Federal Policy Recommendations to Support State Implementation of Medicaid-Funded Mobile Crisis Programs

John O'Brien, M.S.; Vikki Wachino, M.P.P.;
Jordan Gulley, L.I.C.S.W.; Kevin Martone, L.S.W.

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Background and Purpose

Many state and local governments and communities across the country are redesigning their crisis response systems to better meet the needs of people who experience crises as a result of their behavioral health conditions. These efforts are motivated by a desire to connect people to the mental health and addiction services they need, while reducing reliance on law enforcement and hospitals as the first line of response when behavioral health crises occur.

Federal policy plays a key role in supporting community-level initiatives to develop effective behavioral health crisis response systems. "Behavioral health" is a term that encompasses both mental health and substance use concerns. Crisis response programs are called on to respond to both sets of issues. Over the past several years, the federal government has created new policies to advance stronger crisis responses. For instance:

- In 2020, Congress passed a law to make 988 the nationwide three-digit phone number for mental health crisis and suicide prevention, operating through the existing National Suicide Prevention Lifeline. By July 2022, all telecommunications companies will be required to route 988 calls to the Lifeline, which has a nationwide network of call centers.
- COVID relief legislation provided significant increases in U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) grant funds, including $1.5 billion for the Community Mental Health Services Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) programs and creating a $75 million set-aside for crisis services.
- The American Rescue Plan Act (ARPA) of 2021 established a new state Medicaid option to provide community mobile crisis intervention services for individuals experiencing a mental health or substance use disorder (SUD) crisis.[1] The Centers for Medicare and Medicaid Services (CMS) has awarded $15 million in planning grants to support states' efforts to implement strategies to address these provisions.
- Recently, CMS released a State Health Official Letter that provided guidance regarding the scope and payment for mobile crisis intervention services that was created through ARPA.[2] This guidance provides additional information to states regarding this service, describes mobile crisis service best practices, and illustrates the important partnership between CMS and SAMHSA in the development and implementation of this initiative, including its relationship to 988 implementation.

These recent federal policies, which are being implemented at the state and local levels, build on national guidelines for behavioral health crisis care issued by SAMHSA in 2020. They articulate core components of effective crisis systems, including 24/7 crisis lines, 24/7 mobile crisis response, and crisis stabilization programs.[3]

This brief and recommendations are consistent with recent State Health Official guidance and identify additional actions that the executive branch and Congress could take to support successful implementation of the new policies. While it focuses primarily on implementation of Medicaid mobile crisis provisions for individuals experiencing a mental health or SUD-related

crisis, it also identifies opportunities to develop a broader service continuum that meets the needs of people experiencing a behavioral health crisis.

Figure 1. The federal executive branch and federal policy play key roles in supporting community-level initiatives to develop effective behavioral health crisis response systems. Here are several ways in which federal agencies could build on recent policies to expand access to crisis services and encourage states, local governments, and communities to implement new policies effectively:

Key Federal Executive Branch Policy Recommendations

- Undertake coordinated federal policymaking, messaging, guidance, and grantmaking across agencies, and particularly across CMS and SAMHSA.
- Issue coordinated CMS-SAMHSA guidance identifying grant funding and Medicaid authorities that can be used to support 988 functions.
- Encourage states to consider start-up and implementation funds for mobile crisis as allowable workforce activities to expand workforce capacity under new Home and Community Based Services guidance, and encourage states to use Children's Health Insurance Program (CHIP) health services initiatives to develop mobile crisis services for children and youth.
- Support workforce development through Health Resources and Services Administration (HRSA) loan repayment and grantmaking, and identify opportunities under SAMHSA block grants to support workforce capacity-building.
- Consider flexibility in meeting new Medicaid mobile crisis 24/7 requirements, including in rural and frontier communities.
- Encourage flexibility and innovation in states' approaches to financing mobile crisis services with respect to payment models and rate methodologies.
- Issue guidance on ways of carrying out core mobile crisis services to promote consistency in screening and assessment; stabilization and de-escalation; and coordination of referrals.
- Develop a limited set of measures to evaluate the effectiveness and impact of mobile crisis services.
- Build on past efforts to promote access to community-based behavioral health services by updating guidance on services that can help prevent crises, such as Assertive Community Treatment and coordinated specialty and support services.
- Conduct joint CMS-SAMHSA reviews of state crisis service continuums to provide technical assistance in helping to build a continuum of care.
- Expand the Department of Health and Human Services' Behavioral Health Coordinating Committee to include the Department of Housing and Urban Development and the Department of Justice.
- Require or encourage states to braid funding across federal state and local payers.
- Provide SAMHSA guidance to states on strategies for reimbursing for crisis services through grant funds, promoting alignment with Medicaid fee schedules.

