Research Data Brief

Variation in services offered by Certified Community Behavioral Health Clinics and community mental health centers

Authors: Allison Wishon and Jonathan D. Brown (Mathematica)

June 2021

Key findings

- A higher percentage of Certified Community Behavioral Health Clinics (CCBHCs) provided most types of services than community mental health centers (CMHCs) across all states with CCBHCs.
- For most services, the difference in the percentage of CCBHCs versus CMHCs providing the service was larger in the states participating in the CCBHC demonstration than in the states not participating in the demonstration.
- A higher percentage of CCBHCs than CMHCs provided services to all populations included in the 2020 National Mental Health Services Survey and offered treatment at no charge or for minimum payment in demonstration and non-demonstration states.

Community mental health centers (CMHCs) across the country can vary in the scope of services they provide. This variation is, in part, because of differences across states and communities in the availability of funding and staff to provide services. Further, some evidence suggests that payment rates for CMHCs historically have not covered the full cost of the services they currently provide, making it challenging to expand or offer a more comprehensive array of services.

The Certified Community Behavioral Health Clinic (CCBHC) model aims to ensure that all consumers who seek care have access to a common set of services. CMHCs or other behavioral health organizations must provide the following nine types of services to qualify as a CCBHC: crisis mental health services; screening, assessment, and diagnosis; outpatient mental health and substance use disorder (SUD) treatment; person-centered treatment planning; primary care screening and monitoring of key health indicators; targeted case management; psychiatric rehabilitation; peer support; and intensive services for members of the armed forces and veterans.[1]

There are currently two primary ways in which an organization could qualify as a CCBHC:

1. **The CCBHC demonstration.** Established by the Protecting Access to Medicare Act of 2014, the demonstration required state Medicaid programs to reimburse CCBHCs through an enhanced prospective payment rate designed to cover the total cost of the full scope of CCBHC services. Eight states originally participated in the demonstration and, after a two-year planning phase, began delivering CCBHC services using the new payment system in mid-2017. States certified that clinics met the CCBHC criteria and provided technical assistance throughout the demonstration. Demonstration states could exercise some discretion in applying the criteria and designing specific service packages to support implementation of the CCBHC model. The demonstration is ongoing, and some states have taken steps to expand or implement the CCBHC model through Medicaid section 1115 demonstrations or amendments to their Medicaid state plans.

2. **The CCBHC expansion (CCBHC-E) grant program.** Authorized by Congress in 2018 and administered by the Substance Abuse and Mental Health Services Administration, the CCBHC-E grant program awards clinics two years of grant funding to provide CCBHC services. Clinics in demonstration states and those in non-demonstration states are eligible for CCBHC-E funding. CCBHC-E grantees must meet the same basic criteria as CCBHCs participating in the demonstration, but the grant does not alter Medicaid reimbursement or require that state agencies play a role in supporting implementation or oversight of the grants. CCBHC-E grantees must begin providing CCBHC services within four months of grant award. CCBHC-E grants have been awarded in two cohorts starting in 2018.[2]

