PLANNING FOR CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC PROGRAM SUSTAINABILITY:

Lessons from State Medicaid Leaders

Center for Health Care Strategies

NATIONAL COUNCIL for Mental Wellbeing

AUTHORS:

- **Logan Kelly, MPH**
  Senior Program Officer, Center for Health Care Strategies
- **Kelsey Brykman, MS**
  Senior Program Officer, Center for Health Care Strategies

CONTRIBUTING PROJECT TEAM:

- **Rebecca Farley David, MPH**
  Senior Advisor, National Council for Mental Wellbeing
- **Joseph Parks, MD**
  Medical Director, National Council for Mental Wellbeing

IN BRIEF

Many United States residents with serious mental health and substance use conditions struggle to access care. In response, the Certified Community Behavioral Health Clinic (CCBHC) model was created to improve access to evidence-based, person-centered and integrated care.

Select states launched CCBHC Medicaid demonstrations in 2017, and now these states are considering how to sustain current demonstrations. Other states are considering whether to begin participation in this demonstration as enabled by the Bipartisan Safer Communities Act of 2022. CCBHC demonstrations include time-limited enhanced federal funding for states – which both encourages state participation and raises questions for sustainability once enhanced funding expires.

This brief, funded by the National Council for Mental Wellbeing, draws on interviews with current and former state Medicaid leaders to explore how implementation of two other programs with temporary enhanced federal funding in Medicaid – the primary care fee bump and Section 2703 Health Homes – may offer lessons for how demonstration states can plan for CCBHC sustainability.

State leaders who grappled with financial sustainability of these initiatives framed their decisions around alignment with overall state priorities, stakeholder influence and payment reform goals. States seeking to implement or sustain CCBHCs may consider: 1) defining how CCBHC implementation and budgetary support advances state priorities, 2) engaging a wide range of stakeholders to build lasting support and inform program design, 3) leveraging data to measure health and cost impact and 4) aligning CCBHC implementation with value-based payment efforts.

BACKGROUND

The number of individuals in the United States with serious mental health and substance use challenges (sometimes referred to broadly as "behavioral health" conditions) is growing. These individuals often face barriers to care and frequently do not receive needed treatment.[1,2] To improve access to high quality mental health and substance use care, Section 223 of the Protecting Access to Medicare Act of 2014 authorized demonstrations of the CCBHC model.[3]

Ten states[i] have participated in the CCBHC Medicaid demonstration, through which designated provider agencies receive increased funding to deliver an expanded array of mental health and substance use services and physical health screenings, while meeting federal program criteria.[4] The Bipartisan Safer Communities Act of 2022 expanded the opportunity for any state or territory that did not participate in the initial demonstration to apply to join the demonstration.[5]

During the demonstration period, participating states receive enhanced federal medical assistance percentage (FMAP) for CCBHC services delivered to Medicaid-enrolled recipients. Policymakers and stakeholders in states that will receive planning grants to participate in the next round of demonstrations,[ii] as well as those in current demonstration states that are continuing the CCBHC model, will need to plan for how to pay for the program when enhanced federal funding ends. States not participating in the CCBHC demonstration may also consider how to implement the CCBHC model in the absence of enhanced federal funding.

The Patient Protection and Affordable Care Act of 2010 (ACA) offers two distinct examples to learn from: the Medicaid primary care fee bump and Section 2703 health homes. Both initiatives included temporary enhanced federal funding that required states seeking to continue the programs to develop strategies to financially sustain them. Decisions about financial sustainability are closely tied to program design – states evaluate whether the program levers and flexibilities can help deliver on overarching state goals, and whether the program and funding opportunities can be adapted to their own state needs and policy context.

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i The 10 states that have participated in the Medicaid CCBHC demonstration to date are: Kentucky, Michigan, Minnesota, Missouri, Nevada, New York, New Jersey, Oklahoma, Oregon and Pennsylvania.

ii New CCBHC planning grants for states are anticipated to be announced in March 2023. Source: Cooperative Agreements for Certified Community Behavioral Health Clinic Planning Grants, Substance Abuse and Mental Health Services Administration, accessed January 30, 2023.

