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MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

Certified Community Behavioral Health Clinics in Michigan:

Evaluation Results from the CCBHC Demonstration in Michigan

Demonstration Years 1 – 3 (FY2022 – 2024)

JUNE 2025

CENTER FOR HEALTH AND RESEARCH TRANSFORMATION

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List of Acronyms

The following acronyms are used in this report.

ACT	Assertive Community Treatment
BH-TEDS	Behavioral Health Treatment Episode Data Set
CARES	Coronavirus Aid, Relief, and Economic Security
CCBHC	Certified Community Behavioral Health Clinic
CHRT	Center for Health and Research Transformation
CMH	Community Mental Health
CMHSP	Community Mental Health Service Programs
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease 2019
CPT	Current Procedural Terminology
D-MI	Democrat from Michigan
DBT	Dialectical Behavior Therapy
EBP	Evidence-Based Practices
ED	Emergency Department
EHR	Electronic Health Records
FY	Fiscal Year
HCPCS	Healthcare Common Procedure Coding System
I/DD	Intellectual or Developmental Disability

ICD-10	International Classification of Diseases, 10th revision
LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, and Asexual
LOCUS	Level of Care Utilization System
MDHHS	Michigan Department of Health and Human Services
MHEF	Michigan Health Endowment Fund
MHSIP	Mental Health Statistics Improvement Program
NPI	National Provider Identifiers
PAMA	Protecting Access to Medicare Act
PIHP	Prepaid Inpatient Health Plans
PPS	Prospective Payment System
R-MO	Republican from Missouri
SAMHSA	Substance Abuse and Mental Health Services Administration
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SUD	Substance Use Disorder
TCN	Transaction Control Number
YSS-F	Youth Services Survey for Families

Executive Summary

Introduction

In 2009, Senator Debbie Stabenow (D-MI) along with Senator Roy Blunt (R-MO) introduced the bipartisan Excellence in Mental Health Act to *"increase access to community behavioral health services for all Americans and improve Medicaid reimbursement for community behavioral health services."* [1] This Act established criteria for federally qualified community behavioral health centers which included the provision of nine required services, and addressed how these services would be reimbursed based mainly on provider costs.

The Protecting Access to Medicare Act (PAMA) of 2014 provided the creation and evaluation of a two-year demonstration for CCBHCs in up to eight states[2]. The original eight states launched their demonstration in 2017 and included Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon and Pennsylvania[3].

On August 5, 2020, the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 authorized two additional states, Michigan and Kentucky, to join the Demonstration. As a result, the Michigan Department of Health and Human Services (MDHHS) was approved by the Centers for Medicare and Medicaid Services (CMS) to participate in a two-year Certified Community Behavioral Health Clinic (CCBHC) Demonstration with a start date of October 1, 2021, with 13 sites.

The Bipartisan Safer Communities Act of 2022 extended the CCBHC Demonstration an additional four (4) years resulting in a six-year long demonstration for Michigan, slated to end in September 2027. Michigan expanded the CCBHC Demonstration in October 2023 (FY24), to include 17 additional sites. CCBHC Demonstration sites are selected by the state to provide high-quality outpatient behavioral health services to anyone with a behavioral health diagnosis.

Background

CCBHCs are non-profit organizations or units of a local government behavioral health authority designed to provide comprehensive, integrated mental health and substance use disorder (SUD) services to anyone who walks through their door, regardless of their

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[1] https://www.congress.gov/bill/117th-congress/senate-bill/2069/text
[2] CCBHC Demonstration Background | Medicaid
[3] CCBHC History and Background | SAMHSA

diagnosis, insurance status, ability to pay, or residence. Additionally, CCBHCs must follow standards intended to make services more available and accessible, including expanding service hours, utilizing telehealth, engaging in prompt intake and assessment processes, offering 24/7 crisis interventions, and following person- and family-centered treatment planning and service provision. Any fees or payments required by the clinic for such services will be reduced or waived to ensure accessibility and availability.

Unlike traditional service organizations that operate differently in each state or community, CCBHCs are required to meet established and standardized criteria related to care coordination, crisis response and service delivery, and to be evaluated by a common set of quality measures. The Demonstration requires CCBHCs, directly or through designated collaborating organizations (DCOs), to provide a set of nine (9) comprehensive core services deemed necessary to facilitate access, stabilize crises, address complex mental illness and addiction, and emphasize physical/behavioral health integration. These services include the following:

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
- Screening, assessment and diagnosis, including risk assessment.
- Person and family-centered treatment, including risk assessment and crisis planning.
- Outpatient mental health and substance use services.
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
- Targeted case management.
- Psychiatric rehabilitation services.
- Peer support and counselor services and family supports.
- Intensive, community-based mental health care for members of the armed forces and veterans.

Additionally, CCBHCs are required to collect, report and track a robust set of encounter, outcome, and quality data that includes persons served characteristics, staffing, access to services, use of services, screening, prevention, treatment, care coordination, other

processes of care, costs and individual outcomes. CCBHCs also provide additional data to measure the effectiveness of the Demonstration and inform planning for potential future expansion of the CCBHC model state.

In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. This sustainable payment model, termed the Prospective Payment System (PPS), differs from funding models that relied upon Medicaid reimbursement and time-limited grant funding to support pockets of innovation for specific populations. Through its enhanced payment rate, the PPS reimbursement structure offers greater financial predictability and viability in financing CCBHC services.

The Michigan CCBHC Demonstration launched on October 1, 2021, with 13 participating sites, referred to as the Intervention Group throughout this report.

In October 2023, the Michigan CCBHC Demonstration was expanded to include another 17 sites, referred to as the Expansion Group throughout this report. The sites included in the Expansion Group are provided in Appendix D.

Additionally, a Comparison Group was created by identifying comparable non-CCBHC CMHs.

The comparative findings presented in this report will primarily focus on the experiences of Michigan CCBHCs in the Intervention Group to Michigan non-CCBHCs in the Comparison Group. However, data from all three groups (the Intervention Group, Expansion Group, and Comparison Group) is included in aggregate totals for client-level and claims-level analyses in findings to present a comprehensive overview of the data.

Methodology

In 2022, with funding from the Michigan Health Endowment Fund (MHEF), the Center for Health and Research Transformation (CHRT) was contracted by MDHHS to conduct an evaluation of the Michigan CCBHC Demonstration. The purpose of the evaluation was three-fold:

Goal 1: Understand how the CCBHC Demonstration was implemented among the original 13 Demonstration sites

Goal 2: Measure the impact of the CCBHC Demonstration, particularly in expanding access to and participation in behavioral health services for underserved populations

Goal 3: Inform the design of the service model for future expansion throughout the state

CHRT worked collaboratively with the MDHHS CCBHC program team to design all elements of the evaluation, including evaluation questions and key metrics. These are:

- **Implementation Successes and Challenges:** From the perspective of CCBHCs and their Pre-Paid Inpatient Health Plan (PIHP) counterparts, what are the lessons learned from the first 1-2 years of CCBHC implementation? What did they see as the biggest successes? The greatest challenges?
- **Service Utilization:** How did utilization in core CCBHC services increase or change over time? What services were expanded? What differences in uptake and utilization across populations occurred?
- **Access to Core Services by Eligible Individuals:** How did access to core behavioral health services change during the Demonstration period? How did access change for different groups (i.e., by race/ethnicity, gender, urban-rural geography, age, and by behavioral diagnoses)?
- **Patient Outcomes:** What impact did the CCBHC Demonstration have on emergency department (ED) utilization?
- **Patient Satisfaction:** How do those served by CCBHCs rate their experiences with the CCBHC model? What aspects were most positively rated? What areas indicate opportunities for improvement by CCBHCs?
- **Sustainability:** From the perspective of CCBHCs and their PIHP counterparts, what is most important and necessary to ensure the sustainability of CCBHC services?

To address the goals and evaluation questions, CHRT developed a mixed methods process and outcomes evaluation approach that utilizes three major sources of data:

- Qualitative interviews with CCBHCs and PIHPs conducted August-November 2023;
- Medicaid administrative and claims data from FY2018-2024; and
- Patient experience survey data, collected and reported June-September 2023.

Details are provided in Appendices A, B, and C of the full report.

The evaluation timeframe for this report covers the Demonstration period of FY2022-FY2024 (October 1, 2021-September 30, 2024). For claims analysis, a pre-intervention

period was defined as FY2018-FY2021. The start and end dates of the pre-intervention period were chosen to capture service utilization patterns both prior to and during the COVID-19 pandemic, ensuring that any effects of the pandemic on service utilization were accounted for in the analysis. Qualitative interviews and patient experience surveys were conducted and collected in 2023.

Key Findings

The CCBHC Demonstration has significantly improved access to behavioral health care in Michigan. The increase in services for groups that have been conventionally excluded from the publicly funded behavioral health system in Michigan is noteworthy, **particularly for veterans and individuals with mild to moderate severity of behavioral health needs.**

Among the nine (9) core services, Screening, Assessment and Diagnosis stands out as the most utilized service. While not surprising, as it may represent the "lowest hanging fruit" of all the core services, it is an important first step toward getting individuals in the door to access the care they need. Outpatient Substance Use Services and Crisis Services increased significantly as well among the CCBHCs (compared to a Comparison Group of non-CCBHCs). The large increase in individuals receiving these services demonstrates both the need for CCBHCs and how the Demonstration is transforming the behavioral health care system to address all needs in one, highly integrated system.

Interviews conducted with CCBHC and PIHP leaders and staff further emphasized how removing barriers related to insurance type and severity requirements has improved access to services. Expanding availability of evidence-based practices (EBPs) in service delivery, coupled with a "no wrong door" approach has led to improvements in access to and quality of care. Overall themes emerging from the interviews included best practices for successful implementation. Staffing shortages and payment methodologies were cited as challenges to successful implementation and operation of the CCBHC service model. Learnings from the Demonstration could be invaluable to informing overall system improvement and function as a case study for other CCBHCs efforts across the nation.

Taken together, the findings presented in this evaluation provide a robust picture of the successes, challenges and lessons for sustainability and improvement of the CCBHC Demonstration and future implementation and expansion. Examining the results through the lens of each evaluation goal reveals several key findings.

Goal 1: Understand how the CCBHC Demonstration is implemented among the original 13 Demonstration sites.

The biggest lessons the CCBHCs and PIHPs highlighted for future implementation efforts included an emphasis on managing growth through continuous quality improvement and a steady focus on progress which they felt led to better longer-term outcomes for both the CCBHCs and the persons served. CCBHCs also emphasized developing deliberate processes and mechanisms to manage growth through planning and collaboration to deal with increased demand, challenges in staffing, and the need to expand partnerships and infrastructure.

The use of data integration from the start, particularly through Electronic Health Records (EHR) and dashboard technologies, was essential for meeting reporting requirements and improving patient outcomes, including better engagement with underserved groups such as veterans and LGBTQIA+ individuals.

Additional lessons focused on the importance of advocacy at the state and federal levels to expand and secure funding for CCBHCs, as well as the need for effective communication to ensure staff fully embraced the new model.

Finally, a flexible mindset and incremental approach to tackling complex challenges, such as EHR systems and new funding streams, were essential to the success of the CCBHC model. Celebrating small successes along the way helped maintain motivation through periods of significant change.

Goal 2: Measure the impact of the CCBHC Demonstration, particularly in expanding access to and participation in behavioral health services for underserved populations.

Increased Service Utilization

By far, the CCBHC Intervention Group demonstrated substantial and significant growth across all core behavioral health services compared to the Comparison Group of non-CCBHC CMH service providers throughout the study period. Outpatient Substance Use Services in particular saw the highest utilization growth from FY2018 to FY2024, though only a small proportion of the population used this service. The substantial growth in utilization of Outpatient Substance Use Services among those served by the CCBHC Intervention Group stands out for the sixfold growth (498%) in unique individuals served and an eightfold (758%) increase in the number of services provided to this population. This growth may be due in part to expanded access to services through CCBHCs as well as shifts in the way service encounters are billed.

Despite tremendous growth in the number of services provided and the number of unique individuals served, the proportion of services by service type was maintained at relatively consistent levels across all years of the Demonstration (FY2022-FY2024). This indicates that the CCBHCs were able to keep up with the increased demand for core services among individuals they serve.

Of note is the inclusion of the mild to moderate population in the CCBHC model. While this population represents a smaller part of the CCBHC population compared to individuals with Serious Mental Illness (SMI), the mild to moderate population experienced a larger percent of growth in claims and individuals receiving core services under the CCBHC Demonstration compared to the SMI population.

Improving Access to Behavioral Health Services

To be eligible for CCBHC services, an individual must have a qualifying behavioral health diagnosis. Overall, CCBHCs succeeded at identifying eligible individuals and enrolling them in a CCBHC and did so with marked improvement since the beginning of the Demonstration (FY2022). There remains opportunity for improvement, most likely within the Expansion Group as those CCBHCs are not as far along in implementation as those in the Intervention Group, who started two years earlier. This is evidenced by comparing the overall totals and percentages (which include both groups) of CCBHC-eligible individuals being served in a CCBHC with those totals and percentages only in the Intervention Group, where nearly all CCBHC-eligible individuals have been served by a CCBHC.

Prior to the CCBHC Demonstration, the percentage of CCBHC-eligible individuals who received a core service remained steady, fluctuating between 75% to 78% from FY2018 to FY2021. Between the final non-Demonstration year (FY2021) and the most recent Demonstration year (FY2024), the percentage of CCBHC-eligible individuals who received a core service grew from 78% to 85%. While the number of CCBHC-eligible individuals who received a core service increased every year since FY2020, the largest percent growth was observed from FY2021 to FY2022 (13% increase), in alignment with the initial Demonstration rollout.

This suggests that the CCBHC Demonstration resulted in expanded access to core behavioral health services among those with a CCBHC-eligible diagnosis.

Increased access is notable elsewhere:

- CCBHCs were successful at bringing veterans into CCBHCs, nearly doubling this population since FY2022.

- The percentage of CCBHC-eligible individuals served by rural and urban sites who received a CCBHC service remained stable from FY2022 to FY2023 and then experienced a large increase from FY2023 to FY2024. Across all years, CCBHC-eligible individuals served by rural sites were more likely to have received a CCBHC service compared to urban sites.

Impact on All-Cause Emergency Department (ED) Utilization

The CCBHC Demonstration had a small but significant impact on ED utilization, with an observed overall decline of 2.4% when comparing ED utilization before and after each individual received CCBHC services.

Other findings related to the impact of the CCBHC Demonstration on ED utilization were mixed. While the overall ED utilization rate was higher among individuals receiving CCBHC services from the Intervention Group compared to the Comparison Group, the relative decrease was more pronounced over the Demonstration period. The Intervention Group experienced a 25% decrease from FY2023 to FY2024. The Comparison Group also experienced a reduction in ED utilization over this period, but at a lower rate of decrease (16%).

These small and mixed impacts on ED utilization warrant additional monitoring. It may also be that ED utilization is a difficult metric to impact in a relatively short time span given the complexities of co-morbidities and social factors that can influence health outcomes. Further investigation may be able to more fully assess the CCBHC impact on ED utilization over time.

Goal 3: Inform the design of the program for future expansion throughout the state

The patient experience survey data and qualitative interviews provided important insights into ways that the State of Michigan should continue to work to improve the model and enhance the likelihood of sustainability.

Continue to focus on improving patient experience and satisfaction with CCBHCs. Patient satisfaction is generally very high but areas for improvement include a focus on outcomes, functioning and social connection.

Scale resources and staffing at the state level to support the expansion and integration of CCBHCs into the broader behavioral health system. At the time of these interviews, the state planned to expand the Demonstration to include additional sites, alongside the 13 sites in the Intervention Group, but those sites worried that there was not adequate staff members assigned to manage the Demonstration. CCBHCs emphasized

recognizing the Demonstration as a system-wide transformation, not just a program, and to provide proper planning and support to facilitate this change. Along with increased funding, adequate staffing at the state level is necessary for the expansion and integration of CCBHCs across different sectors.

State alignment on policies and regulations from different sectors is vital for sustaining progress achieved through the Demonstration. At the time of the interviews, some CCBHCs felt there was a lack of coordination and that different parts of the behavioral health system, such as reporting and administrative requirements, overlapped or even conflicted with one another. It is essential for all parties to align their understanding and approach, viewing CCBHCs as a fundamental component of a larger transformation of the community mental health system, and address these challenges together.

Provide flexibility in service requirements to support diverse organizational structures for CCBHCs without compromising their existing external partnerships. Some CCBHCs encountered challenges with the requirement to provide 51% of services internally, which required restructuring staffing and discontinuing established and effective contracts with external partners. Those CCBHCs hope to continue engaging with MDHHS and state authorities to find solutions that accommodate their service models while preserving the benefits of their existing community and regional partnerships.

Monitor the payment methodology and the adequacy of reimbursement for the non-Medicaid population. Multiple CCBHCs expressed concern about whether the PPS funding model can continue to adequately reimburse services for the non-Medicaid population as that service population grows.

The above key themes were shared with MDHHS in February 2024, and helped guide them in engaging with CCBHCs and PIHPs to better address the sustainability and expansion efforts of the Demonstration. MDHHS has since been actively working on these issues since the interviews were conducted.

Recommendations

From the evaluation results, several recommendations emerge for future action as the State of Michigan looks to continue to implement and expand the CCBHC model:

- Celebrate the successes of the CCBHC Demonstration to further build engagement and excitement of current and future participants and build the case at all levels for continuation.
- Monitor the impact of staffing constraints on CCBHCs' ability to deliver services and tie this to state level strategies to address the behavioral health workforce shortage. This is particularly acute for rural providers.
- Identify successful strategies within CCBHCs that facilitate success at overcoming staffing and capacity limitations. This could be done by conducting case studies to better understand the elements that CCBHCs use to address these challenges.
- Take steps to enhance and improve the PPS payment model to ensure ongoing access for non-Medicaid individuals.
- Continue to monitor patient experience and satisfaction, especially on the domains related to outcomes, functioning and social connection.
- Consider conducting interviews or focus groups with individuals served by CCBHCs to understand more fully the aspects of their experience that contribute to higher or lower ratings and tie to patient outcomes.
- Understand and address competing regulatory, financial, and community constraints that stress CCBHC functioning and that risk continued expansion. Develop greater flexibility in required criteria where possible.
- Build on the successful inclusion of the mild to moderate population by continuing to ensure adequate support and staffing for this population into CCBHC models.
- Focus future evaluation activities on analyzing patient health outcomes and integration with primary care.

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Introduction

Legislative History

In 2009, Senator Debbie Stabenow (D-MI) along with Senator Roy Blunt (R-MO) introduced the bipartisan Excellence in Mental Health Act to *"increase access to community behavioral health services for all Americans and improve Medicaid reimbursement for community behavioral health services."* [4] This Act established criteria for federally qualified community behavioral health centers which included the provision of nine required services, and addressed how these services would be reimbursed based mainly on provider costs.

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[5] CCBHC Demonstration Background | Medicaid
[6] CCBHC History and Background | SAMHSA

status, ability to pay, or residence. Additionally, CCBHCs must follow standards intended to make services more available and accessible, including expanding service hours, utilizing telehealth, engaging in prompt intake and assessment processes, offering 24/7 crisis interventions, and following person- and family-centered treatment planning and service provision. Any fees or payments required by the clinic for such services will be reduced or waived to ensure accessibility and availability.

Unlike traditional service organizations that operate differently in each state or community, CCBHCs are required to meet established and standardized criteria related to care coordination, crisis response and service delivery, and to be evaluated by a common set of quality measures. The Demonstration requires CCBHCs, directly or through designated collaborating organizations, to provide a set of nine (9) comprehensive core services deemed necessary to facilitate access, stabilize crises, address complex mental illness and addiction, and emphasize physical/behavioral health integration. These services include the following:

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
- Screening, assessment, and diagnosis, including risk assessment.
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
- Outpatient mental health and substance use services.
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
- Targeted case management.
- Psychiatric rehabilitation services.
- Peer support and counselor services and family supports.
- Intensive, community-based mental health care for members of the armed forces and veterans.

Additionally, CCBHCs are required to collect, report, and track a robust set of encounter, outcome, and quality data that includes persons served characteristics, staffing, access to services, use of services, screening, prevention, treatment, care coordination, other

processes of care, costs, and individual outcomes. CCBHCs are also requested to provide additional data to measure the effectiveness of the Demonstration and inform planning for potential future expansion of the CCBHC model state.

In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. This sustainable payment model, termed the Prospective Payment System (PPS), differs from funding models that relied upon Medicaid reimbursement and time-limited grant funding to support pockets of innovation for specific populations. Through its enhanced payment rate, the PPS reimbursement structure offers greater financial predictability and viability in financing CCBHC services.

The Michigan CCBHC Demonstration launched on October 1, 2021, with 13 participating sites, referred to as the Intervention Group throughout this report. In October 2023, the Michigan CCBHC Demonstration was expanded to include another 17 sites, referred to as the Expansion Group throughout this report. The sites included in the Expansion Group are provided in Appendix D. Additionally, a Comparison Group was created by identifying comparable non-CCBHC CMHs. The comparative findings presented in this report will primarily focus on the experiences of Michigan CCBHCs in the Intervention Group to Michigan non-CCBHCs in the Comparison Group. However, data from all three groups (the Intervention Group, Expansion Group, and Comparison Group) is included in aggregate totals for client-level and claims-level analyses in findings to present a comprehensive overview of the data.

CCBHC Sites in Michigan

The Michigan CCBHC Demonstration launched on October 1, 2021, with 13 participating sites; these original 13 sites will be referred to as the Intervention Group throughout this report. The CCBHCs included in the Intervention Group included 10 Community Mental Health Service Providers (CMHSPs) and 3 non-profit behavioral health providers (or non-CMHSP) outlined below:

Figure 1

CCBHC Intervention Group Sites

Intervention Group (10/01/2021 - Present)	Counties Served	Rural or Urban	CMHSP or non-CMHSP
Community Mental Health Authority of Clinton, Eaton, Ingham Counties	Clinton, Eaton, Ingham	Urban	CMHSP
CNS Healthcare	Oakland County	Urban	Non-CMHSP
EasterSeals MORC	Oakland	Urban	Non-CMHSP
HealthWest	Muskegon	Urban	CMHSP
Integrated Services of Kalamazoo	Kalamazoo	Urban	CMHSP
Macomb County Community Mental Health	Macomb	Urban	CMHSP
Pivotal	St. Joseph	Rural	CMHSP
Saginaw County Community Mental Health Authority	Saginaw	Urban	CMHSP
St. Clair County Community Mental Health	St. Clair	Urban	CMHSP
The Guidance Center	Wayne	Urban	Non-CMHSP
The Right Door for Hope and Wellness	Ionia	Rural	CMHSP
Washtenaw County Community Mental Health	Washtenaw	Urban	CMHSP
West Michigan Community Mental Health	Mason, Lake, Oceana	Rural	CMHSP

In October 2023, the CCBHC Demonstration was expanded to include another 17 sites; these sites will be referred to as the Expansion Group throughout this report. The sites included in the Expansion Group are provided in Appendix D. The comparative findings presented in this report will primarily focus on the experiences of Michigan CCBHCs in the Intervention Group to Michigan non-CCBHCs in the Comparison Group. However, data from all three groups (the Intervention Group, Expansion Group, and Comparison Group) is included in aggregate totals for client-level and claims-level analyses in findings to present a comprehensive overview of the data.

Evaluation Approach

Evaluation Purpose and Goals

In 2022, with funding from MHEF, CHRT was contracted by MDHHS to conduct an evaluation of the Michigan CCBHC Demonstration. The purpose of the evaluation is three-fold:

1. Understand how the CCBHC Demonstration is implemented among the original 13 Demonstration sites
2. Measure the impact of the CCBHC Demonstration, particularly in expanding access to and participation in behavioral health services for underserved populations
3. Inform the design of the program for future expansion throughout the state

CHRT worked collaboratively with the MDHHS CCBHC implementation team to design all elements of the evaluation, including evaluation questions and key metrics. These are:

- **Implementation Successes and Challenges:** From the perspective of CCBHCs and their PIHP counterparts, what are the lessons learned from the first 2-3 years of CCBHC implementation? What did they see as the biggest successes? The greatest challenges?
- **Service Uptake and Utilization:** How did uptake and utilization in core CCBHC services change over time? What services were expanded? What differences in uptake and utilization across populations occurred?
- **Access to Core Services by Eligible Individuals:** How did access to core behavioral health services change during the Demonstration period? How did

access change for different groups (i.e., by race/ethnicity, gender, urban-rural geography, age, and by behavioral diagnoses)?

- **Patient Outcomes:** What impact did the CCBHC Demonstration Project have on emergency department (ED) utilization?
- **Patient Satisfaction:** How do those served by CCBHCs rate their experiences with the CCBHC model? What aspects were most positively rated? What areas indicate opportunities for improvement by CCBHCs?
- **Sustainability:** From the perspective of CCBHCs and their PIHP counterparts, what is most important and necessary to ensure the sustainability of CCBHC services?

Methodology and Data Sources

To address the goals and evaluation questions, CHRT developed a mixed-methods process and outcomes evaluation approach that utilizes three major sources of data: qualitative interviews with CCBHCs and PIHPs conducted August-November 2023. Medicaid administrative and claims data from FY2018-2024; and patient experience survey data, collected and reported June-September 2023. Details for each data source and methodology are provided below as well as in Appendices A, B, and C.

Timeframe

The evaluation timeframe for this report covers the Demonstration period of FY2022-2024 (October 1, 2021 – September 30, 2024). For claims analysis, a pre-intervention period was defined as FY2018-2021. The start and end dates of the pre-intervention period were chosen to capture service utilization patterns both prior to and during the COVID-19 pandemic, ensuring that any effects of the pandemic on service utilization are accounted for in the analysis. Qualitative interviews and patient experience surveys were conducted and collected in 2023.

Qualitative Interviews with CCBHCs and PIHPs (August to November 2023)

Qualitative interviews were conducted to assess the impact of the CCBHC Demonstration in Michigan from the perspective of those on the ground implementing it. The primary goals were to understand improvements in access to and quality of behavioral health services and to inform future expansion by developing a set of learnings. Interviews were conducted in two phases: CCBHC interviews from August 7–31, 2023, and PIHP interviews

from October 20–November 1, 2023.

A total of 19 interviews were completed, with 12 CCBHC organizations and 7 PIHPs participating. To capture varied perspectives on the Demonstration's implementation and outcomes, interviews targeted a diverse range of staff roles. CCBHC participants included executive leadership (e.g., Chief Executive Officers, Chief Operating Officers, Chief Financial Officers), clinical administrators, program directors (e.g., Directors of Adult Services, Quality Improvement, and Compliance), care coordinators, support staff, and others. PIHP interviews included regional leads, financial officers, program analysts, and integrated care coordinators, representing both administrative and clinical oversight roles.

All interviews were conducted virtually via Zoom, with two or more members of each region's team participating. A semi-structured interview guide -- developed separately for the CCBHC and PIHP interviews -- ensured consistency across interviews while allowing for in-depth exploration of relevant topics. This approach provided a comprehensive understanding of participants' experiences with the Demonstration's implementation, challenges, and opportunities.

All interviews were audio-recorded with participant consent, professionally transcribed, and reviewed for accuracy. A thematic analysis approach was used to analyze qualitative data. The analysis team developed an initial codebook based on the interview guides and key evaluation questions. Codes were refined through an iterative process, ensuring consistency and accuracy in application. Multiple team members independently coded a subset of transcripts to establish inter-coder reliability, with discrepancies resolved through discussion and consensus.

Data were coded and analyzed using NVivo software, which facilitated the organization, retrieval, and examination of themes across transcripts. The team tracked code frequencies to identify commonly discussed topics across both CCBHC and PIHP participants.

Medicaid Administrative and Claims Data

Data source and study population

Medical claims and population data were provided to the evaluation team by Optum Government Solutions and retrieved from the Michigan Department of Health and Human Services (MDHHS) Data Warehouse. The datasets for FY2024 were prepared after the end of the fiscal year. However, due to the timing of when the data was extracted, the runout

period for this fiscal year may be shorter than those of previous years, which may lead to less complete data. While it is not expected to have substantial impacts on the analysis, this may have contributed, in part, to some observed downward trends in FY2024 compared to previous years.

The population data files included patient-level identifiers, demographic variables, and identifiers for the CCBHC and comparison groups to which individuals were attributed. To create a unique patient ID, a “UNIQUE ID” variable was created that incorporated the beneficiary’s Medicaid ID (“BENEFICIARY ID”) and the Payer Person ID (“CON UNIQUE ID”). This identifier was applied to both population and claims datasets. The justification for creating a new UNIQUE ID is based on the following:

- A separate Payer Person ID (CON UNIQUE ID) is assigned to a unique person by each service provider. Thus, persons receiving services from multiple providers will have multiple Payer Person IDs (CON UNIQUE IDs) in claims data, leading to duplication in population count.
- While each Medicaid beneficiary has a distinct Medicaid ID (BENEFICIARY ID) used across all service providers, persons not on Medicaid during an encounter do not have a Medicaid ID (BENEFICIARY ID) listed in claims data.

The UNIQUE ID variable utilizes the Medicaid ID (BENEFICIARY ID) if one exists for a claims line. If no Medicaid ID (BENEFICIARY ID) is present, then the UNIQUE ID variable used the Payer Person IDs (CON UNIQUE ID). While this does not eliminate duplicate counts entirely, it offers a more precise estimate of the unique population count compared to using either of the IDs alone.

To assess key outcome metrics for uptake/utilization, improved access to behavioral health services, and patient health outcomes (Emergency Department utilization), the evaluation analyzed Michigan Medicaid outpatient claims data from FY2018-2024. The analysis defined the pre-intervention period as FY2018-2021, and an intervention period of FY2022-2024. The Intervention Group includes the 13 sites that entered the Demonstration in October 2021. To analyze the impact of the CCBHC Demonstration model of care versus the standard care model of the CMHSPs, a Comparison Group was created by identifying and including claims from comparable non-CCBHC CMH service providers (Figure 2). The Comparison Group included both those who had a CCBHC-eligible diagnosis, and those without a CCBHC-eligible diagnosis, unless otherwise noted in the analysis.

Figure 2

Comparison Group (non-CCBHC CMHSPs in Michigan)

Comparison Group (non-CCBHC CMHSPs in Michigan)
Bay-Arenac Behavioral Health
Woodlands Behavioral Healthcare Network (Cass County CMH Authority)
CMH for Central Michigan
Gogebic CMH Authority
Gratiot Integrated Health Network
Hiawatha Behavioral Health
Huron Behavioral Health
Lenawee CMH Authority
Livingston County CMH Authority
Manistee-Benzie CMH dba Centra Wellness Network
Montcalm Center for Behavioral Health dba Montcalm Care Network
Newaygo County Mental Health Center
North Country CMH
Northeast Michigan CMH Authority
Northern Lakes CMH Authority
Northpointe Behavioral Healthcare Systems
Pathways
Shiawassee County CMH Authority dba Shiawassee Health & Wellness
Tuscola Behavioral Health Systems
Van Buren Community Mental Health Authority
Wellvance (AuSable Valley CMH Services)

The claims analysis is broken out as follows for each set of outcome measures:

- **Intervention Group and Comparison Group analyses:** To assess impact of the CCBHC Demonstration, this analysis compares outcomes between the Intervention Group and a Comparison Group of non-CCBHC Community Mental

Health Services Programs (CMHSPs) in Michigan. These analyses include the pre-intervention period (FY2018-2021) and the Demonstration period (FY2022-2024).

- **Aggregate analysis of service utilization and unique persons served:** To provide the most comprehensive analysis of overall changes in service utilization and numbers of persons served, data from all three groups (the Intervention Group, Expansion Group, and Comparison Group) were included in aggregate totals for all client-level and claims-level analyses. This included stratifications by race, gender, and severity to improve the accuracy and generalizability of the results.

Analytic Definitions and Measures

The following definitions were used in the analysis:

- **Claim line**: A claim line is a formal payment request submitted by a healthcare provider for a specific service or procedure rendered to a person. Each individual claim line is identified by a unique claim line Transaction Control Number (CLAIM LINE TCN) and represents one service or procedure received during a visit or encounter. Throughout this report, a claim line may also be referred to as a "service."
- **Encounter**: An encounter represents a documented visit between a patient and a healthcare provider during which specific services are provided. Each encounter is identified by a unique Transaction Control Number (TCN) and can align with one or more claims submitted for reimbursement. Throughout this report, an encounter may also be referred to as a "visit."
- **CCBHC**: A specific flag was created in the claims data that identified a provider or site that was certified as a Demonstration CCBHC. This flag used national provider identifiers (NPIs) to match sites to the claims files where available.
- **CCBHC individual or person-served**: An individual patient's claims were attributed to a CCBHC based on the presence of a CCBHC Demonstration Encounter Code (T1040 procedure code – Medicaid certified community behavioral health clinic services, per diem), which designated the service as covered under the CCBHC model's payment structure as opposed to regular Medicaid.
- **CCBHC-eligible**: CCBHC-eligible individuals were defined by the presence of behavioral health diagnosis codes (International Classification of Diseases, or ICD, 10th revision) outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail). These individuals were eligible for services but may not have been

enrolled in a CCBHC (indicated by presence of the T1040 code submitted on an eligible CCBHC service), hence not all eligible individuals had claims attributed to the CCBHC model. CCBHC-eligible persons can be in either the Intervention, Expansion, or Comparison Group.

- **Core services**: Core services were defined by the presence of CCBHC services outlined in the CCBHC Demonstration Handbook. While CCBHCs as well as the Comparison Group provide these services, CCBHCs are required to report these services in conjunction with a T1040 code to bill for CCBHC Demonstration encounters. This evaluation included procedure codes assigned to the following 8 core service categories: Crisis Services; Screening, Assessment and Diagnosis (including risk assessment); Treatment Planning; Outpatient Substance Use Services; Outpatient Mental Health Services; Targeted Case Management; Psychiatric Rehabilitation; and Peer and Family Support Services. A ninth core service category (Intensive Community-based Mental Health Services for the Armed Services/Veterans) did not have any procedure codes associated with it and was instead identified using a separate flag for veteran status (see below).
- **Veteran-status**: A veteran status flag from the Behavioral Health Treatment Episode Data Set (BH-TEDS) identifying individuals as "Veteran" or "Not a Veteran" was matched to claims files for access and utilization analysis.
- **Urban-rural location**: An urban-rural flag was created based on the county location of each clinic and used definitions from the U.S. Census Bureau to designate counties as either urban or rural.[7] Urban/rural designations for each CCBHC in the Intervention and Expansion groups are provided in Appendix D.
- **Severity of behavioral health need**: The severity of behavioral health needs was identified through the Level of Care Utilization System (LOCUS) assessment scores. A score between 10 and 16 indicates a mild to moderate behavioral health intensity, while a score above 16 indicates serious mental illness (SMI)[8].
- **Emergency Department (ED) utilization**: ED utilization was measured by the total number of all-cause ED visits divided by total number of patient months and then scaling the result to represent the number of ED visits per 1,000 patient months. ED visits were identified in Medicaid claims data using Current Procedural Terminology

[7] Urban and rural definitions from the U.S. Census Bureau with designations provided by the Michigan Department of Health and Human Services.
[8] A small percentage (less than 1%) of LOCUS assessment scores fell below the 10-16 range and were removed from analysis.

(CPT) codes ranging from 99281-99285, and patient months were determined by the number of Medicaid-eligible months for each patient during the study period.

As appropriate, additional stratifications were analyzed, including race/ethnicity, gender, age urban/rural CCBHC location, and veteran status. Race/ethnicity and gender variables were aggregated into categories where volumes were too low to analyze independently. Age was calculated based on date of birth and end of each fiscal year. Individuals were then aggregated into adult and child categories, where adults were identified as ages 22 and older, and children were identified as ages 21 and under.

Throughout the analysis, total unique counts of individuals by various stratifications such as by demographic or Intervention/Comparison Group may differ from overall total counts due to missing data.

To test for significant differences in core service uptake and utilization by the various stratifications, Pearson's Chi Square tests with post hoc analyses were run. Unless otherwise noted, the standard for significance was $p<0.05$. A paired t-test was conducted to test for significant change in ED utilization over time among CCBHC individuals.

See Appendix C for more detailed methods and data specifications.

Patient Experience Surveys

As part of their participation in the CCBHC Demonstration, sites are required to gather patient experience data. The goal of the survey is to measure and track levels of satisfaction with the CCBHC model, including perceptions about access to services, quality of services, social connectedness, functioning, and outcomes among adults and families of children/youth. The survey data included in the report was provided to the evaluation team by the CCBHCs in the Intervention Group and was collected between June and September 2023.

The analysis was guided by the following questions:

- What areas of patient experience are CCBHCs doing well in?
- What areas of patient experience can be improved upon?
- What disparities in self-reported experiences exist across different population groups?
- Based on these baseline findings, what changes or adjustments to improve patient experience and data collection might be considered?

A detailed discussion of methodology is provided in Appendix B, including a breakdown of demographic characteristics of survey respondents.

Adults and children were surveyed about their experiences and satisfaction using different instruments: the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey and the Youth Services Survey for Families (YSS-F).

The MHSIP survey is designed to measure six domains of adult patient experience and satisfaction: (1) Satisfaction, (2) Access, (3) Quality and Participation, (4) Outcomes, (5) Functioning, and (6) Social Connectedness. To measure satisfaction and experience, the survey asks individuals to rate the extent to which they agree with 36 statements across all 6 domains. Twelve of the 13 CCBHCs are included in this analysis. One site developed their own unique survey and hence that data was omitted.

The YSS-F survey is designed to measure six domains of youth patient experience and satisfaction: (1) Appropriateness, (2) Access, (3) Participation, (4) Cultural Sensitivity, (5) Outcomes, and (6) Social Connectedness. To measure patient experience and satisfaction in these domains, the survey asks the parents/guardians of youth served by a CCBHC to rate the extent to which they agree with 26 statements. Eleven of 13 sites are included in the analysis. One site developed their own unique survey and hence that data was omitted. A second site did not receive a response to their survey from family/caregivers.

In addition to measures of satisfaction and experience, the evaluation team analyzed differences in ratings by race, ethnicity, gender, age and urban/rural designation. These analyses are not included here but instead can be found in the "Patient Experience of CCBHC Services" Report.

Data Considerations and Limitations

Detailed descriptions of the methodology and variables used in each analysis are provided throughout this report. In addition, the following data limitations should be considered when interpreting the findings. More specifics on these limitations are included in Appendix E.

Qualitative Interviews

Interviews were conducted in two phases: CCBHC interviews from August 7–31, 2023, and PIHP interviews from October 20 to November 1, 2023. The data and responses reflect the experience of CCBHCs and PIHPs in the Intervention Group up to the end of their second Demonstration year (FY2023) and hence represent their perspective and learnings at that

point in time. MDHHS has since worked with CCBHCs and PIHPs to improve implementation and has addressed some to the challenges raised in the interviews.

Medicaid Claims Analysis

Overall, Medicaid claims provided the most comprehensive and robust data to evaluate service utilization at CCBHCs and non-CCBHC CMHSPs. However, there are also some limitations with healthcare claims data. First, the analysis makes assumptions that services were coded as intended on the claims. Second, claims may have missing data that can impact extrapolation by subpopulations in the analysis. Claims data also do not provide direct insight into contributing factors that may have affected CCBHC service utilization, including cultural, socioeconomic, or other specific reasons. Detailed limitations are listed below:

- Due to the timing of the analysis, FY2024 data had a shorter runout period than previous years which may lead to less complete data. While it is not expected to have substantial impacts on the analysis, this may contribute, in part, to some observed downward trends compared to previous years.
- Despite rigorous cleaning and coding of the data to remove duplication, duplicative counts of individuals may still be possible in some analyses.
- The assignment of service codes corresponding to each CCBHC core service was determined by MDHHS and approved by CMS at the launch of the Demonstration and is subject to change.
- Outpatient mental health and substance use services were broken out to analyze each sub-category individually. Procedure codes were used to categorize each group depending on code descriptions. Individuals were excluded from the mental health and substance use services analysis in cases where procedure codes could not be clearly defined or the service could not be distinguished as either mental health or substance use.
- For severity of behavioral health need stratification analyses, a small percentage (less than 1%) of LOCUS assessment scores fell below the 10-16 range and were removed from analysis. LOCUS assessment scores to determine severity were not available for FY2018, so claims data from 2018 was excluded from baseline averages.

