

BUILDING BLOCKS: HOW MEDICAID CAN ADVANCE MENTAL HEALTH AND SUBSTANCE USE CRISIS RESPONSE

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Many communities in the U.S. are reexamining the way in which they respond to people who are experiencing a mental health or substance use disorder crisis. Public recognition of growing rates of mental health issues and addiction, and of law enforcement's outsized role in behavioral health crisis response, are helping to drive this reappraisal.¹ Crisis response programs that prioritize behavioral health interventions can improve health outcomes. They can also promote public safety and reduce the likelihood that people have negative and unnecessary interactions with the criminal legal system. Addressing racial equity issues in the health and criminal legal systems is a primary focus of crisis response redesign in many communities.²

Medicaid coverage underpins the ability of states to advance access to behavioral health services, including crisis services, for people with low incomes. Implementation of new laws is driving interest in using Medicaid to advance crisis response. This paper describes crisis services and how they are provided and financed. It identifies five Medicaid building blocks that states can use to strengthen crisis response and expand behavioral health services. It illustrates these building blocks with examples, drawn from recent literature and state Medicaid programs, of ways that Medicaid is already supporting crisis response.³

The terms behavioral health and mental health and addiction or substance misuse/disorder are used interchangeably in this report. In the cases where behavioral health is used it is intended to represent both mental health and addiction.

Crisis Response Services Play a Key Role in Addressing Behavioral Health Issues in Communities

Crisis response services promote stability when people face a crisis. Crisis response services are intended to be available to anyone in need and are typically provided in community settings. They are often deployed to respond to crises faced by people with conditions such as serious mental illness (SMI), substance use disorder (SUD), and intellectual and developmental disabilities (I/DD). Conditions like unstable housing and domestic violence also precipitate crisis response.⁴ The goal of crisis services is to provide stability to a person in crisis and, when needed, connect the individual to treatment and services.⁵ The Substance Abuse and Mental Health Services Administration (SAMHSA) describes crisis care as “the most basic element of mental health care.”⁶

Crisis response also serves as a behavioral health service access point. Crisis intervention services can help people with acute behavioral health needs access needed services and treatment, and reduce reliance on institutions such as jails, hospitals, and emergency departments. SAMHSA defined three core elements of comprehensive crisis care: regional crisis call centers, crisis mobile team response, and crisis receiving and stabilization services. But it also noted that crisis systems operate within larger systems of care in communities. Others have described the importance of access to crisis services and supports in a spectrum of settings.⁷ The most commonly-provided crisis services are 23-hour crisis stabilization units, short term residential services, 24/7 crisis hot or warm lines, crisis intervention teams (CIT), mobile crisis services (including ongoing stabilization services), ambulatory crisis centers, and peer services.⁸ In many jurisdictions, a combination of these services are offered, though the details, structure, and reach of services vary from place to place.⁹

New federal laws are encouraging crisis response redesign. Congress recently enacted the first financial incentive for states to advance crisis services through Medicaid. As part of a COVID relief law, it established an increased Medicaid matching rate for some mobile crisis response services (see text box to the right).¹⁰ In addition, implementation of a new law that Congress passed in 2020 designating “988” as a crisis response number to address suicide risk and other behavioral health crises is generating additional attention for crisis response redesign.¹¹ These new laws align with growing community interest in crisis response that promotes health and behavioral health interventions rather than relying primarily on law enforcement approaches.

Crisis response is associated with improved health and criminal legal outcomes. Evidence regarding the impact of crisis response programs is still emerging, but some initiatives have been associated with reductions in emergency department and other inpatient services use, as well as diversion from corrections.¹² Reducing reliance on these high-cost institutions (e.g., jails, prisons, and hospitals) has produced cost savings for some states and localities.¹³ There is also evidence that some crisis models can reduce unnecessary arrests and use of force.¹⁴ Moreover, some crisis interventions are associated with reduced suicidal disposition.¹⁵ When they operate as part of a broader continuum, these services can contribute to better health outcomes by facilitating access to crisis stabilization services, community mental health programs, and housing.¹⁶

Medicaid Mobile Crisis Services Can Receive Enhanced 85 Percent Federal Matching Rate

The American Rescue Plan Act, the COVID-19 relief law enacted in March, offers a new financial incentive through Medicaid for states to provide 24/7 mobile crisis services to people who are experiencing a mental health or substance use disorder crisis in a community setting.

