Characterizing Crisis Services Offered by Certified Community Behavioral Health Clinics: Results From a National Survey

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Objective: The authors aimed to examine how certified community behavioral health clinics (CCBHCs) fulfill crisis service requirements and whether clinics added crisis services after becoming a CCBHC.

Methods: National survey data on CCBHC crisis services were paired with data on clinic features and the demographic and socioeconomic characteristics of the counties within a CCBHC service area. The dependent variables were whether CCBHCs provided the three categories of CCBHC crisis services (i.e., crisis call lines, mobile crisis response, and crisis stabilization) directly or through another organization and whether these services were added after becoming a CCBHC. Descriptive statistics and multivariable logistic regression analyses were performed with data about clinics and the counties they served. In total, 449 CCBHCs were surveyed in the summer of 2022, with a response rate of 56%. The final sample comprised 247 clinics.

Results: The number of CCBHC employees per 1,000 people within a CCBHC service area was significantly and positively associated with clinics providing some crisis services directly (mobile crisis response: adjusted OR [AOR]=1.46, 95% CI=1.08–1.98; crisis stabilization services: AOR=1.60, 95% CI=1.17–2.19). Compared with clinics that did not receive a CCBHC Medicaid bundled payment, clinics that received this payment had higher odds of adding mobile crisis response (AOR=2.52, 95% CI=1.28–4.97) and crisis stabilization services (AOR=3.19, 95% CI=1.51–6.72) after becoming a CCBHC.

Conclusions: CCBHC initiatives, particularly CCBHC Medicaid bundled payments, may provide opportunities to increase the availability of behavioral health crisis services, but the sufficiency of this increase for meeting crisis care needs remains unknown.

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Rising rates of suicide and drug overdose deaths (1, 2), along with the increased attention to behavioral health problems among individuals who are unhoused, incarcerated, or interacting with law enforcement (3–6), have exposed failures within existing behavioral health crisis systems. In particular, many clinicians and researchers have focused on inadequacies and inconsistencies in crisis continua. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines three core components of crisis care: 24/7 call centers, mobile crisis response teams, and crisis stabilization facilities (7–9). However, empirical research characterizing the behavioral health crisis system remains limited (10–13).

Recently, the federal government made several substantive investments in behavioral health crisis care (14), including initiatives involving community behavioral health centers. Certified community behavioral health clinics (CCBHCs) fulfill SAMHSA criteria related to the delivery of nine categories of care for mental and substance use disorders, regardless of patients' ability to pay. Organizations may become designated as a CCBHC through two mechanisms. First, the Centers for Medicare and Medicaid Services has

HIGHLIGHTS

- The authors explored whether certified community behavioral health clinics (CCBHCs) offered behavioral health crisis care directly or through another organization and whether clinics added these services before or after becoming a CCBHC.
- The number of employees per population within a CCBHC service area was positively associated with offering mobile crisis response and crisis stabilization services directly, and clinics that received a CCBHC Medicaid bundled payment had higher odds of adding these services after becoming a CCBHC than clinics that did not.
- CCBHC initiatives may provide opportunities to increase the availability of behavioral health crisis services, but the sufficiency of this increase remains unknown.

authorized programs in states under the federal Section 223 Medicaid Demonstration or Medicaid flexibilities that pay participating clinics primarily by using a per diem or monthly encounter-based, bundled rate for all CCBHC services. Second, SAMHSA awards CCBHC expansion grants to organizations in any state that meet or will meet federal CCBHC criteria. Whereas organizations in states without a CCBHC Medicaid bundled payment may become designated as a CCBHC only through the expansion grant program, clinics in states with an authorized CCBHC Medicaid bundled payment may become a CCBHC through the state Medicaid demonstration, the expansion grant program, or both. As of July 2024, >500 organizations have been designated as a CCBHC (15).

A primary difference between the Medicaid bundled payment and the expansion grant program is that the former alters Medicaid reimbursement for clinics to address previous shortfalls in Medicaid payments for community mental health services and to offer more sustained support for the intensive CCBHC requirements (16–18). The payment achieves these goals through its design: the CCBHC Medicaid bundled payment model is structured to reflect clinics' real costs of expanding services. Specifically, in the first year, clinics' payment rates include anticipated costs of fulfilling all CCBHC criteria. States then determine a schedule for updating payment rates to reflect historical cost data. In contrast, the SAMHSA CCBHC expansion grants provide a fixed amount of money (up to $4 million) for a set period (2 years for the grantees in this analysis).

