

# Mobile Crisis Teams: A State Planning Guide for Medicaid- Financed Crisis Response Services

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## Abbreviations Used in this Document

<b>AHCCCS</b>	Arizona Health Care Cost Containment System
<b>ARPA</b>	American Rescue Plan Act of 2021
<b>BH-ASO</b>	Behavioral Health Administrative Service Organization (Washington)
<b>CCBHC</b>	Certified Community Behavioral Health Clinic
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>CSU</b>	Crisis Stabilization Unit
<b>DBHDD</b>	Department of Behavioral Health and Developmental Disabilities (Georgia)
<b>ESP</b>	Emergency Services Program (Massachusetts)
<b>FMAP</b>	Federal Medical Assistance Percentage
<b>GCAL</b>	Georgia Crisis and Access Line
<b>MBHP</b>	Massachusetts Behavioral Health Partnership
<b>MCO</b>	Managed Care Organization
<b>MCT</b>	Mobile Crisis Team
<b>RBHA</b>	Regional Behavioral Health Authority (Arizona)
<b>SPA</b>	State Plan Amendment
<b>SUD</b>	Substance Use Disorder

For a glossary of terms, please see [Appendix B](#).

## Introduction and Purpose

In many communities, behavioral health crisis response currently consists of a fragmentary array of services rather than a cohesive system. Individuals experiencing acute crisis may touch several separate and often inappropriate systems — 911, first responders, hospital emergency departments, and even jails — without ever receiving adequate behavioral health treatment. Without a comprehensive crisis system, law enforcement personnel and first responders, who are frequently ill-equipped to stabilize the situation, become the default primary responders. Police interaction with individuals experiencing a behavioral health crisis — which refers to a crisis related to an individual’s mental illness and/or substance use disorder (SUD) — increases the likelihood of traumatic and adverse outcomes, such as the individual’s being arrested, handcuffed, imprisoned, involuntarily hospitalized, injured, or even killed.<sup>1</sup>

These detrimental and avoidable outcomes can be extremely adverse for people with behavioral health conditions; and more frequently impact communities of color.<sup>2</sup> In 2018, people with mental illness accounted for 25 percent of all fatalities at the hands of police, with many of those deaths occurring during a response to a mental health emergency.<sup>3</sup> People of color also experience rates of unmet need for mental health services that exceed those of white people.<sup>4</sup> The coronavirus pandemic called widespread attention to these racial disparities in behavioral health care, and this attention, coupled with the racial unrest precipitated by a broken response to community behavioral health emergencies, led to bipartisan legislation to advance behavioral health crisis reform.<sup>5 6</sup> The national legislation and federal investments described below have provided opportunities for states to examine their current crisis services and create in their place a robust system of support for individuals in distress.

- The National Suicide Hotline Designation Act of 2020 mandated a nationwide and easy-to-remember telephone number, 988, that will route calls through National Suicide Prevention Lifeline (NSPL) call centers across the country beginning in July 2022. The 988 line has the potential to create both a centralized access point, and — with careful planning and expansion of services — a comprehensive crisis system.<sup>7</sup>
- The American Rescue Plan Act of 2021 (ARPA) provides a state Medicaid option, through state plan amendment or waiver, for community mobile crisis intervention services for five years. ARPA incentivizes state participation with an 85-percent enhanced Federal Medical Assistance Percentage (FMAP) for the first three years of qualifying services, starting in April 2022.<sup>8</sup> This legislation represents the first time federal law has recognized mobile crisis response as a specific and separate optional Medicaid benefit.
- The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) increased financial investments (\$1.5 billion) in the Community Mental Health Services Block Grant (MHBG) and Substance Abuse and Treatment Block Grant (SABG) programs, with a \$75 million set-aside for crisis services. States are required to dedicate at least five percent of their MHBG to the support of crisis systems for adults or children with behavioral health conditions.<sup>9</sup>

This planning guide offers a review of the requirements of ARPA related to community-based mobile crisis intervention services, and identifies planning considerations for states in developing or refining mobile crisis services that qualify for the enhanced FMAP. While the primary focus is on mobile crisis, this guide also highlights state considerations that will support a more robust crisis continuum, including 988 planning.

## **Mobile Crisis Services, 988, and the Crisis Continuum**

SAMHSA's 2020 national guidelines for behavioral health crisis care emphasize that crisis care should be available to anyone, anytime, anywhere.<sup>10</sup> The three core components of an effective crisis system are 24/7 clinically staffed crisis call centers; 24/7 mobile crisis team (MCT) response in the community to provide assessment and referral; and crisis stabilization units that provide short-term (up to 24 hours) stabilization services in a non-hospital setting.<sup>11</sup> With the impending deadline for 988, many states are rethinking how their crisis systems currently operate and perform. 988 lays the foundation for an effective emergency response system for individuals experiencing behavioral health crisis; while this guide focuses on state planning to expand MCTs within the larger framework of 988, a fully transformed crisis system will require system expansion of all three core foundational components.<sup>12</sup>

MCTs enable individuals to access care in real time through community-based interventions, wherever an individual is located within the community. The use of trained behavioral health professionals allows for connection to appropriate intervention and resources, and to more effective community stabilization, in the least restrictive setting possible.<sup>13</sup> An overall cost-benefit analysis indicates that mobile crisis services reduce community cost by decreasing unnecessary hospitalizations, reducing hospital readmissions, diverting behavioral-health-related arrests for individuals in acute crisis, and connecting individuals to ongoing supports to deter future crises.<sup>14</sup> Currently, the availability of community-based MCTs is inconsistent, there is wide variability in services provided to individuals in distress, and MCTs do not guarantee that an individual who needs access to treatment gets it. Access to services can be limited by lack of available services, an individual's refusal of treatment, lack of integration of MCT into upstream services, or other extenuating circumstances. Strong state leadership is needed to ensure not only availability, but also quality and consistency of MCT in order to promote the best outcomes.

## **Medicaid Mobile Crisis Team Opportunity under ARPA**

Some states and localities have longstanding mobile crisis programs, and prior to the passage of ARPA, 35 states covered MCT through Medicaid.<sup>15</sup> States can and do cover MCT through a range of Medicaid authorities, including the rehabilitative services option, Home and Community Based Services (HCBS) under 1915(i) and 1915(c) waivers, managed care waivers, and comprehensive section 1115 demonstrations.<sup>16 17</sup> In addition, under Medicaid Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) provisions, children and youth under 21 enrolled in Medicaid are entitled to any treatment or procedure that is covered under federal Medicaid law if that treatment or service is necessary to "correct or ameliorate" a child's physical and behavioral health conditions. This applies to mobile crisis as well as other services.<sup>18</sup>

The new ARPA mobile crisis provision is distinct from these longstanding authorities. States that meet ARPA requirements<sup>19</sup> are eligible to receive an 85-percent federal matching rate, the enhanced FMAP, for state spending on mobile crisis services. States with existing programs may refine them to meet the requirements in order to qualify for the enhanced matching rate, or these states can maintain their existing programs under other Medicaid authorities without the benefit of the enhanced matching rate. States must receive approval from the Centers for Medicare and Medicaid Services (CMS) to offer MCT under the ARPA provision. For states that wish to take up this new optional benefit to qualify for the 85-percent FMAP, the funds need to supplement, not supplant, the level of state spending for MCT services in the fiscal year before the first quarter in which a state elects this option.<sup>20</sup> In order to qualify for the enhanced FMAP, MCT services must meet the requirements outlined in the sidebar.

