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OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

Certified Community Behavioral Health Clinics Demonstration Program: Report to Congress, 2022

Prepared for
the Office of the Assistant Secretary for Planning and Evaluation (ASPE)
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by
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Office of the Assistant Secretary for Planning and Evaluation

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CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS DEMONSTRATION PROGRAM: REPORT TO CONGRESS, 2022

Authors

Allison Wishon, Jonathan Brown, Stefanie Pietras and Rain Sabin
Mathematica Policy Research

Joshua Breslau, Courtney Kase, Michael Dunbar and Brian Briscombe
RAND Corporation

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Abstract

Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 (P.L. 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 new Medicaid prospective payment system (PPS) 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). In August 2020, the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) expanded the demonstration to two new states (Kentucky and Michigan). The demonstration was originally authorized for two years, but Congress has extended it several times and it is currently authorized in the original states through September 30, 2025, through October 31, 2027, in Michigan, and through January 31, 2028, in Kentucky. Section 223(d)(7)(A) of PAMA requires the HHS Secretary to submit an annual report to Congress on the use of funds provided under all demonstration programs conducted under this subsection. Each report must include assessments of: (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 presents findings from an ongoing evaluation of the CCBHC demonstration. Building on previous evaluation findings of the initial two years of the demonstration, this report assesses the implementation and outcomes of the demonstration beyond its first two years for the seven original states that have continued participating (excluding Pennsylvania based on the state's 2019 withdrawal from the program). The report describes findings on state demonstration oversight and expansion of the model since the end of the second demonstration year (DY) and early implementation experiences in the two new states. It then describes specific findings as they relate to the PAMA topics of access to care and scope of services. Finally, the report provides information on demonstration payment rates and costs for the first four DYs for states with available data. Findings in this report draw on data collected through document review; interviews with a state official in each state; and analysis of CCBHC cost reports, and state reports of payment rates and client counts. Future reports will present findings on the PAMA topics using additional data sources, including an assessment of the impact of the demonstration on Medicaid service utilization and costs among beneficiaries who did and did not receive CCBHC services.

Principal findings. State officials in the original demonstration states reported transitioning past planning and launch activities by the second DY and generally reported maintaining the demonstration consistently since that time. Officials noted only minor changes to states' approaches in recent years and do not anticipate major changes in the future. States have continued to monitor adherence to demonstration requirements and provide technical assistance to CCBHCs. CCBHCs have largely worked to maintain and expand activities related to access to care put into place in early DYs rather than introduce new activities, and officials perceived that several demonstration features, such as telehealth requirements and the PPS, helped CCBHCs maintain service access during the national public health emergency related to the COVID-19 pandemic. Officials in the original states generally did not report any major changes to the scope of services offered by CCBHCs since the end of DY2. The initial

implementation experiences of the new demonstration states appeared consistent with early experiences from the original states.

States made some changes to PPS payment rates in all DYs, but changes were larger between DY1 and DY2 than they were in subsequent years, reflecting most states' decision not to change PPS payment rates after DY2 beyond adjusting for inflation. Total costs of clinic operations reported in cost reports remained relatively stable across the first four DYs in Oregon and Minnesota but increased more than 25 percent in Missouri, New York, and Oklahoma. The most consistent contributor to changes in total costs across states was the change in the cost per client served and not in the number of clients served or cost per visit; clients were making more visits.

Acronyms

The following acronyms are mentioned in this report.

ACT	Assertive Community Treatment
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
CARES Act	Coronavirus Aid, Relief, and Economic Security Act (Public Law 116-136)
CBT	Cognitive Behavioral Therapy
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
DBT	Dialectical Behavior Therapy
DCO	Designated Collaborating Organization
DY	Demonstration Year
EBP	Evidence-Based Practice
EHR	Electronic Health Record
HHS	U.S. Department of Health and Human Services
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer (or Questioning)
MCO	Managed Care Organization
MEI	Medicare Economic Index
P.L.	Public Law
PAMA	Protecting Access to Medicare Act (Public Law 113-93)
PCP	Primary Care Physician
PHE	Public Health Emergency
PPS	Prospective Payment System
QBP	Quality Bonus Payment
SAMHSA	HHS Substance Abuse and Mental Health Services Administration
SOC	System of Care
SPA	State Plan Amendment
SUD	Substance Use Disorder
TCM	Targeted Case Management

Executive Summary

Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 (P.L. 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. Demonstration states certify that participating clinics offer nine types of services to all people who seek care; however, states have some flexibility to tailor these services to align with Medicaid state plans and community needs.[1] Services must be person and family-centered, trauma-informed, recovery-oriented, culturally and linguistically competent, and responsive to the needs of the community. 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 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 funding source. 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.[2] States set PPS rates for each CCBHC by dividing projected total allowable costs by the projected number of visit-days (for PPS-1) or visit-months (for PPS-2) to develop rates intended to cover the expected costs of providing the full scope of required demonstration services. To set the rates at the outset of the demonstration, states collected data on clinics' historical operating costs using an Office of Management and Budget approved cost report provided by the U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS). In the second demonstration year (DY) and every year thereafter, states had the option to adjust their rates (a process called re-basing) for all or some CCBHCs based on the prior year's cost reports to reflect actual spending. States can also adjust rates for inflation using the Medicare Economic Index (MEI).

In 2015, 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.[3] The criteria provide a framework for certifying CCBHCs, but states can exercise some discretion in applying the criteria. In 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 originally authorized each state to participate in the demonstration for two years and was scheduled to end in 2019, but Congress has extended it several times and it is currently

[1] 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) 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.

[2] PPS-1 states have the option to provide CCBHCs with QBPs based on their performance on quality measures. PPS-2 states are required to provide QBPs based on performance on quality measures.

[3] 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.

authorized through September 30, 2025. In August 2020, the Coronavirus Aid, Relief, and Economic Security Act (P.L. 116-136) expanded the demonstration to two new states (Kentucky and Michigan). The Bipartisan Safer Communities Act (P.L. 117-159), enacted in June 2022, authorizes all remaining states to apply to participate in the demonstration beginning in 2024 and extends the demonstration through October 2027 in Michigan, and through January 2028 in Kentucky.[4] As of July 2022, nine states (all of the original demonstration states except Pennsylvania, and the two new states) and 78 CCBHCs are participating in the CCBHC demonstration.[5] Seven states reimburse CCBHCs using the PPS-1 model and two states (Oklahoma and New Jersey) use the PPS-2 model.

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).

Summary of Key Findings from DY1 and DY2 as Reported in the 2021 Report to Congress

- CCBHCs implemented a range of activities to improve access to care; increased the number of clients served; expanded services and hired and trained staff; developed partnerships with external providers; enhanced their data systems; and changed many of their care processes. State agencies played a critical role in supporting the demonstration.
- Overall, the quality of care provided to CCBHC clients was comparable to available benchmarks, such as data that state Medicaid programs voluntarily report to CMS for the Medicaid and CHIP Child and Adult Health Care Quality Measures Core Sets, and performance on some measures improved over time. However, there was room for improvement on several measures.
- States experienced some initial challenges in setting the PPS rates, but over time these rates came into greater alignment with CCBHC costs in all but one state.
- In two of the three states included in the impact analyses, Medicaid beneficiaries who received care from CCBHCs experienced a statistically significant reduction in behavioral health emergency department visits relative to those who received care from other community behavioral health clinics. There was also evidence from sensitivity analysis that CCBHCs may have reduced hospitalizations in the same two states.
- In the one state in which costs could be analyzed relative to a comparison group, total Medicaid costs increased significantly more for CCBHC clients than the comparison group.

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' 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).

As the demonstration has continued in the original states and expanded to others, ASPE contracted with Mathematica and the RAND Corporation in 2021 to further evaluate the demonstration. For the original

[4] HHS will award planning grants for states (excluding the ten states that have been selected to participate in the demonstration at the time of this report) to develop proposals to participate and may select up to ten states to participate in the demonstration every two years beginning on July 1, 2024.
[5] Pennsylvania chose not to continue participation after the initial two years and left the demonstration in 2019.

seven states that continued the demonstration (excluding Pennsylvania), the current evaluation is assessing the implementation and outcomes of the demonstration beyond its initial two years. In addition, the evaluation will now cover the two states that began participating in the demonstration in 2021.

This report describes state demonstration oversight and expansion of the model since the end of the second DY and early implementation experiences in the two new demonstration states. It then describes specific findings as they relate to the PAMA topics of access to care and scope of services. The report also describes how states and CCBHCs adapted during the COVID-19 public health emergency (PHE). Finally, the report provides information on demonstration payment rates and costs for the first DYs for states with available data. Findings in this report draw on data collected through document review; interviews with a state official in each demonstration state; and analysis of CCBHC cost reports, and state reports of PPS rates and client counts.

A. Demonstration Implementation Progress Since DY2

State officials reported that states' approaches to demonstration oversight, monitoring, and the structures and processes states and CCBHCs put in place have generally not changed since the end of the second DY. In the first two years of the demonstration, states and CCBHCs reported that they had addressed most early challenges and were consistently adhering to the CCBHC certification criteria by the end of DY2. Since then, state officials described ongoing efforts to refine certain processes and requirements and build on state and clinic efforts to expand access to services they achieved in the first two years. States have continued to monitor adherence to the certification criteria through periodic re-certification processes typically performed every one to three years. They also have continued to seek feedback on demonstration requirements and operations from stakeholders through workgroups and advisory bodies, and adjust technical assistance approaches and oversight to align with their current stage of implementation and the present technical assistance needs of CCBHCs.

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 maintaining the demonstration consistently since then. State officials reported making only minor changes to their approaches in recent years, such as modifying the frequency and methods of state contact with CCBHCs or requiring CCBHCs to employ new types of staff, and do not anticipate major changes in the future. The number of CCBHCs participating in the demonstration have remained the same since DY2 in five of the original demonstration states, but it grew slightly in one and decreased in another. Missouri added four new demonstration CCBHCs in 2022,[6] and Oregon decertified three CCBHCs during a period of funding instability in 2019-2020 but has since re-certified one.

Some states have pursued other financing mechanisms to support or expand the CCBHC model due to concerns that demonstration funding might end. For example, four demonstration states obtained state plan amendments (SPAs) to expand CCBHC services to providers not participating in the demonstration, and four other demonstration states are planning to use SPAs or Medicaid Section 1115 demonstration authority for this purpose. In addition to alternative Medicaid financing mechanisms, behavioral health providers that meet the requirements to become a CCBHC are leveraging the HHS Substance Abuse and Mental Health Services Administration (SAMHSA) CCBHC Expansion (CCBHC-E) grants and state-specific financing to cover the costs of services for the uninsured and underinsured and to help new clinics launch the model. Most state officials reported a goal of aligning requirements for

[6] These four clinics were included in the state's original demonstration application but were not able to launch the model during the original demonstration period.

all CCBHCs regardless of funding mechanism to ensure consistency in the quality and delivery of care by CCBHCs across the state.

State officials perceived that several features of the demonstration helped CCBHCs continue to provide services during the PHE related to the COVID-19 pandemic. Although the COVID-19 pandemic presented challenges for CCBHCs, several state officials shared their view that CCBHCs were better equipped to transition to new ways of delivering care relative to other behavioral health providers in their states. State officials reported that the PPS provided steady and consistent funding while allowing CCBHCs some flexibility to adapt to changing circumstances and client needs. They also reported that the telehealth requirements in the certification criteria prepared CCBHCs to quickly transition away from in-person services during the early months of the pandemic. Most CCBHCs were offering some services via telehealth prior to the COVID-19 pandemic and thus had infrastructure in place to some extent to facilitate the transition to virtual care. For example, Oklahoma CCBHCs were already providing consultation to external providers and some services to clients via technologies such as tablets (iPads) before the pandemic, which set up CCBHCs to pivot to telehealth for a broader range of services. Although officials reported that telehealth generally facilitated access to care during the pandemic, its implementation presented challenges for certain regions or client populations, such as those in rural communities in which internet coverage is not widespread. Some state officials also commented that certain types of services included in the CCBHC certification criteria were difficult to deliver via telehealth, such as physical health screenings requiring lab work and group therapies.

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. Many officials noted that their states and CCBHCs have not made any major changes related to access to care requirements in later years of the demonstration. A few states reported minor changes, such as modifying requirements for intake procedures or requiring new staff types. As with the first two DYs, behavioral health workforce shortages continued to contribute to access-related challenges in most states by, for example, potentially compromising CCBHCs' ability to conduct intakes in a timely manner or meet scope of service requirements, with new factors, such as the pandemic, further compounding staffing shortages.

States and CCBHCs continue to work to meet the needs of children, adolescents, and their families. State officials reported that efforts to serve children in CCBHCs have often involved interagency collaborations within the state and partnerships at the clinic level. Multiple state officials noted collaborations between CCBHCs and schools, and CCBHCs have often bolstered their child and youth services through specialized staffing models, such as a specific peer support model tailored for youth with substance use disorders.

State officials in the original demonstration states generally did not report any major changes to the scope of CCBHC services offered by clinics since the end of the second DY. States did not make changes to scope of service requirements, and officials did not note any specific challenges CCBHCs faced maintaining services since the end of the second DY. However, some states had not conducted re-certifications since the end of DY2, partially due to the COVID-19 PHE, which limited officials' ability to report whether CCBHCs had been able to maintain the full scope of required services in recent years. State officials often commented on CCBHCs' role in addressing various state priorities and contributing to various service-related initiatives, such as crisis system transformation and the rollout of the 988 Suicide & Crisis Lifeline, primary care integration, and care coordination efforts, although the exact role and integration of the CCBHC in the broader systems was still being defined in states.

The initial implementation experiences of the new demonstration states appeared consistent with early experiences from the original states. Officials in Kentucky and Michigan reported working quickly to certify clinics and launch their demonstrations by, for example, convening workgroups and sorting through various regulatory issues and CCBHC technical assistance needs. Officials reported that the states and CCBHCs worked closely together to launch the model, navigate early implementation challenges, expand services and reach, and raise awareness about the CCBHCs in communities. State officials reported working through some of the same early challenges the original demonstration states addressed, such as helping CCBHCs set up data systems and processes for collecting and reporting quality measures and address workforce shortages**.**

B. Demonstration Payment Rates and Costs in DY1 to DY4

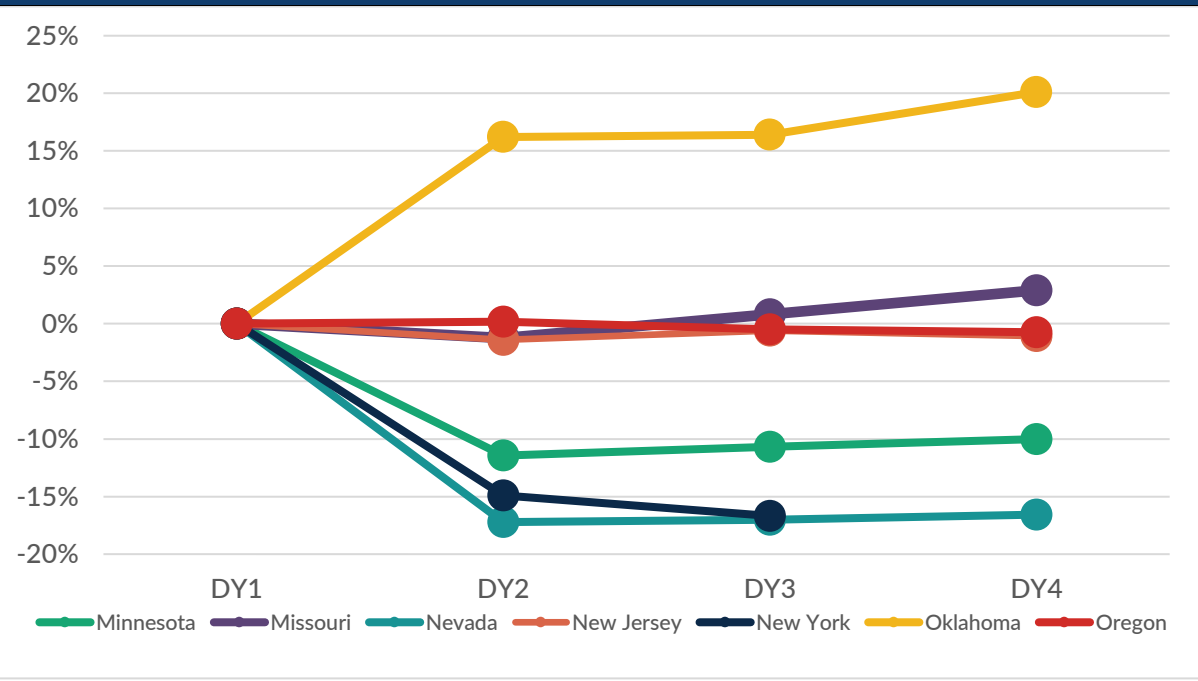
1. Changes in Payment Rates

States made some changes to payment rates in all DYs, but changes were much larger between DY1 and DY2 than they were in subsequent years, reflecting most states' decision not to re-base PPS rates after DY2. Although most states (five out of the original seven) re-based PPS rates for DY2 (re-calculated rates based on the previous year's cost reports), only Missouri re-based rates thereafter.[7] All states adjusted for inflation using the MEI for DY2 and DY3, and all but Missouri and New York adjusted for inflation for DY4.[8] Between DY1 and DY2, the average change in CCBHC rates varied from a decrease of 17 percent in Nevada to an increase of 16 percent in Oklahoma. More states had decreases in average rates during this period than increases. Between DY2 and DY3 and between DY3 and DY4, the changes in rates translated to a much smaller percentage change (from 1 percent to 5 percent depending on the state).