Crisis behavioral health services represent one of the nine required CCBHC service categories. Current SAMHSA criteria require that CCBHCs offer all three core components of the crisis continuum: telephone, text, and chat crisis intervention call centers that meet 988 Suicide & Crisis Lifeline standards; a 24/7 behavioral health mobile crisis response that arrives within 1 hour (2 hours for rural and frontier communities) from dispatch; and crisis receiving and stabilization services that deescalate the crisis and connect individuals to the least-restrictive safe setting for ongoing care. These services may be offered directly or through designated collaborating organizations (DCOs) that are certified, licensed, or state-sanctioned providers of behavioral health crisis services (19). The original SAMHSA CCBHC criteria mandated that clinics offer mobile crisis response and crisis stabilization but not crisis call line services (20); crisis call lines were added as a required service in the 2023 CCBHC criteria update (19).

Despite the investment in CCBHCs to improve crisis services across the country (21–24), minimal research exists on how CCBHCs offer crisis care and whether crisis services were added to fulfill CCBHC requirements. Research on the mechanism of delivering crisis services (i.e., direct or through another organization) provides information about the characteristics of local crisis continua (16, 25); provision of crisis services through partnerships suggests but does not indicate that a clinic relies on existing crisis resources to meet CCBHC criteria. In contrast, direct delivery of such services suggests that no crisis provider in the community delivers crisis care in line with the CCBHC requirements or that the CCBHC is fulfilling demand unmet by the existing crisis infrastructure in its service area. Furthermore, although research suggests that CCBHCs that receive per diem or monthly Medicaid reimbursement added crisis services after becoming a CCBHC (16), it is not clear whether this finding extends to organizations that exclusively participate in the CCBHC expansion grant program. Building on other research surveying CCBHCs (26), we used data from a national survey of all CCBHCs to determine the prevalence of CCBHCs that offer the three types of crisis services directly and of clinics that added these services after becoming a CCBHC. We also sought to identify the correlates of these outcomes of interest.

METHODS

Between July 14 and August 26, 2022, the Harris Poll, on behalf of the National Council for Mental Wellbeing, surveyed the 449 organizations designated as CCBHCs by federal and state authorities (25). To date, this is the only survey of all CCBHCs. The survey completion rate was 56% (N=249), a rate that is better than or comparable to those of other recent surveys of safety-net providers of health services (27, 28). Two organizations were dropped from the analysis because of incomplete survey data, yielding a final sample of 247 clinics.

If an organization does not meet all CCBHC requirements at the time of designation, SAMHSA and state authorities grant provisional certification, a set period in which clinics must fulfill CCBHC criteria. We excluded CCBHCs that reported that they were still working toward fulfilling the crisis service requirement, resulting in samples of 240 and 231 clinics for analyses related to mobile crisis response and crisis stabilization services, respectively. All CCBHCs included in the analysis provided crisis call lines.

We explored two dependent variables. First, we assessed whether the CCBHCs provided the three types of crisis services—crisis call lines, mobile crisis response, and crisis stabilization—directly or through an agreement with a DCO (19). We grouped the small proportion of organizations reporting that they offered mobile crisis response (N=10, 4%) and crisis stabilization (N=10, 4%) both directly and through a DCO into the direct service category. The second dependent variable assessed whether CCBHCs added the three crisis services before or after becoming a CCBHC.

Independent variables included a combination of demographic, socioeconomic, and organizational measures gathered from additional sources and survey responses. Several variables characterized the counties within the area served by a CCBHC, which was distinct from the population actually served by the clinic. (Appendix 1 in the online supplement to this article describes the process for collecting county-level CCBHC service areas.) Although

45% (N=111) of the CCBHCs served a single county, most served multiple counties. Therefore, measures were calculated on the basis of the characteristics of all of the counties within a CCBHC service area.

