



**Cost Savings Associated with Certified Community
Behavioral Health Clinics (CCBHC)**

Joint Chairmen's Report of 2025 (Page 172)

Maryland Department of Health

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| Glossary of Key Abbreviations | |
|--------------------------------------|--------------------------------------------------------------|
| Abbreviation | Definition |
| ASO | Administrative Services Organization |
| ASPE | Assistant Secretary for Planning and Evaluation |
| BHA | Behavioral Health Administration |
| BHASO | Behavioral Health Administrative Service Organization |
| BSCA | Bipartisan Safer Communities Act |
| CAA | Consolidated Appropriations Act |
| CCBHC | Certified Community Behavioral Health Clinic |
| CCBHC-E | Certified Community Behavioral Health Clinic Expansion grant |
| CMS | Centers for Medicare & Medicaid Services |
| COLA | Cost-of-living adjustment |
| DY | Demonstration Year |
| FFP | Federal Financial Participation |
| FFS | Fee-for-service |
| FMAP | Federal Medical Assistance Percentage |
| FY | Fiscal Year |
| JCR | Joint Chairmen's Report |
| M&S | Myers and Stauffer |
| MEI | Medicare Economic Index |
| MH | Mental Health |
| MMIS | Medicaid Management Information System |
| OMHC | Outpatient mental health clinic |
| PAM | The Protecting Access to Medicare Act |

| Glossary of Key Abbreviations | |
|--------------------------------------|-----------------------------------------------------------|
| Abbreviation | Definition |
| PPS | Prospective Payment System |
| QBP | Quality Bonus Payment |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SB | Senate Bill |
| SOSA | Scope of services activities |
| SUD | Substance Use Disorder |

Executive Summary

Pursuant to the requirements of the 2025 Joint Chairmen's Report, the Maryland Department of Health (the Department) completed this assessment of the fiscal implications, feasibility, and potential cost savings associated with implementing Certified Community Behavioral Health Clinics (CCBHCs) in Maryland. Specifically, the report evaluates anticipated implementation costs, prospective payment methodologies, comparative experience from other states, expected impacts on utilization and outcomes, and data and evaluation capacity.

The CCBHC model, established under Section 223 of the Protecting Access to Medicare Act (PAMA) and expanded through subsequent federal legislation, is designed to ensure access to coordinated comprehensive behavioral health care. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age. States participating in the CCBHC Demonstration commit to paying for the delivery of services for Medicaid participants. While sites must serve all individuals who request care, states are not obligated to reimburse sites for services delivered to individuals not enrolled in Medicaid. The CCBHC Demonstration requires sites to provide an expansive array of behavioral health services, including some that may not be covered by non-Medicaid payers.

The CCBHC model is supported by a cost-based Prospective Payment System (PPS) for Medicaid participants. The CCBHC PPS is designed to finance the full scope of CCBHC core services, including care coordination, 24/7 access to care, and multidisciplinary team-based care, which can be difficult to support under fee-for-service payment models.

In 2023, Senate Bill (SB) 362 mandated the Department to apply for the CCBHC Planning Grant for Fiscal Year 2025 (FY25) and for inclusion in the state CCBHC four-year Demonstration program for FY26. Maryland was awarded a one-year CCBHC Planning Grant on December 31, 2024, and subsequently received a no-cost extension through December 30, 2026. Building on ongoing Planning Grant activities, Maryland has submitted its application to participate in the 2026 CCBHC Demonstration. At the time of this report, Substance Abuse and Mental Health Services Administration (SAMHSA) has not yet announced awardees for the Demonstration.

The fiscal impact of implementing CCBHCs is expected to be \$6.2 million in General Funds (GF) in Demonstration Year 1 (DY1) for two sites. Within the CCBHC model, states have no obligation to offset costs for uncompensated care for individuals not enrolled in Medicaid. As such, clinics face uncompensated care costs from serving uninsured individuals and individuals with non-Medicaid insurance (i.e. commercial, Medicare, Veterans Health Administration) that may not reimburse for the full scope of services provided by CCBHCs. While the Department anticipates that some costs may be offset by commercial payers reimbursing for services they already cover, clinics will not be made whole by commercial reimbursement and general funds may still be needed.

The report estimates the fiscal impact under two implementation pathways in Maryland: Pathway A, Two-CCBHC Sites across 4 years proposed in the Demonstration application, and Pathway B, a phased expansion of up to five sites by Demonstration Year 4 (DY4). Across both pathways, total DY1 costs are estimated at \$12.8 million, with \$5.8 million in federal funding available for Medicaid-eligible services. Over four years, total Demonstration costs will range from \$57.3 million to \$85.2 million. The State's GF exposure is projected between \$27.8 million and \$41.9 million.

The potential general fund impact varies depending on the payment model for individuals not enrolled in Medicaid. The bottom-line Total General Funds (GF) in Table 1 illustrate the estimated total fiscal impact for the State, including State Medicaid match and residual costs for uninsured individuals and non-Medicaid populations not fully reimbursed by third-party payers (commercial insurers, Medicare, and VHA).¹

¹ These figures are estimates as of April 24, 2026. Total fiscal impact has been reduced from estimates shared with the General Assembly during the 2026 legislative session. Additional assumptions are discussed further in Section III of the Report.

Table 1. Estimated CCBHC Demonstration Fiscal Impact Summary²

| Cost Category | DY1 (Both Pathways: 2 Sites) | Pathway A: Two Sites Over 4 Years | Pathway B: Expansion up to 5 Sites by DY4 |
|--------------------------------------------------------------------------|------------------------------------|-----------------------------------------|-------------------------------------------------|
| Estimated CCBHC Demonstration Cost | \$12,793,731 | \$57,338,153 | \$85,195,812 |
| Total cost for Medicaid individuals | \$8,865,807 | \$39,599,214 | \$57,706,693 |
| <i>Federal Share (65%)</i> | <i>\$5,827,111</i> | <i>\$25,941,169</i> | <i>\$37,711,030</i> |
| <i>State Match Share (35%)</i> | <i>\$3,038,696</i> | <i>\$13,658,046</i> | <i>\$19,995,663</i> |
| Total Cost for Non-Medicaid Individuals | \$3,927,924 | \$17,738,938 | \$27,489,119 |
| Financing for Non-Medicaid Costs | | | |
| <i>Commercial Payer (15.4% Market Share, 30% Service Costs Covered)</i> | <i>\$606,023</i> | <i>\$2,736,865</i> | <i>\$4,241,178</i> |
| <i>Medicare (2.9% Market Share, 20% of Service Costs Covered)</i> | <i>\$112,226</i> | <i>\$506,827</i> | <i>\$785,403</i> |
| <i>VHA (2.1% Market Share, 15% of Service Costs Covered)</i> | <i>\$84,170</i> | <i>\$380,120</i> | <i>\$589,053</i> |
| <i>Uninsured (20.0% Market Share)</i> | <i>\$785,585</i> | <i>\$3,547,788</i> | <i>\$5,497,824</i> |
| Potential Financial Gap (59.6%) | \$2,339,920 | \$10,567,339 | \$16,375,661 |
| Total CCBHC Costs (TF) | \$12,793,731 | \$57,338,153 | \$85,195,812 |
| <i>Federal Funds (FF) (Medicaid Only)</i> | <i>\$5,827,111</i> | <i>\$25,941,169</i> | <i>\$37,711,030</i> |
| <i>Non-State Dollars (Commercial, Medicare, VHA)</i> | <i>\$802,419</i> | <i>\$3,623,812</i> | <i>\$5,615,634</i> |
| Total State General Funds (GF) (Medicaid Match + Uninsured + Gap) | \$6,164,201 | \$27,773,172 | \$41,869,148 |

Finally, this report discusses the experience of other states. National evaluations conducted by the U.S Department of Health and Human Services' Assistant Secretary for Planning and Evaluation (ASPE) indicate that CCBHC Demonstration outcomes have varied across states. While some states experienced reductions in hospitalizations and increased access to outpatient behavioral health services, impacts on emergency department (ED) use, quality measures, and overall Medicaid costs were mixed. In some states evaluated, increases in outpatient and ambulatory utilization were not fully offset by reductions in inpatient care, resulting in higher total Medicaid spending. These findings highlight the importance of a deliberate, evidence-informed approach as Maryland evaluates the potential fiscal and system impacts of CCBHC participation.

