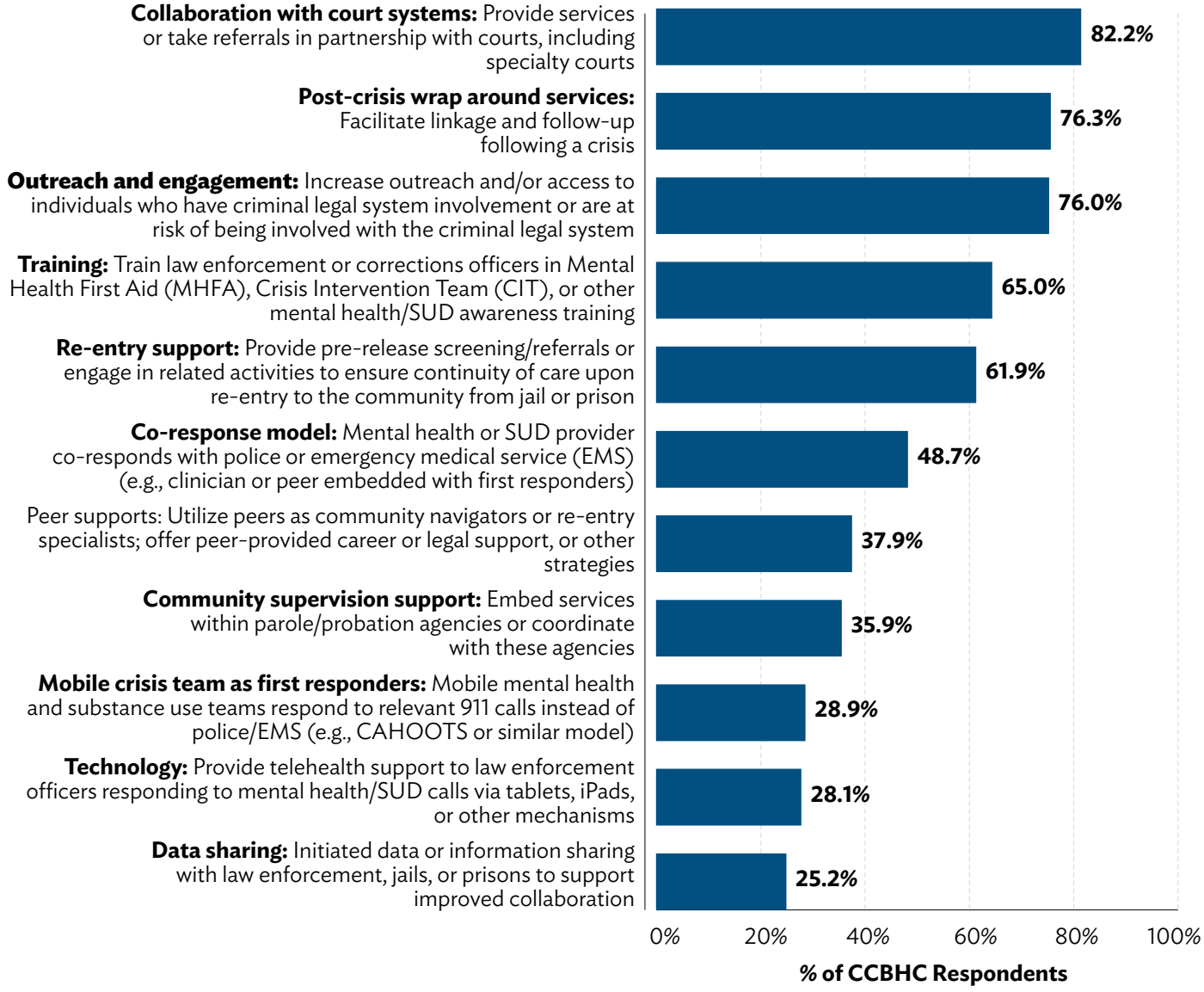
of outpatient care. These individuals are more likely to have high levels of unmet needs and are frequent recipients of hospital and ED services (see "Access Expansions: Expanding Timely Access to Care"). Steady and decreasing rates of hospital/ED utilization in the context of growing client populations with higher levels of unmet need underscores CCBHCs' ability to provide care that helps people manage their conditions and stay out of higher-intensity care settings.

> *"Our CCBHC reduced emergency room and hospitalization reoccurrences to 0% within 30 days of discharging from services. In 2025, our CCBHC behavioral health outpatient services reduced 180-day readmission rates to 3.8%."*
>
> **— Gateway Community Services, Florida (CCBHC-E grantee)**

IMPROVING COLLABORATION WITH CRIMINAL JUSTICE AND PUBLIC SAFETY PARTNERS

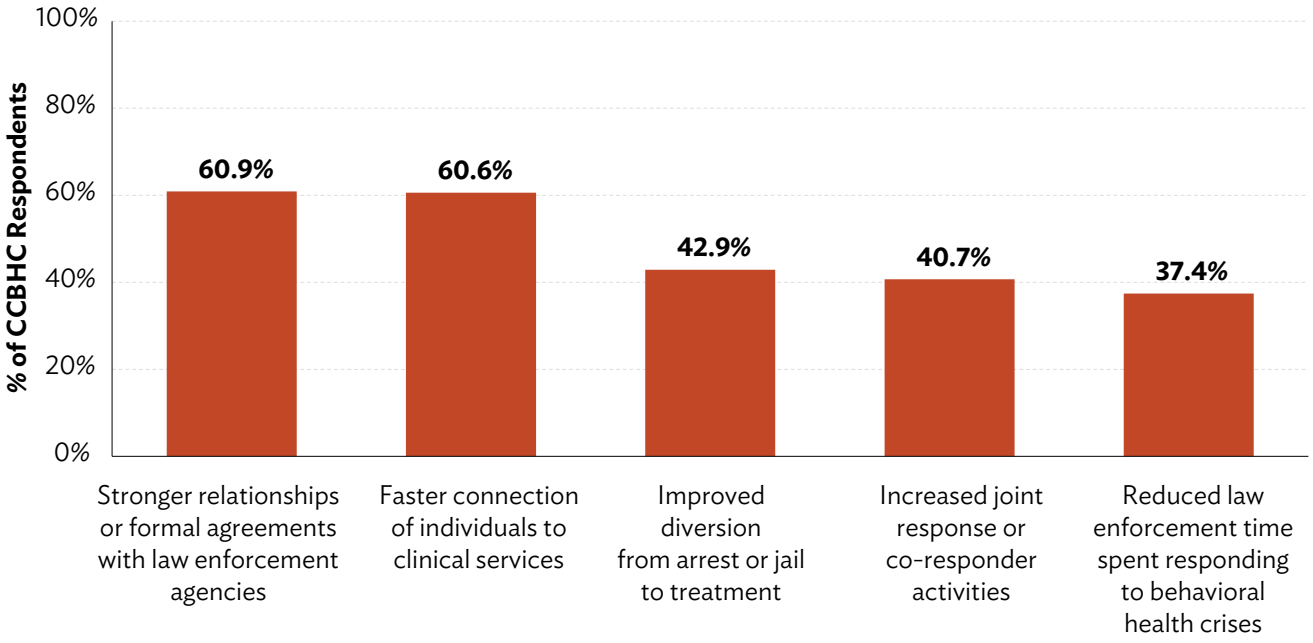
CCBHCs are enhancing collaboration with criminal justice and public safety partners to improve crisis response, increase diversion to treatment and support individuals with behavioral health needs across the continuum of care. They engage in a wide range of collaborative activities with criminal justice partners to support individuals at every stage, from crisis response to reentry and ongoing treatment. This work is particularly critical given the high prevalence of behavioral health conditions among justice-involved populations. According to the U.S. Department of Justice, 44% of individuals in jail and 37% of individuals in prison have a mental illness, and 63% of people in jail and 58% in prison have an SUD (Bureau of Justice Statistics, 2017a; Bureau of Justice Statistics, 2017b). More recent research continues to demonstrate high rates of mental health and substance use disorders among incarcerated populations, suggesting the behavioral health needs remain substantial within correctional settings (Baranyi et al., 2022).

CCBHCs' Collaborative Activities with Criminal Justice and Public Safety Partners



The vast majority of CCBHCs (98.3%) are actively engaged in one or more innovative activities with criminal justice and public safety agencies to improve outcomes for people who have criminal legal system involvement or are at risk of being involved with the criminal legal system.

Observed Justice-involved Outcomes



CCBHCs' partnerships with criminal justice entities are improving arrest diversion and other justice system outcomes. These results suggest that CCBHCs are helping shift behavioral health crisis intervention away from reliance on law enforcement and other public safety responses and toward timely clinical care, community-based stabilization and connection to ongoing treatment and recovery supports.