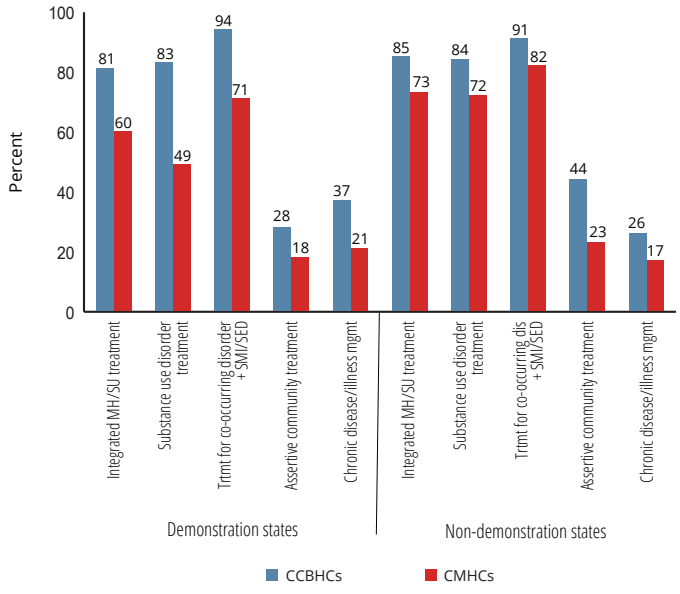
Until now, survey data have not been available to directly compare the services provided by CCBHCs and CMHCs. Such information would help to understand how the CCBHC model affects the availability of care in communities. This information would be useful to have for demonstration and non-demonstration states given that the demonstration began before either the CCBHC-E grant program or the expansion of CCBHCs through other financing mechanisms, possibly allowing more time for CCBHCs in demonstration states to establish services than those in non-demonstration states. There could also be differences between demonstration and non-demonstration states due to the different funding streams used to support the CCBHC model. This study used data from the 2020 National Mental Health Services Survey (N-MHSS) to examine the types of services available at CCBHCs and CMHCs in the eight original demonstration states (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, Pennsylvania) and in non-demonstration states. We also examined whether CCBHCs and CMHCs target special populations or have certain characteristics.

The N-MHSS is an annual survey of specialty mental health treatment facilities across all states and territories. The N-MHSS collects information on the services available from facilities and their organizational characteristics, including some of the services CCBHCs must provide. N-MHSS also collects information on the populations served by these facilities and whether they have programs targeted to specific populations. In 2020, the N-MHSS allowed facilities to self-identify as CCBHCs.[3] A total of 336 facilities reported being a CCBHC in 2020. In all, there were 156 CCBHCs in the original 8 demonstration states and 180 CCBHCs in 24 non-demonstration states. A total of 1,953 facilities reported being CMHCs: 267 in demonstration states and 1,686 in non-demonstration states.

Services

Outpatient mental health and substance use disorder services. CCBHCs must provide outpatient mental health and SUD services that are evidence-based or best practices consistent with the needs of individual consumers. A higher proportion of CCBHCs than CMHCs offer SUD treatment, integrated mental health and SUD treatment, treatment for co-occurring disorders, assertive community treatment, and chronic disease management in demonstration and non-demonstration states (Figure 1). There were fewer differences between CCBHCs and CMHCS for many of the other mental health services (not shown). For example, about 96 percent of CCBHCs and CMHCs offered individual psychotherapy in demonstration and non-demonstration states.

Figure 1. Proportion of CCBHCs and CMHCs that offered outpatient services



Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey data (2020).

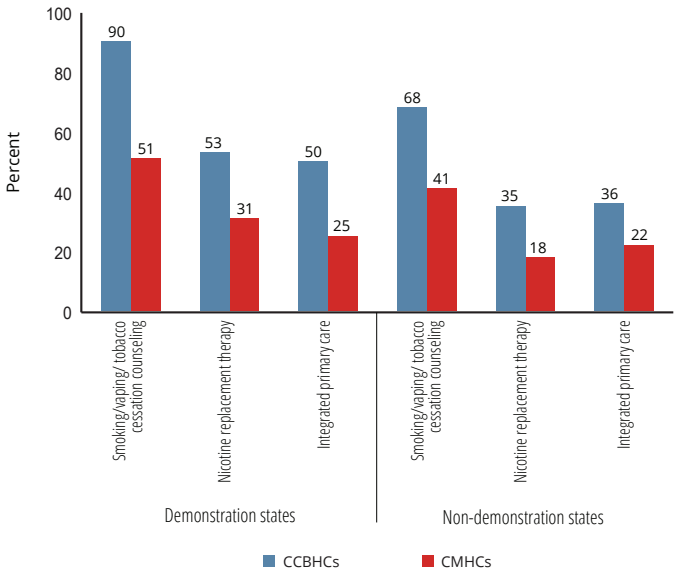
CCBHC = Certified Community Behavioral Health Clinic; CMHC = community mental health center; MH = mental health; SED = serious emotional disturbance; SMI = serious mental illness; SU = substance use