[7] Missouri implemented a modified rate re-base for DY4. Prior to the COVID-19 pandemic, the state had planned to implement a rate re-base for all CCBHCs for DY4, and the state used CCBHCs' 2019 cost reports to assess whether a clinic's re-based rates would increase or decrease. For clinics for which the rate increased, the state used the increased rate for DY4. However, the state left the rates the same as in the DY3 if the clinic's rate was to decrease based on 2019 cost report data. The state adopted this approach to avoid potentially placing additional financial strain on CCBHCs due to the pandemic.

[8] DY4 rates in New York were not yet approved at the time of this report. The state was paying clinics their DY3 rates while pursuing a proposed rate computation adjustment.

Exhibit ES.1. Percentage Change in Average CCBHC PPS Rates from DY1 to DY4



Source: Mathematica and the RAND Corporation's analysis of state-reported PPS rates.

Notes: To facilitate comparisons from year to year we adjusted rates to 2022 dollars using the MEI. The figure reflects changes in rates relative to DY1 for each DY. DY4 rates were not available for New York because the state is working on a proposed rate computation adjustment for DY4 and paying DY3 rates in the meantime. DY1 = 2017-2018, DY2 = 2018-2019, DY3 = 2019-2020, DY4 = 2020-2021. Appendix A, Tables A.1 to A.7 provide payment rates for each CCBHC.

2. Changes in Total Costs and Potential Contributors to Changes in Costs

Total costs of clinic operations remained relatively stable across the first four DYs in Oregon and Minnesota but increased more than 25 percent in Missouri, New York, and Oklahoma. There were no states in which total costs were lower in DY4 relative to DY1.

The most consistent contributor to changes in costs across states was the change in the cost per client served and not in the number of clients served or cost per visit; clients were making more visits. The average cost per client served increased in all four states for which cost report and client data were available, with changes from DY1 to DY4 ranging from 14 percent to 57 percent. The increase in cost per client served was driven by an increase in the average number of visits per client for all states with available data. Changes in the average number of visits per client ranged from an increase of 15 percent, to an increase of 33 percent. Changes in cost per visit, however, were less than 11 percent in each of the four states with available data and, except for New York, the average number of clients served was relatively stable in the four states.

Findings on changes in costs and factors contributing to those costs have implications for interpreting how the ways CCBHCs are delivering care over the course of the demonstration change. For example, the cost data indicate that CCBHCs have provided more frequent visits to clients as the demonstration has progressed, resulting in an increase in average cost per client. At this stage in the evaluation, we are unable to draw further conclusions about the impact that these changes have on the

quality of care. However, the findings reported here can contribute to our understanding of the how the costs of the CCBHC model might develop over time.

Exhibit ES.2. Summary of Percent Change in Costs and Cost Components from DY1 to DY4

	Total clinic operating costs	Average number of clients served	Average cost per client	Average number of visit-days or visit-months per client	Average number of visit-days or visit-months	Average cost per visit-day or visit-month
Minnesota	6%	-10%	14%	18%	3%	-5%
Missouri	27%	NA	NA	NA	26%	-6%
Nevada	NA	132%	NA	NA	NA	NA
New Jersey	NA	25%	NA	NA	NA	NA
New York	54%	26%	16%	15%	52%	1%
Oregon	1%	-10%	22%	18%	5%	-1%
Oklahoma	74%	4%	57%	33%	52%	11%

Source: Data for total operating costs and average number of visit-days or visit-months come from Mathematica and the RAND Corporation's analysis of CCBHC cost reports. Average number of clients served, cost per client, and visit-days or visit-months come from Mathematica and the RAND Corporation's analysis of CCBHC cost reports, state-reported client counts, and state quality measure reports.

Note: Analyses are limited by missing cost report data for Nevada and New Jersey for DY2 to DY4. Cost report data for DY3 and data on the number of clients served for DY4 were missing for Missouri. Calculations for average cost per client, average number of clients served, and average number of visits per client require both cost reports and number of clients served.

C. Future Evaluation Activities

In each year of the evaluation, we will submit an annual report synthesizing findings related to changes in ongoing demonstration operations and implementation and answering additional evaluation questions related to the PAMA topics of access, quality and scope of services, and costs. Future reports will present the perspectives of CCBHC staff and clients, examine further changes over time in costs and quality of care, and present findings from additional state official interviews and clinic-level surveys.

Future reports will also summarize findings on the impact of the demonstration on service utilization and costs using Medicaid claims and encounter data from select states. The impact analysis will examine service utilization trends among Medicaid beneficiaries who did and did not receive CCBHC services.

I. Overview of the Certified Community Behavioral Health Clinic Demonstration

Section 223 of the Protecting Access to Medicare Act (PAMA) of 2014 (P.L. 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. Demonstration states certify that participating clinics offer nine types of services to all people who seek care, including those with serious mental illness, serious emotional disturbance, and substance use disorders (SUDs). 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 support; and (9) 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,[9] and recovery-oriented, culturally and linguistically competent, and responsive to the needs of the community served. CCBHCs can have formal relationships with Designated Collaborating Organizations (DCOs) to provide demonstration services, but they must maintain clinical responsibility for services the DCO provides to CCBHC clients. Even if CCBHCs do not engage DCOs, they 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 evening and weekends) and in convenient locations (for example, by providing services in clients' homes and elsewhere in the community).

Following each demonstration year (DY), states must report 21 measures that assess the quality of care provided to CCBHC clients. These are calculated from Medicaid claims and managed care encounter data, electronic health records (EHRs), 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.

The demonstration requires participating states to reimburse CCBHC services through a new 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 the following 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 clinic-specific

[9] The CCBHC criteria note that a trauma-informed approach to care realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved in the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization. The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues.

payment rates, which can vary across CCBHCs within a state. In PPS-1 states, the clinic-specific rate is the same for all CCBHC clients; PPS-2 clinic-specific 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 a provider's performance on quality measures. CCBHCs also submit standardized cost reports to the state after each DY. The cost reports include information on clinic operating costs and the number of daily (for PPS-1 states) or monthly (for PPS-2 states) visits to the clinic in each DY.

A. Certified Community Behavioral Health Clinic 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 2016). 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 contexts.

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 originally authorized each state to participate in the demonstration for two years and was scheduled to end in 2019, but it has been extended by Congress several times and 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 its expansion by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136). The Bipartisan Safer Communities Act (P.L. 117-159), enacted in June 2022, authorizes all remaining states to apply to participate in the demonstration beginning in 2024 and extends the demonstration through October 2027 in Michigan, and through January 2028 in Kentucky. HHS will award planning grants to states (excluding the ten states that have been selected to participate in the demonstration at the time of this report) to develop proposals to participate in the demonstration. Beginning July 1, 2024, and every two years thereafter, HHS may select up to ten additional states to participate in the demonstration.

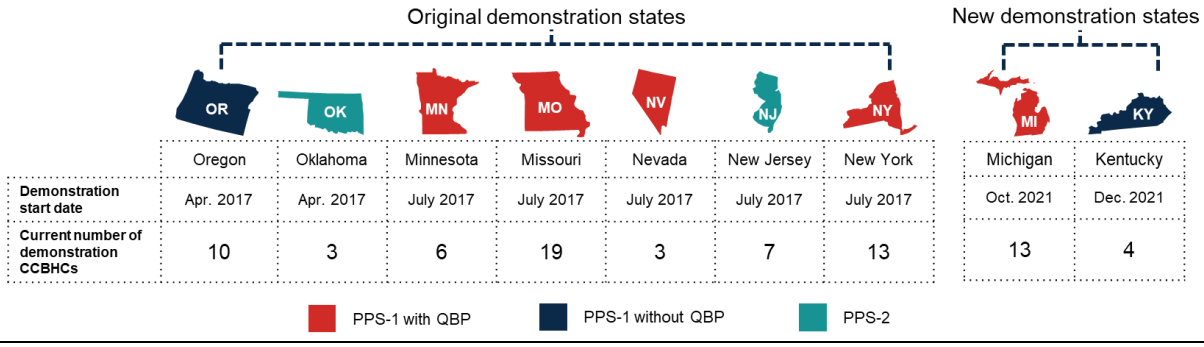
Beyond the CCBHC demonstration, some demonstration states and non-demonstration states have expanded the model through other Medicaid authorities, including state plan amendments (SPAs) and Section 1115 demonstration waivers (Brown et al. 2021). The HHS Substance Abuse and Mental Health Services Administration (SAMHSA) has supported implementation of the CCBHC model through the 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.

B. Current Landscape of Certified Community Behavioral Health Clinics Demonstration

As of July 2022, nine states participate in the CCBHC demonstration (Exhibit I.1), which includes all but one 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 initial two years. Seven states reimburse CCBHCs using the PPS-1 model, and two states use the PPS-2 model. Seven of the nine states offer CCBHCs QBPs tied to performance on quality measures, including five of the seven PPS-1 states where QBPs are not required.

Exhibit I.1. Status of CCBHC Demonstration States



	Oregon	Oklahoma	Minnesota	Missouri	Nevada	New Jersey	New York	Michigan	Kentucky
Demonstration start date	Apr. 2017	Apr. 2017	July 2017	July 2017	July 2017	July 2017	July 2017	Oct. 2021	Dec. 2021
Current number of demonstration CCBHCs	10	3	6	19	3	7	13	13	4

PPS-1 with QBP | PPS-1 without QBP | PPS-2

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

Notes: Of the 12 original clinics in Oregon, 3 stopped participating in the demonstration in 2019; the state has re-certified 1. Missouri added 4 clinics during since the end of DY2, increasing its total from 15 to 19. Pennsylvania dropped out of the demonstration entirely at the end of the original demonstration period.

As of July 2022, there are 78 CCBHCs across the nine states. The number of CCBHCs within some states has changed over time. Since the end of the second DY, Missouri has added four CCBHCs[10] while Oregon decertified three of its original CCBHCs, later re-certifying one CCBHC (see Chapter III for more information).

C. Evaluation of the Certified Community Behavioral Health Clinic Demonstration

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 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.
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). As the demonstration has continued in the original states and expanded to others, ASPE contracted with Mathematica and the RAND Corporation in

[10] These four clinics were included in the state's original demonstration application but were not able to launch the model during the original demonstration period.

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 (excluding Pennsylvania). The evaluation also examines implementation and outcomes in Kentucky and Michigan. Finally, the evaluation provides information to address PAMA's requirements for reports to Congress and inform decisions about future implementation of the model.

This report describes state demonstration oversight and expansion of the model since the end of the second DY and early implementation experiences in the two new demonstration states. It then describes specific findings as they relate to the PAMA topics of access to care and scope of services. The report also describes how states and CCBHCs adapted during the COVID-19 public health emergency (PHE). Finally, this report provides information on demonstration payment rates and costs for the first four years of the demonstration for states with available data. Chapter II summarizes the data sources and methods we used in this report. Chapters III and IV summarize findings related to demonstration implementation and costs, and Chapter V presents conclusions.

II. Data Sources and Methods

The findings in this report are based on the following data sources: (1) a review of state documents; (2) interviews with a state demonstration official in each state; (3) payment rates provided by states, and (4) cost reports for DY1 to DY4 for the original demonstration states.

A. Qualitative Sources

1. State Document Review

We reviewed planning grant materials and demonstration applications for the two new demonstration states and conducted targeted searches of demonstration states' websites as needed to inform other analyses. Our review of state documents helped us better understand Kentucky and Michigan's early implementation plans and experiences, state characteristics, and the context in which each state implemented the demonstration. We focused our review of applications and planning documents in the new states because we gathered information from these documents to answer many of the evaluation questions for the original demonstration states when evaluating the initial two years of the demonstration (Brown et al. 2021).

2. Interviews with State Officials

In spring 2022, we conducted semi-structured telephone interviews with one state Medicaid or behavioral health agency official knowledgeable about CCBHC demonstration maintenance and implementation in each of the nine demonstration states. Most respondents were CCBHC Project Directors or Project Managers. One researcher led the interview and another took notes. The interviews focused on gathering information about the implementation of the demonstration since the end of the original two-year demonstration period. Interview topics included questions about recent steps states and CCBHCs have taken to increase access to care; successes and challenges maintaining and implementing the full scope of services; PPS rate-setting processes; and the effects of COVID-19 on access, scope of services, quality, and costs.

B. Quantitative Sources

1. State Reports of PPS Rates

State officials in the seven original demonstration states provided information on the PPS rate paid to each clinic in DY1 through DY4. For PPS-1 states, we received information on the daily amounts paid to each CCBHC. For the PPS-2 states, we received information on the standard rates for each CCBHC. We received CCBHC rates for all four DYs in all states but New York, which is working on a proposed rate computation adjustment for DY4 and paying DY3 rates in the meantime. For each state, we calculated average rates for each DY and then calculated the percentage change in average rates from year to year.

2. CCBHC Cost Reports

CCBHCs submit cost reports to states, and states submit them to the HHS Centers for Medicare & Medicaid Services (CMS) within nine months of the end of each DY. Cost reports were initially used by states to set clinic-specific PPS rates, but they also provide data in sufficient granularity to allow exploration of certain implementation issues. For all CCBHCs (those in PPS-1 and PPS-2 states), the

reports contain information on staffing costs, projected direct and indirect costs to establish rates, actual direct and indirect costs, number of visits, method for allocating indirect costs to CCBHC services, and total number of CCBHC services provided by provider profession. The reports auto-calculate the resulting PPS rates by using allowable costs reported in the spreadsheets. The reports accommodate the likelihood that CCBHCs provide non-CCBHC services, so they allow for the elimination of those costs from the reimbursement rate calculation.

Because the cost reports are designed to inform the calculation of PPS rates, they include information on the total number of clinic visit-days (PPS-1) or visit-months (PPS-2) that occurred during the DY. Visit-days are unique days in which a client received at least one demonstration service, and visit-months are months in which a client received at least one demonstration service. The reports include all visit-days or months for all clients, not just those covered under Medicaid or the PPS. In addition, the cost reports contain breakdowns of the staffing costs by types of staff, although different states use different methods for categorizing clinic staff, so they do not lend themselves to cross-state comparisons. The operating costs reflected in the cost reports include direct costs, such as labor and medical supplies, and indirect costs, such as rent payments.

We obtained all available cost reports that the original seven states still participating in the demonstration submitted to CMS for DY1 to DY4. In total, we obtained cost reports for at least three DYs from 46 of the 56 CCBHCs eligible for cost report analyses. As Exhibit II.1 shows, some of the cost reports were missing at the time of this report, so we could not include them in the analysis.

Exhibit II.1. CCBHC Cost Report Availability

State	Number of CCBHCs eligible for cost report analysis	Number of CCBHCs with cost reports for at least 3 DYs	Cost reports missing
Minnesota	6	6	No reports missing
Missouri	15[a]	15[a]	Missing DY3 for 15 clinics
Nevada	3	0	Missing DY2 to DY4 for all 3 clinics
New York	13	13	No reports missing
Oregon	9[b]	9	Missing DY3 report for one clinic
New Jersey	7	0	Missing DY1 to DY4 for all 7 clinics[c]
Oklahoma	3	3	No reports missing

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

a. Missouri originally certified 15 clinics and then certified 4 more clinics in 2021. We obtained cost reports for the 15 original clinics.

b. Oregon decertified 3 CCBHCs in 2019 and re-certified 1. Nine CCBHCs in Oregon participated in the demonstration in all 4 DYs included in our analyses. Of these, the evaluation team is missing 1 report for 1 clinic. We excluded the 3 clinics that were decertified in Oregon after DY2 from trend analyses.

c. New Jersey submitted cost reports, but the reports included projected rather than actual costs and were therefore excluded from our analysis (because they are not comparable with those of other states).

To allow us to compare costs across DYs, we applied the Medicare Economic Index (MEI), a measure of inflation in the health care sector, to the cost data to adjust for inflation over time. For the comparisons in this report, we inflated costs reported in each DY to 2022 dollars. To describe changes in CCBHC costs over time, we examined the percentage change in the following from DY1 to DY4:

- Total clinic costs from DY1 to DY4, which is the amount that clinics reported spending during each year of the demonstration.
- Total visit-days or months, which is the total number of client visit-days for PPS-1 clinics and total visit-months for PPS-2 clinics, as reported in the cost reports. Total visit-days or months could change from year to year if the CCBHCs experience a change in the number of clients or in these clients' average visit-day or month frequency.
- Costs per visit-day or visit-month, calculated by first dividing the total costs by the number of visit-days or months. Per visit-day or month costs would change across years if there were changes in the total costs or the number of visit-days or months. For example, if total costs increased and the number of visit-days or months remained the same, the per visit-day or month costs would increase.
- Costs per CCBHC client served, calculated by dividing the total costs by the number of unique clients CCBHCs served.

We present comparisons across years as percentages because of dramatic variation in costs, and numbers of clients and visits across states.

3. Number of Clients Served

We received information on the number of unique clients served at each CCBHC in DY1 to DY4 from state officials, supplemented when needed and possible with information from states' quality measure reports. We used these data to assess trends over time in the numbers of clients served. We also used counts of clients served in conjunction with the cost report data to calculate the number of visits per client and cost per client served.[11]

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 single state official, and, in some cases, state officials were relatively new to the state or to the CCBHC demonstration. Additionally, certain documents we reviewed were outdated (for example, demonstration applications submitted in 2016), and the information they include could have changed. Missing data on costs, number of visits, or number of clients served led us to exclude some clinics or states from analyses.

