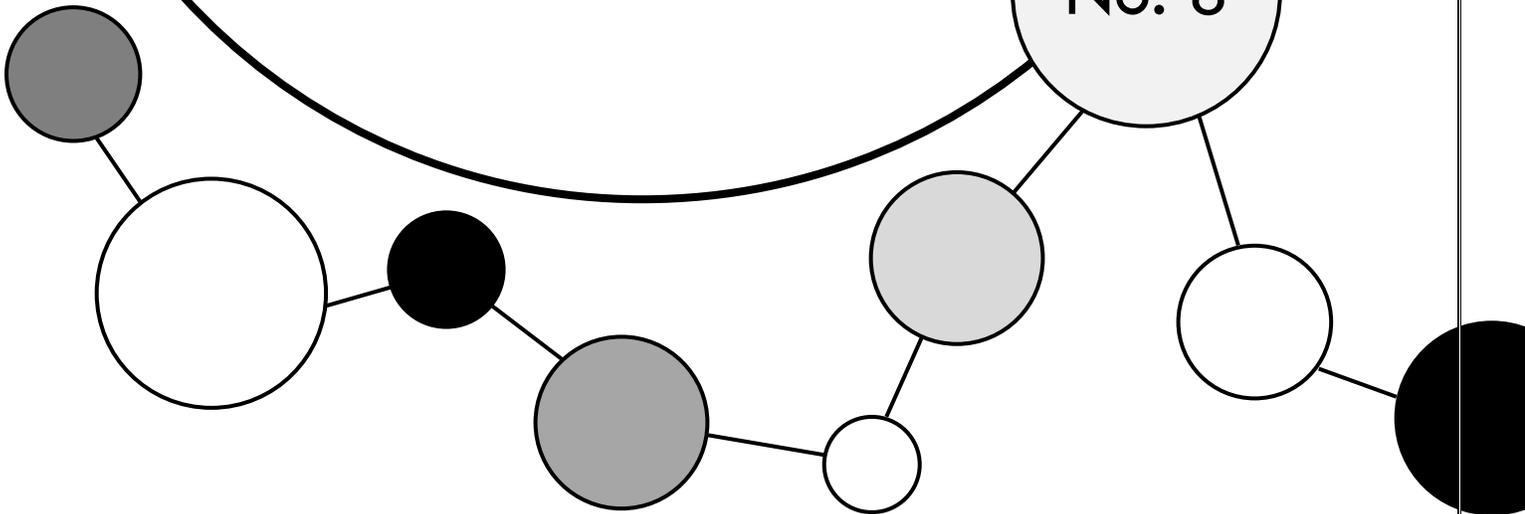


Funding Opportunities for Expanding Crisis Stabilization Systems and Services

No. 8



NASMHPD

Ready to Respond:
Mental Health Beyond Crisis and COVID-19

September 2021

Funding Opportunities for Expanding Crisis Stabilization Systems and Services

Kirsten K. Beronio, J.D.

Director of Policy and Regulatory Affairs
National Association for Behavioral Healthcare

(Previously) Senior Policy Advisor for Behavioral Healthcare
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services.

Cover Art by Malkah Pinals

***Eighth in the 2021 Ready to Respond Series of Ten Technical Assistance Briefs
focused on Beyond Beds, Reimagining a Sustainable and Robust Continuum of
Psychiatric Care***



National Association of State Mental Health Program Directors
www.nasmhpd.org/content/tac-assessment-papers

September 2021

Disclaimer

The views, opinions, content, and positions expressed in this paper are those of the author and do not necessarily represent or reflect the official views, opinions, or policies of any governmental, academic, or other institution with whom the author is affiliated; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. government, any state government, academic or other institution.

Recommended Citation

Beronio, K.K. (2021). *Funding Opportunities for Expanding Crisis Stabilization Systems and Services*. Technical Assistance Collaborative Paper No. 8. Alexandria, VA: National Association of State Mental Health Program Directors.

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS2832012000211/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Abstract:

Recent dramatic increases in federal funding for mental health care and addiction treatment have created significant new opportunities to expand access to behavioral healthcare. At the same time, designation of a three-digit nationwide crisis hotline (988) has highlighted the need for increased crisis call center capacity and crisis stabilization services in most communities. Development of statewide crisis stabilization systems that provide support through call centers, mobile crisis teams, and crisis stabilization centers can provide an essential framework for improving connections to needed services and supports while simultaneously decreasing reliance on emergency departments and law enforcement. Unprecedented increases in federal block grants and increased Medicaid support for mobile crisis and home and community-based services offer states a multi-faceted opportunity to significantly improve care for individuals experiencing mental health or addiction crises. This paper discusses the following recent developments and implications for improving access to crisis stabilization services.

Highlights:

- Supplemental mental health and substance use disorder block grant funding can support the leadership, planning, coordination, and implementation steps needed to develop comprehensive statewide crisis stabilization systems. This increased federal funding along with substantial new grant opportunities can incentivize and support providers to expand crisis stabilization programs and services.
- Existing and newly enacted Medicaid authorities can bolster expanded crisis stabilization programs and provide reliable funding for these programs going forward. This paper details various opportunities in Medicaid to finance crisis stabilization programs and services including a recently enacted enhanced federal Medicaid match for mobile crisis teams and increased federal Medicaid funding for home and community-based services;
- Expanded coverage of telehealth is critical for on-going improvements to crisis stabilization systems. This paper discusses the importance of continued coverage of telehealth after the Covid-19 public health emergency ends, including services via audio-only technology. It also describes some recent improvements to Medicare coverage of tele-behavioral health;
- This paper also outlines some promising opportunities to support crisis stabilization systems through alternative payment models and demonstrations.

Recommendations for the Post-COVID-19 Future:

1. Invest in statewide crisis stabilization systems;
2. Improve coverage of crisis services and reimbursement rates to increase availability of crisis stabilization programs; and
3. Support providers to expand access to crisis stabilization services.

The paper concludes with recommendations for additional federal policies to support state crisis stabilization systems and programs.

Several developments over the past year, driven in part by COVID-19, have created a unique opportunity to increase access to mental health and substance use disorder services, in particular crisis intervention and stabilization services. These developments include the enactment of a federal law designating 988 as a behavioral health crisis hotline that will be easy to remember and available nationwide by July 2022.¹ In addition, the significant impact of COVID-19 on behavioral health and the spike in overdose deaths during the pandemic have led Congress to dramatically increase funding for mental health and substance use disorder federal block grants and create significant new opportunities to support behavioral healthcare in Medicaid. Furthermore, several high-profile, tragic incidents have led to growing recognition of the need for alternatives to law enforcement responses to behavioral health emergencies, particularly among people from racial minority or disadvantaged communities. This paper will focus on how new federal funding opportunities can support development of crisis stabilization systems that can serve as alternatives to unnecessary use of emergency departments and law enforcement to assist individuals experiencing behavioral health crises.

Behavioral Health Before, During, and After the COVID-19 Pandemic

Before the pandemic, the United States was already experiencing multiple behavioral health crises. Although overall overdose deaths had declined slightly in 2018, the number of people dying from overdoses of synthetic opioids, cocaine, and psychostimulants was increasing at an alarming pace.² Rates of suicide had also been rising steadily, up 35% between 1999 and 2018.³ Serious behavioral health conditions had become so prevalent and elevated, they had driven down overall life expectancy in the United States.^{4,5}

During the COVID-19 pandemic, national surveys have repeatedly shown dramatic increases in the incidence of anxiety and depression.⁶ Suicidal ideation increased,⁷ and drug overdoses increased almost 30% with more than 93,000 deaths in 2020.⁸ Although suicide rates seemed to level off and even decreased last year,⁹ these overall findings are preliminary and differ by demographic subgroups.

As concerns about COVID-19 infection subside, mental health and substance use disorders may remain elevated for many people. Experiences with epidemics in the past indicate that the impact on behavioral health may continue for years to come.^{10,11,12} Children and adolescents are at risk of depression and anxiety during and after the pandemic ends according to a review of more than 80 studies on the impact of social isolation.¹³ Therefore special attention should be paid to them and other vulnerable populations, including minorities and underserved communities at greater risk of on-going challenges.

Designation of 988 Sparks Increased Support for Crisis Stabilization Services

The National Suicide Hotline Designation Act (Pub. L. 116-172), establishing 988 as a nationwide toll-free mental health crisis and suicide prevention hotline, presents a significant new opportunity to address increased behavioral health needs. An easy to remember three-digit number will be an important new resource for people struggling with behavioral health crises as well as their family and friends. The Act requires that all calls to 988 be directed to the pre-existing National Suicide Prevention Lifeline funded and overseen by the Substance Abuse and Mental Health Services Administration (SAMHSA) or the Veterans Crisis Line overseen by the U.S. Department of Veterans Affairs. An order by the Federal

Communications Commission has set the deadline for telecommunications providers to implement this change as July 16, 2022.¹⁴

In recognition of the expected increase in call volume and the need for additional capacity to answer these calls, Congress included a provision in the 988 Designation Act clarifying that states may enact fees on telephone services including mobile phone services.¹⁵ In particular, the Act specifies that nothing in the legislation or the Communications Act of 1934 or otherwise prohibits states from imposing fees on telephone services including mobile phones for 988 related services. These fees are to be used for routing calls made to 988 to a crisis center and providing crisis outreach and stabilization services in response to these calls. Several states have enacted legislation authorizing such fees.

In addition, Congress increased funding for the Lifeline network that will underpin 988 by \$5 million in the SAMHSA FY 2021 appropriations included in the Consolidated Appropriations Act (Pub. L. 116-260) (for a total of \$24 million for FY 2021). The President’s Budget for FY 2022 calls for \$102 million for the National Suicide Prevention Lifeline. Furthermore, the House of Representatives, Labor, Health and Human Services, and Education FY 2022 funding bill reported out of the full Appropriations Committee on July 15, 2021 includes over \$113 million for the Lifeline.

Improvements to the Lifeline call center network as well as expansions of mobile crisis teams and crisis receiving and stabilization centers are needed to improve services and supports for individuals struggling with behavioral health crises. Furthermore, these crisis stabilization systems and services can help decrease over-reliance on emergency rooms and law enforcement responses to behavioral health crises.^{16,17}

SAMHSA has issued National Guidelines for Behavioral Health Crisis Care that focus on several levels of crisis intervention and stabilization including regional crisis call centers, mobile crisis teams, and crisis receiving and stabilization centers.¹⁸ These guidelines envision regional call centers that are available 24/7 and clinically staffed to provide telephonic crisis intervention services. These centers should triage calls to facilitate assessments and coordinate additional support as needed including ideally with the capacity to dispatch mobile crisis teams if necessary.¹⁹

Mobile crisis teams can help resolve and de-escalate situations when an individual is experiencing a crisis in the community or at the person’s home. In addition, back-up by psychiatrists or other clinicians should be available. Furthermore, mobile crisis response providers should have good relationships with mental health and addiction treatment providers in their communities including crisis stabilization residential beds and inpatient settings.

Recent State Laws Funding Crisis Stabilization Services

Colorado (SB21-154)

-with a telecommunications user fee

Nevada (SB 390)

- with a telecommunications user fee

Virginia (SB1302)

-with a telecommunications user fee

Washington (HB 1477)

-with a telecommunications user fee

Utah (SB155)

-appropriates funding
-no telecommunications user fee

For those who require more assistance than a mobile crisis team can provide, the SAMHSA National Guidelines call for crisis receiving and stabilization centers and sub-acute crisis residential facilities. Crisis receiving and stabilization facilities are open 24 hours a day, seven days a week and are staffed with multidisciplinary teams that include prescribers, nurses, clinicians, and peers. The Guidelines call for these centers to accept walk-ins, ambulance, fire, and police drop-offs.

Leadership is Key for Developing and Supporting Crisis Stabilization Systems

The advent of 988 has drawn attention to the need for collaboration and investment in expanding crisis stabilization programs and services into coordinated systems. However, leadership and concerted efforts are needed to direct various substantial new funding streams as well as to coordinate many critical stakeholders into developing coordinated crisis stabilization systems that include at least the core components described in the SAMHSA National Guidelines.

State mental health and substance use disorder agencies have the expertise in behavioral health treatment and crisis stabilization as well as relationships with many of the various stakeholders that are required for leading this effort. Moreover, these agencies oversee use of mental health and substance use disorder block grant funds that Congress has dramatically increased over the past year to facilitate and encourage bold action by the states in addressing new and on-going behavioral health crises.

Substantially Increased Block Grant Funding Creates New Opportunities

At the end of 2020 and again this spring, Congress infused significant new funding into the MHBG and SAPTBG as part of the Consolidated Appropriations Act, 2021 (CAA)²⁰ and through the American Rescue Plan Act (ARPA).²¹

In the CAA, in addition to the regular appropriations for the block grants and other programs administered by SAMHSA, supplemental appropriations provided an additional \$825 million for the MHBG and \$1.65 billion for the SAPTBG for FY 2021. SAMHSA announced award of these funds March 11, 2021,²² and states have until March of 2023 to expend these supplemental funds.

Overview of SAMHSA Block Grants

Annual appropriations for formula-based block grants administered by SAMHSA provide important federal funding to support state mental health and SUD services and systems. Most recently, these block grants, the Community Mental Health Services Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), were funded at over \$757 million and \$1.858 billion respectively for FY 2021.¹ Congress and SAMHSA set general parameters on the use of these funds while leaving distributions and additional refinements to the state mental health and SUD agencies. Although other funding sources, e.g., Medicaid, cover a much higher percentage of overall spending on mental health and SUD services, the block grants represent a partnership between the federal and state governments specifically aimed at addressing mental health and SUD issues. In addition, these block grant funds provide a safety net for those who need mental health and SUD services.