² Total CCBHC Demonstration Costs include all daily service costs, administrative staffing, BHASO expenses, and rebasing costs.

I. Introduction

Pursuant to the requirements of the 2025 Joint Chairmen’s Report (JCR, page 172), the Maryland Department of Health (the Department) respectfully presents this report to assess fiscal implications, feasibility, and potential cost savings associated with investing in CCBHCs, as well as opportunities to leverage federal funding. The Department has submitted its application to participate in the CCBHC Demonstration, which is subject to review and approval by SAMHSA. The Joint Chairmen’s Report requires that the report include the following information:

- anticipated implementation costs to participate in the Demonstration program and a description of the methodology used to estimate these costs;
- potential payment for services, including prospective payment methodologies;
- a cost benefit analysis of the CCBHC model that includes potential cost savings related to emergency department visits and potentially avoidable hospital utilization, as well as improved health outcomes for CCBHC participants;
- data collection and analytic needs under the model;
- CCBHC implementation costs and cost savings in other U.S. states;
- description of impact on funding, service delivery, and types of services provided by Maryland CCBHCs currently in operation, should the federal SAMHSA Planning and Demonstration grants not be pursued; and
- impact on eligibility to participate in the planning and Demonstration grant program in the future, should the current SAMHSA award not be accepted.

The CCBHC Demonstration was established by the Protecting Access to Medicare Act (PAMA) of 2014 (Public Law 113-93)³, and has been expanded and extended by the 2022 Bipartisan Safer Communities Act (BSCA) (Public Law 117-159).⁴ The Consolidated Appropriations Act (CAA) of 2024 (Public Law 118-42)⁵ created a permanent state plan option for state Medicaid programs to implement CCBHCs at 1905(a)(31).

The CCBHC Demonstration is not a grant program; rather, it authorizes states to receive an enhanced federal match when paying a prospective payment system (PPS) for outpatient behavioral health centers that are certified by the state to provide the nine services required by PAMA:

- Crisis behavioral health services
- Outpatient mental health and substance use services
- Person- and family-centered treatment planning
- Community-based mental health care for veterans
- Peer supports, peer counseling, and family/caregiver supports
- Targeted case management

³ <https://www.congress.gov/bill/113th-congress/house-bill/4302>

⁴ <https://www.congress.gov/bill/117th-congress/senate-bill/2938/text>

⁵ <https://www.congress.gov/bill/118th-congress/house-bill/4366>

- Outpatient primary care screening and monitoring
- Psychiatric rehabilitation services
- Screening, diagnosis and risk assessment

Within the PPS, the CCBHC receives a payment for each day or month that a Medicaid patient receives one of these nine core services. CCBHCs must provide services to anyone seeking help for mental health or substance use conditions, regardless of ability to pay, age, or place of residence. CCBHCs must also meet federal requirements,⁶ as well as any additional requirements determined by the state, regarding staffing, availability and accessibility of services, care coordination, scope of services, quality and other reporting, and organizational authority and governance.

States may enter the CCBHC Demonstration, and receive federal matching funds at the state's enhanced Children's Health Insurance Program (CHIP) rate (65% in Maryland), by first applying to SAMHSA and the Centers for Medicare & Medicaid Services (CMS) for a CCBHC Medicaid Planning Grant. After the completion of a Planning Grant, states may then apply for entrance to the CCBHC Demonstration; the Bipartisan Safer Communities Act authorized the selection of up to ten additional states to participate in the Demonstration every two years, beginning July 1, 2024. States added to the Demonstration through the BSCA are allowed 16 fiscal quarters in the Demonstration, when they are allowed to claim the enhanced match rate. As created by the CAA, states now have the option of pursuing a Medicaid state plan amendment to permanently authorize CCBHCs.

While SAMHSA and CMS jointly administer the CCBHC Demonstration, SAMHSA also provides CCBHC Expansion (CCBHC-E) grants to support providers in delivering comprehensive 24/7 access to community-based mental health (MH) and substance use disorder (SUD) services. These grants are designed to help providers establish CCBHC programs, meet CCBHC criteria, improve existing CCBHC programs, and cover the costs of uncompensated care. Notably, CCBHC-E Grantees must self-attest to meeting the National CCBHC Certification criteria; however, SAMHSA does not require that grantees undergo the certification process required of CCBHCs within state Demonstrations. CCBHC-E grantees are permitted to continue applying for SAMHSA funding after their first award period, and after entering a state Demonstration.

CCBHC History in Maryland

In October 2015, the U.S Department of Health and Human Services (HHS), through SAMHSA, awarded CCBHC Planning Grants to Maryland and other states as a first cohort to support the development of proposals to participate in the Medicaid CCBHC Demonstration. During the 2015 - 2016 planning period, Maryland assessed operational readiness, provider capacity, certification requirements, and fiscal implications associated with implementing the CCBHC

⁶ <https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf>

model. However, due to operational concerns and cost requirements discovered through the Planning Grant, the state withdrew its application and did not pursue the Demonstration. Specifically, the Department was concerned that substance use disorder (SUD) providers would have been unable to meet the certification requirements and be unable to compete to become a CCBHC within the timeframe of the Demonstration.⁷

Beginning 2018, Maryland behavioral health providers received SAMHSA CCBHC-E Grants to support service expansion and alignment with federal CCBHC criteria. Participation in the Expansion Grant program is based on provider self-attestation and does not constitute state certification. Expansion grantees do not operate under the Medicaid CCBHC PPS system and are not subject to state-led certification or rate-setting processes. From 2018 through 2024, Maryland providers listed in Table 2 below received Expansion Grant funding for at least one year.

Table 2. CCBHC Expansion Grant-Funded Sites in Maryland⁸

| Provider | Locations |
|---------------------------------------------------------------------------|-------------------------------------------|
| Arundel Lodge, Inc. | Anne Arundel County |
| Cornerstone Montgomery, Inc.* | Montgomery County |
| Healthport (formerly Lower Shore Clinic Inc)* | Dorchester, Somerset, Wicomico, Worcester |
| Montgomery County Maryland | Montgomery County |
| Sheppard Pratt Health System (funded at Mosaic Community Services, Inc.)* | Baltimore City, Baltimore County |
| Volunteers of America Chesapeake, Inc.* | Baltimore City, Prince George’s County |
| Gaudenzia | Baltimore City |

*Four providers operating at five sites across Maryland received funding in 2023 or 2024.