MEDICAID PRIMARY CARE FEE BUMP

The ACA required that all states, in both Medicaid fee-for-service and managed care delivery systems, increase fees for primary care services to Medicare levels for a two-year period between 2013 and 2014. This policy, known as the primary care fee bump, was funded through a 100% federal-match subsidy and designed to ensure necessary primary care provider capacity to meet the needs of individuals newly eligible for coverage under Medicaid expansion.

Prior to the fee bump, average Medicaid rates for primary care services were less than 60% of Medicare rates, though these rates varied widely by state.[6] State participation was mandatory, and the fee bump methodology and rate changes were set at the federal level and could not be customized by states. While the federal government did not continue to pay for these increased rates after 2014, nearly 35% of states either entirely or partially continued the fee bump rates as of 2018.[7] Recent analyses of the fee bump impact showed mixed results in improving care access.[8]

MEDICAID SECTION 2703 HEALTH HOMES

Section 2703 of the ACA established a state plan option to provide health home services for eligible Medicaid enrollees with chronic conditions and/or a serious mental illness. In states that pursue this option, provider organizations may become health homes by delivering a core set of services that emphasize care coordination, community supports and integration of physical and mental health and substance use treatment services.

During the first two years of implementation, each state receives an enhanced federal match of 90% for health home services. State participation is voluntary and states can customize the population of focus, rates and operational requirements within certain parameters. As of September 2022, 18 states and the District of Columbia operate a total of 33 health home programs.[9] Nine additional states operated health home programs at one point and subsequently discontinued them.[10] Overall, health homes have generally shown mixed results, with some evidence of improved quality and outcomes, but limited impact on spending; however, longer participation in the model is associated with improved outcomes.[11]

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

Section 223 of the Protecting Access to Medicare Act of 2014 established the Medicaid CCBHC demonstration to increase access to integrated, person-centered, trauma-informed and recovery-oriented care. Under this demonstration, participating states certify designated provider agencies (most frequently community behavioral health centers) to deliver an expanded array of mental health and substance use treatment services, including care coordination, crisis response and evidence-based mental health and substance use treatment services. Demonstration states must use a prospective payment system (PPS) rate[12] designed to support flexible funding that accounts for the costs of providing these services.

State participation in this model is voluntary and the demonstration gives states discretion to tailor the model to their own needs, including certifying and decertifying individual CCBHCs, adding additional certification criteria, adjusting the rate-setting process and incorporating aspects of value-based performance payments. In addition to the federal demonstration, the Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded more than 400 grants to individual clinics to support provision of CCBHC services. Moreover, as of February 2022, nine states not participating in the demonstration are pursuing CCBHC implementation through Medicaid 1115 waivers, state plan amendments, legislation or appropriations (Appendix A).

Evaluations of the CCBHC demonstration are ongoing, but state officials have reported that the model has demonstrated beneficial impacts on access and outcomes.[13,14] The number of CCBHCs nationwide has grown from 66 in 2017 to more than 500 in 2022. The Safer Communities Act created a new opportunity for additional states to participate in the CCBHC demonstration. Appendix A shows CCBHC participation by state.

METHODS

The Center for Health Care Strategies, with support from the National Council for Mental Wellbeing, conducted a series of interviews with current and former state Medicaid leaders to explore lessons for sustaining new programs with time-limited enhanced federal funding. The interviewed states varied in terms of their decisions to sustain the fee bump and/or health homes and shared the considerations that drove those decisions.