Physical health services. CCBHCs must provide primary care screening and monitoring of key health indicators and health risks. In the CCBHC demonstration, some states layered additional primary care service requirements onto the certification criteria for demonstration CCBHCs, such as requiring clinics to provide primary care services on site for a certain number of hours per week. A higher proportion of CCBHCs than CMCHs offered physical health screenings in demonstration and non-demonstration states. For example, a higher percentage of CCBHCs than CMHCs provided the following services:

- **Hepatitis C screening:** 18 percent of CCBHCs versus 5 percent of CMHCs in demonstration states and 21 percent of CCBHCs versus 6 percent of CMHCs in non-demonstration states
- **HIV testing:** 12 percent of CCBHCs versus 5 percent of CMHCs in demonstration states and 22 percent of CCBHCs versus 7 percent in CMHCs in non-demonstration states
- **Tuberculosis screening:** 28 percent of CCBHCs versus 13 percent of CMHCs in demonstration states and 19 percent of CCBHCs versus 6 percent of CMHCs in non-demonstration states
- **Tobacco use screening:** 91 percent of CCBHCs versus 75 percent of CMHCs in demonstration states and 76 percent versus 66 percent in CMHCs in non-demonstration states

A higher percentage of CCBHCs than CMHCs offered smoking, vaping, and tobacco cessation counseling; nicotine replacement therapy; and integrated primary care services in demonstration states and non-demonstration states (Figure 2).

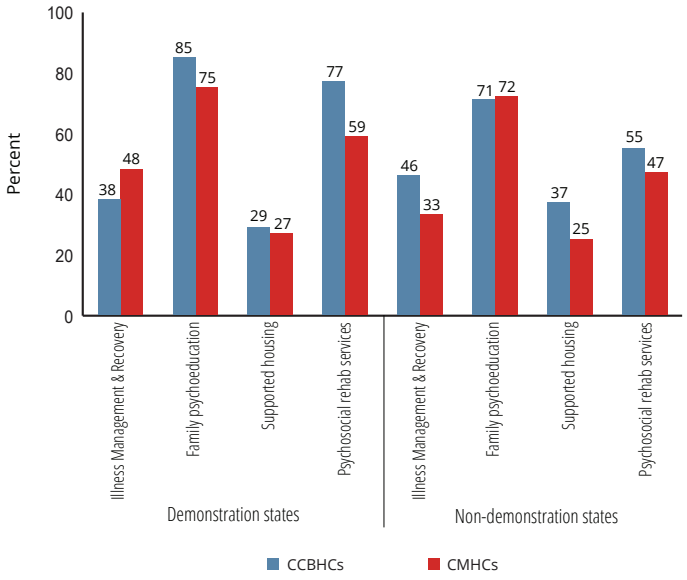
Figure 2. Proportion of CCBHCs and CMHCs that offer tobacco cessation services and integrated primary care



Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey data (2020).

Psychiatric rehabilitation services. States participating in the CCBHC demonstration had to establish a minimum set of evidence-based and other psychiatric rehabilitation services that demonstration CCBHCs must provide. CCBHC-E grantees are also responsible for providing evidence-based and other psychiatric rehabilitation services, but the grant program does not require any specific services. A higher proportion of CCBHCs than CMHCs offer most psychiatric rehabilitation services included in the N-MHSS in demonstration and non-demonstration states (for example, 42 percent of CCBHCs and 23 percent of CMHCs in demonstration states and 47 percent of CCBHCs and 34 percent of CMHCs provided supported employment).[4] Some psychiatric rehabilitation services were more common among CCBHCs, and other services were more common among CMHCs; this varied by demonstration and non-demonstration states (Figure 3). For example, Illness Management and Recovery was more commonly offered by CMHCs than CCBHCs in demonstration states, but the opposite was true in non-demonstration states.

Figure 3. Proportion of CCBHCs and CMHCs that offered psychiatric rehabilitation services



Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey data (2020).