In this legislation, Congress also set aside \$35 million of the regular FY 2021 MHBG appropriation specifically to fund crisis stabilization programs. The House Appropriations Committee report included the following description of this set-aside:

“Furthermore, the Committee directs a new five percent set-aside of the total for evidence-based crisis care programs addressing the needs of individuals with serious mental illnesses and children with serious mental and emotional disturbances. The Committee directs SAMHSA to use the set-aside to fund, at the discretion of eligible States and Territories, some or all of a set of core crisis care elements including: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or State-wide crisis call centers coordinating in real time.”²³

In the notices of awards sent to states regarding their FY 2021 MHBG funding awards, SAMHSA included several pages of guidance regarding the new set-aside for crisis services [See Appendix A]. SAMHSA specified that these set-aside funds must be used to finance “core crisis care elements including centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or state-wide crisis call centers coordinating in real time.”²⁴

List of Abbreviations

| | |
|--------|--|
| ARPA | American Rescue Plan Act |
| CAA | Consolidated Appropriations Act, 2021 |
| MHBG | Community Mental Health Services Block Grant |
| SAPTBG | Substance Abuse Prevention & Treatment Block Grant |

States were required to submit revisions to their MHBG plans with detailed descriptions of the status of the state’s crisis system including access to local crisis call centers, availability of mobile crisis units, and the availability and/or utilization of short-term crisis receiving and stabilization centers. States were also required to describe proposed or planned activities for this 5% set-aside funding. In addition, SAMHSA stated that “states may need to dedicate the rest of the current fiscal year to planning, training, and/or infrastructure development while targeting program implementation for the following year.”²⁵

With the ARPA, enacted just a few months later in March of 2021, the federal government provided an additional \$1.5 billion for the MHBG and \$1.5 billion for the SAPTBG. States have until September 30, 2025 to use these funds. SAMHSA announced these state allocations of these funds on May 18, 2021.²⁶ Although the specific set-aside provision for crisis stabilization was not included in the ARPA legislation, SAMHSA sent guidance to state mental health commissioners and substance use disorder directors encouraging states to focus some of the ARPA block grant funding to develop a behavioral health crisis stabilization continuum [in Appendix B]. SAMHSA urged states to ensure crisis services are available to various populations including people living in remote areas and underserved communities as well as children with serious emotional disturbances.

Table 1: Recent Increases in Mental Health and Substance Abuse Block Grants (Dollars in Millions)

| | FY 2020 Appropriations Enacted 12/2019 | FY 2021 Appropriations Enacted 12/2020 | FY 2021 CAA Supplemental Appropriations Enacted 12/2020 | ARPA Enacted 3/2021 |
|---------------|---|--|--|--------------------------------|
| MHBG | \$722.571 | \$757.571 (including \$35 million for crisis set-aside) | \$825.000 | \$1,500.000 |
| SAPTBG | \$1,858.079 | \$1,858.079 | \$1,650.000 | \$1,500.000 |

More recently, the President’s Budget for FY 2022 proposed “a set-aside of \$75 million of MHBG funds to support state efforts to build much needed crisis systems.”²⁷ This proposed increase more than doubles the amount provided for FY 2021 and is another step toward a 10% set-aside that many advocates are urging Congress to enact. Furthermore, the House Labor, Health and Human Services, and Education FY 2022 Appropriations bill proposes to increase the MHBG to \$1.58 billion and includes a 10% crisis set-aside.²⁸ This bill would also provide \$100 million for a Mental Health Crisis Response Pilot Program to establish or expand mobile crisis teams. In addition, the bill would also increase the SAPTBG by \$1 billion to \$2.8 billion and increase the State Opioid Response Grants by \$500 million to \$2 billion with a 10% set-aside for recovery services. Although the federal FY 2022 appropriation legislation is not yet final, these developments indicate that increased block grant funding levels and the set-aside for crisis services may be maintained at least in some fashion in the near term.

Supplemental Block Grants Can Support Development of Statewide Crisis Stabilization System

In guidance regarding the ARPA supplemental MHBG funding [in Appendix B], SAMHSA specifically recommends that states use these funds to develop partnerships among crisis continuum stakeholders including--

- Operators of Lifeline/988 call centers,
- Law enforcement,
- Providers of crisis stabilization services
- Hospitals and health systems,
- Housing authorities,
- Peer recovery services providers, and
- Substance use treatment providers

Development of crisis stabilization programs and services into coordinated behavioral health crisis systems will require collaboration with a number of additional entities including --

- State Medicaid agency leaders,
- Insurance commission officials,

- Emergency transportation providers,
- 911 operators,
- Other hotline operators in the state,
- People with lived experiences of behavioral health conditions and their families,
- Representatives of underserved communities, and
- Other state and local regulatory agencies that oversee emergency services (if applicable).

The SAMHSA ARPA guidance also recommends use of the additional MHBG funds to--

- Support implementation of information technology including increasing availability of broadband,
- Fund implementation of electronic health records by behavioral healthcare providers,
- Support use of Global Positioning System (GPS) technology to improve crisis response times,
- Finance implementation of texting capabilities among providers,
- Support the use of telehealth including for medication assisted treatment, and
- Fund implementation of electronic bed registries.

These activities and resources highlighted by SAMHSA comprise fundamental ways the federal block grants can be invested to support development of comprehensive coordinated crisis response systems. Flexible funding like the MHBG and SAPTBG can more readily support these types of investments than programs like Medicaid, Medicare, or private insurance programs which nonetheless should cover the services provided through crisis systems and programs.

State agencies should consider using the supplemental block grant funds to support a number of additional activities aimed at developing statewide crisis stabilization systems. An initial step could be an assessment of existing providers of crisis stabilization services including any existing hotlines and call centers. This planning should also include an assessment of which call centers in the state already participate in the Lifeline/988 network, what their capacity will be to accept increased calls coming in through 988, and whether additional capacity to answer 988 calls will be needed. Planning for coordination among existing crisis hotlines within the state would be helpful. In addition, protocols for how 988 will interface with 911 must be developed.

Block grant funding could also support an environmental scan of the existing mobile crisis units and crisis stabilization centers

Summary of Steps for Building Crisis Stabilization Systems

-Assess availability of existing crisis hotlines, call centers, mobile crisis, and crisis stabilization centers and address barriers in regulations and reimbursement

-Determine which call centers participate in the SAMHSA Lifeline and assess their capacity to respond to 988 calls

-Develop protocols for responding to 988 calls and other hotlines including 911 and for coordinating with other call centers and crisis responders in the region and/or state

-Provide training to crisis services personnel on how to provide equitable responses to disadvantaged communities

-Implement electronic systems for tracking availability of mobile crisis teams and openings in crisis stabilization facilities in real time

- Amend state laws that block use of alternative emergency response systems and create other barriers to

-Expand use of peers for crisis stabilization and expand scopes of practice for other behavioral health practitioners as well

- Collect data to assess impact and ensure quality

throughout the state to determine where additional services and programs exist and where there are gaps or improvements are needed. An assessment of Medicaid reimbursement rates for crisis stabilization services could help identify barriers to broader availability of services. In addition, block grant funding could support implementation of best practices for staffing mobile crisis units and other crisis stabilization programs. Crisis system development should support training for crisis services personnel to ensure equitable responses to disadvantaged communities. Furthermore, states should examine whether existing laws or regulations may impede development of alternatives to existing emergency response systems including rules against transporting individuals to alternative settings that are not emergency departments.

In addition, state agencies should collaborate on improving technological support for crisis response. Block grant funding could be used to improve the capacity of crisis response providers to provide services via telehealth. States should also consider using block grant funds to develop or improve existing electronic systems for tracking openings in crisis stabilization facilities and programs in real time.²⁹ In addition, these activities should include planning and funding data collection improvements and quality assurance programs for crisis stabilization services.

In light of widespread shortages of behavioral health providers, it is important that state behavioral health leaders reassess the limits on the types of providers permitted to offer behavioral healthcare especially crisis stabilization services. In this regard, states should assess whether existing scope of practice laws are unreasonably limiting practitioners' authority to assess and support those experiencing behavioral health crises.

State efforts to plan and fund increased availability of crisis stabilization services and systems should include support for coverage of peer support specialists as part of crisis stabilization teams. Peers can provide a knowledgeable and calming presence that can greatly help to deescalate a behavioral health crisis. There is growing evidence on the effectiveness of peer support services at improving outcomes for individuals struggling with mental illness or addiction while reducing costs.^{30,31} Some 39 states cover peer support services in their Medicaid programs with 23 states covering them for mental health and addiction, 12 states only covering their services for mental health, and four for addiction only.³² Block grant funding could be used to assess barriers to increased use of peers for behavioral health crisis response and to develop strategies for securing on-going support for peer support services, e.g., through expanding Medicaid coverage.

Medicaid Coverage of Peer Supports

States may cite the following Medicaid authorities to support coverage of peer support services:

- Rehabilitative services optional authority;
- Medicaid managed care plans under section 1915(b) authority;
- as a home and community-based services Medicaid state plan benefit under section 1915(i) or through a HCBS waiver under 1915(c).
- as part of section 1115 demonstrations;
- included in the benefits that Certified Community Behavioral Health Clinics must provide as part of the on-going Medicaid demonstration and expansion grant program.

Crisis system planning should also include an assessment of how crisis stabilization services are currently funded in the state as well as in other states including with fee-for-service Medicaid coverage, any managed care arrangements as well as whether providers are billing Medicare or commercial insurance for any of the services they provide. As 988 may significantly increase calls to behavioral health hotlines and demand for crisis stabilization services, support for these services should be increased with sustained funding sources. A discussion of how Medicaid can support these services follows. Moreover, coverage of crisis intervention and stabilization services provided to individuals covered by Medicare and private insurance should not fall solely on state and local governments as is now often the case.

States should encourage and support crisis stabilization providers to bill Medicare for covered services provided to Medicare beneficiaries. Medicare covers crisis psychotherapy (CPT Codes 90839 and 90840),³³ and according to CMS, 90839 is one of the most commonly used codes for billing Medicare for mental health services.³⁴ Although only certain provider types are eligible to bill these codes including psychiatrists, psychologists, and clinical social workers, and crisis stabilization providers likely will not have many higher-level credentialed providers on staff or at least not available 24/7, they 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 they supervise thereby allowing Medicare to reimburse for services provided by a broader array of practitioners.³⁵ Furthermore, Medicare covers crisis psychotherapy when provided via telehealth including audio-only telehealth.³⁶ Therefore, a crisis stabilization services provider may be able to leverage the capacity of a small number of higher credentialed staff to provide services that can be covered by Medicare, particularly since CMS recently clarified that supervision for “incident to” services may be provided via two-way audio-visual technology.³⁷

State governments should also use their regulatory leverage to ensure commercial insurers contribute to covering the cost of crisis stabilization services either through fees or by including crisis services providers in their provider networks. It would also be important to ensure that the benefits for crisis stabilization services in state regulated plans are comprehensive.

Several states have acted upon the provision in the 988 Designation Act encouraging implementation of fees on telephone services to fund development of crisis stabilization services.³⁸ However, it is not clear how many states will enact similar fees, and additional sources of on-going support for crisis stabilization services will be critical. As discussed below, new and existing opportunities in Medicaid offer promising new options for supporting crisis stabilization systems in a more predictable way.

Funding for Provider Implementation and Construction Costs is Needed to Expand Crisis Stabilization Programs

As gaps in availability of crisis stabilization services are identified, block grant funds could also potentially be used to help cover implementation, start-up, and improvement costs for new crisis stabilization services and programs in different regions or counties of the state as well as provider costs for standing up these services. These kinds of costs are not generally covered by insurers or healthcare coverage programs like Medicaid and Medicare. Start-up and improvement costs for providers of crisis stabilization services include hiring staff and developing billing capabilities so that providers can bill insurance and coverage programs like Medicaid and Medicare. The guidance issued by SAMHSA

regarding recent increases in the block grant funds encourages use of these funds to cover some of these implementation and improvement costs including coordination at the local level, adoption of health information technology including availability of broadband and cellular technology for providers, improving telehealth capabilities, and implementing electronic health record systems.

However, there are certain significant limitations on the use of block grant funding, including a prohibition on the use of Block Grant funds for construction costs. This limitation applies to both MH and SAPTBGs. Federal laws regarding the use of MHBG and SAPTBG specify that states may not use these funds “to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility”.³⁹ However, a waiver of the prohibition on use of funds for construction, although not land acquisition, is authorized in the SAPTBG.⁴⁰ To qualify for this waiver, states must demonstrate that adequate treatment cannot be provided in existing buildings. In addition, a state must have a plan that minimizes costs of construction, and the state must agree to provide a one-to-one match in cash for the federal funding used for construction. Nonetheless, in light of the substantial recent increases in funding for the SAPTBG, states may have more of an incentive and opportunity to apply for a waiver of the construction cost prohibition and utilize SAPTBG dollars to significantly support expansion of SUD treatment services.