To support states in creating structures for mobile crisis services through this option, CMS awarded \$15 million in planning grants to 20 state Medicaid agencies.<sup>21</sup> These one-year planning grants will be used to support states in developing, preparing for, and implementing MCT under this Medicaid program. States can use planning grant dollars to assess current services, enhance capacity, strengthen information systems, train MCT staff, and receive technical assistance in the development of state plan amendments, waiver program requests, or demonstration applications.<sup>22</sup> In December 2021, CMS issued additional guidance for state planning which has been incorporated into this planning guide.

## Report Methodology

To inform the development of this guide, the Technical Assistance Collaborative, with support from the California Health Care Foundation and Schusterman Family Philanthropies, conducted an environmental scan of five states — Arizona, California, Georgia, Massachusetts, and Washington — and a study of national best practices in crisis response. The best practices and recommendations offered here for standing up or enhancing community mobile crisis

## Mobile Crisis Team Requirements for the 85-Percent Enhanced Federal Medical Assistance Percentage under ARPA

Under **Section 9813 of the American Rescue Plan Act**, MCT services must be in the community, rather than a hospital setting, and must be provided to individuals experiencing a mental health or substance use disorder crisis. Mobile crisis teams must:

- Consist of a 24/7 multidisciplinary team that includes one or more behavioral health care professionals or paraprofessionals with behavioral health expertise. Multidisciplinary teams can consist of nurses, social workers, psychiatrists, peer support specialists, or other behavioral health specialists.
- Provide screening and assessment; stabilization and de-escalation; and coordination with and referrals to health and social support services in a timely manner.
- Ensure staff is trained in trauma-informed care, de-escalation, and harm reduction strategies.
- Maintain relationships with relevant community providers, such as primary care providers, behavioral health providers, crisis respite providers, community health care facilities, and managed care organizations.
- Maintain privacy and confidentiality of information consistent with federal and state requirements.

ARPA grants states discernment to offer MCT statewide or only in certain areas, to selectively contract with providers, to make MCT available to specific Medicaid populations, and to define parameters for timely response of MCTs.

interventions are gleaned from that research and from key informant interviews with state Medicaid authorities, state and county behavioral health authorities, law enforcement, managed care organizations (MCOs), advocacy organizations, and individuals with lived expertise in each state.

This planning guide describes seven key considerations for state mobile crisis system planning:

- Coordinating triage and dispatch
- Availability and capacity of mobile crisis services
- Mobile crisis staffing and competency
- Integrating mobile services into the crisis continuum of care
- Provider selection, contracting, and monitoring
- Financing that utilizes multiple funding sources
- Protocols and appropriate roles for law enforcement in crisis response

A comprehensive overview of each state’s approach to these planning areas is included in [Appendix A](#).

### State Crisis Funding and Infrastructure Considerations

To provide context, a broad overview of existing crisis services funding and infrastructure in each of the five states reviewed is presented in Table 1.

Table 1: Crisis Funding and Infrastructure in Five States

State	Funding	System Infrastructure
<b>Arizona Health Care Cost Containment System (AHCCCS)</b>	AHCCCS braids Medicaid (capitation rate), local funding, and grants to pay Regional Behavioral Health Authorities (RBHAs) for crisis services for all, regardless of insurance.	As of 2021, AHCCCS contracts with the state’s three RBHAs to provide and oversee all crisis services (call centers, mobile crisis teams [MCTs], and crisis stabilization units) in their respective geographic regions. Regional crisis call centers screen and deploy MCTs within each RBHA region. (There will be a slight system realignment in 2022.)
<b>California Department of Health Care Services</b>	Limited crisis intervention services are covered by a specialty mental health benefit service under Medicaid as a carve-out of comprehensive managed care, and are provided by some counties; however, mobile crisis response services are not yet a Medicaid benefit. 66% of counties with MCTs utilize Medicaid in some capacity.	As of 2021, approximately two-thirds of the 58 counties in California have MCTs of varying design and utilization. California is investing \$2.2B of state funding in the Behavioral Health Continuum Infrastructure Program to award competitive grants to support construction of new facilities or investments in mobile crisis infrastructure.



State	Funding	System Infrastructure
<p><b>Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)</b></p>	<p>Medicaid Administrative Claiming funds the entire crisis system, including MCT.</p>	<p>DBHDD contracts directly with two MCT providers for services in 6 regions encompassing all 159 counties in Georgia. The Georgia Crisis and Access Line (GCAL), a statewide crisis call center hub, screens calls and deploys MCTs statewide using GPS technology and a statewide live bed registry to support MCTs in connecting individuals to stabilization services. The hub also allows access to community behavioral health outpatient content, promoting rapid engagement and coordination post-crisis.</p>
<p><b>Massachusetts Behavioral Health Partnership (MBHP)</b></p>	<p>Emergency Services Programs (ESPs), including MCT, are funded through Medicaid (state plan) and state funds. Youth MCTs are covered under Early Periodic Screening Diagnosis Treatment under the Medicaid state plan.</p>	<p>An interagency agreement between the state mental health authority and the state Medicaid authority, MassHealth, authorizes MassHealth's vendor, MBHP, to manage the provision of crisis services delivered by network ESPs. ESPs deploy their MCTs, and the state has a public-facing statewide bed registry to allow for real-time connection to stabilization services.</p>
<p><b>Washington State Health Care Authority (HCA)</b></p>	<p>HCA locally funds Behavioral Health Administrative Service Organizations (BH-ASOs). HCA requires that MCOs contract with BH-ASOs to fulfill the Medicaid portion. MCOs and BH-ASOs usually agree upon a capitation payment.</p>	<p>The Washington State HCA contracts with BH-ASOs to oversee crisis services. Some ASOs are county-led, reflecting counties' historical role in behavioral health service provision. With 988 planning, the state is moving toward a statewide bed registry and technology-based MCT deployments.</p>

As highlighted in Table 1, important variation exists among the states interviewed in the extent to which Medicaid is currently used to cover crisis services, including MCTs. These five states were selected because of their diverse approaches to design, structure, and financing of crisis services, with emphasis on MCTs. Four of the states (Arizona, Georgia, Massachusetts, and Washington) have longstanding statewide mobile crisis programs with varying levels of coverage and response capability. These states may make modest modifications to their existing programs to meet the requirements of ARPA and to qualify for the enhanced FMAP. California has implemented mobile crisis services in some areas, should it choose to pursue ARPA funding for MCT it will need to make more substantial changes than the other states.

Currently in California, limited crisis intervention services are covered under a specialty mental health benefit and provided by the counties, but mobile crisis is not presently a Medicaid benefit. Historically, counties have had discretion in the structure and implementation of MCTs.

