INNOVATION AND DETERMINATION
How Three States Are Achieving Comprehensive, Coordinated, and Sustainable Behavioral Health Crisis Systems

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Innovation and Determination: How Three States Are Achieving Comprehensive, Coordinated, and Sustainable Behavioral Health Crisis Systems

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Abstract:
State mental health leaders and their numerous partners are enthusiastic about building crisis services systems because they understand the value to both the individuals utilizing the services and the states’ mental health systems overall. Yet, the challenges associated designing, building, and funding crisis systems often seem so onerous that they are viewed as barriers that are too difficult or time-consuming to overcome. To help illuminate approaches to overcome these barriers, this paper reviews the current work within three states. These states, Arizona, Utah, and Virginia had a vision for their crisis systems and the conviction to creatively design, build, and adequately fund them. They averted the decades old mindset that all behavioral health system changes are funded through grants, embraced rather than feared learning about complex but ample Medicaid opportunities, and used legislation where it would benefit the new design. Though many states are identifying similar and other strategies, this paper looks at the stepwise approaches used in three unique state systems in creating their new crisis services systems and their successes in developing diverse and sustainable financing methods.

Highlights:
To build a crisis continuum,

- Arizona:
  - Incrementally expanded expectations for the delivery system to create more crisis services capacity,
  - Used a managed care structure to ensure provider choice, comprehensive services, and budget optimization; and
  - Braided additional funding into managed care contracts to cover services that are not compensable by Medicaid.

- Utah:
  - Utilized strategic initiatives to plan and implement crisis programs and track goals and outcomes,
  - Built a crisis system overseen by a Behavioral Health Crisis Response Commission, and
  - Funded Behavioral health services in Utah’s Public Behavioral Health System through 6 funding streams.

- Virginia:
  - Began a crisis system transformation with a vision document incorporating recommendations for improvements in behavioral health care for the Medicaid population,
  - Relied upon and credited the Medicaid expansion for shifting the behavioral health system,
  - Continued to expand funding options, with their 988 service fee solidifying sustainability, and
  - Was the first state to enact 988 legislation and with a user fee (March 18, 2021).
Recommendations for Policymakers:

1. Establishing a vision and the approach to system design is critical.
2. Looking within Medicaid is a key strategy for expanding services and funding opportunities.
3. Facilitating adoption of approaches to reduce health inequities and utilize best practices will improve quality.
4. Establishing a multi-year incremental approach can be an important strategy for a smooth implementation given the size and scale of developing these systems.
5. Integrating physical and behavioral health provides for additional gains.
6. Exploring MCO capitation rate options may result in finding cost containment and service flexibility.
7. Identifying the most appropriate service billing codes will assist with generating revenue and promoting parity.
8. Committing to community-based partnerships with payers, providers, organizations, and law enforcement will help solve problems and improve relationships.
The nation has grown in its understanding of the importance of better serving individuals experiencing a suicidal or behavioral health crisis. States are increasingly recognizing the need to build and finance effective service systems to better serve individuals during such crises, in order to improve mental health outcomes, responsibility manage available funding, and save lives. However, across states, crisis services are inconsistent, inadequate, and uncoordinated, and they have not yet realized the vision of “continuums of services” and often do not represent “systems” at all. There are many reasons for these limitations especially in the context of provision of crisis services: definitions of services and provider types vary, organizations and types of services differ, and funding mechanisms are insufficient, siloed, and divergent. Searching for solutions has brought states to the reality that there is no one-size-fits-all crisis system. The essential components of building crisis systems will require creativity, patience, money, compassion and determined collaborators. This paper will examine how three states, Arizona, Utah, and Virginia, created crisis service systems by building on the mix of crisis services already in place while using a different combination of service delivery and financing methods to advance toward sustainable models.

Arizona’s Behavioral Health Crisis System

For more than 20 years, Arizona has been developing a behavioral health crisis system that has shown considerable success in serving individuals experiencing a crisis. This system has also succeeded in keeping people experiencing a crisis out of jails and hospital emergency departments. It is a system of best practices to which states around the nation are looking to for guidance.

The Path to 988 in Arizona

The desire to progress toward a crisis “system” in Arizona began in the Phoenix metropolitan area with a vision of what a patient-centered crisis system should be, and later grew incrementally to become a regionally-based, statewide system. The state’s approach to crisis services was premised on a model of identified best practices that would serve anyone, anywhere, anytime. The architects began with building a partnership that included providers, advocates, Managed Care Organizations (MCO), state agency leaders and law enforcement. The partnership determined that the MCO contracts would serve as the vehicle to realize the services with the following values, guiding system principles and goals:

1. Member and family member involvement at all system levels;
2. Collaboration with the greater community;
3. Effective innovation by promoting evidence-based practices;
4. Expectation for continuous quality improvement;
5. Cultural competency
6. Improved health outcomes;
7. Reduced health care costs;
8. System transformation;
9. Transparency;
10. Prompt and easy access to care; and
Arizona was the last state to implement a Medicaid program, establishing in October 1982 the Arizona Health Care Cost Containment System (AHCCCS pronounced 'access'), which is Arizona's Medicaid program. Since its inception, Arizona has operated under an 1115 waiver establishing mandatory managed care except for Native American tribes. In 2000, Arizona leveraged the 1115 waiver to expand coverage up to 100% of the Federal Poverty Level (FPL). Some of the expansion populations were frozen during the Great Recession from 2011 to 2013. As a result of legislation enacted in 2013, Arizona restored and expanded coverage up to 138% FPL as established in the Affordable Care Act, which also included enhanced federal matching funds for certain populations. Today, AHCCCS covers 2.1 million Arizonans or roughly 28% of the State’s population. Federal funding through Titles XIX (Medicaid) and Title XXI (Children’s Health Insurance Program – CHIP) of the Social Security Act is provided to AHCCCS through the Centers for Medicare and Medicaid Services, under the Department of Health and Human Services.

For the first thirty years of the program, AHCCCS operated a carve-out of behavioral health services administered by Regional Behavioral Health Authorities (RBHAs). Starting in 2014, through a series of competitive procurements, Arizona began integrating services. This process began with the RBHAs integrating services for individuals with serious mental illness. Over the next several years, AHCCCS has been integrating physical health and behavioral services at the MCO payer level for all Medicaid populations.

As detailed in Figure 1, Arizona has several different MCO contracts:

- The RBHAs are responsible for providing fully integrated services for individuals with serious mental illness and crisis services for all Arizonans.
- AHCCCS Complete Care (ACC) plans are responsible for providing services to the vast majority of AHCCCS members including most children, parents, and adults without dependent children.
- Arizona Long Term Care System (ALTCS) MCOs provide a fully integrated products for those individuals that require long term services and supports.
Arizona’s experience building crisis services provides several lessons. As states evaluate options to expand crisis services, delivery system design decisions will be a critical component for leaders to evaluate. With 69% of Medicaid beneficiaries enrolled in comprehensive managed care plans nationally, MCOs play a critical role in the fiscal implications for states. This fiscal impact will necessitate policy-level decisions regarding how services are delivered in a comprehensive crisis system.