The concept of developing and implementing mobile crisis programs is not new; some states and localities have longstanding mobile crisis programs. The new ARPA provisions may encourage states with existing programs to refine them. In other states, current crisis service provision is patchwork, relying explicitly or by default on law enforcement and hospital emergency departments, neither of which is designed to meet the needs of individuals experiencing behavioral health crises. The absence of appropriate behavioral health crisis response can result in law enforcement's serving as behavioral health first responders, which

can in turn lead to unwarranted arrests and incarceration for people with acute behavioral health needs, as well as unnecessary use of inpatient services.

The ARPA provisions may encourage states with limited or no mobile crisis capacity to develop these services. However, in all cases, addressing these conditions requires not just mobile crisis teams, but a system of response and behavioral health service provision that meets peoples' needs. This brief begins by discussing ways that federal agencies, particularly CMS and SAMHSA, can build on their recent efforts to strengthen behavioral health crisis response by supplying states, localities, and providers with specific, practical approaches to develop or enhance mobile crisis intervention services. This includes opportunities to advance implementation of the new 988 law and to build access to crisis services, a step which will be key to the ultimate effectiveness of 988 and crisis response. It also addresses opportunities to use mobile crisis implementation to strengthen Medicaid's connection to 988 implementation.

The brief next identifies important issues in mobile crisis implementation— workforce, provider capacity, payment, operationalizing core service features, and quality and outcomes measurement — and describes ways that federal agencies can support state and local efforts to address these issues successfully. It also identifies ways that federal agencies can support development of a broader crisis continuum. The brief concludes by identifying legislative approaches that Congress could consider to further advance states' ability to provide a full continuum of crisis services. A companion paper addresses state considerations for planning related to implementing the new Medicaid mobile crisis incentive with consideration of the broader crisis services continuum.[4]

Key Opportunities for Congress to Advance Crisis Services

- Establish an enhanced federal Medicaid matching rate for a range of crisis services in addition to mobile crisis.
- Establish crisis service provider capacity development grants.
- Expand commercial insurers' role in covering crisis services.
- Ask the Government Accountability Office to review licensing, accreditation, quality, and staffing of crisis services.

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Opportunities for Federal Agencies to Advance Crisis Response

The Federal Role in Advancing Crisis Response

Federal action to advance crisis response takes place primarily through policy-setting and grantmaking. Responsibilities are spread and shared by several federal agencies (see text box), with CMS and SAMHSA playing leading roles in advancing behavioral health crisis response. Coordinated federal policy, shared messaging, shared guidance, grantmaking, and, where possible, coordinated decision-making among federal agencies will maximize the impact of any new policies, and help improve coordination at the state and local levels. The recent guidance from CMS regarding mobile crisis intervention is an example of CMS and SAMHSA coordination, combining important programmatic and financing information for states that are taking advantage of the new ARPA opportunity for community mobile crisis services and tying mobile crisis to the broader set of crisis services. This brief identifies specific actions that individual agencies can take, as well as noting instances in which coordinated, cross-agency efforts could have significant impact.

Federal Agencies that Support Behavioral Health Crisis Response

The Centers for Medicare and Medicaid Services (CMS) sets federal policy with respect to Medicaid, Medicare, and Marketplace, including the new Medicaid mobile crisis incentive.

The Substance Abuse and Mental Health Services Administration (SAMHSA) develops guidance and information to states regarding crisis services and provides block grant and discretionary funding to states for crisis services.

The Health Resources and Services Administration (HRSA) provides funding to increase the supply of behavioral health professionals and the quality of the behavioral health workforce.

The Department of Justice Bureau of Justice Assistance (BJA) provides funding and supports for innovative cross-system collaboration for individuals with mental illnesses or co-occurring mental health and substance use disorders who encounter the justice system.

The Department of Housing and Urban Development (HUD) sets federal policy and provides housing assistance to individuals in need of affordable housing, including rapid rehousing and permanent supportive housing.