Table 1. Characteristics of Interviewed States

State	*Primary Care Fee Bump*	*Medicaid Health Home Models*
Colorado	Maintain fee bump	None
Iowa	Maintain fee bump	Chronic medical conditions health home model launched in 2012; serious mental illness (SMI) health home model launched in 2013
Michigan	Partially continue fee bump	SMI health home model launched in 2014; chronic condition health home model launched in 2016; opioid treatment health home model launched in 2018
New Jersey	Partially continue fee bump	SMI health home model launched in 2014; serious emotional disturbance (SED) health home model launched in 2014
New York	Did not continue fee bump	Chronic medical conditions and SMI health home model launched in 2012; chronic condition (intellectual and/or development disabilities) health home model launched in 2018.
Oklahoma	Did not continue fee bump	Terminated health home SPA
Oregon	Partially continue fee bump	Terminated health home SPA
South Dakota	Did not continue fee bump	Chronic medical conditions and SMI health home model launched in 2013
Tennessee	Did not continue fee bump	SMI health home model launched in 2017

As stakeholders, including state policymakers, consider how to launch or sustain CCBHCs, this brief provides insights on key considerations for supporting sustainability over the long term.

LESSONS FOR IMPLEMENTING AND SUSTAINING CCBHC PROGRAMS

1. Define and Communicate How CCBHC Implementation and Budgetary Support Advances State Priorities

Interviewees described that while many factors influenced state decision about whether to sustain health home and fee bump programs, such as political priorities of elected officials, local health care markets and existing Medicaid payment and care delivery policies, the most important factor was the extent to which the initiatives addressed state-specific health care priorities. Interviewees explained that for new and complex delivery system reform initiatives, the enhanced match is "likely to help those who are wavering or on the edge to make them more excited," can have a "kickstarting" effect and can help protect a program from funding cuts. These findings suggest that the temporary enhanced FMAP is a supporting consideration but is unlikely to be the main deciding factor in whether a similar program is sustained.

Many states interviewed decided to implement and sustain funding for the health home program because it improved care coordination for treatment of mental health and substance use challenges, addressed access challenges and promoted care transformation to better address mental health and substance use conditions. In contrast, some interviewees described that their states opted not to fully continue the fee bump because primary care provider access was not a key problem in their state. One former state Medicaid director described, "If [a new federal opportunity] is not something that you were already pursuing, you'll be unlikely to continue it." State leaders must also assess the impact of implementing programs with overlapping goals. As an example, one state ended its health home program to instead advance a broader patient-centered medical home initiative.[15]

New Medicaid programs are often resource-intensive to implement. When states roll back programs, the changes can be costly and disruptive to providers, managed care plans and members. Many states that have sustained health homes committed to long-term sustainability from the outset, including by incorporating costs into Medicaid budgets beyond the enhanced FMAP period. Such commitment was a key factor in both building stakeholder support for change and securing funding to sustain health homes once the enhanced FMAP ended. Upfront commitment to making health homes permanent demonstrated state expectations that the program would be worth providers' near-term implementation burdens. Alternately, some states were not committed to sustaining the fee bump and communicated to providers that the future of this rate increase was uncertain. As a result, interviewees noted that stakeholders were less invested in the program.

Implications for Sustaining CCBHCs

Policymakers and other stakeholders seeking to support sustainable implementation of CCBHC programs should communicate how this model can advance state health care priorities. States should conduct upfront planning and budgeting to sustain CCBHCs after the enhanced FMAP ends. To provide assurance to providers of the state's long-term commitment to the model, states should consider making permanent changes to relevant regulations and policies, such as through State Plan Amendments (SPAs) submitted by some states. Providers will then be more likely to meaningfully alter program staffing and structure and optimize CCBHC outcomes. Appendix A lists the states that have submitted SPAs to make CCBHC services covered benefits under Medicaid.