To advance a crisis system that would leverage Medicaid to serve anyone, anywhere, Arizona incrementally expanded expectations for the delivery system to create more capacity to serve all Arizonans. The AHCCCS Managed care structure ensured provider choice, and an array of comprehensive services for members. As part of the expansion enacted in 2000, Arizona also leveraged the Rehabilitative State Plan option to create a more expansive behavioral health service package (Figure 2).
Figure 2: Rehabilitative State Plan Options

<table>
<thead>
<tr>
<th>Arizona’s Medicaid Expansion Benefits</th>
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<tbody>
<tr>
<td>• Screening</td>
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<tr>
<td>• Assessment</td>
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<tr>
<td>• Diagnosis</td>
</tr>
<tr>
<td>• Mental health and addiction treatment services</td>
</tr>
<tr>
<td>• Targeted case management</td>
</tr>
<tr>
<td>• Psychiatric rehabilitation services</td>
</tr>
<tr>
<td>• Peer and family supports</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current AHCCCS Covered Behavioral Health Services include, but are not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient hospital services • Behavioral Health Inpatient Facilities (BHIF) • Behavioral Health Residential Facilities (BHRF) • Partial care (supervised day program, therapeutic day program, medical day program) • Individual therapy and counseling • Group and/or family therapy and counseling Emergency/crisis behavioral health services • Behavior management (behavioral health personal assistance, family support, peer support) • Evaluation and diagnosis • Psychotropic medication, including adjustment and monitoring of medication • Psychosocial Rehabilitation (living skills training; health promotion; pre-job training, education and development; job coaching; and employment support) • Laboratory and Radiology Services for medication regulation and diagnosis • Screening • Case Management Services • Emergency Transportation • Non-Emergency Medical Transportation • Respite Care (with limitations) • Therapeutic foster care services</td>
</tr>
</tbody>
</table>

Additional Contract Requirements

Arizona braids additional funding into the MCO contracts to cover services that are not compensable by Medicaid. These funding sources include SAMHSA block grants, state only funds and county funding. Finally, Arizona also has been a leader in leveraging strategies to better align services for dually eligible Medicare and Medicaid members.

Arizona has leveraged its regulatory authority to greatly expand expectations for MCOs and providers to deliver crisis services for all Arizonans through contracts and policy. The AHCCCS program is a partnership that includes the State of Arizona, its counties, the federal government, MCOs, and AHCCCS members. At the state level, the program is administered by the Arizona Health Care Cost Containment Administration. The Administration’s basic responsibility is to plan, develop, implement, and administer an indigent health care program based on competitively bid prepaid capitated contracts designed to provide quality health care while containing costs. The Administration’s main responsibilities are member services, quality assurance of medical care, provider and plan oversight, procurement of MCOs, and program operations. AHCCCS oversees the delivery of behavioral health services and the administration of all SAMHSA block grant funds.
The RBHAs within the contractor’s geographic service area(s) are responsible for the delivery of timely crisis services, including telephone, community-based mobile and facility-based stabilization (including observation not to exceed 24 hours). The RBHAs were awarded specialty contracts that assume the financial risk (via actuarially sound capitation rates that reflect actual costs) for crisis services during the first 24 hours of a crisis onset, and any services required after the 24th hour are the financial responsibility of the regular MCOs. The managed care aspect of the system provided flexibility by averting a bed limit under Medicaid’s Institutions for Mental Diseases (IMD) waiver that would have had a negative impact on reimbursement. Requests for Proposals and the resulting contracts included a list of requirements that have brought considerable improvements to the system.

Arizona requires contractors to provide a robust behavioral health crisis services network available to any Arizona resident regardless of health insurance coverage. Services are predicated on the Crisis Now model and include:

- 24/7/365 crisis telephone lines operated by trained crisis specialists. The crisis lines are available in all 15 counties and 4 Tribal Nations. They include a line for teens, veterans, COVID-19, and the National Suicide Prevention Lifeline (NSPL). The state has executed a plan to move to a single statewide call center vendor and is looking to expand services to include chat capability.

- 24/7 mobile crisis teams (MCTs), including youth MCTs, are staffed by behavioral health professionals who travel to the individual experiencing a crisis and provide assessment and stabilization services. These teams will triage the individual to a higher level of care, as appropriate. Regional crisis call centers screen and deploy MCTs within each RBHA region.

- Facility-based crisis stabilization centers offer crisis stabilization and observation, including access to Medication Assisted Treatment (MAT). This service is also provided through the RBHAs.

The contract requirements for crisis stabilization centers are detailed in Figure 3.

**Figure 3: Request for Proposals/Contract Provisions’ Requirements for Managed Care Behavioral Health Organizations (MCBHO) Crisis Stabilization Centers**

- stabilization of individuals as quickly as possible
- solution-focused and recovery-oriented interventions including avoidance of unnecessary hospitalization, incarceration, or placement in segregated settings
- engagement of peer and family support services
- assessment of and connection to the individual’s needs/supports and services
- no prior authorization
- subcontracted providers to deliver crisis services/response during regular business hours
- local county-based stabilization services to prevent out-of-area transport
- coordination of crisis services on tribal lands with the tribes’ crisis providers
- data and information sharing through a health information exchange to analyze, track, and trend crisis service utilization data for service improvement
- care coordination and collaborative relationships with community partners including fire, police, emergency medical services, hospital emergency departments, Arizona Medicaid, and providers of public health and safety services
- annual training on mental health and crisis services
- information sharing for timely access to Court Ordered Evaluation
- services that are community based and recovery oriented
- MCBHO enrollment within 24 hours of a member engaging in crisis services outside of the system
- defined call center telephone response times
- mobile crisis teams’ capabilities, crisis stabilization settings and capabilities
- geographic capitation rates
- provider network capabilities and expectations, and
- service standards, provider qualifications, and coding for and definitions of covered services

**Crisis Services Coding**

*Figure 4* highlights the codes Arizona designates to be used for billing services and defines the services.