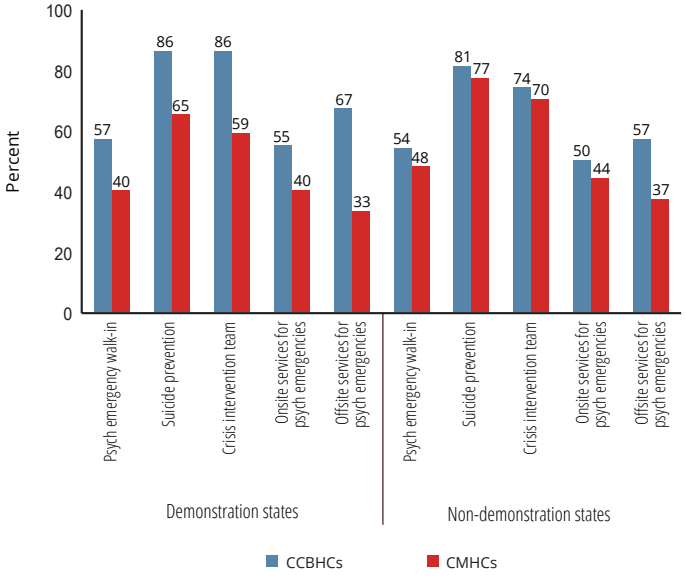
Note: See endnotes for definitions of terms.[5]

CCBHC = Certified Community Behavioral Health Clinic; CMHC = community mental health center

Crisis behavioral health services. CCBHCs must provide crisis services available and accessible 24 hours a day. In demonstration states, a larger percentage of CCBHCs than CMHCs provided all types of crisis services (Figure 4). CCBHCs in non-demonstration states also provided crisis services more often than CMHCs.

Peer support services. CCBHCs must provide peer specialist and recovery coaches, peer counseling, and family and caregiver supports. Demonstration states had to specify the scope of peer and family services CCBHCs should provide based on the needs of the population served. CCBHC-E grantees are also responsible for providing peer support services but have flexibility to determine the specific services offered. In demonstration states, 75 percent of CCBHCs provided peer support services versus 43 percent of CMHCs. In non-demonstration states, 59 percent of CCBHCs provided peer support services versus 49 percent of CMHCs.

Figure 4. Proportion of CCBHCs and CMHCs that offered crisis services



Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, National Mental Health Services Survey data (2020).

Notes: Suicide prevention services include identifying risk factors; educating staff on identifying the signs of suicidal behavior and using methods to detect risk; and the assessment, intervention, and management of suicidal patients including treatment of an underlying mental or substance use disorder, and use of psychotropic medication, supportive services, and education. Hotlines help individuals to contact the nearest suicide prevention mental health provider.

CCBHC = Certified Community Behavioral Health Clinic; CMHC = community mental health center

Populations and facility characteristics

A higher percentage of CCBHCs than CMHCs offered services to all the populations included in the survey (for example, children with serious emotional disturbance, people with co-occurring mental health and substance use disorders, and those experiencing first-episode psychosis) in demonstration and non-demonstration states (results not shown). There was little difference between demonstration states and non-demonstration states in the percentages of CCBHCs versus CMHCs that provided services to these populations. There were, however, a few exceptions:

- The differences in the percentages of CCBHCs versus CMHCs providing services to transitional-age young adults was larger in demonstration states (53 percent versus 35 percent) than in non-demonstration states (41 percent versus 40 percent).
- The differences in the percentages of CCBHCs versus CMHCs providing services to adults with serious mental

illness was also larger in demonstration states (73 percent versus 65 percent) than in non-demonstration states (65 percent versus 64 percent).

- Conversely, the difference in the percentages of CCBHCs versus CMHCs providing services to veterans was larger in non-demonstration states (41 percent versus 20 percent) than in demonstration states (31 percent versus 19 percent).