Interviewees suggested that many states may be well-primed for CCBHC adoption given the nationwide crises in workforce shortages and access to mental health and substance use services. As one interviewee said, state officials widely recognize that behavioral health and crisis services are an immediate, "fire at the door" issue. States may choose to leverage the enhanced match for mobile crisis services provided in the American Rescue Plan Act of 2021 to fund CCBHC services and increase crisis services capacity.[16]

CCBHCs can also be a critical component of state health equity goals, given existing disparities in mental health and substance use condition burden and/or care access among communities of color, people with disabilities and LGBTQ+ individuals.[17,18,19] States can target these or other priority areas through their CCBHC certification criteria and value-based performance incentive payments, which some states detail in their respective SPAs. States should also consider leveraging the enhanced upfront federal funding for CCBHCs to support additional upfront investments of state dollars for infrastructure development and training.

2. Engage a Wide Range of Stakeholders to Build Lasting Support and Inform Program Design

Building stakeholder support, including within state government, is a critical aspect of implementing new Medicaid programs and sustaining programs over time. This stakeholder support is especially important to sustain a program that requires additional state funding to compensate for a reduced federal match after the initial program launch.

Interviewees emphasized the value of engaging different types of stakeholders, such as providers, consumer advocates, state agency leaders and legislators. Provider organizations and associations are generally supportive of initiatives to increase health system investments and can be a bulwark against program rollbacks down the line. Maintaining funding will be challenging if a program lacks a cohesive constituency of support. Interviewees noted that often these initiatives are evaluated after brief time periods. In instances where there are gaps in data on the specific impacts of a given policy, or when it is too soon to expect to see program-wide results, stakeholder support can play an important role in informing policymakers' decisions on whether to sustain a program.

Multiple interviewees reported that their state chose to partially continue the fee bump due to the political and stakeholder input on the program, even though the short time window for evaluation did not yet allow for conclusive data on its impact.[20] In one state, once the fee bump was implemented, an interviewee noted "providers were rather adamant and loud to make sure rates stayed consistent, and demonstrated increased capacity for Medicaid patients that would be lost [if the rate increase was not sustained]."

Consumer advocates can also strengthen momentum toward delivery system reforms. While consumer advocacy played less of a role in fee bump decision-making – as the policy was a less directly consumer-facing policy – interviewees shared that it advanced health homes programs that more clearly aligned with existing advocates' priorities.

Building a collective agenda and buy-in across multiple types of stakeholders can be particularly powerful. For example, one state described how its health home program was initiated and implemented with support of a multi-stakeholder workgroup including representatives from the state legislature, the Indian Health Services, and provider organizations. The workgroup's close involvement in program development resulted in broad support and commitment to the health home initiative over time.

Implications for Sustaining CCBHCs

States considering or just starting to plan for CCBHC implementation should engage a variety of stakeholders, such as provider organizations, managed care organizations, consumers and key multi-agency state government staff during the planning, design and implementation processes. Multi-stakeholder engagement is a requirement for states receiving planning grants.[21] Involving stakeholders at each step can help develop a program aligned with stakeholder needs and build the broad base of support necessary for sustaining a program in the long run. This support can be especially helpful given it may take a few years before CCBHC programs are fully implemented and impacts are realized.

Many states with existing CCBHC programs have continued regular stakeholder meetings throughout implementation and beyond. Other states may similarly consider opportunities to educate stakeholders on emerging program evidence, collaborate with program champions to help communicate program benefits and refine the CCBHC program as needed.

The CCBHC model is designed to achieve more integrated care and this work requires breaking down the siloes that may exist between programs administering physical health and mental health and substance use care. In some states, CCBHC programs are led by behavioral health departments that are separate from Medicaid agencies. In these cases, ensuring that the CCBHC model is responsive to and aligned with Medicaid priorities, and engaging Medicaid officials in the design and implementation process, are important to create a long-term sustainability plan and ultimately to deliver on the promise of advancing more integrated care. States may also consider opportunities to collaborate and align with other agencies serving specific populations that may benefit from CCBHCs, such as criminal justice and child-serving agencies.

3. Leverage Data to Build the Case for Sustaining CCBHC Programs

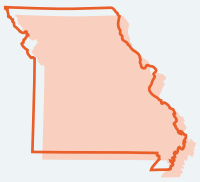
Access, cost and quality data helped build the case for or against sustaining health home and fee bump programs. Interviewees emphasized that the health home or fee bump program's impact on access was one of the most critical considerations for determining whether to sustain the respective program. Some key measures of access are provider availability, time and distance measures of network adequacy, providers accepting new patients, appointment availability and volume of certain services.

