



STATES' OPTIONS AND
CHOICES IN FINANCING

988

AND CRISIS SERVICES
SYSTEMS

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TABLE OF CONTENTS

INTRODUCTION.....	5
STATES’ OPERATIONAL READINESS FOR 988	6
SECTION 1: ENHANCING AND FUNDING THE LIFELINE CRISIS CONTACT CENTER NETWORK . 8	
COMPLEXITIES OF THE LIFELINE CRISIS CONTACT CENTER NETWORK.....	8
NATIONAL SUICIDE PREVENTION LIFELINE PLANNING COMPONENTS.....	9
FEDERAL FINANCING FISCAL YEARS 2019-2022.....	10
SECTION 2: ENHANCING AND FUNDING THE BEHAVIORAL HEALTH CARE	
CRISIS SERVICES SYSTEM.....	12
BEHAVIORAL HEALTH CARE CRISIS SERVICES SYSTEM.....	12
STEPS FOR BUILDING A MISSING COMPONENT–CRISIS STABILIZATION SYSTEMS.....	13
STATE OPTIONS FOR FINANCING CRISIS SERVICES SYSTEMS	14
A. Utilizing 988 Related Fees on Telecommunication Users.....	14
B. Medicaid Reimbursements.....	15
C. Expanding Benefits to Cover Crisis Services	16
D. Options for Medicaid Matching.....	19
E. Existing Medicaid Authorities that Support Coverage.....	20
F. New Medicaid Support for Crisis Stabilization Services and Systems.....	21
G. New Set Aside for Mental Health Block Grant Funds.....	22
H. Direct Engagement with the Governor vs. State Legislative Committees for 988-specific Funding.....	23
I. Other Government Funding Sources.....	23
J. Insurance-Related Sources for Financing	24
K. Offsets for Savings in Health Care and Public Safety Costs	27
L. Partnerships with Stakeholder Groups with Resources for 988.....	29
SECTION 3: STATE BY STATE ANALYSIS OF FUNDING PLANNED OR PROPOSED	31
STATE LEGISLATION ENACTED WITH A FEE.....	31
Colorado: Senate Bill 154.....	31
Nevada: SB390	31
Virginia: SB1302	31
Washington: HB1477.....	32
STATE LEGISLATION ENACTED WITHOUT A FEE	32
Illinois: HB2784.....	32
Indiana: HB1468	33
Utah: SB155.....	33
STATE LEGISLATION REQUIRING A COMPREHENSIVE STUDY.....	33

Nebraska: LB247	33
New York: S6194B/A7177B.....	34
Oregon: HB2417	34
Texas: SB No. 1–General Appropriations Act.....	34
STATES WITH LEGISLATION ELIGIBLE FOR CONSIDERATION IN THE 2022 SESSION	35
California: AB988	35
Florida: SB478.....	35
Hawaii: HB1665, SB2205, SB2736, and SB3237.....	35
Illinois: SB2945.....	36
Kansas: HB2281	36
Kentucky: HB546 And HB373	36
Maryland: HB293 and SB241	37
Massachusetts: S. 2584, HB2081, S. 1274, and HB4269.....	37
Michigan: HB5353 and HB5354	37
Mississippi: HB732	37
New Jersey: A5496	37
Ohio: HB468.....	38
West Virginia: SB181	38
RESOLUTIONS	38
Alabama: HJR168.....	38
Idaho: HR11 and SB1125.....	38
EXAMPLES OF STATES WITHOUT LEGISLATION BUT WITH ROBUST CRISIS SYSTEMS	39
OBSTACLES AND OPPOSITION RELATED TO FINANCING	40
What has been the response to the industry?.....	41
Is the industry united in their opposition to a fee?.....	41
CONCLUSION	42
REFERENCES	44

STATES' OPTIONS AND CHOICES IN FINANCING 988 AND CRISIS SERVICES SYSTEMS

INTRODUCTION

The National Suicide Hotline Designation Act (S.2661) presents a significant new opportunity to address increased behavioral health needs. As the July 16, 2022 deadline for the new 988 Suicide Prevention and Mental Health Crisis Hotline number specified in the federal statute approaches, state planning is underway, and many states are submitting or passing bills to implement it. State mental health and substance use disorder agencies have considerable expertise in behavioral health and crisis systems as well as relationships with many of the various stakeholders that are required for leading this effort. The agencies now have both the responsibility and opportunity to build on their existing infrastructures or to reconfigure their current systems to meet their visions. They also have the responsibility to finance the system to be developed. Financing may be an even more challenging task, as the key goal is to provide sustainable funding. The Federal Communications Commission (FCC) envisioned that funding would function as it does for 911, through state-managed monthly fees that apply to all telecommunications carriers, and interconnected Voice over Internet Protocol (VoIP) service providers including one-way VoIP providers, and CMRS providers and providers of interconnected text messaging services. Although states clearly understand the benefit of that method, many are struggling with stakeholders' or legislators' perceptions of the fee as a "tax." New sources of short-term funding available from the federal government, including from the American Rescue Plan Act of 2021 have in some cases lessened the focus on the need for longer-term sustainable funding for 988 even though these short-term resources are critical for ramping up the Lifeline/988 system. This paper identifies building blocks that states can use to strengthen behavioral health crisis response and crisis systems of care, and short summaries of actions states are taking to finance them.

STATES' OPERATIONAL READINESS FOR 988

In 2018, the National Conference of State Legislatures (NCSL) posed a question to their members about suicide prevention that speaks to state readiness. "How likely is it that your state can reach the national goal of reducing suicide by 20% by 2025 at current resource levels?" More than 50% of states responded to the survey "very unlikely or somewhat unlikely." The states were also asked to identify the barriers to reaching the goal. The top barriers identified by states, territories and tribes were sufficient funding, adequate staffing, surveillance resources, suicide prevention legislation and policies, and coordination and integration of services between partners. NCSL also inquired about the state of their infrastructure. Only 32 states had specific offices/units dedicated to suicide prevention. The average number of staff dedicated to suicide prevention was 2.9 and 23.5% of states had only one dedicated staff person. Budgets ranged from \$0 to \$4.9 million, but 21.6% of states had no suicide prevention budget. In addition, most local call centers received minimal direct federal funding to support their operations and instead relied on funding from local, state, and private sources, as well as the significant utilization of volunteers. The funding mix differed among centers depending on the state and locality.

Vibrant Emotional Health, which administers the National Suicide Prevention Lifeline (Lifeline), and The National Council for Mental Wellbeing also conducted a national survey of call centers resulting in responses from 338 centers and released a "Crisis Services Survey Report" on March 13, 2019. The purpose of the survey was to learn about the scope and scale of crisis services, as well as their obstacles. The respondents had on average been in operation for over 26 years. The obstacles, starting with the most prevalent, were high staff turnover, lack of qualified applicants for positions, lack of funding, limited staff capacity, and limited resources for professional development and

training. When asked why resources had increased 4.6% from FY17 to FY18, 40% responded it was due to an increase in public funding. However, 20-30% reported decreases in public or private funding. Separately, in March 2021, via a landscape analysis survey conducted through fifty 988 State Planning Grants funded by Vibrant, 66% of the Lifeline centers responding to the survey (N=187) said they would be ready and able to handle upwards of a 30% increase in Lifeline call volume via 988 but only if they were able to secure funding to increase staffing.

During Spring 2022, the Substance Abuse and Mental Health Services Administration (SAMSHA) worked with stakeholders to develop "operational readiness criteria" for states/territories and tribes to self-assess their Lifeline readiness in categories such as Lifeline contact center capacity, technology and data, crisis care continuum capacity and capacity tracking, and communication and external engagement. It will provide direction and guidance as

The nation took a significant step forward with the enactment of the National Suicide Hotline Designation Act and the FCC ruling, but it is now in the hands of the states' leaders to move it forward.

states continue to plan for the transition to 988. The nation took a significant step forward with the enactment of the National Suicide Hotline Designation Act and the FCC ruling, but it is now in the hands of the states' leaders to move it forward. They know their needs, but this is the time for the leaders to ask themselves if they have adequately communicated the needs through the state hierarchy to their Governor and their legislative policy and budget committees, so they will be prepared to answer questions and make decisions

SECTION 1: ENHANCING AND FUNDING THE LIFELINE CRISIS CONTACT CENTER NETWORK

COMPLEXITIES OF THE LIFELINE CRISIS CONTACT CENTER NETWORK

State and local Lifeline crisis contact centers are preparing to transition to a new network structure that accommodates the three-digit number (988) and will be built directly on the existing Lifeline number (800-273-TALK), established in 2005. This work is incredibly complex, requires the system administrator to guide and bridge the network of independent centers, onboard centers into the network, provide a technology infrastructure, set training and performance standards, and collect performance data. The Lifeline, which operates 24 hours a day, 7 days a week, contains four primary elements:

- 1) a network of almost 200 independently operated and funded local call centers, including (as of April 2022) 52 chat/text centers and three Spanish language centers;
- 2) twelve national backup centers;
- 3) a connection for veterans and service members to be routed to the Veterans Crisis Line (VCL); and
- 4) a single national system administrator.

Callers are routed to the nearest local crisis center (based on area code), but if the local crisis centers are unable to answer, Lifeline re-routes the call to other in-state and national Lifeline centers that have agreed to serve as backups. Because most local centers are not yet able to handle chat and text, the crisis centers in the Lifeline network with those capabilities are able to apply for funding to provide chat and text services nationally. Of the 38 chat/text centers that were in the Lifeline network in mid-2021, half receive \$250,000 per year each in federal support to provide national level Lifeline chat services as contracted “core” chat centers. The other half respond only on an ad hoc basis as “support centers” receiving a limited federal stipend of \$2,500-\$5,000. While the capacity of the Lifeline network’s member centers continues to grow, analysis in December 2020 indicated that Lifeline member centers were able to respond to approximately 85% of calls. However, due to the limited number of chat/text centers at that time, only 56% of texts and 30% of chats received responses. While there are many reasons callers/chatters/texters may abandon their outreach to the Lifeline before a center can answer, the most common reason is likely driven by longer response times, particularly in relation to chats and texts.

In FY18, the Lifeline averaged 185,367 calls per month for a total of 2,224,408 calls answered. In FY19, call volume decreased to an average of 179,575 per month with a total of 2,154,903 calls answered. In FY20, call volume increased to an average of 182,086 per month for a total of

2,185,036 calls answered. Over 3.6 million contacts were received by the Lifeline in 2021—over 2.5 million calls, 1 million chats and over 81,000 texts. In addition, over 540,000 calls were routed to the Veterans Crisis Line in 2021.

