MDHHS
Michigan Department of Health & Human Services

MICHIGAN'S CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC) DEMONSTRATION

Demonstration Year 1: October 1, 2021 – September 30, 2022

Contents

OVERVIEW OF MICHIGAN'S CCBHC DEMONSTRATION

The Federal Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 expanded the CCBHC demonstration to include Michigan as a Certified Community Behavioral Health Clinic (CCBHC) Demonstration state in August 2020. The demonstration launched in October 2021 with a planned implementation period of two years. The Safer Communities Act was signed with provisions for CCBHC Demonstration expansion, extending Michigan's demonstration through September 2027. Thirteen sites, including 10 CMHSPs and 3 non-profit behavioral health providers, are certified and monitored by MDHHS and are participating in the demonstration. Certification criteria are listed on the right side of the page. The CCBHC model increases access to a comprehensive array of behavioral health services by serving all individuals with a behavioral health diagnosis, regardless of insurance or ability to pay.

CCBHC Certification Components

1. Staffing Requirements
2. Availability and Accessibility of Services
3. Care Coordination across the full spectrum of health services
4. Scope of Services
5. Quality and Other Reporting
6. Organizational Authority, Governance, and Accreditation

The Centers for Medicare and Medicaid Services (CMS) requires CCBHCs, directly or through designated collaborating organizations, to provide a set of nine comprehensive services to address the complex and myriad needs of persons with mental health or SUD diagnoses. This full array of services must be made available to all consumers and represent a service array necessary to facilitate access, stabilize crises, address complex mental illness and addiction, and emphasize physical/behavioral health integration.

CCBHC program requirements stipulate that CCBHCs cannot refuse service to any person based on ability to pay, residence, or severity of need, expanding the population eligible for the robust service array. Any fees or payments required by the clinic for such services will be reduced or waived to ensure appropriate accessibility and availability. Additionally, CCBHCs must follow standards intended to make services more available and accessible, including expanding service hours, utilizing telehealth, engaging in prompt intake and assessment processes, offering 24/7 crisis interventions, and following person and family-centered treatment planning and service provision.

The summary that follows provides an overview of the population served, services provided, and performance metrics of CCBHCs within year one of Michigan's CCBHC demonstration. Data sources used include service encounter data[1], beneficiary information stored in the MDHHS Data Warehouse, and CCBHC-reported performance metrics.

[1]Encounter data pulled March 2023 (program counts) and February 2023 (statewide metrics)

PERSONS SERVED

Throughout the first demonstration year (DY1), 62,626 unique individuals received CCBHC services. Of those, 89 percent were enrolled in Medicaid and 11 percent did not have Medicaid at the time of service. Among the Medicaid beneficiaries, 65 percent had traditional Medicaid, 24 percent had Healthy Michigan Plan benefits, and 10% had unknown coverage.

Age

CCBHCs provide evidence-based, age-appropriate treatment across the lifespan. Children under the age of 18 represented 25 percent of the total number of individuals receiving CCBHC services. 19.5% of service recipients were Transition Age Youth (age 15-25), the age group with the highest risk for onset of behavioral health symptoms. Adults age 65 and up represented 5.4 percent of the service population.

County of Residency

CCBHCs are unique in that they must serve all Michiganders, regardless of county of residency. Most services, (97 percent) were provided to individuals residing in the CCBHC service area. However, the percent of individuals without Medicaid who had a county of residence outside of a CCBHC service area was much higher than (7.7 percent vs. 1.1 percent, respectively) Medicaid beneficiaries. This suggests that individuals without Medicaid may be traveling across county lines to receive services at CCBHCs. A small number of Medicaid beneficaries (n=48) lived out of the state of Michigan.