Other recently enacted Covid-19 relief funding for states and localities can also help support development of crisis stabilization programs. The Coronavirus State and Local Fiscal Recovery Funding included in the ARPA is potentially an even more flexible source of funding than the SAMHSA block grants. The U.S. Department of Treasury awarded the \$350 billion in emergency funding to state, local, territorial, and Tribal governments on May 10, 2021. This funding can be used to cover costs incurred through December 31, 2024. The Department of Treasury announcement^{41,42} and interim final rule specifically refer to behavioral health services including “crisis intervention” and “hotlines or warmlines” as allowable uses of these funds.⁴³ There does not appear to be any prohibition on the use of these funds to cover construction costs. The allocations to the states and localities are posted on the Department of Treasury website.⁴⁴

Furthermore, the House of Representatives recently revived the practice of earmarking federal funding for local community projects and Members of Congress were invited to recommend specific local projects to the House Appropriations Committee for FY 2022 funding. The House Appropriations Committee included funding for a long list of these community projects in the FY 2022 appropriations bill reported out of the full Committee on July 15, 2021. Although funding for these projects is not final, many projects on the list (at least 135) focus on mental health and substance abuse. Moreover, at least fourteen projects are focused on funding crisis services, and some of these projects would specifically fund facilities and equipment costs related to providing behavioral health crisis services. The full list of projects is posted on the House Appropriations Committee website.⁴⁵

Grants for Community Mental Health Centers and Certified Behavioral Health Clinics Can Support Development of Crisis Stabilization Programs and Services

The CAA included significant new funding for discretionary grant programs that can help support implementation of crisis stabilization services, including \$825 million in grants for community mental

health centers (CMHCs). Applications were due on May 21, 2021 for these grants that may be used for the following purposes:

- Enhancing the capacity of CMHC staff to address crisis and emergency response;
- Supporting increased capacity for and availability of crisis beds;
- Expanding mobile crisis mental health services;
- Coordinating with crisis centers/hotlines to ensure that strong referral pathways are established and/or restored;
- Developing and implementing outreach strategies and referral pathways for vulnerable populations, such as minority populations and individuals residing in economically disadvantaged communities;
- Training and supporting peer staff to serve as integral members of the team to address mental health needs; and
- Providing diversion services to promote alternatives to hospitalization and incarceration, e.g., multiple intercept model.⁴⁶

This funding may not be used for major construction or renovations, but up to 20 percent of the total grant award for each budget period may be used for infrastructure development and up to \$75,000 may be used for renovations. A set of frequently asked questions posted by SAMHSA clarifies that:

“[I]nfrastructure development does not relate to construction or alteration/renovations of brick and mortar structures. Infrastructure in this context is systemic infrastructure activities that support services, for which there are no individual services delivered. Examples include the development and maintenance of a crisis-response capacity, including hotlines, mobile crisis teams, web-based check-in groups (for medication, treatment, and re-entry follow-up), drop-in centers, respite services, etc. Please note that on page 49 of the FOA, applicants may request up to \$75,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project.”⁴⁷

Recent federal Covid-19 relief legislation also greatly increased funding for Certified Community Behavioral Health Clinic (CCBHC) expansion grants. These grants support provision of comprehensive behavioral health supports and care coordination by clinics that are also required to provide, among other services, 24/7 crisis stabilization services. The CAA allocated an additional \$250 million specifically for CCBHC expansion grants. In addition, ARPA provided an additional \$420 million for CCBHC expansion grants. The general prohibition on use of funds for construction also applies to CCBHC grants along with the allowance for up to \$75,000 for renovations. Nonetheless, these grants can be used to improve access to crisis intervention services including mobile crisis teams and peer supports.⁴⁸

Medicaid Can Cover Some State Agency Costs for Improving Crisis Stabilization Systems

In addition to covering crisis stabilization services, Medicaid can also support state development and implementation activities to improve access to crisis stabilization services for Medicaid beneficiaries. A 2018 CMS letter to State Medicaid Directors regarding “Opportunities to Design Innovative Service Delivery Systems” for individuals with serious mental health conditions points out that states “may be able to access administrative match for crisis call centers.”⁴⁹ This “administrative match” provides

federal Medicaid reimbursement for 50% of the proportion of the costs attributable to serving Medicaid beneficiaries. This administrative match is different from the federal medical assistance percentage (FMAP) that states receive for Medicaid covered services and therapies provided to Medicaid enrollees. For example, Georgia accesses federal Medicaid funding to help cover administrative costs associated with operating a modern statewide crisis system that includes a hotline with the capability for dispatching 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 since these populations are most likely to need crisis stabilization services.

In addition, some administrative costs can be reimbursed at a higher federal matching rate, under federal authorities that comprise the Medicaid Information Technology Architecture (MITA) according to the 2018 CMS guidance on Opportunities to Design Innovative Delivery Systems.⁵⁰ Under the MITA authorities, information technology costs can qualify for 90% federal match for implementation costs and 75% match for operating costs. The 2018 guidance specifically refers to this enhanced federal match under MITA as available “to help states establish crisis call centers to connect beneficiaries with mental health treatment as well as to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions.”⁵¹ In addition, according to this CMS guidance, “development by the state of data-sharing capabilities between hospitals and community-based mental health providers”⁵² regarding admissions and discharge for acute care may qualify for the enhanced MITA federal matching rates.

The 2018 CMS guidance also refers to the enhanced match under MITA being available for state development of telehealth-enabling technology. Furthermore, this guidance refers to state costs for developing electronic bed registries as qualifying for enhanced federal reimbursement of “90% for development costs and 75% for operational costs”.⁵³ Other examples of costs that may qualify for this higher match include providing cell phones or iPads to mobile crisis teams to facilitate telehealth services with a clinician at another location during a crisis intervention, developing and implementing software applications to facilitate communication between crisis call centers and supervisory clinicians with mobile crisis team staff, and implementing text and chat technologies that many beneficiaries, including younger people, may be more comfortable using as part of the services offered by crisis call centers.

States may also be able to use untapped Children’s Health Insurance Program (CHIP) funds for Health Services Initiatives (HSIs) focused on crisis stabilization services tailored to children and adolescents. HSI options allow states to use a limited amount of their annual CHIP allotments and receive the higher federal CHIP matching rate (generally about 15% percentage points higher than Medicaid for a state) for projects aimed at improving children’s health.⁵⁴ This spending 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.⁵⁵ A number of states use this source of flexible funding for projects related to behavioral health services, including suicide and violence prevention for lesbian, gay, bisexual, and transgender youth.⁵⁶ In addition, some states have used this funding to support development of poison control centers that provide emergency advice and referral assistance.^{57,58}

Existing Medicaid Authorities Support Coverage of Crisis Intervention and Stabilization Services

Medicaid is one of the largest sources of funding for mental health and substance use disorder services in the United States,⁵⁹ and many of the individuals who require crisis services are Medicaid beneficiaries. Therefore, Medicaid has a large role in determining access to behavioral health services including mental health and addiction crisis stabilization services. Practically, all state Medicaid programs do cover crisis intervention or stabilization services based on a variety of federal Medicaid authorities.⁶⁰

CMS directly addressed this topic in the guidance regarding “Opportunities to Design Innovative Services Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.” That guidance pointed out that the following state plan benefits can authorize coverage of behavioral health crisis services: clinic services, diagnostic services, rehabilitative services, physicians’ services, other licensed practitioner services, as well as the health home benefit, and primary care case management.⁶¹ CMS specified that the services directly coverable with these authorities include screening, assessment, diagnosis, mental health and addiction treatment services, targeted case management, psychiatric rehabilitation services, peer supports, and family supports.

The 2018 Medicaid guidance further explained that some activities and costs that are key components of providing crisis stabilization services are not directly coverable. For example, provider costs for outreach and team supervision cannot be directly covered by regular Medicaid authorities. However, CMS explained that costs related to delivery of covered services may be incorporated into the reimbursement rates for the covered services.

Thus, in addition to providing comprehensive coverage of crisis intervention and stabilization services in their Medicaid programs, states should also ensure that their Medicaid reimbursement rate methodologies for crisis services incorporate the ancillary costs CMS pointed out as not directly coverable in the 2018 Medicaid guidance. These ancillary costs or activities include outreach and engagement with individuals in crisis and with other health care and public service providers as well as team coordination and supervision that are critical to crisis intervention and stabilization.

Furthermore, as the SAMHSA National Guidelines for Behavioral Health Crisis Care advised, reimbursement rates for crisis intervention and stabilization should take into account the need for these programs to be available at all times for unscheduled, emergency care similar to the rate structure for emergency department care and ambulance transports.⁶² The exigencies of providing crisis services that require providers to be available and on-call twenty-four hours a day seven days a week makes these types of programs difficult to finance using traditional fee-for-service or encounter-based methods.

Moreover, crisis stabilization reimbursement methodologies should allow for professional fees to be billed separately from the more inclusive team-based capacity rates for crisis stabilization. These professional fees can generally be billed to Medicare as discussed above; however, the team-based crisis stabilization rates most likely cannot. Therefore, separating out the professional fees can facilitate seeking Medicare reimbursement for those services. 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.

CMS has previously approved Medicaid payment methodologies and team-based capacity reimbursement rates sometimes paired with separately billed professional fees in a number of states. Below are examples of 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 for all Medicaid eligible consumers. Services include assessment, immediate crisis resolution and de-escalation, counseling, referral to appropriate services including arranging for transport or admission, consultation with physicians or other qualified providers, and follow-up as necessary with the individual and/or caretaker/family member within 14 days of an episode of PERS care. Reimbursements include an “episode of care” payment for mental health services provided by PERS certified assessors and PERS specialists. An episode of care must include at a minimum a comprehensive face-to-face assessment and a disposition with either a transfer or discharge. There are 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 the appropriate CPT codes. In addition, follow-up services are reimbursed per one-hour unit of service.⁶³
- Delaware covers mobile and facility-based crisis intervention services available 24 hours a day seven days a week to provide assessment, crisis stabilization and de-briefing with the beneficiary, crisis counseling, consultation with other qualified providers, psycho-education and supportive services for families and consumers, recovery/discharge planning, follow-up as necessary with the beneficiary and the beneficiary’s caretaker or family member, linkages to other services, and arranging for transfers, transport and admissions as necessary. Reimbursement for facility services is at a per diem rate, and mobile crisis services reimbursement rates are paid per 15-minute intervals.⁶⁴
- New York provides coverage of comprehensive crisis intervention services through its Medicaid managed care program as part of statewide effort to provide “a coordinated behavioral health crisis response system available to all New Yorkers”. The state has a comprehensive set of reimbursement rates that includes telephonic crisis response for 15-minute intervals and per diem rates for telephonic crisis responses that extend beyond 90 minutes. New York also has set rates for mobile crisis response in 15-minute intervals, per diem rates for mobile crisis interventions that last 90 to 180 minutes, and a different per diem rate for mobile crisis interventions that last for at least three hours. In addition, the state has set higher rates for teams of two with licensed professionals and unlicensed/certified peer support specialists. New York has also established reimbursement rates for crisis follow-up services in 15-minute intervals with different rates for single licensed providers and single peer providers and higher rates for two person teams comprised of a licensed provider and peer. New York is covering adult and child crisis residential services as part of this crisis intervention and stabilization program. The state has established suggested rates for crisis residential services for individuals over 21 and mandated rates for crisis residential services for individuals under 21.⁶⁵ New York’s benefit and bill guidance includes the following description of this benefit:

“The Crisis Residence component of the Crisis Intervention benefit is designed to reimburse providers to integrate Crisis Residence services into existing behavioral health crisis response systems. Crisis Residence programs are an important part of the statewide comprehensive crisis service continuum. These programs differ regionally according to local needs and resources. Crisis Residence programs work with community-based organizations, hospitals, schools, law enforcement, and other entities to address the needs of individuals experiencing a mental health crisis.”⁶⁶

The 2018 CMS guidance also pointed out that managed care authorities can support crisis stabilization services. Managed care arrangements can offer more flexibility regarding some restrictions in Medicaid and can include coverage of additional services not as directly covered by regular Medicaid authorities. Moreover, managed care organizations can facilitate use of multiple funding streams for crisis stabilization services including Medicaid reimbursement for services, MHBG and SAPTBG block grant funds and other federal grant funding, as well as state and local funds.⁶⁷

Importantly, state agencies should ensure that reimbursement rates for mobile crisis units are sufficient to support two person teams. The new mobile crisis intervention benefit in Medicaid discussed below requires at least two person teams for a mobile crisis service to qualify for an 85% federal match.

New Opportunities are Available in Medicaid to Support Crisis Stabilization Services and Systems

Medicaid programs in every state cover some form of crisis stabilization services using a variety of authorities and reimbursement approaches.⁶⁸ However, in a number of states there are still significant gaps in services covered (e.g., some states do not provide Medicaid reimbursement for mobile crisis services) and certain providers are excluded or limited in the types of services they can provide; for example, a number of states do not allow peers to participate in their Medicaid programs.⁶⁹ Furthermore, there are long-standing restrictions on the availability of Medicaid reimbursement for residential treatment settings with over 16 beds referred to as the Institutions for Mental Diseases (IMD exclusion).⁷⁰

The 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 qualifying mobile crisis intervention services and an increased federal match for home and community-based services (HCBS) including benefits covered under the Medicaid rehabilitative services, case management, and 1915(i) authorities.⁷¹

Requirements for Mobile Crisis Teams to Qualify for Increased Federal Medicaid Match

- Include at least two members
- Include one professional authorized to conduct an assessment (additional team member may be a peer)
- Be available 24/7 every day
- Be trained in trauma-informed care, de-escalation, and harm reduction
- Provide services outside hospitals or other facilities
- Be able to provide screening/assessment, stabilization, and coordination with health and social services and supports
- Have relationships with local medical and behavioral health providers

Increased Federal Medicaid Match for Mobile Crisis Stabilization Teams

Section 9813 in the ARPA incentivizes states to establish or expand Medicaid coverage for mobile crisis services with an 85% federal matching rate for covered services provided by qualifying mobile crisis units. This enhanced federal match is available for 12 quarters during the five-year period starting April of 2022. Qualifying mobile crisis services are defined as covered items and services that are furnished to a beneficiary outside a hospital or facility who is experiencing a mental health or substance use disorder crisis. These services must be provided by a multidisciplinary team that includes at least one behavioral health professional authorized to conduct an assessment of the individual under state law and other professionals or paraprofessionals with appropriate expertise in crisis response including peer support specialists. Members of these teams must be trained in trauma-informed care, de-escalation strategies, and harm reduction. These teams must be available 24 hours a day every day to provide screening and assessment, stabilization and de-escalation, and coordination and referrals to health, social, and other services and supports in a timely manner. To qualify for the enhanced match, states must provide assurances that they will use the additional federal funds to supplement and not supplant state funding for mobile crisis services based on the level of state funding during the prior fiscal year.