> *"AltaPointe expanded training for law enforcement across our seven-county region, using virtual reality simulation technology that allows officers to practice responding to behavioral health crises in realistic scenarios. Tablet devices placed in patrol vehicles allow officers to connect individuals directly with a clinician through 24/7 telehealth consultation. As these partnerships and tools have expanded, Crisis Center utilization has increased while arrests related to behavioral health crises have declined. Law enforcement agencies also report significant reductions in use-of-force incidents and officer injuries during behavioral health calls, while the presence of clinicians during high-risk situations has helped reduce fatal outcomes."*
>
> **— AltaPointe Health, Alabama (Medicaid CCBHC)**

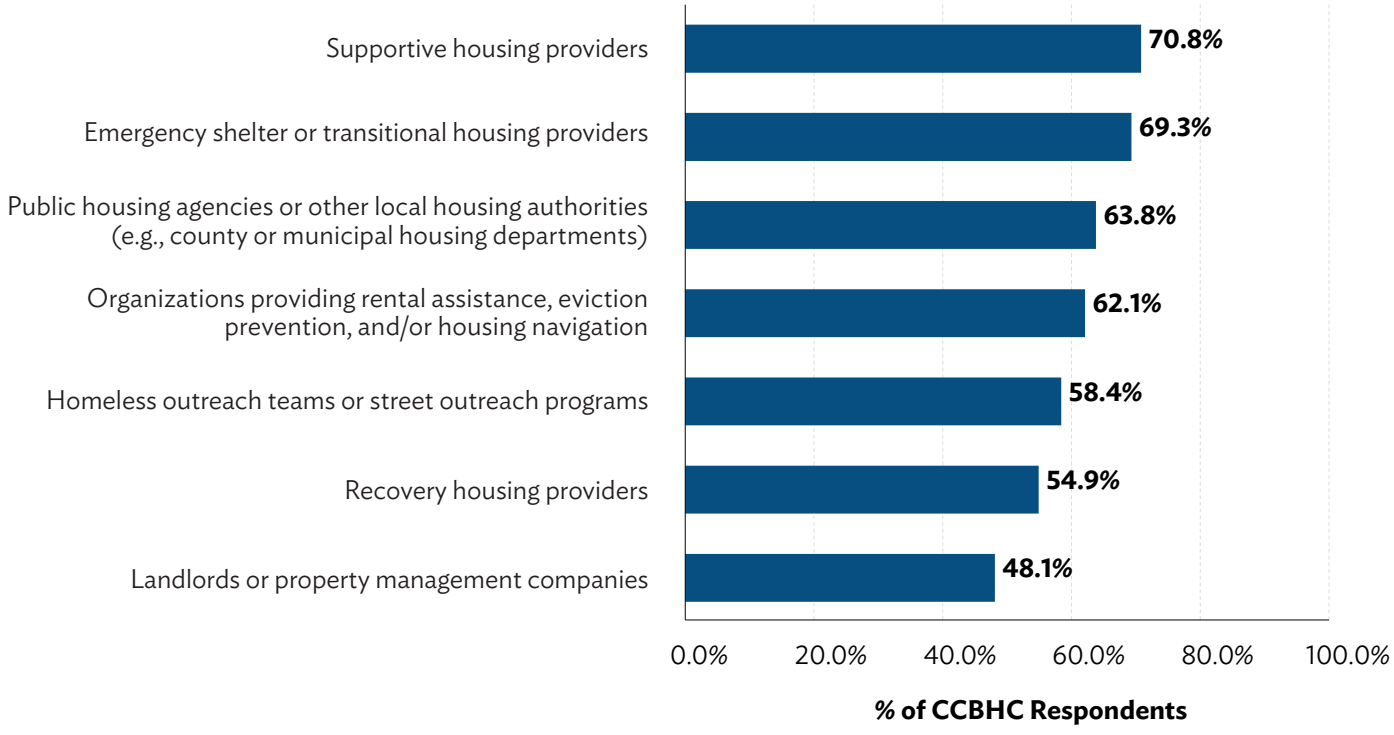
ADDRESSING HOMELESSNESS AND UNEMPLOYMENT AMONG CCBHC CLIENTS

Behavioral health outcomes are influenced by more than clinical care alone: Social factors that affect health, including housing and employment, play a critical role in an individual's ability to engage in treatment and achieve recovery. For people with SMI, homelessness and unemployment are particularly significant challenges associated with poorer health outcomes, increased crisis service utilization and greater difficulty maintaining long-term recovery (Richards & Kuhn, 2022; Yang et al., 2024). CCBHCs are working to address these challenges through improved services and connections to community housing and employment partners.

Addressing Homelessness

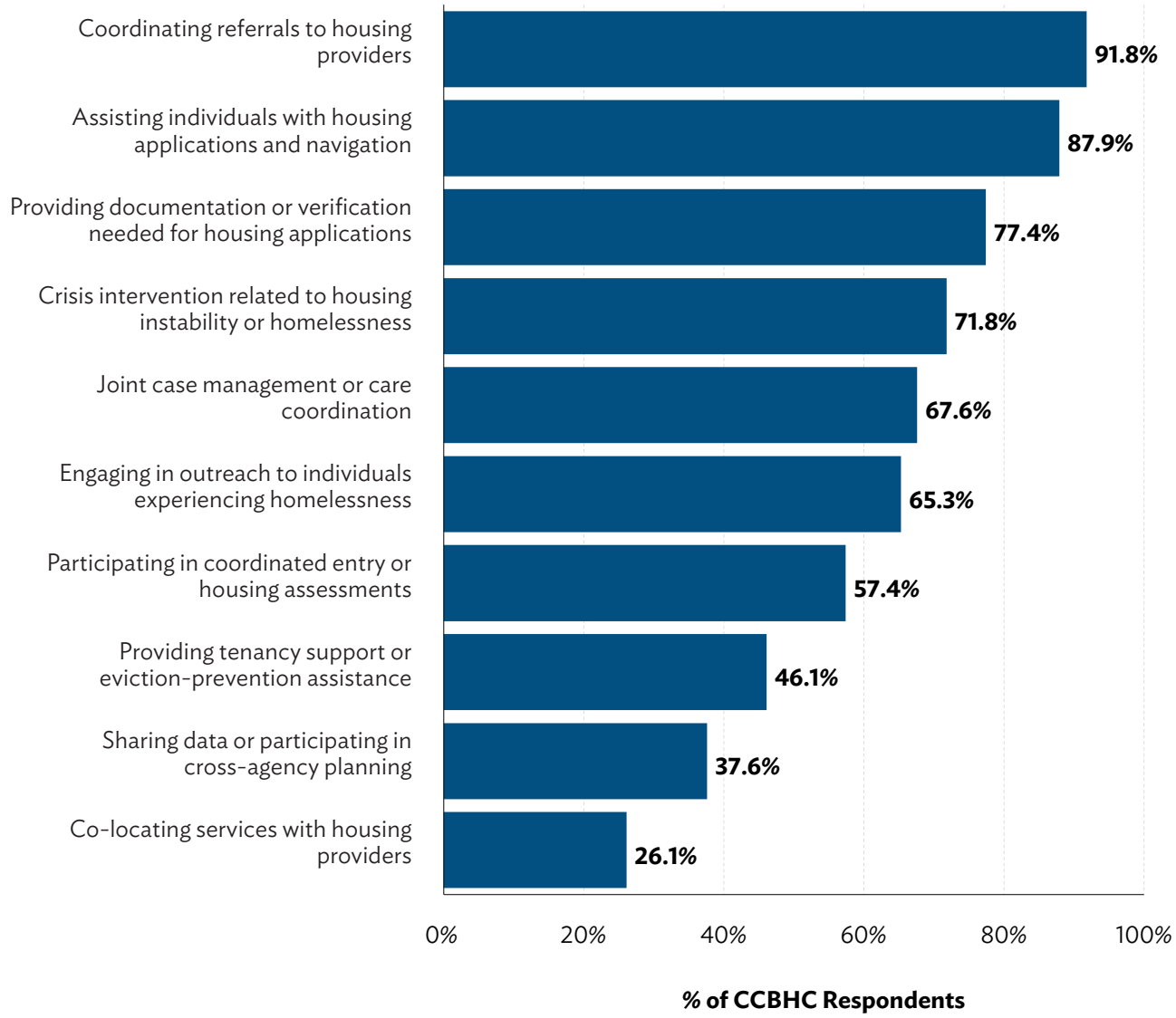
In 2024, more than 2 in 10 adults experiencing homelessness on any single night had SMI (KFF, 2024). CCBHCs are making strides to prevent and address homelessness among their clients. Although not a federal requirement of the CCBHC model, 94.3% of CCBHCs report having partnerships with one or more housing and homelessness entities.