California, like other states, is considering a statewide approach using the ARPA opportunity for enhanced federal funding for MCTs. States with county-driven systems may have additional planning considerations compared to states with a more centralized crisis response system, such as Georgia. California's approach, contrasted with states with longstanding and statewide MCT programs, was included in our review to ensure that recommendations in this planning guide would be relevant to all states regardless of their crisis delivery system structure or pre-ARPA use of MCTs. State leadership plays a critical role in overcoming fragmentation and supporting consistent crisis services across any state. Although many crisis functions are planned and administered by local governments, states lay the groundwork for local implementation through policy-setting, funding, and overseeing the provision of behavioral health crisis services.

## Key Considerations for State Mobile Crisis System Planning

### Coordinating Triage and Dispatch

While there are no direct requirements in ARPA for how to triage crisis calls and dispatch MCT services, this process is the linchpin of an effective crisis system.<sup>23</sup> A strong triage process and rapid connection to MCTs ensures the safety of the individuals in distress and of the staff responding, and is essential for navigating critical situations in a timely manner. MCT services are often embedded in call centers, or work closely with them, to support deployment. Some call centers have the technological capacity to support MCTs in accessing available options for stabilization through connection to a bed registry. Bed registries are up-to-date electronic databases of bed availability in behavioral health settings, including but not limited to public and private psychiatric hospitals, psychiatric bed space within broader hospitals, crisis stabilization beds, crisis respite centers, detoxification units, and recovery homes.<sup>24</sup> While not all states currently have these technological capacities, CMS highlights the best practice of integrating real-time GPS technology between call centers and MCTs. CMS also authorizes Medicaid matching funds to be utilized to support information technology system integration activities for 988.<sup>25</sup>

The states interviewed generally deployed MCTs in one of three ways: via a statewide call center, via regionally based call centers, or via provider-specific call centers that directly dispatch their own teams.

### Centralized Deployment

- The Georgia Crisis and Access Line (GCAL) serves as the state's single National Suicide Prevention Lifeline (NSPL) call center, and is a centralized crisis call center hub that deploys MCTs statewide. Through GPS tracking and monitoring technology, GCAL can identify the closest team for a timely response and connect with teams in the field. GCAL monitors bed capacity through a live bed registry (including detox and stabilization beds) to support mobile teams in facilitating stabilization connections. GCAL uses a brief, scripted screening process, which includes a flag for SUD-related concerns, to deploy mobile teams once medical safety is established. Because of the integrated nature of the hub system, GCAL can identify and deploy existing intensive service resources (such as an Assertive Community Treatment team) that are already engaged with the individual.

### Regional Deployment

- Washington operates regional call centers that coordinate and dispatch MCTs throughout the state. The Washington Health Care Authority currently affords Behavioral Health Administrative Service Organizations (BH-ASOs) discernment in creating their triage and dispatching processes. Washington's 988 bill (HB 1477) identifies plans for technological advancements in 2023 including enhancing its ability to track calls, technologically deploy MCTs, and connect to a statewide bed registry. This legislation also establishes a Tribal behavioral health and suicide prevention line in order to enhance culturally responsive and clinical care for a traditionally underserved population.<sup>26</sup>

- Arizona currently runs three regional call centers which deploy mobile crisis teams. Two Regional Behavioral Health Authorities (RBHAs) utilize the same vendor to technologically dispatch MCT. Starting in fiscal year 2023, after a realignment, Arizona will require use of one centralized crisis line vendor, which must comply with NSPL requirements. Technology, such as GPS enhanced devices that link to the statewide crisis line, will be advanced to deploy and track MCTs and ensure direct communication between MCTs and the call center.

### Provider/Team-Based Deployment

- In Massachusetts, an individual seeking assistance can call the local Emergency Services Program (ESP) number directly to access the MCT. There is also a statewide automated number that, although it is not staffed, provides a centralized number for individuals to call regardless of where they are located and redirects callers to their nearest ESP based on ZIP code. While deployment mechanisms may vary by provider, Massachusetts has a statewide bed registry to support MCTs identifying possible connections to stabilization services while in the field.
- Of the 35 counties that provide MCTs in California, approximately 37 percent dispatch MCTs directly from the sheriff's office, 22 percent through a county access line, and 18 percent from a dedicated crisis line.

### State Planning Recommendations for Triage and Dispatch

An ideal system would embed MCT deployment into a statewide or regional call center, because having a single number leads to less confusion for individuals in crisis, allows for swift connection to the full continuum of crisis care, and ensures timely and accurate communication between crisis call centers and MCTs.<sup>27</sup> However, some states lack call center capacity, many communities have MCT numbers that are known and utilized locally, and other communities have a sparse existing crisis infrastructure. With the vast array of call centers and varying degrees of capacity and training, state planning should start by assessing the current capacity statewide for call centers and response. States need to lay the groundwork by requiring coordination among MCT programs and existing crisis call centers, including NSPL, peer warm lines, locally run crisis lines, 911 Public Safety Answering Points (PSAPs), and law enforcement offices. States and localities may also need to invest in adequate call center capacity and training in order to support staff in knowing when MCT dispatch is required. States can set standards, such as a triage screening script, to guide call center staff in obtaining information and identifying when to initiate a response from an MCT. State planning should assess technological capacity, including but not limited to GPS capabilities; integration with health information technology; capacity to track calls and mobile deployments; and electronic programs for data collection. The majority of states will also need to consider opportunities for standing up or enhancing live bed registries to support MCTs in facilitating community stabilization. Throughout the U.S., 33 states have created or are in the process of creating a live bed registry, including several of the states interviewed for this guide.<sup>28</sup>

States and localities should coordinate with community partners in order to create a successful system of response, and they should begin that process early. In states still considering action steps for 988 implementation, planning efforts should give consideration to the existing crisis continuum including call centers, MCT dispatch, and other crisis system infrastructure which will

support 988 call volume. Legislation can support cross-sector planning by ensuring representation across community stakeholders; currently, however, only 12 states have passed 988 legislation, with varying approaches to planning for its implementation.<sup>29</sup> For example, Washington's HB 1477 requires the formation of cross-sector task forces or committees charged with crisis system planning. This has set the stage for strong collaboration between key stakeholders such as hospitals; law enforcement and other safety personnel; people with lived expertise; MCOs; private insurance companies; and other community partners.<sup>30</sup> Planning efforts should also include state and local entities responsible for supporting the development, deployment, and delivery of MCT services.