Under the SAMHSA CCBHC-E grants, participating providers attest to delivering outpatient mental health and substance use disorder services, care coordination, and crisis-related support consistent with CCBHC service expectations. These providers are enrolled in Maryland Medicaid and continue to receive fee-for-service (FFS) Medicaid reimbursement for covered services; the Expansion Grants supplement, rather than replace, existing Medicaid payments. However, because grant funding is time-limited and not tied to a comprehensive, cost-based PPS, service scope, consistency, and sustainability may vary across providers. According to the

⁷ https://dlslibrary.state.md.us/publications/JCR/2019/2019_103-104.pdf

⁸ <https://www.samhsa.gov/grants/grants-dashboard>

Community Behavioral Health Association of Maryland, the CCBHC-E grantees have used these funds for a wide range of activities,⁹ including the following:

- Cornerstone Montgomery: Added Nurse Care Navigators and translation services
- Sheppard Pratt: Expanded care coordination and access to primary care
- Healthport: Expanded Assertive Community Treatment (ACT) and 7-day access
- Volunteers of America: Psychiatric Urgent Care
- Gaudenzia: Expanded reach in high-need urban areas

In 2023, Senate Bill (SB) 362 mandated the Department to apply for the CCBHC Planning Grant for Fiscal Year 2025 (FY25) and for inclusion in the state CCBHC four-year Demonstration program for FY26. Maryland was awarded a one-year CCBHC Planning Grant on December 31, 2024, and subsequently received a no-cost extension through December 30, 2026.

Building on ongoing Planning Grant activities, Maryland submitted its application to participate in the 2026 CCBHC Demonstration on March 31, 2026. At the time of the drafting of this report, SAMHSA has not yet announced awardees for the 2026 CCBHC Demonstration. If awarded, Maryland would be required to implement coverage and PPS payment for CCBHC services no later than July 1, 2027. Participation in the Demonstration requires provision of services through at least two sites, one of which must be located in a rural area.

II. CCBHC Payment Model and Rate Design

As a part of Planning Grant activities, the Department has elected to implement the CCBHC prospective payment system using the PPS-1 model, a clinic-specific daily rate methodology. Under PPS-1, a CCBHC receives a fixed daily reimbursement for any day a Medicaid beneficiary receives PPS-triggering services, covering the expected cost of all CCBHC-required services provided that day. This daily bundled rate is analogous to the payment model used by Federally Qualified Health Centers, ensuring clinics have predictable funding to support comprehensive care. States may also incorporate Quality Bonus Payments (QBP) into PPS-1 to reward clinics that meet performance benchmarks, although these bonuses are optional under the daily-rate model.¹⁰ The Department favors PPS-1 for its simplicity and alignment with CCBHC's focus on integrated, whole-person care, as it incentivizes clinics to provide a full continuum of services each day without regard to individual fee-for-service (FFS) billing. Feedback from a stakeholder meeting held in October 2025 similarly indicates support for the PPS-1 model based on its relative ease of implementation.

As part of Maryland's application to participate in the CCBHC Demonstration, the Department developed provisional PPS-1 rates informed by provider-submitted cost and visit data that have

⁹

https://mgaleg.maryland.gov/meeting_material/2026/hlt%20-%20134140271751715017%20-%20CCBHC%20impact%20-%20Maryland%20%28CBH%29.pdf

¹⁰ [CCBHC Prospective Payment System \(PPS\) & Quality Bonus Payments \(QBPs\)](#)

undergone preliminary State review but have not yet been fully validated. In addition, CCBHC certification is currently provisional, and both rates and participating providers may change following completion of Planning Grant validation and certification activities, expected to conclude by December 30, 2026.

Federal guidance allows several alternative CCBHC payment models, highlighted in this report for contrast. The PPS-2 model offers a monthly bundled rate (instead of daily) and requires additional adjustments like outlier payments for high-cost cases and mandatory quality bonuses. Newer options (PPS-3 and PPS-4) also use daily or monthly rates but integrate special higher rates for crisis services and other features. These alternatives can provide more complex financing structures (for example, monthly rates can include separate payments for high-need populations or costly episodes). However, the Department selected PPS-1 due to its straightforward daily structure and flexibility – any needed enhancements (such as higher rates for crisis care or quality incentives) can be layered onto the PPS-1 foundation if necessary. This approach minimizes administrative complexity during the startup phase, is aligned with stakeholder preference, and mirrors what many other states have successfully implemented.

Maryland’s Rate-Setting Approach

The Department is taking concrete steps to design and implement the PPS-1 model. The Department has contracted Myers and Stauffer (M&S), a national Medicaid rate-setting contractor, to support PPS rate development, cost-report training, and readiness assessment.¹¹ A standardized cost report template (created by CMS¹²) is being used to collect detailed expense data from candidate clinics. The Department has drafted and approved the scope of services and activities (SOSA) and the state certification standards (aligned with SAMHSA’s CCBHC criteria) that will be used by M&S to inform cost reporting and rate setting. PPS-1 rates will be finalized for Demonstration Year 1 (DY1) and updated in accordance with federal requirements. Rates will be rebased in DY2 based on new cost reports reflecting actual cost and visit information from DY1, and in DY3 based on actual DY2 cost and visit data. In DY4, PPS rates will be updated using the Medicare Economic Index (MEI) inflation factor.¹³

III. Implementation Plan and Anticipated Implementation Costs

This section outlines the State’s anticipated timeline, assumptions, and estimated fiscal impact for implementing the CCBHC Demonstration over a four-year period. For purposes of estimating anticipated implementation costs, this report evaluates two implementation pathways in Maryland: Pathway A, two CCBHCs operating across all demonstration years as proposed in the Demonstration application; and Pathway B, a phased expansion, beginning with two sites and

¹¹ <https://myersandstauffer.com/areas-of-expertise/certified-community-behavioral-health-clinics-planning-grant/>

¹² <https://www.medicaid.gov/medicaid/financial-management/certified-community-behavioral-health-clinic-ccbhc-Demonstration/ccbhc-cost-reporting>

¹³ [Section 223 Certified Community Behavioral Health Clinic Demonstration Prospective Payment System \(PPS\) Guidance](#)

expanding to 5 by Demonstration Year 4 (DY4). The analysis in this section also details the total projected costs and federal and state Medicaid matching requirements for each. Finally, the Department also modeled the costs of non-Medicaid individuals to illustrate the State’s estimated General Fund exposure and potential savings.

Proposed Implementation Timeline and Assumptions for Cost Estimation

To provide context for the pathways and financial projections detailed below, it is important to first outline the State’s anticipated implementation timeline and the baseline assumptions used to build these models.

Per federal guidance, the CCBHC Demonstration operates as a four-year initiative during which states implement, refine, and evaluate the CCBHC model and PPS structure. Maryland is actively engaged in preparatory activities funded by the CCBHC Planning Grant. These activities are already underway and key milestones in 2025-2026 include:

- **Establishing a CCBHC steering committee and stakeholder workgroups**, with regular monthly meetings. The Department’s Office of Health Care Financing (Medicaid) and the Behavioral Health Administration (BHA) have been working with providers, advocates, and consumers to help shape the program design.
- **Completing planning grant requirements and finalizing operational plans.** The Department has developed and approved the SOSA and is developing certification criteria and processes aligned with SAMHSA’s updated criteria to ensure a clear pathway for existing clinics to become state-certified CCBHCs. The Department has also engaged M&S to support the development of cost reporting requirements and to collect cost reporting data from providers to inform PPS rates.¹⁴ By the end of 2026, the Department expects to have selected the initial cohort of CCBHC sites. Medicaid and BHA have also been working with the relevant teams and Carelon to build out and update the Medicaid Management Information System (MMIS) and Carelon systems to accommodate CCBHC billing, including shadow billing.

