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The Impact of Certified Community Behavioral Health Clinics on Children, Youth, and their Families

KEY POINTS

- Certified Community Behavioral Health Clinics (CCBHCs) added services to expand care for children, youth, and their families. Evidence-based practices and school-based services were particularly important (for example, 88 percent of CCBHCs provided services in schools in 2024, up from 51 percent in 2018) to meet the needs of this population.
- CCBHCs used many strategies to engage children, youth, and their families in care, including fostering strong referral partnerships, raising awareness of available child/youth-focused services in the community, and implementing improvements in access to make receiving care easier. The number of children/youth served by CCBHCs has increased during the demonstration, suggesting CCBHC engagement efforts have been successful.
- CCBHCs and states identified partnerships as a particularly important way for clinics to reach children, youth, and their families; remove barriers to care; and improve service provision for this population. Formal and informal partnerships with child-relevant external entities were common.
- Some CCBHCs are implementing child/youth-focused quality improvement efforts, which may have resulted in improvements in performance on relevant quality measures.

BACKGROUND

Nearly one in five children and youth experience a mental, emotional, behavioral, or developmental disorder, and the rates of emotional distress among children continue to climb (U.S. Surgeon General 2021). In 2023, more than 12 percent of adolescents had experienced serious thoughts of suicide, and 3 percent had a recent suicide attempt (SAMHSA 2024). However, only about 20 percent of adolescents in need of services receive care due to service delivery and access barriers (Sappenfield et al. 2024; U.S. Surgeon General 2021).

Section 223 of the Protecting Access to Medicare Act of 2014 (Public Law 113-93) authorized the CCBHC demonstration to allow states to test a different strategy for delivering and reimbursing a comprehensive array of services provided in community behavioral health (BH) clinics. The demonstration aims to improve the availability, quality, and outcomes of outpatient services provided in these clinics and reimburses CCBHC services through a Medicaid prospective payment system intended to cover the expected cost of providing CCBHC services to Medicaid beneficiaries. As of February 2025, 20 states have been selected to participate in

the demonstration.[1] The U.S. Department of Health and Human Services developed criteria for CCBHCs, which include requirements specifically intended to enhance access to care for children/youth and their families (**Exhibit 1**; SAMHSA 2023).

This brief explores ways demonstration CCBHCs and states have served, engaged, and partnered with other entities to support children/youth and their families; identifies CCBHC quality improvement efforts related to improving care for children/youth and their families; and concludes by considering how CCBHCs are meeting their potential to serve children/youth and their families. Findings reflect interviews with state officials and demonstration CCBHC leaders, CCBHC surveys, and CCBHC quality measures; data were collected between 2018 and 2025, from the eight states and select clinics.[2] (see Appendix A for further details on data sources and methods.)

Exhibit 1. CCBHC certification criteria specific to serving children/youth and their families

Staffing

- CCBHCs must have staff appropriate to address the needs of people receiving services, including staff with expertise in addressing trauma and promoting the recovery of children/youth with serious emotional disturbance.

Care Coordination

- CCBHCs must develop care coordination partnerships with schools, child welfare agencies, juvenile justice agencies and facilities (including drug, mental health, veterans, and other specialty courts); Indian Health Service youth regional treatment centers; residential or inpatient facilities that serve children/youth; and state licensed and nationally accredited child placing agencies for therapeutic foster care service.
- CCBHCs must have protocols in place for transitioning children/youth from residential or inpatient facilities to community settings.
- CCBHC treatment teams must include the person receiving services, such as children/youth and their families, caregivers, or legal guardians, and must use a person- and family-centered approach.

Scope of Services

- CCBHCs must provide required CCBHC services across the lifespan, with tailored approaches for children and families.
- Services and supports for children/youth must be family/caregiver-driven, youth-guided, and developmentally appropriate.
- Children/youth must receive evidence-based age-appropriate screening, preventive interventions, and treatments based on environmental factors, social determinants of health, and common physical health condition indicators.
- States should consider requiring clinics to assess the social service needs of consumers, with necessary referrals to child welfare and juvenile justice agencies.

Source: Mathematica analysis of 2023 CCBHC certification criteria (SAMHSA 2023).
CCBHC = Certified Community Behavioral Health Clinic.

[1] In 2016, the U.S. Department of Health and Human Services selected eight states to participate in the demonstration (Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania). Nevada and Pennsylvania ended their participation in 2023 and 2019, respectively. The Coronavirus Aid, Relief, and Economic Security Act (Public Law 116-136) expanded the demonstration to two new states (Kentucky and Michigan) in 2020, and the Bipartisan Safer Communities Act, enacted in 2022, authorized all states to apply to participate beginning in 2024 (Public Law No: 117-159). Beginning July 1, 2024, and every two years thereafter, the U.S. Department of Health and Human Services may select up to 10 additional states for the demonstration. In June 2024, the department welcomed 10 additional states into the demonstration, though data from these new states are not included in this brief.

[2] Surveys were collected from all CCBHCs participating in the demonstration for at least one year at the time of data collection.

FINDINGS

A. CCBHC services and staffing to support children/youth and their families

1. Services CCBHCs provide to support children/youth and their families

CCBHCs provide a wide range of specialty outpatient mental health (MH)/substance use disorder (SUD) services, evidence-based practices (EBPs), and other services to support children/youth and their families. Almost all CCBHCs provided specialty MH/SUD services for children and youth during the demonstration, with slight variations over time and by state (**Exhibit 2**; see Appendix B for full findings). About three-quarters of CCBHCs provided community wraparound services for children and youth, although the proportion varied by state. Most CCBHCs provided these services directly and not through designated collaborating organizations (DCOs).[3]

Exhibit 2. Percentage of demonstration CCBHCs that provided child- and family-relevant outpatient MH and/or SUD services

Service	Added at the beginning of the demonstration (%)	Provided service directly or by DCO	
		2018 (%)	2024 (%)
Specialty MH/SUD services for children and youth	22	87	79
Community wraparound services for youth/children[a]	15	76	77
Therapeutic foster care[a]	1	7	9

Source: 2018 and 2024 CCBHC surveys.

Note: The 2018 clinic survey included all 67 CCBHCs participating in the demonstration at the time of data collection; the 2024 clinic survey included the 78 CCBHCs participating in the demonstration for at least one year at the time of data collection.