**Figure 4: Arizona Crisis Services Billing Codes (FY22)**

<table>
<thead>
<tr>
<th>Emergency Department (CPT coding)</th>
<th>varies</th>
<th>varies</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281 – 99285 Emergency department visit for the evaluation and management of a patient. Code depends on key components involved.</td>
<td>varies</td>
<td>varies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crisis Intervention Services (Mobile, Community Based) (HCPCS coding)</th>
<th>Physician</th>
<th>MCO</th>
</tr>
</thead>
<tbody>
<tr>
<td>H2011 HT Crisis Intervention Service, multi-disciplinary team</td>
<td>$71.89</td>
<td>$51.34</td>
</tr>
<tr>
<td>H2011 Crisis Intervention Service, per 15 minutes</td>
<td>$48.64</td>
<td>$34.74</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crisis Intervention Services (Stabilization, Facility Based) (HCPCS coding)</th>
<th>varies</th>
<th>varies</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9484 Crisis Intervention Mental Health Services – (Stabilization) Up to 5 hours.</td>
<td>$88.66</td>
<td>$63.33</td>
</tr>
<tr>
<td>S9485 Crisis Intervention Mental Health Services – (Stabilization) From 5 to 24 hours.</td>
<td>$490.71</td>
<td>$350.51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Crisis Intervention (Telephone)</th>
<th>varies</th>
<th>varies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varies Use appropriate case management service code</td>
<td>varies</td>
<td>varies</td>
</tr>
</tbody>
</table>

The overall allocation of costs by service is as follows: call centers 10.7%, mobile crisis teams 15.7%, and crisis receiving and stabilization facilities 73.6%.
Funding

As highlighted above, Arizona deploys a diverse financial strategy to achieve its goal of comprehensiveness and sustainability. Medicaid financing is fully leveraged, and state and local dollars are braided to cover the costs of the uninsured and underinsured. In fiscal year (FY) 2020, 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). Medicaid funding is provided to the RBHA MCOs through a designated capitation rate that was established to fund crisis services.

As part of the strategy to leverage appropriate Medicaid claiming, the state also can have the crisis call centers’ hotlines bill Medicaid for crisis intervention and emergency management services rendered by mental health providers employed by the hotlines. Although some states have been successful in using Medicaid administrative match to support call center activity, at this time Arizona is the only state that has been identified that leverages program funding. The sources of funding for the FY22 budget for the entire behavioral health system in Arizona can be seen in Figure 5.

Figure 5: Depiction of Arizona’s Funding Allocations for Behavioral Health

Enhancing the Crisis System Continuum in Advance of Building 988

In 2021, AHCCCS facilitated more than 10 stakeholder meetings and focus groups with people who have lived experience with behavioral health crises and conducted a survey of those with lived experience who have engaged with the crisis system. The survey received responses from 589 people in Arizona, including 180 individuals who had engaged with the crisis system for themselves, and 391 individuals
who had engaged with the crisis system for someone else. A summary of survey results was presented to stakeholders in December 2021 and relevant survey results have been integrated into the 988 and crisis continuum plan as they relate to SAMHSA’s processes and qualities for a successful crisis management system:

- Standardizes crisis care processes and quality.
- Promote suicide prevention as a core component of healthcare services.
- Focuses on resolving mental health and SUD conditions.
- Decreases psychiatric bed overuse and eliminates ED boarding.
- Decreases drain on law enforcement.
- Decreases fragmentation of behavioral healthcare.

Three regional RBHAs have a contract with AHCCCS to cover the continuum of behavioral health crisis services. Individuals who are not Medicaid beneficiaries may receive crisis services from the RBHAs for up to 72 hours. By contract MCOs must serve individuals who are Medicaid beneficiaries after 24 hours and the RBHAs serve non-Medicaid beneficiaries for up to 72 hours. All these services are covered by a mix of State and Medicaid funding.6

Arizona will employ an “airport model” using GPS technology to enhance their ability to notify mobile crisis teams to deploy, track their geographic locations, and ensure communications are operational. As their model has an established and successful relationship with law enforcement, a behavioral health professional will be in contact with the responding officer to assist. These calls will be considered a priority for MCT responses, currently with an average 30-minute response time.7 Arizona already has one of the highest answer rates for the Lifeline today and these strategic steps should ensure that Arizona is well positioned to have the capacity necessary as 988 implementation goes live nationally.

**Barriers, Challenges, and Unique Population Needs**

Arizona’s Crisis Services System is a comprehensive and coordinated system, but no good plan is created without first addressing the barriers.

**Medicaid carveout:** The State staff worked to convince lawmakers that eliminating a behavioral health carveout was a sensible plan. They used data (premature deaths of individuals with mental illness and better care through a service continuum) to highlight the dramatic negative impact increased fragmentation had on those experiencing both chronic medical conditions in addition to significant behavioral health needs. Although provider groups and some advocacy organizations had historically opposed integration efforts, the legislature moved unanimously to support the efforts of the Executive branch to transform the delivery system. Arizona began integration efforts in 2015 after the State expanded Medicaid.

**Billing codes for Mobile Crisis Services:** A limitation in almost every state is billing for mobile crisis services that includes travel time in addition to time with the individual. Billing coding and funding for crisis services must progress to sustain services. Lack of parity with medical care through insurance loopholes make it difficult for providers to obtain reimbursement and patients to get affordable care.
Rural area challenge: Workforce shortages are everywhere but with rural areas in particular there are limits to geographic accessibility. Arizona was able to address workforce issues with a telehealth response system during the pandemic that includes a handoff to physicians who respond to the crisis virtually. Arizona has also provided extensive limited funding for workforce investments by leveraging the enhanced Home and Community Based Funding authorized by the American Reinvestment Program Act (ARPA).

Affordable Care Act (ACA) conflict: The ACA benefitted the Arizona system by covering the costs that had been absorbed for some of the population that was uninsured and underinsured individuals for about 10 years.

Sovereignty of Tribal Nations: The 22 Native American tribes in Arizona have the right to define their own crisis services (some consistent with cultural beliefs) and the sovereignty of tribal governments including tribal law enforcement are critical to recognize in developing partnerships. As a result, the crisis “system(s)” for the 22 tribes continue to evolve as they are shaped by each Tribe.

Lessons Learned
Even a very well thought out plan and effective system changes come with some regrets and lessons learned. Arizona would have preferred to be able to work through the nationwide issues presented by private insurance and ERISA health plans related to behavioral health parity. The Mental Health Parity and Addictions Equity Act (MHPAEA) (2008)\(^8\) and the Consolidated Appropriations Act (CAA) (2021)\(^9\) provided regulatory authority to the Department of Health and Human Services and the Department of Labor to ensure coverage of behavioral health services are equivalent to that of physical health services. However, enforcement at the federal level has been problematic, and as such states are beginning to take enforcement actions on their own. Arizona would also like to encourage related changes in Medicare policy. Expanding the system services to children (including those in foster care), individuals with substance use disorders (SUD), and individuals with intellectual and developmental disabilities (IDD) became a recognized need, and these expansions are currently being planned.

Sustainability of the System
There are five factors that were critical in creating a sustainable crisis system in Arizona:

1. Strong system design that created an accountable organization with expectations and funding to develop a system that would serve all Arizonans.
2. Comprehensive funding strategy that fully leverages Medicaid and braids other funding sources to cover the uninsured and underinsured.
3. Incredible community partnerships between payers, providers, community organizations, agency leaders and law enforcement to solve complex operational and logistical issues and overcome historical silos.
4. Strong State leadership and commitment to work through and resolve complex funding, billing, operational and policy issues.
5. An incremental approach that continually looks to improve the system to better serve Arizonans.
Utah’s Behavioral Health Crisis System

Utah has made considerable progress toward a crisis system with efforts by leadership to improve suicide prevention and crisis services. It has roots tackling a broad range of areas such as prevention services through schools, firearm safety education legislation, a student safety and crisis tip line commission, peer-to-peer suicide prevention, resiliency, anti-bullying programs in elementary schools, programs that target populations at high risk such as LGBTQ+ youth, and certification of assertive community treatment teams (ACT teams).