Drawing from the Economic Research Service of the U.S. Department of Agriculture, we assessed rurality by including the average rural-urban continuum code (RUCC) among all counties served by a CCBHC. RUCC values range from 1 (counties in metro areas of >1 million population) to 9 (completely rural or <2,500 urban population and not adjacent to a metro area). The Centers for Disease Control and Prevention's WONDER (Wide-Ranging Online Data for Epidemiologic Research) database provided the 2020 population served by a CCBHC, measured as the sum of all county populations within a CCBHC service area. We included covariates for the proportion of the 2021 population within a CCBHC service area identifying as Black or Hispanic in the Census Demographic and Housing Characteristics File. To assess poverty rates, we used the Census Small Area Income and Poverty Estimates to identify the number of persons with incomes <100% of the federal poverty level per 1,000 persons within the CCBHC service area in 2021. The number of uninsured persons per 1,000 people within a CCBHC service area in 2020 was gathered from the American Community Survey (ACS). In addition, we used the ACS to add a covariate for the 2021 5-year estimate for the number of people enrolled in Medicaid per 1,000 persons within a CCBHC service area.

From the Harris Poll, we included in our analyses an indicator for whether the organization received a CCBHC Medicaid bundled payment, coded as 0 if the CCBHC participated only in the CCBHC expansion grant program and 1 if the CCBHC received a bundled payment for all CCBHC services. Of note, organizations that do not receive a CCBHC Medicaid bundled payment may still bill Medicaid but do not receive the CCBHC bundled rate. Also from the Harris Poll, we included a proxy for organization size: the number of CCBHC employees per 1,000 people within a CCBHC service area.

This study was deemed exempt by the institutional review board at New York University. All analyses were conducted with Stata, version 18.0, and were weighted with survey-specific weights to produce estimates that represented the proportion of CCBHCs in each state that received and CCBHCs that did not receive a CCBHC Medicaid bundled payment in summer 2022. (Appendix 2 in the online supplement contains information on the weighting scheme.) We present descriptive statistics and multivariable logistic regression analyses examining how CCBHCs offered crisis care (i.e., directly or through a DCO) and when they began offering crisis services.

RESULTS

Most CCBHCs provided crisis call lines (84%), mobile crisis response (79%), and crisis stabilization (82%) directly (Table 1). Each crisis service was already being offered by most clinics before they received CCBHC designation (crisis call lines, 75%; mobile crisis response, 59%; crisis stabilization, 73%), although differences were found between clinics receiving and not receiving a CCBHC Medicaid bundled payment. Among clinics that received a CCBHC Medicaid bundled payment, the proportion that added mobile crisis response and crisis stabilization after becoming a CCBHC and the proportion that offered these services before were similar (mobile crisis response: after designation, 56%; before designation, 44%; crisis stabilization: after designation, 46%; before designation, 54%). In contrast, for clinics that did not receive the CCBHC Medicaid bundled payment, the proportion that added these services after becoming a CCBHC was substantially lower than the proportion of clinics that offered the crisis service before receiving the CCBHC designation (mobile crisis response: after designation, 35%; before designation, 65%; crisis stabilization: after designation, 19%; before designation, 81%).

Table 2 presents the means of the continuous independent variables for CCBHCs that offered crisis services directly and those that offered services through a DCO. Mean RUCC values (i.e., rurality) were significantly higher for CCBHCs that directly offered mobile crisis response (mean RUCC value=3.27) and crisis stabilization (mean RUCC value=3.11), compared with clinics that provided these services through a DCO (mobile crisis response, mean RUCC value=1.71; crisis stabilization, mean RUCC value=2.19). Additionally, compared with clinics that offered services through a DCO, clinics that provided direct services had a greater mean number of CCBHC employees per 1,000 persons within a CCBHC service area for mobile crisis response (direct services, mean=0.90; DCO, mean=0.15) and crisis stabilization (direct services, mean=0.84; DCO, mean=0.28). Except for clinics offering crisis call lines, the mean size of the population within a CCBHC service area (mobile crisis response: direct services, 902,852; DCO, 1,571,659; crisis stabilization: direct services, 1,088,159; DCO, 1,177,049) and the proportion of the CCBHC service area population identifying as Black (mobile crisis response: direct services, 0.09; DCO, 0.16; crisis stabilization: direct services, 0.09; DCO, 0.16) were lower for CCBHCs that offered these services directly.