NATIONAL SUICIDE PREVENTION LIFELINE PLANNING COMPONENTS

The Lifeline is working diligently to guide states' planning as this best facilitates creating a coordinated crisis system through the new 988 universal dialing code of the Lifeline. Vibrant provided the states with [grant opportunities](#) to support the planning and as part of the Request for Applications, a detailed [template](#) to guide it. The template provides an excellent picture of the scope of the 988 system and an understanding of the need for financing to support it now and into the future. It also describes eight core areas with goals for June 30, 2022 (Phase 1) and June 30, 2023 (Phase 2). A brief description of the enormous task to be accomplished by June 30, 2023 can be seen below.

8 Core Areas for Phases 1 and 2

CORE AREA 1: Ensure Statewide 24/7 Coverage for 988 Calls, Chats, and Texts.

State/territories will have ensured there is both statewide/territory-wide 24/7 primary and backup coverage for every county by in-state Lifeline member crisis contact centers for 988 calls, and crisis chat/text.

CORE AREA 2: Secure Adequate, Diversified, and Sustained Funding Streams for Lifeline Member Centers.

States/territories will have secured sustained funding from diversified sources sufficient to support the Lifeline centers for the dedicated handling of 988 crisis contacts and follow-up calls, including expected annual volume increases.

CORE AREA 3: Expand and Sustain Center Capacity to Maintain Target In-State/Territory Answer Rates for Current and Projected Call, Text, and Chat Volume.

States/territories will have achieved and maintained a 90% or higher in-state answer rate for Lifeline/988 calls and at least 80% of the 988 Year 1 projected chat/text volume.

CORE AREA 4: Support Crisis Centers in Meeting Lifeline's Operational Standards, Requirements, and Performance Metrics.

States/territories will have created a plan for meeting and maintaining operational standards, minimum membership requirements, and minimum performance metrics for 988 including alignment with Lifeline's key clinical standards, adoption of the unified contact management and a unified call routing platform.

CORE AREA 5: Convene a Coalition of Key Stakeholders to Advise on 988 Planning and Implementation.

State/territories will have had regular meetings with key stakeholders

and formed a 988 Planning Grant Coalition or similar groups to maintain a significant focus on 988 readiness through the end of Phase 2.

CORE AREA 6: Maintain a Comprehensive, Updated Listing of Resources, Referrals, and Linkages; Plan for Expanded Services. All Lifeline centers in the states/territories will have access to a shared, comprehensive statewide/territory-wide list of resources, referrals, and linkages to crisis care continuum of treatment resources/services.

CORE AREA 7: Ensure All State/Territory Centers Can Provide Best Practice Follow-Up to 988 Callers/Texters/Chatters. All Lifeline centers in the state/territories will be able to provide follow-up calls to callers, texters, and chatters using Lifeline’s best practices and guidelines. Centers will also have specified which center(s) will collectively be ready to handle a minimum of 100% or higher follow-up/outbound call volume.

CORE AREA 8: Plan and Implement Marketing for 988. SAMHSA and Vibrant Emotional Health, the administrator of the Lifeline, will create the national messaging and branding for 988 but will guide the states in developing strategies for promoting the new number. States and their stakeholders are required to identify key audiences, resources, dissemination channels, and other key elements, customizing the messaging for their purposes, and tracking data and impact.

As the implementation and maintenance of the complex contact center systems will be costly, states are looking to the federal government and their own governments for funding to finance the 988/Lifeline contact network and/or the continuum of services needed by individuals experiencing a crisis. SAMHSA has increasingly provided for the states and the NSPL to build the contact center infrastructure.

FEDERAL FINANCING FISCAL YEARS 2019-2022

In FY19, SAMHSA supported the continuation of the Suicide Lifeline grant by providing \$5.4 million in supplemental funding to enhance access to the Lifeline and strengthen the capacity of the Lifeline network to answer calls as rapidly as possible. In addition, SAMHSA awarded two new Crisis Center follow-up grants to provide an integrated hub. In FY20, SAMHSA again funded the continuation of the Suicide Lifeline and provided \$12 million in COVID-19 supplemental funding to enhance and increase the capacity and strengthen the Lifeline Network in states with highest need as well as the Lifeline’s backup centers. SAMHSA also provided a supplement of \$7 million using CARES Act funding to initiate a text service and to expand Lifeline’s crisis chat capacity. In addition, SAMHSA funded the continuation of two Crisis Center Follow-up grants and with CARES Act funding provided multi-year funding for three additional Crisis Center Follow-up Expansion grants. Congress’s history of funding for the Lifeline follows: FY18 \$7.2 million; FY19 \$12 million; FY20 \$19 million; FY21 \$24 million; and FY22 \$172 million, that was allocated late 2021 and detailed below.

In the FY21 Labor-HHS Appropriations Bill and Mental Health Block Grant (MHBG) appropriations bill, Congress identified two overarching goals that must inform 988's launch and future operations:

- **Strengthening and expanding the safety net capabilities** of the Lifeline, providing life-saving services to all who contact 988; and
- **Transforming our country's behavioral health crisis care system**, so that services are available to anyone, anywhere, anytime.

The [SAMHSA FY22 Congressional Justification](#) outlines the request for FY22, demonstrating their commitment to their goals with a total of \$282 million. An allocation of \$177 million (\$152 million new plus \$24.6 million existing) was made with a focus on strengthening and expanding the national backup network of centers that respond to calls, chats and texts when local centers are unable to answer, and centralized chat/text response services and backup center capacity, including the Spanish subnetwork. Separately, SAMHSA allocated an additional \$105 million directly to State Mental Health Agencies which, in turn, would subaward at least 85% of funds directly to Lifeline centers within their state in order to build up the workforce across local crisis call centers. The funding directly to states is short term, spanning two years with the clear expectation that the state will increasingly fund the in-state response to 988 contacts. For the first time, the FY21 Appropriations Act also instituted a 5% set-aside to the SAMHSA Mental Health Block Grant (MHBG) to support crisis services planning and development in every state.

SECTION 2: ENHANCING AND FUNDING THE BEHAVIORAL HEALTH CARE CRISIS SERVICES SYSTEM

BEHAVIORAL HEALTH CARE CRISIS SERVICES SYSTEM

The Federal Government’s FY22-24 commitment to financing the contact centers network reflects a strong commitment to supporting 988 readiness both at the state and national level. However, state investment in Lifeline member centers—who are the front door for 988 services—is still primarily seen as a responsibility of states. States will work collaboratively with both SAMHSA and Vibrant, as the

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administrator of the Lifeline, to ensure systems are in place for continuous quality improvement. At the same time, the states must also prepare to meet the demand for a continuum of behavioral health care services including expanding mobile crisis response and crisis stabilization services for those who contact 988. Financing again stands as the major obstacle. The weak links in each state/territory/tribe’s existing behavioral healthcare systems are evident to those working in behavioral health, but not as clear to those outside the field. There is both a task to educate about those needs and to identify methods to fix them. States and the Lifeline network are working diligently to ensure that the network components all work together to keep up with call, text and chat demand. A hole in the mental health and substance use treatment services continuum would have the same impact, preventing it from working efficiently and effectively like a “system” and thus not fully serving the individuals it is intended to help. The services identified as critical to a complete crisis service system are—24/7 regional crisis call center hub, centrally deployed 24/7 mobile crisis teams (whose staff should include behavioral health professionals and peers), short-term residential crisis receiving and stabilization services, and follow-up and prevention services, all with real-time coordination capabilities.

These factors bring the system into compliance with the National Guidelines for Behavioral Health Crisis Care - A Best Practice Toolkit and assist in meeting the Lifeline’s standards for risk assessment and engagement. Because these services have demonstrated their value in many locations in the country, states planning to reconfigure their systems can look to those areas service systems and financing methodologies as models.

STEPS FOR BUILDING A MISSING COMPONENT – CRISIS STABILIZATION SYSTEMS

Crisis receiving and stabilization services are an important “no wrong door” component of a crisis services system. The National Guidelines state that “it is important to fund these facility-based programs so they can deliver on the commitment of never rejecting a first responder or walk-in referral in order to realize actual emergency department and justice system diversion.” These vital components of the system are mostly missing, particularly in non-metropolitan areas, and therefore will need to be developed and funded.

A list of steps for building crisis stabilization systems is provided in a report entitled “[Funding Opportunities for Expanding Crisis Stabilization Systems and Services](#)” by the National Association for Behavioral Healthcare, and is summarized in the bullets below:

- Assess availability of services and address barriers in regulations and reimbursement
- Determine call centers capacity to respond to 988 contacts and protocols for coordination with 911 and other hotlines
- Implement electronic systems for real time tracking of availability of mobile crisis teams and crisis stabilization facility openings
- Amend state laws that create barriers to the use of alternative emergency response systems
- Train crisis services personnel provision of equitable responses to disadvantaged populations
- Expand use of peers for crisis stabilization and expand scopes of practice for other behavioral health practitioners
- Collect data to assess impact and ensure quality

Crisis system planning must also include an assessment of how current crisis stabilization services are organized and funded. Collaboration with and utilization of resources from federal, state and

county governments should be utilized to spread innovative municipal/regional approaches. An injection of new funding may be the easiest route, but sustainability is key. Financing may derive from a reallocation of existing resources or reconfiguration of existing services. Wake County, North Carolina and Philadelphia, Pennsylvania fund their mobile crisis and crisis stabilization initiatives through Medicaid behavioral health managed care organizations (MCOs), which have the flexibility to reinvest health care savings to fund innovative programs. To develop new sustainable funding streams, Fort Collins, Colorado and San Antonio, Texas used local ballot initiatives to institute a marginal municipal tax increase devoted to funding crisis response and stabilization initiatives.

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STATE OPTIONS FOR FINANCING CRISIS SERVICES SYSTEMS

States and territories have come to the realization that the federal government cannot be looked to as the permanent financier of the crisis services system. **SAMHSA has played an increasingly strong and critical role in shoring up the network infrastructure, but the states need to now take fiscal responsibility for sustaining that system and transforming their behavioral health crisis services systems.** In this context, sustaining may include diversifying sources of funding. Following is a discussion of methods for states to explore as they seek methods to financially sustain a reimagined crisis services system that will adequately serve the needs of their populations:

A. UTILIZING 988 RELATED FEES ON TELECOMMUNICATION USERS

Congress authorized states to pass user fees on telephone lines (commercial landline, mobile service, prepaid wireless voice service, and interconnected voice over internet protocol service lines), the same mechanism used to fund most 911 systems. For example, 911 fees assessed from telephone lines will raise approximately \$3 billion in 2020. It has been legal and acceptable in most of the country for 911 telecommunications providers to charge fees on their customers and to remit the collected fees to the relevant governmental bodies. Although this is a widely utilized and sustainable funding mechanism for 911, it has proved to be controversial for 988 as some perceive it as another tax and some telecommunications companies have lobbied against it. The federal law allows states to assess telecommunication fees for the purpose of (1) routing calls to 988 call centers approved by NSPL, and (2) for personnel and the provision of crisis services (acute mental health, crisis outreach, and stabilization services resulting from calls to 988). As there has been confusion regarding exactly what the law allows, the language from the Federal statute is provided below:

SEC. 4. <<NOTE: 47 USC 251a.>> STATE AUTHORITY OVER FEES.