In addition, cost data only include information on services provided by and operating costs for the CCBHCs as reflected in clinic cost reports. These data do not capture all factors that could influence changes in costs. The data only include information on services provided by and operating costs for the CCBHCs as reflected in clinic cost reports. CCBHCs' costs might change over time due to many internal and external factors not reflected in the cost reports. CCBHC clients might have received additional services from non-CCBHC providers. For example, the cost report data do not include the costs of hospitalizations or emergency room visits, so any these analyses do not reflect any offsets in costs to other providers or systems.

[11] We did not receive information on the number of clients served for DY4 directly from the state or from quality measure reports for Missouri. We also did not include counts for the three Oregon CCBHCs that stopped participating in the demonstration after DY2 in trend analyses.

III. Demonstration Implementation Progress since Demonstration Year 2

This chapter presents findings related to the implementation of the demonstration since the end of DY2. Because the implementation findings from the previous evaluation of the demonstration left off at the end of the original two-year demonstration period, we first describe updates regarding state demonstration oversight and expansion of the model since mid-2019 and early implementation experiences in the two new demonstration states. We then describe specific findings as they relate to the PAMA topics of access to care and scope of services.

A. State Demonstration Implementation and Oversight Experiences

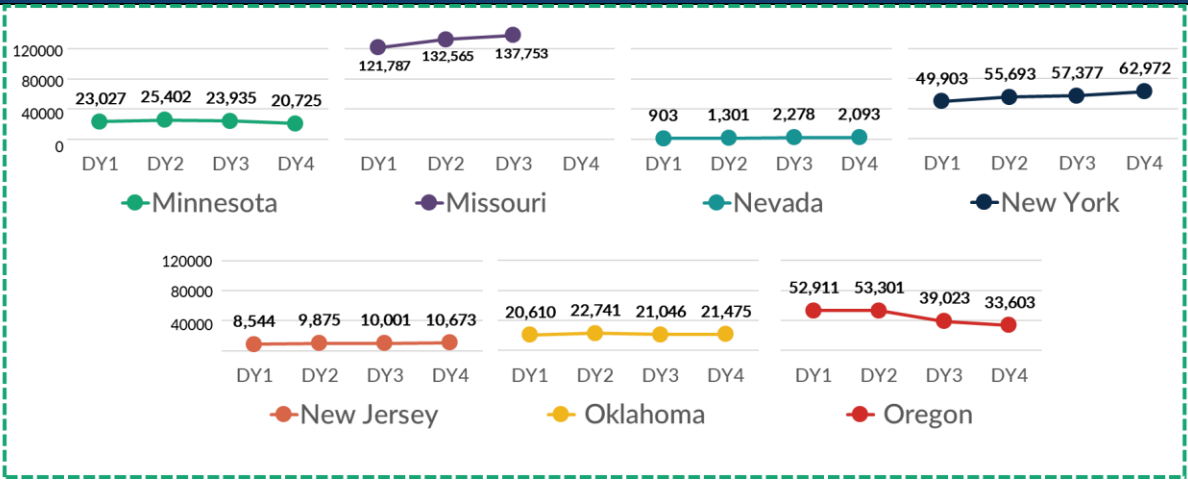
In the first two years of the demonstration (DY1 and DY2), states and CCBHCs focused on expanding and sustaining services, hiring and training staff, and implementing and sustaining new care processes to meet the certification criteria. States and CCBHCs reported having addressed most early implementation challenges and consistently adhering to the certification criteria by the end of DY2, and have continued to refine processes and requirements, and build on early successes since that time. For the most part, state officials reported maintaining services and implementing the demonstration in recent years consistently with how they implemented it toward the end of DY2. They did not report making any major changes to their approaches to the demonstration, such as major changes to demonstration monitoring or oversight processes or CCBHCs' required scope of services, or future plans for the demonstration.

The number of CCBHCs participating in the demonstration have remained the same since the end of DY2 in all but two states. Missouri added four new demonstration CCBHCs in January 2022. These four clinics were included in the state's original demonstration application but were not able to launch the model during the original demonstration period. Experienced CCBHCs in the state have helped the four new demonstration CCBHCs launch in 2022.

Oregon decertified three clinics since the end of DY2 but has been working to restore its original number. There was a period of significant funding instability in the state after the end of the original two-year demonstration period. Nine clinics were able to keep operating as CCBHCs during gaps in federal and state authorization in 2019-2020 using county funds, but three clinics elected to stop participating altogether. The state re-certified one of these clinics in 2021 and is working to bring the other two back into the demonstration. The state also lost its project team dedicated to demonstration oversight, technical assistance, financial management, and evaluation around the same period and is rebuilding the team this year. Compliance oversight and technical assistance activities were largely halted during gaps in funding and the loss of the project team, but the new team plans to resume them soon. Given this recent period of disruption, the state is now thinking about fortifying the CCBHCs through multiple funding mechanisms and is in the process of re-certifying the remaining CCBHCs it lost. State staff are also checking in with CCBHCs to identify any technical assistance needs. The state official views this year as a soft reopening as it collaborates with clinics to make sure clinics' continue to adhere to the CCBHC certification criteria and meet clients' needs.

In five of the seven original demonstration states still participating in the demonstration, the number of unique clients who received CCBHC services annually increased from DY1 to DY4. The decrease over time in the number of clients CCBHCs served annually in Oregon could reflect the decertification of three clinics in DY3.

Exhibit III.I. Changes in the Number of Clients Served by CCBHCs Over Time



Source: Mathematica and RAND Corporation's analysis of client counts provided by state officials and CCBHC quality measures data.

Note: Only 3 years of data were available for Missouri at the time of this report.

Overall, state officials reported largely transitioning past the initial planning and launch activities of early years by the end of DY2. State officials noted that stakeholders value the services available from CCBHCs, and they reported settling into consistent state-CCBHC interactions and support processes as well as investing in activities to improve, expand, and sustain CCBHCs. For example, the official in New Jersey reported that other stakeholders, such as the criminal justice system and non-CCBHC providers, have begun to value CCBHCs more as a result of CCBHCs': (1) open-access hours, which are attractive to those providing referrals to them; (2) success in marketing themselves to their communities; and (3) quality improvement efforts. Nevada's official described the state as being in a "nice cycle" of demonstration oversight provided by a large core state team comprising state Medicaid staff, the Department of Public Health and Behavioral Health (overseeing certifications), and a contractor that assists CCBHCs with data collection and reporting. New York's official similarly reflected on the steady support its state team has provided to CCBHCs, highlighting how the PHE prompted the state to pivot from its site visits with CCBHCs to monthly virtual contacts to check in with CCBHC leads on pandemic-related topics, such as CCBHCs' transition to telehealth and staffing and access issues.

State officials also reported ongoing state and CCBHC efforts to expand access to care and tailor services to the needs of communities. Oklahoma's official, for example, noted that its CCBHCs have continued to increase coordination with community partners such as police departments and emergency rooms by expanding an initiative to supply them with tablet computers (iPads) to facilitate consultation on demand.

New states' initial implementation experiences appeared consistent with early experiences from the original states. As described below, states and CCBHCs worked closely together to launch the model, navigate early challenges such as setting up quality reporting systems and receiving technical assistance; expand services and reach; and raise awareness of the CCBHCs in communities.

Closer Look: Early implementation in new demonstration states

As was the case with the original demonstration states, Michigan and Kentucky received planning grants in October 2015 to begin certifying their clinics. These states, however, were not selected in December 2016 to participate in the demonstration. In both states, some clinics that participated in the certification process later received CCBHC-E grants from SAMHSA to begin implementing the model. For example, Michigan's official noted that most of the states' clinics (11 of the 13) applied for and received SAMHSA CCBHC-E grants in the interim, and Kentucky's official noted that at least two of its clinics received CCBHC-E grants as well. In August 2020, HHS announced that Kentucky and Michigan would begin participating in the demonstration as a result of expansion of the demonstration by the CARES Act. These states quickly mobilized to launch the demonstration. For example, state officials in Michigan convened multiple CCBHC workgroups to deliberate on and develop solutions for various implementation issues, such as the intersection of the demonstration's requirements and existing state regulations. Likewise, the official in Kentucky shared that the work the state did to prepare CCBHCs during the planning grant period in 2016 allowed CCBHCs to quickly transition to the model and begin to meet the demonstration requirements.

Michigan and Kentucky launched their demonstrations in October 2021 and January 2022, respectively, and the state officials described some of the same early implementation challenges experienced by the original eight demonstration states. Michigan's official noted that certifying 13 CCBHCs within a short time period was more difficult than anticipated because some CCBHCs needed more support and consultation than the state expected. By the end of April 2022, however, all 13 CCBHCs were fully certified. The Kentucky official noted that the state had difficulties implementing its processes for collecting quality measure data and gaining clarity on which versions of measures to use. The state also decided shortly before the demonstration began to switch from having the clinics complete the SAMHSA-supplied quality measure reporting workbooks to collecting the raw data from CCBHCs, which led to additional work for the state. It took time for the state to navigate the process to receive technical assistance, but once the state was able to obtain technical assistance, they reported that the support has been very helpful. As of May 2022, one of their biggest challenges is resolving the billing process for managed care organizations (MCOs) to reimburse CCBHCs; a few MCOs are still working to update their systems to accommodate CCBHC-specific billing codes that trigger payments from the state.

1. Ongoing Demonstration Oversight and Technical Assistance

In the initial DYs, the original demonstration states focused on fulfilling CCBHC certification requirements and providing technical assistance to clinics to help them overcome challenges. Since the end of DY2, most state officials reported continuing to monitor CCBHCs' ability to fully meet all of the certification criteria and providing technical assistance. Their current oversight and administrative processes, however, reflect that they have moved beyond initial demonstration launch activities, such as establishing and monitoring billing and quality reporting systems, and are now focusing on providing ongoing supervision of the structures and processes states and clinics put in place in early DYs.

State officials described a variety of approaches to monitoring CCBHC compliance with demonstration requirements, with official monitoring or re-certification typically occurring on a 1-3 year cycle. For example:

- **Minnesota** re-certifies its CCBHCs every three years. The state will be re-certifying its CCBHCs in 2022.
- **Missouri** tries to align the timelines for the various certification processes that individual CCBHCs are subject to across state programs, so they are not constantly being reviewed. For example, there are other certification requirements CCBHCs must adhere to related to being

Medicaid health homes, community psychiatric rehabilitation programs, and other designations that the state tries to align.

Nevada uses corrective action plans if needed after it completes annual site visits to all CCBHCs; it may revisit CCBHCs within 3-6 months depending on the severity of issues identified. The state official shared that recent site visits have revealed only minor issues.

New Jersey has CCBHCs complete annual self-evaluation questionnaires. Before the pandemic, this information would inform the state's on-site monitoring. Now, the state follows up with each CCBHC virtually and will discuss any issues or discrepancies between CCBHCs' self-assessments and state data. Typically, the state holds 2-3 individual sessions each year with each CCBHC.

New York similarly has CCBHCs submit documentation that supports their adherence to the certification criteria; the state reaches out to its field offices to corroborate this information and drafts corrective action plans as needed. The state is completing a review in 2022.

Oklahoma re-certifies CCBHCs every 1-3 years depending on the CCBHC's performance during its most recent certification. The state also hopes to resume conducting clinical content reviews that include, for example, review of client records to ensure they reflect certain programmatic requirements, in 2022 after pausing them during the pandemic.

Oregon is preparing for a re-certification in 2023 now that the state team is fully staffed again.

Closer Look: Monitoring adherence in new demonstration states

Officials from the two new states described plans for monitoring adherence to demonstration requirements that are similar to those of the original demonstration states. Michigan plans to visit each CCBHC every year. In the summer of 2022, the state plans to review outstanding issues from the certification process and implementation progress. Kentucky is still fine-tuning its monitoring process but plans to send data workbooks to CCBHCs to populate them with updated information on service delivery, staffing, hours of operation, and so on. The state is developing a weighted scoring approach to assess continued certification. The state official envisions that clinics should also be able to use these workbooks internally as a tool for monitoring their performance and to facilitate discussions with the state regarding any challenges. Kentucky plans to visit sites in 2022 as well.

Technical assistance. States (or their contractors) have continued to provide technical assistance on a range of topics related to the certification requirements, billing, and quality measures and improvement, sometimes through monthly meetings with CCBHCs and other times on a targeted or as-needed basis. States use different approaches to provide this technical assistance, and some states have changed their approach over time. For example, New Jersey targets most of its quality improvement-related technical assistance now to CCBHCs struggling to improve their performance on quality measures. Other states have leveraged contractors to provide technical assistance. For example, the vendor for Oklahoma's population health management platform provides technical assistance to CCBHCs on quality improvement using measures from its population health platform. Nevada hired a data contractor in January 2022 to provide data support, such as help with calculating quality measures, and to provide access to a large training library to all CCBHCs in the state (regardless of funding mechanism). As

described earlier in this chapter, New York meets monthly with CCBHCs to discuss various issues and solve problems together. Oklahoma similarly meets monthly with CCBHCs to monitor implementation progress and provide technical assistance. Officials in Minnesota and Nevada reported providing opportunities for CCBHCs that are participating in the demonstration and those financed through other Medicaid mechanisms, such as SPAs, to meet with the state for technical assistance and to provide input on demonstration requirements and monitoring.

States have also provided technical assistance and trainings on behavioral health services. For example, within the last few years, New York has provided technical assistance and training on psychiatric rehabilitation services and integration of care to help CCBHCs strengthen their programs. Missouri offered a learning collaborative on trauma-informed care and regularly provides training for various types of staff such as law enforcement liaisons. Several state officials mentioned that the National Council for Mental Wellbeing has been a resource to states themselves (informing their own technical assistance) or directly to CCBHCs. New York, for example, encourages CCBHC staff to attend the National Council's webinars**.**

Closer Look: Technical assistance in new demonstration states

Similar to the experience of the original demonstration states, officials from the two new demonstration states reported providing considerable technical assistance to CCBHCs after their selection for the demonstration and during its first DY. Officials in Michigan regularly convened CCBHCs before the demonstration launched to work through various implementation plans. More recently, the state provided training on different tracking systems that it requires CCBHCs to use to monitor the demonstration. The National Council for Mental Wellbeing also helped CCBHCs in Michigan establish relationships with DCOs, including helping the CCBHCs write their DCO agreements. Kentucky also held weekly meetings with each CCBHC and provided technical assistance mostly focused on how to calculate the required quality measures using data from EHR systems; the state has also established quarterly meetings to provide support on PPS billing processes.

2. Expansion and Sustainability of the CCBHC Model through Alternative Financing Mechanisms

Sustaining and expanding the CCBHC model has been a priority for most demonstration states, particularly because of the uncertainty regarding ongoing funding for the demonstration at certain points during the demonstration. Demonstration states are using or pursuing financing mechanisms beyond the demonstration to sustain and expand the CCBHC model. This includes alternative Medicaid financing strategies and funding beyond Medicaid including SAMHSA CCBHC-E grants.

Expansion through Medicaid SPAs and Medicaid Section 1115 demonstrations. Four of the original demonstration states (Missouri, Minnesota, Nevada, and Oklahoma) and one non-demonstration state (Kansas) have established Medicaid SPAs to support the CCBHC model, and four other demonstration states (New Jersey, New York,[12] Oregon, and Kentucky) are planning to pursue or are exploring using SPAs or Medicaid Section 1115 demonstrations for this purpose. Most of the states with approved SPAs

[12] New York has submitted a SPA to cover CCBHC services through Medicaid. The SPA is currently in a pending status with CMS.

pursued these other federal authorities in early DYs when it was uncertain whether the demonstration would continue.

States with existing SPAs have attempted to ensure that CCBHCs financed through the SPA provide similar services to CCBHCs participating in the demonstration and that they comply with certification criteria regardless of funding source. For example, Nevada certifies all CCBHCs operating in the state the same way--regardless of whether they are funded under the state plan, demonstration, or SAMHSA CCBHC-E grants--to ensure the same quality of care across clinics implementing the model. State officials noted a few differences, however, between CCBHCs financed through the SPA versus the demonstration, such as the following:

- In Missouri and Oklahoma, CCBHCs financed through the demonstration and SPA must comply with the same certification criteria and scope of services requirements. In Oklahoma, however, CCBHCs financed through the SPA are not reimbursed for certain wellness activities that are covered for CCBHCs participating in the demonstration.
- In Minnesota, CCBHCs financed through the SPA can receive the PPS payment for beneficiaries enrolled in some state medical assistance programs, such as refugee medical assistance, but CCBHCs financed through the demonstration cannot receive the PPS payment for these populations. The CCBHCs financed through the SPA, however, do not receive the PPS payment for dually enrolled Medicare-Medicaid beneficiaries for which Medicare is the primary payer, whereas they do under the demonstration. CMS did not permit the state to allow provider-to-provider consultations to generate a PPS claim under the SPA, whereas it does under the demonstration.
- New Jersey, New York, Oregon, and Kentucky are at different stages in the planning and application process for Section 1115 demonstrations or SPAs to finance CCBHCs.