If SAMHSA awards a Demonstration Grant to Maryland, the Department anticipates services would begin July 1, 2027. State fiscal years (SFY) would align with the Demonstration Years (DY) as follows:

¹⁴ <https://myersandstauffer.com/areas-of-expertise/certified-community-behavioral-health-clinics-planning-grant/>

| <i>Table 3. Demonstration Year and State Fiscal Year Alignment</i> | |
|--------------------------------------------------------------------|------------------------------------|
| Demonstration Year (DY) | State Fiscal Year (SFY) |
| DY1 | SFY28 (July 1, 2027-June 30, 2028) |
| DY2 | SFY29 (July 1, 2028-June 30, 2029) |
| DY3 | SFY30 (July 1, 2029-June 30, 2030) |
| DY4 | SFY31 (July 1, 2030-June 30, 2031) |

CCBHC Demonstration Cost Estimation Assumptions

Cost estimates are based on the Department’s preliminary modeling and assumptions described below. These include assumptions related to payer mix, third-party reimbursement, and uncompensated care, and are informed by utilization data from existing Maryland CCBHC expansion grantees, federal guidance, and national experience from other Demonstration states.¹⁵

1. **Number of participating CCBHCs:** For purposes of cost estimation, the Department used two CCBHCs operating across all four Demonstration years for Pathway A. In Pathway B, the Department assumes two CCBHCs in DY1 and DY2, expanding to three CCBHCs in DY3, and scaling up to five CCBHCs by DY4.
2. **Utilization baseline:** FY24 utilization data from the Hilltop Institute for a CCBHC-E provider is used as the baseline for Medicaid-eligible and visit-days per client. Based on Hilltop data, the clinic served 1,226 unique Medicaid CCBHC clients with an average of 7.6 Medicaid CCBHC visit-days per client.
3. **Client growth:** An average of 15 percent increase in PPS-triggering client visit-days is assumed in DY1, reflecting early implementation ramp-up and expanded service availability permitted under federal CCBHC guidance and observed in national evaluations by Assistant Secretary for Planning and Evaluation (ASPE). Annual growth of 5 percent is assumed in DY2 - DY4, consistent with stabilization trends reported in later Demonstration years.¹⁶
4. **Payment model:** Maryland will use the PPS-1 daily rate model. CCBHC service costs are calculated on an inclusive cost basis covering all required services provided to Medicaid, non-Medicaid, and uninsured clients; federal Medicaid matching funds are

¹⁵ These cost estimates have been updated as of April 24, 2026. The two adjustments reflect 1) changing the source for the payer mix (Assumption 7) from BHA data on crisis services to the payer mix observed in other states, as reported in the 2024 ASPE Report, to better reflect non-Medicaid payers; and 2) updating uncompensated care and third-party reimbursement (Assumption 8) to include partial payment by commercial plans, Medicare, and VHA. Overall, these adjustments do not change the state share for Medicaid clients and administrative costs, but lower General Fund requirements for non-Medicaid clients compared to the original analysis.

¹⁶ [CCBHC Annual ASPE Report 2024](#)

claimed only for the Medicaid beneficiaries. For estimation purposes, an average daily rate of approximately \$320 (2024 dollars) is assumed, consistent with recent Demonstration state experience.¹⁷ Actual PPS rates will be established through the formal cost reporting and rate-setting process.¹⁸

5. **Rebasing:** Rates will be rebased in DY2 and DY3 using actual cost and visit data from prior demonstration years (i.e., DY1 for DY2 and DY2 for DY3). Following the submission and review of cost reports, final PPS-1 rates will be established and applied retroactively, with reconciliation performed as necessary to align payments with the rebased rates. In DY4, PPS rates will be established by trending each providers' DY3 rate using the MEI, consistent with federal requirements and standard practice. The maximum estimated cost of rebasing PPS rates is assumed to be \$162,990, based on M&S costs included in the CCBHC Planning Grant.¹⁹
6. **Inflation:** Interim PPS-1 rates for DY2 and other following DYs will be developed by applying the MEI to prior DY PPS rates. For modeling purposes, PPS rates are assumed to increase annually by 3 percent, consistent with MEI-based updates between rebasing periods. In addition, administrative staffing and oversight costs are assumed to increase by 2 percent annually to reflect average cost-of-living adjustments (COLA).
7. **Payer mix:** The 2024 ASPE Report on the federal evaluation of the CCBHC Demonstration provides the payer mix for six original Demonstration states for DY 1-5: Minnesota, Missouri, New Jersey, New York, Oklahoma, and Oregon.²⁰ To estimate Maryland's costs, the Department's analysis uses the average DY1 payer mix of Minnesota, New Jersey, New York, and Oregon. Missouri and Oklahoma are excluded because as of DY1 (2017-2018), these states had not yet expanded Medicaid, and therefore had higher uninsured populations than can be expected in Maryland. As such, this JCR report assumes the following payer mix:
 - 65% Medicaid clients
 - 7% uninsured clients
 - 18% commercially insured clients
 - 5% Medicare clients
 - 5% VHA and others
8. **Uncompensated Care and Third-Party Reimbursement:** CCBHCs are required under PAMA Section 223 (a)(2)(B) to provide services regardless of payer or ability to pay.

¹⁷ Provisional rates for the Demonstration application were similar to the average used for this report: Healthport- \$318.50, Sheppard Pratt- \$349.34, Volunteers of America- \$385.42.

¹⁸ PPS rate average for FY2025 from four states ([Michigan](#), [Missouri](#), [New York](#), and [Illinois](#))

¹⁹ This amount reflects a conservative, maximum estimate. While the Planning Grant estimate was based on supporting up to ten clinics, the Department anticipates only two certified CCBHCs in DY1 and DY2. Actual rebasing costs may therefore be lower; however, costs are not necessarily proportional to the number of participating clinics. No inflation adjustment is applied, as the assumed amount represents a not-to-exceed estimate for rebasing during the Demonstration period.

²⁰ Office of the Assistant Secretary for Planning and Evaluation (ASPE). CCBHC Demonstration Program: Report for Congress, 2024.

https://aspe.hhs.gov/sites/default/files/documents/6bd57531905262229d08148d6754b2a/CCBHC%20AnnualReport_2024%20Final%20Cleared%20Version%207%2030.pdf

However, Medicaid reimbursement is only available for services provided to Medicaid-eligible individuals.²¹ As a result, services delivered to non-Medicaid populations, including uninsured and underinsured individuals, may not be fully reimbursed, leaving the cost burden to be borne by CCBHCs.

