Michigan's Certified Community Behavioral Health Clinic (CCBHC) Demonstration Annual Report

Demonstration Year 3: Oct. 1, 2023 – Sept. 30, 2024

MDHHS
Michigan Department of Health & Human Services

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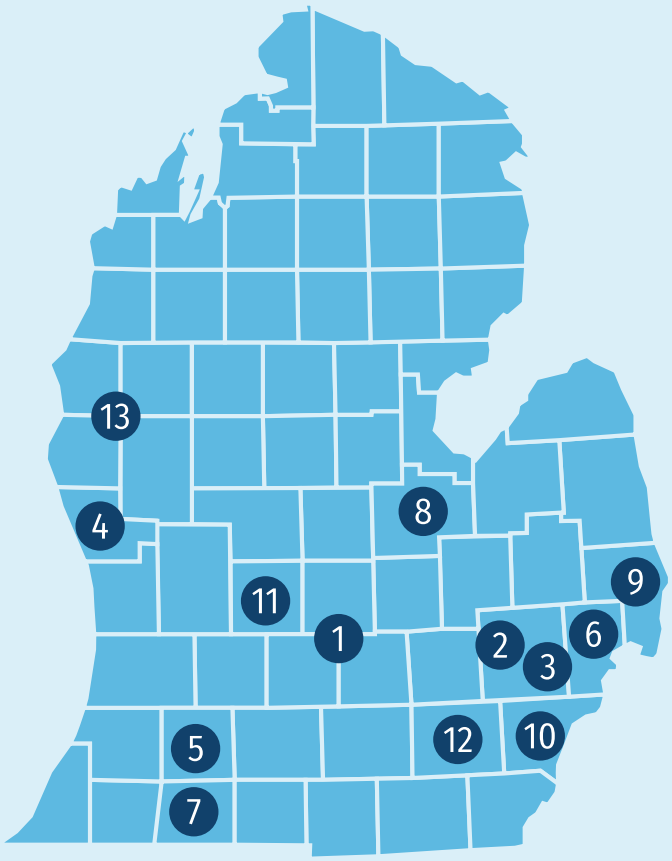
Overview of Michigan's CCBHC Demonstration

The Federal Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 expanded the Certified Community Behavioral Health Clinic (CCBHC) Demonstration to include Michigan in August 2020. The Michigan Department of Health and Human Services (MDHHS) officially launched the demonstration in October 2021, initially structured as a two-year implementation period. Subsequent federal legislation, including the Bipartisan Safer Communities Act, authorized expansion of the CCBHC Demonstration and extended Michigan's participation to a total of six years, with the demonstration scheduled to conclude in September 2027.

When Michigan launched the CCBHC Demonstration, 13 sites, including 10 Community Mental Health Service Programs (CMHSPs) and three nonprofit behavioral health providers, became state-certified CCBHC clinics. The 13 sites outlined below were Michigan's certified demonstration sites for the first two demonstration years (DY), collectively referred to in this report as Cohort 1.

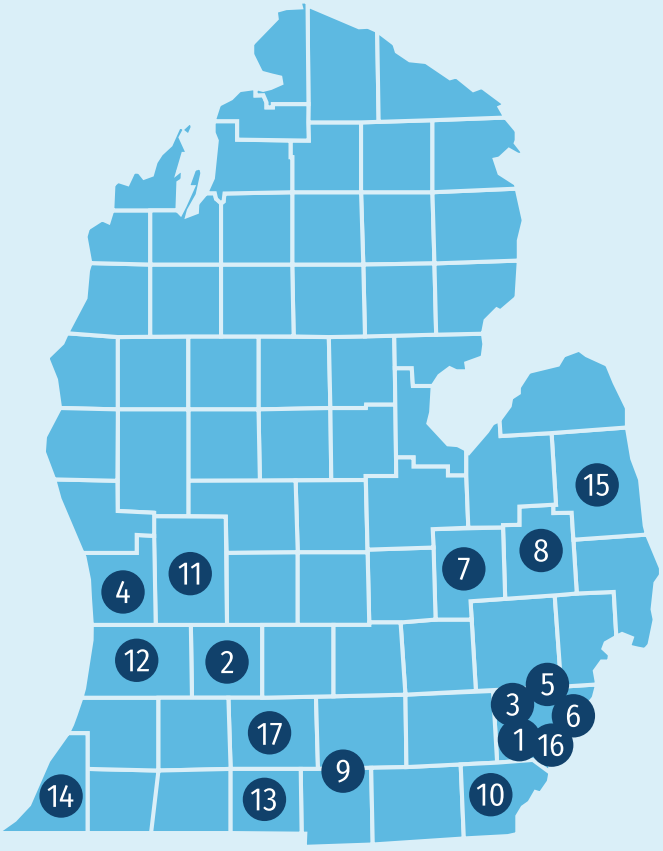
Cohort 1 Certified Demonstration Sites



1. Community Mental Health Authority of Clinton, Eaton and Ingham Counties.
2. CNS Healthcare (Oakland County).
3. Easterseals MORC (Oakland County).
4. HealthWest (Muskegon County).
5. Integrated Services of Kalamazoo (Kalamazoo County).
6. Macomb County Community Mental Health.
7. Pivotal (St. Joseph County).
8. Saginaw County Community Mental Health Authority.
9. St. Clair County Community Mental Health Authority.
10. The Guidance Center (Wayne County).
11. The Right Door for Hope and Wellness (Ionia County).
12. Washtenaw County Community Mental Health.
13. West Michigan Community Mental Health (Lake, Mason, and Oceana Counties).

In 2023, MDHHS was approved to expand the CCBHC Demonstration. The expansion was limited to Community Mental Health Service Providers (CMHSPs) and select existing Substance Abuse and Mental Health Services Administration (SAMHSA) grantees, whose funding expired in August or September 2023. This expansion decision aligns with MDHHS's goal supporting continuity of CCBHC service delivery and infrastructure for those with SAMHSA grants that expire directly preceding the October 1, 2023, expansion start date (DY3). All providers who met certification requirements were notified of their certification status by September 1, 2023. The following 17 providers, including 12 CMHSPs and five nonprofit behavioral health providers, were selected to join the demonstration in October 2023 (DY3), collectively referred to in this report as Cohort 2.

Cohort 2 Certified Demonstration Sites



1. Arab Community Center for Economic and Social Services (Wayne County).
2. Barry County Community Mental Health Authority.
3. CNS Healthcare (Wayne County).
4. Community Mental Health of Ottawa County.
5. Development Centers (Wayne County).
6. Elmhurst Home (Wayne County).
7. Genesee Health System.
8. Lapeer County Community Mental Health.
9. LifeWays (Hillsdale and Jackson County).
10. Monroe County Community Mental Health Authority.
11. Network180 (Kent County).
12. OnPoint (Allegan County).
13. Pines Behavioral Health Services (Branch County).
14. Riverwood Center (Berrien County).
15. Sanilac County Community Mental Health.
16. Southwest Counseling Solutions (Wayne County).
17. Summit Pointe (Calhoun County).

The CCBHC model expands access to a comprehensive array of outpatient behavioral health services by serving all individuals with a behavioral health diagnosis, regardless of insurance status, age, residence, severity of need, or ability to pay. The Centers for Medicare and Medicaid Services (CMS) require CCBHCs, directly or through designated collaborating organizations (DCOs), to provide nine comprehensive services addressing complex needs of persons with a mental health or substance use disorder (SUD) diagnosis. These services must be available to all consumers and represent a service array necessary to facilitate access, stabilize crises, address complex mental illness and addiction, and emphasize coordination of physical and behavioral health services. The services included are listed on the right.

