# ANALYSIS

## Oregon Health Authority

## Certified Community Behavioral Health Clinics

**Analyst:** Matt Stayner

**Request:** Acknowledge the receipt of a report from the Oregon Health Authority on the administration of the Certified Community Behavioral Health Clinic program specifying:

1) investments and categorized spending in the 2021-23 biennium, to include number of people served,
2) barriers to having fully utilized available funds,
3) specifics on health outcomes based on individual participant's results,
4) reduced costs resulting from the program,
5) recommendations on the whether to redirect funding from non-CCBHC programs to increase this program funding, and
6) the impact of ending the pilot and discontinuing funding beyond the 2023-25 biennium.

**Analysis:** The report provides a relevant and informative discussion of the enumerated items requested in the budget note. Subsequent to the issuance of the budget note, HB 4002 (2024) directed OHA to expand and make permanent the Certified Community Behavioral Health Clinic (CCBCH) program through a state plan amendment. Therefore, the discussion of redirecting funding from other programs to the CCBHC program and impacts of ending the pilot program are no longer applicable. This is also addressed in a policy package included in the Governor's budget that would provide additional funding to expand the CCBHC program statewide, a requirement of the state plan amendment.

The report notes the difficulty in tracking exact costs for specified services of CCBHCs that is somewhat indicative of tracking the funding and costs of the publicly funded mental health care system in Oregon, generally, due to the multiple funding conduits and entities involved. In addressing the barriers to fully utilizing provided funding, the report indicates that utilization of wraparound funding is highly dependent on the difference between costs estimated under the prospective payment system for CCBHCs and the actual service payments received.

In addressing health outcomes, the report details a higher than comparative success rate in certain CMS measures around engagement and initiation for substance use disorder (SUD) treatment and follow-up treatment from mental illness hospitalizations, but also details lagging performance in other CMS core set measures, particularly around medication management. The report attributes the lower comparative performance in these measures to the higher general level of behavioral and physical health need acuity of individuals served within the CCBHC population vs the general Medicaid population.

Although not specifically required in the budget note, the report provided significant detail on utilization of CCBHC services broken down by race, ethnicity, gender, and age. Additional comparative demographic statistics of inpatient visits, emergency department utilization, and user satisfaction surveys were also included.

The report attempts to address the question of reduced costs resulting from the program using select statics to calculate changes in service utilization that, in turn, results in comparative savings or increases in costs over time. This limited analysis may or may not be truly indicative of any long-term changes to cost structures resulting from the CCBHC program.

**Recommendation:** The Legislative Fiscal Office recommends acknowledging receipt of the report.

**Request:** Report on the Certified Community Behavioral Health Center program in response to a budget note to Senate Bill 5525 (2023) by the Oregon Health Authority (OHA).

**Recommendation:** Acknowledge receipt of the report.

**Discussion:** OHA is reporting on the Certified Community Behavioral Health Center (CCBHC) program as directed in a budget note to Senate Bill 5525 (2023), OHA's main budget bill for the 2023-25 biennium. The budget note directs OHA to report to the Joint Committee on Ways and Means by February 1, 2025 with the following information:

- Investments and categorized spending in the 2021-23 biennium, including the number of people served,
- Barriers to having fully utilized available funds,
- Specifics on health outcomes based on individual participant's results,
- Reduced costs resulting from the program
- Recommendations on the whether to redirect funding from non-CCBHC programs to increase this program funding, and
- The impact of ending the pilot and discontinuing funding beyond the 2023-25 biennium.

OHA submitted their report timely on January 14, 2025, in response to the budget note.

**Program History**
The CCBHC model provides an integrated array of community-based physical and behavioral health services to Oregonians with complex behavioral health needs regardless of their ability to pay. Oregon was one of eight states selected by the federal government in 2017 to implement the CCBHC demonstration program. Startup funds were provided through a federal grant, with operating costs of CCBHCs paid through enhanced Medicaid reimbursement for providing a defined set of services to adults and children with complex behavioral health needs. Twelve CCBHC clinics were established in Oregon during the initial implementation. Projected savings from reduced need for other services were originally intended to fund the program, but those savings did not materialize. This led to significant budgetary strain and programmatic uncertainty during the first two biennia of operations; several demonstration sites closed temporarily due to lack of funds. The Legislature approved ongoing funding for the original 12 clinics as part of House Bill 5024 (2021), OHA's main budget bill for the 2021-23 biennium.

With the pending expiration of the CCBHC demonstration in September 2025 Oregon needed to determine how to structure the program for it to continue. House Bill 4002 (2024) established the program in state law and directed OHA to request federal approval to add the program to its Medicaid state plan. Once the program is part of the Medicaid state plan, Oregon can no longer restrict providers from seeking to become

certified due to lack of funding. OHA anticipates an additional 15 sites will seek to become certified in the 2025-27 biennium; the Governor's Budget for 2025-27 includes an additional $14.1 million General Fund and $33.7 million Federal Funds to support the expansion.

**CCBHC Report**

OHA reported to the Joint Committee on Ways and Means in early Spring 2023, evaluating the CCBHC program. The evaluation found modest increases in access to behavioral health treatment and primary care, mixed results on whether the services improved health outcomes, lowered overall health care costs or improved overall community health and an increase in the cost of care for CCBHC clients compared to similar Coordinated Care Organizations (CCO) members. In response to limitations with the report methodology and the challenges in drawing firm conclusions from the time period being evaluated due to the pandemic and programmatic disruptions, the 2023 Legislature requested a follow-up report in the form of a budget note.

OHA's report addresses the main topics requested in the budget note. During 2021-23 CCBHCs provided primarily outpatient mental health services (48 percent of total encounters), outpatient substance use disorder treatment (15 percent), and peer and family support services (11 percent). While the program was not using its full budget in 2019-21, adjustments to the rate model and a return to full participation by several clinics resulted in close to full expenditure of the program's budget in 2021-23. OHA found that the population served by CCBHCs received better care than the overall CCO population on some quality measures. The CCBHC population also saw reduced inpatient hospitalization and emergency department use during the period examined. OHA estimated the CCBHC program saves $7 million per year compared with the Community Mental Health Programs CMHP in Oregon. To determine cost savings, OHA compared CMHP service utilization with CCBHC service utilization, with differences between the two being attributed as savings to the CCBHC program. It should be noted that some of the savings is in the form of cost avoidance rather than budgetary savings that can offset the cost of program expansion. Finally, OHA recommends the program be continued as planned through House Bill 4002 (2024).

January 21, 2025

Senator Kate Lieber, Co-Chair
Representative Tawna Sanchez, Co-Chair
Joint Committee on Ways and Means
900 Court Street NE
State Capitol
Salem, OR 97301

SUBJECT: Report on Certified Community Behavioral Health Clinics

Dear Co-Chairs and Committee Members:

In response to a budget note in HB 5525 (2023), please find attached a report on Certified Community Behavioral Health Clinics. The report can also be found on OHA's website here.

Sincerely,

Sejal Hathi, MD MBA
Director

EC: Sen. Winsvey Campos
Rep. Andrea Valderama

# Spending, Service Utilization and Outcomes in the Oregon Certified Community Behavioral Health Clinic Demonstration Program, 2021-2023 Biennium

Report to the Oregon State Legislature in satisfaction of SB 5525 (2023 Regular Session)

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# Executive Summary

A budget note in SB 5525 (2023 session) directed the Oregon Health Authority (OHA) to conduct an analysis of the Certified Community Behavioral Health Clinic (CCBHC) Program, with a focus on: i) investments and categorized spending in the 2021-23 biennium, to include number of people served, ii) barriers to having fully utilized available funds, iii) specifics on health outcomes based on individual participant's results, iv) reduced costs resulting from the program, v) recommendations on whether to redirect funding from non-CCBHC programs to increase this program funding, and vi) the impact of ending the pilot and discontinuing funding beyond the 2023-25 biennium.

Analysis of points v and vi are no longer applicable after legislation passed in 2024 (HB 4002) directing OHA to expand CCBHCs through a state plan amendment. Once CCBHCs are an approved part of Oregon's Medicaid State Plan, OHA will be required to cover the cost of services in compliance with federal regulations for state plan services. To ensure adequate Medicaid funding for CCBHC services provided under the state plan, the Governor's Office has submitted a sustainable budget with appropriate federal match in the Governor's Request Budget.

## Key Findings

### Investments and Spending

In the 2021-2023, biennium, Oregon $61.3 million in wraparound payments and open card payments for CCBHC services. Outpatient mental health treatment services accounted for the largest share of the CCBHC services paid (337k, 48%). The next highest shares were outpatient substance use disorder treatment (115k, 15%) and peer and family support services (86k, 11%). Crisis services made up 2% of paid encounters, representing 14,000 encounters.
OHA increased utilization of CCBHC funds from 81% in the 2019-2021 biennium to 95% in the 2021-2023 biennium. The loss of three clinics in 2019 accounted for the biggest barrier to fully funds in 2019-2021. OHA was able to recertify the clinics for the

2021-2023 biennium and adjust rates to reflect actual cost more accurately, resulting in greater usage of the budgeted funds.

## Utilization

The number of individuals served at CCBHCs remained stable between FY 2022 and FY 2023, dropping slightly from 35,890 total persons served to 35,364. Among CCBHC service users, total service use did not vary appreciably by race, ethnicity, or sex. Children and youth (0-17) and young adults (18-25) used proportionally fewer services overall, and adults aged 26-64 used proportionally more services overall.

## Health Outcomes

The CCBHC population demonstrates better outcomes than the Coordinated Care Organization (CCO) member population on many Centers for Medicare & Medicaid Services (CMS) Core Quality Measures (see page 25). This is notable because CCBHCs likely serve a population of higher acuity individuals than the general CCO population.

Although the CCBHC population generally saw greater utilization in emergency department visits and inpatient stays for mental health, substance use disorder, and physical health compared to the non-CCBHC population, the CCBHC population saw greater reductions in the rate of inpatient stays and emergency department visits, primarily for physical health and substance use disorders.

Although CCBHCs generally saw fewer positive responses across all domains of the Mental Health Statistics Improvement Survey (18+) and Youth Services Survey (0-17), CCBHCs saw greater or equivalent improvement compared to non-CCBHCs.

## Reduced Costs

During 2022-2023, CCHBCs generated an estimated annual cost savings of $7 million, primarily through lowering ED and inpatient utilization. Although the CCBHC population had higher overall costs than the non-CCBHC CMHP population, CCBHCs appeared better at lowering utilization rates for high-cost services. The magnitude of estimated cost savings is lower than the additional costs of the CCBHC program itself.

# Introduction

The Certified Community Behavioral Health Clinic (CCBHC) program is a federal demonstration program which seeks to drive behavioral health transformation across the nation through an innovative payment model — the prospective payment system —and a set of stringent clinical and operational standards that exceed those typically found in outpatient behavioral health settings. The program is overseen and implemented by three federal agencies: the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare & Medicaid Services (CMS) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE).

Several core aspects of the CCBHC model contribute to its promise and success in transforming community behavioral health:

1. **Clinics are required to provide integrated, coordinated, holistic care to all, regardless of ability to pay**. Clinics must provide a broad array of services, including primary care screening and monitoring, crisis services, outpatient mental health and substance use disorder services, screening, diagnosis and risk assessment, targeted case management, peer and family support, person- and family-centered treatment planning, psychiatric rehabilitation services, and community-based mental health care for veterans. CCBHCs are expected to coordinate care across organizations and settings in their community, ensuring their clients have seamless access to high-quality physical and behavioral health care, and have their housing, employment, educational and other economic and social needs met.
2. **The model drives quality improvement and a focus on addressing local needs.** Every three years, clinics must engage a wide variety of community partners to develop a community needs assessment, which is used to inform staffing, services, and goals for improvement. In addition, clinics develop individualized continuous quality improvement plans that leverage qualitative and quantitative data to track and improve outcomes, with an explicit focus on improving outcomes for populations experiencing health disparities. Finally, state agencies and clinics are required to submit annual reports on nationally

recognized behavioral health metrics, which enables the state and clinics to track performance year-over-year.

3. **The payment model enables clinics to provide high-quality care and "meet patients where they are."** Clinics are paid a prospective payment system (PPS) rate that accounts for the actual costs associated with providing CCBHC services. With the historic underfunding of the outpatient behavioral health safety net, the CCBHC payment model has improved clinics' ability to recruit and retain providers and to invest in the administrative infrastructure needed to deliver high-quality care. Under this payment model, clinics are paid a single bundled rate regardless of the number, type, or intensity of services provided. This allows clinics to focus on the services needed, rather than the services with higher reimbursement rates. The inclusion of indirect costs, such as staff transportation, allows clinics to cover the expenses associated with non-billable services, such as travel. Combined with general program requirements, this allows CCBHCs to serve individuals in community settings and beyond the four walls of the clinic.

Oregon was one of the first eight states to join the federal CCBHC demonstration program in 2017 and is currently in its final year of operation under the demonstration. Oregon has 12 demonstration clinics covering 21 sites across 14 counties. Nine clinics are Community Mental Health Programs (CMHPs), one is a healthcare delivery system, and two are non-profit behavioral health providers.

A 2022 evaluation of Oregon's CCBHC program, conducted by the OHSU-PSU School of Public Health, has showed that CCBHCs are improving access to care across the state. According to the evaluation, CCBHCs demonstrated a 4.9% increase in number of individuals served between 2017 and 2021. Non-CCBHC Community Mental Health Programs, by comparison, experienced a 4.2% *decrease* in the number of individuals served over the same time period. Rural and remote CCBHC communities saw the greatest gains in access, with 16.1% and 22.5% increases in numbers of individuals served, respectively.

In a budget note in SB 5525 (2023 session), the State Legislature directed the Oregon Health Authority (OHA) to conduct additional analysis of the CCBHC program, addressing the following:

1. Investments and categorized spending in the 2021-23 biennium, to include number of people served,
2. Barriers to having fully utilized available funds,
3. Specifics on health outcomes based on individual participant's results,
4. Reduced costs resulting from the program,
5. Recommendations on whether to redirect funding from non-CCBHC programs to increase this program funding, and
6. The impact of ending the pilot and discontinuing funding beyond the 2023-25 biennium.

The data provided in this report covers the 2021 – 2023 time period for clinics operating under the demonstration program. It is important to note that the agency's responses to the last two issues — recommendations on redirecting funding to the demonstration and the impact of ending the demonstration — account for a major policy shift that occurred in the last year. Pursuant to HB 4002 (2024), OHA is pursuing a state plan amendment which would make CCBHC services a permanent part of Oregon's Medicaid plan. OHA's authority under the state plan amendment fundamentally differs from its authority under the demonstration program. It is no longer relevant to assess the implications of discontinuing the program. In addition, financing decisions are different once CCBHCs operate under a state plan.

## Investments and Categorized Spending

The budget for the CCBHC program includes fee-for-service (FFS) payments for services provided to Oregon Health Plan open card members, as well as "wraparound" payments that clinics can receive when total reimbursement from their coordinated care organizations (CCOs) is lower than what they are entitled to under the prospective payment system (PPS).

**Prospective Payment System (PPS):** The CCBHC prospective payment system is a bundled rate calculated by dividing the total allowable costs by the total number of encounters. Allowable costs include both direct costs (staff compensation) and indirect costs (rent, office supplies, transportation, etc.). Encounters are the number of daily visits regardless of payor type. This sets a uniform rate across all services provided.

The function of the wraparound payment is to ensure that a clinic receives, at minimum, their PPS rate for services. If a clinic receives a higher level of reimbursement from a coordinated care organization relative to what they would receive under their PPS rate, the state does not recoup the difference – the clinic is allowed to keep any funds that exceed total reimbursement under their PPS rate. The payments are calculated on a quarterly basis, based on total reimbursement received from CCOs during a three-month time period.

In the 2021-2023 biennium, the state spent $50.2M on wraparound payments and $11.1M on FFS payments, for a total of $61.3M in CCBHC program spending.