When measuring access, interviewees recommended conducting a rigorous assessment of relevant unmet needs prior to program implementation to understand the precise access issues that a program should address. For instance, one state evaluating the fee bump found that it did not impact access to care since existing safety-net systems had already been meeting primary care needs. Other key measures for health homes (along with CCBHCs) include quality of care, patient experience, clinical outcomes, utilization and cost.

Different stakeholder groups may value different types of metrics. Government stakeholders often place high value on evidence of cost-effectiveness; these analyses should take into account both immediate programmatic costs as well as increases or reductions to spending elsewhere in the health care system.

Implications for Sustaining CCBHCs

Policymakers and advocates who are building the case for sustaining CCBHCs should consider how to effectively collect data and generate a robust evidence base on CCBHC program impact. CCBHC program requirements for quality metric collection are a strong starting point for evaluation efforts. At the same time, states may consider whether additional cost, access or quality data are needed to customize impact analyses to individual state contexts. States with more limited data or analysis capabilities may also consider how to best leverage what they have and gradually build to more complex analyses over time. As examples, interviewees described how quality data and qualitative anecdotes generated early support for health homes before cost data were available, and how data from stakeholders such as provider organizations can supplement state-collected data.



STATE SPOTLIGHT: *Missouri's Shared CCBHC Data Platform*

When Missouri's CCBHC demonstration launched in 2017, the Missouri Behavioral Health Council, a membership organization for state behavioral health providers, decided to fund and coordinate statewide member access to a population health management platform. This platform created a single database to aggregate data across multiple sources, including claims, clinical and eligibility data as well as data on state reporting requirements and outcome measures. Additionally, the database pulls information from the multiple electronic health records used by CCBHCs. This statewide approach supports providers to improve the delivery of care and conduct financial and operational analyses of CCBHC data and equips the state with comprehensive data to drive value-based payment approaches.

Expenditure data from within and outside Medicaid can help design a cost-effective CCBHC structure and communicate the impact of the program. Specifically, states may be able to incorporate certain activities within the CCBHC scope of services and PPS rate that were previously not billable to states' Medicaid plans under fee-for-service. Common examples include outreach and engagement activities, population health management, client support at key moments such as during care transitions or upon release from incarceration and more.

In the planning stage, states should carefully review any activities not currently billable (and potentially being provided with 100% state funds) to determine if those activities are an allowable service or cost within the broader more flexible CCBHC framework. States can then calculate and track the ongoing value of the federal match (both initially and when the enhanced FMAP expires) that results from bringing previously state-funded services appropriately under their defined CCBHC service package.

Cost impacts of the CCBHC program will shift over time and depending on the scope of the analysis. States will likely experience increased Medicaid spending during the first few years as the CCBHC program is launched. However, analysis of the budget impacts outside Medicaid (including for state-only mental health and substance use services, human services, and criminal justice) can show a more comprehensive picture of the overall impact of CCBHCs.

4. Align CCBHC Implementation with Value-based Payment Efforts

Another factor that impacts program sustainability is the degree of alignment with Medicaid agency value-based payment (VBP) goals. Medicaid agencies are increasingly moving away from fee-for-service payments to providers, which incentivize a high volume of services, toward VBP arrangements[22] that hold providers accountable for delivering efficient and high-quality care.

Many interviewees emphasized that a key factor in determining whether to sustain the fee bump and health home programs was the extent to which these programs aligned with ongoing Medicaid payment reforms. For example, many states that ended the fee bump described the bump as a policy solution built on a fee-for-service architecture, which did not tie payment to value. One interviewee described how the proliferation of VBP made fee-for-service rates a less important issue over time; another interviewee said that VBP or managed care quality incentives provided a more appealing way to invest in primary care and population health than the fee bump policy.