CCBHC Housing Partnerships



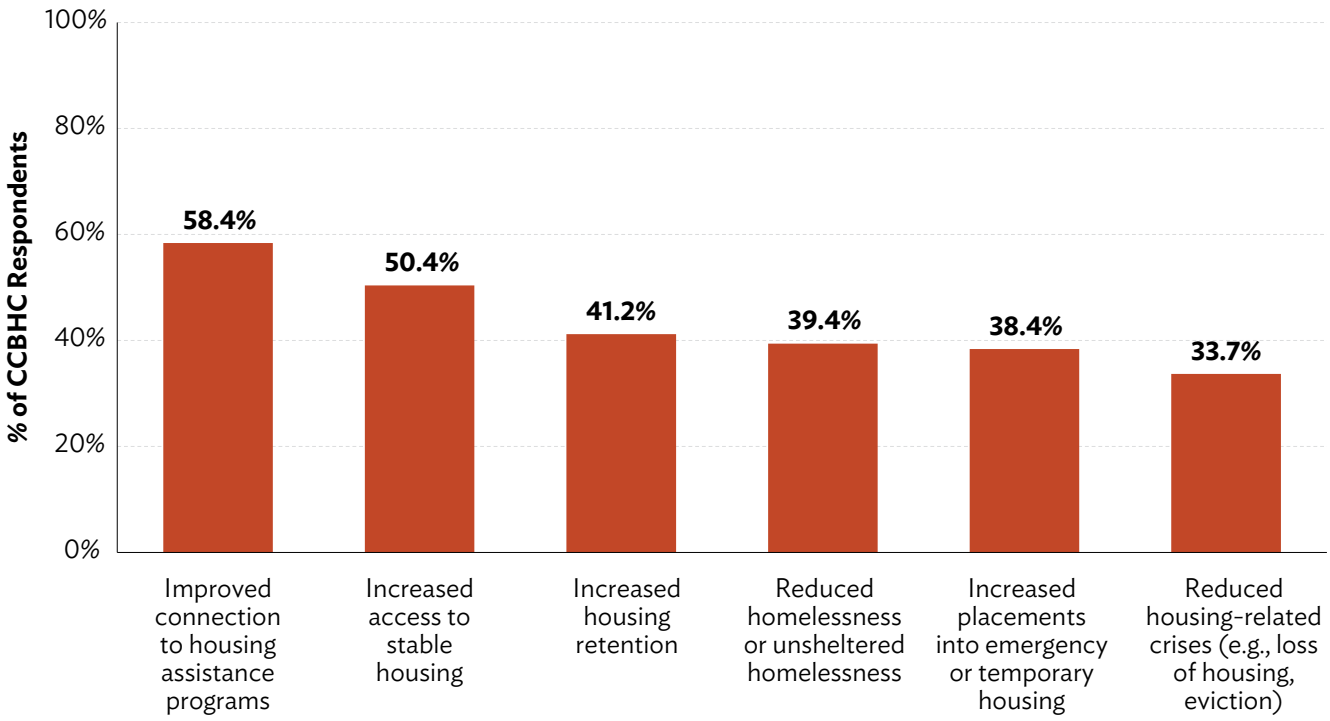
These partnerships enable CCBHCs to address housing-related needs alongside behavioral health treatment. CCBHCs' most frequently reported homelessness-related activities include coordinating referrals to housing providers (91.8%), assisting individuals with housing navigation (87.9%), and crisis intervention related to housing instability and homelessness (71.8%).

CCBHC Housing-related Activities with Partners



CCBHC efforts to address homelessness have proven effective. CCBHCs' work to move clients toward greater housing stability through targeted assistance and supports. Nearly three-quarters of CCBHCs (73.1%) reported one or more positive housing-related outcomes, including improved connection to housing assistance programs, increased access to stable housing and reduced homelessness among CCBHC clients.

CCBHCs Reporting Positive Housing-Related Outcomes Among Clients Served



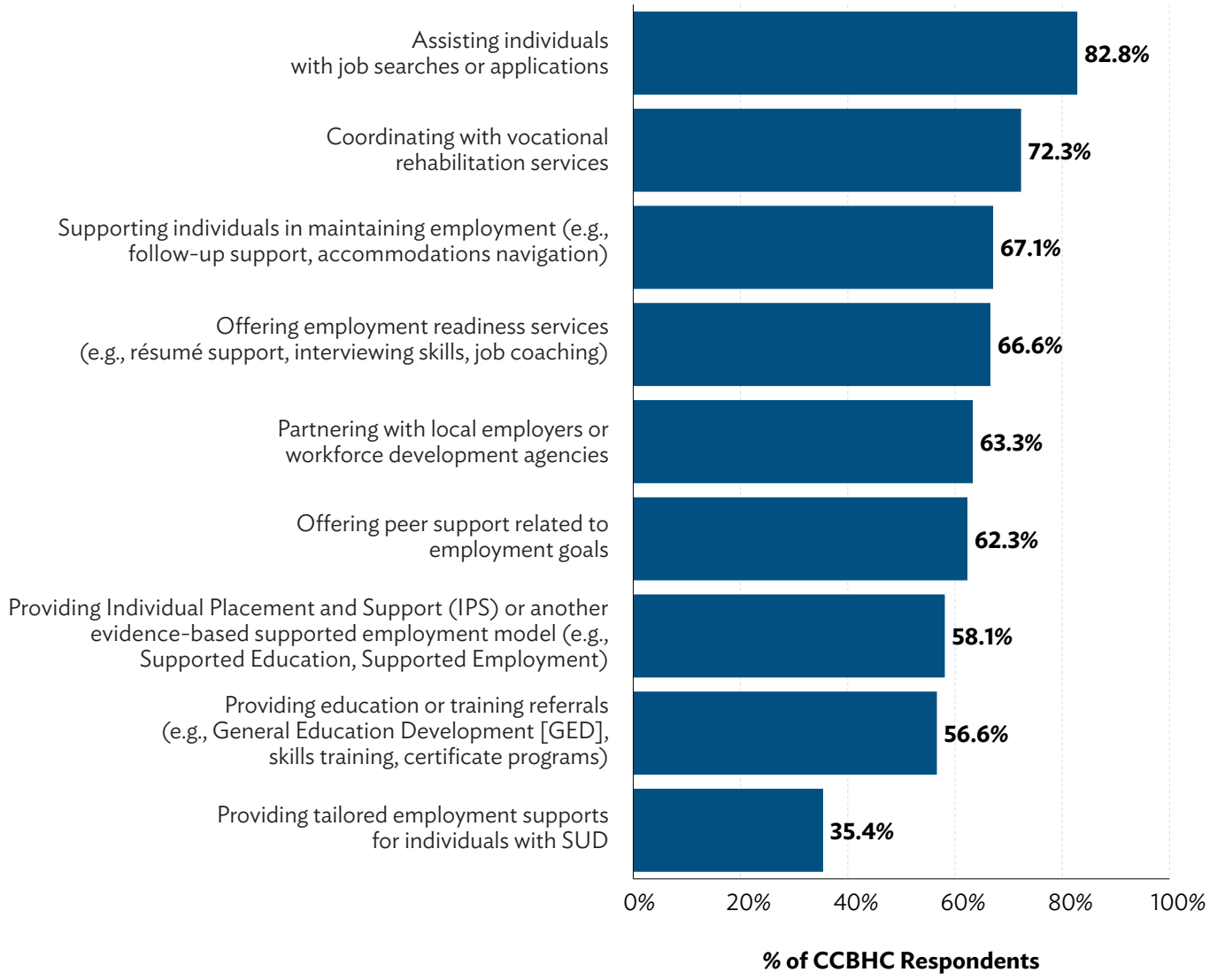
"We have seen meaningful progress through increased connection to resources and housing supports as a result of our CCBHC Infrastructure and Advancement grant. Expanded peer support and care coordination services have strengthened our ability to engage individuals experiencing housing instability. Strategically placing staff at the low-barrier shelter has allowed us to connect with individuals in real time, build trusting relationships and provide immediate linkage to behavioral health services, housing resources and other essential supports."

— Comprehensive Healthcare, Washington (CCBHC-E grantee)

Addressing Unemployment

Research consistently shows that employment is associated with improved behavioral health, recovery, and quality of life and can help reduce dependence on the behavioral health system over time (Drake & Wallach, 2020). Nearly all (98.8%) CCBHCs provide one or more services to help clients gain and/or maintain employment. The most reported employment-related services include assisting individuals with job applications and searches (82.8%), coordinating with vocational rehabilitation services (72.3%) and supporting individuals in maintaining employment (67.1%).