Table 3 compares clinics that added crisis care after becoming a CCBHC with clinics that already offered these services before CCBHC designation. The number of uninsured persons per 1,000 people within a CCBHC service area was lower for CCBHCs that after receiving CCBHC designation added a mobile crisis response (after designation, 71.9; before designation, 82.7) and crisis stabilization (after designation, 68.8; before designation, 82.6). Furthermore, the Medicaid enrollment rate was higher for CCBHCs that added a mobile crisis response after CCBHC designation (after designation, 151.1; before designation, 144.8), and the poverty rate was lower for clinics that added crisis stabilization services after CCBHC designation (after designation, 121.7; before designation, 135.7).

In adjusted analyses (Table 4), the number of employees per 1,000 people within a CCBHC service area was

TABLE 1. Crisis services provision among CCBHCs, by receipt of CCBHC Medicaid bundled payment and service delivery mode and implementation[a]

Service type and Medicaid bundled payment status	Offered crisis service directly			Offered crisis service via a DCO			Pearson χ^2	df
	N	%	95% CI	N	%	95% CI		
Crisis line (N=247)								
All	207	84	78–88	40	16	12–22		
CCBHC Medicaid bundled payment	65	90	80–95	7	10	5–20	2.94	246
No CCBHC Medicaid bundled payment	142	81	74–86	33	19	14–26		
Mobile crisis response (N=240)								
All	192	79	73–84	48	21	16–27		
CCBHC Medicaid bundled payment	61	84	72–91	11	16	9–28	1.08	239
No CCBHC Medicaid bundled payment	131	78	70–84	37	22	17–30		
Crisis stabilization (N=231)								
All	189	82	76–86	42	18	14–24		
CCBHC Medicaid bundled payment	58	82	70–90	12	18	11–30	.00	230
No CCBHC Medicaid bundled payment	131	82	75–87	30	19	13–26		
Service type and Medicaid bundled payment status	**Added crisis service after becoming a CCBHC**			**Added crisis service before becoming a CCBHC**			**Pearson χ^2**	**df**
	N	%	95% CI	N	%	95% CI		
Crisis line (N=198)								
All	49	25	20–32	149	75	68–81		
CCBHC Medicaid bundled payment	18	32	21–46	42	68	54–79	1.90	197
No CCBHC Medicaid bundled payment	31	23	16–31	107	77	69–84		
Mobile crisis response (N=240)								
All	96	41	34–47	144	59	53–66		
CCBHC Medicaid bundled payment	41	56	44–68	31	44	33–56	9.52*	239
No CCBHC Medicaid bundled payment	55	35	27–43	113	65	57–73		
Crisis stabilization (N=231)								
All	60	27	21–34	171	73	67–79		
CCBHC Medicaid bundled payment	30	46	34–58	40	54	42–66	16.95**	230
No CCBHC Medicaid bundled payment	30	19	14–26	131	81	74–86		

[a] Percentages were weighted with survey-specific weights. See appendix 2 in the online supplement for details on the weighting scheme; appendix 3 contains the unweighted proportions. Forty-nine responses were missing to the question whether an organization added a crisis call line after becoming a certified community behavioral health clinic (CCBHC). DCO, designated collaborating organization.

* $p<0.01$, ** $p<0.001$.

significantly and positively associated with whether a CCBHC directly provided mobile crisis response (adjusted OR [AOR]=1.46) and crisis stabilization services (AOR=1.60), compared with via a DCO. Compared with clinics that did not receive the Medicaid bundled payment, clinics that received this payment had significantly higher odds of adding mobile crisis response (AOR=2.52) and crisis stabilization (AOR=3.19) services after receiving CCBHC designation.

DISCUSSION

In this study, we used the only national survey of all CCBHCs to expand on the minimal research into the CCBHC requirement that clinics provide crisis services (16, 25), adding to the growing literature characterizing federal, state, and local crisis systems (10–13). We found that the factors associated with the delivery and addition of crisis call lines differed from the factors that were correlated with the other crisis services. The number of CCBHC employees per 1,000 people within a CCBHC service area was positively associated with the likelihood that the CCBHC directly provided mobile crisis response and crisis stabilization services but not with provision of crisis call line services. Because mobile crisis response and stabilization services are more costly and sensitive to capacity limits than are crisis call lines, the aforementioned difference in factors may reflect differences in the resource intensity of the services provided (29–32). Moreover, in alignment with other research (16), we found that clinics that received a CCBHC Medicaid bundled payment were more likely than CCBHCs that did not receive this payment to have added mobile crisis response and crisis stabilization, but not crisis call lines, after CCBHC designation. This finding may reflect billing differences; health insurers are more likely to reimburse for mobile crisis response and crisis stabilization than for crisis call line services (33, 34). Consequently, organizations may be more likely to add these services in response to a billing change, such as the CCBHC Medicaid bundled payment, than to add crisis call lines.