Expansion through other funding mechanisms. Beyond Medicaid, CCBHCs are using SAMHSA CCBHC-E grants and state-specific financing to cover the costs of services for the uninsured and underinsured, to help new clinics launch the model, and collaborate with state behavioral health authorities and state Medicaid Offices. Several state officials noted that some CCBHCs in their state have benefited from the flexibility of the CCBHC-E grants to fill gaps in services. For example, in Oklahoma, some CCBHCs participating in the demonstration have used CCBHC-E grant funding to expand services, such as supported employment services using the individual placement and support model, to new populations. Officials across several states anticipated that CCBHCs participating in the demonstration and clinics that wish to become CCBHCs would apply for future SAMHSA CCBHC grants. In addition, Oregon has designated about $300 million every two years from its state marijuana tax to develop behavioral health resource networks. The state official reported that many of the CCBHCs applied to function as or be part of these networks.

CCBHC model during COVID-19

"The flexibility that the CCBHC [model] provides allowed the providers to meet individuals' needs quickly and effectively [during the COVID-19 pandemic] in a way that I think without the PPS-2, they would not have been able to flex like that. …They responded to a very different set of needs very quickly and met the clients there."

New Jersey state demonstration official

3. Impact of the COVID-19 Pandemic on CCBHC Model Implementation

The COVID-19 PHE required CCBHCs to adapt their care in numerous ways, most notably by transitioning some or all care to telehealth. Many state officials reported that CCBHCs were better equipped to transition than other behavioral health providers because of some of the demonstration's features (notably, access and service [telehealth] requirements and the PPS). In general, state officials noted that CCBHCs were able to transition relatively seamlessly to virtual care and maintained service quality with minimal disruptions; the PPS gave them flexibility to meet clients' needs, and CCBHCs found ways to adapt.

CCBHCs varied in the extent to which they were leveraging telehealth before the pandemic,[13] and several state officials noted that CCBHCs were better positioned to transition services to telehealth than other providers in the state. They noted the following:

- Minnesota's official reported that its CCBHCs already had telehealth technology in place, so they were ahead of other providers in the state and did a "phenomenal job" transitioning to virtual care. The official highlighted that some CCBHCs supplied tablets to clients to enable them to meet virtually.
- Oklahoma CCBHCs were already providing consultation to external providers and some services to clients via tablets (iPads) before the pandemic, which set them up to pivot to using telehealth for a broader range of services.
- New York and Missouri officials reported that some CCBHCs were equipped to provide services via telehealth prior to the pandemic, which allowed them to transition more easily than if CCBHCs had not had the infrastructure previously. The Missouri official said one CCBHC used its Medicaid health home primary care physician (PCP) consultant to host "talk to the doc" virtual sessions. Clients could drop in and ask the doctor COVID-related questions about handwashing, social distancing, and such.
- Oregon's official noted that the state had already written electronic and telephone access into its state-specific CCBHC demonstration standards during the planning grant phase. The standards require CCBHCs to, at minimum, provide access to behavioral health advice by telephone 24 hours a day and seven days a week to ensure that CCBHC consumers, caregivers, and families can obtain behavioral health advice via telephone from a live person at all times.
- Nevada had previously limited telehealth for certain demonstration services because the state viewed telehealth as not clinically appropriate for some core CCBHC services (Wishon Siegwarth et al. 2020). Nevada made additional services available via telehealth during the pandemic, including targeted care management and psychiatric rehabilitation services.
- In New Jersey, some multisite CCBHCs were able to leverage telehealth as a staff extender during open-access hours. If staffing on site was limited during open-access hours, staff in other locations could assist with initial assessments.

Although officials reported that telehealth generally facilitated access to care during the pandemic, its implementation presented challenges for certain regions or consumer populations. In Minnesota, some

[13] The evaluation of the first two DYs found that 70 percent of CCBHCs reported offering some telehealth services in DY2, but the extent to which specific demonstration services were available by telehealth and to whom is unknown.

clinicians at rural CCBHCs had to drive to areas with better cell service and provide telehealth sessions in their cars. Similarly, areas such as upstate New York had limited internet access, which hampered provision of telehealth services to some extent. States reported that clients with fewer financial resources also faced challenges, such as having a limited number of phone minutes; some might have struggled with telehealth if they were not technologically savvy; and other clients with more acute needs, perhaps exacerbated by the pandemic, might simply have needed in-person services to be effective. Some state officials commented that certain types of services included in the certification criteria were difficult to deliver via telehealth. For example, officials in Oklahoma and Oregon shared that CCBHCs struggled to collect information on body mass index or blood pressure as part of primary care screenings without seeing clients in person. Group services were also sometimes more difficult to deliver via telehealth, and drop-in services such as clubhouse services had to be temporarily discontinued.

Telehealth as a facilitator during COVID-19

"The state requirements…[regarding] telephone and electronic access…[were] key to keeping the CCBHCs open and running through the pandemic….Almost all of our clinics reported that that was the critical difference of what allowed them to continue being a CCBHC during the pandemic."

Oregon state demonstration official

The official in New Jersey said CCBHCs experienced an influx of clients, likely because of increased anxiety from the pandemic and the fact that many other providers were not able to see these clients based on the insurance they accepted. The increased use of telehealth during the pandemic also presented an unintended consequence for staffing in the state: some clinicians have left CCBHCs to create exclusive telehealth practices so that they can work from home. Certain CCBHCs limited or cut open-access hours during peak pandemic times because of staffing issues or to minimize the spread of COVID-19. Still, CCBHCs in the state worked to overcome barriers to accessing care. For example, in addition to offering services via telehealth, staff from most of New Jersey's CCBHCs provided home-visits during the pandemic to reach their clients and make sure they were safe; CCBHC staff also helped ensure clients' needs were met by bringing them food and medication during home visits.

States have different plans for continuing the telehealth flexibilities that began during the COVID-19 pandemic. For example, as of May 2022, in Oklahoma, the increased telehealth flexibilities instituted by the state in response to the pandemic have yet to be phased out. In Nevada, the governor recently ended the PHE, so the official suspected telehealth flexibilities would soon be removed. Officials in other states did not comment on formal changes to telehealth policies but did share various reflections on how the use of telehealth could impact CCBHCs in the future. For example, Oregon's official noted that some CCBHCs continue to have fewer in-person visits because clients preferred telehealth. New York has seen more CCBHC clients during the pandemic, and caseloads have yet to return to pre-pandemic levels.[14] The state official shared that they have found that telehealth decreases no-show rates, which increases access because CCBHC providers can spend more of their day seeing clients rather than having unexpected, unused appointment slots in their day.

Although state officials emphasized that they have not rigorously analyzed the pandemic's impacts on costs, some were able to share their perceptions on how costs changed over time. Oklahoma's official noted that the state's CCBHCs saved money on transportation costs because of telehealth, and New York and Minnesota's officials offered observations about changes to operating costs such as increases in costs

[14] To maximize access during the PHE, New York reduced the standard billable session time for mental health and SUD outpatient services to enable CCBHC (and non-CCBHC) providers to hold more clinic sessions in a day.

for personal protective equipment and cleaning. New York's official also noted additional costs related to the purchase of laptops, tablets, and remote technology or software licenses for staff.

Closer Look: The impact of COVID-19 on organizations that became CCBHCs in new demonstration states

Although the new states did not begin participating in the demonstration until the second year of the COVID-19 pandemic, officials in the new demonstration states reported observations similar to the other state officials on COVID-19's effects on behavioral health clinics that became CCBHCs, and offered a few unique examples.[15] Officials in both states reported that telehealth was rarely used by clinics in the new states before the pandemic, so there was a learning curve to help clinics make the transition. In Michigan, some populations did not have access to the technology needed for telehealth services, so CCBHCs developed workarounds, such as using Wi-Fi centers in schools that clients could visit to access telehealth technology. Another issue was monitoring medications and making sure clients could access medications for SUD when it was not safe to come to the CCBHCs. In the beginning of the PHE the number of clients accessing services dropped in Kentucky, but the numbers have stabilized, and the state official reported that clients are satisfied with telehealth services. Before the PHE the Kentucky Medicaid agency required prior authorizations for most inpatient and outpatient behavioral health services, but the state decided to suspend these during the pandemic, which helped to maintain access, and it has chosen not to reinstate prior authorizations for behavioral health services at the time of our data collection.

B. Access to Care

The CCBHCs model is intended to expand access to care in the communities they serve and engage new consumers in care. The certification criteria specify that CCBHCs must provide accessible care, including 24-hour crisis management services; engage consumers quickly through prompt intake services; and treat all consumers, regardless of their ability to pay. PAMA requires that HHS's reports to Congress include an assessment of access to community-based mental health services under Medicaid in the area or areas of a state the CCBHC demonstration targets compared with other areas of the state. To this end, we examined state and CCBHC successes and challenges in maintaining access-related activities since the end of DY2 and highlight changes in the activities CCBHCs have engaged in to increase access to care.

In the first two DYs, CCBHCs implemented a wide range of activities to increase access to care (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 beyond the clinic walls 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 shared that CCBHCs have largely worked to maintain and expand existing access-related activities rather than introduce new activities since the end of DY2. Many officials noted that their states and CCBHCs did not make any major access-related changes. As we described above, however, the PHE influenced access-related initiatives such as the expansion of telehealth.

A few state officials mentioned continuing to address access to care and the client experience since the end of DY2 by exploring changes to existing requirements. For example, the CCBHC criteria require

[15] Kentucky and Michigan were alerted that they had been selected to participate in the demonstration in July 2021 and kicked off their demonstrations in October 2021 (Michigan) and January 2022 (Kentucky) respectively.

CCBHCs to provide an initial evaluation and begin to provide services to consumers with routine service needs within ten business days, and states can institute more stringent time requirements. New Jersey considered reducing the requirement for evaluating non-crisis clients from ten business days to 5-7 business days, but it delayed this plan when the pandemic hit, and CCBHCs' performance on the quality measure related to time to initial evaluation worsened due to the pandemic.[16] The state intends to resume its plan to revise its requirements when the clinics have restabilized. Oklahoma's official shared that the state addressed admissions from a different angle by changing processes to improve the client intake experience. Since July 2021, the state has adjusted its admissions processes so that clients can participate in an extended admissions process in which they complete pieces of the evaluation process across multiple visits instead of needing to complete 4-5 hours of intake at once.

Addressing access: Integrating with 988

Overall, states were still figuring out how CCBHCs would be involved in the rollout of the national 988 Suicide & Crisis Lifeline, but officials noted that CCBHCs would play an important role as part of the crisis services continuum, offering critical crisis services such as mobile crisis and, in some cases, crisis stabilization services. Oklahoma's official noted that the state had already selected a call center vendor, and New Jersey's official noted it already has a mental health screening center that CCBHCs leveraged to date through a DCO relationship, but this could change with the 988 rollout.

States have also addressed access issues through various requirements and investments tied to staffing since the end of DY2. Oklahoma began requiring CCBHCs to have a dedicated outreach worker to reach out to those most in need, such as clients with multiple crisis or emergency department visits or who were recently discharged from an inpatient facility. Assigning this responsibility to a dedicated staff member who does not otherwise carry a caseload ensures that outreach is a priority and does not fall by the wayside amid competing demands. New York took a different approach, reversing caseload caps in March 2022 for psychiatric rehabilitation services and TCM. The state official said CCBHCs felt the caps were limiting access to services for individuals. The expectation now is that supervisors would still monitor caseloads and efficacy of services.

New Jersey and Minnesota have focused on increasing the capacity of CCBHC staff to provide certain services, which state officials reported has improved access for consumers. New Jersey advocated and negotiated with its licensing body to waive existing state regulations under which behavioral treatment programs had to be licensed as Opioid Treatment Programs to prescribe or dispense buprenorphine; additionally, providers could not initiate the induction of a client to buprenorphine (a medication for opioid use disorder) unless the provider had met ambulatory withdrawal management licensure regulations. Under the regulations, ambulatory care providers could prescribe buprenorphine, but had to meet additional requirements under their licensure. Under the state's licensure waiver, qualified providers practicing in CCBHCs are authorized to prescribe buprenorphine, enabling more clients to access medications more quickly and easily. The state official noted that they saw many clients who originally sought treatment from CCBHCs for mental illnesses seek buprenorphine treatment after this change. Similarly, Minnesota encouraged the use of peer services over the past few years through the state-specific impact measures it selected to monitor progress toward meeting demonstration goals as well as through specific certified training, which has helped to expand the peer role in CCBHCs and increase the hours of services provided by these staff accordingly. Minnesota clinics have three peer models: a

[16] One CCBHC, for example, tripled its admissions during the pandemic because it was one of the only providers in the area to keep its doors open, so the state considered this an improvement in access when viewed from a different lens.

certified peer specialist for adults with mental illness, peer support for clients in recovery from SUD, and family peer support.[17]

With few exceptions, state officials noted that CCBHCs have been able to maintain access since the end of DY2 despite some challenges related to the COVID-19 pandemic and staffing shortages. As we described above, CCBHCs were largely expanding and sustaining existing access-related activities rather than introducing new activities, although the COVID-19 pandemic prompted some new access-related activities such as telehealth and home visits. Oklahoma is increasing access through expanded services and settings. The state increased its standards related to the availability of urgent care recovery centers, which give clients access to less formal crisis care to address urgent symptoms before a formal crisis stay is warranted. Some of the state's CCBHCs have also started intensive outreach services for high-need clients who might not meet Assertive Community Treatment (ACT) criteria or be ready for it.

Access to care in CCBHCs

"When thinking about comparisons like this, we typically compare the CCBHCs to our Medicaid specialty behavioral health providers [Community Mental Health Services Programs]. One of the biggest changes is the expansion in mobile crisis services. Our [Community Mental Health Services Programs] are required to offer some type of mobile crisis--either part time during the day or for certain hours or days overnight, but few met the 24/7 requirement. They also struggled with whom to serve…if they were limited to the Medicaid population. [The CCBHC model] has opened the door to a lot of new participants. CCBHCs also are open later hours than the non-CCBHCs, and many non-CCBHCs limit services to [those with severe disorders]. At non-CCBHCs, someone with less severe needs may be referred back to the community or to their Medicaid health plan to find a different provider."

Michigan state demonstration official

State officials consistently reported that CCBHCs offer better access to care than non-CCBHC counterparts because there are fewer barriers to care and more supportive policies in place. For example:

- Unlike other behavioral health providers, Nevada's CCBHCs are not required to obtain prior authorization for Medicaid services, which enables them to provide same day and same week services. There also are no limitations for the nine core services, including limits to the number of services clients can receive in a calendar year, which clients face in other settings.
- Oklahoma's official echoed other state officials by describing the model's expanded hours and same-day access, and also mentioned the new designated outreach worker role the state required, as CCBHC advantages.
- In New Jersey, the state official noted a large difference in CCBHCs' access-related activities versus non-CCBHCs because CCBHCs are focused on improving access and have adopted various creative strategies such as setting up a 24/7 provider line, which is helpful if, for example, clients run out of medications. One of New Jersey's CCBHCs implemented just-in-time scheduling, which is an approach that allows for medication management appointments to be scheduled more quickly and closer in time to when clients request them.
- Oregon's official said that some top state officials advocated for exploring an expansion of the CCBHC model to all 36 of the state's county Community Mental Health Programs because of perceptions within the state that the model offers clear advantages.

[17] According to SAMHSA, family peer support provides guidance, advocacy and camaraderie for parents and caregivers of children and youth receiving behavioral health and related services. See https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/family-parent-caregiver-support-behavioral-health-2017.pdf.

- Missouri's official noted that CCBHCs use wellness coaching and integrated treatment for co-occurring disorders, unlike non-CCBHCs. In addition, CCBHCs are required to collaborate with clients' PCPs and help establish linkages to PCPs if a client reports not having one.

Closer Look: Access in new demonstration states

For the new states, raising awareness of CCBHCs through marketing campaigns was a common goal. Michigan is developing a statewide media plan[18] and hopes to push it out in each of the CCBHC regions to increase awareness of new services. The state has experienced some pushback from CCBHCs that are struggling with workforce shortages because they are concerned about increased foot traffic and consumers' disappointment if clinics cannot provide the services as quickly as expected because of the lack of staff. The state is learning to be more mindful of the CCBHCs' individual challenges as it explores how to encourage access. In addition, many of the state's CCBHCs have their own marketing initiatives to raise awareness of their CCBHC status and ability to serve all who need services; some of these CCBHCs have leveraged part of their SAMHSA CCBHC-E grant funds for this marketing. The state has focused on care coordination agreements, which have helped to raise awareness of CCBHCs in the community and led to more referrals. Kentucky's official reported a lot of media activity (such as press releases) and said that the state's four CCBHCs have been doing well using their websites for marketing. The state has also provided presentations to different stakeholders about the CCBHC demonstration.

The two states' CCBHCs are maintaining access-related activities they conducted before the demonstration and expanding to meet the certification criteria and focus on new priorities. In Michigan, many CCBHCs were already engaging in the access activities required by the certification criteria, such as expanded hours and days of services and provision of services in alternative settings. Now, they have expanded to offer 24/7 crisis services and are helping to connect consumers transitioning from incarceration with CCBHCs for care. The state has been interested in monitoring how well different populations of interest, such as Medicaid beneficiaries with mild to moderate needs, people with private insurance who are not getting all their service needs met elsewhere, and people without insurance are able to access CCBHCs. The official thinks access has increased already, especially for the non-Medicaid population.

In Kentucky, each of the state's CCBHCs has added staff to ensure expanded hours of operation per the certification requirements. A few CCBHCs are in rural areas, and CCBHC staff have also been thinking about how to meet clients' transportation needs to ensure transportation to services. For example, one clinic has launched mobile services so the CCBHC can reach very rural areas. Although the state official noted it is too early to assess increases in access overall, they shared that one CCBHC's crisis intervention consultations increased by 25 percent in the first four months. The official said that CCBHCs' access activities are "night and day" compared with non-CCBHCs because the increased funding has enabled CCBHCs to hire additional staff and extend hours, which the non-CCBHCs are not able to provide.