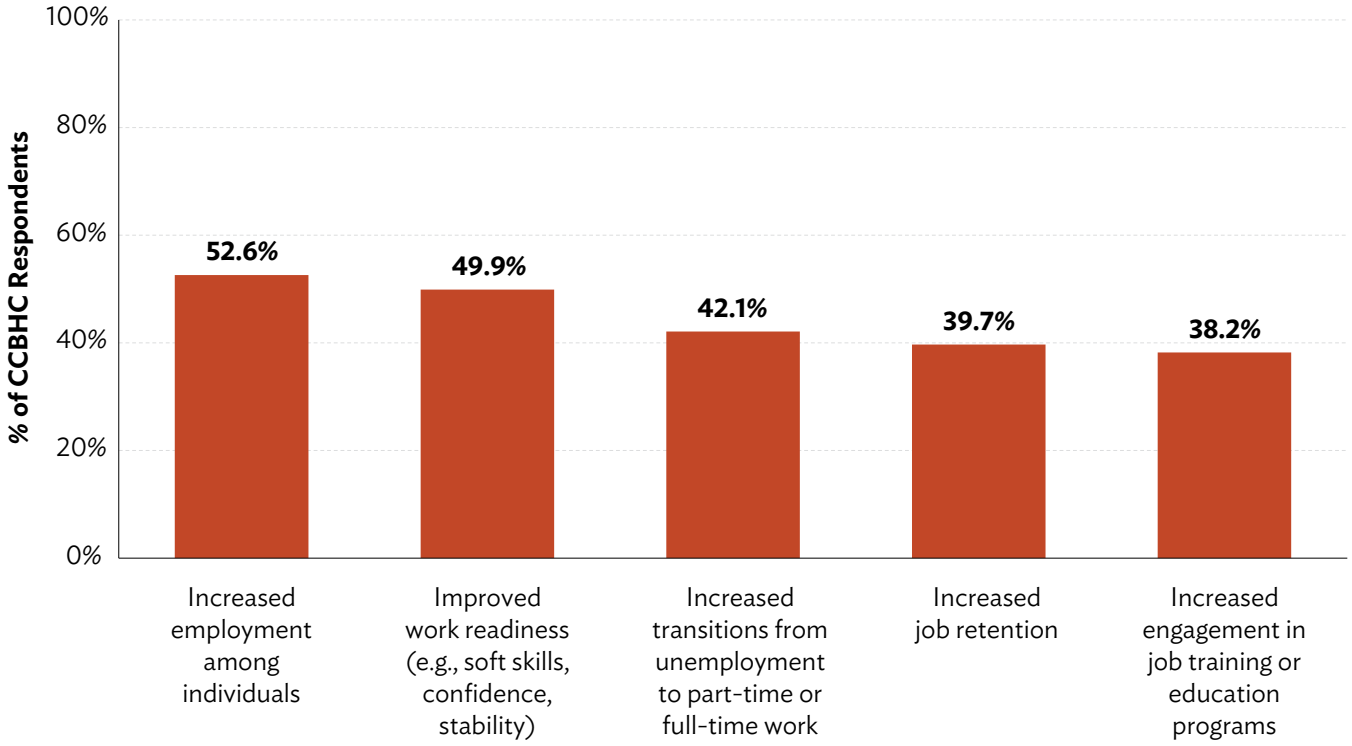
Strategies for Supporting Individuals Gain Employment



CCBHCs' employment-related efforts have yielded promising results. CCBHCs' dedicated focus on helping clients achieve and maintain employment has driven improvements across several domains, including increased employment and improved work readiness among clients. Sustaining and scaling these outcomes will be particularly important as states implement new Medicaid community engagement requirements in the coming year. By helping individuals secure and maintain employment, pursue education

and strengthen community connections, CCBHCs may play an important role in supporting continued access to Medicaid coverage and services for people with behavioral health conditions.

Employment-related Outcomes Among CCBHC Clients



"Every month this past year, Oklahomans in our IPS [individualized placement and support] program secured jobs — with our team averaging three new job starts monthly and building an employer pipeline through nearly eight interviews each month. We are integrating housing and employment: Our new Emergency Housing Program weaves IPS directly into a 90- to 180-day stabilization pathway, aligning evidence-based employment supports with rapid access to housing and clinical care. We manage IPS with live data: Our Power BI system tracks adult supportive-service indicators, enabling fast course-corrections on job development, placements and retention."

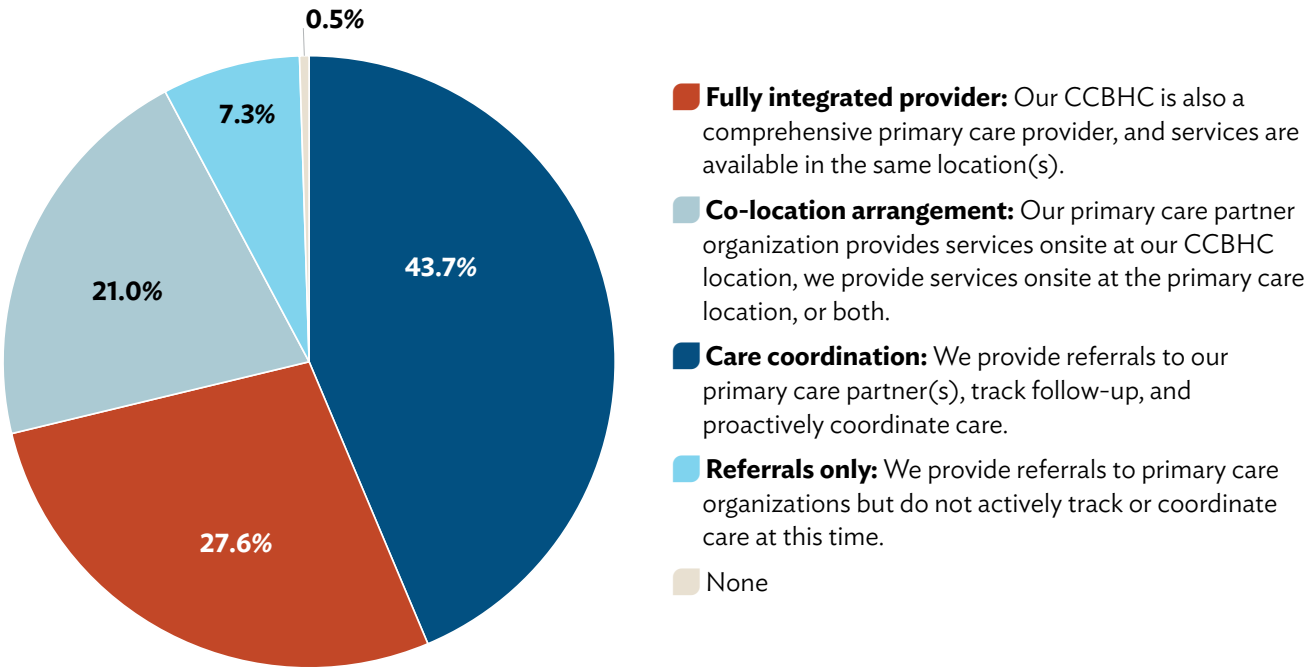
— Counseling and Recovery Services of Oklahoma (Medicaid CCBHC)

PRIMARY CARE COORDINATION AND INTEGRATION

CCBHCs play a critical role in bridging the gap between behavioral and physical health care by leveraging care coordination partnerships and integrated care models to improve access to primary care for the individuals they serve. While primary care itself is outside the CCBHC scope of services, CCBHCs are responsible for screening and monitoring of key health indicators and establishing strong partnerships with primary care providers to ensure clients' whole health needs are met. The majority of CCBHCs (90.1%) directly deliver primary care screening and monitoring, with the remainder using a DCO for this function.

Nearly half of CCBHCs exceed minimum requirements by making comprehensive primary care available on-site. Over 27% of clinics reported their CCBHC is a fully integrated primary care and behavioral health provider with all services available in the same location. An additional 21.0% of CCBHCs reported that they have a co-location arrangement with a local primary care provider. Together, 48.6% of CCBHCs offer behavioral health and primary care services at the same location.

Approaches to Facilitating Primary Care for CCBHC Clients



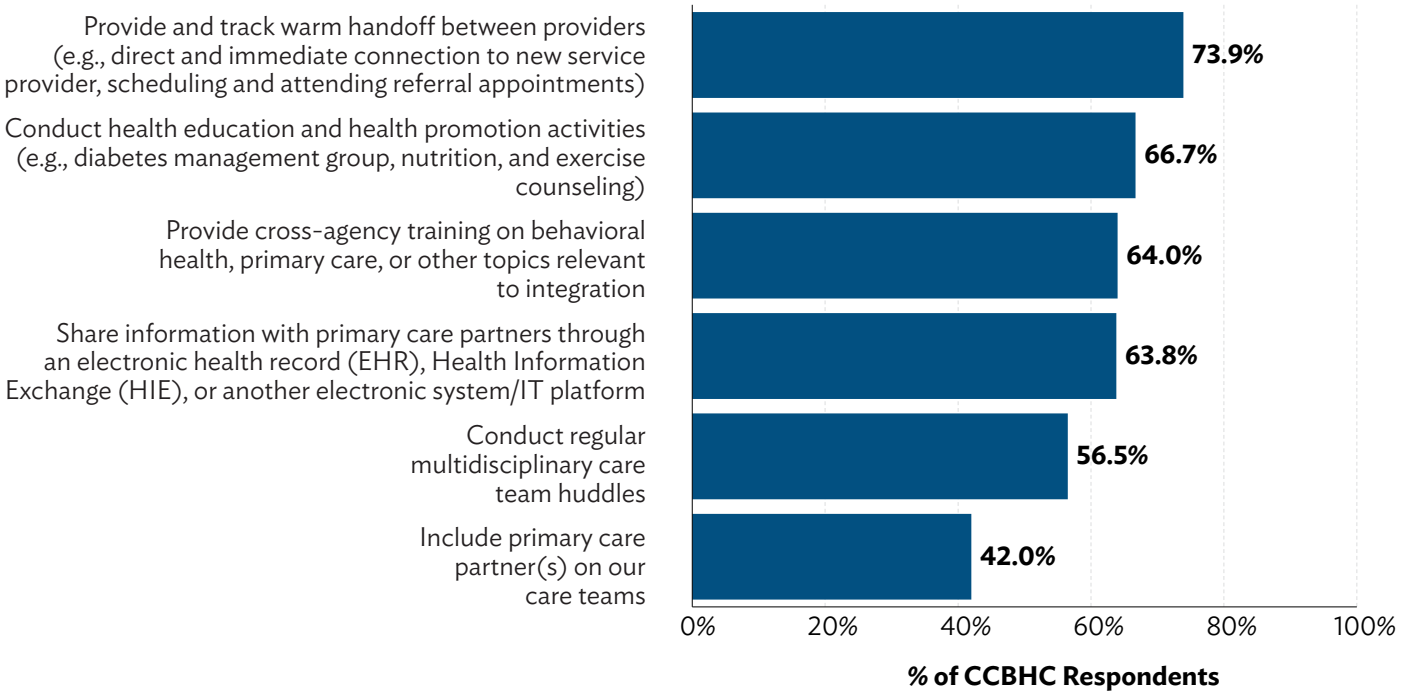
Among the CCBHCs that shared further information on their co-location arrangements, 69.0% reported that their primary care partner provides services on-site at the CCBHC facility, 18.4% reported that the CCBHC provides services on-site at the primary care partner's facility, and 12.6% reported doing both.