Race and Ethnicity

Participating CCBHC demonstration sites are dispersed throughout the state of Michigan and serve diverse populations. Statewide, 65 percent of CCBHC service recipients identified their primary race as White, 23 percent as African American/Black, 4 percent as Hispanic, 1 percent as American Indian/Alaskan Native, 0.6 percent as Asian American, 0.1 percent as Native Hawaiian & Other Pacific Islander. Roughly 87 percent of CCBHC service recipients identified their ethnicity as non-Hispanic, ethnicity was not reported for 9 percent of service recipients, and the remaining 4 percent representing Hispanic, Mexican, Mexican American, Puerto Rican, Cuban, Chicano, and other ethnicities.

Sex and Gender Identity

Overall, 48.9 percent as men/cisgender men, 48 percent of CCBHC service recipients identified as women/cisgender women, and 1.9 percent identified as non-cisgender (representing an array of identities including transgender, non-binary/genderqueer, gender fluid, questioning, agender, bigender, two spirit, androgynous, and other). Approximately, 49.4 percent reported a sex at birth of female, and 49.3 percent reported a sex at birth of male, with 1.2 percent unknown.

Military History

CCBHC certification standards outline specific requirements that sites must follow when serving veterans and individuals with military backgrounds, including required staff training in military culture, care coordination responsibilities, monitoring, and connections to veteran supports. About 2.5 percent of CCBHC service recipients reported military involvement, including 2 percent of Medicaid beneficiaries and 4 percent of individuals without Medicaid.

DIAGNOSIS

Individuals must have a behavioral health diagnosis to receive services at a CCBHC. The prevalence of primary diagnoses among the service population can help with understanding the broader needs of individuals seeking treatment and the associated services they receive. Mood (affective) disorders were most common (reported on 37.6 percent of all service encounters), followed by Schizophrenia, Schizotypal, Delusional, and Other Non-Mood Psychotic Disorders (22.1 percent), and Anxiety, Dissociative, Stress-Related, Somatoform and Other Nonpsychotic Mental Disorders (15.3 percent). Encounters for Non-Medicaid service recipients were more likely to have a primary Mood, Anxiety, or Substance Use Disorder diagnosis and less likely to have a Schizophrenia/Psychotic disorder diagnosis.

Intellectual and Developmental Disabilities

Roughly 5.1 percent of CCBHC encounters had a primary diagnosis within the category of an Intellectual Disabilities and Underlying Causes of IDD. Individuals with primary IDD needs can receive CCBHC services if they also have a mental health or substance use disorder diagnosis.

Substance Use Disorder

23.2% percent of those served were diagnosed with a primary or secondary Psychoactive Substance Use disorder, resulting in over 12,000 co-occurring service delivery encounters. Only 3.2 percent of all CCBHC service encounters had a primary Substance Use Disorder diagnosis (category of Mental and Behavioral Disorders Due to Psychoactive Substance Use). This may increase as SUD services expand and awareness increases of their availability at CCBHCs.

SERVICES DELIVERED

CCBHCs are required to provide nine core services (listed on the right).

Services can be provided directly by the CCBHC or via a contractual relationship with a designated collaborating organization.