## Availability and Capacity of Mobile Crisis Services

ARPA requires that MCT services be delivered in the community, not in hospitals or other facility settings, in order to qualify for the enhanced FMAP. MCTs must be available 24/7 and must provide screening and assessment, de-escalation, and stabilization services.<sup>31</sup> ARPA affords states the autonomy to decide whether to provide a statewide benefit for mobile response or to provide benefits only in certain areas. Recent guidance issued by CMS highlights the preference for response within an hour of call but also affords states the latitude to utilize telehealth options to support mobile crisis assessment and stabilization, which can be particularly effective in supporting geographic accessibility throughout a state.<sup>32</sup>

## Assessment, De-Escalation, and Stabilization

The ability to assess a situation and determine an appropriate intervention to ensure safety and stability is imperative to effective MCT response. SAMHSA's national crisis care guidelines suggest that assessment should consist of a comprehensive biopsychosocial assessment, including but not limited to: collection of psychiatric, substance use, social, familial and legal history as well as an explicit exploration of risk to the individuals or the community.<sup>33</sup> While this is the ideal, several states reported that in implementation, depending on the acuity of symptom presentation and the clinician's focus on treatment and resolution of the crisis, assessment during a critical situation might be an abridged version of a comprehensive assessment.<sup>34</sup> For this reason, many interviewed states afford providers some clinical discernment when assessing. Due to the nature of the work, many of the states interviewed stressed the need for some flexibility around assessments and documentation criteria but also set broad guidance on necessary content for assessment and documentation, such as:

- Assessment of suicidality and homicidality
- Evaluation of risk to self and the community
- Mental status exam and diagnostic impressions
- Exploration of current and historic psychiatric functioning and substance use
- Determination of medical conditions
- Exploration of medications
- Collection of collateral information from family, friends, others as appropriate
- Identification of strengths and supports
- Creation of a crisis plan/Wellness Recovery Action Plan (WRAP)

## Services coverage

Four of the states interviewed (Arizona, Georgia, Massachusetts, and Washington) currently had statewide mobile crisis provision with 24/7/365 coverage. In California, the availability and capacity of MCT varies by county. Based on a survey conducted by the California County Behavioral Health Directors Association<sup>35</sup>, of 52 counties that responded, 35 reported having mobile crisis services. However, most of these did not provide 24/7 coverage. In many areas without 24-hour coverage, individuals with lived experience reported that law enforcement was the only option.

Massachusetts reported that approximately half of its crisis assessments are conducted in a hospital setting. This is likely a cultural issue related to the strength of the “medical model” in the state. The key informants we interviewed believe that the difficulty with shifting their system to assessment in the community was due to the number of prominent hospitals and their affiliations with world-renowned medical schools. In Boston, for example, there are several hospitals within a quarter of a mile of one another, making them an easily accessible option for individuals just walking into a hospital emergency department. Despite adequate community-based resources, this dynamic has resulted in the hospital setting becoming the cultural default for individuals in crisis. Additionally, it was reported that these hospitals have historically struggled with trusting and referring to providers external to their own systems, and have shown discomfort in releasing individuals who may be at risk back into the community for stabilization, even when this might be appropriate. Massachusetts has taken measures to increase community engagements by MCTs, including increasing rates for assessments conducted within the community, and implementing education strategies around hospital diversion and stabilization services.

## Timely Response

All states interviewed regulated response times of providers, with the majority requiring response within an hour of the initial call. Washington defines a maximum response time of two hours for emergent concerns and 24 hours for urgent calls. Arizona and Washington both identified frontier and remote locations as potential challenges for providers. In frontier areas, an MCT may have to travel for hours to reach an individual in crisis, with response time increased by treacherous weather or poor road conditions. Both Washington and Arizona created regionally based systems that support mobile crisis structurally and financially in areas with less population density. CMS’s recent guidance acknowledges the role of telehealth, allowing states to consider telehealth and hybrid strategies to ensure prompt response to acute concerns.

## State Planning Recommendations for Availability and Capacity

States should focus on ensuring crisis intervention and stabilization in the least restrictive setting possible, and should provide guidance on medical necessity to support this process. As Massachusetts noted, state planning for a successful system may require simultaneous community and system shifts, as the default service providers have often been emergency responders and hospital systems. Some advocacy groups reported that the community not within the behavioral health system had limited knowledge of the resources available to individuals experiencing crises, outside of a hospital. States should engage in educational approaches and target key community partners early in the process. Both states and localities need to plan for ongoing collaboration with hospitals, first responders, and community members to promote knowledge of

and trust in MCTs. As crisis capacity builds, and services shift in expectation and scope, states should consider targeted marketing strategies to educate the public.

State planning to define assessment and documentation criteria should allow flexibility for MCTs to focus on treatment and resolution of the crisis in the moment. Additionally, states should consider the best way to allow individuals receiving services to be active participants in the assessment process. One option is psychiatric advance directives (PADs), which allow individuals to legally document their treatment wishes in the event that they are unable to make decisions during a behavioral health crisis. State utilization of PADs would enable individuals in crisis to have a voice in their care, but the capability to make use of this tool will depend on the state's legislation regarding PADs.<sup>36</sup> Currently, only 25 states have statutes regulating use of PADs and in certain states, like Minnesota, regulations require MCT assessments to include the individual's PAD, if applicable.<sup>37 38</sup> In 2020, SAMHSA created a mobile application that allows individuals to create a PAD that is readily accessible via mobile telephone in the event of a crisis.<sup>39 40</sup> States can support legislative efforts to increase access to PADs, and states with statutes should set standards to include PADs in MCT evaluation and crisis stabilization planning, as appropriate.

## Mobile Crisis Staffing and Competency

To qualify for the enhanced FMAP, MCTs must consist of a multidisciplinary team that includes at least one behavioral health care professional qualified under state law to provide assessment within their authorized scope of practice, and other professional or paraprofessional staff with behavioral health expertise. States have latitude to determine the composition of their multidisciplinary teams. All team member training must include de-escalation, trauma-informed care, and harm reduction techniques. To further support harm reduction techniques, CMS advises that MCT teams be equipped with naloxone and harm reduction supplies such as fentanyl strips and suboxone.<sup>41 42</sup>

Staffing and training are key factors in ensuring quality services provision by MCTs. The individuals interviewed for this report who utilized MCTs reported that staff approach and skill at navigating a stressful situation affected the quality of interaction and overall experience with MCTs. The involvement of peer support staff — individuals with lived experience of recovery from a behavioral health condition who are able to provide support to individuals based on their lived expertise<sup>43</sup> — was a key component of developing trust in MCTs. Staffing composition and training requirements were areas where most states interviewed provided precise guidance.

## Staff Composition

Multidisciplinary teams can be built with psychiatrists, nurses, medical doctors, social workers, behavioral health technicians, and peer support specialists. Four of the states interviewed (Arizona, Georgia, Massachusetts, and Washington as well as certain programs in California) currently require that a qualified behavioral health professional (QBHP) be the person conducting or responsible for the assessment, as a QBHP's clinical expertise is conducting comprehensive assessments. Currently, states vary in the way in which they define QBHPs; some states require independent licensure whereas others allow provisionally licensed or license-eligible individuals to conduct the assessment under the supervision of an independently

licensed practitioner. Washington and Georgia encourage MCT providers to utilize peer support staff but the inclusion of peers as team members is not required. In 2022, Arizona will require that 25 percent of all contracted MCTs have a peer specialist. Advocates noted that in addition to peer support, there was significant value in having a family member with lived experience as part of MCTs working with youth, as the whole family is experiencing a crisis and could benefit from the added supports. Georgia enables certified peer specialist parents to be members of MCTs.