**Table 1. CCBHC Program Expenditures, 2021 – 2023 Biennium**

| | FY 2022 | FY 2023 | Total Spent | Budget* |
|---|---|---|---|---|
| **Wrap** | $26,069,220 | $24,131,051 | $50,200,271 | $52,404,658 |
| **FFS** | $5,069,610 | $5,987,141 | $11,056,751 | $12,006,568 |
| **Total** | $31,138,830 | $30,118,192 | $61,257,022 | $64,411,226 |

*Note:* *Budget amounts for Wrap reflect reduction of approximately $55M in funds that occurred during the March 2023 rebalance.

Of the $61.3M spent in the 2021-2023 biennium, $11.8M came from state general funds and $49.5M came from the federal Medicaid match, for an average federal match rate of 81%.

CCOs are not required to report expenditures on CCBHCs through explicit, dedicated reporting. However, it is possible to estimate CCO expenditures using Medicaid claims

data. To do so, the OHA Behavioral Health Analytics team compiled data on claims for CCBHC-billable services, delivered by CCBHCs, that were paid by CCOs during 2021-2023 biennium. Based on this data, OHA estimates that CCOs spent $33 million on CCBHC services in FY 2022 and $38 million in FY 2023, for a total of $71 million over the 2021-2023 biennium. Note that these estimates may not account for CCO spending through alternative payment models, such as per-member, per-month payments to providers (also known as sub-capitation.) Payments for services delivered in these alternative arrangements may show up as $0 in Medicaid claims data. The estimate for CCO spending, therefore, represents a *minimum* estimate for payments made to CCBHCs.

**Table 2. Estimated CCO expenditures on CCBHC services, 2021 – 2023 biennium**

| | FY 2022 | FY 2023 | Total |
|---|---|---|---|
| **Estimated CCO expenditures** | $33,066,899 | $38,065,999 | $71,132,898 |

Spending by CCBHC service category is challenging to estimate for several reasons. First, CCBHCs exclusively receive their PPS rate for FFS payments, which is a bundled rate paid per day, regardless of the number or type of services provided. Second, although CCBHCs bill CCOs in the same fashion as any other behavioral health provider, not all clinics are paid by CCOs on a fee-for-service basis. Some receive reimbursement through alternative payment models, such as a per-member, per-month capitation rate, which, similar to the PPS, functions as a blended rate. Third, wraparound payments cannot be disaggregated into service categories as they are paid in lump sum. Finally, CCBHC PPS rates are calculated based on total clinic costs and the federal cost report does not require clinics to break out costs for specific services.

Because CCBHC providers and CCOs are still required to submit encounter information to the state's Medicaid database, it is possible to understand the number and type of services the funding supports overall. To determine this, the Behavioral Health Analytics team analyzed both FFS and CCO encounter data for all CCBHC

services in the 2021-2023 biennium and categorized data into nine CCBHC service buckets:

1. Crisis Services, including 24-hour mobile crisis and crisis stabilization
2. Outpatient Mental Health Treatment
3. Outpatient Substance Use Disorder Treatment
4. Peer and Family Support Services
5. Person-Centered Treatment Planning
6. Primary Care Screening and Monitoring
7. Psychiatric Rehabilitation Services
8. Screening, Assessment, Diagnosis and Risk Assessment
9. Targeted Case Management

In the 2021-2023 biennium, outpatient mental health treatment accounted for the largest share of CCBHC encounters (377k, 48%), followed by outpatient substance use disorder treatment (115k, 15%) and peer and family support services (86k, 11%).

**Table 3. CCBHC service encounters, by number and percent of total, 2021-2023 biennium**

| | Number | % of Total |
|---|---|---|
| Outpatient Mental Health Treatment | 376,914 | 48% |
| Outpatient Substance Use Disorder Treatment | 115,439 | 15% |
| Peer and Family Support Services | 85,785 | 11% |
| Screening, Assessment, Diagnosis and Risk Assessment | 58,884 | 7% |
| Psychiatric Rehabilitation Services | 48,480 | 6% |
| Primary Care Screening and Monitoring | 37,642 | 5% |
| Targeted Case Management | 34,404 | 4% |
| Crisis Services | 15,598 | 2% |

| | | |
|---|---|---|
| Person-Centered Treatment Planning | 14,288 | 2% |
| **Total** | **787,434** | **100%** |

## Barriers to OHA Fully Utilizing Funds

As noted, OHA's dedicated CCBHC program spending on Oregon Health Plan members is divided into two categories: FFS payments for services provided to open card members and wraparound payments for services provided to Coordinated Care Organization (CCO) members. In general, fee-for-service spending is less variable than wraparound payment spending. CCBHCs bill the Oregon Health Authority (OHA) directly for services provided to open card members. As such, the only variables to this bucket of money are the prospective payment system (PPS) rate and the utilization of services. Generally, there are few challenges paying out the portion of the budget earmarked for services provided to open card members with a usage rate of 90% or higher. Since OHA pays clinics directly when services are provided to open card members, the only impact effecting capacity to fully use the funds earmarked for open card members is service utilization.

**Table 4. Fee-for-service usage rate, 2019-2021 and 2021-2023 biennia**

| Biennium | Budget | Actuals | Usage Rate |
|---|---|---|---|
| 2021-2023 | $12,006,568 | $11,056,751 | 92% |
| 2019-2021 | $10,340,588 | $9,310,600 | 90% |

*Note:* For open card members, CCBHCs have spent a majority of the budget allotted. Usage rate increased by 2%.

For the 2019-2021 biennium, the biggest factor in using the full CCBHC funds was the loss of three clinics that dropped out of the demonstration in 2019. The demonstration was set to end March 2019, but there were multiple federal extensions, which created

uncertainty around the program. Most CCBHCs were able to find support from their counties to continue to provide CCBHC services through the period of uncertainty; however, three clinics were unable to secure alternative funding and dropped the program. The CCBHC budget was not adjusted to account for the loss of three clinics.

OHA was able to bring the clinics back into the demonstration in 2021 and 2022. This increased capacity to utilize more of the budget. Additionally, OHA rebased the CCBHCs' PPS rates in 2023. As directed by CMS, OHA allowed clinics to include anticipated costs when establishing initial PPS rates. These initial rates were increased annually by the Medicare Economic Index (MEI) established by CMS. In order to align the rates with actual costs, OHA recalculated each clinic's PPS rate to account for only actual cost through the 2023 rebase. This resulted in greater alignment within the purpose of the PPS rate and increased capacity to fully utilize the funds.

The most variable bucket is wraparound payments made for CCO members. This is a result of changes in CCO funds received in relation to changes in prospective payment system rates. In addition to the impact of the three clinics dropping from the program, changes in investments CCOs have made in behavioral health funding have resulted in lower or no wraparound payments to some clinics.

**Table 5. Usage rate by biennium for CCO wraparound payments**

| Biennium | Budget | Actuals | Usage Rate |
|---|---|---|---|
| 2021-2023 | $52,404,658 | $50,200,271 | 96% |
| 2019-2021 | $84,228,707 | $67,471,195 | 80% |

*Note*: Usage rate increased by 16% for wraparound payments.

Prior to rebasing in 2023, multiple CCBHCs did not receive a wraparound payment for several quarters because the amount they received from their CCO was greater than the amount they were entitled to through their PPS rate. As CCOs increased their investment in behavioral health spending and clinics negotiated higher capitation amounts from their CCO, the amount received from their CCO grew at a faster pace that their PPS rate was adjusted through MEI. The 2023 rebase resulted in several

clinics receiving a substantially higher PPS rate such that they were once again entitled to more than their CCO was paying them.

As OHA continues to monitor PPS rates to ensure they accurately reflect costs to sustainably provide services, the program should see greater spending of the allocated budget.

**Table 6. Usage rate for total CCBHC budget**

| Biennium | Budget | Actuals | Usage Rate |
|---|---|---|---|
| 2021-2023 | $64,411,226 | $61,257,022 | 95% |
| 2019-2021 | $94,569,295 | $76,781,795 | 81% |

*Note*: Usage rate increased by 14% for total CCBHC budget.

Nine of the current 12 clinics are set to be rebased again, with an effective date of April 1, 2024. These 9 clinics made significant investments in staff wages by leveraging behavioral health investments from the Oregon Health Authority. These investments were not captured in the previous rebase and resulted in higher PPS rates. This upcoming rebase should further OHA's capacity to utilize all available funds for the CCBHC program.

# Service Utilization

## Numbers Served by Year

The total number of persons served by CCBHCs remained relatively stable between FY 2022 and FY 2023, dropping 1%, from 35,890 total persons served to 35,364. The total number of unique persons served across the full 2021-2023 biennium was 50,031.

White service users comprised the largest share of the CCBHC service population, followed by Hispanic or Latino service users and Black or African American service users. The demographic mix of service users remained relatively unchanged year-to-year, except for white service users, who comprised 50% of the CCBHC population in

FY 2022 vs. 59% of the population in FY 2023. This result should be interpreted with caution, as the number and proportion of service users with unknown or declined race/ethnicity information decreased sharply over this time period, from 15,613 (44%) in FY 2022 to 9,768 (28%) in FY 2023. It is possible that shifts in racial and ethnic demographics could be attributable, in part, to improved collection of demographic data over time.

**Table 7. CCBHC service users by race and ethnicity, FY 2022 - FY 2023**

| | 2022 | | 2023 | | % Change |
|---|---|---|---|---|---|
| **Race/Ethnicity** | **Number** | **%** | **Number** | **%** | |
| American Indian or Alaska Native | 808 | 2% | 973 | 3% | 20% |
| Asian | 326 | 1% | 358 | 1% | 10% |
| Black or African American | 1,342 | 4% | 1,485 | 4% | 11% |
| Hispanic or Latino | 2,059 | 6% | 2,421 | 7% | 18% |
| Middle Eastern or North African | * | * | * | * | * |
| Native Hawaiian or Pacific Islander | 129 | <0.5% | 169 | <0.5 % | 31% |
| Other Single Race | 496 | 1% | 446 | 1% | -10% |
| Two or More Unspecified Races | 45 | <0.5% | 1,048 | 3% | 2,229% |
| Unknown/Declined to Answer | 15,613 | 44% | 9,768 | 28% | -37% |
| White | 17,768 | 50% | 20,725 | 59% | 17% |

*Note:* *Estimate suppressed due to small numbers (fewer than 5 persons with specific service per subgroup); statistically unreliable.

People aged 26-64 made up the largest share of the CCBHC service user population (58%), followed by children and youth aged 0-17 (26%) and young adults aged 18-25 (14%). Although older adults (65+) make up the smallest share of CCBHCs users (3%), they were the only age demographic that grew in numbers between FY 2022 and FY 2023.

**Table 8. CCBHC service users by age bracket, FY 2022 – FY 2023**

| | 2022 | | 2023 | | |
|---|---|---|---|---|---|
| **Age** | **Number** | **%** | **Number** | **%** | **% Change** |

| | | | | | |
|---|---|---|---|---|---|
| 0-17 | 9,284 | 26% | 9,137 | 26% | -2% |
| 18-25 | 5,184 | 14% | 4,920 | 14% | -5% |
| 26-64 | 20,691 | 58% | 20,541 | 58% | -1% |
| 65+ | 1,121 | 3% | 1,163 | 3% | 4% |
| Unknown | 305 | 1% | 303 | 1% | -1% |

In FY 2022, persons assigned female at birth accounted for 55 percent of the CCBHC service user population and persons assigned male at birth accounted for 45 percent of the population. There was no change in demographic mix by sex in FY 2023.

**Table 9. CCBHC service users by sex, FY 2022 – FY 2023**

| | 2022 | | 2023 | | |
|---|---|---|---|---|---|
| **Sex** | **Number** | **%** | **Number** | **%** | **% Change** |
| Female | 19,887 | 55% | 19,625 | 55% | -1% |
| Male | 16,021 | 45% | 15,751 | 45% | -2% |

## Differences in Service Utilization

### Service Utilization by Race and Ethnicity

Among CCBHC service users, overall service use does not appear to vary much across racial and ethnic demographic groups, with the proportionality of total services matching the proportionality of the service users in most cases.

**Table 10. Composition of CCBHC population compared to percent of services used, by race and ethnicity, FY 2022 and FY 2023, all services**

| | 2022 | | 2023 | |
|---|---|---|---|---|
| **Race and Ethnicity** | **% CCBHC Population** | **% of Total Services** | **% CCBHC Population** | **% of Total Services** |
| American Indian or Alaska Native | 2% | 2% | 3% | 2% |
| Asian | 1% | 1% | 1% | 1% |
| Black or African American | 4% | 4% | 4% | 4% |
| Hispanic or Latino | 6% | 5% | 7% | 6% |
| Middle Eastern or North African | * | * | * | * |
| Native Hawaiian or Pacific Islander | <0.5% | <0.5% | <0.5% | <0.5% |

| | | | | |
|---|---|---|---|---|
| Other Single Race | 1% | 1% | 1% | 1% |
| Two or More Unspecified Races | <0.5% | <0.5% | 3% | 2% |
| Unknown/Declined to Answer | 44% | 38% | 28% | 23% |
| White | 50% | 50% | 59% | 60% |

*Note:* *Estimate suppressed due to small numbers (fewer than 5 persons with specific service per subgroup).

When looking at service utilization within specific service categories, however, some differences in utilization across racial and ethnic groups are apparent (see Table 1 in Appendix 1 for full data.) Notably:

- Black or African American service users used proportionally more substance use disorder services than other demographic groups: in FY 2022 and FY 2023, they made up 4% of the CCBHC population but accounted for 6-7% of all SUD services. Similarly, in FY 2023, Hispanic or Latino service users made up 7% of the CCBHC population but accounted for 10% of service use. Conversely, white service users had used proportionally fewer SUD services: although they made up 50 – 59% of the population in FY 2022 and FY 2023, they accounted for 39 – 52% of SUD service use.
- Hispanic or Latino service users used slightly fewer outpatient mental health services relative to their population size – although they comprised 6-7% of the CCBHC population in FY 2022 – FY 2023, they only accounted for 4-5% of outpatient mental health service use.

White service users used proportionally more primary care screening and monitoring services, accounting for 57% and 67% of services in FY 2022 and FY 2023, respectively. Black or African American service users and Hispanic or Latino service users used slightly fewer primary care screening and monitoring services. That said, the number of people receiving primary care screening and monitoring increased overall and across all demographic groups between FY 2022 and FY 2023

**Table 11. Composition of CCBHC population compared to percent of services used, by race and ethnicity, FY 2022 and FY 2023, select services**

| | 2022 | | 2023 | |
|---|---|---|---|---|
| | % of CCBHC Population | % of Total Services | % of CCBHC Population | % of Total Services |
| **Outpatient Substance Use Disorder Treatment** | | | | |
| American Indian or Alaska Native | 2% | 2% | 3% | 3% |
| Asian | 1% | * | 1% | * |
| Black or African American | 4% | 6% | 4% | 7% |
| Hispanic or Latino | 6% | 7% | 7% | 10% |
| Middle Eastern or North African | * | * | * | * |
| Native Hawaiian or Pacific Islander | <0.5% | * | <0.5% | * |
| Other Single Race | 1% | 1% | 1% | 1% |
| Two or More Unspecified Races | <0.5% | * | 3% | 2% |
| Unknown/Declined to Answer | 44% | 43% | 28% | 24% |
| White | 50% | 39% | 59% | 52% |
| **Outpatient Mental Health Treatment** | | | | |
| American Indian or Alaska Native | 2% | 2% | 3% | 2% |
| Asian | 1% | 1% | 1% | 1% |
| Black or African American | 4% | 3% | 4% | 4% |
| Hispanic or Latino | 6% | 4% | 7% | 5% |
| Middle Eastern or North African | * | * | * | * |
| Native Hawaiian or Pacific Islander | <0.5% | * | <0.5% | <0.5% |
| Other Single Race | 1% | 1% | 1% | 1% |
| Two or More Unspecified Races | <0.5% | <0.5% | 3% | 2% |
| Unknown/Declined to Answer | 44% | 41% | 28% | 26% |
| White | 50% | 48% | 59% | 59% |
| **Primary Care Screening and Monitoring** | | | | |
| American Indian or Alaska Native | 2% | 2% | 3% | 2% |
| Asian | 1% | * | 1% | * |
| Black or African American | 4% | 2% | 4% | 2% |
| Hispanic or Latino | 6% | 3% | 7% | 4% |
| Middle Eastern or North African | * | * | * | * |
| Native Hawaiian or Pacific Islander | <0.5% | * | <0.5% | * |
| Other Single Race | 1% | * | 1% | * |
| Two or More Unspecified Races | <0.5% | * | 3% | 2% |
| Unknown/Declined to Answer | 44% | 34% | 28% | 22% |
| White | 50% | 57% | 59% | 67% |

*Note:* Blue indicates higher service use and orange indicates lower service use relative to the composition of the population.