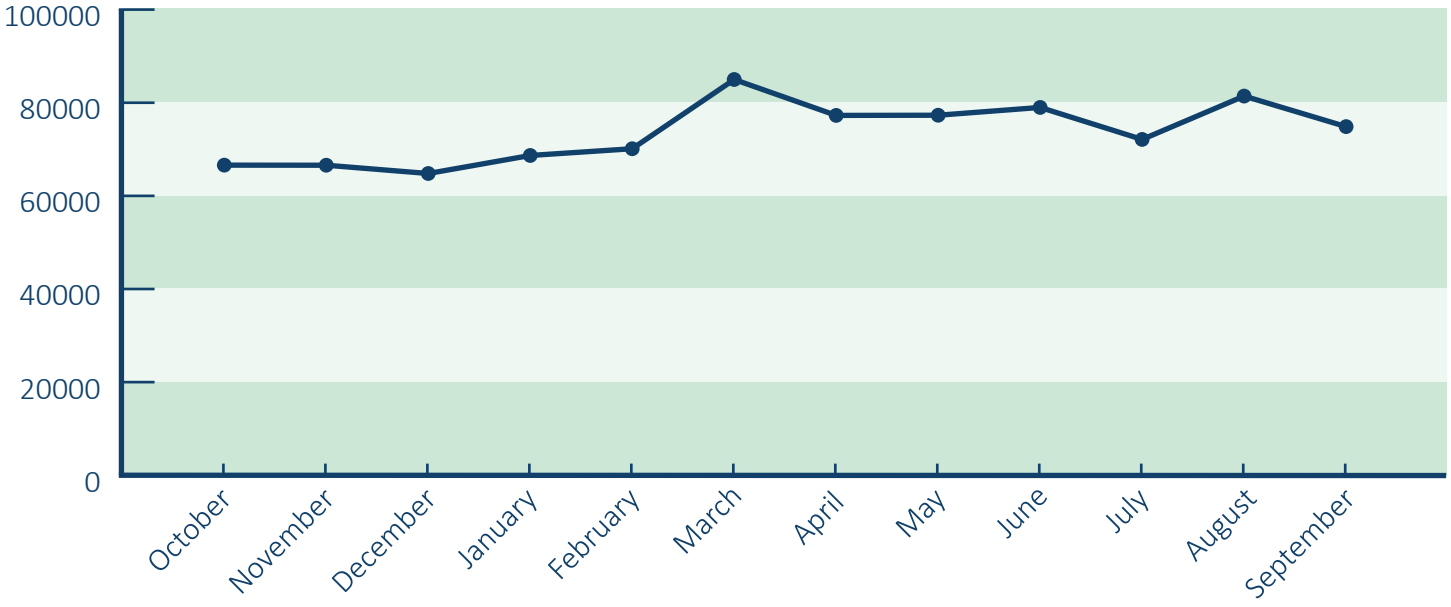
Service utilization can be measured in multiple ways. Daily visits are a measure of both population and services provided, counting each service day per individual. Daily visits correspond directly to CCBHC funding, as CCBHCs are reimbursed the PPS-1 rate for each daily visit. An alternative way to measure service utilization is to measure service encounters, which showcase the actual services provided during the demonstration year.

1. Crisis mental health services, including 24/7 mobile crisis response.
2. Screening, assessment, and diagnosis, including risk assessment.
3. Patient-centered treatment planning.
4. Outpatient mental health and substance use services.
5. Targeted case management.
6. Outpatient clinic primary care screening and monitoring of key health indicators and health risk.
7. Psychiatric rehabilitation services.
8. Peer support and counselor services and family supports.
9. Intensive, community-based mental health care for members of the armed forces and veterans.

Daily Visits

A total of 883,779 daily visits were provided by the 13 participating CCBHCs during DY1. The number of visits remained consistent at the beginning of the fiscal year, but increased slightly in the spring of 2022, peaking with 84,992 visits during March of 2022. On average, 1.12 CCBHC services were provided at each daily visit.

Total Number of Daily Visits by Month FY22 (Demonstration Year 1)



Service Encounters

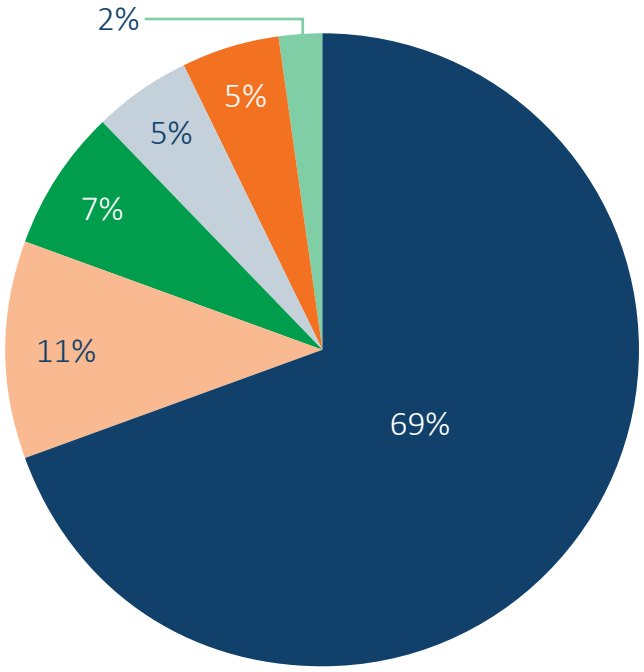
A total of 1,019,246 CCBHC services were provided during DY1. Nearly half (47 percent) of all service encounters were for Outpatient Mental Health and Substance Use Services. Targeted Case Management services comprised the second largest share (30 percent of all services), followed by peer and family support services (6 percent), psychiatric rehabilitation services (5 percent), treatment planning (3 percent) and crisis services (2 percent).

