



**ASPE**  
ASSISTANT SECRETARY FOR  
PLANNING AND EVALUATION

**OFFICE OF BEHAVIORAL HEALTH,  
DISABILITY, AND AGING POLICY**

# **Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2023**

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

by  
Mathematica Policy Research  
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**July 2024**

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# **CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS DEMONSTRATION PROGRAM: REPORT TO CONGRESS, 2023**

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## Abstract

Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA; Public Law 113-93) authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration to allow states to test a new strategy for delivering and reimbursing a comprehensive array of services provided in community behavioral health clinics. The demonstration aims to improve the availability, quality, and outcomes of outpatient services provided in these clinics. The demonstration requires participating states to reimburse CCBHC services through a Medicaid prospective payment system intended to cover the full costs of CCBHC services for Medicaid beneficiaries. In 2016, the U.S. Department of Health and Human Services (HHS) selected eight states to participate in the demonstration (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania). The demonstration was originally authorized for two years, but Congress has extended it multiple times and it is currently authorized in the original states through September 2025. In August 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; Public Law 116-136) expanded the demonstration to two new states (Kentucky and Michigan). The Bipartisan Safer Communities Act, enacted in June 2022, authorizes all states to apply to participate in the demonstration beginning with two rounds of planning grants to allow up to ten states to participate every two years starting in 2024. (Public Law 117-159).

PAMA mandates that the HHS Secretary submit an annual report to Congress that assesses: (1) access to community-based mental health services under Medicaid; (2) the quality and scope of services provided by CCBHCs; and (3) the impact of the demonstration on federal and state costs of a full range of mental health services. This report describes findings as they relate to the PAMA topics of access to care and scope of services, focusing on care coordination services and activities. The report also provides information on changes in the quality of care during the first four years of the demonstration for states with available quality measures and quality bonus payments states made to CCBHCs based on quality measure performance. The report builds on detailed findings on demonstration implementation, quality improvement, and costs included in previous evaluation reports and focuses on qualitative and quantitative data collected through the evaluation since the spring of 2022.

## Acronyms

The following acronyms are mentioned in this report.

ADD-BH	Follow-up Care for Children Prescribed ADHD Medication
ADHD	Attention Deficit Hyperactivity Disorder
ADT	Admission, Discharge, Transfer alert
AMA	American Medical Association
AMM-BH	Antidepressant Medication Management
AOD	Alcohol and Other Drug
ASC	Unhealthy Alcohol Use--Screening and Brief Counseling
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
BMI-SF	Body Mass Index Screening and Follow-up Plan
BSCA	Bipartisan Safer Communities Act
CARES Act	Coronavirus Aid, Relief, and Economic Security Act (Public Law 116-136)
CCBHC	Certified Community Behavioral Health Clinic
CCBHC-E	Certified Community Behavioral Health Clinic Expansion
CHIP	Children's Health Insurance Program
CMS	HHS Centers for Medicare & Medicaid Services
COVID-19	Novel Coronavirus
CY	Calendar Year
DCO	Designated Collaborating Organization
DEP-REM-12	Depression Remission at Twelve Months
DY	Demonstration Year
EBP	Evidence-Based Practice
ED	Emergency Department
EHR	Electronic Health Record
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Center
FUA	Follow-up after Emergency Department Visit for Alcohol or Other Dependence
FUH-BH	Follow-up after Hospitalization for Mental Illness
FUM	Follow-up after Emergency Department Visit for Mental Illness
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	U.S. Department of Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HOU	Housing Status
I-EVAL	Time to Initial Evaluation measure
IET-BH	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
MAT	Medication-Assisted Treatment
MHSIP	Mental Health Statistics Improvement Program

NCQA	National Committee for Quality Assurance
PAMA	Protecting Access to Medicare Act (Public Law 113-93)
PCPI	Physician Consortium for Performance Improvement
PCR-BH	Plan All-Cause Readmission Rate
PEC	Patient Experience of Care measure
PHE	Public Health Emergency
PHQ	Patient Health Questionnaire
PPS	Prospective Payment System
QBP	Quality Bonus Payment
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure
SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SPA	State Plan Amendment
SRA	Suicide Risk Assessment
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications
SUD	Substance Use Disorder
TCM	Targeted Case Management
TSC	Tobacco Use--Screening and Cessation Intervention
URS	Uniform Reporting System
VHA	Veterans Health Administration
WCC-BH	Weight Assessment for Nutrition and Physical Activity for Children/Adolescents
Y/FEC	Youth/Family Experience of Care survey

## Executive Summary

Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA) authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration, which allows states to test a different strategy for delivering and reimbursing a comprehensive array of services provided in community behavioral health clinics. The demonstration aims to improve the availability, quality, and outcomes of outpatient services provided in these clinics. Demonstration states certify that participating clinics offer nine types of services to all who seek care, including people with serious mental illness (SMI), serious emotional disturbance (SED), and substance use disorders (SUDs).<sup>1</sup> States have some flexibility, however, to tailor services to align with their Medicaid state plans and other regulations and to meet the needs of the communities they serve. Services must be person and family-centered, trauma-informed, and recovery-oriented. CCBHCs must maintain relationships with a range of health and social service providers to facilitate referrals and coordinate care. CCBHCs can partner with Designated Collaborating Organizations (DCOs) to provide required services but the CCBHCs must assure that these services meet CCBHC standards through a formal, signed agreement. CCBHCs must also offer services during accessible hours (including evening and weekends) and in convenient locations (for example, by providing services in clients' homes and elsewhere in the community).

The demonstration requires participating states to reimburse CCBHC services through a Medicaid prospective payment system (PPS). The PPS is intended to cover the expected costs of CCBHC services for Medicaid beneficiaries and provide CCBHCs with a stable source of funding. States select one of two PPS models to reimburse all CCBHCs in the state: a fixed daily payment (PPS-1) for each day a Medicaid beneficiary receives demonstration services or a fixed monthly payment (PPS-2) for each month in which a Medicaid beneficiary receives demonstration services. After each demonstration year (DY), states must report measures that assess the quality of care provided to CCBHC clients.<sup>2</sup> Quality measure reporting provides CCBHCs and state officials with standardized metrics to monitor the quality of care and inform quality improvement efforts. PPS-1 states have the option to provide CCBHCs with quality bonus payments (QBPs) based on their performance on quality measures. PPS-2 states must provide QBPs.

In October 2015, the U.S. Department of Health and Human Services (HHS) awarded planning grants to 24 states to begin certifying clinics to become CCBHCs, establish their PPS, and develop the infrastructure to support the demonstration. HHS developed criteria (as required by PAMA) for certifying CCBHCs in six areas.<sup>3,4</sup> In December 2016, HHS selected eight states to participate in the demonstration (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania). The demonstration was originally authorized for two years and scheduled to end in July 2019, but Congress

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<sup>1</sup> These services include: (1) crisis mental health services; (2) screening, assessment, and diagnosis; (3) patient-centered treatment planning; (4) outpatient mental health and substance use services; (5) outpatient clinic primary care screening and monitoring; (6) targeted case management (TCM); (7) psychiatric rehabilitation services; (8) peer support, counselor services, and family supports; and (9) intensive, community-based mental health care for members of the armed forces and veterans.

<sup>2</sup> Before March 2023, demonstration states had to report 21 measures. Updates to the CCBHC certification criteria (SAMHSA 2023) in March 2023 require states to report 18 measures, with the option to report seven others beginning with calendar year 2025.

<sup>3</sup> The areas are: (1) staffing; (2) availability and accessibility of services; (3) care coordination; (4) scope of services; (5) quality and reporting; and (6) organizational authority.

<sup>4</sup> HHS updated the certification criteria in March 2023 to reflect lessons learned from several years of implementation and changes to the national service delivery landscape since the criteria were developed in 2015 (SAMHSA 2023).

has extended it multiple times and it is now authorized through September 2025 for the original states. In August 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; Public Law 116-136) expanded the demonstration to two new states from among the states that received planning grants. HHS selected Kentucky and Michigan to join the demonstration. The Bipartisan Safer Communities Act (BSCA), enacted in June 2022, extended the existing demonstration programs through 2025 for the original eight states and up to six years past the date of joining the demonstration for Michigan and Kentucky (Public Law 117-159). The BSCA also authorizes all states to apply to participate in the demonstration beginning in 2024. In March 2023, HHS awarded planning grants to 15 states to develop proposals to participate in the demonstration. In 2025, HHS will award additional planning grants to states. Beginning July 1, 2024, and every two years thereafter, HHS may select up to ten additional states to participate in the demonstration. In February 2023, HHS also provided guidance that existing demonstration states could certify additional clinics.

As of July 2023, eight states participate in the demonstration, including six of the original demonstration states (Minnesota, Missouri, New Jersey, New York, Oklahoma, and Oregon) and Kentucky and Michigan.<sup>5</sup> Six states reimburse CCBHCs using the PPS-1 model and two states (Oklahoma and New Jersey) use the PPS-2 model. In spring and early summer 2023, officials reported 80 clinics participating in the demonstration.<sup>6</sup> At that time, five states--Kentucky, Michigan, Missouri, New York, and Oregon--were planning to certify additional demonstration clinics as a result of the new flexibility to do so, suggesting that demonstration states consider the demonstration a sound investment and an attractive ongoing source of funding for CCBHCs. These states anticipated adding between three and 26 demonstration clinics, depending on the state.

PAMA mandates that HHS submit annual Reports to Congress that assess: (1) access to community-based mental health services under Medicaid in the area or areas of a state targeted by a demonstration program as compared to other areas of the state; (2) the quality and scope of services provided by CCBHCs as compared to community-based mental health services provided in states not participating in a demonstration program and in areas of a demonstration state that are not participating in the demonstration; and (3) the impact of the demonstration on the federal and state costs of a full range of mental health services (including inpatient, emergency, and ambulatory services). In September 2016, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with Mathematica and its subcontractor, the RAND Corporation, to evaluate the implementation and impacts of the demonstration and provide information for Reports to Congress. The evaluation included the eight original states and covered the two-year period for which the demonstration was initially authorized (Brown et al. 2021).

As the demonstration has continued in the original states and expanded to others, ASPE contracted with Mathematica and the RAND Corporation in late 2021 to further evaluate the demonstration. The current evaluation assesses the implementation and outcomes of the demonstration beyond its initial two years in the seven states that continued the demonstration as of September 2021 and the two new states that joined the demonstration in 2021. This report describes findings as they relate to the PAMA topics of access to care and scope of services, focusing on care coordination services and activities, as allowed by data

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<sup>5</sup> Pennsylvania chose not to continue participation after the initial two years. Minnesota ended its participation in the demonstration on December 31, 2022, but rejoined the demonstration on July 1, 2023. Nevada ended its participation in the demonstration on July 1, 2023.

<sup>6</sup> This includes the clinics in Kentucky, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, and Oregon that participated in the demonstration in 2023.



collection activities in the past year. Future reports will focus on the impact of the demonstration on federal and state costs. This report also provides information on changes in the quality of care during the first four years of the demonstration for states with available quality measures. The report builds on detailed findings on demonstration implementation and quality improvement included in previous evaluation reports and focuses on qualitative and quantitative data collected through the evaluation since the spring of 2022. Findings in this report draw on interviews with state officials in each demonstration state; a survey of all participating CCBHCs in 2023, and state and CCBHC-reported quality measures available for analysis as of March 2023.

## A. Access to Care

**In recent years of the demonstration, CCBHCs in the original demonstration states have worked to maintain and expand activities to increase access to care.**<sup>7</sup> State officials and CCBHCs highlighted a range of activities to attract new clients and make services more accessible. For example, open-access or same-day scheduling is a common way CCBHCs provide accessible services. Ninety-four percent of CCBHCs reported offering open-access or same-day scheduling for CCBHC services. Several CCBHCs also reported focusing recently on promoting their services to the public as a means of increasing access, through improving their television, radio, and online presence. States and CCBHCs also highlighted the efforts of CCBHC outreach and intake staff, including peer specialists, to engage new clients. Most state officials also noted CCBHCs expanded access to care via telehealth, facilitated, in part, by changes in telehealth policies during the COVID-19 pandemic. All CCBHCs reported offering at least one CCBHC service by telehealth in 2023, an increase of 30 percent from 2019 (70 percent). CCBHCs also have continued to offer services in locations outside the physical clinic location to expand access to care. CCBHCs most commonly reported offering services in clients' homes (89 percent), schools (86 percent), as well as in social service organizations and justice-related facilities, such as courts (78 percent each). A substantially higher percentage of CCBHCs reported providing services in clients' homes, schools, justice-related locations, and shelters in 2023 than 2019.

**States and CCBHCs have focused on integrating CCBHCs with 988 call centers and state crisis systems to increase access to care.** CCBHCs reported different ways of coordinating with 988 crisis service systems to rapidly link people in crisis to needed services to improve access. In most states, 988 call centers are staffed and operated by other entities and connect people to CCBHCs' crisis services, such as mobile crisis teams, as needed. CCBHCs typically provide mobile crisis services directly. Across states, 7 percent of CCBHCs reported operating directly as a state 988 provider, and 43 percent reported receiving direct referrals from 988. Other CCBHCs mentioned establishing a formal relationship with a local/regional crisis hotline that fields 988 calls (14 percent). A few states also described recent efforts to increase access to crisis stabilization units that coordinate with CCBHCs.

**The number of people served by CCBHCs has increased steadily over time, but the characteristics of CCBHC clients have generally not changed.** Across the original demonstration states remaining in the demonstration, the overall number of unduplicated adults and children/adolescents served by CCBHCs each year increased from 286,089 people in DY1 to 315,349 people in DY4. The number

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<sup>7</sup> Public Law 117-159 requires that creates requirements regarding the availability and accessibility of services, including: crisis management services that are available and accessible 24 hours a day, the use of a sliding scale for payment, and no rejection for services or limiting of services on the basis of a patient's ability to pay or a place of residence. These form the basis of accessibility and availability requirements in the CCBHC certification criteria (SAMHSA 2023a).

served has gradually increased every year in all states but Minnesota and Oregon.<sup>8</sup> With few exceptions, client age, gender, and race and ethnicity remained consistent across years. Similarly, insurance source was largely consistent over time, with Medicaid as the most common source.

**Performance on several access-related quality measures remained relatively stable over time.** From DY1 to DY4, the percentage of new clients receiving an initial evaluation within ten days of first contact with the CCBHC remained stable (69 percent to 73 percent for adults and 68 percent to 72 percent for children/adolescents). The mean number of days to initial evaluation decreased slightly from DY1 to DY4 for adults (9.1 days versus 8.4 days) but more substantially for children/adolescents (9.9 days versus 7.2 days). Across states, most adult CCBHC clients and family members of child/adolescent recipients had generally positive perceptions of access to care between DY1 and DY4.

**States and CCBHCs continue to struggle with the nationwide shortage in behavioral health providers, which has challenged their ability to expand services.** Nearly 90 percent of CCBHCs reported difficulties with staffing and workforce development when asked about challenges related to access to care, almost to the exclusion of any other challenges. Although hiring new staff remains difficult, some states have tried to assist CCBHCs in meeting higher demand for specialized services by hiring experts to provide trainings for CCBHCs to expand knowledge and skills among current staff.

## **B. Scope of Services: Care Coordination**

**CCBHCs have continued to invest in staff and tools to support care coordination.** State officials highlighted several ways that CCBHCs have worked to improve care coordination, such as increasing staff capacity to coordinate care and using certain tools (including electronic health records [EHRs]) to share information across staff and providers within the CCBHC. For example, a Michigan official noted that many CCBHCs have hired dedicated nurses to help coordinate and manage care. Nearly all (97 percent) CCBHCs reported that their EHR systems generate electronic care plans to support care coordination. Most CCBHCs reported using data dashboards (85 percent) and patient portals (61 percent). Such tools might be used to support clinical information sharing between providers within clinics and with clients.

**CCBHCs have established and maintained relationships with a wide variety of external providers, with some variation over time.** Officials reported that the strength of partnerships can differ depending on contextual factors, such as duration of partnerships and staff turnover. CCBHCs have had varying degrees of success in setting up formal, non-DCO relationships with external entities, as required by the criteria.<sup>9</sup> For the most part, however, the percentage of CCBHCs reporting formal relationships has remained stable over time. State officials reported providing support to CCBHCs to help them meet requirements for formal care coordination agreements.

**DCO relationships remain uncommon across demonstration states, and state officials reported that this has mostly remained consistent during the demonstration.** CCBHCs in Kentucky, Nevada, and Oklahoma do not have any DCO relationships; other states reported that CCBHCs have few DCO

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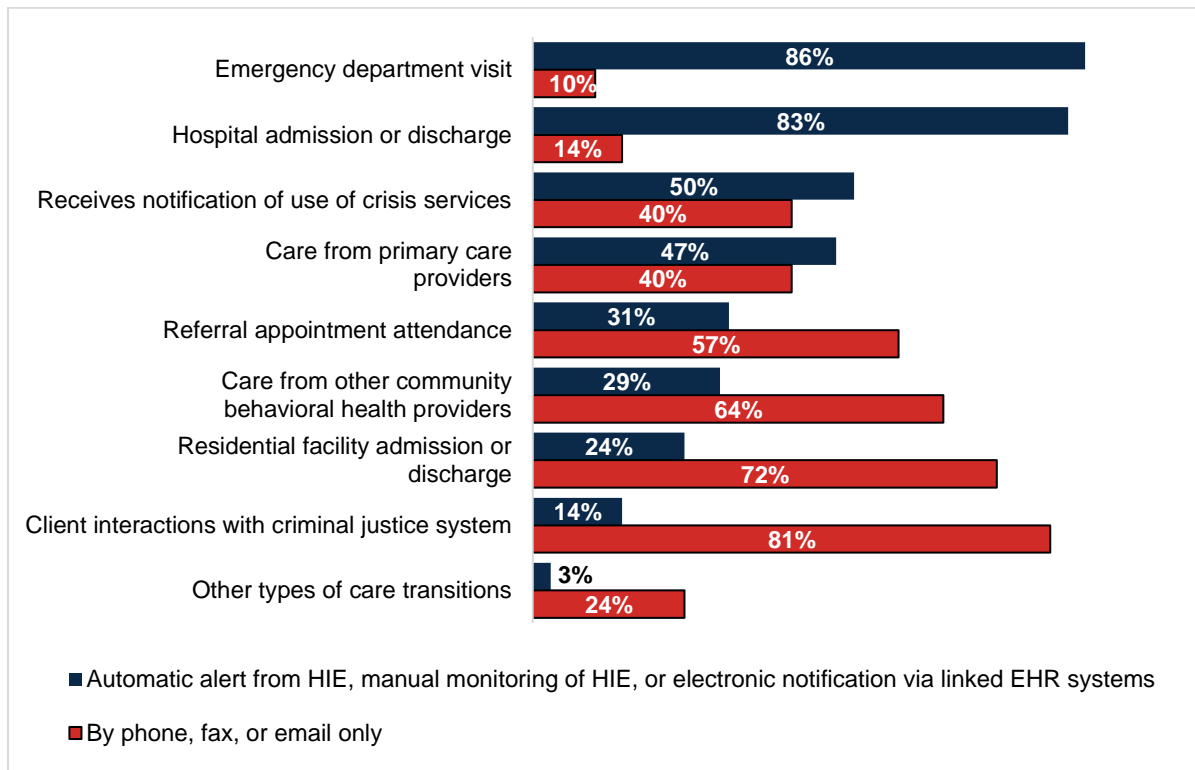
<sup>8</sup> Oregon decertified three clinics in 2019 (DY3) during a period of funding instability.

<sup>9</sup> Before March 2023, the CCBHC certification criteria specified that CCBHCs establish agreements outlining care coordination expectations with external organizations. Although agreements are still expected and strongly encouraged, the revised CCBHC criteria will no longer require formal agreements; instead, the criteria focus on care coordination partnerships. SAMHSA has expanded the ways by which the partnerships can be documented to allow for more flexibility in situations in which a formal agreement cannot be executed.

partners. In 2023, CCBHCs most frequently reported DCO relationships for crisis services (26 percent). Only 11 percent of CCBHCs used DCOs for primary care screening and monitoring, and less than 9 percent of CCBHCs used DCOs for the other required CCBHC services. Michigan is the only state where DCO relationships are common for a variety of services, including SUD and crisis services. Thirty-eight percent of CCBHCs in Michigan have relationships with DCOs to provide person and family-centered treatment planning services and outpatient mental health or SUD services, and 31 percent provide psychiatric rehabilitation services, peer support services, or TCM through DCOs.

**CCBHCs use a variety of tools to share information with external providers.** State officials reported that CCBHCs in most states have access to a health information exchange (HIE) or other statewide platform or data clearinghouse, but not all CCBHCs responding to the survey reported using these exchanges. In all, 60 percent reported using state-operated HIEs, and 29 percent reported using privately operated exchanges. In addition, 71 percent of CCBHCs reported they exchange clinical information with external providers electronically.

**Exhibit ES.1. Percentage of CCBHCs that Receive Notifications about Client Care Transitions, by Type of Service**



Source: Mathematica’s analyses of the 2023 CCBHC survey.

Notes: The denominator for each category is the total number of survey respondents (n = 72). Within each category, percentages might not sum to 100% because CCBHCs either do not receive notifications for that care transition type or reported “other” method of receiving notification about clients’ care transitions. CCBHC responses regarding “other” methods included information obtained via daily care coordination, co-located service providers, or tracking EHR updates.

**More than 80 percent of CCBHCs learn of clients’ emergency department visits or hospital admission or discharge via automatic alerts from HIEs, manual monitoring of exchanges, or from**

**automatic alerts from linked EHR systems.** They are less likely to learn of these care transitions via phone, fax, or email. In contrast, most CCBHCs rely on phone, fax, or email to receive notifications of care from other community behavioral health providers, residential facility admissions, or client interactions with the criminal justice system (81 percent) (Exhibit ES.1).

**Aggregate performance on quality measures focused on care coordination exceed national benchmarks and remained stable during the first four years of the demonstration.** Across states, the percentage of CCBHC clients who received follow-up care within 30 days after an emergency department visit remained stable over time. Although aggregate performance on these measures has not substantially improved during the demonstration, these performance results are substantially higher than national benchmarks. For example:

- The percentage of clients who received follow-up care within 30 days after a mental health-related emergency department visit ranged from 69 percent to 71 percent across DYs. By comparison, national benchmark performance on this measure was 54 percent each year.
- The percentage of CCBHCs clients who received follow-up care within 30 days after a SUD-related emergency department visit ranged from 39 percent to 40 percent. By comparison, national benchmark performance on this measure ranged from 20 percent to 23 percent over time.
- Outpatient visits within 30 days of discharge from a hospitalization for a mental illness ranged from 73 percent to 76 percent for adults and 77 percent to 80 percent for children. Performance on these measures was also substantially higher than the national benchmarks, which ranged from 52 percent to 58 percent for adults and from 65 percent to 66 percent for children.

## C. Quality of Care

**Officials from multiple states shared the perception that CCBHCs provide higher-quality care than other providers, citing the commitment to care coordination and the requirement to offer evidence-based practices as primary attributes of the model that improve quality.** Officials also generally perceived quality of care provided by CCBHCs improved over time, re-emphasizing the model's expanded offerings and noting improvements in performance on quality measures. Consistent with previous DYs, officials in most states reported continuing to provide technical assistance to CCBHCs to support quality measure reporting. Several state officials noted meeting at regular intervals with CCBHCs to troubleshoot data collection challenges and guide reporting activities. Building EHR capacity to pull accurate data for measure reporting is an active area of focus for newer demonstration states.

**Performance on quality measures has varied somewhat over time, and relative to available state benchmarks.** For example, across states:

- Across CCBHCs, the percentage of CCBHC clients with major depressive disorder who received a suicide risk assessment (SRA) improved by over 20 percentage points from DY1 to DY4 for both adults and children/adolescents, from 59 percent to 82 percent, and 55 percent to 78 percent, respectively. However, it is unclear what is driving this large change. States varied with respect to trends over time.
- Performance on measures of CCBHC clients who received initial and subsequent treatment for alcohol and other drug treatment after diagnosis was similar to or exceeded available state benchmarks in all DYs.

- Seventy-six percent of CCBHC clients with schizophrenia or bipolar disorder who received antipsychotic medications also received diabetes screening during DY1 and this remained stable through DY4 (74 percent). Performance on this measure was similarly stable from DY1 to DY4 in all states except for New Jersey and Oklahoma which improved in certain DYs.
- In DY1, 52 percent of CCBHC clients with major depression who received antidepressant medications remained on their medication during the acute phase of their depression, and 38 percent remained on their medication during a longer continuation phase of treatment. Across CCBHCs, performance on these measures has not substantially changed during the demonstration, and within states, performance was generally similar to available state-specific benchmarks for all DYs.

Exhibit ES.2. Award of QBPs				
State (number of CCBHCs)	Number of CCBHCs that Received Payments and Total Aggregate Payments to CCBHCs			
	DY1	DY2	DY3	DY4
Minnesota (6)	2 of 6 Total payments: \$740,049	None; thresholds not met	None; thresholds not met	None; thresholds not met
Missouri (15)	15 of 15 Total payments: \$17,210,855	15 of 15 Total payments: \$19,138,499	15 of 15 Total payments: \$22,123,047	15 of 15 Total payments: \$14,852,349
New York (13)	None; state reported that thresholds not met	None; state reported that thresholds not met	None; state reported that thresholds not met	None; state reported that thresholds not met
New Jersey (7)	6 of 7 Total payments: \$27,000	6 of 7 Total payments: \$132,000	6 of 7 Total payments: \$339,500	7 of 7 Total payments: \$250,321
Oklahoma (3)	None; state reported that thresholds not met	None; state reported that thresholds not met	n.a.	n.a.

Source: Mathematica and the RAND Corporation's analysis of state official reports.

Note: Five of the original demonstration states responded to questions from the evaluation team about QBPs. Oregon does not award QBPs and data were unavailable for Nevada. Michigan selected the PPS-1 with QBP but has not yet begin awarding payments.

n.a.= not available.

**Several states awarded QBPs from DY1 to DY4.** The HHS Centers for Medicare & Medicaid Services required states with QBP systems to use six measures to award QBPs. However, states set the measure performance thresholds and some states required CCBHCs to meet performance on additional measures. States varied considerably in the performance thresholds used to award QBPs (Brown et al. 2021). States also set the amount of the QBPs and had the option to modify the parameters of the QBPs over the course of the demonstration. Of the 44 CCBHCs eligible for QBPs, 23 received payments in DY1 and 22 received payments in DY4 (Exhibit ES.2). In Missouri and New Jersey, nearly all CCBHCs received a

payment in all DYs, with variation across the years in the total amount paid. In contrast, some states, including New York in all DYs, Minnesota in DY2 to DY4, and Oklahoma in DY1 and DY2, did not make any payments, indicating that none of their clinics met the thresholds for quality performance set by the state in those DYs.

**CCBHCs and states described various continuous quality improvement activities as a result of participation in the demonstration.** CCBHCs commonly reported activities related to improving performance on specific quality measures, such as implementing a more standardized clinical workflow to improve SRA and prevention (60 percent), improving timeliness of follow-up after hospitalization (40 percent), and improving psychiatric medication adherence (20 percent). A large percentage of CCBHCs (82 percent) reported using data dashboards, report cards, and risk-stratification (that is, assigning a risk status based on health status and other factors to a client, and using their risk status to direct and improve care) to monitor or improve quality of care, ranging from 33 percent in Nevada to 100 percent in Kentucky and Oklahoma. Consistent with the survey results, multiple state officials mentioned that states and CCBHCs leverage data dashboards to inform clinic quality improvement initiatives and make use of quality measure data to improve quality of care.

# I. Overview of the Certified Community Behavioral Health Clinic Demonstration

## A. Demonstration Background

Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA, Public Law: 113-93) authorized the Certified Community Behavioral Health Clinic (CCBHC) demonstration, which allows states to test a different strategy for delivering and reimbursing a comprehensive array of services provided in community behavioral health clinics. The demonstration aims to improve the availability, quality, and outcomes of outpatient services provided in these clinics. Demonstration states certify that participating clinics offer nine types of services to all people who seek care, including people with SMI, SED, and substance use disorders (SUDs). These services include the following:

- Crisis mental health services.
- Screening, assessment, and diagnosis.
- Patient-centered treatment planning.
- Outpatient mental health and substance use services.
- Outpatient clinic primary care screening and monitoring.
- Targeted case management (TCM).
- Psychiatric rehabilitation services.
- Peer support, counselor services, and family support.
- Intensive, community-based mental health care for members of the armed forces and veterans.

States have some flexibility, however, to tailor these services to align with their Medicaid state plans and other regulations and to meet the needs of the communities they serve.

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

After each demonstration year (DY), states must report measures that assess the quality of care provided to CCBHC clients.<sup>10</sup> These are calculated from Medicaid claims and managed care encounter data, electronic health records, and surveys of CCBHC clients and their family members. These measures assess best practices in care delivery (for example, timely follow-up after discharge from a hospital), outcomes (for example, improvement in depression symptoms), and clients' and family members' experiences with care. Quality measure reporting provides CCBHCs and state officials with standardized metrics to monitor the quality of care and inform quality improvement efforts.

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<sup>10</sup> Before March 2023, demonstration states had to report 21 measures. Updates to the CCBHC certification criteria in March 2023 (<https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf>) require states to report only 18 measures with the option to report seven others beginning with calendar year (CY) 2025.

The demonstration requires participating states to reimburse CCBHC services through a Medicaid prospective payment system (PPS). The PPS is intended to cover the expected costs of CCBHC services for Medicaid beneficiaries and provide CCBHCs with a stable source of funding. States select one of two PPS models to reimburse all CCBHCs in the state: a fixed daily payment (PPS-1) for each day a Medicaid beneficiary receives demonstration services or a fixed monthly payment (PPS-2) for each month in which a Medicaid beneficiary receives demonstration services. States set the payment rates, which can vary across CCBHCs in a state. PPS-1 states have uniform rates for all clients; PPS-2 rates have multiple categories: a standard rate and separate rates for special populations that the state defines. PPS-1 states have the option to provide CCBHCs with quality bonus payments (QBPs) based on their performance on quality measures. PPS-2 states must provide these payments based on quality measures. CCBHCs also submit standardized cost reports to the state after each DY. The cost reports include information on clinics' operating costs and the number of daily (for PPS-1 states) or monthly (for PPS-2 states) visits to the clinics in each DY.

## **B. CCBHC Demonstration Rollout**

In October 2015, the U.S. Department of Health and Human Services (HHS) awarded planning grants to 24 states to begin certifying clinics to become CCBHCs, establish their PPS, and develop the infrastructure to support the demonstration. To support the first phase of the demonstration, HHS developed criteria (as required by PAMA) for certifying CCBHCs in six areas: (1) staffing; (2) availability and accessibility of services; (3) care coordination; (4) scope of services; (5) quality and reporting; and (6) organizational authority (SAMHSA 2016a). The criteria provide a framework for certifying CCBHCs, but states can exercise some discretion in applying the criteria to support implementation of the CCBHC model in their local context. The certification criteria specify that CCBHCs must provide accessible care, including 24-hour crisis management services; engage people quickly through prompt intake services; and provide treatment for all adults, children, and adolescents regardless of their ability to pay. HHS updated the certification criteria in March 2023 to reflect lessons learned from several years of implementation and the changes to the national service delivery landscape since the criteria were developed in 2015 (SAMHSA 2023a). These updates include alignments to improve applicability of the criteria to demonstration and non-demonstration CCBHCs, guidance regarding the components of a comprehensive crisis system, and increased focus on SUDs and overdose in light of the ongoing national overdose crisis.

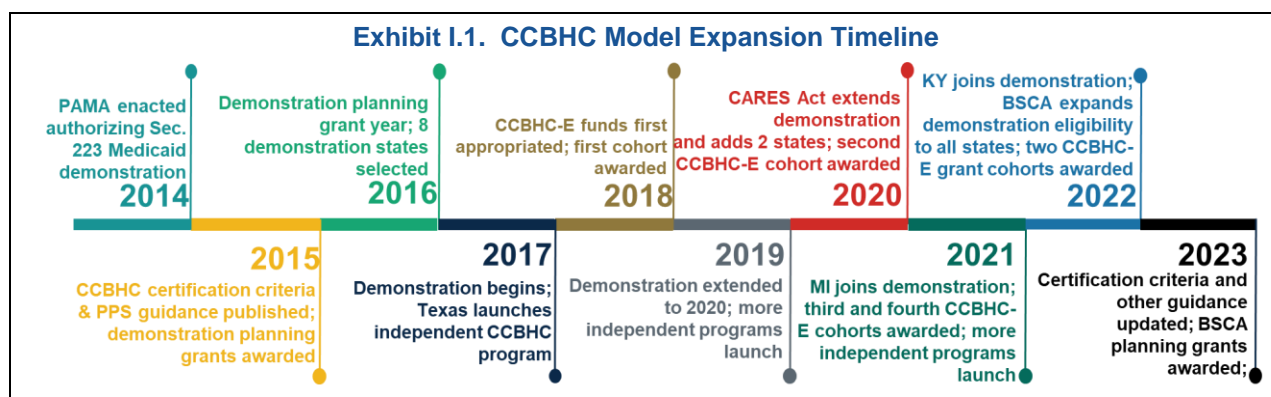
In December 2016, HHS selected eight of the 24 planning grant states to participate in the demonstration (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania). The demonstration was originally authorized for two years and scheduled to end in July 2019, but Congress has extended it multiple times (ASPE 2021). It is currently authorized through September 2025 for the original states.

In August 2020, HHS announced that Kentucky and Michigan would begin participating in the demonstration as a result of the demonstration's expansion by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act; Public Law 116-136) which allowed HHS to add two states from among the original 24 planning grant states. The Bipartisan Safer Communities Act, enacted in June 2022, authorizes all states to apply to participate in the demonstration beginning in 2024 (Public Law 117-159). In February 2023, HHS provided guidance to existing demonstration states permitting them to certify additional CCBHCs. In March 2023, HHS awarded planning grants to 15 states to develop proposals to participate in the demonstration. HHS will award additional planning grants to states in 2025. Beginning



July 1, 2024, and every two years thereafter, HHS can select up to ten additional states to participate in the demonstration. Beginning July 1, 2024, and every two years thereafter, HHS can select up to ten additional states to participate in the demonstration.

The HHS Substance Abuse and Mental Health Services Administration (SAMHSA) has supported implementation of the CCBHC model through the CCBHC-Expansion (CCBHC-E) grant program. CCBHC-E grants provide funding directly to clinics but do not change Medicaid payment or require states to certify clinics or oversee the grants.<sup>11</sup> To date, SAMHSA has awarded six cohorts of CCBHC-E grants. Demonstration CCBHCs can participate in both the demonstration and CCBHC-E grant program. Beyond the CCBHC demonstration, some demonstration states and non-demonstration states have independently expanded the model through other Medicaid authorities, including state plan amendments (SPAs) and Section 1115 demonstration waivers (Wishon et al. 2023; Brown et al. 2021).

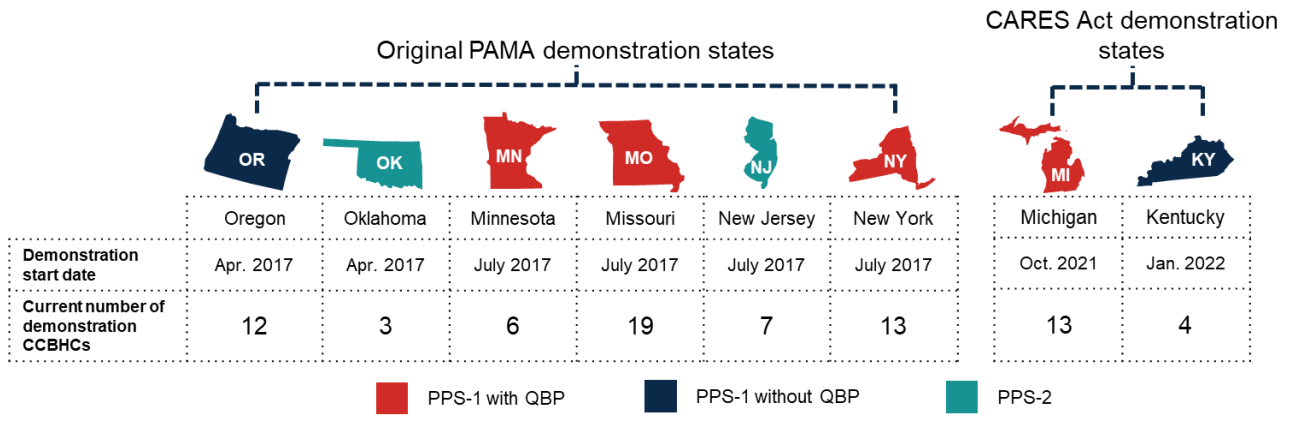


### C. Current Landscape of CCBHCs in Demonstration States

As of July 2023, eight states participate in the CCBHC demonstration (Exhibit I.2), which includes all but two of the original demonstration states and the two new states (Michigan and Kentucky) that began participating in 2021. Pennsylvania chose not to continue participation after the first two years. Nevada ended its participation in the demonstration on July 1, 2023. Minnesota ended its participation in the demonstration on December 31, 2022, but rejoined on July 1, 2023. Six states reimburse CCBHCs using the PPS-1 model, and two states use the PPS-2 model. Six of the eight states offer CCBHCs QBPs tied to performance on quality measures.

<sup>11</sup> CCBHC-E grantees that are not certified by their states must submit an attestation describing how they meet the CCBHC certification criteria.

### Exhibit I.2. Status of CCBHC Demonstration States in July 2023



Source: Mathematica and the RAND Corporation’s analysis of data from interviews with state officials.

Notes: Of the 12 original clinics in Oregon, three stopped participating in the demonstration in 2019. As of July 2023, the state has re-certified them all. Missouri added four clinics in 2022, increasing its total from 15 to 19. These clinics were included in the state’s original demonstration application but were not able to launch the model during the original two-year demonstration period. Pennsylvania ended its participation in the demonstration at the end of the original demonstration period. Minnesota ended its participation on December 31, 2022, but rejoined in July 1, 2023. Nevada ended its participation in the demonstration on July 1, 2023.

In state official interviews in spring and early summer 2023, officials reported 80 clinics participating in the demonstration.<sup>12</sup> The number of CCBHCs has changed slightly since last year, from 78 to 80 as Oregon re-certified two of the three clinics it had decertified in 2019.<sup>13</sup> Minnesota’s six clinics stopped participating in the demonstration at the end of 2022 but rejoined in July 2023. Nevada’s three clinics ended their participation in the demonstration in July 2023. In all states, at least one demonstration CCBHC had received a SAMHSA CCBHC-E grant since 2018, and, in some states, all demonstration CCBHCs had received a CCBHC-E grant. State officials reported that demonstration CCBHCs used CCBHC-E grants to cover the costs of services for the uninsured and underinsured, to help launch the model in new clinic locations, or fill gaps in services (Wishon et al. 2023). Some CCBHCs in the newer demonstration states, Kentucky and Michigan, became CCBHC-E grantees to implement the model before their state was selected to participate in the demonstration. The percentage of CCBHCs reporting that they received a CCBHC-E grant ranged from 33 percent in Nevada to 100 percent in Kentucky and Oklahoma, with an average of 69 percent. CCBHCs also reported the number of clinic locations offering CCBHC services, ranging from five in Nevada to 127 in Missouri.<sup>14</sup>

<sup>12</sup> This includes clinics in Kentucky, Michigan, Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, and Oregon that participated in the demonstration in 2023.

<sup>13</sup> The state re-certified one of three clinics in 2022.

<sup>14</sup> Some CCBHCs have multiple clinic locations, with some locations funded by the demonstration, some funded by a CCBHC-E grant, or both.

**Exhibit I.3. Percentage of Demonstration CCBHCs receiving CCBHC-E Grants**

State	Percentage of CCBHCs Reporting Ever Receiving a CCBHC-E Grant <sup>a</sup>
Kentucky	100
Michigan	85
Minnesota	25
Missouri	47
Nevada	33
New Jersey	86
New York	92
Oklahoma	100
Oregon	40

Source: Mathematica and the RAND Corporation’s analyses of data from a 2023 survey of demonstration CCBHCs.

Note:

- a. The denominator for the percentage calculation is the number of CCBHCs that responded to a survey of demonstration CCBHCs conducted in spring 2023 (n = 72).