**Table 12. Number receiving primary care screening and monitoring services, by race and ethnicity, FY 2022 – FY 2023**

| | 2022 | 2023 |
|---|---|---|
| **Race and Ethnicity** | **Persons Served - Total** | **Persons Served - Total** |
| All | 5,756 | 6,552 |
| American Indian or Alaska Native | 154 | 173 |
| Asian | * | * |
| Black or African American | 132 | 164 |
| Hispanic or Latino | 188 | 275 |
| Middle Eastern or North African | * | * |
| Native Hawaiian or Pacific Islander | * | * |
| Other Single Race | * | * |
| Two or More Unspecified Races | * | 148 |
| Unknown/Declined to Answer | 2,013 | 1,513 |
| White | 3,470 | 4,398 |

## Service Utilization by Age

Children and youth aged 0-17 and young adults aged 18-25 had lower overall service use, and adults 26-64 had slightly higher overall service use. Service use among older adults was roughly proportional to the underlying CCBHC population.

**Table 13. Composition of CCBHC population compared to percent of services used, by age, FY 2022 and FY 2023, all services**

| | 2022 | | 2023 | |
|---|---|---|---|---|
| **Age** | **% CCBHC Population** | **% of Total Services** | **% CCBHC Population** | **% of Total Services** |
| 0-17 | 26% | 23% | 26% | 23% |
| 18-25 | 14% | 11% | 14% | 11% |
| 26-64 | 58% | 62% | 58% | 62% |

| | 2022 | | 2023 | |
|---|---|---|---|---|
| Age | % CCBHC Population | % of Total Services | % CCBHC Population | % of Total Services |
| 65+ | 3% | 3% | 3% | 4% |

*Note:* Blue indicates higher service use and orange indicates lower service use relative to the composition of the population.

Some notable differences in service use by age group appear when examining specific service categories:

- Adults 26-64 used disproportionately more crisis services: this age group comprised 58% of the CCBHC population but accounted for 67% of services for both FY 2022 and FY 2023. Children and youth aged 0-17 had relatively lower rates of crisis service utilization.
- Adults 26-64 had slightly lower use of outpatient mental health services: they comprised 58% of the CCBHC population but accounted for 55-56% of service use.
- Outpatient substance use disorder treatment services utilization was much higher among adults 26 – 64 compared to children and youth aged 0-17 and young adults aged 18-25. Adults 26-64 accounted for 82-83% of overall SUD service use.
- Children, youth and young adults tended to use fewer primary care screening and monitoring services relative to their population size. Adults aged 26-64 had higher relative service use (58% of the population but accounted for 65% of services), with only very slightly higher service use seen among older adults ages 65+ (3% of the population but accounted for 5% of services).
- Children and youth aged 0-17 and older adults aged 65+ had proportionally higher use of peer and family support services, whereas young adults 18-25 and adults 26-64 had proportionally lower use of services.
- Psychiatric rehabilitation service utilization was much higher among adults aged 26-64 (58% of the population, 73-76% of service use) compared with children

and youth 0-17 (26% of the population, 16-18% of service use) and young adults 18-25 (14% of population, 4-6% of service use.)

**Table 14. Composition of CCBHC population compared to percent of services used, by age, FY 2022 and FY 2023, select services**

| | 2022 | | 2023 | |
|---|---|---|---|---|
| Age | % CCBHC Population | % of Total Services | % CCBHC Population | % of Total Services |
| **Psychiatric Rehabilitation Services** | | | | |
| 0-17 | 26% | 16% | 26% | 18% |
| 18-25 | 14% | 4% | 14% | 6% |
| 26-64 | 58% | 76% | 58% | 73% |
| 65+ | 3% | * | 3% | * |
| **Peer and Family Support Services** | | | | |
| 0-17 | 26% | 32% | 26% | 31% |
| 18-25 | 14% | 7% | 14% | 6% |
| 26-64 | 58% | 54% | 58% | 54% |
| 65+ | 3% | 7% | 3% | 7% |
| **Primary Care Screening and Monitoring** | | | | |
| 0-17 | 26% | 18% | 26% | 19% |
| 18-25 | 14% | 12% | 14% | 11% |
| 26-64 | 58% | 65% | 58% | 64% |
| 65+ | 3% | 5% | 3% | 5% |
| **Outpatient Substance Use Disorder Treatment** | | | | |
| 0-17 | 26% | 4% | 26% | 6% |
| 18-25 | 14% | 12% | 14% | 12% |
| 26-64 | 58% | 83% | 58% | 82% |
| 65+ | 3% | * | 3% | * |
| **Outpatient Mental Health Treatment** | | | | |
| 0-17 | 26% | 29% | 26% | 27% |
| 18-25 | 14% | 13% | 14% | 13% |
| 26-64 | 58% | 55% | 58% | 56% |
| 65+ | 3% | 3% | 3% | 3% |
| **Crisis Services** | | | | |
| 0-17 | 26% | 14% | 26% | 15% |
| 18-25 | 14% | 16% | 14% | 16% |
| 26-64 | 58% | 67% | 58% | 67% |
| 65+ | 3% | * | 3% | * |

*Note:* Blue indicates higher service use and orange indicates lower service use relative to the composition of the population.

## Service Utilization by Sex

Overall service utilization by sex matched the underlying CCBHC population, but there were notable differences in service use for some categories of services. Persons assigned female at birth used disproportionately fewer psychiatric rehabilitation services and outpatient substance use disorder treatment use and disproportionately more outpatient mental health treatment services.

**Table 15. Composition of CCBHC population compared to percent of services used, by sex, FY 2022 and FY 2023**

| | 2022 | | 2023 | |
|---|---|---|---|---|
| **Sex** | **% of CCBHC Population** | **% of Services** | **% of CCBHC Population** | **% of Services** |
| **Total** | | | | |
| Female | 55% | 55% | 55% | 55% |
| Male | 45% | 45% | 45% | 45% |
| **Psychiatric Rehabilitation Services** | | | | |
| Female | 55% | 32% | 55% | 32% |
| Male | 45% | 68% | 45% | 68% |
| **Outpatient Substance Use Disorder Treatment** | | | | |
| Female | 55% | 48% | 55% | 46% |
| Male | 45% | 52% | 45% | 54% |
| **Outpatient Mental Health Treatment** | | | | |
| Female | 55% | 61% | 55% | 61% |
| Male | 45% | 39% | 45% | 39% |

*Note:* Blue indicates higher service use and orange indicates lower service use relative to the composition of the population.

It is important to note that demographic differences in service utilization may or may not reflect the existence of health disparities. Additional analysis is needed to

understand whether a difference would be an expected outcome or not for a certain population. For example, if service users in a specific demographic have a higher need for a particular set of services, such as substance use disorder services, it would not be unexpected to see higher use of services in that population. Additional analysis is also necessary to understand if differences in service use among subgroups is driven by the relative number of service users, the relative acuity of service users, or both. Finally, this analysis only examines differences in service use among those who received CCBHC services at CCBHCs. This dataset does not allow OHA to make comparisons of service use at CCBHC sites vs. non-CCBHC sites, and population-level data for the CCBHC's full-service area would be needed to understand a CCBHC's relative performance on meeting the needs of its community.

# Health Outcomes

## Centers for Medicare and Medicaid Services (CMS) Core Set Measures

Certified Community Behavioral Health Clinics (CCBHC) demonstrate promise in improving health outcomes. When comparing the CCBHC statewide population to Coordinated Care Organization (CCO) statewide member population, CCBHCs generally demonstrate better outcomes on CMS core set measures (Table 16, Figure 1). This is particularly significant when noting that CCBHCs likely have a population of higher acuity individuals than the general CCO population, as CCBHCs have target populations of adults with severe mental illness (SMI), children with severe emotional disturbance (SED), and individuals with chronic illness.

Higher outcomes may be a result of a few things within the CCBHC model. CCBHCs are required to report on specific metrics as part of participation within the demonstration. This emphasis on data reporting and metric performance specific to CCBHCs encourages CCBHCs to actively seek process and policy improvements to driver better outcomes. This is solidified by requirements to have a continuous quality improvement plan, which much include some of the required metrics, such as follow-up from emergency department visits and inpatient hospitalization.

In addition to requirements to track quality improvement, CCBHCs must partner with community partners through formal agreements. These agreements require that care

coordination go beyond referring and follow-up, and include sharing of treatment information, progress, and data as needed and within client preference. This allows for greater attention to engagement and progress among an individual's treatment team.

**Table 16. CMS Core Set Measures comparison of CCBHC population to CCO population**

| Population | DY5 (CCBHC) / CY2021 (CCO) | | DY6 (CCBHC) / CY2022 (CCO) | |
|---|---|---|---|---|
| | Population Size | Percent | Population Size | Percent |
| **IET: Initiation** | | | | |
| CCBHC Statewide | 5091 | 43% | 5223 | 46% |
| CCO Statewide | 39287 | 39% | 51194 | 42% |
| **IET: Engagement** | | | | |
| CCBHC Statewide | 5091 | 21% | 5223 | 22% |
| CCO Statewide | 39287 | 15% | 51194 | 16% |
| **PCR** | | | | |
| CCBHC Statewide | 3299 | 9% | 3576 | 9% |
| CCO Statewide | 28904 | 8% | 29541 | 8% |
| **FUM: 30- Day** | | | | |
| CCBHC Statewide | 2733 | 81% | 2865 | 80% |
| CCO Statewide | 9176 | 68% | 9523 | 67% |
| **FUM: 7- Day** | | | | |
| CCBHC Statewide | 2733 | 68% | 2865 | 64% |
| CCO Statewide | 9176 | 55% | 9523 | 53% |
| **FUH: 30- Day** | | | | |
| CCBHC Statewide | 1492 | 76% | 1876 | 72% |
| CCO Statewide | * | * | 3657 | 59% |
| **FUM: 30- Day** | | | | |
| CCBHC Statewide | 1492 | 51% | 1876 | 45% |
| CCO Statewide | * | * | 3657 | 39% |
| **AMM: Acute Phase** | | | | |

| | | | | |
|---|---|---|---|---|
| CCBHC | | | | |
| Statewide | 1481 | 46% | 1321 | 47% |
| CCO Statewide | * | * | 23825 | 49% |
| **AMM: Continuation Phase** | | | | |
| CCBHC | | | | |
| Statewide | 1481 | 20% | 1321 | 21% |
| CCO Statewide | * | * | 23825 | 23% |
| **SAA** | | | | |
| CCBHC | | | | |
| Statewide | 1543 | 54% | 1561 | 54% |
| CCO Statewide | * | * | 6002 | 66% |

*Note:* Blue indicates better performance and orange indicates poorer performance.
* CCO Statewide data for this measure was not available as it was not required to be calculated for mandatory CMS Core Set activities until CY 2022.

The results for the CCO Statewide population are based on reports generated for CMS Core Set Measure reporting.

National Committee for Quality Assurance (NCQA) Measure Certification Note: A calculated measure result (a "rate") from a Healthcare Effectiveness Data and Information Set (HEDIS) measure that has not been certified via NCQA's Measure Certification Program, and is based on unadjusted HEDIS specifications, may not be called a "Health Plan HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as "Uncertified, Unaudited Health Plan HEDIS Rates".

**Measures Key**

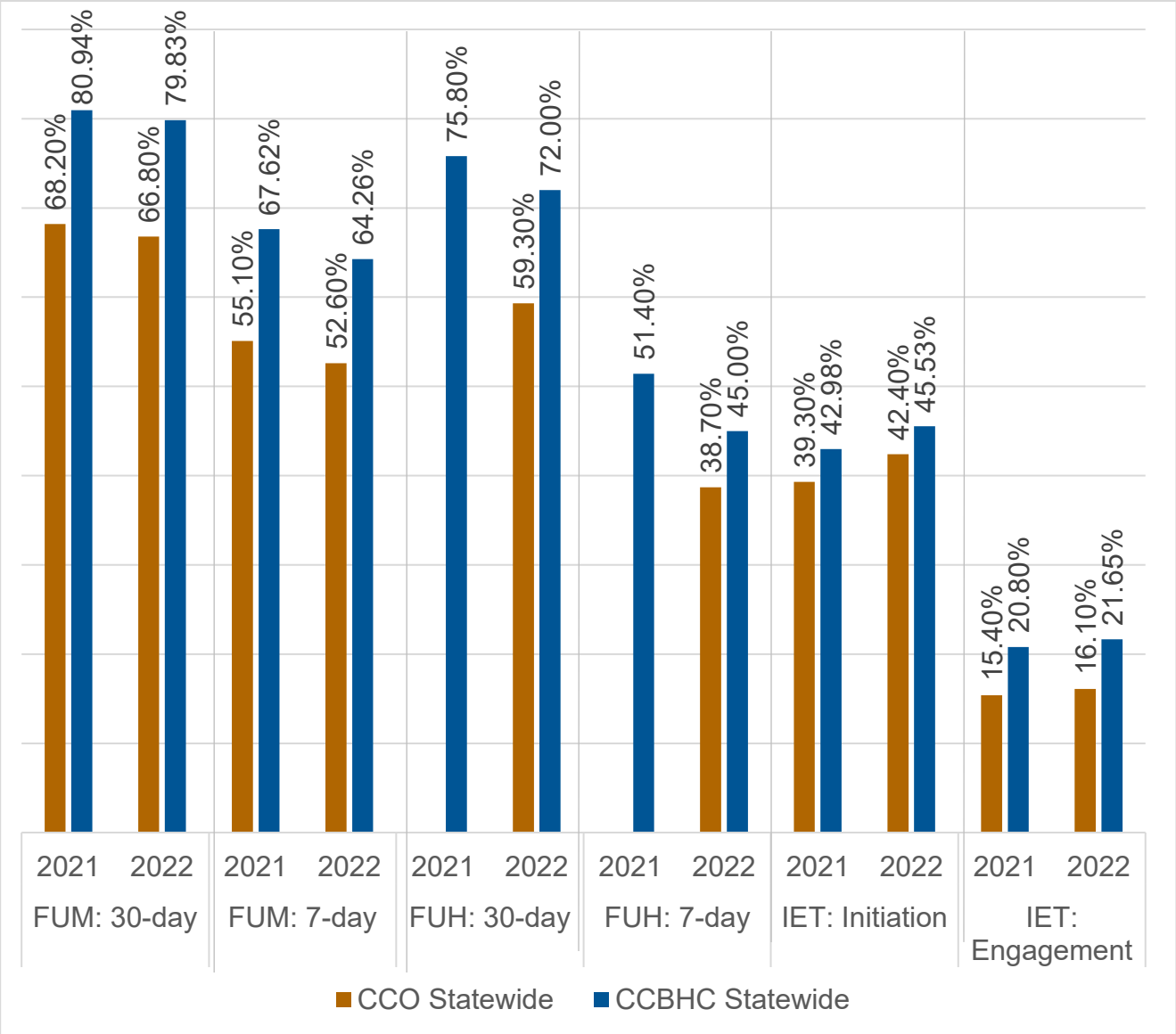
| | | |
|---|---|---|
| AMM: Acute | Antidepressant Medication Management: Effective Acute Phase Treatment | Proportion of beneficiaries ages 18+ who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 84 days (12 weeks). |
| AMM: Continuation | Antidepressant Medication Management: Effective Continuation Phase Treatment | Proportion of beneficiaries ages 18+ who were treated with antidepressant medication, had a diagnosis of major depression, and who remained on an antidepressant medication for at least 180 days (6 months). |
| FUH: 30-day | 30-day Follow-Up after Hospitalization for Mental Illness | Proportion of discharges for beneficiaries ages 21+ who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 30 days after discharge. |

| | | |
|---|---|---|
| FUH: 7-day | 7-day Follow-Up after Hospitalization for Mental Illness | Proportion of discharges for beneficiaries ages 21+ who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider within 7 days after discharge. |
| FUM: 30-day | 30-day Follow-Up after ED Visit for Mental Illness | Proportion of ED visits in beneficiaries ages 6+ where the primary diagnosis was mental illness or intentional self-harm, and for which the beneficiary received follow-up within 30 days of the ED visit. |
| FUM: 7-day | 7-day Follow-Up after ED Visit for Mental Illness | Proportion of ED visits in beneficiaries ages 6+ where the primary diagnosis was mental illness or intentional self-harm, and for which the beneficiary received follow-up within 7 days of the ED visit. |
| IET: Engagement | Engagement of Substance Use Disorder Treatment | Proportion of new SUD episodes in beneficiaries 18+ that have evidence of treatment engagement within 34 days of initiation. |
| IET: Initiation | Initiation of Substance Use Disorder Treatment | Proportion of new SUD episodes in beneficiaries 18+ that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days. |
| PCR | Plan All-Cause Readmissions | Proportion of acute inpatient and observation stays in beneficiaries ages 18+ that were followed by an unplanned acute readmission for any diagnosis within 30 days of initial stay. |
| SAA | Adherence to Antipsychotic Medications for Individuals with Schizophrenia | Proportion of beneficiaries ages 18+ during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period. |

CCBHCs demonstrate higher performance in most CMS core set metrics. Most notably, CCBHCs demonstrate higher performance in initiation and engagement of substance use treatment services (IET: Initiation and IET: Engagement). CCBHCs also demonstrated higher performance in follow-up from mental illness hospitalization (FUH: 30-day and FUH: 7-day) as well as higher performance in follow-up from mental illness emergency department visit (FUM: 30-day and FUM: 7-day). Additionally, CCBHCs and CCOs demonstrate similar trends between 2021 and 2022 Where there

was improvement among the CCO population, there was improvement in the CCBHC population.