Notably, there were no reported encounters for Primary Care Screening and Assessment, however this is likely due to a limited number of available billing codes rather than a lack of activity. The number of crisis services provided may be underrepresented as well due to inconsistent reporting and utilization in some areas of state-sanctioned crisis systems that do not bill the T1040 for identification.

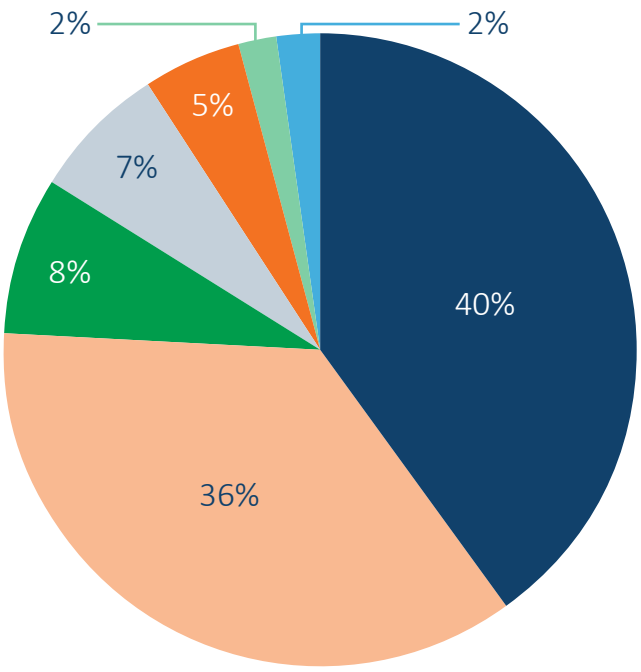
Of all CCBHC services, 77 percent were provided to adults and 23 percent to children. Although CCBHCs must offer all CCBHC services across the lifespan, the service array provided to children and youth differs from adults. The most significant proportional difference could be found with targeted case management, which made up a much larger share of the services provided to adults than children.

- Outpatient Mental Health and Substance Use Services
- Targeted Case Management
- Screening, Assessment and Diagnosis
- Peer/Family Support
- Treatment Planning
- Crisis Services
- Psychiatric Rehabilitation

Percentage of Youth Services



Percentage of Adult Services



ACCESS

The CCBHC model is intended to significantly expand access to behavioral health services. Of the 454,235 identified Medicaid beneficiaries in the service area with a behavioral health diagnosis identified in the last 18 months, 9.7 percent received a CCBHC service in the calendar year. Out of all eligible beneficiaries, 1.3 percent received a crisis service. These penetration measures will act as a baseline to measure the overall impact of the CCBHC model over time.

Telehealth

Telemedicine grew substantially as a behavioral health service modality during the COVID-19 pandemic, and CCBHC requirements encourage the use of telehealth to increase access. In DY1, 39 percent of daily visits (342,270) were provided via telehealth. 76 percent of CCBHC service recipients received at least one service via telehealth.

Services to Individuals with Mild to Moderate Needs

Many CCBHC sites have traditionally only provided specialty behavioral health services to adults and children with severe, chronic, and complex needs. With the mandate to serve individuals with any behavioral health diagnosis, CCBHCs were able to expand their reach and serve a new population. 16,114 individuals received services (26 percent of all persons served), accounting for approximately 85,085 Medicaid daily visits.

