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An Analysis of the Financial Impact of New York State's Certified Community Behavioral Health Clinic (CCBHC) Demonstration Program

HEALTH MANAGEMENT ASSOCIATES (HMA) AND
EDRINGTON HEALTH CONSULTING, AN HMA COMPANY

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Executive Summary

The US Congress created the Certified Community Behavioral Health Clinic (CCBHC) program to address escalating workforce shortages, rising behavioral health need, and fragmentation within the nation's behavioral health delivery system. New York State has participated in the federal CCBHC demonstration program since 2017. 15 outpatient behavioral health clinics in the state have received a prospective payment system (PPS) rate that results in a higher per-visit rate in exchange for adhering to a federally mandated set of 115 standards. Through participation in the demonstration, New York State has received an enhanced Federal Medical Assistance Percentage (FMAP), which means that the federal government pays a larger portion of the bill for CCBHC services than for other Medicaid services.[1]

Based on our actuarial analysis, CCBHCs had to reduce inpatient/emergency department (ED) costs by 0.9 percent among the mental health (MH) population[*] in counties served by CCBHCs to generate sufficient savings to cover the extra costs associated with the higher payment rate. To generate those savings, up to 3.8 percent[†] of the Medicaid MH population in the CCBHC counties would need to have access to CCBHC services. The penetration rate[2] for CCBHC services within the CCBHC counties is 10.6 percent. We cannot say precisely how this change affected spending on inpatient care or the exact number of Medicaid members who have access to necessary CCBHC services; however, **the substantial gap between the necessary 3.8 percent and the actual penetration of 10.6 percent indicates that the state experienced a significant return on its modest investment**, which averaged $9.7 million per year.

If New York State had received the usual 50% FMAP, a 2.5% reduction in inpatient/ED spending for the MH population in CCBHC counties would have been required to break even. That level of savings would require at most a 10.8 percent penetration among the MH population. Because 10.6 percent and 10.8 percent are within a margin of uncertainty, these results are ambiguous, indicating that **absent enhanced FMAP, New York's CCBHC initiative would essentially break even from a state share/cost perspective. In this case, the return comes in the form of a healthier Medicaid mental health population.**

These data suggest that **from the perspective of the state's share of Medicaid spending, conversion of outpatient capacity to CCBHC is budget neutral if New York is receiving the usual 1:1 Medicaid match from the federal government and reduces state spending if New York is receiving enhanced CCBHC demonstration match.** Conversion of outpatient clinic capacity through the Centers for Medicare & Medicaid Services demonstration period, during which New York receives an enhanced federal matching

[*] Our analysis leveraged PSYCKES data on OMH's Tableau Visualization website. Those data are only for the MH population, meaning that these analyses cover only Medicaid recipients with mental health visits, excluding members who access SUD services but not mental health services. **As such, these savings estimates are underestimated**. Publicly available data include a data set for the substance use disorder population, but those data cannot be deduplicated against the mental health population database. It is thus infeasible to conduct this analysis for the entire behavioral health population. Development of a publicly available Medicaid BH population database would help researchers, policymakers, advocates, and others by facilitating more precise analyses.

[†] Because we were unable to identify which Medicaid members had received CCBHC services, we could not link CCBHC utilization directly to ED/inpatient costs. Hence, the analysis assumes that every member has the same levels of ED/inpatient use. If the members who CCBHCs serve were a historically higher utilizing population than the general MH population, the necessary penetration would be lower.

rate, generates substantial savings. The federal government is expected to issue guidance soon that will enable states to open their demonstration programs to more providers. When they do, **New York could realize significant cost savings if policymakers choose to broadly expand the demonstration and make CCBHC services available to more Medicaid recipients**.

What Is the CCBHC Program?

The US behavioral health crisis has been growing rapidly, with one in five adults experiencing mental illness and substance use disorders (SUDs) nationwide.[3,4] New York State has 202 mental health provider shortage areas (HPSAs), and roughly 80 percent of behavioral health needs go unmet.[5] Congress enacted Section 223 of the Protecting Access to Medicare Act (PAMA) (P.L. 113-93), which authorized a two-year Community Behavioral Health Clinic (CCBHC) demonstration program for up to eight states to address these workforce shortages, the rising behavioral health burden and its associated costs, and fragmentation within the behavioral health delivery system. Key PAMA provisions established:

- **A federal definition and CCBHC certification criteria** across six key program areas: Staffing, availability and accessibility of services, care coordination, scope of services, quality and other reporting, and organizational authority and governance[6]
- **A prospective payment system (PPS)** that considers the historical and anticipated real cost of care for payment of CCBHC services
- **An enhanced federal medical assistance percentage (FMAP)** reimbursement to states for Medicaid-covered services that CCBHCs deliver to Medicaid populations.[7]

The US Department of Health and Human Services (HHS) awarded $22.9 million in planning grants to 24 states in October 2015. The following year, in December 2016, HHS selected eight states to participate in the demonstration: Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania. Michigan and Kentucky were added in 2020.

A few states are also moving forward with their own state-run CCBHC programs through their Medicaid State Plan Amendment (SPA) or Section 1115 waiver. Though they differ, the SPA and 1115 waiver pathways both offer states the ability to provide the PPS to CCBHCs moving forward with Centers for Medicare & Medicaid Services' approval.

What Is a CCBHC?