CCBHC program requirements stipulate that CCBHCs cannot refuse service to any person based on ability to pay or residence, thereby expanding the population eligible for the robust array of services. 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 designed to enhance access, including expanding service hours, utilizing telehealth, implementing prompt intake and assessment processes, offering 24/7 crisis interventions, and using person- and family-centered approaches to treatment planning and service provision.

The following summary provides an overview of Michigan's third CCBHC demonstration year (DY3), including the population served, services provided, comparisons with previous demonstration years, and CCBHC performance metrics. Data sources include service encounter data[1], person served information stored in the MDHHS Data Warehouse, and CCBHC-reported performance metrics.

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

[1] Encounter data available in MDHHS Data Warehouse as of April 2025 (program counts) and February 2025 (statewide metrics).

Overview of Demonstration Year 3

Demonstration Year 3 (DY3) was largely shaped by an update to the CCBHC Demonstration Criteria, released by SAMHSA in February 2023. The updates emphasized enhanced crisis care, including 24/7 access, alignment with the 988 Suicide and Crisis Lifeline, and rapid-response mobile crisis teams, while advancing health equity, strengthening opioid crisis interventions, and introducing Behavioral Health Urgent Care (BHUC) services. Cohort 2 CCBHCs (17 new clinics in DY3) were initially certified under the original SAMHSA criteria. In April 2024, all CCBHCs were recertified using the 2023 criteria in preparation for DY4, which began October 2024. MDHHS allowed flexibility for certain requirements, such as establishing BHUCs and completing comprehensive community needs assessments, with full implementation expected by Oct. 1, 2025.

Throughout DY3, MDHHS provided extensive technical assistance — programmatic and financial — to ensure CCBHCs were prepared to implement the 2023 criteria successfully. MDHHS conducted its first-ever on-site reviews of the Cohort 1 CCBHC's (original 13 clinics) to assess service implementation, identify barriers, and strengthen state-level monitoring.

These site reviews informed several certification and monitoring changes during DY3 and in preparation for DY4, including but not limited to:

Certification Levels

During both initial certification and recertification, MDHHS assigned certification levels based on application scoring. These levels include *Full Certification, Full Certification with a Corrective Action Plan (CAP)*, and *Provisional Certification*. MDHHS also added CCBHC Decertification, determined by failure to abide by CCBHC policy and requirements. CCBHCs must have *Full Certification* at the time of entry into the demonstration.

Standardized Tools

MDHHS developed staffing plan and readiness assessment templates to support current CCBHCs and guide potential future expansion sites.

TF Modifier Implementation

In efforts to better understand the population served, CCBHCs were required to submit a TF modifier with every service delivered to an individual with mild to moderate needs. This change was essential for monitoring this population and informing budget and rate-setting processes.

DCO Policy Changes

Rural CCBHCs were given the option to enter DCO contracts with other CCBHCs to meet certification requirements. Urban CCBHCs can DCO with other CCBHCs for compliance with required Evidence-Based Practices.

Accreditation

MDHHS aligned CCBHC Certification with the Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission (TJC) accreditation standards, waving 33 CCBHC application standards if the CCBHC demonstrated the three-year CARF or TJC accreditation during the certification process.

Crisis Services

To align with the updated SAMHSA certification criteria, MDHHS introduced a Behavioral Health Urgent Care (BHUC) requirement in DY3. BHUCs provide walk-in assessment and crisis support for individuals experiencing acute behavioral health needs. This new requirement helped guide statewide BHUC definitions and requirements, adding a new resource to the crisis continuum. CCBHCs were given a year to meet full staffing requirements.

Nursing Codes

MDHHS added nursing assessment codes to the list of eligible services to support clinics that provide on-site screening and assessment for physical health conditions.

On-Site Reviews

MDHHS determined that site visits would occur at least once every three years to verify that program requirements are being met and implemented in practice.

Overall, this first round of on-site reviews highlighted consistency across the 13 CCBHCs in staffing (Peer Supports and Veteran Navigators), the full crisis continuum of services available, including 24/7 mobile crisis response teams, standardized assessment and screening tools, care coordination, and partner agreements. All CCBHCs had either collocated Federally Qualified Health Centers (FQHCs) or an FQHC within steps of their CCBHC location, enhancing their capacity to address physical health needs through accessible primary care services. The new MDHHS site visit process is an exciting addition to MDHHS's monitoring and its ability to measure CCBHC impact on the state.

Persons Served

Throughout the third Demonstration Year (DY3), 133,387 unique individuals received CCBHC services, representing increases of 77.8% compared to DY2 and 113.0% compared to DY1. From DY2 to DY3, the number of persons served with non-Medicaid coverage increased by nearly 183%. This shift in coverage distribution corresponds with a decrease in the share of persons served with Medicaid coverage from 88.1% in DY2 to 81.1% in DY3. This reduction may be attributed to the conclusion of the federal COVID-19 Public Health Emergency Declaration in May 2023. The end of the emergency declaration resulted in redetermination of Medicaid coverage, which had been paused during the emergency. This likely contributed to a decline in the number of persons with Medicaid coverage and a corresponding increase in the number of persons served with non-Medicaid coverage.

	Persons Served	% Change from DY2
Total unique persons served	133,387	77.8%

Insurance Payer	Persons Served	% of Persons Served	Change from DY2 (Percentage Points)
Medicaid	108,131	81.1%	-7.0
Traditional Medicaid	76,926	57.7%	-6.0
Healthy Michigan Plan	31,205	23.4%	-1.0
Non-Medicaid	25,256	18.9%	+7.0

Age

CCBHCs provide evidence-based, age-appropriate treatment across the lifespan. In DY3, children under the age of 18 represented 23.2% of the total CCBHC service population (including Medicaid and non-Medicaid populations). Among the total service population, persons aged 10-14 years and 30-34 years were the largest age groups served, together accounting for 19.1% of the total population. In contrast, individuals aged 75 years and older were the smallest age group served, accounting for only 1.1% of the total service population.

Age	Persons Served	% of Persons Served	Change from DY2 (Percentage Points)
0-4	1,462	1.1%	-0.2
5-9	7,928	5.9%	-0.5
10-14	12,360	9.3%	-1.0
15-17	9,184	6.9%	-0.7
18-21	7,731	5.8%	0.0
22-25	8,112	6.1%	0.0
26-29	9,365	7.0%	-0.4
30-34	13,073	9.8%	0.0
35-39	11,643	8.7%	+0.4
40-44	9,961	7.5%	+0.2
45-49	8,456	6.3%	+0.5
50-54	8,459	6.3%	+0.1
55-59	7,982	6.0%	+0.1
60-64	7,194	5.4%	+0.1
65-69	4,542	3.4%	+0.3
70-74	2,223	1.7%	+0.1
75-79	941	0.7%	+0.1
80-84	342	0.3%	+0.1
85+	129	0.1%	+0.0
Unknown	2,300	1.7%	+0.6

Race and Ethnicity

Participating CCBHC demonstration sites are located across the state of Michigan and serve diverse populations. From DY2 to DY3, the number of persons served increased by more than 73% across all reported racial categories and by over 40% across all ethnicities. From DY2 to DY3, each racial category saw an increase of more than 74% in the number of persons served, and each ethnicity group saw an increase of more than 40%. The majority of persons served identified as white (62.1%) and non-Hispanic (81.3%), though both groups saw slight declines compared to DY2 — white decreased from 63.6% in DY2, and non-Hispanic decreased from 85.6% in DY2.