A Path to 988 in Utah

Utah consistently ranks in the top ten in the United States for suicide deaths. From 2016 to 2018, Utah had an average of 647 suicides per year and 4,574 suicide attempts. The Division of Substance Abuse and Mental Health (DSAMH) has been taking action to change this using strategic initiatives to plan, develop and implement programs, while tracking goals and outcomes. Their planning has identified five primary strategic initiatives with a focus on:

1. Prevention and early intervention
2. Adoption of the Zero Suicide model
3. Promoting recovery
4. Improved care for children and youth, and
5. Health system integration.

A foundation for suicide prevention in Utah was formed prior to the first Utah Suicide Prevention State Plan in 2017 (Figure 6). SB37 (2017) created a statewide Lifeline call center (local call centers were already in place). In 2019, the Utah Department of Commerce Division of Occupational and Professional Licensing (DOPL) required a suicide prevention training course for physicians. In 2021 four bills targeting suicide were enacted: Utah HB60 that provides for the transfer of unused funds in the Concealed Weapons Account to the DSAMH for suicide prevention efforts; Utah HB336 created a program to provide training to health care organizations related to reducing suicides; Utah SB127 required congregate care programs to maintain suicide prevention policies; and Utah SB155 created the 988 Mental Health Crisis Assistance Account, designed to strengthen and fund the crisis system. The account was appropriated $15.9M to support all 988 services as well as the continuum of crisis services including 988 call centers, mobile crisis outreach teams (MCOTs), crisis receiving and stabilization and a list of other state agencies performing related tasks. This comprehensive funding approach has helped the continuum’s growth. Their primary funding sources are provided in Figure 7.
Crisis System Oversight: The Utah Behavioral Health Crisis Response Commission, effective March 11, 2021 and Code Section 63-18202, provides oversight/recommendations for the crisis system including what would comprise a sustainable funding source, a 988 fee to improve financial assistance, and a requirement for their Medicaid agency to adopt or apply for a state plan amendment or waiver to support crisis services. Membership represents private and public mental health partnerships, state Medicaid authorities, 911 Public Service Access Points (PSAP), law enforcement, persons with lived experience (member of the public), the telecommunications industry, and six members of the legislative body. A working group of the Commission has developed processes and procedures for the relationship between 911 and 988 like that operating in Los Angeles now. The new procedures are currently being implemented in Salt Lake City. The Commission is also responsible for modeling financial options.

Crisis Contact Centers: Suicide contact centers have contracts with the Local Mental Health Authorities (LMHAs) and counties. Utah’s contact centers’ call volume was 79,645 in FY19, followed by a 32% growth in total calls between FY20 and FY21. During that period 1,353 lifesaving interventions were initiated for the callers at imminent risk of suicide. The centers are funded with General Funds and Federal ARPA and COVID-19 funds. Senate Bill 155 (2021) created the Statewide Behavioral Health Crisis Response Account that authorizes funding through legislative appropriations or private donations. Funds are maintained in a restricted and non-reverting fund managed by DSAMH. The account would then be used for the costs of running 988 including assistance to local crisis teams. It was supported in committee by several organizations including the Chiefs of Police Association. The bill also created and tasked the Behavioral Health Crisis Response Commission to make recommendations to prepare for the implementation of the statewide 988 hotline.

Mobile Response Teams: Utah’s Mobile Crisis Outreach Teams (MCOTs) are run by the LMHAs rather than by the contact centers. However, the crisis center provides dispatch support based on the assessed need of the caller for in-person crisis support and coordinates dispatches for MCOTs across the State.
SB37 (2017) Statewide Crisis Line created the Mental Health Crisis Line Commission that later became the Behavioral Health Crisis Response Commission guiding the call centers and MCOTs including monitoring response times and ensuring accreditation standards for the MCOTs. MCOTs are available throughout the State and, with exception of a few rural areas, function 24/7. MCOT teams are staffed by a master’s level clinician and a certified peer support specialist who has lived through their own experiences with mental health challenges.

**Crisis Receiving and Stabilization centers:** Utah has two official crisis receiving and stabilization centers (Davis and Utah Counties) providing short-term (23-hour) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment. Four more are planned, one in a rural area and three in urban/suburban areas. Two will be operated by an LMHA and the others by a private provider in partnership with their local mental health authorities. The largest of the new centers are planned to open in 2023-2024 making available: 32 beds for receiving and 23 beds for stabilization and withdrawal management services; high acuity short-term residential treatment units; and case management and assisted care transitions and transportation. Additional centers are planned for the southwest area of the State for 2024, the four corners area of the State, and urban Weber County. Although they accept walk-ins, referrals and police drop-offs, law enforcement is also a priority for drop-offs at the crisis receiving and stabilization centers.

A pilot in Davis County reported that in the seven months the receiving center has been open, 228 people have been helped. Without these services, 45% of those referred by law enforcement would have gone to jail, and 18% would have gone to the emergency department. Another 19% would have stayed home, 9% would have gone to a different emergency shelter or crisis center, and the remaining nine percent selected “other.” Forty to fifty percent of individuals experiencing a crisis are dropped-off by law enforcement. However, early results from a study being conducted by the University of Utah demonstrate a reduction in law enforcement drop-offs when community referrals increase, as well as success in diverting patients from emergency departments and lowering health care systems’ costs.

**Funding Behavioral Health Services**

Sixty-one percent of Utahans are covered by employer-sponsored insurance, which is the highest rate of employer-sponsored insurance in the country. Although only 12% of Utahns are enrolled in Medicaid, it is the primary funder of behavioral health services in the State. Utah became a Medicaid expansion State when it received approval from the Centers for Medicare and Medicaid Services (CMS) to implement an expansion (effective April 2019) to incorporate adults earning up to 100% of the federal poverty level (FPL). The expansion provided a 70% federal/30% state match rate. Then in December 2019 a second expansion was approved for Utah adults with annual incomes up to 138% of the FPL. This expansion became effective January 2020 with a 90% federal/10% state match rate and with an expectation of an additional 120,000 adults as beneficiaries. Between 2013 and early 2021 the Medicaid enrollment had increased 37% significantly reducing the number of uninsured individuals in the State.
The Division of Substance Abuse and Mental Health (DSAMH) operates within the Department of Health and Human Services and is responsible for overseeing Utah’s Public Mental Health Delivery Systems. DSAMH contracts with the counties and State funding is appropriated to provide behavioral health services to Medicaid enrollees, uninsured individuals, and other underinsured populations. The General Fund appropriation supports both the Local Mental Health Authorities (LMHAs) and the Utah State Hospital and provides leverage for the funding they receive from SAMHSA federal block grants.25