CCBHCs are community-based providers that offer comprehensive evidence-based, integrated mental health and SUD treatment in connection with primary care and social services for both children and adults. Although Medicaid funds the CCBHC program, PAMA mandated that CCBHCs cannot refuse care to anyone based on their place of residence or inability to pay, as well as the use of a sliding fee scale adjusted for an individual's income. Nonetheless, the emphasis is on the most vulnerable, highest-need populations that are most likely to benefit from coordinated, integrated behavioral health care. These populations include individuals with serious mental illness (SMI) and severe SUD, children and adolescents with a serious emotional disturbance (SED), and people with co-occurring mental, substance use, or physical health disorders (CODs).

How Do CCBHCs Differ from Other Outpatient Behavioral Health Clinics?

CCBHCs offer a distinctive approach to behavioral health care. The model operates within the guideposts defined in the federal certification criteria, which set specific standards for behavioral health service delivery in CCBHCs.[8] These criteria require clinics to provide person-centered, trauma-informed, and recovery-oriented care to integrate primary and behavioral health care and address clients' unique social needs to serve the whole person. They also set standards for timeliness of access and require CCBHC governance to include substantial consumer representation.

> "What distinguishes this program from other efforts to provide behavioral health services to Medicaid beneficiaries is its:
>
> (1) emphasis on coordinated care across the full spectrum of high-quality and accessible behavioral and physical health care, and
>
> (2) a restructured payment system allowing clinics to deliver high-quality services."
>
> *-SAMHSA, CCBHC Demonstration Program, Report to Congress, 2017*

The CCBHC criteria emphasize several core principles:

A set of minimum required services: CCBHCs must provide at least nine core services, either directly or via formal relationships with partner designated collaborating organizations (DCOs):

- ✓ 24/7 crisis services
- ✓ Treatment planning
- ✓ Screening, assessment, diagnosis, and risk assessment
- ✓ Outpatient mental health and substance use SUD services
- ✓ Targeted case management
- ✓ Outpatient primary care screening and monitoring
- ✓ Community-based mental health care for veterans
- ✓ Peer, family support, and counselor services
- ✓ Psychiatric rehabilitation services

Specialized staffing: CCBHCs must maintain a staffing plan informed by a community needs assessment to ensure centers have appropriate staff to meet the clinical, cultural, and linguistic needs of the service area. Staff must be licensed, credentialled, and certified and include individuals with training and expertise in treating trauma, SED, SMI, and SUD, such as:

- Psychiatrists
- Nurses
- Licensed clinical social workers, mental health counselors, psychologists, and addiction counselors
- Case managers
- Peer specialists and recovery coaches
- Community health workers

CCBHC certification criteria also set standards for staff training in cultural competence; person- and family-centered, recovery-oriented, evidence-based, and trauma-informed care; and primary care/behavioral health integration.

Integrated, coordinated care: Care coordination is the cornerstone of the CCBHC model. The CCBHC serves as a single point of entry to address the medical, behavioral, and social needs of each client in a seamless and timely manner. CCBHCs coordinate care both internally among clinical staff and through collaborative partnerships and data sharing with community providers and organizations. PAMA requires CCBHCs to establish formal care coordination agreements and expectations with community partners such as federally qualified health centers (FQHCs), hospitals, independent outpatient clinics, psychiatric and substance use detoxification facilities, law enforcement and criminal justice systems, veterans' organizations, child welfare agencies, and schools, among others. An analysis showed that 81 percent of state certified CCBHCs and federal grantees increased referrals to primary care, and 96 percent of CCBHCs and grantees established partnerships with criminal justice agencies.[9]

Evidence-based practices (EBPs): The CCBHC model promotes the consistent use of EBPs and outcome-driven treatment. CCBHCs must train their staff in EBPs and monitor for fidelity to the model. One key outcome of the CCBHC program has been the dramatic increase in the availability of medication-assisted treatment (MAT) for individuals with opioid use disorders, with 65 percent of CCBHCs and grantees reporting an increase in the number of clients engaged in MAT services.[10]

Cultural/linguistic competence and behavioral health disparities: CCBHCs are expected to target disparities in access and health outcomes to promote health equity within their communities. CCBHCs must offer culturally and linguistically appropriate screening tools, interpretation/translation services, and auxiliary aids to meet the unique needs of clients with limited English proficiency, low literacy levels, and disabilities. Staff must receive training in cultural and linguistic competence, including competence in serving military members and veterans.

Standardized data collection, monitoring, and reporting: CCBHCs are required to collect, track, and report a standard set of encounter, clinical outcome, and quality data to ensure accountability. CCBHC criteria emphasize the development or enhancement of health information technology (IT) systems to expand and improve data collection and analysis, health information exchange, and population health management. CCBHCs also are expected to develop and maintain a continuous quality improvement plan to evaluate the quality and safety of service delivery and opportunities for advancement.

The Prospective Payment System (PPS)

Underlying, and fundamental to, the CCBHC Demonstration program is the PPS—a clinic-specific encounter rate paid to reimburse clinics for the expected cost of care. Clinics can earn quality bonus payments (QBP) if they meet a defined set of required quality measures.[11] According to the National Council for Mental Wellbeing 2022 CCBHC Impact Report, states cited the PPS as paramount to the success of their CCBHC programs.[12] The report further demonstrates that although federal funding enabled CCBHC expansion (CCBHC-E) grantees (who do not receive a PPS rate) to achieve significant improvements across all identified metrics, state-certified CCBHCs, supported by the PPS, had more opportunities to:

- **Invest in workforce expansion**: Historically low salaries and reimbursement rates, as well as insufficient training, negatively affect the ability of behavioral health providers to recruit and

retain a robust and highly qualified behavioral health workforce both nationwide and in New York State.[13,14] The CCBHC model and associated PPS allow for a huge investment in the expansion of the behavioral health workforce in the face of dire shortages. Clinics can incorporate current and future staffing costs into their PPS rate, enabling them to hire more staff and recruit more qualified and diverse staff at competitive salaries. This enhanced funding also allows clinics to improve staff satisfaction and retention and to expand services through staff training and development. CCBHCs added an average of 44 new staff members per clinic in compared with an average of 20 staff among CCBHC-Es, a result of more successful staff recruitment and retention.[15]