QUALITY PERFORMANCE

States participating in the CCBHC demonstration are responsible for the collection and reporting of specified measures. States use administrative encounter data from Medicaid populations to calculate the measures, which can be grouped into three main categories based on the type of performance being measured: Care Coordination and Follow-Up Care, Screening and Treatment Monitoring, and Timeliness of Services.

Care Coordination and Follow-Up Care

As part of their substantial care coordination responsibilities, CCBHCs must have established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric, detoxification, and residential settings to a safe community setting. These protocols should involve active follow-up after discharge and as, appropriate, a plan for prevention and safety, as well peer services.

Three required measures monitor a CCBHC's ability to follow-up with consumers after visits to the emergency department or hospitalization: Follow-Up After Emergency Department Visit for Mental Illness (FUM), Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA), Follow-Up After Hospitalization for Mental Illness (FUH). On each of these measures, CCBHC average rates exceeded the statewide average for all Medicaid beneficiaries.

State-Reported Metrics: Care Coordination and Follow-Up Care		Statewide Average	CCBHC Average
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	7 Day Follow-Up	46.49	62.09
	30 Day Follow-Up	61.39	77.17
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)	7 Day Follow-Up	14.81	21.45
	30 Day Follow-Up	24.09	63.55
Follow-Up After Hospitalization for Mental Illness (FUH)- *Adult*	7 Day Follow-Up	41.57	45.97
	30 Day Follow-Up	63.51	70.11
Follow-Up After Hospitalization for Mental Illness (FUH)- *Child*	7 Day Follow-Up	60.58	59.55
	30 Day Follow-Up	82.09	83.49

Screening and Treatment Monitoring

CCBHCs are required to review progress toward goals and update treatment plans every three to six months. As part of their primary care screening and monitoring responsibilities, CCBHC collect data both internally and from primary care partners to monitor co-occurring health conditions and manage medication adherence.

State-Reported Metrics: Screening and Treatment Monitoring		Statewide Average	CCBHC Average
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)		76.31	80.92
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)		57.24	56.70
Antidepressant Medication Management (AMM-AD)	Acute	56.21	49.06
	Chronic	33.78	29.82
Plan All-Cause Readmissions Rate (PCR-AD)	Observed Rate	9.36	12.03
	Expected Rate	9.37	9.72
	O/E Ratio	1.00	1.24
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)	Initiation	38.37	43.54
	Engagement	11.10	12.31

NEXT STEPS AND FUTURE OUTLOOK

In fiscal year 2023, The Michigan Department of Health and Human Services (MDHHS) received funding to expand the CCBHC Demonstration. Expansion was limited to Community Mental Health Service Providers (CMHSPs) and selected existing CCBHC SAMHSA grantees, whose funding expired in August or September 2023. This expansion decision aligns with MDHHS's goal to support continuity of CCBHC service delivery and infrastructure for those with SAMHSA grants that expire directly preceding the October 1, 2023 expansion start date. The CCBHC Program team is developing additional trainings and technical assistance opportunities to enhance MDHHS's efforts for future expansion opportunities.

SAMHSA released updated criteria in March 2023 for certifying CCBHC clinics in compliance with statutory requirements outlined under Section 223 of PAMA. Michigan CCBHC Demonstration clinics are expected to implement the new criteria beginning fiscal year 2025.

Michigan is committed to supporting the CCBHC model and measuring its transformative effect on behavioral and physical health care. The model, as shown in the data above, allows Michigan CCBHC demonstration clinics to expand the scope of mental health and substance use services in their community and serve anyone who walks through the door, regardless of their diagnosis or ability to pay. MDHHS has partnered with an external evaluator to conduct a formal evaluation of the first two years of the Demonstration. This evaluation is intended to help measure the impact of the demonstration. The evaluation and continuous efforts of stakeholders, Michiganders, and State leaders will drive the future of the CCBHC Demonstration in Michigan.