## D. Overview of CCBHC Evaluation

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

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

In September 2016, the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with Mathematica and its subcontractor, the RAND Corporation, to evaluate the implementation and impacts of the demonstration and provide information for HHS’s Reports to Congress. The evaluation included the eight original demonstration states and covered the two-year period for which the demonstration was initially authorized (Brown et al. 2021). Because the demonstration has continued in the original states and expanded to others, ASPE contracted with Mathematica and the RAND Corporation in late 2021 to further evaluate the demonstration. The current evaluation assesses the implementation and outcomes of the demonstration beyond its initial two years in the seven states that continued the demonstration as of September 2021 and the two new states that joined the demonstration in 2021. To date, the current evaluation has produced one annual report (Wishon et al. 2023).

This present report describes findings as they relate to the PAMA topics of access to care and scope of services, focusing on care coordination services and activities. This report also provides information on

changes in the quality of care for the first four years of the demonstration for states for which data are available. The report builds on detailed findings on demonstration implementation and quality improvement included in previous evaluation reports and focuses on qualitative and quantitative data collected through the evaluation since spring 2022. Future reports will focus on changes in state and federal costs as those data and analyses become available. Chapter II summarizes the data sources and methods we used in this report. Chapters III, IV, and V summarize findings related to the PAMA topics, and Chapter VI presents our conclusions.

#### **Key Findings from Prior Evaluation Reports**

1. In early DYs, states and CCBHCs implemented activities to improve access, increased the number of clients served, expanded types of services and service capacity, hired and trained staff, developed partnerships with external providers, and changed many of their care processes. The initial implementation experiences of the new demonstration states (Kentucky and Michigan) appeared consistent with early experiences from the original states.
2. Quality of care in the first two DYs was comparable to available benchmarks, and performance on some measures improved over time. Results for several measures suggested room for improvement.
3. State officials in the original demonstration states reported transitioning past the planning and launch activities of early years by the second year of the demonstration and have generally been implementing the demonstration consistently since. CCBHCs have largely worked to maintain and expand activities related to access to care that they put into place in the early stages of the demonstration rather than introduce new activities or services.
4. Some states have pursued other financing mechanisms to support or expand the CCBHC model.

## II. Data Sources and Methods

### A. Qualitative Sources

**Interviews with state officials.** In April and May 2023, we conducted semi-structured telephone interviews with state Medicaid or behavioral health agency officials knowledgeable about CCBHC demonstration implementation in each of the eight states participating in the demonstration at the time of interviews. In addition to state officials, a few states included respondents who are involved with demonstration oversight but who are not employed directly by the state. For example, one state included a former state employee who was previously responsible for demonstration oversight but now works for a provider organization and another included a consultant from a local university who provides training, technical assistance, and conducts on-site reviews and re-certifications. Interviews ranged from two to six respondents per state (28 respondents total). One researcher led the interview, and another took notes. We asked interviewees for permission to audio-record the discussions to confirm the accuracy and completeness of interview notes. Each interview lasted about 90 minutes. Interviews included questions about recent steps states and CCBHCs had taken to increase access to care, coordinate care, and report on and improve performance of quality measures. We reviewed interview responses separately for each state and identified cross-state themes. We also conducted targeted searches of demonstration states' websites and other websites as needed to interpret states' responses and inform other analyses. Qualitative findings in this report draw from interviews conducted in 2023, but they might reference complementary findings from previous evaluation reports.

### B. Quantitative Sources

**CCBHC quality measures.** SAMHSA provided states and CCBHCs with the technical specifications and a standard reporting template for the required demonstration quality measures (SAMHSA 2016a). We obtained the quality measure data for DY1-DY4 from ASPE. During this period, CCBHCs had to report 21 quality measures.<sup>15</sup> CCBHCs reported nine of the measures using clinical data typically derived from electronic health records (EHRs) or other electronic administrative sources. States reported the other 12 measures based on Medicaid claims, managed care encounter data, and surveys of CCBHC clients and family members. Most required clinic-reported measures that focus on processes within the clinic, such as whether screening and services were provided, and one measure, remission from depression, pertains to treatment outcomes. Several of the state-reported measures also assess processes of care but include services that were delivered outside the CCBHC. This report includes analysis of the 21 required quality measures for CCBHCs for which data were complete (up to 53 clinics, depending on the measure; see Appendix A).<sup>16</sup>

Before analyzing the quality measures, we examined the comparability and completeness of the data across clinics and states. We reviewed information that clinics provided about modifications they made to the measure specifications. We excluded some CCBHCs or states from the analysis of a measure if their modification to the measure specification compromised comparability with other CCBHCs or states.

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<sup>15</sup> Updates to the CCBHC criteria in 2023 have altered the number of measures that states and CCBHCs must report in future years.

<sup>16</sup> Unless otherwise noted, analyses of Oregon data are limited to the nine clinics with data available for all four DYs and exclude clinics the state decertified in 2019.

When the reported modifications were minor, we included the data in the analysis.<sup>17</sup> When necessary, we communicated with state officials to clarify reported deviations from the measure specifications or to gather more information about the measure reporting process. Because the number of consumers in the denominator was small for some clinics in several of the measures, we aggregated measure performance to the state level. We report statewide performance on a measure only if the denominator includes at least 30 consumers across all CCBHCs in the state. This denominator threshold aligns with that used in previous CCBHC demonstration evaluation reports (Brown et al. 2021; Breslau et al. 2020) and with guidelines for public reporting of CCBHC measures (SAMHSA 2016b).<sup>18</sup> We report aggregate performance across all CCBHCs in a state and describe overall trends and variability across states.

To contextualize the performance of the CCBHCs on the quality measures, we draw on state-level performance on similar measures in the same measurement years. Benchmarks come from the HHS Centers for Medicare & Medicaid Services (CMS) Annual Reporting on the Quality of Care for Adults in Medicaid and Children in Medicaid and CHIP (CMS 2023) and state-level performance on the Mental Health Statistics Improvement Program (MHSIP) survey from the SAMHSA Uniform Reporting System (URS) (SAMHSA 2023b). Benchmarks are not available for all measures and not reported by all states in all DYs (see Appendix A for benchmark data availability).

State officials in five of the seven original demonstration states remaining in the demonstration also provided follow-up information via email on the number of CCBHCs awarded QBPs and the total amount of payments made to clinics. We report select quality measures and information on QBPs in the text. Full data for all measures are available in Appendix B.

**CCBHC survey.** From February to March 2023, CCBHCs in all demonstration states completed a survey that collected information on the clinic's structure, the activities it engaged in to increase access to care, its care coordination activities and processes, its quality improvement activities, and other topics related to the certification criteria. In late 2022, we asked state demonstration leaders to confirm or update contact information for each participating CCBHC that should receive the survey. State demonstration leaders confirmed contact information for 74 demonstration clinics.<sup>19</sup> In collaboration with state leaders in each state, we conducted extensive outreach to clinic leaders via telephone and email before and during survey administration to encourage clinics' participation and answer any questions. Of the 74 CCBHCs surveyed, we received responses from 72. To analyze the survey data, we computed descriptive statistics (for example, frequencies and percentages) using Excel and SAS. We summarize findings across the 72 CCBHCs that responded and also include findings from select open-ended survey questions on access, care coordination, and quality. Select state-level findings are available in Appendix C.

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<sup>17</sup> For example, some data for the measure were captured in an EHR and others were obtained from paper medical records, but the clinic did not deviate from the measure specification.

<sup>18</sup> For purposes of the CCBHC demonstration program, all measures must be reported regardless of the size of the eligible population. If the denominator is less than 30, however, the technical specifications stipulate that measure results will not be used for any public reporting or for purposes of the national evaluation.

<sup>19</sup> Four of six Minnesota demonstration CCBHCs that stopped participating in the demonstration at the end of 2022 responded to survey outreach and completed the survey. The survey sample for Missouri included 15 of 19 demonstration CCBHCs. The state did not provide contact information in time for the four CCBHCs that it added to the demonstration in 2022 to be included in the survey. The survey sample for Oregon included ten of 12 clinics participating in the demonstration in Oregon as of July 2023. The sample excluded two of three clinics Oregon decertified in 2019; we included the clinic that was re-certified in 2022.

**Findings presented in this report should be interpreted in the context of several limitations of the available data.** Interview data generally reflect the perspective of a few state officials, and, in some cases, state officials were relatively new to the state or to the CCBHC demonstration. The information reported in interviews, state documents, and the CCBHC survey reflect the status of implementation at the time data were collected. States and CCBHCs might have continued to make changes and implement new programs and procedures. The clinical settings and populations covered by the benchmark measures might not be comparable to CCBHCs and the populations they serve; therefore, comparisons of the CCBHC measures to benchmarks should be understood heuristically and not as evidence of the impact of the CCBHC demonstration on quality of care.

### III. Access to Care

The CCBHC model is intended to expand access to high-quality care in the communities that clinics serve and engage new clients in care. The certification criteria specify that CCBHCs must provide accessible care, including 24-hour crisis management services; engage people quickly through prompt intake services; and treat all who seek services regardless of their ability to pay or place of residence. To address the PAMA requirements on access, we first examine states' plans to increase access to CCBHC services by expanding the number of CCBHCs participating in the demonstration. We then examine changes in the number and characteristics of people served by CCBHCs and explore activities reported by states and CCBHCs meant to improve access to care. Finally, we describe changes in performance on access-related quality measures.

#### A. State Plans to Expand the Number of Demonstration Certified Community Behavioral Health Clinics

In February 2023, HHS released guidance allowing demonstration states to add new CCBHCs to their demonstration programs for the first time since the demonstration's inception (HHS 2023). States can add CCBHCs at any time in 2023 and at the beginning of their DY annually thereafter. In spring 2023, five states--Kentucky, Michigan, Missouri, New York, and Oregon--were planning to certify additional demonstration clinics. State officials' estimates of the expected number of new CCBHCs in the demonstration ranged from three to 26, depending on various factors such as funding, state legislative authorization, and clinic interest. Because of the time and effort involved in certifying and preparing providers for the demonstration, states typically planned to add new clinics and begin delivering services in late 2023 and beyond. Some states described phased approaches. Michigan, for example, plans to add community mental health service providers (many of which are CCBHC-E grantees) that can meet the criteria in fiscal year 2024 and add CCBHC-E grantees that are other types of providers than community mental health service providers in fiscal year 2025. New York plans to add half its 26 new CCBHCs in July 2024 and the remaining in 2025.

State officials shared reflections on the types of providers they would likely add to the demonstration and early insights into planning. A few shared that they expected to focus on CCBHC-E grantees. For example, a Kentucky official explained that expansion grant clinics were "on the track on the train," whereas non-expansion clinics would be at the "boarding stage," so adding grantees to the demonstration would be more efficient. The state was planning to survey the CCBHC-E grantees in the state to assess how much technical assistance would be needed to prepare them to transition to the demonstration. Oregon officials noted that they plan to add clinics if state legislation related to the CCBHC demonstration is enacted.

Except for Missouri, none of the states planning to add clinics to the demonstration fund CCBHCs under other Medicaid authorities. Missouri obtained SPA approval to fund three CCBHCs through the state Medicaid plan because the state expected the demonstration to end. Now that the demonstration is continuing, however, Missouri plans to transition funding for these three CCBHCs to the demonstration to take advantage of the demonstration's enhanced match rate. The rest of the states planning to add clinics under the demonstration are considering SPAs for the future or have put their SPA plans on hold.

New Jersey is not planning to add new CCBHCs to the demonstration, and Oklahoma has not made a final decision. These states fund or are on the pathway to funding CCBHCs under other Medicaid authorities. New Jersey is pursuing a SPA that would not have statewideness requirements. It has



permission from the CMS to overlay a Section 1115 waiver of statewideness through the end of the demonstration waiver period if the SPA is approved. Oklahoma is still deciding whether to move funding for CCBHCs currently funded under its SPA, which has been in place since 2019, to the demonstration.

## B. Changes to the Number and Characteristics of Clients Served across Demonstration Years

The number of unique people served each year by CCBHCs participating in the demonstration has increased steadily over time. Although the number of clinics for which data are available varies from year to year, the overall number served increased from 286,089 people in DY1 to 315,349 people in DY4 (Exhibit III.1). The number served has gradually increased each year in all states but Minnesota and Oregon, the latter of which decertified three clinics in 2019 (DY3) during a period of funding instability. At the state level, the largest changes from DY1 to DY4 were in New York (49,903 to 62,972) and Missouri (121,787 to 145,949).

Exhibit III.1. Number of People Served by CCBHCs in Each DY				
State	DY1 (2017-2018)	DY2 (2018-2019)	DY3 (2019-2020)	DY4 (2020-2021)
Aggregate	286,089	308,831	303,911	315,349
Minnesota	23,027	25,402	23,935	20,725
Missouri	121,787	132,565	137,753	145,949
New Jersey	17,851	19,129	20,396	21,742
New York	49,903	55,693	57,377	62,972
Oklahoma	20,610	22,741	24,647	25,583
Oregon	52,911	53,301	39,803 <sup>a</sup>	38,378 <sup>a</sup>

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 quality measure reports and state responses to follow-up questions.

a. Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3.

States and CCBHCs also report on certain characteristics of the people served each year, including age, gender, race and ethnicity, and insurance status. With few exceptions, characteristics of clients generally remained stable across years (see Appendix B for detailed findings). For example, across states:

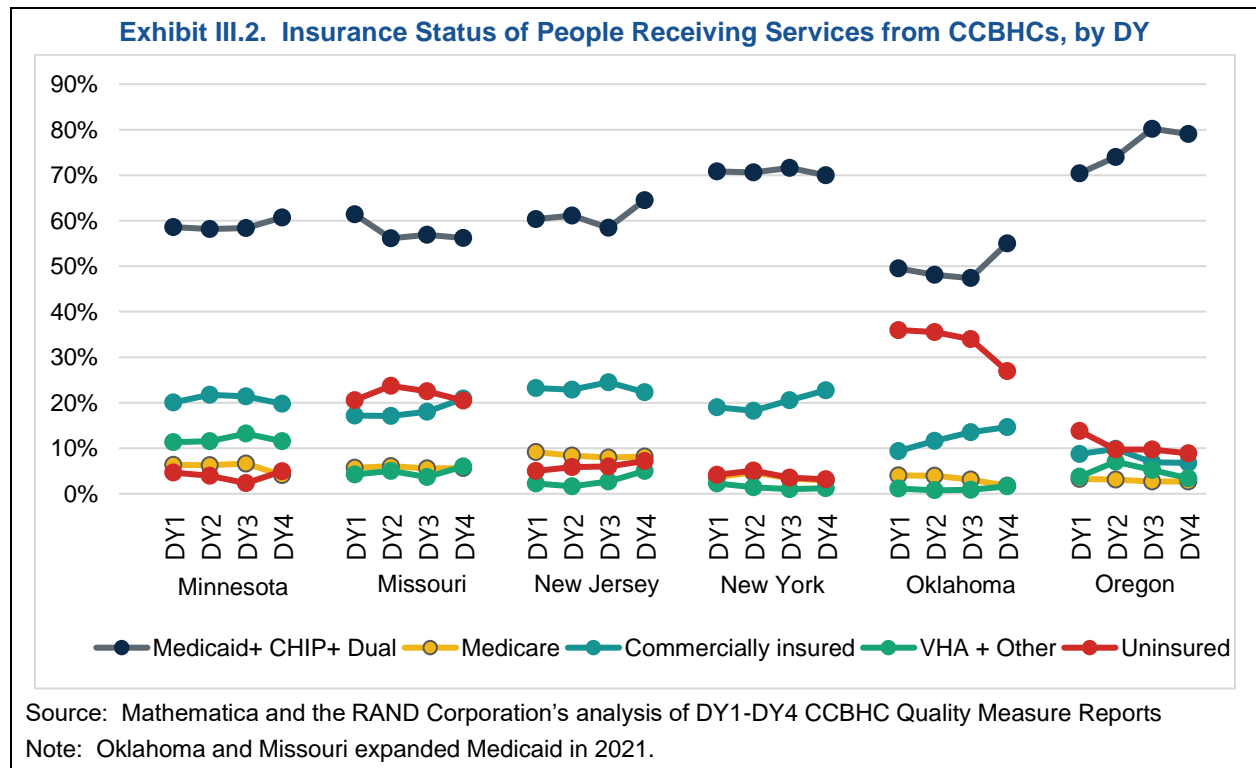
- In all, 76 percent of CCBHC clients were adults and 24 percent were children or adolescents (age 0-17 years) each DY. The proportions of adults and children were generally stable within states over time, except for an increase in the proportion of adults of about 5 percent from DY1 to DY4 in New Jersey (Appendix Exhibit B.2).
- More CCBHC clients were female than male in all states except New York, where more clients were male than female, with the proportion who were female across all states ranging narrowly from 51 percent to 53 percent over DYs (Appendix Exhibit B.1). New Jersey, where the proportion female ranged from 55 percent to 57 percent each year, had the largest gender gap.<sup>20</sup>

<sup>20</sup> Across states and years, 0-1 percent of people served were reported in “other” or “unknown” gender categories.

- Most people served by CCBHCs in each DY were White, ranging from 70 percent to 73 percent over DYs. Twelve percent of clients were Black or African American consistently each DY, and the percentage of clients who were Hispanic or Latino ranged from 8 percent to 10 percent over DYs (ranging from 4 percent in Missouri in DY4 to 19 percent in New Jersey in DY2).

There were two notable changes in the distribution of insurance status across DYs (Exhibit III.2.). First, in Oklahoma and Oregon, the proportion of people served by CCBHCs who were covered by Medicaid increased. In Oklahoma, the proportion of clients who were uninsured decreased as the proportion covered by Medicaid increased, a trend that was likely the result of the state’s Medicaid expansion in July 2021. Medicaid expansion occurred prior to the demonstration period in Oregon, however, and there was no increase in the proportion of clients covered by Medicaid in Missouri despite Medicaid expansion beginning in October 2021.

Second, in Missouri, New York, and Oklahoma, an increasing proportion of clients were covered by commercial insurance over time. This trend could have implications for the financing of CCBHCs in these states, though the drivers of the trend are not clear. The proportion of clients covered by commercial insurance could increase because of people changing from public to commercial coverage over time or an increase in the number of people who are commercially insured initiating care in CCBHCs.



**Client characteristics in new states.** Although Kentucky and Michigan are not yet reporting quality measures, state officials in both states noted that CCBHCs served approximately the number of people they anticipated serving in their first DY. Kentucky expected to serve 50,200 and ended up serving 49,890. Michigan expected to serve 73,881, and the state ended up serving about 62,500. The Michigan

state official also noted that characteristics of clients served by CCBHCs were generally what the state expected.

### **C. State and Certified Community Behavioral Health Clinic Activities to Increase Access to Care**

The increase in the number of unique people served by demonstration CCBHCs each year suggests that efforts to increase access to care might have been successful at attracting new clients. In the first two DYs, CCBHCs implemented a wide range of activities to increase access to services (Brown et al. 2021). These activities included, for example, accommodating same-day and walk-in appointments, expanding operating hours, increasing outreach to underserved populations, and moving service delivery outside the clinic to reach people in their homes and communities. CCBHCs also established and sustained partnerships with external providers to facilitate referrals and coordinate care.

**In general, state officials reported that, in more recent years of the demonstration, CCBHCs have worked to maintain and expand activities put in place in the initial years of the demonstration, and some CCBHCs have introduced new activities.** States and CCBHCs highlighted the following:

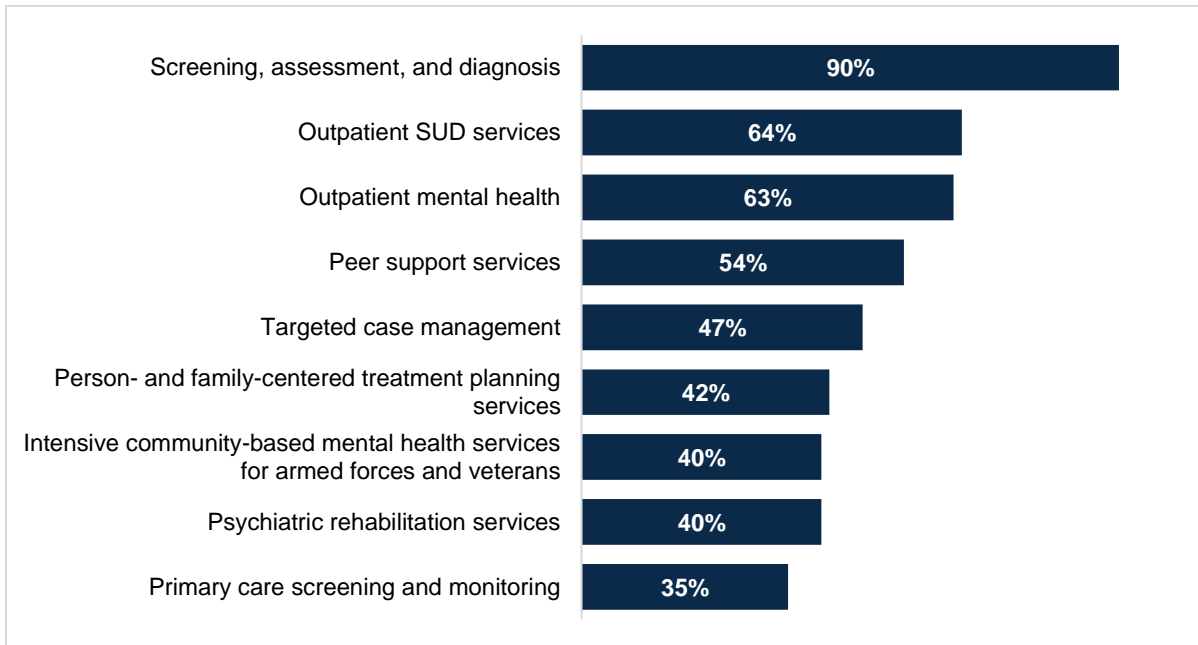
- **Engaging clients through outreach.** Several CCBHC survey respondents reported focusing in the last year on advertising and promotion, mentioning increasing television, radio, and online advertisements; improving their websites; and enhancing their social media presence to engage new people in care. One CCBHC, for example, said that “in order to increase awareness--thus increasing access to care--[the CCBHC has] implemented marketing campaigns, which include radio, billboard, and social media campaigns.” State officials in Nevada and Kentucky echoed this message, mentioning that they work with CCBHCs to enhance their online presence and ensure their websites are easily accessible. In all, 10 percent of CCBHCs mentioned increasing awareness of services through media and advertising through events such as health fairs.

States and CCBHCs also highlighted outreach-focused staff as a means to increase access to services and engage new people in care. Missouri officials, for example, reported adding 41 adult community behavioral health liaisons in fiscal year 2022 to its existing cohort of liaisons to coordinate with law enforcement and connect adults with behavioral health care. In July 2022, Missouri launched the youth behavioral health liaison program, modeled after the adult liaison program, to help prevent justice involvement and increase access to services among youth. Schools, law enforcement, and youth services agencies contact the liaisons for help linking youth to behavioral health services at CCBHCs. Fourteen percent of CCBHCs reported creating new staff positions to engage new people in services and improve the service enrollment experience, highlighting staff such as outreach, access, or engagement specialists or intake workers, including peers.

- **Open-access scheduling.** One significant way that many CCBHCs increased access to care in the initial years of the demonstration was by implementing or increasing the availability of open-access or same-day scheduling, which is a scheduling method that allows all clients to receive an appointment on the day they request one (Wishon et al. 2023; Brown et al. 2021). By DY2, officials in all states reported that CCBHCs had begun offering same-day appointments to improve availability of services. Although data on the percentage of clinics that offer open-access or same-day scheduling at the beginning of the demonstration are unavailable, as of April 2023,

nearly all (94 percent) CCBHCs reported offering open-access or same-day scheduling.<sup>21</sup> CCBHCs most frequently reported offering open-access or same-day scheduling for screening, assessment, and diagnosis (90 percent) (Exhibit III.3). In addition, more than half of CCBHCs offer open-access or same-day scheduling for outpatient SUD services (64 percent), outpatient mental health services (63 percent), and peer support services (54 percent). Officials in several states said that CCBHCs continue to work to make open-access scheduling more available. Oregon officials, for example, noted that several CCBHCs are working on initiatives to increase open-access (or same-day scheduling) capability.

**Exhibit III.3. Proportion of CCBHCs that Offer Open-Access or Same-Day Scheduling, by Service Type**



Source: Mathematica and the RAND Corporation’s analyses of the 2023 CCBHC survey.

Notes: The denominator for each category is the total number of survey respondents (n = 72). Categories are not mutually exclusive.

- Telehealth.** Consistent with previous evaluation years, most state officials noted that they were able to achieve increased access by expanding telehealth, focusing in particular on extending telehealth policies implemented during the pandemic. Accordingly, 100 percent of CCBHCs surveyed in 2023 reported offering at least one CCBHC service by telehealth, an increase of 30 percent from DY2 (70 percent). State officials in Missouri, New York, and Kentucky said that expanding telehealth services has increased access. CCBHC providers and other providers in New York have told officials that telehealth helped them engage people in new ways, particularly those who might not be willing to come into the clinic. A CCBHC in New York reported its investments in telehealth, saying “we have worked to strengthen and train our staff in tele-mental

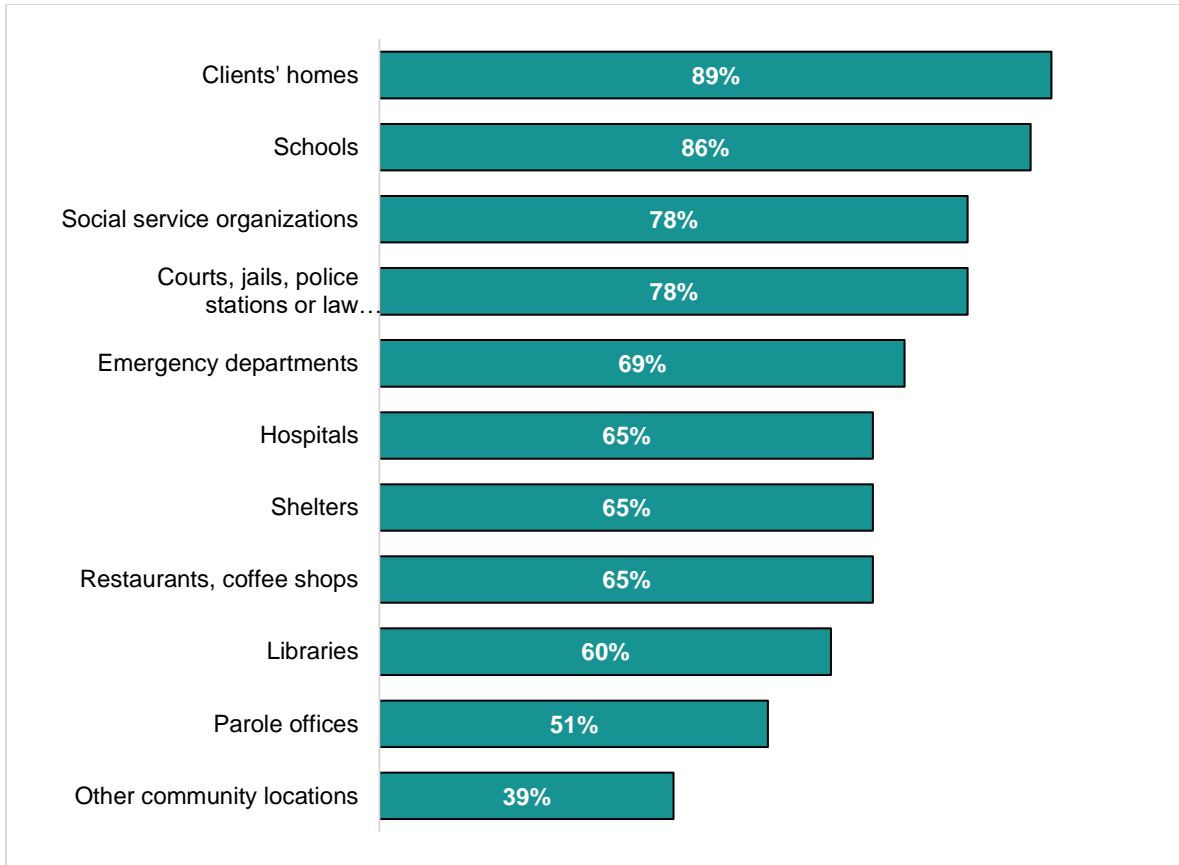
<sup>21</sup> We excluded crisis services from this analysis because CCBHCs are required to provide crisis services 24 hours a day.

health. We have a HIPAA compliant platform and can work with our consumers via video or telephone services.”

Several states reported changes to statewide Medicaid policies that would allow CCBHCs to provide telehealth services and provide timely care following the end of the federal COVID-19 public health emergency (PHE) on May 11, 2023 (see Appendix Exhibit A.3. for the demonstration years relative to the timing of COVID-19 PHE declarations). Michigan is continuing telehealth policies put in place during the pandemic, including allowing audio-only telehealth. Kentucky is continuing its telehealth policies as well, and it has relaxed its Medicaid prior authorization requirements for behavioral health services during the PHE and plans not to reinstate those requirements except for residential and inpatient SUD treatment. It is unclear, however, to what extent other demonstration states have made similar changes or planned to maintain telehealth flexibilities after the PHE ended.

- **Serving people outside of clinic locations.** As reported in earlier DYs, CCBHCs have continued to offer services in locations outside the physical clinic location. For example, a state official from Nevada shared that one CCBHC is now providing school-based mental health services in a designated office space. CCBHCs have also considered ways to support clients beyond traditional in-office services. For example, a state official in Oklahoma noted that CCBHCs responded to rising drug use and overdose by engaging in harm reduction tactics, including adding vending machines containing naloxone and fentanyl testing strips. CCBHCs most commonly reported offering services in clients’ homes (89 percent), schools (86 percent), as well as in social service organizations and justice-related facilities (78 percent respectively) (Exhibit III.4).

**Exhibit III.4. Proportion of CCBHCs Offering Services in Locations Outside the CCBHC**



Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: The denominator for each category is the total number of survey respondents (n = 72). Categories are not mutually exclusive.

Notably, the percentage of CCBHCs providing services outside the clinic location has increased substantially for all location categories included in the current survey and a survey conducted in DY2 (Brown et al. 2021). A higher percentage of CCBHCs reported providing services in clients' homes, schools, justice-related locations, and shelters (Exhibit III.5).

**Exhibit III.5. Proportion of CCBHCs Offering Select Services Outside the CCBHC, 2019 and 2023**

Location	2019	2023
Clients' homes	78%	89%
Schools	47%	86%
Courts, jails, police stations, or law enforcement offices	33%	78%
Shelters	11%	65%

Source: Mathematica and the RAND Corporation's analysis of the CCBHC Annual Progress Report Demonstration Year 2, March 2019 and 2023 CCBHC survey.

Note: The denominator for each category is the total number of respondents (n = 66 and n = 72). Categories are not mutually exclusive.

- **Focusing on needs of special populations.** Officials in several states mentioned focusing attention on increasing access among certain underserved populations, such as people involved with the justice system and children and youth. For example, New Jersey CCBHCs are partnering with a prison re-entry program to ensure people are connected to behavioral health care quickly after they are released. Oklahoma state officials noted an increase in need among youth transitioning out of the child welfare system, including youth with disabilities and youth with SMI, and the state is exploring ways CCBHCs might fill gaps in care. For example, CCBHCs are exploring creative housing environments and targeted teams for these populations. A Michigan official noted the state is working through how to guide CCBHCs on serving populations with a primary diagnosis of intellectual and developmental disability with ancillary depression, anxiety, or other mental illness and how to implement home and community-based services rules and navigate that crossover.

**As in previous DYs, states and CCBHCs continue to struggle with the nationwide shortage in behavioral health providers, which has challenged their capacity to expand access to new clients.**

Nearly 90 percent of CCBHCs responding to the survey mentioned difficulties with staffing and workforce development when asked about challenges related to access to care, almost to the exclusion of any other challenges. Several CCBHCs shared that staffing is their number one implementation challenge. For example, one CCBHC shared that “the number one challenge has been staff shortages. We are actively working on recruitment and retention and have developed a workplan in order to implement new goals. We also recently brought on a part-time position to assist with recruitment of interns in hopes that some interns will become employees.” A Michigan official said that its CCBHCs are using DCOs as a strategy to address workforce shortages and expand capacity. The state has provided DCO trainings to support this effort.

Although hiring new staff remains difficult, some states have tried to assist CCBHCs in meeting higher demand for specialized services by hiring experts to provide trainings for CCBHCs to expand knowledge and skills among current staff. For example, a Nevada state official noted that CCBHCs’ needs assessments indicated an uptick in the number of clients with an eating disorder diagnosis, and CCBHC staff had limited expertise in these conditions. In response, the state hired experts to train CCBHC providers on eating disorders. Similarly, an Oklahoma official noted that CCBHCs have grappled with how they might meet the needs of the aging population for whom it can be challenging to distinguish between diagnoses of Alzheimer’s disease, other dementias, and SMI. To help address this challenge, the state hired an aging expert who is bringing in a national trainer on evidence-based practices (EBPs) for older adults to support providers.

**Kentucky, a new demonstration state, has continued to face specific access challenges related to transportation, which it has addressed through telehealth and transportation-related policy changes, mobile units, and general outreach to raise awareness of services.** Kentucky state officials highlighted transportation as a primary barrier because the state is primarily rural. For example, clients with Medicaid transportation benefits must call the Medicaid transportation broker 72 hours before their appointment to schedule transportation, and they often encounter wait-times after appointments as other clients are picked up and dropped off by the same transportation provider. CCBHCs have enhanced telehealth services, which have helped address these barriers by providing the option to receive care virtually rather than in person. Some of the CCBHCs are transportation brokers for Medicaid. A state official noted that the demonstration has helped CCBHCs to hire drivers, which the official thought likely has helped increase access as well. In addition, the state recently removed a requirement that households

had to be carless to be eligible for Medicaid's non-emergency transportation services. Making households with a car eligible for transportation services could create an influx of transportation requests, and the state official expressed concerns about the ability of transportation brokers to meet the demand. At least one CCBHC has a fully equipped mobile unit that travels to distant communities and provides services on-site. State officials noted this unit has helped mitigate transportation demand and increase access. CCBHCs also lead grassroots engagement and outreach, including exhibiting at local events, such as county fairs, which state officials said has helped increase community awareness of services.

**Officials from Michigan, the other new demonstration state, shared how pivoting to the CCBHC model has already helped expand access to services (and continuity of care) for new populations.**

Michigan officials said that youth aging out of the children's system can more seamlessly cross over into the adult system and continue receiving services fluidly at CCBHCs (because CCBHCs provide both adult and child services in-house). Traditionally, there has been more of a disconnect because children's programs have been run and funded separately with different requirements. Officials viewed this seamless transition as a victory for CCBHCs. In addition, before launching the demonstration, community mental health centers were limited to serving clients with severe mental illness. Now CCBHCs can serve anyone who walks in rather than having to refer people with mild-to-moderate needs elsewhere or move people in and out of treatment at the clinic if they transition between serious and mild-to-moderate needs. Finally, Michigan officials noted that they were initially concerned about whether CCBHCs would have the financial resources to serve people without Medicaid, but, because of the PHE, many people stayed on Medicaid, and the non-Medicaid population did not end up being large.

#### **D. Increasing Access through Crisis Services: Integrating Certified Community Behavioral Health Clinics with 988 Lines and State Crisis Systems**

The CCBHC certification criteria specify that CCBHCs or a state-sanctioned provider acting as a DCO for the CCBHC are required to provide 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization. Although SAMHSA's 2023 revised criteria continue to require these three services, SAMHSA has updated the criteria to align with SAMHSA's national guidelines for a comprehensive crisis system (such as requiring CCBHCs to establish protocols to track referrals made from the call center to the CCBHC or its DCO to ensure timely crisis care) and the transition to the national 988 Suicide & Crisis Lifeline (such as having a care coordination partnership with the 988 call center serving the CCBHC's area), among other crisis-related updates.

States have continued to invest in overseeing the coordination of crisis service components, including the integration of CCBHCs with 988 call centers and state-sanctioned crisis systems. In New Jersey, CCBHCs have DCO arrangements with the state crisis system, and the state has worked to ensure that CCBHCs provide adequate follow-up after people interact with the crisis system (including hospitals) by requiring all CCBHCs conduct performance improvement projects to improve follow-up. In addition, because the state noticed a lot of children without SED diagnoses visiting emergency departments, New Jersey's Department of Human Services, Division of Mental Health and Addiction Services has been collaborating with the Department of Children and Families. The state is trying to increase access to and availability of CCBHC services for youth because CCBHCs vary in their experience serving this population. Kentucky is currently securing an administrative service organization to oversee mobile crisis services and 23-hour crisis stabilization. The state indicated that mobile crisis utilization has been low and that it would like to divert more people from emergency rooms and law enforcement to more appropriate care.



Several states have leveraged grants, SPAs, or other sources of funding to expand crisis services. For example, Oregon's SPA was recently approved to implement mobile crisis services; the SPA will largely be directed at providers that serve as community mental health programs in the state, which includes most CCBHCs. Missouri state officials noted that recent grants have enabled CCBHCs to hire more mobile crisis staff to meet the increased demand from the 988 line; the state chose to direct the funding to the CCBHCs because they were already required to provide mobile response.

CCBHCs reported different ways of coordinating with 988 crisis service systems to rapidly link people in crisis to needed services. In all, 7 percent of CCBHCs reported operating directly as a state 988 provider, and 43 percent reported receiving direct referrals from 988. Other CCBHCs mentioned establishing a formal relationship with a local/regional crisis hotline that fields 988 calls (14 percent). In most states, 988 call centers are staffed and operated by other entities and connect people to CCBHCs' crisis services, such as mobile crisis teams, as needed. For example, the Michigan Crisis and Access Line is Michigan's 988 call center. Many CCBHCs in the state use this line for after-hours coverage or to fill a gap in crisis care. The line is not intended to replace CCBHCs' 24/7 lines but instead provides another mechanism to obtain support. Nevada currently has an interim 988 vendor while it seeks a permanent vendor; interactions with CCBHCs are still in the early days, according to officials. A few state officials discussed DCO arrangements with call centers. For example, New York officials mentioned that several CCBHCs contract with an entity to manage a crisis call center that directs people back to CCBHCs to provide services. This call line was established before the transition to the 988 crisis, so the state is still determining alignment and integration. Some Missouri CCBHCs have DCO arrangements with independent hotlines if they are not serving as 988 call centers themselves. In Kentucky, all CCBHCs operate 988 call centers.

CCBHCs typically provide mobile crisis services directly, with a few exceptions. New Jersey CCBHCs have DCO arrangements with the state-sanctioned crisis system to provide mobile crisis services. Michigan's mobile crisis service arrangements vary by region, as urban areas have long-standing state-sanctioned crisis systems they can leverage through DCO arrangements. Although CCBHCs in Michigan's urban areas typically share mobile teams, CCBHCs in non-urban areas provide mobile crisis for their counties. Some New York CCBHCs also use DCOs to provide CCBHC services; because some counties fund crisis services using state funds, the DCO arrangement for these CCBHCs covers the administrative costs of reporting back to the CCBHCs about the services provided to their clients. CCBHCs in Oregon, Nevada, Oklahoma, Missouri, and Kentucky provide mobile crisis services directly. Oklahoma officials described the typical workflow in their state: The 988 call center alerts the mobile crisis team about the crisis, and the mobile team decides, after assessing the individual, whether to resolve the crisis on the spot or whether the individual could benefit from an urgent recovery center or crisis center. (CCBHCs offer both of these types of centers in Oklahoma).

A few states described recent efforts to increase access to crisis stabilization units that coordinate with CCBHCs. Missouri has opened 18 new crisis stabilization units in 2022 and 2023 as the result of investments from the state budget to ensure at least one unit is available in each of the nine state patrol areas. All behavioral health crisis centers are attached to a CCBHC in Missouri, but not all CCBHCs have a behavioral health crisis center yet. State officials noted that law enforcement has greatly appreciated these centers. Kentucky is planning to add 23-hour crisis stabilization units through a SPA so that a more appropriate level of care will be available to CCBHCs than the emergency room.