- **Expand scope of and access to services**: CCBHCs have enhanced capacity to increase caseloads, extend clinic hours, reduce wait times, offer same- or next-day care, and respond to additional service needs, such as youth crisis services and substance use disorder care, through the hiring of specialized staff (e.g., mobile crisis, SUD counselors, child psychiatrists). The PPS also provides CCBHCs the flexibility to restructure their care teams to leverage non-clinical staff such as care coordinators and peer specialists, thereby increasing clinicians' capacity. CCBHCs reported a 30 percent increase in client caseload on average versus an 18 percent increase among CCBHC-Es.[16]
- **Conduct nonbillable activities**: Most of the core CCBHC principles outlined above constitute nonbillable activities such as care coordination, collaboration with primary care and other partners, outreach and engagement, EBP adoption and fidelity monitoring, staff training, investment in IT infrastructure and data collection activities. The PPS provides sustainability to these clinics to offer wraparound services and pay for operational activities that are essential to improving outcomes by reimbursing clinics for the actual cost of care. In New York, the CCBHC designation also enables clinics to integrate mental health and SUD services and to pay for services not otherwise billable under their current licensure.
- **Prepare for value-based payment (VBP)**: The PPS rate gives CCBHCs the opportunity to gain experience with data analysis, population health management, risk stratification, and quality bonus payments to prepare for participation in VBP arrangements.

New York State's Opportunity

The federal Bipartisan Safer Communities Act of 2022 expanded the Medicaid CCBHC Demonstration program to more states, allowing up to 10 states to join the program every two years and extends the demonstration program timeline for existing states. Existing CCBHC demonstration states are ineligible to apply for the latest round of planning grants; however, SAMHSA was authorized to open their demonstration programs to more providers. SAMHSA is developing further guidance for these states. This upcoming federal opportunity creates a chance for New York to consider expanding its demonstration program. To inform policymakers' response to this opportunity, the New York State Council for Community Behavioral Healthcare contracted with HMA and Edrington Health Consultants to assess the impact on New York State's budget for the existing CCBHC initiative.

Our analysis found that the CCBHC Demonstration program was budget neutral for New York State if 3.8 percent of the Medicaid recipients in the mental health population in counties served by a demonstration CCBHC[17] had access to a CCBHC. That level of penetration would enable the state to

reduce the overall inpatient/emergency department (ED) spend among the mental health population by 0.8 percent.

Exhibit 1: CCBHC Cost Effectiveness with Enhanced FMAP from the CCBHC Demonstration

Per Visit Expense			
	2018	2019	Average
CCBHC	$255	$224	$239
Reference clinics[18]	$130	$129	$130

State Share			
	2018	2019	Average
CCBHC	$89	$78	$84
Reference clinics	$65	$64	$65

CCBHC Additional State Cost			
	2018	2019	Total
CCBHC visits	494,089	539,273	1,033,362
Additional state funds	$11,952,027	$7,511,182	$19,463,209

Reductions Needed for Cost Neutrality			
	2018	2019	Total
ER spending in CCBHC counties	$198,373,605	$210,524,476	$408,898,081
IP spending in CCBHC counties	$1,950,925,611	$2,104,276,333	$4,055,201,944
Total	$2,149,299,216	$2,314,800,809	$4,464,100,025
Inpatient and ED savings required	1.1%	0.6%	0.9%

Penetration Needed to Generate ED/Inpatient Reductions for Cost Neutrality			
	2018	2019	Total
CCBHC penetration needed	3.8%	3.8%	3.8%
ED savings in CCBHC counties	$2,201,016	$2,336,061	$4,537,077
Inpatient savings in CCBHC counties	$16,964,608	$18,368,367	$35,332,975
Total	$19,165,624	$20,704,428	$39,870,052
State funds (50% FMAP)	$9,582,812	$10,352,214	$19,935,026
Additional state CCBHC costs	$11,952,027	$7,511,182	$19,463,209
State fund savings	($2,369,215)	$2,841,032	$471,817

Without the enhanced FMAP, which is scheduled to end in 2027 under the federal demonstration, the analysis found that the CCBHC initiative would have been budget neutral if 10.8 percent of New York State's mental health population Medicaid recipients had access to CCBHCs, which would reduce inpatient/ED spending among the mental health population by 2.5 percent.

Exhibit 2: CCBHC Cost Effectiveness with New York's Regular FMAP

Per Visit Expense			
	2018	2019	Average
CCBHC	$255	$224	$239
Reference clinics	$130	$129	$130

State Share			
	2018	2019	Average
CCBHC	$127	$112	$119
Reference clinics	$65	$64	$65

CCBHC Additional State Cost			
	2018	2019	Total
CCBHC visits	494,089	539,273	1,033,36211
Additional state funds	$30,849,451	$25,631,619	$56,481,070

Reductions Needed for Cost Neutrality			
	2018	2019	Total
ED spending in CCBHC counties	$198,373,605	$210,524,476	$408,898,081
Inpatient spending in CCBHC counties	$1,950,925,611	$2,104,276,333	$4,055,201,944
Total	$2,149,299,216	$2,314,800,809	$4,464,100,025
Inpatient and ED Savings Required	2.9%	2.2%	2.5%