The finding that the number of CCBHC employees per 1,000 persons within a CCBHC service area was positively correlated with offering some crisis services directly was suggestive, but by no means indicative, of characteristics of

TABLE 2. Characteristics associated with CCBHCs offering services directly or through a DCO[a]

Service type and characteristic	Offered service directly		Offered service through a DCO			
	M	95% CI	M	95% CI	t	df
Crisis call line (N=247)						246
Rurality (average RUCC among counties within CCBHC service area)	3.02	2.30–3.34	2.47	1.78–3.16	1.43	
Population (in CCBHC service area)	1,023,387	776,244–1,270,531	1,391,765	749,517–2,034,014	−1.05	
Black (rate per population within CCBHC service area)	.10	.09–.12	.14	.10–.18	−1.77	
Hispanic (rate per population within CCBHC service area)	.16	.14–.18	.15	.11–.18	.53	
Poverty rate (N of individuals living at <100% FPL per 1,000 persons within CCBHC service area)	131.2	124.7–137.6	132.9	118.3–147.5	−.22	
Uninsured (rate per 1,000 persons within CCBHC service area)	79.7	73.8–85.6	69.0	57.2–80.8	1.59	
Medicaid enrollment (rate per 1,000 persons within CCBHC service area)	147.4	144.1–150.8	147.7	141.7–153.8	−.09	
CCBHC employees (rate per 1,000 persons within CCBHC service area)	.80	.62–.93	.48	.11–.86	1.44	
Mobile crisis response (N=240)						239
Rurality (average RUCC among counties within CCBHC service area)	3.27	2.93–3.62	1.71	1.33–2.10	5.95***	
Population (in CCBHC service area)	902,852	662,973–1,142,733	1,571,659	1,053,247–2,090,071	−2.31*	
Black (rate per population within CCBHC service area)	.09	.08–.11	.16	.13–.20	−3.7***	
Hispanic (rate per population within CCBHC service area)	.15	.13–.17	.18	.14–.22	−1.45	
Poverty rate (N of individuals living at <100% FPL per 1,000 persons within CCBHC service area)	130.8	123.9–137.7	134.4	122.5–146.2	−.51	
Uninsured (rate per 1,000 persons within CCBHC service area)	81.3	75.0–87.5	66.7	56.6–76.8	2.42*	
Medicaid enrollment (rate per 1,000 persons within CCBHC service area)	146.1	142.7–149.5	152.1	145.7–158.6	−1.62	
CCBHC employees (rate per 1,000 persons within CCBHC service area)	.90	.72–1.08	.15	.07–.22	7.7***	
Crisis stabilization (N=231)						230
Rurality (average RUCC among counties within CCBHC service area)	3.11	2.76–3.45	2.19	1.56–2.81	2.54*	
Population (in CCBHC service area)	1,088,159	795,752–1,380,567	1,177,049	853,159–1,500,939	−.40	
Black (rate per population within CCBHC service area)	.09	.08–.11	.16	.12–.20	−3.1**	
Hispanic (rate per population within CCBHC service area)	.16	.14–.18	.16	.12–.20	.10	
Poverty rate (N of individuals living at <100% FPL per 1,000 persons within CCBHC service area)	130.7	123.9–137.5	137.8	124.0–151.6	−.91	
Uninsured (rate per 1,000 persons within CCBHC service area)	80.7	74.5–86.9	71.0	58.7–83.2	1.39	
Medicaid enrollment (rate per 1,000 persons within CCBHC service area)	146.7	143.3–150.0	151.6	144.5–158.6	−1.24	
CCBHC employees (rate per 1,000 persons within CCBHC service area)	.84	.67–1.02	.28	.10–.45	4.53***	

[a] Percentages and means were weighted with survey-specific weights. See appendix 2 in the online supplement for details on the weighting scheme. Data for the characteristics of population, Black, Hispanic, and CCBHC employees were not log-transformed. CCBHC, certified community behavioral health clinic; DCO, designated collaborating organization; FPL, federal poverty level; RUCC, rural-urban continuum code.