FQHCs are the most common primary care partners for CCBHCs. Respondents reported substantial engagement with FQHCs across all levels of integrated and coordinated care arrangements, highlighting the critical role of these partnerships in advancing whole-person care and addressing the physical health needs of individuals receiving behavioral health services. Among CCBHCs that partner with DCOs for primary care screening and monitoring, 69.4% reported that an FQHC was their DCO partner. FQHCs were also the primary care partner for 76.5% of the CCBHCs that had a co-location arrangement and 70.2% of CCBHCs with primary care coordination partnerships.

> *"We have a partnership with the local FQHC to provide both primary care and pharmacy services at our primary psychiatric services program. Staff from the FQHC participate in ongoing provider meetings as well as case consultation. This has aided in closing gaps in programming for customers and helping to coordinate care across programs in real time."*
>
> **— Summit Pointe, Michigan (Medicaid CCBHC)**

CCBHCs are engaging in a variety of strategies to advance coordinated and integrated care. Nearly all (96.6%) CCBHCS surveyed reported engaging in one or more activities to facilitate access to primary care among their clients, with the most common activities including providing and tracking warm handoffs between providers, conducting health education and promotion activities, and providing cross-agency training. These findings demonstrate that CCBHCs are moving beyond simple referral relationships and are implementing operational, clinical and technological approaches that support integrated, coordinated, whole-person care.

Care Coordination Activities Undertaken by CCBHCs



Access to primary care is increasing among CCBHC clients. The majority of CCBHCs (76.3%) reported that referrals to primary care have increased since becoming a CCBHC, including 34.1% reporting that referrals have increased by 20% or more. Even among respondents that were fully integrated care providers, 83.2% 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.

INVESTING IN THE BEHAVIORAL HEALTH WORKFORCE

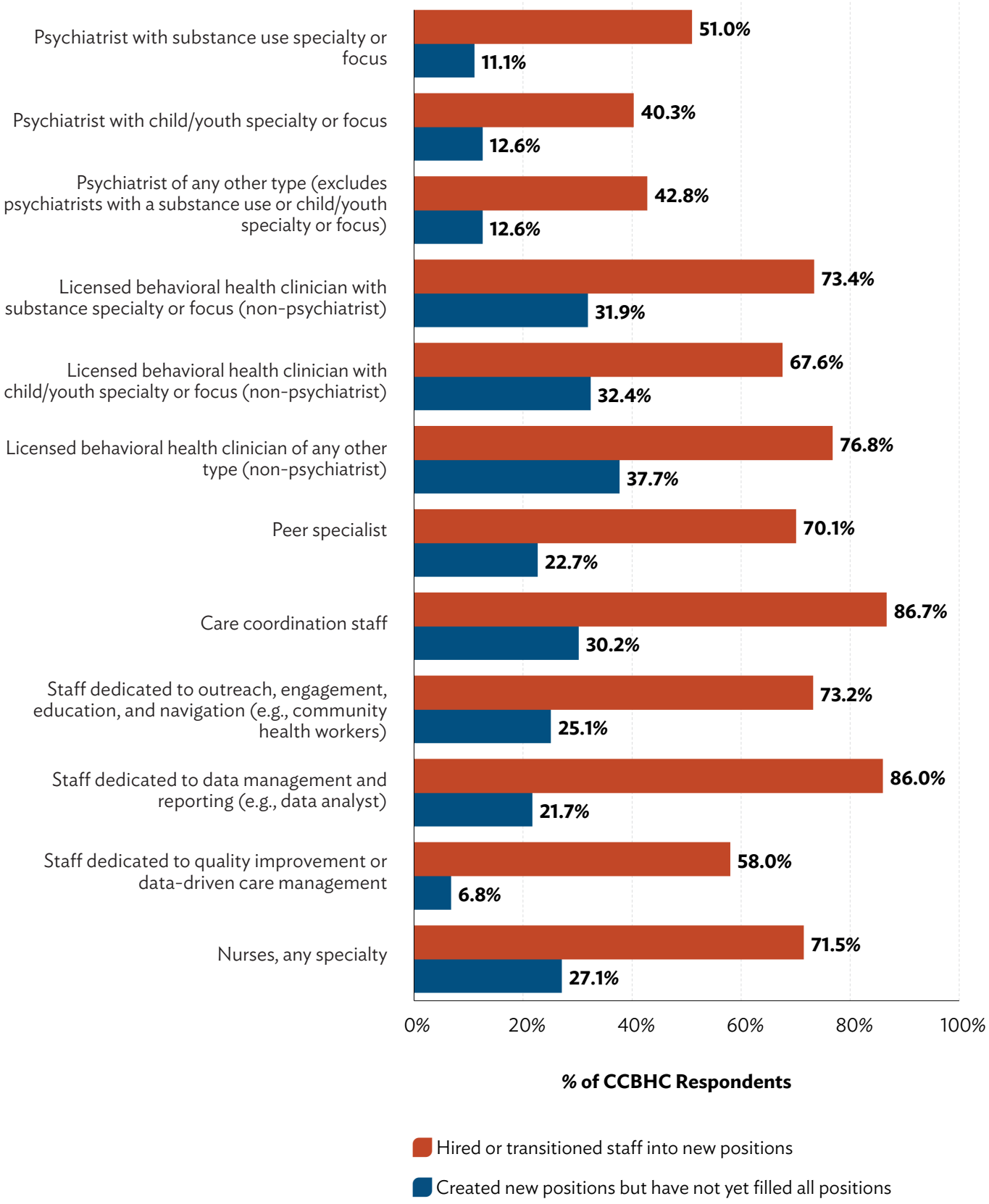
As of April 2026, the Health Resources and Services Administration (HRSA) estimates that approximately 153 million people live in Mental Health Professional Shortage Areas (HPSAs), with a need of more than 7,000 additional practitioners[7] to meet the demand for care (HRSA, 2026).

CCBHCs have significantly expanded their workforce, with particularly high gains among Medicaid CCBHCs. In 2025, 392 CCBHCs reported a total of 92,841 staff positions (including both filled and vacant roles), or a median of 149 staff positions per clinic. Among the 372 CCBHCs that reported the staffing levels both prior to becoming a CCBHC and in 2025, over 85% increased their number of staff positions following implementation of the model. They reported a total of 32,086 newly created staff positions. The median increase was 31 staff positions per clinic.

Workforce growth was particularly high among Medicaid CCBHCs, whose cost-related reimbursement has enabled them to improve both hiring and retention. Among Medicaid CCBHCs, the median number of staff grew from 142 in the year prior to CCBHC certification to 223 in 2025, representing a 57.0% increase. In contrast, the number of staff positions among CCBHC-E grantees grew from a median of 30 in the year before their grant award to 44 in 2025, a 46.7% increase. These differences are likely attributable, in part, to the different funding mechanisms for each clinic type. While both types of CCBHCs have enhanced financial resources to support workforce investment, the CCBHC PPS available to Medicaid CCBHCs is expressly designed to support the full cost of delivering CCBHC services, including the staffing investments necessary to meet community needs. This financing structure may provide CCBHCs with greater resources to recruit, hire and retain staff over time.

7 Practitioners Needed to Remove HPSA Designation is the number of additional psychiatrists needed to achieve a population-to-psychiatrist ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated) in all designated mental health HPSAs, resulting in their removal from designation. While mental health HPSA designations can include core mental health providers in addition to psychiatrists, most mental health HPSA designations are currently based on the psychiatrists only to population ratio. HPSA designations based on psychiatrists only do not take into account the availability of additional mental health services provided by other mental health providers in the area, such as clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists (KFF, 2025).

Experience Filling Newly Created Staff Positions Since Becoming a CCBHC



CCBHCs are using the model to expand clinical capacity while strengthening the staffing infrastructure needed to support whole-person care and successful client outcomes. Since certification, CCBHCs have made substantial workforce investments across both direct care and non-clinical roles. These investments include positions that increase access to clinical services (e.g., psychiatrists, other licensed behavioral health clinicians, nurses), as well as positions that are essential to care delivery but can be difficult to sustain in a traditional fee-for-service billing environment (e.g., care coordinators, data analysts, outreach and engagement staff, quality improvement staff, peer specialists).