Penetration Needed to Generate ED/Inpatient Reductions for Cost Neutrality			
	2018	2019	Total
CCBHC penetration needed	10.8%	10.8%	10.8%
ED savings in CCBHC counties	$6,255,518	$6,639,333	$12,894,851
Inpatient savings in CCBHC counties	$48,215,203	$52,204,832	$100,420,034
Total	$54,470,721	$58,844,164	$113,314,885
State funds (50% FMAP)	$27,235,360	$29,422,082	$56,657,443
Additional state CCBHC costs	$30,849,451	$25,631,619	$56,481,070
State fund savings	($3,614,090)	$3,790,463	$176,373

To ascertain whether New York generated a return on its investment in enhanced rates, we compared the penetration needed to break even with the level of penetration achieved by the same level of investment. **In the CCBHC counties, the penetration rate of services was 10.6 percent.**

Exhibit 3: CCBHC Penetration Rates

CCBHC Penetration						
	2018		2019		Total	
	CCBHC counties	Statewide	CCBHC counties	Statewide	CCBHC counties	Statewide
CCBHC visits	466,872	494,089	503,665	539,273	970,537	1,033,362
Total visits	4,608,091	6,642,840	4,584,173	6,638,259	9,192,263	13,281,099
CCBHC penetration	10.1%	7.4%	11.0%	8.1%	10.6%	7.8%

Conclusion

During 2018 and 2019, New York CCBHCs provided more than one million visits to the state's Medicaid population. New York's Medicaid program invested $19.5 million more in those visits than it would have if the services were provided outside of the CCBHC program. For New York's Medicaid program to offset those costs, 0.9 percent of inpatient and ER spending by the mental health population in counties served by CCBHCs had to be avoided.

We then leveraged OMH data regarding the inpatient and ED reductions experienced by members who had been served through a CCBHC to calculate the percentage of members in those counties who needed access to CCBHC services to impact 0.9 percent of the spend. As a result, we determined that if CCBHCs had reached 3.8 percent of the mental health population, the state share of Medicaid would have been budget neutral.

Next, we then compared that 3.8 percent to the actual penetration of CCBHC services and determined that 10.6 percent of the visits in counties served by CCBHCs were provided at a CCBHC facility. Hence, CCBHCs have produced savings for New York's share of Medicaid.

We then attempted to ascertain whether the savings generated would have offset the investment made if New York were no longer participating in the demonstration and, thus, no longer receiving increased federal financial participation for CCBHC services. In this scenario the results were less clear but appear to indicate that CCBHCs would be budget neutral with respect to the state share of Medicaid if they did not generate enhanced federal match.

These findings suggest that the increased costs of a large-scale implementation of CCBHCs—as Michigan, Minnesota, Missouri, Nevada, Oregon, and Texas have done—would be offset by reductions in inpatient and ED spending. If that large-scale implementation occurs with the enhanced FMAP of the CCBHC demonstration, it can yield a net positive for New York's share of Medicaid.

Appendices

Appendix A: Methodology and Limitations

Edrington Health Consulting (EHC), an HMA Company, was asked to use publicly available New York Medicaid data to analyze the additional cost to New York of operating CCBHCs and model multiple scenarios around potential savings generated through the CCBHCs.

Data

The data used in this analysis included publicly available dashboards and data downloads published by New York's OMH, available at https://omh.ny.gov/omhweb/tableau/county-profiles.html, and Medicaid enrollment reports that the New York Department of Health (NY DOH) has published online at https://www.health.ny.gov/health_care/medicaid/enrollment/historical/enrollment_trends.htm. Savings figures presented at the National Council for Mental Wellbeing's February 17, 2022, meeting, The Certified Community Behavioral Health Clinic (CCBHC) Model: A Learning Collaborative for State Government Officials, were used to support CCBHC savings assumptions.

EHC decided to use 2018 and 2019 data. The 2017 data indicated a program ramping up, so EHC chose to disregard them. Because of the pandemic restrictions in 2020, those data were outliers, so EHC disregarded those figures as well. 2019 data are the most recent non-pandemic lockdown data available publicly.

Methodology

EHC downloaded the New York OMH's Part I: Medicaid Utilization database for the mental health population and New York DOH July enrollment data published in 2014–2020. Due to time constraints, we multiplied July membership by 12 to estimate annual membership.

The OMH data contain a variable, Program Type, that allows identification of specific services. Using this flag, EHC summarized CCBHC services and comparable non-CCBHC services (identified by the program type value of an OMH licensed clinic, Office of Addiction Services and Supports (OASAS) clinic (FS), OASAS clinic (HP), and OASAS clinic (other). The OMH data included paid amount and units of service, so EHC could directly calculate the per-unit cost of CCBHCs and licensed clinics.

The calculated value varies by year, but CCBHC unit costs ranged from $224 to $255, whereas OMH licensed clinics ranged from $129 to $130 in 2018–2019. Because the CCHBCs receive an enhanced FMAP of 65 percent, the additional cost to the state is less than the total unit cost difference. The state share of the per-unit cost is $78–$89 for CCBHCs and $64–$65 for OMH licensed clinics. Based on the annual units of service provided by CCBHCs, this results in an additional cost to the State of $7.5 million to $12 million annually, varying due to both unit cost differences and volume of service differences across years.

Next, EHC analyzed the savings that would be necessary to fund the state share of the additional expense that CCBHCs incur. We began by looking at the total reduction in inpatient and ED services that would be necessary to create the state fund savings required to offset the additional CCBHC expense.

