Mobile Crisis Response: Considerations for State Medicaid Agencies

Authors: Caroline Logan, Morgan Michaels & Meaghan Hunt

Mobile crisis response (MCR) systems are designed to provide immediate (24/7) services to individuals who are suffering from acute behavioral health episodes–including those related to mental illness and substance use. They are intended to serve any individual in need, anywhere. MCR systems can be specialized to treat adults, children, or both. To date, they have been effectively deployed in numerous states, cities, and other localities and have been associated with effective diversion from the justice system and emergency departments (EDs), reduced inpatient hospitalizations, and cost savings.[1] As states grapple with the ongoing health, social, and economic impacts of the COVID-19 public health emergency, strategies such as MCR may be a promising intervention to address behavioral health needs in the community. The American Rescue Plan Act, passed in March 2021, created an option for state Medicaid agencies to cover community-based MCR intervention services with an 85 percent federal match for the next five years,[2] which will likely spur additional states to implement these programs. Here, we highlight the role that state Medicaid agencies play in standing up MCR programs, common implementation challenges, and additional policy considerations as states move toward implementation.

A NOTE ON TERMINOLOGY

As the field has emerged, the terminology to describe mobile crisis services has evolved. In 2020 the Substance Abuse and Mental Health Services Administration (SAMHSA) issued guidance on best practices in crisis care and defined the elements of an effective and comprehensive crisis response system. These elements are:

1) A 24/7 regional or state-wide call center staffed with clinical staff and providing intervention via telephone, text or chat;

2) A mobile crisis response comprising clinical staff and peers who can respond to an individual in the community in a timely manner;

3) Crisis receiving and stabilizing facilities which can provide short term stabilization services.

Reference: SAMHSA National Guidelines for Behavioral Health Crisis (2020)

The Role of Medicaid in Paying for Mobile Crisis Response

MCR systems are a potential policy solution to help improve behavioral health outcomes for Medicaid beneficiaries and reduce long-standing disparities within the program. Medicaid is the single largest

payer for mental health care services[3] and covers roughly 20 percent of substance misuse services in the United States. Mandatory Medicaid benefits include physician services and inpatient psychiatric care. Many states have expanded behavioral health coverage beyond these services through waivers and other flexibilities to include community-based rehabilitation services and non-clinical care such as peer supports, non-emergency transportation, and supportive services.[4]

Despite broad coverage of behavioral health services, disparities persist between Medicaid beneficiaries and individuals with private insurance in access to behavioral health services and evidence-based best practices.[4] Even within Medicaid programs there are disparities in access to services and the receipt of evidence-based clinical best practices. For example, despite a higher rate of mental health diagnosis, Black Medicaid beneficiaries are less likely to receive community-based mental health services than their white peers; the use of community-based services is considered a best practice for the provision of this care.[4] People with mental health and substance use conditions – especially people of color – are also overrepresented in the justice system as mental health crises often inappropriately result in incarceration rather than needed treatment.

Our environmental scan of the role of Medicaid in current MCR systems found significant variation in how states use Medicaid agencies to fund and implement MCR. We also identified some unique and universal challenges. At a minimum, Medicaid can reimburse providers for the clinical services they provide to individuals in the community, but typically cannot cover the required infrastructure, staffing, training, or other program start-up costs. For example, many MCR programs follow a "firehouse" staffing model where clinicians are available 24/7 but this type of staffing presents financial challenges, as providers are unable to bill Medicaid for the hours they spend staffing the system but not providing clinical care.

Possible Funding Sources for MCR Programs:

Federal Grants: SAMHSA block grants (mental health and substance use), Projects for Assistance in Transition from Homelessness (PATH) grants, Cross Area Service Program (CASP) grants, Certified Community Behavioral Health Clinic (CCBHC) grants;

Private or Foundation Funding

Medicaid: Rehabilitation services, clinical services, 1115 demonstration waivers, 1915(b) and 1915(c) waivers, and provider reimbursement for covered services;

State and Local General Funds

Self Pay & Private Insurance Companies

Beyond these basic structures, state Medicaid agencies can use waivers such as 1115 or 1915(b) or (c) to cover auxiliary services within their MCR system—such as transportation or services provided in a crisis stabilization center—or partner with other payors to support MCR systems. Below are specific examples of how states can use Medicaid funding and waivers to fund MCR implementation.