(a) Authority.--

(1) In general.--Nothing in this Act, any amendment made by this Act, the Communications Act of 1934 (47 U.S.C. 151 et seq.), or any Commission regulation or order may prevent the imposition and collection of a fee or charge applicable to a commercial mobile service or an IP-enabled voice service specifically designated by a State, a political subdivision of a State, an Indian Tribe, or village or regional corporation serving a region established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.) for 9-8-8 related services, if the fee or charge is held in a sequestered account to be obligated or expended only in support of 9-8-8 services, or enhancements of such services, as specified in the provision of State or local law adopting the fee or charge.

(2) Use of 9-8-8 funds.--A fee or charge collected under this subsection shall only be imposed, collected, and used to pay expenses that a State, a political subdivision of

a State, an Indian Tribe, or village or regional corporation serving a region established pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.) is expected to incur that are reasonably attributed to--

(A) ensuring the efficient and effective routing of calls made to the 9-8-8 national suicide prevention and mental health crisis hotline to an appropriate crisis center; and

(B) personnel and the provision of acute mental health, crisis outreach and stabilization services by directly responding to the 9-8-8 national suicide prevention and mental health crisis hotline.

Virginia was the first state to pass a 988 user fee—\$0.08 per line for prepaid wireless and \$0.12 for subscription wireless to support all crisis centers that will answer 988 contacts. As of March 2022, Washington, Nevada, and Colorado also authorized small fees. Fees are not a new concept as they have been used to fund 911 systems since the 1970s. A fee is logically the most reliable method for sustained funding for a growing system. As 911 and 988 serve separate purposes, they require separate sustainable funding streams. The difference between 911 and 988 systems is that 911 is currently used for all emergencies, including behavioral health emergencies and 988 will be a universal dialing code for the suicide prevention and mental health crisis hotline. Calls to 988 will be managed by counselors at Lifeline member centers who are highly trained to assist people in emotional distress or suicidal crisis.

B. MEDICAID REIMBURSEMENTS

Recent Federal Medicaid laws have created new options for states and localities to strengthen and build better crisis response systems. Medicaid can cover a range of behavioral health services varying by population and authority, however not all state Medicaid Programs cover the full range of services. Medicaid’s coverage is generally more comprehensive than private insurance coverage. Behavioral health crisis services are funded through a patchwork of sources—primarily Medicaid, SAMHSA grant funding, private insurance, and state and local funds. It is estimated that millions of crisis calls that now go through 911 will be managed by state 988 crisis lines.

The Federal Medicaid Program requires states to cover a core list of health services, but many states add additional services they deem essential as “state-only services,” meaning financed only by the state. Although most states are using Medicaid to pay for some form of crisis services, states should examine whether their crisis systems are aligned with SAMHSA’s National Guidelines for Behavioral Health Crisis Care ([SAMHSA 2020a](#), [SAMHSA 2020b](#)), and with current reimbursement and funding opportunities. For example, some states may find that they could utilize Medicaid reimbursements for Lifeline/988 services as several states, including Arizona, have already done via 1115 waivers (explained below). However, it is important to note that there are key clinical considerations when determining whether to utilize Medicaid for Lifeline/988 calls, including careful protocols to ensure the process for gaining consent for calls

does not disrupt the crisis de-escalation and safety assessment process that is foundational to the Lifeline service.

A [Kaiser Family Foundation 2018 survey](#) “Medicaid Behavioral Health Services: Crisis Services” asked states to report coverage of services in their fee-for-service (FFS) programs for [categorically needy \(CN\)](#) traditional Medicaid adults ages 21 and older. The survey did not ask about medically needy (MN) coverage groups. Of the 46 states that responded 43 covered crisis services and three did not. “Covered” did not equate with comprehensive as twelve states had notable limits on services or days or other utilization controls.

Because Medicaid has not financed a full continuum of crisis services, states frequently use other local sources and even donations. However, [Medicaid programs](#) in a growing number of states are taking a growing role in supporting the crisis continuum although in some cases their crisis services may not align with SAMHSA’s guidelines.

C. EXPANDING BENEFITS TO COVER CRISIS SERVICES

Although Medicaid provides access to a broad array of behavioral health services, states are required to provide some benefits (such as hospital services), but many other services are optional. Therefore, expanding benefits provides options for states. In the [“Building Blocks: How Medicaid Can Advance Mental Health and Substance Use Crisis Response”](#) report released by Well Being Trust in 2021, authors Vikki Wachino and Natasha Camhi outlined the following options for Medicaid coverage of crisis services.

Rehabilitative services option. [Medicaid’s rehabilitative services option](#) is used to cover community-based mental health and substance use services. States can cover diagnostic, screening, preventive, and rehabilitative services needed to treat physical or mental disabilities and restore individual functioning. Louisiana uses the rehabilitative services option to cover crisis intervention services and follow up services. New Mexico offers crisis stabilization services and crisis triage centers. New Jersey covers 24/7 mobile services to children and families, and New York offers a set of services that includes crisis intervention as well as therapy, family support, and evaluation to people with intellectual and developmental disabilities with significant behavioral health needs.

Clinic option. The Medicaid clinic option covers services provided at a clinic and directly by or under the supervision of a physician. It can be used to cover outpatient behavioral health services and for individuals who are homeless. Clinic services can be provided by clinic personnel operating outside of the clinic setting, but the individual must be transported to a clinic in order to receive services. Maine and Wisconsin have reported using the clinic option to support some crisis services.

Services provided by some licensed practitioners. Under “other licensed practitioners” authority states have flexibility to cover medical or remedial non-physician services provided by licensed practitioners such as paramedics and clinical social workers.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). EPSDT is a comprehensive pediatric benefit that guarantees children’s access to all medically necessary optional and mandatory benefits if the service is medically necessary. EPSDT is unique in that it assures access to crisis services whether the state has elected any optional benefits. Massachusetts covers mobile crisis services for children in a state plan amendment under EPSDT as covered rehabilitative services.

Certified Community Behavioral Health Clinics (CCBHC). Crisis mental health services are one of the nine core services that are required to be provided by CCBHCs including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization. CCBHCs operate in 40 states and the District of Columbia. They can be authorized through Medicaid state plan amendments, waivers, or the use of grant funding.

Home and Community-based Services (HCBS). HCBS offer the option of receiving care in the home or community. HCBS can include a wide range of services and be authorized under several different Medicaid authorities, including 1915(i) state plan amendments and section 1915(c) waivers. In HCBS programs, crisis services operate as part of a broader benefit package.

Of the states that have established 1915(i) programs for people with mental health and substance use disorders, crisis intervention is one of the most offered service categories.

Section 1915(c) HCBS waivers. Using 1915(c) waivers, states may cover services to seniors and people with disabilities who meet an institutional level of care. These waivers can be designed to serve specific populations, locations, cover case management, habilitation services, and respite care. States are encouraged to have crisis plans for HCBS participants.

Section 1915(i) programs. Section 1915(i) programs offer another means of providing HCBS. The difference between 1915(c) and 1915(i) is that under 1915(i), states can offer home and community-based services to specified populations, regardless of whether the services meet an institutional level of care requirement. Of the states that have established 1915(i) programs for people with mental health and substance use disorders, crisis intervention is one of the most offered service categories. Maryland’s 1915(i) program, part of

a 2014 state plan amendment, serves seniors and people with disabilities and includes 24/7 mobile crisis response services.

Managed Care to Organize Service Delivery. Managed care is the most common method of service delivery in Medicaid. In 2019, forty states including the District of Columbia had managed care plans covering over 53 million individuals. States can establish and organize managed care systems through several different authorities and use them to establish crisis services as part of a broader delivery system. It offers flexibility to cover nontraditional benefits, to customize provider networks, and use contract requirements to ensure quality, access, and service provision standards.

“In lieu of” services. States and managed care organizations can authorize crisis services through Medicaid managed care contracts as an “in lieu of” service. In lieu of services are alternative services and settings that are cost effective and clinically appropriate substitutes for services and settings authorized under a state plan. Managed Care Organizations (MCOs) may choose whether to offer them, but the individual cannot be required to use them. Short-term crisis residential services were added as in lieu of services in 2016. Florida and Oregon use some MCOs to provide crisis services as in lieu of services.

1115 waivers. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that are “budget neutral” to the federal government. They give states additional flexibility to design and improve their programs. In general, demonstrations are approved for an initial five-year period, but can be extended up to an additional three to five years, depending on the populations served. An additional five-year extension may also be approved. The waiver goals are to reduce emergency department psychiatric boarding and hospital readmissions, improve community-based care and care coordination, continuity of care after inpatient stays, and improve crisis stabilization services.

Medicaid authorities may assist in building crisis care infrastructures for 988 and can also fund crisis stabilization programs without a section 1115 demonstration, including crisis call centers; provide an **administrative match** for developing and operating a crisis call center; as well as for an enhanced match of 90% and 75% respectively, if the state can demonstrate that it is using information technology to develop and operate a call center.

Section 1915(a) waivers. 1915a waivers enable the establishment of managed care programs with a limited geographic scope, designing programs to include crisis services as part of a larger set of community-based behavioral health services, and targeting a specific set of providers who have expertise and experience in providing community-based behavioral health services. An example is Wisconsin’s “Wraparound Milwaukee” program, which serves youth through children’s mobile crisis teams that can provide crisis intervention and case management to families. Wisconsin reported in 2014 that the program was effective in reducing use of residential treatment centers and inpatient psychiatric hospitalization.

Section 1915(b) waivers. 1915b waivers offer the opportunity to create statewide managed care systems or establish a network of specific types of providers (such as behavioral health providers). Michigan used a 1915(b) managed care waiver and other sources to cover a continuum of services that includes crisis response. Residential and ambulatory services as well as mobile crisis teams and crisis call lines are covered by the waiver. New York offers a set of behavioral health services in a network that is limited to Certified Community Behavioral Health Centers through a 1915(b) waiver.

New Community-based Mobile Crisis Intervention Services. On December 28, 2021, the Centers for Medicare & Medicaid Services (CMS) announced it is working with states to

promote access to Medicaid services for people with mental health and substance use disorder (MH/SUD) crises. This has opened a door for supporting community-based mobile crisis intervention services for individuals with Medicaid. It requires that crisis response teams include one qualified behavioral health care professional who can provide an assessment. Other professionals and paraprofessionals with expertise in MH/SUDs crisis response may also be included.