Using the physical health, mental health, and substance use categories shown in Table 1, EHC calculated a total fund expenditure of $2.1 billion−$2.3 billion annually in the counties operating a CCHBC, or in which a CCBHC across county lines was providing a significant percentage of care to county residents. To offset the additional state share expense of CCBHCs, the clinics would need to generate a 0.6 percent to 1.1 percent reduction in combined inpatient and ED expense for the mental health population.

Table 1 – Program Type values used for Inpatient and Emergency Room

Program Type	IP/ER Designation	PH/BH Designation
MH Inpatient	IP	Behavioral Health
SUD Inpatient	IP	Behavioral Health
Non-BH Inpatient	IP	Physical Health
MH Emergency	ER	Behavioral Health
SUD Emergency	ER	Behavioral Health
Non-BH Emergency	ER	Physical Health

Finally, EHC examined demonstration year 1 and demonstration year 2 savings that New York reported at the National Council of Mental Wellbeing meeting (see Appendix C). This report stated that individuals receiving CCBHC services had shown the following cost reductions:

- 27 percent per month in BH inpatient services
- 26 percent per month in BH ED services
- 20 percent per month in PH inpatient services
- 30 percent cost per month in PH ED services

EHC wanted to apply these percentage savings to determine whether CCHBCs had been cost-effective. Unfortunately, publicly available data do not allow for the identification of non-CCBHC expenses for individuals using CCBHC services, so a direct calculation was unattainable. Instead, EHC looked at the percent of inpatient and ED spending that individuals using a CCBHC would need to generate to offset the CCBHC state fund expense.

Our analysis showed that based on applying the State's savings rates (see the bullets above) to the mental health population in CCBHC counties, if 3.8 percent of the combined Inpatient and Emergency Room spend was generated by CCBHC utilizers, then the CCBHC program would be cost effective during 2018 and 2019. Over this period, the CCBHCs would have generated $19.9 million in state fund savings against $19.4 million in additional state fund expenses, yielding a net savings of $472,000 over the two-year span. Please note that the 3.8 percent figure does not mean that 3.8 percent of the Medicaid mental health population use a CCBHC, but rather that 3.8 percent of Medicaid mental health member Inpatient and Emergency Room expense must be driven by CCBHC utilizers

Limitations

All analyses were built on summary-level data publicly available through the aforementioned sites and publications. If patient-level data were available, a direct connection between CCBHC visitors and total

cost of care could be established, allowing for both a confirmation of the state's savings percentages as well as a rigorous analysis of the impact of substituting CCBHC services for licensed clinic visits. This methodology also would provide a more precise picture of how many people need access to a CCBHC to account for 3.8 percent of inpatient and ED expenditures.

The analyses were conducted on a database of the mental health population. Members who only utilize SUD services were not included in the database, and so were not considered. While there is a database of the SUD population available, it cannot be deduplicated against the mental health population database.

All county designations are based on the recipient county, so members who cross county lines to receive CCBHC services generate a related expense for a county that lacks a CCBHC. Exhibits that demonstrate the average cost per CCBHC use a simple average. If service volume varies by CCBHC, actual experience could differ from the program average.

Annual Medicaid enrollment by county was estimated using July membership multiplied by 12. This was necessary due to time constraints involved in obtaining membership for the full time period necessary for the analysis.

Not all metrics and data sources were available by age, so the analysis does not split out children, seniors, or individuals dually eligible for Medicaid and Medicare.

Appendix B: Detailed Tables

CCBHC Locations

County	CCBHC Provider
Nassau	Central Nassau Guidance & Counseling Center
Monroe	University of Rochester, Strong Memorial Hospital
Franklin and St. Lawrence	Citizen Advocates, Inc.
Onondaga	Helio Health
Erie	(1) Spectrum (2) Lake Shore Behavioral Health (3) Mid-Erie Mental Health Services
Orange	Bikur Cholim
Queens	New Horizon Counseling Center, Inc.
Bronx	(1) PROMESA (2) VIP, Inc. (3) Samaritan Daytop Village
Kings and New York	Services for the Underserved

CCBHC Penetration, 2018

CCBHC Penetration during the Demonstration, 2018				
County	**CCBHC**	**Reference Clinics**	**Total**	**CCBHC Penetration**
Albany	(0)	62,406	62,406	0.0%
Allegany	285	13,451	13,736	2.1%
Bronx	75,697	850,002	925,699	8.2%
Broome	363	60,399	60,762	0.6%
Cattaraugus	3,581	28,201	31,782	11.3%
Cayuga	842	33,799	34,641	2.4%
Chautauqua	1,445	57,954	59,399	2.4%
Chemung	(0)	50,503	50,503	0.0%
Chenango	(0)	14,594	14,594	0.0%
Clinton	668	34,802	35,470	1.9%
Columbia	(0)	22,121	22,121	0.0%
Cortland	372	30,877	31,249	1.2%
Delaware	(0)	7,773	7,773	0.0%
Dutchess	(0)	71,568	71,568	0.0%
Erie	166,169	243,342	409,511	40.6%
Essex	1,303	6,761	8,064	16.2%
Franklin	21,855	6,823	28,678	76.2%
Fulton	(0)	32,726	32,726	0.0%
Genesee	1,323	24,450	25,773	5.1%
Greene	(0)	18,363	18,363	0.0%
Hamilton	(0)	(0)	(0)	28.6%
Herkimer	(0)	17,489	17,489	0.0%