	Persons Served	% of Persons Served	Change from DY2 (Percentage Points)
Race			
White	82,867	62.1%	-1.5
African American/Black	32,203	24.1%	-0.1
Hispanic	5,900	4.4%	+0.9
American Indian/Alaska Native	2,021	1.5%	+0.4
Asian American	728	0.55%	+0.1
Native Hawaiian & Other Pacific Islander	129	0.10%	+0.1
Middle Eastern/North African	7	0.01%	0.0
Other Single Race	211	0.16%	+0.1
Two or More Races	817	0.61%	0.0
Unknown	8,304	6.2%	0.0
Refused to Provide	200	0.15%	0.0
Ethnicity			
Non-Hispanic	108,441	81.3%	-4.3
Hispanic	5,086	3.8%	+4.4
Mexican	209	0.2%	0.0
Mexican American	135	0.1%	0.0
Puerto Rican	93	0.1%	0.0
Cuban	36	0.0%	0.0
Chicano	6	0.0%	0.0
Other	14	0.0%	0.0
Unknown	19,367	14.5%	0.0

Sex and Gender Identity

Overall, 96.3% of persons served identified as Man/Cisgender Man (49.1%) or Woman/Cisgender Woman (47.2%), while the remaining 3.7% identified as another gender or were recorded as unknown. Gender identity and sex at birth remained consistent with trends observed in DY1 and DY2.

	Persons Served	% of Persons Served	Change from DY2 (Percentage Points)
Gender Identity			
Man/Cisgender Man	65,553	49.1%	+0.14
Woman/Cisgender Woman	62,902	47.2%	-0.57
Non-binary/Genderqueer	821	0.6%	+0.59
Transgender Man	617	0.5%	+0.01
Transgender Woman	381	0.3%	-0.04
Genderfluid	243	0.2%	-0.02
Gender Questioning	119	0.1%	-0.05
Agender	100	0.1%	-0.04
Bigender	50	0.0%	-0.03
Two Spirit	22	0.0%	+0.02
Androgynous	14	0.0%	0.00
Unknown	2,300	1.7%	0.00
Other	265	0.2%	0.00
Sex at Birth			
Male	66,183	49.6%	+0.07
Female	64,904	48.7%	-0.66
Unknown	2,300	1.7%	+0.59

Military History

CCBHC certification standards outline specific requirements that sites must meet when serving veterans and individuals with military backgrounds, including staff training in military culture, care coordination responsibilities, monitoring and connections to veteran supports. Persons served with military involvement continue to make up 3% of the service population, representing nearly 123,000 individuals.

	Persons Served	% of Persons Served	Change from DY2 (Percentage Points)
No military involvement	126,966	95.2%	-0.78
Military involvement	4,121	3.1%	+0.20
Unknown	2,300	1.7%	+0.59

County of Residency

CCBHCs are unique in that they must serve all Michiganders, regardless of their county of residence. Services to individuals residing outside the CCBHC service area more than doubled from DY2, increasing by 220%, from 5.8% to 11.2% of all services. Services to individuals residing in a county without a CCBHC (including unknown counties) fell sharply from 2.7% in DY2 to 1.8% in DY3. This is likely due to the expansion of CCBHCs into 13 additional counties in DY3.

	Services Provided	% of Services Provided	Change from DY2 (Percentage Points)
CCBHC services provided to individuals residing outside of the CCBHC's service area	226,378	11.2%	+5.4
CCBHC services provided to individuals who reside in a county without a CCBHC (or an unknown county)	36,941	1.8%	-0.9
CCBHC services provided to individuals who reside outside of the state of Michigan	265	0.2%	+0.1

Diagnoses

Individuals must have a behavioral health diagnosis to receive services at a CCBHC. The prevalence of primary diagnoses among the service population can help inform understanding of the broader needs of individuals seeking treatment and the associated services they receive.

The most common primary diagnoses in Demonstration Year 3 (DY3) were mood disorders (31.1%), schizophrenia/psychotic disorders (21.1%), and substance use disorder (SUD) (15.6%). Persons served with non-Medicaid coverage were more likely than those with Medicaid coverage to report diagnoses of Mood Disorders (38.5% vs. 29.9%) and Schizophrenia/Psychotic Disorders (22.9% vs. 20.8%). In contrast, they reported fewer diagnoses of SUD (12.7% vs. 16.2%) and behavioral and emotional disorder (3.9% vs. 7.6%).

A notable increase in SUD diagnoses was observed from DY2 to DY3, rising from 3.3% to 15.6% of diagnoses (an 805% increase). This may be explained by the addition of 17 CCBHC clinics and CCBHC demonstration policy changes that support the expansion and availability of SUD services at CCBHCs.

Diagnosis	DY3 Encounters	% of Encounters	Change from DY2 (Percentage Points)
Mood (affective) disorders	727,040	31.1%	-6.1
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	493,269	21.1%	-1.4
Mental and behavioral disorders due to psychoactive substance use	365,280	15.6%	+12.4
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	293,447	12.6%	-2.6
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	164,966	7.1%	-0.6
Intellectual disabilities and underlying causes of intellectual and developmental disabilities (IDD)	84,943	3.6%	-0.5
Pervasive and specific developmental disorders	72,252	3.1%	-0.4
Other diagnosis	70,989	3.0%	-0.3
Disorders of adult personality and behavior	37,858	1.6%	-0.4
Unspecified mental disorder	13,264	0.6%	+0.3
Mental and behavioral issues due to known physiological conditions	10,546	0.5%	-0.2
Behavioral syndromes associated with physiological disturbances and physical factors	1,481	0.1%	0.0

Services Delivered

Service utilization reflects how individuals access and engage with CCBHC services. It is measured through daily visits, which count the number of days an individual receives CCBHC services, and service encounters, which capture the distinct services provided during each daily visit. The following sections provide details for each measure. Daily visits count the number of days an individual receives CCBHC services. Because more than one service can be provided during a daily visit, service encounters count the total number of services provided during the demonstration year.

Daily Visits

Each day an individual receives CCBHC services counts as a daily visit, which directly corresponds to CCBHC funding, as CCBHCs are reimbursed for each daily visit under the Prospective Payment System - 1 (PPS-1).