Examples of Medicaid's Role in Mobile Crisis Response

Medicaid Provider Reimbursement & State Block Grants: Some states rely on Medicaid provider reimbursement combined with SAMHSA block grants or other funding streams to create two separate but parallel MCR systems – one for Medicaid beneficiaries and one for individuals with other types of insurance. Delaware, Kentucky, and Nebraska all operate similar types of programs. For example, when a client utilizes crisis response services in Nebraska, Medicaid and private insurance are billed first, while state revenue pays for services used by the uninsured.[5] This structure may work best in states that have expanded Medicaid eligibility to include a greater proportion of adults.

The Nebraska System of Care (NeSOC) also includes Youth Mobile Crisis response, funded in large part by a SAMHSA system of care block grant.[6] Mobile crisis response varies by region throughout the state, with clinical mobile crisis teams sometimes partnering with law enforcement. Depending on the rurality of the

region, risk assessment and intervention services may be offered in-person or via telehealth.[7] Mental health crisis services for rural adults, farmworkers, and ranch workers are provided at the community level, via the Nebraska Rural Response Hotline and other grassroots services.[8]

1115 Waivers: 1115 research and demonstration waivers provide states the authority to waive certain Medicaid requirements in order to conduct experimental projects and policy demonstrations. Additionally, the HHS secretary may permit federal financial contributions for Medicaid costs that are not usually eligible for the federal match. These waivers are commonly used to expand coverage to previously ineligible groups and services, and to test payment and delivery system reforms, including in the areas of mental and behavioral health. Recently, states have used 1115 waivers to cover residential SUD treatment in institutes for mental disease (IMD) and delivery system reforms to improve services for adults with SMI or children with SED.[9]

A few states have successfully used 1115 waivers (combined with other funding streams) to fund MCR systems. For example, the Arizona Health Care Cost Containment System (AHCCCS) Complete Care crisis system is one of the most comprehensive in the country, serving all Arizona state residents regardless of insurance status. The Complete Care system features a statewide crisis hotline, mobile response teams, and crisis stabilization units throughout the state, with the option to refer to a higher level of care if needed. Behavioral health providers staff the mobile response teams, with law enforcement officers transporting most patients to the crisis centers. Law enforcement is guaranteed drop-off and client processing time of no more than 10 minutes, which incentivized officers to participate, particularly in the early stages of the program.[10] Although many states have Medicaid 1115 waivers for behavioral mental health and substance use treatment, Arizona was among the first to use a 1115 waiver to finance mobile crisis response. Other states that have used this approach include Alaska[11] and New York.[12]

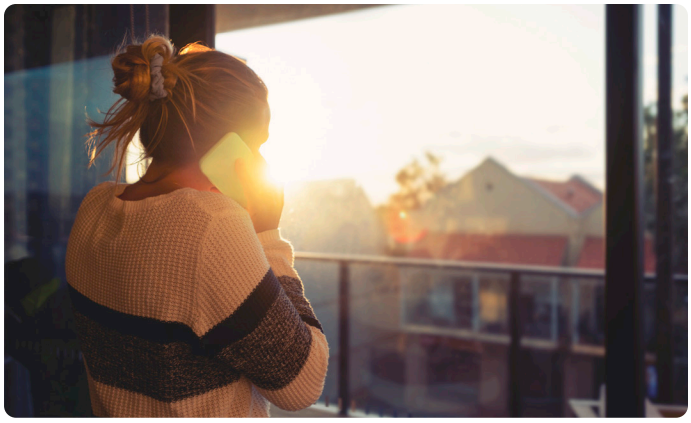
1915 Waivers: Medicaid Section 1915(b) "Freedom of Choice" waivers allow states to experiment with innovative delivery systems, such as managed care. States commonly use 1915(b) waivers to influence client choice among providers, "carve out" services from traditional Medicaid coverage, and mandate managed care enrollment. Section 1915(c) HCBS waivers, on the other hand, allow states to provide home- and community-based services to enrollees who might otherwise need institutional care in hospitals, nursing homes, or long-term care facilities.[9] Some states have used 1915 waivers to cover community-based mobile crisis response systems. For example in Michigan, the state mental health agency uses concurrent 1915(b) and 1915(c) waivers to contract with regional plans and providers to offer crisis services and behavioral health managed care, respectively. Individuals in managed care are served by Prepaid Inpatient Health Plans (PIHPs), while Medicaid Community Mental Health Service Providers (CMHSPs) provide services to non-Medicaid eligible individuals. Medicaid health plans serve individuals with mild to moderate mental health symptoms, but individuals in crisis are transferred to the behavioral health carve-out plan. Michigan's regional plans and providers offer 24/7 crisis hotlines and walk-in centers, but mobile crisis response is only available in urban areas.[13]