Within the CCBHC model, there are two sources of uncompensated care: services provided to uninsured individuals, and services provided to individuals with commercial insurance, Medicare and VHA that are not fully reimbursed. Because non-Medicaid payers are not required to pay CCBHCs the full PPS rate, CCBHCs typically bill these payers on a fee-for-service basis. While commercial insurance plans may cover certain behavioral health services when medically necessary, reimbursement levels vary and are not standardized. In particular, components of the required CCBHC service array, such as care management, peer support services, crisis services, and psychiatric rehabilitation services, are not consistently covered or fully reimbursed by commercial insurers. In Maryland, Insurance Code Section 15-802 (2025) requires plans to provide inpatient benefits, partial hospitalization, and outpatient and intensive outpatient benefits for the diagnosis and treatment of a mental illness, emotional disorder, drug use disorder, or alcohol use disorder when medically necessary.²² However, because more prescriptive requirements for commercial plans do not exist in Maryland, coverage of specialty behavioral health services varies across plans.

States are not obligated to mitigate the costs of uncompensated care, which CCBHCs are required to absorb as “bad debt.”²³ However, to ensure the sustainability of the model, many states have acted to share the cost of uncompensated care. State legislatures have the ability to mandate that commercial insurers reimburse CCBHCs at their PPS rate or provide coverage of these services. New York passed legislation requiring commercial insurers to pay CCBHCs their PPS rates, effective January 1, 2025.²⁴ During the 2026 Maryland legislative session, SB 738 proposed a similar mandate requiring commercial insurers to provide coverage for mobile crisis and crisis stabilization services; however, this bill did not advance out of committee.²⁵ Legislation mandating commercial plans to pay CCBHCs their full PPS rates would reduce the burden of uncompensated care on both CCBHC providers and the State. Additionally, to address uncompensated care costs for serving uninsured individuals, other states, such as Minnesota, Georgia, Texas, and Kansas, provide state-only funds.²⁶ The CCBHCs themselves may mitigate

²¹ <https://www.medicaid.gov/medicaid/financial-management/downloads/updated-ccbh-pps-guidance-02152024.pdf>

²² <https://mgaleg.maryland.gov/mgaweb/laws/StatuteText?article=gin§ion=15-802>

²³ <https://www.samhsa.gov/sites/default/files/ccbhc-demonstration-application-2026.pdf>

²⁴ <https://omh.ny.gov/omhweb/bho/commercial-billing-resources-for-certified-community-behavioral-health-clinics.pdf>

²⁵ <https://mgaleg.maryland.gov/2026RS/bills/sb/sb0738F.pdf>

²⁶ CCBHC State Technical Center (March 19, 2026). Managing CCBHC Uncompensated Care.

<https://acrobat.adobe.com/id/urn:aaid:sc:VA6C2:75a8acfc-0643-4d80-ad6c-41d7567065ee>

uncompensated care costs by applying for grant funding, including SAMHSA CCBHC-E grants.²⁷

To estimate third-party reimbursement, the Department conducted a crosswalk analysis comparing services covered by commercial insurance plans in Maryland²⁸ (e.g., individual market Kaiser Silver plan), Medicare, and VHA against the nine core CCBHC services using HCPCS codes. Three out of eight core CCBHC services are partially or fully covered by these payers. The ninth core CCBHC service, related to veterans, was excluded from the crosswalk analysis because Maryland does not currently have codes specific to that category on its scope of services and activities (SOSA). After weighting each service's estimated relative cost contribution, the Department assumes that commercial payers will reimburse approximately 30 percent of the PPS cost, Medicare will reimburse 20 percent, and VHA will reimburse 15 percent. These expected reimbursement rates are relatively low because higher-cost CCBHC services, such as crisis response, care coordination, and psychiatric rehabilitation, are not consistently reimbursed under fee-for-service models. This assumption reflects the experience of providing care to the uninsured and underinsured through Maryland's Public Behavioral Health System, which indicates that commercial coverage does not fully reimburse the comprehensive scope of CCBHC-required services.

The remaining costs, specifically the full costs for the uninsured population and the financial gap left by partial third-party reimbursement, are assumed to be covered by General Funds through the Behavioral Health Administration (BHA) payment system. This aligns with the current BHASO model, which uses state-only dollars to cover this population at the equivalent Medicaid rate.

9. **Federal match rates:** A 65 percent Federal Medical Assistance Percentage (FMAP) is assumed for CCBHC PPS service payments, 50 percent FMAP for administrative costs including rebasing costs, and 75 percent FMAP for BHASO-related costs. Federal match is only applicable to Medicaid participants.
10. **Administrative staffing:** DY1 staffing includes two Health Policy Analysts and one Administrator III, consistent with program oversight and reporting needs.
11. **BHASO costs:** \$1.2 million total funds per Demonstration year will be required for BHASO to implement necessary system changes and support staff required to oversee and monitor CCBHC billing, claims processing, and program operations.

Pathway A: Two CCBHCs Operating Across Four Years of the Demonstration

This pathway represents the primary implementation approach, reflecting exactly the model the Department submitted in Maryland's CCBHC Demonstration application. This section evaluates

²⁷ <https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/expansion-grants>

²⁸ <https://mgaleg.maryland.gov/mgawebsite/laws/StatuteText?article=gin§ion=15-802>

the anticipated CCBHC Demonstration costs assuming two CCBHCs operating across all four Demonstration Years.

Under this model, the Department projects the total estimated Demonstration cost over the four-year period to be \$57.3 million in total funds. Costs are expected to increase from approximately \$12.8 million in DY1 to \$15.8 million in DY4, driven by standard patient growth and inflationary adjustments. Of the \$57.3 million total cost, federal Medicaid matching funds are projected to cover \$25.9 million, requiring \$13.7 million in State Medicaid match. The remaining \$17.7 million in costs are attributed to care for non-Medicaid individuals. Table 4 below details the comprehensive, year-by-year cost breakdown for this baseline pathway.

Table 4. Pathway A: Estimated CCBHC Costs for the Two-Site Baseline Proposed in the Demonstration

| Cost Category | DY1 (2 sites) | DY2 (2 sites) | DY3 (2 sites) | DY4 (2 sites) | 4-Year Total Cost |
|-------------------------------------------------------------|----------------------|----------------------|----------------------|----------------------|--------------------------|
| CCBHC Service Costs for Medicaid individuals | \$7,294,716 | \$7,889,235 | \$8,532,208 | \$9,227,583 | \$32,943,743 |
| Administrative Staffing and Oversight | \$371,091 | \$378,513 | \$386,083 | \$393,805 | \$1,529,492 |
| BHASO Costs | \$1,200,000 | \$1,200,000 | \$1,200,000 | \$1,200,000 | \$4,800,000 |
| Rebasing Costs | \$0 | \$162,990 | \$162,990 | \$0 | \$325,980 |
| Total Medicaid Costs | \$8,865,807 | \$9,630,738 | \$10,281,281 | \$10,821,388 | \$39,599,214 |
| <i>Federal Match</i> | <i>\$5,827,111</i> | <i>\$6,298,754</i> | <i>\$6,720,472</i> | <i>\$7,094,831</i> | <i>\$25,941,169</i> |
| <i>State Match</i> | <i>\$3,038,696</i> | <i>\$3,331,984</i> | <i>\$3,560,809</i> | <i>\$3,726,556</i> | <i>\$13,658,046</i> |
| Total costs for non-Medicaid individuals at PPS rate | \$3,927,924 | \$4,248,050 | \$4,594,266 | \$4,968,699 | \$17,738,938 |
| Total Estimated CCBHC Cost | \$12,793,731 | \$13,878,788 | \$14,875,547 | \$15,790,086 | \$57,338,153 |

Pathway B: Phased Expansion up to Five Sites by DY4

The Department developed a second implementation pathway modeling a phased expansion in the event the State decides to add more sites as the implementation progresses. This approach begins with two sites in DY1 and DY2, expands to three sites in DY3, and scales up to five sites in DY4.