The ARP Act also appropriated \$15 million in planning grants to support development of state plan amendments, section 1115 demonstrations, or section 1915(b) or 1915(c) waivers to provide qualifying community-based mobile crisis intervention services. CMS issued the notice of funding opportunity for these planning grants on July 13, 2021.⁷² CMS included the following actions among the examples of activities for which planning grants could be used:

- “Technical assistance on planning emergent intervention and crisis services and the integration with crisis call centers, crisis intervention centers, and longer-term post-crisis care coordination programs and resources such as community-based recovery supports;
- Conducting a statewide needs assessment for community-based mobile crisis intervention services, including such factors as provider capacity, provider qualifications, scope of services furnished, equity strategies, and privacy protections;
- Enrolling prospective Medicaid providers and making technical assistance available for meeting Medicaid claiming requirements for furnishing community-based mobile crisis intervention services;
- Building linkages and developing collaborations of community-based mobile crisis intervention services with National Suicide Prevention Lifeline crisis call centers and first responders;
- Building and strengthening partnerships with relevant state and local partners (e.g., Single State Agencies for substance abuse and mental health); and
- Assessment of state information systems to identify options for improving interagency communication and data sharing for facilitating individuals’ access to on-going treatment and to prevent recurring crises”.⁷³

Ideally, these planning grants can support and encourage participation by state Medicaid agencies in statewide crisis services planning along with other crisis intervention stakeholders. These planning funds could encourage collaboration among these stakeholders on how Medicaid coverage policies can support broader availability of crisis stabilization services and how the MHBG and SAPTBG and other grant funding can be used to complement (instead of overlap) Medicaid coverage of crisis services including by covering fixed costs for establishing and operating mobile crisis teams. These collaborations could also explore other mechanisms for supporting crisis stabilization services including incorporating these services into coverage provided by Medicaid managed care plans as well as reimbursement rate methodologies for crisis stabilization services that take into account that these services must be available all the time and are accessed unpredictably on an emergency basis. In addition, this planning could include discussion of opportunities for expanded coverage and availability of crisis services presented by section 9817 of ARPA provision offering enhanced Medicaid funding for HCBS (discussed below).

Enhanced Federal Medicaid Funding for Home and Community-Based Services and Infrastructure

The ARPA includes another opportunity to increase Medicaid support for crisis stabilization services with section 9817 offering states a ten-percentage point increase in their federal matching rate for HCBS. This increased federal matching rate applies to state spending on HCBS from April 1, 2021 through March of 2022. State spending eligible for the enhanced federal match includes spending on benefits covered under a number of federal Medicaid authorities including the rehabilitative services benefit, the case management benefit, 1915(i) state plan option, and section 1115 demonstrations all of which often serve as the authorizing provisions for Medicaid coverage of crisis stabilization and other behavioral health services.

In recently issued guidance⁷⁴, CMS specifies that the additional federal funding amounting to 10% of a state's spending on HCBS from April 1, 2021 through March 31, 2022 must be used by the state on improvements or expansions of HCBS. These improvements or expansions can take place over a three-year period from April 2021 through March 31, 2024. The guidance further explains that this increased federal funding can be reinvested one time between April 1, 2021 and March 31, 2022 to cover the state share of additional HCBS *services* (the authorities for which are listed in Appendix B of the guidance).

There are two fundamental requirements for states to qualify for the additional federal funding for HCBS: 1) states must use the federal funds to supplement and not supplant state funding for HCBS; and 2) states must implement or supplement one or more activities to enhance, expand, or strengthen HCBS in their Medicaid program.

Regarding the first requirement, CMS guidance specifies that states may not impose stricter eligibility standards for HCBS than those in effect on April 1, 2021. In addition, states must maintain coverage of HCBS in effect as of that date including the services and amount, duration, and scope of that coverage. Finally, states must maintain provider payment rates for HCBS in effect as of April 1, 2021. These maintenance of effort requirements apply until the additional federal funds are fully expended.

Regarding the second requirement, CMS guidance advises that states must spend state funding equivalent to the increased federal matching funds to implement or supplement activities to enhance, expand, or strengthen HCBS. These activities must expand, enhance, or strengthen HCBS beyond what is available under the state Medicaid program as of April 1, 2021. State activities and spending to strengthen or expand HCBS can extend through March 31, 2024.

Several of the HCBS authorities listed in Appendix B of this guidance and eligible for the enhanced match and reinvestment are used by states to authorize Medicaid coverage of crisis stabilization services. Therefore, states could use this opportunity to significantly expand Medicaid coverage of crisis stabilization services authorized under the rehabilitative services option or case management authority or other HCBS authority in Appendix B with the additional federal funding provided by this provision of the ARPA. The guidance specifies that states may reinvest additional federal funding provided under this provision to cover the state matching funds for additional HCBS services and be eligible for the higher federal matching rates one time between April 2021 and March 2022.

In addition, many of the activities listed in Appendices C and D including those related to capacity building, infrastructure development, and improvements to reimbursement that states are encouraged to use these additional federal HCBS Medicaid funds on could be used by states to improve their crisis stabilization services and systems.

The CMS guidance explicitly recommends use of these federal HCBS funds for certain activities to improve mental health and substance use disorder services. This section specifically refers to skill rehabilitation to “assist eligible individuals in receiving mental health services, substance use treatment and recovery services, and necessary rehabilitative services” and expanding capacity including “recruiting additional behavioral health providers, increasing payment rates for providers, expanding access to telehealth.” Furthermore, although many of the other activities in Appendices C and D are framed as ways to expand and improve HCBS for people with physical or intellectual disabilities, these same types of activities could also help improve behavioral health crisis stabilization services. These other activities include --

- Increasing payment rates for care providers;
- Activities to recruit and retain care providers and professionals;
- Workforce training, technology costs (referring specifically to assistive technology, but could also include technology used to provide crisis services including iPads for law enforcement and/or mobile crisis teams and internet costs for new and/or expanded crisis stabilization centers);
- Educational materials (focused on COVID-19 but could also include 988 and telehealth);
- Language assistance including sign language (could also be implemented in crisis service systems to improve care for minority and underserved communities);
- Establishing toll free phone lines and marketing and outreach campaigns that could support 988 implementation;
- Providing person-centered planning and training (also critical for people experiencing a behavioral health crisis);
- Improvements to quality measurement;
- Developing cross-system partnerships among managed care plans, providers, and social support agencies including housing and employment supports;

- Caregiver training and respite, expanding the use of telehealth including investments in infrastructure including start-up costs, e.g., equipment, internet connectivity and activation costs, providing smartphones, and computers;
- Covering costs of implementing health information technology;
- Care coordination enhancements such as notification systems for hospital admission, discharge, and transfer notifications; and
- Implementing integrated care models.

All of these activities to enhance HCBS could be implemented by states specifically to improve and expand mental health and substance use disorder crisis stabilization services.

The guidance specifies that participating states are required to submit an initial spending plan estimating the total amount of federal funding the state plans to claim as the 10% federal match increase for HCBS. In addition, this plan must include a description of activities that the state will implement with these additional federal matching funds between April 1, 2021 and March 31, 2024. The guidance also points out that this plan should also explain how the state plans to sustain these activities beyond March of 2024. States also have to submit quarterly reports updating the estimates of the amount of federal funds the state expects to draw down due to the increased federal matching funds, any spending on the planned activities, and progress reports on those activities.

Moreover, the guidance also states that the initial and quarterly reports should include “any additional federal funds attributable to the increased federal match that the state expects to receive by reinvesting” the additional federal funds to cover the state share for additional HCBS services. As mentioned above, CMS did specify that the state must explain in their initial and quarterly reports how activities funded in this way will be sustained. As a result, use of some of this federal funding to cover fixed-cost infrastructure and capacity building activities may help lessen difficulty later on of maintaining expanded coverage of services.

A number of states have posted their plans for the use of this additional federal funding to expand and enhance HCBS. Some of these plans are fairly general and could support a variety of activities including activities to expand and improve crisis stabilization services. Moreover, some states indicate they plan to refine their plans in subsequent reports to CMS.

Massachusetts proposed to access an additional \$500 million in federal funding for HCBS under section 9817 of the ARPA.⁷⁵ The state has proposed to focus this funding on HCBS workforce, access, and technology/infrastructure improvements. In addition, the state’s plan indicates the additional federal funding will be used to support implementation of its “Roadmap for Behavioral Health Reform” issued in early 2021.⁷⁶ This Roadmap calls for a more centralized service enabling people to call or text to access mental health and addiction treatment and expanded availability of treatment including at night and on weekends, more community-based alternatives to emergency department crisis services, and more culturally relevant care. In addition, the state proposes an across-the-board payment increase and enhancements including hiring bonuses and internship and training opportunities for direct care workers. Furthermore, the state will invest in expanding access to HCBS services including Community Behavioral Health Centers and navigation supports in emergency departments and inpatient settings, as well as increased use of technology to improve communication, case management, coordination among

providers, data sharing, and caregiver directories. The state indicates it plans to further refine these plans going forward.

California's plan⁷⁷ proposes to draw down an additional \$4.6 billion in federal funding for HCBS. The state proposes to focus these funds on increasing and supporting HCBS direct care workers through training, stipends, bonuses, and career pathways. In addition, the state proposes use of these funds for improvements to transitions and navigation with HCBS including navigators in emergency rooms to screen and refer to mental health or SUD programs and services to assist individuals leaving criminal justice settings. The state proposes to use these funds to incentivize managed care plans to address homelessness. In addition, California proposes to use these funds for rehabilitation and construction of residential facilities for senior citizens. The state proposes to fund a contingency management pilot program for individuals with stimulant use disorder. In addition, the state proposes to fund several technology infrastructure projects focused on improving care for individuals with disabilities and senior citizens.

The Indiana plan proposes to use more than \$877 million in additional federal funding on HCBS workforce development, enhancing HCBS with specialized programs for different groups, building provider capacity, and caregiver training and support.⁷⁸ These proposed activities include investment in expanding the capability and capacity of the Indiana Crisis System based on the SAMHSA National Guidelines for Behavioral Health Crisis Care. These efforts will include support for one or more call centers with 24/7 call coverage. In addition, the state proposes to provide funding to behavioral health providers to expand mobile crisis support and crisis stabilization services.

Additional Avenues to Support Crisis Stabilization through Medicaid

In the 2018 Letter to State Medicaid Directors on "Opportunities to Design Innovative Service Delivery Systems for Adults with Serious Mental Illness or Children with Serious Emotional Disturbance", CMS highlighted increasing availability of crisis stabilization services as a key strategy for improving care for Medicaid beneficiaries with SMI or SED. This CMS guidance specifies that "[c]ore elements of crisis stabilization programs include development of regional or statewide crisis call centers coordinating access to care in real time, centrally deployed mobile crisis units available 24 hours a day seven days a week, and short-term, sub-acute residential crisis stabilization programs."⁷⁹ The letter also points out that these services can help divert Medicaid beneficiaries with these conditions from unnecessary stays in emergency departments and involvement with law enforcement.

Furthermore, this CMS guidance highlights that a long-standing prohibition on Medicaid reimbursement for services provided to beneficiaries residing in IMDs may apply to a core component of crisis stabilization systems, sub-acute crisis residential crisis stabilization programs, if those facilities have more than 16 beds. However, the letter describes how states may be able to cover these services for no more than 15 days under a Medicaid managed care rule that applies to comprehensive risk-based managed care organizations or prepaid inpatient hospital plans.⁸⁰

This State Medicaid Director letter also established a section 1115 demonstration initiative that waives the IMD exclusion to allow Medicaid coverage for crisis residential settings with over 16 beds in states that agree to take a number of steps to improve community-based behavioral health care in the state.

These additional actions referred to as “Milestones” in the guidance include committing to increased funding for community-based services including crisis call centers, mobile crisis units, and observation/assessment centers. As a result, this demonstration initiative frees up local and state funding previously dedicated to covering services in IMDs, so these funds can be used to support improvements in crisis intervention and stabilization programs.

States with these section 1115 demonstrations are also required to conduct in-depth annual assessments of the availability of mental healthcare throughout the state including the availability of the crisis stabilization services (including call centers, mobile crisis, and crisis stabilization centers). States are also required to provide updates on actions taken to increase availability of these services.

In addition, participating states are expected to report quarterly or annually on specific performance measures including emergency department utilization, inpatient utilization, and readmission following hospitalization in an inpatient psychiatric facility, follow-up after hospitalization for mental illness, access to preventive/ambulatory care, total costs, and per capita costs for mental health among beneficiaries in inpatient or residential setting compared to all other beneficiaries.⁸¹

As of July 2021, CMS has approved applications from the following states for these demonstrations: District of Columbia, Idaho, Indiana, Oklahoma, Utah, Vermont, and Washington. In addition, Massachusetts, Alabama, and New Mexico have submitted formal applications.

CMS previously established a similar section 1115 demonstration program in 2015 that was revised in 2017. This initiative likewise allows coverage of services for beneficiaries in IMDs including crisis residential settings primarily to receive SUD treatment. These demonstrations also require states to take a number of steps to improve the SUD treatment continuum of care in their state. In addition, states are required to report on a set of performance measures and metrics on a wide range of issues including the following topics: initiation and engagement in treatment, use of opioids, continuity of medication to treat opioid use disorder, treatment offered at discharge and follow-up after discharge, emergency department utilization, inpatient stays, and readmissions among beneficiaries with SUD. CMS has approved 32 states for these 1115 demonstrations and an additional three states have formally submitted applications.

These demonstrations incentivize states to enhance their crisis stabilization systems in order to meet the requirements or milestones to improve access to community-based care. In addition, statewide implementation of crisis stabilization services and the crisis system improvement activities discussed above should help states perform well on the milestones and performance measures for these demonstrations.

Telehealth is a Key Component of Enhanced Crisis Stabilization Services and Systems

Use of telehealth to provide mental health and addiction treatment services grew exponentially during the COVID-19 public health emergency. Almost 40% of Medicare beneficiaries accessed office visits via telehealth and 60% accessed mental health services via telehealth.⁸² Services delivered to Medicaid and CHIP beneficiaries via telehealth also increased dramatically particularly in the use of telehealth for mental health services.⁸³ In addition, commercial insurers greatly expanded coverage of telehealth, with private insurance claims data consistently showing mental health conditions to be among the most

frequent reason for telehealth visits. As utilization of telehealth overall has begun to decline, utilization of telehealth for mental health treatment has remained strong, far outpacing the level of continued use of telehealth for other conditions.⁸⁴

The availability of telehealth undoubtedly preserved access to behavioral healthcare to a significant degree. However, for many disadvantaged individuals, this alternative avenue was not sufficient to maintain access. Data recently released by CMS indicate that Medicaid enrollees' access to mental health and SUD services decreased dramatically during the pandemic and did not fully recover despite greater use of telehealth.⁸⁵ This decrease in utilization of behavioral healthcare was pronounced among children and youth during the pandemic perhaps due to the lack of access to behavioral healthcare through schools.⁸⁶

Crisis call centers, mobile crisis service providers, and crisis stabilization centers often provide services via telehealth. Continued expanded coverage of telehealth with reimbursement rates on par with in-person services will help support broader availability of crisis services that can hopefully address some of the behavioral health impact and expected increased need for mental health and SUD treatment services resulting from the Covid-19 pandemic.