The Division of Medicaid and Health Financing (DMHF) funds the provision of select mental health services provided to Medicaid beneficiaries in the fee-for-service system and beneficiaries enrolled in Medicaid managed care plans (Accountable Care Organizations (ACOs), the HOME Program, and the Children’s Health Insurance Program (CHIP). Most of these services are carved out of fee-for-service (FFS) Medicaid and provided through Prepaid Mental Health Plans (PMHPs) that contract with the LMHAs and are paid a capitated rate for Medicaid enrollees accessing services through the LMHAs. The LMHAs are the major provider for the Public Mental Health Services serving Medicaid enrollees, uninsured individuals, and underinsured populations as well as individuals with Medicare and private insurance. Currently there are 13 LMHAs serving all 29 counties. Funds are allocated to the LMHAs using a needs-based funding formula and the counties are required to provide a fund match of 20% or more. Under the expansion, the Medicaid bundled rate is 7%, but under the FFS system only 3 counties are billing Medicaid. DSAMH’s goal is to maximize the discrete and bundled billing of Medicaid. The share of the State match provided by the LMHAs is used to fund the outpatient portion of the capitated rates paid to the PMHPs, but the State share for the cost of inpatient care is appropriated directly to DSAMH.26,27

Public behavioral health preventive services and education are made available through the Utah Department of Health and Human Services and financed with both State and Federal funds (Figure 8 & 9).
Figure 8: Mandated Mental Health and Substance Use Benefits Provided by Local Mental Health Authorities (LMHA)

- inpatient mental health services
- residential care
- psychotropic medication management
- case management
- outpatient mental health services
- 24-hour crisis care and services
- community supports, including in-home services, housing, family support services, and respite services
- consultation and education services, including case consultation, collaboration with other county service agencies, public education, and public information

Figure 9: Medicaid Covered Mental Health and Substance Use Benefits

- psychiatric diagnostic evaluations
- psychological testing
- psychotherapy for crisis
- nurse medication management
- psychosocial rehabilitative services
- psychotherapy with evaluation and management services
- qualified targeted case management (provided only to Medicaid recipients with SMI and individuals with SUD)
- mental health assessments
- psychotherapy
- pharmacological management
- therapeutic behavioral services
- peer support services

Funding Behavioral Health Services for Children, Youth and Families

The Children, Youth and Families system is managed through the LMHAs, and the contracted providers’ scope of work for the system is funded through numerous sources including appropriations and grant funding. DSAMH provides the data collection and analyses. Youth mobile outreach crisis teams are available 7am to 11pm every day of the year and offer consultation and support to individuals, families, schools, treatment providers, and first responders. Follow-up services, like ongoing support including intensive in-home stabilization services and referrals to health care providers and behavioral health services in the community, are also provided.

Funding for Physical Health

Physical health services are provided through Utah’s Medicaid ACOs. Because they only cover limited mental health screening, evaluation, and maintenance services, Medicaid patients in need of mental health care who seek treatment from their primary care provider are typically referred to the LMHAs.

Challenges for the Public Behavioral Health System

Utah identifies one of the greatest challenges that their system faces currently is the recent strains associated with workforce issues. The size of the provider workforce is not keeping pace with the growing number of Medicaid enrollees. This is coupled with the fact that only a small percentage of
Utah’s mental health workforce accept Medicaid patients (35.7% in 2015). Utah’s urban areas had 171 mental health full-time equivalents (FTE) per hundred thousand people in 2015. Rural areas, however, only had 141 FTEs per hundred thousand people. The State is undergoing a further system transformation with the integration of the Department of Human Services with the Department of Health to build a more inclusive public health system, the Department of Health and Human Services. Though there are promises with this shift, there are also challenges as the new agency will shift budgets, positions and organizational framework and yet continue to work on building out this crisis continuum.

Lessons Learned
Utah shared three lessons learned while building their crisis system:

1. Use leveraging to the extent possible;
2. Move to discreet billing codes but be sure to both enforce a crisis system funding route and build the administrative infrastructure to support it; and
3. Obtain legislative and stakeholder backing for any policy issues.

Sustainability of the System
There are three factors that provide for the support for a sustainable crisis system in Utah:

1. History of policymakers actively supporting continued growth in suicide and crisis services;
2. Behavioral Health Crisis Response Commission, a large and diverse group, whose sole purpose is providing guidance for the system and examining sustainable funding sources with required reporting in December 2021 and December 2022; and
3. Diversified list of funding sources, strong in General Funds, Medicaid financing, and Federal Block Grants.

Virginia’s Behavioral Health Crisis System
Virginia’s journey to a system for crisis services began about five years ago when the Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Medical Assistance Services (DMAS) collaborated with the Farley Center at the University of Colorado to develop an enhancement proposal for a trauma-informed, evidence-based, and cost-effective behavioral health care continuum. The agencies also conducted a service analysis to identify gaps and existing services, review evidence-based practices, and perform a stakeholder survey. This collaboration resulted in the development of a vision document entitled the “Virginia Medicaid Continuum of Behavioral Health Services” (2018) which provided recommendations to achieve the vision of improved behavioral health care for Virginia’s Medicaid population. The recommendations included a comprehensive review of evidence-based practices, an examination of current services and gaps in Medicaid-covered behavioral health services, and input from diverse stakeholders invested in better behavioral health care for all Virginians. The recommended enhancement initiative redirected Medicaid toward an integrated behavioral health system. Concurrent with the planning efforts, Virginia was also initiating a shift in the Medicaid program that included an eligibility expansion (effective January 1, 2019), as well as a process to integrate behavioral health services into managed care organizations (MCO). The shift to Medicaid expansion changed the behavioral health landscape in Virginia, as it created greater necessity for Community Service Boards to bill Medicaid as the uninsured population decreased and the overall
demand for services increased. It also underscored the need for the full behavioral health network of providers to meet this need. Indeed, current data demonstrates that most Medicaid members participate in services with private providers rather than with community service boards in Virginia.

**The Path to 988 in Virginia**

The overall vision of behavioral health enhancement in 2018 was to rebalance Virginia’s Medicaid behavioral health system away from high-cost inpatient hospital and residential settings toward lower cost outpatient, prevention and promotion services, and evidence-based community services, while maintaining budget neutrality and not increasing the overall spending of the Medicaid program. This enhancement initiative redirected Medicaid toward integrated behavioral health services, outpatient services, and comprehensive community-based crisis supports that included the pillars of a crisis services system – warm lines, 24/7 crisis call centers, peer crisis services, mobile crisis services, 23-hour stabilization, and short-term crisis residential stabilization services.

**The Path to Medicaid as an Option for Funding and Enhancing Crisis Services**

DBHDS credits the Medicaid expansion for shifting the behavioral health system, by increasing the population eligible for Medicaid services and increasing the role of Medicaid in the public system. Virginia authorized major changes to its Medicaid program in 2018, including expanded eligibility to cover more adults, including those without children; cross disability and generational expansions; and employment and housing support for high need populations. More than 674,000 Virginians are currently enrolled in Medicaid because of expanded eligibility rules that took effect in January 2019. More than 300,000 individuals enrolled in Medicaid expansion during the first eight months. The total uninsured rate declined from 12.3% to 11% between 2018 and 2019. Prior to these changes behavioral health was a carveout, and emergency departments were the door to the crisis system.