Jefferson	371	48,041	48,412	0.8%
Kings	13,183	999,032	1,012,215	1.3%
Lewis	(0)	10,259	10,259	0.0%
Livingston	1,983	22,532	24,515	8.1%
Madison	2,089	23,402	25,491	8.2%
Monroe	38,312	336,172	374,484	10.2%
Montgomery	(0)	25,548	25,548	0.0%
Nassau	17,181	165,883	183,064	9.4%
New York	10,339	601,984	612,323	1.7%
Niagara	4,103	104,145	108,248	3.8%
Oneida	419	85,795	86,214	0.5%
Onondaga	51,074	148,707	199,781	25.6%
Ontario	1,423	29,998	31,421	4.5%
Orange	4,406	72,027	76,433	5.8%
Orleans	639	16,983	17,622	3.6%
Oswego	3,175	43,280	46,455	6.8%
Other	-	-	-	0.0%
Otsego	(0)	10,275	10,275	0.0%
Putnam	(0)	13,313	13,313	0.0%
Queens	33,200	610,411	643,611	5.2%
Rensselaer	(0)	43,514	43,514	0.0%
Richmond	380.99	137,627	138,008	0.3%
Rockland	18,998	30,531	49,529	38.4%
Saint Lawrence	2,678	31,872	34,550	7.8%
Saratoga	(0)	28,433	28,433	0.0%
Schenectady	(0)	49,415	49,415	0.0%
Schoharie	(0)	9,821	9,821	0.0%
Schuyler	(0)	4,333	4,333	0.0%
Seneca	(0)	15,336	15,336	0.0%
Steuben	(0)	33,798	33,798	0.0%
Suffolk	1,489	245,109	246,598	0.6%
Sullivan	(0)	12,428	12,428	0.0%
Tioga	-	13,254	13,254	0.0%
Tompkins	(0)	39,695	39,695	0.0%
Ulster	(0)	47,588	47,588	0.0%
Warren	(0)	12,125	12,125	0.0%
Washington	(0)	15,266	15,266	0.0%
Wayne	1,702	42,265	43,967	3.9%
Westchester	342	250,776	251,118	0.1%
Wyoming	8,896	9,471	18,367	48.4%
Yates	(0)	7,389	7,389	0.0%
Statewide	494,089	6,148,751	6,642,840	7.4%
CCBHC Counties	466,872	4,141,219	4,608,091	10.1%

CCBHC Penetration Rates in 2019

CCBHC Penetration during the Demonstration, 2019				
County	**CCBHC**	**Reference Clinics**	**Total**	**CCBHC Penetration**
Albany	(0)	64,791	64,791	0.0%
Allegany	403	14,547	14,950	2.7%
Bronx	65,207	821,022	886,229	7.4%
Broome	455	60,274	60,729	0.7%
Cattaraugus	4,347	26,873	31,220	13.9%
Cayuga	1,399	39,160	40,559	3.4%
Chautauqua	2,347	49,476	51,823	4.5%
Chemung	(0)	46,723	46,723	0.0%
Chenango	(0)	13,698	13,698	0.0%
Clinton	701	39,149	39,850	1.8%
Columbia	(0)	23,239	23,239	0.0%
Cortland	415	29,947	30,362	1.4%
Delaware	(0)	8,657	8,657	0.0%
Dutchess	(0)	55,853	55,853	0.0%
Erie	186,982	239,520	426,502	43.8%
Essex	1,526	6,358	7,884	19.4%
Franklin	22,502	6,875	29,377	76.6%
Fulton	(0)	31,352	31,352	0.0%
Genesee	1,288	23,100	24,388	5.3%
Greene	(0)	18,298	18,298	0.0%
Hamilton	(0)	(0)	(0)	33.3%
Herkimer	(0)	17,334	17,334	0.0%
Jefferson	379	44,923	45,302	0.8%
Kings	16,907	998,248	1,015,155	1.7%
Lewis	(0)	8,624	8,624	0.0%
Livingston	2,059	22,480	24,539	8.4%
Madison	2,325	24,466	26,791	8.7%
Monroe	45,513	324,598	370,111	12.3%
Montgomery	(0)	24,668	24,668	0.0%
Nassau	18,223	167,929	186,152	9.8%
New York	9,553	608,164	617,717	1.5%
Niagara	7,731	95,701	103,432	7.5%
Oneida	596	84,131	84,727	0.7%
Onondaga	52,645	145,156	197,801	26.6%
Ontario	1,360	31,071	32,431	4.2%
Orange	8,301	71,446	79,747	10.4%
Orleans	509	16,351	16,860	3.0%
Oswego	4,225	42,382	46,607	9.1%
Other	1,608	79,470	81,078	2.0%
Otsego	(0)	12,124	12,124	0.0%
Putnam	(0)	12,128	12,128	0.0%

Queens	31,079	591,733	622,812	5.0%
Rensselaer	(0)	40,320	40,320	0.0%
Richmond	711.98	137,121	137,833	0.5%
Rockland	26,587	31,623	58,210	45.7%
Saint Lawrence	4,440	31,044	35,484	12.5%
Saratoga	(0)	32,099	32,099	0.0%
Schenectady	(0)	46,758	46,758	0.0%
Schoharie	(0)	12,180	12,180	0.0%
Schuyler	(0)	11,520	11,520	0.0%
Seneca	(0)	9,246	9,246	0.0%
Steuben	(0)	37,241	37,241	0.0%
Suffolk	1,464	272,460	273,924	0.5%
Sullivan	316	13,401	13,717	2.3%
Tioga	(0)	13,332	13,332	0.0%
Tompkins	224	38,167	38,391	0.6%
Ulster	(0)	29,986	29,986	0.0%
Warren	(0)	17,147	17,147	0.0%
Washington	-	16,182	16,182	0.0%
Wayne	2,212	43,843	46,055	4.8%
Westchester	439	234,420	234,859	0.2%
Wyoming	9,853	9,919	19,772	49.8%
Yates	(0)	7,598	7,598	0.0%
Statewide	539,273	6,098,986	6,638,259	8.1%
CCBHC Counties	503,665	4,080,508	4,584,173	11.0%