The significance of expanded Medicare coverage of telehealth services for improving access to crisis stabilization services should not be overlooked since Medicare coverage policies often influence Medicaid and commercial insurance. Moreover, continued coverage of audio-only telehealth services will be critical since telehealth crisis services are often provided via telephone calls. Among Medicare beneficiaries who had a telehealth visit last summer and fall, over half of them accessed care using a telephone only.⁸⁷ Furthermore, coverage of audio-only telehealth services enables access to behavioral healthcare in areas where broadband service is often not available to support video interactions. Low-income populations and homeless individuals are also less likely to have access to telehealth services via video-conference technology.

In addition, availability of care through audio-only telehealth is even more important in rural areas due to the common shortage of behavioral healthcare providers in those areas. According to the Health Resources and Services Administration (HRSA), there are more than 5,700 mental health provider shortage areas across the United States, with more than one-third of Americans (119 million people) living in these shortage areas.⁸⁸ Telehealth services can help extend the capacity of behavioral health services to reach individuals in need of behavioral healthcare including crisis services in those shortage areas.

Recent legislation has significantly improved Medicare coverage of telehealth for beneficiaries in need of mental health or substance use disorder treatment. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT Act)⁸⁹ improved Medicare coverage of telehealth for SUD treatment by eliminating the limitation on coverage to services provided in certain rural geographic areas and the requirement that beneficiaries travel to originating site facilities to access telehealth services. (Currently, CMS has waived these limits on telehealth during the pandemic.) Due to this change in the law, even after the public health emergency is over, Medicare beneficiaries will be able to access SUD services via telehealth from their homes or communities and regardless of the geographic area they are in. Furthermore, these changes also require that reimbursement for providers be at the same rate as if these services were provided in-person, although facility fees would not be provided.⁹⁰

Similar improvements to Medicare coverage of mental health services via telehealth to beneficiaries at home and regardless of geographic locations were enacted as part of the CAA.⁹¹ In addition, in a recent rulemaking implementing this provision, CMS has also proposed to maintain Medicare coverage of audio-only technology for telehealth services for mental health and certain SUD treatment.⁹² These changes could help support Medicare coverage of telehealth services provided by crisis stabilization services providers, but a requirement that the beneficiary must have seen the provider in-person within the prior six months is a significant barrier to the utility of these provisions for improving access to crisis stabilization services. Exceptions to this preexisting treatment relationship requirement should be allowed for behavioral health crisis situations.

Opportunities to Support Crisis Stabilization through Alternative Payment Models and Demonstrations

As discussed above, reimbursement for crisis stabilization services must be structured differently than payment for other mental health or substance use disorder services. Payment methodologies and rates must take into account the need to have crisis stabilization services available around the clock and accessible without appointments or even notice. These services also generally require a team-based approach to care that is sometimes provided in the community by a mobile crisis unit, sometimes in a crisis receiving/observation center, and sometimes an emergency room or other setting, including jails. These types of services demand a flexible funding approach that factors in the variety of resources needed to provide this type of care.

Certified Community Behavioral Health Clinic Model

The Medicaid CCBHC demonstration is one example of how a comprehensive flexible payment methodology can be developed that includes mobile crisis services in the community as well as crisis stabilization services in a clinic setting. This demonstration supports provision of a comprehensive array of services by community mental health centers with a cost-based daily or monthly Medicaid payment rate. The Medicaid demonstration was the basis for the CCBHC expansion grants described above that were increased substantially in the CAA and ARPA. There are also quality improvement features included in the demonstration. States have the option to provide bonus payments to CCBHCs that meet certain quality metrics. In addition, CCBHCs and states are required to report on performance measures aimed at assessing the impact of this demonstration. The demonstration includes 10 states.⁹³ It started in 2016 and has been extended many times most recently until September 30, 2023.

Several of the Medicaid CCBHC demonstration states have added their CCBHC payment rates to their Medicaid state plans. In Missouri, for example, the state plan amendment adding this payment rate for clinics that qualify as CCBHCs refers to the Rehabilitative Services Option for authority. This payment methodology incorporates all the costs of providing 24/7 crisis stabilization services including mobile crisis services and also including the costs of activities that go into providing these services that are not as directly covered by existing Medicaid authorities including outreach and engagement costs, care coordination, and team-based consultation costs.

In addition to this Medicaid demonstration, the CCBHC expansion grant program has funded development of CCBHCs in all but about ten states.⁹⁴ These grants do not include the Medicaid

reimbursement model incorporated into the demonstration. However, availability of CCBHCs in a state, even those that are funded by SAMHSA discretionary grants, could facilitate development of a Medicaid payment rate modeled after the payment rates in the CCBHC demonstration that could cover all the costs that go into providing 24/7 crisis stabilization services.

Emergency Triage, Treat, and Transport (ET3) Model

The Center for Medicare and Medicaid Innovation (CMMI) within CMS recently kicked off a new payment model for emergency services for Medicare beneficiaries that is closely aligned with the objectives of increasing crisis stabilization services.⁹⁵ This model, the Emergency Triage, Treat and Transport (ET3) model, pays for transportation of Medicare beneficiaries to alternative locations instead of the settings to which beneficiaries are generally required to be brought, usually hospital emergency departments. Participants in the five-year program that started in January of 2021 are 184 public and private Medicare-enrolled ambulance providers in 36 states. The model will test 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. The alternative settings where participating ambulance providers may bring beneficiaries include primary care offices, urgent care clinics, and community mental health centers or other destinations approved by CMS. Crisis stabilization centers should also qualify as alternative settings where Medicare beneficiaries could be brought. Payments to participants will be tied to performance on key quality measures in the third year of the demonstration.

This nationwide demonstration highlights the need for alternatives to emergency departments for those who do not really need to be there, and the need for greater flexibility in state and federal regulations regarding emergency response and where individuals experiencing a behavioral health crisis may be brought for stabilization services. In addition, this demonstration points out the need for improvements to Medicare coverage of crisis stabilization services. As described above, Medicare coverage for crisis stabilization services is generally limited to crisis psychotherapy (CPT codes 90839 and 90840), but many crisis stabilization centers do not bill for these codes because they do not have the staff with the right credentials.

CMMI also announced a complementary opportunity for local governments where emergency transport providers participating in the ET3 model are located. This additional opportunity will provide funding to expand emergency and non-emergency medical triage services in these locations. As currently structured, access to triage services funded with these grants would have to be provided in response to calls to 911. However, 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. State mental health and substance use disorder agencies should identify whether any of the providers in their state are participating in this program⁹⁶ and incorporate those activities into their planning for coordinated and comprehensive crisis stabilization systems.

CMMI in collaboration with the Center for Medicaid and CHIP Services at CMS issued guidance on how states could implement similar payment and care delivery models in their Medicaid programs.⁹⁷ This guidance describes various Medicaid authorities and payment policies that states could implement in order to support emergency transport for Medicaid beneficiaries to alternative destinations instead of

emergency departments and to cover practitioners including EMTs providing services to Medicaid beneficiaries on the scene of a 911 response.

This joint guidance points out that under federal law Medicaid may cover emergency response services provided on the scene without transport by EMTs who are under the supervision of a physician or other licensed practitioners including licensed paramedics. In addition, Medicaid may cover services provided on the scene by unlicensed practitioners under the preventive services Medicaid authority although these services must be recommended by and under the supervision of a licensed provider. This guidance could be useful in considering how to structure Medicaid coverage of mobile crisis teams.

In addition, the joint guidance points out some issues for states to consider in implementing Medicaid coverage of crisis stabilization services including whether state policies and regulations prohibit emergency response personnel from transporting individuals to alternative destinations or prohibit providing treatment on the scene of the emergency without providing transportation. In addition, the guidance encourages states to consider whether the state Medicaid program covers the relevant HCPCS codes for emergency response services.

In this guidance, CMS points out that federal Medicaid law and regulations do not specify that emergency transportation must be to a hospital and indicates that these issues are determined in state law and regulation. CMS also specifies that a number of state Medicaid agencies have implemented Medicaid coverage of transportation to alternative destinations and CMS lists crisis stabilization centers as examples of alternative destinations that state Medicaid agencies may include in their initiatives. CMS also highlights that Medicaid managed care plans may have flexibility to cover alternative destinations and transportation services.

Partnerships with Hospitals and Health Systems: The Maryland Example

Maryland has a unique approach to healthcare financing that may be instructive for how to encourage greater collaboration between hospitals and community-based providers on development of crisis stabilization programs and services. The Health Services Cost Review Commission (HSCRC) sets the reimbursement rates that all payers (e.g., Medicare, Medicaid, commercial) must pay hospitals in the state. This program required a waiver from the Centers for Medicare and Medicaid Services so that Medicare could be included in this all-payer initiative.⁹⁸ The most recent renewal of this waiver agreement between Maryland and CMS requires the state to meet certain benchmarks regarding care for Medicare beneficiaries in the state in terms of spending and performance measures. To keep control over spending for Medicare beneficiaries in the state, the HSCRC has offered grant funding for regions and localities in the state to support development of collaborations between hospitals and community-based providers to help drive down spending while increasing quality of care. A recent round of grants focused on supporting development of crisis stabilization systems in different regions within the state with the hope that these efforts will result in establishment of programs that offer individuals experiencing behavioral health crises alternatives to going to the hospital emergency departments.⁹⁹ Hospitals are key stakeholders in efforts to develop crisis stabilization facilities and programs as alternatives to emergency departments, and states are encouraged to coordinate with them in efforts to improve crisis stabilization systems and increase availability of crisis stabilization programs and services.

Conclusion

The dual national crises of increased drug overdoses and high rates of suicide demand a new approach to addressing behavioral health crises. Designation of 988 as a nationwide toll-free hotline is a galvanizing event that should spur renewed focus on developing comprehensive coordinated crisis stabilization systems that can respond to the needs of 988 callers with local resources and support. Fortunately, several game-changing opportunities have arisen to help support state and local efforts including tremendous increases in federal block grant funding, a number of opportunities to enhance Medicaid funding for these programs, and greatly expanded coverage of telehealth services.

Recommendations for State Policy Makers Regarding Increased Block Grant and Medicaid Funding

I. Invest in Statewide Crisis Stabilization Systems

- Develop and coordinate statewide improvements to crisis stabilization programs by convening stakeholders with vested interests in increasing access to these services in addition to state mental health and substance use disorder agencies including state Medicaid agency leaders, law enforcement, hospital/health system emergency departments, crisis stabilization services providers, insurance commissioners, emergency transportation providers, 911 operators, other hotline and public service number operators, housing authorities, people with lived experiences of having serious behavioral health conditions, peer support specialists, families of adults or children with serious behavioral health conditions, representatives of underserved communities and populations, as well as possibly other state and local regulatory agencies that regulate providers of emergency services;
- Conduct a gap analysis regarding capacity of existing crisis stabilization centers, mobile crisis teams, and call centers and assess the need for increased capacity and coordination among these programs;
- Enhance health information technology including by expanding broadband, providing technology for telehealth, and improving or establishing electronic systems for tracking which providers have capacity to care for individuals in crisis;
- Pursue Medicaid funding for state administrative costs, including enhanced match for health information technology, for improving crisis stabilization systems and services including development and operation of call centers and electronic systems for tracking crisis stabilization programs' capacity to accept individuals in crisis, as well as support for improvements to providers' telehealth capabilities (in proportion to the degree to which Medicaid enrollees benefit from these improvements);
- Consider funding call center operations through contracts to support rapid responses regardless of coverage;
- Develop protocols for when responses to hotline calls should come through 911 or 988 as well as policies for when and how law enforcement should be involved in crisis response activities;
- Remove state limitations on coverage of interventions provided outside of hospitals;
- Eliminate restrictions on emergency transportation only to hospital emergency departments to allow reimbursement for transportation to crisis centers, clinics, and other settings;
- Explore whether CHIP funding for HSIs is available to support development of specialized crisis stabilization services for children and adolescents; and
- Develop data collection and quality assurance programs for crisis stabilization programs;

II. Improve Coverage of Crisis Services and Provider Reimbursement to Increase Availability of Stabilization Programs

- Reconsider how crisis stabilization services are financed to determine whether additional Medicaid authorities are available for covering crisis services;
- Access additional federal Medicaid funding through the 10% increased federal match rate for HCBS to improve and expand crisis stabilization programs;
- Revise Medicaid reimbursement rates for crisis stabilization programs to address the need for team-based capacity that is available around the clock and allow professional fees to be billed separately from the team-based payment in part to facilitate reimbursement by other payors including Medicare;
- Ensure Medicaid reimbursement rates for mobile crisis stabilization services are sufficient to support two-person teams;
- Add coverage of peer supports to the state Medicaid program, if not already covered, and authorize peers support providers to support clinicians in providing crisis stabilization services;
- Develop and submit a state plan amendment or other authorization to access the 85% federal Medicaid match to expand mobile crisis services beginning April of 2022;
- Ensure coverage of telehealth for behavioral health services including audio-only telehealth with comparable reimbursement rates to in-person treatment in Medicaid and state-regulated insurance;
- Authorize and support billing by call center staff for telehealth services provided to callers;
- Require health insurers offering coverage plans in the state, including Medicaid managed care plans, to cover crisis stabilization services and include crisis stabilization providers in their networks; and
- Apply for section 1115 demonstrations for innovative service delivery systems for individuals with SUD, SMI, or SED to expand coverage of crisis residential settings that qualify as IMDs;

III. Support Providers to Expand Access to Crisis Stabilization Services

- Cover providers' start-up costs for establishing new crisis stabilization programs including hiring staff and developing capacity to bill Medicaid, commercial insurance, and Medicare;
- Work with crisis services providers to improve their capacity to bill Medicare and commercial insurance, as well as Medicaid, for covered crisis services;
- Encourage hiring of peer support specialists particularly by crisis stabilization programs, and incentivize development of stepped up career opportunities for peers;
- Reexamine limits on scope of services for providers of crisis stabilization services to ensure they are not unnecessarily restrictive;
- Support provider establishment of crisis stabilization programs to address the needs of special populations with flexible funding for start-up costs and training; and
- Provide training for providers and other crisis stakeholders regarding crisis responses for special populations including children with serious behavioral health conditions, underserved and minority communities, and individuals with IDD.