[a] CCBHCs responding to the survey may have interpreted this to include high-fidelity wraparound or a broader service.

CCBHC = Certified Community Behavioral Health Clinic; DCO = designated collaborating organization; MH = mental health; SUD = substance use disorder.

CCBHCs offer many specific specialty services and EBPs to children/youth and families, noting, for example, parent–child interaction therapy, dialectical behavioral therapy for adolescents, and EBPs targeting specific populations or behaviors such as transition-age youth, youth suicide risk, and youth substance use. About one-fifth of CCBHCs described providing specialized youth and/or family crisis services, including through offering youth-focused mobile crisis services and child- or youth-ready onsite crisis centers or units. For example, one CCBHC in New York established a seven-day-a-week walk-in crisis and assessment service for children and adolescents. Similarly, several CCBHCs across states expanded their crisis receiving centers to specifically accommodate children/youth and their families. CCBHCs also commonly cited delivery of youth peer and family support services when describing key activities to serve children/youth and their families.

CCBHCs added child/youth services at the beginning of the demonstration and have continued to expand their child/youth service array over time. For example, 22 percent of CCBHCs added specialty MH/SUD services and 15 percent of CCBHCs added community wraparound services at the beginning of the demonstration (**Exhibit 2**). In 2024, 15 percent of CCBHCs described changing their scope of services in the last 12 months to better serve children and youth, often through adding or expanding specialty MH/SUD services. Clinics recently added services such as youth intensive outpatient services and urgent care, adolescent SUD recovery groups, infant MH services, first-episode psychosis programs, team-based care, and services for transition-age youth.

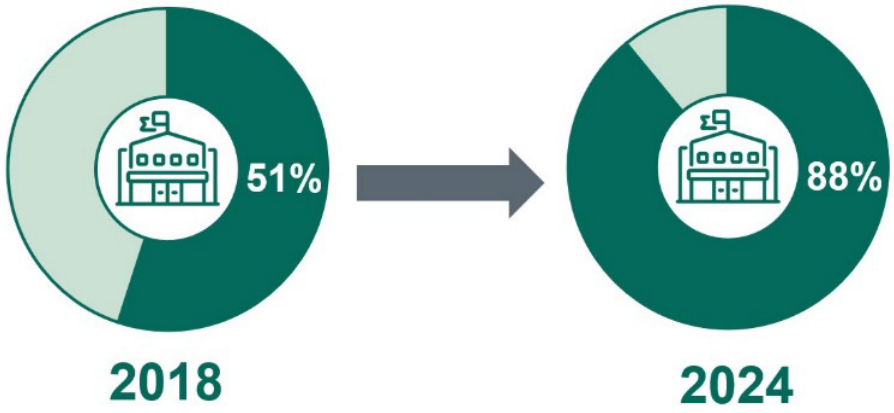
[3] A DCO is an entity outside the direct supervision of a CCBHC that has a formal agreement to provide certain required services the CCBHC does not deliver itself. The CCBHC remains clinically and financially accountable for these services, including ensuring they meet certification standards.

2. Child/youth and family service settings

Most CCBHCs highlighted providing school-based services as a primary strategy for serving children, and the proportion of CCBHCs providing services in schools has increased dramatically over time (Exhibit 3). CCBHCs have provided services in school settings since the beginning of the demonstration to facilitate referrals and increase locations for accessing care. Only about half of CCBHCs, however, provided services in schools in 2018. In contrast, 88 percent of CCBHCs provided services in schools in 2024, with all CCBHCs providing school-based services in several states (Kentucky, Missouri, Minnesota, Oklahoma, and Oregon).

States and CCBHCs shared that school-based initiatives have made services easier for families to access and allowed CCBHCs to identify and serve children in need of behavioral health services whom they would not have otherwise reached. For example, state officials in Oregon noted an increase in school-based services since the beginning of the demonstration and shared they have increased access among children and youth in rural areas, given that schools are easier to reach. As one clinic in New York noted, "By putting a clinician at the school, we're able to provide the support in the community versus having the family have to travel, sometimes 30 or more minutes, to get to our main clinic location." The clinic, which did not offer services to youth before the demonstration, now provides services in 20 schools. CCBHC staff within schools primarily provide counseling on-site, and children can then access additional CCBHC services either remotely through telehealth or at the main clinic location. The clinic's school-based CCBHC clinicians can coordinate closely with teachers and other school staff as well as the broader CCBHC treatment team to meet a child's needs. Another CCBHC described providing school-based services using a team-based approach, embedding a care coordinator, therapist, and behavioral health coach within schools. The team worked together to provide needed services to students and staff, including prevention, early intervention, direct care services, consultation and education to teachers, crisis intervention, stabilization, and more. If a student's needs escalate beyond what a therapist can handle in the school setting, schools have iPads that can connect the student directly to a specialist at the CCBHC.

Exhibit 3. Percentage of demonstration CCBHCs providing services in schools



Source: 2018 and 2024 CCBHC surveys.
Note: The 2018 clinic survey included 67 CCBHCs; the 2024 clinic survey included 78 CCBHCs.
CCBHC = Certified Community Behavioral Health Clinic.

CCBHCs also commonly provide services to children/youth and their families in other community locations, such as hospitals, pediatricians' offices, homes, and through telehealth. For example, several CCBHCs mentioned the importance of serving children and their families in their homes to improve access and treat the family unit together. One CCBHC rented space to deliver child/youth services in community centers to provide easier access to services in locations in which children might already be using. Several CCBHCs deliver certain child/youth services through telehealth, allowing the providers and families to schedule services at flexible and convenient times wherever they are in the community.

To support and improve provision of services to children/youth and their families, some CCBHCs also made changes to their clinic's physical space. A few CCBHCs added buildings or centers for children and families. For example, one Oklahoma CCBHC opened two dedicated Brief Stay Therapeutic Homes designed to prevent children from repeatedly returning to inpatient care and state custody.[4] During a family's week-long stay at these homes, the CCBHC provides intensive treatment, observing parent/guardian interactions with children through video and audio recordings and providing advice directly to the parent/guardian through an earpiece. The CCBHC noted working to adapt the program into a mobile concept, taking the treatment into families' own homes when possible. A Minnesota CCBHC similarly described adding a building dedicated to serving children/youth, which has allowed it to expand the number and types of services it provides this population. One CCBHC opened a new state-of-the-art child-serving center, and Oklahoma CCBHC opened five family assessment centers since the beginning of the demonstration. One opened a new state-of-the-art child-serving center. Finally, several other CCBHCs developed new facilities specifically to serve transition-aged youth.