CCBHCs must also serve all consumers who seek help regardless of ability to pay. To this end, a higher percentage of CCBHCs than CMHCs offered treatment at no charge or for minimal payment in demonstration states (85 percent of CCBHCs versus 78 percent of CMHCs) and non-demonstration states (72 percent of CCBHCs versus 70 percent of CMHCs). Similarly, a higher percentage of CCBHCs than CMHCs (95 percent versus 78 percent) offered a sliding fee scale in demonstration states. A slightly higher percentage of CMHCs, however, provided a sliding fee scale than CCBHCs in non-demonstration states (87 percent versus 84 percent).

Discussion

With few exceptions, a higher percentage of CCBHCs than CMHCs provided services described in the CCBHC certification criteria. There were differences between CCBHCs and CMHCs for services that have not historically been universally available from CMHCs, such as SUD treatment and psychiatric rehabilitation services. CCBHCs also were more likely to provide treatment at no charge or for minimum payment and to serve all specific populations included in the N-MHSS. For a few services, a higher percentage of CMHCs provided services than CCBHCs. For example, a higher percentage of CMHCs provided Illness Management and Recovery in demonstration states, and a higher percentage of CMHCs than CCBHCs provided family psychoeducation in non-demonstration states. For most services included in our analysis, the difference in the percentage of CCBHCs versus CMHCs that offered the services was larger in demonstration states than in non-demonstration states.

Several factors could explain why there were often differences in the availability of certain services from CCBHCs and CMHCs in demonstration states versus non-demonstration states. This could be because the demonstration began before either the CCBHC-E grant program or the expansion of CCBHCs through other financing mechanisms (like Medicaid Section 1115 demonstrations), and therefore CCBHCs in demonstration states have had more time to put into place services than those in non-demonstration states. In addition, states were required to play a role in supporting CCBHCs in demonstration states and ensuring they provide the full scope of CCBHC services whereas state involvement and oversight likely varies more across clinics that have become CCBHCs through other financing mechanisms that have different oversight requirements. However, we cannot definitively draw these distinctions between CCBHCs that participate in different financing models because N-MHSS does not include information about the funding mechanism the clinic used to become a CCBHC. Further monitoring and analysis using future years of N-MHSS data would provide valuable information to assess changes over time in the availability of services in CCBHCs and CMHCs and to identify gaps in care in communities.

Suggested Citation:

Wishon, A. & J. Brown. Variation in services offered by Certified Community Behavioral Health Clinics and community mental health centers. May 2021. Submitted to Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD under contract HHSS283201600001C/LC-001-BHSIS.

Endnotes

1 Substance Abuse and Mental Health Services Administration. "Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics." Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016. Available at https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf.

2 Substance Abuse and Mental Health Services Administration. "FY 2018 Certified Community Behavioral Health Clinic Expansion Grants." Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018. Available at https://www.samhsa.gov/sites/default/files/grants/pdf/revised-ccbhc-final-5-24-18.pdf.

3 N-MHSS defines CCBHCs as "facilities that are responsible for directly providing (or contracting with partner organizations to provide) nine types of services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care. The demonstration program represents the largest investment in mental health and addiction care in generations."

4 These services include the following: Illness Management and Recovery, family psychoeducation, education services, housing services, supported housing, psychosocial rehabilitation services, vocational rehabilitation services, and supported employment.

5 N-MHSS defines psychiatric rehabilitation services as follows: Illness Management and Recovery uses a standardized individual or group format based on five evidence-based practices: (1) psychoeducation, (2) behavioral tailoring, (3) relapse prevention training, (4) coping skills training, and (5) social skills training. Family psychoeducation helps consumers and their families and supporters through relationship building, education, collaboration, and problem solving to do the following: (1) learn about mental illness, (2) master new ways of managing their mental illness, (3) reduce tension and stress within the family, (4) provide social support and encouragement to each other, (5) focus on the future, and (6) find ways for families and supporters to help consumers in their recovery. Supported housing is independent, normal housing with flexible, individualized supportive services that allow individuals to maintain as much independence as possible. Psychosocial rehabilitation services offered individually or in groups provide therapeutic or intervention services such as daily and community-living skills, self-care, and skills training (such as grooming, bodily care, feeding, social skills training, and basic language skills).