### Staff Training and Competency

States interviewed identified some common themes for required training. Beyond the ARPA-required topics of de-escalation, trauma-informed care, and harm reduction techniques, they also included:

- Nonviolent crisis intervention training
- Conflict resolution
- Motivational Interviewing
- Risk management and crisis planning (including WRAP and crisis safety planning tools)
- Cultural awareness/competency and responsiveness
- CPR/First Aid
- Psychiatric medications and side effects

Additionally, states discussed the importance of ensuring MCT members' competency for working with specific populations. The Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry's *Roadmap to the Ideal Crisis System* identifies the need for specialization in working with children and adolescents, older adults, people with intellectual/developmental disabilities, members of cultural and linguistic minorities, people with opioid use disorder, people with eating disorders, and forensic populations.<sup>44</sup> All have unique needs that MCTs should be equipped to handle. Some states utilize specialty teams while other states take a blended approach. Georgia expects all teams to be competent in responding to all individuals above the age of four who are in crisis, regardless of the origin of crisis. To ensure appropriate crisis response to specific subpopulations, Georgia requires a board-certified behavior analyst to be a consultative part of any crisis response to an individual with an intellectual or developmental disorder, and expects a complement of behavior support staff to be accessible for these specific individuals. Massachusetts and Arizona have specialty teams, including youth MCTs, and attempt to respond based on the specific nature of each crisis; however, all MCTs are cross-trained in order to provide prompt response as needed. Cross-training ensures that all MCT staff receive training in rendering culturally appropriate care regardless of the age, race, ethnicity, disability, or crisis of the person in need.

### State Planning Recommendations for Staffing and Competency

Workforce shortages were a major challenge identified by every key informant interviewed. The current behavioral health workforce shortage, which has been exacerbated by the COVID-19 pandemic, may pose a threat to successful implementation of crisis response systems.<sup>45 46</sup> In their planning efforts, states should consider avenues to incentivize workforce development, including loan forgiveness programs for crisis workers and hazard pay enticements. States should consider strategies to enhance workforce supports for all staff, but particularly for their peer workforce due to the critical role they can play in engaging and supporting individuals in crisis.



Washington is creating an online training platform available to peer specialists working in crisis response throughout the state. States can further support peer staff by requiring that direct supervisors participate in ongoing training regarding supervision techniques to fully support peer specialists, or by offering peer supervisors who also have lived expertise. Strategies to support the peer workforce should also address the level of trauma that individuals can face in the day-to-day work. Arizona's Peer and Family Career Academy, whose programs meet the Arizona Health Care Cost Containment System's policy requirements for continued education for peer support specialists, is creating a statewide support network to create peer-to-peer coaching and enhanced supports to allow for personal identification of triggers and to process emotions activated when working as a peer support specialist.<sup>47</sup> This support will enhance workforce resilience for peer and family supporters working within the crisis system and is geared to improve workforce retention. State planning can define the standards for supervision for all staff in order to improve clinical practice and staff retention, as many crisis workers cited emotional support and processing with their supervisor as factors adding to job satisfaction.<sup>48</sup>

State planners should consider the best approaches to ensure competent staff, including standardization of staff training to ensure both that it covers all relevant topics and that it supports culturally competent and clinically appropriate crisis response. Standardizing training can decrease variation within service provision across teams and localities. States should invest in training programs to support initial and ongoing knowledge and skill development among MCT members. States awarded CMS planning grants for mobile crisis can use the funds to train providers and enhance provider capacity.<sup>49</sup> Many states have 988 legislation to establish inter-agency commissions that include legislators and key stakeholders, tasked with creating cross-agency plans to support crisis capacity. States should leverage these collaborations to discuss workforce strategies such as loan forgiveness programs, tuition assistance support, and other initiatives to promote workforce development.<sup>50</sup> An effective emergency mental health response system is cost-effective for the state as it decreases reliance on a public safety response.

States should evaluate the needs of specific populations and set expectations to ensure that MCTs are equipped to provide appropriate care for all. States should employ a mechanism that includes input from individuals and families with lived expertise, to assess population needs and quality of MCT services on an ongoing basis. For example, Arizona has several advisory councils that provide input to enhance the clinical service of crisis teams, including an autism advisory council. From day one, planning for mechanisms to increase staff competency should ensure that individuals with lived expertise and representatives of disadvantaged communities, particularly BIPOC communities, are drivers in system creation and implementation as well as part of the ongoing evaluation. Additionally, states should establish mechanisms to ensure language accessibility to provide culturally appropriate care.

### **Integrating Mobile Services into the Crisis Continuum of Care**

ARPA-qualifying community-based mobile crisis intervention services require coordination with, and referrals to, other needed services and supports, and maintaining relationships with relevant community partners including medical and behavioral health providers, community health centers, crisis respite centers, managed care organizations, and others.<sup>51</sup> MCTs should be part of an integrated system of crisis care and should link individuals to all necessary medical

and behavioral health services to help resolve the current situation and prevent future crises. Inclusion of substance use crisis within the behavioral health service definitions is an essential element in the crisis continuum. MCTs trained in SUD risk assessment are uniquely positioned to respond to substance-use-related crises in the community and to facilitate access to the most appropriate level of care.<sup>52</sup> Crisis stabilization centers, inpatient hospitalization, detoxification facilities, and treatment in the community (e.g., community mental health clinics, opioid treatment programs, in-home therapy, family support services, crisis and peer respite services, and therapeutic monitoring) are important options for crisis care and follow-up.<sup>53</sup> (See [Appendix B](#) for definitions). Successful connection to upstream services (Assertive Community Treatment, intensive home-based therapy, peer support, recovery support services, outpatient SUD treatment, housing services, etc.) assists individuals in maintaining stability in the community and safeguards the crisis system from becoming overwhelmed.

CMS guidance also requires some form of follow-up care within 48 hours, in order to attempt to connect individuals to upstream services. This follow-up care during the transition can bolster the likelihood that the individual will follow through on service referrals. A state's infrastructure can support the efficacy of this process. In Georgia, information from the state's Administrative Services Organizations is integrated into the GCAL system. This enables crisis staff to determine what type of services a person is receiving, and to alert their existing providers to request follow-up. Similarly, in Arizona, each RBHA's centralized call center allows MCTs to access a person's history and behavioral health provider information, if the individual is connected to a managed care organization and has a behavioral health condition. This enables the MCT to ensure efficient follow-up.

Resource limitations may present barriers to accessing the crisis continuum and upstream services. Many of the interviewed states described insufficient crisis stabilization units (CSUs) in communities, particularly in rural areas, and limited CSUs for children specifically. A lack of stabilization services may result in MCTs defaulting to the use of hospital settings, which would undermine the potential of MCTs to prevent unnecessary hospitalizations. Rural counties in California and elsewhere are balancing the desire to create CSUs with the reality that they may not be able to fiscally sustain them due to low population density and intermittent demand. Some states reported occasional delays in service connection caused by provider capacity challenges or waitlists, particularly in remote areas.