3. CCBHC staffing to serve children/youth and their families

Most CCBHCs expanded their workforce and hired specialized staff to serve children/youth and their families during the demonstration. CCBHCs often mentioned hiring care coordinators/case managers, peer support specialists, and family support providers specifically focused on serving children/youth. For example, a CCBHC in Kentucky created a new child/youth treatment coordinator role to collaborate across the CCBHC's programs and community members to develop tailored services and programming for children and youth. Many CCBHCs cited the increased demand for services among children and youth as one of the main reasons for trying to add more staff to serve this population, and they highlighted the invaluable role of specialized staff in meeting their needs.

> *"…there's nothing like [having a family peer worker or family case manager] who has gone into someone's home and [can share with the broader treatment team], 'you're complaining because mom isn't getting a kid [to the clinic]. Mom has cancer and no groceries and three younger children….' It's not that therapists are insensitive to [families' circumstances], but when you have a care team that's more engaged in people's everyday life, it changes your perspective on the challenges that the family is facing. So, I think adding peers and case managers was a game changer."*
>
> — Oregon CCBHC staff, 2024

CCBHCs directly employ child and adolescent psychiatrists, and most have been able to maintain staff in this role. In all, 64 percent of CCBHCs employed a child/adolescent psychiatrist in 2019, up from 58 percent before certification. Although some CCBHCs have encountered local workforce shortages for child/youth providers, only 22 percent of CCBHCs had a substantial gap (two months or more) in employing a child/adolescent psychiatrist in 2024, and 36 percent of CCBHCs sought to add more child/adolescent psychiatrists during the same period. There was substantial variation across states in unfilled child/adolescent psychiatrist staff roles and CCBHCs trying to expand staffing by hiring more of this role in the 2024 survey.

[4] The CCBHC cited this work as an example of how the demonstration has allowed the flexibility to develop creative solutions to serving populations with specialized needs, such as children/youth and families. It is unclear whether this effort is funded in whole or in part through the prospective payment system; however, PAMA and demonstration guidance specify that costs for inpatient care, residential treatment, and room and board cannot be included in the PPS calculation or payment under the demonstration.

The demonstration payment model and staffing flexibilities have helped some CCBHCs overcome challenges hiring and retaining staff to serve children/youth and their families, though workforce shortages remain. CCBHCs described struggling with a lack of providers trained for or interested in serving children and adolescents of all ages, especially the youngest children (ages 0 to 5). Several CCBHCs had trouble encouraging child-serving (and other) providers to come back to in-person work after the COVID-19 pandemic. State officials also reported CCBHCs sometimes struggling to pay child/youth providers competitively enough to prevent some from moving to private practice or schools, which often offer more flexible work schedules. The higher prospective payment system rate paid under the demonstration has helped some CCBHCs recruit and retain specialized providers, and the demonstration's flexibility has allowed CCBHCs to implement other creative solutions to staffing challenges. For instance, one CCBHC converted an outpatient staffing position to a fully school-based position given the school-based positions' appeal to providers.

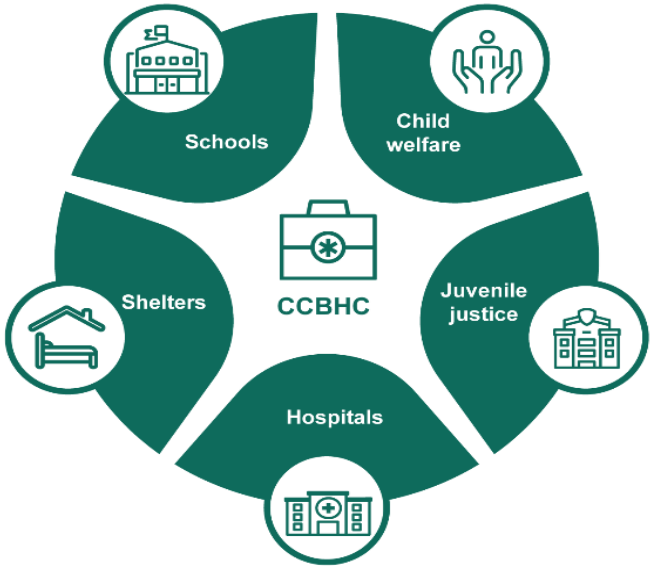
B. Processes and activities CCBHCs have implemented to engage children/youth and their families in services

1. Strategies to engage children/youth and their families in care

Referrals from external entities play a key role in bringing children/youth and their families into CCBHC services. Almost all CCBHCs (99 percent) received referrals from "schools and other child service providers" in 2024, highlighting several specific entities as key referral partners (**Exhibit 4**). Schools are an especially common referral source for children/youth and their families, and almost all CCBHCs highlighted school-based services as a primary strategy for reaching children/youth. Referrals from schools increased during the demonstration, in large part because of increases in provision of school-based services (as described above). For example, one Kentucky clinic offering school-based services reported 349 referrals into care from area schools, which state officials characterized as a sizable increase. A clinic in New York credited the school-based services they began offering under the demonstration as a key way of increasing awareness of their services among the community and increasing referrals to their CCBHC.

To expedite entry to services for children/youth from external referral sources, such as a school or hospital, some CCBHCs have established specific referral procedures for this population. For example, a CCBHC described the process of receiving and following up on referrals from hospitals as beginning with the CCBHC receiving an alert about a hospitalized child. The CCBHC quickly visits the hospital to start services and coordinates with hospital staff for outpatient and discharge planning as the child or parent sees fit. They try to do much of this work while the child is still in the hospital, in coordination with the hospital case manager, helping ensure a smooth transition from hospital to CCBHC after discharge.

Exhibit 4. Commonly cited CCBHC referral sources for children/youth and families



Source: Mathematica analysis of 2024 CCBHC survey open-ended responses and qualitative data collected throughout the demonstration.
CCBHC = Certified Community Behavioral Health Clinic.