D. OPTIONS FOR MEDICAID MATCHING

ADMINISTRATIVE MATCH.

Medicaid supports activities to improve access for crisis stabilization services for some state and local administrative costs associated with providing crisis services such as support for 988 and other crisis call lines. The administrative match is 50% in all states. Medicaid can match state spending on the share of the call line that is attributable to Medicaid and CHIP beneficiaries. There is also flexibility for crisis call line services to be billed as services rather than administrative spending. An enhanced matching rate is available for developing call centers and technologies that connect people with MH/SUDs to mobile crisis call centers.

It is important to make a distinction between this administrative match and the federal medical assistance percentage (FMAP). FMAP is the federal payment share of reimbursement which is based on a formula that considers the average per capita income for each state relative to the national average. By law, the FMAP cannot be less than 50%. Georgia accesses Federal Medicaid funding to help cover administrative costs for their statewide crisis system that includes a hotline that dispatches mobile crisis teams. The state demonstrates the proportion of costs attributable to Medicaid beneficiaries by estimating the percent of residents with serious mental illness, addiction, and intellectual disabilities/developmental disabilities who are enrolled in Medicaid.

In addition, some administrative costs can be reimbursed at a higher federal matching rate, 90%, under the Medicaid Information Technology Architecture (MITA) and a 75% match for operating costs for mental health treatment and links to mobile crisis teams. It also applies to the development of data-sharing capabilities between hospitals and community-based mental health providers for state development of telehealth-enabling technology and electronic bed registries (with enhanced reimbursement of 90% for development costs and 75% for operational costs). Providing cell phones or iPads for mobile crisis teams to use to facilitate telehealth services with a clinician at another location, creating software applications to facilitate communication between crisis contact centers and supervisory clinicians with mobile crisis team staff, and implementing text and chat technologies are other examples of costs that may qualify for a higher match.

HEALTH SERVICES INITIATIVES.

These options permit states to receive the higher federal Children’s Health Insurance Program (CHIP) Medicaid matching rate (about 15 percentage points higher than Medicaid for a state) for projects aimed at improving children’s health. This is subject to the overall 10% cap on the use of CHIP funds for administrative purposes which must also account for spending to administer the CHIP funds. Some states use this flexible funding for projects such as suicide and violence prevention for LGBTQ youth.

ADULTS AND CHILDREN.

Additional Medicaid authority under the 21st Century Cures Act provides an administrative match opportunity for community-based services, for adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED). This includes demonstration projects under section 1115(a) SMI/SED demonstration opportunity.

E. EXISTING MEDICAID AUTHORITIES THAT SUPPORT COVERAGE

Virtually all state Medicaid programs cover crisis intervention or stabilization services using one or more Federal Medicaid authorities. In November 2018 guidance, “Opportunities to Design Innovative Services Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance,” states were notified that state plan benefits can authorize coverage that includes screening, assessment, diagnosis, mental health and addiction treatment services, targeted case management, psychiatric rehabilitation services, peer and family supports. Costs related to delivery of covered services may be included in the reimbursement rates. In this case states would want to incorporate ancillary costs identified as not directly coverable in the 2018 Medicaid guidance as part of their rate methodology. Reimbursement rates for crisis intervention and stabilization need to account for unscheduled 24/7 availability. Crisis stabilization reimbursement methodologies should be constructed such that professional fees are billed separately from the more inclusive team-based capacity rates because professional fees can generally be billed to Medicare.

The following are examples from states that have implemented comprehensive team-based capacity reimbursement rates in their Medicaid programs:

- The New Jersey Medicaid program covers Psychiatric Emergency Rehabilitation Services (PERS) including mobile services. Reimbursements include an “episode of care” payment for PERS certified assessors and PERS specialists. New Jersey has established rates for the first 23.99 hours (including a higher rate for mobile crisis intervention), and an additional hourly rate for care that extends beyond 24 hours in a crisis intervention facility. Psychiatrists and other licensed professionals bill separately for time spent on direct therapy using CPT codes. In addition, follow-up services are reimbursed per one-hour unit of service.

- Delaware covers 24/7 mobile and facility-based crisis intervention services and arranging for transfers, transport, and admissions. Reimbursement for facility services is at a per diem rate, and mobile crisis services reimbursement rates are paid per 15-minute interval.

TRANSPORT TO ALTERNATIVE DESTINATIONS.

In structuring a methodology to cover mobile crisis teams, Medicaid offers joint guidance for transporting beneficiaries to alternative destinations (non-emergency department) and covering practitioners in a variety of situations—including EMTs on the scene of a 911 response, on the scene without transport by EMTs, and on the scene by unlicensed practitioners under the preventive services Medicaid authority. In addition, the joint guidance extends to coverage of crisis stabilization services for transport to alternate destinations (including crisis stabilization centers) and coverage of the relevant HCPCS codes for emergency response services.

Maryland has had a Medicare waiver since 1977 that allows the Health Services Cost Review Commission (HSCRC) to set hospital rates for all payers (Medicare, Medicaid, and private insurers) in the State. To better control costs and improve quality, in recent years they began issuing grants to encourage greater collaboration between hospitals and community-based providers to develop crisis stabilization programs and services. A recent round of grants focused on supporting development of crisis stabilization systems in different regions within the State with the intent that hospitals will establish programs that offer individuals experiencing behavioral health crises alternatives to going to the hospital emergency departments.

F. NEW MEDICAID SUPPORT FOR CRISIS STABILIZATION SERVICES AND SYSTEMS

The American Rescue Plan Act of 2021 (ARPA) established two important new opportunities for states to increase support for crisis stabilization services in their Medicaid programs: an increased federal matching rate for five years for *qualifying* mobile crisis intervention services and for HCBS including benefits covered under the Medicaid rehabilitative services, case management, and 1915(i) authorities. It is potentially an even more flexible source of funding than the SAMHSA block grants. This new mobile crisis intervention benefit in Medicaid must involve one or more behavioral health professionals, including nurses, social workers, peer support specialists, and other professionals or paraprofessionals, one professional to provide an assessment/screening and an additional team member may be a peer, for a mobile crisis service to qualify for an 85% federal match. The team must be available 24/7, trained in trauma-informed care, de-escalation, and harm reduction, provide services outside hospitals or other facilities, and be able to provide stabilization, and coordination with health and social services and supports, and have relationships with local medical and behavioral health providers. States have a choice of offering mobile crisis services in limited geographic areas or for only specific populations.

Although Medicaid programs in every state cover some form of crisis stabilization services, several states do not provide Medicaid reimbursement for mobile crisis services, and some do not allow peers to participate in their Medicaid programs. The Medicaid program will pay for 85% of state spending on these mobile crisis services for the first three years in which these services are in place if the new matching funds do not supplant existing state funding. To qualify for the enhanced matching rate, effective April 2022–December 2024, the mobile crisis services must be authorized by the state and federal government in a state plan or waiver.

The Department of Treasury announcement and interim final rule specifically refer to behavioral health services including “crisis intervention” and “hotlines or warmlines” as allowable uses of these funds. There does not appear to be any prohibition on the use of these funds to cover construction costs. It also includes \$15 million in state planning grants for developing a state plan amendment or waiver request (e.g., Section 1915(b) or 1915(c)). The allocations to the states and localities are posted on the [Department of Treasury](#) website.

G. NEW SET ASIDE FOR MENTAL HEALTH BLOCK GRANT FUNDS

Mental Health Block Grants (MHBGs) have a reputation for providing the flexibility states need to be innovative in planning and providing services. [The Consolidated Appropriation Act of 2021 \(P.L. 116-260, Section 2701\)](#) includes a new 5% set aside in SAMHSA’s MHBG for evidence-based crisis care programs to address the needs of individuals with serious mental illness (SMI) and children with serious emotional disorders (SED). The House Appropriations

Committee specifically directed SAMHSA to use the set-aside to fund eligible states and territories for some or all of a set of core crisis care elements.

The application required states to submit revisions to their MHBG plans with detailed descriptions of the status of a state’s crisis system. States have until September 30, 2025, to spend the funding. SAMHSA encouraged states to focus some of the funding for the crisis stabilization continuum, special populations such as remote areas and underserved communities as well as children with SEDs. The funds may not be used for construction costs that relate to both MH/SA Prevention and Treatment Block Grants (SAPTBG) unless a waiver has been granted. The waiver requires a one-to-one match in cash for the federal funding used for construction among other requirements. For example, in the 988 State Planning Grants funded

to 50 agency awardees by Vibrant Emotional Health in 2021, preliminary analysis of the January 2022 final 988 plans indicated 19 states were allocating MHBG funds directly to support Lifeline/988 call, chat and text functions.

It is important to understand who holds the budgeting power in the state, especially if the state is seeking an appropriation from the budget.

H. DIRECT ENGAGEMENT WITH THE GOVERNOR VS. STATE LEGISLATIVE COMMITTEES FOR 988-SPECIFIC FUNDING

All state constitutions require that the state legislature enact appropriations for monies to be spent from the treasury. In that sense all legislatures control state budgets. However, Governors' powers to propose a budget set the terms of the discussion and give them the upper hand in many states. It is important to understand who holds the budgeting power in the state, especially if the state is seeking an appropriation from the budget for crisis services rather than, or in addition to, a bill with either a fee on telecommunications services and/or an appropriation. For example, the Maryland constitution gives the Governor more power than in most states. The Governor sets the revenue estimates that establish the basis for State spending; is required to submit a balanced budget proposal to the General Assembly; and the budget proposal includes all planned expenditures for the fiscal year. It is presented as both a budget bill and in detailed budget book volumes. The General Assembly can only cut the operating budget and cannot add to the budget. But there are states where the legislature dominates the process to the extent of producing a full alternative to the Governor's proposed budget. For example, Arizona, Colorado, New Mexico, Oklahoma, and Texas legislatures develop a state budget independently of the Governor. When planning a financing strategy, knowing who holds budgeting power in the state is particularly important.

I. OTHER GOVERNMENT FUNDING SOURCES

MEDICARE.

Despite the universal and growing need, most private insurers, Medicare, TRICARE, and large group health plans do not generally cover or pay for crisis services. Medicare and TRICARE are regulated solely by the federal government and therefore outside of the scope of states. Psychotherapy covers individuals in crisis, but not mobile crisis services, specifically.