- The timeframe for ED Utilization analyses spanned from FY2019-2024, as data on eligible Medicaid months was not accessible for FY2018 during the time of analysis.
- Because the total ED Utilization measure relied on eligible Medicaid months to calculate patient months, only Medicaid beneficiaries are represented in the analysis.
- A small proportion (less than 10%) of the total CCBHC population included an Intellectual or Developmental Disability (I/DD) diagnosis. Due to potentially unique needs of the I/DD population, this group was excluded from ED Utilization analyses.
- Certain socio-demographic categories for race/ethnicity and gender were collapsed for analyses and presentation due to low numbers/cell counts.
- Throughout the analysis, total unique counts of individuals such as by demographic or Intervention/Comparison group may differ from overall total patient counts due to missing data.

Patient Experience Surveys

- Surveys included in this report were conducted in 2023 and represent point-in-time perspectives.
- Twelve of the 13 CCBHCs are included in the analysis for patient experience among adults. One site developed their own unique survey and hence their data was omitted. Eleven of 13 sites are included in the analysis for patient experience among family/caregivers of youths. One site developed their own unique survey and hence their data was omitted. A second site did not receive a response to their survey from family/caregivers. Sites did not uniformly collect age, gender and racial/ethnic data; hence not all 13 sites provided this data.
- Low survey response rates have resulted in small sample sizes at each site relative to the Substance Abuse and Mental Health Services Administration's (SAMHSA) guidance for reaching out to "300 consumers per CCBHC."[9]

[9] SAMHSA's specifications for the Patient Experience of Care Survey (PEC) provides the following guidance for reporting: "Oversample CCBHCs and comparison clinics in order to generate sufficient sample size, specifically reaching out to 300 consumers per CCBHC and comparison clinic."

- MHSIP and YSS-F domain scores were created by averaging individuals' responses to the questions for each domain. Individuals who did not respond to at least two-thirds of the questions in a domain were omitted from the scoring.

Detailed Findings

The following section presents detailed evaluation findings aligned with the evaluation goals. To understand implementation successes, challenges, and lessons learned from the original 13 Demonstration sites (Goal 1), the evaluation used the key themes and responses from CCBHC and PIHP interviews. Analysis on Medicaid claims data was used to measure the impact of the CCBHC Demonstration on service uptake and utilization, access to services, and patient outcomes (Goal 2). This included examining overall trends, comparing metrics between Intervention and Comparison groups, and stratification by race/ethnicity, gender, age, urban/rural locations, veteran status, and severity of behavioral health needs (mild to moderate vs. SMI). Lastly, to inform the design of the program for future implementation, the report draws upon key themes from CCBHC and PIHP interview responses pertaining to the Demonstration's sustainability, as well as analysis of patient experience survey data.

Goal 1: Understand how the CCBHC Demonstration is implemented among the original 13 Demonstration sites.

To understand early experiences with the CCBHC Demonstration and to document implementation successes and challenges, interviews were conducted with all CCBHCs and their PIHP counterparts. The interviews were designed to elicit insights and learnings from the first year of CCBHC implementation, and what they saw as their biggest successes and challenges.

Some of the major themes that emerged from the interviews are detailed below and include:

- Expanded access to care through core services
- Improved quality of care through implementation of evidence-based practices
- Improved patient outcomes attributed to improved access and quality of care
- Learnings and advice on implementing the CCBHC model

Expanded Access to Care

Most of the CCBHCs indicated that the model has transformed access by removing traditional barriers such as insurance type and severity of need. A major theme that emerged from the interviews was that the CCBHC helped create a "no wrong door" approach, which provides a path to more coordinated and immediate care, regardless of the patient's insurance status. Several CCBHCs shared that telehealth, mobile services, and flexible staffing have extended services to underserved populations, particularly in rural areas. Many clinics noted that the growth of telehealth, especially during the COVID-19 pandemic, significantly improved accessibility with innovations like audio-only services further enhancing care delivery. Home and community-based services, including 24/7 mobile crisis teams, were highlighted as a key factor in ensuring crisis care directly in clients' environments, bypassing the need for law enforcement involvement.

> *"It's our…promise that if someone comes to our front door—whether through our referral system or just walking in—we'll serve them. I think that's made the biggest impact because there's no wrong door for them. They have immediate access, and they don't have to deal with the eligibility requirement through the Medicaid system."*
> *— CCBHC Staff Member*

> *"We had to grow and expand our outpatient therapy clinic, and with that, the demand for psychiatric care increased as well. However, this growth brought its own challenges. As services expanded, we had to keep up with staffing, which has been tough due to shortages. For psychiatric care, we've had to ensure we have enough prescribers to meet the growing demand, which has been another hurdle."*
> *— CCBHC Staff Member*

However, despite this success, challenges remain. Most interviewees identified limited resources in rural areas as a barrier, particularly for mobile crisis services for youth. Additionally, broadband limitations were frequently cited as a challenge to the effectiveness of telehealth services, with audio-only options being insufficient for clients with more intensive needs, creating disparities in access to care via telehealth.

> *"We're in a rural setting with fewer resources, but the CCBHC Demonstration has significantly impacted us by providing more opportunities and resources to improve treatment quality, enhance evidence-based practices, and offer staff training. It supports our mission and vision, making our efforts more sustainable while strengthening our role in mental health and SUD services for our communities. However, the implementation of these practices can be burdensome at times due to staffing levels."*
> *— CCBHC Staff Member*

Most PIHPs interviewees indicated that expanding provider networks, especially in rural areas, and establishing CCBHCs improved access to care through stronger community partnerships and enhanced service coordination. Several respondents highlighted introducing enhanced payment models, like the Prospective Payment System (PPS), as key to expanding provider capacity, reducing eligibility barriers, and facilitating quicker connections to care. These changes notably improved access to mental health, developmental disabilities, and substance use disorder services. Most of the PIHPs reported that they employed a community-focused resource allocation strategy to ensure services meet local needs so that they could increase referrals to a CCBHC, particularly in areas affected by opioid use. The integration of CCBHCs fostered peer learning and sharing of best practices, while uniform care standards across regions helped build trust in the system.

"The ability to serve more people with mild to moderate types of mental health needs, who traditionally have not met criteria for community mental health services, is significant." — PIHP Staff Member

However, PIHPs and CCBHCs also identified the expansion of services and rising demand as being complicated by staffing limitations. Workforce shortages, particularly in rural areas, were noted for the impact on key services such as therapy and home-based programs. Interviewees stressed the need for ongoing efforts to address these challenges and ensure the CCBHC model's expansion and success.

Improvements in Quality of Care

A major theme in the interviews was the significant improvements in the quality of care facilitated by the CCBHC Demonstration. Many respondents highlighted how these models expanded the availability of evidence-based practices (EBPs), such as Assertive Community Treatment (ACT). Enhanced funding through the CCBHC Demonstration allowed providers to expand teams and better implement EBPs. The need for data tracking and the reporting on quality measures enabled continuous refinement of services.

"The CCBHC model has strengthened the use of EBPs like Motivational Interviewing and Trauma-Informed Care, making sure that clients get high-quality interventions regardless of where they seek care." — PIHP Staff Member

However, several challenges were noted in translating service expansions into measurable quality improvements, especially in rural areas. Staffing shortages, particularly for home-based children's services, were cited as a significant barrier. The rapid implementation of the CCBHC model revealed complexities in maintaining consistent use of evidence-based

practices across clinics, particularly in resource-limited settings. Ensuring sustainability, especially for non-Medicaid populations, was a concern, and there were concerns that the payment model may not be sustainable for non-Medicaid individuals.

Impact on Patient Outcomes

CCBHC interviews revealed that many felt the changes introduced by the CCBHC model improved patient outcomes by facilitating more timely access to care and reducing delays in treatment. Most clinics reported that financial barriers and the severity of conditions previously prevented many individuals from receiving care, but these barriers had been minimized. For example, one CCBHC reported significantly reduced hospitalization rates due to successful community-focused initiatives. Evidence-based practices like Dialectical Behavior Therapy (DBT) were also credited with contributing to improved treatment outcomes and client satisfaction.

> *"The difference is night and day—people aren't waiting until they're in crisis. We're seeing folks earlier, which changes outcomes."*
> *— PIHP Staff Member*

However, the CCBHC interviewees also emphasized that while increased access led to positive outcomes, translating these gains into measurable long-term results was complex. Several clinics expressed concern about sustaining and consistently implementing evidence-based practices due to staffing and resource limitations, particularly in rural areas.

Most interviewees noted positive impacts on patient outcomes, with more timely access to care and improved service delivery. The CCBHC model was particularly effective in ensuring that individuals, especially those from underserved populations, received timely mental health services that reduced delays in treatment. Interviewees indicated a noticeable decrease in hospitalization rates for adults and children, which reflected the success of community-based initiatives like the mental health rapid response program.

> *"We've seen marked improvements in recovery outcomes, as clients who engage with the CCBHCs report better overall mental health and a stronger sense of community."*
> *— PIHP Staff Member*

The adoption of evidence-based practices, such as DBT, also contributed to improved patient outcomes. CCBHCs achieved better patient satisfaction and treatment adherence by providing a more coordinated and comprehensive approach. However, several

respondents emphasized the challenges in ensuring the long-term sustainability of these improvements, particularly in rural areas where workforce shortages persist.

Learnings and Insights

Interviews with the CCBHCs and PIHPs highlighted several key lessons for future expansion:

- Embracing continuous improvement, rather than aiming for "gold standard" services right away, allows for manageable growth and better long-term outcomes.
- Collaboration among CCBHCs proved vital in easing transitions, fostering shared learning, and tackling common challenges.
- Data integration from the start, particularly through EHRs and dashboard technologies, was essential for meeting reporting requirements and improving patient outcomes, including better engagement with underserved groups such as veterans and LGBTQIA+ individuals.
- Additional lessons focused on the importance of advocacy at the state and federal levels to expand and secure funding for CCBHCs, as well as the need for effective communication to ensure staff fully embraced the new model.
- Peer support and recovery coaches significantly improved client engagement, while flexibility in service delivery, such as telehealth and community-based outreach, enhanced access to care.
- Managing rapid growth in client numbers required careful planning, expanding infrastructure, and increasing staffing.
- Finally, a flexible mindset and incremental approach to tackling complex challenges, such as EHR systems and new funding streams, were essential to the success of the CCBHC model. Celebrating small successes along the way helped maintain motivation through periods of significant growth and change.

"The other important lesson—well, I guess it's a lesson too—is the value of working collaboratively. Not just with your own local community and partners here, but with other CCBHCs as well. Helping each other out, learning from one another, and acknowledging mistakes—that's crucial. I mean, collaboration is always important. That's probably the biggest thing I'd emphasize."
— CCBHC Staff Member

Goal 2: Measure the impact of the CCBHC Demonstration, particularly in expanding access to and participation in behavioral health services for underserved populations.

Changes in service utilization, individuals served and outcomes, like emergency department (ED) utilization, were measured through Medicaid claims analysis. Specifically, the analysis addressed the following questions:

- **Service Uptake and Utilization:** How did uptake and utilization in core CCBHC services change over time? What services were expanded? What differences in uptake and utilization across populations occurred?
- **Access to Core Services by Eligible Individuals:** How did access to core behavioral health services change during the Demonstration period? How did access change for different groups (i.e., by race/ethnicity, gender, urban-rural geography, age, and by behavioral health diagnoses)?
- **Patient Outcomes:** What impact did the CCBHC Demonstration Project have on ED utilization?

Behavioral Health Core Service Utilization

Comparing service utilization among individuals served by the Intervention and Comparison Groups

One of the aims of the CCBHC Demonstration is to expand access to high quality outpatient behavioral health services. To analyze the impact of the CCBHC Demonstration model of care, utilization of core behavioral health services was compared among the Intervention Group and Comparison Group (as defined in the methodology section). This comparison analyzed service uptake among people with a behavioral health diagnosis pre-Demonstration (FY2018-2020) versus CCBHCs post-Demonstration (FY2022-2024) and looked at the number of persons receiving behavioral health core services, CCBHC service utilization, and overall CCBHC number of services.

Increase in individuals receiving behavioral health core services

In FY2024, those who received care from the Intervention Group CCBHCs were significantly more likely to have received any behavioral health core service ($p<0.0001$) compared to their counterparts who only received care from non-CCBHC CMHs (i.e., the Comparison Group).[10] From FY2018-2024, the Comparison Group saw declines in three

[10] A Pearson's Chi Square test showed this finding to be statistically significant ($p<0.0001$).

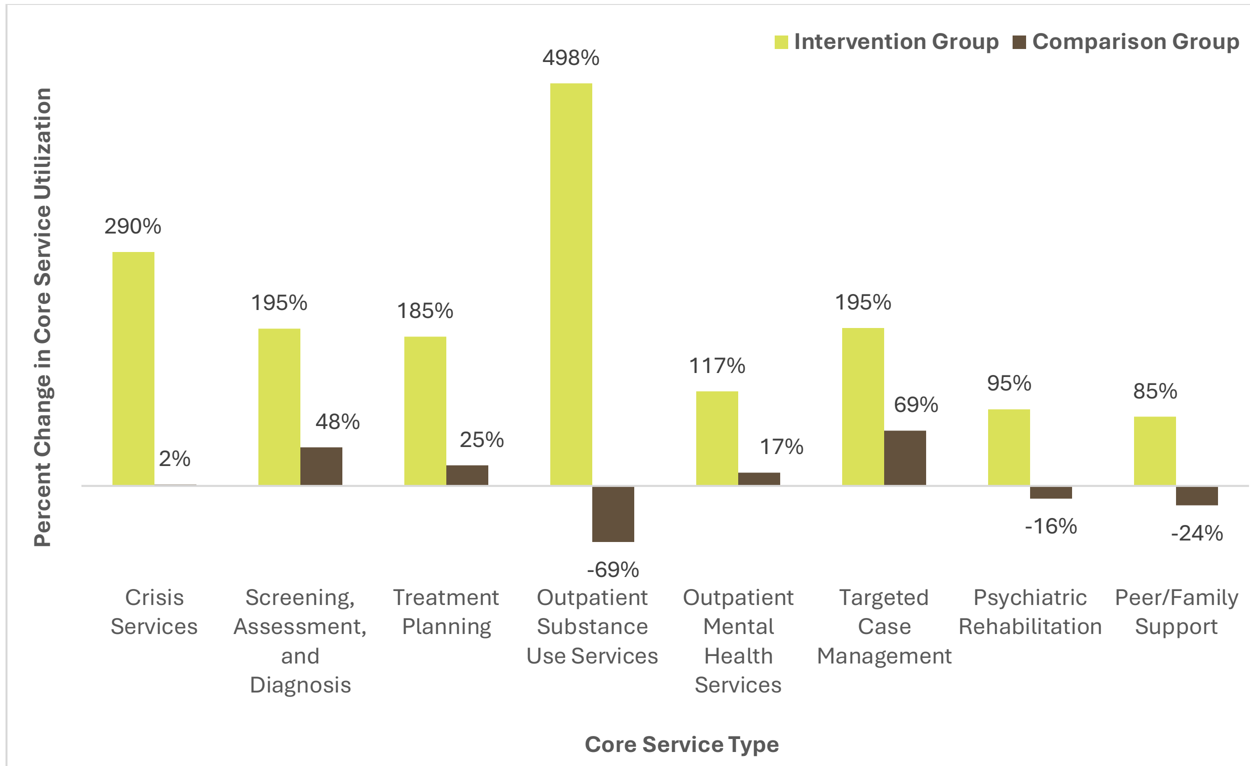
service categories: Outpatient Substance Use (-69%), Peer/Family Support (-24%), and Psychiatric Rehabilitation (-16%). The Intervention Group, on the other hand, experienced substantial increased utilization in all services.

- Across all service categories, there were increases in the total number of individuals receiving services in the Intervention Group from FY2018-2024, while the Comparison Group had fewer individuals receiving Outpatient Substance Use Services, Psychiatric Rehabilitation, and Peer and Family Support Services (see Figure 3).
- Throughout the study period, Outpatient Substance Use Services had the lowest utilization compared to the other behavioral health core services (0.4% in FY2018 – 0.8% in FY2024) (Figures 4.1 and 4.2). However, from FY2018-2024, Outpatient Substance Use Services saw the largest percent growth in the number of individuals served by the Intervention Group (498%). During the same period, there was a decrease in the number of individuals who received Outpatient Substance Use Services in the Comparison Group (Figure 5.2), which amounted to a decrease of 69%. (Figure 3)

CHRT

Figure 3

Percent Change in Total Number of Unique Individuals Receiving Core Services, FY2018–2024



The graph above shows the percentage change in the number of individuals who received each CCBHC core service between FY2018 and FY2024.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2018-2024

Trends in the Percent of Individuals Receiving/Utilizing Services

Across all core service categories, there were larger annual increases in the proportion of individuals in the Intervention Group who received core services compared to those in the Comparison Group (Figures 4.1 and 5.1). The proportion, rather than totals, is measured to account for demographic and population shifts over time, as well as to address differences in population size between the intervention and comparison groups. Specific stand out findings include:

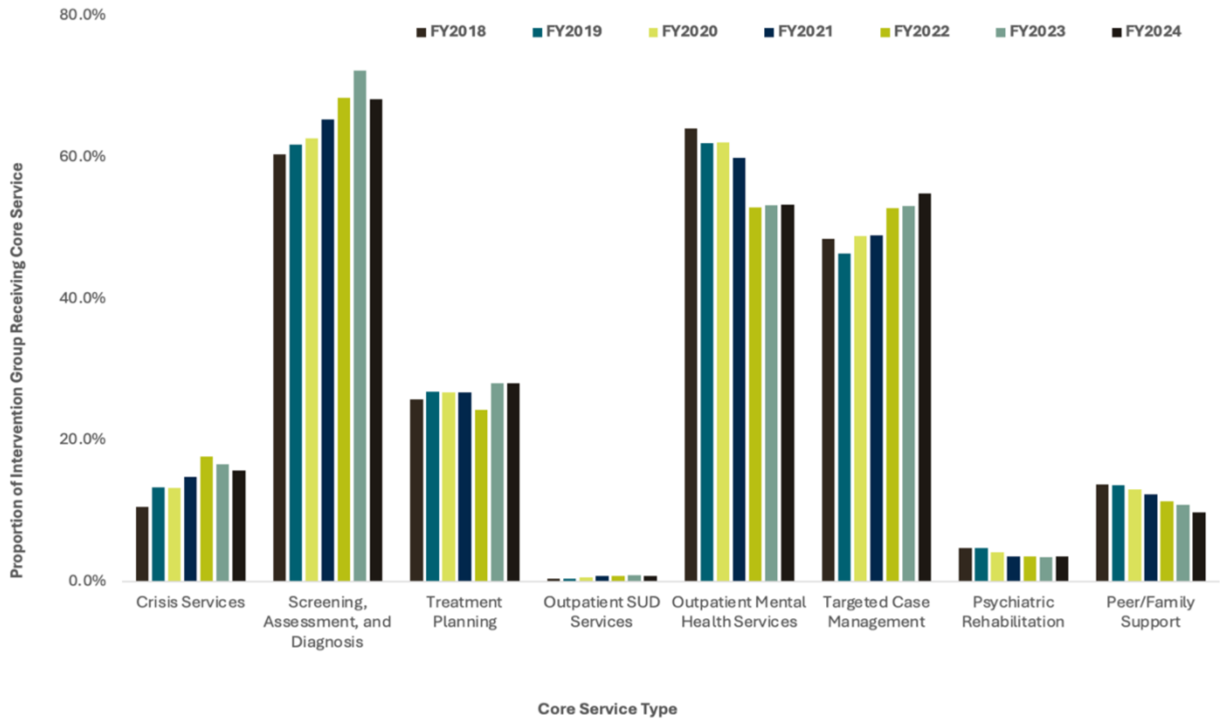
- The proportion receiving Outpatient Substance Use Services in the Intervention Group had consistent annual increases throughout much of the study period, while

those receiving these services in the Comparison Group had consistent decreases in the same period.

- Crisis Services and Screening Services also saw consistent increases in individuals in the Intervention Group receiving these services: 10.5% received Crisis Services in FY2018, increasing to 17.6% in FY2022 and leveling off by FY2024. Those who received Screening Services increased 13% from FY2018-2024, with the largest increase occurring from FY2022 to FY2023.
- Both the Intervention Group and the Comparison Group had high proportions of the population receiving Screening Services, with 60.4% and 64.1% receiving services in FY2018, respectively. By FY2024, the proportion of the population in the Intervention Group receiving Screening Services increased to 68.2%, while the Comparison Group increased to 74.7%.
- In the Comparison Group, Targeted Case Management was the service category with the highest growth in those receiving services (32.9%) from FY2018-2024 with some annual fluctuations. Throughout the study period, the Intervention Group had higher proportions of those receiving Targeted Case Management, as compared to the Comparison Group (54.9% v. 38.4% in 2024, respectively).

Figure 4.1

Intervention Group: Proportion of Unique Individuals Receiving Core Services, FY2018-2024

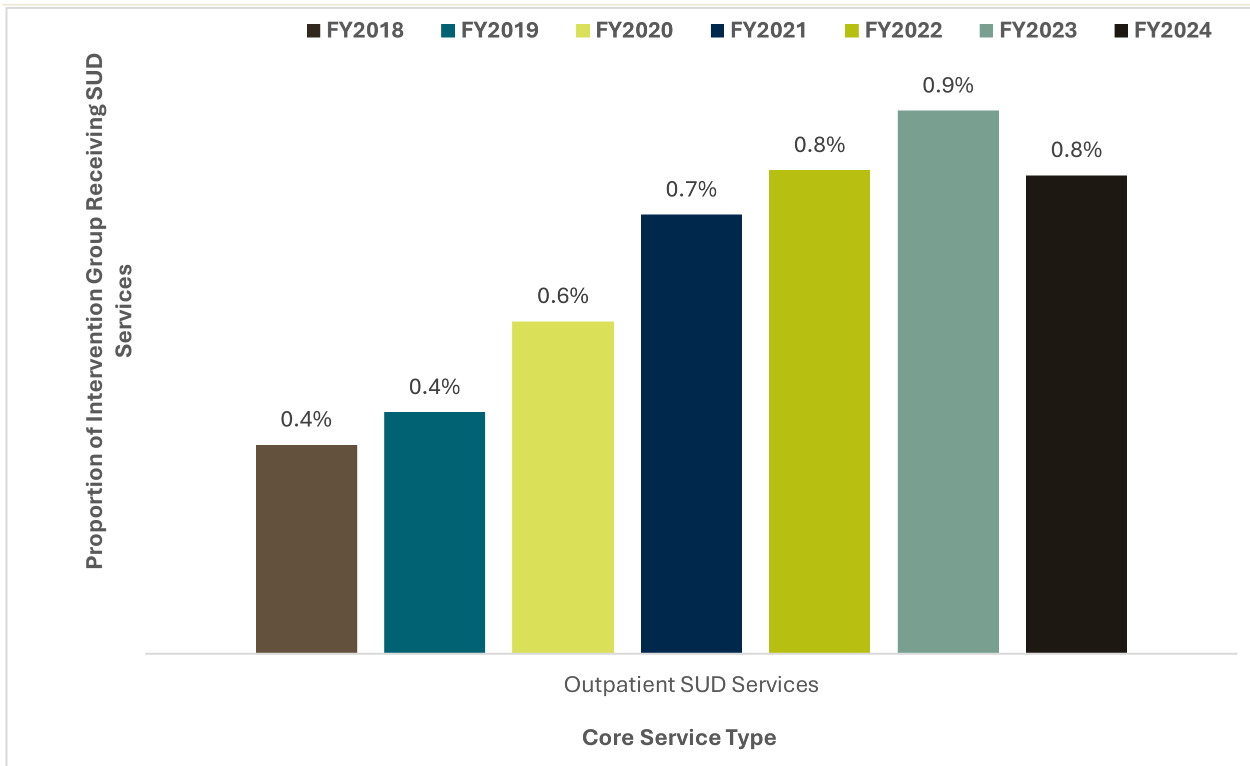


The graph above shows the proportion of the Intervention Group who received each core service between FY2018 and FY2024.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2018-2024.

CHRT

Figure 4.2

Intervention Group: Proportion of Unique Individuals Receiving Outpatient SUD Services, FY2018-2024

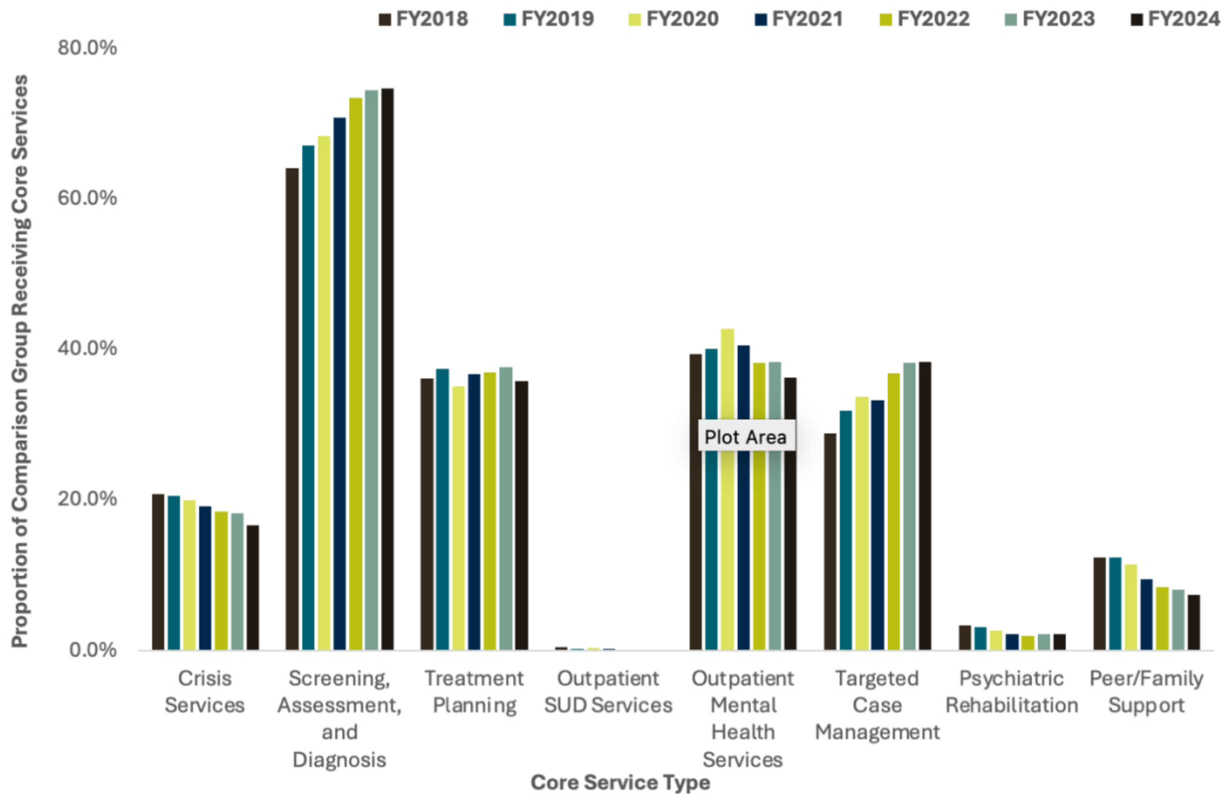


The graph above shows the proportion of the Intervention Group who received Outpatient SUD Services between FY2018 and FY2024.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2018-2024

CHRT

Figure 5.1

Comparison Group: Proportion of Individuals Receiving Services, FY2018-2024



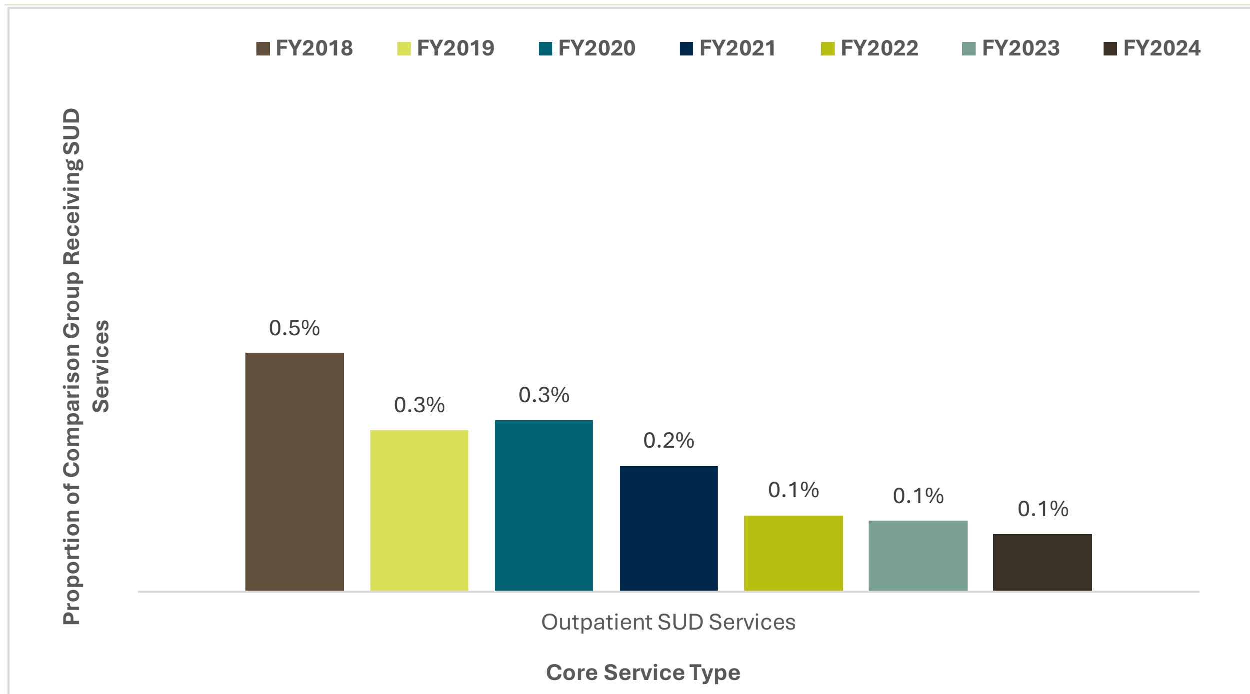
The graph above shows the proportion of the Comparison Group who received each core service between FY2018 and FY2024.

Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2018-2024

CHRT

Figure 5.2

Comparison Group: Proportion of Individuals Receiving Outpatient SUD Services, FY2018-2024



The graph above shows the proportion of the Comparison Group who received Outpatient SUD Services between FY2018 and FY2024.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2018-2024

Trends in Total Number of Core Behavioral Health Services

The total number of services provided increased dramatically throughout the Demonstration period for the Intervention Group. Overall, the total core services for the Intervention Group grew from 604,602 claims in FY2018 to 1,182,936 claims in FY2024, representing over 95% growth. By comparison, total claims for core services decreased during the study period in the Comparison Group, from 1,202,088 claims in 2018 to 1,158,545 claims in FY2024, representing a 3.6% decrease.

Across individual service categories, the Intervention Group had substantially higher growth in the number of claims, compared to the Comparison Group (Figure 6). More specifically:

- Concordant with the growth in the total number of unique persons receiving Outpatient Substance Use Services in the Intervention Group, the percent growth in

claims for these services was substantial, with an increase of 758% from FY2018-2024.

- Additional service categories with substantial growth in the number of claims from FY2018-2024 in the Intervention Group included Screening, Assessment, and Diagnosis (210%), Crisis Services (209%), and Treatment Planning (160%). Claims for Targeted Case Management Services had the highest growth among the Comparison Group, with an increase of 41% from FY2018-2024.
- Meanwhile, the total claims for Peer and Family Support Services decreased from FY2018-2024 in both the Intervention Group and the Comparison Group, with a decrease of 19% and 56%, respectively.

By far, the CCBHC Intervention Group demonstrated substantial and significant growth across all core behavioral services compared to their counterparts providing care within the usual system of behavioral health care. The substantial and significant growth in utilization of Outpatient Substance Use Services among those served by the CCBHC Intervention Group stands out for the sixfold growth in unique persons served and an eightfold increase in the number of services provided to this population.

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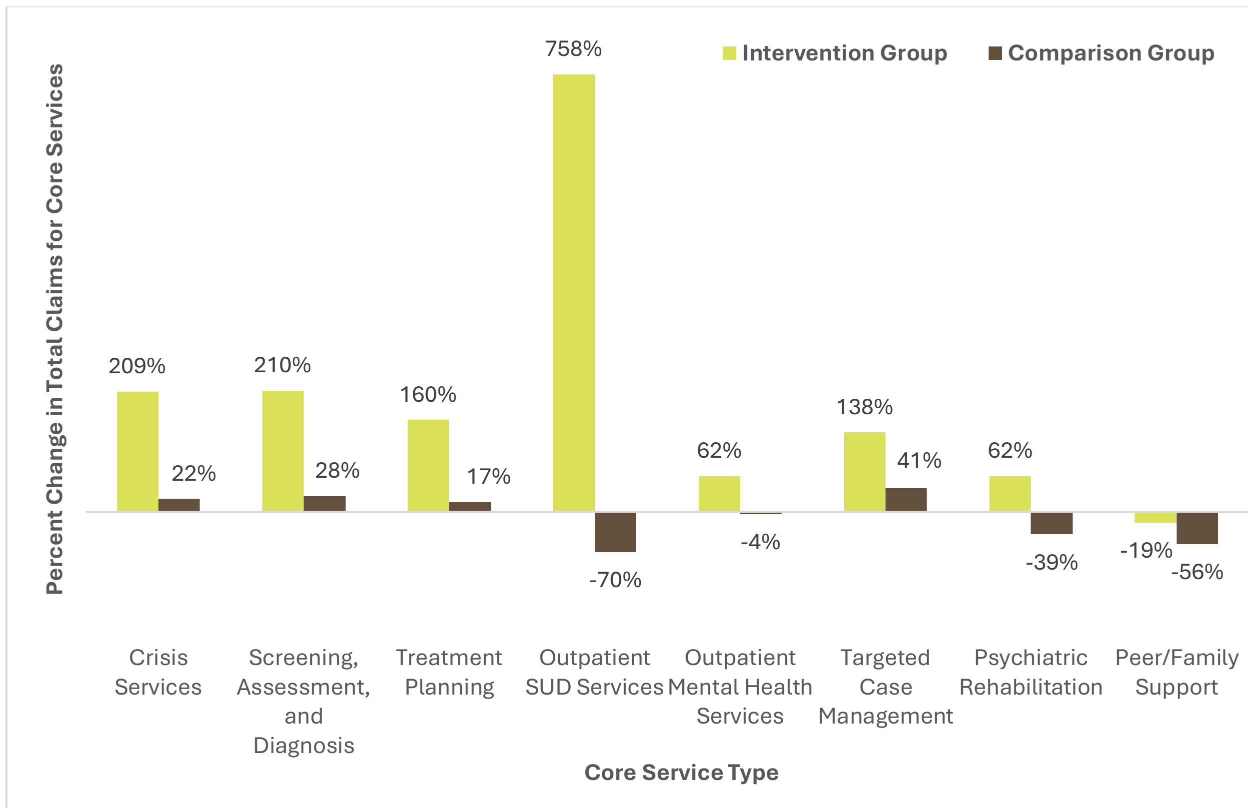
Figure 6

Percent Change in Total Claims, FY2018-2024



The graph above shows the percentage change in the number of claims received for each CCBHC core service between FY2018 and FY2024.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2018-2024

Trends in Core Service Utilization Among the CCBHC Population

Overall Trends in Core Service Utilization

One of the key questions of the evaluation was to understand the extent to which the CCBHC Demonstration expanded or increased core behavioral health services for those served by a CCBHC (i.e., those whose claims included the presence of a CCBHC Demonstration Encounter Code).[11] Specifically, questions that guided this analysis included: How did utilization of core services change over the Demonstration period

[11] CCBHC population refers to those who were attributed to a CCBHC based on the presence of a CCBHC Demonstration encounter code (i.e., a T1040 code). Given that the CCBHC Demonstration Encounter Code was first available in FY2022, the analyses in this section included only data from FY2022-2024.

(FY2022-2024)? How did utilization change for different demographic groups (e.g., by race/ethnicity, gender, urban-rural geography, age, and by behavioral diagnoses)?

To address these questions, the evaluation analyzed trends in the number of core service claims, the percentage of total core service claims by core service type, the number of unique individuals served for each core service, and the percentage of CCBHC participants who received each core service type. Given our focus on core service utilization within the CCBHC population, our analysis was limited to claims for CCBHC persons in both the Intervention and Expansion Groups (identified by presence of the CCBHC Demonstration Encounter Code) within the Demonstration years of FY2022 to 2024.

Overall, there were large increases in core service utilization among the population served by a CCBHC from FY2022-2024. There were substantial increases in both the number of core service claims and number of individuals receiving core services:

- Both the number of claims and the number of individuals were highest for Screening, Assessment, and Diagnosis Services (Figure 7 and Figure 9).
- Use of Outpatient Mental Health Services and Targeted Case Management Services also grew considerably between FY2022-2024 (Figure 7 and Figure 9).
- Outpatient Substance Use Services, Crisis Services, Treatment Planning and Psychiatric Rehabilitation were the least used services, which may be consistent with the overall demand/need within the larger population (Figure 7 and Figure 9).
- The proportion of individuals receiving Peer/Family Support and Targeted Case Management Services experienced very slight decreases in FY2024 (Figure 10).
- The proportion of both the number of core services and individuals receiving each type of core service stayed relatively consistent between FY2022-2024 because of the overall increase in the number of services provided and unique individuals being served (Figure 8 and Figure 10).

The fact that services were maintained at relatively consistent levels indicates that the CCBHCs were able to keep up with the increased demand for core services among individuals they serve, despite challenges noted in the interview data with CCBHCs and PIHPs.