Other Non-Medicaid Funding Streams: Many states supplement Medicaid funding with other funding streams such as federal block grants, private grant funding, or general state and local revenues. Colorado presents a prominent example, supplementing funding for Colorado Crisis Services with state revenue from cannabis legalization. In 2017, Colorado passed SB17-207, "Strengthen Colorado Behavioral Health Crisis System," which authorized appropriations from the state's marijuana tax revenues to finance and expand MCR teams that were not adequately funded by Medicaid alone.[14] Colorado Crisis Services include two call/text lines (one for adults, one for youth), walk-in crisis stabilization/evaluation centers, mobile response by clinicians, and respite services providing transitional assistance and referrals.[15] The second hotline, "Below the Surface," is dedicated to teens and youth struggling with issues such as school/grades, bullying, dating/relationships, suicidal thoughts, fights/conflict, drugs/alcohol, parents/family issues, and anxiety.[16] Other states that rely on non-Medicaid state revenues to fund aspects of crisis response include Massachusetts and Wisconsin.[13]

Common Implementation Challenges

Our environmental scan also identified common implementation challenges in MCR systems that state Medicaid agencies may need to consider:

- **Infrastructure Investments:** Implementing a new MCR system requires significant investment in IT infrastructure and staff hiring and training. For example, localities may need to invest in data-sharing capabilities so that crisis responders have a real-time awareness of system capacity for stabilization services. States may need to rely on local or state funds to cover these expenses.
- **Staff Training:** SAMHSA recommends that MCR systems be staffed by licensed mental health and substance use professionals. In addition, many states and localities have included certified peer specialists and/or other members of the lived-experience workforce (including non-licensed individuals) to provide additional support to individuals in crisis.[17] While including non-licensed professional staff in a MCR system is considered a best clinical practice, it also creates additional considerations for billing, service provision and supervision.[18]
- **Cultural Competency:** MCR systems are a promising practice that, when well-designed and implemented, can contribute to a state's heath equity agenda. However, to successfully deploy MCR to help address disparities, providers and other members of the crisis response team need to be well trained, specifically in culturally responsive crisis care.
- **Adapting MCR for Pediatric Populations:** In addition to cultural competency, MCR systems and their workforce must include staff with the specialized training to respond effectively to children and youth in crisis. This training should, at a minimum, provide an understanding of how to engage with parents and caregivers, the clinical skills necessary to accurately assess the unique treatment needs and diagnostic presentations of youth in crisis, and a working knowledge of local pediatric systems of care.
- **MCR in Rural Areas:** MCR systems have and can be implemented with success in rural areas but doing so requires special considerations. Rural areas have lower population density, and often have fewer resources (e.g., data infrastructure, response teams, and staff) that must be pooled to effectively "cover" their service population.[19] Mobile and telehealth technologies can play an important role in bridging resource gaps and overcoming challenges presented by physical distance.[19]



Other Policy Considerations:

The recently passed American Rescue Plan Act includes up to $15 million in planning grants for states interested in creating MCR systems, as well as increased opportunities for states to pursue 1115 waivers. This increased funding will likely incentivize more states to implement these programs. Beyond these 1115 waivers, states will need to consider other concurrent initiatives from federal and local government, foundations, and other private players. Some of the other policy changes to consider include:

- In addition to expanding waivers to include MCR services, the American Rescue Plan Act of 2021 includes a number of other funding streams states can use to enhance behavioral health crisis response, including: block grants for community mental health and SUD prevention and treatment, funding for mental health and SUD treatment training for health care professionals and public safety officials, and community-based funding for local SUD treatment programs,[20] all of which could be leverage to further support development of MCR systems in states and communities.
- In July 2022, SAMHSA will introduce a nationwide suicide prevention hotline (988) which will serve as a single point of entry for individuals in mental health crisis. As states and localities develop their own local MCR systems, they will need to align systems of care with planned 988 services.
- Increased public dialogue and calls for reform around law enforcement response to individuals in behavioral health crisis have led several municipalities to consider "public health-only" models of emergency response to suspected behavioral health crisis incidents. If and where legislators restructure regulations for responding to such incidents, local MCR systems will need to adjust to accommodate changes in response protocols.[21]

References

[1] Gordon, S. Y. (2020) Building State Capacity to Address Behavioral Health Needs Through Crisis Services and Early Intervention.

[2] Musumeci, M. (2021). Medicaid Provisions in the American Rescue Plan Act (Vol. 2021). San Francisco, CA: Kaiser Family Foundation [KFF].

[3] Centers for Medicare & Medicaid Services [CMS]. Behavioral Health Services. Retrieved March, 2021, from https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/index.html

[4] McMullen, E. K. (2021). Policy Options to Improve Access to Behavioral Health Services for Adults. Washington, DC: Medicaid and CHIP Payment and Access Commission [MACPAC].

[5] Shaw, R. (2020). Financing Mental Health Crisis Services *Beyond Beds: Crisis Services* (Vol. 7). Alexandria, VA.

[6] Substance Abuse and Mental Health Services Administration [SAMHSA]. SM-16-009 Individual Grant Awards. Retrieved March, 2021, from https://www.samhsa.gov/grants/awards/2016/sm-16-009

[7] Office of Governor Pete Ricketts. (2017). Gov. Ricketts Launches New Behavioral Health Crisis Response Initiative [Press release]. Retrieved from https://governor.nebraska.gov/press/gov-ricketts-launches-new-behavioral-health-crisis-response-initiative

[8] Farm Crisis Response Council. Rural Response: The Nebraska Rural Response Hotline - A Statewide Hotline to Respond to Farm, Ranch and Rural Callers.

[9] DePriest, K., Vaziri, S., Tunnell, K., & Adams, C. (2021). Medicaid 201: An Overview of State Plan Amendments & Waivers. Washington, DC: Institute for Medicaid Innovation.

[10] Vestal, C. (2020). 'Arizona model' for behavioral health crisis care gains attention from other states: AZ Central.

[11] Alaska Mental Health Trust Authority. (2019). Medicaid Section 1115 Behavioral Health Waiver Demonstration Project: .

[12] New York State Department of Health. (2019). Crisis Intervention Benefit: Mobile Crisis Component Benefit and Billing Guidance.

[13] Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014). Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. Rockville, MD.

[14] Strengthen Colorado Behavioral Health Crisis System, SB17-207 C.F.R. (2017).

[15] Colorado Health Institute. (2016). Four Years Later: An Update on Colorado Crisis Services. Denver, CO.

[16] Colorado Crisis Services. Retrieved March, 2021, from https://coloradocrisisservices.org/below-the-surface/

[17] Mette, E., Townley, C., & Purington, K. (2019). 50-State Scan: How Medicaid Agencies Leverage their Non-Licensed Substance Use Disorder Workforce: National Academy for State Health Policy [NASHP].

[18] Substance Abuse and Mental Health Services Administration [SAMHSA]. (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration [SAMHSA].

[19] Substance Abuse and Mental Health Services Administration [SAMHSA]. (2019). Tailoring Crisis Response and Pre-Arrest Diversion Models for Rural Communities.

[20] American Rescue Plan Act of 2021 (H.R. 1319) (2021).

[21] DeLaus, M. (2020). Alternatives to Police as First Responders: Crisis Response Programs: An Explainer: Government Law Center at Albany Law School.

For more information, please contact:

Caroline Logan, Ph.D., MPH
Senior Associate
Health & Environment Division

Caroline_Logan@abtassoc.com

abtassociates.com