The hiring patterns underscore the breadth of this workforce expansion. CCBHCs reported high rates of hiring for care coordination staff (86.7%), staff dedicated to data management and analytics (86.0%), and data-driven health management (58.0%) — roles that are central to coordinating services, tracking outcomes, using data to guide care and driving quality improvement. CCBHCs also reported strong hiring for nurses of any specialty (71.5%), peer specialists (70.1%) and outreach and engagement staff (73.2%), reflecting investments in the team-based supports needed to connect people to care, monitor progress and keep clients engaged for the duration of their treatment.

At the same time, CCBHCs are increasing clinical capacity in roles that directly expand access to behavioral health treatment. Approximately 67% to 82% of CCBHCs reported hiring licensed behavioral health clinicians with specific specialties, including substance use and child/youth. Many also hired psychiatrists with substance use specialties (51.0%) and child/youth specialties (40.3%). However, the data also shows that hiring remains challenging: Between 11% and 38% of CCBHCs reported creating clinical staff positions that have not yet been filled, with vacancies also common among non-clinical roles.

These findings highlight the scale and growth of the CCBHC workforce along with the persistent challenges related to the national workforce shortage, underscoring the continued pressure on clinics to meet rising demand for behavioral health services.

"One of the most significant impacts of our designation as a CCBHC has been the expansion of access to psychiatric services. Using the power of the [CCBHC PPS], we were able to increase our psychiatry staffing hours by 40%. Before CCBHC implementation, the average wait time for a psychiatric evaluation was approximately three months. Today, we offer psychiatric evaluations for both adults and children within a few days and often as quickly as the next day, effectively eliminating wait times. This represents a major improvement in access to care and a significant success for our agency and the people we serve."

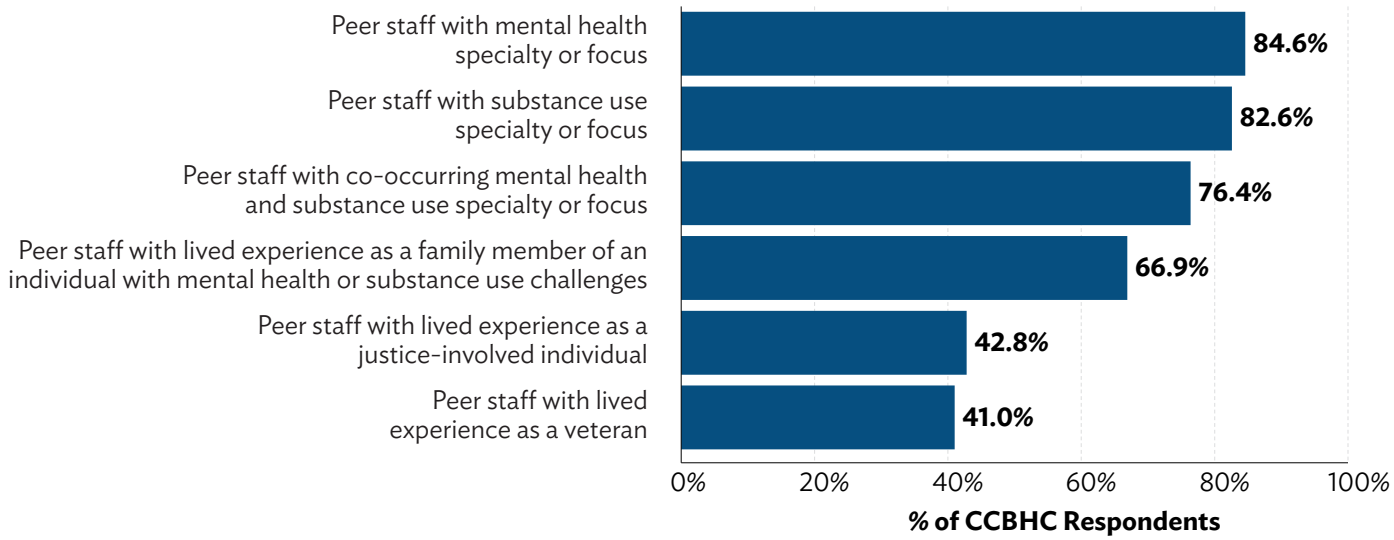
— Transitions of Western Illinois (Medicaid CCBHC)

"CCBHO status has assisted us in being able to develop an Addiction Fellowship for physicians."

— Ozark Center, Missouri (Medicaid CCBHC)

CCBHCs are increasingly hiring peer staff into their workforce, recognizing their critical role in improving engagement, retention and outcomes in behavioral health. Peer support services are a core component of the CCBHC model, grounded in lived experience and focused on building trust, promoting recovery and supporting individuals in navigating complex systems of care. Seventy percent of CCBHCs reported hiring peer specialists with a wide range of lived experiences, reflecting the growing role of peer support in engaging individuals in care through a CCBHC.

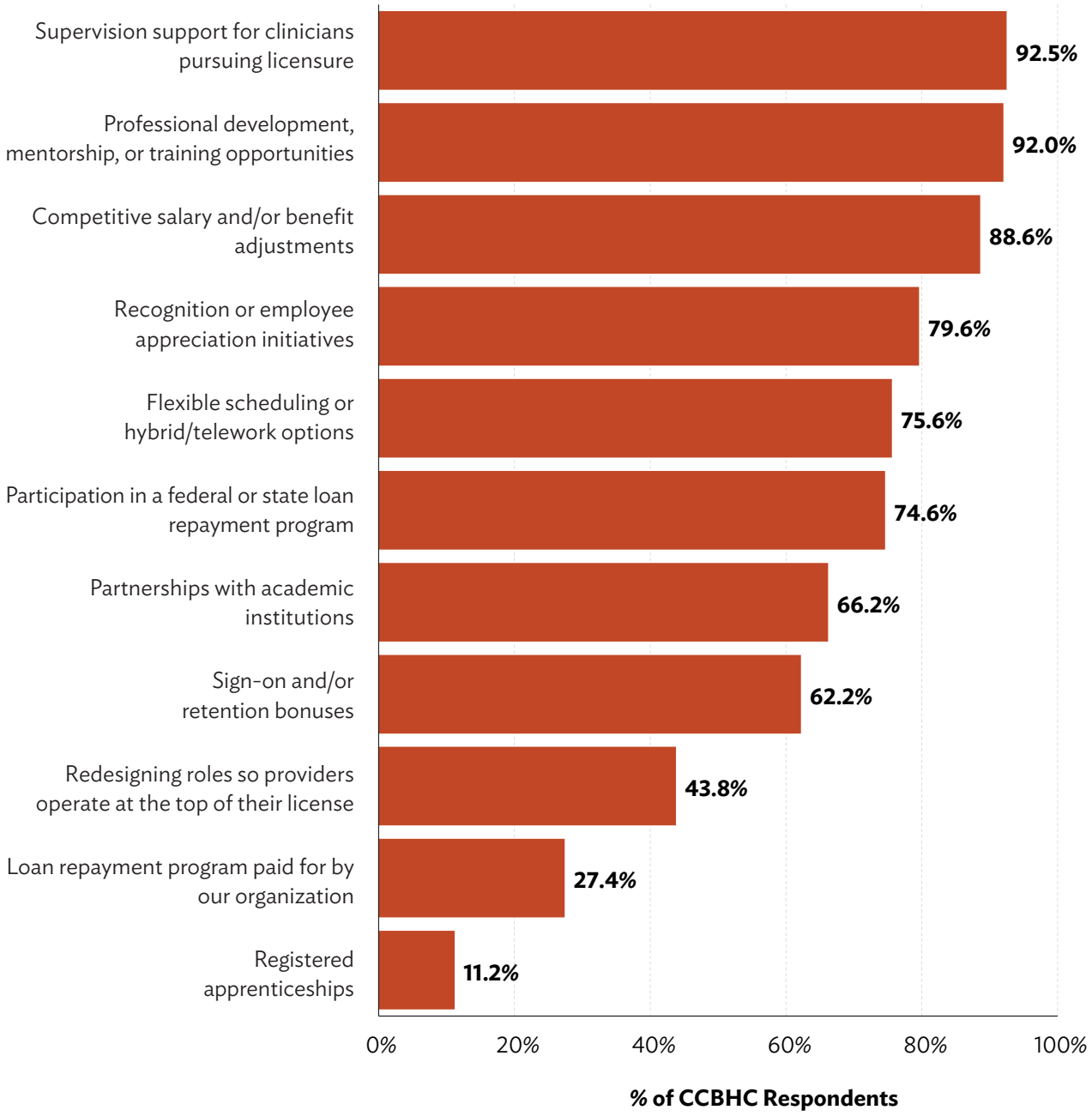
Types of Peer Staff Positions Within CCBHCs



CCBHCs' vacancy rates are substantially lower than the national average in the behavioral health sector. Of the 92,841 CCBHC staff positions reported, 84,544 (91.1%) have been filled, while 8,295 positions remain vacant. This reflects an overall vacancy rate of 8.9%, substantially lower than the national overall vacancy rate of 21.2% in for mental health workers and psychiatric aides (Hospital & Healthcare Compensation Service, 2024). CCBHCs are engaging in a variety of strategies to strengthen workforce growth and long-term retention. The most commonly reported strategies focus on strengthening the clinical workforce through supervision and career development. Nearly all CCBHCs provide supervision support for clinicians pursuing licensure (92.5%), as well as professional development, mentorship and training opportunities (92.0%).