Such actions and collaborations would build on a history of federal collaboration to accomplish important behavioral health innovations. Over the past decade, collaborative efforts designed Medicaid health homes for individuals with serious mental illness (SMI) and SUDs; created a Center for Integrated Health Solutions; and implemented key initiatives such as Certified Community Behavioral Health Clinics, supportive housing, and benefit designs for mental health and SUD services.[5] Federal agencies have also collaborated on critical guidance related to the application of the Americans with Disabilities Act, allowing individuals with mental disabilities to exercise their right to live in the community rather than in institutions. More recently, federal agencies have partnered on activities to implement the Mental Health Parity and Addiction Equity Act and the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

The Medicaid Mobile Crisis Enhanced Match and Other New Crisis Policies

A new Medicaid option encourages states to provide mobile crisis response services to people who are experiencing a mental health or SUD crisis in a community setting. These mobile crisis programs must include these key components:

- 24/7 multidisciplinary teams that can provide a person in crisis with: screening and assessment; stabilization and de-escalation; and coordination and referrals
- One or more behavioral health professionals or paraprofessionals, including nurses, social workers, and peer support specialists, who are trained in trauma-informed care, de-escalation, and harm reduction strategies
- Relationships maintained with community providers, such as primary care providers, behavioral health providers, and community health centers, as well as managed care organizations
- Privacy and confidentiality of information maintained

States can decide to offer mobile crisis services only in certain areas of the state, make them available only to specific Medicaid populations, and contract selectively with providers. The law provides an 85-percent federal matching rate for the first three years to state Medicaid programs that meet these requirements, and includes a state maintenance of effort requirement. The law also provided $15 million in planning grants for 20 states to develop these authorities.[6, 7] The following State Medicaid Authorities were awarded planning grants: Alabama, California, Colorado, Delaware, Kentucky, Massachusetts, Maryland, Maine, Missouri, Montana, North Carolina, New Mexico, Nevada, Oklahoma, Oregon, Pennsylvania, Utah, Vermont, Wisconsin, and West Virginia.[8]

Congress has recently taken additional steps to strengthen crisis response and behavioral health. ARPA provided additional grant funds to SAMHSA, building on resources provided in COVID relief legislation passed in 2020, to increase mental health and substance use block grant funding and create a specific crisis services set-aside. For instance, SAMHSA through MHBG funds provides targeted funding ($75 million) to ensure that individuals having a mental health crisis have access to timely and quality care.[9] This increase provides states with resources to build out their crisis systems.

Supporting 988 Implementation

State and local governments face an imperative to modify or stand up 988 crisis response systems to respond to mental health crisis calls by July 2022. The success of these systems in meeting peoples' needs will depend not just on call response, but on connecting callers to behavioral health services, including mobile crisis response services. 988 implementation coincides with the introduction of the new Medicaid mobile crisis incentive. These two innovations can and should work in tandem, and collaboration between CMS and SAMHSA can help advance coordinated implementation at the state level.

Financing 988 call services — both the operations associated with call response and access to associated behavioral health services — is a key challenge.[10] Several financing approaches can

be used. Historically, state and local funding has been the primary financing source for call response services. The federal law that established 988 allows states to require a surcharge on wireless telecommunications services. To date, four states have passed legislation requiring a surcharge to finance 988 call response functions; they have plans to utilize this surcharge to finance the provision of some crisis services. An additional eight states have pending 988 legislation — some of which will include a surcharge.[11] In addition, SAMHSA is providing grant funding for 988 implementation. These grants support states and territories in developing clear strategies for coordinating call center capacity, funding, and communication to launch 988, and in planning for the long-term improvement of in-state answer rates for 988 calls. This funding to states can also underwrite some of the costs for 988 start-up.

States and local governments can also use federal grant funding to support start-up activities. Some states, for example, are currently using MHBG funds to underwrite call center activities. In addition, Medicaid can support crisis call response functions to the extent that these functions serve Medicaid beneficiaries.[12] Medicaid beneficiaries constitute a significant share of crisis callers and crisis service recipients in some states. In Colorado, for instance, Medicaid beneficiaries account for 87 percent of current mobile crisis services users.[13] This number may not be reflective of all states and communities, as various factors influence crisis call center volume by Medicaid beneficiaries, including the number of Medicaid beneficiaries in a state, the number and type of call centers that exist in a state, and the ability of call centers to track this data. In contrast, in Georgia, a non-expansion state, Medicaid accounted for only 20 percent of crisis continuum costs in 2019.[14]

The recent guidance issued by CMS identifies ways that some Medicaid authorities that provide enhanced funding for information technology can help support 988 functions. It also notes the availability of Medicaid administrative funding for crisis call lines, dispatch, and other functions. These tools could help advance state and local efforts to finance and implement 988 and related services.

Financing Initial Mobile Crisis Implementation

State and local governments have often provided funding for mobile crisis services. They will likely incur additional costs in standing up Medicaid mobile crisis services, such as buying equipment and vehicles, developing provider capacity, hiring staff, and conducting development and training activities. The federal government can help support state and local development and launch of mobile crisis services, in addition to funding that state and local governments provide directly. Because Medicaid generally covers services, not equipment or other expenses incurred in developing services, the primary source of federal financial support for mobile crisis start-up is likely to be grant funding. SAMHSA can encourage states to use MHBG and SABG funds to build Medicaid mobile crisis start-up capacity.