1. Staffing as a Challenge for Maintaining Access

Workforce shortages and staff turnover across the behavioral health system were a common challenge mentioned by states and CCBHCs during the first two years of the demonstration (Brown et al. 2021). Maintaining a sufficient workforce continued to be a key issue for CCBHCs in most states since the end

[18] The media plan includes print media, marketing in settings such as doctor's offices, social media, and a radio spot.

of DY2, with new factors, such as the COVID-19 pandemic and unintended consequences of other state behavioral health initiatives, compounding this challenge. For example, a state official reported that although the enhanced Medicaid matching rate and the ability to have a CCBHC-specific PPS rate helped CCBHCs in New York provide competitive salaries and maintain staff in the past, recent state investments in other areas of outpatient mental health and SUD services regarding staffing have somewhat eroded CCBHCs' edge in offering competitive salaries. Similarly, New Jersey's official noted that although the PPS is generous relative to historical Medicaid payments and provides flexibility for CCBHCs to hire different types of staff, applicants seeking employment from CCBHCs and current CCBHC staff have salary expectations that are much higher now than before the COVID-19 pandemic.

Staffing challenges in CCBHCs

"The great resignation happened, so just massive workforce shortage, which then affects all of our access requirements… Definitely, from the provider side, that's probably the biggest problem, and then it creates extra administrative burden for the ones who do stick around, and that creates even more burnout and, in turn, workforce shortage."

State demonstration official

Other state officials echoed this sentiment. According to multiple state officials, staffing challenges may affect access within CCBHCs because they might compromise their ability to conduct intakes in a timely manner and challenge CCBHCs' ability to meet scope of service requirements. For example:

- Oregon's official noted that meeting Oregon's state-specific requirement to provide 20 hours of primary care services on site has been difficult for about half of the CCBHCs due, in part, to staffing shortages.
- Michigan's official described the workforce shortage as the biggest impediment to implementation so far; as we noted previously, some Michigan demonstration CCBHCs raised concerns to the state about overwhelming CCBHCs with too many clients before they are fully staffed. The state is helping address the staffing shortage by aligning with other workforce efforts in the state such as student loan forgiveness and other incentives.
- New York's official noted that raising awareness of the CCBHC model has had unintended consequences related to staffing: as hospitals and case managers better understand the CCBHC model, more people with severe conditions have been referred to CCBHCs. Providing care for these clients requires more staff time, especially if there are delays transitioning clients along the continuum of care, so some staff, including more seasoned practitioners, have been leaving to work in less intensive programs.

State staffing strategies

"One of the things that CCBHCs are supposed to do is to help with…funding the staffing piece, so they're trying to sort out how they can do that to bring in and retain staff and align with some of our other state efforts that are designed to really support and increase the workforce. So we're working on some student loan forgiveness projects and some other incentives to get people to stay and stick around and work in these settings."

Michigan state demonstration official

Staffing shortages compounded by the pandemic also affected opportunities for interactions between CCBHCs and the state. For example, chief executive officers of CCBHCs in Minnesota had decreased capacity to participate in workgroups facilitated by the state during the PHE, and CCBHC leaders also discouraged the state from offering staff trainings to protect clinicians' time for direct care.

2. Needs Assessments

The CCBHC criteria require that states develop an initial needs assessment to inform demonstration planning and the certification process and that CCBHCs regularly update the assessment. A needs assessment is a systematic approach to identifying community needs and determining a clinic's capacity to address the needs of the population it serves. In general, needs assessments continue to be conducted in demonstration states since the end of DY2, albeit with some delays because of the COVID-19 pandemic or state leadership turnover in certain cases. Several states were just resuming needs assessment activities at the time of our interviews. For example, Minnesota has not conducted a statewide needs assessment since 2016 but expects each demonstration clinic to complete a needs assessment this year using a template the state's contractor created for the 2016 assessment. As of May 2022, New York's CCBHCs were in the process of updating their needs assessments as part of their self-review against the certification criteria. These needs assessments were delayed because of the PHE and are being conducted for the first time since the initial two-year demonstration period. Oregon has also tasked CCBHCs with completing their needs assessments this year, which has required CCBHCs to be resourceful because a state data tool that provided county-level data is no longer available to inform this analysis. The state plans to work with individual clinics after they have identified any unmet needs to develop strategies to address these needs before a full re-certification occurs in 2023. Oklahoma clinics have recently conducted their second needs assessments, which have informed quality improvement activities. Some of these needs assessments have been shared with new CCBHCs supported through the SPA as models to assist new clinics and encourage consistency across funding sources.

A few state officials mentioned that CCBHCs may have worked on separate needs assessments throughout the years for other entities such as private insurers and the criminal justice system. Nevada's official described how the state tries to align efforts across entities. Nevada conducts a global statewide needs assessment every few years to satisfy needs assessment requirements across various funding streams and programs at the same time.

Closer Look: Needs assessments in new demonstration states

Demonstration states must conduct a needs assessment as part of the application process. These needs assessments informed CCBHCs' efforts to increase access to care in demonstration states. As a result of the needs assessment in Michigan, many CCBHCs prioritized diversity, equity, and inclusion trainings to ensure staff effectively serve populations in their community. For example, one CCBHC provided a comprehensive training on serving LGBTQ adults and children. Kentucky CCBHCs prioritized addressing transportation issues and thinking creatively about how to help clients access services if they chose not to use telehealth. Kentucky's needs assessment also identified the need to recruit and retain specific CCBHC staff, such as peer support specialists, as indicated in its demonstration application.

As part of its needs assessment, Michigan asked CCBHCs to think through how to incorporate the state's centralized crisis response call center, the Michigan Crisis and Access Line, which will soon transition to 988, into their operations. For example, some CCBHCs might leverage it to provide coverage after hours. The state requires formal care coordination protocols to be in place between the Michigan Crisis and Access Line and CCBHCs. For example, CCBHCs should send crisis alerts to the Michigan Crisis and Access Line staff about clients who likely will go into crisis, and these staff will use the crisis alert guidance to plan for providing support to the individual and send follow-up reports back to the CCBHC if they provide support (Michigan Department of Health and Human Services 2022).

3. Reaching and Serving Children, Adolescents, and Their Families in CCBHCs

PAMA requires CCBHCs to provide services to all who seek help, including children and adolescents. Accordingly, the CCBHC certification criteria include multiple requirements related to these populations. For example, CCBHCs must have staff with relevant expertise and provide services for children and youth that are "family-centered, youth-guided, and developmentally appropriate."

Efforts to serve children in CCBHCs have often involved interagency collaborations in the state and partnerships at the clinic level.

Several states mentioned partnerships at the state agency level:

- New Jersey's official reported that the state has a well-developed Children's System of Care (SOC) that provides many of the state's children's behavioral health services.[19] However, the state received feedback from families that they appreciate receiving services for the entire family, including children's care, in one location at CCBHCs, which has prompted the state to revisit discussions with the state's Department of Children and Families regarding how to better integrate CCBHCs with the broader state Children's SOC.
- Nevada is also working with its SOC, whose staff will train CCBHCs this year on the resources available related to serving children, adolescents, and families.

Multiple state officials noted collaborations between CCBHCs and schools:

- Michigan's official reported that CCBHCs have established care coordination agreements with local schools.
- The New York official noted that, as children and adolescents have been returning to schools after the pandemic, the state has strongly encouraged a greater behavioral health presence within them. One county pushed to have a behavioral health professional in every school and relied heavily on the CCBHC serving the area to facilitate those placements.
- Kentucky's official noted that a few CCBHCs have hired staff to be consultants for schools. One CCBHC reported to the state that the staff member had facilitated 349 referrals to CCBHC care from the area schools.
- In Missouri, CCBHCs have strong collaborations with the Children's Division (that oversees foster care) and juvenile justice services in addition to schools.

[19] SOCs offer a spectrum of community-based services and supports for children and youth with or at risk for behavioral health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life. See https://www.isbe.net/Documents/soc-brief-2010.pdf.

CCBHCs have often bolstered their child and youth services through specialized staffing models:

- Although Michigan has followed a specific peer support model tailored for youth with SUD, the demonstration has prompted the state to acknowledge the need for a more extensive continuum of family supports for different populations and is increasing peer youth and family support as part of the certification process.
- Oregon's official noted that among the four clinics the official had recently talked with, most have a qualified mental health professional who specializes in child and family services or relationships with community organizations serving children. One of the clinics offers peer services geared toward children, but another is struggling to maintain staff for children's services.
- Minnesota's official noted that CCBHCs needed to add staff who are competent in treating children and families at the start of the demonstration because the clinics had been primarily adult-focused before the demonstration. Minnesota's official shared that the state is considering whether requiring CCBHCs to provide adolescent SUD services, which requires additional program licensure for providers, is warranted because some clinics have good community partners who provide this service. Further, some clinics say they do not have enough adolescent clients needing SUD services to justify having an SUD program for adolescents.

C. Scope of Services

The CCBHC criteria establishes a minimum scope of services for CCBHCs and requires states and CCBHCs to adopt evidence-based practices (EBPs). The demonstration does allow states to select some services and EBPs to address specific community needs and align with Medicaid state plans and other state regulations. CCBHCs varied in the types of services they provided and populations they served before the demonstration, and consequently required different changes to meet certification requirements. Officials reported that, as a result of the certification process, CCBHCs provided a more comprehensive and broader range of services than other community behavioral health organizations elsewhere in the state. CCBHCs were generally able to sustain the delivery of the required services during the first two years of the demonstration.

In general, state officials in the original demonstration states did not report any major scope of service changes since the end of DY2. States did not change the scope of service requirements, and officials did not note any specific challenges CCBHCs faced maintaining services. But, as we described previously, some states had not conducted re-certifications in some time, so officials were not sure whether CCBHCs' ability to provide the full scope of services had been affected by workforce shortages, for example.

New York's official reflected on scope of services in relation to funding and sustainability considerations. Some of the state's demonstration CCBHCs received CCBHC-E grants and augmented their demonstration programs by adding services beyond the required scope of services, including clubhouse programs, social rehabilitation programs, or services similar to ACT using these funds. One demonstration CCBHC broadened its crisis service capacity. New York is now considering the sustainability of these services. For example, if CCBHCs do not receive additional federal grants, the state wonders whether the CCBHCs will be able to continue these newly added services. Even if they were

awarded new grants, some CCBHCs would experience a gap in funding between the grants, and they are struggling to figure out how to keep services currently funded by grants going. In sustainability discussions, the state has been considering whether to require ACT and clubhouse services as part of the CCBHC model. For now, it has not made any changes to demonstration requirements.

In addition, state officials often commented on CCBHCs' role in addressing various state priorities and contributing to various initiatives, such as crisis system transformation, primary care integration, and care coordination efforts, although the exact role and integration of the CCBHC in the broader systems was still being defined in some states. For example, Missouri has focused on improving its crisis response and increasing the number of liaisons with law enforcement as part of the broader behavioral health care system. Oklahoma has set a standard to ensure all areas have adequate urgent care coverage, which has prompted CCBHCs to increase the availability of urgent recovery centers and services. Aligning with the state's focus on primary care integration, CCBHCs in New Jersey have taken steps to partner with Federally Qualified Health Centers and become licensed as primary care providers themselves. Two clinics are implementing the living room model, which provides an alternative to hospitalization for people experiencing a mental health crisis and often includes peer support services and a more relaxed environment akin to a living room.

Closer Look: Scope of services in new demonstration states

Before the demonstration, Kentucky's four CCBHCs were community mental health centers that provided a wide range of services, including SUD services, so joining the demonstration mostly meant expanding the clinics' reach rather than adding new services. The Department for Medicaid Services also collaborated with its Department of Behavioral Health, Developmental and Intellectual Disabilities to determine which EBPs to require and also collaborated together to train CCBHC staff on at least four EBPs.

Michigan's clinics were also able to pivot to the service requirements of the CCBHC model relatively easily because ten of its 13 CCBHCs were Community Mental Health Services Programs, which provide a broad array of services to people with serious needs. The other three CCBHCs were contracted providers within Community Mental Health Services Program networks and served the same population. Still, there were some gaps in service that had to be filled. Traditionally, for example, SUD services were often provided by separate organizations, in part because of the separation of funding streams for mental health and SUD treatment. Community Mental Health Services Programs previously had 24/7 crisis lines, but they provided mobile crisis services less consistently.[20] The state also requires CCBHCs to offer 12 EBPs and recommends seven others.[21] For example, the state's CCBHCs must provide dialectical behavior therapy (DBT) but can choose whether to also provide DBT for adolescents, a modified version of the EBP. Three of the recommended EBPs are framed as

[20] These service gaps mirrored the experiences of the original demonstration states. An evaluation of the first two DYs found that CCBHCs across the original demonstration states commonly added outpatient mental health services, SUD services, or both (63 percent of CCBHCs), and crisis behavioral services (51 percent of CCBHCs) as a result of certification (Brown et al. 2021).

[21] The state requires: "Air Traffic Control" Crisis Model with MiCAL; ACT; Cognitive Behavioral Therapy (CBT); DBT; Infant Mental Health; Integrated Dual Disorder Treatment; Motivational Interviewing for adults, children, and youth; Medication-Assisted Treatment; Parent Management Training--Oregon and/or Parenting through Change; Screening, Brief Intervention, and Referral to Treatment; Trauma-Focused CBT; and Zero Suicide. The state recommends: DBT for Adolescents; Permanent Supportive Housing; Supported Employment (IPS model); and EBPs of the CCBHC's choice addressing trauma in adult populations, needs of transition age youth, and chronic disease management (Michigan Department of Health and Human Services 2022).

choices for CCBHCs, such as "an EBP of the CCBHC's choice that addresses trauma in adult populations." The state has given CCBHCs one year to provide all of the required EBPs.

Use of DCOs. Currently, none of Kentucky's CCBHCs are using DCOs, but the state official suspects CCBHCs may reconsider as the demonstration progresses. For example, CCBHCs may eventually leverage the statewide mobile crisis system, currently in its infancy, through DCO relationships.[22] In contrast, to meet demonstration scope of service requirements, some of Michigan's CCBHCs contract with DCOs for SUD services, and several CCBHCs leverage DCOs to provide crisis services. Two CCBHCs have contracted with DCOs to provide other services.

[22] Kentucky CCBHCs' decision not to pursue DCO relationships is consistent with the original demonstration states'. In general, DCO relationships were rarely pursued in the first two DYs except for suicide/crisis hotlines or warmlines, with 30 percent of CCBHCs developing relationships with these types of providers.

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IV. Demonstration Payment Rates and Costs from Demonstration Year 1 to Demonstration Year 4

Medicaid programs typically reimburse community behavioral health organizations through negotiated fee-for-service or managed care rates, and some evidence suggests that these rates have not historically covered the full cost of the services these clinics provide to Medicaid beneficiaries (Scharf et al. 2015). The demonstration addresses this problem by allowing states to use projected costs to develop a PPS that reimburses CCBHCs based on the total cost of providing comprehensive services to all people who seek care. In this chapter, we describe the process states used to establish PPS rates and changes in those rates over the first four years of the demonstration. We also summarize costs of the CCBHCs over the first four years of the demonstration, focusing on changes in total clinic costs and factors that might contribute to these changes. The goal of these analyses is to understand the overall patterns of change in the rates and costs across demonstration states and CCBHCs, which is important information for understanding for understanding the extent to which CCBHC payment rates have covered the costs of services.

PPS rates changed more between the first two years of the demonstration than in subsequent years. In four demonstration states (Minnesota, Nevada, New York, and Oklahoma), there were increases or decreases of 10 percent or more in the average PPS rates from DY1 and DY2 but no changes of this magnitude in later years. In the remaining three states (Oregon, New Jersey, Missouri), average PPS rates were relatively stable across all DYs. The smaller changes in rates from DY2 to DY4 could reflect states' concerns about the impact of service delivery disruptions during the COVID-19 pandemic on the representativeness of the data used to adjust the rates (Section A below describes the process states can use to adjust rates based on previous year's costs). It might also suggest decisions by states to avoid potentially disrupting CCBHCs by changing their funding in the middle of the PHE. The comparatively small changes in rates after DY2 could also reflect stabilization in patterns of care and CCBHC costs over time.

With respect to total CCBHC costs in the first four DYs, two patterns emerge from the comparisons of changes over time in the states for which sufficient data were available to facilitate comparisons, as Exhibit IV.1 shows. First, total clinic operating costs reported in clinic cost reports remained stable (Minnesota and Oregon) or increased (Missouri, New York, and Oklahoma) during the demonstration, with increases from DY1 to DY4 in excess of 25 percent in the latter three states (Exhibit IV.1).[23]

Since the total clinic costs are equal to the number of visits multiplied by the cost per visit, changes in total costs in cost reports could be driven by changes in the cost per visit or changes in the total number of visits. In addition, the total number of visits might change because of changes in the number of clients served by CCBHCs or changes in the number of visits per client. We examined if these factors were associated with changes in total CCBHC costs. In three of the four states with cost report data available to facilitate comparisons, the observed increases in total clinic operating costs reflect increases in the cost per client served and not in the cost per visit-day (PPS-1 states) or visit-month (PPS-2 states).[24] The cost per client increased by more than ten percent in all four states for which data were available, while changes in cost per visit were less than 11 percent in these states. Further, the increase in cost per client likely reflects an increase in the average number of visit-days or visit-months per client, which rose by at

[23] In this report, we present comparisons across years as percentages because of dramatic variation in costs reported in cost reports, and numbers of clients and visits across states.