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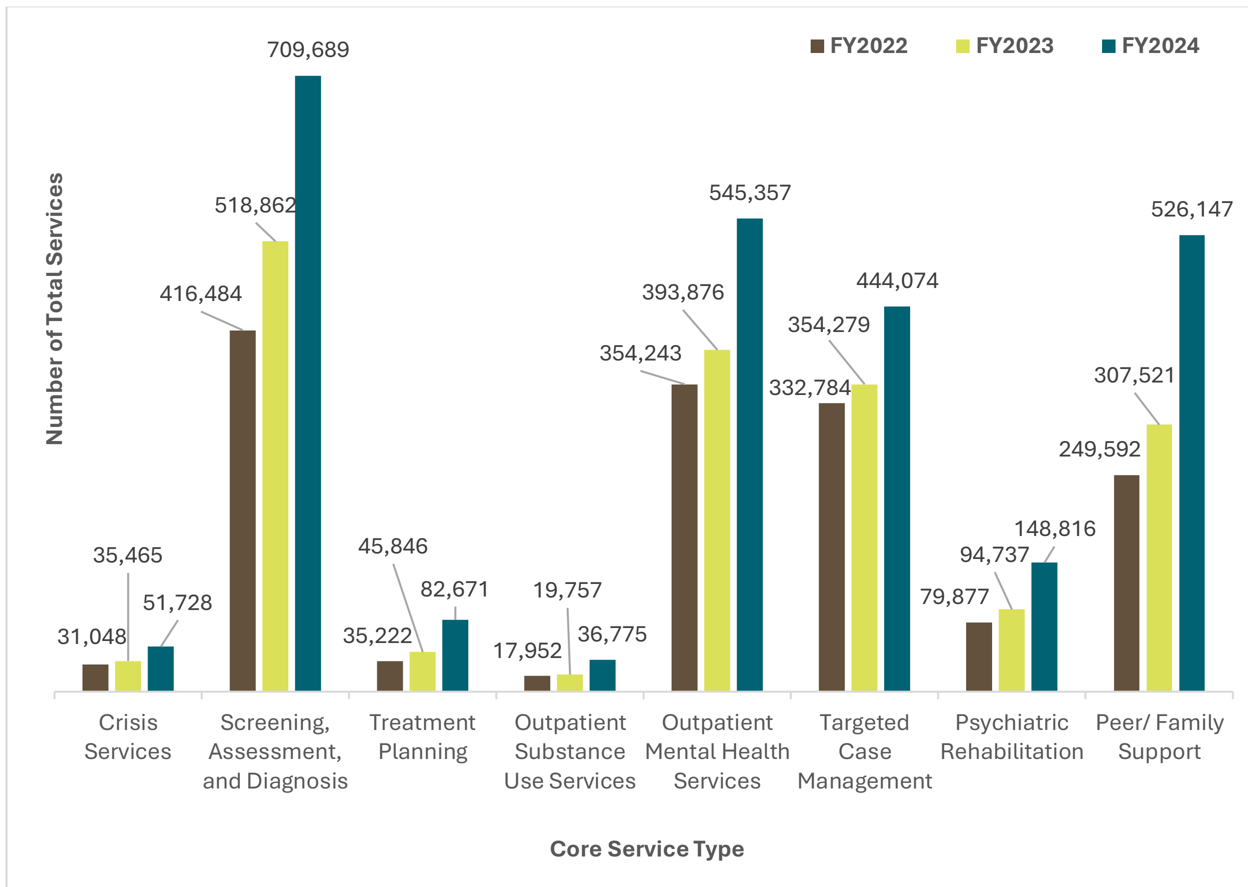
Figure 7

Number of CCBHC Core Services by Type for the CCBHC Population, FY2022-2024



The graph above shows the total number of core services received from those served by CCBHCs in FY2022, FY2023, and FY2024.
*FY2024 includes 17 new CCBHCs that have not been included in this analysis.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2022-2024

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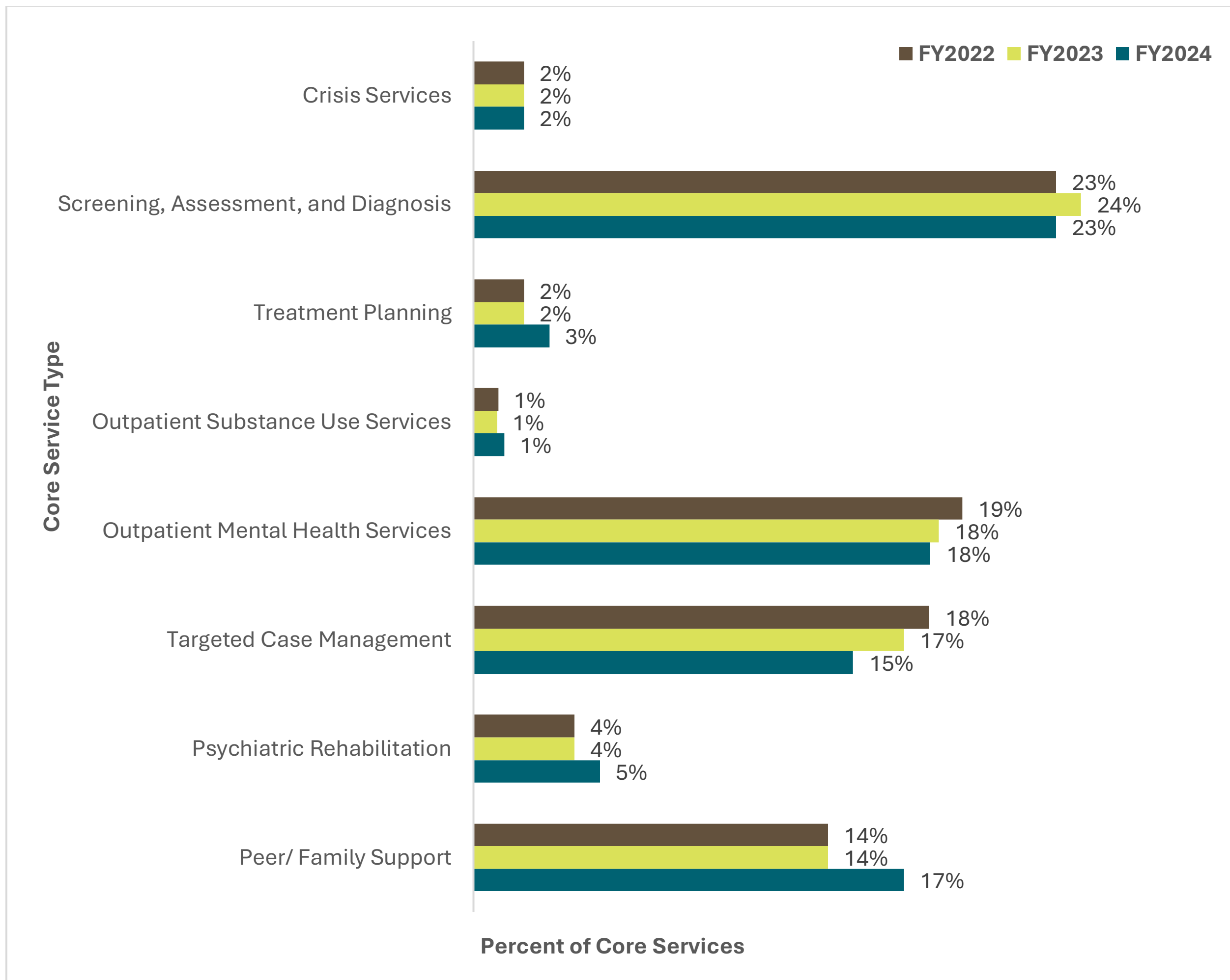
Figure 8

Percent of Total CCBHC Core Service for Each Service Type for the CCBHC Population, FY2022-2024



The graph above shows the total percentage of core services received within each core service type among the CCBHC population in FY2022, FY2023, and FY2024 (The denominator for this percentage is all core service claim lines with a CCBHC Encounter Code). The exact placement of bars may differ for the same whole numbers due to rounding errors.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2022-2024

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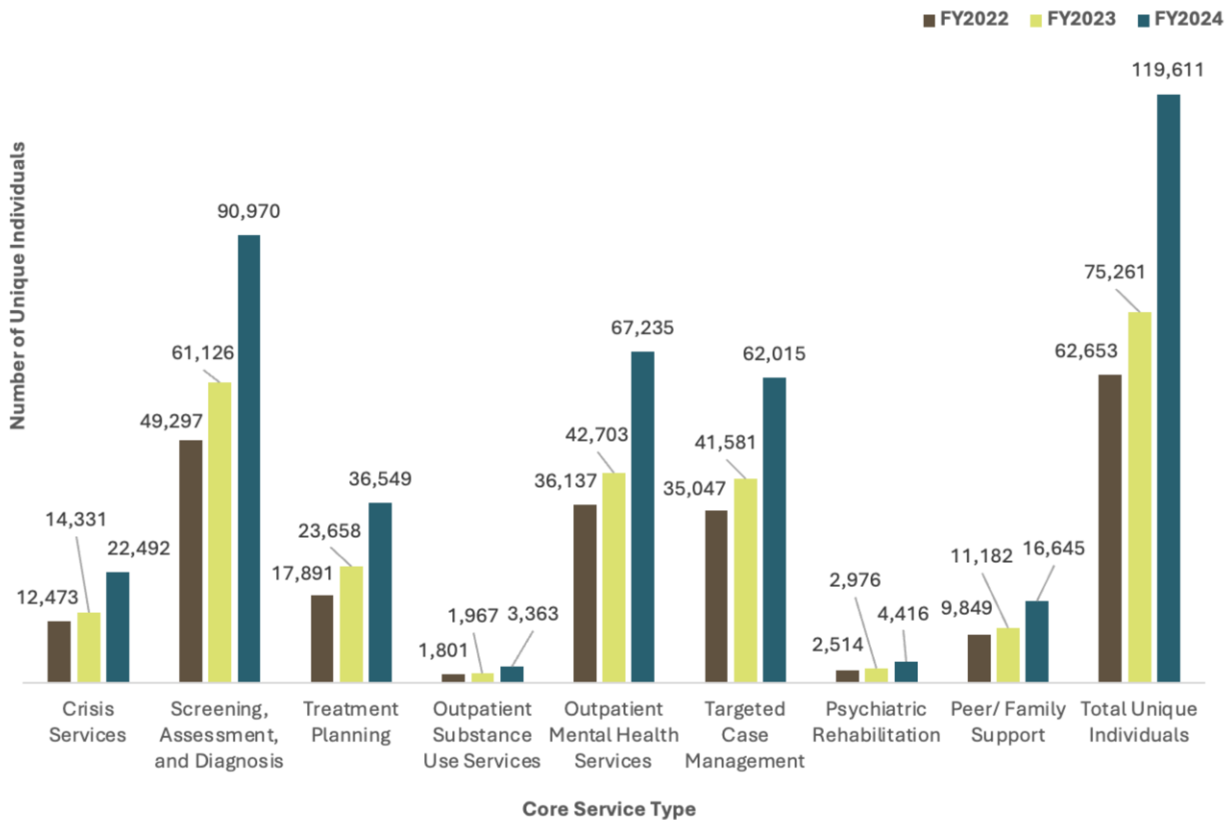
Figure 9

Number of Unique Individuals by Core Service Type for the CCBHC Population, FY2022-2024

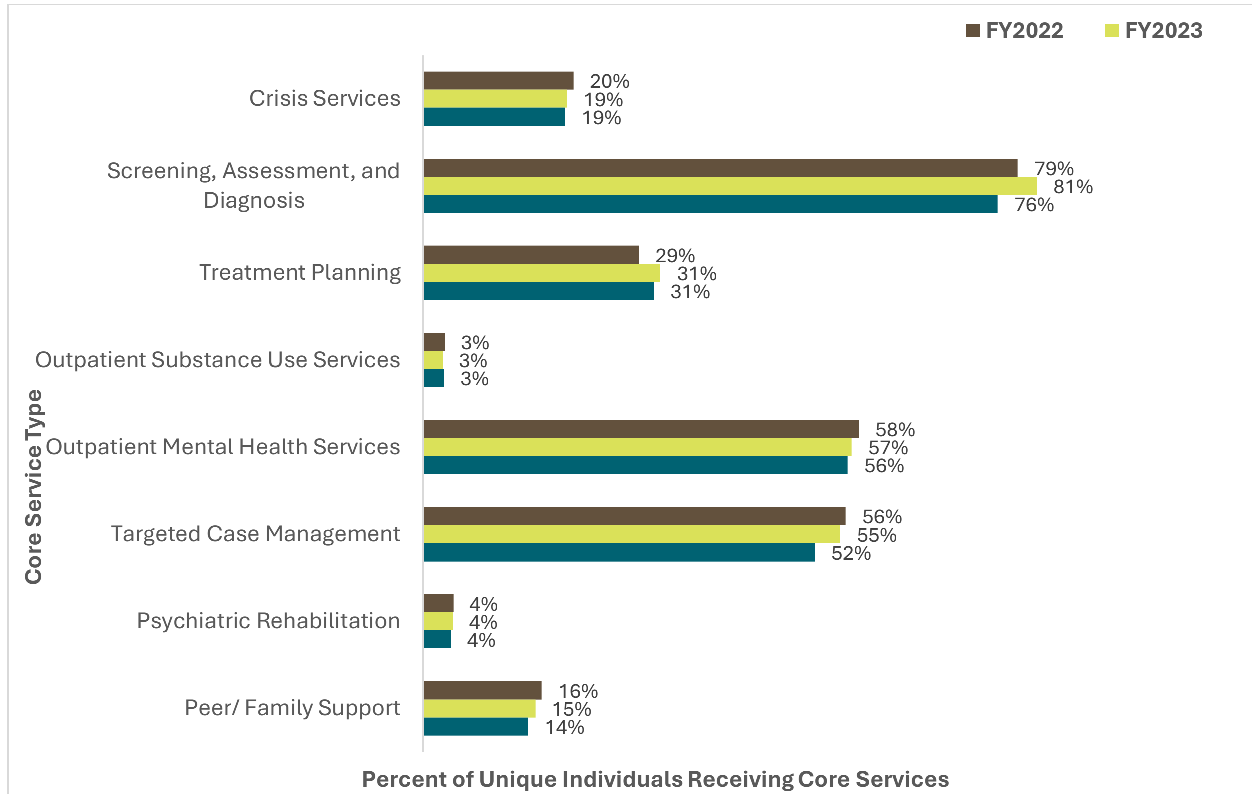


The graph above shows how many unique individuals within the CCBHC population received each core service type in FY2022, 2023, and 2024. Total Unique Individuals refers to the total number of people who had any CCBHC service (each person may have had multiple services, so the total will not equal the sum of the population of each individual service).
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2022-2024

CHRT

Figure 10

Percent of CCBHC Individuals Who Received Each Core Service Type for the CCBHC Population, FY2022-2024



The graph above shows the percentage of individuals who received each core service in FY2022, 2023, and 2024. The denominator for this percentage is all unique individuals with a CCBHC Encounter Code.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2022-2024

Utilization Differences for Adults by Severity of Behavioral Health Needs[12]

Under the CCBHC Demonstration model, behavioral health providers serve anyone with an eligible behavioral health diagnosis, regardless of severity/acuity of diagnosis (mild to moderate or SMI). Under the standard system of care, CMHSPs are limited in their ability to provide care for the mild to moderate population due to network requirements and priority populations. The CCBHC model seeks to address these limitations by providing a payment model that enables providers to care for the mild to moderate population without the

[12] On a claims level, the severity of the individual at the time of the service date is determined first by the most recent available LOCUS assessment score prior to the service date. If no LOCUS assessment score existed prior to the service date, then severity was determined by the next available LOCUS assessment score after the service date.

constraints of the standard system. The following set of analyses examine the extent to which the Demonstration improved access to services for the mild to moderate population, as well as which core services experienced the greatest increase in serving the mild to moderate population.[13] Adults were identified as either "mild to moderate" or "SMI" based on their LOCUS assessment scores. A score between 10 and 16 corresponded to the "mild to moderate" category, while a score above 16 corresponded to the "SMI" category. The analysis examined changes from the pre-Demonstration period (FY2019-2021) and the Demonstration period (FY2022-2024), as well as overall analysis of differences in core service utilization between the mild to moderate and SMI populations for FY2024. Trends in claims and persons served for the mild to moderate group are provided for the overall CCBHC-eligible population, while the proportion of claims for each core service is measured only among the CCBHC service population.

Although they represent a smaller portion of the CCBHC population, the mild to moderate population experienced greater growth in claims and individuals receiving core services under the CCBHC Demonstration compared to the SMI population.

Specific findings include:

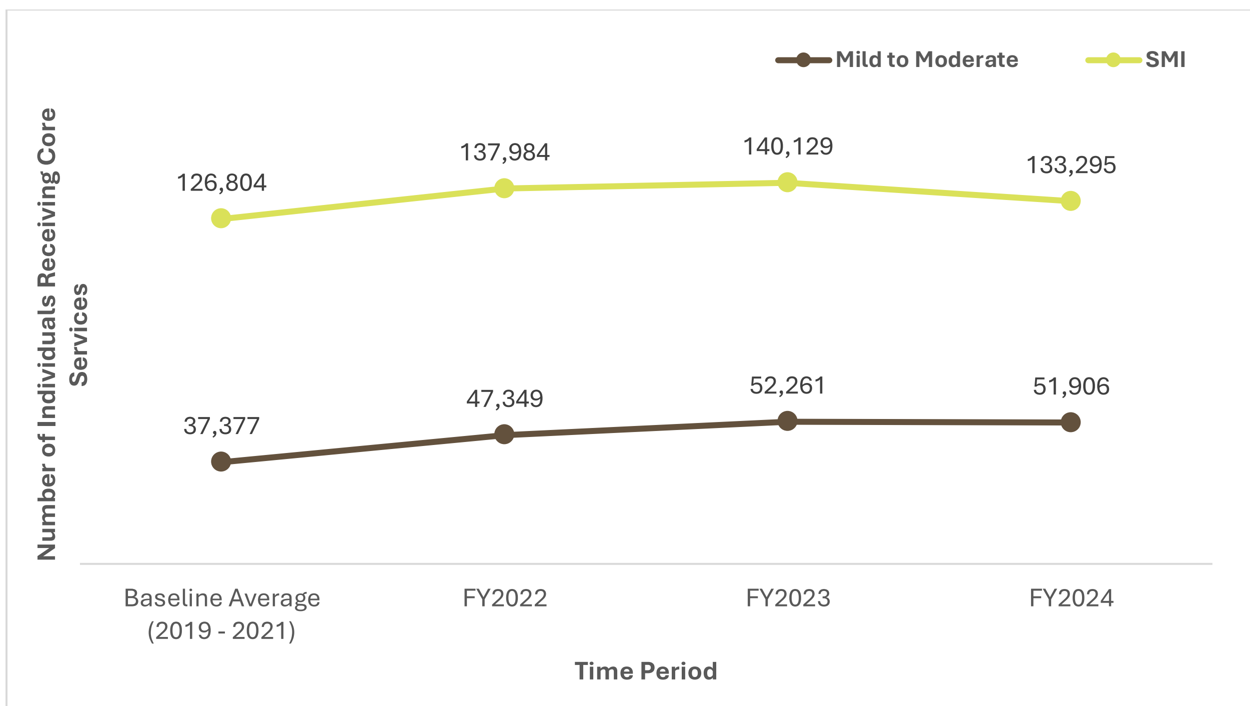
- The mild to moderate population showed a larger percentage growth in number of individuals receiving core services compared to the SMI population from FY2022-FY2024. The largest growth occurred in FY2023, when there were 40% more mild to moderate individuals receiving core services compared to their pre-Demonstration baseline average (FY2019-FY2021).[14] (Figures 11 and 12)
- The mild to moderate population showed a larger percentage growth in core service claims compared to the SMI population from FY2022-FY2024. The largest growth occurred in FY2023, when there were 35% more claims in core services for the mild to moderate population compared to FY2019-2021. (Figures 13 and 14)
- Among CCBHC individuals, a higher proportion of those with SMI received Targeted Case Management (64%), Outpatient Mental Health Services (64%), Treatment Planning (32%), Crisis Services (18%), and Peer/Family Support (14%) compared to the mild to moderate population. (Figure 15)
- Mild to moderate individuals had a higher proportion of claims for Screening and Assessment (33%) compared to those with SMI (24%). SMI individuals had a higher

[14] LOCUS assessment scores to determine severity were not available for FY2018. As such, claims data from FY2018 was excluded from the baseline average.

proportion of claims for Outpatient Mental Health Services (25%) and Targeted Case Management (22%) compared to mild to moderate individuals (19% and 17% respectively). (Figure 16)

Figure 11

Number of Unique Individuals Served (Mild to Moderate v. SMI), FY2022-2024

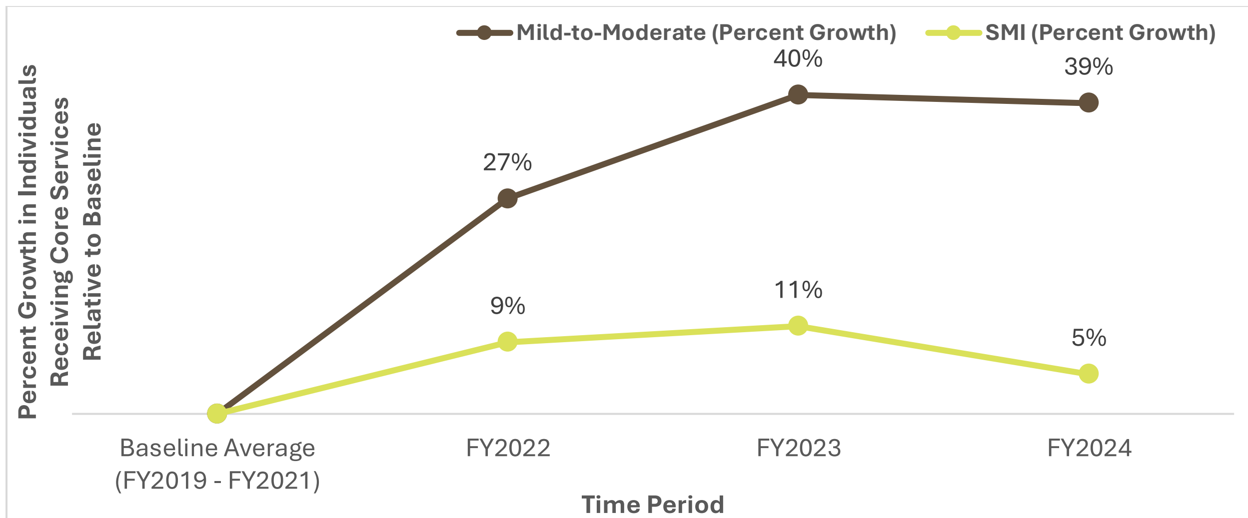


This graph shows the count of unique CCBHC-eligible mild to moderate and SMI individuals who received core services in FY2022, 2023, and 2024 compared to the respective baseline average number of people who received the same services between FY2019 and FY2021.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2022-2024

CHRT

Figure 12

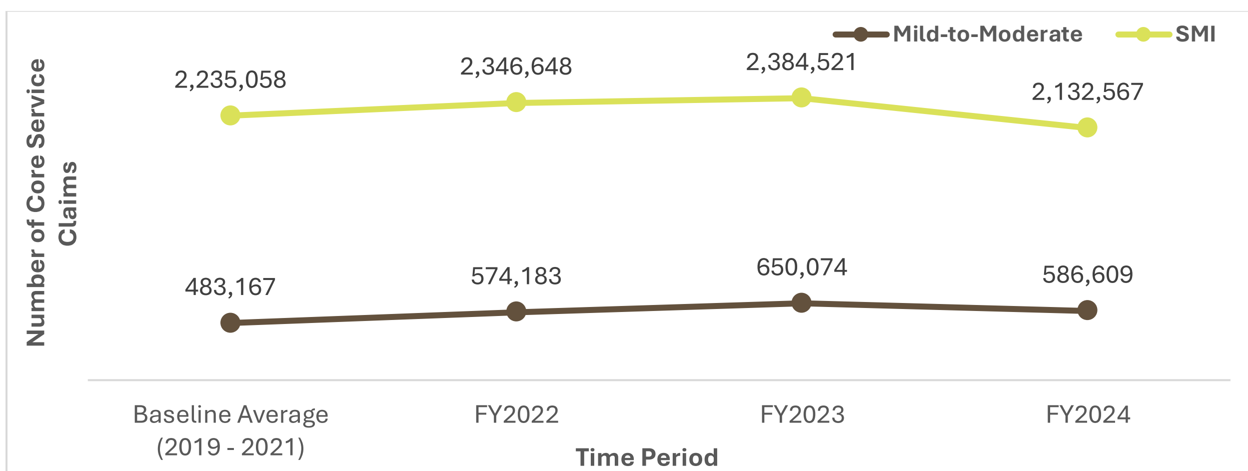
Percentage Growth of Unique Individuals Served (Mild to Moderate v. SMI), FY2022-2024



This graph shows the percentage growth of unique CCBHC-eligible mild to moderate and SMI individuals who received core services in FY2022, 2023, and 2024 compared to the baseline average between FY2019-2021.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2022-2024

Figure 13

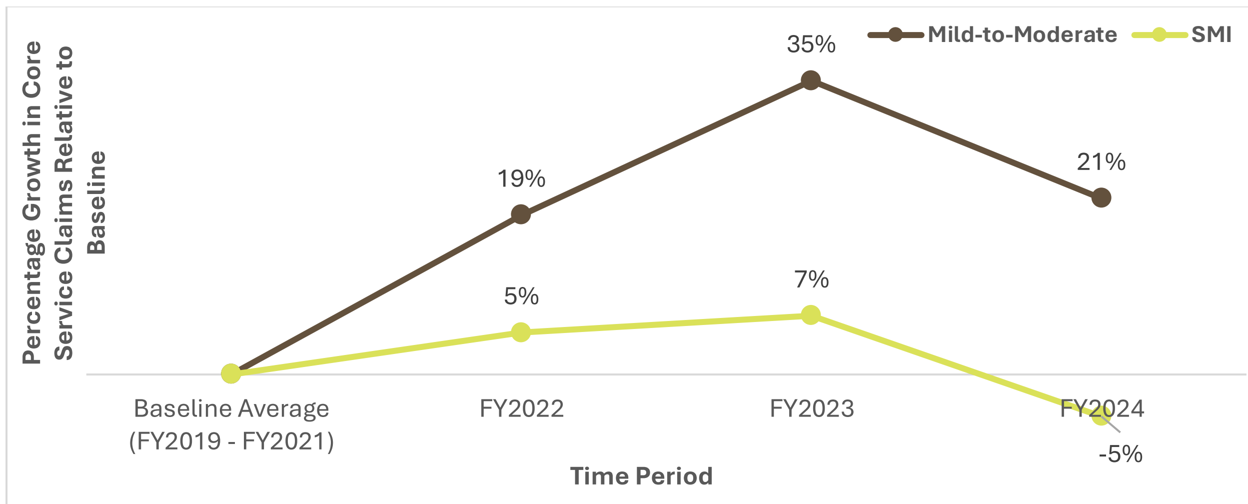
Count of Core Services (Mild to Moderate v. SMI), FY2022-2024



This graph shows how many core services were received in FY2022, 2023, and 2024 by the CCBHC-eligible mild to moderate and SMI populations compared to the baseline average of core service claims between FY2019-2021.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2022-2024

Figure 14

Percentage Growth of Core Services (Mild to Moderate v. SMI), FY2022-2024

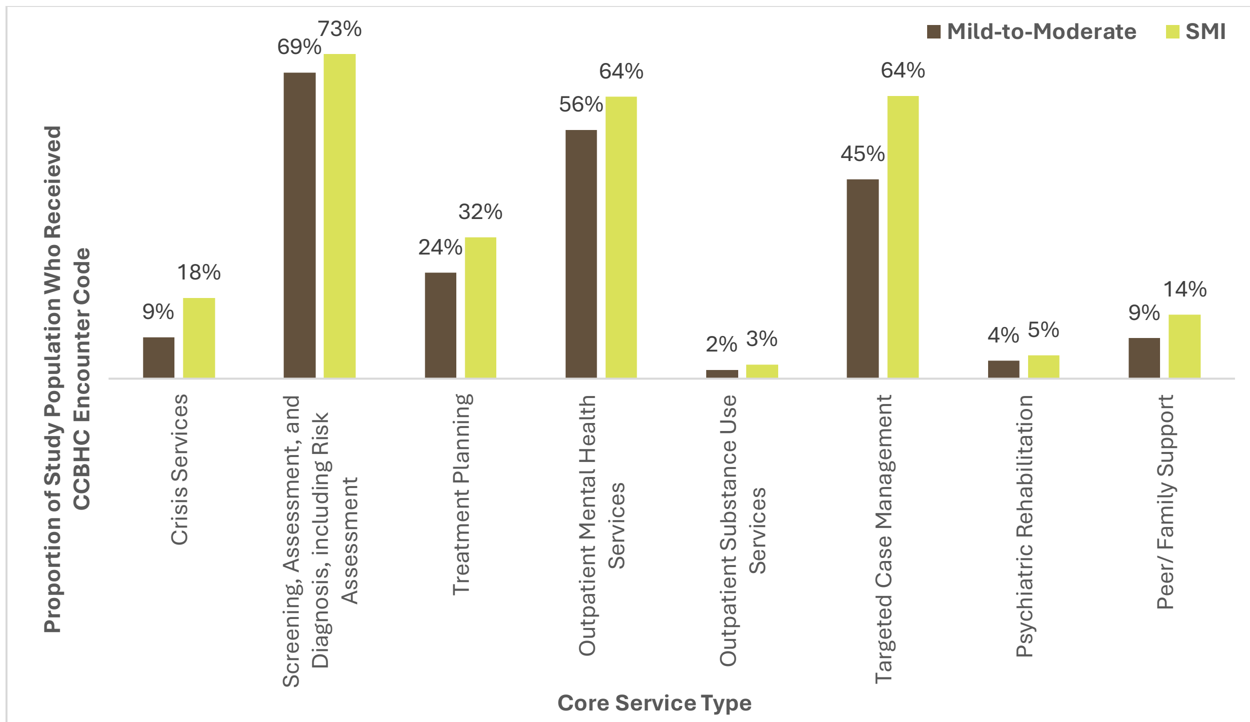


This graph shows the percentage growth of core services received in FY2022, 2023, and 2024 by the CCBHC-eligible mild to moderate and SMI populations, compared to the baseline average between FY2019-2021.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2022-2024

CHRT

Figure 15

Proportion of CCBHC Population Receiving each Core Service (Mild to moderate v. SMI, FY2024)

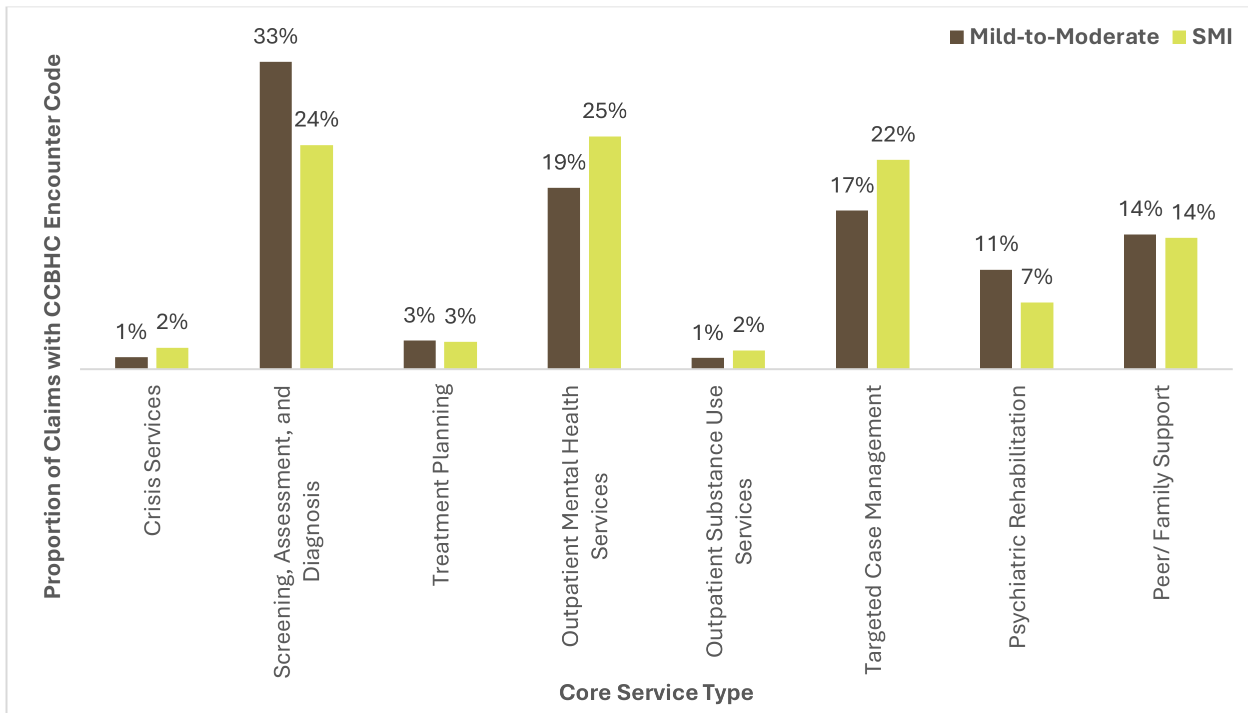


This graph shows the proportion of the CCBHC population (those who received a CCBHC Encounter Code) who received each core service type, broken out by those with mild to moderate and serious (SMI) behavioral health needs in FY2024.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2024

CHRT

Figure 16

Proportion of Claims for Each Core Service (Mild to Moderate v. SMI, FY2024)



This graph shows the proportion of claims from the CCBHC population (had a CCBHC Encounter Code) received for each core service type, with the denominator being the total core number of core service claims from the CCBHC population and is broken out by those with mild to moderate and SMI behavioral health needs in FY2024.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2024

Differences and Disparities in Core Service Utilization among Key Populations

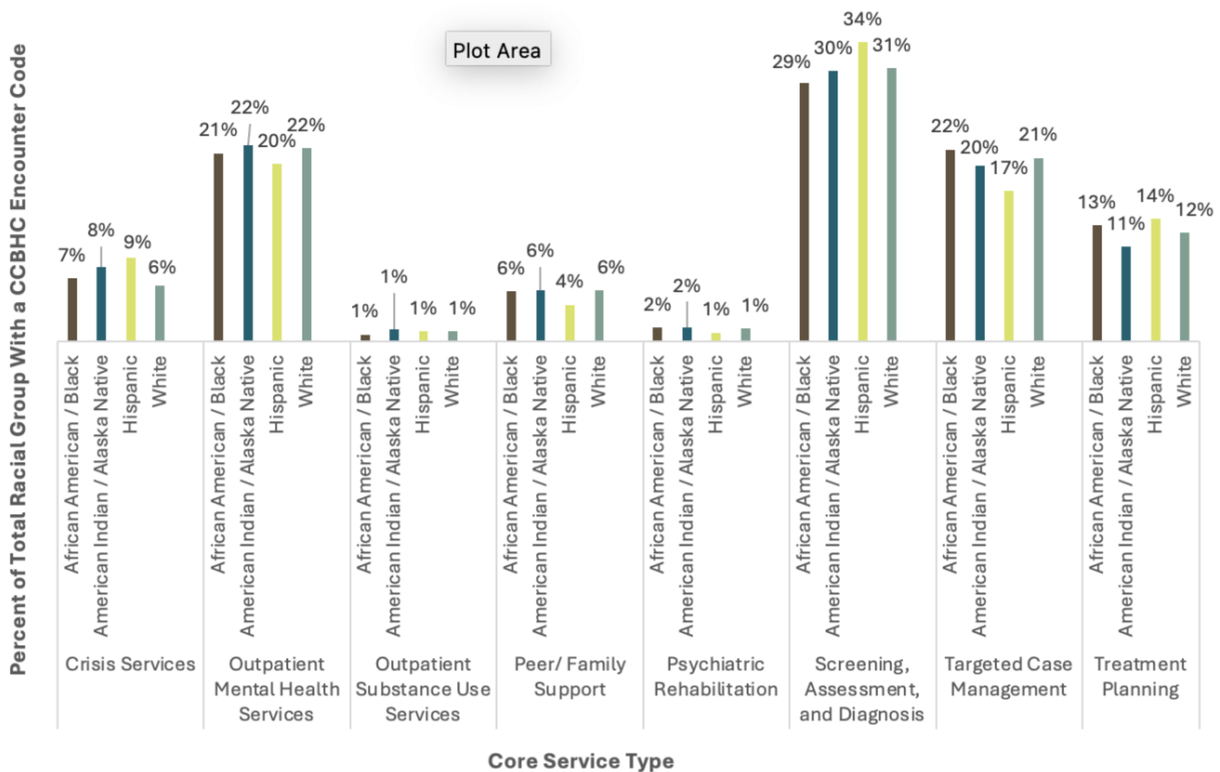
An important part of the evaluation is to understand the characteristics of persons being served by the CCBHCs and identify key differences or disparities in utilization across groups. The analysis examined the following: race/ethnicity of individual served, age of the person served, urban/rural location of the CCBHC, and veteran status of the person served. ***Across all groups, the increases in service utilization were mostly consistent with the overall trends in the larger CCBHC population, with a few notable differences.*** The analysis below shows the percent of individuals served by a CCBHC (the CCBHC population) who received core services in FY2024 and highlights key differences within the different populations. For all analysis on differences or disparities, only FY2024 (which included 17 new CCBHCs) was used to show most recent data for key populations and to better highlight differences that emerged.

Core Service Utilization by Race/Ethnicity

Overall, the distribution of core services the CCBHC population received was relatively consistent across racial groups. One notable difference: compared to other racial groups, a higher percentage of Hispanic persons received Screening, Assessment and Diagnosis Services (34% in FY2024). (See Figure 17)

Figure 17

Percentage of Individuals Receiving Each Core Service by Race/Ethnicity (FY2024)



This graph shows the percentage of each racial group that received each core service in 2024. The denominator is total individuals in each racial group with a CCBHC Demonstration Encounter Code. Further, this graph represents the four racial groups with the highest population counts. The bar heights for data labels indicating 1% may appear slightly different, as their exact values are rounded to the nearest whole number.

Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2024

Core Service Utilization by Gender

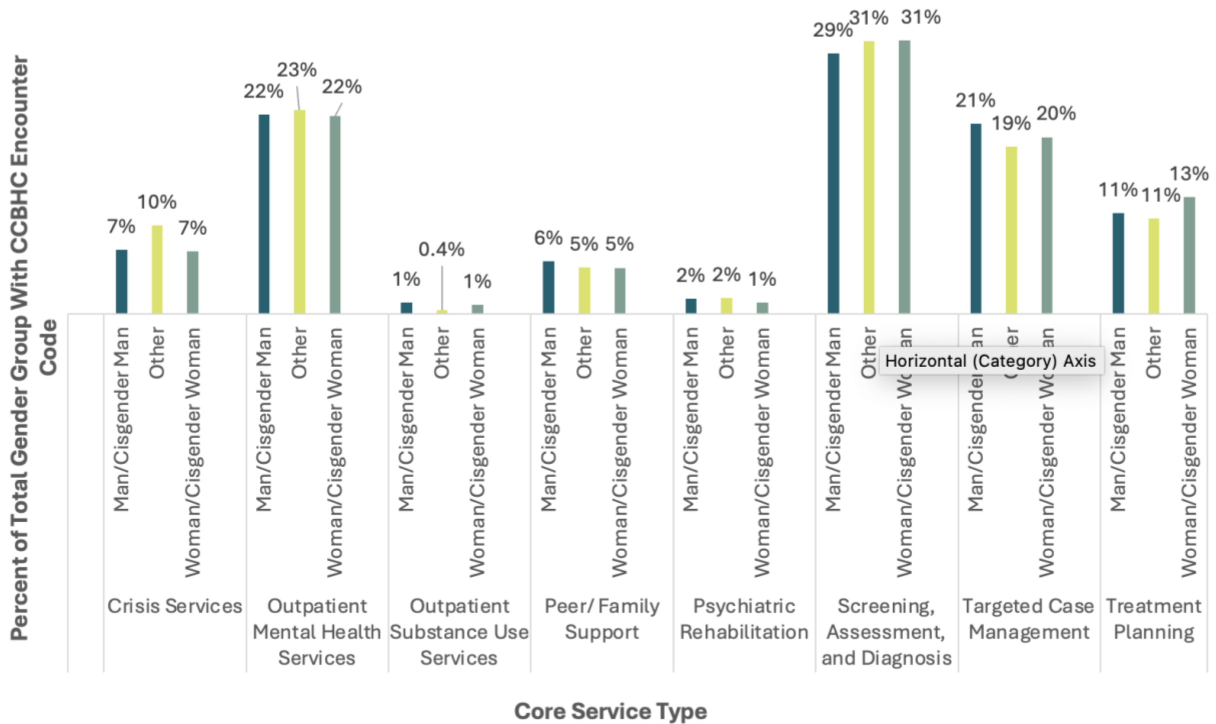
Overall, the distribution of core services among the CCBHC population was relatively consistent across gender groups (See Figure 18). Although the population counts grew

across the study period, the increases were consistent with CCBHC population growth, so the proportion did not change in a meaningful way. Two notable findings include:

- There was a slightly higher percentage of individuals in the 'other' category (which includes genderfluid, transgender and non-binary populations) who received Crisis Services in FY2024 (10%).
- There was a slightly higher proportion of women who received Treatment Planning Services in FY2024 (13%).