## E. States' Performance on Access-Related Measures

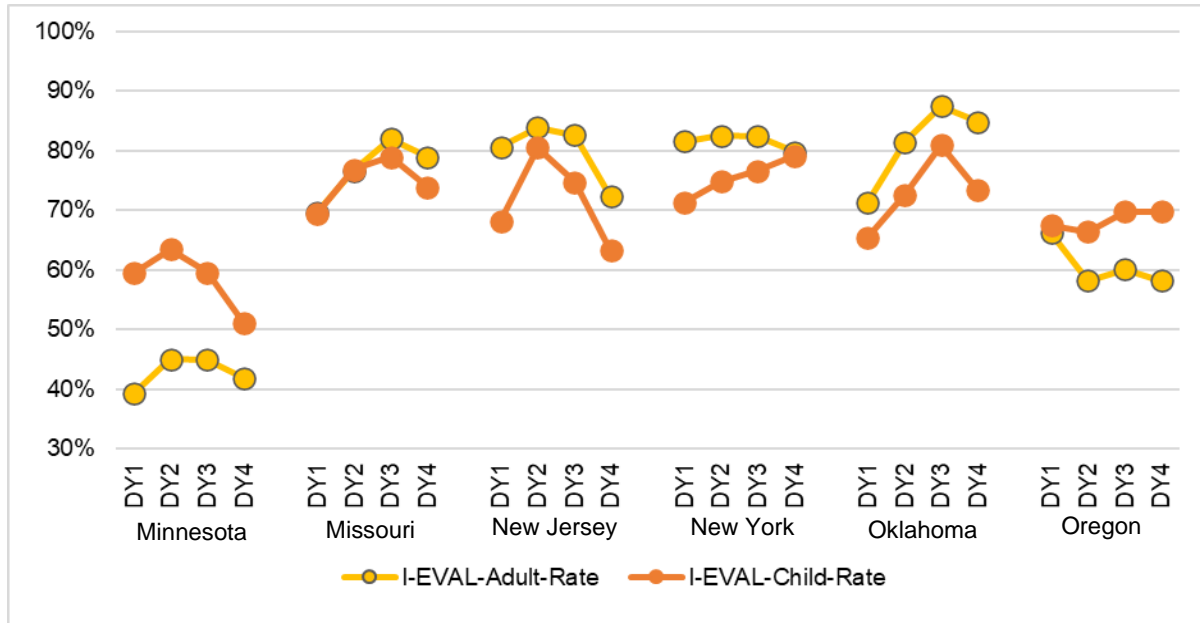
The CCBHC certification criteria require that all people new to services with routine (non-urgent or emergency) needs should receive an initial evaluation within ten business days (SAMHSA 2023a, 2016). CCBHCs must report performance on a related measure (Time to Initial Evaluation measure, or I-EVAL). The I-EVAL comprises two components: (1) the percentage of new clients who received an initial evaluation within ten business days of first contact with the clinic; and (2) the average number of days until that initial evaluation occurred. I-EVAL is calculated separately for adult (ages 18 and older) and for child/adolescent CCBHC clients.

Across all states, aggregate performance on both components of the I-EVAL measure remained relatively stable over time and was similar for adults and children/adolescents (Appendix Exhibit B.9). From DY1 to DY4, the percentage of new clients receiving an initial evaluation within ten days of first contact across states rose slightly from 69 percent to 73 percent for adult clients and from 68 percent to 72 percent for child/adolescent clients. Similarly, the mean number of days to initial evaluation decreased slightly from DY1 to DY4 for adults (9.1 days versus 8.4 days) and children/adolescents (9.9 days versus 7.2 days). By DY4, five demonstration states reported fewer than ten mean days to initial evaluation for adults, and four states reported fewer than ten mean days to initial evaluation for child/adolescent clients.

Relative to DY1, two states (Missouri and Oklahoma) showed improvements (that is, an increase greater than or equal to 5 percentage points) in DY4 performance for both the adult and child/adolescent measures relative to DY1 (Exhibits III.6 and III.7). New York showed stability in the adult measure and improvement in the child measure. The remaining states showed decreases in performance for one or both of the adult and child measures. Pandemic-related staffing and care provision challenges may in part account for decreases in performance.

Trends for one component of the measure tended to align with trends for the other component, with a few notable exceptions (see Exhibits III.6 and III.7). For example, in New Jersey, the percentage of clients receiving initial evaluation within ten days declined from DY1 to DY4, and the average days to initial evaluation increased (adults: 7.5 days to 9.5 days; children/adolescents: 11.0 days to 14.2 days; Appendix Exhibit B.X). In addition, most states performed similarly on I-EVAL measures for adult and child/adolescent populations within each DY and over time. One exception to this pattern was in Minnesota, where the percentage of clients receiving initial evaluation within ten days was about 20 points higher for children/adolescents (59 percent) than for adult clients (39 percent) in DY1. In DY1, adult clients averaged 20.6 days to initial evaluation compared with 10.1 days to initial evaluation for children/adolescents. This discrepancy in performance for adults and children/adolescents diminished over time. This was driven at least in part by a decrease in performance on the first metric (percentage of clients seen within ten days) for children/adolescents (from 59 percent to 51 percent) and corresponding improvement for adult clients (from 39 percent to 42 percent).

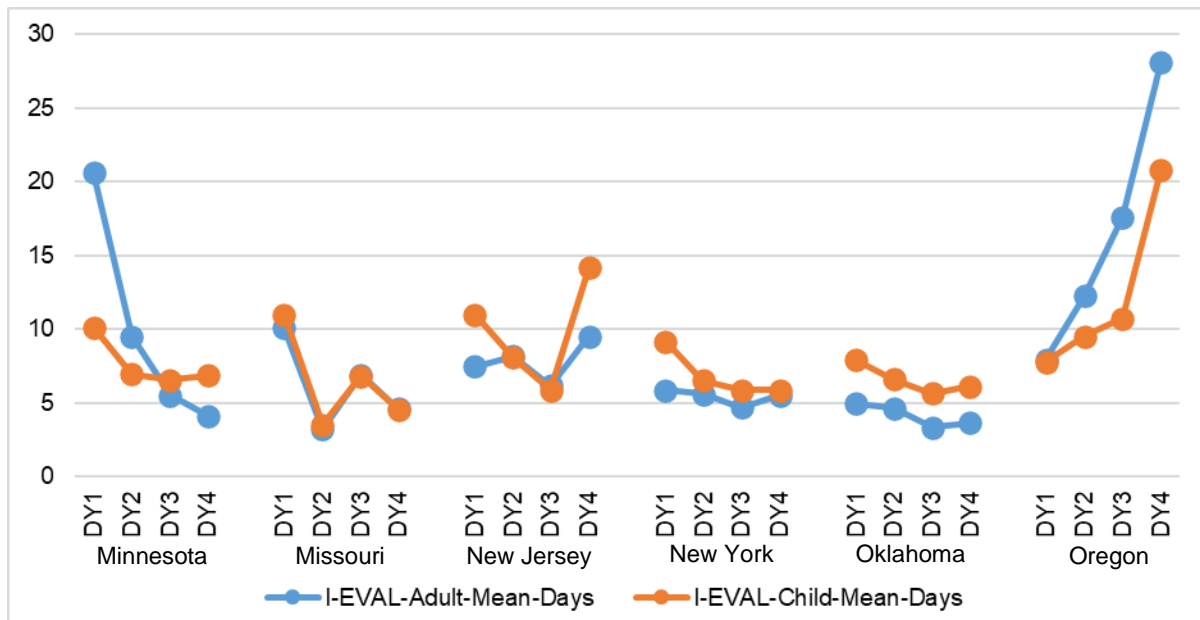
**Exhibit III.6. I-EVAL Rate within 10 days, Adult and Child/Adolescent**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures.

Notes: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit III.7. I-EVAL Mean Days, Adult and Child/Adolescent**

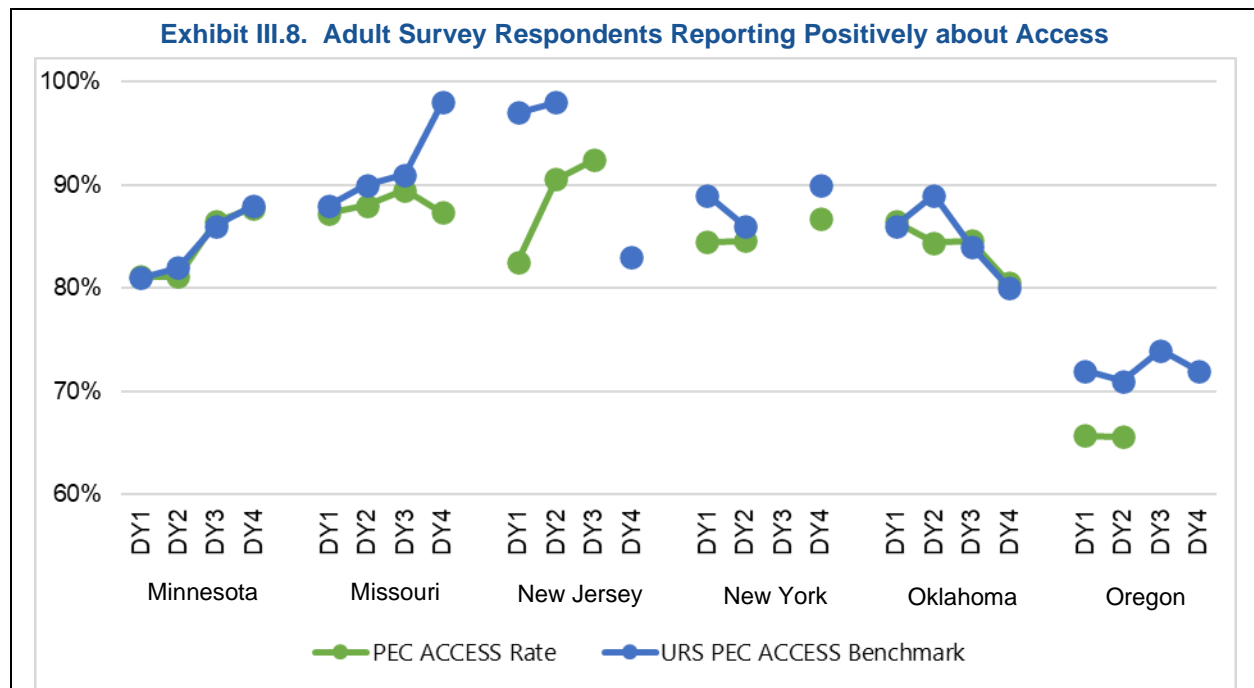


Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures.

Notes: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

Clients' and family members' perceived access to care is another important metric for understanding access to CCBHC services. States collect and report data on perceptions of access to CCBHC care by surveying a sample of adult CCBHC clients (the Patient Experience of Care [PEC] measure) and family members and caregivers of child/adolescent CCBHC clients (the Youth/Family Experience of Care [Y/FEC] measure). As Exhibit III.8 shows, across states, most adult CCBHC clients had generally positive perceptions of access to care in DY1 to DY4. Similarly, across states, most family members of child/adolescent CCBHC clients had generally positive perceptions of access to care in DY1-DY4 (Exhibit III.9). Yet a significant portion (ranging from more than 10 percent to more than 30 percent) of clients and family members did not report positively about access in some states.

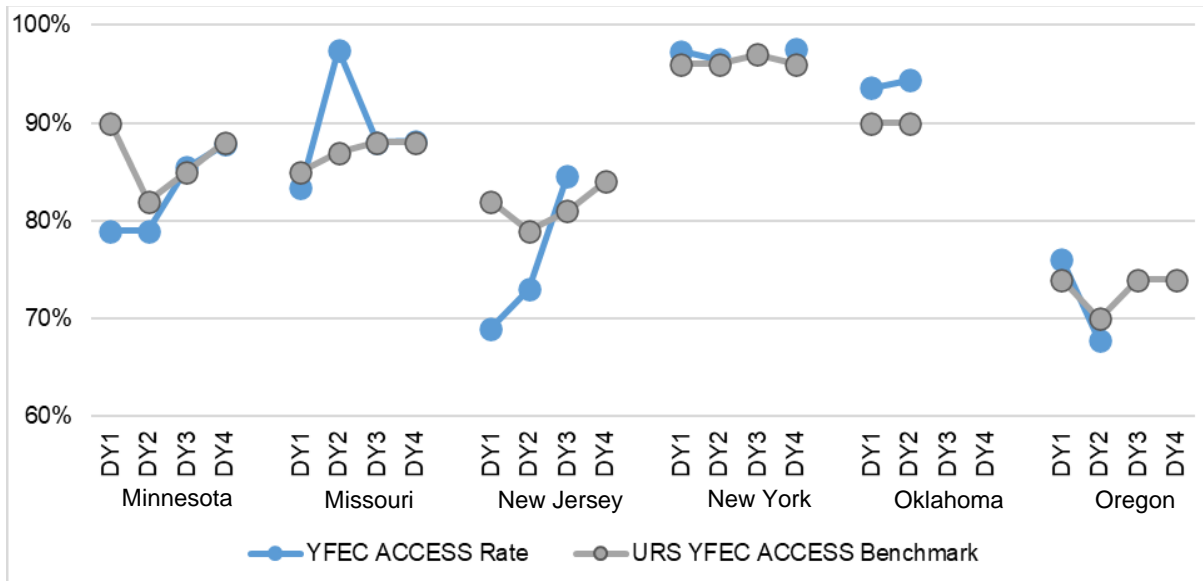
When possible, we have presented performance on the CCBHC PEC-Access measures with state-specific benchmarks from the URS. For adults, changes over time and performance relative to benchmarks varied somewhat across states. In most states, however, performance on this measure fell within 5 percentage points of available state URS benchmark data, suggesting that CCBHC clients' perceived access is comparable to that of clients in the URS. Similarly, the performance on the Y/FEC measure mostly tracked with changes over time and performance relative to available benchmarks.



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks reported are from the Annual Report URS Tables, available at <https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>.

Notes: Oregon began the demonstration with 12 CCBHCs but decreased to nine CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. PEC measure data are not available from New Jersey for DY4, New York for DY3, Oregon for DY3-DY4. Benchmark data are not available from New Jersey or New York for DY3. See Appendix Exhibit B.28 for sample sizes. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit III.9. Youth and Family Survey Respondents Reporting Positively about Access**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks reported are from the Annual Report URS Tables, available at <https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>.

Notes: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. Y/FEC data are not available from New York for DY3, Oklahoma for DY3-DY4, or Oregon for DY3-DY4. Benchmark data are not available for Oklahoma for DY3-DY4. See Appendix Exhibit B.33 for sample sizes. The DY3 and DY4 measurement years include the COVID-19 PHE.

## IV. Scope of Services: Care Coordination

The CCBHC certification criteria require CCBHCs to provide integrated and coordinated care that is person and family-centered and addresses all aspects of a person's health. PAMA requires CCBHCs to coordinate care across settings and providers to ensure seamless transitions across health services, and to establish partnerships and formal relationships with a range of other providers. CCBHCs must ensure adequate communication and collaboration between and among them, including formal relationships with DCOs. The chapter highlights how states have supported CCBHCs' care and care coordination activities in recent years and describes some of the processes that CCBHCs use to coordinate care between individual providers and staff within CCBHCs and with external providers.

### A. State Support of Care Coordination Activities and Related Policy Initiatives

Throughout the demonstration, state officials have reported supporting CCBHCs' care coordination efforts by providing guidance and technical assistance to help develop DCO relationships and external partnerships, facilitating information sharing through various health information technology (HIT) solutions such as health information exchanges (HIEs), and implementing various other state-level initiatives (Brown et al. 2021; Wishon Siegwarth et al. 2020).

**In the most recent DY, state officials most often highlighted supporting CCBHCs' efforts to improve care coordination in two ways: by conducting state-level care coordination reviews and implementing state-level staffing initiatives.** For example, in New York, the state conducted in-person chart reviews and staff interviews in the third DY to ensure charts were accessible to everyone working with the client and that treatment plans were person centered. These reviews stopped during the pandemic, but the state reviewed sample charts from CCBHCs during needs assessment updates in 2022 to make sure charts still included the information the state expected. A Nevada official noted that the state reviews treatment plans and goals for a sample of clients when it reviews CCBHCs annually and discusses with CCBHC staff if they identify that appropriate services are not being provided for a given client.

Officials in several states also reported supporting care coordination through state-level staffing initiatives. Oklahoma, for example, has established a care coordination team in the state office supporting the CCBHC demonstration that provides support to CCBHCs' dedicated care coordinators. The state team works with CCBHCs to monitor a "most-in-need" list of clients with the highest acuity needs and engage them in services. The state care coordination team also facilitates collaboration among other agencies, such as child welfare and adult protective services, to serve people with higher acuity needs and holds a monthly call with CCBHC care coordination leads to discuss strategies. The official noted that they have recently heard from some CCBHCs that 40-50 percent of their most-in-need list has been engaged, demonstrating progress in serving a hard-to-reach group who frequently seeks services in hospitals and emergency departments.

Missouri has more than doubled the number of adult community behavioral health liaisons in recent years and recently introduced youth behavioral health liaisons who work with schools, law enforcement, and other agencies to connect youth with behavioral health care at CCBHCs (see below).

### **Spotlight: Missouri's Youth Behavioral Health Liaisons**

**New initiative:** Missouri introduced youth behavioral health liaisons to CCBHCs in July 2022. Youth liaisons serve as CCBHC contacts for schools, law enforcement, and youth agencies; these entities know to reach out to liaisons if a child needs behavioral health services. The liaisons began their work by building relationships with schools and other partners. The state keeps a list of liaisons updated on its website, and the state's youth services manager has given presentations to various statewide groups to raise awareness of this new initiative. State officials reported that, in March 2023, 30% of the liaisons' referrals came from schools and 25% from law enforcement. Referrals represent youth who might be experiencing a behavioral health crisis or who could benefit from behavioral health services.

**Motivation:** Missouri has had a successful adult behavioral health liaison program since before the CCBHC demonstration began. Over time, it was clear there was a need for youth liaisons because adult liaisons would receive referrals for youth and were less equipped to help them. Missouri has wanted to add youth liaisons for some time, but it needed to secure funding. SAMHSA block grants helped them fund about 31 positions and then the state legislature funded eight more positions for provider areas with the highest referral using state general revenue. Currently, all liaisons are located in CCBHCs.

**Reception:** State officials noted that they have been able to show that the new initiative is necessary and successful. They have heard success stories from agencies and parents who have had positive referral experiences. The governor highlighted the program in the recent State of the State and brought a youth liaison to the address to be recognized.

### **A few states also reported supporting efforts to better coordinate children's services across systems.**

For example, a Missouri official noted that several CCBHCs conduct independent assessments for the state's child welfare division as part of state implementation of the Family First Prevention Services Act (Public Law: 115-123). They receive referrals from the division and assess their need for out-of-home placement. Similarly, a Michigan state official noted that the state is collaborating with children's systems to revamp children's services and make sure they are provided in a more coordinated manner, focusing on aspects such as children's crisis systems or assessment tools used. The state has been supporting the children's systems in review of children's services and helping to coordinate with CCBHCs.

**Several state officials shared how other state policy initiatives intersect with CCBHCs' care coordination activities and influence the ways some CCBHCs coordinate care, often highlighting the role of health homes programs and managed care entities plans.** In some cases, officials noted that the intersection has resulted in better care coordination. For example, a Michigan official noted that the state recently expanded health homes so more CCBHCs are health homes as well. The official suggested that there is more capacity as a result to provide strong care coordination. The state also mentioned that Michigan's prepaid inpatient health plans, a type of managed care plans, have historically coordinated care for Medicaid beneficiaries receiving SUD services, and the state has invested time in navigating the shift of that responsibility to CCBHCs. An Oregon official noted that care coordination efforts at all CCBHCs have been affected by Measure 110, which decriminalized personal possession of specific drugs to redirect users to behavioral health services. The state designated about \$300 million from its state marijuana tax to build behavioral health resource networks in all counties. Each network provides five services: SUD treatment, harm reduction, housing, supported employment, and peer support services. CCBHCs function as a behavioral health resource network or part of one, partnering with other organizations to provide certain services. In addition, coordinated care organizations, which are managed care plans, in Oregon identify high utilizers in their region and regularly communicate this information with various types of providers, including CCBHCs. A New York official shared that the state's health

homes program predates the CCBHC demonstration; only a small proportion of CCBHC clients are in health homes, and they receive care coordination from the health home rather than CCBHCs. However, the official also noted that health homes coordinate with CCBHCs and have infrastructure to improve care coordination, such as the ability to identify when clients are in the hospital. New Jersey currently has a single license project underway that might lead to licensing changes in the future, which could expand CCBHCs' ability to provide more coordinated primary care services internally. A New Jersey official said that the CCBHCs are currently limited in the extent that they can provide primary care services because of licensing requirements in the state. They can provide the required primary care screening and referrals but would like to bolster their on-site primary care capacity like other states have done, such as Oregon.

#### **Spotlight on Internal Coordination: Oregon**

Oregon is unique in that the CCBHC demonstration has a state-specific requirement for CCBHCs to provide 20 hours of primary care services a week, which goes beyond the certification requirements for primary care screening and monitoring. Oregon state officials reported that CCBHCs vary in how primary care is coordinated with other services. Some CCBHCs might have a daily huddle with primary care providers, but larger CCBHCs might have structured time weekly for the primary care provider, therapist, and psychiatrist to coordinate clients' care. CCBHCs have shared with officials that a balance between ad hoc communication and structured meetings is ideal to support care coordination. Although some of Oregon's CCBHCs have been able to meet the primary care requirement on-site, others have needed to seek out other arrangements. One CCBHC, for example, has found it challenging to maintain enough clients to support providing on-site primary care because their population often has their own primary care providers, and episodes of care are short. As a result, the CCBHC partners with external primary care providers and co-locates a CCBHC therapist in the primary care provider office.

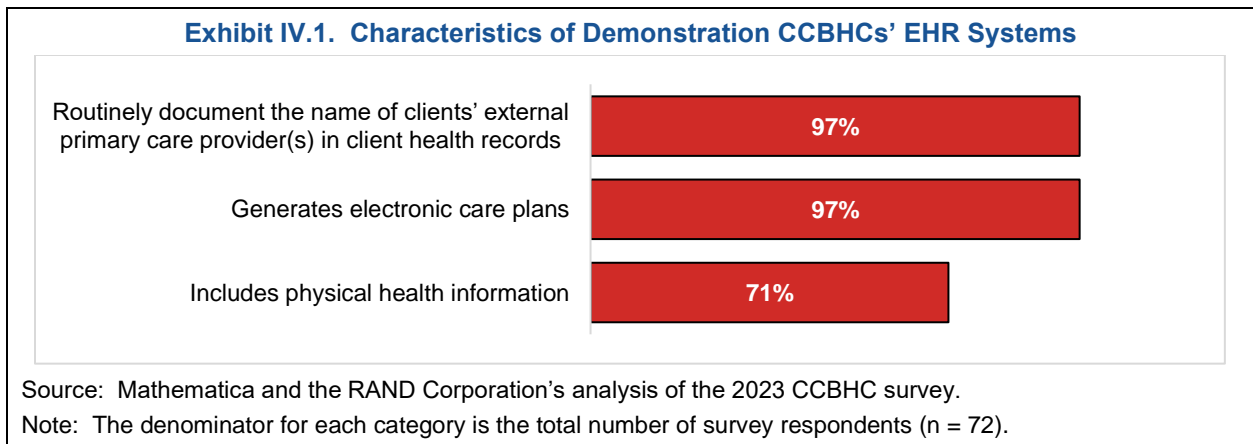
## **B. Care Coordination Activities within the Certified Community Behavioral Health Clinic**

**Overall, state officials reported that CCBHCs are successfully coordinating care across individual providers within a CCBHC, and officials generally perceived CCBHCs' efforts to coordinate care internally as improving the care provided to clients.** For example, New York officials noted that most people who require SUD services receive their mental health and SUD services from the same CCBHC clinician, allowing a single person to coordinate those services. Occasionally, separate CCBHC clinicians will provide care, but they will do so in a highly coordinated way and use a single treatment plan. Similarly, an Oregon official appreciated that staff are able to identify the needs clients have and work together as a team to “wrap the individual in a more holistic approach.” In Nevada, officials reported that care coordination occurs seamlessly between different CCBHC staff, such as peer specialists and clinicians. Officials said that consumers seem to be satisfied with CCBHC services according to surveys, and CCBHCs have reported a “remarkably low” number of hospitalizations, suicide attempts, and completed suicides during officials' annual reviews.

**State officials highlighted several ways that CCBHCs have worked to improve care coordination, such as increasing capacity among staff to coordinate care and using certain tools (including EHRs):**

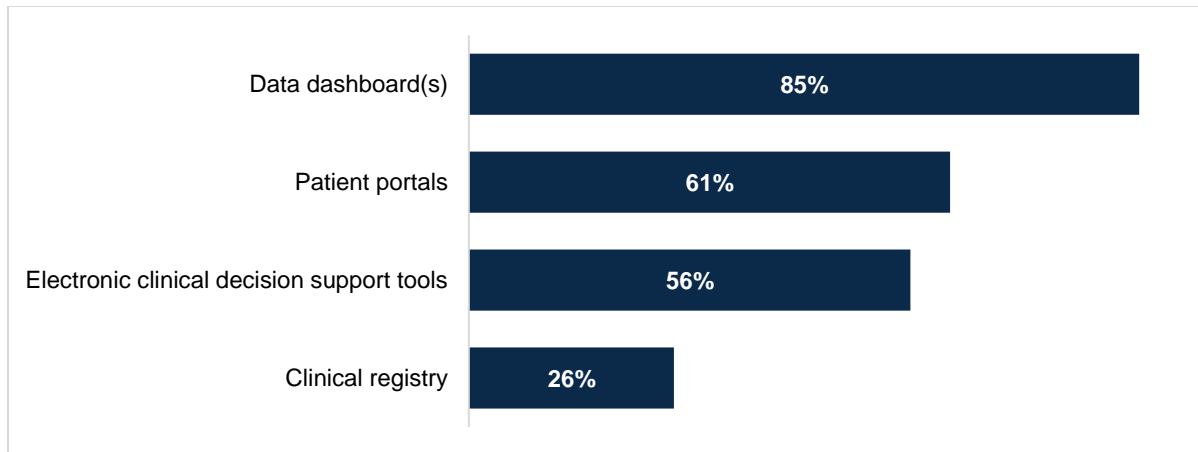


- Increasing staff capacity.** A Michigan official noted that many CCBHCs have hired dedicated nurses to help coordinate and manage care, especially to help those with less severe or chronic mental health conditions, which is a new population for these clinics. The official explained that medication management for those with mild or moderate disorders shifted to the CCBHCs and away from other prescribers, so nurses help track and monitor care for these clients. The official reflected that the nurses’ check-ins with clients improve retention and the quality of care. Nurses keep people engaged and connected to physical and behavioral health care and their prescriptions filled. A New York official similarly recounted that some CCBHCs hired additional medical staff to conduct lab work and collect blood samples earlier in the demonstration so they can monitor people’s chronic medical conditions, and other CCBHCs have partnered with or applied for Federally Qualified Health Center (FQHC) status to better coordinate or directly provide care for physical health conditions.
- Use of tools to coordinate care internally.** EHRs and other information technology tools, for example, help CCBHCs share information internally among providers and calculate quality measures that could inform care coordination efforts. Nearly all (97 percent) CCBHCs reported that their EHR systems generate electronic care plans, a slight increase from 2019 when 92 percent of CCBHCs reported this function (Exhibit IV.1; 2019 data not shown). A similar percentage reported that providers routinely document the name of clients’ external primary care providers in client health records. A smaller share of CCBHCs reported that their EHRs contain physical health information (71 percent) (Exhibit IV.1). States varied somewhat in their availability of physical health information in the EHR, ranging from 29 percent of CCBHCs in New Jersey to 100 percent of CCBHCs in Kentucky, Nevada, and Oklahoma (Appendix Exhibit C.6).



In addition, most CCBHCs reported using data dashboards (85 percent) and patient portals (61 percent). Such tools might be used to support clinical information sharing between providers within clinics and with clients (Exhibit IV.2).

**Exhibit IV.2. Percentage of CCBHCs Reporting Use of Specific HIT Tools**



Source: Mathematica and the RAND Corporation's analyses of the 2023 CCBHC survey.

Note: The denominator for each category is the total number of survey respondents (n = 72).

Officials from the demonstration states that began participating in 2017 reflected on CCBHCs' challenges working with HIT vendors throughout the demonstration to enhance or implement systems that could support care coordination. New York and Nevada officials shared the difficulty over time of updating EHRs to support the demonstration. A New York official noted that over the last six years, many CCBHCs have switched EHR vendors, indicating that EHR updates have been particularly challenging to navigate. CCBHCs must see each time whether the vendor is willing to make a particular update and then whether it will incur an additional cost. For example, one change CCBHCs needed to make was adding staff to clients' treatment plans in the EHR. CCBHCs have made sure that all CCBHC staff involved in a client's care--from behavioral health and SUD clinicians to care managers and peer specialists--are able to review progress notes. A Nevada official said that working with EHR vendors has been challenging in their state as well; CCBHCs invest in updates that come with an extra cost, and they do not always get what they expect. The official, however, noted that one CCBHC was planning to try a new EHR designed specifically for CCBHCs that would have more care coordination functionality and include live dashboards to track the CCBHCs' quality measures.

A Missouri official also shared that some CCBHCs have changed EHRs over time. CCBHCs have encountered issues with securing technology support for their dashboards. An official from Oregon noted that although most CCBHCs have internal dashboards or are in the process of building them, it has been more challenging to find analysts who can build interactive dashboards in rural areas. Some CCBHCs have needed to use Excel, which the official says can be "clunky and difficult."

### **C. Care Coordination between Certified Community Behavioral Health Clinics and External Providers and Partners**

**CCBHCs have established and maintained formal (non-DCO) and informal relationships with a wide variety of external providers, with some variation over time.** In 2023, CCBHCs most frequently reported formal (non-DCO) relationships--for example, relationships that involve a memorandum of understanding or letter of agreement between the CCBHC and outside organization--with schools (86 percent), mental health/drug courts (79 percent), adult criminal justice agencies/courts (76 percent), FQHCs (72 percent), emergency departments (71 percent), and employment services or supported

employment (69 percent). CCBHCs also reported informal relationships with various providers, ranging from 19 percent with an informal relationship with mental health/drug courts to 56 percent with informal relationships with juvenile justice agencies and primary care providers. (Exhibit IV.3).

Exhibit IV.3. Percentage of CCBHCs with Formal and Informal Relationships with External Organizations, by Type					
Provider Type	Percentage Reporting a Formal Relationship		Percentage Reporting an Informal Relationship		Percentage of CCBHCs Reporting a Formal and/or Informal Relationship
	2019	2023	2019	2023	2023
Federally Qualified Health Centers	59	72	26	28	92
Rural Health Clinics	32	21	20	31	50
Primary Care Providers	62	58	41	56	99
Urgent Care Centers	41	28	36	47	69
Emergency Departments	73	71	30	40	97
988 Suicide & Crisis Lifeline Call Center	N/A	61	N/A	24	85
Suicide and Crisis Hotlines and Warmlines	45	58	24	32	85
Residential (non-hospital) Crisis Settings	47	44	32	43	83
Inpatient Psychiatric Facilities	68	63	39	43	94
Psychiatric Residential Treatment Facilities	53	58	45	42	93
Substance Use Disorder Residential Treatment Facilities	61	60	36	44	97
Medical Detoxification Facilities	54	44	42	49	86
Ambulatory Detoxification Facilities	45	47	41	46	86
Post-Detoxification Step-Down Facilities	42	42	41	42	79
Hospital Outpatient Clinics	42	43	52	51	86
Medication-Assisted Treatment Providers for Substance Use	53	65	38	36	96
Opioid Treatment Program	N/A	47	N/A	51	90
Schools	79	86	18	22	97
School-Based Health Centers	42	35	18	38	67
Child Welfare Agencies	55	57	47	47	97
Therapeutic Foster Care Service Agencies	39	33	47	50	81
Juvenile Justice Agencies	52	46	44	56	93
Adult Criminal Justice Agencies/Courts	68	76	29	29	99
Mental Health/Drug Courts	76	79	24	19	93
Law Enforcement	53	65	47	42	99
Indian Health Service or Other Tribal Programs	17	32	20	22	49
Indian Health Service Youth Regional Treatment Centers	6	13	15	24	35
Department of Veterans Affairs Treatment Facilities	50	50	39	46	92
Homeless Shelters	44	44	47	53	90
Housing Agencies	61	61	38	46	96
Employment Services or Supported Employment	52	69	36	31	93

Exhibit IV.3 (continued)					
Provider Type	Percentage Reporting a Formal Relationship		Percentage Reporting an Informal Relationship		Percentage of CCBHCs Reporting a Formal and/or Informal Relationship
	2019	2023	2019	2023	2023
Older Adult Services	39	35	50	54	85
Other Social and Human Service Providers	52	47	47	53	93
Consumer-Operated/Peer Service Provider Organizations	44	44	46	39	78

Source: Mathematica's analyses of the 2023 CCBHC survey and CCBHC Annual Progress Report Demonstration Year 2 (March 2019).

Note: The denominator for each category is the total number of survey respondents (n = 72 and n = 66). CCBHCs could report formal and informal relationships with any provider type. Categories reported as N/A in 2019 were not included in the 2019 progress report.

Before March 2023, the CCBHC certification criteria specified that CCBHCs establish agreements outlining care coordination expectations with external organizations.<sup>22</sup> **CCBHCs have experienced varying degrees of success in setting up such formal agreements with different entities.** An Oklahoma official noted that CCBHCs have struggled to engage primary care in a formal memorandum of agreement, so they transitioned to a less formalized care coordination agreement. Nevada, New York, New Jersey, and Michigan officials all noted that it was difficult to establish agreements with local veteran facilities. A New York official explained that the local veteran hospitals did not feel they had the authority to sign an agreement without receiving approval from the federal U.S. Department of Veterans Affairs, which did not arrive. CCBHCs also have experienced varied success partnering with Tribal organizations. Although Michigan CCBHCs have well-established agreements with Tribal entities, a New York official noted that Tribal organizations in that state have resisted entering into formal agreements that result from a federally authorized demonstration because of their sovereignty. A Michigan official said that it has been difficult for CCBHCs to establish agreements with courts.

The quality of partnerships can vary as well. A Nevada official said that forging partnerships with law enforcement can be difficult, noting, for example, that if law enforcement brings someone to a CCBHC once and the person is not able to get the solution they need, they might not return. Nevada officials have also heard about difficulties with hospitals, sharing an anecdote that it took three days for a CCBHC counselor to learn that one of the CCBHC's clients was in a hospital, and then the hospital was resistant to allowing non-hospital staff in. Missouri officials provided examples of contextual factors that can influence the success of partnerships, such as a key contact in a partner organization leaving, causing a broken link.

Although they had some struggles establishing formal agreements or strong partnerships with specific entities, state officials also shared partnership successes. For example, in Missouri, if a person goes to a behavioral health crisis center outside their service area because it is closer to them, they will be referred to the CCBHC in their service area for follow-up care. A New Jersey official shared that other systems are increasingly interested in CCBHC services and CCBHCs have, for example, partnered with a system

<sup>22</sup> Although agreements are still expected and strongly encouraged, the revised CCBHC criteria will no longer require formal agreements; instead, the criteria focus on care coordination partnerships. SAMHSA has expanded the ways by which the partnerships can be documented to allow for more flexibility in situations in which a formal agreement cannot be executed.

of homeless shelters, a prison re-entry system, and organizations for refugees. According to the state official, the ready access to care at CCBHCs was especially appealing for the prisoner re-entry program for ensuring people are connected with care quickly (as opposed to the traditional model, the person described, of people being handed a card for a psychiatrist for an appointment two months later). A Nevada official shared that it was initially difficult to set up care coordination agreements with schools, but one CCBHC is now providing school-based mental health services in a designated office space.

Officials from the states that joined more recently, Kentucky and Michigan, reported having firm foundations for meeting the agreement requirements of various external organizations. A Kentucky official said that CCBHCs have historically had extensive formal agreements with many of the required entities, but not with primary care, so it has been a work in progress to enhance these relationships. Some of the state's CCBHCs have hired a nurse to develop a working relationship with external primary care providers and develop memoranda of understanding for information sharing. Similarly, a Michigan official noted that although many CCBHCs have had well-established care coordination

"I think the CCBHCs working with individual school districts... are in the process of working out who can do what and how can they best complement each other and spell it out very clearly in the agreement so they aren't competing over Medicaid dollars and instead they're both looking at the needs of the school as a whole and who can best do what to meet the needs of all those kids."

-- Michigan state official

policies with external providers, formalizing these partnerships has helped to clarify expectations. Original demonstration states have also experienced benefits from these required partnerships. For example, a New York official recounted hearing from CCBHC staff earlier in the demonstration that the care coordination requirement had prompted them to forge partnerships with service agencies they had not had the time to establish relationships with yet, and this connection has helped them better serve people regardless of whether the outreach resulted in a formal agreement.

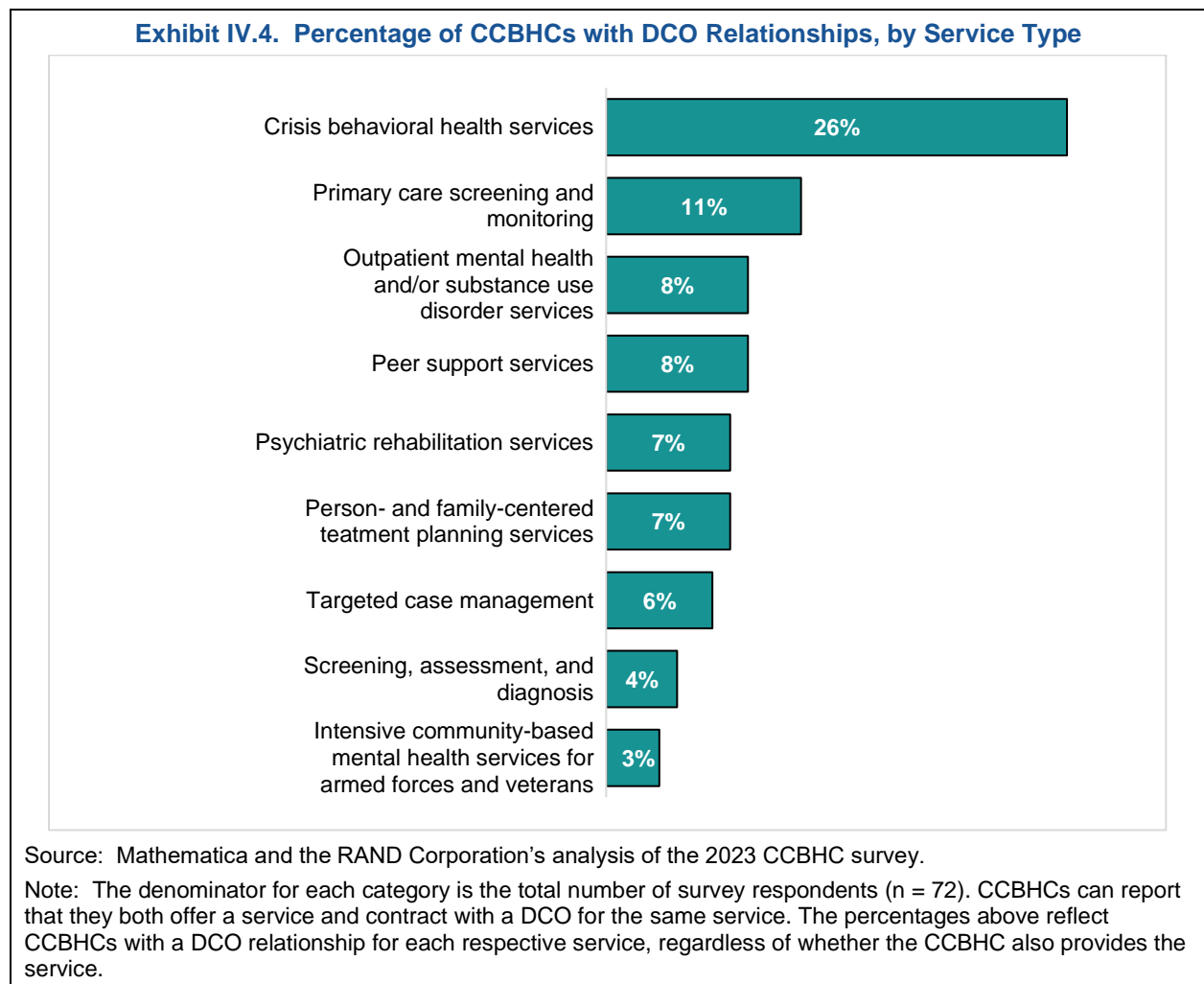
**States provide support to CCBHCs to help them meet certification requirements for formal care coordination agreements with various external organizations and providers.** For example, Nevada officials reported having clinics complete a care coordination checklist as part of the state's ongoing oversight. The state uses this to assess whether CCBHCs' care coordination agreements are current, formal, and being used. If CCBHCs do not have an agreement with one of the required external partners, states ask to see evidence of their outreach, such as letters and meetings. A New York official similarly shared that as part of its updated needs assessment last year, the state checked whether the agreements between CCBHCs and other providers were still in place and, if they were not, that CCBHCs were working to restore them. The state also checked whether there were new providers in the community with which CCBHCs should have agreements. Kentucky, a newer demonstration state, has been encouraging CCBHCs to revisit their long-standing agreements with various entities from before joining the demonstration to make them more specific and better meet the criteria. The state has communicated to CCBHCs that enhanced relationships with community providers are an expectation of the demonstration.