**Figure 1. Comparison of CMS Core Set Measures: CCBHC demonstrates better performance**



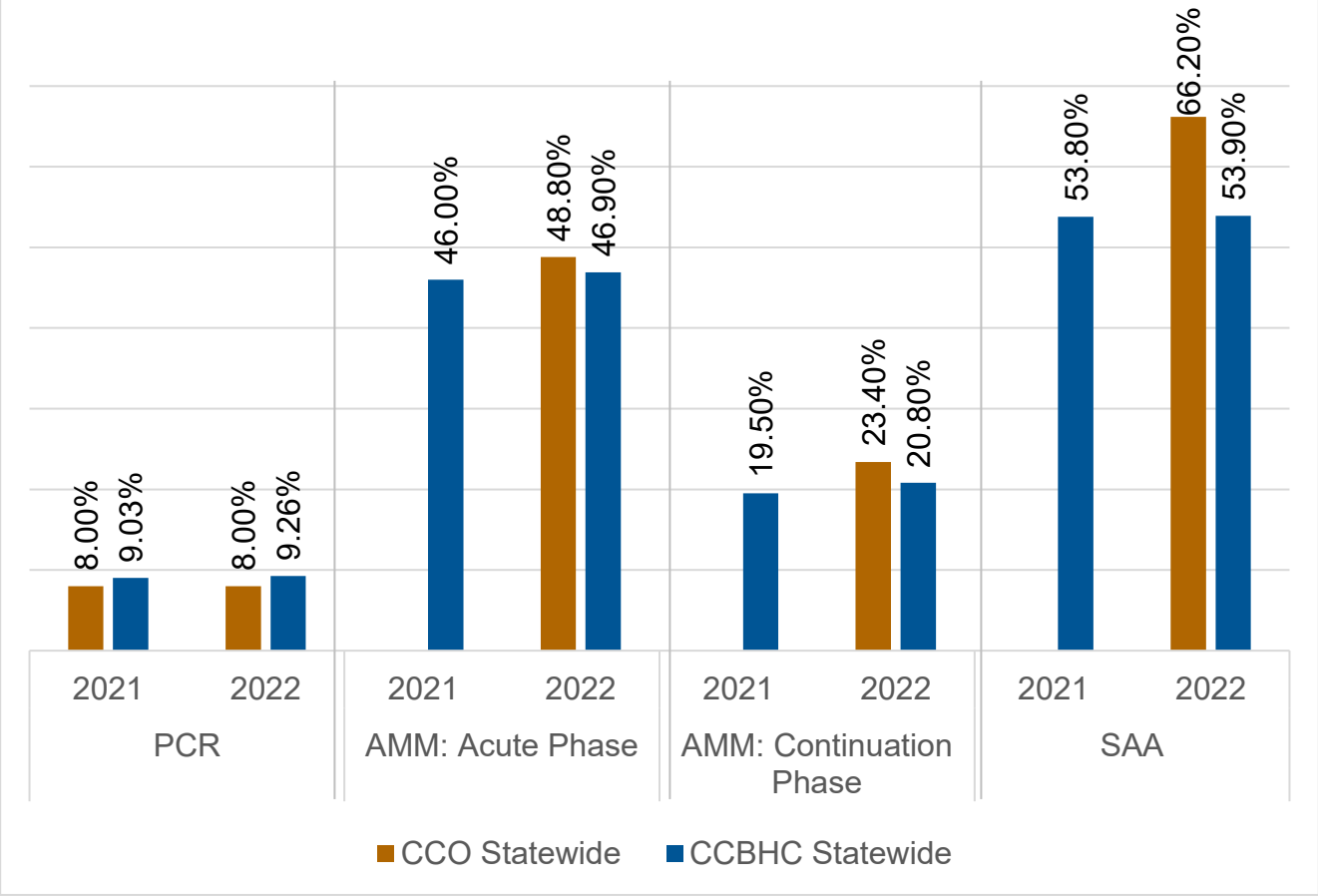

*Note*: The results for the CCO Statewide population are based on reports generated for CMS Core Set Measure reporting.

NCQA Measure Certification Note: A calculated measure result (a “rate”) from HEDIS measure that has not been certified via NCQA’s Measure Certification Program, and is based on unadjusted HEDIS specifications, may not be called a “Health Plan HEDIS

rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as "Uncertified, Unaudited Health Plan HEDIS Rates".

Although CCBHCs generally demonstrate better outcomes, there is room for improvement. CCBHCs underperform on Antidepressant Medication Management: Effective Acute Phase Treatment and Effective Continuation Phase Treatment (AMM: Acute Phase and AMM: Continuation Phase). Additionally, CCBHCs have lower performance on Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) and Plan All-Cause Readmissions (PCR).

**Figure 2. Comparison of CMS Core Set Measures: CCBHC demonstrates poorer performance**




*Note*: The results for the CCO Statewide population are based on reports generated for CMS Core Set Measure reporting.

NCQA Measure Certification Note: A calculated measure result (a “rate”) from HEDIS measure that has not been certified via NCQA’s Measure Certification Program, and is based on unadjusted HEDIS specifications, may not be called a “Health Plan HEDIS rate” until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as “Uncertified, Unaudited Health Plan HEDIS Rates”.

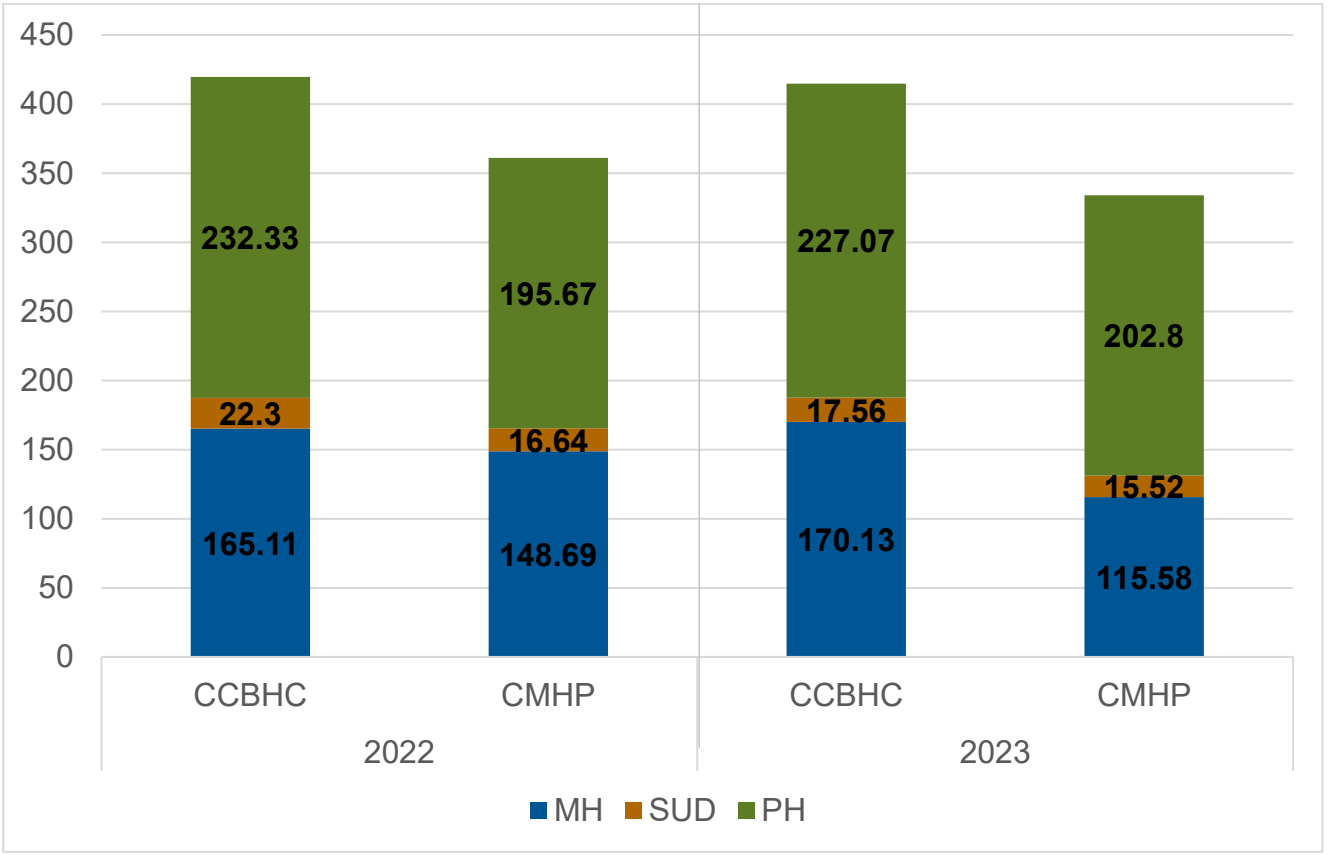
While out of the scope of this current study, CCBHCs generally see individuals with higher acuity and greater behavioral and physical health needs. As such, it is expected that CCBHCs would have a higher plan all-cause readmission rate as higher needs populations tend to have higher readmissions rates. Additionally, higher acuity individuals face higher barriers to medication compliance, which may impact metrics related to medication compliance such as AMM: Acute Phase, AMM: Continuation Phase, and SAA.

When compared to the general CCO population, CCBHCs typically demonstrate higher health outcomes, with the exception of measures in which serving higher acuity individuals creates challenges in generating the same outcomes.

## Inpatient Hospitalization Utilization

Although the CCBHC population generally experiences higher rates of inpatient visits for mental health, substance use disorder, and physical health conditions as compared to similar non-CCBHC populations, the CCBHC population saw comparative reductions in substance use disorder and greater reductions in physical health inpatient visits. While Community Mental Health Programs (CMHP) saw in increase in inpatient visits per 1,000 people for physical health conditions (195.67 to 202.8), CCBHCs who are also CMHPs saw a decrease (232.22 to 227.07). CMHPs saw a decrease in mental health inpatient visits (148.69 to 115.59) whereas CCBHCs saw an increase (165.11 to 170.13). Both populations saw a comparable decline in substance use disorder inpatient visits.

**Figure 3. Comparison of inpatient visits per 1,000 persons**




*Note:* Figure demonstrates higher inpatient visits per 1,000 people for CCBHCs and CMHPs across mental health, substance use disorder, and physical health in both 2022 and 2023.

## Race and Ethnicity

In general, the percent of total persons with an inpatient visit by race and ethnicity align with the percent of total CCBHC population by race and ethnicity. Notable exceptions are greater proportion of white persons with an inpatient visit compared to total CCBHC population for all inpatient visits, mental health (MH) visits, physical health (PH) visits, and substance use disorder (SUD) visits. This may suggest white individuals are more likely to engage in inpatient services.

Hispanic or Latino persons make up a smaller percent of total persons with an inpatient stay for MH, SUD, and all visits for 2023 and for PH for both 2022 and 2023. This may suggest Hispanic or Latino persons are less likely to engage in inpatient services.

In 2022, Black or African American persons made up a disproportionately high percentage of total persons with SUD inpatient visits. This may suggest, in 2022, Black or African Americans were more likely to engage in SUD inpatient services.

**Table 17. Proportion of CCBHC clients with inpatient visits across race and ethnicity compared to proportion of total CCBHC population**

| Race and ethnicity | Fiscal Year | % of Total Persons with IP Visits | % of Total CCBHC Population |
|---|---|---|---|
| **All Inpatient Visit Types** | | | |
| American Indian or Alaska Native | 2022 | 3% | 3% |
| American Indian or Alaska Native | 2023 | 3% | 3% |
| Asian | 2022 | 1% | 1% |
| Asian | 2023 | 1% | 1% |
| Black or African American | 2022 | 6% | 5% |
| Black or African American | 2023 | 5% | 5% |
| Hispanic or Latino | 2022 | 5% | 6% |
| Hispanic or Latino | 2023 | 4% | 7% |
| Middle Eastern or North African | 2022 | 0% | 0% |
| Middle Eastern or North African | 2023 | * | 0% |
| Native Hawaiian or Pacific Islander | 2022 | 0% | 1% |
| Native Hawaiian or Pacific Islander | 2023 | 1% | 1% |
| Other Single Race | 2022 | 0% | 1% |
| Other Single Race | 2023 | 0% | 1% |
| Two or More Unspecified Races | 2022 | 2% | 2% |
| Two or More Unspecified Races | 2023 | 3% | 3% |

| Race and ethnicity | Fiscal Year | % of Total Persons with IP Visits | % of Total CCBHC Population |
|---|---|---|---|
| Unknown/Declined to Answer | 2022 | 18% | 20% |
| Unknown/Declined to Answer | 2023 | 16% | 19% |
| White | 2022 | 65% | 61% |
| White | 2023 | 67% | 62% |
| **Mental Health Inpatient Visits** | | | |
| American Indian or Alaska Native | 2022 | 3% | 3% |
| American Indian or Alaska Native | 2023 | 2% | 3% |
| Asian | 2022 | 1% | 1% |
| Asian | 2023 | 2% | 1% |
| Black or African American | 2022 | 6% | 5% |
| Black or African American | 2023 | 6% | 5% |
| Hispanic or Latino | 2022 | 6% | 6% |
| Hispanic or Latino | 2023 | 4% | 7% |
| Middle Eastern or North African | 2022 | 0% | 0% |
| Middle Eastern or North African | 2023 | * | 0% |
| Native Hawaiian or Pacific Islander | 2022 | 0% | 1% |
| Native Hawaiian or Pacific Islander | 2023 | 1% | 1% |
| Other Single Race | 2022 | 1% | 1% |
| Other Single Race | 2023 | 1% | 1% |
| Two or More Unspecified Races | 2022 | 2% | 2% |
| Two or More Unspecified Races | 2023 | 3% | 3% |
| Unknown/Declined to Answer | 2022 | 18% | 20% |
| Unknown/Declined to Answer | 2023 | 17% | 19% |
| White | 2022 | 63% | 61% |
| White | 2023 | 64% | 62% |
| **Physical Health Inpatient Visits** | | | |
| American Indian or Alaska Native | 2022 | 3% | 3% |
| American Indian or Alaska Native | 2023 | 3% | 3% |
| Asian | 2022 | 1% | 1% |