**Other Collaborations and Concurrent Events that Drove Change**

**Stakeholders:** Project BRAVO (originally called Behavioral Health Redesign and then Behavioral Health Enhancement), was launched in 2018 under the leadership of DMAS and DBHDS with strong stakeholder engagement. Over 100 stakeholders from provider groups, community service boards (CSBs), providers, criminal justice, Public Safety Answering Points (PSAPs), and mobile crisis teams collaborated with the State agencies on a continuum of behavioral health enhancements through a multi-phase initiative. Then funding cuts and COVID-19 caused delays, but BRAVO achieved broader financing through service enhancements (Figure 10) that were all implemented by December 2021.
Call Center Changes: In order to improve crisis call centers and become compliant with the National Suicide Prevention Lifeline’s (NSPL) accreditation standards and answer rates, Virginia applied for planning and implementation grants, and purchased a data platform. The 988 call centers are organized into five regions and accredited by the NSPL. Call centers request insurance information enabling them to direct uninsured individuals to State reimbursed services. Each regional hub (State fiscal agent who subcontracts with the call centers) will have memorandums of understanding (MOUs) with service providers in their area. The MOUs allow private crisis providers to bill Medicaid or other insurance, or when available, receive payment from the regional hub if the provider serves an uninsured person. This arrangement allows call centers to dispatch any type of mobile crisis service provider, whether State-funded or private. Virginia’s 911 call matrix has four risk levels—routine (level 1), moderate (level 2), urgent (level 3) and emergent (level 4). The 911 call centers triage the first two levels to regional 988 call centers, including moderate calls requiring in-person intervention. Three NSPL call centers serve the entire State, and 40 emergency service lines are associated with each of the CSBs. Currently, there are six crisis lines for children spread regionally across Virginia, and four adult and child I/DD crisis lines. These efforts have improved the in-state call answering rate by 35 percentage points, from 50% to 85%.

Mobile Crisis Teams: System Transformation Excellence and Performance, or STEP – Virginia, a group of executive directors from the 40 CSBs, convened to work on implementation of mobile crisis teams, and crisis system quality, outcomes, and universality. Mobile crisis service delivery reflects the provider patterns found overall in the Medicaid behavioral health program—most services are provided by private providers, while the CSBs serve as the safety net with a mandate to serve the un- and under-insured. CSBs were accustomed to a system funded through general revenues and block grants with more flexibility in funding than that of private providers. However, private providers in all regions are required to be linked to the CSB Regional Hub and the data platform. As Virginia worked through stakeholder engagement issues around crisis systems development, CSB and private providers were challenged to consider their roles in creating a comprehensive system for the commonwealth. Both sets of stakeholders worked collaboratively to develop the protocols that are the backbone of the establishment of Marcus Alert programs, named for Marcus-Davis Peters, a young, Black biology teacher who was killed by Richmond police in 2018 while experiencing a mental health crisis. The initiative was implemented in all regions of the State to provide evidence-based responses to behavioral health emergencies and reduce negative outcomes involving the use of force in law enforcement interactions when an individual is experiencing a crisis related to mental health, substance use, or I/DD challenges.

Because a behavioral health emergency requires a behavioral health response, DBHDS worked with the Department of Criminal Justice Services to create a framework for a statewide implementation plan to achieve this behavioral health response and each locality was required to use the framework to write a more specific local plan. Per Senate Bill 1302 by July 1, 2026, CSBs in Virginia with a population base greater than 40,000 must establish community care teams (CCTs) or mobile crisis teams (MCTs) with protocols in place for a diversion of certain 911 calls to 988 crisis call centers, and for law enforcement participation in the Marcus alert system. An MCT includes a mental health professional, a peer recovery specialist, or a family support partner. A CCT includes a mental health service provider and may also include registered peer recovery specialists and law enforcement agencies, but with mental health providers leading to help stabilize and law enforcement providing backup support. Children’s mobile
crisis teams were prioritized in 2020. The Commonwealth has been thoughtful about developing a system for all generations and needs, but it is still growing and at risk of exceeding capacity.

Virginia addresses health disparities by requiring provision of linguistically and culturally competent care. Teams must also reflect the diversity of the community and include individuals with lived experience. Managed Care Organizations are all in network for mobile response. In addition, the legislation required reports on successes and problems, analysis of operations, any disparities in response and outcomes by race and ethnicity, and recommendations for program improvements.

**Crisis Receiving and Stabilization Services:** Virginia has 36 Crisis Intervention Team Assessment Centers (CITAC), 12 Adult Crisis Stabilization Units (CSU), 3 State funded child CSUs, 5 Crisis Therapeutic Homes (CTH) for adults with an I/DD, and 2 CTHs for children with I/DD. Comprehensive crisis receiving centers are funded by the DBHDS through CSBs. Crisis receiving centers use Medicaid billing, general funds, and block grants. One CSB contracts with a private provider for their crisis receiving center. Prevention following a crisis is community-based and uses community stabilization as a bridge to prevent cycling until longer term community services are available.38

**Funding Crisis Services:** Virginia Medicaid provides an array of behavioral health services through two Medicaid Managed Care programs, CCC Plus and Medallion 4.0, and contracts with six Managed Care Organizations (MCOs) and the Medicaid Behavioral Health Services Administrator, to provide healthcare coverage for these services. However, Virginia has taken the approach of many other states and is looking to funding sources to cover infrastructure and services not covered by Medicaid. The mix of financing methods described below will enhance the sustainability of system funding.

**SAMHSA Grant Funding:** For Fiscal Year 2022, the Commonwealth was awarded $20,807,818 in Mental Health Block Grant (MHBG) funds and $46,202,091 in Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds from the Substance Abuse and Mental Health Services Administration (SAMHSA). Other SAMHSA funding was also provided for a total of $67,009,909. These funds support a wide variety of services provided by Virginia’s community services boards and private providers.