CCBHCs have increased awareness of and entryways to their child/youth services through attending and hosting community events. One CCBHC in Missouri, for example, attended school open houses and parent–teacher nights to educate the community about the range of services they provide. In Oregon, a CCBHC offered physical health exams for youth at the county fair before start of a school year. The CCBHC advertised the physical health exams to help participate in school sports and allowed families to participate in voluntary wellness and mental health screening and enroll in other CCBHC services. CCBHCs in Kentucky and Oregon described partnering with local summer camps to provide outreach and limited services and participating in targeted summer outreach events for when students are out of school.

"We have a referral form that is completed by the school. That sheet of paper alerts everybody within the system that this kid is on our radar. The school's job is to inform the parent that we have these services that are offered in our space. And then we come on board to start to talk about our services, what we can provide, and how we can assist with particular things that are going on with that child."

— Missouri CCBHC staff, 2024

CCBHCs implemented changes to improve access to care for children/youth and their families, such as ensuring family-friendly operating hours, improving intake processes, and making services available in children's homes and communities. CCBHCs expanded hours to better accommodate children/youth and their families, keeping clinics open evenings and weekends so families with children in school and working parents and caregivers could receive services outside school and business hours. CCBHCs also improved intake and scheduling processes to get children/youth into the clinic more efficiently, streamlining intake paperwork, adjusting workflows, and better monitoring and evaluating intake capacity for this population. A few CCBHCs provided transportation support specifically to children/youth or used their mobile crisis teams to conduct outreach to children/youth and their families in the community. For instance, one clinic described how a child may have a few sessions with a mobile crisis clinician in the community, and then be transitioned into ongoing care at the clinic.

2. Engagement outcomes that could be impacted by CCBHC strategies to engage children/youth and their families in care

CCBHCs believe their engagement efforts are succeeding in bringing in more children/youth clients, a finding which may be supported by increased child/youth caseloads and improved CCBHC performance on access-related quality measures.

Across all states, the number of children and adolescents served from the first to the fifth demonstration year increased by 24 percent, from 68,661 in Demonstration Year 1 (DY1) to 85,084 in DY5.[5] The number of child/adolescent clients served by CCBHCs increased from DY1 to DY5 in all states except New Jersey and Oregon. The proportion of client caseloads represented by children and adolescents (ages 0 to 17) has, however, remained steady during the demonstration (24 percent across states from DY1 to DY5) with some variation by state (see Appendix B for full data).

"[Our child/youth patient population] has grown exponentially. In 2018 I think we were serving around 74 [child/youth] clients. In 2024, we served over a thousand. We joined the demonstration in 2017. So, in that time, we have just absolutely grown."

— Minnesota CCBHC staff, 2024

Across all states, wait times for initial CCBHC services decreased slightly for children and adolescents. CCBHCs often highlighted strategies to enhance initial engagement processes, which may have contributed to improvements in performance on measures of timely

[5] The number of adults served also increased over time, resulting in the overall proportion of child/adolescent clients staying the same. Proportions of client caseloads represented by children and adolescents in most states were similar to the aggregate (within a few percent) each year; only New Jersey was substantially lower at 14 percent in DY5.

access to care. CCBHCs must report performance on the *Time to Initial Evaluation measure, or I-EVAL*. I-EVAL is calculated separately for child/adolescent CCBHC clients (ages 0 to 17) and adults, and comprises two components: (1) the percentage of new clients who received an initial evaluation within 10 business days of first contact with the clinic, and (2) the average number of days until that initial evaluation occurred. From DY1 to DY4, the percentage of new child and adolescent clients receiving an initial evaluation within 10 days of first contact rose slightly across states from 68 to 72 percent. Similarly, the mean number of days to initial evaluation among this population decreased from 9.9 days in DY1 to 7.2 days in DY4 (see Appendix B for full data).

Family members of child/adolescent CCBHC clients also had positive perceptions of access to care at CCBHCs. In DY4 (or the most recent prior year available if DY4 were not available), 87 percent of family members had a positive perception of access to care on the *Youth/Family Experience of Care* measure, in all states, with the proportion reporting positively ranging from 68 percent in Oregon to 98 percent in New York. Minnesota and New Jersey showed improvement over time of at least 5 percentage points from DY1 to DY4 in the proportion of family members responding positively about access, with the rest of the states mostly showing more modest improvements or remaining roughly the same.

C. Partnerships and collaboration structures to serve children/youth and their families

CCBHCs must establish partnerships with various external providers and service organizations to support coordinated care, facilitate service consultation and access, and enhance outreach and engagement in their communities. The criteria strongly encourage CCBHCs to forge partnerships formally, through either DCO relationships or formal, signed care coordination agreements (SAMHSA 2023). A DCO is an entity outside the direct supervision of a CCBHC engaged in a formal financial relationship to deliver some of the nine required services the CCBHC does not deliver itself.[6] Other formal (non-DCO) relationships are generally documented through signed care coordination agreements, such as a memorandum of understanding (MOU), or unsigned written joint protocols. Outside of DCO and other formal relationships, CCBHCs maintain informal partnerships with a broad range of facilities and providers.

CCBHCs have partnered with a wide range of external child-serving entities and providers to reach and serve children and youth. In the 2024 survey, CCBHCs most commonly reported formal (non-DCO) relationships with schools, psychiatric residential treatment facilities, child welfare agencies, and juvenile justice agencies, though formal relationships were fairly common with all child/youth-relevant entities captured in the survey except Indian Health Service youth regional treatment centers (**Exhibit 5**). Informal relationships were also common across child-serving entities, especially with Early Head Start/Head Start programs, therapeutic foster care service agencies, and a broad category of "other programs and services for young children." DCO relationships were not common, with less than five percent of CCBHCs having DCO arrangements with child/youth-relevant entities.

When formalized, CCBHCs often operationalized partnerships with child-serving entities through MOUs. But rather than the level or method of formalization, CCBHCs often prioritized whether a partnership was meeting the goals of more comprehensive and coordinated care. CCBHCs cited MOUs with schools, hospitals, and a few other external entities, but also described the value of informal partnerships and relationships in allowing them to reach and serve children/youth and their families. State officials expressed similar sentiments as CCBHCs, with New York, for example, referencing CCBHCs using a combination of MOUs "and other arrangements" to "maximize pathways to care".