| Race and ethnicity | Fiscal Year | % of Total Persons with IP Visits | % of Total CCBHC Population |
|---|---|---|---|
| Asian | 2023 | 1% | 1% |
| Black or African American | 2022 | 6% | 5% |
| Black or African American | 2023 | 5% | 5% |
| Hispanic or Latino | 2022 | 4% | 6% |
| Hispanic or Latino | 2023 | 4% | 7% |
| Middle Eastern or North African | 2022 | * | 0% |
| Middle Eastern or North African | 2023 | * | 0% |
| Native Hawaiian or Pacific Islander | 2022 | 0% | 1% |
| Native Hawaiian or Pacific Islander | 2023 | 1% | 1% |
| Other Single Race | 2022 | 1% | 1% |
| Other Single Race | 2023 | 0% | 1% |
| Two or More Unspecified Races | 2022 | 2% | 2% |
| Two or More Unspecified Races | 2023 | 2% | 3% |
| Unknown/Declined to Answer | 2022 | 17% | 20% |
| Unknown/Declined to Answer | 2023 | 15% | 19% |
| White | 2022 | 67% | 61% |
| White | 2023 | 68% | 62% |
| **Substance Use Disorder Inpatient Visits** | | | |
| American Indian or Alaska Native | 2022 | * | 3% |
| American Indian or Alaska Native | 2023 | * | 3% |
| Asian | 2022 | * | 1% |
| Asian | 2023 | * | 1% |
| Black or African American | 2022 | 7% | 5% |
| Black or African American | 2023 | 5% | 5% |
| Hispanic or Latino | 2022 | 4% | 6% |
| Hispanic or Latino | 2023 | 3% | 7% |
| Middle Eastern or North African | 2022 | * | 0% |
| Middle Eastern or North African | 2023 | * | 0% |
| Native Hawaiian or Pacific Islander | 2022 | * | 1% |

| Race and ethnicity | Fiscal Year | % of Total Persons with IP Visits | % of Total CCBHC Population |
|---|---|---|---|
| Native Hawaiian or Pacific Islander | 2023 | * | 1% |
| Other Single Race | 2022 | * | 1% |
| Other Single Race | 2023 | * | 1% |
| Two or More Unspecified Races | 2022 | * | 2% |
| Two or More Unspecified Races | 2023 | * | 3% |
| Unknown/Declined to Answer | 2022 | 18% | 20% |
| Unknown/Declined to Answer | 2023 | 21% | 19% |
| White | 2022 | 66% | 61% |
| White | 2023 | 67% | 62% |

*Note:* Blue indicates higher proportion inpatient visits to proportion of CCBHC population and orange indicates lower proportion of inpatient visits to proportion of CCBHC population.

* Estimate suppressed due to small numbers (fewer than 5 persons with IP visits per subgroup).

Values ≥ 5 and < 12 are statistically unreliable due to small numbers; interpret with caution.

## Age

As anticipated, adults 65+ make up a disproportionate number of physical health inpatient visits and all inpatient visits. Children 0-17 are less represented in inpatient visits across all inpatient visits. Older adults, generally, have higher physical health care needs. It is not unexpected to see a higher proportion of inpatient visits for older adults 65+. Generally, children have fewer physical health needs which may result in lower representation for physical health related inpatient visits. It is outside the scope of this study to further explore reasons behind underrepresentation or overrepresentation for mental health and substance use disorder inpatient hospitalizations. One potential explanation to explore further are disparities in diagnoses that may increase or decrease likelihood of such hospitalizations and/or barriers to accessing inpatient services across age.

Adults 26-64 make up the greatest percentage of physical health inpatient visits and are disproportionately represented at a higher percentage than older adults 65+. While notable, it is well documented that individuals with severe mental illness experience higher rates of chronic illness such as hypertension, diabetes, COPD, and other physical illness. Adults 26-64 also make up a disproportionately higher percentage of all visits, mental health visits, and substance use disorder visits. This may suggest that this age group is most likely to engage in inpatient services and need higher outpatient treatment and prevention services to divert from higher levels of care.

Along with adults 26-64, young adults 18-25 make up a disproportionately higher percentage of mental health inpatient stays. This is consistent with research demonstrating young adults as being particularly vulnerable to mental illness, particularly first-time episodes of psychosis.

**Table 18. Proportion of CCBHC clients with inpatient visits across age compared to proportion of total CCBHC population**

| Age | Fiscal Year | % of Total Persons with IP Visits | % of Total CCBHC Population |
|---|---|---|---|
| **All Inpatient Visits** | | | |
| 0-17 | 2022 | 8% | 25% |
| 0-17 | 2023 | 8% | 26% |
| 18-25 | 2022 | 13% | 14% |
| 18-25 | 2023 | 14% | 13% |
| 26-64 | 2022 | 70% | 58% |
| 26-64 | 2023 | 69% | 57% |
| 65+ | 2022 | 9% | 3% |
| 65+ | 2023 | 9% | 4% |
| **Mental Health Inpatient Visits** | | | |
| 0-17 | 2022 | 8% | 25% |
| 0-17 | 2023 | 8% | 26% |
| 18-25 | 2022 | 18% | 14% |
| 18-25 | 2023 | 18% | 13% |
| 26-64 | 2022 | 70% | 58% |
| 26-64 | 2023 | 70% | 57% |
| 65+ | 2022 | 4% | 3% |
| 65+ | 2023 | 4% | 4% |

| Age | Fiscal Year | % of Total Persons with IP Visits | % of Total CCBHC Population |
|---|---|---|---|
| **Physical Health Inpatient Visits** | | | |
| 0-17 | 2022 | 8% | 25% |
| 0-17 | 2023 | 8% | 26% |
| 18-25 | 2022 | 11% | 14% |
| 18-25 | 2023 | 11% | 13% |
| 26-64 | 2022 | 69% | 58% |
| 26-64 | 2023 | 69% | 57% |
| 65+ | 2022 | 12% | 3% |
| 65+ | 2023 | 12% | 4% |
| **Substance Use Disorder Inpatient Visits** | | | |
| 0-17 | 2022 | 4% | 25% |
| 0-17 | 2023 | 2% | 26% |
| 18-25 | 2022 | 6% | 14% |
| 18-25 | 2023 | 11% | 13% |
| 26-64 | 2022 | 88% | 58% |
| 26-64 | 2023 | 83% | 57% |
| 65+ | 2022 | 2% | 3% |
| 65+ | 2023 | 4% | 4% |

*Note:* Blue indicates higher proportion inpatient visits to proportion of CCBHC population and orange indicates lower proportion of inpatient visits to proportion of CCBHC population.

* Estimate suppressed due to small numbers (fewer than 5 persons with IP visits per subgroup). Values ≥ 5 and < 12 are statistically unreliable due to small numbers; interpret with caution.

## Sex

Persons assigned male at birth make up disproportionally higher rates of MH inpatient visits than persons assigned female at birth and most significantly make up most of the SUD inpatient visits. Persons assigned female at birth disproportionately make up more of the PH inpatient visits. Across all types, persons assigned female at birth have disproportionally higher inpatient visits.

**Table 19. Proportion of CCBHC clients with inpatient visits across sex compared to proportion of total CCBHC population**

| Sex | Fiscal Year | % of Total Persons with IP Visits | % of Total CCBHC Population |
|---|---|---|---|

| | | | |
|---|---|---|---|
| **All Inpatient Visits** | | | |
| Female | 2022 | 57% | 55% |
| Female | 2023 | 57% | 55% |
| Male | 2022 | 43% | 45% |
| Male | 2023 | 43% | 45% |
| **Mental Health Inpatient Visits** | | | |
| Female | 2022 | 48% | 55% |
| Female | 2023 | 50% | 55% |
| Male | 2022 | 52% | 45% |
| Male | 2023 | 50% | 45% |
| **Physical Health Inpatient Visits** | | | |
| Female | 2022 | 62% | 55% |
| Female | 2023 | 61% | 55% |
| Male | 2022 | 38% | 45% |
| Male | 2023 | 39% | 45% |
| **Substance Use Disorder Inpatient Visits** | | | |
| Female | 2022 | 39% | 55% |
| Female | 2023 | 36% | 55% |
| Male | 2022 | 61% | 45% |
| Male | 2023 | 64% | 45% |

*Note:* Blue indicates higher proportion inpatient visits to proportion of CCBHC population and orange indicates lower proportion of inpatient visits to proportion of CCBHC population.

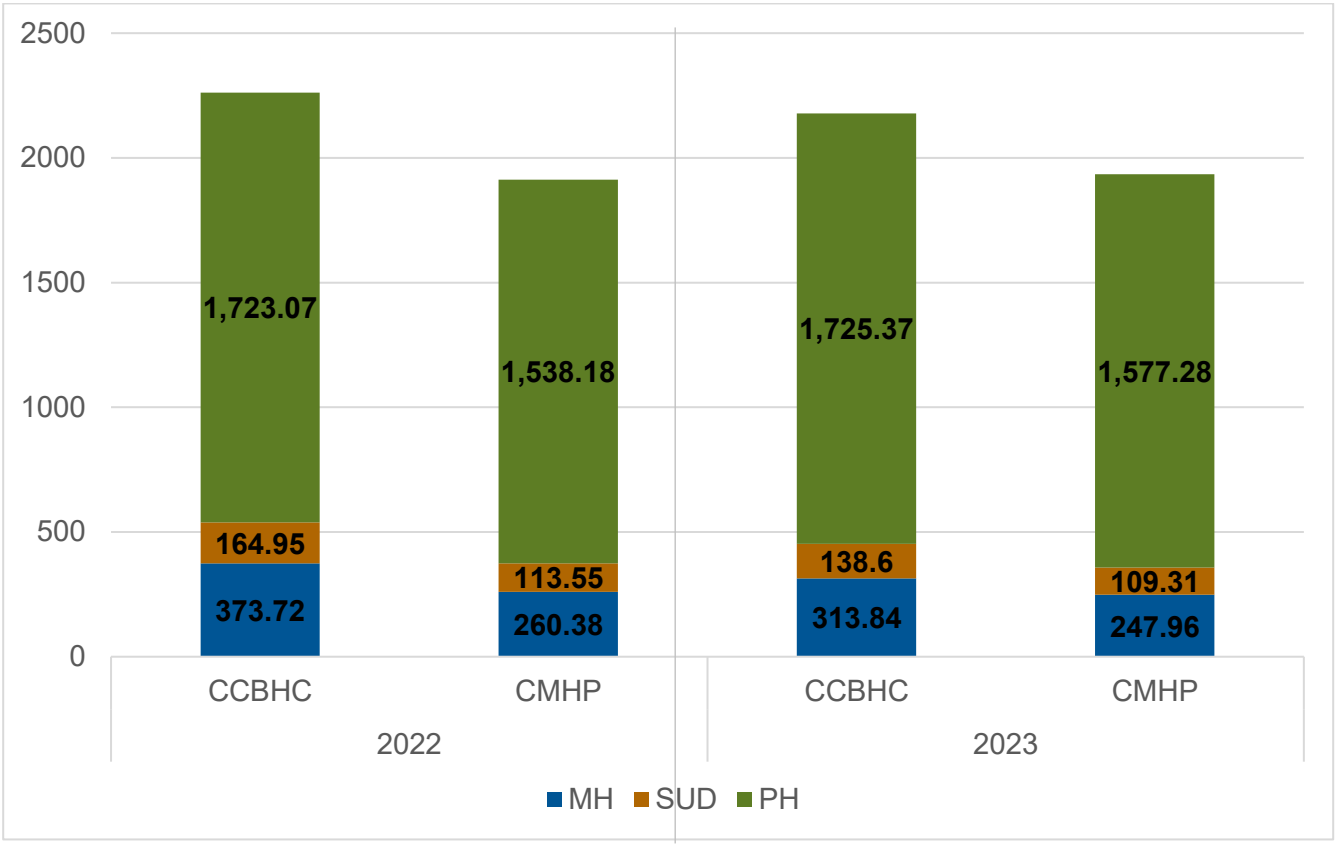
* Estimate suppressed due to small numbers (fewer than 5 persons with IP visits per subgroup); statistically unreliable.
Values ≥ 5 and < 12 be statistically unreliable due to small numbers; interpret with caution.

## Emergency Department Utilization

CCBHCs demonstrate similar trends for emergency department visits as for inpatient visits. The CCBHC population has a higher number of emergency department (ED) visits per 1,000 persons than CMHPs across all visit types, mental health, substance use disorder, and physical health. Both CCBHCs and CMHPs saw a reduction in mental health and substance use disorder visits and both saw an increase in physical health visits. While both saw an increase in physical health ED visits, CCBHCs saw a smaller increase (2.3 compared to 39.1). This could be a result of greater emphasis on

physical health care needs of individuals served within CCBHCs. CCBHCs are required to provide physical health care screening and monitoring as well as 20 hours of onsite primary care.

**Figure 4. Comparison of emergency department visits per 1,000 Persons**




*Note:* Figure demonstrates higher emergency department visits per 1,000 people for CCBHCs and CMHPs across mental health, substance use disorder, and physical health in both 2022 and 2023.

## Race and Ethnicity

In general, there is little disparity of statistical significance for emergency department visits across race and ethnicity within the CCBHC population. Table 7 demonstrates that the proportion of ED visits across race and ethnicity generally align with proportion of CCBHC population. Black or African American persons have slightly higher MH emergency department visits in proportion to CCHBC population in 2022 and 2023 suggesting they may be more likely to visit the ED for mental health symptoms.

Hispanic or Latino persons disproportionately saw fewer ED visits for MH in 2023 suggesting they may be slightly less likely to visit the ED for MH.

Most notably, American Indian or Alaska Native persons saw disproportionately higher ED visits for SUD and Hispanic or Latino persons saw disproportionately lower ED visits for SUD. This suggests American Indian or Alaska Native persons may be more likely to engage in ED services for SUD while Hispanic or Latino persons may be less likely. This is consistent in both 2022 and 2023.