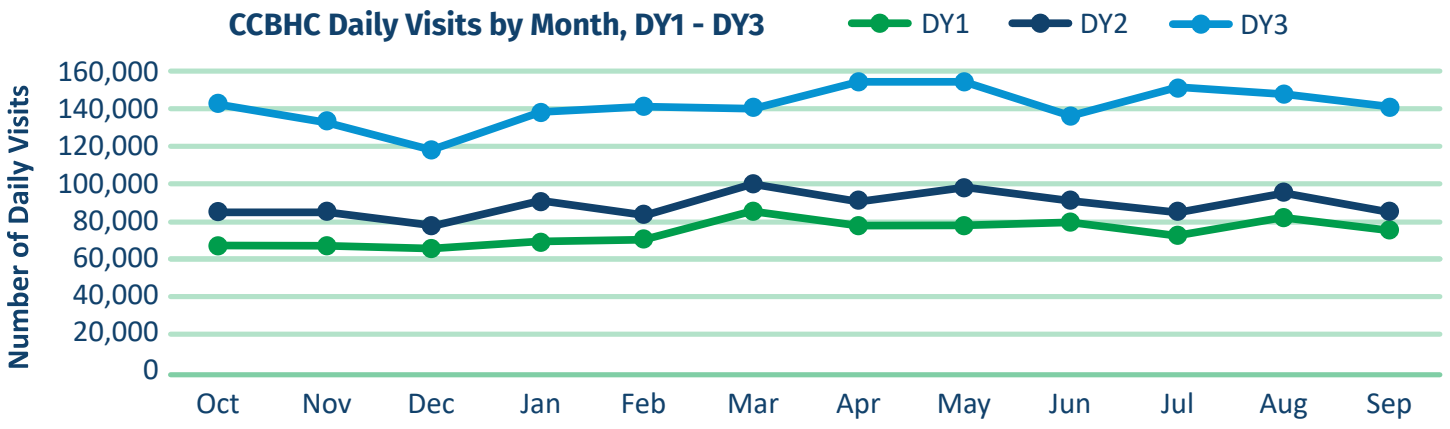
The number of daily visits in Demonstration Year 3 (DY3) increased by 61.2% from DY2, adding 648,302 daily visits across the 30 participating CCBHCs. On average, 1.19 CCBHC services were provided per daily visit, a slight increase from 1.15 in DY2 and 1.12 in DY1.

	Count	% Change from DY2
Daily visits	1,707,776	61.2%
Average services per daily visit	1.19	3.48%

Daily Visits by Month

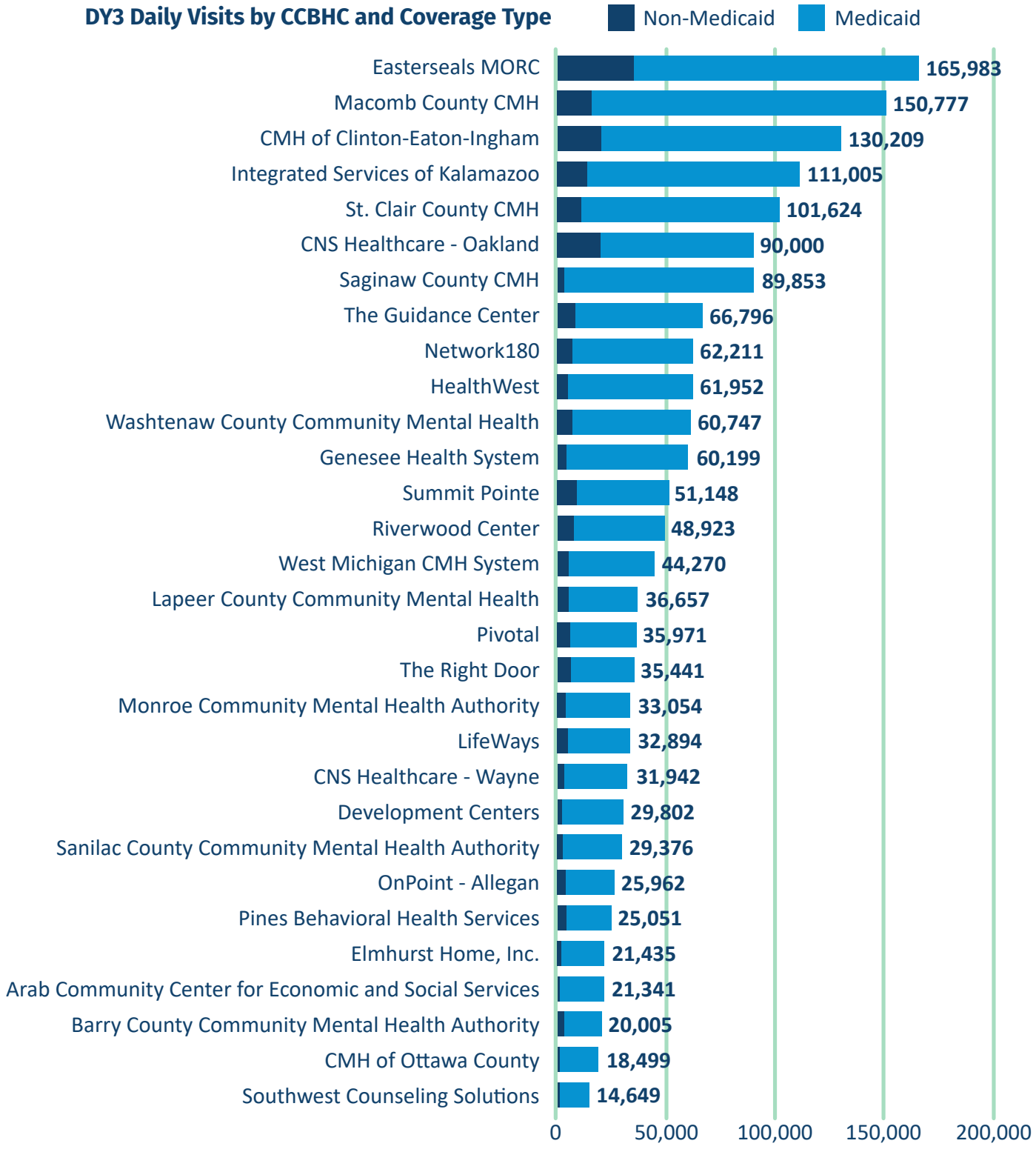
The number of daily visits per month has increased each year since DY1, reaching an average of 142,315 per month in DY3 (a 93.2% increase from DY1). The largest monthly increase occurred in July, with 80.4% more daily visits than in July DY2. March saw the most visits in DY1 (9.6%) and DY2 (9.4%), while May became the peak month in DY3 (9.1%). December continued to have the fewest visits, reflecting typical seasonal patterns.

Diagnosis	DY3 Encounters	% of Encounters	Change from DY2 (Percentage Points)
2023			
October	143,440	8.4%	+0.47
November	133,320	7.8%	-0.09
December	118,776	7.0%	-0.36
2024			
January	138,934	8.1%	-0.39
February	142,350	8.3%	+0.49
March	141,552	8.3%	-1.08
April	155,316	9.1%	+0.58
May	155,324	9.1%	-0.13
June	136,218	8.0%	-0.57
July	151,964	8.9%	+0.95
August	148,651	8.7%	-0.19
September	141,931	8.3%	+0.33



Daily Visits by CCBHC

CCBHCs throughout Michigan vary in service volume based on community needs and population size. All CCBHCs are committed to providing high quality, comprehensive care. Daily visits in DY3 ranged from 1,226 to 135,031. Smaller or more rural CCBHCs may offer fewer daily visits because they serve smaller populations. The proportion of total daily visits attributable to individuals without Medicaid coverage varies significantly across CCBHCs, ranging from 3% to as high as 22% at individual sites.



Service Encounters by CCBHC Core Service

A total of 2,030,006 CCBHC services were provided during DY3, an increase of 78.5% from DY2 and 99.2% from DY1. The top three core services with the most service encounters have remained consistent from DY1 to DY3, consisting of outpatient mental health and substance use services, targeted case management, and peer/family support, which together make up 85% of total services.