[6] CCBHCs must assure that these services meet CCBHC standards through a formal, signed agreement.

Exhibit 5. Percentage of CCBHCs that had relationships with child/youth-relevant external facilities/providers, by relationship type

External facility/provider	Non-DCO formal relationship[a]		Informal relationship[a]		DCO[a]	
	2018 (%)	2024 (%)	2018 (%)	2024 (%)	2018 (%)	2024 (%)
Schools	76	79	28	21	0	1
Psychiatric residential treatment facilities	60	54	42	42	1	0
Child welfare agencies	64	53	39	42	0	1
Juvenile justice agencies	57	53	39	42	0	1
School-based health centers	31	37	30	32	0	0
Therapeutic foster care service agencies	46	21	46	46	0	3
IHS youth regional treatment centers	6	8	19	21	0	0
Infant and Early Childhood MH Consultation programs	NA	31	NA	36	NA	4
Early Head Start/Head Start programs	NA	29	NA	49	NA	1
Other programs and services for families with young children	NA	29	NA	59	NA	3

Source: 2018 and 2024 CCBHC surveys.

Notes: The 2018 clinic survey included all 67 CCBHCs participating in the demonstration at the time of data collection; the 2024 clinic survey included the 78 CCBHCs participating in the demonstration for at least one year at the time of data collection. Infant and Early Childhood MH Consultation programs, Early Head Start/Head Start programs, and other programs and services for families with young children were added to the CCBHC survey after 2018.

[a] The clinic survey says the following and then asks the clinic to select DCO, formal, informal, or no relationship for each category: *"Does your CCBHC have relationships with any of the following types of external facilities or providers? For each, indicate the type of relationship or that there is no relationship. Formal relationships might involve a signed care coordination agreement or unsigned written joint protocol."*

DCO = designated collaborating organization; IHS = Indian Health Service; MH = mental health; NA = not available in 2018 survey.

In describing their work with children/youth and their families, CCBHCs highlighted relationships with many other child-serving entities, including local departments of health and human services, local medical offices and hospitals, and crisis and stabilization service providers. Most CCBHCs noted specific education-related partnerships such as with school behavioral health providers, colleges and universities, state departments of education, and school liaisons to departments of public health, underscoring the crucial importance of schools for meeting the needs of children and youth. For example, a CCBHC in Missouri worked with local schools and colleges to pilot a Behavioral Health Outreach Coordinator program that helps the CCBHC better identify and support youth with current or emerging behavioral health challenges.

"Typically, there's more than one area of complication. It could be complications at school, complications in the home, and then starting to get introduced to the corrections system. So, how do you get in there quicker and wrap around? When youth are identified…what are those early stages where [the CCBHC] can engage and get involved and try to repair or help with maintaining the family home?"

— Michigan CCBHC staff, 2024

CCBHCs strongly believe partnerships help to ensure children and youth receive timely, high-quality services to which they might otherwise not have access. CCBHCs described partnerships under the demonstration as key to reaching children and youth who might not have visited the CCBHC, such as those experiencing behavioral health problems in schools or in juvenile justice facilities. Partnerships also allowed CCBHCs to more efficiently reach children/youth in moments of crisis, by, for example, standardizing and facilitating health information exchange to notify clinics of a child or youth's hospitalization. Finally, CCBHCs established partnerships to allow children/youth to remain engaged with systems with which they might be more familiar while still benefiting from CCBHCs' service offerings, citing maintaining trust as a key component of serving children/youth. For

example, CCBHCs in New York partnered with local agencies that specialize in children and family behavioral health services to allow families to remain connected with their trusted existing providers while offering them the additional supports of the CCBHC.

CCBHCs encountered few challenges establishing partnerships to serve children/youth and their families and have developed strong relationships with these partners. One New Jersey CCBHC said, "We have been fortunate to work with engaged and supportive partners who share our commitment to serving children and their families effectively…As a result of our longstanding service provisions, we have fostered positive relationships." However, a few states have found working across siloed agencies to support CCBHCs in serving children/youth and their families to require investment. Several states have helped CCBHCs establish child-focused partnerships. For example, they have facilitated network-building with agencies that directly serve children/youth by hosting networking opportunities and directly linking CCBHCs with child/youth-serving agencies, and they have collaborated with state child-serving agencies and teams (where they exist) to encourage these agencies to consider coordinating with CCBHCs.

> *"Nobody, quote, owns youth. We all have our piece, right? So, when it's siloed, it's messy. Working with those entities to make sure that we're serving youth cohesively has been a big effort."*
>
> — Missouri state officials, 2024

CCBHCs' partnerships and efforts to coordinate care after hospitalizations may be affecting follow-up care for children and youth. CCBHCs often partnered with hospitals and emergency departments to serve children and youth during hospitalizations and other times of crisis. The strength of these partnerships and care coordination structures could influence performance on measures of timely follow-up care after acute care events. The aggregate 30-day rate on the *Follow-up After Hospitalization for Mental Illness Child/Adolescent* quality measure was 77 percent in DY4, with stable performance from DY1 to DY4 (see Appendix B for full data). **CCBHC performance on this measure was about 12 percentage points higher than the Child Core Set state median over the same period.**[7] At the state level, measure performance was similarly high and stable over time, meeting or exceeding available state median data except in New Jersey, where CCBHC performance was low but increased by 22 percentage points from DY1 to DY4, exceeding state median data performance by the end of the period.[8]

D. Quality improvement (QI) efforts states and CCBHCs are implementing related to serving children/youth and their families

Some CCBHCs have implemented QI efforts focused on children/youth, but the nature of these efforts varies. Several CCBHCs are focusing QI efforts on specific child/youth sub-populations. For example, a New Jersey CCBHC is seeking to better serve the most complex and high-risk children and youth and is reviewing service gaps and planning enhanced programming for this group. A few other CCBHCs described QI plans related to improving care for transition-age youth. Finally, several other CCBHCs are working to improve processes to more efficiently engage children and youth, such as enhancing school-based treatment referral and child/youth intake and admissions processes.