Alternately, some states were able to integrate VBP incentives into health homes program design. This flexibility to align health homes with broader state payment reform was a key factor for gaining state buy-in to sustain these programs.

Implications for Sustaining CCBHCs

To support sustainability and uptake, state and federal policymakers may consider how the CCBHC program can support and align with broader Medicaid payment reforms. On this front, the federal CCBHC payment guidance for the Medicaid demonstration[23] requires adherence to a broad framework while also offering opportunities for states to design and customize their CCBHC PPS model (see Table 2 for an overview of CCBHC payment options).

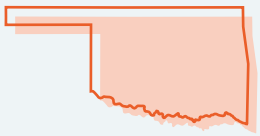
Table 2: CCBHC Prospective Payment System Options: States participating in the CCBHC demonstration may choose between the following payment methodologies for clinics.

Certified Clinic Prospective Payment System (PPS-1)	*Certified Clinic Prospective Payment System Alternative (PPS-2)*
☑ Daily, clinic-specific rate based on expected cost of services. ☑ States have the option, but are not required, to implement quality bonus payments in which clinics receive a bonus for meeting state-selected quality benchmarks.	☑ Monthly, clinic-specific rate based on expected cost of services. States develop separate rates for different sub-populations to account for varying levels of service need. ☑ Clinics only receive the payment for months they deliver at least one CCBHC service to a patient. ☑ Outlier payments reimburse clinics for very high-cost beneficiaries, whose costs exceed a state defined threshold. ☑ States must implement quality bonus payments.

The CCBHC demonstration provides a number of opportunities for states to develop VBP approaches for paying CCBHCs. As one example, states have the option to offer pay-for-performance payments to clinics though quality bonus payments (QBPs). Through QBPs, clinics may receive bonus payments for meeting state-defined performance benchmarks on quality measures.[24] All but two of the 10 states that have participated in CCBHC demonstrations chose to implement QBPs.[25] The PPS-2, or monthly payment model, incorporates additional elements of value-based payment. This option allows states to pay CCBHCs monthly rates similar to capitated payments which provide incentives for CCBHCs to efficiently and effectively manage care.[26,27] Two demonstration states have implemented the CCBHC PPS-2 model.[28]

In addition to these VBP options, the CCBHC demonstration also offers additional areas of discretion in payment design that may help states customize the payment model in alignment with state-specific goals. For example, state have flexibility in whether and how often CCBHC rates will be recalculated to keep them in line with program costs, the definition of a billable encounter and whether and how PPS rates will be administered through managed care.

At the same time, the federal framework does not allow for unlimited flexibility. For instance, program requirements define a minimum scope of services for CCBHCs and states must follow a cost-related payment methodology.[29] State officials will need to think carefully about how the CCBHC model may align or interface with other state payment and delivery system reform initiatives. As states plan for CCBHC initial implementation and sustainability, they may benefit from learning from how other states have tailored the CCBHC model to their payment reform goals. States should also plan for how they aim to integrate CCBHCs with broader VBP goals in the long term, including once the CCBHC enhanced FMAP funding ends.



STATE SPOTLIGHT: *Oklahoma's PPS-2 Monthly Rate*

Oklahoma implemented the CCBHC demonstration's monthly payment option and is aiming to improve care and reduce costs through better serving patients with complex needs. The payment methodology includes one rate tier for the general population and another for individuals with high hospital and emergency department utilization. This approach incentivizes CCBHCs to proactively reach out to and engage with individuals, including those who may be hard-to-reach but have unmet health needs. The model introduces elements of downside risk if CCBHCs do not achieve the desired number of encounters. CCBHCs may also receive bonus payment for quality performance.[30]

Federal and state policymakers may also consider what types of technical assistance or infrastructure supports[31] are needed to further support uptake of PPS-2, which may be more challenging for states and providers to implement than PPS-1 because it requires providers to take on more financial risk. States can support providers by providing technical assistance or infrastructure supports, such as shared statewide care coordination and population health management systems that states can use for required reporting and provider accountability. In many instances, these costs can be covered in their PPS rate as allowable program activities.