Figure 18

Percentage of Individuals Receiving Each Core Service by Gender (FY2024)



This graph shows the percentage of each gender group that received each core service in 2024. The denominator is total individuals in each gender group with a CCBHC Demonstration Encounter Code. The bar heights for data labels indicating 1% may appear slightly different, as their exact values are rounded to the nearest whole number.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2024

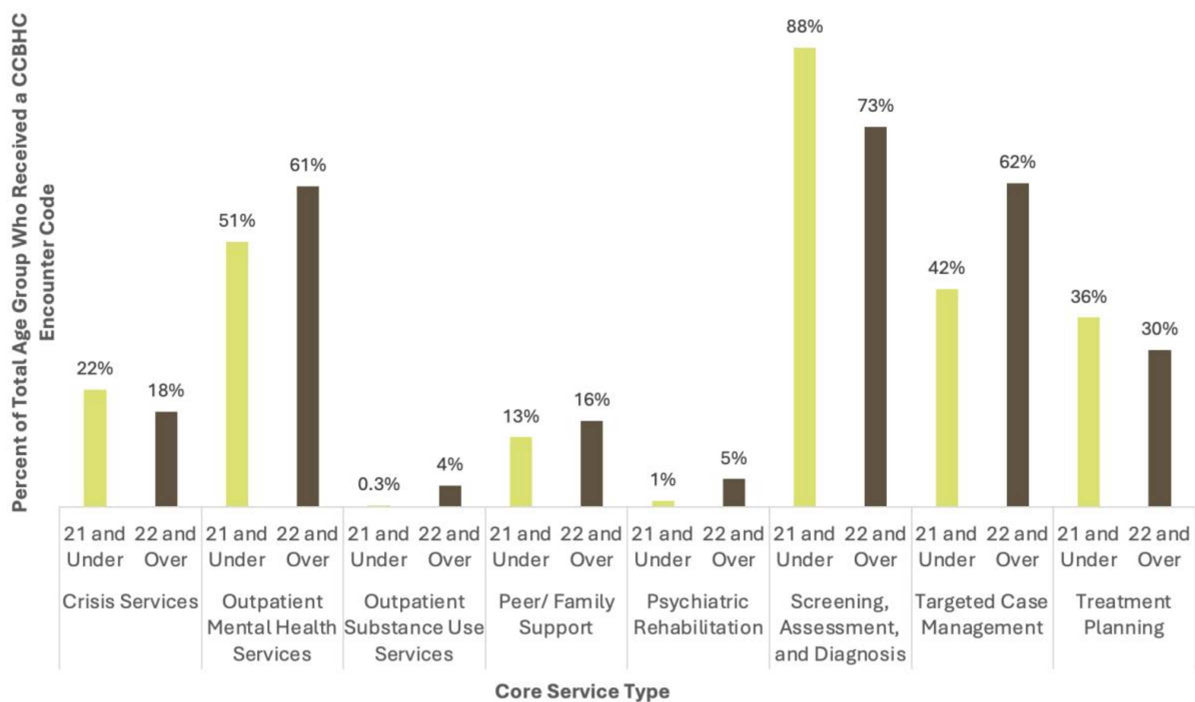
Core Service Utilization by Age

Overall, the distribution of core services utilized by the CCBHC population in FY2024 was relatively consistent across both children (21 and under) and adults (22 and over). More

children received Screening, Assessment and Diagnostic Services compared to adults. Over 60% of adults each year had Targeted Case Management Services, compared to approximately 40% of children. In addition, more children had Treatment Planning Services compared to adults (36% in 2024 compared to 30%, respectively). (See Figure 19)

Figure 19

Percentage of Children and Adults Receiving Each Core Service (FY2024)



This graph shows the percent of each age group that received each core service in 2024. The denominator is total individual adults and children with a CCBHC Demonstration Encounter Code.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2024

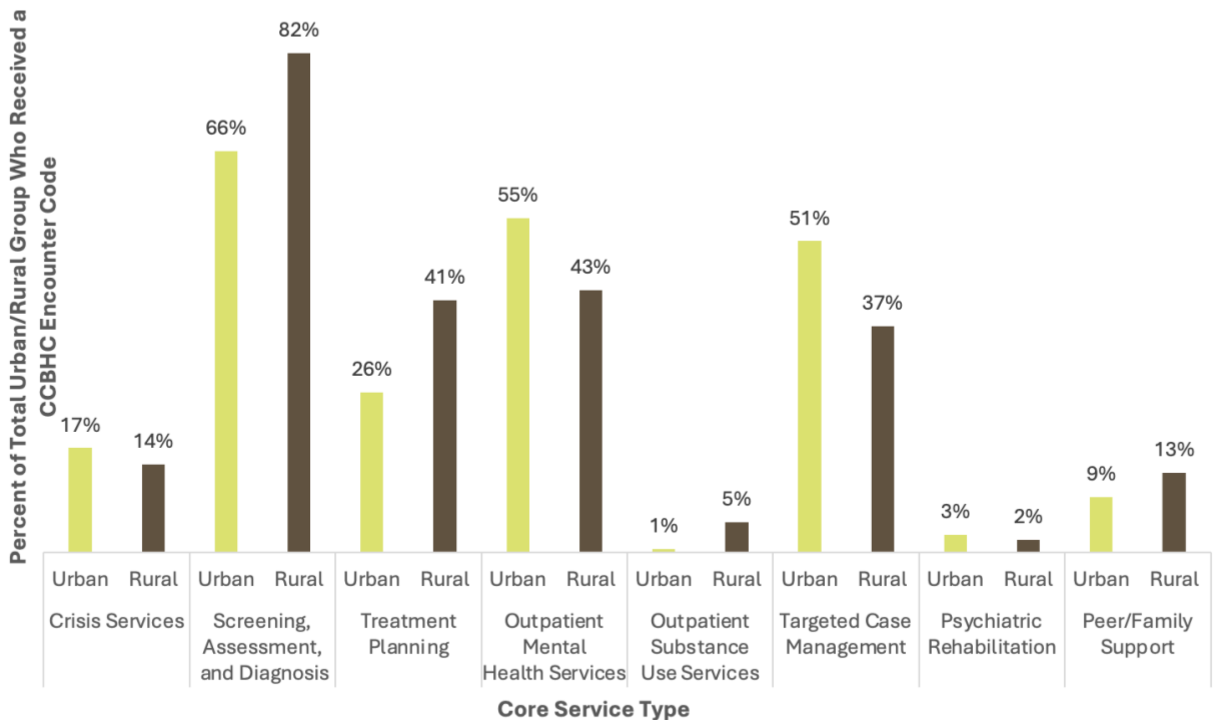
Core Service Utilization by Urban-Rural CCBHCs

Overall, the distribution of core services the CCBHC population received between FY2022 and FY2023 was relatively consistent across location designations (rural vs. urban). However, in FY2024, persons served by rural CCBHCs were more likely than those served by urban CCBHCs to receive Screening Assessment and Diagnosis Services (82%), Treatment Planning Services (41%), Peer/Family Support Services (13%), and Outpatient Substance Use Services (5%). (See Figure 20)

In FY2024, CCBHC individuals served by urban CCBHCs were significantly more likely than those served by rural CCBHCs to receive Targeted Case Management (51%), Outpatient Mental Health Services (55%), Crisis Services (17%), and Psychiatric Rehabilitation (3%). (See Figure 20)

Figure 20

Percentage of CCBHC individuals Served for Each Core Service by Urban vs. Rural CCBHCs (FY2024)



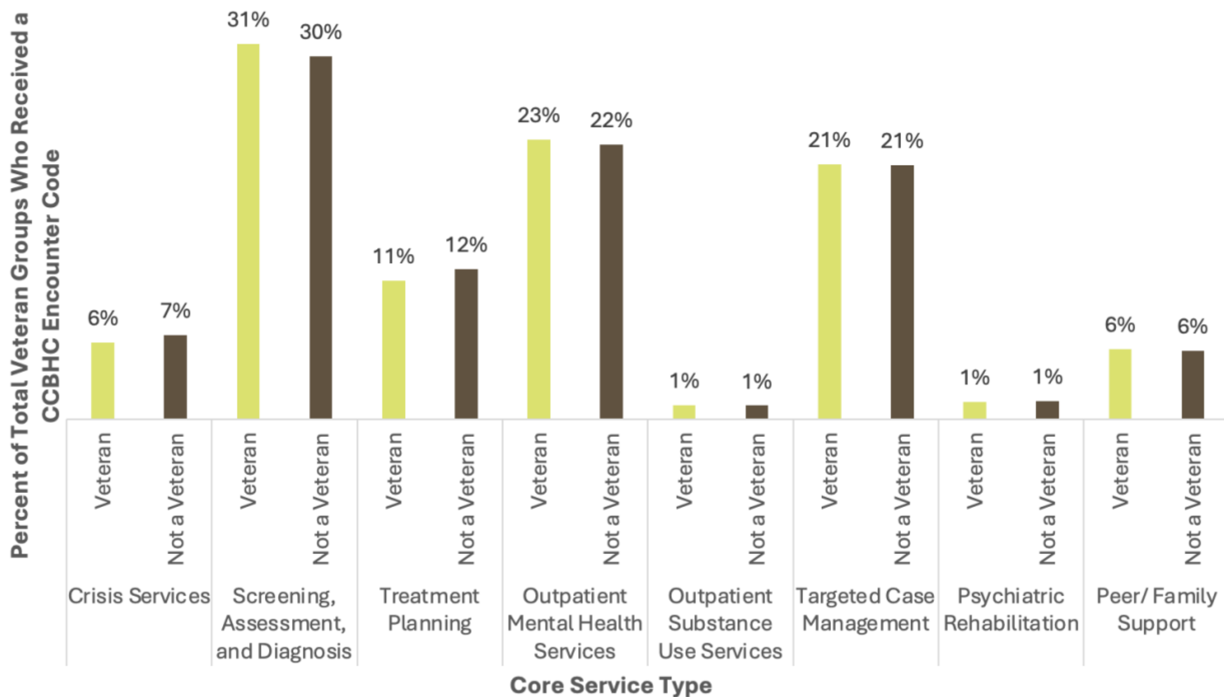
This graph shows the percent of both urban and rural groups that received each core service in 2024. The denominator is total individuals from both rural and urban sites with a CCBHC Demonstration Encounter Code.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2024

Core Service Utilization by Veteran Status

Overall, the distribution of core services the CCBHC population received from FY2022-2024 was relatively consistent across those individuals with veteran status. Although the counts increased over time, the increases were consistent with CCBHC population growth, so the proportion did not change in a meaningful way. Consistent with the overall CCBHC population, veterans were most likely to receive Screening, Assessment, and Diagnosis Services. (See Figure 21)

Figure 21

Percentage of Individuals Receiving a Core Service by Veteran Status (FY2024)



This graph shows the percentage of veteran groups that received each core service in FY2024. The denominator is total individuals in both the veteran and non-veteran groups with a CCBHC Demonstration Encounter Code. The bar heights for data labels indicating 1% may appear slightly different, as their exact values are rounded to the nearest whole number.

Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2024

Access to Behavioral Health Services by CCBHC-eligible Individuals

The evaluation next examined how the CCBHC Demonstration impacted CCBHC-eligible individuals and their ability to access core behavioral health services and be served within a CCBHC. CCBHC-eligible individuals are those with a behavioral diagnosis that makes them eligible for enrollment in CCBHC services and hence represents the total potential target population that could be enrolled in a CCBHC. The evaluation sought to assess how this population changed as a measure of how effectively CCBHCs are expanding access to behavioral health care.

Overall Trends in the CCBHC-eligible Population

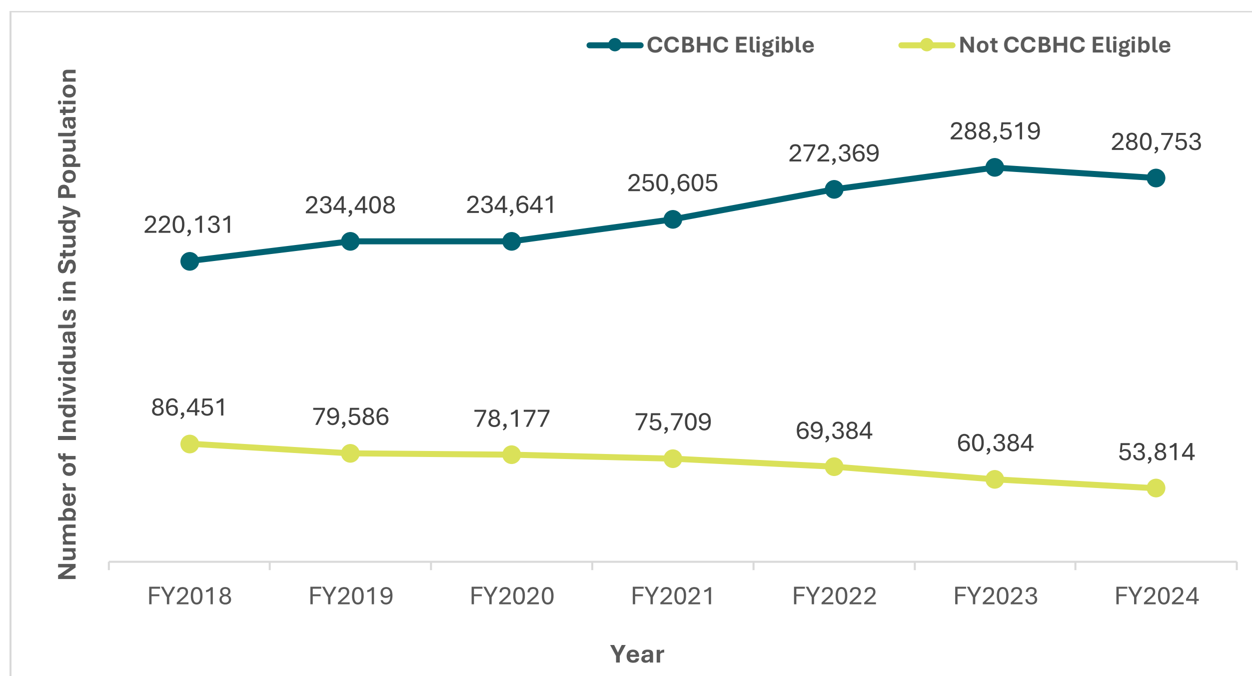
The number of CCBHC-eligible individuals increased steadily from FY2018-2023, but in FY2024 there was a slight decrease (Figure 22). However, those who were CCBHC-eligible

has steadily increased from 72% of the total study population in FY2018 to 84% of the total study population in FY2024, reflecting an estimated overall increase of 12% (Figure 23).

This increase could be attributable to two factors. First, it could reflect a growth in behavioral health needs, which was a pattern commonly observed across the US during the COVID-19 pandemic.[15] Second, it could reflect improvements in rates of screening and behavioral health diagnosis.

Figure 22

Number of CCBHC-Eligible Individuals (FY2018-2024)

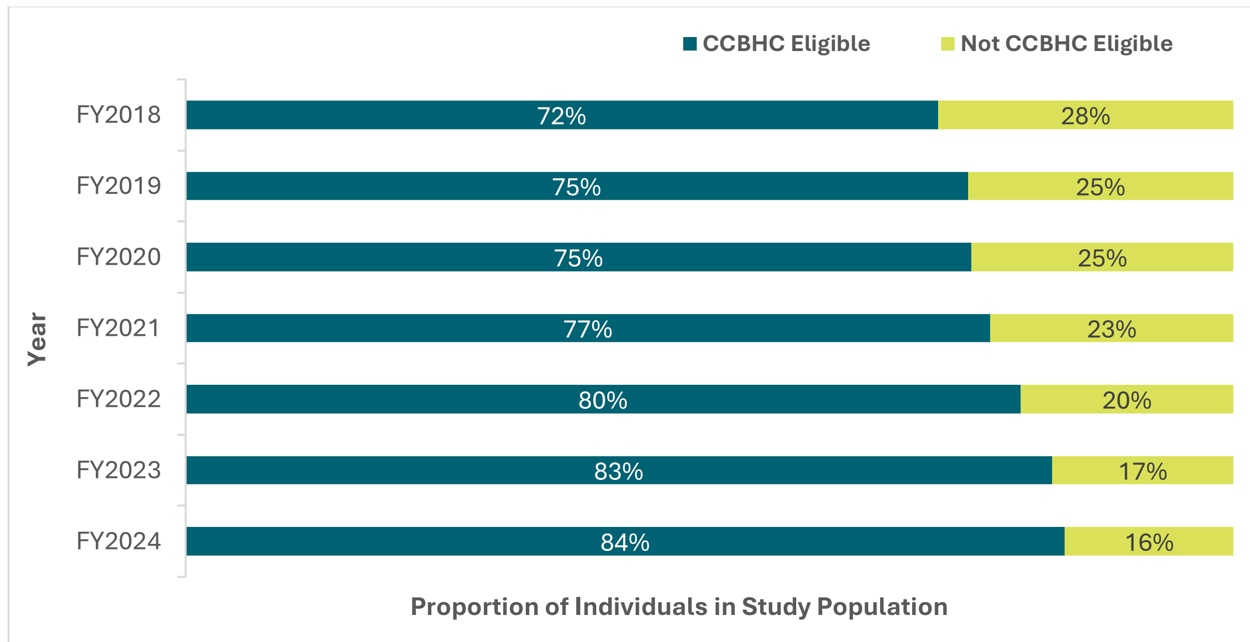


This graph shows the count of CCBHC Eligible v. not Eligible individuals between FY2018-2024. CCBHC-eligible individuals were defined by the presence of behavioral health diagnosis codes outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail). These individuals were eligible for services but may not have been enrolled in a CCBHC (indicated by presence of the CCBHC Encounter Code), hence not all eligible individuals had claims attributed to the CCBHC model.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2018-2024

[15] Panchal, N., Saunders, H., Rudowitz, R., & Cox, C. (2023, March 20). *The implications of COVID-19 for mental health and substance use*. Kaiser Family Foundation. https://www.kff.org/mental-health/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

Figure 23

Percentage of Individuals With a CCBHC-Eligible Diagnosis (FY2018-2024)



This graph represents the proportion of individuals served by CCBHC or non-CCBHC CMH service providers who have a CCBHC eligible diagnosis between FY2018-2024. CCBHC-eligible individuals were defined by the presence of behavioral health diagnosis codes outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail). These individuals were eligible for services but may not have been enrolled in a CCBHC (indicated by presence of the CCBHC Encounter code), hence not all eligible individuals had claims attributed to the CCBHC model.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2018-2024

Access to Core Behavioral Health Services by CCBHC-eligible Individuals Pre- and Post-Demonstration

Trends in the number and percentage of individuals with a CCBHC-eligible diagnosis who received a core behavioral health service were examined from FY2018-2024. This analysis shows the change over time—from Pre-Demonstration to the Demonstration period—in the number and percent of the CCBHC-eligible population who received a core service compared to those that did not receive a core service.

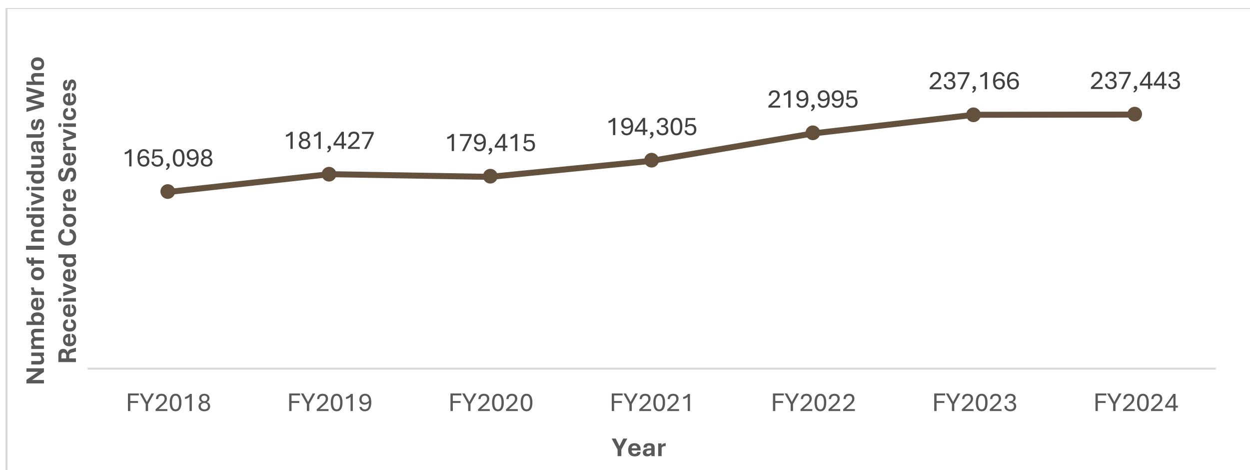
- From FY2021-2024, the percentage of CCBHC-eligible individuals who received a core service grew from 78% to 85%. The largest increase was observed in FY2022, in alignment with the initial Demonstration rollout (Figure 25).

- The number of CCBHC-eligible individuals who received a core service increased every year since 2020; however, the biggest percent growth was observed from FY2021 to FY2022 (13%) (Figure 24).

This suggests that the CCBHC Demonstration resulted in expanded access to core behavioral health services among those with a CCBHC-eligible diagnosis.

Figure 24

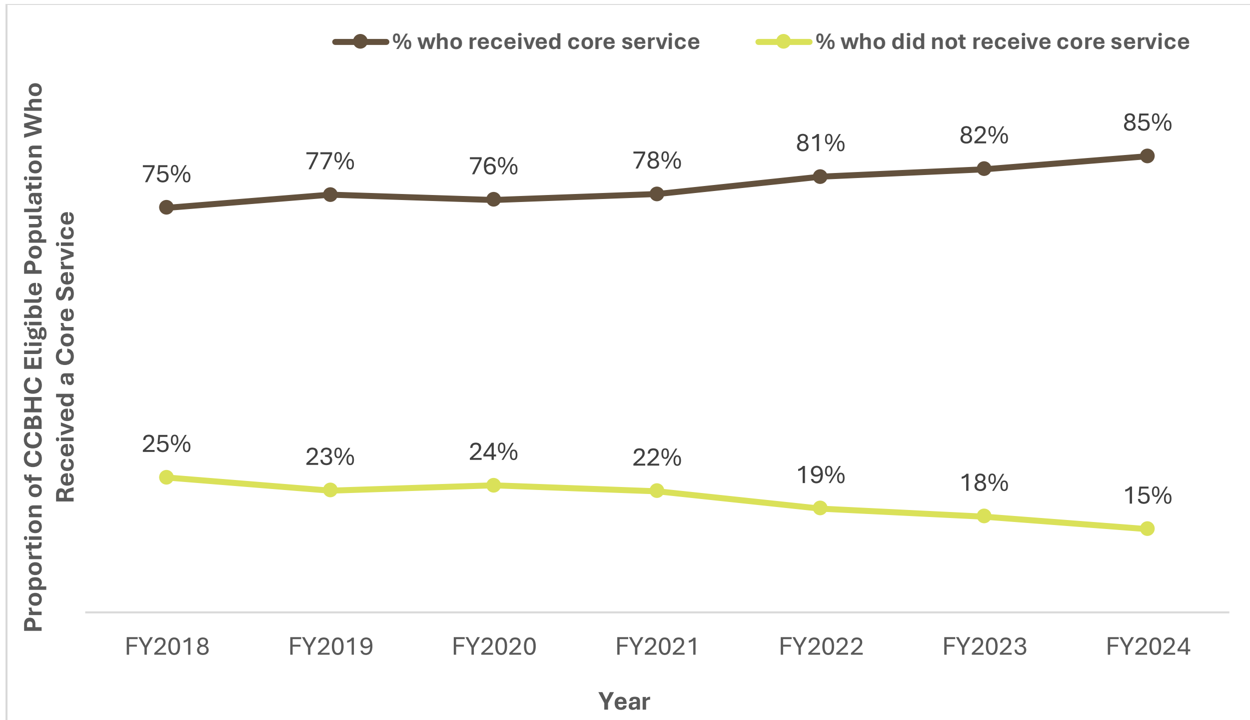
Number of CCBHC-Eligible Individuals Who Received Any Core Service (FY2018-2024)



This graph shows the number of CCBHC-eligible individuals who received a core service between FY2018-2024. CCBHC-eligible individuals were defined by the presence of behavioral health diagnosis codes outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail).
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2018-2024

Figure 25

Percent of CCBHC-Eligible Individuals Who Did v. Did Not Receive a Core Service (FY2018-2024)



This graph shows the percentage of CCBHC Eligible individuals who received a core service between FY2018-2024. CCBHC-eligible individuals were defined by the presence of behavioral health diagnosis codes outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail).
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2018-2024

Access to CCBHCs by People with a CCBHC-Eligible Diagnosis

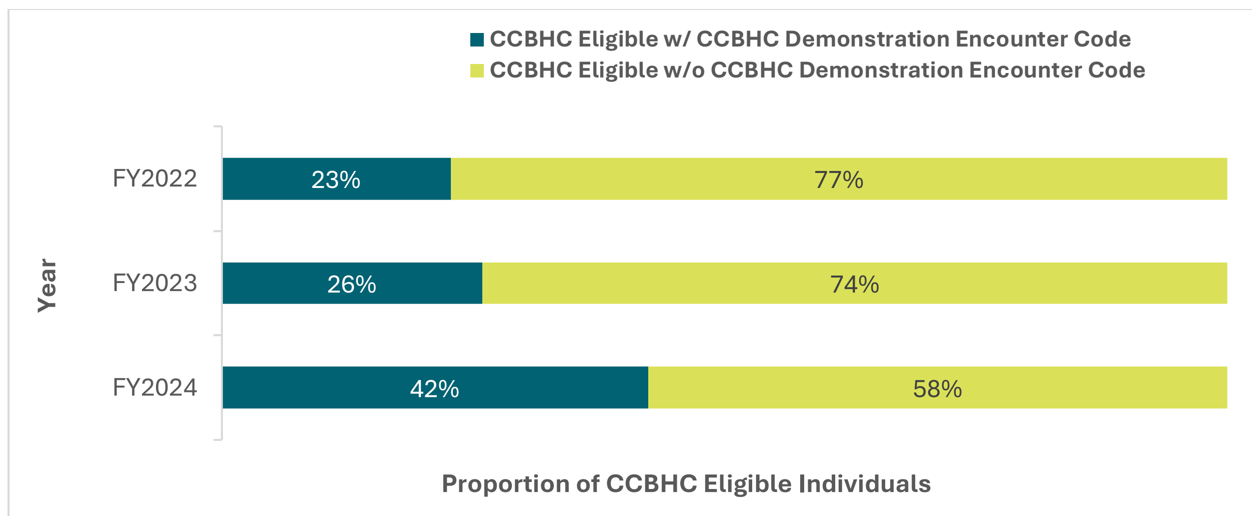
To understand how well the CCBHC-eligible population is being enrolled and served by CCBHCs, the analysis next considered the numbers and percentages of CCBHC-eligible individuals who were served by a CCBHC from FY2022-2024. Throughout this section, being served by a CCBHC is defined as the presence of a CCBHC Demonstration Encounter Code (i.e. T1040 code) which signifies enrollment in and service through a CCBHC. Analyses were limited to FY2022-2024 because CCBHC Demonstration Encounter Codes were not made available until FY2022. This analysis includes both Intervention and Expansion Groups.

Key findings include:

- The proportion of those individuals who were both CCBHC-eligible and received a CCBHC service shows a nearly 20% increase, as well as a corresponding decrease in those who are eligible but did not receive a CCBHC service (Figure 26).
- The largest increase was observed from 2023 to 2024. This likely reflects the addition of the Expansion Group sites to the Demonstration.

Figure 26

Percentage of CCBHC-Eligible Individuals with a CCBHC Demonstration Encounter Code (FY2022-FY2024)



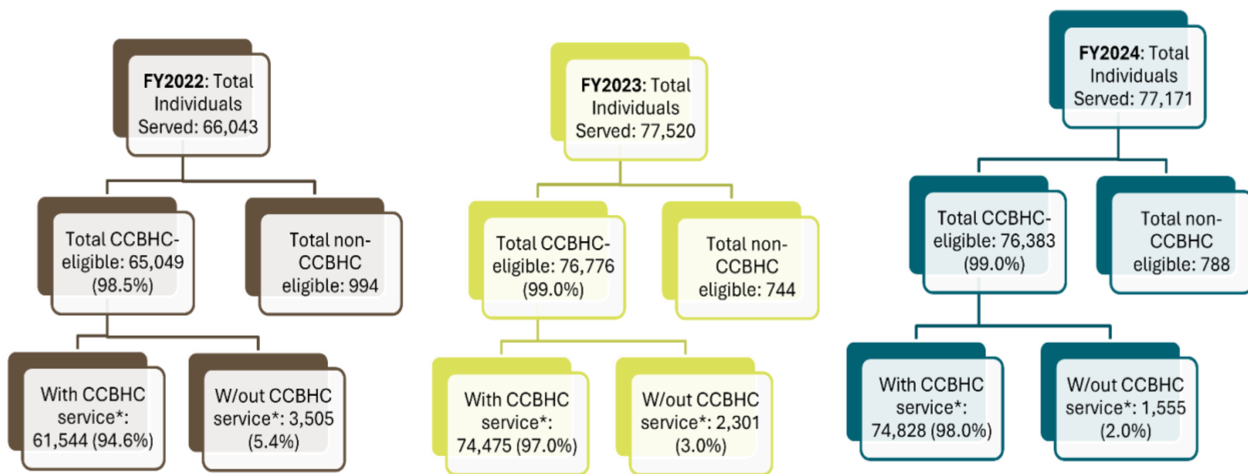
This graph shows the percentage of CCBHC-eligible individuals who also received services from a CCBHC (received a CCBHC Encounter Code) between FY2022-2024. CCBHC-eligible individuals were defined by the presence of behavioral health diagnosis codes outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail). A patient's claims were attributed to a CCBHC based on the presence of a CCBHC Demonstration Encounter Code, which designated the service as covered under the CCBHC model's payment structure as opposed to regular Medicaid.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2022-2024

Access to CCBHC Services Among the Intervention Group Individuals

Nearly all CCBHC-eligible individuals served by the Intervention Group had a CCBHC service in FY2024 (98%). This represents a 3.4% increase from the start of the intervention phase in FY2022, where 94.6% of the CCBHC-eligible population received a CCBHC service. (See Figure 27)

Figure 27

Change in Percentage of CCBHC-Eligible Population in the Intervention Phase, Intervention Group Only (FY2022 - FY2024)



CCBHC service is defined by any presence of CCBHC Demonstration Encounter Code which designated the service as covered under the CCBHC model's payment structure as opposed to regular Medicaid.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2022-2024

Overall, CCBHCs have done very well at identifying eligible individuals and enrolling them in a CCBHC with marked improvement since FY2022. There remains opportunity for improvement, most likely within the Expansion Group as those CCBHCs are not as far along in implementation as those in the Intervention Group, which started two years earlier. This is evidenced by comparing the overall totals and percentages (which include both groups) of CCBHC-eligible individuals being served in a CCBHC (Figure 26) with those totals and percentages only in the Intervention Group, where nearly all CCBHC-eligible individuals have been served by a CCBHC. (Figure 27)

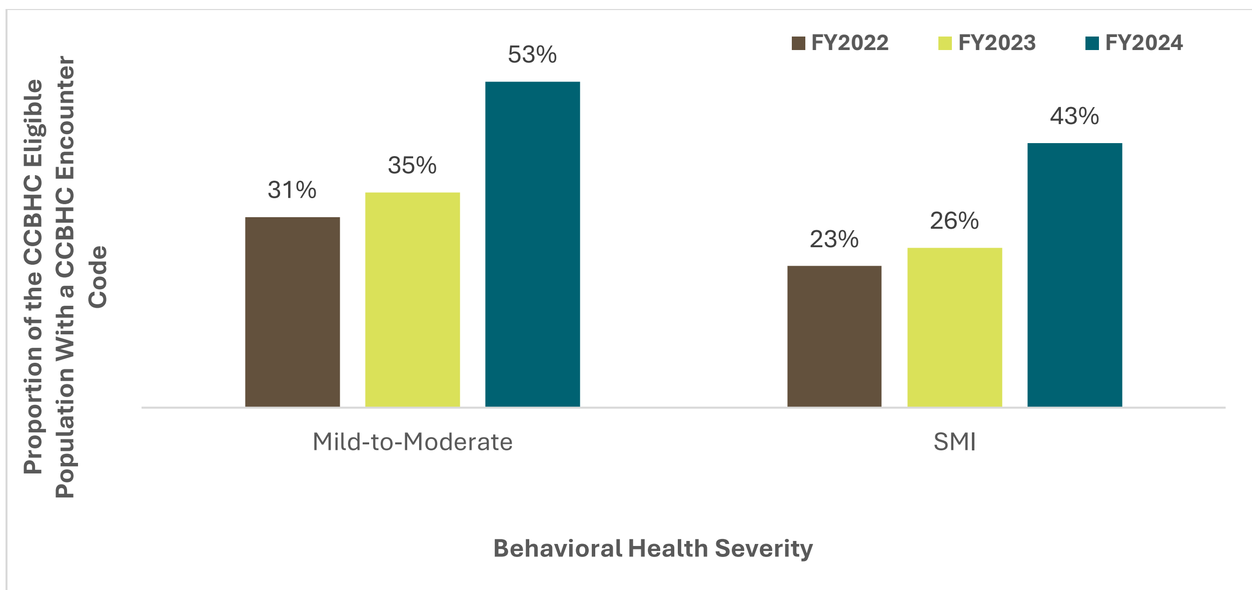
Access Differences by Severity of Behavioral Health Needs

The ability of individuals with mild to moderate behavioral health needs to access CCBHC services is a pivotal feature of the CCBHC model and is key to expanding access to behavioral health services in Michigan. CCBHCs have been successful at including this population in its service model as both evidenced from qualitative interviews with the CCBHC and PIHP staff and from the claims analysis.

The proportion of CCBHC-eligible individuals who received a CCBHC service increased for both mild to moderate individuals and those with serious mental illness (SMI) between FY2022-2024. The proportion was consistently higher among mild to moderate individuals (31% in FY2022, 35% in FY2023, and 53% in FY2024) compared to SMI individuals (23% in FY2022, 26% in FY2023, and 43% in FY2024). (Figure 28).

Figure 28

Percentage of CCBHC-Eligible Population with CCBHC Services, by Severity (FY2022-FY2024)



This graph shows the proportion of the CCBHC-eligible population with a CCBHC Encounter Code broken up by mild to moderate and serious mental illness (SMI) behavioral health designations. CCBHC-eligible individuals were defined by the presence of behavioral health diagnosis codes outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail). A patient's claims were attributed to a CCBHC based on the presence of a CCBHC Demonstration Encounter Code, which designated the service as covered under the CCBHC model's payment structure as versus regular Medicaid.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2022-2024

Differences and Disparities in Access to CCBHCs among Key Populations

An important part of the evaluation is to understand the characteristics of persons being served by the CCBHCs and identify key differences or disparities. The analysis of access to CCBHC services also examined race/ethnicity of individual served, age of the person served, urban/rural location of the CCBHC, and veteran status of the person served.

Access Differences by Race-Ethnicity

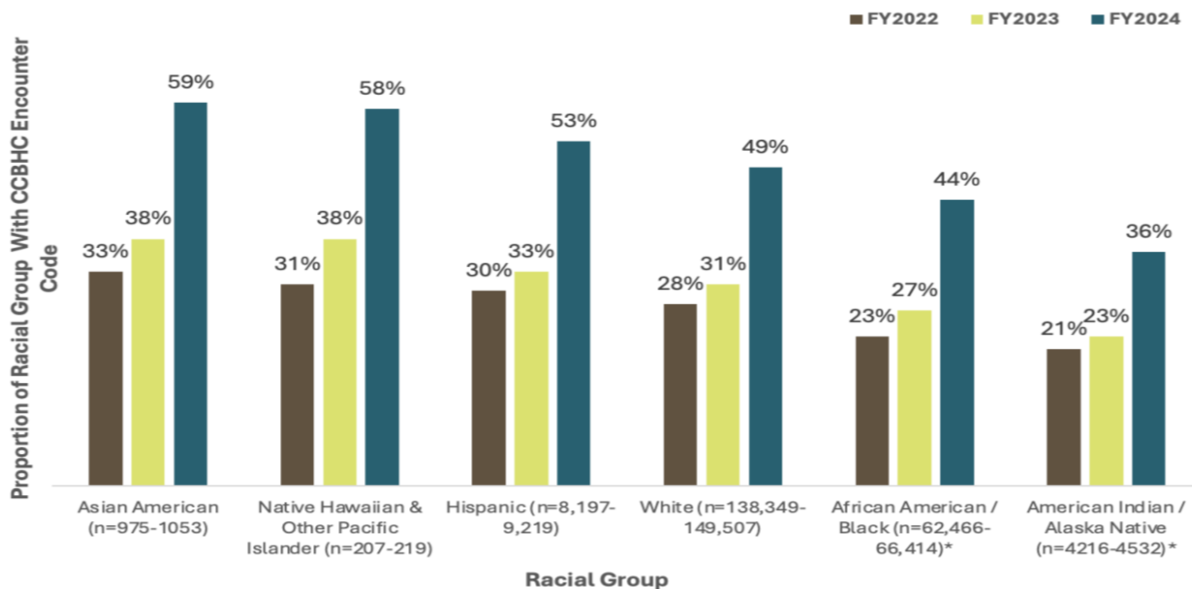
The percentage of CCBHC-eligible individuals of all racial groups who received a CCBHC service increased between FY2022-2024, especially between 2023 and 2024 (Figure 29). This aligns with the overall population trend and reflects the overall growth of the CCBHC Demonstration and the number of sites. Notable differences include:

- A greater percentage of Asian American, Native Hawaiian/Other Pacific Islander, and Hispanic individuals received CCBHC services compared to White individuals.
- African American/Black and American Indian/Alaskan Native individuals who were CCBHC-eligible were less likely to receive CCBHC services compared to other racial/ethnic groups.

These differences may be attributable to the inclusion of a specific region or a relatively large CCBHC in the FY2024 expansion and should be further investigated to better understand this trend.