### **State Planning Recommendations for Integration into the Continuum of Crisis Care**

To promote MCT efficacy, states should evaluate the existing array of crisis stabilization services and the availability of community-based services to provide ongoing care, and should explore opportunities to enhance both as necessary. Some states have used Certified Community Behavioral Health Clinics (CCBHCs), which provide all-inclusive services, to enhance mobile crisis response, particularly in rural areas, while simultaneously expanding stabilization and upstream services.<sup>54</sup> CCBHCs are positioned to provide comprehensive care in that they operate crisis services but also have the ability to offer same-day access to behavioral health services in a non-hospital setting.<sup>55</sup>

Timely access to upstream services is imperative to promote ongoing health, so states should examine options that incentivize community providers to prioritize appointments and intakes for individuals recently engaged by MCTs. States can also define expectations for MCTs to ensure extended engagement to account for additional follow-up visits when clinically justified. Extended engagement by the MCT can assist with determining appropriate services for someone who is “new” to the behavioral health system, as it can be hard to discern diagnostic criteria for connection to ongoing services or determine level of care in an acute situation, without follow-up post-stabilization.

State planning should account for resource or financial challenges that create barriers to successful connection to upstream services. All interviewed states, to some degree, reported limitations on ensuring prompt access to follow-up care for individuals with private insurance. Commercial coverage has historically not provided strong coverage of behavioral health crisis services, including follow-up services, and the behavioral health system is fiscally unequipped to provide ongoing support to these individuals. Arizona’s unique approach of leveraging state funds and Medicaid dollars allows the RBHAs to support individuals in crisis who are not Medicaid eligible for up to 72 hours, allowing for more stabilization and time to coordinate any needed upstream services. For individuals covered under Medicaid, MCOs are expected to provide services for their enrollees after 24 hours.

## **Provider Selection, Contracting, and Monitoring**

The ARPA legislation allows states to offer qualifying community-based mobile crisis intervention services without regard to Medicaid requirements that pertain to choice of provider or written agreement for services.<sup>56</sup> This permits states to enter into selective contracts with providers of mobile crisis services and allows those providers to provide services without formal intake processes. Procurement processes allow state and local governments to select the provider or providers who can best meet the needs of their residents. Contracting requirements are essential in detailing expectations of services and specifying anticipated outcomes with key performance indicators. Such contracts are the vehicles by which states can develop measurable performance criteria and drive continuous quality improvement.<sup>57</sup>

The vision set forth by states for effective MCTs should inform the development of quality and performance measures designed to monitor effectiveness and ensure provider-level accountability. An accountability structure is essential to aligning stakeholders around common system goals, and provides a forum to monitor data and performance in order to make adjustments that improve quality. An active contract monitoring process is an oversight and accountability tool which provides states with a method to assess quality, effectiveness, equity, and performance. SAMHSA’s national crisis care guidelines address the importance of monitoring system and provider performance. These guidelines stress that in addition to monitoring fidelity to best practice, states and other funders should develop a systemic process to continuously analyze data for performance evaluation. Active contract monitoring of key performance indicators should provide for a transparent process, which will support quality improvement efforts.

States vary in their approaches to contracting for and monitoring mobile crisis services. Georgia opted to contract directly with two providers to provide mobile crisis services throughout the

state, with one of these providers also operating the GCAL crisis call center. State leaders felt that selective contracting allowed for higher quality and more consistent service. The Health Care Authority in Washington contracts its crisis response system with one BH-ASO in each region. Seven out of ten regions opted to become county-governed BH-ASOs; Beacon Health Options, a national managed behavioral health care organization, was selected as the BH-ASO for the other three regions.<sup>58</sup> This arrangement allows for the unique expertise of local public behavioral health entities in planning and implementing services in their communities. Each region contracts with service providers and is required to provide an annual performance report to HCA. The Arizona Health Care Cost Containment System contracts with three RBHAs to manage and contract with various providers for behavioral health care and crisis response.

### **State Planning Recommendations for Contracting and Monitoring**

State contracting should consider both the successes of localities and national best practices in order to set a basic crisis framework while allowing flexibility for localities to personalize implementation to best meet their community's needs. States should strive to strike this balance when evaluating the best approach to provider requirements. Because there is currently no standardized approach to MCTs and thus no tool for measuring fidelity, states should define expectations and set standards for statewide data collection to measure performance. States should regularly collect data points such as:

- Average response time for mobile crisis intervention
- Percentage of individuals who receive follow-up care within 24 or 48 hours
- Disposition of the case (i.e. number of individuals taken to a psychiatric hospital voluntarily and the number taken involuntarily; individuals connected to CSUs; individuals connected to respite)
- The number and percentage of crisis calls when the MCT engages/requests police response
- The number and percentage of individuals who receive mental health and/or community-based SUD services within a defined period following a mobile crisis team intervention
- The number and percentage of individuals who receive follow-up contact by the MCT within a defined period
- The number and percentage of encounters that included a peer support specialist as part of the MCT

Data systems must be developed to support evaluation and quality improvement, to examine the use of measures within and across systems, and to encourage regular examination of cross-system data. Data should inform team capacity decisions, illuminate trends regarding crisis calls and response, guide strategies for sustainability of programs, and help measure efficacy of the behavioral health system as a whole. States and counties need to promote coordination with other agencies, such as state hospital associations, law enforcement, and first responders, through creation of memoranda of understanding in order to effectively track data across sectors, assess MCT performance, and promote quality improvement.

## Financing that Utilizes Medicaid and other Funding Sources

States will need to develop or amend their state plan or waiver program under Sections 1115, 1915(b), or 1915(c) to ensure qualifying community-based mobile intervention services under ARPA requirements. Under the state plan amendment (SPA), states can use the rehabilitative services option to cover community-based services — including MCTs — that provide diagnostic, screening, preventive, and rehabilitative services.<sup>59</sup> States can also cover Home and Community Based Services under the SPA (under 1915i) which allows states to target specific populations.<sup>60</sup> Additionally, states' use of waiver authorities through implementation of mandatory managed care (1915b), creation of innovative demonstrations to test policy innovations (1115), or provision of community-based services (1915c), can be used to support their MCT.<sup>61 62</sup>

While Medicaid plays an important role in supporting crisis services for Medicaid recipients, states still face the challenge of funding services for people who are ineligible for Medicaid, including those who are uninsured or privately insured. Rarely does commercial insurance cover the cost of MCT services, so states are left with identifying alternative ways to fund these services. Additionally, there are components essential to providing mobile services that differ from office-based behavioral health services. The infrastructure and service components of crisis response can be compared to the responsibilities of a firehouse, which must remain ready to respond at a moment's notice. This includes supporting teams when there is idle time, supporting outreach efforts to individuals when no contact is made, and supporting start-up or technology costs for MCT operations.