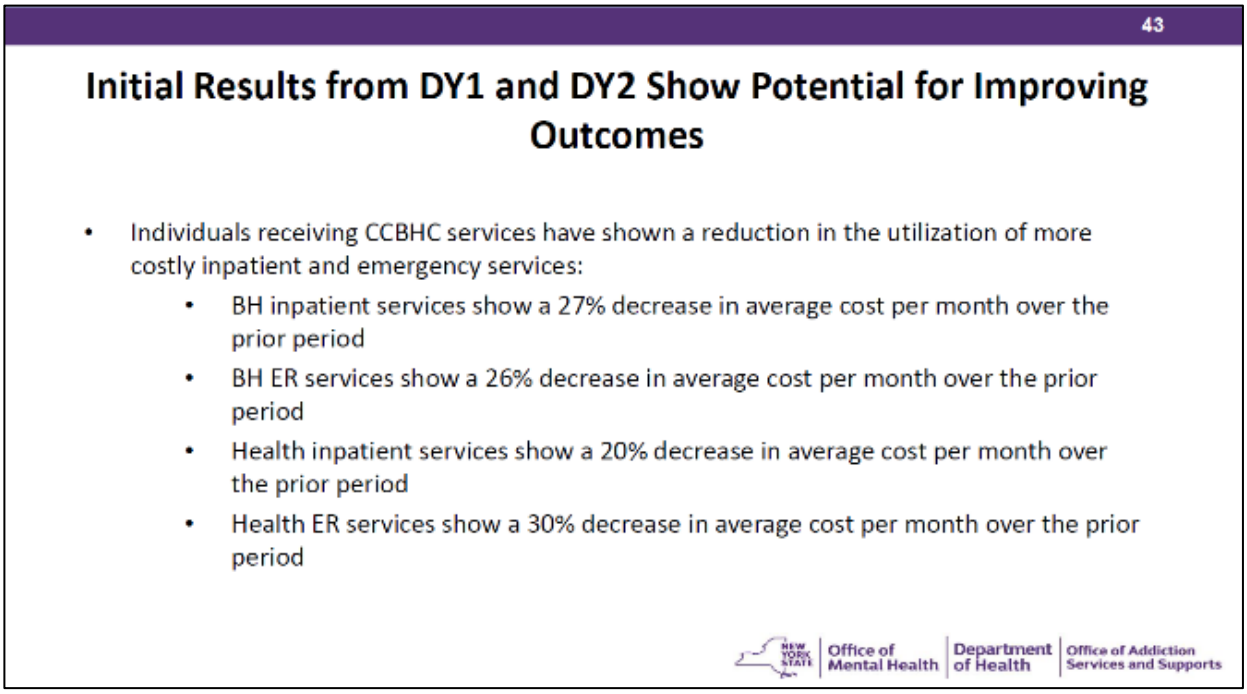
CCBHC Penetration Two-Year Average

Total CCBHC Penetration during the Demonstration				
County	**CCBHC**	**Reference Clinics**	**Total**	**CCBHC Penetration**
Albany	(0)	127,197	127,197	0.0%
Allegany	688	27,998	28,686	2.4%
Bronx	140,904	1,671,024	1,811,928	7.8%
Broome	818	120,673	121,491	0.7%
Cattaraugus	7,928	55,074	63,002	12.6%
Cayuga	2,241	72,959	75,200	3.0%
Chautauqua	3,792	107,430	111,222	3.4%
Chemung	(0)	97,226	97,226	0.0%
Chenango	(0)	28,292	28,292	0.0%
Clinton	1,369	73,951	75,320	1.8%
Columbia	(0)	45,360	45,360	0.0%
Cortland	787	60,824	61,611	1.3%
Delaware	(0)	16,430	16,430	0.0%
Dutchess	(0)	127,421	127,421	0.0%
Erie	353,151	482,862	836,013	42.2%
Essex	2,829	13,119	15,948	17.7%
Franklin	44,357	13,698	58,055	76.4%
Fulton	(0)	64,078	64,078	0.0%

Genesee	2,611	47,550	50,161	5.2%
Greene	(0)	36,661	36,661	0.0%
Hamilton	(0)	(0)	(0)	30.8%
Herkimer	(0)	34,823	34,823	0.0%
Jefferson	750	92,964	93,714	0.8%
Kings	30,090	1,997,280	2,027,370	1.5%
Lewis	(0)	18,883	18,883	0.0%
Livingston	4,042	45,012	49,054	8.2%
Madison	4,414	47,868	52,282	8.4%
Monroe	83,825	660,770	744,595	11.3%
Montgomery	(0)	50,216	50,216	0.0%
Nassau	35,404	333,812	369,216	9.6%
New York	19,892	1,210,148	1,230,040	1.6%
Niagara	11,834	199,846	211,680	5.6%
Oneida	1,015	169,926	170,941	0.6%
Onondaga	103,719	293,863	397,582	26.1%
Ontario	2,783	61,069	63,852	4.4%
Orange	12,707	143,473	156,180	8.1%
Orleans	1,148	33,334	34,482	3.3%
Oswego	7,400	85,662	93,062	8.0%
Other	1,608	79,470	81,078	2.0%
Otsego	(0)	22,399	22,399	0.0%
Putnam	(0)	25,441	25,441	0.0%
Queens	64,279	1,202,144	1,266,423	5.1%
Rensselaer	(0)	83,834	83,834	0.0%
Richmond	1,093	274,748	275,841	0.4%
Rockland	45,585	62,154	107,739	42.3%
Saint Lawrence	7,118	62,916	70,034	10.2%
Saratoga	(0)	60,532	60,532	0.0%
Schenectady	(0)	96,173	96,173	0.0%
Schoharie	(0)	22,001	22,001	0.0%
Schuyler	(0)	15,853	15,853	0.0%
Seneca	(0)	24,582	24,582	0.0%
Steuben	(0)	71,039	71,039	0.0%
Suffolk	2,953	517,569	520,522	0.6%
Sullivan	316	25,829	26,145	1.2%
Tioga	(0)	26,586	26,586	0.0%
Tompkins	224	77,862	78,086	0.3%
Ulster	(0)	77,574	77,574	0.0%
Warren	(0)	29,272	29,272	0.0%
Washington	(0)	31,448	31,448	0.0%
Wayne	3,914	86,108	90,022	4.3%
Westchester	781	485,196	485,977	0.2%
Wyoming	18,749	19,390	38,139	49.2%
Yates	(0)	14,987	14,987	0.0%
Statewide	1,033,362	12,247,737	13,281,099	7.8%
CCBHC Counties	970,537	8,221,726	9,192,263	10.6%