Figure 29

Percentage of CCBHC-Eligible Individuals who had a CCBHC Demonstration Encounter Code, by Race/Ethnicity (FY2022-FY2024)



This graph shows the proportion of each racial group with a CCBHC Encounter Code out of all CCBHC-eligible individuals in that racial group. CCBHC-eligible individuals were defined by the presence of behavioral health diagnosis codes outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail). An individual patient's claims were attributed to a CCBHC based on the presence of a CCBHC Demonstration Encounter Code, which designated the service as covered under the CCBHC model's payment structure as opposed to regular Medicaid. Of those who were CCBHC-eligible, American Indian/Alaskan Native and Black/African American individuals were significantly less likely to have a CCBHC Encounter Code than other races in 2022, 2023, and 2024. Pearson Chi-Square tests with post-hoc analyses showed these differences by race to be statistically significant at the $p<0.05$ level.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2022-2024

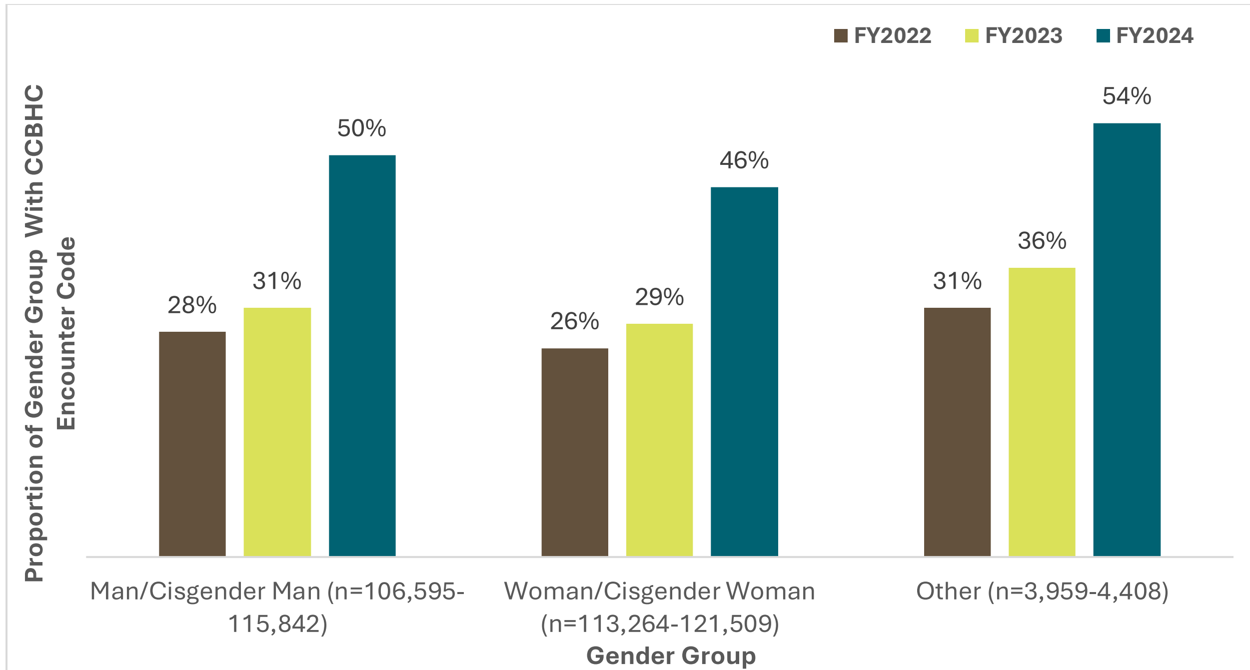
Access Differences by Gender

The percentage of CCBHC-eligible individuals who received a CCBHC Service increased between FY2022-2024 across genders, with a notable jump in CCBHC services across all groups between FY2023 and FY2024 (Figure 30). Individuals in the 'Other Gender' category were more likely to have a CCBHC service, while Women/Cisgender Women were less likely to have been served by a CCBHC. [16]

[16] The 'other' gender category included those who identified as agender, bigender, gender questioning, genderfluid, non-binary/genderqueer, transgender man, transgender woman, two spirit, and androgynous.

Figure 30

Percentage of CCBHC-Eligible Individuals with a CCBHC Demonstration Encounter Code by Gender (FY2022-FY2024)[17]



This graph shows the proportion of each gender group with a CCBHC Encounter Code out of all CCBHC-eligible individuals in that gender group. CCBHC-eligible individuals were defined by the presence of behavioral health diagnosis codes outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail). An individual patient's claims were attributed to a CCBHC based on the presence of a CCBHC Demonstration Encounter Code, which designated the service as covered under the CCBHC model's payment structure as opposed to regular Medicaid.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2022-2024

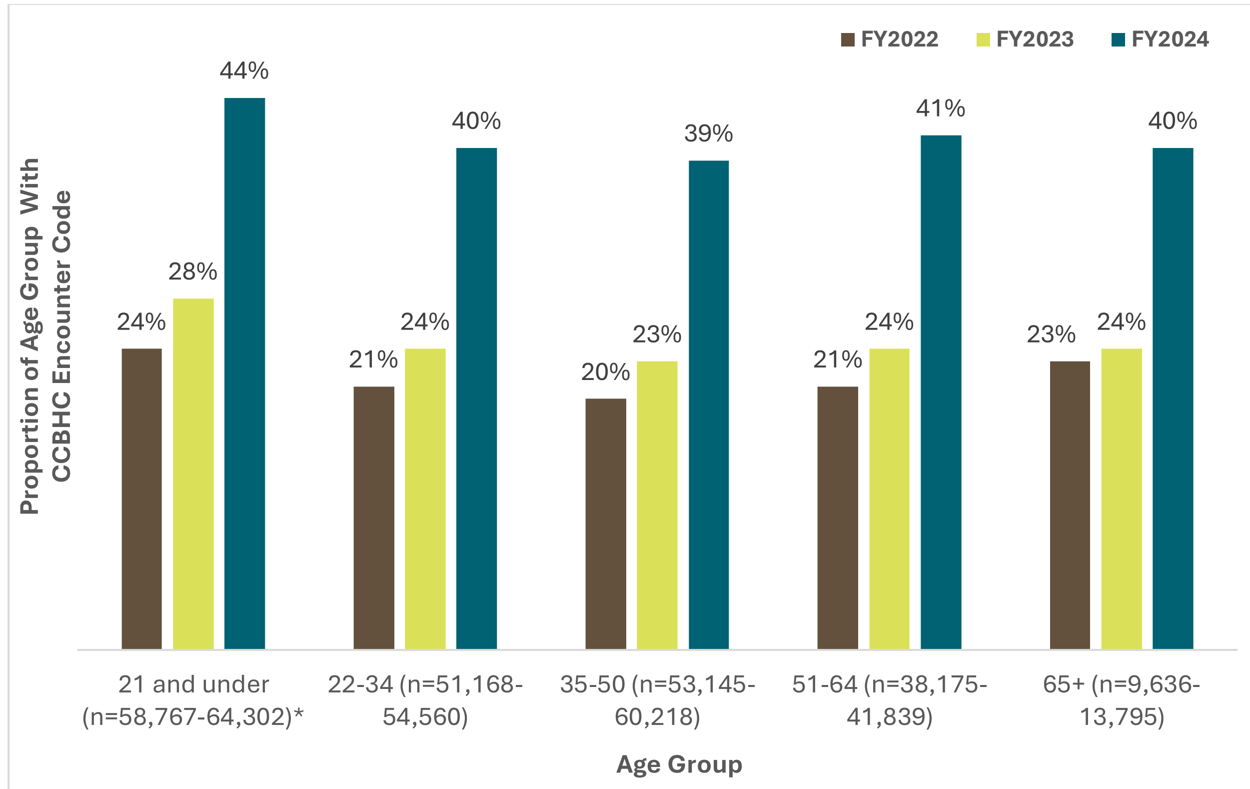
Access Differences by Age

The percentage of CCBHC-eligible individuals in each age group who received a CCBHC service increased between FY2022-2024, especially between 2023 and 2024. Across all years, CCBHC-eligible individuals who were 21 and under were more likely than older individuals to have received a CCBHC service. (Figure 31)

[17] The 'other' gender category included those who identified as agender, bigender, gender questioning, genderfluid, non-binary/genderqueer, transgender man, transgender woman, two spirit, and androgynous.

Figure 31

Percentage of CCBHC-Eligible Individuals with a CCBHC Demonstration Encounter Code, by Age Group (FY2022-2024)



This graph shows the proportion of each age group with a CCBHC Encounter Code out of all CCBHC-eligible individuals in that age group. CCBHC eligible individuals were defined by the presence of behavioral health diagnosis codes outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail). An individual patient's claims were attributed to a CCBHC based on the presence of a CCBHC Demonstration Encounter Code, which designated the service as covered under the CCBHC model's payment structure as opposed to regular Medicaid. Pearson Chi-Square tests with post-hoc analyses show statistically significant differences between children and adults across all years at the $p<0.05$ level (Exception: no significant difference in proportion with CCBHC Encounter Code between 21 and under and 65+ in 2022).
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2022-2024

Access Differences by Urban-Rural CCBHCs

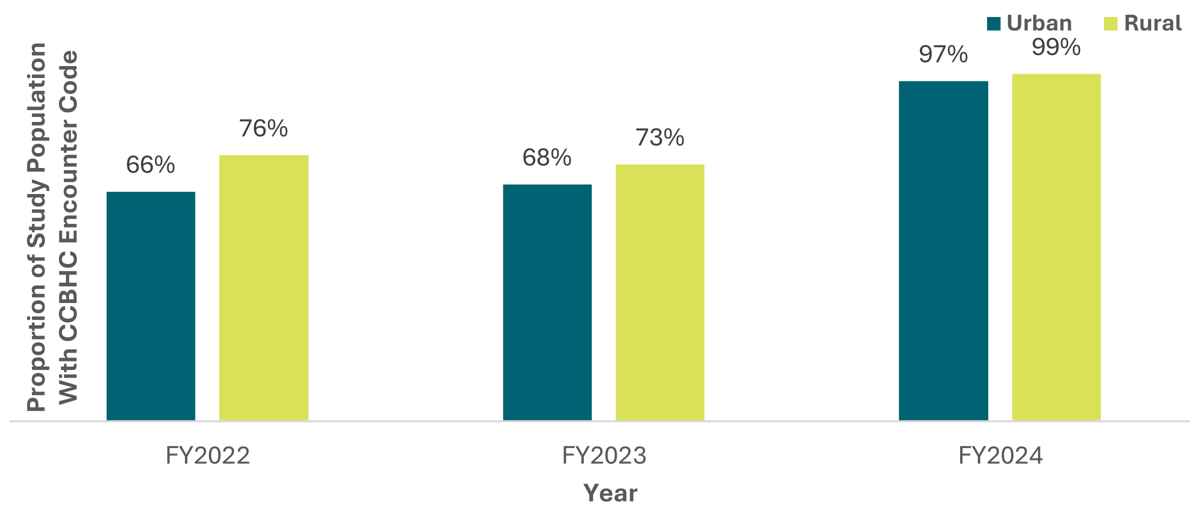
Across all years, CCBHC-eligible individuals served by rural sites were more likely to have received a CCBHC service. (Figure 32)

The overall patterns for urban and rural sites were similar. The percentage of CCBHC-eligible individuals served by rural and urban sites who received a CCBHC service remained stable from FY2022-2023 and then experienced a large increase from 2023 to

2024. This likely reflects the addition of the Expansion Group sites to the Demonstration. By 2024, almost all CCBHC-eligible individuals were served by CCBHCs regardless of geographic location.[18]

Figure 32

Percentage of CCBHC-Eligible Individuals Served by Urban vs. Rural sites with a CCBHC Demonstration Encounter Code (FY2022-2024)[19,20]



This graph shows the proportion of the CCBHC-eligible population with a CCBHC Encounter Code by urban and rural CCBHC sites out of the total CCBHC-eligible population. CCBHC eligible individuals were defined by the presence of behavioral health diagnosis codes outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail). An individual patient's claims were attributed to a CCBHC based on the presence of a CCBHC Demonstration Encounter Code, which designated the service as covered under the CCBHC model's payment structure as opposed to regular Medicaid.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2022-2024

Access Differences by Veteran Status

The percentage of CCBHC-eligible veterans who received a CCBHC service increased between FY2022-2024, especially between FY2023-2024. The proportion of veterans served by CCBHCs almost doubled, from 25% in FY2022 to 47% in FY2024 (Figure

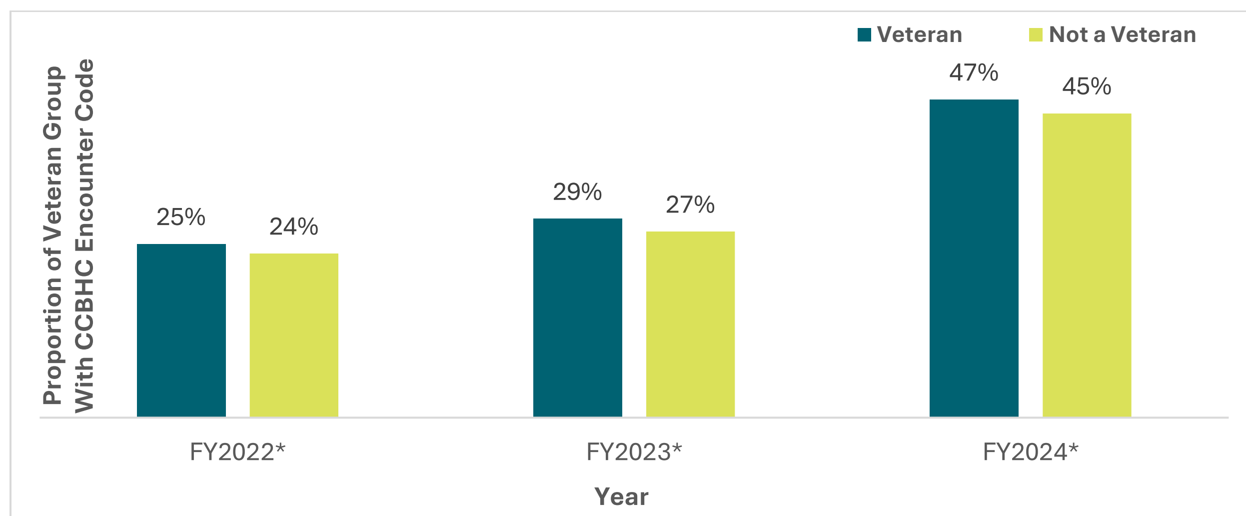
[19] Only CCBHC-eligible individuals served by the Intervention Group or the Expansion Group sites are included in these analyses. This is because categorizing non-CCBHC CMH sites in the comparison group as urban or rural was beyond the scope of this report.
[20] Individuals who received services from both urban and rural sites in the Intervention and Expansion groups are included in both denominators for each fiscal year. Only CCBHC-eligible individuals served by the Intervention Group or the Expansion Group sites are included in these analyses. CCBHC eligible individuals were defined by the presence of behavioral health diagnosis codes outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail). An individual patient's claims were attributed to a CCBHC based on the presence of a CCBHC Demonstration Encounter Code, which designated the service as covered under the CCBHC model's payment structure as opposed to regular Medicaid.

35). Overall rates of CCBHC service use among veterans were consistent with the non-veteran population.

CCBHCs have done well at including veterans or those with connection to the armed services into CCBHCs, nearly doubling this population since FY2022. This also reflects the overall growth in access to CCBHCs among the general population, which is further supported by the addition of 17 new CCBHCs in the Expansion Group.

Figure 33

Percentage of CCBHC-Eligible Veterans with a CCBHC Demonstration Encounter Code, (FY2022-2024)[21]



This graph shows the proportion of each veteran group (veterans and non-veterans) who received CCBHC services (received a CCBHC Encounter Code) out of all CCBHC-Eligible individuals between FY2022 and 2024. Of those who were CCBHC Eligible, veterans were significantly more likely to have a CCBHC Encounter Code than non-veterans in FY2022, 2023, and 2024.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2022-2024

Patient Outcomes—Emergency Department (ED) Utilization

One of the underlying goals of the CCBHC Demonstration is to improve both behavioral and physical health outcomes and in so doing avoid more costly and potentially avoidable utilization of emergency department (ED) services. Frequent or avoidable use of ED services can indicate underlying issues with accessing routine primary or preventive care for both medical and behavioral health conditions. In this section, the impact of the CCBHC Demonstration on ED utilization is examined as a health outcome measure to

[21] CCBHC eligible individuals were defined by the presence of behavioral health diagnosis codes outlined in the CCBHC Demonstration Handbook (see Appendix C for more detail). An individual patient's claims were attributed to a CCBHC based on the presence of a CCBHC Demonstration Encounter Code, which designated the service as covered under the CCBHC model's payment structure as opposed to regular Medicaid.

assess the extent to which it improves the overall health of CCBHC service recipients. To measure ED utilization, the analysis used a measure of total ED visits per 1,000 patient months.[22] This measure is commonly used by the Centers for Medicare and Medicaid Services (CMS) to track trends in all-cause ED usage for Medicaid beneficiaries.[23] For this analysis, pre-Demonstration and Demonstration periods were determined at an individual level based on whether an ED visit occurred before or after an individual's first CCBHC service (noted by presence of the CCBHC Demonstration Encounter Code 'T1040'). This was necessary to calculate patient months, which serves as the measure's denominator.[24]

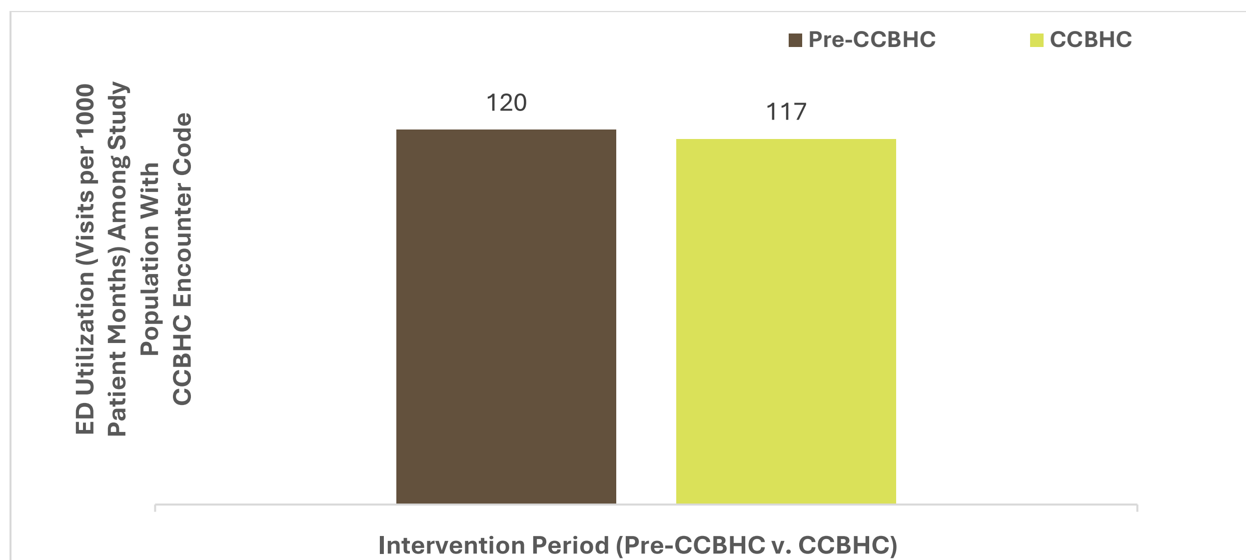
Pre-Demonstration and Demonstration Period Overall Change in ED Utilization for Individuals Served by a CCBHC

In assessing change in the pre-Demonstration and Demonstration periods, a small but significant decline of 2.4% in ED utilization was observed for the overall CCBHC population (i.e., includes both the Intervention and Expansion Groups). (Figure 36)

[22] Unique ED Visits were identified by procedure codes within the range 99281 – 99285
The timeframe for the denominator (total patient months) includes total eligible Medicaid months from FY2019 to FY2024 (10/1/2018 – 9/30/2024) from individuals before and after receiving CCBHC services (identified by date of first 'T1040' procedure code).
Total eligible Medicaid months were used to calculate patient months, since the ED procedure codes are not present for non-Medicaid individuals in the claims dataset.
[23] https://mmshub.cms.gov/sites/default/files/State-LevelAll-CauseEDUtilization-PublicComment-MeasureInformationForm.pdf
[24] Claims data from 2018 was excluded from the calculation of ED Utilization as information on Medicaid-eligible months for that year was unavailable during the time of analysis.

Figure 34

Pre- and Post-Demonstration Change in Emergency Department Utilization Among Individuals Served by a CCBHC, Intervention and Expansion Groups (1000 x Total ED Visits/Total Patient Months), 2019-2024[25]



This graph shows Emergency Department (ED) utilization both before individuals received their first CCBHC Encounter Code and after they received this code, denoting that they began to receive CCBHC specific services. A decline of 2.4% in ED Utilization (from 120 to 117) was observed for the overall CCBHC population. A paired t-test shows this change to be significant at the p <.0001 level.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, FY2019-2024

Pre-Demonstration and Demonstration Period Differences in ED Utilization by Severity of Behavioral Health Need

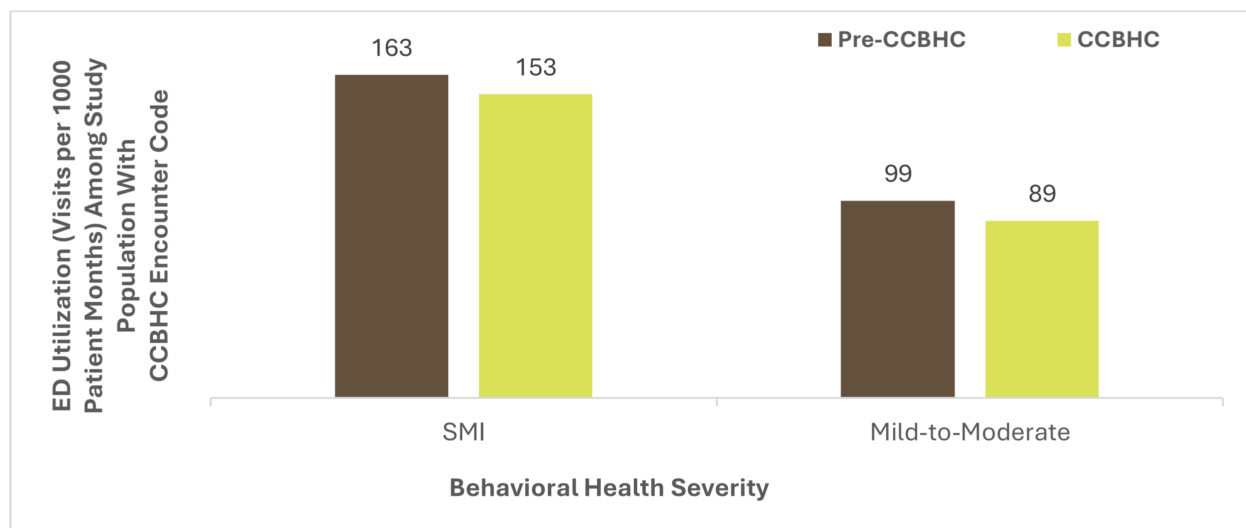
To see if the impact of receiving a CCBHC service on ED utilization varied depending on the severity of individuals' behavioral health needs, individuals were grouped as either "mild to moderate" or "SMI" based on their LOCUS assessment scores and rates of ED utilization for each group were compared. [26] The analysis showed reductions in ED utilization for both groups, with a more pronounced decrease observed among individuals with SMI compared to those with mild to moderate needs. ED utilization decreased for individuals across both

[25] For this analysis, pre-CCBHC and CCBHC periods were determined at an individual level based on whether an ED visit occurred before or after an individual's first CCBHC Demonstration Encounter Code. This was necessary to calculate patient months, which serves as the measure's denominator.
[26] Individuals with missing LOCUS assessment scores were removed from stratification analysis. This resulted in the removal of 187,943 ED visits and 2,746,880 patient months from the overall total. Individuals whose severity changed during the timeframe (i.e. has presence of two or more severity values) were removed from stratification analysis due to ambiguity in determining patient months before and after change in severity. (10,854 out of 99,700 individuals were removed)

categories, with the highest percentage decrease occurring for SMI individuals (10% decrease), while mild to moderate individuals experienced a 6% decrease. (Figure 37)

Figure 35

Pre- and Post-Demonstration Emergency Department Utilization by Severity of Behavioral Health Diagnosis. 2019-2024[27]



This graph shows Emergency Department (ED) utilization both before a patient received a CCBHC Encounter Code and after they received this code, denoting that they began to receive CCBHC specific services, broken out by behavioral health severity.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2019-2024

Pre-Demonstration and Demonstration Period Differences in ED Utilization by Mental Health and Physical Health Diagnoses

To better understand reasons behind ED utilization among CCBHC individuals, the analysis examined whether the primary diagnosis assigned to an ED visit was behavioral- or physical health-related. Behavioral health was defined as a visit with an ICD-10 primary diagnosis code that included a variety of behavioral health- and substance use-related diagnoses. [28,29]. Any primary diagnosis not attributed to behavioral health was then assigned to the physical health group. While additional refinement may be necessary for

[27] For this analysis, pre-CCBHC and CCBHC periods were determined at an individual level based on whether an ED visit occurred before or after an individual's first CCBHC Demonstration Encounter Code. This was necessary to calculate patient months, which serves as the measure's denominator. Emergency Department Utilization was measured as total ED visits per 1000 patient months.

[28] Unique ED Visits were identified by distinct combinations of (1) an individual's unique ID and (2) service date for each claim line with an ED procedure code. Depending on how a unique ED visit is identified as above, some individuals received both a behavioral health and physical health primary diagnosis on the same day, especially if they had claims submitted from multiple providers. A total of 47,197 ED Visits included both a behavioral health and physical health primary diagnoses.

[29] The ICD-10 diagnosis codes used for this analysis were in the F01-F99 range. A full list of ICD-10 diagnosis codes can be found at https://www.cms.gov/medicare/coordination-benefits-recovery/overview/icd-code-lists

this metric, it is slightly more nuanced than all-cause ED visit data and provides a high-level indication of potential reasons for ED visits and of the potential impact of CCBHCs on ED utilization.

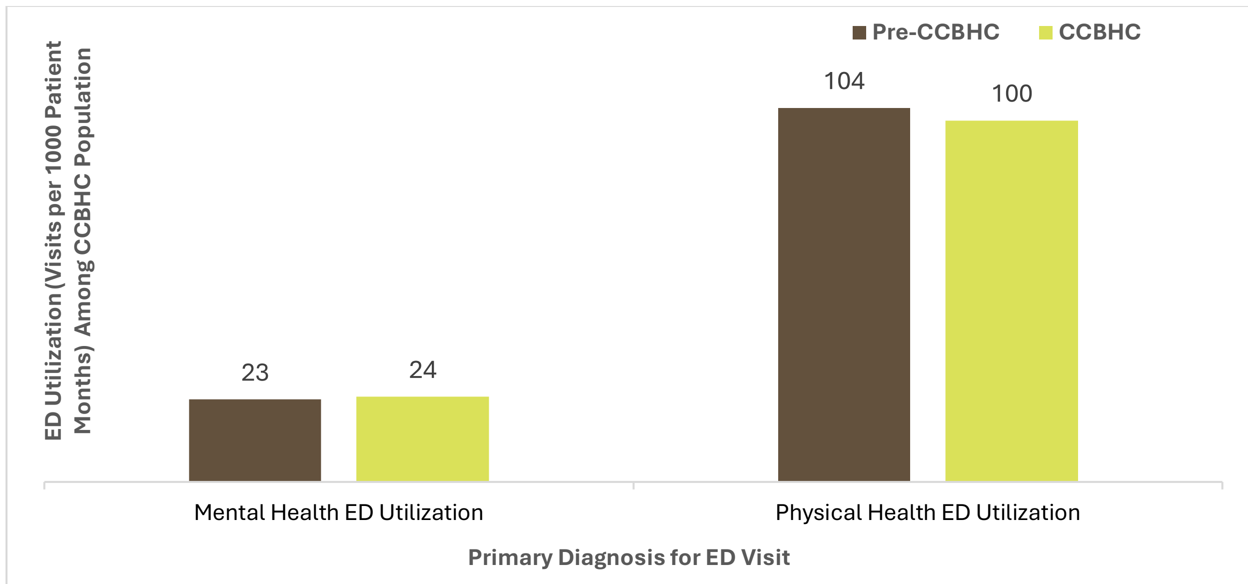
The analysis shows that CCBHCs have mixed impact on ED utilization for both physical and behavioral health groups:

- Physical Health ED utilization decreased for individuals served by a CCBHC by 3.4%, but;
- Behavioral Health ED utilization increased for individuals served by a CCBHC by 3.3%.(Figure 38)

This mixed result could be attributed to the inclusion of both the Intervention and Expansion Groups in this analysis where the Expansion Group started implementation two years later than the Intervention Group and may not have yet realized impact. It also could be that it is difficult for the ED utilization metric to show an impact in a relatively short time span given the complexities of co-morbidities and social factors that can influence health outcomes. This will warrant further investigation to more fully assess the CCBHC impact on ED utilization over time.

Figure 36

Pre-Demonstration and Demonstration Period Changes in ED Utilization by Primary Diagnosis, 2019-2024[30]



This graph shows Emergency Department (ED) utilization both before a patient received a CCBHC Encounter Code and after they received this code, denoting that they began to receive CCBHC-specific services, broken out by primary diagnosis.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2019-2024

Differences in ED Utilization during the Demonstration Period (FY2022-2024): Intervention and Comparison Groups

In Year 1 of the Demonstration period (FY2022), ED utilization was generally higher among individuals receiving care from the Intervention Group CCBHCs compared to those receiving care from non-CCBHC CMHs in the Comparison Group. This could be due to unique characteristics of individuals served in the Intervention Group relative to the Comparison Group. Because the analysis does not consider patient characteristics, pre-existing health status, co-morbidities or other risk factors, it is hard to determine more precise reasons for these differences. Future analyses will continue to monitor this to track the influence of these factors on the outcome variables and other health outcomes.

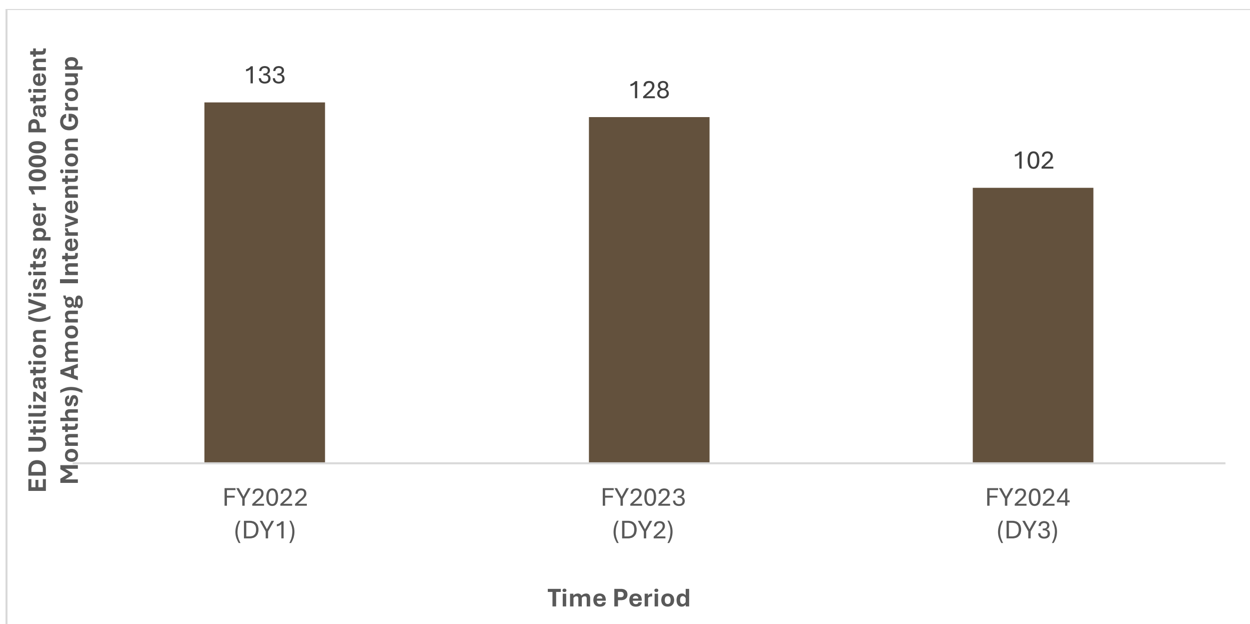
Compared to FY2023, ED utilization decreased in FY2024 among both the Intervention Group CCBHC individuals and Comparison Group individuals. While the overall ED

[30] For this analysis, pre-CCBHC and CCBHC periods were determined at an individual level based on whether an ED visit occurred before or after an individual's first CCBHC Demonstration Encounter Code. This was necessary to calculate patient months, which serves as the measure's denominator. Emergency Department Utilization was measured as total ED visits per 1000 patient months.

utilization rate was higher among individuals receiving CCBHC services from the Intervention Group, the relative decrease was greater over the Demonstration period. The Intervention Group experienced a 25% decrease from FY2023-2024. The Comparison Group also experienced a reduction in ED utilization over this time-period, but at a lower rate of decrease (16%). (Figures 39 and 40)[31]

Figure 37

Changes in ED Utilization During Demonstration Period (FY2022-2024): Intervention Group

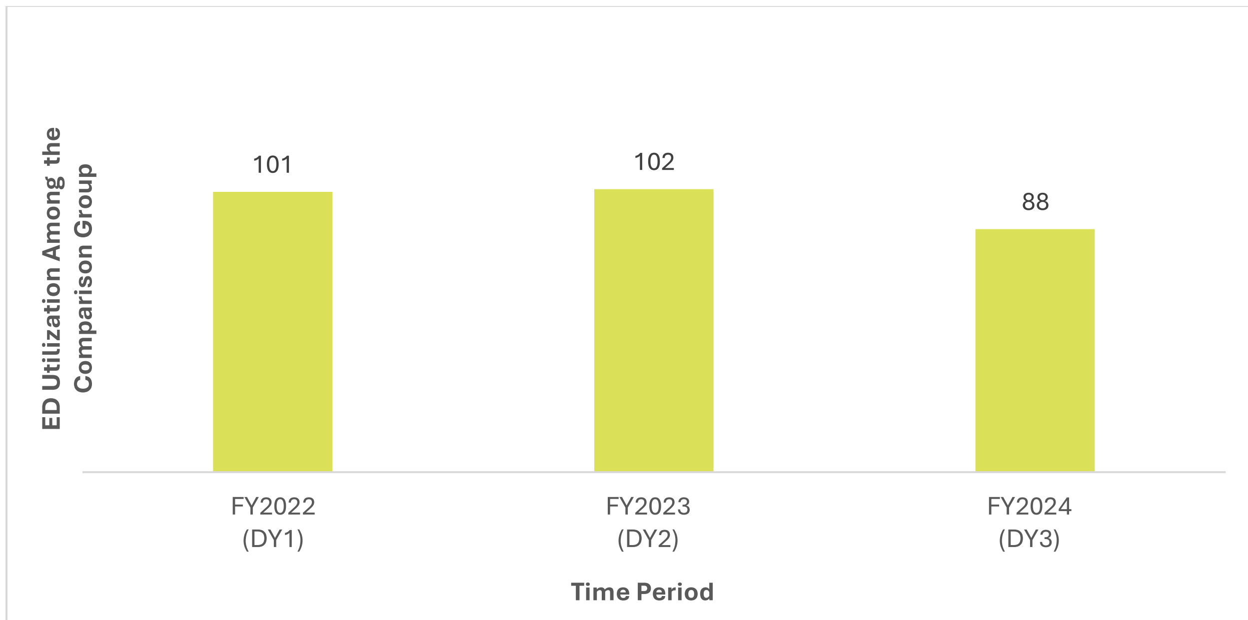


This graph shows Emergency Department (ED) utilization for individuals in the Intervention Group. Emergency Department Utilization was measured as total ED visits per 1000 patient months.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2022-2024

[31] A patient month represents a single month of Medicaid enrollment for a specific individual. For this analysis, the timeframe in the measure's denominator is limited to the total number of patient months for each fiscal year.

Figure 38

Changes in ED Utilization During the Demonstration Period (FY2022-2024): Comparison Group



This graph shows Emergency Department (ED) utilization for individuals in the Comparison Group. Emergency Department Utilization was measured as total ED visits per 1000 patient months.
Data Source: CHRT Analysis of Michigan Medicaid Claims Data, 2022-2024

Goal 3: Inform the design of the program for future expansion throughout the state

The final evaluation goal focuses on analyzing external feedback to help inform and share future CCBHC implementation. This is examined through two main sources of data:

- Patient Satisfaction Surveys. The surveys rated the overall experience by individuals served through a CCBHC. These surveys detail areas where CCBHCs shine and areas that can be improved.
- Qualitative interviews with CCBHCs and Prepaid Inpatient Health Plans (PIHPs). These interviews reveal opportunities to enhance implementation to ensure sustainability of CCBHC services.

While data was collected in 2023 among the Intervention Group only and represents a single point-in-time assessment, the information provides important context and insights

that can inform the State of Michigan as it looks to continue and further expand the CCBHCs.

Patient Experience Surveys

As part of their participation in the CCBHC Demonstration, sites are required to gather patient experience data utilizing a survey. The goal of the survey is to measure and track levels of satisfaction with the CCBHC model by persons served, including perceptions about access to services, quality of services, social connectedness, functioning, and outcomes among adults and families of children/youth. Adults and children are surveyed using different instruments: the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey and the Youth Services Survey for Families (YSS-F).

The MHSIP survey is designed to measure six domains of adult patient experience and satisfaction: (1) Satisfaction, (2) Access, (3) Quality and Participation, (4) Outcomes, (5) Functioning, and (6) Social Connectedness. To measure satisfaction and experience, the survey asked patients to rate the extent to which they agreed with 36 statements across all six domains. Twelve of the 13 CCBHC are included in this analysis. One site developed their own unique survey and that data was omitted.

The YSS-F survey is designed to measure six domains of youth patient experience and satisfaction: (1) Appropriateness, (2) Access, (3) Participation, (4) Cultural Sensitivity, (5) Outcomes, and (6) Social Connectedness. To measure patient experience and satisfaction in these domains, the survey asks the parents/guardians of youth patients to rate the extent to which they agreed with 26 statements. Eleven of 13 sites are included in the analysis. One site developed their own unique survey and that data was omitted. A second site did not receive any responses to their survey from family/caregivers.

The evaluation team analyzed the survey results from 2023 using the following questions:

- What are the CCBHCs doing well?
- What areas can be improved upon?
- What disparities in self-reported experiences exist across different population groups?
- Based on these baseline findings, what changes or adjustments to improve patient experience and data collection might be considered?

A detailed discussion of methodology is provided in Appendix B including a breakdown of demographic characteristics of survey respondents. In addition to measures of

satisfaction and experience, the evaluation team analyzed differences in ratings by race, ethnicity, gender, age and urban/rural designation. These analyses are not included here but instead can be found within the full "Patient Experience of CCBHC Services" Report.

According to Individuals Receiving Care from a CCBHC, What are the Areas Where CCBHCs are Doing Well?

According to both the MHSIP (Figure 41) and YSS-F (Figure 42) responses, the CCBHC Demonstration performed exceptionally well in areas related to access to services and quality of and participation in care. This demonstrates that from the patients' perspective, CCBHCs were successful in increasing access to behavioral health services, providing what patients perceive as high quality of care, and engaging patients in their own care. Specifically:

- Among adults, experience with the CCBHCs is very positive with positive ratings ranging from 73 to 92%. Notably, 'Quality and Participation' (92%) was the most highly rated domain of CCBHC experience, followed by 'Satisfaction' (89%) and 'Access' (84%).
- Similarly, the YSS-F survey reflected high satisfaction and positive experiences as reported by caregivers/parents of children receiving care.
    - Most respondents gave 'Cultural Sensitivity' and 'Participation' domains the highest rankings (96% and 93%, respectively).
    - 'Appropriateness' and 'Access' were next highest, each with an 87% positive rating.

According to Individuals Receiving Care Through a CCBHC, What are the Areas That can be Improved?