Some states have developed tools to support CCBHCs in developing and maintaining care coordination agreements. For example, an Oklahoma official noted that their state created an agreement form that CCBHCs can use with schools to address concerns about not duplicating services and ensuring client's choice of providers. Similarly, Michigan has provided examples of agreements to CCBHCs as part of their technical assistance. The state has also offered a few trainings with primary care providers and

FQHCs to discuss what these relationships should look like and how CCBHCs and these entities can work together.

### **CCBHCs' Use of DCOs**

**As in previous evaluation years, DCO relationships remain relatively uncommon across demonstration states, and state officials reported that this has remained relatively consistent over the course of the demonstration.** CCBHCs most frequently established DCO relationships to provide crisis behavioral health services (26 percent). Only 11 percent of CCBHCs used DCOs for primary care screening and monitoring, and less than 9 percent of CCBHCs leveraged DCO relationships for the other required CCBHC services (Exhibit IV.4).



CCBHCs in Kentucky, Nevada, and Oklahoma do not have any DCO arrangements (Appendix Exhibit C.11). A Nevada official explained that the state reviewed CCBHCs' various contracts with external entities in late 2022 and assessed whether any were DCO arrangements. The official learned in the process that CCBHC staff prefer to offer services themselves because they feel it is easier to coordinate services and they would rather get paid for services than pay others, consistent with reports from state

officials in early DYs that CCBHCs preferred to provide services directly (Brown et al. 2021). In addition, there have been some quality issues for non-DCO contracted services in the past that have required corrective action. Some CCBHCs leaders were concerned about how working with DCOs would affect cost reporting.

Other states reported that CCBHCs have some DCO arrangements. For example, Missouri requires CCBHCs to provide all services directly except for crisis services; DCO arrangements have been working well because the CCBHCs had existing relationships with their DCOs, which are crisis call center providers. As noted previously, New York CCBHCs also have some DCO arrangements for crisis services; the PPS covers the administrative cost of the crisis service partner to report back to CCBHCs about services delivered rather than paying for the actual crisis services because counties fund the crisis services in certain areas with state funds.

In contrast with other states that use DCOs more sparingly or not at all, Michigan CCBHCs use DCO arrangements for a variety of services, including SUD and crisis services.<sup>23</sup> In fact, 38 percent of the state's CCBHCs use DCOs to provide person- and family-centered treatment planning services and outpatient mental health or SUD services, and 31 percent provide psychiatric rehabilitation services, peer support services, or TCM through DCOs. The state originally allowed its CCBHCs to establish DCOs that provide any service if the CCBHC had capacity to provide at least five of the required services directly. Now the state is reconsidering this approach and trying to put parameters in place so the use of DCOs does not, according to an official, "spiral out of control." The state is considering making sure CCBHCs' community needs assessments support the use of DCO arrangements to provide certain services, and the state also wants to ensure that people have the same access to CCBHC services regardless of their point of entry so that if someone comes to a DCO seeking CCBHC services, that person will be connected to the CCBHC immediately for a same-day appointment. In general, though, officials felt DCO arrangements are working well in the state. CCBHC leaders have commented on the added administrative burden of billing on behalf of DCOs, but state officials believe this financial oversight role also helps to naturally curb growth in the use of DCOs. The state official noted that many CCBHCs have a dedicated nurse to help manage care and help with care coordination, particularly for clients being served in DCOs.

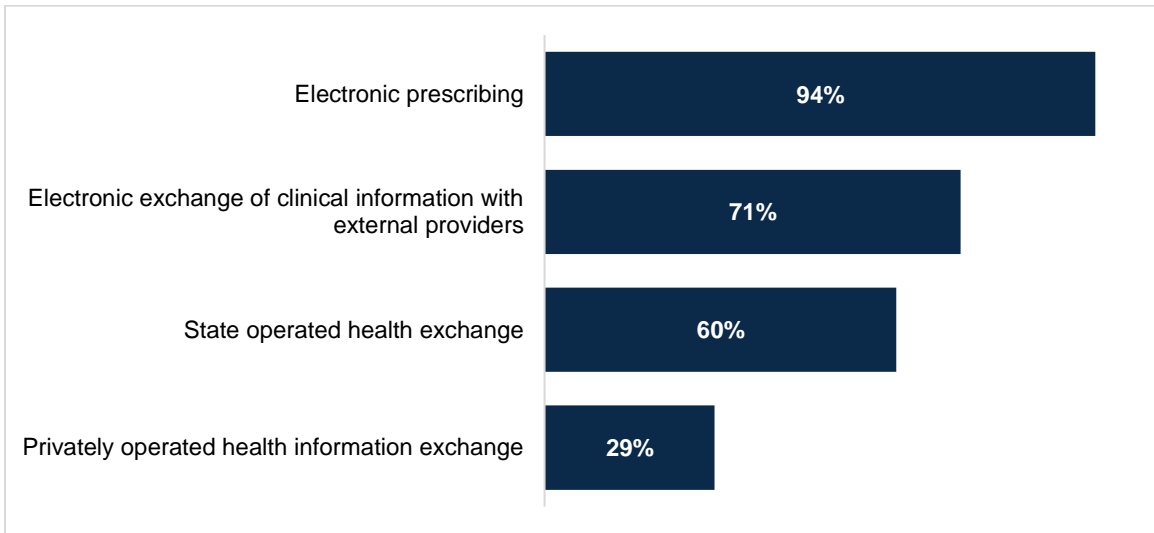
### ***Tools CCBHCs Use to Coordinate Care Externally***

In addition to using HIT to facilitate coordination internally, CCBHCs use a variety of tools to share information externally, coordinate care with outside providers and organizations, and improve coordination of care transitions. State officials reported that CCBHCs in most states have access to a HIE or other statewide platform or data clearinghouse, but not all CCBHCs responding to the survey reported using these exchanges. In all, 60 percent reported using state-operated HIEs, and 29 percent reported using privately operated exchanges. In addition, 71 percent of CCBHCs reported they exchange clinical information with external providers electronically. Most CCBHCs (94 percent) prescribe medications electronically (Exhibit IV.5).

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<sup>23</sup> Federal guidance at the beginning of the demonstration required CCBHCs to provide four of the nine service types directly; however, a determination by HHS when Michigan joined the demonstration concluded that CCBHCs are not required to directly provide any service type. This may, in part, explain the higher number of DCOs in Michigan. However, consistent with findings in previous reports (Wishon et al. 2023; Brown et al. 2021), officials in original states have continued to report a strong preference among CCBHCs to provide services directly despite increased flexibility in the types of services DCOs can provide.

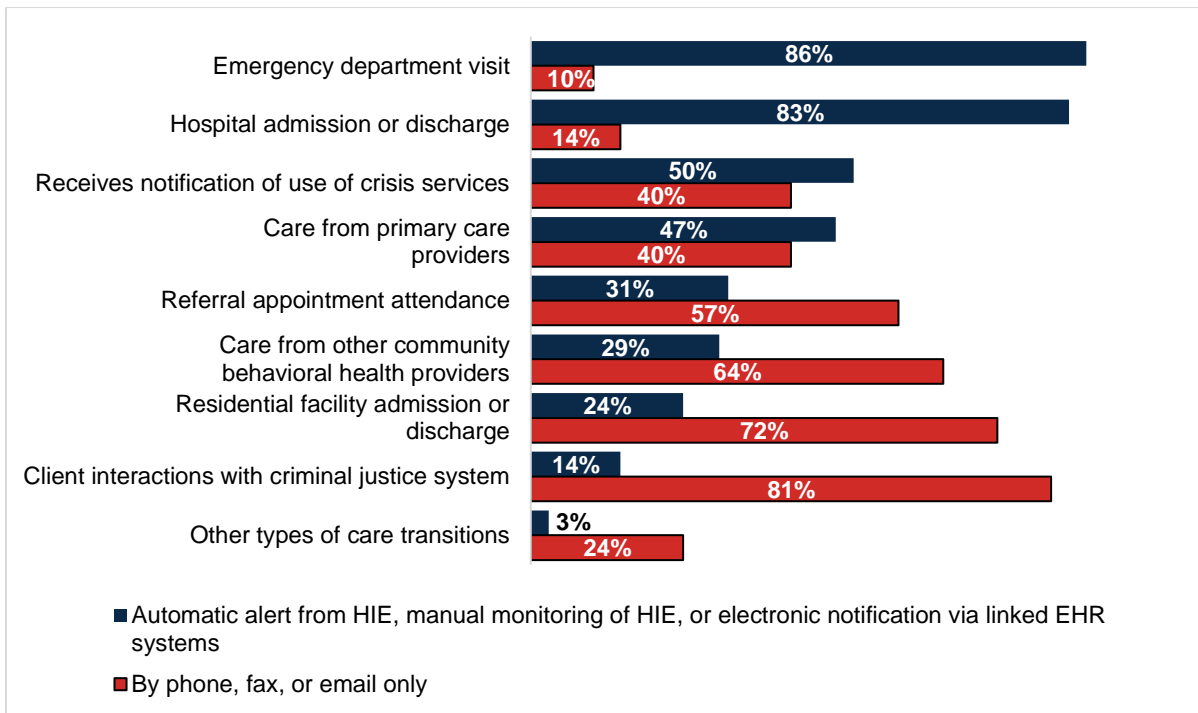
**Exhibit IV.5. Percentage of CCBHCs that Use HIT Connected to Outside Providers or Exchanges**



Source: Mathematica’s analyses of the 2023 CCBHC survey.

Note: The denominator for each category is the total number of survey respondents (n = 72).

**Exhibit IV.6. Percentage of CCBHCs that Receive Notifications about Client Care Transitions, by Type of Service**



Source: Mathematica’s analyses of the 2023 CCBHC survey.

Notes: The denominator for each category is the total number of survey respondents (n = 72). Within each category, percentages might not sum to 100% because CCBHCs either do not receive notifications for that care transition type or reported “other” method of receiving notification about clients’ care transitions. CCBHC responses regarding “other” methods included information obtained via daily care coordination, co-located service providers, or tracking EHR updates.



More than 80 percent of CCBHCs learn of clients' emergency department visits or hospital admission or discharge via automatic alerts from HIEs, manual monitoring of exchanges, or from automatic alerts from linked EHR systems. They are less likely to learn of care transitions via phone, fax, or email for emergency department visits and hospital use (10 percent and 14 percent, respectively). In contrast, most CCBHCs rely on phone, fax, or email to receive notifications of care from other community behavioral health providers (64 percent), residential facility admissions (72 percent), or client interactions with the criminal justice system (81 percent) (Exhibit IV.6).

Although several state officials described integrated electronic systems, some state officials highlighted areas for improvement, varied uptake in their state, and the role of care coordination agreements in ensuring information transfers:



**Kentucky** offers a HIE, but only some CCBHCs use it. Officials noted that with the variety of EHR systems, it is difficult for various providers to use it. The state is working through some challenges related to transmitting SUD information because that information is protected differently. Officials noted, however, that all CCBHCs can transmit and receive data from local hospitals, either electronically or via phone call if a CCBHC client is discharged or admitted. Some CCBHCs also receive daily reports from psychiatric hospitals.



**Michigan** has a HIE that serves as a clearinghouse for what services people are using and provides admission, discharge, transfer (ADT) alerts and information on crisis service utilization. The state also has a system that enables CCBHCs to share some limited documents with a client's next provider to facilitate care coordination.



**Missouri** offers a statewide care manager system that generates alerts when people with Medicaid are in the hospital or emergency department. Community behavioral health liaisons use this tool for their work, and CCBHC staff also use this tool for conducting independent assessments for the state's child welfare division.<sup>24</sup> Some CCBHCs also subscribe to one of the four HIEs in the state. The state is launching a statewide open beds platform in phases. As part of the platform, it has rolled out crisis modules for mobile response dispatch and will implement a referral module next to enable CCBHCs (and other providers) to refer out clients and receive new clients via referrals. At the time of the interview, the state was piloting this module with partners from the Department of Corrections. The last module will help identify open residential beds.



In **New Jersey**, all CCBHCs have access to the statewide HIE and receive ADT alerts, but they vary in the extent they can input or export other data.

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<sup>24</sup> As an example of a recent technology-related care coordination scenario, Missouri's care manager tool has traditionally given agencies 30 days of notice before an individual's redetermination for Medicaid. During the PHE, this feature was shut off. With the ending of the PHE, the state faced difficulties turning the feature back on, so it has had to rely on traditional fixes until it can get the technology working again.



**Nevada** noted that although CCBHCs have access to a HIE, information is limited, and it is not widely used. CCBHCs do not receive ADT type data because hospitals do not have access to a list of CCBHC clients.



**New York** offers a HIE that CCBHCs can join. In addition, most CCBHCs have care coordination agreements with area hospitals, which officials noted stipulate that the CCBHC should be notified when their clients are admitted or discharged. The state's Office of Mental Health provides a web-based application that uses Medicaid claims history and HIE data to provide information to CCBHCs and other providers on clients' service utilization, labs, and medications filled at specific pharmacies. It enables CCBHCs to identify people who might require additional care.



In **Oklahoma**, starting July 1, 2023, every provider must participate in a new statewide HIE. CCBHCs will receive alerts in real-time once the exchange goes live. Before this, CCBHCs had access to elevated care alerts that were limited to the state-operated system, such as state-run inpatient facilities. The state also sends every CCBHC client's physical health, mental health, and dental and pharmacy claims each month to a population health management platform. The platform conducts predictive analysis and places clients in different registries based on behavioral health and physical diagnoses. CCBHC staff can use the application to inform outreach and follow-up care.



Oregon offers a statewide platform that notifies CCBHCs when people on their client registries are admitted. Every clinic receives a list in the morning and has a specific team meet to talk about and address it. Currently, the platform does not include interactions with the crisis system, but they are hoping that the mobile crisis SPA will allow them to track that as well.

CCBHC staff might also coordinate care with other providers through shared EHRs. For example, an Oklahoma official noted that the demonstration CCBHCs have robust EHRs, and two are on an EHR that has a module that enables them to obtain treatment records from other providers. An Oregon official noted that the CCBHCs that share an EHR with multiple types of community providers are able to access information more easily than other CCBHCs that do not have a shared EHR, though the latter might need to do records requests instead of accessing the information seamlessly. The official noted that care coordination is a statewide challenge because of infrastructure limitations. External care coordination can differ by region and what resources are available. Rural CCBHCs have an easier time coordinating care because there are fewer providers with whom to develop relationships, whereas urban CCBHCs might need to strategize and identify the top providers clients are using and focus on developing relationships with them. The official noted that one CCBHC in a rural area has an App that enables real-time HIPAA compliant communication with local providers, including a FQHC that is co-located and an emergency room across the street.

#### **D. Certified Community Behavioral Health Clinics' Care Coordination Efforts and Outcomes**

Overall, state officials thought CCBHCs' internal and external care coordination efforts have improved care. For example, a New York official noted that when they have conducted audits and staff interviews, they have heard anecdotally that clients find it helpful to have so many services provided in-house. The

official explained that staff use warm handoffs to introduce certain staff even if the client is not interested yet. Staff can view each other’s notes, schedule internally, and communicate with each other about treatment planning, which ultimately benefits clients. An Oregon official appreciated that staff can “identify the needs of clients and work as a team.”

State officials generally thought CCBHCs’ external care coordination efforts improved outcomes, and they shared a variety of reflections and statistics. A Missouri official noted that CCBHCs have experienced a 41 percent increase in total referrals from law enforcement from July 2021 to June 2022. The official also noted that the state has seen a reduction in hospital readmissions and emergency department usage because of hospital follow-ups, which CCBHC staff have done for some time and have excelled at. A Michigan official noted that some clinics have built strong relationships with law enforcement, and now law enforcement is better aware of their services and can use them as a one-stop-shop. A New Jersey official said that CCBHCs have very good client retention, likely in part because of strong external care coordination efforts.

“We had a clinic [that] talked about coordinating with external providers to be able to help a client who had been released to the streets from the hospital and was stuck and had nowhere to go, and they were able to... through coordinating with their community partners... (a) know that had happened and then; (b) go pick this person up and get them connected to where they needed to be in a safe place for them to recover from the surgery that they had...”

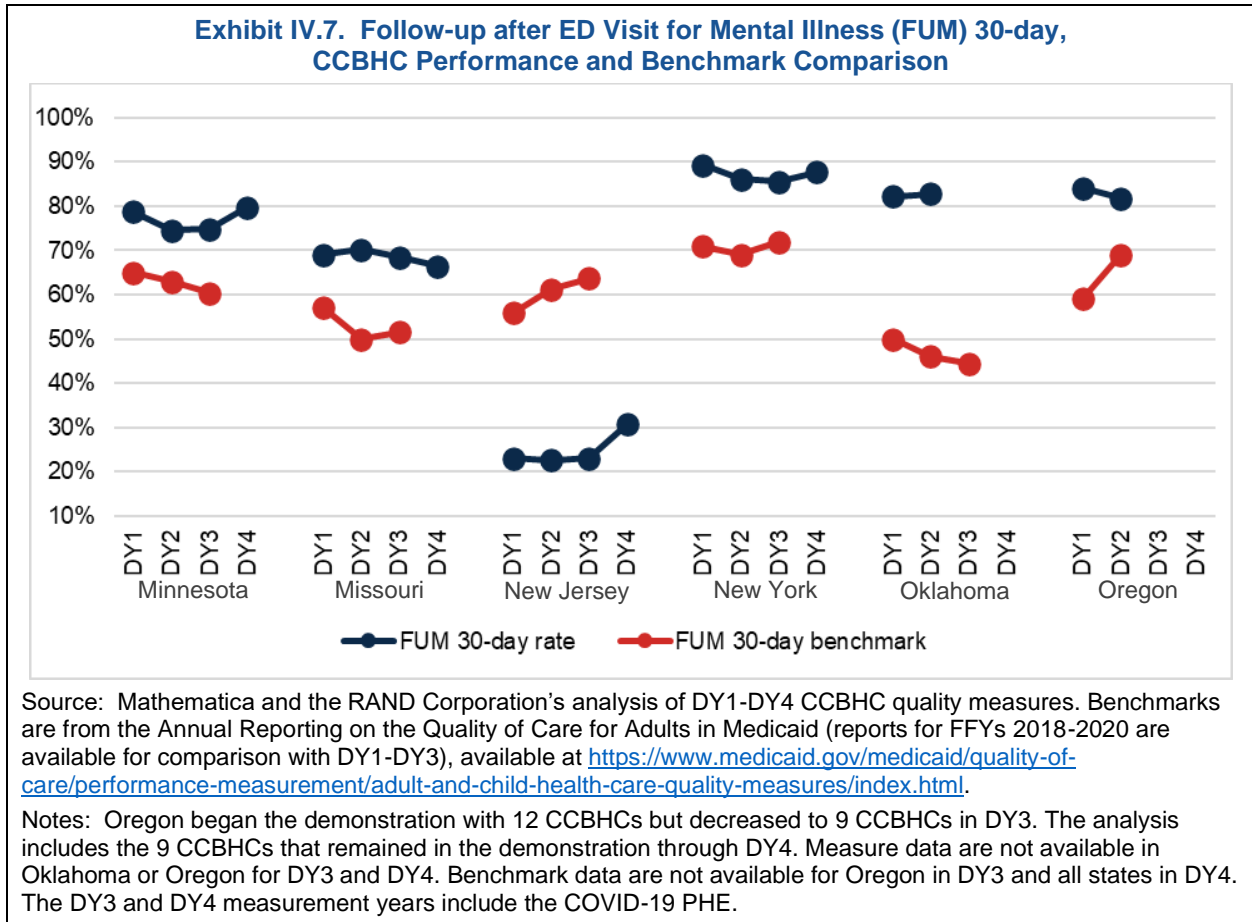
*-- Oregon state official*

Care coordination-related quality measures might also shed light on the effect of CCBHC care coordination activities. For example, after an individual has an acute episode of care involving a visit to an emergency room or an inpatient hospitalization for a mental illness, it is important to continue care on an outpatient basis in the community to ensure that the person receives needed ongoing care and support. The CCBHC requirements relating to care coordination with external providers are intended to address these critical transition periods, and several quality measures that CCBHCs and states are required to report address their effectiveness in doing so. Two measures assess whether there was a timely outpatient mental health visit following an emergency department visit for a mental health or SUD, and two measures assess whether there was a timely outpatient mental health visit following discharge from a hospital stay for a mental illness.

Aggregate performance on the care transitions measures was relatively stable, ranging no more than three percentage points over DYs. Follow-up within 30 days after an emergency department visit for a mental illness ranged from 68 percent to 71 percent across DYs, and follow-up within 30 days after an emergency department visit for a SUD ranged from 37 percent to 40 percent. These performance results were substantially higher than the national benchmark data for the same measures (54 percent for mental health visits and 20 percent to 23 percent for SUDs). Performance on follow-up after an emergency department visit was between 60 percent and 90 percent across states except for New Jersey, where performance was 21 percent for DY1 to DY3 and then rose to 31 percent in DY4. Similarly, performance was higher relative to the state benchmarks in all states except New Jersey. New Jersey state officials mentioned that the state recognized poor performance on follow-up measures and required CCBHCs to conduct quality improvement projects in 2022. Officials reported some improvement in measure performance as a result.

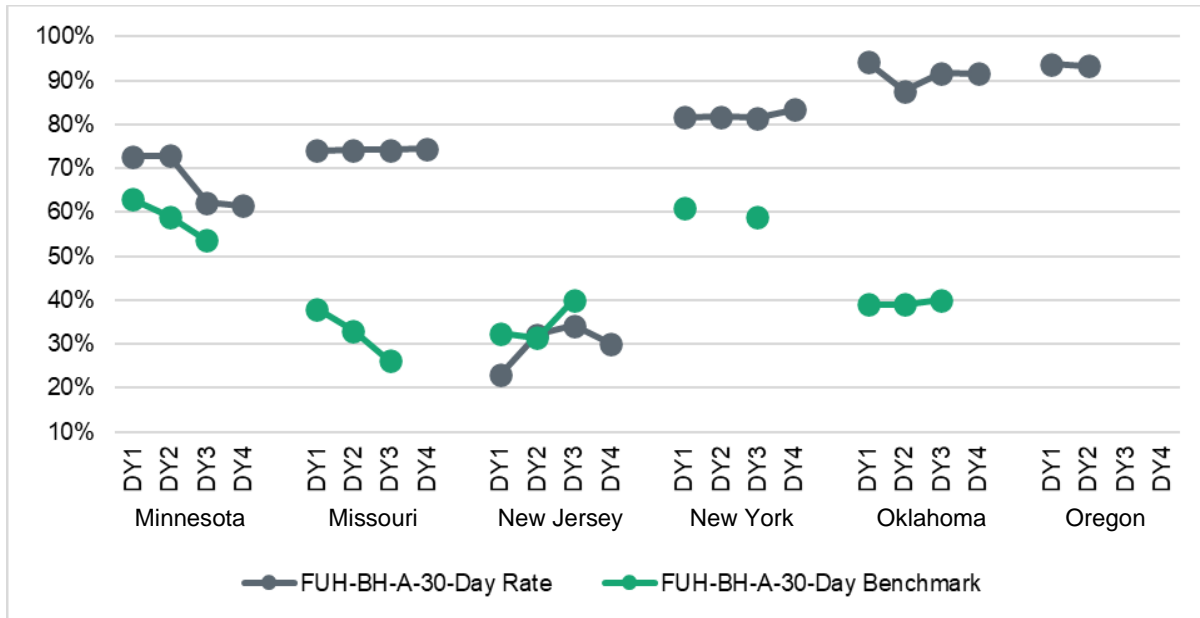
Outpatient visits within 30 days of discharge from a hospitalization for a mental illness ranged from 73 percent to 76 percent for adults and 77 percent to 80 percent for children. Performance on these measures was also substantially higher than the national benchmarks, which ranged from 52 percent to 58 percent

for adults and from 65 percent to 66 percent for children. Performance on all four measures for all demonstration states are available in Appendix B.



Results for follow-up after hospitalization for a mental illness were similar, with relatively consistent performance across years within states and variation across states ranging between 60 percent and 95 percent except for New Jersey. Performance for New Jersey CCBHCs was lower, ranging from 23 percent to 34 percent across DYs. Performance was higher than state benchmarks for most states and in most years for which data are available, with the major exception being New Jersey, where performance in CCBHCs was similar to state benchmarks.

**Exhibit IV.8. Follow-up after Hospitalization for Mental Illness (FUH-BH-A), Adult 30-day, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation’s analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports for FFYs 2018-2020 are available for comparison with DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. Measure data are not available for Oregon in DY3 and DY4. Benchmark data are not available in New York for DY2 or in Oregon for DY1-DY3. The DY3 and DY4 measurement years include the COVID-19 PHE.

## V. Quality of Care

Quality measure reporting provides clinics and state officials with standardized metrics to monitor the quality of care and inform quality improvement efforts. Quality measure reporting also has an important role in the context of the PPS. CCBHC payments are not linked to the provision of individual services. Rather, CCBHCs are paid the same amount regardless of the services they provided during the visit-day or visit-month. In this context, quality measurement provides a mechanism to ensure that quality of care does not suffer. Some states also used the quality measures to award QBPs to CCBHCs that met state-specified performance thresholds. To address the PAMA topic of quality of care provided by CCBHCs compared with other behavioral health providers, this chapter describes states' perceptions of the quality of care relative to other providers in the state and then presents an analysis of changes in quality measure performance for select measures in the first four DYs. We report states' award of QBPs based on quality measure performance and describe the ways CCBHCs and states have used quality measures to change clinical practice and improve quality of care.

### A. Changes in Quality of Care Over Time

When asked for their impressions of how the quality of care provided by CCBHCs compares with that provided by non-CCBHC behavioral health organizations in the state, officials from multiple states shared the perception that CCBHCs provide higher-quality care, citing the commitment to care coordination and the requirement to offer EBPs as primary attributes of the model that improve quality. Officials also generally believed quality of care provided by CCBHCs improved over time, re-emphasizing the model's expanded offerings and noting improvements in performance on quality measures.

For example, Oklahoma officials noted that care is less fragmented because CCBHCs provide everything someone needs in one stop; this includes expansion of crisis services in the last year. Officials also emphasized that CCBHCs provide more team-based care than non-CCBHCs. New Jersey officials noted that CCBHCs' attention to care coordination and awareness of community needs allow for organizational flexibility to respond to emerging community needs, such as coordinating with refugee organizations or sending nurses to clients' homes during the pandemic to ensure they were receiving their medications and had food. State officials from Missouri, New Jersey, and Nevada noted that the CCBHC model's focus on coordination and integration of SUD, mental health, and primary care screening and monitoring was especially helpful for people with co-occurring diagnoses. State officials from New Jersey reported that in addition to providing medication-assisted treatment (MAT) to people with SUDs, CCBHCs have also provided MAT to people with co-occurring SMI in significant numbers, which is a departure from care as usual for people with SMI, as most other mental health services providers in the state do not offer MAT. A Missouri official cited the success of one of the EBPs offered by its

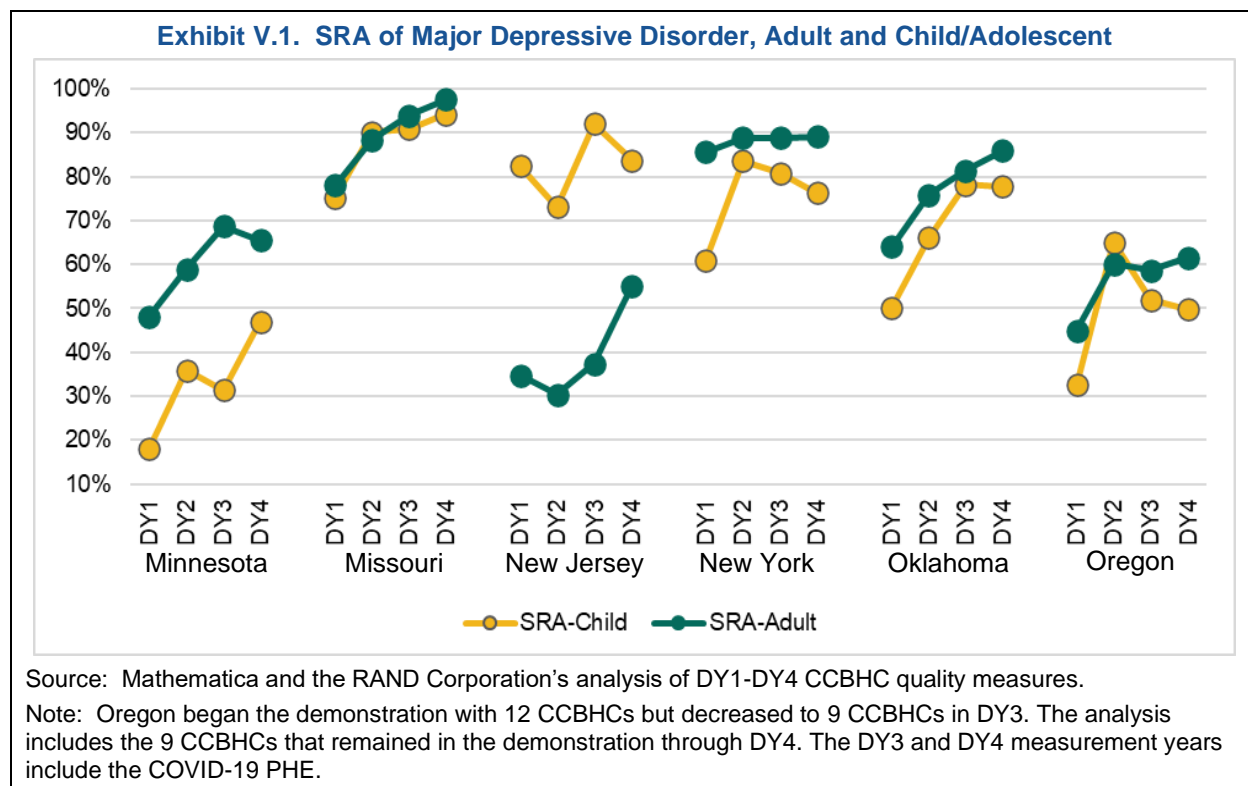
"Just their ability to go above and beyond the other non-CCBHCs in the state is significant, and one of the biggest things is they're able to provide screening assessment, treatment, medication management for children, adolescents, and adults, which essentially was a huge gap in services prior to this.... They're able to treat the whole person much better. Even though it's not a CCBHC requirement, they're able to diagnose medical conditions that are low risk [such as] athlete's foot... and be able to help with medication management on that too, so that's again huge that we don't have to send them down the street for an infection or sore throat... because they have a [physician assistant] in or a physician. They can write a script and that improves things significantly."

-- Nevada state official

CCBHCs, integrated treatment for co-occurring disorders (that is, combined treatment for SUD and other mental health disorders) when discussing the quality of care provided by CCBHCs relative to other providers.

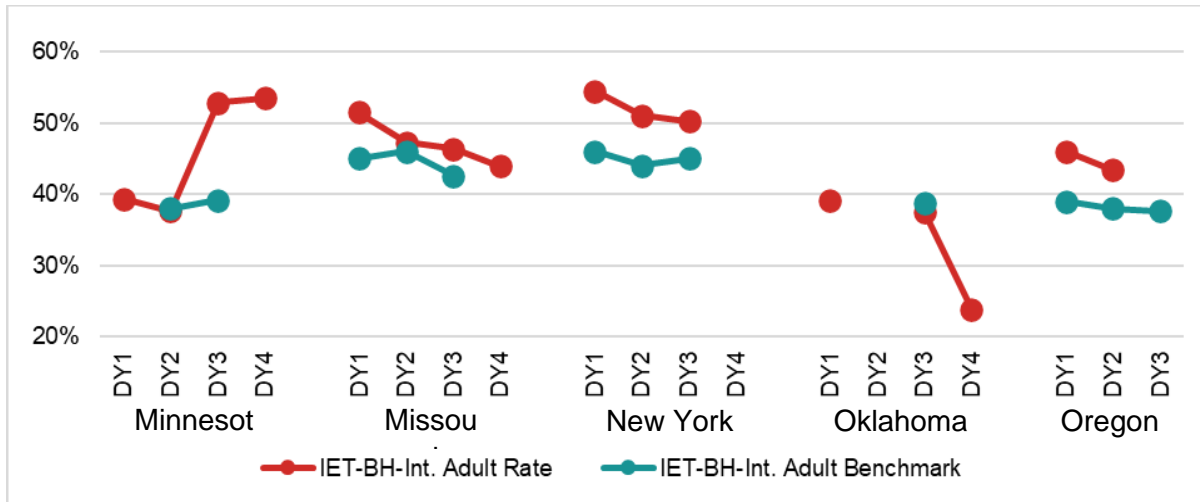
Several state officials cited improvements in quality measures over time relative to benchmarks when describing differences in care quality between CCBHCs and other behavioral health providers. For example, officials in Michigan noted that “preliminary comparisons of the quality metrics have shown that the CCBHCs have higher rates on many of those measures than... our Medicaid population as a whole, which we're able to compare using that state data.” In addition to the quality measure findings on access and care coordination included in Chapters III and IV, we report select quality measures related to several domains within the CCBHC scope of service requirements (behavioral health services, primary care screening and monitoring, and psychiatric medication management). Full data on quality measure performance for all required measures are available in Appendix B.

**Suicidality screening and follow-up.** Depression is a highly prevalent condition in children, adolescents and adults and is associated with many negative outcomes, including suicidal ideation and death by suicide (National Institute of Mental Health n.d.). Screening for suicide risk is important for efforts to prevent suicide (Velupillai et al. 2019). Across states, CCBHCs documented that they conducted a SRA in 82 percent of adults with major depressive disorder during the visit in which they identified a new depressive episode in DY4. CCBHCs documented that they conducted a SRA in 78 percent of visits with a child or adolescent with major depressive disorder in DY4. Aggregate performance on SRA-A and SRA-BH-C improved by over 20 percentage points from DY1 to DY4. (Exhibit V.1), but it is unclear what is driving this large change.



**Substance use screening and treatment.** CCBHCs provide screening and other services to identify people with SUDs and help engage them in substance use treatment. States reported the proportion of CCBHC clients who received treatment for alcohol and other drug treatment after diagnosis, reporting separately for initial (initiation phase) and subsequent (engagement phase) treatment. Across states, performance on the initiation and engagement components of this measure was similar to or exceeded available state benchmarks in all DYs. Performance on the engagement component was markedly higher than available benchmarks in some (three of five) states. For example, in Missouri, rates of treatment engagement for CCBHC clients were about twice as high as state benchmark rates in DYs with available benchmark data (Exhibit V.2). It is important to note, however, that performance was low across all states, with considerable room for improvement; there was no state that exceeded 60 percent performance for treatment initiation or 40 percent for engagement in any DY. States varied with respect to trends over time. In most instances, performance showed slight declines (within 5 percentage points) or moderate-to-substantial increases (more than 10 percentage points) on both initiation and engagement components from DY1 to DY4, suggesting improvements or relative stability in measure performance across DYs.

**Exhibit V.2. IET-BH Adult Initiation Phase, CCBHC Performance and Benchmark Comparison**

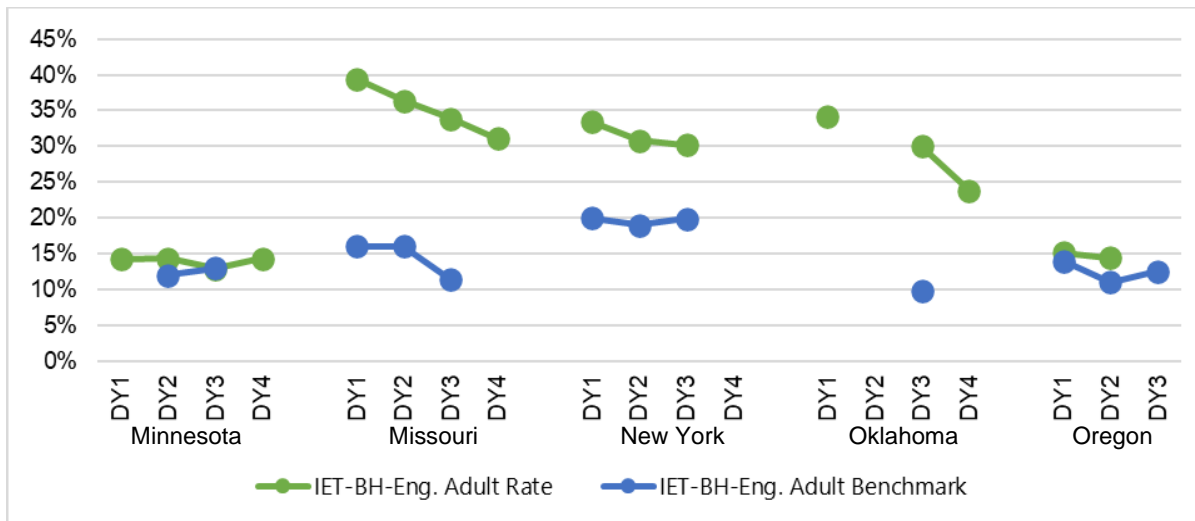


Source: Mathematica and the RAND Corporation’s analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports for FFYs 2018-2020 are available for comparison with DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in New Jersey DY1-DY4, New York DY4, Oklahoma DY2, and Oregon DY3 and DY4. Benchmark data are not available for Minnesota for DY1 or Oklahoma DY1 and DY2. The DY3 and DY4 measurement years include the COVID-19 PHE.



**Exhibit V.3. IET-BH Adult Engagement Phase, CCBHC Performance and Benchmark Comparison**

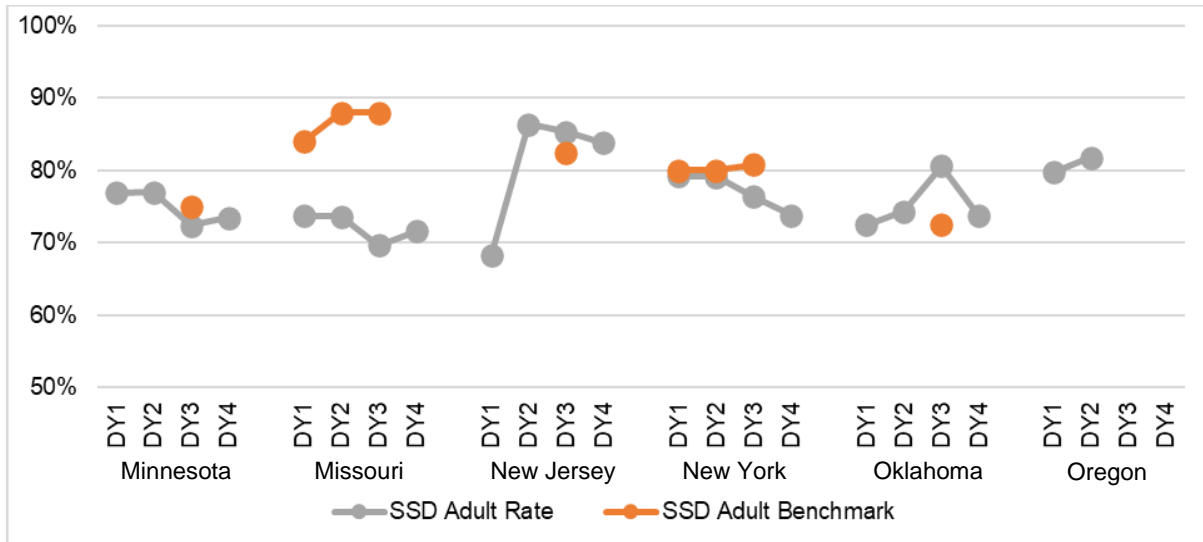


Source: Mathematica and the RAND Corporation’s analysis of DY1-DY4 CCBHC quality reports. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports for FFYs 2018-2020 for DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in New Jersey DY1-DY4, New York DY4, Oklahoma DY2, and Oregon DY3 and DY4. Benchmark data are not available in Minnesota DY1 or Oklahoma DY1 and DY2. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Primary care screening and monitoring.** Because of the elevated risk of metabolic conditions resulting from the use of antipsychotic medications, screening for diabetes among people with schizophrenia or bipolar disorder who take these medications is important for treatment planning and monitoring and reducing risk (for example, by adjusting psychiatric medications that might be contributing to the problem) (NCQA 2021). States reported the proportion of adult CCBHC clients with schizophrenia or bipolar disorder receiving antipsychotic medications who were screened for diabetes. Seventy-six percent of CCBHC clients with schizophrenia or bipolar disorder who received antipsychotic medications also received diabetes screening during DY1 and this remained stable through DY4 (74 percent). Performance on this measure was similarly stable from DY1 to DY4 in all states except for New Jersey and Oklahoma which improved in certain DYs (see Appendix Exhibit B.22). In New Jersey, performance improved by 18 percentage points from DY1 to DY2 and then stabilized. In Oklahoma, performance improved by 7 percentage points from DY2 to DY3. Among states with Medicaid Core Set benchmarks for DY1 to DY3, performance was similar to the benchmark in Minnesota, New Jersey, and New York, higher than the benchmark in Oklahoma, and lower than the benchmark in Missouri (Exhibit V.4).