Some providers may be able to take advantage of telehealth psychotherapy and "incident to" billing policies for higher credentialed providers. The "incident to" policy allows Medicare-enrolled providers to bill for services technically provided by an employee whom the provider supervises. Medicare also covers crisis psychotherapy when provided via audio-only telehealth. CMS recently clarified that supervision for "incident to" services may be provided via two-way audio-visual technology. Additionally, state agencies should ensure that services and consultations by higher credentialed providers via telehealth can be reimbursed as part of or as an adjunct to any team-based care payment methodology.

NEW MEDICARE PAYMENT MODEL.

Emergency Triage, Treat, and Transport (ET3) is a new payment model for emergency services for Medicare beneficiaries that pays for transportation of Medicare beneficiaries to alternative locations instead of traditional, usually hospital emergency departments. The five-year program tests two new Medicare payments:

- 1) for ambulance transport to alternative destinations not currently covered by Medicare; and
- 2) for treatment in place when appropriate by a qualified health care practitioner at the scene of an emergency response or via telehealth. Crisis stabilization centers should qualify as alternative settings for treating Medicare beneficiaries.

Payments to participants will be tied to performance on key quality measures in year three. The Centers for Medicare and Medicaid Innovation also provides funding to expand emergency and non-emergency medical triage services provided in response to calls to 911, but there may be an opportunity to coordinate these improved triage capacities with broader state and local efforts to increase the availability of triage services for callers to 988.

J. INSURANCE-RELATED SOURCES FOR FINANCING

COMMERCIAL INSURERS AND HEALTH PLANS.

Policymakers may want to consider a hybrid funding model to expand crisis intervention services under the American Recovery Plan. Because commercial insurance has taken a limited role in funding mobile crisis services, for the purpose of equity, a new model for funding mobile crisis services could be designed to hold payers accountable. States could include crisis services in their employee health coverage, through state exchanges and/or mandated third-party insurance reimbursement for services rendered to commercially covered individuals. This would provide regulatory leverage to ensure commercial insurers contribute to covering the cost of crisis services either through fees or by including crisis services providers in their provider networks.

States have historically imposed assessments on insurers to fund state priorities (e.g., marketplace operations, coverage for the uninsured, and the non-federal portion of Medicaid programs). Assessments may also be applied to managed care organizations and depending on the structure (typically applied to covered lives), it may be applied to self-insured ERISA plans.

Other insurance-related strategies include adding a service to the essential health benefit (EHB) benchmark plan, enforcing the federal Mental Health Parity and Addiction Equity Act (MHPAEA), and ensuring network adequacy for crisis services. These approaches and others are described below.

New Actions Regarding Crisis Standards and Private Insurance Mandates

New Federal Bill: In October 2021, [HR5611](#), the **Behavioral Health Crisis Services Expansion Act** was introduced to support the provision of behavioral health crisis services along a continuum of care. Specifically, the Department of Health and Human Services (DHHS) must establish standards for 24-7 crisis hotlines, emergency treatment, stabilization services, and other specified components. The bill expands health insurance coverage for behavioral health

crisis services and expands the MHBG to assist states and territories with developing the infrastructure to provide crisis response services. DHHS, in consultation with the Department of Justice, must convene an expert panel to make recommendations concerning training for emergency services dispatchers and crisis call center personnel. It was referred to the Subcommittee on Health on November 11, 2021.

Mandated benefits: States have the authority to require state regulated insurers to cover certain services, called “mandated benefits,” or include certain providers, in their health plans within federal parameters. These mandates are not popular with insurers as they increase their premium costs. States can regulate individual, small, and large group insurance plans thus adding crisis services as mandates, however, the advantage of doing so is limited because ERISA prevents states from imposing mandates on employer plans that are self-insured. Typically, employers with greater than 50 employees (64% nationally in 2021) are self-insured limiting the applicability of benefit mandates only to non-ERISA health plans, only the remaining 36%.

Essential Health Benefits (EHB): The Patient Protection and Affordable Care Act (ACA) requires insurers that sell fully insured individual and small employer health plans to cover at least ten essential health benefits (EHBs), including emergency, mental health, and substance use disorder (SUD) services. States were required to pick from one of ten existing options to serve as a “benchmark” plan. If a state requires insurers to cover a benefit that is over and above the state’s EHB benchmark plan, the state must cover the cost of the additional service for the individual. However, that can be avoided by proving that the scope of benefits is the actuarial equivalent of a “typical” employer plan and that the actuarial cost of adding the new benefit is no greater than the cost of the original benchmark plan. States could use this strategy to add a crisis service if the scope would not exceed that of the available plan options.

Additionally, an update of EHB benchmark plans includes a revision of the definition of emergency services to include mobile crisis services. It requires that the services be covered in the same way other medical services are covered for an acute or emergent medical condition. This may result in compliance with MHPAEA depending on how other medical and behavioral crises are defined.

Network Adequacy: Many states require regulated health plans to contract with a sufficient mix of providers to ensure a range of services and timely access to services for their enrollees. Therefore, in their review of adequacy states could require health plans to include crisis service providers within their contracted network to meet the network adequacy standard.

The “No Surprises” Act: The federal No Surprises Act, effective January 1, 2022, protects patients from unexpected out-of-network medical bills when receiving emergency services and when receiving services from out-of-network physicians working within an in-network facility. If a state included a crisis service in its definition of “emergency services” under either its own surprise billing law or by expanding on the federal standard, that would prohibit the out-of-

network provider from billing the patient for its services. Instead, the provider would need to seek reimbursement directly from the patient's health plan. State and federal payment dispute laws would resolve provider and insurer disputes and the patient would not be held liable for any more than the in-network cost-sharing of the service.

Coding for Health Care Services: Despite the widespread support of the Crisis Now model in public sector mental health systems, no standardized billing coding has been applied to these services. Also, there has been an inconsistent application of available "crisis" codes, including their use by behavioral health providers who do not operate true no-wrong-door crisis services. The lack of consistency in crisis coding application makes the establishment of statewide, regional, or even health plan-specific rates nearly impossible given that the broad application of these codes results in reimbursement of an extremely broad range of actual services. A solution may lie in SAMHSA's National Guidelines for Behavioral Health Crisis Care, published in February of 2020, which further detail minimum expectations and best practice standards for the delivery of three distinct crisis services so coding and reimbursement would be tied to alignment with the National Guidelines.

Mental Health Parity Enforcement

Mental Health Parity and Enforcement Act (MHPAEA) laws are being ignored by insurers and are unenforced by many states, although they are one of the critical foundations for ending discrimination in coverage. A 2018 study revealed that 32 states received a failing grade for their own parity statutes. In the analysis of state parity statutes only one state, Illinois, scored above 79. The Illinois parity statute, which scored 100, goes beyond federal parity protections. Combined, the Federal Parity Law and the Illinois statute apply to most health plans: large employer fully insured and self-insured plans, Medicaid, individual plans, state and local government plans, and federal government plans. The Illinois parity statute also has strong language to increase transparency and hold both insurers and regulators accountable. These steps would strengthen states' parity statutes, setting a solid foundation for enforcement and improving access to treatment for mental illness and substance use disorders. Some suggested actions are proper recognition of conditions by defining mental health conditions to include

all disorders in the Diagnostic and Statistical Manual of Mental Disorders or International Classification of Diseases; no extra restrictions by requiring that out-of-pocket costs and treatment limitations for behavioral health services be equitable with all other types of medical services; more consumer advocacy; designation of a lead for parity to enforce parity laws; better enforcement and compliance; regular analyses; and updated oversight mechanisms through intensive compliance verifications and reviews of consumer complaints, and compelling plans to come into compliance.

The Illinois parity statute has strong language to increase transparency and hold both insurers and regulators accountable.

The following are examples from states that have taken enforcement, compliance, and oversight to their Attorneys General and some have experienced successful outcomes:

- [Arizona's](#) SB1523, or "Jake's Law," requires insurers to submit [detailed analyses](#) on parity compliance every three years.
- Pennsylvania [announced](#) a \$1 million fine against United Healthcare based on violations of MHPAEA and other state regulatory requirements as a result of a recent [market conduct exam](#).
- [Massachusetts](#) reached a settlement with five health insurance companies and two managed mental health care companies based on state investigations into mental health parity violations.
- Rhode Island [announced](#) that United Healthcare had been found in violation of state and federal parity laws, would pay a \$350,000 fine to the state, and contribute \$2.85 million to a community mental health fund.
- Illinois [announced fines against](#) five major insurance companies for violating the MHPAEA.

2022 MHPAEA Report: A new report [2022 MHPAEA Report to Congress: Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage](#) was issued in January 2022 by the Department of the Treasury. The media called it "a scathing report of insurers' compliance with the law as well as states' efforts to require insurers to comply." The conclusion of the report stated, "The Department recommends that Congress consider amending MHPAEA to ensure that MH/SUD benefits are defined in an objective and uniform manner pursuant to external benchmarks that are based in nationally recognized standards." Actions taken by states to strengthen private insurers' compliance will likely align with potential future actions taken by Congress.

K. OFFSETS FOR SAVINGS IN HEALTH CARE AND PUBLIC SAFETY COSTS

Although the goal of 988 is to save and improve lives, 988 also has the potential to lower health care and public safety costs by diverting calls from 911, averting costs for the dispatcher and system, the first responder personnel, and the often-resulting emergency department visit or hospitalization. For example, call/chat/text volume and cost predictions for 988 were calculated by Vibrant Emotional Health in spring 2021. The predictions estimated that, under a medium growth scenario, up to 2 million contacts might be diverted from 911 into the 988 system in the first year, with the number growing to 11 million contacts in year five.

Reducing the dispatch of law enforcement to persons in non-emergent mental health crises frees more resources to respond to public safety needs. Call centers in the Lifeline divert hundreds of thousands of calls from 911 every year. Lifeline dispatches, on average, emergency services for only 2% of calls and of those calls, approximately 60% are done in full collaboration

with the individuals in crisis. Simply put, people in crisis who call the Lifeline often have better health outcomes than people in crisis who are triaged initially via emergency services personnel as is typically the case with mental health crisis calls that start at 911.

Numerous studies have demonstrated that crisis services reduce spending on emergency department (ED) visits and inpatient hospitalizations. In one study, a mobile crisis intervention decreased spending on inpatient admissions by 79%, and in another, the addition of a clinician co-responder reduced costs by 23% compared to regular policing due to fewer inpatient admissions. A claims analysis of crisis stabilization services estimated a \$2.16 return on investment due to savings in inpatient, outpatient, and ED utilization. In 2010, The Health Care Financial Management Association estimated that eliminating unnecessary ED use in the U.S. could save as much as \$4.6 billion annually. Their updated analysis in 2019 increased that figure to \$8.3 billion annually. Their findings were based on an analysis of its 750-hospital database and focused on six chronic conditions—particularly behavioral health, diabetes, and hypertension—to identify patients who could have been treated in less costly settings.