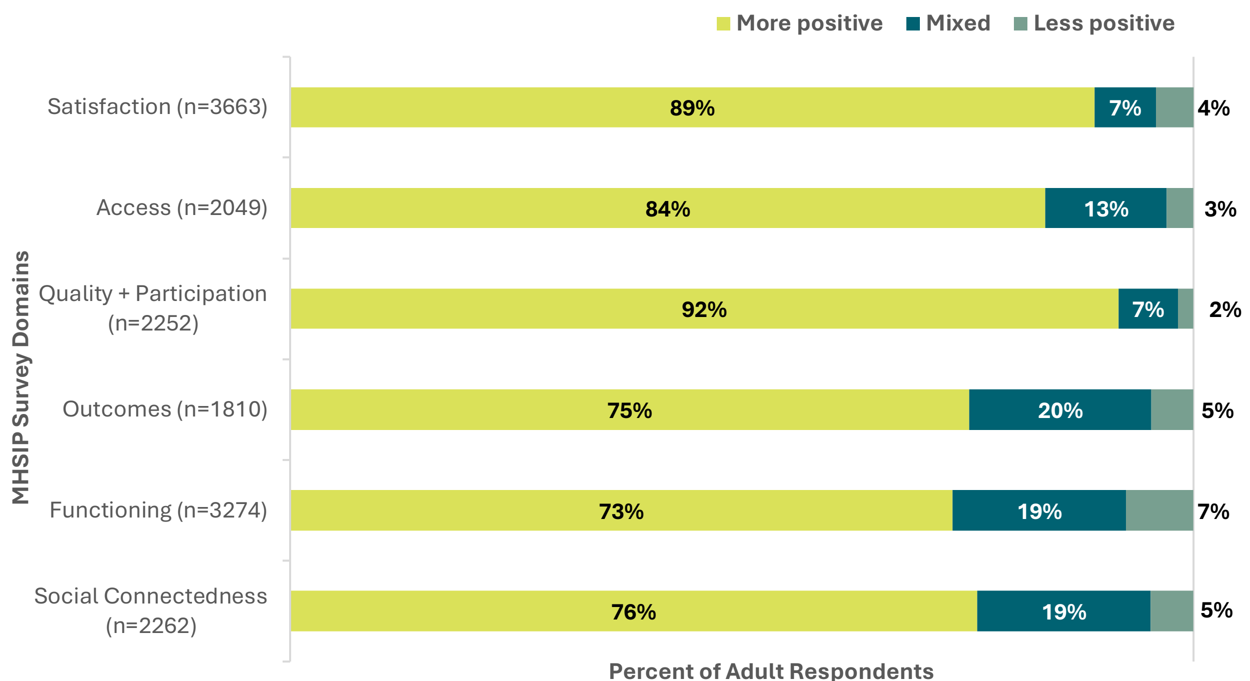
Overall, MHSIP respondents reported more mixed perceptions about their outcomes, functioning, and social connectedness. While still mostly positive, these survey domains were given lower percentages of positive scores. This may reflect the fact that these are areas that require longer term engagement, treatment and monitoring to affect change in perception. While 'Functioning' (73%), 'Outcomes' (75%) and 'Social Connectedness' (76%) were given lower overall ratings, approximately three-quarters of respondents did give positive ratings for each of these domains. (See Figure 41). YSS-F respondents gave the lowest ratings to "Social Connectedness' and 'Outcomes' at 84% and 71%, respectively, but again most respondents provided overall positive ratings across each of

the domains measured (Figure 42).

In addition to the overall ratings for each of the domains discussed above, there is variation by individual survey questions that make up each domain. These variations can provide greater granularity into how CCBHCs can target improvement efforts within domains, even where baseline ratings are high. Please see Appendix B for these detailed findings.

Figure 39

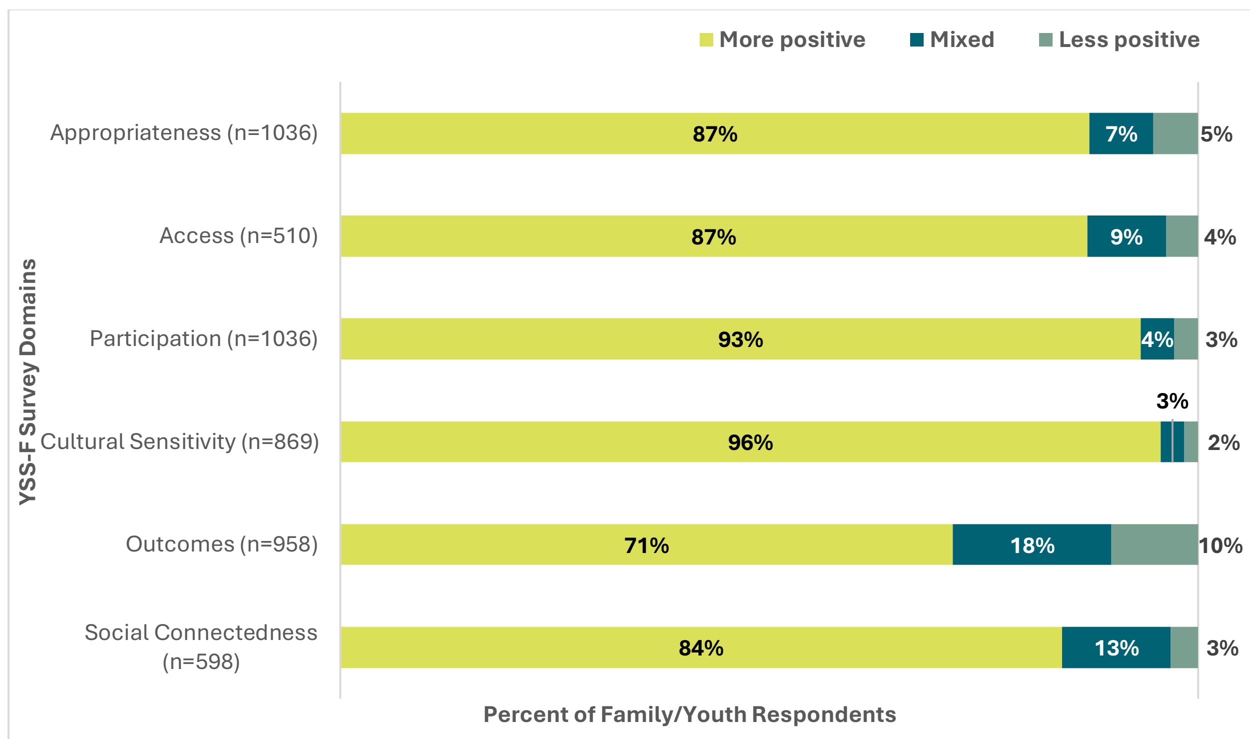
Adult Overall Ratings Across Each Domain



This graph shows the aggregated percentage of each adult response by survey domain, broken out by 'more positive', 'mixed', and 'less positive' responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of MHSIP Adult Consumer Survey, 2023

Figure 40

Family/Youth Overall Ratings for Each Domain



This graph shows the aggregated percentage of each family response (on behalf of youth) by survey domain, broken out by 'more positive', 'mixed', and 'less positive' responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of YSS-F Survey, 2023

What Disparities in Self-Reported Experiences Exist Across Different Population Groups?

The final question guiding the analysis was to examine and explore any disparities in patient experiences uncovered in the survey data. The evaluation examined and compared survey domain scores broken down by race, gender, ethnicity, age, as well as urban/rural designations. Following CMS[32] guidelines, group categories where the sample size was less than ten (n < 10) were omitted from reporting.

[32] "CMS Cell Suppression Policy | Guidance Portal." HHS Guidance, November 30, 2024. https://www.hhs.gov/guidance/document/cms-cell-suppression-policy.

While responses from both adults and families/youth were generally positive across each domain, a few disparities were noted. Among adults, disparities were identified within the 'Satisfaction' domain, as most non-White race categories reported lower satisfaction compared to Whites. Older age groups among adults tended to report more positive experiences across domains as well.

Among families/youth, parents who identified youth as 'More than One Race' tended to report fewer positive responses across domains. Further, within the 'Appropriateness' domain, responses were more positive among parents of males compared to females. Parents of younger youth also reported more positive responses than parents of older youth across domains.

Among both adult and family/youth respondents who selected 'prefer not to answer' for ethnicity, gender, and age generally scored lower than their respective counterparts. Lastly, some of the disparities in domain scores occurred where the 'Other' race category scored the lowest compared to other groups.

Key disparities identified in each survey domain are described separately for adults and families/youth below.

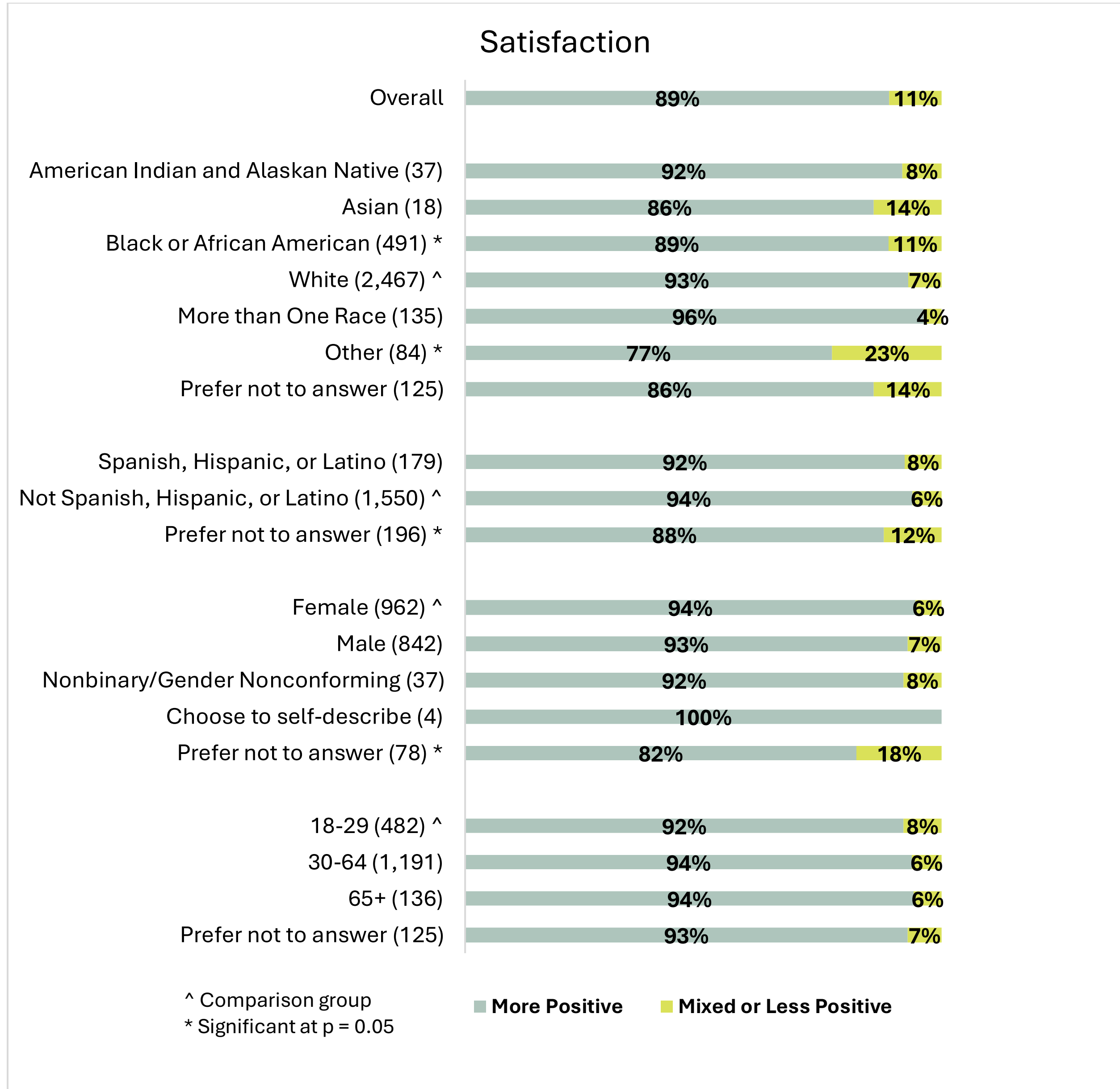
CHRT

Disparities in Experiences for Adults

Satisfaction

Figure 41

Group Differences in MHSIP 'Satisfaction' Domain



This graph shows the aggregated percentage of adult response by race, ethnicity, gender, and age from the Satisfaction survey domain, broken out by 'more positive' and 'mixed or less positive' responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.

Data Source: CHRT Analysis of MHSIP Adult Consumer Survey, 2023

Race - White service respondents and those identified by more than one race had the highest self-reported satisfaction with their services (93% and 96% respectively). Black respondents and those in the 'Other' race category were slightly less likely to report positive satisfaction (at 89% and 77% respectively) compared to White respondents (93%). The percentage of those in the 'Other' race category who reported being satisfied was also significantly lower than those in the Black category.

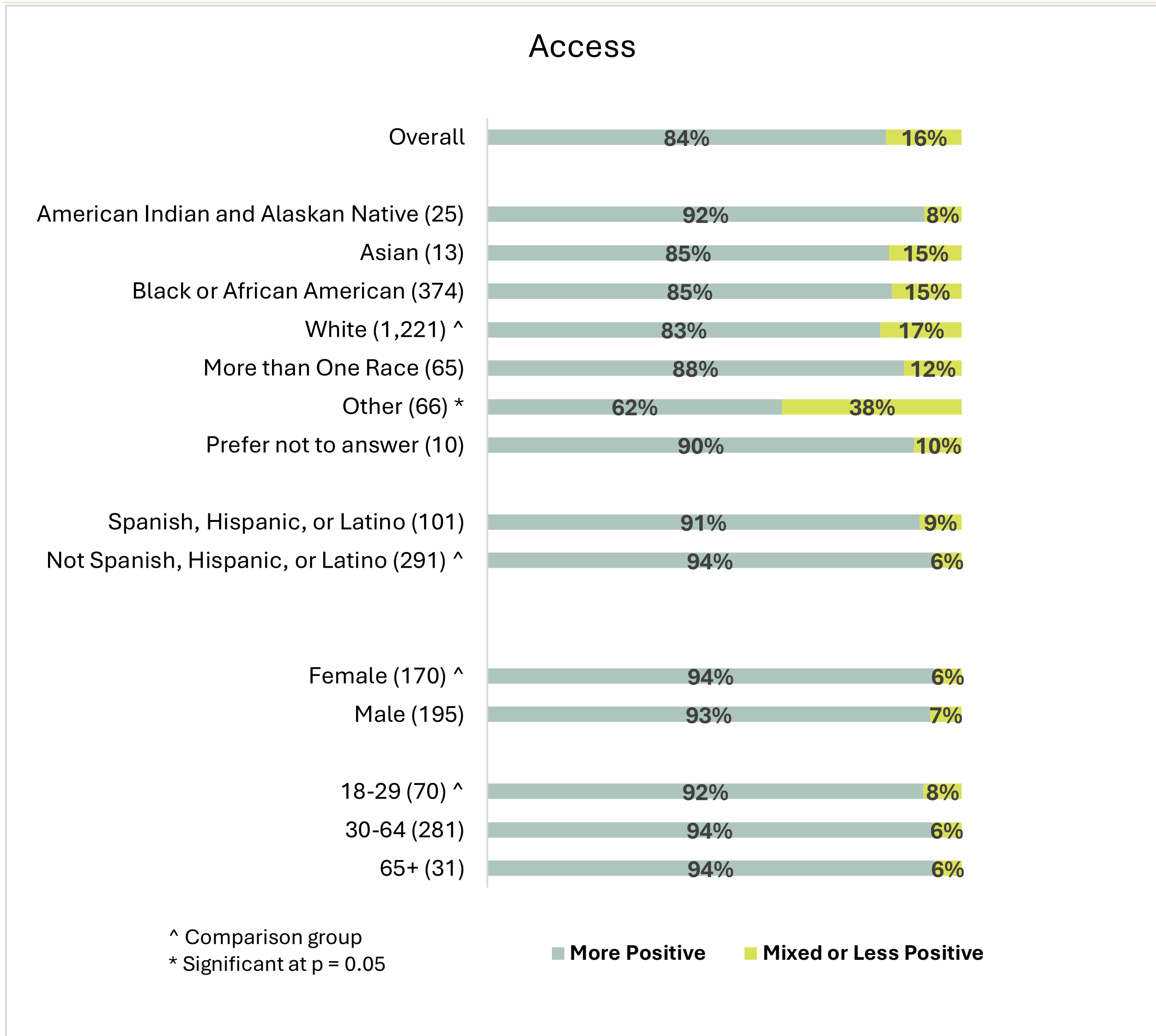
Ethnicity - Those who've selected 'Prefer not to answer' for their ethnicity had a lower percentage of positive responses in the satisfaction domain compared to non-Spanish/Hispanic/Latinos.

Gender - When examining differences among gender identity, those who've selected 'Prefer not to answer' had a lower frequency of positive responses in the satisfaction (82%) domain compared to those who've identified as male or female.

Access

Figure 42

Group Differences in MHSIP 'Access' Domain



This graph shows the aggregated percentage of adult response by race, ethnicity, gender, and age from the Access survey domain, broken out by 'more positive' and 'mixed or less positive' responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of MHSIP Adult Consumer Survey, 2023

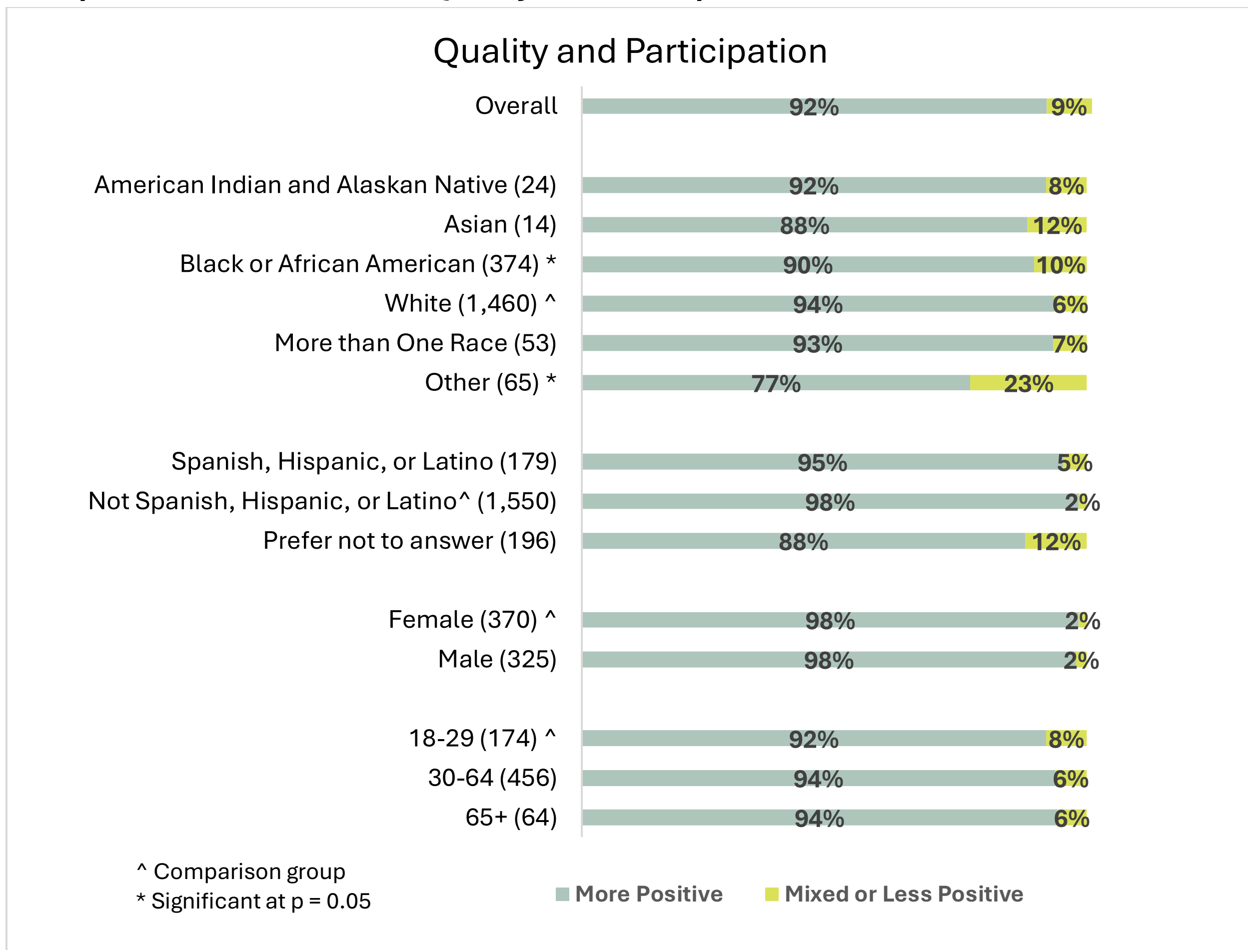
Race - No significant differences were observed between race categories, nor gender, ethnicity, and age categories related to the MHSIP Access Domain. Respondents in the 'Other' race category were less likely to report positively on access to services (62%) (p <

0.05) compared to those who selected “Prefer not to answer” (90%) and those who identified as American Indian/Alaskan Native (AIAN) (92%), Black (85%), White (83%), and ‘More than One Race’ (88%).

Quality

Figure 43

Group Differences in MHSIP ‘Quality and Participation’ Domain



This graph shows the aggregated percentage of adult response by race, ethnicity, gender, and age from the Quality and Participation survey domain, broken out by ‘more positive’ and ‘mixed or less positive’ responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of MHSIP Adult Consumer Survey, 2023

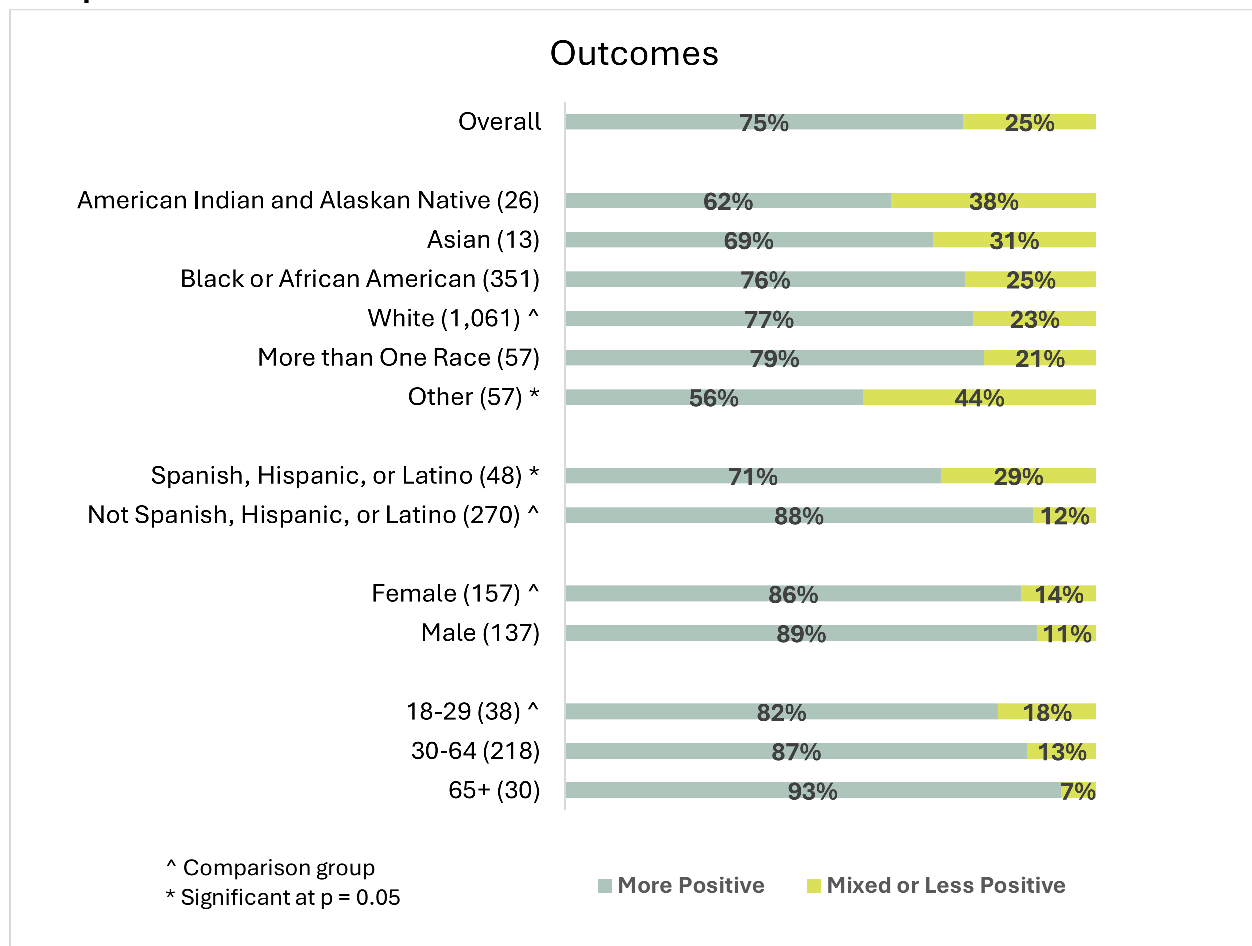
Race – Most (93%) White and Black/African American respondents had a positive perception of the quality of the services they received through the CCBHC, though

Black/African American respondents (90%), were just slightly less positive compared to their White counterparts (94%). Those who responded that their race was ‘Other’ were the least positive (79%) about the quality of services comparted to all other groups.

Outcomes

Figure 44

Group Differences in MHSIP ‘Outcomes’ Domain



This graph shows the aggregated percentage of adult response by race, ethnicity, gender, and age from the Outcomes survey domain, broken out by ‘more positive’ and ‘mixed or less positive’ responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of MHSIP Adult Consumer Survey, 2023

Race - No significant differences were observed between race categories in the MHSIP ‘Outcomes’ Domain. Respondents who reported their race as ‘Other’ were less likely to report positively on their outcomes (62%) compared to those identified as Black (76%),

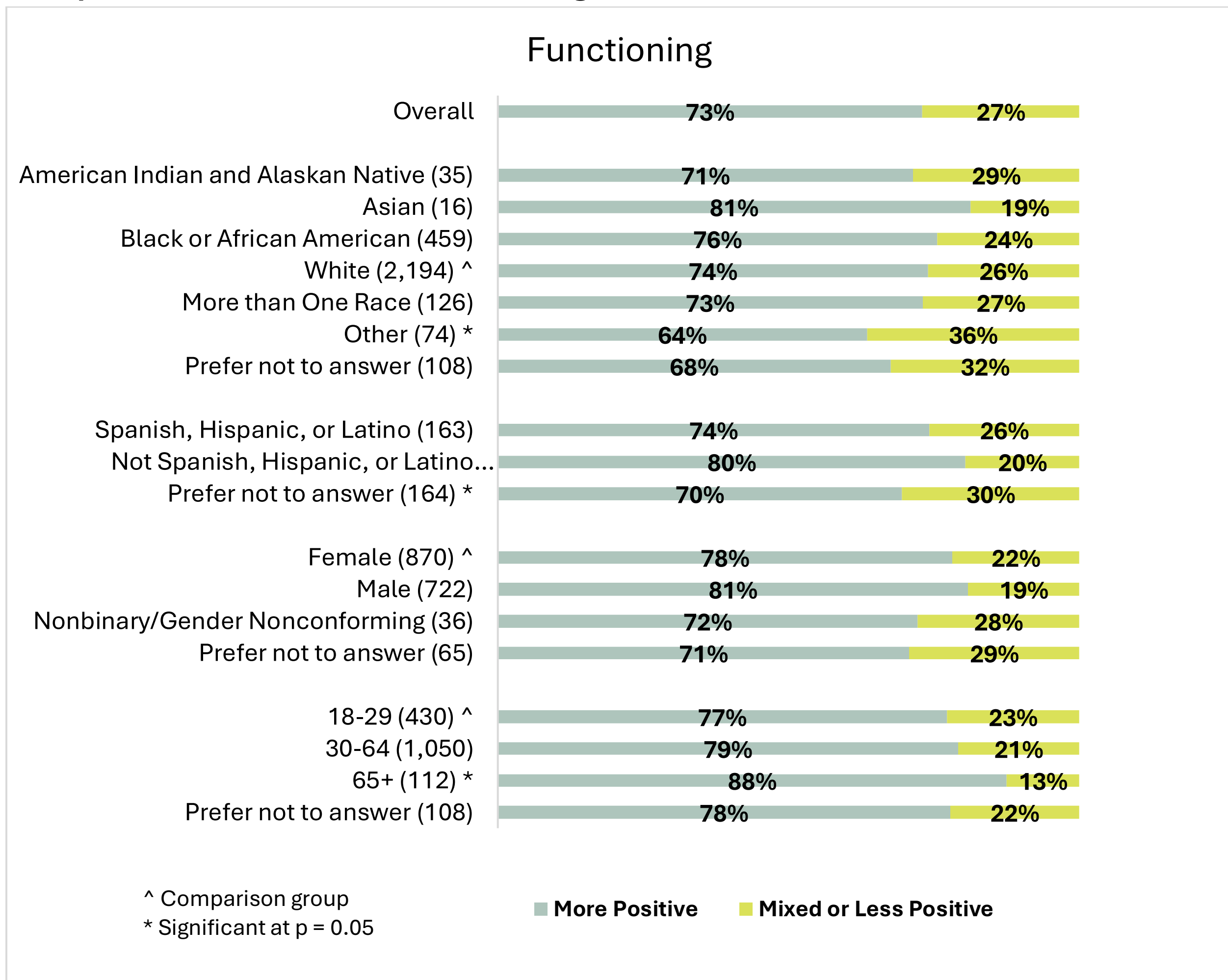
White (77%), and ‘More than One Race’ (79%).

Ethnicity - When examining differences among ethnicity, Spanish/Hispanic/Latino respondents had a lower percentage of positive responses in the outcomes domain (71%) compared to non-Spanish/Hispanic/Latinos (88%) ($p < 0.05$).

Functioning

Figure 45

Group Differences in MHSIP ‘Functioning’ Domain



This graph shows the aggregated percentage of adult response by race, ethnicity, gender, and age from the Functioning survey domain, broken out by ‘more positive’ and ‘mixed or less positive’ responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of MHSIP Adult Consumer Survey, 2023

Race - Respondents in the 'Other' race category were less likely to report improvement in functioning (64%) compared to Black respondents (76%). No significant differences were observed between the other race categories.

Ethnicity - Those who've selected 'Prefer not to answer' for their ethnicity had a lower percentage of positive responses in the functioning domain compared to non-Spanish/Hispanic/Latinos.

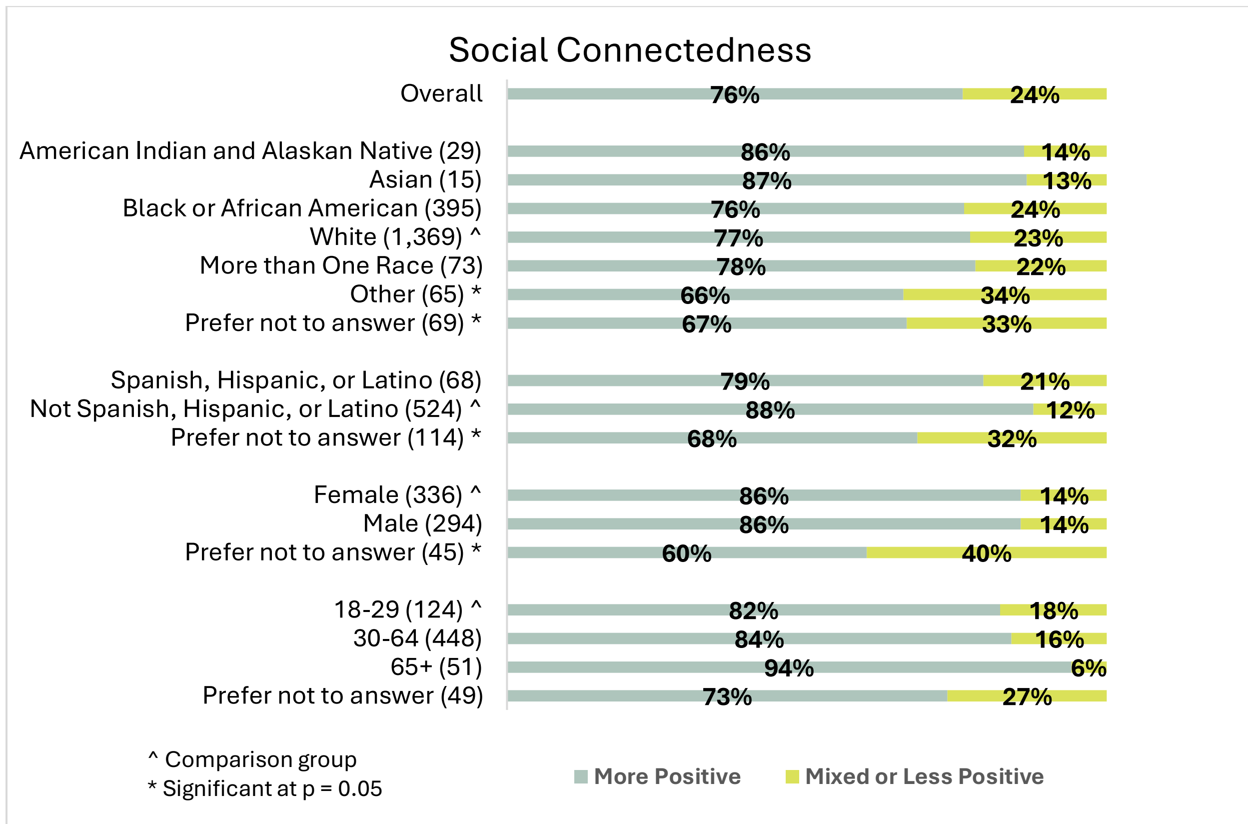
Age - When examining differences among age groups, respondents aged 65 years or older had a higher percentage of positive responses in the functioning domain (88%) compared to the '18-29' and '30-64' age groups.

CHRT

Social Connectedness

Figure 46

Group Differences in MHSIP 'Social Connectedness' Domain



This graph shows the aggregated percentage of adult response by race, ethnicity, gender, and age from the Social Connectedness survey domain, broken out by 'more positive' and 'mixed or less positive' responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of MHSIP Adult Consumer Survey, 2023

Race - Respondents in the 'Other' and 'Prefer not to Answer' race categories were less likely to report improvement in the MHSIP Social Connectedness domain compared to other groups, where 66% and 67% responded positively respectively. Statistical significance was observed among both groups compared to AIAN, but not among other categories. We will continue to monitor these effects in future reports.

Ethnicity - Those who've selected 'Prefer not to answer' for their ethnicity had a lower percentage of positive responses in the social connectedness domain compared to non-Spanish/Hispanic/Latinos.

Gender - When examining differences among gender identity, those who've selected 'Prefer not to answer' had a lower frequency of positive responses in the social connectedness domain (60%) compared to those who've identified as male or female.

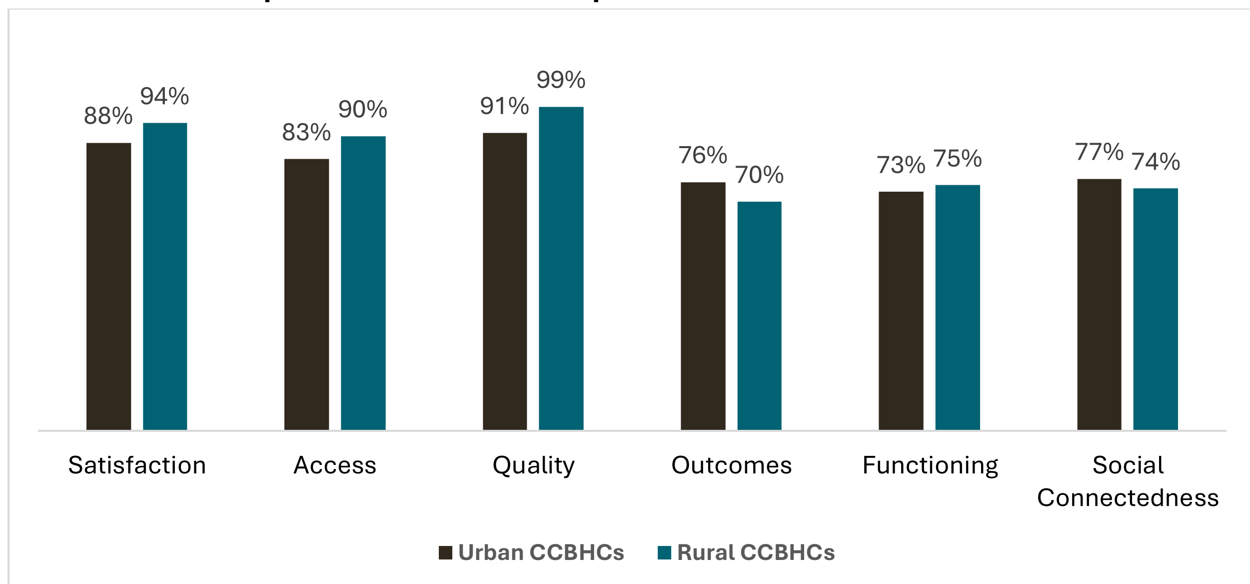
Age - When examining differences among age groups, respondents aged 65 years or older had a higher percentage of positive responses in the social connectedness domain (94%) compared to the '18-29' and '30-64' age groups as well as those who selected 'Prefer not to answer'.

Differences by Urban-Rural CCBHC

When examining differences across urban and rural clinic sites, we found that those who attended rural clinics responded more positively within the satisfaction (94%), access (90%), and quality (99%) domains ($p < 0.05$). However, due to the small number of rural clinics in our analyses, conclusions about experiences should be approached with caution. We will continue to monitor this as the CCBHC program expands and more data becomes available.

Figure 47

Urban-Rural Comparison of Positive Responses in each MHSIP domain



This graph shows the aggregated percentage of positive adult response across survey domains, broken out by responses from urban and rural clinics. Percentages were rounded to the nearest whole number.
Data Source: CHRT Analysis of MHSIP Adult Consumer Survey, 2023

When examining differences across urban and rural clinic sites, we found that those who attended rural clinics responded more positively within the satisfaction (94%), access (90%), and quality (99%) domains ($p < 0.05$). However, due to the small number of rural clinics in our analysis, conclusions about experiences should be approached with caution. We will continue to monitor this as the CCBHC program expands and more data becomes available.

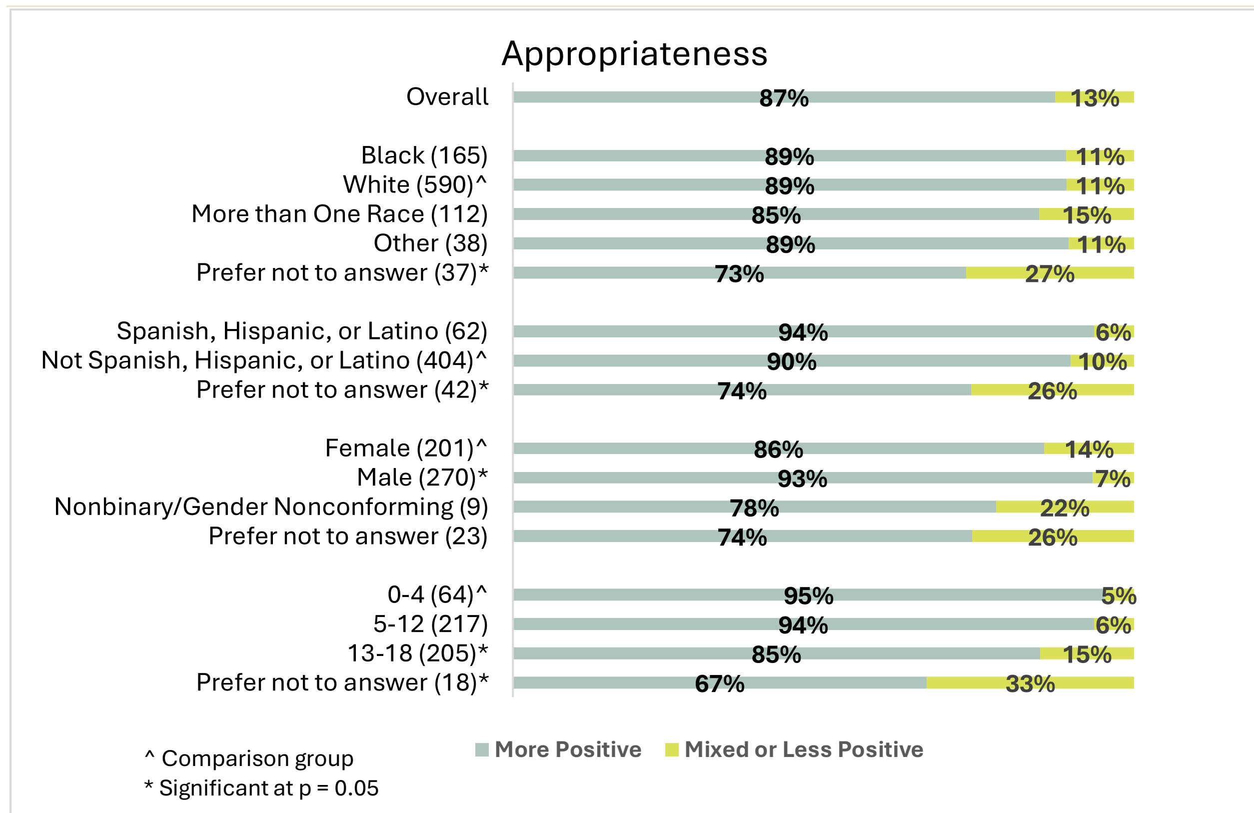
Family (Children/Youth) Disparities in CCBHC Experience

The Children/Youth survey was completed by parents or caregivers of youth patients.