**Exhibit V.4. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD), CCBHC performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation’s analysis of DY1-DY4 CCBHC quality reports. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports for FFYs 2018-2020 for DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

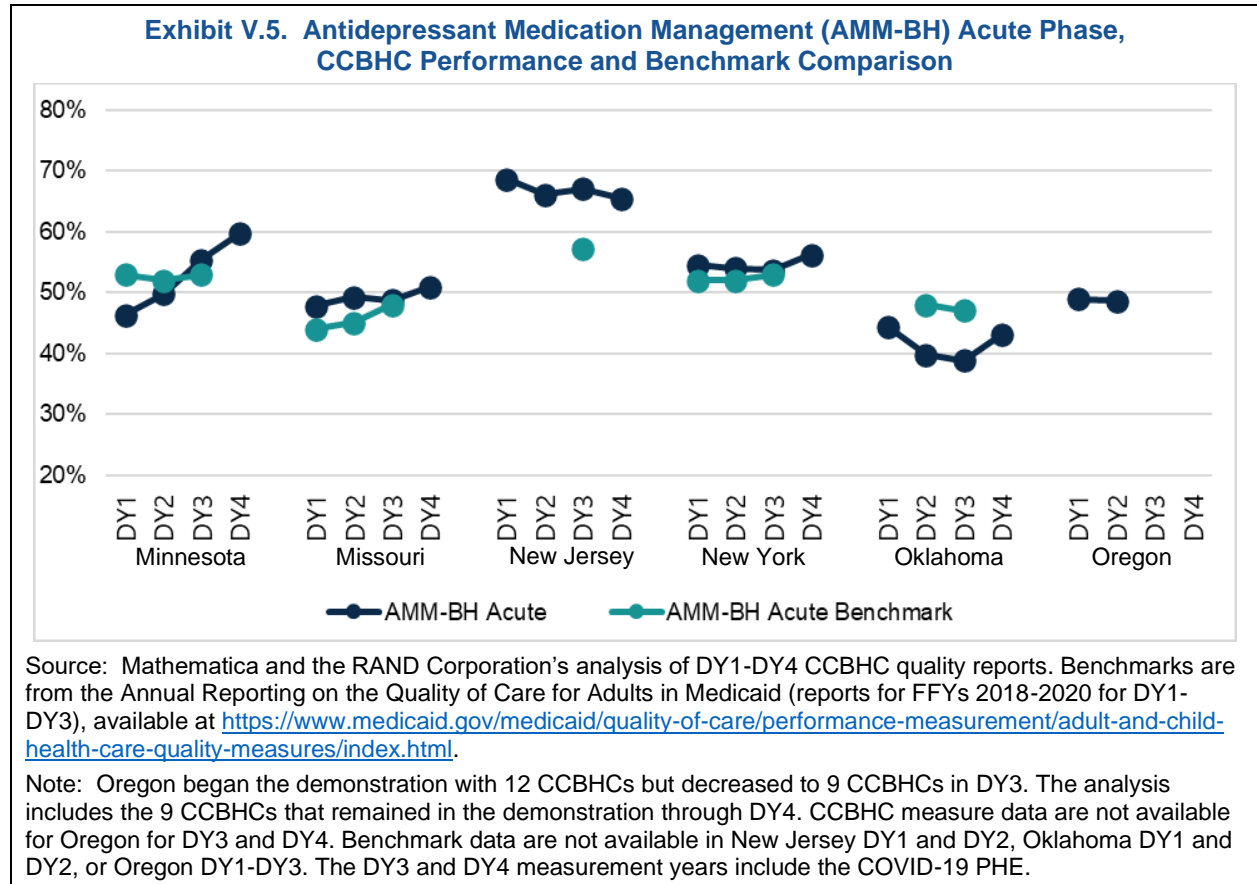
Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available for Oregon for DY3 and DY4. Benchmark data are not available in Minnesota DY1 and DY2, New Jersey DY1 and DY2, Oklahoma DY1 and DY2, or Oregon DY1-DY3. The DY3 and DY4 measurement years include the COVID-19 PHE.

CCBHCs reported the proportion of adults screened for body mass index and, if body mass index was elevated, the proportion for whom a follow-up plan was documented. They also reported the proportion of children and adolescents for whom they documented body mass index percentile. Across states, there was an increase in performance on these measures from DY1 to DY2 and then a decrease in performance from DY3 to DY4. CCBHCs staff completing the quality measure reports noted that the COVID-19 PHE had an effect on physical health screening workflows and in-person visits, so decreases in performance on these two measures is as expected (Exhibit not shown; see Appendix B).

**Psychiatric medication management and adherence measures.** Medication non-adherence (that is, not taking medication as prescribed) is common and can increase risk for negative outcomes (for example, worsening of symptoms and hospitalization) among people prescribed psychiatric medications (Hassan et al. 2009). Efforts to monitor and support medication adherence are associated with improved treatment outcomes (NCQA 2023). States reported on adherence to antidepressant medication in people with major depression. This measure includes two phases: acute (maintaining use for at least 12 weeks) and continuation (maintaining use for six months).

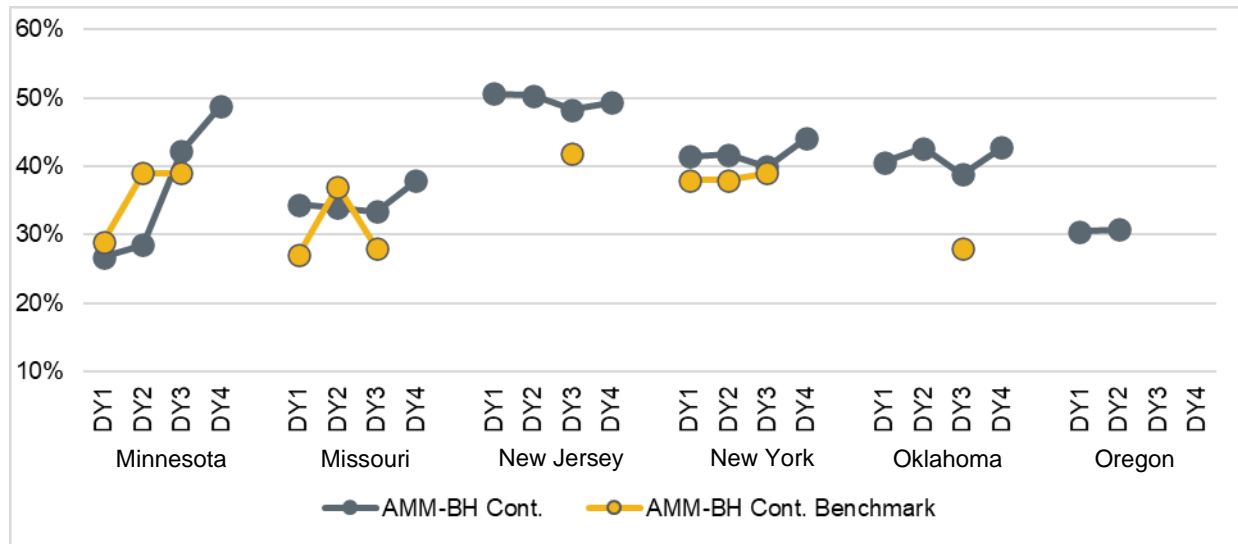
Across all states, aggregate performance on adherence to antidepressant medication in people with major depression remained fairly stable across DYs for both the acute (52 percent in DY1 to 55 percent in DY4) and continuation (38 percent in DY1 to 43 percent in DY4) phase. Within-state trends across all DYs were generally similar, with relative stability or moderate increases in most states (less than 10 percentage points) from DY1 to DY4 on both components. One notable exception to this pattern was observed in

Minnesota, where performance on the continuation phase component rose from 27 percent in DY1 to 49 percent in DY4. Within states, performance was generally similar to available state-specific benchmarks for all DYs (Exhibits V.5 and V.6). States varied considerably, however, on performance for both measure components in each DY.



States also reported on adherence to antipsychotic medications for CCBHC clients with schizophrenia (the Adherence to Antipsychotic Medications for Individuals with Schizophrenia measure, or SAA-BH), but available benchmark data in DY1-DY3 were limited. See Appendix B for findings.

**Exhibit V.6. Antidepressant Medication Management (AMM-BH) Continuation Phase, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation’s analysis of DY1-DY4 CCBHC quality reports. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports for FFYs 2018-2020 for DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available for Oregon for DY3 and DY4. Benchmark data are not available in New Jersey DY1 and DY2, Oklahoma DY1 and DY2, or Oregon DY1-DY3. The DY3 and DY4 measurement years include the COVID-19 PHE.

## B. State Support of Clinic Quality Measure Reporting

Consistent with previous DYs, officials in most states reported continuing to provide technical assistance to CCBHCs to improve the accuracy of quality measure reporting. Several state officials noted meeting at regular intervals with CCBHCs to support data collection and reporting activities. For example, in Missouri, officials meet with CCBHCs annually to explain the specifications and review data challenges. They meet monthly with CCBHC leaders, ensuring CCBHCs are aware of reporting requirements and timelines. In Michigan, the state convenes a monthly metric group for CCBHCs and prepaid inpatient health plans. During these meetings, the state provides technical assistance and offers opportunities for peer learning on how to set up and calculate measures and collect data. Prepaid inpatient health plans vary in their level of involvement and approaches to data monitoring, so it is helpful to provide this avenue for support. Oregon officials meet with data staff from each CCBHC every three weeks to field questions and discuss data needs. In addition to meeting to provide technical assistance, Nevada and Kentucky reported creating manuals to help the CCBHCs understand the specifications.

Building EHR capacity to pull accurate data for measure reporting is an active area of focus for newer demonstration states. In Michigan, CCBHCs found that some data were not correctly pulled from EHRs to calculate measures; all clinics except one use the same EHR vendor, so they brainstormed recommendations for the vendor to improve the EHR-generated report. A Kentucky official indicated that it took some time to get the CCBHCs’ EHRs to a point that they could submit clean data to the state and the state could then calculate the measures. This focus on EHRs aligns with other demonstration states’ experiences: in Nevada, a state consultant has provided technical assistance on how to configure data extracts in EHRs, resulting in increased reporting accuracy. An official in New York said that CCBHCs

now have their EHRs configured appropriately, so there are fewer issues with measure calculation at this point in the demonstration.

### C. Award of QBPs

The payment model for the demonstration allowed states to award QBPs to CCBHCs based on their performance on quality measures to incentivize high-quality care and guard against gaming the payment system. A potential advantage of the PPS is that it affords CCBHCs considerable flexibility to provide individualized care without having to worry about how the delivery of specific billable services impacts the revenue of the clinic. The model could also incentivize withholding care, however, because the CCBHC receives payment for the day (for PPS-1 states) or month (for PPS-2 states) in which the client has an encounter with the CCBHC regardless of the specific services provided. The QBP is designed to counter this incentive by financially rewarding performance on quality measures. States that select the PPS-2 model must implement a QBP system, reflecting the greater amount of flexibility with a monthly as opposed to a daily payment. QBPs are optional for states that select the PPS-1 model. As noted in prior reports, five of the six PPS-1 states elected to implement QBP systems. CMS specified six quality measures states would use to award QBPs, leaving states the option to include five additional measures at their discretion (see Appendix Exhibit A.2 for measures). States implementing QBPs were also free to set the dollar amounts for the bonus payments, the method of distributing payments, and the quality performance thresholds that trigger payments. The quality performance thresholds that trigger payments varied widely across participating states. For example, some states required clinics to equal the previous year’s performance rate and others required clinics exceed the previous year’s performance rate by 15 percent. These parameters of the QBPs could also be modified by the states over the course of the demonstration.

**Exhibit V.7. State QBP Systems**

State (number of CCBHCs)	Amount State Initially Estimated for QBPs per DY	Plans for Use of Required Measures and Optional Measures for QBPs
Minnesota (6)	5% of total payments, or about \$2.5 million	6 CMS-required measures, plus 2 optional measures (CDF-A and PCR-AD)
Missouri (15)	1% of total payments, or about \$4.2 million	6 CMS-required measures
New York (13)	About \$2 million	6 CMS-required measures, plus 1 optional measure (PCR-AD) and 2 state-specific measures
New Jersey (7)	About \$350,000	6 CMS-required measures
Oklahoma (3)	1% of total payments, or about \$1 million	6 CMS-required measures

Source: Mathematica and RAND’s review of state materials and state response to interview questions.

Five states with a total of 44 CCBHCs had QBP programs and provided information to the evaluation team for this report (Exhibit V.7).<sup>25</sup> States varied in the amounts apportioned for the bonus payments, with some states specifying a total dollar amount to be made available to clinics, and other states specifying a percentage of the total CCBHC reimbursement that would be available. Two of the five states, Minnesota and New York, added optional measures to their QBP systems.

Of the 44 CCBHCs eligible for QBPs, 23 received payments in DY1 and 22 received payments in DY4 (Exhibit V.8). In Missouri and New Jersey, nearly all CCBHCs received a payment in all DYs, with variation across the years in the total amount paid. Missouri paid substantially more in bonus payments than the state planned; although the state anticipated payments of up to \$4.2 million, the amounts paid were much higher. In contrast, some states, including New York in all DYs, Minnesota in DY2 to DY4, and Oklahoma in DY1 and DY2, did not make any payments, indicating that none of their clinics met the thresholds for quality performance set by the state in those DYs.

<b>Exhibit V.8. Award of QBPs</b>				
<b>State (number of CCBHCs)</b>	<b>Number of CCBHCs that Received Payments and Total Aggregate Payments to CCBHCs in:</b>			
	<b>DY1</b>	<b>DY2</b>	<b>DY3</b>	<b>DY4</b>
Minnesota (6)	2 of 6; Total payments: \$740,049	None; Thresholds not met	None; Thresholds not met	None; Thresholds not met
Missouri (15)	15 of 15; Total payments: \$17,210,855	15 of 15; Total payments: \$19,138,499	15 of 15; Total payments: \$22,123,047	15 of 15; Total payments: \$14,852,349
New York (13)	None; State reported that thresholds not met	None; State reported that thresholds not met	None; State reported that thresholds not met	None; State reported that thresholds not met
New Jersey (7)	6 of 7; Total payments: \$27,000	6 of 7; Total payments: \$132,000	6 of 7; Total payments: \$339,500	6 of 7; Total payments: \$250,321
Oklahoma (3)	None; State reported that thresholds not met	None; State reported that thresholds not met	n.a.	n.a.

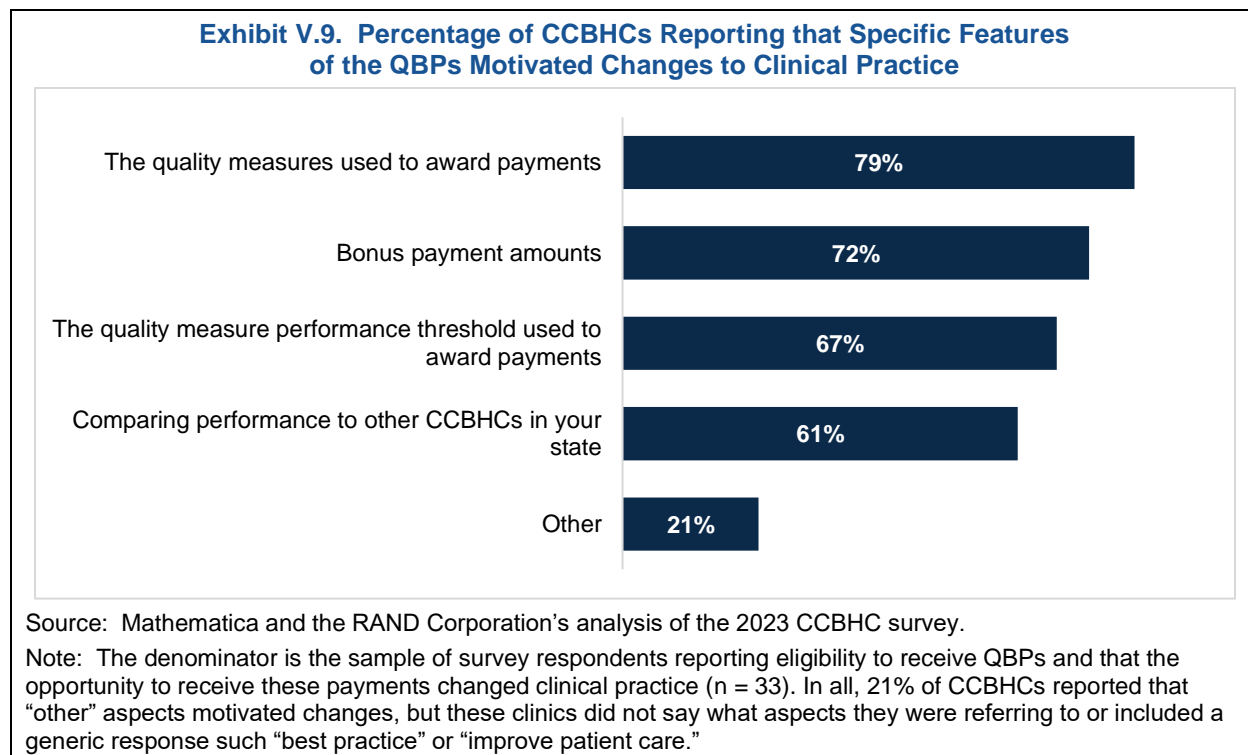
Source: Mathematica and the RAND Corporation's analysis of state official reports.

Notes: Five of the original demonstration states responded to questions from the evaluation team about QBPs. Oregon does not award QBPs and data were unavailable for Nevada. Michigan selected the PPS-1 with QBP but has not yet begin awarding payments.

n.a. = not available.

<sup>25</sup> Oregon and Kentucky elected not to implement a QBP program. Michigan has not been in the demonstration long enough to award QBPs at the time of this report. The evaluation team did not follow up with Nevada given that the state ended its participation in the demonstration.

CCBHCs responding to the survey indicated whether the QBP motivated changes to clinical practice and which aspect of the QBP system motivated those changes. In all, 43 of the CCBHCs eligible to receive QBPs also responded to the CCBHC survey, and 33 (77 percent) agreed that the opportunity to receive QBPs changed clinical practice at their CCBHC and reported on the aspects of the QBPs that motivated changes to clinical practice. Seventy-nine percent indicated the quality measures used to award payments motivated changes to clinical practice, followed by 72 percent and 67 percent that reported the bonus payment amounts and quality measure performance threshold used to award payments, respectively, motivated practice changes (Exhibit V.9).

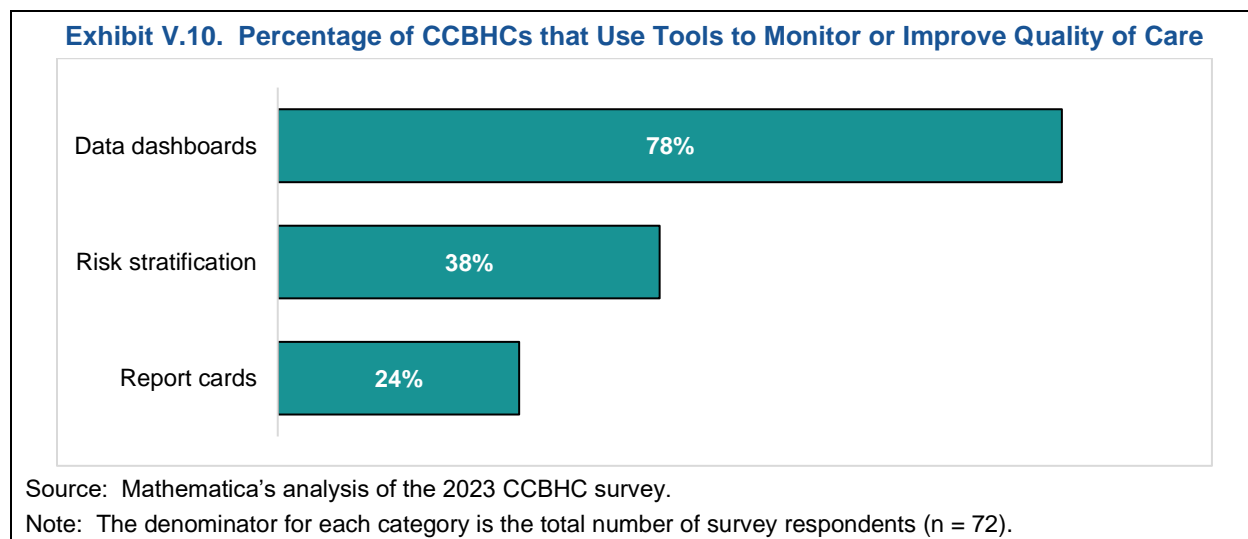


#### **D. Use of Quality Measures and Other Activities to Support Continuous Quality Improvement**

Quality measures are also intended to help support ongoing efforts by CCBHCs to improve care quality, and CCBHCs must have continuous quality improvement plans in place that consider the quality measure data collected. CCBHCs and states described various continuous quality improvement activities underway as a result of participation in the demonstration. Among those describing any continuous quality improvement activities (n = 55 CCBHCs), CCBHCs commonly reported activities related to improving performance on specific quality measures, such as implementing a more standardized clinical workflow to improve SRA and prevention (60 percent), improving timeliness of follow-up after hospitalization (40 percent), and improving psychiatric medication adherence (20 percent). Other CCBHCs described working to increase availability of specific services, such as MAT and psychosocial rehabilitation, improving service availability in certain locations such as in schools and justice-related facilities, and streamlining the intake experience for people entering care. Finally, many CCBHCs mentioned activities to improve the collection and use of quality measure data by automating processes within EHRs.

Seventy-eight percent of CCBHCs reported they used quality measure data collected as part of the demonstration to change clinical practice in the past 12 months, ranging from 0 percent in Nevada to 100 percent in Minnesota, Missouri, New Jersey, and Oklahoma (Appendix Exhibit C.17). For example, one CCBHC mentioned a continuous quality improvement project related to the SRA-BH-C measure. The CCBHC said, “At the beginning of the [continuous quality improvement] project, systems were created for additional reminders and monitoring of clinicians’ completion of suicide risk assessments for at-risk youth. When transitioning to our new EHR, we adopted a universal suicide screening question that expands this; now, at all contacts with all individuals served, the clinician sees a reminder and prompt to assess suicide risk if clinically appropriate.”

A large percentage of CCBHCs (82 percent) reported using data dashboards, report cards, or risk-stratification to monitor or improve quality of care, ranging from 33 percent in Nevada to 100 percent in Kentucky and Oklahoma (Appendix Exhibit C.20). Among them, 78 percent reported using data dashboards, 38 percent reported using risk-stratification, and 24 percent reported using report cards to support quality improvement.



CCBHCs also described other tools, including various internal reports and interactive data visualizations, patient portals, and EHR widgets to monitor quality. Consistent with the survey results, multiple state officials mentioned that states and CCBHCs leverage data dashboards to inform clinic quality improvement initiatives and make use of quality measure data to improve quality of care. For example, Oregon is developing a dashboard that clinics can directly access to compare their performance on quality measures with those of other CCBHCs. Oklahoma’s CCBHCs worked with a vendor earlier in the demonstration to set up individual dashboards to track quality measure performance and inform quality improvement efforts, leading to changes in practice. For example, staff from one CCBHC thought they were performing body mass index measurements on every child, but they learned using the dashboard that they were not screening children served in schools, so they bought portable scales to address this gap. The state has also developed its own dashboard to monitor metrics and practices that are not part of the demonstration quality measures but that state officials feel are nonetheless important, such as the types of services CCBHCs are providing and whether CCBHCs are hiring enough staff. Oklahoma also sends CCBHC claims data to a population health management platform that creates registries and calculates



performance measures for CCBHCs to access directly. As part of a state-led quality improvement initiative that began before the pandemic (and was disrupted by the PHE), each CCBHC selected a performance measure from the platform to target for improved outcomes. For example, one quality improvement project focused on working with physical health providers to ensure that children with asthma have inhalers. Michigan's care coordination platform has quality metric data from different programs that prepaid inpatient health plans can access, and they can review CCBHC performance quarterly. The prepaid inpatient health plans can then export and share beneficiary-level information with CCBHCs if measures have low rates so that CCBHCs can cross reference these reports from the prepaid inpatient health plans with their data and improve workflows (for example, if data suggests that not enough clients are receiving timely follow-up after an emergency department visit).

## VI. Conclusions

**In recent years of the demonstration, CCBHCs in the original demonstration states have worked to maintain and expand activities to increase access to care.** State officials and CCBHCs reported a range of activities to attract new clients and make services more accessible. Several CCBHCs reported focusing recently on advertising and promotion of their services, such as increasing television, radio, and online advertisements. States and CCBHCs also highlighted the efforts of CCBHC outreach and intake staff, including peer specialists, to engage new clients. Open-access or same-day scheduling is another common way CCBHCs provide accessible services. In addition to providing crisis services, 94 percent CCBHCs reported offering open-access or same-day scheduling for other types of outpatient care. Most state officials also noted CCBHCs expanded access to care via telehealth, facilitated, in part, by changes in telehealth policies during the COVID-19 pandemic. All CCBHCs reported offering at least one CCBHC service by telehealth in 2023, an increase of 30 percent from 2019 (70 percent).

**CCBHCs have continued to offer services in locations outside the physical clinic location to expand access to care.** CCBHCs most commonly reported offering services in clients' homes (89 percent), schools (86 percent), as well as in social service organizations and justice-related facilities, such as courts (78 percent each). A substantially higher percentage of CCBHCs reported providing services in clients' homes, schools, justice-related locations, and shelters in 2023 than 2019.

**States have continued to invest in overseeing the coordination of crisis services, including the integration of CCBHCs with 988 call centers and state-sanctioned crisis systems.** CCBHCs reported different ways of coordinating with 988 crisis service systems to rapidly link people in crisis to needed services. In most states, 988 call centers are staffed and operated by other entities and connect people to CCBHCs' crisis services, such as mobile crisis teams, as needed. CCBHCs typically provide mobile crisis services directly. Across states, 7 percent of CCBHCs reported operating directly as a state 988 provider, and 43 percent reported receiving direct referrals from 988. Other CCBHCs mentioned establishing a formal relationship with a local/regional crisis hotline that fields 988 calls (14 percent). A few states also described recent efforts to increase access to crisis stabilization units that coordinate with CCBHCs.

**The number of people served by CCBHCs has increased steadily over time, but the characteristics of CCBHC clients has generally not changed.** Across the remaining original demonstration states, the overall number of unduplicated adults and children/adolescents served by CCBHCs increased from 286,089 people in DY1 to 315,349 people in DY4.<sup>26</sup> The number served has gradually increased each year in all states but Minnesota and Oregon.<sup>27</sup> With few exceptions, client age, gender, race and ethnicity, and insurance status remained consistent across years.

**Performance on several access-related quality measures remained relatively stable over time.** From DY1 to DY4, the percentage of new clients receiving an initial evaluation within ten days of first contact with the CCBHC remained stable (69 percent to 73 percent for adults and 68 percent to 72 percent for children/adolescents). The mean number of days to initial evaluation decreased slightly from DY1 to DY4 for adults (9.1 days versus 8.4 days) but more substantially for children/adolescents (9.9 days versus 7.2 days). Across states, most adult CCBHC clients and family members of child/adolescent recipients had generally positive perceptions of access to care in DY1 to DY4.

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<sup>26</sup> The number of clinics for which data are available varies from year to year.

<sup>27</sup> Oregon decertified three clinics in 2019 (DY3) during a period of funding instability.

**States and CCBHCs continue to struggle with the nationwide shortage in behavioral health providers, which has challenged their ability to expand services to new populations.** Nearly 90 percent of CCBHCs reported difficulties with staffing and workforce development when asked about challenges related to access to care, almost to the exclusion of any other challenges. Although hiring new staff remains difficult, some states have tried to assist CCBHCs in meeting higher demand for specialized services by hiring experts to provide trainings for CCBHCs to expand knowledge and skills among current staff.

**CCBHCs have continued to invest in staff and tools to support care coordination.** State officials highlighted several ways that CCBHCs have worked to improve care coordination, such as increasing staff capacity to coordinate care and using certain tools (including EHRs) to share information across staff and providers within the CCBHC. For example, a Michigan official noted that many CCBHCs have hired dedicated nurses to help coordinate and manage care. Nearly all (97 percent) CCBHCs reported that their EHR systems generate electronic care plans to support care coordination. Most CCBHCs reported using data dashboards (85 percent) and patient portals (61 percent). Such tools might be used to support clinical information sharing between providers within clinics and with clients.

**CCBHCs have established and maintained relationships with a wide variety of external providers, with some variation over time.** Officials reported that the strength of partnerships can differ depending on contextual factors, such as duration of partnerships and staff turnover. CCBHCs have had varying degrees of success in setting up formal relationships with external entities, as required by the criteria.<sup>28</sup> For the most part, however, the percentages of CCBHCs reporting formal relationships has remained stable over time. State officials reported providing support to CCBHCs to help them meet requirements for formal care coordination agreements.

**DCO relationships remain uncommon across demonstration states, and state officials reported that this has mostly remained consistent during the demonstration.** CCBHCs in Kentucky, Nevada, and Oklahoma do not have any DCO relationships; other states reported that CCBHCs have few DCO partners. In 2023, CCBHCs most frequently reported DCO relationships for crisis behavioral health services (26 percent). Only 11 percent of CCBHCs used DCOs for primary care screening and monitoring, and less than 9 percent of CCBHCs used DCO for the other required CCBHC services. Michigan is the only state where DCO relationships are common for a variety of services, including SUD and crisis services. Thirty-eight percent of CCBHCs in Michigan have relationships with DCOs to provide person and family-centered treatment planning services and outpatient mental health or SUD services, and 31 percent provide psychiatric rehabilitation services, peer support services, or TCM through DCOs.

**CCBHCs use a variety of tools to share information with external providers.** State officials reported that CCBHCs in most states have access to a HIE or other statewide platform or data clearinghouse, but not all CCBHCs responding to the survey reported using these exchanges. In all, 60 percent reported

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<sup>28</sup> Before March 2023, the CCBHC certification criteria specified that CCBHCs establish formal agreements outlining care coordination expectations with external organizations. Although agreements are still expected and strongly encouraged, the revised CCBHC criteria will no longer require formal agreements; instead, the criteria focus on care coordination partnerships. SAMHSA has expanded the ways by which the partnerships can be documented to allow for more flexibility in situations in which a formal agreement cannot be executed. CCBHCs are still required to create formal agreements with DCOs to fulfill the requirements under Section 223(a)(2)(D) of PAMA which specifies services that must be offered which, if not available directly through the CCBHC, are provided or referred through formal relationships with other providers.

using state-operated HIEs, and 29 percent reported using privately operated exchanges. In addition, 71 percent of CCBHCs reported they exchange clinical information with external providers electronically.

**More than 80 percent of CCBHCs learn of clients' emergency department visits or hospital admission or discharge via automatic alerts from HIEs, manual monitoring of exchanges, or from automatic alerts from linked EHR systems.** They are less likely to learn of care transitions via phone, fax, or email for emergency department visits and hospital use. In contrast, most CCBHCs rely on phone, fax, or email to receive notifications of care from other community behavioral health providers, residential facility admissions, or client interactions with the criminal justice system (81 percent).

**Aggregate performance on quality measures focused on care coordination exceed national benchmarks but did not improve during the first four years of the demonstration.** Across states, the percentage of CCBHC clients who received follow-up care within 30 days after a mental health-related emergency department visit ranged from 69 percent to 71 percent across DYs, and the percentage of CCBHCs clients who received follow-up care within 30 days after a SUD-related emergency department visit ranged from 39 percent to 40 percent. Although aggregate performance on these measures has not substantially improved during the demonstration, these performance results are substantially higher than the national benchmark data for the same measures (54 percent each year for mental health emergency department visits and 20 percent to 23 percent for SUD emergency department visits). Outpatient visits within 30 days of discharge from a hospitalization for a mental illness ranged from 73 percent to 76 percent for adults and 77 percent to 80 percent for children/adolescents. Performance on these measures was also substantially higher than the national benchmarks, which ranged from 52 percent to 58 percent for adults and from 65 percent to 66 percent for children/adolescents.

**Officials from multiple states shared the perception that CCBHCs provide higher-quality care than other providers, citing the commitment to care coordination and the requirement to offer EBPs as primary attributes of the model that improve quality.** Officials also generally perceived quality of care provided by CCBHCs improved over time, re-emphasizing the model's expanded offerings and noting improvements in performance on quality measures. Consistent with previous DYs, officials in most states reported continuing to provide technical assistance to CCBHCs to support quality measure reporting. Several state officials noted meeting at regular intervals with CCBHCs to troubleshoot data collection challenges and guide reporting activities. Building EHR capacity to pull accurate data for measure reporting is an active area of focus for newer demonstration states.

**Performance on quality measures has varied somewhat over time, and relative to available state benchmarks.** For example, across states:

- Across CCBHCs, the percentage of CCBHC clients with major depressive disorder who received a SRA improved by over 20 percentage points from DY1 to DY4 for both adults and children/adolescents, from 59 percent to 82 percent and 55 percent to 78 percent, respectively. However, it is unclear what is driving this large change. States varied with respect to trends over time.
- Performance on measures of CCBHC clients who received initial and subsequent treatment for alcohol and other drug treatment after diagnosis, was similar to or exceeded available state benchmarks in all DYs.
- Seventy-six percent of CCBHC clients with schizophrenia or bipolar disorder who received antipsychotic medications also received diabetes screening during DY1 and this remained stable through DY4 (74 percent). Performance on this measure was similarly stable from DY1 to DY4 in all states except for New Jersey and Oklahoma which improved in certain DYs.

- In DY1, 52 percent of CCBHC clients with major depression who received antidepressant medications remained on their medication during the acute phase of their depression, and 38 percent remained on their medication during a longer continuation phase of treatment. Across CCBHCs, performance on these measures has not substantially changed during the demonstration, and within states, performance was generally similar to available state-specific benchmarks for all DYs.

**Several states awarded QBPs from DY1 to DY4.** CMS required states with QBP systems to use six measures to award QBPs. However, states set the measure performance thresholds and some states required CCBHCs to meet performance on additional measures. States also set the amount of the QBPs and had the option to modify the parameters of the QBPs over the course of the demonstration. Of the 44 CCBHCs eligible for QBPs, 23 received payments in DY1 and 22 received payments in DY4. In Missouri and New Jersey, nearly all CCBHCs received a payment in all DYs, with variation across the years in the total amount paid. In contrast, some states, including New York in all DYs, Minnesota in DY2 to DY4, and Oklahoma in DY1 and DY2, did not make any payments, indicating that none of their clinics met the thresholds for quality performance set by the state in those DYs.

**CCBHCs and states described various continuous quality improvement activities as a result of participation in the demonstration.** CCBHCs commonly reported activities related to improving performance on specific quality measures, such as implementing a more standardized clinical workflow to improve SRA and prevention (60 percent), improving timeliness of follow-up after hospitalization (40 percent), and improving psychiatric medication adherence (20 percent). A large percentage of CCBHCs (82 percent) reported using data dashboards, report cards, or risk-stratification to monitor or improve quality of care, ranging from 33 percent in Nevada to 100 percent in Kentucky and Oklahoma. Consistent with the survey results, multiple state officials mentioned that states and CCBHCs leverage data dashboards to inform clinic quality improvement initiatives and make use of quality measure data to improve quality of care.

## Future Evaluation Activities

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

Future reports will also summarize findings on the impact of the demonstration on service utilization and costs using Medicaid claims and encounter data from selected states. The impact analysis will examine service utilization trends among Medicaid beneficiaries who received CCBHC services relative to within-state comparison groups.

## References

- Brown, J.D., J. Breslau, A. Wishon, R. Miller, C. Case, M. Dunbar, K. Stewart, B. Briscoe, T. Rose, E. Dehus, and K. DeWitt. "Implementation and Impacts of the Certified Community Behavioral Health Clinic Demonstration: Findings from the National Evaluation." Mathematica, 2021.
- Breslau, J., B. Briscoe, M. Dunbar, C. Kase, J. Brown, A. Wishon Siegwath, and R. Miller. "Interim Cost and Quality Findings from the National Evaluation of the Certified Community Behavioral Health Clinic Demonstration." U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2021.  
<https://aspe.hhs.gov/sites/default/files/documents/90c1c4d1646109391a938b6e25395dc5/ccbhc-interim-cost-quality-findings.pdf>.
- Centers for Medicare & Medicaid Services (CMS). "Adult and Child Health Care Quality Measures." CMS, 2023. <https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.
- Hassan, M., and M.J. Lage. "Risk of rehospitalization among bipolar disorder patients who are nonadherent to antipsychotic therapy after hospital discharge." American Journal of Health-System Pharmacy, vol. 66, 2009, pp. 358-365, <https://doi.org/10.2146/ajhp080374>.
- National Institute of Mental Health. "Suicide Prevention." n.d.  
<https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml>.
- National Committee for Quality Assurance (NCQA). "Diabetes and Cardiovascular Disease Screening and Monitoring for People with Schizophrenia or Bipolar Disorder (SSD, SMD, SMC)." NCQA, 2021. <https://www.ncqa.org/hedis/measures/diabetes-and-cardiovascular-disease-screening-and-monitoring-for-people-with-schizophrenia-or-bipolar-disorder/>.
- National Committee for Quality Assurance (NCQA). "Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)." NCQA, 2023.  
<https://www.ncqa.org/hedis/measures/adherence-to-antipsychotic-medications-for-individuals-with-schizophrenia/>.
- Office of the Assistant Secretary for Planning and Evaluation (ASPE). "Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2020." ASPE, 2021.  
<https://aspe.hhs.gov/sites/default/files/documents/1faadf771e9567b0926e33739341cb50/ccbhc-report-congress-2020.pdf>.
- Substance Abuse and Mental Health Services Administration (SAMHSA). "Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics." SAMHSA, 2016a.  
[https://www.samhsa.gov/sites/default/files/programs\\_campaigns/ccbhc-criteria.pdf](https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf).
- Substance Abuse and Mental Health Services Administration (SAMHSA). "The Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manuals." SAMHSA, 2016b. <https://www.samhsa.gov/section-223/quality-measures>.
- Substance Abuse and Mental Health Services Administration (SAMHSA). "Certified Community Behavioral Health Clinic (CCBHC) Certification Criteria." SAMHSA, 2023a.  
<https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf>.