[24] Visit-days are unique days in which a client received at least one demonstration service. Visit-months are months in which a client received at least one demonstration service.

least 15 percent in the four states for which data are available. In New York, there were increases in both the cost per client and the number of clients.

Exhibit IV.1. Summary of the Percentage Change from DY1 to DY4 in CCBHC Costs, Visits, and Clients

	Total clinic operating costs	Average number of clients served	Average cost per client	Average cost per visit-day or visit-month	Average number of visit-days or visit-months per client	Average number of visit-days or visit-months
Minnesota	6%	-10%	14%	-5%	18%	3%
Missouri	27%	NA	NA	-6%	NA	26%
Nevada	NA	132%	NA	NA	NA	NA
New Jersey	NA	25%	NA	NA	NA	NA
New York	54%	26%	16%	1%	15%	52%
Oregon	1%	-10%	22%	-1%	18%	5%
Oklahoma	74%	4%	57%	11%	33%	52%

Source: Mathematica and the RAND Corporation's analysis of CCBHC cost reports, and client counts reported by states.

Notes: The exhibit reflects percentage change from DY1 to DY4. Analyses are limited by missing cost report data for Nevada and New Jersey for DY2 to DY4. Data on the number of clients served for DY4 were missing for Missouri. Calculations for average cost per client, average number of clients served, and average number of visit-days or months per client require both cost reports and number of clients served.

Cost findings presented in this report should be interpreted in the context of the limitations of the data. First, the data only include information on services provided by and operating costs for the CCBHCs as reflected in clinic cost reports. CCBHCs' costs might change over time due to many internal and external factors not reflected in the cost reports. CCBHC clients might have received additional services from non-CCBHC providers. For example, the cost report data do not include the costs of hospitalizations or emergency room visits, so any these analyses do not reflect any offsets in costs to other providers or systems. Missing data at the clinic or state level on costs, number of visits, or number of clients served also led to our excluding some clinics from the analyses, as we describe below.

A. PPS Rate Development and Changes

Under the demonstration, states set PPS rates for each CCBHC by dividing the projected annual total allowable costs by the projected annual number of visit-days (for PPS-1) or visit-months (for PPS-2) to develop rates intended to cover the expected costs of providing the full scope of services required in the CCBHC certification criteria. Although the formula for calculating the rates is simple, the rate calculation requires accurate data to calculate the allowable costs and number of visit-days or visit-months. To set the rates at the outset of the demonstration, states collected data on clinics' historical operating costs using a cost report template provided by CMS and approved by the Office of Management and Budget. The cost reports collect data on labor costs by provider type; other direct costs, such as medical supplies and insurance; and indirect costs, such as building and administrative costs. For DY2 and every year after, states could re-base rates for all CCBHCs based on the prior year's cost reports to reflect actual spending or they could also adjust rates for inflation using the MEI. Re-basing could increase or decrease the rates to better align them with costs. During DY1, for example, average CCBHC payment rates were higher than CCBHC costs in five states and lower than costs in Oregon (Brown et al. 2021). This meant that the

amount the CCBHCs were paid exceeded the costs of the services they provided in all states except one (Oregon). Five out of the seven original demonstration states included in this report re-based their rates for DY2, and all states adjusted for inflation using the MEI for DY2. In all states except Oklahoma, the average payment rate more closely aligned with costs in the DY. In both DYs, the extent to which the payment rates covered costs for an individual CCBHC varied within states; the payment rate did not cover the costs for all CCBHCs.

Officials in all states reported that their state adjusted rates for inflation only (versus re-basing) for DY3, and all states but Missouri and New York adjusted for inflation for DY4.[25] Missouri is the only demonstration state that has re-based PPS rates since DY2. Officials in some demonstration states reported that their state elected to adjust for inflation only and not re-base because of concerns about the impact of service delivery disruptions during the COVID-19 pandemic on the representativeness of the data used to re-base the rates. The lack of large changes in rates after DY2 might also reflect stabilization in patterns of care and their costs over time.

Closer Look: Rate re-basing in Missouri

Missouri adjusted for inflation for the third DY and then implemented a modified rate re-base for the fourth DY because of the COVID-19 pandemic. Before the pandemic, the state had planned to re-base rates for all CCBHCs that would be effective in DY4. The state used CCBHCs' 2019 cost reports to assess whether a clinic's re-based rates would increase or decrease. For clinics for which the rate increased, the state used the increased rate for DY4, but the state left the rates the same as they were in the third DY if the clinic's rate was to decrease. The state adopted what it termed a "hold harmless" approach to avoid potentially placing additional financial strain on CCBHCs and "an already struggling system due to the pandemic," according to Missouri's official.

Consistent with information provided by state officials, changes in CCBHC rates were generally much larger between DY1 and DY2, when most states both re-based and adjusted for inflation, than they were in subsequent years of the demonstration, when most states only adjusted for inflation (Exhibit IV.2).

Between DY1 and DY2, the average change in CCBHC rates varied from a decrease of 17 percent in Nevada to an increase of 16 percent Oklahoma (Exhibit IV.3). More states had decreases in average rates during this period than increases. The changes in rates between DY2 and DY3 and between DY3 and DY4 only ranged from 1 percent to 3 percent, except for an increase of 5.4 percent between DY3 and DY4 for Oklahoma. Two states, New Jersey and Oregon, had very small decreases in rates over the first four DYs.

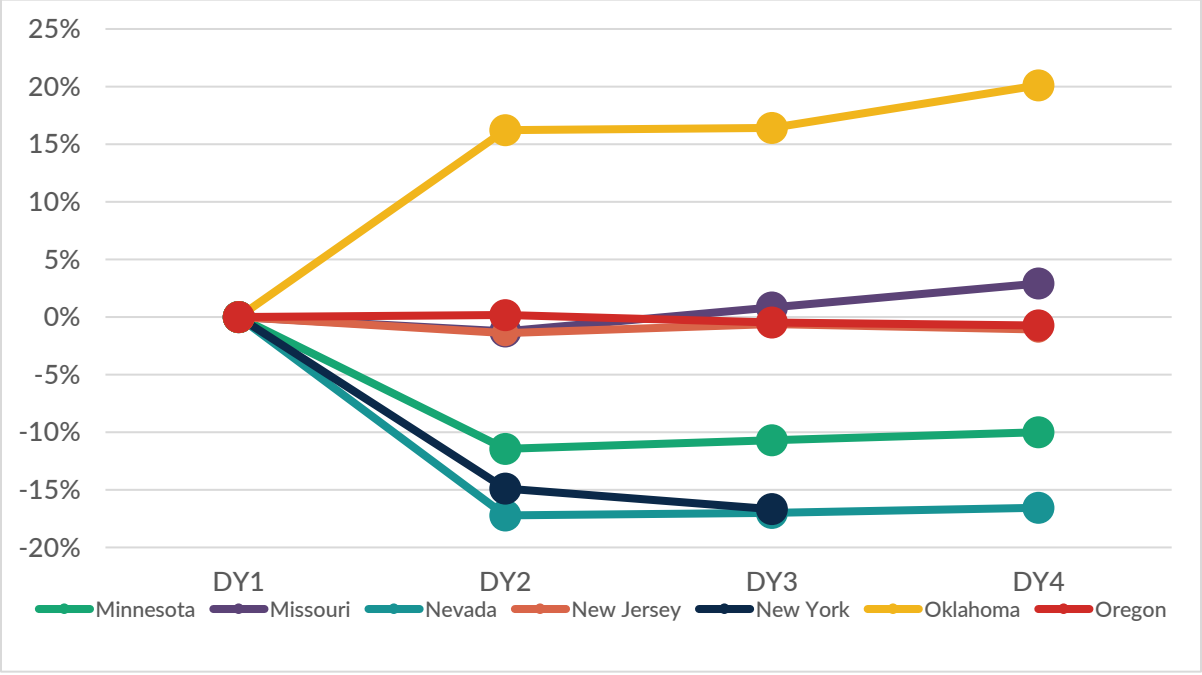
[25] New York is paying its DY3 rate for DY4 while working on a possible modification to the rate computation.

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

Source: Mathematica and the RAND Corporation's analysis of state-reported PPS rates.

Notes: We inflated rates for each DY to 2022 dollars using the MEI to facilitate year-to-year comparisons. All states except for Missouri and Oregon reported re-basing their DY2 PPS rates based on the DY1 cost reports and all states adjusted their DY2 PPS rates for inflation using the MEI. All states reported adjusting rates for inflation for DY3 and all states but Missouri and New York adjusted for inflation for DY4. Missouri reported re-basing rates for some clinics (that is, those with rates that increased based on 2019 cost reports) in DY4. New York is paying its DY3 rate for DY4 while working on a possible modification to the rate computation.

Exhibit IV.3. Percentage Change in Average CCBHC PPS Rates from DY1 to DY4



Source: Mathematica and the RAND Corporation's analysis of state-reported PPS rates.

Notes: To facilitate comparisons from year to year we adjusted rates to 2022 dollars using the MEI. The figure reflects changes in rates relative to DY1 for each DY. DY4 rates were not available for New York because the state is working on a proposed rate computation adjustment for DY4 and paying DY3 rates in the meantime. DY1 = 2017-2018, DY2 = 2018-2019, DY3 = 2019-2020, DY4 = 2020-2021. Appendix A, Tables A.1 to A.7 provide payment rates for each CCBHC.

B. Changes Over Time in Certified Community Behavioral Health Clinics Costs

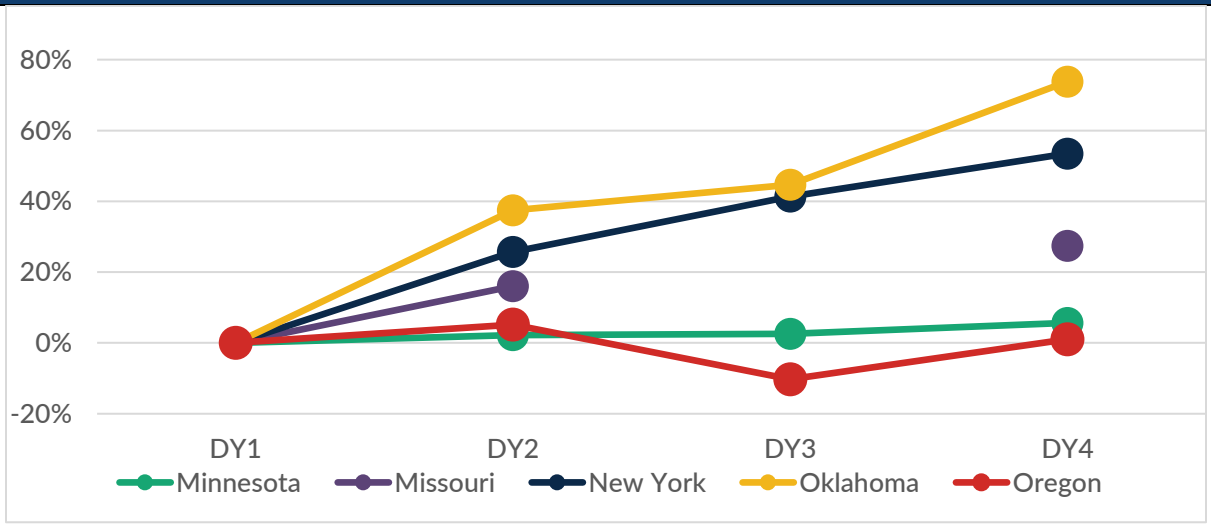
This section summarizes results of our analysis of the changes in CCBHC costs reflected in the cost reports over the first four years of the demonstration.[26] We also summarize the extent which total costs appear to have been driven by changes in the number of clients, visits, or in the cost per visit.

Specifically, we first divided total costs into two components, the cost per visit and the number of visits. (Total cost is simply the product of the cost per visit and the number of visits). The cost per visit is simply the total cost reported by the clinic in their cost report divided by the total number of visits, also reported in the cost report. We then examined whether changes in the number of visits is due to an increase in the number of clients or the average number of visits per client.

1. Changes in Total Clinic Costs

Total CCBHC costs increased from DY1 to DY4 in all five states with data available for analysis (Exhibit IV.4). In Oregon and Minnesota, total costs were relatively constant across DYs; costs did not differ from DY1 costs by more than ten percent in any year of the demonstration and were within five percent of DY1 in DY4. In contrast, costs increased consistently across DYs in New York, Oklahoma, and Missouri. Oregon is the only state in which costs decreased from one year to the next, but this only happened between DY2 and DY3. We did not observe diversions from the overall pattern of increases in costs during the DYs affected by the COVID-19 pandemic.

Exhibit IV.4. Percentage Change in Total CCBHC Costs from DY1 to DY4



Source: Mathematica and the RAND Corporation's analysis of CCBHC cost reports.

Notes: The figure shows the percentage change in total costs in each year relative to DY1. Cost reports were not available for New Jersey or Nevada for DY2 to DY4 and were also unavailable for Missouri for DY3. We adjusted costs to 2022 dollars using the MEI. Appendix A, Tables A.9 to A.13 provide total costs for each CCBHC. The findings in this figure reflect changes in CCBHCs' operating costs as reported in their cost reports rather than changes in Medicaid expenditures for CCBHC services. DY1 = 2017-2018, DY2 = 2018-2019, DY3 = 2019-2020, DY4 = 2020-2021.

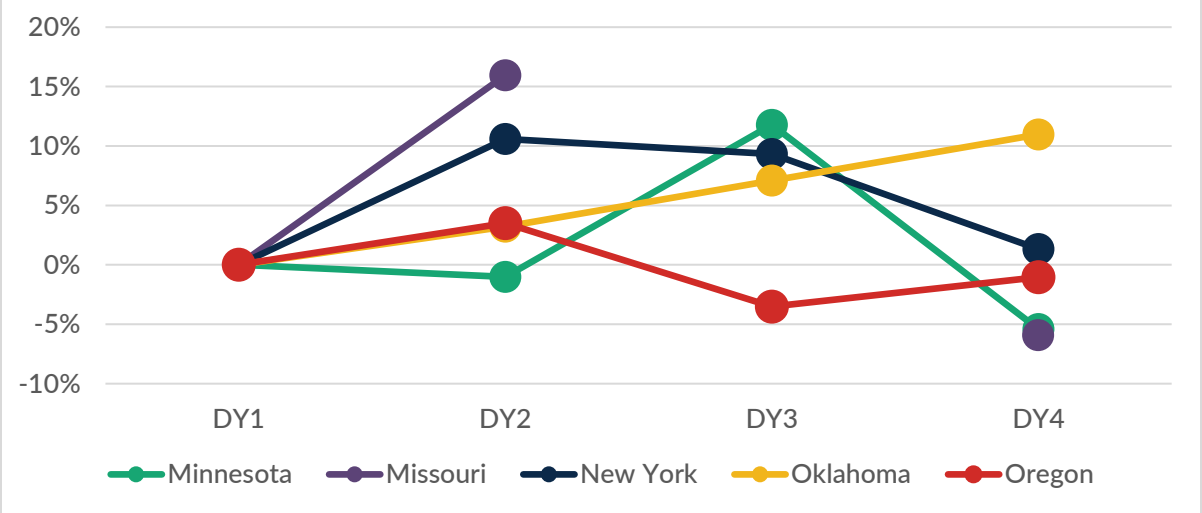
[26] We define costs as total expenditures by CCBHCs as reported on the CCBHC cost reports states submitted to CMS.

2. Potential Contributors to Changes in Total Costs

In this section we report potential sources of changes in the total CCBHC costs reflected in the cost reports. As described above, we examined whether changes in total costs reported in CCBHC cost reports are a function of changes in cost per visit or in the number of visits. Note that it is possible that both components were changing at the same time. We then examined whether changes in the number of visits are due to changes in the number of clients or to changes in the number of visits per client, or both.

Changes in cost per visit. The average changes in CCBHC cost per visit-day (PPS-1 states) or visit-month (PPS-2 states) varied considerably across the first four DYs (Exhibit IV.5). Cost per visit-day increased and decreased across years in the PPS-1 states (Minnesota, Missouri, New York, and Oregon) with varied patterns of increases and decreases in cost per visit-day from year to year. This inconsistent pattern suggests that changes in average cost per visit likely does not explain the consistent increases in total CCBHC costs in these states. In Oklahoma, the PPS-2 state with data available, the cost per visit-month consistently increased across the first four years of the demonstration and therefore may account for the consistent increase in total CCBHC costs in this state.