Appropriateness

Figure 48

Group Differences in YSS-F 'Appropriateness' Domain



This graph shows the aggregated percentage of each family response (on behalf of youth) by race, ethnicity, gender, and age from the Appropriateness survey domain, broken out by 'more positive' and 'mixed or less positive' responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of YSS-F Survey, 2023

Race - Those who selected 'Prefer not to answer' (73%) responded less positively to questions in the appropriateness domain compared to parents of White (89%) and Black children (89%). This effect was significant ($p < 0.05$).

Ethnicity - Those who selected 'Prefer not to answer' (74%) responded less positively to questions in the appropriateness domain compared to parents of both Spanish/Hispanic/Latino children (94%) and non-Spanish/Hispanic/Latino children (90%). This effect was significant ($p < 0.05$).

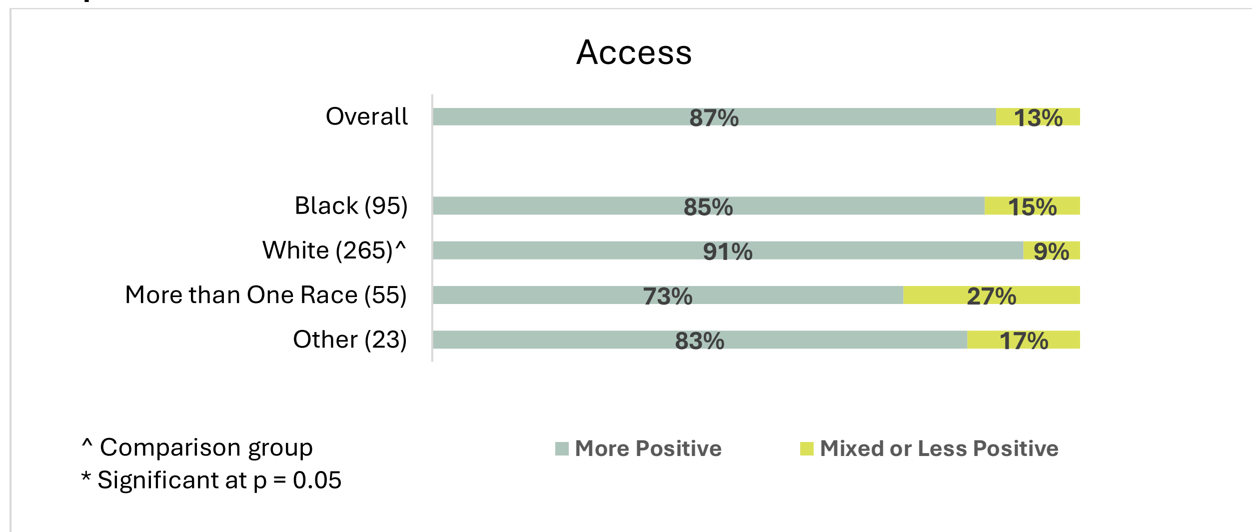
Gender - A higher percentage of parents of males responded positively to the appropriateness domain (93%) compared to females (86%) and parents who selected 'Prefer not to answer' (74%). Both effects were significant ($p < 0.05$).

Age - A greater percentage of parents of children aged '0-4' (95%) and '5-12' (94%) responded positively to the appropriateness domain compared to parents of children in the '13-18' (85%), '18+' (33%), and 'Prefer not to answer' (67%) age categories, and these differences were statistically significant ($p < 0.05$).

Access

Figure 49

Group Differences in YSS-F 'Access' Domain



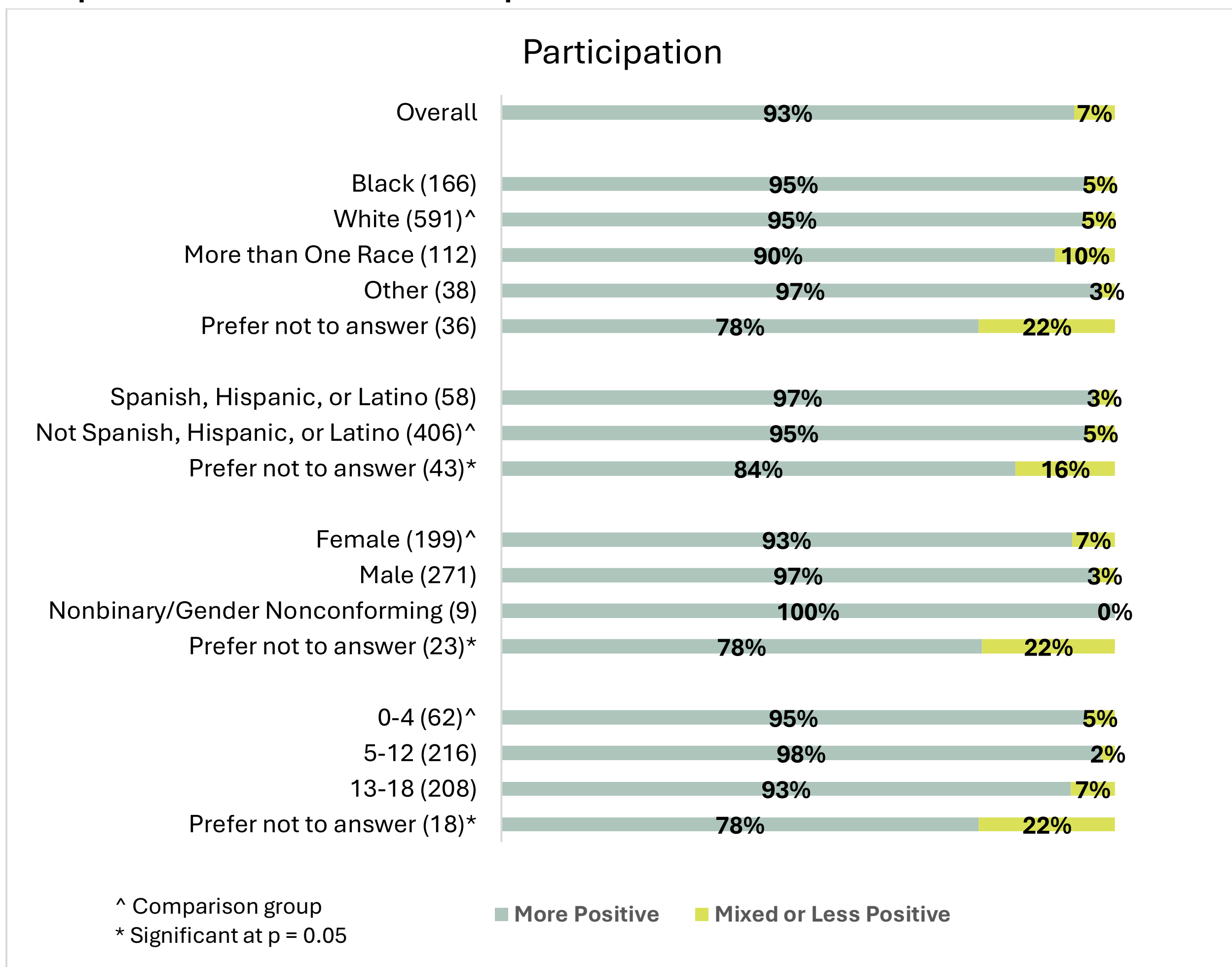
This graph shows the aggregated percentage of each family response (on behalf of youth) by race from the Access survey domain, broken out by 'more positive' and 'mixed or less positive' responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of YSS-F Survey, 2023

Race - A lower percentage of parents who identified their children as 'More than One Race' provided positive responses to the access to services domain (73%) compared to parents of White children (91%). This effect was statistically significant ($p < 0.05$). No significant differences in access domain scores were found among gender, ethnicity, and age.

Participation

Figure 50

Group Differences in YSS-F 'Participation' Domain



This graph shows the aggregated percentage of each family response (on behalf of youth) by race, ethnicity, gender, and age from the Participation survey domain, broken out by 'more positive' and 'mixed or less positive' responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of YSS-F Survey, 2023

Race - Those who selected ‘Prefer not to answer’ (78%) responded less positively to questions in the participation domain compared to parents of white (95%) and Black children (95%) as well as those who selected ‘Other’ (97%). This effect was significant ($p < 0.05$).

Ethnicity - Those who selected ‘Prefer not to answer’ (84%) responded less positively to questions in the participation domain compared to parents of both Spanish, Hispanic, or Latino children (97%) and Not Spanish, Hispanic, or Latino children (95%). This effect was significant ($p < 0.05$).

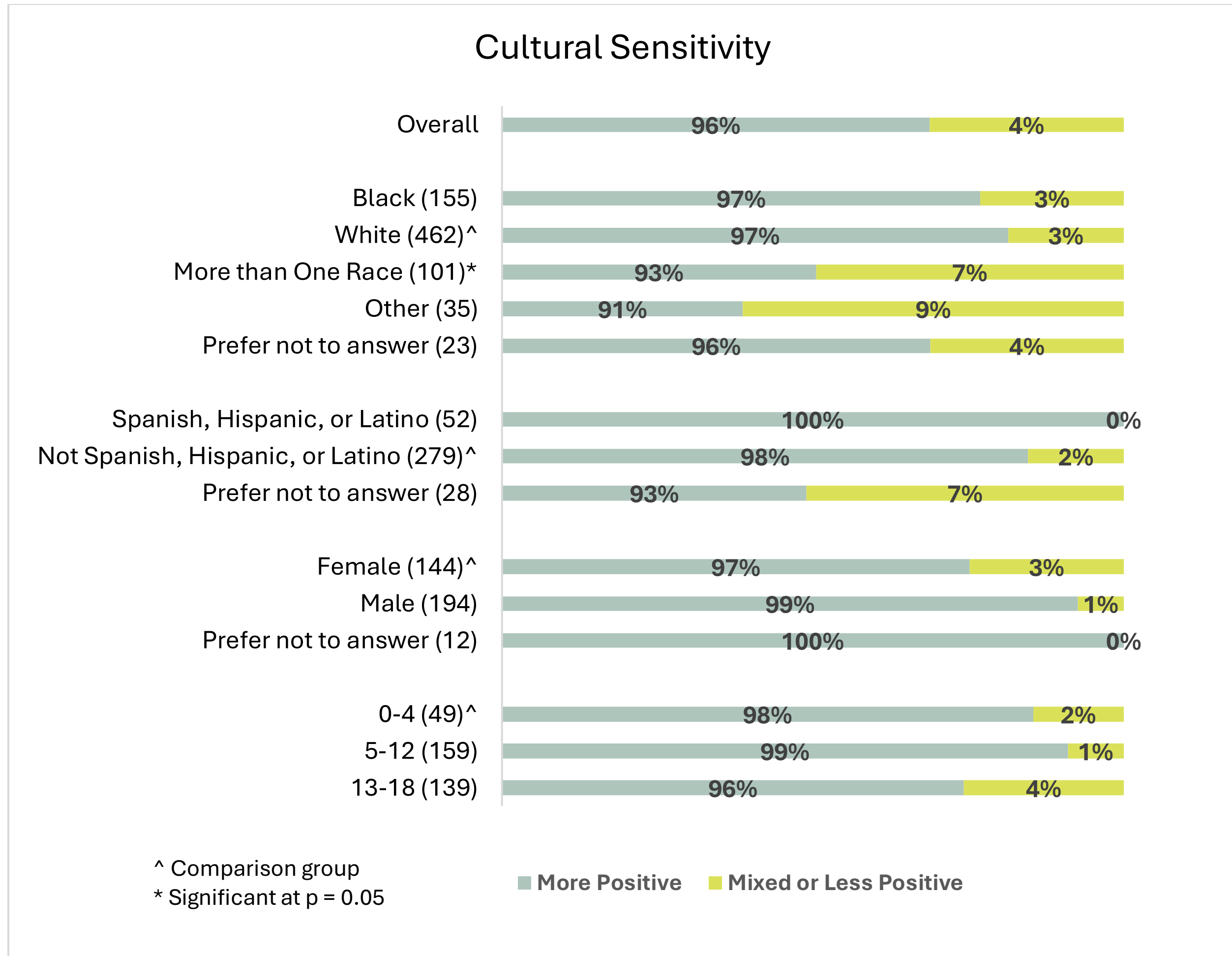
Gender - Those who selected ‘Prefer not to answer’ (78%) responded less positively to questions in the participation domain compared to parents of males (97%). This effect was significant ($p < 0.05$).

Age - A greater percentage of parents of children aged ‘5-12’ responded positively (98%) to the participation domain compared to parents of children in the ‘13-18’ (93%) age group and those who selected ‘Prefer not to answer’ (78%). This was statistically significant ($p < 0.05$).

Cultural Sensitivity/Competency

Figure 51

Group Differences in 'Cultural Sensitivity/Competency' Domain



This graph shows the aggregated percentage of each family response (on behalf of youth) by race, ethnicity, gender, and age from the Cultural Sensitivity domain, broken out by 'more positive' and 'mixed or less positive' responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of YSS-F Survey, 2023

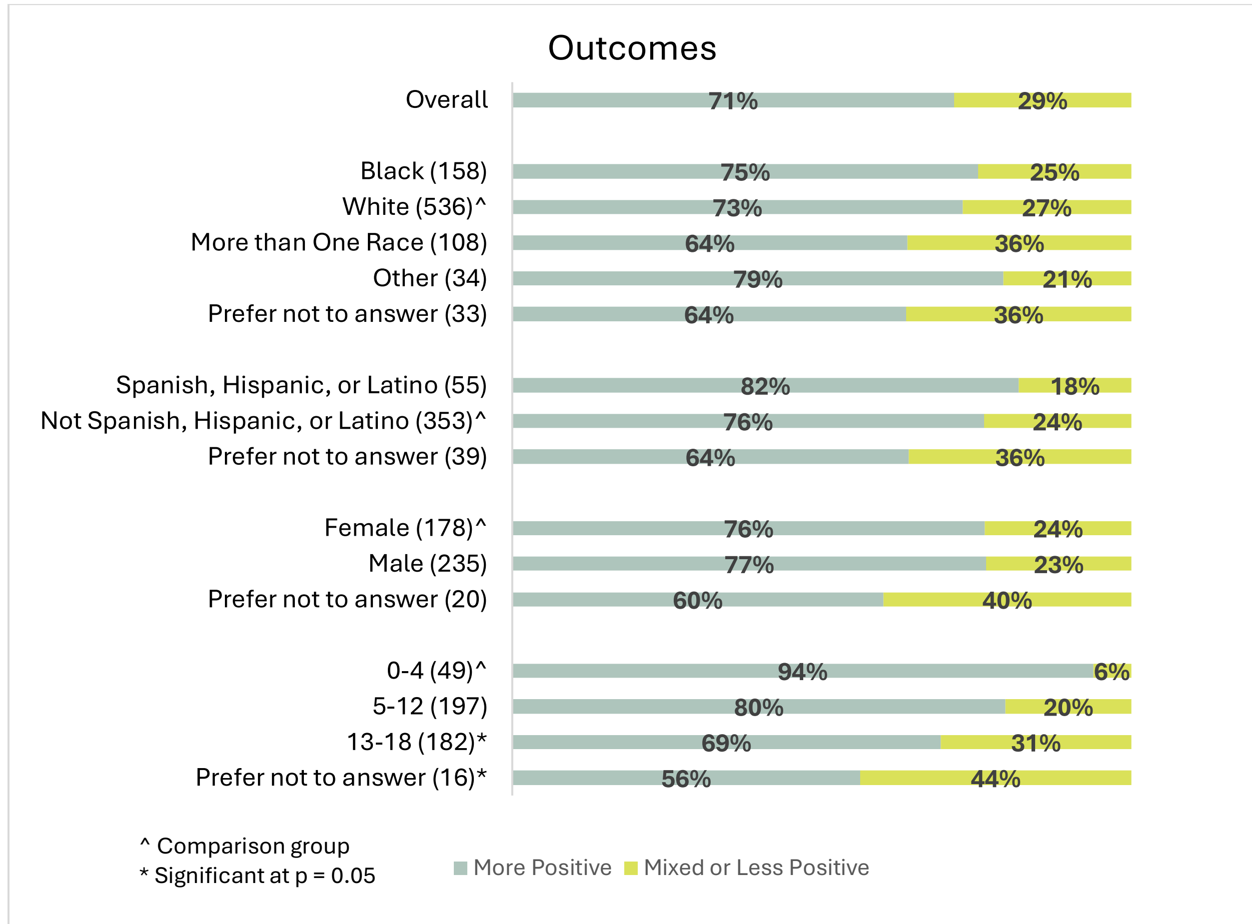
Race - While not statistically significant possibly due to a small sample size, parents who identified their children as Asian reported a lower percentage (83%) of positive responses to the cultural domain compared to both White and Black children (97%). We will continue to monitor these effects in future analysis. No significant differences in access domain scores were found among race, gender, ethnicity, and age.

CHRT

Outcomes

Figure 52

Group Differences in YSS-F 'Outcomes' Domain



This graph shows the aggregated percentage of each family response (on behalf of youth) by race, ethnicity, gender, and age from the Outcomes domain, broken out by 'more positive' and 'mixed or less positive' responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of YSS-F Survey, 2023

Race - Parents of children identified as 'More than one race' had a lower percentage of positive responses to the outcomes domain (64%) compared to other identifiable racial groups. However, the only significant difference in each was in comparison to responses from parents of Black children (75%) ($p < 0.05$).

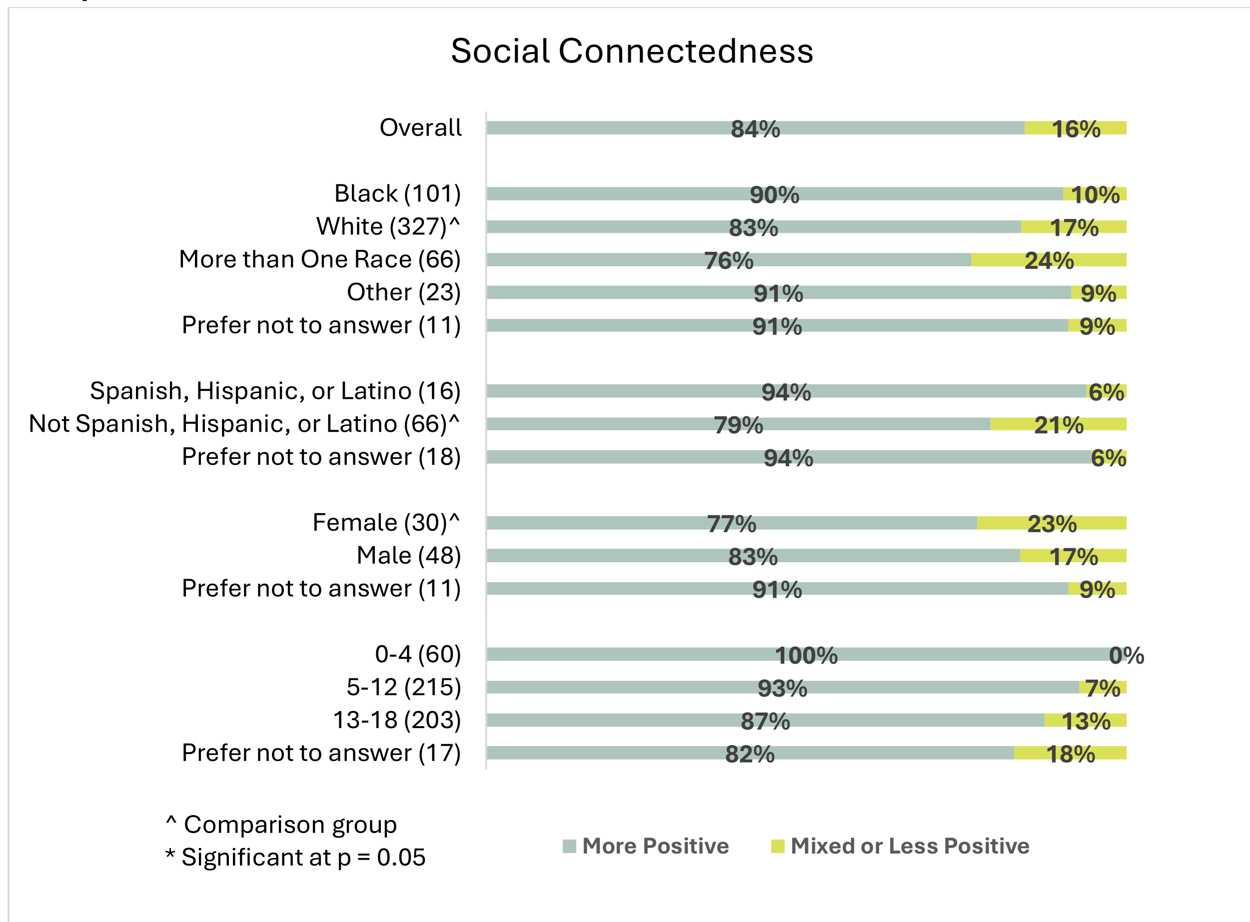
Age - A greater percentage of parents of children aged '0-4' (94%) and '5-12' (80%) responded positively to the outcomes domain compared to parents of children in the '13-

18' (69%) and 'Prefer not to answer' (56%) age categories, and these differences were statistically significant ($p < 0.05$). No significant differences in outcomes domain scores were found among gender and ethnicity.

Social Connectedness

Figure 53

Group Differences in YSS-F 'Social Connectedness' Domain



This graph shows the aggregated percentage of each family response (on behalf of youth) by race, ethnicity, gender, and age from the Social Connectedness domain, broken out by 'more positive' and 'mixed or less positive' responses. Percentages were rounded to the nearest whole number, therefore percentage totals might not exactly equal 100 percent.
Data Source: CHRT Analysis of YSS-F Survey, 2023

Race - Parents of children identified as 'More than one race' had a lower percentage of positive responses to the social connectedness (76%) domain compared to other

identifiable racial groups. However, the only significant difference in each was in comparison to responses from parents of Black children (90%) ($p < 0.05$).

Ethnicity - Those who selected ‘Prefer not to answer’ (94%) responded more positively to questions in the social connectedness domain compared to parents of not Spanish/ Hispanic/Latino children (79%). This effect was significant ($p < 0.05$).

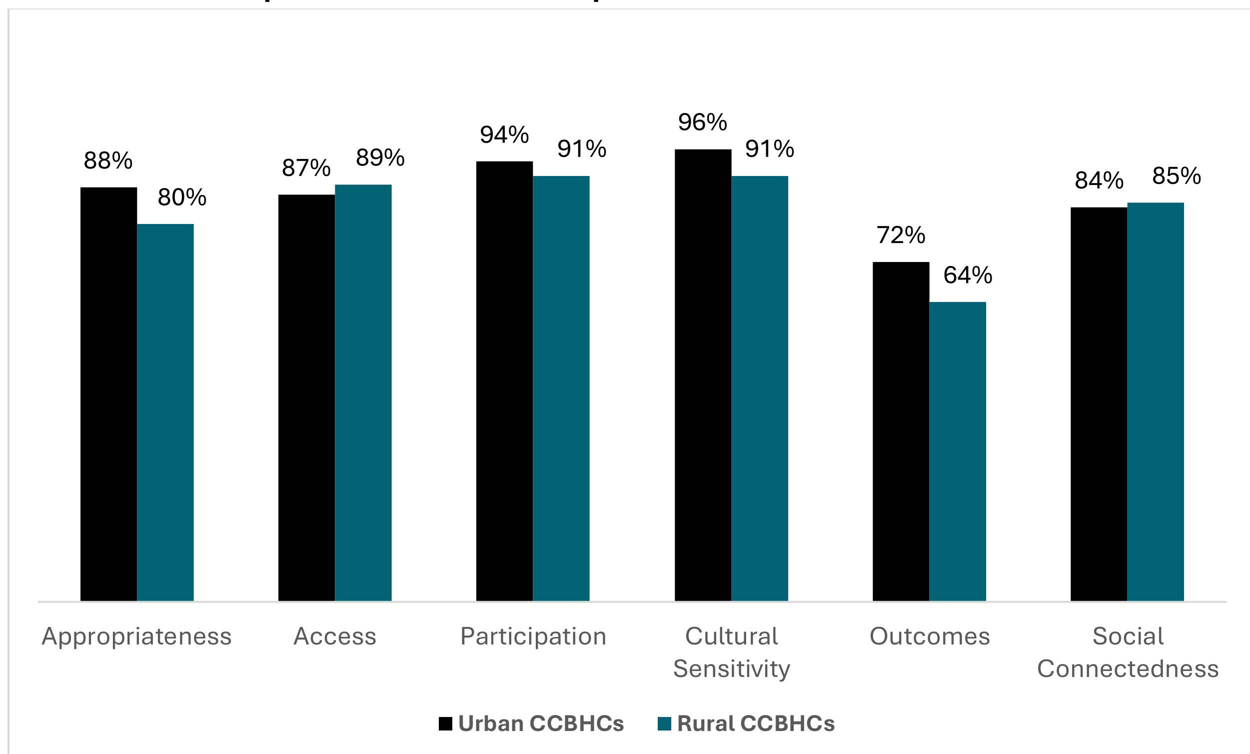
Age - A greater percentage of parents of children aged ‘5-12’ responded positively (93%) to the social connectedness domain compared to parents of children in the ‘13-18’ (87%) age group. This was statistically significant ($p < 0.05$).

No significant differences in social connectedness domain scores were found among gender.

Differences between Urban-Rural CCBHCs

Figure 54

Urban-Rural Comparison of Positive Responses in each YSS-F Domain



This graph shows the aggregated percentage of positive family response (on behalf of youth) across survey domains, broken out by responses from urban and rural clinics. Percentages were rounded to the nearest whole number.
Data Source: CHRT Analysis of MHSIP Adult Consumer Survey, 2023

Parents of children who attended rural clinics had a significantly lower percentage responding positively to the appropriateness (80%) and cultural domains (90%) compared to parents of children who attended urban clinics, but responses to both domains remained highly positive ($p < 0.05$).

However, due to the small number of rural clinics in our analysis, conclusions about experiences should be approached with caution. We will continue to monitor this as the CCBHC program expands and more data becomes available.

Based on These Baseline Findings, What Changes or Adjustments to Improve Patient Experience and Data Collection Might be Considered?

Improve or continue ongoing efforts towards cultural sensitivity: Several disparities were identified in satisfaction scores, as most non-White race categories reported lower satisfaction compared to Whites. Respondents who selected 'prefer not to answer' for ethnicity, gender, and age generally scored lower than their respective counterparts, possibly reflecting a desire to remain anonymous from their more critical responses. CCBHCs should continue implementing targeted engagement initiatives and culturally specific outreach strategies to better understand and meet the unique needs of these groups.

Create or better leverage existing mechanisms to get input and feedback from people with lived experience with CCBHCs: CCBHCs should assess the disparities that exist within their own service areas and address them systematically. This can be achieved by incorporating a client feedback loop through a community advisory board or focus group that consists of members who reflect the diversity of their service population.

Improve collection of race/ethnicity, gender, and age data: Some of the disparities in domain scores occurred where the ‘Other’ race category scored the lowest compared to other groups. This underscores the need to improve data collection by including more race categories. A more detailed breakdown will enable a deeper understanding of which specific racial groups are experiencing lower scores, empowering clinics to tailor their efforts to better address the unique needs of these populations. Furthermore, many CCBHCs (6 out of 13) did not collect gender and age data from MHSIP and YSS-F survey respondents. Those clinics should be encouraged to collect these additional demographics to better identify and address potential disparities within these groups.

Improve survey administration and data collection: A few CCBHCs struggled in obtaining surveys from child caregivers (for YSS-F) or other underrepresented groups. These clinics should consider tailoring survey collection methods to better engage and improve response rates in those populations. This could include offering surveys in multiple formats (e.g. online, paper, mobile-friendly app, etc.) and working with trusted community partners to encourage participation. Flexible scheduling and follow-up reminders may also help increase responses from these groups.

There should also be greater consistency and guidance across CCBHCs regarding the timeframes for survey collection. Aligning collection periods across sites would improve data comparability and the ability to analyze trends and disparities effectively. Ideally, working to standardize data collection protocols, instruments, and timelines would improve the survey data, but this must be done with an understanding of the constraints and needs of each CCBHC.

Develop and implement strategies to boost response rates from persons and families served by CCBHCs. A noted limitation is the relatively low response rates across CCBHC sites which limits the ability for more granular analysis and to develop more definitive conclusions across various populations served by CCBHCs.

Qualitative Interviews with CCBHCs and PIHPs

CCBHCs and PIHPs from the Intervention Group were interviewed toward the end of FY2023 (July-November 2023) on what they thought were most important to ensure sustainability of CCBHC services, the main challenges to sustainability, and the strategies being employed to address these challenges. The common themes drawn from their responses included the following:

Scale resources and staffing at the state level to support the expansion and integration of CCBHCs into the broader behavioral health system. At the time of these interviews, the state planned to expand the Demonstration to include additional sites, alongside the 13 sites in the Intervention Group, but sites worried that there were not adequate staff members assigned to manage the Demonstration. CCBHCs emphasized recognizing the Demonstration as a system-wide transformation, not just a program, and to provide proper planning and support to facilitate this change. Along with increased funding, adequate staffing at the state level is necessary for the expansion and integration of CCBHCs across different sectors.

State alignment on policies and regulations from different sectors is vital for sustaining progress achieved through the Demonstration. At the time of the interviews, some CCBHCs felt there was a lack of coordination where different parts of the system were unaware of each other's actions and how their regulations affect CCBHCs. It is essential for all parties to align their understanding and approach, viewing CCBHCs as a fundamental component of a larger transformation of the community mental health system, and address these challenges together.

Provide flexibility in service requirements to support diverse organizational structures for CMHs without compromising their existing external partnerships. Some CCBHCs encountered challenges with the federal requirement to provide 51% of services internally, which required restructuring staffing and discontinuing established and effective contracts with external partners. Those CCBHCs hope to continue engaging with MDHHS and state authorities to find solutions that accommodate their service models while preserving the benefits of their existing community and regional partnerships.

Examine and address how services toward the non-Medicaid population are reimbursed. Multiple CCBHCs expressed concern with whether the PPS funding model can continue to adequately reimburse services for the non-Medicaid population as that service population continues to grow.

The above key themes were shared with MDHHS in February 2024, and helped guide them in engaging with CCBHCs and PIHPs to better address the sustainability and expansion efforts of the Demonstration. MDHHS has since been actively working on these issues since the interviews were conducted.

Conclusion

The CCBHC Demonstration significantly improved access to behavioral health care in Michigan. The increase in services for groups conventionally excluded from the publicly funded behavioral health system in Michigan is noteworthy, particularly for individuals with mild to moderate severity of needs and veterans.

Among core services, Screening, Assessment and Diagnosis stands out as the most utilized service. While not surprising as it may represent the "lowest hanging fruit" of all the core services, it is an important first step toward getting individuals to access the care they need. Outpatient Substance Use Services and Crisis Services increased substantially as well among the CCBHCs (compared a Comparison Group of non-CCBHCs). The large increase in individuals receiving these services demonstrates both the need for CCBHCs and how the Demonstration is transforming the behavioral health care system to address all needs in one, highly integrated system.

Through findings from the CCBHC and PIHP interviews, it is important to understand how challenges such as payment and staffing shortages affect operations and implementation among CCBHCs, as well as best practices for successful implementation. Learnings from the Demonstration could be invaluable to informing overall system improvement and function as a case study for other CCBHCs.

Taken together, the findings presented in this evaluation provide a robust picture of the successes, challenges and lessons for sustainability and improvement of the CCBHC Demonstration and future implementation and expansion. Looking at results by evaluation goal, there are many key takeaways from the evaluation including the following observations.

Goal 1: Understand how the CCBHC Demonstration is implemented among the original 13 demonstration sites.

The biggest lessons the CCBHCs and PIHPs highlighted for future implementation efforts include a focus on managing growth through continuous quality improvement and a steady focus on progress, rather than trying to do everything all at once. This leads to better longer-term outcomes for both the CCBHCs and the patients. CCBHCs also emphasized developing deliberate processes and mechanisms to manage growth through planning and collaboration to deal with increased demand, challenges in staffing, and the need to expand partnerships and infrastructure.

Using data integration from the start, particularly through EHRs and dashboard technologies, is essential for meeting reporting requirements and improving patient outcomes, including better engagement with underserved groups such as veterans and LGBTQIA+ individuals.

Additional lessons focused on the importance of advocacy at the state and federal levels to expand and secure funding for CCBHCs, as well as the need for effective communication to ensure staff fully embrace the new model.

Finally, a flexible mindset and incremental approach to tackling complex challenges, such as EHR systems and new funding streams, are essential to the success of the CCBHC model. Celebrating small successes along the way helped maintain motivation through periods of significant change.

Goal 2: Measure the impact of the CCBHC Demonstration, particularly in expanding access to and participation in behavioral health services for underserved populations.

Increased Service Utilization

By *far, the CCBHC Intervention Group demonstrated substantial and significant growth across all core behavioral services compared to the Comparison Group of non-CCBHC CMH service providers*. Growth in utilization of Outpatient Substance Use Services among those served by the CCBHC Intervention Group stands out for the sixfold growth (498%) in unique individuals served and an eightfold (758%) increase in the number of services provided to this population. This growth may be due in part to expanded access to services through CCBHCs as well as shifts in the way service encounters are billed.

Despite tremendous growth in the number of services provided and the number of unique individuals served, services were maintained at relatively consistent levels across all years of the Demonstration (FY2022-2024). This indicates that the *CCBHCs met the increased demand for core services among individuals they serve.*

CCBHCs successfully included the mild to moderate population. While this group represents a smaller part of the CCBHC population compared to individuals with SMI, *the mild to moderate population experienced a larger percentage growth in claims and individuals receiving core services under the CCBHC Demonstration compared to the SMI population.*

Improving Access to Behavioral Health Services

Overall, CCBHCs are doing very well at identifying eligible individuals and enrolling them in a CCBHC and have been doing so with marked improvement since the beginning of the Demonstration (FY2022). There remains opportunity for improvement, most likely within the Expansion Group as those CCBHCs are not as far along in implementation as those in the Intervention Group, who started two years earlier. This is evidenced by comparing the overall totals and percentages (which include both groups) of CCBHC-eligible individuals being served in a CCBHC with those totals and percentages only in the Intervention Group, where nearly all CCBHC-eligible individuals have been served by a CCBHC.

From FY2021 to FY2024, the percentage of CCBHC-eligible individuals who received a core service has grown from 78% to 85%. The largest increase was observed in FY2022, in alignment with the initial Demonstration rollout. The number of CCBHC-eligible individuals who have received a core service has increased every year since FY2020; however, the biggest percent growth was observed from FY2021 to FY2022 (13% growth).

This suggests that the CCBHC Demonstration resulted in expanded access to core behavioral health services among those with a CCBHC-eligible diagnosis.

Increased access is notable elsewhere:

- CCBHCs were successful at including veterans into CCBHCs, nearly doubling this population since FY2022. This also reflects the overall growth in access to CCBHCs among the general population.
- The percentage of CCBHC-eligible individuals served by rural and urban sites who had received a CCBHC service remained stable from FY2022 to FY2023 and then experienced a large increase from FY2023 to FY2024. Across all years, CCBHC-eligible individuals served by rural sites were more likely to have received a CCBHC service.

Impact on ED Utilization

The CCBHC Demonstration had a small but significant impact on ED utilization with an observed decline of 2.4% over time for the overall CCBHC population.

Other findings related to the impact of the CCBHC Demonstration on ED utilization were mixed. While the overall ED utilization rate was higher among individuals receiving CCBHC services from the Intervention Group, the relative decrease was more pronounced over the Demonstration period. The Intervention Group experienced a 25% decrease from FY2023-

2024. The Comparison Group also experienced a reduction in ED utilization over this period, but at a lower rate of decrease (16%).

These small and mixed impacts on ED utilization warrant additional monitoring. The ED utilization metric may be difficult to measure in terms of impact in a relatively short time span given the complexities of co-morbidities and social factors that can influence health outcomes. This will warrant further investigation to more fully assess the CCBHC impact on ED utilization over time.

Goal 3: Inform the design of the program for future expansion throughout the state

The patient experience survey data and qualitative interviews provide important insights into ways that the State of Michigan should continue to improve the model and enhance the likelihood of sustainability.

Continue to focus on improving patient experience and satisfaction with CCBHCs. Patient satisfaction is generally very high but areas for improvement include a focus on outcomes, functioning and social connection.

Scale resources and staffing at the state level to support the expansion and integration of CCBHCs into the broader behavioral health system. At the time of these interviews, the state planned to expand the Demonstration to include additional sites, alongside the 13 sites in the Intervention Group, but sites worried that there was not adequate staff members assigned to manage the Demonstration. CCBHCs emphasized the need to recognize the Demonstration as a system-wide transformation, not just a program, and to provide proper planning and support to facilitate this change. Along with increased funding, adequate staffing at the state level is necessary for the expansion and integration of CCBHCs across different sectors.

State alignment on policies and regulations from different sectors is vital for sustaining progress achieved through the Demonstration. At the time of the interviews, some CCBHCs felt there is a lack of coordination with different parts of the system unaware of each other's actions and how their regulations affect CCBHCs. It is essential for all parties to align their understanding and approach, viewing CCBHCs as a fundamental component of a larger transformation of the community mental health system and address these challenges together.

Provide flexibility in service requirements to support diverse organizational structures for CMHs without compromising their existing external partnerships. Some CCBHCs encountered challenges with the federal requirement to provide 51% of services internally, which required restructuring staffing and discontinuing established and effective contracts with external partners. Those CCBHCs hope to continue engaging with MDHHS and state authorities to find solutions that accommodate their service models while preserving the benefits of their existing community and regional partnerships.

Monitor the payment methodology and how well services for the non-Medicaid population are reimbursed. Multiple CCBHCs expressed concern with whether the PPS funding model can continue to adequately reimburse services for the non-Medicaid population as that service population continues to grow.

The above key themes were shared with MDHHS in February 2024, and helped guide them in engaging with CCBHCs and PIHPs to better address the sustainability and expansion efforts of the Demonstration. MDHHS has since been actively working on these issues since the interviews were conducted.

Recommendations

From the evaluation results, several recommendations emerge for future action as the State of Michigan looks to continue to implement and expand the CCBHC model:

- Celebrate the successes of the CCBHC Demonstration to further build engagement and excitement of current and future participants and build the case at all levels for continuation.
- Monitor the impact of staffing constraints on CCBHCs' ability to deliver services and tie this to state-level strategies to address the behavioral workforce shortage. This is particularly acute for rural providers.
- Identify strategies within CCBHCs that succeed at overcoming staffing and capacity limitations. This could be done by conducting case studies to better understand the elements that CCBHCs use to address these challenges.
- Take steps to enhance and improve the PPS payment model to ensure ongoing access for non-Medicaid individuals.
- Continue to monitor patient experience and satisfaction, especially on the domains related to outcomes, functioning, and social connection.

- Consider conducting interviews or focus groups with individuals served by CCBHCs to understand more fully aspects of their experience that contribute to higher or lower ratings and tie to patient outcomes.
- Understand and address competing regulatory, financial, and community constraints that stress CCBHC functioning and risk continued expansion. Develop greater flexibility in required criteria where possible.
- Build on the successful inclusion of the mild to moderate population by continuing to ensure adequate support and staffing for this population in CCBHC models.
- Focus future evaluation activities on analyzing patient health outcomes and integration with primary care.