People in crisis who call the Lifeline often have better health outcomes than people in crisis who are triaged initially via emergency services

Better crisis response benefits the law enforcement and the justice system in other ways as well. Crisis Intervention Team (CIT) training in the Denver Police Department resulted in follow-up care for more than 44% of individuals rather than arrest and incarcerations, saving the state over \$3 million in jail expenses. By changing the response to suicidal callers “barricaded” in their homes, the Tucson Police Department reduced the number of SWAT deployments from fourteen per year to two, at a cost savings of \$15,000 each. Maricopa County, Arizona, has a robust crisis system composed of call centers, mobile teams, and crisis stabilization centers. In 2016, the system served approximately 22,000 individuals and generated savings of \$260 million in hospital spending, \$37 million in ED spending, 45 years of ED psychiatric boarding hours, and 37 full-time equivalents of police officer time and salary.

The Eugene, Oregon Crime Analysis Unit estimates that CAHOOTS teams divert an estimated 58% of calls to 911 that would otherwise have been dispatched to police officers, and the likely number of avoided police calls at 6,346, an estimated savings of \$1.23 million. The unit has stated that number does not tell the full value of the program.

SAMHSA’s Assessment of Savings. Based on the Center for Disease Control and Prevention (CDC) data, **SAMHSA estimated that a 0.1% reduction in suicide mortality will create \$2.4 billion in present value benefits over a ten-year period.** CDC estimated that the 41,149 suicides in 2013 cost the U.S. economy almost \$51 billion and suicide attempts \$12 billion in medical treatment and value of lost work. However, the true bottom line is what

we want and need for individuals in crisis...immediate access to help, hope and healing because it saves lives.

L. PARTNERSHIPS WITH STAKEHOLDER GROUPS WITH RESOURCES FOR 988

WHAT VALUE DOES PHILANTHROPY BRING TO FUNDING CRISIS SYSTEMS?

Philanthropic support takes many forms. It can fund nonprofit programs that provide direct services to those in need; increase the capacity of systems so that programs can function more effectively and efficiently; fund research that underpins programs; and support policy initiatives that are needed to sustain them. Private sector investment in a national crisis hotline is not new. In the early 1970s, the Robert Wood Johnson Foundation was instrumental in supporting the newly established 911. Prior to 911, many people in accidents died on their way to hospitals due to lack of medical treatment en route. Now, dialing 911 is an integral part of saving lives. Community investment in 988 will substantially improve emergency mental health services and suicide prevention.

McKinsey's Insurance Practice partnered with the Insurance Industry's Charitable Foundation to assess the state of and trends in charitable giving in the American insurance industry to highlight opportunities for the industry to achieve greater impact through giving. The results may provide some direction for requests for donations and grants:

- **The level of giving has remained consistent, with a focus on education, health and social services, and community** due to consolidations, and because philanthropy is more oriented to volunteerism. As a result, industry-wide giving has held steady since 2015 at \$560-\$600 million.
- **Companies more evenly value a balance of business needs, stakeholder interests, and community needs** which influence their strategic approach to charitable giving.
- **Measurement of the impact of charitable giving has increased.** Respondents are using key performance indicators to evaluate the benefits of their philanthropic activities.
- **Millennials' preferences have begun to influence charitable giving.** Millennials prefer to work for companies involved in charitable causes, thus making a social impact through their work.
- **Company-organized employee volunteering** rose from 0% (2015) to 17% (2019).
- **Health and social services, community, and education** have continued to be the top causes for donations with health or social services contributions remaining consistent.
- **Geographically**, about 30% of respondents prioritize giving to communities where employees live and work and where significant business is conducted.

- Cash donations or grants continue to make up the bulk of giving (65%).

THE SOZOSEI FOUNDATION.

The Sozosei Foundation is committed to spreading the word about 988. Throughout the year, the Foundation makes [open calls for proposals](#) across program areas. The Foundation believes that there is a clear and urgent need for the philanthropic community to provide planning, seed, research, evaluation, and infrastructure funding to the field as well as resources to assist advocates in establishing robust federal and state policies and locking in future funding streams. They have spoken to the fact that even after the official implementation date of 988, continued philanthropic support will be crucial. Sozosei has identified initial opportunities for philanthropic investment: ensuring adequate funding for 988 implementations, improving 988 and 911 regulations, building an evidence-based local crisis response, ensuring 988 is a well-publicized and received local opportunity, leveraging 988 implementations to increase community-based care, and supporting youth engagement with 988.

THE KENNEDY FORUM.

The Kennedy Forum joined other leading mental health organizations in [calling on Congress](#) to pass the National Suicide Hotline Designation Act.

SECTION 3: STATE BY STATE ANALYSIS OF FUNDING PLANNED OR PROPOSED

With planning for 988 contact centers and a continuum of behavioral health services well underway, states have moved to solidify their efforts for sustainable funding through legislation. The financing and sustainability approaches for bills introduced through January 2022 are discussed below.

STATE LEGISLATION ENACTED WITH A FEE

COLORADO: SENATE BILL 154

Senate Bill 154 establishes a 988 suicide prevention lifeline network, imposes an E-988 surcharge on prepaid wireless services, and creates a unique entity called the “988 Crisis Hotline Enterprise” which is a business within the government. As constructed, the revenues are not State fiscal year spending, and the charges are not a tax, but a fee, because the charges are imposed for the specific purpose of allowing the Enterprise to defray the costs of providing the benefits and services. The revenues are held in a cash fund for the purposes of creating and maintaining the 988 system.

A customer of prepaid wireless services will be charged both an E-988 and an E-911 surcharge. The fee is established annually and must be uniform across technologies used. The initial rate of \$0.18 will be reviewed annually but may not exceed \$0.30 per retail transaction.

The State’s Fiscal Analysis shows an appropriation total of \$5.7 million in cash funds from the 988 Crisis Hotline Cash Fund to the Department of Human Services for FY21-22, \$8.5 for FY22-23, and \$10.7 million to multiple state agencies for implementation and operation of the crisis system and the fund. Expenses anticipated for FY22-23 are \$8.0 million.

NEVADA: SB390

SB390 requires the Division of Behavioral Health within the Department of Health and Human Services to establish one or more 988 hotlines by July 1, 2022. The law requires imposition of a surcharge that must sufficiently support the uses specified (988 operations, technology, mobile crisis and crisis stabilization) but must not exceed \$0.35 for each access line or trunk line. Nevada anticipates \$13.3 million per year in revenue. A fiscal note prepared by the Division indicated that there is no fiscal impact in FY20-21 nor beyond.

VIRGINIA: SB1302

Virginia’s attempt to enact 988 legislation failed with SB1302. However, the bill’s language was moved into a package that passed during a Special Session. Effective on July 1, 2021, Virginia’s legislation was the first in the nation to provide for a 988 surcharge on retail prepaid wireless

services to fund a 988 hotline. Consumers with a subscription wireless plan will pay \$0.12 monthly and those with prepaid wireless services will pay \$0.08 per retail transaction. Revenues from the fees will be spent on the crisis system along the *entire* continuum of care.

In the Governor's budget for the Office of Health and Human Services, funds from the American Rescue Plan Act (ARPA) have been allocated through General Funds for the transformation of the crisis services system (FY23: \$2 million; FY24: \$22 million). Two additional administrative positions are budgeted for the growing crisis services system (FY23: \$300,000; FY24: \$300,000). An appropriation from the e988 funds for operating and maintenance costs of the crisis call center is also budgeted (FY23 \$0; FY24 \$1.7 million). Funding for call center staff will be appropriated in grants to localities (FY23 \$4.7 million; FY24 \$7.5 million).

WASHINGTON: HB1477

Through HB1477, Washington State will have a new excise tax to fund a statewide 988 behavioral health crisis response and suicide prevention line. Beginning October 1, 2021, the tax will be collected on every telephone line and prepaid wireless retail transaction (switched access lines, voice over internet protocol (VOIP) service lines, and radio access lines, and retailers of prepaid wireless services) sourced to Washington. The tax rate is \$0.24 per line or retail sale of prepaid wireless service for the period October 1, 2021–December 31, 2022, and will change to \$0.40 for January 1, 2023, and after. Over 10 years the funds collected will exceed \$400 million.

In addition to the excise tax, Washington provided \$23 million for 988 for two years beginning June 30, 2023, for 988 call routing, call center operations and call center hubs, and another \$1 million for a tribal crisis line and other supporting agencies. The Washington Health Authority will receive an appropriation of almost \$2 million for staffing, planning and other administrative functions.

Office of the Governor/Office of Financial Management sent a bulletin (June 21, 2021) regarding the passage of the bill with a Fiscal Year 988 Tax Line revealing FY22 funding of \$17.9 million, increasing to \$36.1 million in FY23 and out ten years to FY31 at \$48.9 million.

STATE LEGISLATION ENACTED WITHOUT A FEE

ILLINOIS: HB2784

HB2784 relates to the implementation of a 988 system, the "Community Emergency Services and Support Act." The bill language is primarily related to coordination between 988 and 911. The bill does not establish a funding source, although a second bill, SB2945 (see the "States with Legislation Eligible for Consideration in the 2022 Session" section), which was reported favorably on January 11, 2022, would create a 988 trust fund. HB2784 became public law on September 25, 2021 and took effect on January 1, 2022.

INDIANA: HB1468

Indiana's HB1468 will establish a non-reverting 988 Trust Fund from appropriations made by the General Assembly, Federal funds, investment earnings, including interest on money in the fund and other sources. The additional funds and resources required could be supplied through existing staff and resources currently being used in another program, with new appropriations, or through fees collected for the 988 system. Ultimately, the source of funds and resources required to satisfy these requirements of the bill will depend on legislative and administrative actions. The Legislative Services Administration estimates need for three staff positions estimated at \$228,000 (FY22) and \$230,000 (FY23). Indiana's Fiscal Note explains that the bill allows, but does not require, the Division of Mental Health and Addiction to designate 988 crisis centers and exert oversight and coordination of their suicide prevention and crisis services.

UTAH: SB155

SB155, the Mental Health Crisis Assistance bill, is designed to fund and strengthen crisis services. It creates a restricted account for funds, requires Medicaid to adopt or apply for a state plan amendment to support the crisis services and contact center, and requires a detailed report of services and financing by the end of 2021. At this time the Utah Crisis Response Commission is exploring opportunities such as creating a 988 restricted account for fees collected, other funds appropriated by the Legislature, and donations.