In DY3, Current Procedural Terminology (CPT) codes T1001 and T1002—representing Nursing Assessment and Evaluation—were added to the CCBHC Demonstration service codes. This addition enables measurement of the CCBHC core service Outpatient Clinic Primary Care Screening and Monitoring, which had not been tracked before.

Incorporating these codes also shifted the distribution of service encounters across core services, increasing Primary Care Screening's share to 2.3%. This change likely contributed to the decline in Targeted Case Management, which decreased from 27.5% to 22.8% of service encounters. The most significant increases from DY2 to DY3 were in Treatment Planning, which grew by 87% (from 3.2% to 3.6% of services), and Outpatient Mental Health and Substance Use Services, which rose by 70.2% (from 48.0% to 49.5%). These increases reflect expanded availability and utilization of these services within the demonstration.

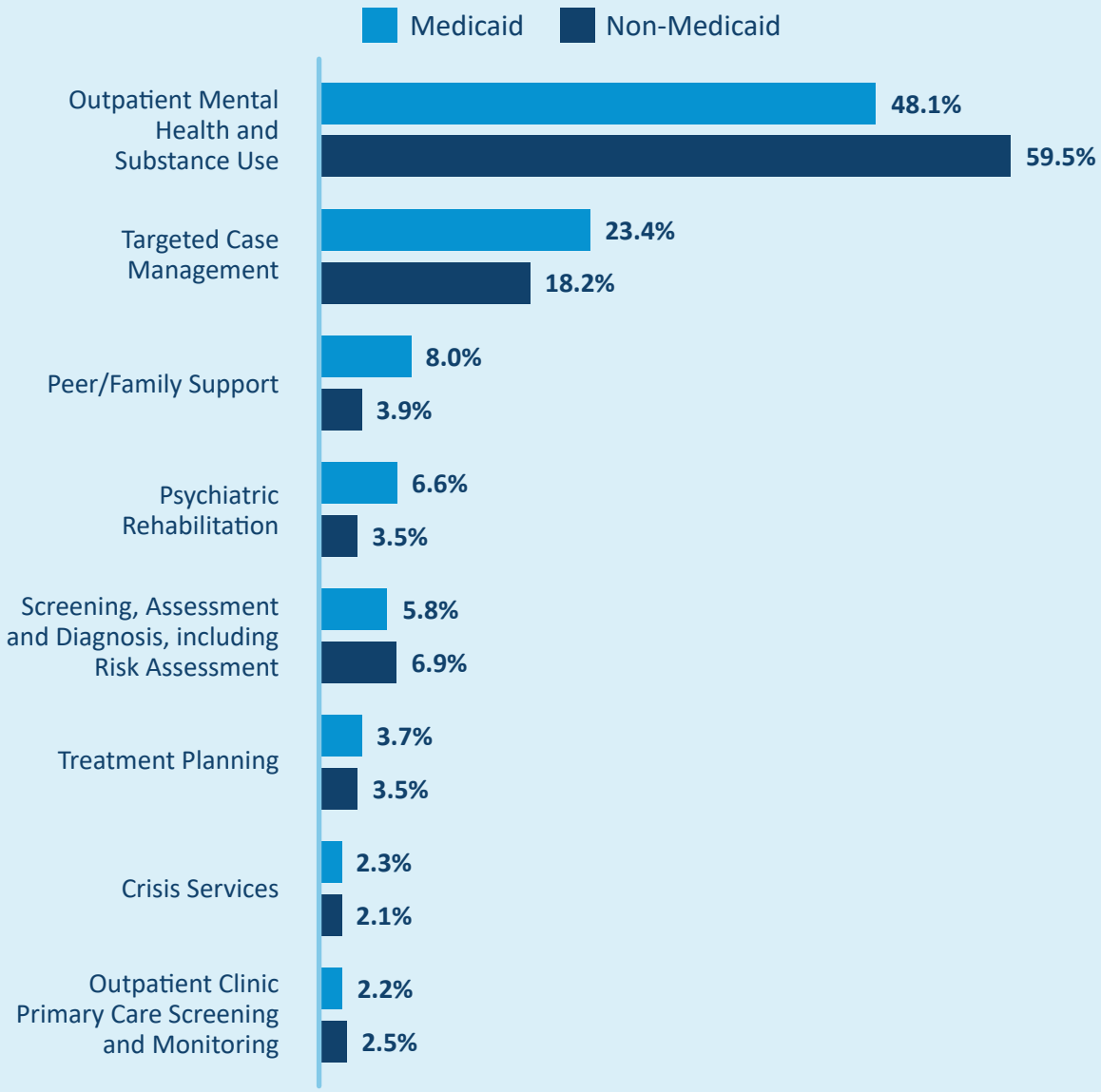
	Count	% Change from DY2
Services provided	2,030,006	78.5%

Core Service	Service Encounters	% of Total Encounters	Change from DY2 (Percentage Points)
Outpatient mental health and substance use services	1,004,627	49.5%	+1.5
Targeted case management	462,587	22.8%	-4.7
Peer/family support	151,208	7.4%	+0.3
Psychiatric rehabilitation	125,789	6.2%	+0.2
Screening, assessment, and diagnosis, including risk assessment	120,223	5.9%	-0.1
Treatment planning	74,070	3.6%	+0.4
Outpatient clinic primary care screening and monitoring	45,834	2.3%	+2.3
Crisis services	45,668	2.2%	+0.2

Service Encounters by CCBHC Core Service and Insurance Payer

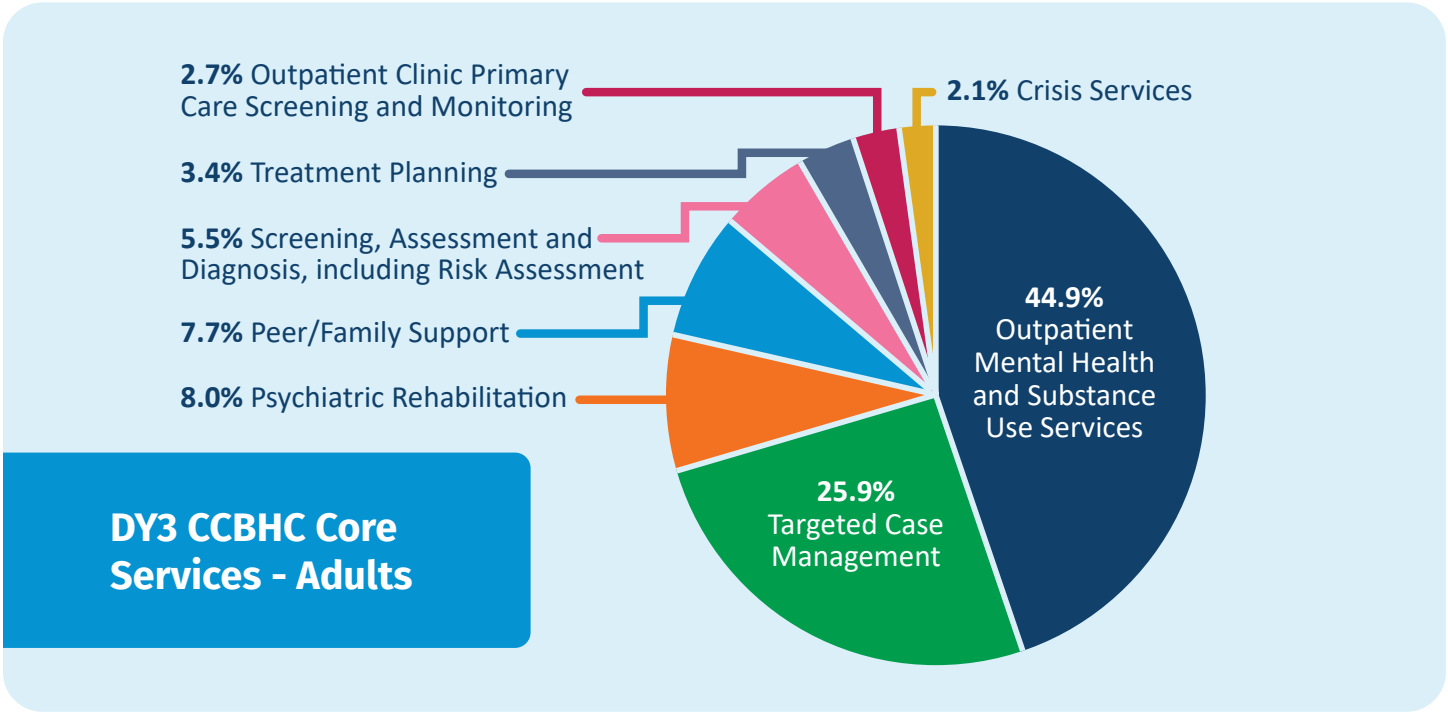
Outpatient mental health and substance use services, targeted case management, and peer/family support were the most commonly used services, regardless of insurance payer. However, utilization proportions varied by coverage type. CCBHC persons served with non-Medicaid coverage reported higher use of outpatient mental health and substance use services than those with Medicaid coverage (59.5% vs. 48.1%), but lower use of targeted case management (18.2% vs. 23.4%) and psychiatric rehabilitation (3.5% vs. 6.6%). This marks a shift from DY2, when psychiatric rehabilitation accounted for a larger share among non-Medicaid individuals than among those with Medicaid coverage.