For this reason, states support MCT through braiding, or combining, Medicaid with other funding streams (state funds, grant dollars, or private dollars). Even with additional enhanced federal matching, states will need to braid costs to cover MCT services not covered by Medicaid (infrastructure costs, services to uninsured individuals, etc.). California, for example, is leveraging state and federal grant dollars to help develop the Behavioral Health Continuum Infrastructure Program (BHCIP) which includes crisis services. BHCIP includes \$2.2 billion to be awarded through competitive grants to qualified entities to construct, acquire, or rehabilitate real estate assets, or to invest in mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources.<sup>63</sup> States often leverage SAMHSA grant dollars to supplement local funding for crisis services. As noted above, SAMHSA invested \$1.5 billion for the MHBG and SABG programs and created a \$75 million set-aside for crisis services.<sup>64</sup> The amount and availability of block grant funds is determined by Congress annually, thus the level of federal investment in crisis services may change in the future.

Each state interviewed approached funding and Medicaid coverage in a slightly different way:

- **Arizona** braids county and state funding with capitated per member per month Medicaid (1115 waiver) funding that is based on service utilization. This is used to pay their RBHAs to provide and oversee crisis response services. This funding structure allows Arizona to provide crisis services for a minimum of 24 hours for individuals enrolled in Medicaid and 72 hours for individuals not receiving Medicaid benefits. It is expected that the MCO to which an individual is enrolled will support the individual after 24 hours.

- **Washington** funds BH-ASOs with block grants and general funds, and requires that MCOs contract with the BH-ASO to ensure funding for crisis services for their enrollees. BH-ASOs and MCOs usually set a capitation rate for payment for all enrollees.
- **Massachusetts** funds its Emergency Services Program, which includes MCT, through state funds and its state plan for Medicaid. MCOs are contractually obligated to utilize ESP services. The state funds its youth MCT program through the Medicaid state plan, as a rehabilitative service under the EPSDT program.
- **Georgia** supports its crisis call center and mobile crisis services through Medicaid Administrative Claiming. Through this option, CMS allows states to claim up to 50 percent of expenditures necessary to administer the state plan and execute activities for Medicaid enrollees.<sup>65</sup> States must ensure that permissible non-federal dollars are used to match the federal costs. Georgia designated a formal protocol for assessing the Medicaid penetration rate. In order to access administrative matching for crisis call centers, a state must justify in a reasonable manner how many callers are Medicaid beneficiaries in order to properly allocate costs to Medicaid.
- **California's** "crisis intervention services" are covered as a specialty mental health benefit under Medicaid, carved out from Medi-Cal managed care plans and provided by some counties. Mobile crisis is an allowable, but not required, modality of service delivery of crisis intervention services. Therefore, there is variation in how counties provide this service. Of the counties that currently provide mobile crisis services, two-thirds utilize Medicaid in some capacity.

Many states have utilized various Medicaid authorities to provide crisis services and to tailor crisis response to the needs of the population. Washington, D.C. covered crisis services under its 1115 waiver to allow for SUD crisis response and SUD mobile outreach. Michigan opted into a statewide managed care option through 1915(b) for crisis services, including MCTs.<sup>66</sup> As noted above, MCOs can assist in centralizing communication and streamlining behavioral health crisis services. States develop Medicaid service definitions for crisis services; broader definitions allow for more flexibility in execution of services.

### State Planning Recommendations for Financing

While there is considerable variation in use of Medicaid for MCTs, many states face similar challenges. Most states interviewed supported mobile crisis services for individuals who were uninsured or privately insured through general funds or grant funds, as commercial insurers did not reimburse for services provided to their members. State planning should take insurance demographics into account, as states with a higher uninsured population might need to enhance local or alternative funding options. With the roll-out of 988 and community efforts to redirect responses to the behavioral health system, states should prepare for an increase in demand for MCT. This increased response may be reflected across payer systems, including individuals with commercial insurance. However, because of 988 implementation planning, states are in a unique position to engage key stakeholders, including commercial insurance companies, in the discussion regarding ongoing financial supports for the crisis response system. For example, Washington started preliminary conversations with the Office of the Insurance Commissioner about the potential for private insurers to reimburse for crisis services provided by BH-ASOs as well as coverage for next-day appointments for their members. Washington's 988 bill required

the formation of a Crisis Response Improvement Strategy committee, an interagency task force, which has allowed the state Medicaid authority to continue that discussion.

## Protocols and Appropriate Roles for Law Enforcement in Crisis Response

Many states and communities across the U.S. are grappling with the design of MCTs and whether and how to involve law enforcement in behavioral health crisis response. MCTs are self-contained teams led by behavioral health professionals and are distinct from crisis intervention teams (CITs) or other law-enforcement-led co-responder models.<sup>67</sup> Recent CMS Medicaid mobile crisis guidance noted that mobile crisis can respond to crisis situations in lieu of law enforcement. Many states, some of which have not had capacity for statewide mobile crisis services, have relied on law enforcement to support crisis response, particularly in rural areas. At times, law enforcement, such as CITs or co-response teams, may be first on scene depending on the community, which call center fielded the initial crisis call, and who was triaged to respond. MCTs operate independently from law enforcement, but generally plan with police and other first responders for situations when law enforcement is present or needed. As states develop and refine MCTs, states must support community-based mobile crisis programs to coordinate with law enforcement on articulating what constitutes a behavioral-health-led intervention versus a law enforcement response, establish roles and boundaries, understand the capacities of each, ensure clear communication, and share applicable data.

### State Planning Recommendations for Law Enforcement Involvement

States should articulate MCT program design through policy and guidance, including staff composition, operation, and Medicaid-reimbursable activities. States should specify the conditions and circumstances for Medicaid reimbursement for MCTs as a standalone, behavioral-health-led service, differentiated from other models that are law-enforcement-led or -involved.

Further, states can take measures to support coordination through guidance, encouraging the creation of task forces and defining protocols for law enforcement involvement. States interviewed for this planning guide broadly set expectations for MCTs to coordinate with law enforcement as part of an effective mobile response. Situations involving co-response operate more efficiently when there is a pre-existing relationship of trust between the two parties. However, law enforcement often cites lengthy response times as the most common factor inhibiting collaboration with mobile crisis response.<sup>68</sup> To mitigate concerns related to response time and to enhance partnerships, Arizona created a dedicated law enforcement line in its call centers, which directly connects law enforcement to a behavioral health specialist for screening and support. The state also established standards that require MCTs to prioritize calls from law enforcement, with an average in-person response time of 30 minutes for calls from police.

States can standardize a shared understanding of when and how to utilize law enforcement in MCT response. Georgia has specific instructions for when law enforcement should be involved and what its roles should be, from taking the lead in order to secure the scene, to following MCTs as a standby safety support. They also leave flexibility to allow for the clinical judgment of the responding clinician to discern if there is a safety risk that would warrant law enforcement support. Often highlighted for its close coordination with law enforcement, Arizona underscored the time that it takes to formulate an effective working relationship with law enforcement.

Therefore, states will need to set the expectation for law enforcement coordination early in MCT planning. States can employ mechanisms to cultivate these relationships on the local, regional, and state levels. Coordination should also focus on interagency data collection as more behavioral health emergencies are funneled to the appropriate MCT response.