* $p<0.05$, ** $p<0.01$, *** $p<0.001$.

the local crisis service environment. A partnership suggests that CCBHCs may be tapping into existing resources rather than building duplicative service capacity. Direct delivery, on the other hand, may indicate that no other crisis provider in the community delivers crisis services in line with CCBHC requirements or that existing crisis providers do not have sufficient capacity to meet the full demand for crisis services, leading the CCBHC to supplement the existing crisis infrastructure.

Differences in the structure of CCBHC Medicaid initiatives and the CCBHC expansion grant program shed light on the finding that clinics that received a CCBHC Medicaid bundled payment were more likely to have added a mobile crisis response and crisis stabilization after CCBHC

TABLE 3. Characteristics associated with clinics that added crisis services before or after becoming a CCBHC[a]

	Added service after becoming a CCBHC		Offered service before becoming a CCBHC			
Service type and characteristic	M	95% CI	M	95% CI	t	df
Crisis call line (N=198)						197
Rurality (average RUCC among counties within CCBHC service area)	2.71	2.13–3.26	3.19	2.79–3.58	−1.40	
Population (in CCBHC service area)	1,058,697	754,488–1,362,906	999,640	672,534–1,326,747	.26	
Black (rate per population within CCBHC service area)	.11	.08–.15	.09	.08–.11	1.20	
Hispanic (rate per population within CCBHC service area)	.16	.12–.20	.15	.13–.18	.33	
Poverty rate (N of individuals living at <100% FPL per 1,000 persons within CCBHC service area)	128.9	118.5–139.2	131.8	123.8–139.8	−.45	
Uninsured (rate per 1,000 persons within CCBHC service area)	79.3	66.7–92.0	80.58	73.7–87.5	−.17	
Medicaid enrollment (rate per 1,000 persons within CCBHC service area)	153.0	146.1–159.8	145.8	141.8–149.8	1.79	
CCBHC employees (rate per 1,000 persons within CCBHC service area)	.60	.38–.83	.86	.66–1.06	−1.68	
Mobile crisis response (N=240)						239
Rurality (average RUCC among counties within CCBHC service area)	2.79	2.32–3.26	3.06	2.67–3.45	−.88	
Population (in CCBHC service area)	1,262,192	873,300–1,651,084	889,762	630,373–1,149,152	1.57	
Black (rate per population within CCBHC service area)	.11	.09–.13	.11	.09–.12	.20	
Hispanic (rate per population within CCBHC service area)	.15	.12–.18	.16	.14–.18	−.71	
Poverty rate (N of individuals living at <100% FPL per 1,000 persons within CCBHC service area)	133.3	122.2–144.4	130.3	123.7–136.9	.45	
Uninsured (rate per 1,000 persons within CCBHC service area)	71.9	64.0–79.8	82.7	75.4–89.9	−1.97*	
Medicaid enrollment (rate per 1,000 persons within CCBHC service area)	151.1	146.1–156.2	144.8	141.1–148.5	2.00*	
CCBHC employees (rate per 1,000 persons within CCBHC service area)	.69	.49–.89	.79	.58–.99	−.68	
Crisis stabilization (N=231)						230
Rurality (average RUCC among counties within CCBHC service area)	2.68	2.11–3.25	3.03	2.67–3.39	−1.02	
Population (in CCBHC service area)	1,213,935	751,079–1,676,792	1,064,760	774,944–1,354,575	.54	
Black (rate per population within CCBHC service area)	.11	.08–.13	.11	.09–.12	.14	
Hispanic (rate per population within CCBHC service area)	.15	.11–.18	.16	.14–.19	−.83	
Poverty (N of individuals living at <100% FPL per 1,000 persons within CCBHC service area)	121.7	111.5–131.9	135.7	128.4–143.0	−2.21*	
Uninsured (rate per 1,000 persons within CCBHC service area)	68.8	59.5–78.1	82.6	75.8–89.3	−2.36*	
Medicaid enrollment (rate per 1,000 persons within CCBHC service area)	150.5	143.9–157.0	146.5	143.1–149.9	1.05	
CCBHC employees (rate per 1,000 persons within CCBHC service area)	.68	.45–.90	.77	.57–.95	−.55	

[a] Percentages and means were weighted with survey-specific weights. See appendix 2 in the online supplement for details on the weighting scheme. Forty-nine responses were missing to the question whether an organization added a crisis call line after becoming a certified community behavioral health clinic (CCBHC). Data for the characteristics of population, Black, Hispanic, and CCBHC employees were not log-transformed. FPL, federal poverty level; RUCC, rural-urban continuum code.