**Table 20. Proportion of CCBHC Clients with Emergency Department Visits Across Race and Ethnicity Compared to Proportion of Total CCBHC Population**

| Race and Ethnicity | Fiscal Year | % of Total Persons with ED Events | % of Total CCBHC Population |
|---|---|---|---|
| **All Emergency Department Visits** | | | |
| American Indian or Alaska Native | 2022 | 3% | 3% |
| American Indian or Alaska Native | 2023 | 3% | 3% |
| Asian | 2022 | 1% | 1% |
| Asian | 2023 | 1% | 1% |
| Black or African American | 2022 | 5% | 5% |
| Black or African American | 2023 | 5% | 5% |
| Hispanic or Latino | 2022 | 6% | 6% |
| Hispanic or Latino | 2023 | 6% | 7% |
| Middle Eastern or North African | 2022 | 0% | 0% |
| Middle Eastern or North African | 2023 | 0% | 0% |
| Native Hawaiian or Pacific Islander | 2022 | 1% | 1% |
| Native Hawaiian or Pacific Islander | 2023 | 1% | 1% |
| Other Single Race | 2022 | 1% | 1% |
| Other Single Race | 2023 | 0% | 1% |
| Two or More Unspecified Races | 2022 | 2% | 2% |
| Two or More Unspecified Races | 2023 | 3% | 3% |
| Unknown/Declined to Answer | 2022 | 19% | 20% |
| Unknown/Declined to Answer | 2023 | 18% | 19% |
| White | 2022 | 63% | 61% |
| White | 2023 | 63% | 62% |
| **Mental Health Emergency Department Visits** | | | |
| American Indian or Alaska Native | 2022 | 3% | 3% |
| American Indian or Alaska Native | 2023 | 3% | 3% |
| Asian | 2022 | 1% | 1% |
| Asian | 2023 | 1% | 1% |

| Race and Ethnicity | Fiscal Year | % of Total Persons with ED Events | % of Total CCBHC Population |
|---|---|---|---|
| Black or African American | 2022 | 6% | 5% |
| Black or African American | 2023 | 6% | 5% |
| Hispanic or Latino | 2022 | 6% | 6% |
| Hispanic or Latino | 2023 | 5% | 7% |
| Middle Eastern or North African | 2022 | 0% | 0% |
| Middle Eastern or North African | 2023 | 0% | 0% |
| Native Hawaiian or Pacific Islander | 2022 | 1% | 1% |
| Native Hawaiian or Pacific Islander | 2023 | 0% | 1% |
| Other Single Race | 2022 | 1% | 1% |
| Other Single Race | 2023 | 1% | 1% |
| Two or More Unspecified Races | 2022 | 2% | 2% |
| Two or More Unspecified Races | 2023 | 3% | 3% |
| Unknown/Declined to Answer | 2022 | 20% | 20% |
| Unknown/Declined to Answer | 2023 | 18% | 19% |
| White | 2022 | 61% | 61% |
| White | 2023 | 63% | 62% |
| **Physical Health Emergency Department Visits** | | | |
| American Indian or Alaska Native | 2022 | 3% | 3% |
| American Indian or Alaska Native | 2023 | 3% | 3% |
| Asian | 2022 | 1% | 1% |
| Asian | 2023 | 1% | 1% |
| Black or African American | 2022 | 5% | 5% |
| Black or African American | 2023 | 5% | 5% |
| Hispanic or Latino | 2022 | 6% | 6% |
| Hispanic or Latino | 2023 | 6% | 7% |
| Middle Eastern or North African | 2022 | 0% | 0% |
| Middle Eastern or North African | 2023 | 0% | 0% |
| Native Hawaiian or Pacific Islander | 2022 | 1% | 1% |
| Native Hawaiian or Pacific Islander | 2023 | 1% | 1% |
| Other Single Race | 2022 | 1% | 1% |
| Other Single Race | 2023 | 0% | 1% |
| Two or More Unspecified Races | 2022 | 2% | 2% |
| Two or More Unspecified Races | 2023 | 3% | 3% |
| Unknown/Declined to Answer | 2022 | 19% | 20% |
| Unknown/Declined to Answer | 2023 | 17% | 19% |
| White | 2022 | 63% | 61% |

| Race and Ethnicity | Fiscal Year | % of Total Persons with ED Events | % of Total CCBHC Population |
|---|---|---|---|
| White | 2023 | 63% | 62% |
| **Substance Use Disorder Emergency Department Visits** | | | |
| American Indian or Alaska Native | 2022 | 4% | 3% |
| American Indian or Alaska Native | 2023 | 4% | 3% |
| Asian | 2022 | 1% | 1% |
| Asian | 2023 | 1% | 1% |
| Black or African American | 2022 | 4% | 5% |
| Black or African American | 2023 | 5% | 5% |
| Hispanic or Latino | 2022 | 5% | 6% |
| Hispanic or Latino | 2023 | 5% | 7% |
| Middle Eastern or North African | 2022 | * | 0% |
| Middle Eastern or North African | 2023 | * | 0% |
| Native Hawaiian or Pacific Islander | 2022 | 1% | 1% |
| Native Hawaiian or Pacific Islander | 2023 | 1% | 1% |
| Other Single Race | 2022 | * | 1% |
| Other Single Race | 2023 | 0% | 1% |
| Two or More Unspecified Races | 2022 | 2% | 2% |
| Two or More Unspecified Races | 2023 | 3% | 3% |
| Unknown/Declined to Answer | 2022 | 20% | 20% |
| Unknown/Declined to Answer | 2023 | 18% | 19% |
| White | 2022 | 63% | 61% |
| White | 2023 | 63% | 62% |

*Note:* Blue indicates higher proportion of emergency department visits compared to CCBHC proportion population. Orange indicates lower proportion of emergency department visits compare to proportion of CCBHC population.
* Estimate suppressed due to small numbers (fewer than 5 persons with IP visits per subgroup); statistically unreliable.
Values ≥ 5 and < 12 be statistically unreliable due to small numbers; interpret with caution.

## Age

Individuals 26-64 disproportionately represent the most ED visits across mental health and physical health. Young adults 18-25 experience disproportionately higher ED visits for mental health compared to the CCBHC population.

Most notably, adults 26-64 make up disproportionately higher ED visits for substance use disorder. Not only are most substance use disorder ED visits within this age group, they also make up significantly more of the ED visits for SUD than total population for CCBHCs. This suggests this age group is most at risk for SUD emergency department visits and need the most outpatient intervention and prevention to divert from the ED.

**Table 21. Proportion of CCBHC Clients with Emergency Department Visits Across Age Compared to Proportion of Total CCBHC Population**

| Age | Fiscal Year | % of Total Persons with ED Events | % of Total CCBHC Population |
|---|---|---|---|
| **All Emergency Department Visits** | | | |
| 0-17 | 2022 | 18% | 25% |
| 0-17 | 2023 | 20% | 26% |
| 18-25 | 2022 | 15% | 14% |
| 18-25 | 2023 | 14% | 13% |
| 26-64 | 2022 | 63% | 58% |
| 26-64 | 2023 | 61% | 57% |
| 65+ | 2022 | 4% | 3% |
| 65+ | 2023 | 5% | 4% |
| **Mental Health Emergency Department Visits** | | | |
| 0-17 | 2022 | 15% | 25% |
| 0-17 | 2023 | 15% | 26% |
| 18-25 | 2022 | 17% | 14% |
| 18-25 | 2023 | 16% | 13% |
| 26-64 | 2022 | 65% | 58% |
| 26-64 | 2023 | 65% | 57% |
| 65+ | 2022 | 3% | 3% |
| 65+ | 2023 | 3% | 4% |
| **Physical Health Emergency Department Visits** | | | |
| 0-17 | 2022 | 19% | 25% |
| 0-17 | 2023 | 21% | 26% |
| 18-25 | 2022 | 15% | 14% |
| 18-25 | 2023 | 14% | 13% |
| 26-64 | 2022 | 63% | 58% |
| 26-64 | 2023 | 61% | 57% |
| 65+ | 2022 | 4% | 3% |
| 65+ | 2023 | 5% | 4% |
| **Substance Use Disorder Emergency Department Visits** | | | |

| Age | Fiscal Year | % of Total Persons with ED Events | % of Total CCBHC Population |
|---|---|---|---|
| 0-17 | 2022 | 5% | 25% |
| 0-17 | 2023 | 6% | 26% |
| 18-25 | 2022 | 13% | 14% |
| 18-25 | 2023 | 11% | 13% |
| 26-64 | 2022 | 80% | 58% |
| 26-64 | 2023 | 80% | 57% |
| 65+ | 2022 | 2% | 3% |
| 65+ | 2023 | 3% | 4% |

*Note:* Blue indicates higher proportion of emergency department visits compared to CCBHC proportion population. Orange indicates lower proportion of emergency department visits compare to proportion of CCBHC population.
* Estimate suppressed due to small numbers (fewer than 5 persons with IP visits per subgroup); statistically unreliable.
Values ≥ 5 and < 12 be statistically unreliable due to small numbers; interpret with caution.

## Sex

Persons assigned male at birth make up proportionally higher rates of mental health ED visits and, most significantly, make up more of the substance use disorder ED visits. Persons assigned female at birth make up more of the physical health ED visits. Across all types, persons assigned female at birth have proportionally higher ED visits.

**Table 22. Proportion of CCBHC clients with emergency department visits across sex compared to proportion of total CCBHC population**

| Sex | Fiscal Year | % of Total Persons with ED Events | % of Total CCBHC Population |
|---|---|---|---|
| **All Emergency Department Visits** | | | |
| Female | 2022 | 57% | 55% |
| Female | 2023 | 57% | 55% |
| Male | 2022 | 43% | 45% |
| Male | 2023 | 43% | 45% |
| **Mental Health Emergency Department Visits** | | | |
| Female | 2022 | 51% | 55% |
| Female | 2023 | 51% | 55% |
| Male | 2022 | 49% | 45% |
| Male | 2023 | 49% | 45% |

| | | | |
|---|---|---|---|
| **Physical Health Emergency Department Visits** | | | |
| Female | 2022 | 58% | 55% |
| Female | 2023 | 58% | 55% |
| Male | 2022 | 42% | 45% |
| Male | 2023 | 42% | 45% |
| **Substance Use Disorder Emergency Department Visits** | | | |
| Female | 2022 | 42% | 55% |
| Female | 2023 | 43% | 55% |
| Male | 2022 | 58% | 45% |
| Male | 2023 | 57% | 45% |

*Note:* Blue indicates higher proportion of emergency department visits compared to CCBHC proportion population. Orange indicates lower proportion of emergency department visits compare to proportion of CCBHC population.
* Estimate suppressed due to small numbers (fewer than 5 persons with IP visits per subgroup); statistically unreliable.
Values ≥ 5 and < 12 be statistically unreliable due to small numbers; interpret with caution.

## Mental Health Statistics Improvement Program Survey- Adults

The Mental Health Statistics Improvement Program Survey is a validated survey provided to adult patients 18+ who received Medicaid-funded mental health and substance use services in the prior calendar year. The survey measures the respondents' perceptions of quality and efficiency of mental health services across multiple domains: general satisfaction, access to services, quality and/or appropriateness of services, treatment outcomes, daily functioning, social connectedness, and participation.

Generally, a lower or equivalent percentage of adult CCBHC respondents, across race/ethnicity, sex, age, and language, reported satisfaction in all domains relative to non-CCBHC respondents. Although fewer CCBHC respondents generally reported satisfaction within each domain, CCBHCs saw greater or equivalent improvement in percentage of respondents reporting satisfaction within each domain.

### Race and Ethnicity

Among adults who identify as two or more unspecified races, a higher percentage of CCBHC respondents reported satisfaction in domains of general satisfaction, access

to services, quality/appropriateness of services and participation relative to non-CCBHC respondents.

**Table 23. Comparison of CCBHC and non-CCBHC respondent satisfaction for adults 18+ who identify as two or more unspecified races in 2023.**

| Domain | CCBHC Population | Non-CCBHC Population |
|---|---|---|
| General Satisfaction | 90.3% | 74.2% |
| Access to Services | 80.6% | 69.7% |
| Quality/Appropriateness | 93.3% | 83.7% |
| Treatment Outcomes | 45.2% | 66.3% |
| Daily Functioning | 64.5% | 66.3% |
| Social Connectedness | 61.3% | 65.5% |
| Participation | 83.9% | 77.6% |

*Note:* This table highlights small portion of data comparing percent satisfied within each domain across race and ethnicity.

Data compares percent satisfaction reported between CCBHC respondents and non-CCBHCs respondents for 2023.

## Sex

Fewer CCBHC respondents reported satisfaction within all domains across sex; however, there was greater improvement in the percentage of respondents assigned male at birth across all domains with notable improvements in participation, treatment

outcomes, daily functioning, and general satisfaction.

**Table 24. Comparison of CCBHC and non-CCBHC respondent satisfaction for 18+ who were assigned male at birth.**

| Domain | 2022 CCBHC Pop. | 2023 CCBHC Pop. | % Change CCBHC | 2022 Non-CCBHC Pop. | 2023 Non-CCBHC Pop. | % Change Non-CCBHC |
|---|---|---|---|---|---|---|
| General Satisfaction | 71.5% | 79.5% | 8.0% | 76.2% | 81.7% | 5.5% |
| Access to Services | 66.3% | 73.1% | 6.8% | 75.1% | 76.5% | 1.4% |
| Quality/ Appropriateness | 76.6% | 83.1% | 6.5% | 78.8% | 84.7% | 5.9% |
| Treatment Outcomes | 48.1% | 57.8% | 9.7% | 54.7% | 61.8% | 7.1% |
| Daily Functioning | 51.8% | 60.0% | 8.2% | 58.6% | 65.3% | 6.7% |
| Social Connectedness | 54.8% | 58.9% | 4.1% | 60.3% | 62.7% | 2.4% |
| Participation | 58.6% | 71.3% | 12.7% | 68.8% | 76.1% | 7.3% |

*Note:* This table highlights a small portion of data comparing percent satisfied within each domain across sex.

Data compares percent satisfaction reported between CCBHC respondents and non-CCBHC respondents for 2022 and 2023. Blue highlights indicate greater improvements between 2022 and 2023 among respondents assigned male at birth within the CCBHC population.

## Age

In 2022, a higher percentage of adults 65+ within the CCBHC population reported satisfaction in the domains of general satisfaction and daily functioning than the non-CCBHC population. In 2023, a higher percentage of CCBHC respondents reported satisfaction in the domains of access to services and social connectedness for adults 65+.

**Table 25. Comparison of CCBHC and non-CCBHC respondent satisfaction for adults 65+ in 2022 and 2023.**

| Domain | 2022 CCBHC Pop. | 2022 Non-CCBHC Pop. | 2023 CCBHC Pop. | 2023 Non-CCBHC Pop. |
|---|---|---|---|---|
| General Satisfaction | 91.2% | 86.7% | 83.9% | 87.0% |
| Access to Services | 85.3% | 85.5% | 91.1% | 77.9% |
| Quality/Appropriateness | 75.0% | 82.7% | 80.4% | 79.6% |
| Treatment Outcomes | * | 55.8% | 64.3% | 66.0% |
| Daily Functioning | 60.0% | 56.8% | 58.9% | 61.2% |
| Social Connectedness | 43.8% | 63.1% | 73.7% | 61.6% |
| Participation | 61.3% | 73.3% | 72.7% | 76.4% |

*Note:* This table highlights small portion of data comparing percent satisfied within each domain across age. Data compares percent satisfaction reported between CCBHC respondents and non-CCBHC respondents for 2022 and 2023. Blue indicates where greater number of CCBHC respondents reported satisfaction.

* Estimate suppressed due to small numbers (fewer than 30 responses for subgroup); statistically unreliable

CCBHCs saw greater improvements in percentage of respondents reporting satisfaction for persons ages 18-25 in the domains of access to services, treatment outcomes, social connectedness, and participation.

**Table 26. Comparison of CCBHC and non-CCBHC respondent satisfaction for persons 18-25 in 2022 and 2023.**

| Domain | 2022 CCBHC Pop. | 2023 CCBHC Pop. | % Change CCBHC | 2022 Non-CCBHC Pop. | 2023 Non-CCBHC Pop. | % Change Non-CCBHC |
|---|---|---|---|---|---|---|
| General Satisfaction | 71.7% | 74.0% | 2.3% | 77.2% | 80.5% | 3.3% |
| Access to Services | 62.9% | 67.8% | 4.9% | 71.9% | 74.4% | 2.5% |
| Quality/ Appropriateness | 82.9% | 82.5% | -0.4% | 82.2% | 85.5% | 3.3% |
| Treatment Outcomes | 47.6% | 58.5% | 10.9% | 61.1% | 62.6% | 1.5% |
| Daily Functioning | 55.8% | 62.6% | 6.8% | 64.2% | 70.2% | 6.0% |
| Social Connectedness | 60.7% | 64.1% | 3.4% | 67.5% | 69.2% | 1.7% |
| Participation | 66.3% | 72.9% | 6.6% | 74.7% | 76.7% | 2.0% |

*Note*: This table highlights small portion of data comparing percent satisfied within each domain across age. Data compares percent satisfaction reported between CCBHC respondents and non-CCBHC respondents for 2022 and 2023. Blue indicates greater improvements between 2022 and 2023 among respondents 18-25 within the CCBHC population.

## Youth Services Survey- Children

The Youth Services Survey is a validated survey provided to caregivers of children and youth under 18 who received Medicaid-funded mental health and substance use services in the prior calendar year. The survey measures the respondents' perceptions of quality and efficiency of mental health services across multiple domains: general satisfaction, access to services, cultural sensitivity, treatment outcomes, daily functioning, social connectedness, and participation.

Generally, fewer or equivalent percentage of CCBHC caregiver respondents reported satisfaction in all domains across sex and age compared to respondents within non-CCBHCs. CCBHCs generally demonstrated equivalent improvement in percentage of caregiver respondents reporting satisfaction within all domains and across sex and age compared to caregiver respondents within non-CCBHC populations with a few notable exceptions.