Under this model, the Department projects the total estimated Demonstration cost over the four-year period to be \$85.2 million in total funds. Due to the addition of new clinics, total costs increase significantly in the later years, rising from approximately \$12.8 million in DY1 to \$37.1 million in DY4. Of the \$85.2 million total cost, federal Medicaid matching funds are projected to cover \$37.7 million, requiring \$20.0 million in State Medicaid match. The remaining \$27.5

million in costs are attributed to care for non-Medicaid individuals. Table 5 below details the comprehensive, year-by-year cost breakdown for this expanded pathway.

Table 5. Pathway B: Estimated CCBHC Costs for Phased Expansion up to Five Sites

| Cost Category | DY1 (2 sites) | DY2 (2 sites) | DY3 (3 sites) | DY4 (5 sites) | 4-Year Total Cost |
|-------------------------------------------------------------|----------------------|----------------------|----------------------|----------------------|--------------------------|
| CCBHC Service Costs for Medicaid Individuals | \$7,294,716 | \$7,889,235 | \$12,798,312 | \$23,068,958 | \$51,051,221 |
| Administrative Staffing and Oversight | \$371,091 | \$378,513 | \$386,083 | \$393,805 | \$1,529,492 |
| BHASO Costs | \$1,200,000 | \$1,200,000 | \$1,200,000 | \$1,200,000 | \$4,800,000 |
| Rebasing Costs | \$0 | \$162,990 | \$162,990 | \$0 | \$325,980 |
| Total Medicaid Costs | \$8,865,807 | \$9,630,738 | \$14,547,385 | \$24,662,762 | \$57,706,693 |
| <i>Federal Match</i> | <i>\$5,827,111</i> | <i>\$6,298,754</i> | <i>\$9,493,439</i> | <i>\$16,091,725</i> | <i>\$37,711,030</i> |
| <i>State Match</i> | <i>\$3,038,696</i> | <i>\$3,331,984</i> | <i>\$5,053,946</i> | <i>\$8,571,038</i> | <i>\$19,995,663</i> |
| Total Costs for non-Medicaid Individuals at PPS rate | \$3,927,924 | \$4,248,050 | \$6,891,399 | \$12,421,746 | \$27,489,119 |
| Total Estimated CCBHC Cost | \$12,793,731 | \$13,878,788 | \$21,438,784 | \$37,084,509 | \$85,195,812 |

Financing Non-Medicaid Costs

As highlighted previously, CCBHCs are required under PAMA Section 223 (a)(2)(B) to provide services regardless of payer or ability to pay. However, federal Medicaid matching funds cannot be used for non-Medicaid individuals.²⁹ Building on this federal guidance and the Department’s estimates of non-Medicaid costs under Pathway A and Pathway B, this report analyzes costs attributed to non-Medicaid individuals to illustrate the potential fiscal impact on State General Funds.

Based on the third-party reimbursement assumptions detailed earlier in this report, this analysis assumes that commercial payers will reimburse approximately 30 percent of the PPS cost, Medicare will reimburse 20 percent, and the VHA will reimburse 15 percent. This limited reimbursement leaves a significant potential financial gap, the remaining costs – including the full cost of care for uninsured individuals – covered by General Funds through the Behavioral Health Administration (BHA) payment system, consistent with the current BHASO model.

Under Pathway A, Table 6 below shows that the total non-Medicaid cost over four years is \$17.7 million. Because third-party payers cover only \$3.6 million of this amount, an estimated \$14.1 million in General Funds through the BHA would be required – covering both the full cost of care for uninsured individuals (\$3.5 million) and the shortfall left by under-reimbursing payers

²⁹ <https://www.medicaid.gov/medicaid/financial-management/downloads/updated-ccbhc-pps-guidance-02152024.pdf>

(\$10.6 million). Under the expanded Pathway B, total non-Medicaid costs reach \$27.5 million. With partial third-party coverage accounting for just \$5.6 million, the projected General Fund requirement would be \$21.9 million over the four-year Demonstration.

Table 6. Financing Non-Medicaid Costs: No Commercial Insurance Mandate, by Pathway

| Cost Category | Pathway A (Two-Site Baseline) | Pathway B (Five-Site Expansion) |
|-------------------------------------------------------------------|------------------------------------------|--------------------------------------------|
| <i>Commercial Payers</i> | \$2,736,865 | \$4,241,178 |
| <i>Medicare</i> | \$506,827 | \$785,403 |
| VHA | \$380,120 | \$589,053 |
| <i>Total Non-State Dollars (Commercial, Medicare, VHA)</i> | \$3,623,812 | \$5,615,634 |
| Uninsured | \$3,547,788 | \$5,497,824 |
| Remaining Costs Not Covered by Payers | \$10,567,339 | \$16,375,661 |
| <i>General funds covered through BHA</i> | \$14,115,127 | \$21,873,485 |
| DY1 General Funds (2 Sites) | \$3,125,505 | \$3,125,505 |
| DY2 General Funds (2 Sites) | \$3,380,234 | \$3,380,234 |
| DY3 General Funds (Pathway B Expands to 3 Sites) | \$3,655,723 | \$5,483,585 |
| DY4 General Funds (Pathway B Expands to 5 Sites) | \$3,953,664 | \$9,884,161 |
| Total Non-Medicaid Costs Over 4 Years | \$17,738,938 | \$27,489,119 |

IV. CCBHC Implementation Costs and Cost Savings in Other U.S. States - Comparative Evidence

Since 2018, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at HHS has submitted Annual Reports to Congress on the CCBHC Demonstration.³⁰ The 2024 Report to Congress (published in summer 2025) provides the first impact evaluation of the CCBHC Demonstration on service use, quality-related outcomes, and costs over time in three original Demonstration states with high-quality Medicaid data.³¹ The evaluation utilized Medicaid claims and encounter data in Minnesota, Nevada, and Oklahoma to conduct a longitudinal difference-in-differences analysis, which compared the outcomes of Medicaid participants who visited a CCBHC to Medicaid participants who visited a similar behavioral health clinic, or care as usual. ASPE’s evaluation showed mixed results on utilization of hospital, emergency

³⁰ <https://aspe.hhs.gov/reports/ccbhc-Demonstration-program>

³¹Office of the Assistant Secretary for Planning and Evaluation (ASPE). CCBHC Demonstration Program: Report for Congress, 2024.

https://aspe.hhs.gov/sites/default/files/documents/6bd575319052622229d08148d6754b2a/CCBHC%20AnnualReport_2024%20Final%20Cleared%20Version%207%2030.pdf

department (ED) and ambulatory care, and found that the Demonstration has not significantly impacted quality metrics. Further, participation in the Demonstration is associated with increased costs to states.