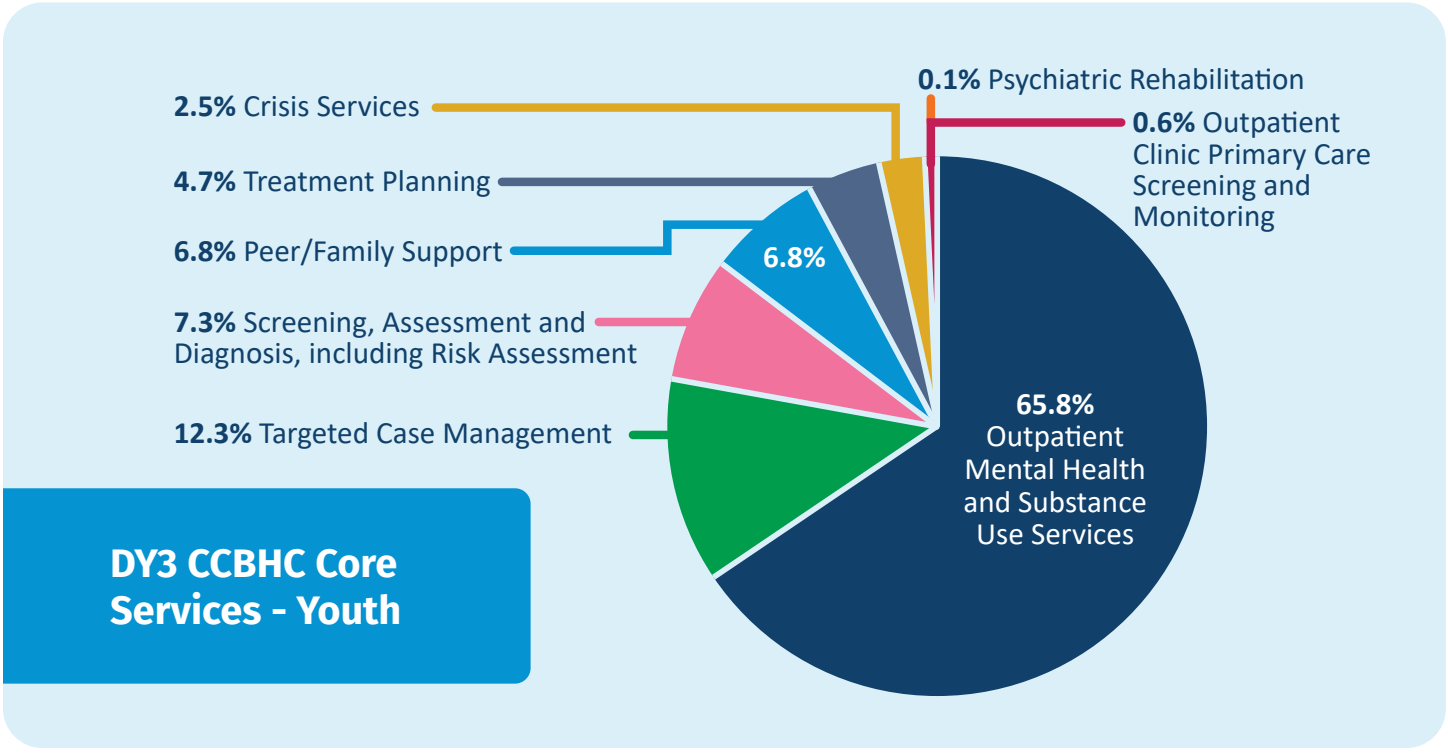
Percent of Service Encounters by CCBHC Core Service and Insurance Payer



Service Encounters by Age

CCBHCs are required to provide services to individuals of all ages. Of all CCBHC services, 78% were provided to adults and 22% to youth, consistent with DY1 and DY2. The distribution of services to adults differs from that to youth. The most notable proportional differences were observed in Outpatient Mental Health and Substance Use Services, which accounted for a larger share of services provided to children than to adults (65.8% vs. 44.9%), and in Targeted Case Management, which represented a greater proportion of services delivered to adults than to children (25.9% vs. 12.3%).





Cohort 1 CCBHC Clinic

"Due to becoming a CCBHC Demonstration Clinic, we have successfully launched a dedicated Community Health Worker (CHW) program, significantly expanding our capacity to address the social determinants of health which can impact a person's health or ability to access health care. This initiative has bridged the gap between clinical care and community needs, ensuring that the individuals we serve and residents across our counties are connected to essential resources — such as housing, food security, and transportation — when they need them most. Below are a couple of testimonials from our CHW highlighting the program's early success:

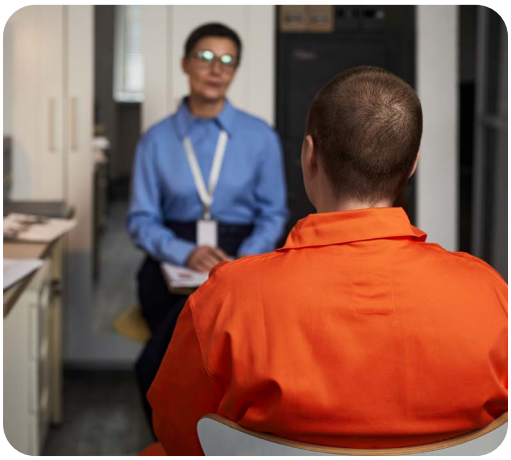
- 'I recently assisted a client who was facing a critical housing and utility crisis due to a back injury that left her unable to work. Her landlord had refused to assist with propane, and she was facing potential eviction. After being contacted by Peer Support, I leveraged my role as a CHW to immediately identify emergency resources. Within 24 hours, one of the churches provided the necessary propane and generously organized a holiday celebration for her children. Shortly thereafter, the client secured new employment and achieved stability. She expressed deep gratitude, noting that without our intervention and resource navigation, she would not have known how to overcome these obstacles.'
- 'I recently walked alongside a woman who had just found the courage to leave an unhealthy relationship. She came to me at a crossroads—homeless, unemployed, and unsure where to turn. It was incredibly rewarding to show her that she didn't have to navigate that path alone. Within a week, we were able to secure a safe place for her to live and provide the mental health support she needed. When we finalized her housing with the first month's rent and deposit, she told me she had never felt so supported in her life. Seeing her move from a place of uncertainty to becoming a stable patient is exactly why I do this work. It's about more than just resources; it's about showing people that a fresh start is truly possible.'"