Due to small numbers reported for CCBHC caregiver respondents (fewer than 30 responses), comparisons across race and ethnicity between CCBHC caregiver respondents and non-CCBHC caregiver respondents is not possible.

**Table 27: Comparison of CCBHC and non-CCBHC caregiver respondent satisfaction for children and youth ages 0-17 in 2022 and 2023.**

| Domain | 2022 CCBHC Pop. | 2023 CCBHC Pop. | % Change CCBHC | 2022 Non-CCBHC Pop. | 2023 Non-CCBHC Pop. | % Change Non-CCBHC |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| General Satisfaction | 64.7% | 71.0% | 6.3% | 67.8% | 75.6% | 7.8% |
| Access to Services | 70.7% | 74.9% | 4.2% | 70.3% | 74.8% | 4.5% |
| Cultural Sensitivity | 83.5% | 89.4% | 5.9% | 85.6% | 92.0% | 6.4% |
| Treatment Outcomes | 55.1% | 57.8% | 2.7% | 60.9% | 67.0% | 6.1% |
| Daily Functioning | 54.9% | 59.3% | 4.4% | 60.7% | 67.0% | 6.3% |
| Social Connectedness | 77.3% | 82.3% | 5.0% | 79.9% | 83.6% | 3.7% |
| Participation | 72.3% | 76.7% | 4.4% | 76.0% | 80.7% | 4.7% |

*Note:* This table highlights small portion of data comparing percent of caregiver respondents reporting satisfaction within each domain across race and ethnicity. Due to suppression of small numbers, table shows total population results.

## Sex

Although CCBHCs had lower or equivalent reported satisfaction across all domains for both children and youth assigned male at birth and children and youth assigned female at birth, CCBHCs saw greater improvement for all but daily functioning for children and youth assigned male at birth. CCBHCs saw a decrease in reported satisfaction among children and youth assigned male at birth for daily functioning.

**Table 28. Comparison of percent of CCBHC caregiver respondents and non-CCBHC caregiver respondents of children and youth 0-17 assigned male at birth reporting satisfaction within domain between 2022 and 2023.**

| Domain | 2022 CCBHC Pop. | 2023 CCBHC Pop. | % Change CCBHC | 2022 Non-CCBHC Pop. | 2023 Non-CCBHC Pop. | % Change Non-CCBHC |
|---|---|---|---|---|---|---|
| General Satisfaction | 61.7% | 70.4% | 8.7% | 68.5% | 71.2% | 2.7% |
| Access to Services | 71.0% | 72.4% | 1.4% | 71.0% | 74.3% | 3.3% |
| Cultural Sensitivity | 82.7% | 89.7% | 7.0% | 86.6% | 90.1% | 3.5% |
| Treatment Outcomes | 54.5% | 54.4% | -0.1% | 60.4% | 64.6% | 4.2% |
| Daily Functioning | 54.5% | 53.7% | -0.8% | 60.2% | 64.8% | 4.6% |
| Social Connectedness | 76.1% | 81.1% | 5.0% | 78.2% | 81.6% | 3.4% |
| Participation | 78.0% | 84.9% | 6.9% | 82.1% | 84.7% | 2.6% |

Note: This table highlights small portion of data comparing percent satisfied within each domain across sex. Blue indicates domain CCBHCs saw greater improvement.

## Age

CCBHCs generally had lower or equivalent satisfaction reports across all ages both in 2022 and in 2023; however, saw meaningful improvements to daily functioning (7.1% change) and social connectedness (11.7%) for ages 13 to 17.

Due to small numbers reported for CCBHC caregiver respondents (fewer than 30 responses), comparisons for children ages 0-5 are not possible.

**Table 29. Comparison of percent of CCBHC caregiver respondents and non-CCBHC caregiver respondents of children and youth 6-17 reporting satisfaction within domain between 2022 and 2023.**

| Domain | 2022 CCBHC Pop. | 2023 CCBHC Pop. | % Change CCBHC | 2022 Non-CCBHC Pop. | 2023 Non-CCBHC Pop. | % Change Non-CCBHC |
|---|---|---|---|---|---|---|
| **Ages 6-12** | | | | | | |
| General Satisfaction | 68.2% | 71.9% | 3.7% | 70.5% | 77.2% | 6.7% |
| Access to Services | 74.3% | 77.4% | 3.1% | 71.2% | 75.6% | 4.4% |
| Cultural Sensitivity | 89.5% | 93.2% | 3.7% | 88.2% | 93.3% | 5.1% |
| Treatment Outcomes | 55.5% | 54.5% | -1.0% | 59.5% | 67.1% | 7.6% |
| Daily Functioning | 54.5% | 55.1% | 0.6% | 59.6% | 66.9% | 7.3% |
| Social Connectedness | 82.6% | 82.0% | -0.6% | 79.9% | 83.6% | 3.7% |
| Participation | 83.2% | 88.7% | 5.5% | 85.3% | 87.2% | 1.9% |
| **Ages 13-17** | | | | | | |
| General Satisfaction | 61.7% | 70.1% | 8.4% | 64.0% | 74.2% | 10.2% |
| Access to Services | 68.9% | 71.3% | 2.4% | 69.2% | 74.1% | 4.9% |

| | | | | | | |
|---|---|---|---|---|---|---|
| Cultural Sensitivity | 79.0% | 86.4% | 7.4% | 82.3% | 90.5% | 8.2% |
| Treatment Outcomes | 55.4% | 59.4% | 4.0% | 61.5% | 67.2% | 5.7% |
| Daily Functioning | 55.4% | 62.5% | 7.1% | 61.3% | 67.2% | 5.9% |
| Social Connectedness | 70.8% | 82.5% | 11.7% | 79.0% | 83.2% | 4.2% |
| Participation | 61.3% | 62.8% | 1.5% | 65.3% | 71.6% | 6.3% |

*Note*: This table highlights small portion of data comparing percent satisfied within each domain across age group. Blue indicates domain CCBHCs saw greater improvement.

## Reduced Costs

CCBHCs have demonstrated cost savings by lowering utilization rates of some higher cost services. OHA evaluated this by defining a population of regular “high behavioral health needs” CCBHC users and a comparable population of CMHP users. These populations were defined as having 10 or more clinic visits in a 12-month period, and the presence of an SUD or higher-acuity MH diagnosis.

As Table 30 demonstrates, high-needs CCBHC users tend to have higher utilization rates across several service categories compared to the similar CMHP population. Although these rates tend to be higher, the CCBHC population demonstrated greater improvements across several higher cost services between fiscal year 2022 and fiscal year 2023.

**Table 30. Comparison of High Behavioral Health Needs Health Care Utilization Attributed to CCBHC or CMHP – Selected Service Areas**

| Service Category | CCBHC Clients Utilization Rates | | | CMHP Client Utilization Rates | | | |
|---|---|---|---|---|---|---|---|
| | SFY22 | SFY23 | % Change | SFY22 | SFY23 | % Change | Relative Improve. |
| Mental Health Services Inpatient | 1,947.5 | 1,466.8 | -24.7% | 1,123.8 | 881.0 | -21.6% | 3.10% |
| Acute Detox Inpatient Hospital | 152.9 | 71.5 | -53.3% | 63.8 | 79.3 | 24.3% | 77.60% |
| Inpatient Hospital – All Other | 1,088.4 | 1,082.6 | -0.5% | 763.0 | 858.8 | 12.6% | 13.10% |
| MH Emergency Department | 732.9 | 529.1 | -27.8% | 465.9 | 449.2 | -3.6% | 24.20% |
| SUD Emergency Department | 517.2 | 353.2 | -31.7% | 461.2 | 403.4 | -12.5% | 19.20% |
| Other Emergency Department | 925.2 | 1,147.7 | 24.0% | 853.1 | 935.9 | 9.7% | -14.30% |
| Outpatient Hospital | 3,536.8 | 3,295.7 | -6.8% | 2,776.2 | 2,687.1 | -3.2% | 3.60% |
| SUD Residential | 3,517.6 | 3,918.3 | 11.4% | 2,185.8 | 2,657.6 | 21.6% | 10.20% |
| Mental Health PRTS/SIP | 775.4 | 441.5 | -43.1% | 700.6 | 740.8 | 5.7% | 48.80% |
| Mental Health Non-Inpatient | 36,910.8 | 35,343.0 | -4.2% | 34,304.3 | 35,691.7 | 4.0% | 8.20% |
| Substance Use Disorder | 13,359.3 | 12,785.3 | -4.3% | 18,093.1 | 19,608.2 | 8.4% | 12.70% |
| Primary Care Physician | 7,246.0 | 6,808.3 | -6.0% | 6,546.8 | 6,408.4 | -2.1% | 3.90% |
| Non-Primary Care Physician | 10,051.3 | 10,645.2 | 5.9% | 10,876.0 | 11,102.2 | 2.1% | -3.80% |
| MH/SUD Drugs | 17,288.2 | 17,899.9 | 3.5% | 17,221.1 | 17,449.6 | 1.3% | -2.20% |

| Service Category | CCBHC Clients Utilization Rates | | | CMHP Client Utilization Rates | | | |
|---|---|---|---|---|---|---|---|
| | SFY22 | SFY23 | % Change | SFY22 | SFY23 | % Change | Relative Improve. |
| Other Prescription Drugs | 32,698.1 | 33,757.6 | 3.2% | 33,195.1 | 33,074.1 | -0.4% | -3.60% |
| DME and Misc. | 4,379.6 | 4,084.5 | -6.7% | 4,526.7 | 4,423.0 | -2.3% | 4.40% |
| NEMT | 9,999.5 | 14,233.6 | 42.3% | 8,822.0 | 11,075.7 | 25.5% | -16.80% |
| MH Adult Residential | 11,506.9 | 10,459.5 | -9.1% | 12,183.1 | 12,068.0 | -0.9% | 8.20% |
| Dental | 1,205.1 | 1,167.6 | -3.1% | 1,185.1 | 1,212.0 | 2.3% | 5.40% |
| Maternity - Inpatient | 41.8 | 93.5 | 123.8% | 53.9 | 57.6 | 6.9% | -116.90% |
| Maternity - Outpatient | 99.0 | 108.6 | 9.7% | 124.1 | 95.4 | -23.1% | -32.80% |
| Maternity - Physician | 102.9 | 154.7 | 50.3% | 150.9 | 134.8 | -10.7% | -61.00% |

*Note*: Table shows comparison of utilization rates per 1,000 member-years for regular clinic users attributed to CCBHC or Community Mental Health Programs (CMHP). Regular clinic users are defined as individuals with more than 10 clinic visits within 365 days. Data excludes dual Medicare/Medicaid and children except for foster children.

Relative improvement indicates differences in % change between CMHP client utilization rates and CCBHC client utilization rates. Blue indicates areas of high-cost savings for CCBHCs.

Table 31 demonstrates the cost savings in fiscal year 2023 between the CCBHC and CMHP populations. Despite higher costs and utilization rates associated with the measured CCBHC population, clinics also generated a relative annual cost savings of approximately $7 million. Although these savings do not fully cover the cost of the CCBHC program, it demonstrates capacity to divert individuals from higher intensity

services and create savings in other areas of the overall healthcare system within Oregon.

**Table 31. Comparison of High Behavioral Health Needs Clients Cost Savings Attributed to CCBHC or CMHP**

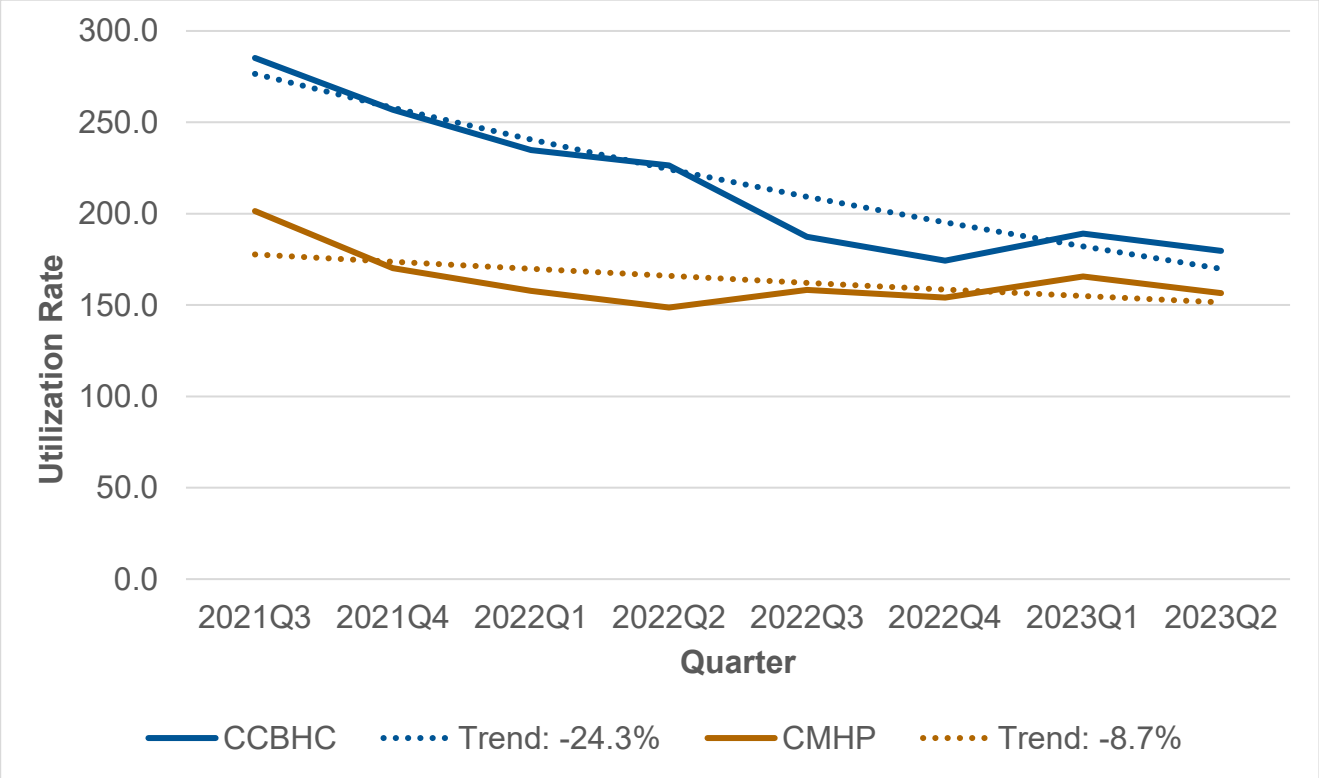
| Service Category | SFY23 Unit Cost | CCBHC Savings | CMHP Savings | Difference in CCBHC and CMHP Savings |
|---|---|---|---|---|
| Mental Health Services Inpatient | $1,197.46 | $47.97 | $24.23 | $23.74 |
| Acute Detox Inpatient Hospital | $1,584.40 | $10.75 | -$2.05 | $12.80 |
| Inpatient Hospital – All Other | $2,072.77 | $0.99 | -$16.55 | $17.54 |
| MH Emergency Department | $598.10 | $10.16 | $0.84 | $9.32 |
| SUD Emergency Department | $627.14 | $8.57 | $3.02 | $5.55 |
| Other Emergency Department | $690.42 | -$12.80 | -$4.76 | ($8.04) |
| Outpatient Hospital | $429.82 | $8.63 | $3.19 | $5.44 |
| SUD Residential | $321.26 | -$10.73 | -$12.63 | $1.90 |
| Mental Health PRTS/SIP | $1,185.06 | $32.97 | -$3.97 | $36.94 |
| Mental Health Other Non-Inpatient | $184.24 | $24.07 | -$21.30 | $45.37 |
| Substance Use Disorder | $74.83 | $3.58 | -$9.45 | $13.03 |
| Primary Care Physician | $126.56 | $4.62 | $1.46 | $3.16 |
| Non-Primary Care Physician | $113.05 | -$5.60 | -$2.13 | ($3.47) |
| MH/SUD Drugs | $156.86 | -$8.00 | -$2.99 | ($5.01) |
| Other Prescription Drugs | $73.07 | -$6.45 | $0.74 | ($7.19) |
| DME and Miscellaneous | $155.72 | $3.83 | $1.34 | $2.49 |
| NEMT | $32.04 | -$11.30 | -$6.02 | ($5.28) |
| MH Adult Residential | $202.59 | $17.68 | $1.94 | $15.74 |
| Dental | $225.54 | $0.70 | -$0.50 | $1.20 |
| Maternity - Inpatient | $1,984.63 | -$8.55 | -$0.61 | ($7.94) |
| Maternity - Outpatient | $315.59 | -$0.25 | $0.75 | ($1.00) |
| Maternity - Physician | $364.72 | -$1.57 | $0.49 | ($2.06) |
| | | $109.28 | -$44.95 | |

| | |
|---|---|
| CCBHC High Needs Patients Member Months | 46,854 |
| Total Estimated Savings for High Needs Patients | $7,226,419 |

*Note*: Table estimates annual cost savings for the CCBHC population using the change in utilization from table 1, times a uniform unit cost for each category of service, normalized to the CCBHC population's member months. Blue indicates areas with high-cost savings of interest.