The new law creates a state option for Medicaid to cover multidisciplinary teams that provide screening and assessment, stabilization and de-escalation, and coordination and referrals to a person who is in crisis. Teams must be trained in trauma-informed care, de-escalation and harm reduction strategies, and have relationships with community providers. They must also involve one or more behavioral health professionals, including nurses, social workers, peer support specialists, and other professionals or paraprofessionals. States can decide to offer mobile crisis services only in certain areas of the state, or make them available only to specific populations.

The federal Medicaid program will pay for 85 percent of state spending on these mobile crisis services for the first three years in which these services are in place, as long as the new matching funds do not supplant existing state funding.¹⁷ To qualify for the enhanced matching rate, which takes effect in April 2022, the mobile crisis services must be authorized by the state and federal government in a state plan or waiver.

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The law also provides for \$15 million in planning grants for states to develop these authorities. The authorities outlined in this paper can be used to implement the new mobile crisis option. The American Rescue Plan Act also increased the federal Medicaid matching rate for services provided under the rehabilitation services option, case management, and other HCBS authorities by ten percentage points for one year (beginning in April 2021).¹⁸ As this paper describes, states can use these authorities to advance crisis services and establish a broader continuum of care.

How Crisis Response Services are Provided and Financed

Crisis response services provided in communities are diverse. Generally, states set the policy parameters of crisis services, and localities—including regions, cities, and counties—are responsible for developing crisis response programs. The specific entities involved in providing these services (such as local mental health organizations), and the types of services provided, vary by program and location. In 2020, SAMHSA issued guidelines offering states and localities a blueprint for implementing crisis services programs.¹⁹ SAMHSA has also identified a need for continuous, reliable funding for crisis services, similar to that used to finance emergency medical services such as fire departments and ambulances.²⁰

Methods of crisis service financing also vary. State and local governments generally use multiple funding sources to support their crisis intervention initiatives. This helps ensure that people obtain services regardless of their insurance status and can insulate programs from the volatility of state and local budgets. Medicaid—which covers health and long-term care services for 75 million low-income Americans—and state funding are the largest sources of crisis service financing.²¹ Other sources include federal block grants (such as SAMHSA’s Mental Health Block grant), local funding, Medicare, the Veterans’ Administration, and private insurance.²² Some states and local governments use “collaborative funding models,” which coordinate funding streams to expand services and minimize gaps and any duplication in service provision. This can help ensure that services are provided based on need rather than available funding.²³

Using Medicaid’s Building Blocks to Expand Crisis Response Services

As one of the nation’s leading health coverage programs, Medicaid has a substantial role to play in supporting states and communities in providing a continuum of crisis services. All or nearly all states cover some crisis services through Medicaid. SAMSHA reported that as of 2012, all 50 states and the District of Columbia were using Medicaid to help finance crisis services.²⁴ However, the scope and nature of the services provided across the states is unclear.

Medicaid is a major source of coverage for behavioral health services. Medicaid’s comprehensive coverage is central to advancing behavioral health services such as crisis response. The prevalence of key mental health conditions and overdose death rates has accelerated markedly during the COVID-19 pandemic.²⁵ Prior to the pandemic, people with low incomes were more likely to have behavioral health conditions than people with higher incomes. Medicaid covers one in every four Americans with serious mental illness, and nearly one in six people with addiction.²⁶ Medicaid coverage provides access to behavioral health services such as counseling, prescription drugs, case management, supportive employment, and supportive housing. Coverage of these services can create a continuum of care for people with behavioral health conditions.