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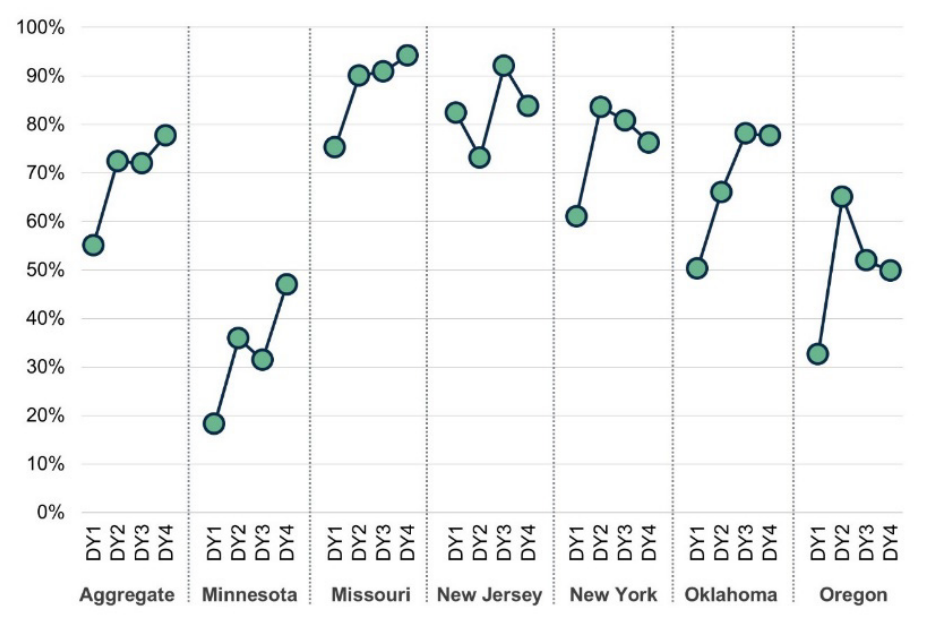
[7] State median data were available for DY1 to DY3 and are from the Annual Reporting on the Quality of Care for Children in Medicaid and CHIP (reports FFY 2018-2020 for DY1-DY3) at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html. See Appendix B for more information.

[8] Although the 22% increase is notable, denominators for this measure were relatively small meaning the number of people represented by this change is modest. See Appendix Exhibit B.6 for full data.

Several CCBHCs have used the child-related quality measures to improve clinical practice. One CCBHC described being motivated by the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents quality measure to implement increased training on the use of a calculator for capturing youth body mass index. Two CCBHCs implemented improved screening and assessment procedures because of the Major Depressive Disorder (MDD): Suicide Risk Assessment child quality measure, and another CCBHC implemented a five-year Zero Suicide model specifically for children. One CCBHC has targeted workflows to improve the Follow-Up After Hospitalization for Mental Illness for Children quality measure.

CCBHC performance on a measure of suicide risk screening and follow-up improved dramatically from DY1 to DY4, possibly affected by CCBHCs' QI efforts in this area. Screening for depression and other physical and behavioral health disorders is an important service CCBHCs provide and was underscored by several CCBHCs as the focus of efforts to improve clinical practice (described above). One such measure is the *Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment*. Across states, CCBHCs documented that they conducted a suicide risk assessment in 78 percent of visits with a child/adolescent with major depressive disorder in DY4 (**Exhibit 6**). Aggregate performance on the measure improved by over 20 percentage points from DY1 to DY4, driven by increases of more than 5 percentage points in all states except New Jersey, where performance was already quite high in DY1. Improved performance on this measure may suggest that CCBHCs' QI efforts to improve care for children and adolescents with depression may be having an impact.

Exhibit 6. Suicide risk assessment of major depressive disorder: measure performance on SRA-BH-C for children/adolescents (ages 6 to 17)



Source: Mathematica and the RAND Corporation's analysis of DY1 to DY4 CCBHC quality measures.
Note: Oregon began the demonstration with 12 CCBHCs but decreased to nine CCBHCs in DY3. The analysis includes the nine CCBHCs that remained in the demonstration through DY4. The DY3 and DY4 measurement years include the COVID-19 PHE.
DY = Demonstration Year; PHE = public health emergency; SRA-BH-C = Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment.

DISCUSSION AND CONCLUSION

CCBHCs have implemented innovative strategies to engage and serve children/youth and their families during the demonstration, from improving workflows to hiring dedicated staff to almost doubling service provision in schools. CCBHCs provide a full range of CCBHC services to children/youth and their families, and have tailored their individual service arrays to address specific population needs. Schools are a critical point of entry to CCBHC services for children/youth, serving as a common source of referrals and key partners for CCBHCs in service delivery and care coordination. Almost all CCBHCs provided school-based services in 2024, and states

and CCBHCs almost universally cited delivery of school-based services as a primary strategy for reaching children and youth. CCBHCs described serving children/youth and their families in myriad ways, working across siloes and through partnerships to break down barriers to serving this population. States have supported CCBHCs throughout this process, in particular through trainings and other resources, and by developing deep commitments to solving difficult problems together.

CCBHCs and states perceive the demonstration's requirements to provide services across the lifespan to have significantly expanded access to behavioral health care for children and youth, and the number of children served by CCBHCs has grown during the demonstration. Some demonstration clinics historically did not serve this population prior to the demonstration, and most CCBHCs added new or expanded services or staff types to better serve children/youth and their families. One CCBHC noted that becoming a CCBHC helped them provide more and deeper services for children and youth, and more collaboration time between staff, schools, and family members to really understand the child's needs and provide the best level of care. In New Jersey, which had a well-established children's system of behavioral health care prior to the demonstration, a CCBHC described wanting to convert all their outpatient locations, including their child office into CCBHCs to "provide this population with comprehensive behavioral health care" and "provide a higher quality of services to children."

Although CCBHCs have implemented a variety of innovative strategies to serve and improve the quality of care for children/youth and their families, gaps remain. Officials in several states shared that CCBHCs have struggled or have needed additional support to serve certain child and youth populations, such as very young children (ages 0 to 5), and those with SUD. Behavioral health workforce challenges are particularly acute among child-serving providers given the smaller pool of candidates with specialized training and experience.

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Appendix A

In this appendix, we provide additional information about the methods, data sources, and limitations of this brief.