Appendix C: New York State OMH Savings Analysis

The information below was presented at the February 17, 2022, National Council for Mental Wellbeing meeting, The Certified Community Behavioral Health Clinic (CCBHC) Model: A Learning Collaborative for State Government Officials.



[1] Usually, the FMAP for New York is 50% for the general population (expansion populations have a higher FMAP). CCBHC enhanced FMAP is at the Children's Health Insurance Program (CHIP) rate, which is usually 65% for New York. As a result of the COVID-19 Public Health Emergency (PHE), New York's general FMAP is currently 62.5% and our FMAP for CHIP is 69.34%. We conducted our analyses using New York's non-PHE FMAP rates (50% and 65%) to ascertain the financial impact of the CCBHC initiative in the absence of a pandemic.

[2] The penetration rate is the percentage of total outpatient BH visits that are provided by a CCBHC. For example, if there are ten total outpatient visits and one is a CCBHC visit, the penetration rate is 10%.

[3] The Satcher Health Leadership Institute. (2022). The Economic Burden of Mental Health Inequities in the United States Report. Retrieved from: https://satcherinstitute.org/wp-content/uploads/2022/09/The-Economic-Burden-of-Mental-Health-Inequities-in-the-US-Report-Final-single-pages.V3.pdf

[4] Centers for Disease Control and Prevention (CDC). 2020 U.S. Drug Overdose data. Retrieved from: https://www.cdc.gov/drugoverdose/deaths/index.html

[5] KFF Analysis of Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, Designated Health Professional Shortage Areas Statistics: Designated HPSA Quarterly Summary, as of September 30, 2022, available at https://data.hrsa.gov/topics/health-workforce/shortage-areas.

[6] The Substance Abuse and Mental Health Services Administration (SAMHSA). Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (samhsa.gov). Retrieved from: https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

[7] The CCBHC Enhanced FMAP is the percentage equivalent to the state's standard Children's Health Insurance Program (CHIP) rate as specified in section 2105(b) of the Social Security Act. For expansion adults, expenditures will be matched at the applicable FMAP for that population. Services for Native Americans are matched at 100 percent.

[8] The Substance Abuse and Mental Health Services Administration (SAMHSA). Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics (samhsa.gov). Retrieved from: https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf
[9] The National Council for Mental Wellbeing. (2022). 20202 CCBHC Impact Report: Expanding Access to Comprehensive, Integrated Mental Health & Substance Use Care. Retrieved from: https://www.thenationalcouncil.org/resources/2022-ccbhc-impact-report/
[10] Ibid.
[11] SAMHSA. Appendix III - Section 223 Demonstration Programs to Improve Community Mental Health Services Prospective Payment System (PPS) Guidance. Retrieved from: https://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-001.pdf#page=94
[12] The National Council for Mental Wellbeing. (2022). 20202 CCBHC Impact Report: Expanding Access to Comprehensive, Integrated Mental Health & Substance Use Care. Retrieved from: https://www.thenationalcouncil.org/resources/2022-ccbhc-impact-report/
[13] Martiniano R, Krohmal R, Boyd L, Liu Y, Harun N, Harasta E, Wang S, Moore J. The Health Care Workforce in New York: Trends in the Supply of and Demand for Health Workers. Rensselaer, NY: Center for Health Workforce Studies, School of Public Health, SUNY Albany; March 2018.
[14] Human Services Council. (2017). Undervalued & Underpaid: How New York State Shortchanges Nonprofit Human Services Providers and their Workers. Restore Opportunity Now (RON) report.
[15] National Council for Mental Wellbeing. (2022). 2022 CCBHC Impact Report: Expanding Access to Comprehensive, Integrated Mental Health & Substance Use Care. Retrieved from: https://www.thenationalcouncil.org/resources/2022-ccbhc-impact-report/
[16] Ibid.
[17] 13 agencies operate 16 CCBHC access points in 12 counties: Bronx (x3), Erie (x3), Franklin, Kings, Monroe, Nassau, New York, Onondaga, Orange, Queens, St. Lawrence, and Wyoming. In addition, due to the penetration of CCBHC services for residents of Cattaraugus, Essex, and Rockland counties among the MH population, those three counties were included as CCBHC counties in our analysis.
[18] OMH Licensed Clinic, OASAS Clinic (FS), OASAS Clinic (HP), and OASAS Clinic (Other)