Funding in the FY21 988 Bill includes a \$2,451,800 one-time supplement. In FY22, \$1,851,800 ongoing builds on a \$2.2 million budget for crisis line as well as prior Mobile Crisis Outreach Team and Receiving Center funding. The appropriation in the Base Budget Bill for 988 includes FY22 \$6,947,200 ongoing and FY23 \$15,903,100 ongoing. Utah has budgeted \$27.4 million from State, federal and private funding sources. They expect Medicaid penetration to scale up to 40-50% for reimbursement on all service lines (pending CMS approval).

STATE LEGISLATION REQUIRING A COMPREHENSIVE STUDY

NEBRASKA: LB247

The State of Nebraska passed LB247 which creates a Mental Health Crisis Hotline Task Force to develop an implementation plan for Nebraska to integrate and utilize a 988 mental health crisis hotline. The Task Force will determine how to integrate local mental health crisis hotlines; develop a plan for staffing a statewide mental health crisis hotline; and conduct a cost analysis to determine how a fee structure could be designed to cover the costs. The first meeting was held on April 29, 2021, and additional meetings are planned through June 2022.

NEW YORK: S6194B/A7177B

S6194B/A7177B would provide for the efficient and effective routing of 988 contacts, personnel, crisis outreach and the establishment of a trust. As the Senate and House did not agree upon sustained funding via a fee, a financial analysis is required to examine available and new revenue sources to support the 988 services. The report was to be submitted to designated parties on or before December 31, 2021. In January 2022, New York announced funding for 988 services of \$35 million for FY22-23 and \$60 million in FY23-24. Note: Bill numbers for 2022 are A8711 and S7850.

OREGON: HB2417

Through HB2417, the legislature set aside General Fund dollars to implement 988 call centers and infrastructure. Legislators will continue to explore the most sustainable funding sources. The Oregon statute does not mandate a fee but raises the question whether a fee should be proposed to pay expenses incurred. A report will include that if a fee is proposed, the following information should be included: (a) the proposed fee amount; (b) the proposed mechanism for the fee, including the type of telecommunications lines or accounts on which the fee will be imposed; (c) the allocation of the fee revenue, including the crisis services to which the fee will be allocated, the estimated cost of those services, and whether any portion of the fee revenue will be eligible for Medicaid match; and (d) whether the proposed fee revenue will supplant any existing funding.

The Oregon Impact Statement explains that the bill directs the Oregon Health Authority (OHA) to provide grants to cities or funding to county community mental health programs to fund mobile crisis intervention teams and other specified programs. It appropriates \$10 million in General Funds to the OHA to provide grants and funding for mobile crisis intervention teams and funds one full-time position at the White Bird Clinic in the City of Eugene. A work group will study continuing to fund crisis services.

TEXAS: SB NO. 1—GENERAL APPROPRIATIONS ACT

The Texas State Legislature in their General Appropriations Act (Senate Bill 1—General Appropriations Act) included language regarding a “Study Related to 9-8-8 Implementation.” It directed their Health and Human Services Commission to study “the adequacy and efficacy of existing National Suicide Prevention Lifeline (NSPL) infrastructure.” In addition, the Commission is to make recommendations for sources of sustainable funding for the NSPL infrastructure and crisis response services and submit a report by September 1, 2022. No fiscal information was provided.

STATES WITH LEGISLATION ELIGIBLE FOR CONSIDERATION IN THE 2022 SESSION

CALIFORNIA: AB988

The 2022-23 Budget Proposal for California includes \$7.5 million in General Funds for the Office of Emergency Services to begin implementation of the 988 call system and support call technology for volume and call transfers between the 988 and 911 systems. An additional \$108 million in total funds (\$16 million General Fund) would be appropriated for the Department of Health Care Services to add community-based mobile crisis intervention services as a new Medi-Cal benefit as soon as January 1, 2023.

FLORIDA: SB478

The Statewide Office for Suicide Prevention within the Department of Children and Families is to conduct a study to assess the adequacy of the current infrastructure of Florida's NSPL system and the State's behavioral health crisis system and inform the legislature on how best to provide appropriate and sustainable funding for changes required by the 988 Act and the FCC regulations. Florida will also examine mental health block grant funds, the opioid settlement, the American Rescue Plan Act (ARPA), the CARES Act, the Medicaid program or other federal legislation that could be used to support the NSPL and crisis response infrastructure.

HAWAII: HB1665, SB2205, SB2736, AND SB3237

Hawaii introduced four crisis system related bills in January 2022.

HB1665 establishes a core State behavioral health crisis services system. The bill does not speak to how it would be financed; however, the mobile crisis teams would be funded by the State and/or locally. No fund source for the MCTs (Mobile Crisis Teams) has been identified.

SB2205 establishes a task force to develop an implementation plan for a suicide hotline. The bill requires an appropriation for FY22-23 from general revenues of an amount that was left blank in the bill. Also, two bills have been introduced that would create mobile crisis teams.

SB2736 would appropriate general revenues of \$1,700,000 or "so much thereof as may be necessary" for FY22-23 for a program like CAHOOTS.

SB3237 would expand and develop crisis response services for children and be financed through an appropriation of general revenues of \$1,700,000 or "so much thereof as may be necessary" for FY22-23.

ILLINOIS: SB2945

SB2945 was not enacted but was referred to the Assignments Committee on October 26, 2021. It describes the components of the Fund: (1) appropriations by the General Assembly, (2) grants and gifts intended for deposit in the Fund; (3) interest, premiums, gains, or other earnings on the Fund; and (4) moneys from any other source that are deposited in or transferred to the Fund.

KANSAS: HB2281

Kansas had proposed a monthly \$0.50 surcharge to be imposed effective July 2022 on accounts of any exchange telecommunications service, wireless telecommunications service, VOIP service or other service capable of contacting a hotline center. A fee would not be imposed on prepaid wireless service. The surcharges would generate about \$17.4 million each year, including \$5.5 million for mobile crisis response teams, \$4 million for crisis stabilization services, and about \$2.8 million for a mobile crisis services program for individuals with intellectual or developmental disabilities. Another \$3 million is dedicated to Kansas call centers for staffing the suicide-prevention hotline and about \$1 million for a statewide media campaign. The State had a tiered cellphone charge of \$0.50, \$0.45, \$0.40 or \$0.35. However, since the bill stalled, the House Appropriations Committee agreed to put \$7 million into the State budget for 988 services (less than what would have been generated by the \$0.50 surcharge on phones). In early March, the fee was reduced to \$0.20. The House proposal provides \$1.5 million for call center staffing, \$3 million for mobile crisis response teams and \$2 million for crisis stabilization services.

KENTUCKY: HB546 AND HB373

HB546 included a description of the types of funds that would become part of a restricted and permanent fund overseen by the cabinet. Included in that list are individual exchange-line taxes, private commercial telephone service or owners of a dispersed private telephone system for collecting and remitting the subscriber charge; and a tax on any provider of interconnected VOIP local and 988 emergency services for compensation.

Kentucky also intends to utilize the 5% crisis set aside required funding to support current efforts aimed at the implementation of 988 services (text and chat) in Kentucky and to support programming aimed at the delivery of evidence-based practices to address substance use disorders. Specifically, funding will be used to increase crisis response capacity. The bill failed and is not eligible for consideration in 2022. However, the State plans to use about \$3.3 million from COVID and ARPA block grant funds for implementation of Lifeline response.

HB373 has been introduced (2022) and would establish a 988 mental health crisis hotline and create a 988 oversight board. A crisis restricted fund would hold the proceeds from a 988 service charge of \$0.70 and become effective January 1, 2023.

MARYLAND: [HB293](#) AND [SB241](#)

In January 2022, two companion bills, HB293 and SB241 were introduced to create a Trust Fund for 988. The bills also provide that for FY22, the Governor would appropriate \$10 million for the 988 Trust Fund.

MASSACHUSETTS: [S. 2584](#), [HB2081](#), [S. 1274](#), AND [HB4269](#)

A State 988 Commission will be formed to provide ongoing 988 strategic oversight and guidance including recommendations for possible user fees.

MICHIGAN: [HB5353](#) AND [HB5354](#)

Michigan has two bills related to 988—one creates the crisis system (HB5353) and the other defines the funding (HB5354). Neither would take effect unless the other is enacted. Hotline operations are expected to cost between \$1 million to \$2.5 million annually. The sources of funds are the state's 988 phone charge and prepaid wireless 988 charges, grants and other sources. The Department of Treasury will establish both a monthly State 988 charge and a prepaid wireless 988 charge to cover a statewide 988 crisis system and the continuum of services. Service suppliers will bill \$0.55 and a prepaid wireless 988 charge (2% per retail transaction or 5% for bundled products) must be collected for each retail transaction. These charges may be adjusted for continuous operation, volume increase, and maintenance.

MISSISSIPPI: [HB732](#)

Mississippi has introduced HB732, which creates a study commission on the 988 comprehensive behavioral health crisis response system. The commission will assess and develop recommendations for crisis response services and adequately funding crisis response services statewide thus sustaining the call centers and crisis services. The bill was voted favorably out of the committee, but no fiscal impact information was provided.

NEW JERSEY: [A5496](#)

A5496 is a bill for consideration in 2022. The source of their 988 funds would be a statewide 988 fee assessed on users, appropriations, grants and more. The statewide fee would be imposed on commercial mobile services or IP-enabled voice services. The 988 fee is not to be applied to mobile service users who receive benefits under the federal Lifeline program. It would be a fixed rate that provides for the creation, operation, and maintenance of the system as well as the continuum of services to be provided. Revenue generated by the 988 fees would be expended only in support of 988 services or enhancements and would be maintained in a 988 trust. The bill was refiled for the 2022–2023 session. The financing is the same, but there are new companion bill numbers, [A2036](#) and [S311](#).

OHIO: HB468

HB468 will create a 988-fund consisting of General Fund appropriations, donations, and other monies. Within 90 days, the Ohio Department of Mental Health and Addiction Services will adopt rules regarding oversight of the hotline. Tasks will be assigned to a new agency, commission, or other entity to complete the planning and implementation necessary. It will also ensure an effective date of July 16, 2022, to be consistent with the 988 Act and FCC rules.

WEST VIRGINIA: SB181

West Virginia's Core Behavioral Health Crisis Services System bill (SB181) was introduced in January 2022. The bill would establish a trust fund from a combination of sources—a statewide 988 fee assessed on users, State appropriations, and other sources. The fund is to be used to pay expenses for ensuring the efficient and effective routing of calls made to 988, to the designated hotline center(s), staffing and technological infrastructure with necessary enhancements, personnel and the provision of acute behavioral health, crisis services, data, related quality improvement activities, and oversight of the fund. The monthly fee would be charged to each resident that is a subscriber of commercial mobile and/or IP-enabled voice services. The fee would be established in a separate section of the statute: Chapter 24, Public Service Commission, Article 6, which authorizes a fee for the 911 system. It would begin July 1, 2022 and be collected from each in-State two-way service subscriber. The 988 fee would be \$0.11 per month and will be shown as a separate fee on the subscriber's bill. However, in early March 2022 the fee was eliminated, and the funding source was changed to the State's budget.