- Substance Abuse and Mental Health Services Administration (SAMHSA). “Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics.” SAMHSA, 2016a.
- Substance Abuse and Mental Health Services Administration (SAMHSA). “Uniform Reporting System (URS): Annual Report.” SAMHSA, 2023b. <https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>.
- U.S. Department of Health and Human Services (HHS). “Guidance on Addition of CCBHCs to Section 223 State Demonstration Programs.” HHS, 2023. <https://www.samhsa.gov/sites/default/files/guidance-addition-of-ccbhcs-existing-state-demonstration-programs.pdf>.
- Velupillai S., G. Hadlaczky, E. Baca-Garcia E, et al. “Risk Assessment Tools and Data-Driven Approaches for Predicting and Preventing Suicidal Behavior.” *Frontiers of Psychiatry*, 2019, vol. 10, no. 36.
- Wishon, A., S. Pietras, J. Breslau, C. Kase, M. Dunbar, R. Sabin, B. Briscoe, and J. Brown. “Findings from the National Evaluation of the Extension to the Certified Community Behavioral Health Clinic Demonstration: First Annual Report.” U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2023.
- Wishon Siegwarth, A., R. Miller, J. Little, J. Brown, C. Kase, J. Breslau, and M. Dunbar. “Implementation Findings from The National Evaluation of the Certified Community Behavioral Health Clinic Demonstration.” U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2020. <https://aspe.hhs.gov/reports/implementation-findings-national-evaluation-certified-community-behavioral-health-clinic-0>.

## Appendix A. Quality Measure Report Status and Measure Descriptions

Below is a table summarizing the quality measure data available for analysis at the time of the report.

Exhibit A.1. Quality Measure Report Status		
State	Number of CCBHCs	Quality Measure Report Status DY1-DY4
Minnesota	6	No reports missing
Missouri	15	No reports missing
Nevada	3	Missing clinic and state measures for all 3 clinics in DY1-DY4
New Jersey	7	No reports missing
New York	13	No reports missing
Oklahoma	3	No reports missing
Oregon	9	Missing state measures for all 9 clinics in DY3 and DY4

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality reports.

Note: Oregon began the demonstration with 12 CCBHC but decreased to 9 CCBHCs in DY3. Therefore, we analyzed quality reports of the 9 CCBHCs that were consistent across DY1-DY4 in Oregon. At the time the report was written, Nevada was excluded from analyses due to missing measures. In June 2023, partial data were received from Nevada for some years.

Exhibit A.2. CCBHC and State-Reported Quality Measures Required for DY1-DY4				
Reported Measures	Clinic-Reported or State-Reported Measures	Potential Data Source(s)	Measure Steward <sup>a</sup>	Required for QBP
Time to Initial Evaluation (I-EVAL)	Clinic-reported	EHR, electronic scheduler	SAMHSA	No
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-BH-C)	Clinic-reported	EHR, client records	AMA-PCPI	Yes
Adult Major Depressive Disorder: Suicide Risk Assessment (SRA-A)	Clinic-reported	EHR, client records	AMA-PCPI	Yes
Screening for Clinical Depression and Follow-up Plan (CDF-BH)	Clinic-reported	EHR, client records	CMS <sup>b</sup>	Optional
Depression Remission at Twelve Months (DEP-REM-12)	Clinic-reported	EHR, client records, client follow-up with standard measure (PHQ-9)	Minnesota Community Measurement	Optional
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)	State-reported	Claims data/ encounter data	CMS	Yes
Antidepressant Medication Management (AMM-BH)	State-reported	Claims data/ encounter data	NCQA	Optional
Follow-up Care for Children Prescribed ADHD Medication (ADD-BH)	State-reported	Claims data/ encounter data	NCQA	Optional
Adult Body Mass Index Screening and Follow-up Plan (BMI-SF)	Clinic-reported	EHR, client records	CMS	No



**Exhibit A.2 (continued)**

<b>Reported Measures</b>	<b>Clinic-Reported or State-Reported Measures</b>	<b>Potential Data Source(s)</b>	<b>Measure Steward<sup>a</sup></b>	<b>Required for QBP</b>
Weight Assessment for Nutrition and Physical Activity for Children/Adolescents (WCC-BH)	Clinic-reported	EHR, encounter data	NCQA	No
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)	State-reported	Claims data/ encounter data	NCQA	No
Tobacco Use--Screening and Cessation Intervention (TSC)	Clinic-reported	EHR, encounter data	AMA-PCPI	No
Unhealthy Alcohol Use--Screening and Brief Counseling (ASC)	Clinic-reported	EHR, client records	AMA-PCPI	No
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)	State-reported	EHR, client records	NCQA	Yes
Follow-up After Emergency Department Visit for Mental Illness (FUM)	State-reported	Claims data/ encounter data	NCQA	No
Follow-up after Emergency Department Visit for Alcohol or Other Dependence (FUA)	State-reported	Claims data/ encounter data	NCQA	No
Follow-up After Hospitalization for Mental Illness, ages 21+ (FUH-BH-A)	State-reported	Claims data/ encounter data	NCQA	Yes
Follow-up after Hospitalization for Mental Illness, ages 6-21 (FUH-BH-C)	State-reported	EHR, client records, client follow-up with standard measure (PHQ-9)	NCQA	Yes
Plan All-Cause Readmission Rate (PCR-BH)	State-reported	Claims data/ encounter data	NCQA	Optional
Patient Experience of Care (PEC) Survey adult	State-reported	MHSIP survey	SAMHSA	No
Youth/Family Experience of Care survey (Y/FEC)	State-reported	MHSIP survey	SAMHSA	No
Housing Status (residential status during the reporting period) (HOU) <sup>c</sup>	State-reported	URS	SAMHSA	No

Source: Substance Abuse and Mental Health Services Administration. "The Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manuals." Rockville, MD: SAMHSA, 2016. Available at <https://www.samhsa.gov/section-223/quality-measures>.

Notes:

- a. Measure Steward is the organization that is responsible for maintaining documentation on the justification, evidence, specifications, use, and results of the measure.
- b. CDF-BH measure no longer National Quality Forum endorsed.
- c. The HOU measure contained an error in the reporting form and only provided space for 1 set of numbers; thus, states were unable to report HOU at 2 time-points as intended in the technical specification. Some states reported HOU at 1 time-point during the entire reporting period, while others reported the combined total of HOU collected at 2 time-points during the reporting period or edited the reporting form in some way. The data for this measure could not be analyzed.

Below is a table summarizing the benchmark data available for analysis relative to demonstration year quality measure data available and relative to the timing of COVID-19 PHE declarations.

<b>Exhibit A.3. Benchmark Data Availability</b>				
<b>Demonstration Year (DY)</b>	<b>DY start dates for CCBHC States (OK and OR) (MN, MO, NJ, NV, NY)</b>	<b>CMS Adult and Child Core Set Reports for Benchmarks</b>	<b>URS Output Tables for PEC and Y/FEC for Benchmarks</b>	<b>COVID-19 PHE Declarations</b>
DY1	(April 1, 2017 - March 30, 2018) (July 1, 2017 - June 30, 2018)	FFY 2018 CMS Adult and Child Core Set reporting generally reflects services provided in CY 2017	FY 2018 URS output tables	NA
DY2	(April 1, 2018 - March 30, 2019) (July 1, 2018 - June 30, 2019)	FFY 2019 CMS Adult and Child Core Set reporting generally reflects services provided in CY 2018	FY 2019 URS output tables	NA
DY3	(April 1, 2019 - March 30, 2020) (July 1, 2019 - June 30, 2020)	FFY 2020 CMS Adult and Child Core Set reporting generally reflects services provided in CY 2019	FY 2020 URS output tables	January 31, 2020 COVID-19 National PHE
DY4	(April 1, 2020 - March 30, 2021) (July 1, 2020 - June 30, 2021)	n.a. Pending FFY 2021 CMS Adult and Child Core Set reporting not yet published	FY 2021 URS output tables	April, July, and October 2020, January 2021 COVID-19 National PHE Renewals
DY5	(April 1, 2021 - March 30, 2022) (July 1, 2021 - June 30, 2022)	n.a.	n.a.	April, July, October 2021, January 2022 COVID-19 National PHE Renewals
DY6	(April 1, 2022 - March 30, 2023) (July 1, 2022 - June 30, 2023)	n.a.	n.a.	April, July, October 2022, January 2023 COVID-19 National PHE Renewals End of federal PHE May 11, 2023

Source: Benchmarks are drawn from CMS Annual Reporting on the Quality of Care for Adults in Medicaid and Children in Medicaid and CHIP and state-level performance on the MHSIP survey from the SAMHSA URS, available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html> and <https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>. List of declarations of PHE available at <https://aspr.hhs.gov/legal/PHE/Pages/default.aspx>.

NA = not applicable; n.a. = not available.

## Appendix B. Supplemental Quality Measure Findings

This appendix includes tables of quality measure denominators and results for all measures, and figures for select measures.

### Access to Care Measures

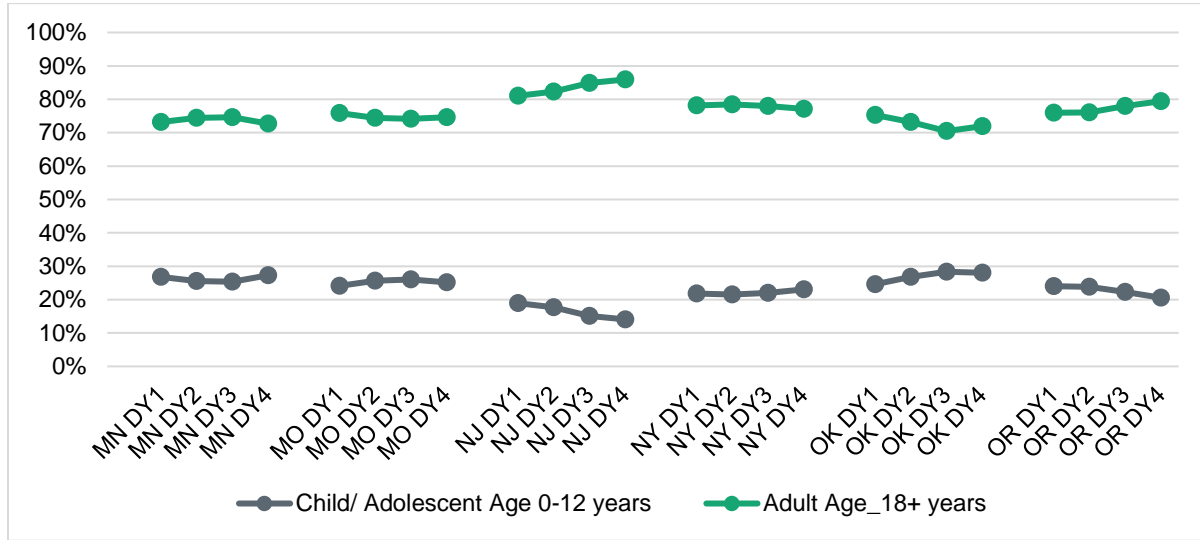
#### Client Caseload Characteristics

Exhibit B.1. Age and Gender of Clients from CCBHCs, by State and Year							
	Number of CCBHCs	Denominator	Child/ Adolescent Age 0-17 Years	Adult Age 18+ Years	Gender Female	Gender Male	Gender Other Option or Not Reported
DY1	56	286,089	24%	76%	52%	48%	0%
DY2	56	308,831	24%	76%	51%	48%	1%
DY3	53	303,911	24%	76%	52%	48%	0%
DY4	53	315,349	24%	76%	53%	46%	1%
MN DY1	6	23,027	27%	73%	51%	49%	0%
MN DY2	6	25,402	26%	74%	50%	49%	0%
MN DY3	6	23,935	25%	75%	50%	50%	0%
MN DY4	6	20,725	27%	73%	51%	47%	2%
MO DY1	15	121,787	24%	76%	53%	47%	0%
MO DY2	15	132,565	26%	74%	52%	47%	0%
MO DY3	15	137,753	26%	74%	53%	47%	0%
MO DY4	15	145,949	25%	75%	54%	45%	0%
NJ DY1	7	17,851	19%	81%	56%	44%	0%
NJ DY2	7	19,129	18%	82%	55%	44%	0%
NJ DY3	7	20,396	15%	85%	56%	44%	0%
NJ DY4	7	21,742	14%	86%	57%	43%	0%
NY DY1	13	49,903	22%	78%	48%	52%	0%
NY DY2	13	55,693	22%	78%	48%	52%	0%
NY DY3	13	57,377	22%	78%	49%	51%	0%
NY DY4	13	62,972	23%	77%	52%	48%	0%
OK DY1	3	20,610	25%	75%	52%	48%	0%
OK DY2	3	22,741	27%	73%	52%	48%	0%
OK DY3	3	24,647	28%	70%	51%	48%	0%
OK DY4	3	25,583	28%	72%	53%	47%	0%
OR DY1	12	52,911	24%	76%	52%	48%	1%
OR DY2	12	53,301	24%	76%	50%	46%	3%
OR DY3	9	39,803	22%	78%	51%	46%	2%
OR DY4	9	38,378	21%	79%	52%	45%	4%

Source: Mathematica and RAND analysis of DY1-DY4 CCBHC quality measures and state response to follow-up questions.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. Client characteristic tables and figures include data from all 12 original clinics in DY1-DY2; analysis of Oregon's client characteristics did not show material changes in aggregate performance when data for the 3 clinics were removed. The DY3 and DY4 measurement years include the COVID-19 PHE. Quality measure reports which include client characteristics were not available for Nevada for any DYs. Kentucky and Michigan had not begun reporting at the time of this report.

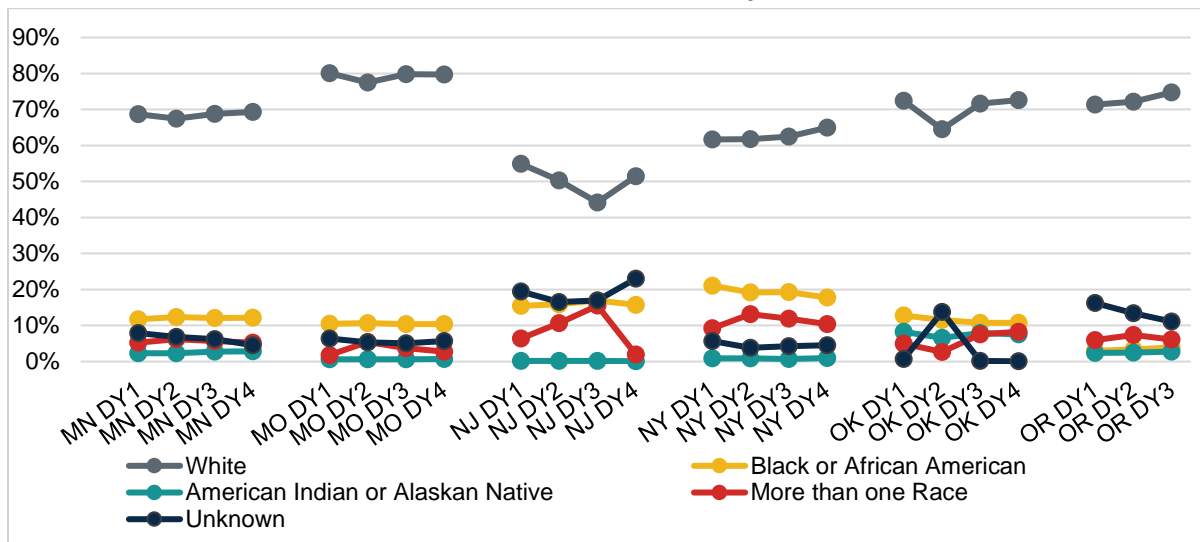
**Exhibit B.2. Age of CCBHC Clients, by State and Year**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures and state response to follow-up questions.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. Client characteristic tables and figures include data from all 12 original clinics in DY1-DY2; analysis of Oregon's client characteristics did not show material changes in aggregate performance when data for the 3 clinics were removed. The DY3 and DY4 measurement years include the COVID-19 PHE.

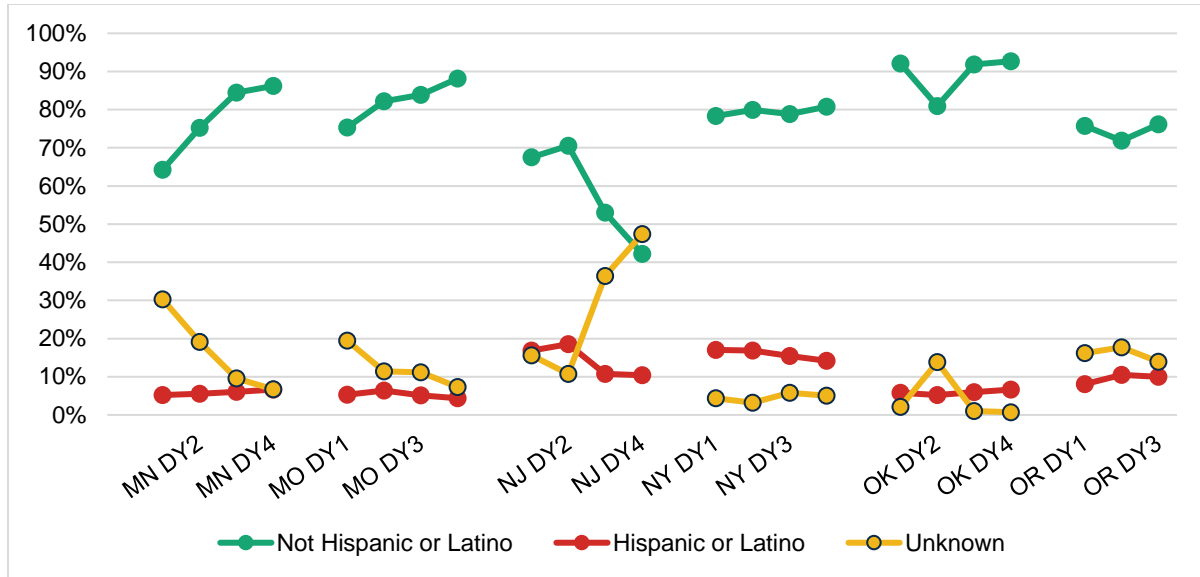
**Exhibit B.3. Race of CCBHC Clients, by State and Year**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. Client characteristic tables and figures include data from all 12 original clinics in DY1-DY2; analysis of Oregon's client characteristics did not show material changes in aggregate performance when data for the 3 clinics were removed. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.4. Hispanic or Latino Ethnicity of CCBHC Clients, by State and Year**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. Client characteristic tables and figures include data from all 12 original clinics in DY1-DY2; analysis of Oregon's client characteristics did not show material changes in aggregate performance when data for the 3 clinics were removed. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.5. Insurance Status of Clients from CCBHCs, by State and Year**

Aggregate DYs	Number of CCBHCs	Denominator	Medicaid + CHIP + Dual	Medicare	Commercially Insured	VHA + Other	Uninsured
DY1	56	286,089	64%	5%	16%	4%	15%
DY2	56	308,831	62%	5%	16%	5%	16%
DY3	53	303,911	62%	5%	17%	4%	15%
DY4	52	307,408	62%	4%	19%	5%	14%
MN DY1	6	23,027	59%	6%	20%	11%	5%
MN DY2	6	25,402	58%	6%	22%	12%	4%
MN DY3	6	23,935	58%	7%	21%	13%	2%
MN DY4	6	20,725	61%	4%	20%	12%	5%
MO DY1	15	121,787	61%	6%	17%	4%	21%
MO DY2	15	132,565	56%	6%	17%	5%	24%
MO DY3	15	137,753	57%	6%	18%	4%	22%
MO DY4	15	145,949	56%	6%	21%	6%	20%
NJ DY1	7	17,851	60%	9%	23%	2%	5%
NJ DY2	7	19,129	61%	8%	23%	2%	6%
NJ DY3	7	20,396	58%	8%	25%	3%	6%
NJ DY4	6	13,801	65%	8%	22%	5%	7%
NY DY1	13	49,903	71%	4%	19%	2%	4%
NY DY2	13	55,693	71%	5%	18%	1%	5%
NY DY3	13	57,377	72%	3%	21%	1%	4%
NY DY4	13	62,972	70%	3%	23%	1%	3%
OK DY1	3	20,610	49%	4%	9%	1%	36%
OK DY2	3	22,741	48%	4%	12%	1%	36%
OK DY3	3	24,647	47%	3%	14%	1%	34%
OK DY4	3	25,583	55%	2%	15%	2%	27%
OR DY1	12	52,911	70%	3%	9%	4%	14%
OR DY2	12	53,301	74%	3%	10%	7%	10%
OR DY3	9	39,803	80%	3%	7%	5%	10%
OR DY4	9	38,378	79%	3%	7%	3%	9%

Source: Mathematica and the RAND Corporation’s analysis of DY1-DY4 CCBHC quality measures and state response to follow-up questions.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. Client characteristic tables and figures include data from all 12 original clinics in DY1-DY2; analysis of Oregon’s client characteristics did not show material changes in aggregate performance when data for the 3 clinics were removed. Insurance status categories were not mutually exclusive and percentages may not add to 100% for each state DY. Oklahoma Medicaid expansion took effect July 1, 2021, which may have influenced changes in DY3-DY4. Oregon DY2 and DY3 is over 100% and the state possibly double counted their CHIP clients. One clinic in New Jersey did not report in DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.6. Hispanic or Latino Ethnicity of Clients from CCBHCs, by State and Year**

Aggregate DYs	Number of CCBHCs	Denominator	Ethnicity Not Hispanic or Latino	Ethnicity Hispanic or Latino	Ethnicity Unknown
DY1	56	286,089	76%	9%	16%
DY2	56	308,831	79%	10%	12%
DY3	53	303,911	81%	8%	11%
DY4	53	315,349	82%	8%	10%
MN DY1	6	23,027	64%	5%	30%
MN DY2	6	25,402	75%	6%	19%
MN DY3	6	23,935	84%	6%	10%
MN DY4	6	20,725	86%	7%	7%
MO DY1	15	121,787	75%	5%	19%
MO DY2	15	132,565	82%	6%	11%
MO DY3	15	137,753	84%	5%	11%
MO DY4	15	145,949	88%	4%	7%
NJ DY1	7	17,851	67%	17%	16%
NJ DY2	7	19,129	71%	19%	11%
NJ DY3	7	20,396	53%	11%	36%
NJ DY4	7	21,742	42%	10%	47%
NY DY1	13	49,903	78%	17%	4%
NY DY2	13	55,693	80%	17%	3%
NY DY3	13	57,377	79%	15%	6%
NY DY4	13	62,972	81%	14%	5%
OK DY1	3	20,610	92%	6%	2%
OK DY2	3	22,741	81%	5%	14%
OK DY3	3	24,647	92%	6%	1%
OK DY4	3	25,583	93%	7%	1%
OR DY1	12	52,911	76%	8%	16%
OR DY2	12	53,301	72%	10%	18%
OR DY3	9	39,803	76%	10%	14%
OR DY4	9	38,378	73%	11%	16%

Source: Mathematica and RAND analysis of DY1-DY4 CCBHC quality measures and state response to follow-up questions.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. Client characteristic tables and figures include data from all 12 original clinics in DY1-DY2; analysis of Oregon's client characteristics did not show material changes in aggregate performance when data for the 3 clinics were removed. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.7. Race and Ethnicity of Clients from CCBHCs, by State and Year**

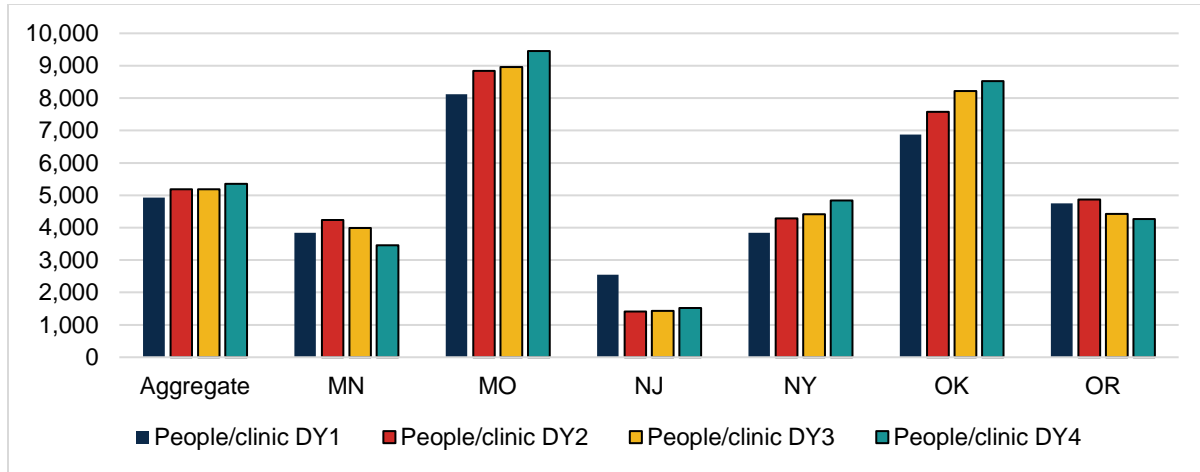
Aggregate DYs	Number of CCBHCs	Denominator	White	Black or African American	American Indian or Alaskan Native	Native Hawaiian or Pacific Islander	Asian	More than One Race	Unknown
DY1	56	286,089	72%	12%	2%	0%	1%	5%	9%
DY2	56	308,831	70%	11%	2%	0%	1%	7%	8%
DY3	53	303,911	72%	12%	2%	0%	1%	7%	6%
DY4	53	315,349	73%	12%	2%	0%	1%	5%	7%
MN DY1	6	23,027	69%	12%	2%	0%	4%	5%	8%
MN DY2	6	25,402	67%	12%	2%	0%	5%	6%	7%
MN DY3	6	23,935	69%	12%	3%	0%	5%	6%	6%
MN DY4	6	20,725	69%	12%	3%	0%	6%	5%	5%
MO DY1	15	121,787	80%	10%	1%	0%	0%	2%	6%
MO DY2	15	132,565	77%	11%	1%	0%	0%	5%	5%
MO DY3	15	137,753	80%	10%	1%	0%	0%	4%	5%
MO DY4	15	145,949	80%	10%	1%	0%	0%	3%	6%
NJ DY1	7	17,851	55%	15%	0%	0%	3%	6%	19%
NJ DY2	7	19,129	50%	16%	0%	0%	4%	11%	16%
NJ DY3	7	20,396	44%	17%	0%	0%	4%	16%	17%
NJ DY4	7	21,742	51%	16%	0%	0%	4%	2%	23%
NY DY1	13	49,903	62%	21%	1%	0%	1%	9%	6%
NY DY2	13	55,693	62%	19%	1%	0%	1%	13%	4%
NY DY3	13	57,377	62%	19%	1%	0%	1%	12%	4%
NY DY4	13	62,972	65%	18%	1%	0%	1%	10%	5%
OK DY1	3	20,610	72%	13%	8%	0%	1%	5%	1%
OK DY2	3	22,741	65%	12%	7%	0%	1%	3%	14%
OK DY3	3	24,647	72%	11%	8%	0%	1%	8%	0%
OK DY4	3	25,583	73%	11%	8%	0%	1%	8%	0%
OR DY1	12	52,911	71%	3%	2%	0%	1%	6%	16%
OR DY2	12	53,301	72%	3%	2%	0%	1%	7%	13%
OR DY3	9	39,803	75%	4%	3%	1%	1%	6%	11%
OR DY4	9	38,378	72%	4%	3%	1%	1%	5%	15%

Source: Mathematica and RAND analysis of DY1-DY4 CCBHC quality measures and state response to follow-up questions.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. Client characteristic tables and figures include data from all 12 original clinics in DY1-DY2; analysis of Oregon's client characteristics did not show material changes in aggregate performance when data for the 3 clinics were removed. The DY3 and DY4 measurement years include the COVID-19 PHE.



**Exhibit B.8. Number of Clients per Clinic, by State and Year**



Source: Mathematica and RAND analysis of DY1-DY4 CCBHC quality measures and state response to follow-up questions.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The figure includes data from the 9 CCBHCs that remained certified in all DYs. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.9. Access to Care/Timeliness of Initial Evaluation: Measure Performance on I-EVAL**

Aggregate DYs	Adult (I-EVAL) Denominator	Adult (I-EVAL) % within 10 days	Adult (I-EVAL) Average # Days	Child/ Adolescent (I-EVAL) Denominator	Child/ Adolescent (I-EVAL) % within 10 days	Child/ Adolescent (I-EVAL) Average # Days
DY1	92,000	69%	9.1	17,616	68%	9.9
DY2	99,178	73%	5.7	18,023	74%	5.3
DY3	106,898	77%	7.2	17,794	76%	6.8
DY4	105,740	73%	8.4	22,456	72%	7.2
MN DY1	10,709	39%	20.6	1,401	59%	10.1
MN DY2	8,276	45%	9.5	1,107	63%	7.0
MN DY3	9,387	45%	5.5	1,336	60%	6.6
MN DY4	7,960	42%	4.1	1,492	51%	6.9
MO DY1	31,177	70%	10.1	6,830	69%	11.0
MO DY2	36,382	77%	3.2	7,669	77%	3.5
MO DY3	47,824	82%	6.9	9,384	79%	6.8
MO DY4	46,238	79%	4.6	12,075	74%	4.6
NJ DY1	10,715	81%	7.5	1,702	68%	11.0
NJ DY2	8,305	84%	8.2	1,502	80%	8.1
NJ DY3	6,884	83%	6.2	923	75%	5.9
NJ DY4	6,471	72%	9.5	1,056	63%	14.2
NY DY1	16,922	82%	5.9	3,236	71%	9.2
NY DY2	19,930	82%	5.6	3,020	75%	6.5
NY DY3	20,173	82%	4.7	2,798	77%	5.9
NY DY4	19,359	80%	5.5	3,789	79%	5.9
OK DY1	10,684	71%	5.0	1,787	65%	7.9
OK DY2	10,296	81%	4.7	1,981	73%	6.6
OK DY3	11,419	87%	3.3	2,065	81%	5.7
OK DY4	10,464	85%	3.7	2,036	73%	6.1
OR DY1	11,793	66%	8.0	2,660	67%	7.8
OR DY2	15,989	58%	12.3	2,744	66%	9.5
OR DY3	11,211	60%	17.6	1,288	70%	10.7
OR DY4	15,248	58%	28.1	2,008	70%	20.8

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. A lower average number of days means better performance. The DY3 and DY4 measurement years include the COVID-19 PHE.

## Scope of Services Measures

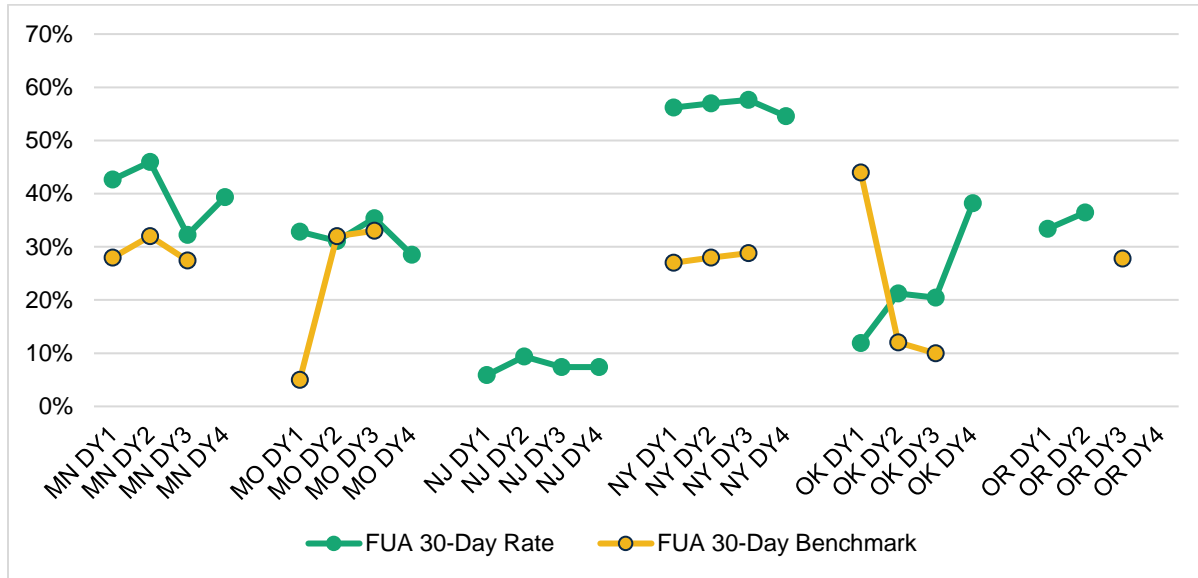
### 1. Care Coordination Measures

Exhibit B.10. Follow-up after ED Visits: Measure Performance on Follow-up after ED for Mental Health: 30-day (FUM 30-day) and Follow-up after ED Visit for Alcohol or Other Dependence: 30-day (FUA 30-day)						
Aggregate DYs	FUM 30-Day Denominator	FUM 30-day Rate	FUM 30-day Benchmark	FUA 30-day Denominator	FUA 30-day Rate	FUA 30-Day Benchmark
DY1	13,948	71%	54%	5,745	39%	20%
DY2	13,647	68%	54%	6,272	39%	21%
DY3	10,435	69%	54%	4,893	40%	23%
DY4	11,097	69%	n.a.	5,193	37%	n.a.
MN DY1	2,441	79%	65%	1,037	43%	28%
MN DY2	2,123	75%	63%	910	46%	32%
MN DY3	1,118	75%	60%	552	32%	27%
MN DY4	1,065	80%	n.a.	590	39%	n.a.
MO DY1	5,066	69%	57%	1,562	33%	5%
MO DY2	5,172	70%	50%	1,645	31%	32%
MO DY3	4,883	68%	52%	1,677	35%	33%
MO DY4	4,799	66%	n.a.	1,791	29%	n.a.
NJ DY1	1,816	23%	56%	562	6%	n.a.
NJ DY2	1,983	23%	61%	950	9%	n.a.
NJ DY3	1,876	23%	64%	674	7%	n.a.
NJ DY4	2,491	31%	n.a.	675	7%	n.a.
NY DY1	2,496	89%	71%	1,719	56%	27%
NY DY2	2,403	86%	69%	2,034	57%	28%
NY DY3	2,200	86%	72%	1,902	58%	29%
NY DY4	2,384	88%	n.a.	1,993	55%	n.a.
OK DY1	348	82%	50%	42	12%	44%
OK DY2	616	83%	46%	66	21%	12%
OK DY3	n.a.	n.a.	45%	88	20%	10%
OK DY4	n.a.	n.a.	n.a.	144	38%	n.a.
OR DY1	1,781	84%	59%	823	33%	n.a.
OR DY2	1,350	82%	69%	667	36%	n.a.
OR DY3	n.a.	n.a.	n.a.	n.a.	n.a.	28%
OR DY4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports FFY 2018-2020 for DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in Oklahoma in DY3 and DY4 and Oregon DY3 and DY4. Benchmark data are not available in New York DY2 or Oregon DY1-DY3. The DY3 and DY4 measurement years include the COVID-19 PHE.  
n.a. = not available.

**Exhibit B.11. Follow-up after ED Visit for Alcohol or Other Dependence (FUA), 30-day, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation’s analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports FFY 2018-2020 for DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in Oregon DY3 and DY4. Benchmark data are not available in New York in DY4 or Oregon DY1 and DY2. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.12. Follow-up after Hospitalization for Mental Illness Adult (FUH-BH-A 30-day)  
and Follow-up after Hospitalization for Mental Illness Child/Adolescent (FUH-BH-C 30-day)**

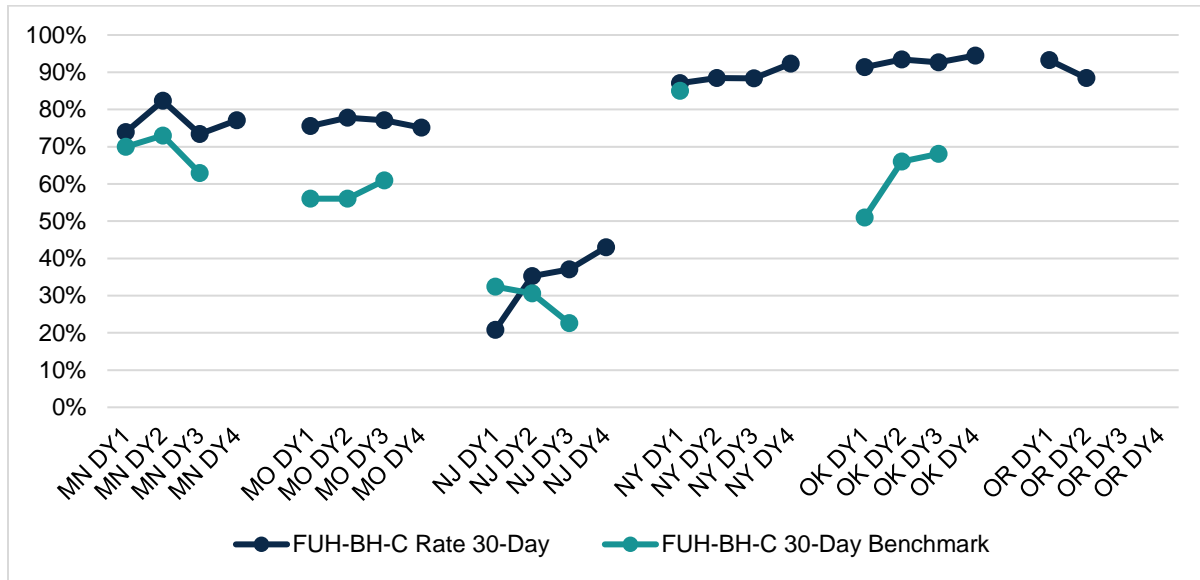
	FUH-BH-A 30- Day Denominator	FUH-BH-A 30-Day Rate	FUH-BH-A 30-Day Benchmark	FUH-BH-C 30 Day Denominator	FUH-BH-C 30-Day Rate	FUH-BH-C 30-Day Benchmark
DY1	7456	75%	58%	4699	77%	65%
DY2	7937	76%	53%	5279	80%	66%
DY3	6406	73%	52%	4539	78%	66%
DY4	7181	74%	n.a.	5123	77%	n.a.
MN DY1	1271	73%	63%	668	74%	70%
MN DY2	1125	73%	59%	644	82%	73%
MN DY3	946	62%	54%	327	73%	63%
MN DY4	797	61%	n.a.	363	77%	n.a.
MO DY1	3565	74%	38%	3146	76%	56%
MO DY2	3738	74%	33%	3497	78%	56%
MO DY3	3478	74%	26%	3457	77%	61%
MO DY4	4205	74%	n.a.	3824	75%	n.a.
NJ DY1	323	23%	32%	77	21%	32%
NJ DY2	418	32%	31%	105	35%	31%
NJ DY3	249	34%	40%	89	37%	23%
NJ DY4	292	30%	n.a.	114	43%	n.a.
NY DY1	1437	82%	61%	372	87%	85%
NY DY2	1531	82%	n.a.	442	88%	n.a.
NY DY3	1493	82%	59%	379	88%	n.a.
NY DY4	1604	83%	n.a.	495	92%	n.a.
OK DY1	190	94%	39%	288	91%	51%
OK DY2	308	88%	39%	470	93%	66%
OK DY3	240	92%	40%	287	93%	68%
OK DY4	283	92%	n.a.	327	94%	n.a.
OR DY1	670	94%	n.a.	148	93%	n.a.
OR DY2	817	93%	n.a.	121	88%	n.a.
OR DY3	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
OR DY4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

Source: Mathematica and the RAND Corporation’s analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports FFY 2018-2020 for DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in Oregon DY3 and DY4. Benchmark data are not available in New York DY2, or Oregon DY1-DY3. The DY3 and DY4 measurement years include the COVID-19 PHE.

n.a. = not available.

**Exhibit B.13. Follow-up After Hospitalization for Mental Illness (FUH-BH-C), Child 30-day, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation’s analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports FFY 2018-2020 are available for comparison to DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in Oregon DY3 and DY4. Benchmark data not available in New York DY2 and DY3, or Oregon DY1-DY3. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.14. Plan All-Cause Readmission Rate (PCR-BH)**

	PCR-BH Adult Denominator	PCR-BH Adult Rate
DY1	27892	23%
DY2	25042	16%
DY3	17257	18%
DY4	18613	19%
MN DY1	3048	22%
MN DY2	2786	22%
MN DY3	2145	12%
MN DY4	2195	12%
MO DY1	13144	26%
MO DY2	8219	24%
MO DY3	7442	26%
MO DY4	7473	26%
NJ DY1	1397	20%
NJ DY2	2175	14%
NJ DY3	2096	11%
NJ DY4	2335	25%
NY DY1	7043	24%
NY DY2	8321	8%
NY DY3	5033	12%
NY DY4	6068	11%
OK DY1	417	10%
OK DY2	669	10%
OK DY3	541	11%
OK DY4	542	16%
OR DY1	2843	15%
OR DY2	2872	13%
OR DY3	n.a.	n.a.
OR DY4	n.a.	n.a.