* $p<0.05$.

designation. Because the CCBHC Medicaid bundled payment model is designed to provide a sustainable financial foundation for the service line expansions necessary to fulfill CCBHC criteria, particularly resource-intensive ones such as provision of crisis services, clinics receiving their state's CCBHC Medicaid bundled payment may be more financially secure, enabling them to launch and sustain new mobile crisis response and crisis stabilization capacity. In contrast, the CCBHC expansion grants may primarily attract applicants that already offer these services because the lump sum awards do not provide sufficient financial resources to support the costs of launching and sustaining new crisis services.

If this explanation is valid, planned expansions of CCBHC Medicaid bundled payments may increase the availability of crisis care, although our study did not investigate whether

TABLE 4. Odds of demographic, socioeconomic, and organizational characteristics being associated with CCBHCs offering crisis services directly and adding crisis services after becoming a CCBHC[a]

	Provided service directly (reference: via a DCO)		Added service after becoming a CCBHC (reference: before)	
Service and characteristic	AOR	95% CI	AOR	95% CI
Crisis call line				
Rurality (average RUCC among counties within CCBHC service area)	.83	.57–1.21	.99	.72–1.35
Population (in CCBHC service area)	.73	.46–1.16	1.45	.88–2.39
Black (rate per population within CCBHC service area)	.58	.33–1.03	1.16	.66–2.03
Hispanic (rate per population within CCBHC service area)	1.53	.77–3.03	.67	.35–1.29
Poverty rate (N of individuals living at <100% FPL per 1,000 persons within CCBHC service area)	1.00	.99–1.01	1.00	.99–1.01
Uninsured (rate per 1,000 persons within CCBHC service area)	.99	.98–1.01	1.01	1.00–1.03
Medicaid enrollment (rate per 1,000 persons within CCBHC service area)	1.01	.99–1.04	1.01	.99–1.02
CCBHC Medicaid bundled payment (reference: no payment)	2.53*	1.02–6.28	1.56	.63–3.87
CCBHC employees (rate per 1,000 persons within CCBHC service area)	1.00	.77–1.30	1.21	.89–1.66
Mobile crisis response				
Rurality (average RUCC among counties within CCBHC service area)	1.10	.75–1.63	.92	.75–1.15
Population (in CCBHC service area)	1.20	.69–2.08	1.43	.94–2.18
Black (rate per population within CCBHC service area)	.50	.25–1.01	.74	.48–1.13
Hispanic (rate per population within CCBHC service area)	1.05	.55–2.03	.78	.49–1.23
Poverty rate (N of individuals living at <100% FPL per 1,000 persons within CCBHC service area)	1.00	.99–1.01	1.01	1.00–1.02
Uninsured (rate per 1,000 persons within CCBHC service area)	1.00	.98–1.02	1.00	.99–1.01
Medicaid enrollment (rate per 1,000 persons within CCBHC service area)	1.01	.99–1.03	1.01	1.00–1.03
CCBHC Medicaid bundled payment (reference: no payment)	.78	.30–2.05	2.52**	1.28–4.97
CCBHC employees (rate per 1,000 persons within CCBHC service area)	1.46*	1.08–1.98	1.03	.80–1.32
Crisis stabilization				
Rurality (average RUCC among counties within CCBHC service area)	1.06	.78–1.45	1.04	.79–1.36
Population (in CCBHC service area)	1.42	.82–2.48	1.40	.84–2.33
Black (rate per population within CCBHC service area)	.82	.45–1.50	1.22	.67–2.19
Hispanic (rate per population within CCBHC service area)	.94	.50–1.78	1.01	.58–1.74
Poverty rate (N of individuals living at <100% FPL per 1,000 persons within CCBHC service area)	1.00	.99–1.01	.99	.98–1.00
Uninsured (rate per 1,000 persons within CCBHC service area)	.99	.97–1.01	1.00	.99–1.01
Medicaid enrollment (rate per 1,000 persons within CCBHC service area)	.99	.97–1.01	1.00	.99–1.02
CCBHC Medicaid bundled payment (reference: no payment)	.62	.23–1.71	3.19**	1.51–6.72
CCBHC employees (rate per 1,000 persons within CCBHC service area)	1.60**	1.17–2.19	1.24	.92–1.66