Compensation and workplace environment also play a key role in retention. A majority of CCBHCs report making market-competitive adjustments to salaries and benefits (88.6%) and implementing employee recognition and appreciation initiatives (79.6%). Additionally, 75.6% of CCBHCs provide flexible scheduling or hybrid/telework options, reflecting efforts to improve work-life balance and reduce burnout.

Recruitment & Retention Strategies Employed by CCBHCs



INNOVATIONS IN VALUE-BASED CARE AND TECHNOLOGY

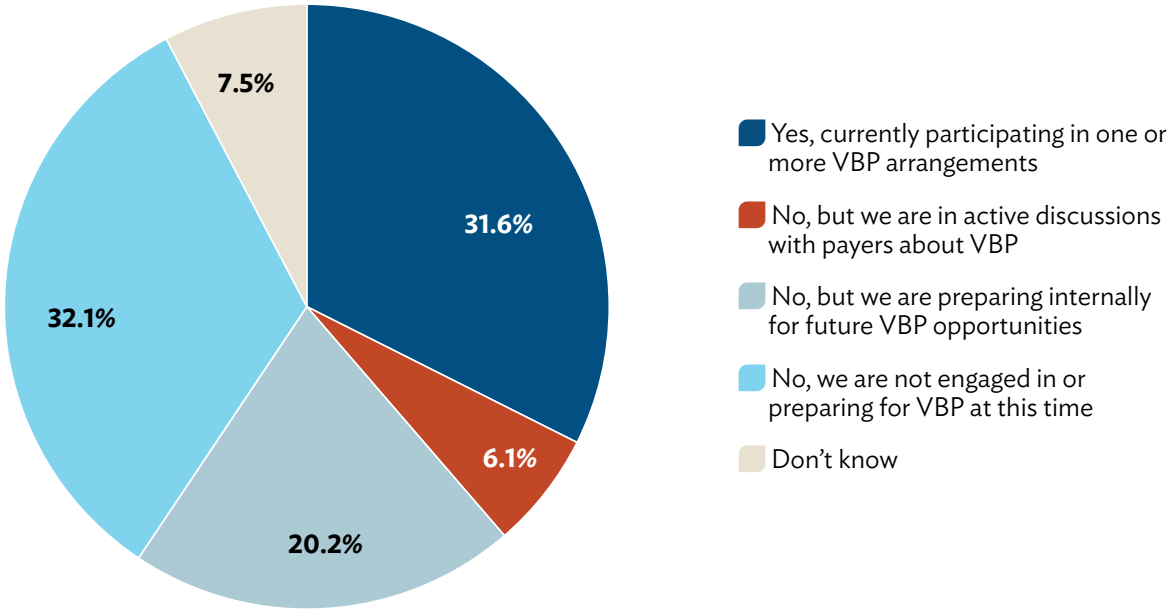
As the health care sector moves increasingly toward payment models linked to quality and outcomes, the CCBHC PPS has helped advance behavioral health toward value-based care. Under the widely used Health Care Payment Learning & Action Network (HCPLAN) Alternative Payment Model Framework (2017), the CCBHC PPS represents a prospective, bundled payment for comprehensive specialty services and may include a pay-for-performance element if states have opted to include quality bonus payments. For most states, this is a significant step forward from traditional fee-for-service payment models with no link to quality or value.

New to the 2026 CCBHC Impact Survey, this section examines how CCBHCs are engaging with value-based payment (VBP) models and clinically integrated networks (CINs) beyond the traditional CCBHC PPS. For the purposes of this section, VBP refers to payment models that tie reimbursement to quality, outcomes or cost-effectiveness, rather than solely to service units. These models may include incentive payments, shared savings, shared risk or population-based payments, all of which are designed to improve outcomes while reducing overall health care costs.

CCBHC status helps organizations build the capabilities needed to participate in VBP. CCBHCs are well-positioned for success in these arrangements because their certification requirements include many of the capabilities necessary for value-based care: coordinated care teams, integration of evidence-based mental health and substance use services, use of data and quality measures to drive outcomes and quality improvement, and attention to both the clinical and social factors that influence health outcomes. By improving access to timely care and reducing reliance on costly EDs, hospitalizations and other crisis services, CCBHCs are advancing many of the same goals that underpin value-based care.

CCBHCs are participating in VBP arrangements, reflecting broader efforts across the health care system to align payment with quality, outcomes and cost-effectiveness. More than a third of survey respondents are currently participating in one or more VBP arrangements (31.6%) or in active discussions with payers about establishing VBP (6.1%). An additional 20.2% are preparing internally for VBP opportunities. Participation varies by clinic type, with Medicaid CCBHCs reporting substantially higher engagement in VBP than CCBHC-E grantees (41.1% vs. 20.6%). This may be a reflection of the more established financing infrastructure and payer relationships available to Medicaid CCBHCs. VBP arrangements with commercial insurers are particularly important for CCBHCs, which must provide the full range of services to anyone who walks through their doors, but only receive PPS for those who are enrolled in Medicaid. VBP arrangements with non-Medicaid payers can help support the cost of delivering CCBHC services to commercially insured clients.

CCBHC Engagement with Value-based Payment Arrangements

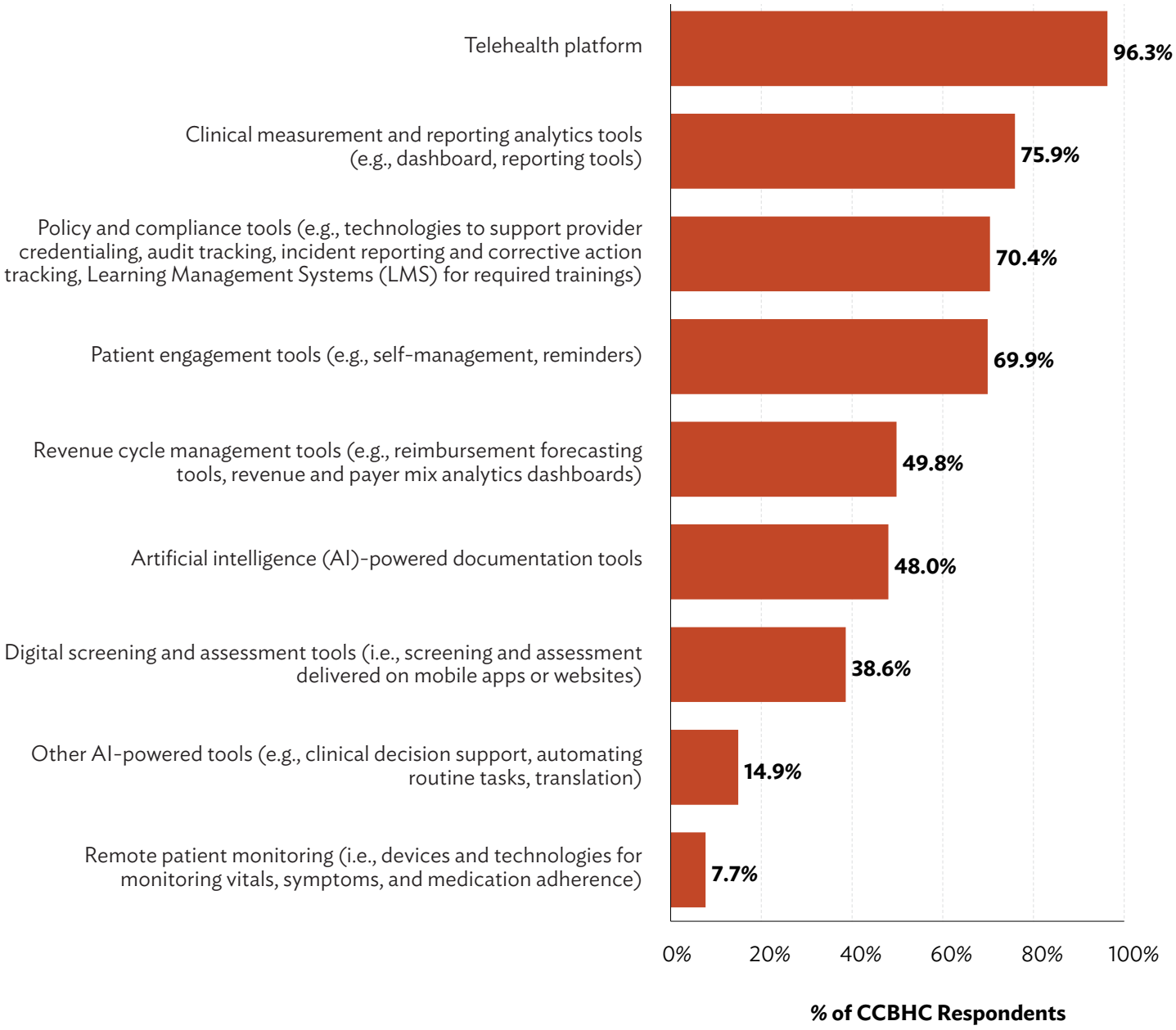


CCBHCs are also participating in CINs,[8] which provide critical infrastructure to accelerate value-based care. The survey also asked about CCBHCs' engagement with CINs, defined as a formal collaboration between health care providers to improve health outcomes and reduce costs. Almost 1 in 4 (24.4%) CCBHCs participate in a CIN, including 15.7% in a behavioral-health-focused CIN and 8.7% in a multi-specialty or cross-sector CIN. CIN participants reported numerous ways the CIN advances their capacities to engage in value-driven efforts, including data sharing or data analytics support (71.3%), quality improvement and performance measurement activities (63.4%), contracting support (53.8%) and care coordination support for shared clients (44.1%).