There are some targeted ways that Medicaid itself can help support the development of mobile crisis services. The planning grants recently awarded by CMS are one way of doing this.[15] In guidance to states on implementing the temporary increase to the federal medical assistance percentage (FMAP) for Medicaid home and community-based services (HCBS) provided in ARPA, CMS recently identified workforce support, such as recruiting behavioral health

providers, and mental health and SUD capacity expansions as types of activities that qualify for the enhanced FMAP.[16] CMS can encourage states, through additional or revisions to existing guidance, to explicitly designate start-up and implementation funds for mobile crisis and other services as allowable workforce activities to expand behavioral health capacity. CMS could also encourage states to use Children's Health Insurance Program (CHIP) health services initiatives (HSIs) to develop mobile crisis services for children and youth. Using HSIs, states can use a limited amount of CHIP administrative funding to implement initiatives to improve the health of eligible children. States have substantial flexibility to determine the focus, scope, and design of these initiatives.[17]

Workforce Strategies

The national behavioral health workforce shortage, which has been exacerbated by the COVID-19 pandemic, is a key challenge to overcome in implementing mobile crisis response systems.[18] [19] The ARPA statute and recent CMS guidance include a few staffing and organizational requirements for mobile crisis intervention providers. Mobile crisis intervention services must be rendered by a multidisciplinary team, and there must be at least one behavioral health care professional on the team who can conduct an assessment (based on state's practice act laws and rules). The legislation suggests, but does not require, other types of practitioners and staff with appropriate experience to be part of the team. These include peers: individuals with lived experience who are in recovery from a mental health condition and/or an SUD. The legislation also requires team members to be trained in trauma-informed care, de-escalation strategies, and harm reduction, the latter specialization clearly emphasizing the need for mobile crisis services to be provided to individuals with SUD. Harm reduction techniques can also be utilized working with populations with HIV and with persons experiencing homelessness. CMS guidance also notes the importance of language access and compliance with the Americans with Disabilities Act. States have some latitude in how they design their multidisciplinary teams. At the same time, states may be required by CMS, as a condition of their state plan amendment, to provide specific information regarding the overall organizational qualifications of the entities that will "house" mobile crisis intervention teams. States have developed various organizational requirements to ensure the appropriate oversight and quality of mobile crisis intervention teams. For instance, some states require crisis providers to be accredited by a national accrediting organization; others are certified by the state's behavioral health authority.[20] Other states have required that organizations offering mobile crisis intervention teams be licensed to offer this service.[21] [22]

A practical challenge that mobile crisis providers face is recruiting and retaining personnel to staff and oversee mobile crisis teams. Some states are implementing workforce development strategies such as signing bonuses, loan repayment strategies, tuition assistance, and other financial aid for education advancement and licensure for the behavioral health workforce. Some states, including Connecticut and Louisiana, have developed Centers of Excellence (COEs) to support providers in their efforts to deliver high-quality crisis services.

The federal government could support these efforts through existing loan forgiveness programs for certain staff, particularly behavioral health clinicians employed by mobile crisis programs[23] or through HRSA's loan repayment program.[24] HRSA could consider grantmaking opportunities to

expand the behavioral health workforce with a specific focus on crisis service provision. This could include a partnership with SAMHSA to develop a national training and technical assistance center that promotes the development of mobile crisis response services and other behavioral health services. CMS and SAMHSA could also highlight the availability of MHBG and SABG to support workforce development and capacity-building. These block grant funds could help crisis intervention teams obtain the competencies required by ARPA (de-escalation, trauma-informed care, and harm reduction) as well as other skills necessary to provide crisis care. HCBS guidance released earlier this year focused on workforce enhancements that include activities to recruit and retain direct support professionals and offering incentive payments to recruit and retain such professionals.

Provider Network Development Strategies

Recruiting and contracting with providers is a key state Medicaid function. Under the new ARPA mobile crisis response incentive, states can selectively contract with providers and can offer services in only parts of the state, rather than statewide. Contracting with a small network of providers may simplify oversight and be simpler for call centers who dispatch or law enforcement who will refer individuals to mobile crisis services. States that are beginning to build their mobile response capacity are considering efforts to begin implementation in select geographic areas that may be able to more readily support mobile crisis efforts, with the goal of offering this service statewide over time.