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data not available in Oregon DY3 and DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

n.a. = not available.

## 2. Behavioral Health Service Measures

Exhibit B.15. Adult Major Depressive Disorder: SRA-A, and Child/Adolescent Major Depressive Disorder: SRA-BH-C				
	SRA-A Denominator	SRA-A Rate	SRA-BH-C Denominator	SRA-BH-C Rate
DY1	123,626	59%	50,775	55%
DY2	158,248	70%	63,522	72%
DY3	148,036	81%	60,692	72%
DY4	174,589	82%	66,328	78%
MN DY1	22,529	48%	8,537	18%
MN DY2	21,597	59%	11,450	36%
MN DY3	19,873	69%	13,090	31%
MN DY4	22,551	65%	8,533	47%
MO DY1	42,864	78%	14,495	75%
MO DY2	65,963	88%	14,472	90%
MO DY3	78,282	94%	15,442	91%
MO DY4	75,346	98%	21,487	94%
NJ DY1	19,419	35%	4,394	82%
NJ DY2	23,115	30%	3,526	73%
NJ DY3	14,786	37%	3,293	92%
NJ DY4	25,988	55%	5,236	84%
NY DY1	7,271	86%	14,463	61%
NY DY2	8,626	89%	22,121	84%
NY DY3	12,682	89%	23,681	81%
NY DY4	28,188	89%	25,477	76%
OK DY1	5,534	64%	911	50%
OK DY2	6,649	76%	1,476	66%
OK DY3	9,771	81%	2,492	78%
OK DY4	9,066	86%	2,571	78%
OR DY1	26,009	45%	7,975	33%
OR DY2	32,298	60%	10,477	65%
OR DY3	12,642	59%	2,694	52%
OR DY4	13,450	62%	3,024	50%

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.



**Exhibit B.16. Initiation and Engagement for Alcohol or Other Drug Use:  
Measure Performance on IET-BH, Adult**

	IET-BH Initiation Adult Denominator	IET-BH Initiation Adult Rate	IET-BH Initiation Core Set benchmark	IET-BH Engagement Adult Denominator	IET-BH Engagement Adult Rate	IET-BH Engagement Core Set benchmark
DY1	11,723	50%	40%	11,723	29%	16%
DY2	12,366	47%	41%	12,368	27%	16%
DY3	9,829	50%	43%	9,829	28%	17%
DY4	4,701	48%	n.a.	4,701	24%	n.a.
MN DY1	2,375	39%	n.a.	2,375	14%	n.a.
MN DY2	2,134	38%	38%	2,134	14%	12%
MN DY3	1,828	53%	39%	1,828	13%	13%
MN DY4	1,903	53%	n.a.	1,903	14%	n.a.
MO DY1	2,259	52%	45%	2,259	39%	16%
MO DY2	2,399	47%	46%	2,399	36%	16%
MO DY3	2,377	46%	43%	2,377	34%	11%
MO DY4	2,756	44%	n.a.	2,756	31%	n.a.
NY DY1	6,076	54%	46%	6,076	33%	20%
NY DY2	6,375	51%	44%	6,375	31%	19%
NY DY3	5,584	50%	45%	5,584	30%	20%
NY DY4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
OK DY1	41	39%	na	41	34%	n.a.
OK DY2	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
OK DY3	40	38%	39%	40	30%	10%
OK DY4	42	24%	n.a.	42	24%	n.a.
OR DY1	972	46%	39%	972	15%	14%
OR DY2	1,436	43%	38%	1,438	14%	11%
OR DY3	n.a.	n.a.	38%	n.a.	n.a.	13%
OR DY4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

Source: Mathematica and RAND analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports FFY 2018-2020 reports are available for comparison to DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in New Jersey DY1-DY4, New York DY4, Oklahoma DY2, or Oregon DY3 and DY4. Benchmark data are not available in Oklahoma DY1 and DY2. New Jersey clinics are excluded from all DY IET-BH analysis due to missing years of reports and differing specifications. In New York DY4 all reports excluded from this analysis because HEDIS changes to specifications were implemented, thus making New York DY4 data different in comparison to other years and states. Oklahoma DY2 data excluded due to the denominator being less than 30. The DY3 and DY4 measurement years include the COVID-19 PHE.

n.a. = not available.

**Exhibit B.17. Screening for Clinical Depression and Follow-up Plan (CDF-BH)  
and Depression Remission at Twelve Months (DEP-REM-12)**

	CDF-BH Adult Age 18-64 Denominator	CDF-BH Adult Age 18-64 Rate	DEP-REM-12 Adult Age 18+ Denominator	DEP-REM-12 Adult Age 18+ Rate
DY1	76,087	52%	15,213	8%
DY2	91,106	66%	25,883	6%
DY3	77,096	73%	23,488	10%
DY4	83,475	72%	25,319	12%
MN DY1	9,918	27%	1,103	14%
MN DY2	8,859	54%	2,843	8%
MN DY3	8,965	51%	2,990	5%
MN DY4	9,130	38%	1,716	14%
MO DY1	15,452	49%	3,841	7%
MO DY2	21,396	62%	8,887	5%
MO DY3	14,870	76%	6,400	8%
MO DY4	22,366	81%	9,861	7%
NJ DY1	4,413	50%	0	n.a.
NJ DY2	5,485	83%	1,036	3%
NJ DY3	6,889	87%	1,617	1%
NJ DY4	5,957	89%	1,461	9%
NY DY1	21,035	60%	3,579	10%
NY DY2	24,576	81%	3,344	18%
NY DY3	23,897	79%	3,338	15%
NY DY4	24,225	76%	2,966	9%
OK DY1	8,995	82%	1,330	2%
OK DY2	9,499	86%	3,430	3%
OK DY3	10,012	88%	3,281	4%
OK DY4	10,781	93%	3,385	6%
OR DY1	16,274	46%	5,360	8%
OR DY2	21,291	46%	6,343	2%
OR DY3	12,463	50%	5,862	16%
OR DY4	11,016	44%	5,930	23%

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports FFY 2018-2020 for DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

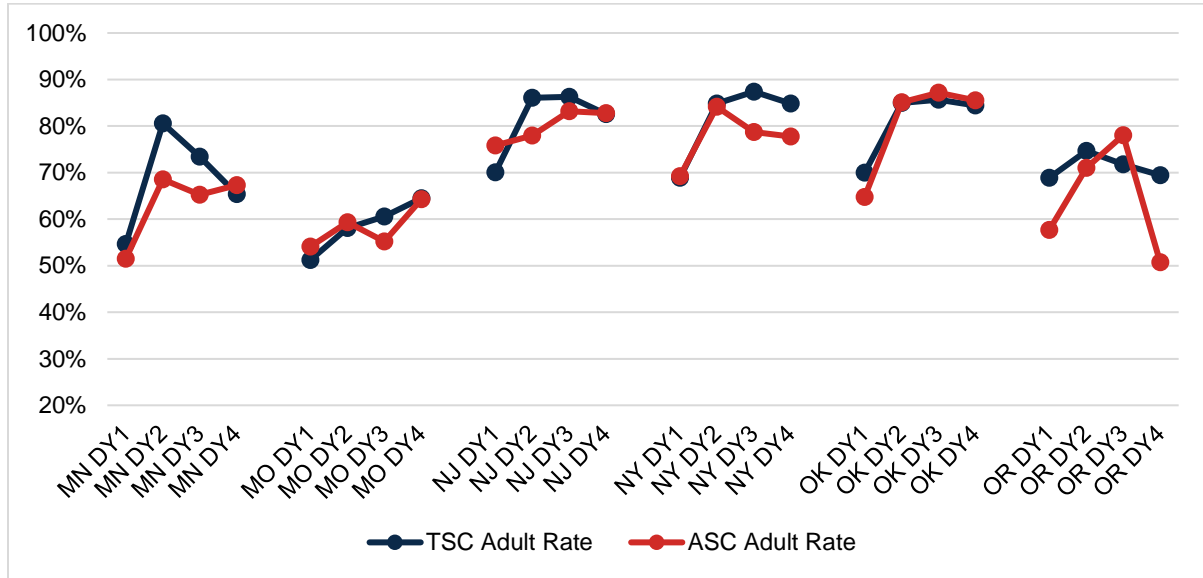
**Exhibit B.18. Tobacco Use--Screening and Cessation Intervention (TSC)  
and Unhealthy Alcohol Use--Screening and Brief Counseling (ASC)**

	TSC Adult Denominator	TSC Adult Rate	ASC Adult Denominator	ASC Adult Rate
DY1	151,703	63%	130,385	61%
DY2	166,276	75%	152,265	72%
DY3	180,585	74%	144,866	71%
DY4	186,367	74%	161,873	70%
MN DY1	11,015	55%	9,605	51%
MN DY2	12,356	81%	9,966	69%
MN DY3	13,280	73%	10,579	65%
MN DY4	11,660	65%	8,783	67%
MO DY1	46,383	51%	37,596	54%
MO DY2	50,919	58%	50,131	59%
MO DY3	69,528	61%	51,881	55%
MO DY4	71,364	64%	61,255	64%
NJ DY1	9,744	70%	10,080	76%
NJ DY2	15,336	86%	14,134	78%
NJ DY3	16,107	86%	14,029	83%
NJ DY4	15,732	83%	13,906	83%
NY DY1	38,752	69%	29,671	69%
NY DY2	42,722	85%	33,373	84%
NY DY3	43,773	87%	34,692	79%
NY DY4	48,632	85%	37,619	78%
OK DY1	15,333	70%	15,333	65%
OK DY2	16,759	85%	16,744	85%
OK DY3	19,911	86%	19,917	87%
OK DY4	21,083	84%	21,079	86%
OR DY1	30,476	69%	28,100	58%
OR DY2	28,184	75%	27,917	71%
OR DY3	17,986	72%	13,768	78%
OR DY4	17,896	69%	19,231	51%

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.19. Tobacco Use--Screening and Cessation Intervention (TSC) and Unhealthy Alcohol Use--Screening and Brief Counseling (ASC)**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

### 3. Physical Health Measures

**Exhibit B.20. Weight Assessment for Nutrition and Physical Activity for Children/Adolescents (WCC-BH) and Adult Body Mass Index Screening and Follow-up Plan (BMI-SF)**

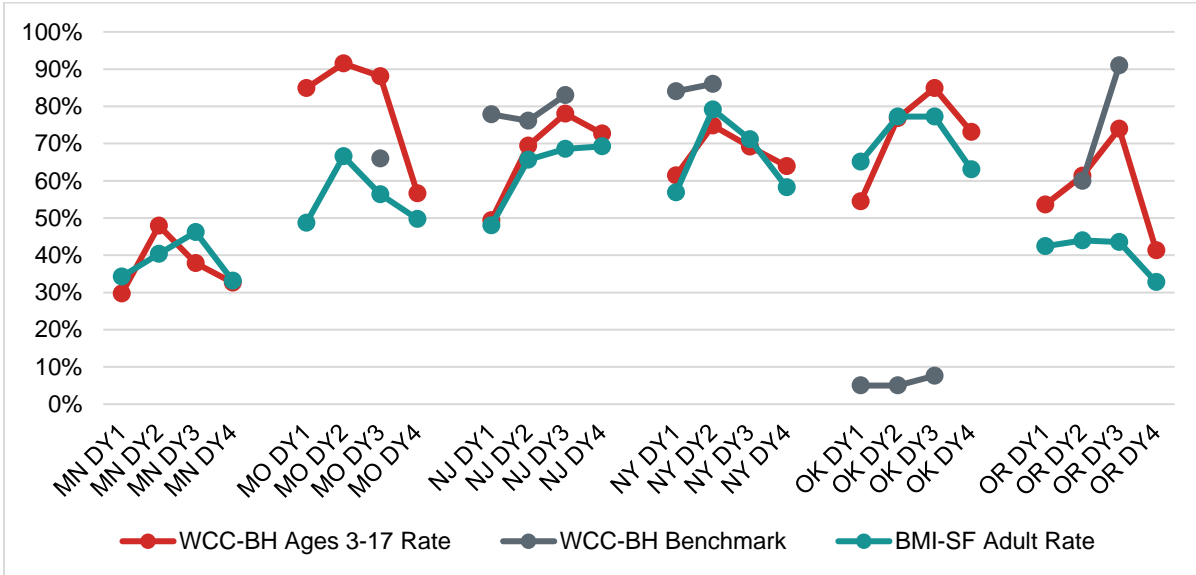
	WCC-BH Ages 3-17 Denominator	WCC-BH Ages 3-17 Rate	WCC-BH Benchmark	BMI-SF Adult Denominator	BMI-SF Adult Rate
DY1	41,572	58%	57%	133,453	50%
DY2	47,711	74%	61%	144,089	65%
DY3	45,518	76%	67%	154,582	62%
DY4	45,203	57%	n.a.	154,108	53%
MN DY1	5,769	30%	n.a.	11,559	34%
MN DY2	5,173	48%	n.a.	11,538	40%
MN DY3	4,690	38%	n.a.	9,393	46%
MN DY4	4,333	33%	n.a.	6,474	33%
MO DY1	8,869	85%	n.a.	31,404	49%
MO DY2	13,511	91%	n.a.	31,092	67%
MO DY3	14,855	88%	66%	51,859	56%
MO DY4	14,638	57%	n.a.	52,167	50%
NJ DY1	3,093	49%	78%	9,795	48%
NJ DY2	3,463	69%	76%	13,269	66%
NJ DY3	2,469	78%	83%	13,910	69%
NJ DY4	1,734	73%	n.a.	10,993	69%
NY DY1	8,704	61%	84%	38,232	57%
NY DY2	9,659	75%	86%	41,547	79%
NY DY3	10,450	69%	n.a.	42,802	71%
NY DY4	11,725	64%	n.a.	47,773	58%
OK DY1	5,014	54%	5%	15,237	65%
OK DY2	5,881	77%	5%	16,574	77%
OK DY3	6,891	85%	8%	17,045	77%
OK DY4	7,084	73%	n.a.	17,968	63%
OR DY1	10,123	54%	n.a.	27,226	42%
OR DY2	10,024	61%	60%	30,069	44%
OR DY3	6,163	74%	91%	19,573	44%
OR DY4	5,689	41%	n.a.	18,733	33%

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports FFY 2018-2020 are available for comparison to DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

n.a. = not available.

**Exhibit B.21. Weight Assessment for Nutrition and Physical Activity for Children/Adolescents (WCC-BH) and Adult Body Mass Index Screening and Follow-up Plan (BMI-SF), CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation’s analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports FFY 2018-2020 are available for comparison to DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.22. Diabetes Screening for People with Schizophrenia  
or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)**

	SSD Adult Denominator	SSD Adult Rate	SSD Adult Benchmark
DY1	17,136	76%	80%
DY2	18,946	77%	80%
DY3	12,927	74%	80%
DY4	13,988	74%	n.a.
MN DY1	1,223	77%	n.a.
MN DY2	1,100	77%	n.a.
MN DY3	1,307	72%	75%
MN DY4	1,361	73%	n.a.
MO DY1	8,434	74%	84%
MO DY2	8,216	74%	88%
MO DY3	5,441	70%	88%
MO DY4	5,918	72%	n.a.
NJ DY1	977	68%	n.a.
NJ DY2	2,007	86%	n.a.
NJ DY3	999	85%	82%
NJ DY4	1,162	84%	n.a.
NY DY1	3,635	79%	80%
NY DY2	4,016	79%	80%
NY DY3	4,494	76%	81%
NY DY4	4,811	74%	n.a.
OK DY1	647	72%	n.a.
OK DY2	1,049	74%	n.a.
OK DY3	686	81%	73%
OK DY4	736	74%	n.a.
OR DY1	2,220	80%	n.a.
OR DY2	2,558	82%	n.a.
OR DY3	n.a.	n.a.	n.a.
OR DY4	n.a.	n.a.	n.a.

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports FFY 2018-2020 are available for comparison to DY1-DY3), available at <https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in Oregon DY3 and DY4. Benchmark data are not available in Minnesota DY1 and DY2, New Jersey DY1 and DY2, Oklahoma DY1 and DY2, and Oregon DY1-DY3. The DY3 and DY4 measurement years include the COVID-19 PHE.

n.a. = not available.

#### 4. Medication Management and Adherence Measures

Exhibit B.23. Antidepressant Medication Management (AMM-BH)						
	AMM-BH Acute Denominator	AMM-BH Acute Rate	AMM-BH Acute Benchmark	AMM-BH Cont. Denominator	AMM-BH Cont. Rate	AMM-BH Cont. Benchmark
DY1	9,846	52%	50%	9,846	38%	34%
DY2	10,491	52%	51%	10,491	38%	34%
DY3	9,285	53%	53%	9,277	39%	36%
DY4	9,895	55%	n.a.	9,895	43%	n.a.
MN DY1	1,055	46%	53%	1,055	27%	29%
MN DY2	1,024	50%	52%	1,024	29%	39%
MN DY3	1,015	55%	53%	1,015	42%	39%
MN DY4	1,021	60%	n.a.	1,021	49%	n.a.
MO DY1	3,369	48%	44%	3,369	34%	27%
MO DY2	3,304	49%	45%	3,304	34%	37%
MO DY3	3,301	49%	48%	3,301	33%	28%
MO DY4	3,546	51%	n.a.	3,546	38%	n.a.
NJ DY1	1,425	69%	n.a.	1,425	51%	n.a.
NJ DY2	1,248	66%	n.a.	1,248	50%	n.a.
NJ DY3	1,274	67%	57%	1,274	48%	42%
NJ DY4	1,418	66%	n.a.	1,418	49%	n.a.
NY DY1	2,630	55%	52%	2,630	41%	38%
NY DY2	3,061	54%	52%	3,061	42%	38%
NY DY3	3,152	54%	53%	3,144	40%	39%
NY DY4	3,321	56%	n.a.	3,321	44%	n.a.
OK DY1	446	44%	n.a.	446	41%	n.a.
OK DY2	933	40%	48%	933	43%	n.a.
OK DY3	543	39%	47%	543	39%	28%
OK DY4	589	43%	n.a.	589	43%	n.a.
OR DY1	921	49%	n.a.	921	31%	n.a.
OR DY2	921	49%	n.a.	921	31%	n.a.
OR DY3	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
OR DY4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

Source: Mathematica and RAND analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports FFY 2018-2020 for DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-coreset/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in Oregon DY3 and DY4. Benchmark data are not available in New Jersey DY1 and DY2, Oklahoma DY1 and DY2, and Oregon DY1-DY3. Benchmark data are not available in New Jersey DY1 and DY2, Oklahoma DY1 and DY2, and Oregon DY1-DY3. The DY3 and DY4 measurement years include the COVID-19 PHE.

n.a. = not available.



**Exhibit B.24. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)**

	SAA-BH Adult Denominator	SAA-BH Adult Rate	SAA-BH Adult Benchmark
DY1	9,373	60%	59%
DY2	9,791	57%	61%
DY3	8,168	60%	61%
DY4	8,952	60%	n.a.
MN DY1	735	60%	n.a.
MN DY2	688	54%	n.a.
MN DY3	790	64%	69%
MN DY4	828	63%	n.a.
MO DY1	4,477	67%	65%
MO DY2	4,384	66%	65%
MO DY3	4,516	66%	59%
MO DY4	5,155	64%	n.a.
NJ DY1	123	49%	n.a.
NJ DY2	44	41%	n.a.
NJ DY3	n.a.	n.a.	67%
NJ DY4	n.a.	n.a.	n.a.
NY DY1	1,930	52%	63%
NY DY2	2,071	54%	64%
NY DY3	2,253	57%	64%
NY DY4	2,366	57%	n.a.
OK DY1	538	33%	n.a.
OK DY2	889	28%	n.a.
OK DY3	598	29%	29%
OK DY4	598	32%	n.a.
OR DY1	1,570	61%	n.a.
OR DY2	1,715	52%	n.a.
OR DY3	n.a.	n.a.	n.a.
OR DY4	n.a.	n.a.	n.a.

Source: Mathematica and RAND analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Adults in Medicaid (reports FFY 2018-2020 for DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-coreset/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in New Jersey DY3 and DY4, Oregon DY3 and DY4. Benchmark data are not available in Minnesota DY1 and DY2, New Jersey DY1 and DY2, Oklahoma DY1 and DY2, and Oregon DY1-DY3. The DY3 and DY4 measurement years include the COVID-19 PHE.

n.a. = not available.

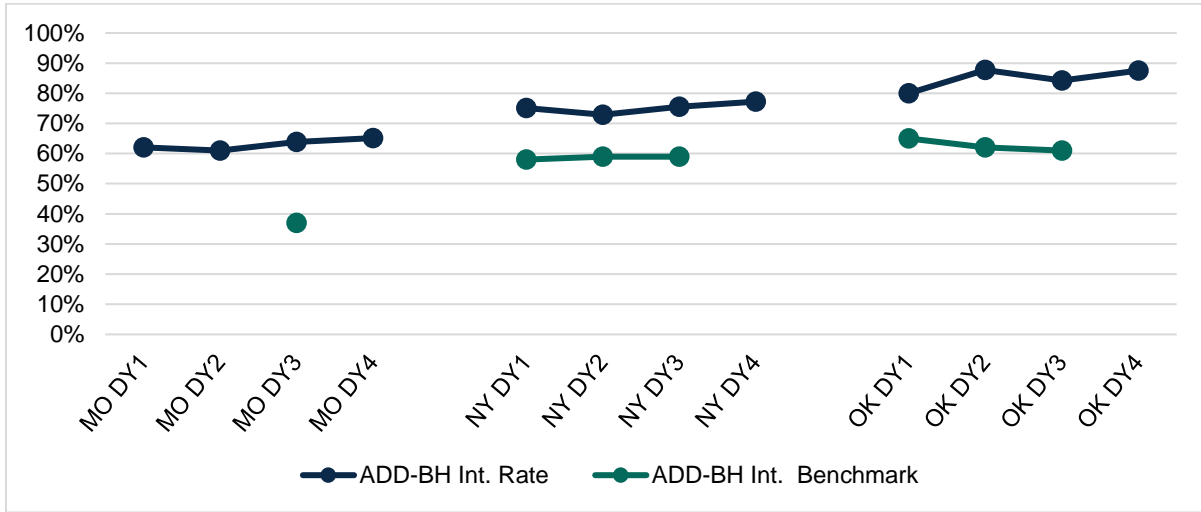
**Exhibit B.25. Follow-up Care for Children Prescribed ADHD Medication (ADD-BH):  
Measure Performance**

	ADD-BH Int. Denominator	ADD-BH Int. Rate	ADD-BH Int. Benchmark	ADD-BH Cont. Denominator	ADD-BH Cont. Rate	ADD-BH Cont. Benchmark
DY1	2278	0.67	0.49	910	0.83	0.59
DY2	2484	0.67	0.48	778	0.90	0.59
DY3	2188	0.67	0.47	824	0.89	0.57
DY4	1994	0.69	n.a.	754	0.91	n.a.
MN DY1	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
MN DY2	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
MN DY3	n.a.	n.a.	0.38	n.a.	n.a.	0.43
MN DY4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
MO DY1	1605	0.62	n.a.	638	0.83	n.a.
MO DY2	1674	0.61	n.a.	562	0.91	n.a.
MO DY3	1633	0.64	0.37	582	0.91	0.45
MO DY4	1484	0.65	n.a.	558	0.92	n.a.
NJ DY1	n.a.	n.a.	0.33	n.a.	n.a.	0.36
NJ DY2	n.a.	n.a.	0.33	n.a.	n.a.	0.37
NJ DY3	n.a.	n.a.	0.33	n.a.	n.a.	0.37
NJ DY4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
NY DY1	349	0.75	0.58	128	0.77	0.66
NY DY2	383	0.73	0.59	143	0.83	0.66
NY DY3	396	0.76	0.59	166	0.83	0.64
NY DY4	325	0.77	n.a.	119	0.85	n.a.
OK DY1	80	0.80	0.65	40	0.78	0.64
OK DY2	163	0.88	0.62	73	0.92	0.69
OK DY3	159	0.84	0.61	76	0.89	0.67
OK DY4	185	0.88	n.a.	77	0.90	n.a.
OR DY1	244	0.83	n.a.	104	0.90	n.a.
OR DY2	264	0.81	n.a.	n.a.	n.a.	n.a.
OR DY3	n.a.	n.a.	0.64	n.a.	n.a.	0.74
OR DY4	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Children in Medicaid and CHIP (reports FFY 2018-2020 for DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in Minnesota DY1-DY4, New Jersey DY1-DY4, Oregon DY3-DY4. Benchmark data are not available in Minnesota DY1 and DY2, Missouri DY1 and DY2, and Oregon DY1 and DY2. The DY3 and DY4 measurement years include the COVID-19 PHE. n.a. = not available.

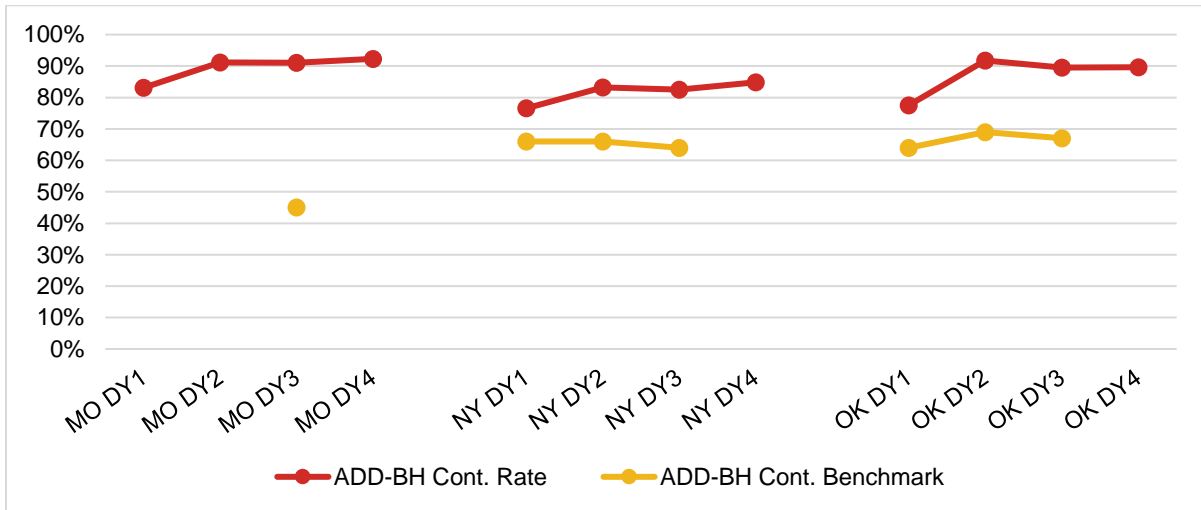
**Exhibit B.26. Follow-up Care for Children Prescribed ADHD Medication (ADD-BH), Initiation Phase, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Children in Medicaid and CHIP (reports FFY 2018-2020 for DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in Minnesota DY1-DY4, New Jersey DY1-DY4, or Oregon DY3 and DY4. Benchmark data are not available in Minnesota DY1 and DY2, Missouri DY1 and DY2, or Oregon DY1 and DY2. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.27. Follow-up Care for Children Prescribed ADHD Medication (ADD-BH), Continuation Phase, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks are from the Annual Reporting on the Quality of Care for Children in Medicaid and CHIP (reports FFY 2018-2020 for DY1-DY3), available at <https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in Minnesota DY1-DY4, New Jersey DY1-DY4, or Oregon DY3 and DY4. Benchmark data are not available in Minnesota DY1 and DY2, Missouri DY1 and DY2, or Oregon DY1 and DY2. The DY3 and DY4 measurement years include the COVID-19 PHE.

## Adult and Family Experience of Care Measures

Below is a table summarizing the CCBHC and state reported sample size and responses of PEC (adult) data which was then available for analysis.

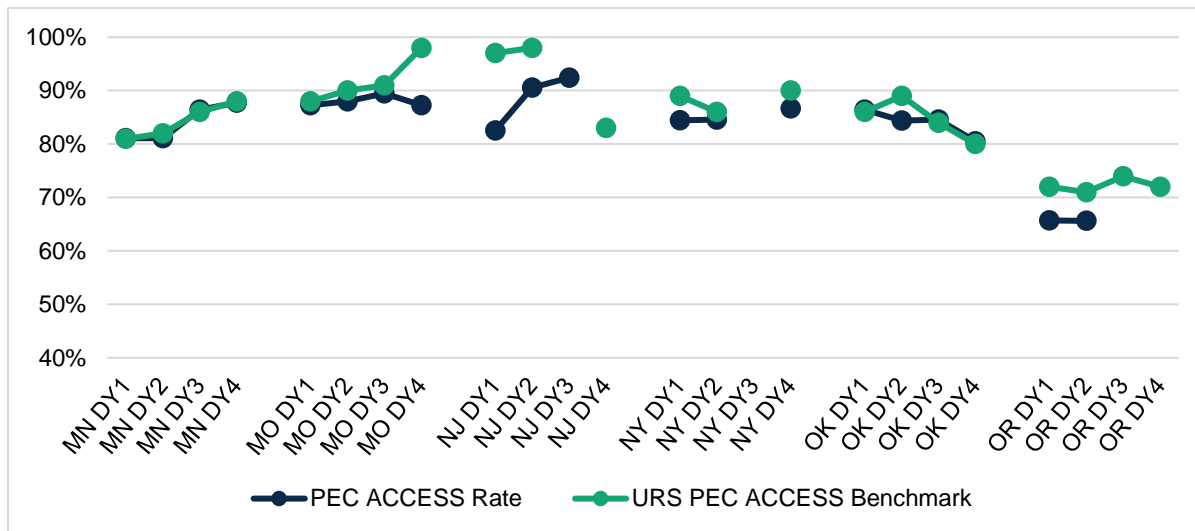
Exhibit B.28. PEC Measure (adult): Surveys Completed				
	CCBHC Adult Clients	Proportion Contacted of Total Adult CCBHC Clients	Proportion Completed of Contacted Adult CCBHC Clients	Proportion Completed of Total Adult CCBHC Clients
DY1	218,460	24%	25%	6%
DY2	234,224	23%	26%	6%
DY3	230,416	7%	48%	3%
DY4	240,083	11%	30%	3%
MN DY1	16,855	14%	43%	6%
MN DY2	18,910	13%	43%	5%
MN DY3	17,864	8%	52%	4%
MN DY4	15,075	16%	29%	5%
MO DY1	92,416	11%	51%	5%
MO DY2	98,692	9%	63%	6%
MO DY3	102,130	9%	57%	5%
MO DY4	108,880	8%	44%	4%
NJ DY1	14,462	23%	40%	9%
NJ DY2	15,745	27%	32%	9%
NJ DY3	17,310	13%	45%	6%
NJ DY4	18,681	n.a.	n.a.	n.a.
NY DY1	39,022	9%	83%	8%
NY DY2	43,695	7%	86%	6%
NY DY3	44,723	n.a.	n.a.	n.a.
NY DY4	48,544	14%	42%	6%
OK DY1	15,516	n.a.	n.a.	15%
OK DY2	16,648	n.a.	n.a.	14%
OK DY3	17,370	n.a.	n.a.	2%
OK DY4	18,412	n.a.	n.a.	1%
OR DY1	40,189	7%	24%	2%
OR DY2	40,534	10%	20%	2%
OR DY3	31,019	n.a.	n.a.	n.a.
OR DY4	30,491	n.a.	n.a.	n.a.

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. PEC data are not available in New Jersey DY4, New York DY3, Oregon DY3 and DY4; at least 2 states noted that surveys were not conducted due to COVID-19 PHE. The DY3 and DY4 measurement years include the COVID-19 PHE.

n.a. = not available.

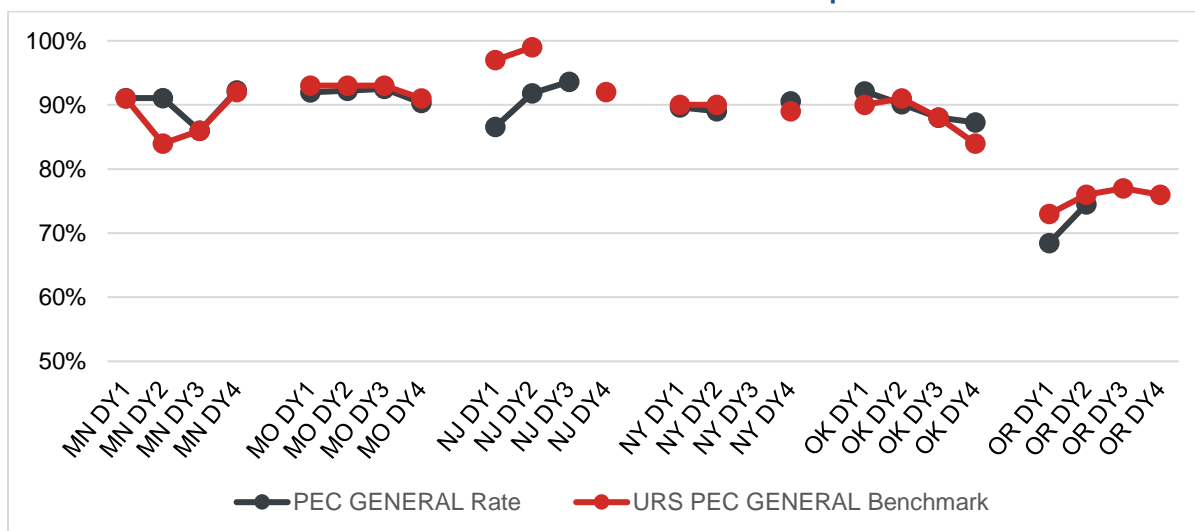
**Exhibit B.29. Adult Survey Respondents Reporting Positively about Access, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks reported are from the Annual Report URS Tables, available at <https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. PEC data are not available in New Jersey DY4, New York DY3, Oregon DY3 and DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

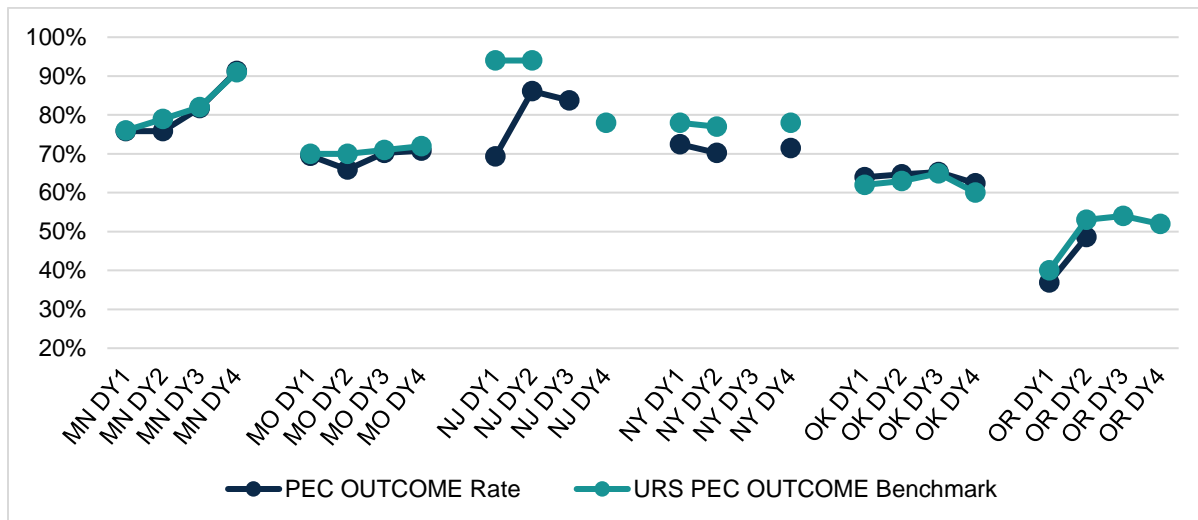
**Exhibit B.30. Adult Survey Respondents Reporting Positively about General Satisfaction, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks reported are from the Annual Report URS Tables, available at <https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. PEC data are not available in New Jersey DY4, New York DY3, Oregon DY3 and DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

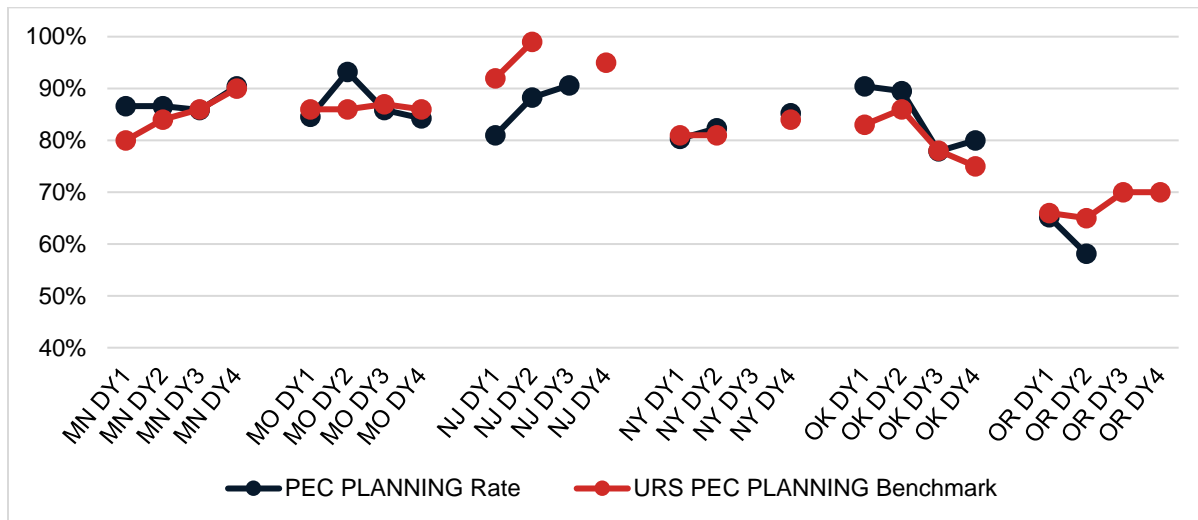
**Exhibit B.31. Adult Survey Respondents Reporting Positively about Outcomes, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks reported are from the Annual Report URS Tables, available at <https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. PEC data are not available in New Jersey DY4, New York DY3, Oregon DY3 and DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.32. Adult Survey Respondents Reporting Positively about Participation in Treatment Planning, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks reported are from the Annual Report URS Tables, available at <https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. PEC data are not available in New Jersey DY4, New York DY3, Oregon DY3 and DY4; at least 2 states noted that surveys were not conducted due to COVID-19 PHE. The DY3 and DY4 measurement years include the COVID-19 PHE.

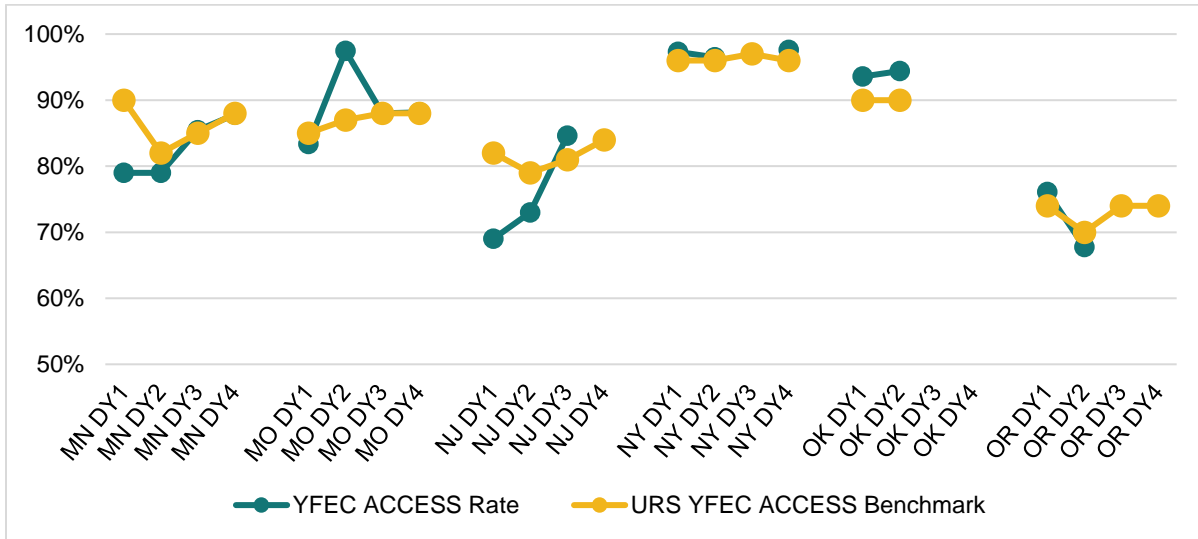
Below is a table summarizing the CCBHC and state reported sample size and responses of Patient (youth/family) Experience of Care Survey (Y/FEC) data which was then available for analysis.