CCBHCs are increasingly leveraging technology to improve and streamline care. CCBHCs report high levels of adoption of foundational technology infrastructure. Nearly all CCBHC respondents (96.3%) use telehealth platforms, reflecting the sustained integration of virtual care into behavioral health service delivery beyond the COVID-19 pandemic. A majority use clinic measurement and improvement analytics (75.9%), policy and compliance tools (70.4%), and patient engagement tools (69.9%). Nearly half (48.0%) report using AI-powered tools, signaling growing but still emerging adoption of advanced technologies.

8 Examples of CINs include Accountable Care Organizations or Independent Practice Associations.

Technology Leveraged by CCBHCs



Taken together, these findings offer an early view of how CCBHCs are driving progress toward cross-sector value collaborations aimed at improving outcomes and reducing costs, in many cases supported by increasing use of advanced technology tools. While this survey did not examine the details of CCBHCs' VBP payers, reimbursement structures or CIN partnerships, future research could explore these arrangements to identify promising models and best practices.

CONCLUSION

The findings from the 2026 CCBHC Impact Survey demonstrate that CCBHCs continue to transform behavioral health systems across the country by expanding access to care, strengthening service delivery and improving coordination across various systems of care. As behavioral health needs remain high nationwide, CCBHCs are helping to close long-standing gaps in care by ensuring that individuals can access comprehensive mental health and substance use services regardless of their ability to pay, age, diagnosis or place of residence.

The survey findings show that CCBHCs are serving more people than ever before. CCBHC respondents reported serving more than 2.5 million people in 2025, representing a 42.4% increase compared to the number of CCBHC clients prior to becoming a CCBHC. Access gains were particularly evident among children and youth, uninsured individuals, and people who previously lacked a source of outpatient behavioral health care.

Beyond expanding access, CCBHCs are strengthening the quality and comprehensiveness of care. CCBHCs reported substantial increases in workforce capacity, expanded availability of evidence-based mental health and substance use treatment, stronger integration with primary care and enhanced coordination with hospitals, EDs, schools, housing providers, justice-involved entities and crisis response systems. Nearly half of individuals with OUD served by CCBHCs received MOUD, substantially exceeding national MOUD treatment rates. At the same time, CCBHCs are addressing the broader factors that influence health and recovery through partnerships focused on housing stability, employment, education and community engagement.

The findings also highlight the important role CCBHCs play in modernizing and integrating behavioral health care within the larger health care system. CCBHCs reported growing participation in VBP arrangements, increasing use of data and technology to improve care. These investments position CCBHCs to continue improving outcomes while supporting more efficient and coordinated care delivery.

As federal and state policymakers continue to address the nation's behavioral health needs, the findings from this survey demonstrate that the CCBHC model provides a scalable framework for expanding access, improving quality, strengthening community partnerships and addressing the complex needs of people with mental health and substance use conditions. Continued investment in the model will be critical to sustaining these gains and ensuring that communities across the country have access to comprehensive, coordinated, person-centered behavioral health care — ultimately ensuring that all people have greater opportunities to achieve health, recovery and wellbeing.

GLOSSARY OF ABBREVIATIONS

AI: artificial intelligence

CBT: cognitive behavioral therapy

CCBHC: Certified Community Behavioral Health Clinic

CCBHC-E: CCBHC Expansion

CCBHO: Certified Community Behavioral Health Organization (Missouri only)

CDC: Centers for Disease Control and Prevention

CIN: clinically integrated network

DBT: dialectical behavioral therapy

DCO: Designated Collaborating Organization

EBP: evidence-based practice

ED: emergency department

FDA: U.S. Food and Drug Administration

FQHC: Federally Qualified Health Center

HCPLAN: Health Care Payment Learning & Action Network

HRSA: Health Resources and Services Administration

HPSA: Health Professional Shortage Area

MOUD: medication for opioid use disorder

NSDUH: National Survey on Drug Use and Health

OUD: opioid use disorder

PPS: Prospective Payment System

SAMHSA: Substance Abuse and Mental Health Services Administration

SED: serious emotional disturbance

SMI: serious mental illness

SUD: substance use disorder

VBP: value-based payment

REFERENCES

An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Pub. L. No. 119–21 (2025). https://www.congress.gov/bill/119th-congress/house-bill/1

Baranyi, G., Fazel, S., Langerfeldt, S. D., & Mundt, A. P. (2022). The prevalence of comorbid serious mental illnesses and substance use disorders in prison populations: a systematic review and meta-analysis. *The Lancet. Public health, 7*(6), e557–e568. https://doi.org/10.1016/S2468-2667(22)00093-7

Bureau of Justice Statistics. (2017a). *Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009* (NCJ 250546). Office of Justice Programs, U.S. Department of Justice. https://bjs.ojp.gov/content/pub/pdf/dudaspji0709.pdf

Bureau of Justice Statistics. (2017b). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12 (NCJ 250612). Office of Justice Programs, U.S. Department of Justice. https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf

Drake, R. E., & Wallach, M. A. (2020). Employment is a critical mental health intervention. *Epidemiology and Psychiatric Sciences, 29*, e178. https://doi.org/10.1017/S2045796020000906

Health Care Payment Learning & Action Network. (2017). *Alternative payment model (APM) framework*. https://hcp-lan.org/wp-content/uploads/2025/08/APM-Framework-White-Paper.pdf

Health Resources and Services Administration. (2026). *Health Workforce Shortage Areas dashboard*. U.S. Department of Health and Human Services. https://data.hrsa.gov/topics/health-workforce/shortage-areas/dashboard

Hospital & Healthcare Compensation Service. (2024, June). *2024 HCS behavioral health study results* [press release]. https://hhcsinc.com/wp-content/uploads/2024/11/2024-BH-Press-Release.pdf

KFF. (2024). *Five key facts about people experiencing homelessness*. https://www.kff.org/medicaid/five-key-facts-about-people-experiencing-homelessness/

KFF. (2025, December 31). *Mental health care Health Professional Shortage Areas (HPSAs)*. https://www.kff.org/other-health/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/

Launders, N., Hayes, J. F., Price, G., Marston, L., & Osborn, D. P. J. (2023). The incidence rate of planned and emergency physical health hospital admissions in people diagnosed with severe mental illness: A cohort study. *Psychological Medicine, 53*(12), 5603–5614. https://doi.org/10.1017/S0033291722002811

Mauri, A. I., Rouhani, S., & Purtle, J. (2025). Characterizing crisis services offered by Certified Community Behavioral Health Clinics: Results from a national survey. *Psychiatric Services, 76*(1), 13–21. https://doi.org/10.1176/appi.ps.20240152

Meng, J. F., & Wiznitzer, E. (2024). Factors associated with not receiving mental health services among

children with a mental disorder in early childhood in the United States, 2021–2022. *Preventing Chronic Disease, 21*, Article 240126. https://doi.org/10.5888/pcd21.240126

Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus, 18*(1), 16–24. https://doi.org/10.1176/appi.focus.20190028

Congressional Budget Office. (2025). *Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline*. https://www.cbo.gov/publication/61570

Protecting Access to Medicare Act of 2014, Pub. L. No. 113–93, 128 Stat. 1040 (2014). https://www.congress.gov/113/plaws/publ93/PLAW-113publ93.pdf

Richards, J., & Kuhn, R. (2022). Unsheltered homelessness and health: A literature review. *AJPM Focus, 2*(1), Article 100043. https://doi.org/10.1016/j.focus.2022.100043

S. Lloyd, president, MTM Services, personal communication, May 19, 2026.

Spencer, M. R., Warner, M., Bastian, B. A., Trinidad, J. P., & Hedegaard, H. (2023). Drug overdose deaths decreased in 2022. *Morbidity and Mortality Weekly Report, 72*(39), 1069–1071. https://doi.org/10.15585/mmwr.mm7239a6

Substance Abuse and Mental Health Services Administration. (2025). *Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health* (HHS Publication No. PEP25-07-007, NSDUH Series H-60). https://www.samhsa.gov/data/sites/default/files/reports/rpt56287/2024-nsduh-annual-national-report.pdf

Yang, Y., Niu, L., Amin, S., & Yasin, I. (2024). Unemployment and mental health: A global study of unemployment's influence on diverse mental disorders. *Frontiers in Public Health, 12*, Article 1440403. https://doi.org/10.3389/fpubh.2024.1440403

Any links to external websites and resources are provided for informational purposes only. The views, opinions and content expressed on those sites are solely those of the original authors or organizations and do not necessarily reflect the views or positions of the National Council. Including these links also does not imply endorsement, oversight or legal relationship with such authors or organizations.