**Commonwealth General Funds:** The Governor’s budget for the Commonwealth is appropriated for 2-year periods. General funds appropriated in the FY2023 budget for crisis services by line item for Year 1 and Year 2 include:

- Community Services Boards and Behavioral Health Authorities pursuant to the STEP-VA process and Chapters 607 and 683, 2017 Acts of Assembly - $117,164,556 in FY 23 and $123,943,663 in FY 24.
- Crisis services for individuals with mental health or substance use disorders - $13,954,924 and $26,954,924 for STEP VA Crisis in both FY 23 and FY 24. The FY 23 amount includes $13.0M in State and Local Fiscal Recovery Funds and the remainder is General Funds.
- 32 drop-off centers to provide an alternative to incarceration for people with serious mental illness and individuals with acquired brain injury and co-occurring serious mental health illness. (Priority for new funding was given to programs that have implemented Crisis Intervention Teams (CIT) and conducted planning for drop off centers.) - $10,500,000 and $10,500,000
- CIT Training programs in six rural communities - $657,648 and $657,648
• Crisis intervention assessment centers in six unserved rural communities - $1,800,000 and $1,800,000
• Crisis Team Assessment Centers of Crisis Stabilization Units (dedicated to a specific geographic area) - $2,000,000 and $9,000,000, plus an additional $7,000,000 from the State and Local Fiscal Recovery Fund in FY23 (dedicated to a specific geographic area)
• STEP-VA for crisis detoxification services - $2,000,000 and $2,000,000
• STEP-VA Marcus Alert - $6,000,000 and $6,000,000
• STEP-VA Crisis Call Center Dispatch - $4,697,020 and $2,697,020, and an additional $4,732,000 in FY23 and $7,453,798 in FY24 from the Crisis Call Center Fund

Service Fees: Virginia was the first state to enact 988 service fee legislation (March 18, 2021). The law is very comprehensive, covering all provisions in the 988 Model Bill and creating 988 crisis contact centers (utilizing calls, chats and texts that are interoperable across emergency response systems), community care teams, and mobile crisis teams. Their Crisis Contact Centers Fund is a dedicated and non-reverting fund. 988 fees from wireless bills include a monthly fee of $0.12 assessed on wireless accounts and $0.08 on prepaid accounts to be deposited into the Crisis Call Center Fund. The fee amounts were based on call center costs using Virginia and Vibrant estimate methodologies. Fee revenues are held in a Crisis Contact Centers Fund and are to be spent on the crisis system along the entire continuum of care including the crisis contact centers, community care, mobile crisis teams, crisis stabilization centers, and the Mental Health Awareness Response and Community Understanding Services (MARCUS) alert system. The bill also provided for 911 enhancements - next generation of 911, i.e., direct dial, notification, and dispatchable location requirements. The 2021 Fiscal Impact Statement provided by the Department of Taxation states that the Crisis Contact Centers Fund would receive $9.2 million in FY22 and $10 million in FY23 and each year beyond (Note: Of the $10 million allocated, half is from 988 legislated fees; in FY23 general fund reimbursements doubled (half fees and half general funds); and an additional $2m is expected from SAMHSA).

The costs associated with establishing a crisis hotline infrastructure were $5 million in FY21 for the Crisis Contact Centers. In FY22, costs are $4.7 million for Crisis Contact Centers staffing and $375,000 for maintenance, and in FY23 would increase to $9.5 million and $500,000, respectively. The 988 call centers infrastructure is not built from scratch but requires leveraging existing local call centers and consolidating their phone numbers as part of the system enhancement.

Crisis Services Medicaid Program and Billing Structure: In the March 2021 Medicaid Bulletin, “Enhanced Behavioral Health Services/Project BRAVO: Behavioral Health Redesign for Access, Value & Outcomes” Virginia implemented programmatic changes and developed new service definitions, prior authorization and utilization review criteria, provider qualifications, and reimbursement rates for crisis services (Figure 10 & 11).
**Figure 10: Services Codes and Reimbursement Rates for New and Affected Services for dates of service on or after December 1, 2021**

<table>
<thead>
<tr>
<th>Service Name/Procedure Code</th>
<th>Rate Range</th>
<th>Modifier Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multisystemic Therapy H2033</td>
<td>$46.03 to $55.03 per 15 minutes</td>
<td>New vs. Established Team QMHP/C/E or CSAC/S Masters vs. bachelor’s degree</td>
</tr>
<tr>
<td>Functional Family Therapy H0036</td>
<td>$34.11 to $44.17 per 15 minutes</td>
<td>New vs. Established Team QMHP/C/E or CSAC/S Masters vs. bachelor’s degree</td>
</tr>
<tr>
<td>Mobile Crisis Response H2011</td>
<td>$63.18 to $117.27 per 15 minutes</td>
<td>LMHP-type Emergency vs. Non-Emergency Custody Order Prescreening QMHP-A/QMHP-C/CSAC with or without PRS or CSAC-A, A/C/E, and # of QMHPs</td>
</tr>
<tr>
<td>Community Stabilization S9482</td>
<td>$35.76 to $76.29 per 15 minutes</td>
<td>LMHP-type QMHP-A/QMHP-C/CSAC with or without PRS or CSAC-A, A/C/E</td>
</tr>
<tr>
<td>23-Hour Crisis Stabilization S9485</td>
<td>$817.83 per diem</td>
<td>Emergency Custody Order (ECO) or Temporary Detention Order (TDO)</td>
</tr>
<tr>
<td>Residential Crisis Stabilization Unit H2018</td>
<td>$684.48 per diem</td>
<td>Emergency Custody Order (ECO) or Temporary Detention Order (TDO)</td>
</tr>
<tr>
<td>Applied Behavior Analysis 97151- 97157 0362T, 0373T</td>
<td>$11.35 to $68.11 per 15 minutes</td>
<td>LBA, LMHP, LABA, Technician Level 2 staff or additional staff with child</td>
</tr>
</tbody>
</table>

Key: QMHP: Qualified Mental Health Professional (QMHP), QMHP-Child, QMHP-Eligible (the same as Board of Counseling QMHP-trainee); CSAC/S: Certified Substance Abuse Counselor or Certified Substance Abuse Counselor Supervisee; LMHP Type: Licensed Mental Health Professional (LMHP), LMHP-Resident, LMHP-Resident in Psychology, or LMHP Supervisee, CSAC/S: Certified Substance Abuse Counselor or Certified Substance Abuse Counselor Supervisee; Technician level includes LMHP-Rs, LMHP-RPs, LMHP-ss, Registered Behavior Technicians (RBTs) and other unlicensed level staff.

* Rates are all subject to a 12.5% rate increase that went into effect July 1, 2022

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* Rates are all subject to a 12.5% rate increase that went into effect July 1, 2022
Figure 11: Implementation Timeline Chart

<table>
<thead>
<tr>
<th>Year</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>• Behavioral health is carved into Medicaid managed care</td>
</tr>
</tbody>
</table>
| 2018 | • Launch of 1115 Medicaid expansion, resulting in a significant shift in financial landscape for behavioral health  
• Move to align crisis services with national best practices ensuring cross disability and generational expansion  
• BRAVO was not funded in Governor’s budget  
• April - rate study funded in budget; used rate increase for Fall 2019 and 2020 budgets |
| 2019 | • May/June - visited GA and AZ to study comprehensive crisis systems  
• September - received 988 implementation grant to improve Call Center answer rates  
• December - Mercer completed a rate study that determined provider reimbursement rates |
| 2020 | • COVID froze the budget and funds were unallotted, but then were reallocated in November 2020 |
| 2021 | • January - year later received planning grant that was implemented in 2019-2021  
• February - funds allotted for Crisis Receiving and Stabilization and MCTs  
• July - purchased data platform  
• July - outpatient CPT crisis codes came on board  
• December - CRS and MCTs went live; rates for all remaining crisis services went live in Medicaid |
| 2022 | • June - MCT dispatch launches |

Barriers, Challenges, and Unique Population Needs

The transition from the original to the new crisis services system required operating two crisis systems simultaneously. Because Virginia is in mid-transition and putting tremendous efforts into education about the new system and its related culture change and because these are large and complex systems, it will take considerable time especially with new partners to realize the benefits.