<b>Exhibit B.33. Youth/Family Experience of Care Survey (Y/FEC): Surveys Completed</b>				
	<b>Child/ Adolescent Age 0-17 Years</b>	<b>Proportion Contacted of Total Child/Adolescent Clients</b>	<b>Proportion Completed of Contacted Child/ Adolescent Clients</b>	<b>Proportion Completed of Total Child/ Adolescent Clients</b>
DY1	67,619	34%	38%	13%
DY2	74,643	34%	50%	17%
DY3	73,478	16%	48%	8%
DY4	75,066	18%	46%	9%
MN DY1	6,172	23%	35%	8%
MN DY2	6,492	22%	35%	8%
MN DY3	6,071	19%	33%	6%
MN DY4	5,650	34%	31%	10%
MO DY1	29,381	33%	43%	14%
MO DY2	33,973	31%	42%	13%
MO DY3	35,807	26%	41%	11%
MO DY4	36,754	24%	32%	8%
NJ DY1	3,389	46%	83%	38%
NJ DY2	3,382	59%	100%	59%
NJ DY3	3,083	48%	100%	48%
NJ DY4	3,061	n.a.	n.a.	n.a.
NY DY1	10,881	12%	59%	7%
NY DY2	11,998	9%	92%	9%
NY DY3	12,654	n.a.	n.a.	n.a.
NY DY4	14,540	20%	100%	20%
OK DY1	5,074	n.a.	n.a.	29%
OK DY2	6,093	n.a.	n.a.	24%
OK DY3	6,986	n.a.	n.a.	n.a.
OK DY4	7,171	n.a.	n.a.	n.a.
OR DY1	12,722	19%	27%	5%
OR DY2	12,705	32%	87%	28%
OR DY3	8,877	n.a.	n.a.	n.a.
OR DY4	7,890	n.a.	n.a.	n.a.

Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. Y/FEC data are not available in New Jersey DY4, New York DY3, Oklahoma DY3 and DY4, Oregon DY3 and DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

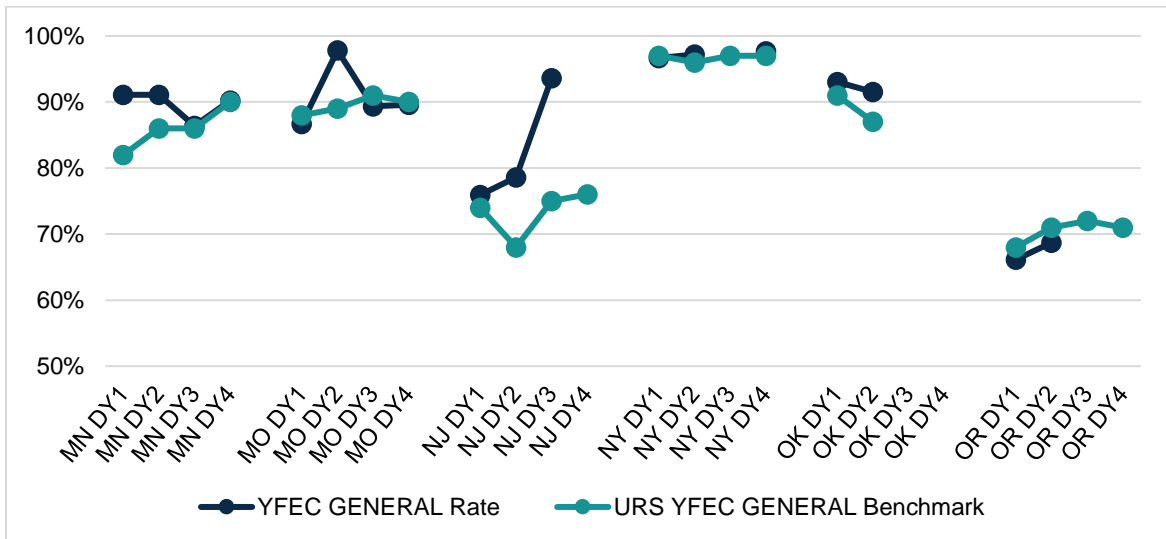
**Exhibit B.34. Youth and Family Survey Respondents Reporting Positively about Access, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks reported are from the Annual Report URS Tables, available at <https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. Y/FEC data are not available in New Jersey DY4, New York DY3, Oklahoma DY3 and DY4, Oregon DY3 and DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.35. Youth and Family Survey Respondents Reporting Positively about General Satisfaction, CCBHC Performance and Benchmark Comparison**

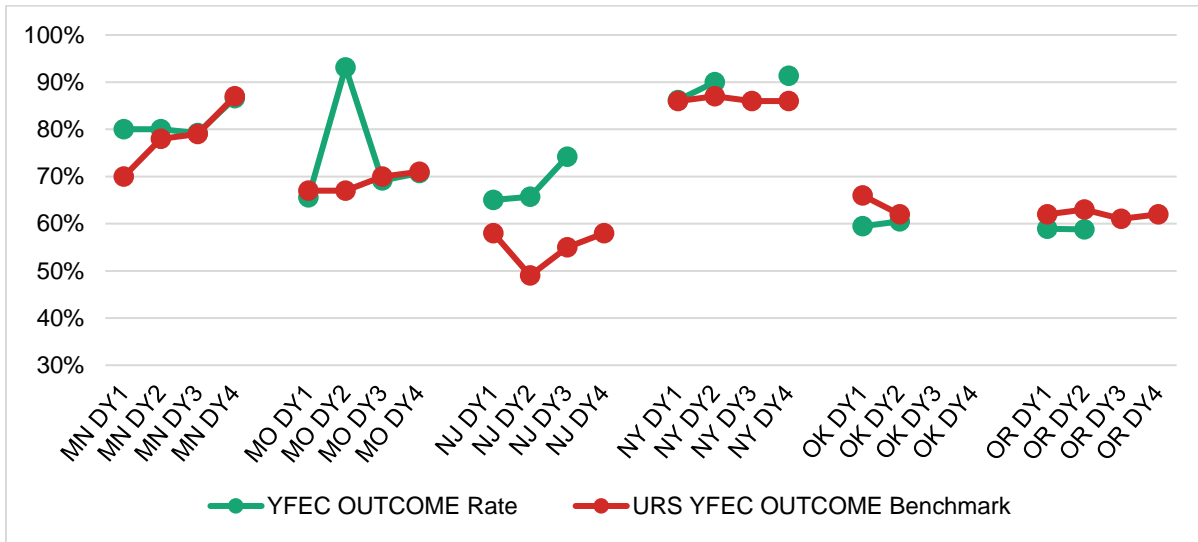


Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures. Benchmarks reported are from the Annual Report URS Tables, available at <https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. Y/FEC data are not available in New Jersey DY4, New York DY3, Oklahoma DY3 and DY4, Oregon DY3 and DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.



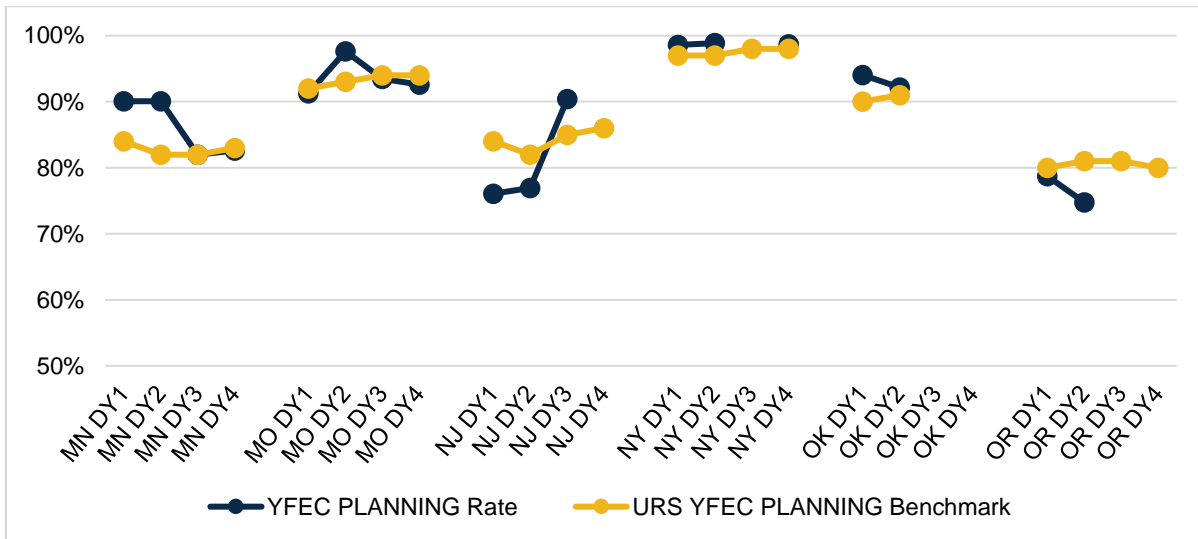
**Exhibit B.36. Youth and Family Survey Respondents Reporting Positively about Outcomes, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures reports. Benchmarks reported are from the Annual Report URS Tables, available at <https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. Y/FEC data are not available in New Jersey DY4, New York DY3, Oklahoma DY3 and DY4, Oregon DY3 and DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.37. Youth and Family Survey Respondents Reporting Positively about Participation in Treatment Planning for Their Children, CCBHC Performance and Benchmark Comparison**



Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measure reports. Benchmarks reported are from the Annual Report URS Tables, available at <https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system>.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. Y/FEC data are not available in New Jersey DY4, New York DY3, Oklahoma DY3 and DY4, Oregon DY3 and DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.

**Exhibit B.38. Measure Performance Across Domains from DY1 to DY4**

Change in Measure Performance from DY1 to DY4	MN	MO	NJ	NY	OK	OR
<b>Access</b>						
Initial Evaluation for New Clients (I-EVAL) ADULT	↔	↑	↓	↔	↑	↓
Initial Evaluation for New Clients (I-EVAL) CHILD	↓	↑	↓	↑	↑	↔
Reporting Positively About Access ADULT SURVEY	↑	↔	n.a.	↔	↓	n.a.
Reporting Positively About Access YOUTH & FAMILY SURVEY	↑	↑	n.a.	↔	↔	n.a.
<b>Scope of services measures: Care coordination</b>						
Follow-up after Emergency Department for Mental Illness: 30-day (FUM 30-day)	↔	↔	↑	↔	n.a.	n.a.
Follow-up after Emergency Department Visit for Alcohol or Other Dependence: 30-day (FUA 30-day)	↔	↑	↔	↔	↑	n.a.
Follow-up after Hospitalization for Mental Illness Adult (FUH-BH-A 30-day)	↓	↔	↑	↔	↔	n.a.
Follow-up after Hospitalization for Mental Illness Child/Adolescent (FUH-BH-C 30-day)	↔	↔	↑	↑	↑	n.a.
<b>Scope of services measures: Behavioral health services</b>						
Adult Major Depressive Disorder: Suicide Risk Assessment (SRA-A)	↑	↑	↑	↔	↑	↑
Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (SRA-BH-C)	↑	↑	↔	↑	↑	↑
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH) Adult INITIATION PHASE	↑	↓	n.a.	n.a.	↓	n.a.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH) Adult ENGAGEMENT PHASE	↔	↓	n.a.	n.a.	↓	n.a.
Antidepressant Medication Management (AMM-BH) ACUTE PHASE	↑	↔	↔	↔	↔	n.a.
Antidepressant Medication Management (AMM-BH) CONTINUATION PHASE	↑	↔	↔	↔	↔	n.a.
<b>Scope of services measures: Primary care screening and monitoring</b>						
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)	↔	↔	↑	↓	↔	n.a.
Source: Mathematica and the RAND Corporation's analysis of DY1-DY4 CCBHC quality measures						

# Appendix C. Supplemental Survey Findings

**Exhibit C.1. CCBHCs that Provided Services Outside of the Physical Clinic Space in the Past 12 Months**

Location	Provided Services in the Past 12 Months	
	N	%
Client's homes	64	90
Hospitals	47	65
Emergency departments	50	69
Restaurants, coffee shops	47	65
Shelters	47	65
Social service organizations	56	78
Schools	62	86
Parole offices	37	51
Courts, jails, police stations or law enforcement offices	56	78
Libraries	43	60
Other community locations	28	39

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey and the CCBHC Annual Progress Report Demonstration Year 2, March 2019.

Notes: Percentages are calculated as a proportion of the total number of CCBHCs responding to the survey (n = 72).

**Exhibit C.2. CCBHCs that Provided Services Outside of the Physical Clinic Space in the Past 12 Months, by State**

Location	State																		Average Percentage of CCBHCs Across States 2023
	Kentucky		Michigan		Minnesota		Missouri		Nevada		New Jersey		New York		Oklahoma		Oregon		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Client's homes	4	100	13	100	3	75	15	100	1	33	4	57	11	85	3	100	10	100	83
Hospitals	3	75	12	92	1	25	14	93	0	0	2	29	5	38	3	100	7	70	58
Emergency departments	4	100	12	92	1	25	15	100	1	33	2	29	4	31	3	100	8	80	66
Restaurants, coffee shops	2	50	12	92	3	75	8	53	0	0	4	57	8	62	1	33	9	90	57
Shelters	3	75	11	85	2	50	11	73	0	0	4	57	7	54	3	100	6	60	62
Social service organizations	4	100	12	92	3	75	13	87	1	33	4	57	9	69	3	100	7	70	76
Schools	4	100	13	100	2	50	15	100	2	67	4	57	9	69	3	100	10	100	83
Parole offices	2	50	8	62	1	25	11	73	1	33	3	43	3	23	2	67	6	60	48
Courts, jails, police stations or law enforcement offices	3	75	12	92	2	50	15	100	1	33	3	43	7	54	3	100	10	100	72
Libraries	2	50	12	92	3	75	10	67	0	0	3	43	4	31	2	67	7	70	55
Other community locations	2	50	6	46	0	0	6	40	1	33	2	29	6	46	1	33	4	40	35

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey and the CCBHC Annual Progress Report Demonstration Year 2, March 2019.

Notes: 2019 percentages reported where data are comparable. Cell values for 2023 data are calculated as a proportion of the total number of CCBHCs responding to the survey in each state: Kentucky = 4, Michigan = 13, Minnesota = 4, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 10. Cell values for 2019 data are calculated as a proportion of the total number of CCBHCs that responded (n = 66).

**Exhibit C.3. CCBHCs that Offer Open-Access or Same-Day Scheduling, by Service Type**

Service	Offer Open Access or Same-Day Scheduling	
	N	%
Screening, assessment, and diagnosis	65	90
Outpatient mental health	45	63
Outpatient SUD services	46	64
Targeted case management	34	47
Primary care screening and monitoring	25	35
Person and Family-centered treatment planning services	30	42
Psychiatric rehabilitation services	29	40
Peer support services	39	54
Intensive community-based mental health services for armed forces and veterans	29	40

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Percentages are calculated as a proportion of the total number of CCBHCs responding to the survey (n = 72).

**Exhibit C.4. CCBHCs that Offer Open-Access or Same-Day Scheduling, by Service Type, by State**

Service	State																		Average Percentage of CCBHCs Across States 2023
	Kentucky		Michigan		Minnesota		Missouri		Nevada		New Jersey		New York		Oklahoma		Oregon		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Screening, assessment, and diagnosis	2	50	13	100	3	75	15	100	2	67	7	100	13	100	3	100	7	70	85
Outpatient mental health	2	50	2	15	3	75	9	60	2	67	6	86	13	100	3	100	5	50	67
Outpatient SUD services	2	50	1	8	1	25	12	80	2	67	6	86	13	100	3	100	6	60	64
Targeted case management	0	0	4	31	2	50	5	33	1	33	6	86	9	69	3	100	4	40	49
Primary care screening and monitoring	1	25	2	15	2	50	2	13	1	33	5	71	6	46	2	67	4	40	40
Person- and Family-centered treatment planning services	1	25	1	8	2	50	5	33	0	0	5	71	9	69	2	67	5	50	41
Psychiatric rehabilitation services	0	0	1	8	3	75	5	33	1	33	5	71	8	62	2	67	4	40	43
Peer support services	1	25	3	23	2	50	10	67	1	33	6	86	9	69	3	100	4	40	55
Intensive community-based mental health services for armed forces and veterans	2	50	5	38	0	0	4	27	2	67	4	57	8	62	2	67	2	20	43

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Cell values are calculated as a proportion of the total number of CCBHCs responding to the survey in each state: Kentucky = 4, Michigan = 13, Minnesota = 4, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 10.

**Exhibit C.5. Characteristics of Demonstration CCBHCs' EHR Systems**

EHR Characteristic	Yes Response	
	N	%
Routinely document the name of clients' external primary care provider(s) in client health records	70	97
Generates electronic care plans	70	97
Includes physical health information	51	71

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Percentages are calculated as a proportion of the total number of CCBHCs responding to the survey (n = 72).

**Exhibit C.6. Characteristics of Demonstration CCBHCs' EHR Systems, by State**

EHR Characteristic	State																		Average Percentage Across CCBHCs 2023
	Kentucky		Michigan		Minnesota		Missouri		Nevada		New Jersey		New York		Oklahoma		Oregon		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Routinely document the name of clients' external primary care provider(s) in client health records	4	100	13	100	4	100	15	100	2	67	6	68	13	100	3	100	10	100	95
Generates electronic care plans	4	100	13	100	4	100	14	93	3	100	7	100	12	92	3	100	10	100	98
Includes physical health information	4	100	9	69	3	75	11	73	3	100	2	29	11	85	3	100	5	50	76

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Cell values are calculated as a proportion of the total number of CCBHCs responding to the survey in each state: Kentucky = 4, Michigan = 13, Minnesota = 4, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 10.

**Exhibit C.7. CCBHCs that Reported Use of Specific HIT Tools**

HIT	Yes Response	
	N	%
Data dashboard(s)	61	85
Patient portals	44	61
Electronic clinical decision support tools	40	56
Clinical registry	19	26

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Percentages are calculated as a proportion of the total number of CCBHCs responding to the survey (n = 72).



**Exhibit C.8. CCBHCs that Reported Use of Specific HIT Tools, by State**

HIT	State																		Average Percentage Across CCBHCs 2023
	Kentucky		Michigan		Minnesota		Missouri		Nevada		New Jersey		New York		Oklahoma		Oregon		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Data dashboard(s)	3	75	13	100	3	75	3	93	1	33	4	57	12	92	3	100	8	80	78
Patient portals	3	75	11	85	0	0	7	47	2	67	6	86	6	46	3	100	6	60	63
Electronic clinical decision support tools	3	75	7	54	2	50	9	60	2	67	3	43	7	54	3	100	4	40	60
Clinical registry	1	25	3	23	0	0	5	33	0	0	1	14	3	23	3	100	3	30	28

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Cell values are calculated as a proportion of the total number of CCBHCs responding to the survey in each state: Kentucky = 4, Michigan = 13, Minnesota = 4, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 10.

**Exhibit C.9. CCBHCs with Formal and Informal Relationships with External Organizations, by Type and State**

Provider Type	State																		Average Percentage Across CCBHCs	
	Kentucky		Michigan		Minnesota		Missouri		Nevada		New Jersey		New York		Oklahoma		Oregon			
	For.	Infor.	For.	Infor.	For.	Infor.	For.	Infor.	For.	Infor.	For.	Infor.	For.	Infor.	For.	Infor.	For.	Infor.		
Federally Qualified Health Centers	75	50	92	0	0	75	73	33	33	67	100	14	69	46	67	0	70	10	64	33
Rural health clinics	50	75	8	23	0	25	20	40	33	67	29	0	23	23	0	67	30	20	21	38
Primary care providers	25	75	62	62	50	50	40	73	33	67	71	57	85	31	33	67	70	40	52	58
Urgent care centers	25	50	8	23	25	50	13	80	0	67	43	71	62	23	33	67	30	30	27	51
Emergency departments	75	50	85	23	25	75	53	67	0	67	86	29	92	23	67	67	80	20	63	47
988 Suicide & Crisis Lifeline call center	100	0	85	15	25	75	53	0	67	33	43	57	31	46	67	0	90	10	62	26
Inpatient psychiatric facilities	100	25	100	8	25	75	33	73	0	100	71	43	77	38	67	0	50	40	58	45
Psychiatric residential treatment facilities	75	25	77	15	50	50	53	60	33	67	57	57	54	31	33	100	60	30	55	48
Substance use disorder residential treatment facilities	50	50	62	38	50	50	60	47	0	100	71	43	85	23	33	67	50	50	51	52
Medical detoxification facilities	75	50	46	31	25	50	20	67	0	100	71	43	62	38	67	0	40	60	45	49
Ambulatory detoxification facilities	25	75	46	38	0	50	40	47	0	100	86	29	69	31	67	67	40	50	41	54
Post-detoxification step-down facilities	50	50	62	31	25	50	33	40	0	100	43	43	54	38	67	33	20	40	39	47
Hospital outpatient clinics	50	50	46	31	0	100	27	80	0	33	71	43	77	31	0	100	40	40	35	56
Medication-assisted treatment providers for substance use	25	75	69	23	75	25	80	13	0	100	71	57	77	38	33	67	60	30	55	48
Opioid treatment program	25	100	54	38	25	75	47	60	0	100	71	43	69	38	67	33	20	40	42	59
Schools	100	0	100	8	75	25	87	7	67	33	86	57	77	38	100	33	80	20	86	25
School-based health centers	0	50	46	15	25	50	33	33	0	67	57	57	77	38	33	33	40	40	30	43
Child welfare agencies	100	0	69	38	75	25	27	73	67	33	57	57	62	31	67	67	50	60	64	43
Therapeutic foster care service agencies	50	50	38	54	0	50	33	40	0	100	29	71	46	46	33	67	30	30	29	56
Juvenile justice agencies	75	25	77	31	50	25	33	80	33	67	29	57	31	62	0	100	60	50	43	55
Adult criminal justice agencies/courts	100	0	92	8	75	25	73	33	33	67	71	43	54	54	100	0	90	20	77	28
Mental health/drug courts	100	0	77	15	50	50	87	0	33	67	86	29	69	38	100	0	90	10	77	23

**Exhibit C.9 (continued)**

Provider Type	State																		Average Percentage Across CCBHCs	
	Kentucky		Michigan		Minnesota		Missouri		Nevada		New Jersey		New York		Oklahoma		Oregon			
	For.	Infor.	For.	Infor.	For.	Infor.	For.	Infor.	For.	Infor.	For.	Infor.	For.	Infor.	For.	Infor.	For.	Infor.		
Law enforcement	75	50	77	23	75	25	67	40	0	100	71	71	38	54	100	0	80	30	65	44
Indian Health Service or other Tribal programs	0	0	54	31	0	75	13	0	33	67	14	14	23	15	67	67	70	20	31	32
Indian Health Service youth regional treatment centers	0	0	15	8	0	75	7	7	0	67	14	14	15	15	0	100	30	40	9	36
Department of Veterans Affairs Treatment Facilities	75	25	31	69	50	25	33	67	0	100	43	57	77	15	67	33	70	20	50	46
Homeless shelters	50	50	46	62	50	50	27	53	33	67	57	71	62	38	33	67	40	40	44	55
Housing agencies	25	75	69	38	50	50	73	40	33	67	57	71	69	31	0	100	70	30	50	56
Suicide/crisis hotlines and warmlines	50	50	54	31	25	75	47	13	33	67	71	43	69	23	100	33	70	30	58	41
Residential (non-hospital) crisis settings	50	25	69	15	75	25	13	67	0	67	43	71	46	54	67	0	50	30	46	39
Employment services and/or supported employment	75	25	69	23	75	25	73	13	0	100	71	43	62	46	67	33	90	20	65	37
Older adult services	25	50	38	46	0	100	13	60	33	67	29	43	69	31	0	100	50	60	29	62
Other social and human service providers	50	50	54	38	50	50	20	73	33	67	29	57	77	31	67	67	50	60	48	55
Consumer-operated/peer service provider organizations	100	0	62	8	0	75	20	53	33	67	57	29	62	38	0	100	40	40	42	46

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Cell values are calculated as a proportion of the total number of CCBHCs responding to the survey in each state: Kentucky = 4, Michigan = 13, Minnesota = 4, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 10.

For. = Formal; Infor. = Informal

**Exhibit C.10. CCBHC DCO Relationships with External Providers, by Service Type**

Service Type	Yes Response	
	N	%
Crisis Behavioral Health Services	19	26
Screening, Assessment, and Diagnosis	3	4
Person and Family-Centered Treatment Planning Services	5	7
Outpatient Mental Health and/or Substance Use Disorder Services	6	8
Psychiatric Rehabilitation Services	5	7
Peer Support Services	6	8
Targeted Case Management	4	6
Primary Care Screening and Monitoring	8	11
Intensive Community-Based Mental Health Services for Armed Forces and Veterans	2	2

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Percentages are calculated as a proportion of the total number of CCBHCs responding to the survey (n = 72).

**Exhibit C.11. CCBHC DCO Relationships with External Providers, by Service Type, by State**

Service Type	State																		Average Percentage of CCBHCs Across States
	Kentucky		Michigan		Minnesota		Missouri		Nevada		New Jersey		New York		Oklahoma		Oregon		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Crisis Behavioral Health Services	0	0	4	31	1	25	7	47	0	0	3	43	4	31	0	0	0	0	20
Screening, Assessment, and Diagnosis	0	0	2	15	0	0	0	0	0	0	1	14	0	0	0	0	0	0	3
Person and Family-Centered Treatment Planning Services	0	0	5	38	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
Outpatient Mental Health and/or Substance Use Disorder Services	0	0	5	38	0	0	1	7	0	0	0	0	0	0	0	0	0	0	5
Psychiatric Rehabilitation Services	0	0	4	31	0	0	0	0	0	0	1	14	0	0	0	0	0	0	5
Peer Support Services	0	0	4	31	0	0	0	0	0	0	1	14	0	0	0	0	1	10	6
Targeted Case Management	0	0	4	31	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
Primary Care Screening and Monitoring	0	0	2	15	0	0	0	0	7	1	2	29	1	8	0	0	2	20	9
Intensive Community-Based Mental Health Services for Armed Forces and Veterans	0	0	0	0	0	0	0	0	7	1	1	1	0	0	0	0	0	0	2

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Cell values are calculated as a proportion of the total number of CCBHCs responding to the survey in each state: Kentucky = 4, Michigan = 13, Minnesota = 4, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 10.

**Exhibit C.12. CCBHCs that Use HIT Connected to Outside Providers or Exchanges**

HIT	Yes Response	
	N	%
Electronic prescribing	68	94
Electronic exchange of clinical information with external providers	51	71
State-operated health information exchange	43	60
Privately operated health information exchange	21	29

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey

Notes: Percentages are calculated as a proportion of the total number of CCBHCs responding to the survey (n = 72)

**Exhibit C.13. CCBHCs that Use HIT Connected to Outside Providers or Exchanges, by State**

HIT	State																		Average Percentage of CCBHCs Across States
	Kentucky		Michigan		Minnesota		Missouri		Nevada		New Jersey		New York		Oklahoma		Oregon		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Electronic prescribing	4	100	13	100	4	100	15	100	2	67	7	100	12	92	3	100	10	100	95
Electronic exchange of clinical information with external providers	3	75	12	92	2	50	11	73	1	33	5	71	9	69	2	67	3	30	62
State-operated health information exchange	4	100	10	77	1	25	7	47	0	0	5	71	10	77	2	67	4	40	56
Privately operated health information exchange	0	0	5	38	1	25	7	47	0	0	2	29	4	31	0	0	2	20	21

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Cell values are calculated as a proportion of the total number of CCBHCs responding to the survey in each state: Kentucky = 4, Michigan = 13, Minnesota = 4, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 10.

**Exhibit C.14. CCBHCs that Receive Notifications about Client Care Transitions, by Service Type**

Service	Yes Response	
	N	%
Receives notification of hospital admission or discharge	71	99
Receives notification of emergency department visit	70	97
Receives notification of residential facility admission or discharge	69	96
Receives notification of use of crisis services	67	93
Receives notification of care from primary care providers	63	88
Receives notification of care from other community behavioral health providers	67	93
Receives notification of client interactions with criminal justice system	70	97
Receives notification of referral appointment attendance	63	88
Receives notification of other types of care transitions	19	26

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Percentages are calculated as a proportion of the total number of CCBHCs responding to the survey (n = 72).

**Exhibit C.15. Percentage of CCBHCs that Receive Notifications about Client Care Transitions, by Service Type**

Service	Automatic Alert from HIE, Manual Monitoring of HIE, or Electronic Notification via Linked EHR Systems	By Phone, Fax, or Email Only
Receives notification of hospital admission or discharge	83%	14%
Receives notification of emergency department visit	86%	10%
Receives notification of residential facility admission or discharge	24%	72%
Receives notification of use of crisis services	50%	40%
Receives notification of care from primary care providers	47%	40%
Receives notification of care from other community behavioral health providers	29%	64%
Receives notification of client interactions with criminal justice system	14%	81%
Receives notification of referral appointment attendance	31%	57%
Receives notification of other types of care transitions	3%	24%

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Percentages are calculated as a proportion of the total number of CCBHCs responding to the survey (n = 72).



**Exhibit C.16. CCBHCs that Receive Notifications about Client Care Transitions, by Service Type, by State**

Service	State																		Average Percentage of CCBHCs Across States 2023
	Kentucky		Michigan		Minnesota		Missouri		Nevada		New Jersey		New York		Oklahoma		Oregon		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Receives notification of hospital admission or discharge	4	100	13	100	14	100	14	93	3	100	7	100	13	100	3	100	10	100	99
Receives notification of emergency department visit	4	100	13	100	4	100	14	93	2	67	7	100	13	100	3	100	10	100	96
Receives notification of residential facility admission or discharge	4	100	12	92	3	75	14	93	3	100	7	100	13	100	3	100	10	100	96
Receives notification of use of crisis services	4	100	12	92	4	100	13	87	2	67	7	100	13	100	3	100	9	90	93
Receives notification of care from primary care providers	4	100	11	85	3	75	13	87	1	33	7	100	13	100	3	100	8	80	84
Receives notification of care from other community behavioral health providers	4	100	12	92	4	100	13	87	2	67	7	100	13	100	3	100	9	90	93
Receives notification of client interactions with criminal justice system	4	100	13	100	3	75	14	93	3	100	7	100	13	100	3	100	10	100	96
Receives notification of referral appointment attendance	4	100	9	69	3	75	14	93	2	67	7	100	13	100	2	67	9	90	85
Receives notification of other types of care transitions	0	0	3	23	2	50	3	20	0	0	4	57	6	46	1	33	0	0	26

Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Cell values are calculated as a proportion of the total number of CCBHCs responding to the survey in each state: Kentucky = 4, Michigan = 13, Minnesota = 4, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 10.

**Exhibit C.17. CCBHCs Reporting that Specific Features of the QBPs Motivated Changes to Clinical Practice, by State**

Service	State																		Average Percentage of CCBHCs Across States 2023
	Kentucky <sup>a</sup>		Michigan		Minnesota <sup>b</sup>		Missouri		Nevada		New Jersey		New York		Oklahoma		Oregon <sup>a</sup>		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
The quality measures used to award payments	---	---	6	75	---	---	12	86	0	0	5	100	1	50	2	100	---	---	69
Bonus payment amounts	---	---	5	63	---	---	12	86	1	50	3	60	1	50	2	100	---	---	68
The quality measure performance threshold used to award payments	---	---	5	63	---	---	10	71	1	50	4	80	1	50	1	50	---	---	61
Comparing performance to other CCBHCs in your state	---	---	2	25	---	---	13	93	0	0	2	40	1	50	2	100	---	---	51
Other	---	---	3	38	---	---	2	17	0	0	1	20	1	50	0	0	---	---	21

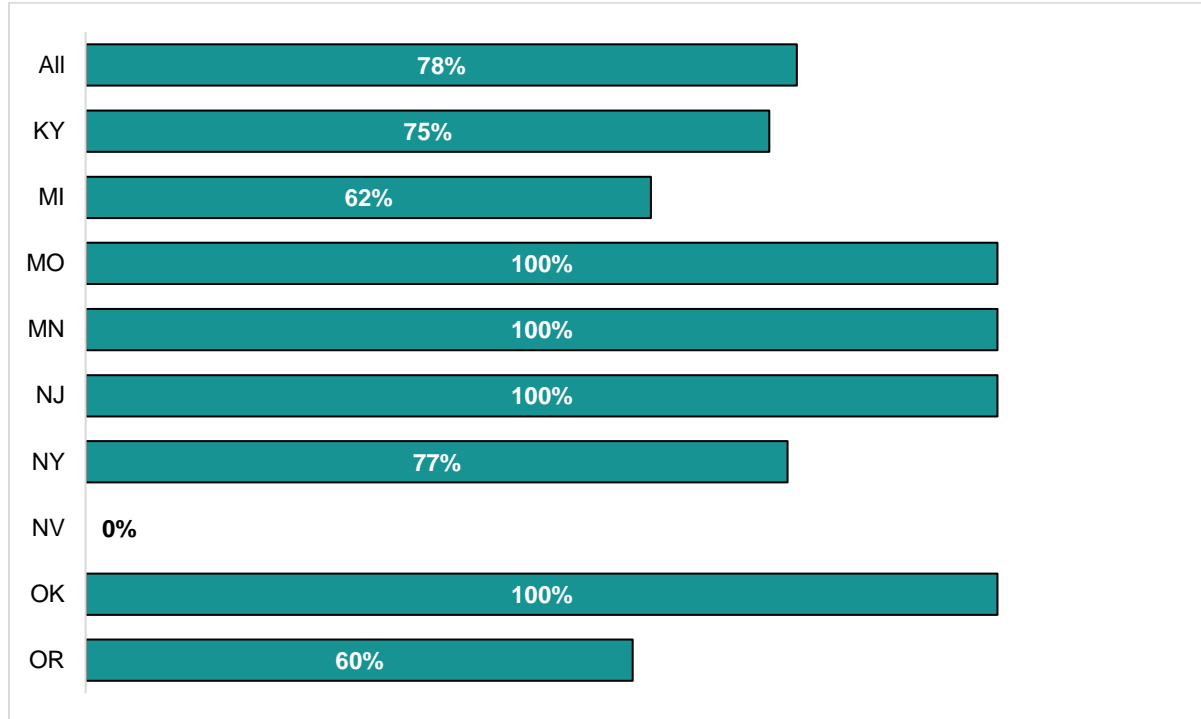
Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Cell values are calculated as a proportion of the total number of CCBHCs in each state that stated that QBPs changed clinical practice: Michigan = 8, Missouri = 14, Nevada = 2, New Jersey = 5, New York = 2, Oklahoma = 2. Two CCBHCs have missing responses (Michigan = 1, New Jersey = 1). The average percentages of CCBHCs across states do not include Kentucky, Minnesota, and Oregon.

a. No Kentucky and Oregon CCBHCs were eligible for QBPs.

b. Minnesota CCBHCs eligible for QBPs (n = 2) did not find QBPs motivated change to clinical practice.

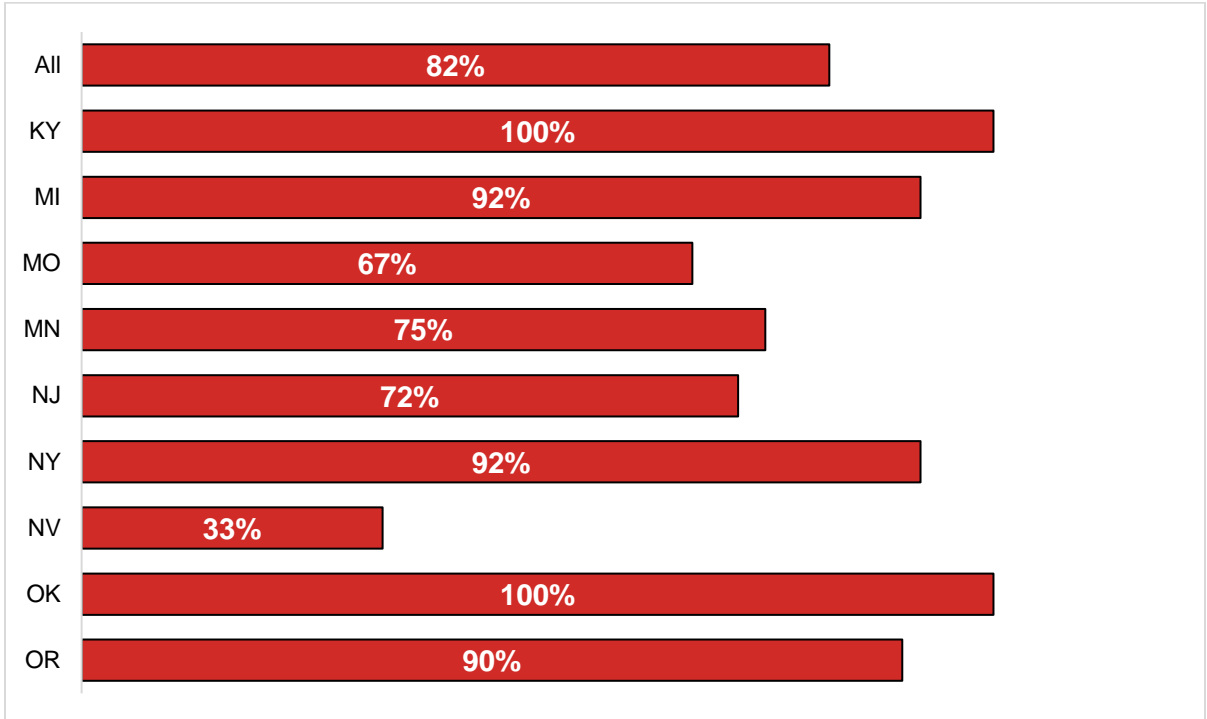
**Exhibit C.18. CCBHCs that Used Quality Measure Data Collected as Part of the Demonstration to Change Clinical Practice, Overall and by State**



Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Calculated as a proportion of the total number of CCBHCs responding to the survey in each state: Kentucky = 4, Michigan = 13, Minnesota = 4, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 10.

**Exhibit C.19. CCBHCs that Use Tools such as Data Dashboards, Report Cards, and Risk-Stratification to Monitor or Improve Quality of Care, Overall and by State**



Source: Mathematica and the RAND Corporation's analysis of the 2023 CCBHC survey.

Notes: Calculated as a proportion of the total number of CCBHCs responding to the survey in each state: Kentucky = 4, Michigan = 13, Minnesota = 4, Missouri = 15, Nevada = 3, New Jersey = 7, New York = 13, Oklahoma = 3, Oregon = 10.

**Exhibit C.20. CCBHCs that Use Tools to Monitor and/or Improve Quality of Care, by Tool**

Tool	Yes Response	
	N	%
Data dashboards	56	95
Risk-stratification	27	46
Report cards	17	29

Source: Mathematica and the RAND Corporation’s analysis of the 2023 CCBHC survey.

Notes: Percentages are calculated as a proportion of the total number of CCBHCs responding “yes” to a question asking if the CCBHC uses tools to monitor and/or improve quality of care (n = 59).

**Exhibit C.21. CCBHCs that Use Tools to Monitor and/or Improve Quality of Care, by Tool, by State**

Tool	State																		Average Percentage Across CCBHCs 2023
	Kentucky		Michigan		Minnesota		Missouri		Nevada		New Jersey		New York		Oklahoma		Oregon		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Data dashboards	3	100	12	100	3	100	10	100	1	100	4	100	12	100	3	100	8	100	100
Risk-stratification	1	33	4	33	2	67	3	30	0	0	4	100	8	67	1	33	4	50	46
Report cards	1	33	3	25	1	33	4	40	1	100	1	25	3	25	1	33	2	25	38

Source: Mathematica and the RAND Corporation’s analysis of the 2023 CCBHC survey.

Notes: Cell values are calculated as a proportion of the total number of CCBHCs that reported using any of these tools to monitor and/or improve quality of care in each state: Kentucky = 3, Michigan = 12, Minnesota = 3, Missouri = 10, Nevada = 1, New Jersey = 4, New York = 12, Oklahoma = 3, Oregon = 8.