[a] Multivariable logistic regression models were weighted with survey-specific weights. See appendix 2 in the online supplement for details on the weighting scheme. Forty-nine responses were missing to the question whether an organization added a crisis call line after becoming a certified community behavioral health clinic (CCBHC). All models contained region as a fixed effect (i.e., Northwest, Midwest, South, and West) to account for potential regional patterns in crisis service systems. Data for the characteristics of population, Black, Hispanic, and CCBHC employees were log-transformed to address data skew. Appendix 4 in the online supplement reports the regression results based on the original forms of the four log-transformed independent variables, and appendix 5 reports the regression results without the region fixed effect. Both appendixes are consistent with the results shown here. DCO, designated collaborating organization; FPL, federal poverty level; RUCC, rural-urban continuum code.

* $p<0.05$, ** $p<0.01$.

this increase is sufficient for meeting crisis care needs. Although the site-specific CCBHC bundled rate reflects the projected need for crisis care (and other needs) according to the CCBHC community needs assessment—completed before the clinic receives CCBHC designation—our data and analysis did not assess whether the addition of crisis services led to a small or a substantial change in crisis care access for the CCBHC population. Previous and future expansions of CCBHC Medicaid bundled payments—such as the Bipartisan Safer Communities Act (Public Law 117–159) expanding the current 10-state Section 223 demonstration program by 10 states every 2 years beginning in 2024 (35) and the 2024 addition of a crisis per diem or monthly rates for mobile crisis response and crisis stabilization services to the Section 223 prospective payment system (24, 36)—provide opportunities for researchers to evaluate whether these payments alone or in combination with other policies sufficiently increase access to crisis care.

Recently, the federal government has invested other Medicaid resources in behavioral health crisis care. For context, federal law does not require that Medicaid programs cover crisis care, but states use a variety of "building blocks"—such as state options, waivers, and federal administrative matching funds—to add these services as a Medicaid benefit (33, 37). As of 2022, Medicaid directors from 22 states and Washington, D.C., reported that their Medicaid programs for adult beneficiaries covered crisis hotlines, and 33 and 28 states reported coverage of mobile crisis response and crisis stabilization, respectively (34). State stakeholders should explore whether and how recent federal investments in Medicaid crisis services,

including the 5-year 85% enhanced Medicaid match for mobile crisis response, can work in partnership with CCBHC Medicaid bundled payments to support the expansion of crisis care (21, 22, 38).

This study had several limitations. First, our findings revealed whether specific CCBHCs provide any amount of crisis services but did not indicate whether this amount was sufficient to meet the access needs of the populations a clinic serves. Second, our analysis explored associations between clinics' delivery and addition of crisis services and the characteristics of the clinics and the counties they serve; however, these associations cannot imply any causal relationships. Third, available data for most of our independent variables preceded our dependent variables by 1 or 2 years; thus, our analysis examined relationships between earlier versions of many of the exposure variables and our outcomes of interest. Fourth, the landscape of CCBHCs has evolved since this survey was administered in 2022, including through the addition of 128 new CCBHC expansion grants in 2023. Consequently, our results may not be generalizable to the CCBHC landscape today. However, these findings serve as a useful benchmark for comparison with results capturing CCBHCs operating under different policy contexts, including recent and planned federal and state investments affecting CCBHCs and crisis services (21, 24, 36).

CONCLUSIONS

Officials across different levels of governments have proposed using CCBHCs as an integral component of improving robust crisis systems (21–24), particularly given the growing need for crisis services resulting from 988 implementation (14). Our findings suggest that CCBHC initiatives, particularly CCBHC Medicaid bundled payments, might be effective tools for increasing the availability of mobile crisis response and crisis stabilization services, although the sufficiency of this increase for meeting crisis care needs remains unknown. As the program expands, future research will provide additional insights into how CCBHC initiatives increase access to and the quality of behavioral health crisis services.

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