Workforce: Although great efforts have been made by the CSBs to stand up mobile crisis teams, staffing shortages have made it difficult. The percent of need for mental health professionals met in Virginia is 42.6%, compared to the national percent of need met (28.1%). The programs below are examples of initiatives underway to address workforce concerns:

The Virginia Health Care Foundation has proposed a pilot program to pay the fees (currently $10,000 or more) for supervision by licensed behavioral health professionals as they work to obtain their licenses. It will target graduates, including people of color and providers hoping to work in underserved areas. There is a contract with the Foundation for $3M for a pilot to remove this barrier.

The Direct Support Professional Career Pathway Program was developed to create a more positive workplace, raise morale, and improve recruitment and retention. It includes partnerships involving DBHDS, community colleges, College of Direct Support, and others. It is envisioned that the career pathway will improve the overall competency level of staff, lead to a more positive workplace.
environment, raise morale, improve recruitment and retention measures at the facilities while supporting higher quality care and service.43

The Virginia Public Sector Leader Program is a leadership development certificate program of Virginia Tech’s School of Public and International Affairs. The curricula are developed by the faculty and the four program levels all address emotional Intelligence, management functions, leadership and decision-making, team building and influence, and strategic process.44

Culture change related to law enforcement’s role in crisis response: Virginia has worked to achieve and desires a culture change regarding a law enforcement response. However, three areas related to law enforcement are hampering progress in that area. Law enforcement is heavily involved and still has concerns about not being on scene (interest in and involvement with MCTs varies geographically). The second barrier is Virginia’s law requiring the individual to be in custody at the crisis centers. In addition, mobile crisis response has a legal base in assessments for temporary detention orders. Using the data platform for future reporting of outcomes such as the number of calls transferred from 911 to 988 and the number of crisis responses handled successfully without law enforcement may be helpful in changing the law enforcement mindset and move Virginia closer to the MARCUS law requirements.

Challenges: As the fee is very important to the sustainability of the crisis system, a challenge was planning the legislative approach for a fee. The agencies were fortunate in finding a legislator who both supported the effort and was creative in structuring a bill that would be successful.

Although all states are suffering with workforce challenges, Virginia was successful in using workforce policy changes to shape the behavioral health system. The Commonwealth expanded nursing scope-of-practice provisions and granted autonomous practice to nurse practitioners, growing the number by 52% in five years. They also began registering Qualified Mental Health Professionals (QMHPs) and peer recovery specialists experiencing a growth to 20,000 over a two-year period.45

Lessons Learned

Virginia shared four lessons they learned while building their crisis system:

- Developing strong partnerships and fostering those partnerships in person (or virtually) is particularly meaningful.
- The path would have been easier if they had engaged in more and earlier partnering for the process, demonstrating accomplishments, and investing in people through truly engaging stakeholders.
- Some conversations are more meaningful when in person, but conversations are the key even if virtual.
- Identifying a crisis point person whose sole responsibility is building out the crisis system would be a tremendous support for facilitating change. All coordination and communications would be through that individual. An additional point person in Medicaid, or one individual representing both agencies, would also be beneficial.
Sustainability of the System

Of the individuals receiving mental health services in SFY2018, 71% of all adults served had a serious mental illness, and 73% of all children served had or were at risk of having a serious emotional disturbance. In addition to growth in the CSBs, Medicaid expansion and integration has resulted in provider expansion through private and non-profit organizations. The need for behavioral health services is growing, and the provider base is growing, but can it grow to fit demand, and can Virginia afford to finance the growth? The financial modeling by the contractor Mercer looked at utilization, billing codes, etc. to help direct the system in a fiscally sustainable direction. A rate structure is critical, and Virginia required the MCOs to use the network and pay established rates. This thoughtful rate approach coupled with MCO mandated expectations around crisis, Medicaid expansion and integration have resulted in Medicaid becoming a significant part of the overall sustainability strategy for Virginia.

The Virginia General Assembly approved Medicaid expansion as part of its FY 2019-2020 budget in May 2018, and enrollment began on November 1, 2018. More than 641,000 people were enrolled as of March 2022. Virginia also has a State-run health exchange that covers over 308,000 individuals in private individual market plans. These programs diversify funding and thus are critical to the sustainability of the system.

Funding sustainability is solidified in the 988 fees and in Medicaid where one in four persons are Medicaid beneficiaries. Given the multi-system involvement of many individuals with behavioral health issues, Virginia’s crisis system approach utilized administrative infrastructure and leveraged strategic funding strategies to improve care coordination and outcomes, manage costs, and better invest resources for a growing crisis delivery system.

Conclusion

In their National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit, SAMHSA emphasizes that crisis services must be designed to serve anyone, anywhere and anytime. Communities that commit to this approach and dedicate resources will see better care, better health outcomes and lower costs. SAMHSA has also noted that a successful crisis management system has the following processes and qualities:

- Standardizes crisis care processes and quality
- Promotes suicide prevention as a core component of healthcare services
- Focuses on resolving behavioral health conditions
- Decreases psychiatric bed overuse and eliminates ED boarding
- Decreases drain on law enforcement
- Decreases fragmentation of behavioral healthcare.

Arizona, Utah, and Virginia have committed to SAMHSA’s best practices and developed well-designed, comprehensive crisis management systems that are supported by their state and

General Resource List

Centering Health Equity in Medicaid: Section 1115 Demonstration Strategies, Authored by Manatt Health, February 2022

Chapter 2: Access to Mental Health Services for Adults Covered by Medicaid, Report to Congress on Medicaid and CHIP, MACPAC, June 2021

Guth, M, State Policies Expanding Access to Behavioral Health Care in Medicaid, Kaiser Family Foundation, Dec 09, 2021

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local governments. The three service features that the three states have in common are those recommended in the *National Guidelines: regional or statewide crisis call centers coordinating in real time; centrally deployed, 24/7 mobile crisis services; and short-term crisis receiving and stabilization. programs.*47 Their effective systems are sustainable in that they have not relied solely on grants, nor on braiding of small or unreliable sources of funding. They have worked to incorporate a mix of funding sources that will grow as their programs grow and have adopted systemwide continuous quality improvement methodologies to ensure that the services work together, offer quality, and are cost-effective thus producing positive outcomes for the individuals they serve. The lessons they have learned in building these services can provide a useful playbook as other states embark on similar activities.

Although three states are highlighted in this paper, it is important to acknowledge that many other states are continuing to push for change that is envisioned with a new crisis services system. For the first time in many decades, there will be opportunities to expand behavioral health crisis services in dramatic ways. Arizona, Utah, and Virginia leaders are to be commended for providing information for this paper that can help others be educated and simultaneously inspired.
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