Appendix A: Qualitative Interviews Methodology

The qualitative interviews were conducted to assess the impact of the Certified Community Behavioral Health Clinics (CCBHC) Demonstration in Michigan. The primary goals were to understand improvements in access to and quality of behavioral health services and to inform future expansion. Interviews were conducted in two phases: CCBHC interviews from August 7–31, 2023, and Prepaid Inpatient Health Plan (PIHP) interviews from October 20–November 1, 2023.

A total of 19 interviews were completed, with 12 CCBHC organizations and 7 PIHPs participating. To capture varied perspectives on the Demonstration's implementation and outcomes, interviews targeted a diverse range of staff roles. CCBHC participants included executive leadership (e.g., Chief Executive Officers, Chief Operating Officers, Chief Financial Officers), clinical administrators, program directors (e.g., Directors of Adult Services, Quality Improvement, and Compliance), care coordinators, support staff, and others. PIHP interviews included regional leads, financial officers, program analysts, and integrated care coordinators, representing both administrative and clinical oversight roles.

All interviews were conducted virtually via Zoom, with two or more members of each region's team participating. A semi-structured interview guide, developed separately for the CCBHC and PIHP interviews, ensured consistency across interviews while allowing for in-depth exploration of relevant topics. This approach provided a comprehensive understanding of participants' experiences with the Demonstration's implementation, challenges, and opportunities.

Data Analysis and Coding

All interviews were audio-recorded with participant consent, professionally transcribed, and reviewed for accuracy. A thematic analysis approach was used to analyze the qualitative data. The analysis team developed an initial codebook based on the interview guides and key evaluation questions. Codes were refined through an iterative process, ensuring consistency and accuracy in application. Multiple team members independently coded a subset of transcripts to establish inter-coder reliability, with discrepancies resolved through discussion and consensus.

Data were coded and analyzed using NVivo software, which facilitated the organization, retrieval, and examination of themes across transcripts. The team tracked code

frequencies to identify commonly discussed topics across both CCBHC and PIHP participants.

Common Themes and Patterns

Access to Care: Improvements in patient access to services and reductions in wait times.

Quality of Care: Enhancements in service delivery, care coordination, and patient experience.

Staffing and Workforce Development: Recruitment challenges, staff retention, and training initiatives.

Data Collection and Utilization: Use of data for quality improvement, reporting, and decision-making.

Impact on Patient Outcomes: Notable patient progress and success stories resulting from the Demonstration.

Prospective Payment System (PPS): Financial considerations, implementation challenges, and benefits of the payment model.

Recommendations for Sustainability and Expansion: Strategies to maintain progress and considerations for future CCBHC phases.

Interview Topics

Opening Context: Participants described their role in the Demonstration.

Progress and Implementation: Focused on care access, quality, service provision changes, challenges, and PPS model impacts.

Core Components: Explored how services such as crisis intervention, outpatient care, case management, and peer support improved patient outcomes.

Accomplishments and Impact: Highlighted significant achievements and benefits.

Sustainability and Lessons Learned: Addressed strategies for sustaining improvements and future recommendations.

Future Steps: Focused on participants' goals for ongoing and future Demonstration phases.

PIHP Interview Guide for CCBHC Demonstration

Goal

To measure the impact of the CCBHCs Demonstration in Michigan, including the role of the Demonstration in increasing access to and improving the quality of behavioral health services, and to guide future expansion in Michigan.

Opening question:

Describe your role as a PIHP as it relates to the CCBHC Demonstration in your region. Give us the 'elevator speech' in 30 seconds or less.

Progress

What changes have been made because of the CCBHC Demonstration at the regional level?

Describe what service coordination, access to and provision of care were like at your region PRIOR to CCBHC Demonstration?

How has it changed since the CCBHC Demonstration? What data and reporting mechanisms are in place to monitor these changes?

How have these changes been beneficial to the clinics, individuals, and community?

Have there been any challenges with the implementation of these changes?

From your experience, what are some successes and challenges of implementing the PPS?

How does the payment model contribute to improving access and quality of services? What impact, if any, have you observed in your region?

Have there been any changes in the range or types of services offered under the PPS system?

Do you feel the risk associated with capitation for CCBHCs has affected any of the services?

Can you describe the financial impact of transitioning to the PPS system in your region?

Is it an improvement in determining payment and covering costs?

If not, are there particular areas that are harder to fit with PPS and why?

What data and reporting mechanisms are in place to monitor the performance and effectiveness of the PPS system?

Do you find the PPS model sustainable for your region?

Are there any differences or specific strategies in how the PPS model is implemented in your region compared to other regions?

Accomplishments

What are your biggest accomplishments since implementing the CCBHC Demonstration?

How has it benefited your region?

How has it benefited your clients and the community?

Sustainability

What do you feel is most important to ensure sustainability of CCBHC services? What would you recommend to sustain progress made through the CCBHC Demonstration?

What are the main challenges faced to ensure sustainability, and how are they being addressed?

Challenges/ Barriers

According to the CCBHC Handbook, PIHPs have a role in ensuring that CCBHC providers in their region "meet CCBHC standards and are available to serve individuals in their designated area." Were there any standards or core components you observed that were particularly challenging for CCBHCs in your region to incorporate?

In addition to any challenges mentioned in the previous questions, were there any additional challenges/barriers encountered through the CCBHC Demonstration?

Lesson Learned

What would you say are the most important lessons learned from the CCBHC?

Is there anything you would do differently if you could go back to the start of the Demonstration? And the initial implementation of the PPS model?

Next steps

Where will you focus your future efforts with the CCBHC Demonstration?

What do you want to work on or accomplish in the next year that so far you have not been able to do?

Are there any plans to modify or refine the PPS model in the future?

How do you envision the PPS system evolving to better meet the needs of CCBHCs and communities in your region?

CCBHC Interview Guide

Goal

To measure the impact of the CCBHCs Demonstration in Michigan, including the role of the Demonstration in increasing access to and improving the quality of behavioral health services, and to guide future expansion in Michigan.

Opening question

Give us the 'elevator speech' about your CCBHC in as few words as possible, i.e. if we had a 30 second elevator ride together and we asked you to tell us about your CCBHC. How would you describe it and what it has accomplished in your community?

Progress

What changes have been made because of the CCBHC Demonstration at the clinic level?

Describe what access to and provision of care was like at your clinic PRIOR to CCBHC Demonstration?

How has it changed since the CCBHC Demonstration?

How have these changes benefited the clinic, individuals, and community?

Have there been any challenges with the implementation of these changes?

The core components of the CCBHC Demonstration include:

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.
- Screening, assessment, and diagnosis, including risk assessment.
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning.
- Outpatient mental health and substance use services.
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk.

- Targeted case management.
- Psychiatric rehabilitation services.
- Peer support and counselor services and family supports.
- Intensive, community-based mental health care for members of the armed forces and veterans, particularly those members and veterans located in rural areas.

Which core components of the CCBHC Demonstration led to improved access and better performance?

Which core components did you find challenging to incorporate?

Provide your perspective on how important the Prospective Payment System (PPS) is related to achieving the goals of the CCBHC.

How does the payment model contribute to improving access and quality of services?

Is it an improvement in determining payment and covering costs?

If not, are there particular areas that are harder to fit with PPS and why?

Do you find the PPS model to be sustainable for your clinic operations?

How has client access to services changed since the incorporation of CCBHC?

Describe how access to services was before the CCBHC Demonstration.

How has the utilization of telehealth and provision of services through home-based, community-based visits changed since the incorporation of CCBHC?

How has your clientele changed since the incorporation of CCBHC? Were you able to serve more or individuals from an underserved group?

What impact, if any, have you observed on quality of care and patient outcomes since the CCBHC Demonstration? Provide specific examples or stories on how your CCBHC has impacted clients.

Accomplishments

What are your biggest accomplishments since implementing the CCBHC Demonstration?

How has it benefited your clinic?

How has it benefited your clients and the community?

Sustainability

What do you feel is most important to ensure sustainability of CCBHC services? What would you recommend to sustain progress made through the CCBHC Demonstration?

What are the main challenges faced to ensure sustainability and how are they being addressed?

Lessons Learned

What would you say are the most important lessons learned from the CCBHC?

What advice would you give to another clinic partaking in the CCBHC Demonstration?

Challenges/ Barriers

In addition to any challenges mentioned in the previous sections, are there any additional challenges/barriers your clinic encountered since participating in the CCBHC Demonstration?

Next steps

Where will you focus your future efforts with the CCBHC Demonstration?

What do you want to work on or accomplish in the next year that so far you have not been able to do?

What would you like to see as a change to further your clinic while being involved in the CCBHC Demonstration?

- Probe: What prevents that from happening?

Are there others we should talk to in your clinic or network to get a clearer/stronger picture of the work at your clinic?

Appendix B: Patient Experience Survey Methodology

As part of their participation in the CCBHC Demonstration, sites are required to gather patient experience data. CCBHCs utilize a survey. The goal of the survey is to measure and track levels of satisfaction with the CCBHC model, including perceptions about access to services, quality of services, social connectedness, functioning, and outcomes among adults and families of children/youth. Adults and children are surveyed using different instruments: the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey, and the Youth Services Survey for Families (YSS-F).

The MHSIP survey is designed to measure six domains of adult patient experience and satisfaction: (1) Satisfaction, (2) Access, (3) Quality and Participation, (4) Outcomes, (5) Functioning, and (6) Social Connectedness. To measure satisfaction and experience, the survey asked individuals to rate the extent to which they agreed with 36 statements across all 6 domains.

The YSS-F survey is designed to measure six domains of youth patient experience and satisfaction: (1) Appropriateness, (2) Access, (3) Participation, (4) Cultural Sensitivity, (5) Outcomes, and (6) Social Connectedness. To measure patient experience and satisfaction in these domains, the survey asks the parents/guardians of youth individuals to rate the extent to which they agreed with 26 statements.

In addition to measures of satisfaction and experience, the evaluation team analyzed differences in ratings by race, ethnicity, gender, age and urban/rural designation.

The analysis was guided by the following questions:

- What areas are CCBHCs doing well?
- What areas can be improved upon?
- What disparities in self-reported experiences exist across different population groups?
- Based on these baseline findings, what changes or adjustments to improve patient experience and data collection might be considered?

The 12 Demonstration sites included in this analysis utilized either the MHSIP Adult Consumer Survey assessment, an abridged version of the MHSIP, or slightly modified

version of the MHSIP to account for regional needs. For children/youth, most of the sites utilized the YSS-F, which was filled out by a parent or caregiver of the CCBHC patient. Data was collected during the second year of the CCBHC Demonstration (FY2023).

Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Survey

The MHSIP survey is designed to measure six domains of adult patient experience and satisfaction: (1) Satisfaction, (2) Access, (3) Quality / Participation, (4) Outcomes, (5) Functioning, and (6) Social Connectedness. To measure patient experience and satisfaction in these domains, the survey asks individuals to rate the extent to which they agreed with 36 statements.

CHRT requested each Demonstration site provide de-identified client-level MHSIP data through a spreadsheet reporting template. Of the 13 Demonstration sites, 12 collected MHSIP data for 3,727 adult individuals. Six of those sites used the original MHSIP survey instrument, and the other 6 used an abridged or slightly modified version of the survey to account for regional needs. One CCBHC site used their own patient experience survey and hence is omitted from this analysis.

Youth Services Survey for Families (YSS-F)

The YSS-F survey is designed to measure six domains of youth patient experience and satisfaction: (1) Appropriateness, (2) Access, (3) Participation, (4) Cultural Sensitivity, (5) Outcomes, and (6) Social Connectedness. To measure patient experience and satisfaction in these domains, the survey asks the parents/guardians of youth individuals to rate the extent to which they agreed with 26 statements. The list of the questions asked within each domain please see Figures B3 and B4, below.

CHRT requested each Demonstration site to provide de-identified client-level YSS-F data through a spreadsheet reporting template. Of the 13 Demonstration sites, 11 collected YSS-F data for 1,062 youth individuals. One CCBHC site used their own patient experience survey and hence is omitted from this analysis. One site received no responses to the YSS-F Survey. Five of those sites used the original YSS-F survey instrument, and 6 used an abridged or slightly modified version of the survey to account for regional needs.

Measures

Patient Experience / Satisfaction Domain Scores

As part of the MHSIP and YSS-F, individuals answered questions about their experiences receiving mental health services. For each question, individuals were asked to rate their level of agreement with a statement based on the following scale: (5) Strongly Agree, (4) Agree, (3) Neutral, (2) Disagree, and (1) Strongly Disagree.

MHSIP and YSS-F domain scores were created by averaging individuals' responses to the questions for each domain. Individuals who did not respond to at least two-thirds of the questions in a domain were omitted from the scoring. Based on a patient's domain score, they were categorized as having a positive experience (average domain score above 3.5 out of 5), mixed experience (average domain score between 2.5 ad 3.5), and a negative experience (average domain score below 2.5 out of 5).[1]

Race and Ethnicity

Eleven of the 13 Demonstration sites collected information on the race and ethnicity of the patient completing the survey. After consulting with sites on how they measure race, sites were asked to categorize their individuals into the following racial categories: (a) American Indian or Alaskan Native, (b) Asian, (c) Black or African American, (d) Middle Eastern or North African, (e) Native Hawaiian or Pacific Islander, (f) White (Caucasian), (g) More than one Race, (h) Other, (i) Prefer not to Answer. For ethnicity, sites were asked to categorize their individuals into the following ethnicity categories: (a) Spanish, Hispanic, or Latino, (b) Not Spanish, Hispanic, or Latino, and (c) Prefer not to answer.

Gender

Seven of the 13 Demonstration sites collected information on the gender of the patient. After consulting with sites on how they measure gender, sites were asked to categorize their individuals into the following gender categories: (a) Male, (b) Female, (c) Nonbinary or Gender Non-conforming, (d) Choose to Self-describe, and (e) Prefer not to Answer.

Age

Seven of the 13 Demonstration sites collected information on the age of the patient. For the MHSIP data, sites were asked to categorize age into the following categories: (a) 18-29 years old, (b) 30-64 years old, (c) 65+ years old, and (d) Prefer not to answer. For the YSS-F data, sites were asked to categorize individuals into the following age categories: (a) 0-4 years old, (b) 5-12 years old, (c) 13-18 years old, and (d) Prefer not to answer.

Survey Demographics

A breakdown of survey demographics and a comparison to state population statistics is presented below.

Adult demographics for the MHSIP survey population are provided in Figure B1 below. Most respondents were White (Caucasian), followed by Black or African American. This race distribution mirrored the overall state population but differed somewhat from the population previously served by State Mental Health Agencies, which comprised a smaller percentage of White (Caucasian). There was also a higher percentage of non-Hispanic (89.7%) and cis-gender females (52.3%) among MHSIP survey respondents compared to SMHA service respondents (82.5% and 45.1%, respectively).

It is difficult to compare the age distribution of both MHSIP and YSSF survey population with previous SMHA service respondents and the state population due to differing age brackets. However, the percentage of those 65 and older is comparable between MHSIP survey respondents (7.6%) and SMHA service respondents (7.4%).

Figure B1

Demographics for MHSIP Survey Population

DEMOGRAPHICS – STATE OF MI	CCBHC ADULTS - MHSIP (2023)*	SERVED BY STATE MENTAL HEALTH AGENCY (SMHA) (2022)**[33]	OVERALL STATE POPULATION (2022)[34]
RACE			
WHITE (CAUCASIAN)	76.1%	64.3%	80.3%
BLACK OR AFRICAN AMERICAN	15.2%	25.4%	15.0%
AMERICAN INDIAN AND ALASKAN NATIVE	1.2%	0.6%	1.0%
ASIAN OR PACIFIC ISLANDER	0.7%	0.7%	3.7%
ETHNICITY			
HISPANIC TOTAL	10.3%	17.5%	5.7%
NOT HISPANIC	89.7%'	82.5%	94.3%
GENDER			
FEMALE / CISGENDER WOMAN	52.3%	45.1%	50.3%
MALE / CISGENDER MAN	45.5%	49.6%	49.7%

[33] "2022 Uniform Reporting Summary Output Tables Executive Summary" Accessed February 7, 2025. https://www.samhsa.gov/data/sites/default/files/reports/rpt42759/Michigan.pdf

[34] "Population by Race." Accessed February 7, 2025. https://vitalstats.michigan.gov/osr/Population/npPopBYRace.asp?Hisp=1.

DEMOGRAPHICS – STATE OF MI	CCBHC ADULTS - MHSIP (2023)*	SERVED BY STATE MENTAL HEALTH AGENCY (SMHA) (2022)**[33]	OVERALL STATE POPULATION (2022)[34]
TRANSGENDER	0.1%	-----	0.38%
NONBINARY OR GENDER NONCONFORMING	2.0%	-----	-----
OTHER / CHOOSE TO SELF-DESCRIBE	0.2%	-----	-----
AGE			
<18	-----	-----	-----
18-44	-----	-----	44.0%
45-64	-----	-----	32.3%
65+	7.6%	7.4%	23.7%
***RESPONSES OF "PREFER NOT TO ANSWER" REMOVED FROM DENOMINATOR** ****INDIVIDUALS WITH MISSING DATA REMOVED FROM DENOMINATOR**			

Data Source: CHRT Analysis of MHSIP Adult Consumer Survey, 2023

Demographics for the YSS-F survey population are provided in Figure B2 below. For the YSS-F, parents or caregivers completed the survey for mostly White (Caucasian) children (62%), followed by Black or African American (17%), and More than One Race (12%). Similarly, 80% of YSS-F respondents completed the survey for non-Hispanic children, 54% for cisgender males, and 43% for children between the ages of 5-12 years old.

Figure B2

Demographics for YSS-F Survey Population

YOUTH CONSUMER DEMOGRAPHICS	PERCENT
RACE (N=980)	
WHITE (CAUCASIAN)	62%
BLACK OR AFRICAN AMERICAN	17%
AMERICAN INDIAN AND ALASKAN NATIVE	<1%
ASIAN	<1%
NATIVE HAWAIIAN OR PACIFIC ISLANDER	
MORE THAN ONE RACE	12%
OTHER	4%
PREFER NOT TO ANSWER	4%
ETHNICITY (N=521)	
SPANISH, HISPANIC, OR LATINO	12%

YOUTH CONSUMER DEMOGRAPHICS	PERCENT
NOT SPANISH, HISPANIC, OR LATINO	80%
PREFER NOT TO ANSWER	8%
GENDER (N=518)	
FEMALE / CISGENDER WOMAN	39%
MALE / CISGENDER MAN	54%
NONBINARY OR GENDER NONCONFORMING	2%
TRANSGENDER	<1%
OTHER / CHOOSE TO SELF-DESCRIBE	<1%
PREFER NOT TO ANSWER	4%
AGE (N=520)	
0-4 YEARS OLD	12%
5-12 YEARS OLD	43%
13-18 YEARS OLD	41%
18+ YEARS OLD	<1%
PREFER NOT TO ANSWER	3%

Data Source: CHRT Analysis of YSS-F Survey, 2023

Summary Results by Domain and Item

Figure B3

Overall Adult's CCBHC Experience by Domain and Item

DOMAIN	PERCENT POSITIVE RESPONSE FOR DOMAIN	DOMAIN QUESTIONS	PERCENT POSITIVE RESPONSE FOR QUESTION
SATISFACTION	89%	I like the services I received here.	92%
		If I had other choices, I would still get services from this agency.	87%
		I would recommend this agency to a friend or family member.	90%
ACCESS	84%	The location of services was convenient (parking, public transportation, distance, etc.).	84%
		Staff were willing to see me as often as I felt it was necessary.	89%
		Staff returned my call in 24 hours.	86%
		Services were available at times that were good for me.	90%
		I was able to get all the services I thought I needed.	82%
		I was able to see a psychiatrist when I wanted to.	78%
QUALITY AND PARTICIPATION	92%	Staff here believe that I can grow, change and recover.	91%
		I felt comfortable asking questions about my treatment and medication.	91%
		I felt free to complain.	81%
		I was given information about my rights.	94%
		Staff encouraged me to take responsibility for how I live my life.	92%
		Staff told me what side effects to watch out for.	79%
		Staff respected my wishes about who is and who is not to be given information about my treatment.	94%
		I, not staff, decided my treatment goals.	88%
		Staff were sensitive to my cultural background (race, religion, language, etc.)	90%
		Staff helped me obtain the information I needed so that I could take charge of managing my illness.	88%
		I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	83%
OUTCOMES	75%	I deal more effectively with daily problems.	84%
		I am better able to control my life.	78%
		I am better able to deal with crisis.	75%

DOMAIN	PERCENT POSITIVE RESPONSE FOR DOMAIN	DOMAIN QUESTIONS	PERCENT POSITIVE RESPONSE FOR QUESTION
		I am getting along better with my family.	71%
		I do better in social situations.	76%
		I do better in school and/or work.	76%
		My housing situation has improved.	68%
FUNCTIONING	73%	My symptoms are not bothering me as much.	70%
		I do things that are more meaningful to me.	79%
		I am better able to take care of my needs.	80%
		I am better able to handle things when they go wrong.	75%
		I am better able to do things that I want to do.	78%
SOCIAL CONNECTEDNESS	76%	I am happy with the friendships I have.	81%
		I have people with whom I can do enjoyable things.	84%
		I feel I belong in my community.	71%
		In a crisis, I would have the support I need from family or friends.	84%

This table shows the questions associated with each MHSIP survey domain, along with the percentage of positive responses for both the overall domain score and each individual question. There was variation in the ways sites implemented their surveys. Four sites did not include a neutral option. In these cases, patient responses were coded as: (1) Strongly Agree, (2) Agree, (4) Disagree, and (5) Strongly Disagree. Domain scores were calculated in the same way as those that included the neutral option, by averaging individuals' responses to the questions for each domain. Other sites used abridged versions of the MHSIP and YSS-F that excluded some questions. In these instances, domain scores were calculated based on the included questions. Individuals who did not have responses for at least two thirds of the original questions for the domain were excluded from the analysis. Some sites added additional questions to their MHSIP Survey. These questions were not included in the analyses.
Data Source: CHRT Analysis of MHSIP Adult Consumer Survey, 2023

Figure B4

Overall Family (Child/Youth) CCBHC Experience by Domain and Item[35]

DOMAIN	PERCENT POSITIVE RESPONSE FOR DOMAIN	DOMAIN QUESTIONS	PERCENT POSITIVE RESPONSE FOR QUESTION
APPROPRIATENESS	87%	Overall, I am satisfied with the services my child received.	89%
		The people helping my child stuck with us no matter what.	90%

[35] There was variation in the ways sites implemented their surveys. Four sites did not include a neutral option. In these cases, patient responses were coded as: (1) Strongly Agree, (2) Agree, (4) Disagree, and (5) Strongly Disagree. Domain scores were calculated in the same way as those that included the neutral option, by averaging individuals' responses to the questions for each domain. Other sites used abridged versions of the MHSIP and YSS-F that excluded some questions. In these instances, domain scores were calculated based on the included questions. Individuals who did not have responses for at least two thirds of the original questions for the domain were excluded from the analysis. Some sites added additional questions to their MHSIP Survey. These questions were not included in the analyses.

DOMAIN	PERCENT POSITIVE RESPONSE FOR DOMAIN	DOMAIN QUESTIONS	PERCENT POSITIVE RESPONSE FOR QUESTION
		I felt my child had someone to talk to when she/he was troubled.	87%
		The services my child and/or family received were right for us.	89%
		My family got the help we wanted for my child.	84%
		My family got as much help as we needed for my child.	83%
ACCESS	87%	The location of services was convenient for us.	91%
		Services were available at times that were convenient for us.	91%
PARTICIPATION	93%	I helped to choose my child's services.	91%
		I helped to choose my child's treatment goals.	94%
		I participated in my child's treatment.	95%
CULTURAL SENSITIVITY	96%	Staff treated me with respect.	94%
		Staff respected my family's religious/spiritual beliefs.	95%
		Staff spoke with me in a way that I understand.	97%
		Staff were sensitive to my cultural/ethnic background.	94%
OUTCOMES	71%	My child is better at handling daily life.	76%
		My child gets along better with family.	74%
		My child gets along better with friends and other people.	74%
		My child is doing better in school and/or work.	70%
		My child is better able to cope when things go wrong.	69%
		I am satisfied with our family life right now.	66%
		My child is better able to do things he or she wants to do.	77%
SOCIAL CONNECTEDNESS	84%	I know people who will listen and understand me when I need to talk.	88%
		I have people that I am comfortable talking with about my child's problems.	91%
		In a crisis, I would have the support I need from family or friends.	82%
		I have people with whom I can do enjoyable things.	86%

This table shows the questions associated with each YSS_F survey domain, along with the percentage of positive responses for both the overall domain score and each individual question. There was variation in the ways sites implemented their surveys. Four sites did not include a neutral option. In these cases, patient responses were coded as: (1) Strongly Agree, (2) Agree, (4) Disagree, and (5) Strongly Disagree. Domain scores were calculated in the same way as those that included the neutral option, by averaging individuals' responses to the questions for each domain. Other sites used abridged versions of the MHSIP and YSS-F that excluded some questions. In these instances, domain scores were calculated based on the included questions. Individuals who did not have responses for at least two thirds of the original questions for the domain were excluded from the analysis.
Data Source: CHRT Analysis of YSS-F Survey, 2023

Appendix C: Claims Analysis Definitions and Data Specifications

CCBHC-Eligible Diagnoses

There are several behavioral health diagnoses that define the CCBHC-eligible population, as highlighted from the CCBHC Demonstration Handbook. The table below specifies the ICD-10 diagnostic codes and descriptions used to identify the CCBHC-eligible population in these analyses. Claims files in each year of the study period included up to 25 diagnoses variables per person. Our analysis looked for the presence of any relevant diagnosis code in each year.

Figure C1

CCBHC Qualifying Diagnosis Codes and Descriptions

ICD-10 Diagnosis Code Range	Diagnosis Code Descriptions
F01-F09	Mental disorders due to known physiological conditions
F10-F19	Mental and behavioral disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F30-F39	Mood [affective] disorders
F40-F48	Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders
F50-F59	Behavioral syndromes associated with physiological disturbances and physical factors
F60-F69	Disorders of adult personality and behavior
F90-F99	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98), Unspecified mental disorder (F99)

CCBHC Core Services

CCBHC core services are defined with the ‘procedure code’ variable in the claims data and were identified in the CCBHC Demonstration Handbook. The procedure code variable incorporates both Current Procedural Terminology (CPT) and Healthcare Common

Procedure Coding System (HCPCS) commonly used in administrative healthcare claims data. We created flags for each core service category, which aggregated the presence of any of the relevant procedure codes at any point in each fiscal year. As requested by MDHHS, we separated outpatient mental health and substance use services to analyze mental health and substance use individually. Procedure codes were categorized in each group depending on the code descriptions, which were verified with MDHHS. For procedure codes that could not be clearly defined in either mental health or substance use, or could overlap between categories, we categorized the codes based on member ID types. For example, where codes were labeled "both/unclear," but member ID type was 88, the service was categorized as substance use. Services were categorized as mental health where the codes were "both/unclear," and member ID type was 89. In cases where member ID type was 20, the service could not be distinguished as either mental health or substance use and was omitted from this analytic subset.

The procedure codes used for core services analyses are based on those provided in Appendix A in the CCBHC Handbook Version 2.0. Additionally, service codes for Outpatient Mental Health and Substance Use Services were further broken down into (1) Outpatient Mental Health Services and (2) Outpatient Substance Use Services based on the following table below:

Figure C2

Service Codes for Outpatient Mental Health and Substance Use Services

Service Code	Service Description	MH or SUD
99202	E & M 15-29 Minutes - Physician	Mental Health or SUD, based on Member Type
99203	E & M 30-44 Minutes - Physician	Mental Health or SUD, based on Member Type
99204	E & M 45-59 Minutes - Physician	Mental Health or SUD, based on Member Type
99205	E & M 60-74 Minutes - Physician	Mental Health or SUD, based on Member Type

Service Code	Service Description	MH or SUD
99211	Established Patient	Mental Health or SUD, based on Member Type
99212	Established Patient 10-19 Minutes	Mental Health or SUD, based on Member Type
99213	Established Patient 20-29 Minutes	Mental Health or SUD, based on Member Type
99214	Established Patient 30-39 Minutes	Mental Health or SUD, based on Member Type
99215	Established Patient 40-54 Minutes	Mental Health or SUD, based on Member Type
99341	Home Visit - New Patient - 20 Minutes	Mental Health
99342	Home Visit - New Patient - 30 Minutes	Mental Health
99343	Home Visit - New Patient - 45 Minutes	Deleted eff. 1/1/23
99344	Home Visit - New Patient - 60 Minutes	Mental Health
99345	Home Visit - New Patient - 75 Minutes	Mental Health
99347	Home Visit - Established Patient - 15 Minutes	Mental Health
99348	Home Visit - Established Patient - 25 Minutes	Mental Health
99349	Home Visit - Established Patient - 40 Minutes	Mental Health
99350	Home Visit - Established Patient - 60 Minutes	Mental Health
H0034	Medication training and support	Mental Health

Service Code	Service Description	MH or SUD
H2010	Medication Algorithm EBP	Mental Health
H2021	Specialize Wraparound Facilitation	Mental Health
T1027	Parent Education	Mental Health
96372	Therapeutic, prophylactic, or diagnostic injection. Report using this procedure code only when provided as a separate service	Mental Health
99506	Home visit for intramuscular injection	Mental Health
H0004	Behavioral health counseling and therapy	SUD
H0025	Behavioral health prevention education service (delivery of services with target population to affect knowledge, attitude, and/or behavior)	Mental Health
H0036	Community psychiatric supportive treatment	Mental Health
H0039	ACT	Mental Health
H2019	Therapeutic Behavioral Services: Use for individual Dialectical Behavior Therapy (DBT)	Mental Health
H0005	Alcohol and/or drug services; group counseling by a clinician	SUD
H0012	Alcohol and/or drug services; subacute detoxification (residential addiction program outpatient)	SUD
H0014	Alcohol and/or drug services; withdrawal management; ambulatory	SUD
H0015	Alcohol and/or drug services; intensive outpatient, 9-19 hours	SUD
H0022	Alcohol and/or drug services; Intervention Service (Early Intervention)	SUD
H0050	Outpatient alcohol/other drug treatment services (brief intervention)	SUD

Service Code	Service Description	MH or SUD
H2035	Outpatient alcohol/other drug treatment services, per hour	SUD
H2036	Outpatient alcohol/other drug treatment services, per diem	SUD

Appendix D: List of CCBHCs in the Intervention and the Expansion Groups

Figure D1

The Intervention Group

Intervention Group (10/01/2021 - Present)	Counties Served	Rural or Urban	CMHSP or non-CMHSP
Community Mental Health Authority of Clinton, Eaton, Ingham Counties	Clinton, Eaton, Ingham	Urban	CMHSP
CNS Healthcare - Oakland County	Oakland County	Urban	CMHSP
EasterSeals MORC - Oakland County	Oakland	Urban	CMHSP
Healthwest	Muskegon	Urban	CMHSP
Integrated Services of Kalamazoo	Kalamazoo	Urban	CMHSP
Macomb County Community Mental Health	Macomb	Urban	CMHSP
Pivotal	St. Joseph	Rural	CMHSP
Saginaw County Community Mental Health Authority	Saginaw	Urban	CMHSP
St. Clair County Community Mental Health	St. Clair	Urban	CMHSP
The Guidance Center	Wayne	Urban	CMHSP
The Right Door	Ionia	Rural	CMHSP

Intervention Group (10/01/2021 - Present)	Counties Served	Rural or Urban	CMHSP or non-CMHSP
Washtenaw County Community Mental Health	Washtenaw	Urban	CMHSP
West Michigan Community Mental Health	Mason, Lake, Oceana	Rural	CMHSP

The Expansion Group was excluded from all group stratification analyses due to only having one year of data available during the timeframe of this report. However, data from the Expansion Group was included in all remaining client-level and claims-level analyses, such as stratification by race, gender, and severity. The Expansion Group will be included in group stratification analyses for future reports once more data is available.

Figure D2

The Expansion Group

Expansion Group (10/01/2023 - Present)	Counties Served	Rural or Urban
Arab Community Center for Economic and Social Services (ACCESS)	Wayne County	Urban
Barry County Community Mental Health Authority	Barry County	Rural
CNS Healthcare - Wayne County	Wayne County	Urban
Community Mental Health of Ottawa County	Ottawa County	Urban
Development Centers, Inc.	Detroit	Urban
Elmhurst Home, Inc.	Detroit	Urban
Genesee Health System	Genesee County	Urban

Expansion Group (10/01/2023 - Present)	Counties Served	Rural or Urban
Lapeer County Community Mental Health	Lapeer County	Urban
LifeWays	Jackson, Hillsdale	Urban
Monroe Community Mental Health Authority	Monroe County	Urban
Network 180 (Kent County Community Mental Health Authority)	Kent County	Urban
OnPoint Behavioral Health	Allegan County	Urban
Pines Behavioral Health Services	Branch County	Rural
Riverwood Center	Berrien County	Urban
Sanilac County Community Mental Health Authority	Sanilac County	Rural
Southwest Counseling Solutions	Kalamazoo County	Urban
Summit Pointe	Calhoun County	Urban

Appendix E: Data Considerations and Limitations

The following is a detailed set of considerations regarding all data included in this report and potential limitations.

Data Source: Medicaid Claims Data	
Category	**Consideration(s)/ Limitation(s)**
Timeframe of Data Collection	Claims data represents a cross-sectional snapshot of services for each person and is not longitudinal. Therefore, this is not intended to represent a person's full treatment episode.
FY2024 Claims Data	The datasets for fiscal year 2024 were prepared after the end of the fiscal year. However, due to the timing of the data extract, the runout period for this fiscal year may be shorter than those of previous years, which may lead to less complete data. While it is not expected to have substantial impacts on the analysis, this may contribute, in part, to some observed downward trends compared to previous years.
Unique Identifier/ Duplication of Population Count	Typically, patients in the claims datasets were assigned a de-identified, unique ID code (referred to as BENEFICIARY ID in the data). In some cases, this variable was missing information, but an alternative ID code (CON UNIQUE ID) was present in the claims. To improve the accuracy of unique population counts, we created a UNIQUE ID variable that incorporated these two different population identifiers. This method does not entirely eliminate duplicate population counts since the CON UNIQUE ID variable is unique to the patient seen by a specific service provider and thus may differ in cases where a patient sees multiple service providers. However, this method still offers a more precise estimate of unique population counts and aligns with identifiers used by MDHHS for analysis.

Data Source: Medicaid Claims Data	
Category	**Consideration(s)/ Limitation(s)**
Categorization of Outpatient Mental Health and Outpatient SUD Services	Outpatient mental health and substance use services were broken out to analyze each individually. Procedure codes were categorized in each group depending on the code descriptions, which were verified with MDHHS. For procedure codes that could not be clearly defined in either mental health or substance use, or could overlap between categories, we categorized the codes based on member ID types. A member ID value of '88' would correspond to an SUD Member ID, while a member ID value of '89' would correspond to a PIHP Member ID for mental health. However, in cases where member ID type was '20', corresponding to a Michigan Health Plan Beneficiary ID, the service could not be distinguished as either mental health or substance use and was omitted from this analytic subset.
Group Comparison Analyses	The Expansion Group was excluded from all group comparison analyses because providers in this group joined the Demonstration on October 1, 2023, which did not allow for sufficient years of data to draw meaningful comparisons during the intervention period (FY2022-2024).
Severity Stratification: LOCUS Assessment Scores	For severity stratification analyses, a small percentage (less than 1%) of LOCUS scores fell below the 10-16 range to be designated as either mild-to-moderate or SMI (greater than 16) and were removed from analysis. On a claims level, the severity of the individual at the time of the service date is determined first by the most recent available LOCUS assessment score prior to the service date. If no LOCUS score exists prior to the service date, then severity is determined by the next available LOCUS score after the service date.

Data Source: Medicaid Claims Data	
Category	**Consideration(s)/ Limitation(s)**
	LOCUS assessment scores to determine severity were not available for 2018. As such, claims data from 2018 was excluded from the baseline average.
ED Utilization Measure	While the CCBHC Demonstration serves both the Medicaid and non-Medicaid populations, ED procedure codes in claims data are only present for Medicaid beneficiaries (identified by the presence of a BENEFICIARY ID value). As such, the ED Utilization measure is limited to only represent the Medicaid population and total eligible Medicaid months are used to calculate patient months. The timeframe for ED Utilization analyses spanned from FY2019 – FY2024, as data on eligible Medicaid months was not accessible for FY2018 during the time of analysis. The I/DD population was excluded from ED Utilization analyses, as their health needs and reasons for ED visits often do not align with the focus of this analysis, which is aimed at measuring health outcomes for persons with behavioral health or SUD needs. When examining differences in ED utilization by severity (i.e. mild-to-moderate vs. SMI), individuals whose severity changed during the timeframe (i.e. scored as both “mild-to-moderate" and “SMI” from two or more LOCUS assessment scores) were removed from stratification analysis due to ambiguity in determining patient months before and after change in severity. Individuals with missing LOCUS assessment scores were removed from analysis as well. In Figure 42, when examining differences in ED utilization by mental health and physical health diagnoses, unique ED Visits were identified by distinct combinations of (1) a

Data Source: Medicaid Claims Data	
Category	**Consideration(s)/ Limitation(s)**
	person's unique ID and (2) service date for each claim line with an ED procedure code. Based on how a unique ED visit is identified as above, some persons received both a behavioral health and physical health primary diagnosis on the same day, especially if they had claims submitted from multiple providers. As such, the total number of ED visits does not equal the sum of mental health ED visits and physical health ED visits.
Gender Stratification	Some gender variables were aggregated into combined categories to both facilitate a streamlined and cleaner interpretation of the findings (when observed independently, the trends across these categories were similar), and accommodate for categories where volumes were too low to analyze independently. These categories included those who identified as agender, bigender, gender questioning, genderfluid, non-binary/genderqueer, transgender man, transgender woman, two spirit, and androgynous.
Total Counts vs. Counts by Stratification Categories	Throughout the analysis, total unique counts of person and various stratifications such as by demographic or intervention/comparison group may differ from overall total patient counts due to missing demographic and/or provider identification data.
Urban v. Rural Comparisons	For urban v. rural comparisons, only CCBHC-eligible individuals served by the Intervention or Expansion Group sites are included. Comparing urban v. rural differences for non-CCBHC CMH sites in the Comparison Group was beyond the scope of this report but may be considered and included in future analyses.

Data Source: Patient Experience Surveys	
Category	**Consideration(s)/ Limitation(s)**
Timeframe of Data Collection	Patient experience surveys were conducted and collected by sites between June – September 2023 during the second year of the Demonstration (FY2023). As such, the data and responses collected are limited to reflect the experiences of persons served up to the end of the second Demonstration year (FY2023).
Inclusion Criteria for each Scoring Domain	MHSIP and YSS-F domain scores were created by averaging patients' responses to the questions for each domain. Patients who did not respond to at least two thirds of the questions in a domain were omitted from the scoring.
Sites Included in Analysis	Twelve of the 13 CCBHC are included in the analysis for patient experience among adults. One site developed their own unique survey and hence their data was omitted. Eleven of 13 sites are included in the analysis for patient experience among family/caregivers of youths. One site developed their own unique survey and hence their data was omitted. A second site did not receive a response to their survey from family/caregivers.
Sites Providing Demographic Data (i.e. Race, Gender, and Age)	Eleven of the 13 demonstration sites collected information on the race and ethnicity of the patient completing the survey. Seven of the 13 demonstration sites collected information on the gender of the patient. Seven of the 13 demonstration sites collected information on the age of the patient.

Data Source: Qualitative CCBHC and PIHP Interviews	
Category	**Consideration(s)/ Limitation(s)**
Timeframe	Qualitative interviews were conducted in two phases: CCBHC interviews from August 7–31, 2023, and PIHP interviews from October 20–November 1, 2023. The data and responses collected are limited to reflect the experience of CCBHCs and PIHPs in the Intervention Group up to the end of the second Demonstration year (FY2023).