In addition, because of workforce and other challenges, some states may initially struggle to have their mobile crisis teams meet the statutory standard that services be available 24/7. Rural and frontier areas, where crisis call volume is lower, travel is time-consuming, and behavioral health workforce shortages are more acute, will be especially challenged to meet this requirement. Although 24/7 response is needed by people in crisis, CMS and SAMHSA may consider flexibility in meeting 24/7 availability, including in rural and frontier communities. Recent guidance recognizes the role that telehealth can play in providing services.[25] Rural communities may find telehealth to be a valuable tool in expanding access to services. In addition, CMS could consider permitting states to undertake a “soft launch” for mobile crisis intervention teams — with 24/7, face-to-face capacity in some areas of the state initially and plans to ensure an adequate 24/7 response in other areas over time. CMS could also work with states that cannot meet the 24/7 or other requirements to cover their mobile crisis programs under other Medicaid authorities such as the rehabilitative services option, 1915b waivers, Home and Community Based Service authorities (1915c and 1915i), and 1115 Research and Demonstration waivers, although the enhanced matching rate would not pertain.

Payment Strategies that Advance Effective Crisis Response Service Provision

Federal guidance can encourage flexibility and innovation in states’ approaches to financing crisis services. States are currently taking, or planning to take, various approaches to Medicaid payment strategies for mobile crisis intervention services.

Payment models

- **Payment for episode-based care** — specific bundled multiday rates for teams that are providing mobile crisis services. These strategies incorporate the initial crisis visit to respond to and de-escalate a crisis and follow-up visits to monitor the initial crisis and provide initial stabilization services (usually with 24 to 48 hours after the initial response). These visits can be carried out virtually or in person.
- **Daily payments for crisis intervention** — similar to episode-based care, states have developed daily payments for initial mobile crisis intervention services that take into account the initial response to de-escalate the crisis and a face-to-face or virtual visit the same day to continue these efforts.
- **Smaller incremental units** — several states have created payment strategies (generally 15-minute or hourly units) to reimburse mobile crisis intervention providers. In these instances, mobile crisis providers are not limited to billing crisis intervention services to a specific timeframe or episode.

Payment rate methodologies

Rate-setting strategies will underpin access to mobile crisis services. In reviewing payment rates for mobile crisis services, CMS and states can discuss assumptions underlying payment rates, and discern how they take into account specific factors, including those that are unique to mobile crisis response. Key issues that can be addressed in rate-setting include:

- **Workforce** — Providing mobile crisis services places specific demands on the staff who carry them out. Services must be provided 24/7 at the site of the crisis, and staff must be able to manage high-risk situations. Recruitment and retention for many occupations is especially challenging now, at this stage of the pandemic. CMS can encourage states to use national benchmarks (such as those provided by the Department of Labor Bureau of Labor Statistics) to help set rates and salaries that account for behavioral health workforce skills and the challenges in providing crisis services.
- **Supervision** — Many states with existing Medicaid mobile crisis programs have established supervision expectations to ensure quality and to support staff in addressing challenging situations. Supervision can include mentoring and training on recovery, clinical care, medical management, and risk management. Supervision costs should be built into states' rates.
- **Productivity** — Setting productivity expectations is a way to provide guidance regarding time spent delivering services directly to the individual in crisis. However, the emergent nature of mobile crisis response makes it challenging to set productivity expectations and rates. Crisis team productivity will also be affected by the mobile nature of the service, as teams may travel several hours (round trip) to respond to a crisis. Including idle or "down time" for crisis teams (periods when they are not responding to crisis) in setting rates can help ensure that the rate reflects the cost of service provision.
- **Staff training** — Education in how to stabilize a crisis, as well as in de-escalation, trauma-informed care, and harm reduction, can be built into rate-setting.
- **Coordinating effective referrals** — Referrals to continuing care are an essential part of the service package, and states may factor these activities into productivity reimbursement

strategies. Identifying appropriate post-crisis services, facilitating referrals to ensure a successful warm hand-off to the next provider, and performing follow-up calls with referral sources to assess engagement after the crisis, should all be activities allowed in the reimbursement methodology.

Carrying Out Core Medicaid Mobile Crisis Functions

Although some states, local governments, and providers have established mobile crisis programs, others will be launching such programs for the first time. Federal guidance from CMS and SAMHSA on how to carry out core mobile crisis functions could support state and local efforts and promote a degree of consistency in crisis response, while also taking into account existing approaches. These core functions fall into three areas: screening and assessment, stabilization and de-escalation, and coordination of referrals to health and other social services that can support people with mental health and substance use crises. CMS and SAMHSA could support states in developing new mobile crisis programs — as well as states and localities looking to bring their existing programs up to new standards — in several specific ways:

- Identifying and making available screening tools that crisis call centers and crisis providers can use to triage calls and determine the best response to a crisis.
- Identifying best practices for stabilization approaches and services during and after a crisis. Several models have been developed to provide stabilization services for up to 15 days after a crisis.[26] These services can provide relief, resolution, and intervention through maintaining the individual at home and in the community; de-escalating behavioral health needs; referring for treatment needs; and coordinating with local providers. In particular, this approach can help people who have not previously interacted with the behavioral health system connect to ongoing services.
- Advancing efforts by mobile crisis teams to develop harm reduction strategies including techniques like the use of fentanyl testing strips and suboxone, as recognized in the December 2021 guidance from CMS.
- Recommend processes to develop individual crisis plans to address “triggers” that might cause a crisis and strategies to deal with crises that do occur.
- Develop meaningful strategies for ensuring referrals once the immediate crisis has been addressed. Operationalizing and tracking referral requirements requires resources on the part of the crisis provider and the organization to whom the referral is made. Federally recommended model language for referral agreements, along with identifying select measures and strategies to monitor referrals, could support smoother connections to ongoing care.

Measuring the Impact of Mobile Crisis Services

Measuring the effectiveness of mobile crisis services in responding to individuals in crisis will help states and the federal government ensure strong service provision. Collecting data, analyzing outcomes, and creating actionable improvement processes builds trust from the public, callers, providers, and payers alike. Appropriate outcome measurements and reporting systems

will assist mobile crisis providers' quality improvement efforts and can provide policymakers and stakeholders with critical information for determining whether such programs should be continued, expanded upon, or modified. CMS and SAMHSA could develop key measurements, to include how well crisis providers resolve or stabilize high-risk situations and link callers to resources. Impact on diverting unnecessary emergency department or hospital visits and reducing the involvement of police could also be measured.

Currently, there are no national standardized quality measures for the delivery of mobile crisis services. Implementing the new mobile crisis initiative provides federal and state policymakers the opportunity to identity key measures and collect data. CMS and SAMHSA could develop a limited set of measures to evaluate the effectiveness of mobile crisis services and the impact of mobile crisis services on the lives of individuals who experience a mental health or SUD crisis. This limited set of measures might include:

- Average and median response time for mobile crisis intervention services (statewide and by team)
- The number and percent of crisis encounters resolved successfully within a state's or jurisdiction's established timeframes
- The number and percentage of individuals who receive crisis follow-up care within a standard timeframe — generally 24 to 48 hours
- The number of mobile crisis calls that required additional first responder support (e.g., from emergency medical services, law enforcement, etc.)
- The number and percentage of individuals engaged by a mobile crisis team who were taken voluntarily to a hospital for medical treatment, to an inpatient psychiatric hospital, or to a crisis stabilization unit
- The number and percentage of individuals involuntarily admitted to a hospital
- The number of individuals supported in connecting to SUD treatment or detoxification services
- The number and percentage of crisis calls in which the mobile crisis team engages/requests police response
- The number and percentage of individuals who receive community-based mental health and/or 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 mobile crisis team within a defined period
- The number and percentage of encounters that included a peer support specialist as part of the mobile crisis team
- Measure of individuals' and families' satisfaction with services (e.g. how likely are they to recommend this service)
- Demographics of service recipients (race, gender, ethnicity, LGBTQ+) for the purposes of evaluation of trends and underserved populations

Federal agencies could encourage states to report some of these measures regularly. Over time, as the reliability and validity of data improve, federal agencies may consider asking states

to report measures through existing reporting processes. For instance, SAMHSA may want to incorporate some of these key measures in its National Outcome Measures, which measure the quality of mental health and SUD services across ten domains. The Center for Medicaid and CHIP Services may also want to consider measures that could eventually be included in the Child and Adult Core Set of Health Care Quality Measures.

Building a Broader Behavioral Health and Social Service Continuum

The most effective strategies for supporting people with behavioral health conditions will reach beyond crisis response to strengthen access to prevention, early intervention, and community-based treatment and recovery-oriented services that can help people avoid crises.[27] In addition, when people do experience crises, the most effective response will connect them to a broader continuum of services that go beyond immediate, short-term mobile crisis response efforts. The federal government has opportunities to encourage state and local governments to build a larger behavioral health service continuum, of which mobile crisis response and other crisis services, such as crisis stabilization, are also part. CMS' mobile crisis guidance identifies Medicaid services with which mobile crisis services can integrate, and notes the availability of mental health block grant funds for developing crisis services.[28]

CMS and SAMHSA have over many years provided considerable guidance and information for states, local governments, and providers to promote access to community-based behavioral health services.[29] Updating and disseminating past SAMHSA guidance would align these approaches with current research and best practices. For example, evidence-based practice toolkits on Assertive Community Treatment (ACT), Illness Management and Recovery, Permanent Supportive Housing, Consumer-Operated Services, and Supported Employment could expand upon their roles in the prevention of and recovery from crisis episodes. CMS and SAMHSA could also promote the availability of CMS guidance on ACT, interventions to provide specialty support services for people who have experienced an initial psychotic episode, and peer supports. They could identify opportunities for using and coordinating the use of SAMHSA block grant funds (MHBG and SABG) and Medicaid authorities to advance the availability of up-stream community services that could reduce the likelihood that people will need crisis services.