RESOLUTIONS

ALABAMA: HJR168

The 9-8-8 Comprehensive Behavioral Health Crisis Communication System Commission created by HJR168 will study several items related to a 988 crisis system. The items related to financing are strategies for identifying and supporting investment in modern technology to triage calls and link individuals to follow-up care, and funding to boost the financial stability and sustainability of call centers, and evidence-based crisis services in every county. The goal is for people experiencing behavioral health crises to receive higher quality supports. The Study Commission was to have submitted a report on or before January 11, 2022. The bill passed but as a resolution, which does not carry the same weight as the law.

IDAHO: HR11 AND SB1125

By way of a resolution the Idaho legislature recognized 988 as the universal mental health and suicide prevention crisis phone number, effective July 2022. The resolution has no references related to financing a 988 crisis care system. The companion bill SB1125 had been introduced

on February 15, 2022 and died in the Health & Welfare Committee on February 16. It was reported that the representatives of telecommunications companies pushed back on the idea and raised so many questions that it was unable to be advanced. The fee would have been imposed only in counties or 911 service areas in which voters had approved the emergency service. A deduction would be allowed for uncollected amounts, and there would be no obligation to pursue uncollected amounts. When the fund exceeded \$100 million, the fee would stop until the fund was reduced to \$50 million. On the other hand, the fee could be adjusted as needed to provide for continuous operation, volume increases, and maintenance, but not exceed the amount collected for 911. The fiscal note for Senate Bill 1125 estimated a \$1 per phone line per month charge to raise \$20 million per year. The hotline has been funded predominantly by individual donors and fundraising efforts, with the remaining 30% coming from State funds. The legislature approved an additional \$300,000 for suicide prevention as part of the Division of Public Health Services' budget.

EXAMPLES OF STATES WITHOUT LEGISLATION BUT WITH ROBUST CRISIS SYSTEMS

Three examples of states that did not pursue 988 legislation but have financed their behavioral health systems with creative funding methodologies follow:

Arizona: Arizona's behavioral health crisis system is operated by the State Medicaid Agency and administered by three regional behavioral health authorities that contract directly with community behavioral health providers. Crisis services include three regional 24-hour hotlines, mobile crisis response teams, and facility-based crisis stabilization. It includes state-of-the-art crisis stabilization facilities statewide. Medicaid in Arizona operates under a broad Section 1115 waiver, allowing for a managed care model, and provides a per member per month payment for crisis services, which funds regional authorities to establish contracts for and oversight of crisis services. In FY20, Arizona spent \$245 million on these services—Medicaid funded the majority (\$217 million) and State and local funds were used to serve individuals who were not eligible for Medicaid (\$28 million). The State also generates funding for its crisis hotlines by billing Medicaid for crisis intervention and emergency management services rendered by mental health providers employed by the hotlines. Arizona's Medicaid billing code for crisis hotlines is H0030 (Behavioral Health Hotline Service in 15-minute increments) and for mobile crisis teams H2011 (HT Crisis Intervention Service - multi-disciplinary team).

Georgia: In 2009, the U.S. Department of Justice sued the State of Georgia for violating the ADA and Supreme Court's Olmstead case on behalf of individuals with serious mental illness or intellectual and developmental disabilities who were stuck in institutional settings due to inadequate community-based care. The settlement agreement gave Georgia about five years to integrate 9,000 people with serious mental illness into the community and required mobile crisis teams and assertive community treatment. The State's current behavioral health crisis system includes mobile crisis teams with GPS dispatch, statewide crisis hotlines, crisis stabilization centers, and a real time psychiatric bed registry that includes 72-hour crisis

residential programs and detoxification beds. In FY19, costs for the State’s crisis continuum were supported by Medicaid (\$12.8 million) and State General Funds (\$45.4 million). Georgia will spend approximately \$3.8 million on 988 Lifeline implementation and \$996,000 for other crisis-related services over the next four years using MHBG, MHBG-COVID and MHBG-ARP funds.

Missouri: Missouri currently operates six crisis hotlines and plans to support them with their set aside funding (\$605,000) to prepare for implementation of the 988 Lifeline. They will use the MHBG-COVID crisis set aside for infrastructure development and 988 call center support (\$3.648 million) and \$2.648 million from the MHBG-ARP also for 988 implementation.

OBSTACLES AND OPPOSITION RELATED TO FINANCING

To date some groups have resisted 988 crisis systems. For example, some members of the law enforcement community see emergencies, including mental health emergencies, as their role, 911

dispatchers may fear the loss of funds as calls are diverted to 988, and some call centers that are not currently Lifeline members may fear calls will be diverted from their services as well. However, the single loudest voice is the telecommunications industry. The industry is supportive of improving the mental health crisis system, but some telecom providers are opposed to the fees proposed for funding it.

It is important to understand and convey that a 988 fee is not imposed on the telecommunications providers but on their customers... 988 fees range from only \$0.08 to \$0.75 per month.

States are seeking sustainable sources of funding, and building small fees into 988 legislation is sustainable, was recommended in the FCC ruling, and has a precedent with 911 fees. It is important to understand and convey that a 988 fee is not assessed on telecommunications providers but on their customers—who individually and at a community level benefit from 988 service offerings. Their opposition is that fees make the customers’ bills larger. Telecom providers are required by states to collect the fees and turn them over to the state in the manner that 911 and other fees are already being managed. The industry is pressuring states’ legislatures to reduce the size of the fees assessed and the scope

of the services to which the fees could apply, preferably covering contact centers only and not crisis treatment or preventive services. State 988 fees proposed through January 2022 range from only \$0.08 to \$0.75 per month.

The telecommunications industry has also expressed that it does not understand how the fees are calculated because states have not made the process transparent. Making the process and calculations transparent should be a government practice and may avert this as a legitimate complaint.

WHAT HAS BEEN THE RESPONSE TO THE INDUSTRY?

The public is generally supportive of a 988 fee. A [NAMI Survey](#) found that nearly 75% of adults surveyed were willing to pay a fee to support 988. The Kennedy Forum has expressed no sympathy for the telecom providers, stating that the industry made billions of dollars with the increase in telehealth and conference calling over the last two years. Senators Ron Wyden and Jeff Merkley of Oregon and Chris Murphy of Connecticut sent a letter to Meredith Baker, CEO of CTIA (which represents the U.S. wireless communications industry) writing, "Telecom lobbyists appear to be pressing state legislatures to reduce the size of the fees assessed, the scope of the services to which the fees could apply, well beyond—and in some cases contrary to—the guardrails already written into law...Every American should be doing everything they can to get those in crisis help when and where they need it, and not working to tie the hands of those who can provide it...we urge CTIA and its member companies to rethink its efforts...and stand up this critical resource."

IS THE INDUSTRY UNITED IN THEIR OPPOSITION TO A FEE?

No. In fact, one company went out of their way to accommodate it. T-Mobile announced that it is the first major wireless provider to make the 988 Lifeline immediately available to its customers.

T-Mobile's Executive Vice President said, "Making 988 available to our customers was a matter of urgency for us, ... to help get this lifesaving tool in the hands of those who will benefit from it."

Beginning on November 20, 2020, their customers who dialed 988 on the T-Mobile network had access to approximately 200 NSPL crisis contact centers that offer real-time, lifesaving mental health services from professionally trained counselors. T-Mobile moved quickly to modify its nationwide network to translate and route 988 calls to the existing NSPL number and update its billing system to ensure no customer would be charged for using the service. T-Mobile's Executive Vice President and Chief Technology Officer Abdul Saad said, "Making 988 available to our customers was a matter of urgency for us, particularly as the COVID-19 pandemic continues and the holiday season approaches. And it's particularly meaningful to launch this during November as we recognize the contributions and acknowledge the sacrifices of our military veterans. I'm proud that T-Mobile is doing our part to help get this lifesaving tool in the hands of those who will benefit from it."

T-Mobile is not alone. AT&T has supported 988 stating that it wants to be part of the solution to combatting suicide. 99% of AT&T's wireless customers can dial 988 right now and their customers on a wireline will be able to do so by July 2022.

CONCLUSION

While state agencies are still managing COVID-19, there are many priorities. Choosing the right path for financing and sustaining 988 crisis contact centers and a continuum of crisis services is also of great importance and the time to act is now. Some suggestions follow:

- Along with the usual funding sources such as appropriations and FMAP, states should also seek non-traditional resources, and preferably sustainable sources.
- The federal waivers and new funding opportunities are a quagmire of legalistic terminology that is best interpreted by states' Assistant Attorneys General (AAG). Conveying the structure of the current behavioral health financing system, the new services planned, and financing needs to AAGs will provide the foundation the AAGs need to assist with reimagining new financial infrastructure.
- States would benefit from contracting with an actuarial service to review historical service usage, predict future usage and costs for each of the possible models. This would serve to provide the most accurate financial predictions thus averting possible losses.
- A team of an Assistant Attorney General, an actuary, and the policy genius on the Medicaid staff will be able to mix and match funding options and financial predictions, thus providing the BEST options to move forward.

There are many factors that will play into a decision regarding financing of the 988 crisis system—state vs. local, the mix of call center types, the mix of crisis services, and the political climate for sustainable funding.

- Systematically collect information about other state models for successfully funding crisis services and discuss options with them to better understand the pros and cons they have experienced.
- The models and corresponding financing options could be presented to a collaboration of state, local and community leadership and stakeholders for review, guidance, and decisions. Use this as your opportunity to be the transparent state leader that you are.
- The next step will be creating a base of supporters prior to considering gubernatorial or legislative support. It is important to identify potential gaps in advance and to have a plan to fill those gaps so that they do not use energy unnecessarily, nor distract from planning, or become someone else's reason you cannot move forward.
- Take the time to educate the stakeholders and the public so they understand the changes being made to the crisis system, why this is preferred over the current system, how to access it, how the financing would work, and that they can be advocates for it.

- Work outside your usual group of friends and find friends in public health, business, and the media to be spokespersons from their perspectives.

Finally, do not be fixed on a single option. It is critical for states to be flexible in their approach, remembering that others have opinions that may be valuable. They may become great advocates. There are many factors that will play into a decision regarding financing of the 988 crisis system— federal vs. state vs. local funds, the mix of contact center types, the structure for mobile crisis services, the mix of crisis treatment and prevention services, and the political climate for sustainable funding. It may require a phased plan, multiple sources of funding, and a public relations campaign. Be strategic, read the stakeholders (friends and foes), include those with diverse voices and lived experience, and do not forget to follow the plan created.

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