Interviews with state officials and CCBHC leaders. In early 2025, we conducted semi-structured, 90-minute virtual interviews with state demonstration officials in each of the eight active demonstration states participating in the demonstration for more than a year at the time of data collection for this brief (Kentucky, Michigan, Minnesota, Missouri, New Jersey, New York, Oklahoma, and Oregon). We also interviewed key CCBHC leadership staff (for example, the CEO or medical director) from a diverse group of 15 CCBHCs across these same states. We interviewed at least one clinic from each of the active demonstration states participating for more than one year. Selected CCBHCs represented various clinic sizes, geographic locations, payment models, DCO arrangements, non-DCO partnerships with external entities, school-based service provision, and use of health information technology. The interviews focused on access, scope of services, care management and coordination, partnerships, and quality improvement efforts to serve children/youth and their families. We reviewed and summarized interview responses separately and conducted thematic analyses across respondents. We then supplemented findings with complementary findings from earlier qualitative data collection (interviews and site visits) documented in previous evaluation reports.

CCBHC survey. In August and September 2024, all 78 CCBHCs with at least one year of participation in the demonstration across eight states (Kentucky, Michigan, Minnesota, Missouri, New Jersey, New York, Oklahoma, and Oregon) completed a survey that collected structured information on clinics' efforts to engage and serve children/youth and their families as well as other topics related to the certification criteria, obtaining a 100 percent response rate. To analyze the survey data, we computed descriptive statistics (for example, frequencies and percentages) using Excel and SAS and summarized findings from select open-ended questions. To provide context to the 2024 survey findings, we included complementary data from the 2018 CCBHC survey when available. This previous survey included the 67 demonstration clinics participating at the time, and obtained a 100 percent response rate. To analyze the survey data, we computed descriptive statistics (for example, frequencies and percentages) using Excel and SAS. We summarized findings across all clinics that responded and also included findings from select open-ended survey questions.

CCBHC quality measures. The U.S. Department of Health and Human Services requires demonstration states to report a set of quality measures (SAMHSA 2016). We obtained the quality measure data from the Office of the Assistant Secretary for Planning and Evaluation and summarized statewide measure performance in previous evaluation reports (Wishon et al. 2023; Brown et al. 2021). In this brief, we present findings on DY1 to DY4 measure performance on four child/youth-relevant measures and characteristics of CCBHC client caseloads for DY1 to DY5. Please see Wishon et al. 2023, section II.B for a detailed description of the methods we used to analyze the quality measures for this and previous reports.

Limitations. CCBHC survey items that collected systematic information about engagement of and care provided to children/youth and their families were limited. Much of the information in this report is based on open-ended survey and interview data, and states and CCBHCs provided varying levels of detail, particularly in earlier years of the demonstration.

Appendix B

In this appendix we present additional data and figures to complement the information included in the main body of the brief.

Appendix Exhibit B.1. Percentage of CCBHCs that provided child/youth- and family-relevant services, directly and by DCO

Service	Added at the beginning of the demonstration (%)	Provided service directly or by DCO		Provided service directly		Provided service by DCO	
		2018 (%)	2024 (%)	2018 (%)	2024 (%)	2018 (%)	2024 (%)
Specialty MH/SUD services for children and youth	22	87	79	87	78	0	5
Community wraparound services for youth/children	15	76	77	75	76	3	4
Therapeutic foster care	1	7	9	6	6	1	3

Source: 2018 and 2024 CCBHC surveys.
Note: The 2018 clinic survey included 67 CCBHCs; the 2024 clinic survey included 78 CCBHCs.
DCO = designated collaborating organization; MH = mental health; SUD = substance use disorder.

Appendix Exhibit B.2. Percentage of CCBHCs that provided child/youth- and family-related services directly or by DCO, overall and by state

Service	Overall (%)	KY (%)	MI (%)	MO (%)	MN (%)	NJ (%)	NY (%)	OK (%)	OR (%)
Specialty MH/SUD services for children and youth	79	100	62	90	100	57	77	67	83
Community wraparound services for youth/children	77	100	100	85	67	43	38	100	92
Therapeutic foster care	9	0	31	5	33	0	0	0	0

Source: 2024 CCBHC survey.
Note: The 2024 clinic survey included 78 CCBHCs.
DCO = designated collaborating organization; KY = Kentucky; MH = mental health; MI = Michigan; MO = Missouri; MN = Minnesota; NJ = New Jersey; NY = New York; OK = Oklahoma; OR = Oregon; SUD = substance use disorder.

Appendix Exhibit B.3. Count and percentage of children/adolescents served by original demonstration state CCBHCs, by state and year

	Number of CCBHCs	Denominator, total caseload count	Child/adolescent age 0–17 years, count	Child/adolescent age 0–17 years, percentage of total caseload
DY1 Aggregate	56	286,089	68,661	24%
DY2 Aggregate	56	308,831	74,119	24%
DY3 Aggregate	53	303,911	72,939	24%
DY4 Aggregate	53	315,349	75,684	24%
DY5 Aggregate	54	340,334	85,084	25%
Minnesota DY1	6	23,027	6,217	27%
Minnesota DY2	6	25,402	6,605	26%
Minnesota DY3	6	23,935	5,984	25%
Minnesota DY4	6	20,725	5,596	27%

	Number of CCBHCs	Denominator, total caseload count	Child/adolescent age 0–17 years, count	Child/adolescent age 0–17 years, percentage of total caseload
Minnesota DY5	6	23,586	6,840	29%
Missouri DY1	15	121,787	29,229	24%
Missouri DY2	15	132,565	34,467	26%
Missouri DY3	15	137,753	35,816	26%
Missouri DY4	15	145,949	36,487	25%
Missouri DY5	15	159,468	41,462	26%
New Jersey DY1	7	17,851	3,392	19%
New Jersey DY2	7	19,129	3,443	18%
New Jersey DY3	7	20,396	3,059	15%
New Jersey DY4	7	21,742	3,044	14%
New Jersey DY5	7	20,121	2,817	14%
New York DY1	13`	49,903	10,979	22%
New York DY2	13	55,693	12,252	22%
New York DY3	13	57,377	12,623	22%
New York DY4	13	62,972	14,484	23%
New York DY5	13	68,248	17,062	25%
Oklahoma DY1	3	20,610	5,153	25%
Oklahoma DY2	3	22,741	6,140	27%
Oklahoma DY3	3	24,647	6,901	28%
Oklahoma DY4	3	25,583	7,163	28%
Oklahoma DY5	3	27,201	7,616	28%
Oregon DY1	12	52,911	12,699	24%
Oregon DY2	12	53,301	12,792	24%
Oregon DY3	9	39,803	8,757	22%
Oregon DY4	9	38,378	8,059	21%
Oregon DY5	10	41,710	8,759	21%

Source: Mathematica and RAND analysis of DY1 to DY5 CCBHC quality measures and state response to follow-up questions.