Cohort 2 CCBHC Clinic

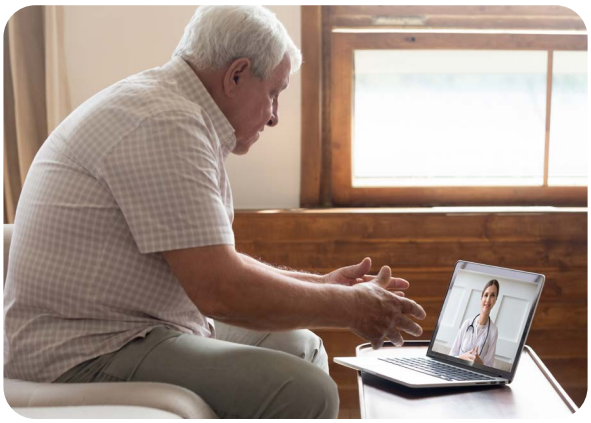
"As a new CCBHC, this model of care has allowed us to have a focused behavioral health urgent care program, a focus on a consistent stream of client services without unnecessary barriers to access and care, as well as allowed us to ensure quality, with an enhanced staff training program ran on a yearly basis."

Access

The CCBHC model aims to significantly expand access to behavioral health services, ensuring individuals receive timely and appropriate care regardless of location or level of need. Access is supported through multiple strategies, including telehealth to overcome geographic and transportation barriers and tailored care for those with mild-to-moderate needs who may not require intensive treatment. In addition, CCBHCs maintain agreements with justice system entities, such as law enforcement and jails, to provide behavioral health services to incarcerated individuals, an important component of reducing gaps in care. These approaches reflect a commitment to promoting equitable service delivery.



Telehealth



In Demonstration Year 3 (DY3), 204,878 daily visits were delivered via telehealth (12% of all daily visits), with Medicaid-covered persons served accounting for 82.5% of all telehealth visits. These results show a notable decrease in the proportion of telehealth visits, dropping from 23.3% in DY2 to 12% in DY3, as well as a decline in the share of persons served using telehealth, which fell from 58% to 37.8%. This decrease may reflect a continued shift in telehealth utilization post-COVID toward more in-person services.

Telehealth	Daily Visits	% of Total Daily Visits	Change from DY2 (Percentage Points)	Persons Served	% of Total Persons Served	Change from DY2 (Percentage Points)
Medicaid	169,012	9.9%	-10.9	40,708	30.5%	-20.8
Non-Medicaid	35,866	2.1%	-0.3	9,735	7.3%	+0.7
Total telehealth	204,878	12.0%	-11.3%	50,443	37.8%	-20.2

Services to Individuals with Mild to Moderate Needs

Many CCBHC sites have traditionally provided only specialty behavioral health services to adults and youth with severe, chronic and complex needs. With the mandate to serve individuals with any behavioral health diagnosis, CCBHCs expanded their scope to reach new populations.

Prior to DY3, each CCBHC was required to complete a template identifying its population with mild-to-moderate behavioral health needs and specifying how it defined the threshold for mild-to-moderate severity. Beginning in DY3, identification relies on standardized clinical tools - scores from the Michigan Child and Adolescent Needs and Strengths Screener (MichiCANS) for youth and the American Association for Community Psychiatry's Level of Care Utilization System (LOCUS 20) for adults, along with mandatory use of the TF modifier on all claims for these services.

In DY3, 21% of daily visits were provided to individuals with mild to moderate behavioral health needs. This measure reflects the implementation of the standardized reporting method, which improved accuracy in identifying this population. Because of this methodology change, direct comparison to DY2 is not appropriate.

	Daily Visits	% of Total Daily Visits
Mild to Moderate Needs	357,390	20.9%

Quality Performance

The CCBHC demonstration requires reporting on several quality measures, including both clinic and state-reported measures. These efforts are designed to enhance accountability, improve service quality and ensure that CCBHCs meet the needs of the communities they serve. CCBHCs are also required to develop and implement a continuous quality improvement plan to enhance clinical practice.

Clinic-reported measures assess how well clinics meet service delivery expectations, including screening and monitoring requirements and the timeliness of services. These measures are self-reported from data collected in electronic health records. State-reported measures focus on the impact of care coordination on follow-up care and readmissions, as well as screening and treatment for specific conditions. States use administrative encounter data from Medicaid populations to calculate these measures.

Quality measures can be grouped into three main categories based on the type of performance measured: care coordination and follow-up care, screening and treatment monitoring, and timeliness of services.

While some measures' rates fluctuated between DY2 and DY3, these changes occurred during a period of rapid expansion, with CCBHCs serving 77.8% more individuals and delivering 78.5% more services than in DY2. This growth has likely introduced operational challenges and greater variability; however, overall performance remained stable, with many measures continuing to show progress and resilience amid increased demand.

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 emergency departments, inpatient psychiatric, detoxification, and residential settings to a safe community setting. At a minimum, protocols include active follow-up after discharge, as well as, as appropriate, a plan for prevention and safety, and peer services.

Three required measures assess a CCBHC's ability to follow-up with persons served after emergency department (ED) visits for mental illness (FUM), ED visits for alcohol and other drug dependence (FUA) or hospitalization for mental illness (FUH). Follow-up after youth hospitalization for mental illness improved in DY3, with 7-day rates increasing by 1.2 percentage points and 30-day rates by one percentage point. Although some measures declined slightly during this period of rapid growth, overall performance remained strong and above statewide benchmarks for all measures.

Care Coordination and Follow-Up Care Measures

		CCBHC Average		Cohort 1		Cohort 2
Measure	**Statewide Average[2]**	**DY3 Rate**	**Change from DY2 (Percentage Points)**	**DY3 Rate**	**Change from DY2 (Percentage Points)**	**DY3 Rate**
Follow-Up After Emergency Department Visit for Mental Illness (FUM)*						
7-Day Follow-Up	**39.9%**	**53.9%**	-6.0	**55.9%**	-4.0	**51.1%**
30-Day Follow-Up	**54.3%**	**72.1%**	-3.4	**73.2%**	-2.3	**70.5%**
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)*						
7-Day Follow-Up	**27.6%**	**36.1%**	-3.5	**39.7%**	-5.5	**39.0%**
30-Day Follow-Up	**42.6%**	**55.1%**	-5.3	**54.2%**	-6.2	**56.4%**
Follow-Up After Hospitalization for Mental Illness (FUH)*						
Adult						
7-Day Follow-Up	**41.8%**	**45.7%**	-0.3	**46.0%**	0.0	**45.2%**
30-Day Follow-Up	**63.4%**	**69.3%**	-0.6	**69.6%**	-0.3	**68.8%**
Child						
7-Day Follow-Up	**60.0%**	**60.5%**	+1.2	**58.8%**	-0.6	**63.6%**
30-Day Follow-Up	**81.8%**	**82.5%**	+1.0	**80.8%**	-0.7	**68.8%**

*State-reported measure

[2] 2023 Child and Adult Health Care Quality Measures Quality.