Federal agencies can also encourage states to go beyond crisis response to develop a full continuum of crisis services, building the ability to not just respond to calls, but also connect callers to services. One mechanism for advancing a continuum of crisis services is the Department of Health and Human Services' (HHS) Behavioral Health Coordinating Council (BHCC), which advances cross-HHS behavioral health policy and has designated crisis as one of its focus areas.[30] [31] [32] Expanding the BHCC to include agencies such as HUD and DOJ could better ensure coordinated crisis policy. These cross-agency partnerships could support states in increasing connection to comprehensive upstream services, including housing. HUD can encourage coordination with crisis service providers and could consider opportunities to prioritize rapid rehousing and emergency housing assistance options for individuals who need housing to promote behavioral health stabilization.

CMS and SAMHSA could further advance a crisis continuum by conducting joint reviews with states of current state service continuums to identify strengths and gaps in current state

Medicaid crisis systems. SAMHSA and CMS could provide joint technical assistance to states in developing crisis services.[33] CMS could also clarify that these types of community services qualify for the 10-percent increase in the federal matching rate for home and community-based services that Congress provided in ARPA, as CMS did for other HCBS services.[34]

Strengthening Financing of Services for People who are *Not* Medicaid-Eligible

Many people who use behavioral health crisis services are not eligible for Medicaid. Some states and localities use their own funds to finance crisis services for people who are uninsured or to cover costs that are not covered either by commercial health plans or by Medicare. Other states are using federal COVID relief grant funds to underwrite initial mobile crisis services for people who are not Medicaid-eligible. Counties in several states have local property tax millages for crisis and other mental health services.

Procurement efforts by SAMHSA and the Bureau of Justice Assistance could require or encourage state strategies that effectively braid funding from federal state and local payers. These recommendations or requirements can encourage states to seek or use Medicaid funding in their efforts to develop mobile crisis responses and provide direction on how to use mental health and substance use block grant or discretionary funds to braid with these Medicaid payments to ensure comprehensive care.

SAMHSA could also provide guidance to states regarding strategies for reimbursing crisis services. Specifically, SAMHSA could encourage states to consider reimbursement strategies that align with those of other payers of crisis services. For instance, SAMHSA could encourage states to use existing Medicaid fee schedules for crisis services provided to non-Medicaid beneficiaries, and encourage states to offer guidance to their crisis providers regarding reimbursement protocols (e.g., clarifying which one is the payer of first resort). While SAMHSA may or may not suggest or require a specific payment strategy, it is in federal and state agencies' best interest to avoid creating incentives to use one payment source over another. This kind of collaboration could ensure that other federal funds support, rather than supplant, Medicaid funding for mobile crisis intervention.

Opportunities for Congress to Advance Crisis Service Provision

The ARPA mobile crisis provision, the new 988 law, and the crisis set-aside in SAMHSA block grants all provide tools to strengthen and develop a more organized response to mental health and SUD crises.

Additional action by Congress could strengthen the full continuum of necessary crisis services, and help states and communities successfully connect people who experience a behavioral health crisis with the right support at the right time. Legislative efforts should be considered that would broaden the ability of Medicare and commercial insurance to cover crisis services, putting other insurers on a par with Medicaid crisis service coverage. States can further address the extent to which crisis services are covered by commercial insurance. The following section explores actions Congress could take in order to expand and strengthen the availability of crisis services.

Establish an Enhanced Federal Matching Rate for Crisis Services

Many states' crisis service continuums have significant gaps in the services they cover, as well as wide variability in program requirements, length of stay, quality, and accreditation.[35] To make services available to more people who need them, Congress could establish key crisis services beyond mobile crisis as optional Medicaid benefits and extend the 85-percent matching rate that it established for mobile crisis services to a broader range of crisis services, including:

- Community-based crisis stabilization service, which can provide short-term case management and linkage to an individual who has experienced a crisis and is in the process of connecting to another treatment service.
- Crisis receiving and stabilization facilities, which provide short-term observation and crisis stabilization services to all referrals in a homelike, non-hospital environment.
- Short-term crisis residential services that offer short-term treatment, including access to medication-assisted treatment for opioid use disorders, and supports in a residential, homelike, non-hospital environment.
- Behavioral health urgent care centers, which are walk-in centers that provide short-term behavioral health crisis intervention and offer a community based, voluntary, home-like alternative to more restrictive settings, such as emergency departments.
- Crisis respite centers and apartments providing 24-hour observation and support by crisis workers (including peers) and trained volunteers to stabilize an individual and connect them with other supports.
- Sobering centers, which offer a safe place for individuals waiting for the effects of alcohol or drug intoxication to decrease while being monitored for underlying medical conditions or injury. These centers provide screening for SUDs, brief interventions including motivational

interviewing, and direct referrals and transfer to substance use treatment, shelter, and other stabilizing services.