CONCLUSION

The CCBHC model is well-positioned to help many states respond to pressing needs and pursue long-term priorities. When the initial CCBHC demonstration ends in 2023, current demonstration states will no longer receive enhanced federal funding. Many current demonstration states are looking to build on the success of this model by making CCBHCs a permanent state program and states newly selected for planning grants will be considering how to establish a strong foundation for new CCBHC programs.

Lessons from previous Medicaid initiatives can help guide states to successfully design and implement their CCBHC programs for sustained success. Stakeholders seeking to support CCBHCs should also focus on engaging an array of stakeholders and leveraging data to measure impact. A synthesis of interview findings with past and current state Medicaid leaders suggests that while enhanced FMAP may catalyze stakeholder interest, it is just one component of the broad work to identify a long-term sustainable funding pathway as connected to the state's overall priorities, including VBP strategies, to ultimately improve the delivery, efficiency and outcomes of care.

APPENDIX A

State	Summary of State-Certified CCBHC Activity
Alabama	n/a
Alaska	Received planning grant in 2015
Arizona	n/a
Arkansas	n/a
California	Received planning grant in 2015
Colorado	Received planning grant in 2015
Connecticut	Received planning grant in 2015
Delaware	n/a
Florida	n/a
Georgia	n/a
Hawaii	n/a
Idaho	Enacted legislation to establish a behavioral health community crisis center model.
Illinois	Received planning grant in 2015; enacted legislation in 2021 to independently implement the CCBHC model.
Indiana	Received planning grant in 2015; enacted legislation in 2022 to independently implement the CCBHC model.
Iowa	Received planning grant in 2015
Kansas	Enacted legislation in 2021 to independently implement the CCBHC model; received approval for State Plan Amendment to define CCBHCs as a Medicaid service.
Kentucky	Participate in demonstration from 2022 to present
Louisiana	n/a
Maine	Allocated funding to hire State Medicaid staff to develop a statewide CCBHC model.
Maryland	Received planning grant in 2015
Massachusetts	Received planning grant in 2015
Michigan	Participate in demonstration from 2021 to present
Minnesota	Participate in demonstration from 2017 to 2022, received approval for State Plan Amendment to define CCBHCs as a Medicaid service.
Mississippi	n/a

Missouri	Participate in demonstration from 2017 to present, received approval for State Plan Amendment to define CCBHCs as a Medicaid service.
Montana	n/a
Nebraska	n/a
Nevada	Participate in demonstration from 2017 to present, received approval for State Plan Amendment to define CCBHCs as a Medicaid service (SPA was later amended to carve out CCBHC services from managed care to be reimbursed under fee-for-service).
New Hampshire	n/a
New Jersey	Participate in demonstration from 2017 to present
New Mexico	Received planning grant in 2015
New York	Participate in demonstration from 2017 to present
North Carolina	Received planning grant in 2015; awarded funding to five CCBHCs through American Rescue Plan Act funding.
North Dakota	n/a
Ohio	n/a
Oklahoma	Participate in demonstration from 2017 to present, received approval for State Plan Amendment to revise the rate methodology for new CCBHCs.
Oregon	Participate in demonstration from 2017 to present
Pennsylvania	Participated in demonstration from 2017 to 2019
Rhode Island	Received planning grant in 2015
South Carolina	n/a
South Dakota	n/a
Tennessee	n/a
Texas	Received planning grant in 2015; launched an independent statewide CCBHC program in 2016.
Utah	n/a
Vermont	n/a
Virginia	Received planning grant in 2015
Washington	Enacted legislation in 2022 to allocate funding for a study on CCBHC implementation.
West Virginia	Enacted legislation in 2022 to independently establish the CCBHC model.
Wisconsin	n/a
Wyoming	n/a

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