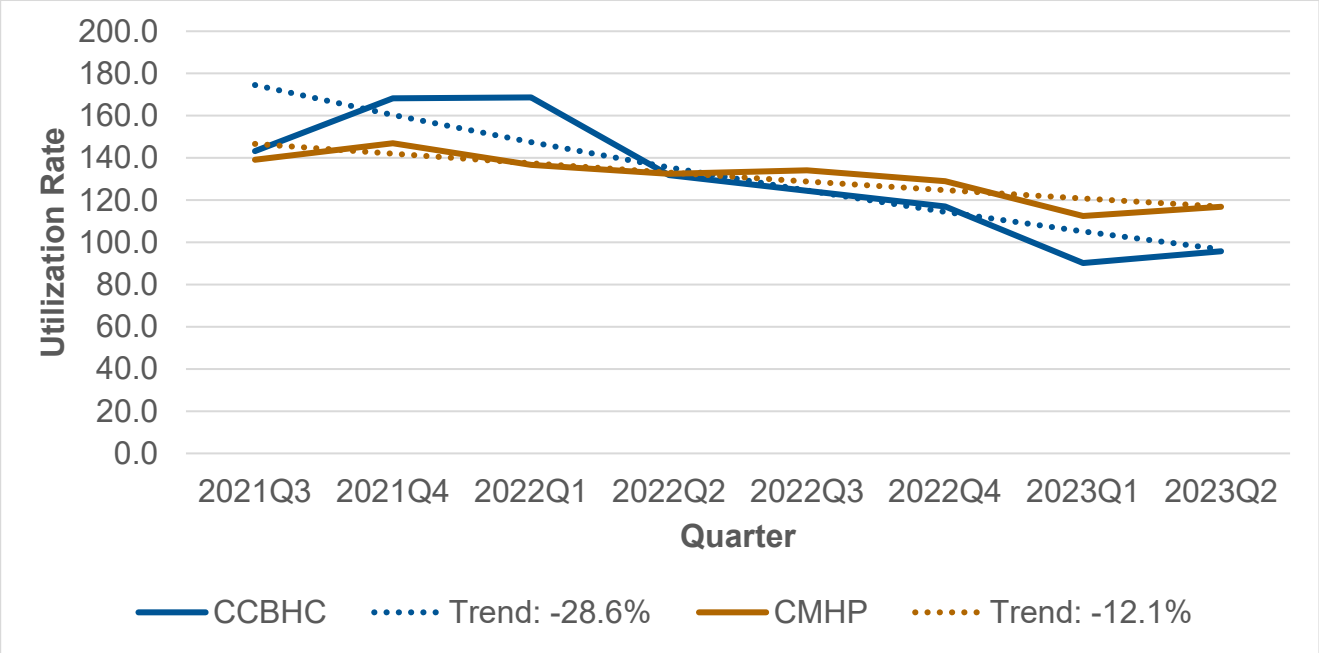
Some of the most notable relative cost savings resulted from emergency department and inpatient hospitalization rates. To illustrate further, Figure 1 highlights a 24.3% annual rate of decrease in mental health emergency department utilization among individuals with high behavioral health needs in CCBHCs compared to an 8.7% decrease within CMHPs. Similarly, Figure 2 demonstrates a 24.5% decrease in substance use disorder emergency department utilization rates compared to a 12.1% reduction for CMHPs. Finally, Figure 3 demonstrates 38.4% reduction in acute detox inpatient hospitalization rates for CCBHCs compared to a 2.4% increase for CMHPs.

**Figure 5. Change in Mental Health Emergency Department Utilization Rates for Clients with Significant Behavioral Health Needs**



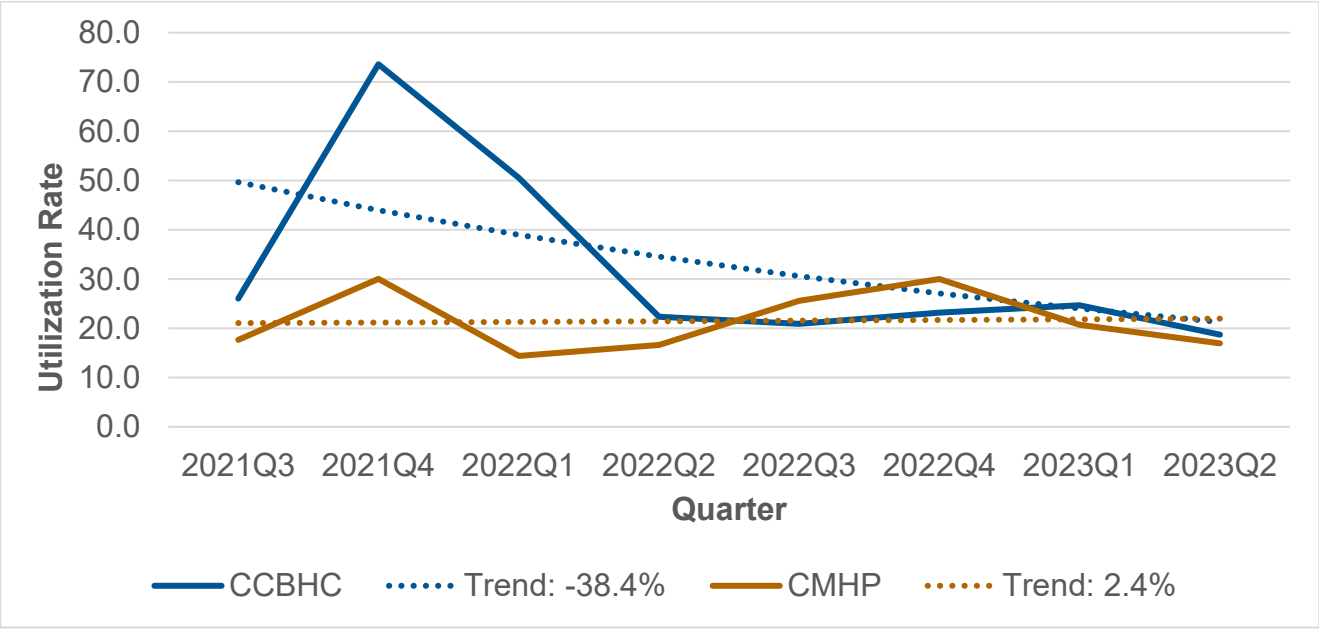

*Note*: This figure demonstrates CCBHC capacity to lower ED utilization rates. Utilization is defined as annual rate of visits for a group of 1,000 members.

**Figure 6. Change in SUD Emergency Department Utilization Rates for Clients with Significant BH Needs**




*Note*: This figure demonstrates CCBHC capacity to lower ED utilization rates. Utilization is defined as annual rate of visits for a group of 1,000 members.

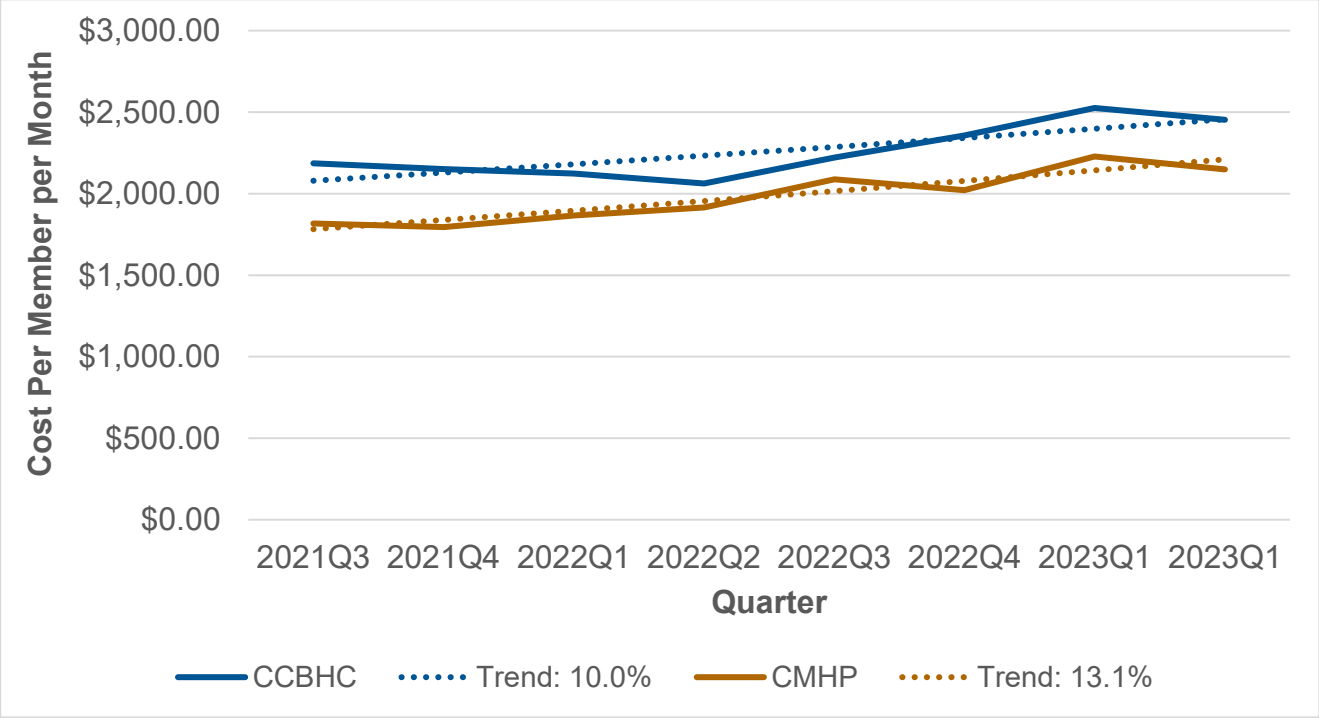
**Figure 7. Change in Acute Detox Inpatient Hospitalization Utilization Rates for Clients with Significant Behavioral Health Needs**



*Note*: This figure demonstrates CCBHC capacity to lower inpatient utilization rates. Utilization is defined as annual rate of visits for a group of 1,000 members.

Despite significant decreases in utilization in some service categories, CCBHCs continue to demonstration a higher total per-member-per-month (PMPM) cost compared to CMHPs. During the 2021-2023 biennium, both CCBHCs and CMHPs experienced an increase in per-member-per-month costs, as is typical in health care. However, CCBHCs saw a slower rate of annual cost growth during this period. Cost increases for both populations may have been higher than usual due to post-pandemic service utilization rebound, as well as increases in behavioral health payment rates authorized by the Legislature in 2022.

**Figure 8. Comparison of Per-Member-Per-Month Cost for Clients with Significant BH Needs**




*Note*: This figure demonstrates upward trend in PMPM costs for both CMHPs and CCBHCs, but with lower cost growth for CCBHCs.

While it is beyond the scope of this study, further exploration of potential cost savings could be reviewed to reflect lower utilization of services that are otherwise funded by

County Financial Assistance Agreements (CFAA), or more frequent coverage of those services under Medicaid. CCBHCs are paid through a prospective payment system (PPS) model that allows for greater flexibility to cover some of the cost that overlaps with CFAAs. This may allow CCBHCs to leverage federal funds in delivering behavioral health services through Medicaid, as opposed to state funded CFAA services through non-CCBHC CMHPs.

Based on 2022 and 2023 comparisons, although the per-member-per-month cost for individuals with significant behavioral health needs is higher, CCBHCs demonstrate capacity to generate significant reductions in higher cost services and generate cost savings in other areas of the healthcare system. Additionally, CCBHCs demonstrate greater capacity to contain cost growth.

## Recommendations on Redirecting Program Funding to the CCBHC Program

At the time SB 5525 passed, the Legislature was considering a proposal to expand the CCBHC program through the federal demonstration via SB 652 (2023 session.) HB 4002 (2024) took a different approach to expansion, directing OHA to expand CCBHC services through a state plan amendment (SPA).

The financing strategy under the demonstration program differs from financing strategy once services are in the state plan. Once CCBHC services are in the state plan, Oregon is subject to federal equal access laws, which prohibit states from artificially controlling the number of providers that join the program. In the demonstration, states have more control over adding new providers because they are not subject to equal access laws. At the same time, HB 4002 explicitly made participation in the CCBHC model voluntary, which limits Oregon's ability to intentionally increase growth. Taken together, this means that OHA has little control over the size of the program and the budget needed to pay for services. Like all other Medicaid services, CCBHC services in the state plan may grow or shrink depending on provider participation and service utilization, and the state and federal governments pay for services actually utilized.

Based on current provider interest, OHA estimates that 12-15 new CCBHC sites will come online in the first year of expansion under SPA. The federal Medicaid match would cover the majority of funds needed to pay for CCBHC services at new sites ($33.7M), with state general funds covering a smaller share ($14.1M). Given the relatively small impact on the state budget, OHA does not recommend redirecting funds from other programs to cover CCBHC services at new sites. Although it is possible that CCBHC expansion could have a larger impact on the state budget farther in the future, it is much too soon to tell what the magnitude of the impact would be, or what the state revenue environment would look like in that circumstance. To ensure adequate Medicaid funding, the Governor's Office has submitted a sustainable budget with appropriate federal match in the Governor's Request Budget.

## Impact of Ending the Demonstration

With the passage of HB 4002, Oregon will add CCBHC services to the Medicaid state plan agreement starting October 1, 2025, so that there is a seamless transition after the demonstration ends on September 30, 2025. At that point, new providers may also begin applying for certification. Tying the effective date of the SPA to the day after the demonstration ends is financially advantageous, as Oregon will be able to draw down the enhanced federal match available under the demonstration for the maximum amount of time.

As noted previously, once Oregon adds CCBHC services to the Medicaid state plan, it is obligated to pay for services utilized. Discontinuing funding is not an option unless the state makes a statutory amendment to HB 4002 to remove CCBHC services from the state plan.

## Conclusion

As evidenced in this report, CCBHCs appear to be making good progress in improving outcomes for the people they serve, in absolute terms and relative to non-CCBHC populations on many domains of care. Although service users at CCBHCs have higher overall costs, greater use of high-acuity services and lower satisfaction with care at

baseline, CCBHCs appear to be making a relatively stronger impact on reducing costs and use of high-acuity services and improving the care experience compared to non-CCBHC providers over time. Further research is needed to understand CCBHCs' performance on addressing health disparities within their own communities, in addition to understanding their relative performance on addressing disparities compared to their non-CCBHC peers.

Although this report did not include qualitative findings from CCBHC providers, anecdotally, clinics and their advocates have expressed strong support for the program and its value to Oregonians. CCBHCs report that they are better able to attract and retain staff and to hire a more diverse array of professionals as a result of participating in the model. They also report that they are better able to serve individuals with the highest needs and go "beyond the four walls" of the clinic to meet people where they are. Finally, many clinics have shared that the CCBHC model — with its focus on tracking data and quality — has necessitated shifts in organizational operations and procedures that are helping to drive better care and outcomes. OHA anticipates that data-driven practice changes will be strengthened in the coming years as the CCBHC team builds out its analytic capacity to share data on utilization, outcomes and health disparities back with providers.

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