Establish Crisis Service Provider Capacity Development Grants

In the 2018 SUPPORT Act, Congress created grants to support states in expanding the availability of SUD service providers. Congress could establish similar grants to develop crisis services provider capacity. The grants could prioritize developing crisis response in rural, frontier, and tribal communities.

Expand Commercial Insurers' Role in Covering Crisis Services

Congress or HHS could advance access to crisis services by expanding coverage of such services by commercial insurers, which generally offer more limited crisis service coverage relative to Medicaid. One way to expand crisis coverage is to ensure that crisis services are included as essential health benefits, which are federally required minimum benefit standards that apply to small group and individual market coverage, including Marketplace coverage. The Behavioral Health Services Expansion Act has been introduced in Congress to include crisis services as essential health benefits. This legislation would also require Medicare and other insurance programs to cover some crisis services, and would require state Medicaid programs to cover crisis service, which is currently not required.

Review Licensing, Accreditation, Quality, and Staffing of Crisis Services

Congress could require the Government Accountability Office to review existing programmatic standards for crisis services and make recommendations to Congress on how to improve service provision, ensure quality, and reduce variation in crisis services for mental health and substance use. The Behavioral Health Crisis Services Expansion Act also charges the Secretary of HHS to create national standards for the crisis response continuum of care.[36]

Conclusion

States are currently making significant changes to their crisis system services, including mobile crisis response. States are taking advantage of existing funding that will be available through federal fiscal year 2024 and possibly longer, depending on future legislation. In addition, 988 rollout in 2022 will require mobile crisis and other services to be available in a timely manner for callers who are experiencing a behavioral health crisis and need immediate relief. Without a timely and effective crisis response system, states' 988 response systems are likely to struggle to connect people to care, and overreliance on law enforcement and hospital emergency departments to address behavioral health crises will continue. Federal agencies and Congress can build on recent policies to further improve crisis systems and transform the patchwork approach to crisis services that exists in much of the country. Federal executive branch policymaking that is proactive in advancing behavioral-health-led crisis services and that fosters collaboration among agencies can encourage coordinated crisis systems locally. Additional Congressional action may expand access to a service continuum that serves people enrolled in Medicaid, commercial, and other forms of insurance.

Notes

[1] American Rescue Plan Act of 2021, Public Law 117-2, Sec. 9813: "State option to provide qualifying community-based mobile crisis intervention services, March 11, 2021." https://bit.ly/3pRXm2q.

[2] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. 2021. "Re: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services" [PDF]. State Health Official Letter #21-008, December 28, 2021. https://bit.ly/3q8ydRv.

[3] U.S. Substance Abuse and Mental Health Services Administration. 2020. *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* [PDF]. Rockville, MD: Substance Abuse and Mental Health Services Administration. https://bit.ly/2XVmxpj

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[7] U.S. Centers for Medicare and Medicaid Services. n.d. "State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services." November 16, 2021. https://bit.ly/2ZcFe8y

[8] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. n.d. "Behavioral Health Services." Medicaid.gov. January 4, 2022. https://bit.ly/3mSNOm8.

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[14] Medicaid and CHIP Payment and Access Commission. 2021. *MACStats: Medicaid and CHIP Data Book* [PDF]. Washington, D.C.: MACPAC. https://bit.ly/3pZPnAD.

[15] U.S. Centers for Medicare and Medicaid Services. n.d. "State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services." November 16, 2021. https://bit.ly/2ZcFe8y.

[16] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. 2021. "Re: Implementation of American Rescue Plan Act of 2021: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency." State Medicaid Director Letter #21-003, May 13, 2021. https://bit.ly/3zsSJyV

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[28] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. 2021. "Re: Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services" [PDF]. State Health Official Letter #21-008, December 28, 2021. https://bit.ly/3q8ydRv.

[29] For instance, SAMHSA's Description of a Good and Modern Addiction and Mental Health Service System clarified the roles of federal agencies that regulate or purchase these services. Its evidence-based practice toolkits and treatment improvement protocols for SUD offered states and providers guidance for implementing various community-based services that may prevent crises from occurring.

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