Recommendations for Additional Federal Policies to Support Crisis Stabilization Systems and Programs

- Establish a permanent ten percent set-aside in the MHBG to support on-going crisis stabilization system expansions and improvements;
- Provide infrastructure funding to states and counties to cover construction of new crisis stabilization facilities;

- Clarify that the IMD exclusion does not apply to crisis stabilization centers because they are focused on providing short-term de-escalation and stabilization and connections to treatment as opposed to being “primarily engaged in providing diagnosis, treatment, or care for persons with mental diseases”;¹⁰⁰
- Require Medicare Advantage, Qualified Health Plans, and Federal Employee Health Benefit Program plans to cover crisis stabilization services;
- Maintain Medicare coverage of telehealth, including audio-only services, with reimbursement on par with rates for in-person services;
- Recognize an exception for behavioral health crises to the Medicare telehealth requirement that the beneficiary must have seen by the provider in-person within the prior six months for Medicare to cover mental health or substance use disorder telehealth services to beneficiaries who are home or in their communities;
- Issue federal guidance on application of parity to crisis stabilization services; and
- Encourage and enable CMMI ET3 model participants to coordinate emergency response activities covered by Medicare through that demonstration with efforts to improve responses to 988 in those communities.

SIGNIFICANT DATES

April 2022: Medicaid 85% federal Match for mobile crisis services goes into effect for twelve quarters

JULY 2022: Three-digit behavioral health crisis and suicide prevention hotline, 988, available nationwide via all telecommunications providers

MARCH 2023: Deadline for states to expend additional MHBG and SAPTBG funding provided in the CAA

MARCH 2024: Deadline for states to spend 10% increase in federal Medicaid match for HCBS

SEPTEMBER 2025: Deadline for states to expend additional MHBG and SAPTBG funding provided in the ARPA

List of Abbreviations

| | |
|--------|---|
| ARPA | American Rescue Plan Act |
| CCBHC | Certified Community Behavioral Health Clinic |
| CHIP | Children’s Health Insurance Program |
| CMS | Centers for Medicare and Medicaid Services |
| CAA | Consolidated Appropriations Act, 2021 |
| ET3 | Emergency Triage, Treat, and Transport |
| IDD | Intellectual or Developmental Disabilities |
| IMD | Institution for Mental Diseases |
| MHBG | Community Mental Health Services Block Grant |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SAPTBG | Substance Abuse Prevention and Treatment Block Grant |
| SMI | Serious Mental Illness |
| SUD | Substance Use Disorder |

NB: The author would like to thank Brenda Jackson for her detailed input and expert guidance.

Appendix A: SAMHSA Guidance on Mental Health Block Grant Set-Aside for Crisis Services

Guidance for the revision of the FY 2020-2021 for the Mental Health Block Grant Application for the new Crisis Services 5% set-aside

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress through the Consolidated Appropriations Act, 2021 and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260], to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. Congress specifically provided an increase to federal fiscal year (FY) 2021 MHBG appropriation over the FY 2020 level to help states meet this new requirement without losing funds for existing services. The appropriation bill includes the following budget language that outlines the new 5 percent set-aside:

Furthermore, the Committee directs a new five percent set-aside of the total for evidence-based crisis care programs addressing the needs of individuals with serious mental illnesses and children with serious mental and emotional disturbances. The Committee directs SAMHSA to use the set-aside to fund, at the discretion of eligible States and Territories, some or all of a set of core crisis care elements including: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or State-wide crisis call centers coordinating in real time.

A fully developed crisis response system is responsive any time and any place. What does a person in crisis need? Someone to talk to, or someone to respond, or a safe place to go for evaluation, stabilization and follow up. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. SAMHSA recognizes that the development of fully accessible and responsive crisis services involves complex problem solving with multiple entities and systems. We also recognize that strategic crisis services implementation can result in better care and cost savings through the reduction in avoidable emergency department visits, psychiatric admissions, police engagement, arrests, incarcerations and 911 calls.

SAMHSA recently developed [Crisis Services: Meeting Needs, Saving Lives](#), which includes “[National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit](#)” as well as other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

SAMHSA is requesting states to implement this 5 percent set-aside through a “request for revision of the 2020-21 MHBG plan” within the Environmental Factors, Section 15. Crisis Services. States are encouraged to fund programs to meet the needs of persons with crisis services, specifically utilizing the SAMHSA’s *National Guidelines for Behavioral Health Crisis Care*, tool kit. States may address the three core services either through enhancing existing program activities or through developing a set of new activities based on the tool kit.

It is expected that the states’ capacity to implement crisis services will vary based on the actual funding from the 5% allocation. It is also recognized that with the timing of the allocation distribution, states may need to dedicate the rest of the current fiscal year to planning, training, and/or infrastructure development while targeting program implementation to the following year. Additionally, many states have begun implementing such models or similar approaches and can build on these existing efforts through their proposed MHBG plan revision. States must submit their plan revision request proposal into the FY 2020-2021 MHBG Behavioral Health Assessment and Plan in Section C. Environmental Factors and Plan, 15. Crisis Services. This section initially requested to report how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from crises. States should also complete line 10, Crisis Services (5%) in Table 2 State Agency Planned Expenditures [MH] under Section B: MHBG.

SAMHSA requests states to submit the following with the proposal.

- Update the checkboxes and add any comments in the comment boxes in Section C. Environmental Factors and Plan, 15. Crisis Services
- Update Table 2 to reflect the 5% set-aside funds

Include a description of the current status of your states crisis program as well as proposed plan for expenditure of the 5% set aside. We recommend the following information when submitting the proposals.

- Description of the status of the state’s current crisis system. Please describe in terms of the following three elements: current access to local crisis call centers, the availability of mobile crisis behavioral health first responder services and the availability and or utilization of short-term crisis receiving and stabilization centers. The suggested framework for describing your states current system capacity is below. Receipt of this data will enable us to track national development and utilization of each of the crisis components over time.
- Stages of Implementation terms:
 - a) The *Exploration-Planning* stage: is the stage when states identify their communities’ needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
 - b) The *Installation* stage: occurs once the state has proposed a plan and begins making the changes necessary to implement the service based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.

- c) *Early Implementation*: occurs when the state has the core crisis service implemented in some parts of the state, about 25% or less persons have access to that service.
- d) *Middle Implementation* stage: occurs when the state has the core crisis service implemented such that about half of the people in your state have access to that service.
- e) *Majority Implementation*: occurs when the state has the core crisis service implemented in most parts of the state so that most people have access.
- f) *Program Sustainment* stage: occurs when implementation is statewide and has a clear funding plan.

We request that you indicate what stage each of the three elements is in your state and submit this back to us in your application.

| | Exploration Planning | Installation | Early implementation Less than 25% of people in state | Middle Implementation About 50% of people in state | Majority Implementation At least 75% of people in state | Program Sustainment |
|--------------------|----------------------|--------------|--|---|--|---------------------|
| Someone to talk to | | | | | | |
| Someone to respond | | | | | | |
| Place to go | | | | | | |

Other program implementation data that might be useful to characterize crisis services system development is suggested below. These are included for your consideration only and we recognize that some of these are not readily available especially in year one. These are based on data components that some states and localities have found useful in measuring impact and outcome of crisis services.

1. Someone to talk to: Call Center Capacity
 - a. Number of locally based crisis call Centers in state
 - i. In the Suicide lifeline network
 - ii. Not in the suicide lifeline network
 - b. Number of Crisis Call Centers with follow up Protocols in place
 - c. Total number of calls statewide and by local crisis call center
 - d. Percent of 911 calls that are identified as MH related
2. Someone to respond: mobile behavioral health crisis capacity

- a. Number of crisis mobile responder teams that are independent of first responder structures (police, paramedic, fire)
 - b. Number of crisis mobile responder teams that are integrated with first responder structures (police, paramedic, fire)
 - c. Number of mobile responders that employ peers
 - d. Number of police responses to mental health crises
- 3. Place to Go: Available resources in the state
 - a. Number of Emergency Departments
 - b. Number of Emergency Departments that operate a specialized behavior health component.
 - c. Number of Crisis Receiving and Stabilization Centers (short term, 23 hr units that can diagnose and stabilize individuals in crisis)
 - d. Number of hours of overtime by law enforcement related to accompaniment of persons with MH conditions in ED or other settings.
 - e. Number of persons boarded in ED (In ED longer than 24 hours and waiting for psychiatric admission.)
- Clearly describe the proposed/planned activities utilizing the 5% set aside for FY 21, including an estimated budget. States may be at different stages for different geographic locations. States will be required to report on what activities have been completed throughout the grant with this set-aside funding.
- Via the revision request, upload the document (word or pdf) using the upload tab into Section C. Environmental Factors and Plan, 15. Crisis Services. Please title this document "Crisis Services in FY 21". Upon submission, SAMHSA will review the revision proposals to ensure they are complete and responsive. Once the revision proposal is approved by SAMHSA, the allotment for the 5 percent set aside will be awarded to the state.

Appendix B: SAMHSA Guidance on American Rescue Plan Act Funding



May 18, 2021

Dear Single State Authority Director and State Mental Health Commissioner:

Public Law 117-2, the American Rescue Plan Act of 2021 (ARPA), signed by President Biden on March 11, 2021, directed the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide additional funds to support states through Block Grants to address the effects of the COVID-19 pandemic for Americans with mental illness and substance use disorders. The COVID-19 pandemic has exposed and exacerbated severe and pervasive health and social inequities in America, including the critical importance of supporting people with mental illness and substance use disorders. As the pandemic swept through the states, societal stress and distress over this newly emerging disaster created the need for nimble and evolving policy and planning in addressing mental and substance use disorder services. SAMHSA, through this guidance, is asking states to improve and enhance the mental health and substance use service array that serves the community.

ARPA allocated \$1.5 billion each for Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block (SABG) grants to the states. States have until September 30, 2025, to expend these funds. Federal block grant monies are provided to support state priorities and SAMHSA asks that states consider the following in developing an ARPA Funding Plan.

A. MHBG Guidance

States must spend the MHBG funds based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart I: Block Grants for Community Mental Health Services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Consistent with HHS Disaster Relief Flexibilities, SAMHSA may waive requirements with respect to allowable activities, timelines, or reporting requirements for the MHBG, as deemed necessary to facilitate a grantee's response to coronavirus.

The MHBG allocation requires states to set aside ten percent (10%) of their total allocation for first-episode psychosis or early SMI programs.

SAMHSA encourages states to consider a focus on support of a behavioral health crisis continuum. An effective statewide crisis system affords equal access to crisis supports that meet needs anytime, anyplace, and for anyone. This includes those living in remote areas and underserved communities as well as youth, older adults, persons of diverse backgrounds, and other marginalized populations; the crisis service continuum will need to be able to equally and adeptly serve everyone. SAMHSA recommends states consider use of the ARPA MHBG funds to develop, enhance, or improve the following:

-
- Develop partnerships with the emerging Suicide Lifeline (9-8-8) systems, Law Enforcement, EMS, health care providers, housing authorities, Housing and Urban Development (HUD) Continuum of Care, hospital systems, peer-based recovery organizations, and substance use specific treatment providers, all of whom have a critical role in the crisis continuum.
 - Utilize five percent of funds for crisis services, as described in the FY 2021 appropriations language.
 - A comprehensive 24/7 crisis continuum for children including screening and assessment; mobile crisis response and stabilization; residential crisis services; psychiatric consultation; referrals and warm hand-offs to home- and community-based services; and ongoing care coordination.
 - Provide increased outpatient access, including same-day or next-day appointments, for those in crisis.
 - Improve information technology infrastructure, including the availability of broadband and cellular technology for providers, especially in rural and frontier areas; use of GPS, to expedite response times, and to remotely meet with the individual in crisis.
 - The adoption and use of health information technology, such as electronic health records, to improve access to and coordination of behavioral health services and care delivery.
 - Consider digital platforms, such as Network of Care, which facilitate access to behavioral health services for persons with SMI-SED.
 - Advance telehealth opportunities to expand crisis services for hard to reach locations, especially rural and frontier areas. Expand technology options for callers, including the use of texting, telephone, and telehealth. Note: States cannot use the funds to purchase any items for consumers/clients.
 - Implement an electronic bed registry that coordinates with existing HHS provider directory efforts and treatment locator system that will help people access information on crisis bed facilities, including their locations, available services, and contact information.
 - Support for crisis and school-based services that promote access to care for children with SED.
 - Develop medication-assisted treatment (MAT) protocols to assist children and adults who are in crisis, which may leverage telehealth when possible.
 - Expand Assisted Outpatient Treatment (AOT) services.
 - Develop outpatient intensive Crisis Stabilization Teams to avert and address crisis.
 - Technical Assistance for the development of enhanced treatment and recovery support services including planning for Certified Community Behavioral Health Clinics (CCBHC).

SAMHSA requests that the following information is included when submitting the proposals:

1. Identify the needs and gaps of your state's mental health services continuum including prevention, intervention, access to crisis services, treatment, and recovery support services.