Screening and Treatment Monitoring

CCBHCs collect data internally and from primary care partners as part of their screening and monitoring responsibilities. This information helps track co-occurring health conditions, ensure medication adherence, and review progress toward treatment goals, with plans updated every three to six months.

CCBHCs maintained strong performance on key measures, with Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD-AD) well above the statewide average across both cohorts. Significant gains included Tobacco Use: Screening & Cessation Intervention (TSC) (+7.7 points) and Suicide Risk Assessment (SRA-A, SRA-C) in Cohort 1 (+7.4 points for adults, +4.7 for children). Cohort 2 demonstrated consistently strong rates in SSD-AD (80.4%) and adult depression screening and follow-up (CDF) (57.2%), reinforcing overall quality. While a few measures declined slightly amid rapid growth, results reflect continued progress and commitment to integrated care.

Screening and Treatment Monitoring Measures

		CCBHC Average		Cohort 1		Cohort 2
Measure	**Statewide Average[3]**	**DY3 Rate**	**Change from DY2 (Percentage Points)**	**DY3 Rate**	**Change from DY2 (Percentage Points)**	**DY3 Rate**
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD-AD) *	**76.8%**	**82.2%**	+0.5	**83.4%**	+1.8	**80.4%**
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD) *	**56.7%**	**55.9%**	+1.0	**54.9%**	0.0	**57.3%**
Antidepressant Medication Management (AMM-AD) *						
Acute	**56.3%**	**50.8%**	-1.0	**51.3%**	-0.4	**49.9%**
Chronic	**34.2%**	**29.7%**	-1.2	**30.4%**	-0.5	**28.7%**
Plan All-Cause Readmissions Rate (PCR-AD) *						
Observed Rate	**9.78%**	**10.9%**	+0.9	**11.4%**	+1.4	**10.3%**

Screening and Treatment Monitoring Measures Cont.

Measure	Statewide Average[3]	CCBHC Average		Cohort 1		Cohort 2
		DY3 Rate	Change from DY2 (Percentage Points)	DY3 Rate	Change from DY2 (Percentage Points)	DY3 Rate
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH) *						
Initiation	**37.1%**	**40.4%**	-0.8	**42.4%**	+1.2	**37.7%**
Engagement	**11.0%**	**13.7%**	+0.4	**13.5%**	+0.3	**13.9%**
Suicide Risk Assessment for Individuals with Major Depressive Disorder (SRA-A, SRA-C) ^						
Adult	—	**77.4%**	-0.7	**85.5%**	+7.4	**62.9%**
Child	—	**61.3%**	-2.6	**68.6%**	+4.7	**46.2%**
Tobacco Use: Screening & Cessation Intervention (TSC)^	—	**67.9%**	+7.7	**66.9%**	+6.8	**69.1%**
Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)^	—	**51.8%**	-8.3	**63.4%**	+3.2	**35.8%**
Depression Screening and Follow-Up (CDF)^						
Adult	—	**52.2%**	+2.2	**48%**	-2.0	**57.2%**
Child	—	**48.3%**	+0.4	**58.1%**	10.2	**35.4%**

*State-reported measure.
^Clinic-reported measure.

[3] 2023 Child and Adult Health Care Quality Measures Quality.

Timeliness of Services

CCBHC certification criteria include specific guidelines for timeliness to ensure prompt access to care. All persons served receive a preliminary screening and risk assessment when requesting services, and if the screening identifies an emergency need, action is taken immediately. Crisis services are available 24/7, and same-day crisis appointments are always available. Services for urgent needs must be provided within one business day of the request, while initial services for routine needs should begin within 14 business days.

Required timeliness measures do not allow exclusions, so individuals who miss appointments or request that services begin more than 14 business days after the initial contact are still included in the calculations. Improving timely access remains a priority as the demonstration progresses, with strategies such as expanding same-day intakes and walk-in services, leveraging telehealth and new technology, and increasing capacity through staff roles like peers to support intake activities are being used.

Timely access improved notably in DY3. The share of new service recipients receiving an initial evaluation within 14 days rose by 6.3 points for adults and 4.9 points for children. Average time to evaluation fell by 5.5 days for adults and 4.6 days for children, reflecting faster access across the system. Cohort 1 showed substantial reductions in days to evaluation (adults −6.3, children −5.4), while Cohort 2 began the demonstration with strong initial rates (adults 59.5%, children 56.4%).

Timeliness Measures

		CCBHC Average		Cohort 1		Cohort 2
Measure	**Statewide Average[4]**	**DY3 Rate**	**Change from DY2 (Percentage Points)**	**DY3 Rate**	**Change from DY2 (Percentage Points)**	**DY3 Rate**
Percentage of New Service Recipients with Initial Evaluation Provided Within 14 Days of First Contact (I-EVAL-1) ^						
Adults	—	**59.1%**	+6.3	**58.9%**	+6	**59.5%**
Children	—	**56.7%**	+4.9	**56.8%**	+5.1	**56.4%**
Average Number of Days Until Initial Evaluation for New Service Recipients (I-EVAL-2) ^						
Adults	—	**17.3**	-5.5 days	**16.5**	-6.3	**18.4**
Children	—	**19.7**	-4.6 days	**18.9**	-5.4	**21.1**

^Clinic reported measure.

[4] 2023 Child and Adult Health Care Quality Measures Quality.

Next Steps and Future Outlook

DY3 was shaped by expansion, updates to certification standards, and efforts to strengthen oversight within Michigan's CCBHC Demonstration. By the end of DY3, all Michigan CCBHC Demonstration clinics were expected to have successfully implemented the new SAMHSA-issued certification criteria. Leading up to DY4, all sites underwent the re-certification process by applying for certification and submitting supporting documentation demonstrating that the standards were met. Newly certified clinics were recertified on select criteria to ensure adherence to the revised requirements.

To align with new policies to increase access to children's behavioral health services, CCBHCs will be trained in the MichiCANS Screener and Comprehensive Assessments. These standardized tools will be used universally across Michigan's children-serving systems to ensure children's needs are appropriately and consistently evaluated and that children are referred to the appropriate level of care.

MDHHS also developed additional internal capacity for certification and oversight by hiring two certification specialists in DY3. These specialists work closely with CCBHC sites to ensure that certification standards are continuously met and to provide technical assistance to improve quality service delivery. To meet growing needs and adequately conduct recertification activities, additional certification staff, including a compliance specialist, will join the team in DY4.

Moving forward, MDHHS remains dedicated to supporting demonstration clinics as they expand access to high-quality mental health and SUD treatment. As the data above show, the addition of 17 new clinics in DY3 substantially expanded the availability of CCBHC services in Michigan communities.

MDHHS will continue to monitor the implementation of the model and continues to partner with evaluators at the University of Michigan's Center for Healthcare Research Transformation (CHRT) to measure the impact of the demonstration. Preliminary evaluation findings are available at **Michigan.gov/ccbhc**.