Exhibit IV.5. Percentage Change in Average Cost Per Visit from DY1 to DY4

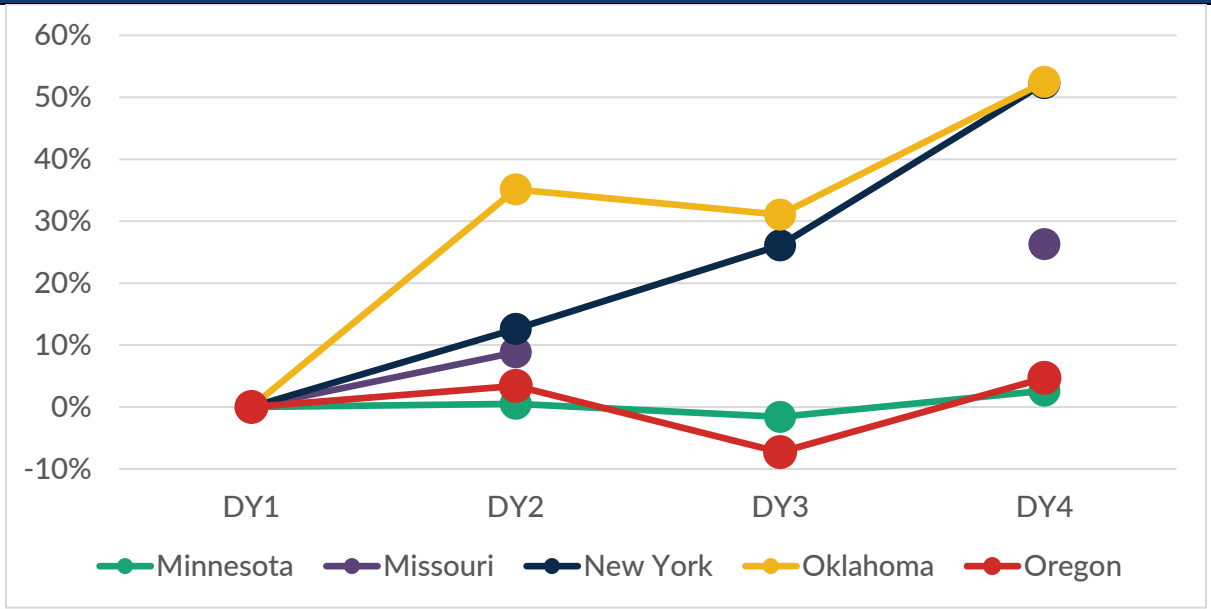


Source: Mathematica and the RAND Corporation's analysis of CCBHC cost reports.

Notes: The figure shows the percentage change in average cost per visit in each year relative to DY1. We calculated cost per visit by dividing the total cost by the total number of visits-days (PPS-1 states: Minnesota, Missouri, New York, Oregon) or months (PPS-2 state: Oklahoma). We adjusted costs to 2022 dollars using the MEI. Cost reports were not available for New Jersey or Nevada and were also unavailable for Missouri for DY3. DY1 = 2017-2018, DY2 = 2018-2019, DY3 = 2019-2020, DY4 = 2020-2021.

The total number of visit-days (PPS-1 states) or visit-months (PPS-2 states) increased from DY1 to DY4 for all states with available data, although the magnitude of increases varied by state (Exhibit IV.6). The number of visits increased consistently across years in New York and Missouri, with some variation across years in Oklahoma. These findings suggest that increases in visit-days (PPS-1 states) or months (PPS-2 state) might have contributed to increases in total CCBHC costs, particularly for New York, Missouri, and Oklahoma. In contrast, in Minnesota and Oregon, the number of visits-days in DY2 to DY4 did not vary more than ten percent from DY1 in any year.

Exhibit IV.6. Percentage Change in Number of Visit-Days or Months Per Year from DY1 to DY4

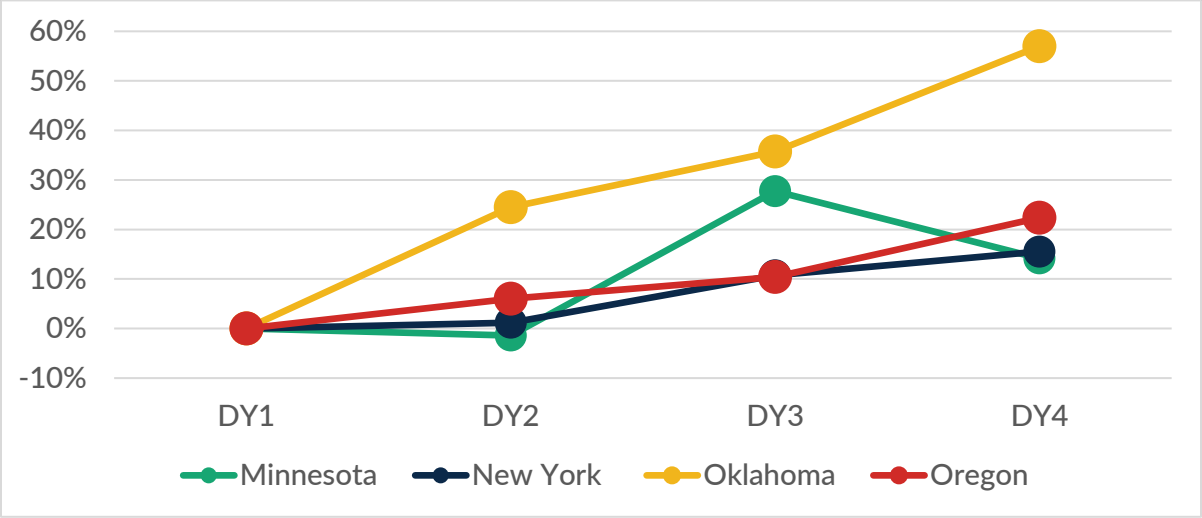


Source: Mathematica and the RAND Corporation's analysis of CCBHC cost reports.

Notes: The figure shows the percentage change in the number of visit-days or months per year in each year relative to DY1. Percentages for Minnesota, Missouri, New York, and Oregon (PPS-1 states) reflect the number of visit-days. Percentages for Oklahoma (PPS-2 state) reflect visit-months (the number of months in which clients had at least one visit). Data for DY3 for Missouri are not available. We excluded one clinic from Oregon because of missing data on clients in DY4. DY1 = 2017-2018, DY2 = 2018-2019, DY3 = 2019-2020, DY4 = 2020-2021.

Changes in cost per client served. The average cost per client increased from DY1 to DY4 in all four states for which data were available, with increases in DY4 relative to DY1 ranging from 14 percent in Minnesota to 57 percent in Oklahoma (Exhibit IV.7). These findings suggest that CCBHCs devoted more resources to individual clients across the DYs. The patterns were generally consistent across states, although Minnesota had a very small decrease of about one percent in DY2, followed by a large increase of more than 25 percent in DY3**.**

Exhibit IV.7. Percentage Change in Average Cost Per Client from DY1 to DY4



Source: Mathematica and the RAND Corporation's analysis of CCBHC cost reports and state-reported CCBHC client counts.

Notes: The figure shows the percentage change in the average cost per client in each year relative to DY1. We calculated cost per client by dividing the total cost by the total number of clients served. We adjusted costs using the MEI to 2022 dollars. Calculations for average cost per client require both cost reports and number of clients served. Analyses are limited by missing cost data for Nevada and New Jersey DY2 to DY4. Cost report data for DY3 and data on the number of clients served for DY4 were missing for Missouri. We excluded one clinic from Oregon because of missing data in DY4. Appendix A, Tables A.14 to A.17 provide changes in average cost per client per year for each CCBHC.

Increases in costs per client served could be a function of increases in the number of clients served or the number of visits per client. The number of visits per client increased in all states, whereas changes in the number of clients served were less consistent, suggesting that the increase in costs might largely reflect increases in the number of visits per client.

- **Number of visits per client**. The number of visits per client increased from DY1 to DY4 in all states for which client count and visit data are available for DY1 to DY4 (Exhibit IV.8). The average number of visit-days per client per year increased slightly in all three PPS-1 states, with an average of 12 visit-days per client per year in DY1 and an average of 14 visit-days per client per year across states in DY4. In Oklahoma, the only PPS-2 state for which data were available, we also observed an increase in the average number of visit-months per client, increasing from visiting the CCBHC in six months in DY1 to visiting the CCBHC in eight months in DY4. (The visit counts in PPS-2 states are not directly comparable to those in PPS-1 states because they are counts of months in which a person had at least one visit rather than counts of visit-days).

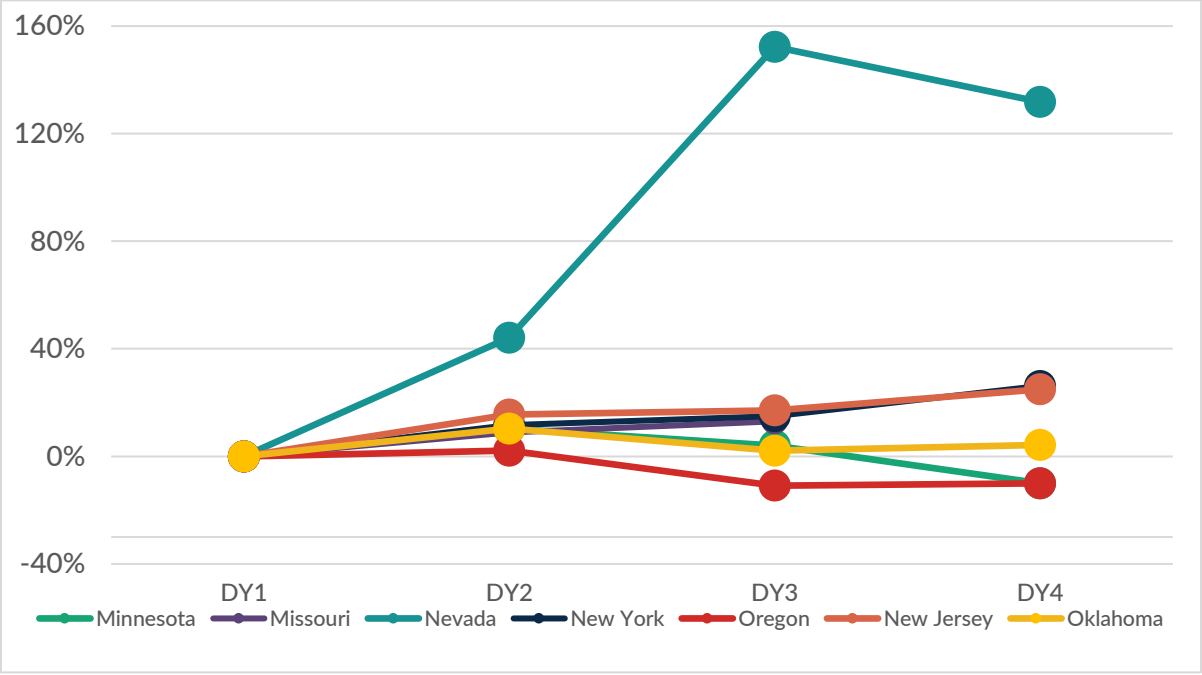
Exhibit IV.8. Average Number of Visit-Days or Months Per Client Per Year from DY1 to DY4				
	DY1	DY2	DY3	DY4
Visit-days (PPS-1)				
Minnesota	11	10	11	13
New York	13	13	14	15
Oregon	11	11	13	13
Visit-months (PPS-2)				
Oklahoma	6	7	7	8

Source: Mathematica and the RAND Corporation's analysis of CCBHC cost reports and state-reported CCBHC client counts.

Notes: Calculations for average visit-days or months per client require both cost reports and number of clients served. Counts for Oklahoma (the only PPS-2 state included in the figure) reflect months with at least 1 visit. Analyses are limited by missing cost report data for Nevada and New Jersey for all 4 years of the demonstration. Cost report data for DY3 and data on the number of clients served for DY4 were missing for Missouri. We excluded 1 clinic from Oregon because of missing data in DY4. DY1 = 2017-2018, DY2 = 2018-2019, DY3 = 2019-2020, DY4 = 2020-2021.

- **Number of clients served**. States differed with respect to changes in the number of CCBHC clients served over time across the DYs (Exhibit IV.9). Compared with DY1, the number of clients served in DY4 increased in four states (Nevada, New York, New Jersey, and Oklahoma), and decreased in two states (Minnesota and Oregon). The increases were about 25 percent in New Jersey and New York and much larger in Nevada (more than 130 percent). In Minnesota and Oregon, the DY4 client count decreased slightly, by about ten percent relative to DY1. As described elsewhere, the decline in the number of CCBHC clients served from DY3 to DY4 for Oregon might be attributable in part to the decertification of three clinics in 2019.

Exhibit IV.9. Percentage Change in Number of Clients Served by CCBHCs from DY1 to DY4



Source: Mathematica and the RAND Corporation's analysis of CCBHC client counts reported by state officials.

Notes: The figure shows the percentage change in the number of clients served in each year relative to DY1. Client count data were not available for Missouri for DY4. We excluded 1 clinic from Oregon because of missing data in DY4. DY1 = 2017-2018, DY2 = 2018-2019, DY3 = 2019-2020, DY4 = 2020-2021.

V. Conclusions

The findings in this report provide insight into how implementation and costs of the CCBHC demonstration have evolved in the seven original demonstration states still participating in the demonstration and initial implementation of the model in two new demonstration states. Findings can inform the efforts of federal and state agencies, community behavioral health organizations, and other stakeholders in the behavioral health system to plan for and implement future CCBHCs.

Overall, state officials in the original demonstration states reported transitioning past the planning and launch activities of early years by the second DY and noted that the structures and processes states and CCBHCs put in place have generally not changed since then. State officials reported minor changes to their implementation approaches in later years of the demonstration, such as modifying the frequency and methods of state contact with CCBHCs or requiring new staff types. They have also continued to refine certain processes and requirements and build on state and clinic efforts to expand access to services and adhere to the certification criteria. States have continued to monitor adherence to the certification criteria through periodic re-certification processes every 1-3 years, to seek feedback on demonstration requirements and operations from stakeholders, and to adjust technical assistance approaches and oversight to align with current needs of CCBHCs. No state officials reported plans for major changes in the implementation of the demonstration.

Some states have pursued other financing mechanisms to support or expand the CCBHC model due to concerns that demonstration funding will end. For example, four demonstration states obtained SPAs to expand the model to providers not participating in the demonstration, and four other demonstration states are planning to use SPAs or Medicaid Section 1115 demonstration authority for this purpose. In addition to alternative Medicaid financing mechanisms, behavioral health providers that meet the requirements to become a CCBHC are leveraging SAMHSA's CCBHC-E grants and state-specific financing to cover the costs of services for the uninsured and underinsured, expand services to new populations, to help new clinics launch the model and collaborate with state behavioral health authorities and state Medicaid Offices. Most state officials reported a goal of aligning requirements for all CCBHCs regardless of funding mechanism to ensure consistency in the quality and delivery of care by CCBHCs across the state.

State officials perceived that several features of the demonstration helped CCBHCs continue to provide services during the PHE related to the COVID-19 pandemic. Although the COVID-19 pandemic presented challenges for CCBHCs, several state officials shared their view that CCBHCs were better equipped to transition to new ways of delivering care relative to other behavioral health providers in their states. State officials reported that the PPS provided steady and consistent funding while allowing CCBHCs some flexibility to adapt to changing circumstances and client needs. They also reported that the telehealth requirements in the certification criteria prepared CCBHCs to quickly transition away from in-person services during the early months of the pandemic. For example, Oklahoma CCBHCs were already providing consultation to external providers and some services to clients via technologies such as iPads before the pandemic, which set up CCBHCs to pivot to telehealth for a broader range of services. Although officials reported that telehealth generally facilitated access to care during the pandemic, its implementation presented challenges for certain regions or client populations, such as those in rural communities in which internet coverage is not widespread. Some state officials also commented that certain types of services included in the CCBHC certification criteria were difficult to deliver via telehealth, such as physical health screenings requiring lab work and group therapies.

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. Many officials noted that their states and CCBHCs have not made any major changes related to access to care requirements in later years of the demonstration. A few states reported minor changes, such as modifying requirements for intake procedures or requiring new staff types. As with the first two years of the demonstration, behavioral health workforce shortages continued to contribute to access-related challenges in most states by, for example, potentially compromising CCBHCs' ability to conduct intakes in a timely manner or meet scope of service requirements, with new factors, such as the pandemic, further compounding staffing shortages.

State officials in the original demonstration states generally did not report any major changes to the scope of services provided by CCBHCs. States did not make changes to scope of service requirements since the end of the second DY, and officials did not note any specific challenges CCBHCs faced maintaining services during this period. Yet some states had not conducted re-certifications in some time, so officials were not sure whether CCBHCs' ability to provide the full scope of services had been affected by factors such as workforce shortages. State officials often commented on CCBHCs' role in addressing various state service priorities and contributing to various service-related initiatives, such as crisis system transformation and the rollout of the 988 Suicide & Crisis Lifeline, and primary care integration although the exact role and integration of the CCBHC in the broader systems was still being defined.

States made some changes to payment rates in all DYs, but changes were much larger between DY1 and DY2 than they were in subsequent years, reflecting most states' decision not to re-base PPS rates after DY2. Although most states (five out of the original seven) re-based PPS rates for DY2, only Missouri re-based rates thereafter. All states adjusted for inflation using the MEI for DY2 and DY3, and all but Missouri and New York adjusted for inflation for DY4. Between DY1 and DY2, the average change in CCBHC rates varied from a decrease of 17 percent in Nevada to an increase of 16 percent in Oklahoma. More states had decreases in average rates during this period than increases. Between DY2 and DY3 and between DY3 and DY4, the changes in rates translated to a much smaller percentage change (from 1 percent to 5 percent depending on the state).

Total costs of clinic operations as reflected in the CCBHC cost reports remained relatively stable across the first four years of the demonstration in Oregon and Minnesota but increased more than 25 percent in Missouri, New York, and Oklahoma. There were no states in which total costs were lower in DY4 relative to DY1.

The most consistent contributor to changes in costs across states reflected in the CCBHC cost reports was the change in the cost per client served and not in the number of clients served or cost per visit; clients were making more visits. The average cost per client served increased in all four states for which data were available, with changes from DY1 to DY4 ranging from 14 percent to 57 percent. The increase in cost per client served in the cost reports was driven by an increase in the average number of visits per client for all states with available data. Changes in cost per visit, however, were less than 11 percent in each of the four states with available data.