-
2. Identify the needs and gaps of your state’s mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.
 3. Describe your state’s spending plan proposal, including a budget that addresses the needs and gaps related to crisis and services continuum.
 4. Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state’s system is responsive to the needs of your residents with SMI and SED. Refer to the [Guidebook](#) on crisis services.
 5. Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.
 6. Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.
 7. Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionately high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.
 8. Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification [criteria](#) in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (<https://www.healthit.gov/isa/>), including but not limited to those standards described in the, the “Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data” section and the “Social Determinants of Health” section.

Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, upload the document (Microsoft Word or pdf) using the tab into the State Information Section, Chief Executive Officer’s Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority [MH]. Please title this document “ARPA Funding Plan 2021 (MH).”

B. SABG Guidance

States are required to plan for, expend, and report on the FY 21 SABG ARPA Supplemental Funding based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart II: Block Grants for Prevention and Treatment of Substance Abuse, and 45 CFR, Part 96, Subpart L.

Consistent with HHS Disaster Relief Flexibilities, SAMHSA may waive requirements with respect to allowable activities, timelines, or reporting requirements for the SABG as deemed necessary to facilitate a grantee’s response to coronavirus.

Accordingly, all regular provisions of the statute and regulations pertaining to the SABG are fully applicable to the planning and expenditure of the SABG ARPA Supplemental Funding.

This includes, but is not limited to, the definitions, assurances, requirements, and restrictions of the SABG standard funding.

The SABG allocation requires states to expend not less than twenty percent (20%) of their total allocation for substance use disorder (SUD) primary prevention services for individuals who do not require treatment for substance abuse, in accordance with 42 USC 300x-22 and 45 CFR 96.124 and 96.125. The SABG allocation also requires “designated states” to expend five percent (5%) of their total allocation for EIS/HIV Services, in accordance with 42 USC 300x-24(b) and 45 CFR 96.128.

The SUD prevention, intervention, treatment, and recovery support services continuum includes various evidence-based services and supports for individuals, families, and communities. Integral to the SABG are its efforts to support health equity through its priority focus on the provision of SUD prevention, treatment, and recovery support services to identified underserved populations. These underserved and marginalized populations include, but are not limited to, pregnant women and women with dependent children; persons who inject drugs; persons using opioids and/or stimulant drugs associated with drug overdoses; persons at risk for HIV, TB, and Hepatitis; persons experiencing homelessness; persons involved in the justice system; persons involved in the child welfare system; Black, Indigenous, and People of Color (BIPOC); LGBTQ individuals; rural populations; and other underserved groups.

SAMHSA recommends states develop, enhance or improve the following through the SABG ARPA funds:

- Develop and expand the use of FDA-approved medications and digital therapeutics as a part of addiction treatment that can provide interactive, evidence-based behavioral therapies for the treatment of opioid use disorders, alcohol use disorders, and tobacco use disorders, along with the implementation of other evidence-based treatments and practices.
- Provide increased access, including same-day or next-day appointments, and low barrier approaches, for those in need of SUD treatment services.
- Direct critical resources in expanding broad-based state and local community strategies and approaches in addressing the drug overdose epidemic, involving SUD prevention, intervention, treatment, and recovery support services.
- Improve information technology infrastructure, including the availability of broadband and cellular technology for providers, especially in rural and frontier areas, and use of GPS to expedite response times and to remotely meet with the individual in need of services.
- The adoption and use of health information technology to improve access to and coordination of SUD prevention, intervention, treatment, and recovery support services and care delivery, consistent with the provisions of HIPAA and 42 CFR, Part 2.
- Advance telehealth opportunities to expand services for hard-to-reach locations, especially rural and frontier areas. Expand technology options for callers, including the use of texting, telephone, and telehealth. Note: States may not use the funds to purchase any items for consumers/clients.

-
- Enhance the primary prevention infrastructure within your state and communities using the Strategic Prevention Framework planning model and implementing evidence-based practices, the six CSAP prevention strategies with an emphasis on environmental approaches.
 - Consider incorporating strategies around adverse childhood experiences to improve substance misuse outcomes among all populations, but especially young adults 18-25 and those over 26 years of age; preventing and reducing marijuana use by youth below the state's legal age of use; and mitigating the impact of increased alcohol access by youth as identified during the COVID-19 pandemic. It is important to identify and address disparities and describe how you are incorporating equitable approaches.
 - Support expansion of peer-based recovery support services (e.g. recovery community organizations, recovery community centers, recovery high schools, collegiate recovery programs, recovery residences, alternative peer group programs) to ensure a recovery orientation which expands support networks and recovery services. These programs are helping people sustain their recovery, engaging families and significant others, bridging the gap between treatment and long-term recovery, and supporting people reentering the community from incarceration.

SAMHSA requests that the following information is included when submitting the proposals:

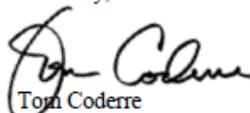
1. Identify the needs and gaps of your state's SUD services continuum, related to developing a comprehensive prevention, intervention, treatment, and recovery support services continuum.
2. Describe how your state's spending plan proposal will address the state's substance use disorder services continuum, including a budget that addresses the needs and gaps related to this continuum.
3. Describe your state's progress in addressing the rising drug overdose rate in many parts of the country, and what steps the state will be taking to improve access to SUD treatment, by improving identification of persons in need, reducing barriers to admission to treatment, and strengthening mechanisms to promote client engagement and retention in SUD treatment and recovery support services.
4. Describe your state's progress in implementing the increased and widespread use of FDA approved medications for the treatment of opioid use disorder, alcohol use disorder, and tobacco use disorder, in combination with other substance use disorder evidence-based treatments and practices.
5. Explain how your state plans to collaborate with other departments or agencies to address the SUD services continuum.
6. Describe how the state plans to use SABG ARPA funding to promote health equity among identified underserved populations, and how it plans to address health disparities in the planning, delivery, and evaluation of SUD prevention, intervention, treatment, and recovery support services.
7. Describe the state's efforts and plans to promote an increased emphasis on the development, delivery, and support of widespread SUD recovery support services, systems, and mechanisms across the state.

-
8. Describe other state priorities or activities that the state plans to fund during the performance period of September 1, 2021 through September 30, 2025 using ARPA funds.
 9. Describe your state plans for enhancing your state's prevention infrastructure which may include incorporating work around ACEs and improving substance misuse outcomes among young adults and older adults. (Primary Prevention set-aside)
 - a. The impact of increased access to marijuana and the state's strategies to prevent misuse by the underage population.
 - b. Strategies to reduce the COVID-19 impact of increased alcohol accessibility and misuse.
 - c. How the state is using equitable strategies to reduce disparities in the state's prevention planning and approaches. Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, upload the document (Microsoft Word or pdf) using the tab into the State Information Section, Chief Executive Officer's Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority [SA]. Please title this document "ARPA Funding Plan 2021 (SA)."
 10. Describe how the state will use, or considered, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support SUD clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (<https://www.healthit.gov/isa/>), including but not limited to those standards described in the "Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data" section and the "Social Determinants of Health" section.

States must upload separate proposals based on MHBG and SABG guidance into the WebBGAS system. Upon submission, SAMHSA will review the proposal to ensure it is complete and responsive. Proposals must be submitted to WebBGAS by Friday, July 2, 2021, 11:59 EST.

SAMHSA is ready and willing to assist you in addressing the needs of individuals with mental illness and substance use disorders. Please feel free to contact your SAMHSA state project officers and grants management specialists with any questions that you may have.

Sincerely,



Tom Coderre
Acting Assistant Secretary for
Mental Health and Substance Use

References

- ¹ The National Suicide Hotline Designation Act of 2020, Pub. L. 116-172 (2020).
- ² Hedegaard H, Minino AM, Warner M: Drug Overdose Deaths in the United States, 1999-2018. Centers for Disease Control and Prevention, National Center for Health Statistics Data Brief, January 2020. <https://www.cdc.gov/nchs/data/databriefs/db356-h.pdf>
- ³ Hedegaard H, Curtin SC, Warner M: Increase in Suicide Mortality in the United States, 1999-2018. Centers for Disease Control and Prevention, National Center for Health Statistics Data Brief, April 2020. <https://www.cdc.gov/nchs/data/databriefs/db362-h.pdf>
- ⁴ Murphy SL, Xu J, Kochanek KD, et al: Mortality in the United States, 2017. Centers for Disease Control and Prevention, National Center for Health Statistics Data Brief, Nov. 2018. <https://www.cdc.gov/nchs/data/databriefs/db328-h.pdf>
- ⁵ CDC Director's Media statement on U.S. Life Expectancy, Thursday, May 29, 2018. <https://www.cdc.gov/media/releases/2018/s1129-US-life-expectancy.html>
- ⁶ Vahratian A, Blumberg SJ, Terlizzi EP, et al: Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic — United States, August 2020–February 2021. *Morb Mortal Wkly Rep* 2021; 70(13):490-494., 2021 https://www.cdc.gov/mmwr/volumes/70/wr/mm7013e2.htm?s_cid=mm7013e2_w
- ⁷ Czeisler MÉ , Lane RI, Petrosky E, et al: Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. *Morb Mortal Wkly Rep* 2020; 69(32):1049–1057. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>
- ⁸ Ahmad FB, Rossen LM, Sutton P: Provisional drug overdose death counts. Centers for Disease Control and Prevention, National Center for Health Statistics Data Brief, 2021. <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>
- ⁹ Ahmad FB, Anderson RN: The Leading Causes of Death in the US for 2020. *JAMA* 2021; 325(18):1829-1830, 2021
- ¹⁰ Hawryluck L, Gold WL, Susan, S: SARS Control and Psychological Effects of Quarantine, Toronto, Canada. *Emerg Infect Dis* 2004; 10(7):1206–1212
- ¹¹ Reardon S: Ebola's mental-health wounds linger in Africa: health-care workers struggle to help people who have been traumatized by the epidemic. *Nature* 2015; 519(7541):13.
- ¹² Goldmann E, Galea S: Mental health consequences of disasters. *Ann Rev Public Health* 2014; 35:169–83. https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-032013-182435?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Aacrossref.org&rfr_dat=cr_pub%3Dpubmed
- ¹³ Loades M, Chatburn E, Higson-Sweeney N., et al: Rapid Systematic Review: the Impact of Social Isolation and Loneliness on the Mental Health of Children and Adolescents in the Context of Covid-19. *J Am Acad Child Adolesc Psychiatry* 2020; 59(11):1218-1239
- ¹⁴ Federal Communications Commission: Designating 988 for the National Suicide Prevention Lifeline. Report and Order, FCC-20-100, 35 FCC Rcd 7373(9), Jul 2020. <https://www.fcc.gov/document/designating-988-national-suicide-prevention-lifeline-0>
- ¹⁵ The National Suicide Hotline Designation Act of 2020, Pub. L. 116-172 (2020).
- ¹⁶ Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2014. <https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4848.pdf>
- ¹⁷ Wachino V, Camhi N: Building Blocks: How Medicaid Can Advance Mental Health and Substance Use Crisis Response. Well Being Trust, May 2021. <https://wellbeingtrust.org/news/how-medicaid-can-advance-mental-health-and-substance-use-crisis-response/>
- ¹⁸ National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2020. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>
- ¹⁹ Ibid.
- ²⁰ Consolidated Appropriations Act, 2021 (Pub. L. 116-260), enacted December 27, 2020. <https://www.congress.gov/bill/116th-congress/house-bill/133/text>
- ²¹ American Rescue Plan Act (Pub. L. 117-2), enacted March 11, 2021. <https://www.congress.gov/bill/117th-congress/house-bill/1319/text>

-
- ²² “With Pandemic Worsening the Mental Illness and Addiction Crisis, Biden Administration to Provide Nearly \$2.5 billion to States, Territories for Treatment, Prevention Aid.” Rockville, MD, Substance Abuse and Mental Health Services Administration, press release, March 11, 2021. <https://www.samhsa.gov/newsroom/press-announcements/202103110230>
- ²³ Labor, HHS, Education Subcommittee, Appropriations Committee, U.S. House of Representatives, Report on FY 2021 Appropriations, Rpt. No. 116-450, p. 149-150 (July 15, 2020).
- ²⁴ Notices of Awards of Community Mental Health Block Grant Funding. Rockville, MD, Substance Abuse and Mental Health Services Administration, Feb. 3, 2021.
- ²⁵ Ibid.
- ²⁶ “HHS Announces \$3 Billion in American Rescue Plan Funding for SAMHSA Block Grants to Address Addiction, Mental Health Crisis.” Rockville, MD, Substance Abuse and Mental Health Services Administration, press release, May 18, 2021. <https://www.samhsa.gov/newsroom/press-announcements/202105181200>
- ²⁷ FY 2021 Justification of Estimates for Appropriations Committees. Rockville, MD, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, 2021. https://www.samhsa.gov/sites/default/files/about_us/budget/fy-2021-samhsa-cj.pdf
- ²⁸ House of Representatives, Labor, Health and Human Services, and Education Appropriations Subcommittee: FY 2022 Appropriations Report. Available at <https://docs.house.gov/meetings/AP/AP00/20210715/113908/HMKP-117-AP00-20210715-SD003.pdf>
- ²⁹ Improving Access to Behavioral Health Crisis Services with Electronic Bed Registries. Alexandria, VA, National Association for Mental Health Program Directors, April 2021. Available at https://www.nasmhpd.org/sites/default/files/Bed_Registry_Full_Report.pdf
- ³⁰ Repper J, Carter T: A Review of the Literature on Peer Support in Mental Health Services. *Journal of Mental Health* 2011; 20:392-411.
- ³¹ Value of peers. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2017. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf
- ³² Open Minds: State Medicaid Reimbursement for Peer Support Services. March 2018.
- ³³ Medicare Mental Health. Medicare Learning Network Booklet, Baltimore, MD, Centers for Medicare and Medicaid Services (CMS), Center for Medicare Services, April 2021. <https://www.cms.gov/files/document/medicare-mental-health.pdf>
- ³⁴ Ibid.
- ³⁵ “Incident To” Guidance. Medicare Learning Network Matters, Baltimore, MD, Centers for Medicare and Medicaid Services (CMS), Center for Medicare Services. <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se0441.pdf>
- ³⁶ List of Telehealth Services for Calendar Year 2021. Washington, DC, Centers for Medicare and Medicaid Services (CMS), Center for Medicare Services. <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
- ³⁷ Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to part B Payment Policies; Final Rule. Washington, DC, Centers for Medicare and Medicaid Services (CMS), Center for Medicare Services, December 28, 2020. <https://www.federalregister.gov/documents/2020/12/28/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part>
- ³⁸ See Nevada SB 390, Utah SB 155, Virginia SB 1302, and Washington HB 1477.
- ³⁹ See 42 U.S.C. § 300x-5(a)(3) and 42 U.S.C. §300x-31(a)(1)(C).
- ⁴⁰ See 42 U.S.C. § 300x-31(c).
- ⁴¹ U.S. Department of Treasury, Press Release, Treasury Launches Coronavirus State and Local Fiscal Recovery Funds to Deliver \$350 billion, May 10, 2021. <https://home.treasury.gov/news/press-releases/jy0169>
- ⁴² Allocations for states and localities is available on the agency website: <https://home.treasury.gov/policy-issues/coronavirus/assistance-for-state-local-and-tribal-governments/state-and-local-fiscal-recovery-funds>
- ⁴³ U.S. Department of Treasury, Coronavirus State and Local Fiscal Recovery Funds, Interim Final Rule, 86 Fed. Reg. 26786 (2021).
- ⁴⁴ U.S. Department of Treasury, Coronavirus State and Local Fiscal Recovery Fund Allocations. <https://home.treasury.gov/policy-issues/coronavirus/assistance-for-state-local-and-tribal-governments/state-and-local-fiscal-recovery-funds>