The impact evaluation showed mixed results. For utilization, the analysis examined changes in hospitalizations, emergency department (ED) visits, and ambulatory visits. The results regarding utilization are summarized in Table 7; the Demonstration resulted in decreased hospitalizations in Nevada and among some groups in Oklahoma, increased ED visits in Minnesota and Oklahoma, and increased behavioral-health ambulatory visits in Minnesota and Nevada.

| <i>Table 7. CCBHC Demonstration Impact on Utilization from the 2024 ASPE Report</i> | | | |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| | Minnesota | Nevada | Oklahoma |
| Hospitalizations | No impact | 23% decrease in all-cause hospitalizations | 15% decrease among adults, 19% decrease among people with SUD; 20% increase among children and adolescents |
| ED Visits | 3% increase in beneficiaries with any ED visit (may be due to COVID-19) | No statistically significant impact; some evidence of decrease in ED visits | 7% increase in the percentage of beneficiaries with any ED visit |
| Ambulatory Visits | 4% increase in behavioral health-related ambulatory visits; 6% decrease in physical health-related ambulatory visits | 19% increase in behavioral-health ambulatory visits | N/A (not included in analysis) |

The Demonstration largely did not impact the assessed quality measures. In Oklahoma, the Demonstration was associated with improvement in antidepressant medication management. However, for the remaining measures across the three states, which included adherence to antipsychotics for individuals with schizophrenia, follow-up after hospitalization for mental illness, follow-up after emergency department visit for mental illness, and follow-up after emergency department visit for alcohol and other drug abuse or dependence, the Demonstration was not associated with statistically significant impacts.

The analysis on costs, which included Nevada and Oklahoma, found that the Demonstration was associated with increased total Medicaid costs. In Nevada, the Demonstration was associated with an increase in average total costs of \$132 per beneficiary per month for CCBHC clients (borderline statistically significant), with an average increase of \$109 per beneficiary per month for all-cause ambulatory visits and an average increase of \$119 per beneficiary per month in

behavioral health-related ambulatory costs. In Oklahoma, the Demonstration was associated with an average increase of \$208 per beneficiary per month in total average costs, driven by an average increase of \$201 per beneficiary per month in behavioral health-related ambulatory costs. While the Demonstration was associated with some decreased inpatient costs in Nevada and Oklahoma, these savings did not offset increases in ambulatory costs.

Ultimately, the ASPE Report impact evaluation does not show that the CCBHC Demonstration leads to cost savings or improvements in the quality of care during the first five years of the Demonstration. The ASPE Reports currently serve as the best source of information in predicting the impacts of entering the CCBHC Demonstration. SAMHSA does not publish an independent evaluation on the impacts of SAMHSA CCBHC-E grantees. The Department continues to monitor the federal evaluation and engage in technical assistance with SAMHSA, CMS, the National Council for Mental Wellbeing, and other states to learn about best practices and developments in other states.

Other states and organizations have undergone independent analyses of their states' CCBHC Demonstrations. The most comprehensive evaluations have been published by Oregon (January 2025)³² and Michigan (June 2025).³³ These analyses continue to show mixed results.

In Oregon, CCBHC clients had mixed performance on quality measures compared to non-CCBHC mental health clients, with CCBHCs performing better on initiation and engagement of SUD treatment services, follow-up from mental illness hospitalization, and mental illness ED visits, and worse on antidepressant medication management and adherence to antipsychotic medications for individuals with schizophrenia and plan all-cause readmissions. The CCBHC population experienced greater utilization of inpatient and ED visits, although the CCBHC population saw greater declines of physical health inpatient stays and smaller growth in physical health ED visits relative to the non-CCBHC population. When comparing "high behavioral health needs"³⁴ CCBHC vs non-CCBHC users, Oregon found higher utilization but greater improvements across CCBHC population, which translated to savings of \$7 million. These savings do not offset the additional costs of the Demonstration. From 2021-2023, Oregon spent \$61.3 million on CCBHC services. While CCBHCs had higher per-member-per-month costs, Oregon indicated that CCBHCs held the potential to contain future cost growth.

Michigan's analysis focused on service utilization and access to care, and did not provide cost data. Compared to non-CCBHC community mental health center clients, CCBHC clients saw an increase in access to care and in utilization of all core behavioral health services. Overall, ED utilization was higher among CCBHC clients, but saw larger decreases in utilization than the

³²

https://www.oregon.gov/oha/ERD/SiteAssets/Pages/Government-Relations/CCBHC%20SB%205525%20Report-final%20version_14Jan2025.pdf

³³ <https://chrt.org/wp-content/uploads/2025/07/CCBHC-Report-FINAL-060225-.pdf>

³⁴ The Oregon Health Authority defined "high behavioral health needs" populations as having 10 or more clinic visits in a 12-month period, and the presence of an SUD or higher-acuity MH diagnosis.

comparison group. ED utilization declined 2.4% when comparing ED utilization before and after each individual received CCBHC services.

Other notable evaluations include Missouri’s annual CCBHC Impact Reports,³⁵ published by the Missouri’s Behavioral Health Council, and a 2022 analysis of New York’s CCBHC Demonstration conducted by Health Management Associates on behalf of the New York State Council for Community Behavioral Healthcare.³⁶ Missouri’s most recent Year 7 Impact Report (2024) shows significant improvements in access to care, hospital and ED utilization, and value-based measures among the CCBHC population, but these results are not compared to a control group, and cost data is not included. For the New York analysis, Health Management Associates calculated the amount that the state would need to reduce ED costs in order to break even for the CCBHC Demonstration. Their analysis demonstrated that the state achieved cost savings using publicly available data; as such, this report did not utilize patient-level data.

At this time, the Department has not included data from the Maryland CCBHC-E Grantees in its analysis. As the CCBHC-E Grantees have completed a wide range of activities under their SAMHSA grants (see Section I for grant activities), any changes observed may be due to variation in interventions implemented by the providers. While these steps reflect progress towards offering the full scope of CCBHC services, the SAMHSA Expansion Grants do not require providers to implement the full suite of service delivery changes as required of Demonstration CCBHCs. The Department will collect data on the services offered by the CCBHC-E Grantees and changes in utilization, outcomes, and cost-savings regarding their clients as part of the certification process as the Department continues to complete its Planning Grant activities. Further, if the State is awarded the Demonstration, the Department will conduct an evaluation of the CCBHC model that includes impacts on quality measures, utilization of emergency departments, in-patient hospital stays, and ambulatory care, and cost savings to the state. To allow for full claims runout, the Department anticipates that the first results of this evaluation will be available 18 months after the start date of the Demonstration. The Department will also contribute to the federal ASPE evaluation of the CCBHC Demonstration as required by SAMHSA.

V. Expected CCBHC Impact and Cost-Benefit Analysis in Maryland

Entering the CCBHC Demonstration could offer benefits for the State. The CCBHC model’s PPS will introduce a new funding model for integrated behavioral health services designed to be a stable funding source for services such as care coordination. Furthermore, the State will be eligible to receive the enhanced federal match rate for the duration of the Demonstration (up to 16 fiscal quarters). The Demonstration may also improve access to care and strengthen the services offered by outpatient mental health centers through the obligation to serve anyone in

³⁵ <https://dmh.mo.gov/certified-community-behavioral-health>

³⁶ <https://nyscouncil.org/wp-content/uploads/2023/01/NYSCCBH-CCBHC-financial-analysis-for-distribution-20221219-1.pdf>

need, expanded hours of service, the provision of crisis stabilization services and certification in new evidence-based practices. In addition, the Demonstration may increase capacity for the CCBHC workforce, improving staff development, performance, and retention.³⁷ Finally, the Demonstration could reduce hospitalizations among CCBHC clients. As part of the Planning Grant activities, the Department is collecting data on the services offered by the CCBHC-E Grantees and changes in utilization, outcomes, and cost-savings regarding their clients, which will inform future cost saving analyses. Further, if the State is awarded the Demonstration, the Department will conduct an evaluation of the CCBHC model that includes impacts on quality measures, utilization of emergency departments, in-patient hospital stays, and ambulatory care, and cost savings to the state.