The initial implementation experiences of the new demonstration states appeared consistent with early experiences from the original states. Officials in Kentucky and Michigan reported working quickly to certify clinics and launch their demonstrations by, for example, convening workgroups and sorting through various regulatory issues and CCBHC technical assistance needs. Officials reported that the states and CCBHCs worked closely together to launch the model, navigate early implementation

challenges, expand services and reach, and raise awareness about the CCBHCs in communities. State officials reported working through some of the same early challenges the original demonstration states addressed, such as helping CCBHCs set up data systems and processes for collecting and reporting quality measures and address workforce shortages.

A. Future Evaluation Activities

In each year of the evaluation, we will submit an annual report synthesizing findings related to changes in ongoing demonstration operations and 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, quality measure 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.

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Appendix

Exhibit A.1. Minnesota CCBHC PPS Rates from DY1 to DY4, by Clinic				
	PPS-1 rates			
	DY1	DY2	DY3	DY4
MN Clinic 1	$298	$177	$179	$180
MN Clinic 2	$289	$295	$297	$299
MN Clinic 3	$345	$311	$313	$316
MN Clinic 4	$762	$712	$718	$724
MN Clinic 5	$513	$444	$448	$451
MN Clinic 6	$390	$361	$365	$367
Average across clinics	**$433**	**$383**	**$387**	**$389**
Source: Mathematica and the RAND Corporation analysis of state-reported CCBHC rates.				
Note: Adjusted using the MEI to 2022 dollars.				

Exhibit A.2. Missouri CCBHC PPS Rates from DY1 to DY4, by Clinic				
	PPS-1 rates			
	DY1	DY2	DY3	DY4
MO Clinic 1	$266	$264	$262	$275
MO Clinic 2	$281	$278	$282	$276
MO Clinic 3	$248	$246	$245	$255
MO Clinic 4	$288	$285	$288	$282
MO Clinic 5	$204	$202	$205	$200
MO Clinic 6	$239	$236	$266	$261
MO Clinic 7	$204	$202	$205	$210
MO Clinic 8	$259	$257	$258	$253
MO Clinic 9	$189	$187	$187	$219
MO Clinic 10	$252	$249	$249	$244
MO Clinic 11	$216	$214	$244	$277
MO Clinic 12	$208	$206	$205	$201
MO Clinic 13	$262	$260	$264	$258
MO Clinic 14	$287	$285	$284	$288
MO Clinic 15	$204	$203	$204	$217
Average across clinics	**$241**	**$238**	**$243**	**$248**
Source: Mathematica and the RAND Corporation analysis of state-reported CCBHC rates.				
Note: Adjusted using the MEI to 2022 dollars.				

Exhibit A.3. Nevada CCBHC PPS Rates from DY1 to DY4, by Clinic				
	PPS-1 rates			
	DY1	DY2	DY3	DY4
NV Clinic 1	$208	$154	$153	$153
NV Clinic 2	$224	$246	$250	$253
NV Clinic 3	$244	$159	$158	$158
Average across clinics	**$225**	**$187**	**$187**	**$188**
Source: Mathematica and the RAND Corporation analysis of state-reported CCBHC rates. Note: Adjusted using the MEI to 2022 dollars.				

Exhibit A.4. New York CCBHC PPS Rates from DY1 to DY4, by Clinic				
	PPS-1 rates			
	DY1	DY2	DY3	DY4
NY Clinic 1	$300	$236	$231	NA
NY Clinic 2	$370	$257	$252	NA
NY Clinic 3	$348	$339	$332	NA
NY Clinic 4	$279	$240	$235	NA
NY Clinic 5	$279	$274	$268	NA
NY Clinic 6	$235	$227	$222	NA
NY Clinic 7	$333	$286	$280	NA
NY Clinic 8	$335	$252	$247	NA
NY Clinic 9	$427	$303	$297	NA
NY Clinic 10	$196	$225	$221	NA
NY Clinic 11	$359	$347	$340	NA
NY Clinic 12	$238	$237	$232	NA
NY Clinic 13	$434	$291	$285	NA
Average across clinics	**$318**	**$271**	**$265**	**NA**
Source: Mathematica and the RAND Corporation analysis of state-reported CCBHC rates. Note: Adjusted using the MEI to 2022 dollars. DY4 rates unavailable as the state is paying clinics DY3 rates while pursuing a potential rate computation adjustment. NA = not available.				

Exhibit A.5. Oregon CCBHC PPS Rates from DY1 to DY4, by Clinic				
	PPS-1 rates			
	DY1	DY2	DY3	DY4
OR Clinic 1	$290	$293	$290	$290
OR Clinic 2	$306	$306	$305	$303
OR Clinic 3	$346	$345	$343	$343
OR Clinic 4	$363	$367	$365	$363
OR Clinic 5	$211	$209	$208	$208
OR Clinic 6	$317	$317	$314	$313
OR Clinic 7	$222	$224	$223	$222
OR Clinic 8	$246	$244	$242	$241
Average across clinics	**$288**	**$288**	**$286**	**$285**
Source: Mathematica and the RAND Corporation analysis of state-reported CCBHC rates. Note: Adjusted using the MEI to 2022 dollars.				

Exhibit A.6. New Jersey CCBHC PPS Rates from DY1 to DY4, by Clinic				
	PPS-2 standard population rates			
	DY1	DY2	DY3	DY4
NJ Clinic 1	$1,173	$921	$929	$924
NJ Clinic 2	$589	$678	$683	$679
NJ Clinic 3	$719	$546	$550	$548
NJ Clinic 4	$715	$657	$661	$658
NJ Clinic 5	$525	$689	$694	$691
NJ Clinic 6	$723	$915	$923	$919
NJ Clinic 7	$568	$536	$540	$538
Average across clinics	**$716**	**$706**	**$712**	**$708**
Source: Mathematica and the RAND Corporation analysis of state-reported CCBHC standard population rates. Note: Adjusted using the MEI to 2022 dollars.				

Exhibit A.7. Oklahoma CCBHC PPS Rates from DY1 to DY4, by Clinic				
	PPS-2 standard population rates			
	DY1	DY2	DY3	DY4
OK Clinic 1	$783	$1,140	$1,142	$1,102
OK Clinic 2	$608	$638	$639	$763
OK Clinic 3	$788	$755	$756	$752
Average across clinics	**$726**	**$844**	**$846**	**$872**
Source: Mathematica and the RAND Corporation analysis of state-reported CCBHC standard population rates. Note: Adjusted using the MEI to 2022 dollars.				

Exhibit A.8. Average Total CCBHC Costs, by State				
State (number of CCBHCs)	**DY1 (2017-2018)**	**DY2 (2018-2019)**	**DY3 (2019-2020)**	**DY4 (2020-2021)**
PPS-1 states				
Minnesota (6)	$12,810,929	$13,089,434	$13,136,704	$13,537,291
Missouri (15)	$28,917,099	$33,551,366	NA	$36,851,109
New York (13)	$10,402,727	$13,076,686	$14,699,781	$15,966,961
Oregon (9)	$17,533,324	$18,438,145	$15,735,893	$17,711,880
PPS-2 states				
Oklahoma (3)	$31,058,747	$42,701,414	$44,939,147	$53,980,177

Source: Mathematica and the RAND Corporation analysis of CCBHC cost reports.

Note: Using cost report data we calculated total clinic costs, adjusted to 2022 dollars using the MEI, for each clinic for each DY. We also calculated total statewide costs by adding together all clinic costs within each state. We then calculated the average costs per clinic, by state. The findings reported are not the total costs of the demonstration or the amount Medicaid paid for CCBHC services but represent CCBHCs' operating costs as reported in their cost reports. Cost reports were not available for New Jersey or Nevada and were also not available for Missouri for DY3. To facilitate comparisons, we adjusted to 2022 dollars using the MEI.

NA = not available.

Exhibit A.9. Minnesota CCBHC Total Costs from DY1 to DY4				
	Cost			
	DY1	**DY2**	**DY3**	**DY4**
MN Clinic 1	$16,530,297	$16,450,146	$14,750,645	$13,034,707
MN Clinic 2	$10,400,554	$10,700,338	$10,951,936	$10,100,203
MN Clinic 3	$18,271,950	$16,585,530	$16,083,164	$15,039,121
MN Clinic 4	$10,924,377	$11,084,274	$10,589,047	$12,937,890
MN Clinic 5	$12,139,561	$13,773,622	$15,063,714	$17,625,409
MN Clinic 6	$8,598,833	$9,942,693	$11,381,715	$12,486,416
Average across clinics	**$12,810,929**	**$13,089,434**	**$13,136,704**	**$13,537,291**

Source: Mathematica and the RAND Corporation analysis of CCBHC cost reports.

Note: Adjusted using the MEI to 2022 dollars.

Exhibit A.10. Missouri CCBHC Total Costs from DY1 to DY4				
	Cost			
	DY1	DY2	DY3	DY4
MO Clinic 1	$82,796,648	$103,254,258	NA	$114,704,667
MO Clinic 2	$7,313,825	$10,011,460	NA	$9,827,667
MO Clinic 3	$14,188,000	$15,368,906	NA	$15,053,461
MO Clinic 4	$134,864,368	$166,949,591	NA	$186,435,098
MO Clinic 5	$12,297,821	$13,564,331	NA	$15,257,196
MO Clinic 6	$20,826,923	$24,992,202	NA	$34,024,051
MO Clinic 7	$13,445,350	$13,684,693	NA	$14,775,888
MO Clinic 8	$10,982,709	$13,361,014	NA	$13,448,265
MO Clinic 9	$6,494,740	$6,661,620	NA	$7,061,418
MO Clinic 10	$29,230,448	$30,424,344	NA	$28,591,986
MO Clinic 11	$19,263,704	$20,021,681	NA	$22,082,837
MO Clinic 12	$16,775,597	$19,118,560	NA	$22,017,904
MO Clinic 13	$28,450,275	$28,322,076	NA	$32,422,115
MO Clinic 14	$22,067,619	$22,577,388	NA	$22,651,241
MO Clinic 15	$14,758,456	$14,958,365	NA	$14,412,836
Average across clinics	**$28,917,099**	**$33,551,366**	**NA**	**$36,851,109**

Source: Mathematica and the RAND Corporation analysis of CCBHC cost reports.

Note: Adjusted using the MEI to 2022 dollars. DY3 cost report data not available for analysis.

NA = not available.

Exhibit A.11. New York CCBHC Total Costs from DY1 to DY4				
	Cost			
	DY1	DY2	DY3	DY4
NY Clinic 1	$26,781,216	$35,255,605	$42,615,340	$46,438,411
NY Clinic 2	$5,721,209	$9,014,706	$12,818,573	$18,896,720
NY Clinic 3	$7,128,976	$11,034,805	$12,682,363	$13,193,859
NY Clinic 4	$7,557,696	$10,226,031	$11,149,034	$12,726,298
NY Clinic 5	$8,335,428	$10,700,543	$11,451,503	$12,369,771
NY Clinic 6	$10,829,830	$14,641,319	$15,176,065	$19,578,810
NY Clinic 7	$9,380,827	$11,714,575	$13,032,170	$13,584,614
NY Clinic 8	$5,506,346	$5,279,525	$5,534,680	$5,354,697
NY Clinic 9	$7,539,137	$8,700,552	$8,117,452	$7,357,504
NY Clinic 10	$12,405,497	$17,253,096	$18,016,206	$19,118,988
NY Clinic 11	$4,110,853	$3,615,147	$3,683,442	$3,546,614
NY Clinic 12	$18,670,106	$19,963,799	$25,093,321	$24,057,850
NY Clinic 13	$11,268,329	$12,597,215	$11,727,005	$11,346,361
Average across clinics	**$10,402,727**	**$13,076,686**	**$14,699,781**	**$15,966,961**

Source: Mathematica and the RAND Corporation analysis of CCBHC cost reports.

Note: Adjusted using the MEI to 2022 dollars.

Exhibit A.12. Oregon CCBHC Total Costs from DY1 to DY4				
	Cost			
	DY1	DY2	DY3	DY4
OR Clinic 1	$31,200,974	$27,267,467	$16,320,619	$19,871,414
OR Clinic 2	$9,574,618	$10,706,135	$8,958,534	$10,315,288
OR Clinic 3	$26,842,670	$29,736,842	$24,370,808	$26,764,898
OR Clinic 4	$10,411,744	$12,747,147	$10,474,136	$11,640,454
OR Clinic 5	$17,374,574	$18,494,227	$18,319,511	$19,647,387
OR Clinic 6	$16,594,421	$16,795,755	$14,923,805	$17,456,132
OR Clinic 7	$2,924,345	$2,482,502	$2,118,218	$2,697,535
OR Clinic 8	$25,343,247	$29,275,087	$30,401,515	$33,301,933
Average across clinics	**$17,533,324**	**$18,438,145**	**$15,735,893**	**$17,711,880**
Source: Mathematica and the RAND Corporation analysis of CCBHC cost reports. Note: Adjusted using the MEI to 2022 dollars.				

Exhibit A.13. Oklahoma CCBHC Total Costs from DY1 to DY4				
	Cost			
	DY1	DY2	DY3	DY4
OK Clinic 1	$43,819,006	$62,525,699	$81,758,797	$102,827,084
OK Clinic 2	$10,901,754	$15,325,646	$10,573,983	$12,342,886
OK Clinic 3	$38,455,481	$50,252,897	$42,484,661	$46,770,560
Average across clinics	**$31,058,747**	**$42,701,414**	**$44,939,147**	**$53,980,177**
Source: Mathematica and the RAND Corporation analysis of CCBHC cost reports. Note: Adjusted using the MEI to 2022 dollars.				

Exhibit A.14. Minnesota CCBHC Cost Per Client from DY1 to DY4				
	Cost per client			
	DY1	DY2	DY3	DY4
MN Clinic 1	$3,313	$4,019	$3,333	$3,148
MN Clinic 2	$2,986	$2,916	$2,987	$2,845
MN Clinic 3	$2,219	$1,571	$1,616	$2,764
MN Clinic 4	$4,573	$4,546	$11,349	$5,979
MN Clinic 5	$7,503	$7,315	$8,094	$9,527
MN Clinic 6	$3,719	$3,604	$3,675	$3,488
Average across clinics	**$4,052**	**$3,995**	**$5,176**	**$4,625**
Source: Mathematica and the RAND Corporation analysis of CCBHC cost reports and state-reported CCBHC clients. Note: Adjusted to 2022 dollars.				

Exhibit A.15. New York CCBHC Cost Per Client from DY1 to DY4				
	Cost per client			
	DY1	DY2	DY3	DY4
NY Clinic 1	$2,033	$2,333	$2,490	$2,234
NY Clinic 2	$3,784	$3,933	$4,290	$4,885
NY Clinic 3	$3,660	$4,426	$5,256	$5,938
NY Clinic 4	$1,720	$2,035	$2,303	$2,545
NY Clinic 5	$2,140	$2,504	$2,404	$2,706
NY Clinic 6	$2,414	$2,935	$3,216	$3,432
NY Clinic 7	$5,025	$5,594	$6,056	$5,961
NY Clinic 8	$3,576	$3,141	$3,804	$4,339
NY Clinic 9	$3,401	$3,663	$3,431	$4,126
NY Clinic 10	$2,122	$2,679	$2,957	$2,842
NY Clinic 11	$7,502	$3,973	$3,857	$4,187
NY Clinic 12	$3,122	$3,838	$4,916	$4,560
NY Clinic 13	$4,511	$4,485	$4,864	$4,253
Average across clinics	**$3,462**	**$3,503**	**$3,834**	**$4,001**
Source: Mathematica and the RAND Corporation analysis of CCBHC cost reports and state-reported CCBHC clients. Note: Adjusted using the MEI to 2022 dollars.				

Exhibit A.16. Oregon CCBHC Cost Per Client from DY1 to DY4				
	Cost per client			
	DY1	DY2	DY3	DY4
OR Clinic 1	$5,819	$4,784	$3,102	NA
OR Clinic 2	$2,451	$3,403	$4,944	$3,360
OR Clinic 3	$4,979	$4,982	$4,038	$5,065
OR Clinic 4	$1,434	$1,726	$1,521	$1,829
OR Clinic 5	$1,926	$1,972	$2,941	$2,524
OR Clinic 6	$2,923	$2,689	$2,351	$3,064
OR Clinic 7	$5,700	$5,316	$5,019	$6,595
OR Clinic 8	$5,142	$5,950	$6,292	$7,610
Average across clinics	**$3,508**	**$3,720**	**$3,872**	**$4,293**

Source: Mathematica and the RAND Corporation analysis of CCBHC cost reports and state-reported CCBHC clients.

Note: Adjusted using the MEI to 2022 dollars.

NA = not available.

Exhibit A.17. Oklahoma CCBHC Cost Per Client from DY1 to DY4				
	Cost per client			
	DY1	DY2	DY3	DY4
OK Clinic 1	$5,383	$6,608	$9,446	$10,951
OK Clinic 2	$2,310	$3,486	$2,780	$3,350
OK Clinic 3	$4,961	$5,657	$4,947	$5,567
Average across clinics	**$4,218**	**$5,251**	**$5,725**	**$6,623**

Source: Mathematica and the RAND Corporation analysis of CCBHC cost reports and state-reported CCBHC clients.

Note: Adjusted using the MEI to 2022 dollars.