-
- ⁴⁵ House of Representatives, Appropriations Committee, Labor, Health and Human Services, and Education Subcommittee: List of Community Projects Funded. <https://appropriations.house.gov/sites/democrats.appropriations.house.gov/files/documents/FY%2022%20LHHS%20Funded%20CPF.pdf>
- ⁴⁶ Community Mental Health Centers Grant Funding Opportunity Announcement. Rockville, MD, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/sites/default/files/grants/pdf/fy-2021-cmhc-foa.pdf>
- ⁴⁷ Frequently Asked Questions on FY 2021 Community Mental Health Center Grant Program Funding Opportunity Announcement. Rockville, MD, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/sites/default/files/grants/pdf/faq/fy-2021-cmhc-foa.pdf>
- ⁴⁸ FY 2021 Certified Community Behavioral Health Clinic Expansion Grants Funding Opportunity Announcement. Rockville, MD, Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/sites/default/files/grants/pdf/fy-2021-ccbhc-foa.pdf>
- ⁴⁹ Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. State Medicaid Directors Letter # 18-011. Washington, DC, Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and CHIP Services, 2018. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>
- ⁵⁰ Ibid.
- ⁵¹ Ibid.
- ⁵² Ibid.
- ⁵³ Ibid.
- ⁵⁴ Frequently Asked Questions (FAQs) Health Services Initiatives. Washington, DC, Centers for Medicare and Medicaid Services, 2017. <https://www.medicaid.gov/federal-policy-guidance/downloads/faq11217.pdf>
- ⁵⁵ Ibid.
- ⁵⁶ Leveraging CHIP to Improve Children’s Health: An Overview of State Health Services Initiatives. Washington, DC, National Academy for State Health Policy. <https://www.nashp.org/leveraging-chip-to-improve-childrens-health-an-overview-of-state-health-services-initiatives/>
- ⁵⁷ CHIP Health Services Initiatives: What They Are and How States Use Them. Washington, DC, Medicaid and CHIP Payment and Access Commission (MACPAC), July 2019. Available at <https://www.macpac.gov/wp-content/uploads/2019/07/CHIP-Health-Services-Initiatives.pdf>
- ⁵⁸ Leveraging CHIP to Improve Children’s Health: An Overview of State Health Services Initiatives. Washington, DC, National Academy for State Health Policy. <https://www.nashp.org/leveraging-chip-to-improve-childrens-health-an-overview-of-state-health-services-initiatives/>
- ⁵⁹ Behavioral Health Spending & Use Accounts 2006-2015. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2019. <https://store.samhsa.gov/sites/default/files/d7/priv/bhsua-2006-2015-508.pdf>
- ⁶⁰ Wachino V, Camhi N: Building Blocks: How Medicaid Can Advance Mental Health and Substance Use Crisis Response. Well Being Trust, May 2021. <https://wellbeingtrust.org/news/how-medicaid-can-advance-mental-health-and-substance-use-crisis-response/>
- ⁶¹ Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance. State Medicaid Directors Letter # 18-011. Washington, DC, Centers for Medicare and Medicaid Services (CMS), Center for Medicaid and CHIP Services, 2018. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>
- ⁶² National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2020. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>
- ⁶³ New Jersey Department of Human Services, Division of Medical Assistance & Health Services Newsletter, Vol. 24 No. 10, October 2015. Available at the following website - search for Vol. 24 No. 10: <https://www.njmmis.com/documentDownload.aspx?fileType=076B9D7D-96DC-4C8A-B9CE-BA46F47DDE1F>
- ⁶⁴ Delaware Adult Behavioral Health DHSS Service Certification and Reimbursement Manual, 2016. <https://dhss.delaware.gov/dhss/dsamh/files/ReimbursementManual.pdf>
- ⁶⁵ New York, Medicaid Reimbursement Rates. https://omh.ny.gov/omhweb/medicaid_reimbursement/

-
- ⁶⁶ Crisis Intervention Benefit: Adult Crisis Residence Benefit and Billing Guidance. Albany, NY, New York Department of Health Office of Mental Health: October 2020. <https://omh.ny.gov/omhweb/bho/docs/adult-crisis-residence-benefit-and-billing-guidance.pdf>
- ⁶⁷ Balfour ME, Stephenson AH, Winsky J, et al: Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies. Alexandria, VA, National Association of State Mental Health Program Directors, August 2020. <https://www.nasmhpd.org/sites/default/files/2020paper11.pdf>
- ⁶⁸ Wachino V, Camhi N: Building Blocks: How Medicaid Can Advance Mental Health and Substance Use Crisis Response. Well Being Trust, May 2021. <https://wellbeingtrust.org/news/how-medicaid-can-advance-mental-health-and-substance-use-crisis-response/>
- ⁶⁹ State Health Facts, Medicaid Behavioral Health Services as of 2018. Kaiser Family Foundation. <https://www.kff.org/statedata/collection/medicaid-behavioral-health-services/>
- ⁷⁰ See Clause (B) following section 1905(a)(29) of the Social Security Act.
- ⁷¹ American Rescue Plan Act, Pub. L. 117-2, Section 9813, State Option to Provide Qualifying Community-based Mobile Crisis Intervention Services and Section 9817, Additional Support for Medicaid Home and Community-based Services During the Covid-19 Emergency. <https://www.congress.gov/bill/117th-congress/house-bill/1319/text>
- ⁷² “\$15 Million Funding Opportunity for State Planning Grants to Bolster Mobile Crisis Intervention Services”. News alert, Centers for Medicare and Medicaid Services, Center for Medicaid and CHIP Services, July 13, 2021. <https://content.govdelivery.com/accounts/USCMSMEDICAID/bulletins/2e7f201>
- ⁷³ American Rescue Plan Act of 2021: Section 9813 State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services. Notice of Funding Opportunity. Washington, DC, Centers for Medicare and Medicaid Services, Center for Medicaid and CHIP Services, July 13, 2021. <https://www.grants.gov/web/grants/search-grants.html?keywords=93.639>
- ⁷⁴ Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-based Services during the Covid-19 Emergency. State Medicaid Director Letter #21-003. Washington, DC, Centers for Medicare and Medicaid Services, Center for Medicaid and CHIP Services, May 13, 2021. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf>
- ⁷⁵ Massachusetts Home and Community-based Services (HCBS) Services Plan. Boston, MA, Massachusetts Office of Health and Human Services Office of Medicaid, June 17, 2021. <https://www.mass.gov/doc/massachusetts-arpa-hcbs-initial-spending-plan-june-2021-0/download>
- ⁷⁶ Roadmap for Behavioral Health Reform: Ensuring the Right Treatment When and Where People Need It, A Multi-Year Plan Summary. Boston, MA, Massachusetts Executive Office of Health and Human Services, February 2021. https://www.mass.gov/doc/roadmap-for-behavioral-health-reform-ensuring-the-right-treatment-when-and-where-people-need-it/download?_ga=2.150074418.543999700.1626644303-538278098.1626644303
- ⁷⁷ American Rescue Plan Act Increased Federal Medical Assistance Percentage for Home and Community-based Services, Initial HCBS Spending Plan Projection. Sacramento, CA, California Department of Health Care Services, July 12, 2021. <https://www.dhcs.ca.gov/Documents/DHCS-HCBS-Spending-Plan-Web-Package-7-12-21.pdf>
- ⁷⁸ Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817. Indianapolis, IN, Indiana Family and Social Services Administration: Proposed July 9, 2021. <https://www.in.gov/fssa/ompp/files/Indiana-HCBS-Enhanced-FMAP-Spending-Plan.pdf>
- ⁷⁹ State Medicaid Director Letter #18-011, “Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance”, Nov. 13, 2018. Washington, DC, Center for Medicaid and CHIP Services, Center for Medicaid and CHIP Services. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>
- ⁸⁰ 42 CFR § 438.6(e).
- ⁸¹ 1115 Demonstration State Monitoring & Evaluation Resources, (includes resources on mental healthcare availability assessment and performance measures). Washington, DC, Centers for Medicare and Medicaid, Center for Medicaid and CHIP Services. <https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html>
- ⁸² Medicare and Medicaid: Covid-19 Program Flexibilities and Considerations for their Continuation. Washington, DC, U.S. Government Accountability Office (GAO), May 2021. <https://www.gao.gov/assets/gao-21-575t.pdf>

-
- ⁸³ Medicaid & CHIP and the Covid-19 Public Health Emergency: Preliminary Medicaid and CHIP Data Snapshot: Services through July 31, 2020. Washington, DC, Centers for Medicare and Medicaid Services (CMS), May 2021. <https://www.medicaid.gov/state-resource-center/downloads/covid19-data-snapshot.pdf>
- ⁸⁴ FAIRHealth Monthly Telehealth Regional Tracker (Accessed May 2021) <https://www.fairhealth.org/states-by-the-numbers/telehealth>
- ⁸⁵ Medicaid & CHIP and the Covid-19 Public Health Emergency: Preliminary Medicaid & CHIP Data Snapshot, Services through October 31, 2020. Washington, DC, Centers for Medicare and Medicaid Services, May 2021. <https://www.medicaid.gov/state-resource-center/downloads/covid-19-medicaid-data-snapshot.pdf>
- ⁸⁶ Panchal N, Kamal R, Cox C: Mental Health and Substance Use Considerations Among Children During the Covid-19 Pandemic. Kaiser Family Foundation, May 26, 2021. <https://www.kff.org/coronavirus-covid-19/issue-brief/mental-health-and-substance-use-considerations-among-children-during-the-covid-19-pandemic/>
- ⁸⁷ Koma W, Cubanski J, Neuman T: Medicare and Telehealth: Coverage and Use During the Covid-19 Pandemic and Options for the Future. Kaiser Family Foundation, May 2021. <https://www.kff.org/medicare/issue-brief/medicare-and-telehealth-coverage-and-use-during-the-covid-19-pandemic-and-options-for-the-future/>
- ⁸⁸ National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025. Rockville, M.D, Health Resources and Services Administration, National Center for Health Workforce Analysis, November 2016. <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/behavioral-health-2013-2025.pdf>
- ⁸⁹ The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act (Pub. L 115-271) Sec. 2001, Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder and Other Substance Use Disorders. <https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf>
- ⁹⁰ Dunham CC, Sprankle, M: The SUPPORT for Patients and Communities Act: Expanding Medicare Coverage of Telehealth Services to Combat the Opioid Crisis. *The National Law Review* 2018. <https://www.natlawreview.com/article/support-patients-and-communities-act-expanding-medicare-coverage-telehealth-services>
- ⁹¹ Consolidated Appropriations Act (Pub. L. 116-260) Division CC, Section 123, Expanding Access to Mental Health Services Furnished Through Telehealth, Dec. 2020. <https://www.govinfo.gov/content/pkg/BILLS-116hr133enr/pdf/BILLS-116hr133enr.pdf>
- ⁹² CY 2022 Medicare Physician Fee Schedule Proposed Rule Fact Sheet. Washington, DC, Centers for Medicare and Medicaid Services (CMS), Center for Medicare Services, July 13, 2021. <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-proposed-rule>
- ⁹³ The ten states participating in the CCBHC Demonstration are Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, Pennsylvania, Michigan, and Kentucky.
- ⁹⁴ FY 2021 Justification of Estimates for Appropriations Committees. Rockville, MD, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services, 2021. https://www.samhsa.gov/sites/default/files/about_us/budget/fy-2021-samhsa-cj.pdf
- ⁹⁵ Emergency Triage, Treat, and Transport (ET3) Model. Washington, DC, Center for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation. <https://innovation.cms.gov/innovation-models/et3>
- ⁹⁶ List of selected ET3 participants here: <https://innovation.cms.gov/media/document/et3-participants>
- ⁹⁷ Center for Medicare and Medicaid Innovation and Center for Medicaid and CHIP Services Joint Informational Bulletin: Medicaid Opportunities in the Emergency Triage, Treat, and Transport (ET3) Model. Washington, DC, Centers for Medicare and Medicaid Services, August 2019. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib080819-3.pdf>
- ⁹⁸ See description of Maryland All-Payer Model on the CMS website. <https://innovation.cms.gov/innovation-models/maryland-all-payer-model>
- ⁹⁹ See description of the Health Services Cost Review Commission Regional Partnership Catalyst Grant Program. <https://hsrc.maryland.gov/Pages/regional-partnerships.aspx>
- ¹⁰⁰ See section 1905(i) of the Social Security Act, 42 U.S.C. 1396d