The CCBHC Demonstration also poses risks for the State. In comparison to states with more limited behavioral health service arrays prior to entering the CCBHC Demonstration, Maryland already provides Medicaid coverage of most of the core services included in the CCBHC model. While the enhanced federal match will be available for the Demonstration, the increases in costs observed in other states suggest that Maryland may be obligated to increase spending for community-based behavioral health services.

At this time, data from Maryland's CCBHC-E Grantees are not included in this analysis, as these grants do not require full implementation of the CCBHC services and payment model. As a result, outcomes from expansion grantees are not directly comparable to those expected under the Demonstration.

VI. Data, Evaluation, and Accountability Framework

Under the CCBHC model, states need to implement a comprehensive data, evaluation, and accountability framework to ensure compliance with federal CCBHC requirements, support program oversight, and inform continuous quality improvement throughout the Demonstration period. This framework aligns required federal and state reporting measures with existing Medicaid and behavioral health data infrastructure to minimize administrative burden while ensuring timely, accurate reporting.

Required Federal and State Reporting Measures

Certified CCBHCs are required to report all federally mandated CCBHC quality, access, and cost measures, including those related to access to care, service utilization, care coordination, quality outcomes, and patient experience, consistent with CMS and SAMHSA guidance (see Appendix A for required CCBHC state and clinic-collected measures). The Department will ensure its ability to collect all required measures by the start of the Demonstration and that participating providers are accountable. The Department may incorporate additional measures over time, as appropriate, with CMS and SAMHSA approval. In addition, the State will collect data necessary

³⁷ <https://aspe.hhs.gov/sites/default/files/documents/45e1fc72fef2004eb05a40162214f6e8/CCBHC-Report-Congress-2025.pdf>

to support Medicaid claiming, PPS rate monitoring, rebasing, and any legislative reporting requirements. Reporting expectations should be incorporated into certification standards and provider agreements. The Department already reports on all of the CCBHC required measures, either through the CMS Core Set, or through routine BHA surveying. CCBHC-E grantees currently must report on required clinic-level measures as a part of their SAMHSA grant terms.

Maryland Data Systems and Analytics Capacity

The Department can leverage existing data systems and analytic resources to support evaluation and oversight, including the MMIS and Carelon (ASO) systems for encounter and utilization data, with analytic support from the Hilltop Institute. These systems will be used to process claims and monitor service utilization, costs, access patterns, and quality trends for both Medicaid and non-Medicaid CCBHC clients. To the extent feasible, data submitted by participating CCBHC providers should be integrated with existing systems to support consistent, statewide analysis.

The Department will also leverage the Chesapeake Regional Information System for our Patients (CRISP), Maryland's statewide health information exchange, as part of its broader data and analytics infrastructure supporting program oversight and evaluation. These systems also support the Department's ability to expand reporting over time, as needed, consistent with federal requirements.

VII. Risks, Alternatives, and Mitigation Strategies

Impact on Funding, Service Delivery, and Services Provided

If the CCBHC Demonstration is not awarded, current CCBHC-E grantees could continue to rely on a combination of fee-for-service Medicaid reimbursement and SAMHSA grant funding to sustain existing services. SAMHSA has confirmed that all current CCBHC-E grantees can re-apply for future rounds of Expansion Grants. In the absence of a CCBHC demonstration, the Department could continue to strengthen existing services delivery approaches, including 1915(i) services for children and youth, targeted case management in outpatient mental health clinics (OMHCs), mobile treatment services, and ASO-supported care coordination models. In addition, the Department will implement the cost-based rate setting process as a part of the HOPE Act, which will potentially increase rates across the state for all community-based behavioral health providers.

Impact on Future Eligibility and Mitigation

As Maryland has submitted its application for the CCBHC Demonstration, the Department will continue to assess readiness and implementation considerations during the ongoing Planning Grant period. Participation in the Demonstration is contingent upon federal approval and completion of certification and rate-setting activities. The Department currently anticipates a

Demonstration start date of July 1, 2027, and retains flexibility to adjust the implementation timeline as needed, subject to federal approval. Upon approval, the Department would proceed with the Demonstration in accordance with federal requirements, and any changes to the approved approach would require CMS and SAMHSA approval. This phased planning approach supports mitigation of fiscal and operational risks while ensuring that the implementation is informed by data, stakeholder input, and Demonstration readiness.

VIII. Conclusion

National evaluations indicate that, while CCBHC implementation has expanded access to care in participating states, impacts on utilization and costs have varied and are influenced by state-specific implementation approaches, service utilization patterns, and payer mix. These findings suggest that outcomes depend significantly on program design, financing structure, and local delivery systems.

Maryland's current behavioral health financing structure supports a broad range of outpatient and crisis services. Preliminary analysis indicates that implementation of a CCBHC Demonstration would involve State fiscal responsibility, with federal Medicaid matching funds projected to support only a portion of total costs during the Demonstration period. With Maryland's Demonstration application submitted, the Planning Grant period provides the Department with an opportunity to further assess affordability, sustainability, and operational readiness, and to refine key policy and financing decisions in advance of potential implementation.

Appendix A: Required CCBHC State and Clinic-Collected Measures

| 1. Behavioral Health Clinic, Clinic-Collected Required Measures | |
|-----------------------------------------------------------------------------------------|-----------------------------|
| Measure Name | Measure Abbreviation |
| 1) Time to Services | I-SERV |
| 2) Depression Remission at Six Months | DEP- REM-6 |
| 3) Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling | ASC |
| 4) Screening for Social Drivers of Health | SDOH |
| 5) Screening for Clinical Depression and Follow-Up Plan | CDF-AD and CDF-CH |

| 2. Behavioral Health Clinic, State-Collected Required Measures | |
|---------------------------------------------------------------------------------------------------------------|-----------------------------|
| Measure Name | Measure Abbreviation |
| 1) Patient Experience of Care Survey | PEC |
| 2) Youth/Family Experience of Care Survey | YFEC |
| 3) Antidepressant Medication Management | AMM-AD |
| 4) Use of Pharmacotherapy for Opioid Use Disorder | OUD-AD |
| 5) Adherence to Antipsychotic Medications for Individuals with Schizophrenia | SAA-AD |
| 6) Plan All-Cause Readmissions Rate | PCR-AD |
| 7) Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication (ADD-CH) | ADHD and ADD-CH |
| 8) Hemoglobin A1c Control for Patients with Diabetes | HBDAD |
| 9) Initiation and Engagement of Alcohol and Other Drug Dependence Treatment | IET-AD) |
| 10) Follow-Up After Hospitalization for Mental Illness | FUH-CH and FUH-AD |
| 11) Follow-Up After Emergency Department Visit for | FUM-AD and FUM-CH |

| 2. Behavioral Health Clinic, State-Collected Required Measures | |
|--------------------------------------------------------------------------------------|-----------------------------|
| Measure Name | Measure Abbreviation |
| Mental Illness | |
| 12) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence | FUA-AD and FUA-CH |