## Conclusion

Crisis services are in the limelight as many states strategically tackle the best way to ensure that individuals have timely and appropriate access to services during a behavioral health emergency. With recent federal legislation, states are in a unique position to support system transformation and create effective emergency response to behavioral health crises. This guide utilized an environmental scan of five states — Arizona, California, Georgia, Massachusetts, and Washington — to recommend strategies for a more robust crisis system that takes into account 988 planning considerations and federal mobile crisis incentives. These states varied in how long they have been providing crisis services, in their infrastructure, and in their capacity to provide crisis services. California’s county-based system was explored to highlight state planning considerations for states in the early stages of standing up comprehensive crisis systems. However, the themes reviewed in this guide are ones that states must consider, regardless of their stage in planning, when implementing Medicaid-funded community-based mobile crisis services under the guidance of the American Rescue Plan Act.

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## Appendix A: Five State Approaches to Mobile Behavioral Health Crisis Response

Key Considerations for State Planning	Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD)	Arizona Health Care Cost Containment System (AHCCCS)	Washington Health Care Authority (HCA)	Massachusetts Medicaid and Children’s Health Insurance Program (MassHealth)	California’s County-Based System
<b>Financing</b>	Medicaid Administrative Claiming funds entire crisis system, including mobile crisis teams (MCTs).	AHCCCS braids Medicaid (capitation rate), local funding, and grants to pay Regional Behavioral Health Authorities (RBHAs) for crisis services for all, regardless of insurance.	HCA locally funds Behavioral Health Administrative Service Organizations (BH-ASOs).  HCA requires managed care organizations (MCOs) to contract with BH-ASOs to fulfill Medicaid portion.  MCOs and BH-ASOs usually agree upon a capitation payment.	Emergency Service Providers (ESPs), including MCTs, are funded through Medicaid (1115 waiver) and state funds.  Youth MCT is covered under Early Periodic Screening Diagnosis Treatment (EPSDT) under the Medicaid state plan.	“Crisis intervention services” are covered by a specialty mental health benefit service under Medicaid as a carve-out of comprehensive managed care.  66% of counties with MCT utilize Medicaid in some capacity.
<b>Triage &amp; Dispatch</b>	Centralized call center, the Georgia Crisis and Access Line (GCAL), which is a National Suicide Prevention Lifeline center, directly dispatches MCTs using GPS technology.	Arizona has 3 regional call centers that dispatch MCTs utilizing GPS technology.  In 2022, all call centers will utilize the same vendor for GPS dispatching.	7 regional call centers that coordinate and dispatch MCTs.  As of 2021, do not have full technological capacity but are developing technology capacity in 2023 due to 988 legislation (HB 1477).	MCTs are run by ESPs in each jurisdiction.  ESP provider-based MCT dispatch.  Statewide bed registry.	37% of MCTs are dispatched directly from a police/sheriff’s office.  22% of MCTs are dispatched through a county access line.  18% of MCTs are dispatched through a dedicated crisis line.

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<b>Availability &amp; Capacity</b>	24/7/365, statewide.	24/7/365, statewide.	24/7/365, statewide.	24/7/365.	72% of counties with MCTs cover the entire county.  73% of counties with MCTs do not operate 24/7 but prioritize services during peak hours.
<b>Staffing &amp; Competency</b>	MCTs are blended teams trained to address substance use disorders, intellectual/developmental disabilities, youth and adult behavioral health crises.  MCT required staffing includes Licensed Clinician, Behavioral Specialist, professional or paraprofessional	Specialty teams and Adult MCTs.  Required trainings and consultation with advisory boards to ensure culturally competent MCT.  Require Qualified Behavioral Health Professional (QBHP) to assess, and require at least 25% of total contracted teams to have peer recovery support.	Adult MCT and building out youth MCT in every region by 2022.  MCT assessments required to be done under the supervision of a QBHP.  Peer support services encouraged but not required.	Youth MCT and adult MCT.  QBHP, certified peer specialists.	14% of counties with MCTs provide youth-specific services.  86% do not have specialized mobile crisis providers but serve all populations in crisis.

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<p><b>Integration into Upstream Services</b></p>	<p>GCAL connected with statewide bed registry to support MCTs in identifying stabilization connections.</p> <p>GCAL connected with provider network to allow follow up with MCO clinical care coordinators.</p> <p>MCTs required follow up within 24 hours to attempt linkage to ongoing services.</p>	<p>AHCCCS requires that MCTs follow up within 72 hours in standards.</p>	<p>Required BH-ASOs to create referral process for upstream services.</p> <p>Required to coordinate with MCOs regarding members who connect with crisis system.</p>	<p>Utilize bed registry to connect to stabilization services.</p> <p>Required follow-up care to support stabilization and linkage.</p>	<p>Currently, counties set specifications for MCTs so variation among counties exist.</p>
<p><b>Contracting &amp; Monitoring</b></p>	<p>DBHDD contracts directly with two providers who cover 6 regions for MCT services.</p> <p>DBHDD provides direct oversight of providers.</p>	<p>AHCCCS contracts with 3 RBHAs, which contract with providers.</p> <p>AHCCCS provides specific regulations to RBHAs.</p> <p>RBHAs are responsible for oversight of providers.</p> <p>Quarterly reports on metrics.</p>	<p>HCA contracts with BH-ASOs and provides broad guidance.</p> <p>BH-ASOs contract with providers and follow their processes for procurement and oversight.</p> <p>HCA requires reports annually.</p>	<p>MassHealth contracts with the Massachusetts Behavioral Health Partnership (MBHP) to oversee the ESP network. One ESP in each of the 21 areas in MA.</p> <p>ESP reports out on MCT metrics to MBHP.</p>	<p>Currently, counties determine provider contracting and monitoring specifications so there is variation in process.</p>

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## Appendix B: Glossary of Terms

**Bed Registry** — Up-to-date electronic databases of bed availability within behavioral health settings, including but not limited to public and private psychiatric hospitals, psychiatric bed space within broader hospitals, crisis stabilization beds, crisis respite centers, detoxification units, and recovery homes.

**Certified Community Behavioral Health Clinic (CCBHC)** — Provides a comprehensive array of services (9 required services) needed to create access, stabilize people in crisis, and provide the necessary treatment for those with the most serious, complex mental illnesses and substance use disorders.

**Crisis Stabilization Unit (CSU)** — Offers an alternative to emergency department and psychiatric hospitalization admission by providing short-term observation (up to 24 hours) and stabilization services in the community.

**De-escalation** — A variety of techniques to prevent situations from intensifying, defuse a situation, and ensure effective communication to resolve the concern.

**Detoxification Facility** — A hospital or residential facility that provides full medical detoxification supports.

**Mobile Crisis** — Teams consisting of a behavioral health specialist and another professional, often a certified peer; the team conducts psychiatric assessments, de-escalates crises, and collaborates to connect individuals to appropriate treatment. Mobile crisis connects with individuals wherever they are including home, work, or other community-based settings, to provide rapid support services.

**Peer Respite** — Short-term voluntary community-based support in a residential, homelike setting where the primary support is provided by individuals with lived expertise.

**Qualified Behavioral Health Professional (QBHP)** — States vary in how they define QBHPs; some require independent licensure whereas others allow provisionally licensed or license-eligible individuals to conduct assessments under the supervision of an independently licensed practitioner.