Notes: Missouri caseload counts reflect the 15 original demonstration clinics. We excluded partial data for several clinics added to the demonstration partway through DY5. Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3 and DY4. One clinic was recertified and began submitting data again by DY5. Quality measure reports for Nevada were excluded as they were only available for DY1. The DY3 and DY4 measurement years include the COVID-19 PHE. In the original states, DY1 = 2017-2018, DY2 = 2018-2019, DY3 = 2019-2020, DY4 = 2020-2021, DY5 = 2021-2022.

CCBHC = Certified Community Behavioral Health Clinic; DY = demonstration year; PHE = public health emergency.

Appendix Exhibit B.4. Count and percentage of children/adolescents served by CARES Act state CCBHCs, by state

	Number of CCBHCs	Denominator, total caseload count	Child/adolescent (age 0–17), count	Child/adolescent (age 0–17), percentage of total caseload
Michigan DY1	13	82,280	20,570	25%

Source: Mathematica and RAND analysis of CCBHC quality measure reports.

Note: CARES Cohort DY1 includes October 2021 - September 2022 in Michigan. Kentucky encountered challenges reporting demographic characteristics of people served in DY1 and resubmitted their quality measure data after the cutoff date for inclusion in this brief. =

CARES = Coronavirus Aid, Relief, and Economic Security Act; CCBHC = Certified Community Behavioral Health Clinic; DY = demonstration year.

Appendix Exhibit B.5. Access to care/timeliness of initial evaluation: child/adolescent measure performance on Initial Evaluation for New Clients (I-EVAL), by state

	I-EVAL child/adolescent (age 0–17) denominator	I-EVAL child/adolescent (age 0–17) rate, % within 10 days	I-EVAL child/adolescent (age 0–17) mean days to evaluation
DY1 Aggregate	17,616	68%	9.9
DY2 Aggregate	18,023	74%	5.3
DY3 Aggregate	17,794	76%	6.8
DY4 Aggregate	22,456	72%	7.2
Minnesota DY1	1,401	59%	10.1
Minnesota DY2	1,107	63%	7.0
Minnesota DY3	1,336	60%	6.6
Minnesota DY4	1,492	51%	6.9
Missouri DY1	6,830	69%	11.0
Missouri DY2	7,669	77%	3.5
Missouri DY3	9,384	79%	6.8
Missouri DY4	12,075	74%	4.6
New Jersey DY1	1,702	68%	11.0
New Jersey DY2	1,502	80%	8.1
New Jersey DY3	923	75%	5.9
New Jersey DY4	1,056	63%	14.2
New York DY1	3,236	71%	9.2
New York DY2	3,020	75%	6.5
New York DY3	2,798	77%	5.9
New York DY4	3,789	79%	5.9
Oklahoma DY1	1,787	65%	7.9
Oklahoma DY2	1,981	73%	6.6
Oklahoma DY3	2,065	81%	5.7
Oklahoma DY4	2,036	73%	6.1
Oregon DY1	2,660	67%	7.8
Oregon DY2	2,744	66%	9.5
Oregon DY3	1,288	70%	10.7
Oregon DY4	2,008	70%	20.8

Source: Mathematica and the RAND Corporation's analysis of DY1 to DY4 CCBHC quality measures.

Note: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. A lower average number of days means better performance. The DY3 and DY4 measurement years include the COVID-19 public health emergency.

Pandemic-related staffing and care provision challenges may in part account for decreases in performance.

DY = demonstration year; I-EVAL = Time to Initial Evaluation measure.

Appendix Exhibit B.6. Follow-up after Hospitalization for Mental Health Child/Adolescent (FUH-BH-C) 30-day measure, overall and by state

	FUH-BH-C 30 Day-Denominator	FUH-BH-C 30-Day Rate	FUH-BH-C 30-Day State Median Data
DY1 Aggregate	4,699	77%	65%
DY2 Aggregate	5,279	80%	66%
DY3 Aggregate	4,539	78%	66%
DY4 Aggregate	5,123	77%	n.a.
Minnesota DY1	668	74%	70%
Minnesota DY2	644	82%	73%
Minnesota DY3	327	73%	63%
Minnesota DY4	363	77%	n.a.
Missouri DY1	3,146	76%	56%
Missouri DY2	3,497	78%	56%
Missouri DY3	3,457	77%	61%
Missouri DY4	3,824	75%	n.a.
New Jersey DY1	77	21%	32%
New Jersey DY2	105	35%	31%
New Jersey DY3	89	37%	23%
New Jersey DY4	114	43%	n.a.
New York DY1	372	87%	85%
New York DY2	442	88%	n.a.
New York DY3	379	88%	n.a.
New York DY4	495	92%	n.a.
Oklahoma DY1	288	91%	51%
Oklahoma DY2	470	93%	66%
Oklahoma DY3	287	93%	68%
Oklahoma DY4	327	94%	n.a.
Oregon DY1	148	93%	n.a.
Oregon DY2	121	88%	n.a.
Oregon DY3	n.a.	n.a.	n.a.
Oregon DY4	n.a.	n.a.	n.a.

Source: Mathematica and the RAND Corporation's analysis of DY1 to DY4 CCBHC quality measures. Comparisons are made to state median data from the Annual Reporting on the Quality of Care for Children in Medicaid and CHIP (reports FFY 2018-2020 for DY1-DY3), available at https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/index.html

Notes: Oregon began the demonstration with 12 CCBHCs but decreased to 9 CCBHCs in DY3. The analysis includes the 9 CCBHCs that remained in the demonstration through DY4. CCBHC measure data are not available in Oregon DY3 and 4. State median data are not available in New York DY2 to 3, or Oregon DY1 to 3. The DY3 and DY4 measurement years include the COVID-19 public health emergency.

DY = demonstration year; FUH-BH-C = Follow-up after Hospitalization for Mental Health Child/Adolescent; n.a. = not available.

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