Medicaid financing underpins its comprehensive coverage and benefits. Medicaid financing takes place through federal matching payments to states. The federal government matches a share of state spending on Medicaid; the matching rate is at least 50 percent but much higher in most states, as well as for some specific populations and services. Crisis services, like other community mental health services, are not established in federal law as a specific Medicaid benefit.²⁷ Rather, the federal government offers an array of policy pathways and broad discretion over how states cover, organize, and finance crisis services. These pathways can be summarized as building blocks.

The five primary building blocks for state crisis service provision



Building Block 1: Expanding Benefits to Cover Crisis Services.

States can authorize crisis services using a range of benefits, most of which are optional for states.



Building Block 2: Increasing Access to Home and Community-Based Services (HCBS).

States can cover crisis services as part of programs that offer community-based services to seniors and people with disabilities.



Building Block 3: Using Managed Care to Organize Service Delivery.

In Medicaid managed care programs, states and plans have flexibility in how they organize the delivery of services, including behavioral health services.



Building Block 4: Strengthening Service Delivery Through Section 1115 Demonstration Waivers.

States can obtain section 1115 demonstration waivers to create a continuum of behavioral health services for adults with serious mental illness and children with serious emotional disturbance.



Building Block 5: Financing Crisis-Related Administrative Spending.

Medicaid matching funds are available to help finance some administrative functions, including those that relate to providing crisis service provision.

States can use these building blocks individually or in combination to advance crisis service provision. Each building block and the specific authorities they encompass are described in greater detail in the following section.



BUILDING BLOCK 1: EXPANDING BENEFITS TO COVER CRISIS SERVICES

Medicaid provides people with access to a broad array of behavioral health services. While states are required to provide some benefits (such as hospital services), many others are optional for states.²⁸ This section describes some of the key benefits, how they can support crisis service provision, and examples of how states use these authorities to cover crisis services.

Rehabilitative services option. Many states use Medicaid's rehabilitative services option to cover community-based mental health and substance use services. This option plays a key role in supporting services for people with serious mental illness, among other groups.²⁹ States can cover diagnostic, screening, preventive, and rehabilitative services that are needed to treat physical or mental disabilities and restore individual functioning.³⁰ The rehabilitative services option offers substantial flexibility for states in both service and setting.³¹ Louisiana uses the rehabilitative services option to cover crisis intervention services, including preliminary assessment and evaluation, referrals to alternative mental health services and short-term intervention, and follow up services.³² New Mexico offers crisis stabilization services and crisis triage centers to provide mental health evaluations, withdrawal management and care, and brief intervention and psychological counseling services, among others under the rehabilitative services option.³³ New Jersey covers 24/7 mobile services to children and families who are in crisis to promote functioning, stability, and relationships in homes and communities using the rehabilitative services option.³⁴ And New York offers a set of services that includes crisis intervention as well as therapy, family support, and evaluation to people with intellectual and developmental disabilities with significant behavioral health needs.³⁵

Clinic option. The Medicaid clinic option covers services that are furnished on-site at a clinic and are provided directly by or under the supervision of a physician.³⁶ States can use the clinic option to cover outpatient behavioral health services, including but not limited to ambulatory services, surgical care, and substance abuse treatment.³⁷ Clinic services can be provided to people who are homeless by clinic personnel operating outside of the clinic setting.³⁸ For other populations, a team may

be dispatched to an individual's home in response to a crisis but the individual must be transported to a clinic in order to receive services.³⁹ In 2014, both Maine and Wisconsin reported using the clinic option to support some crisis services.⁴⁰

Covering services provided by some licensed practitioners. States have flexibility to cover services provided by licensed practitioners such as paramedics and clinical social workers under a specific "other licensed practitioners" authority. These services are medical or remedial non-physician services provided under a licensed practitioner's scope of practice. States have used this authority to cover services provided by licensed marriage and family therapists and licensed addiction counselors, among other professionals.⁴¹ The Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicaid program, recognized the role of this authority in supporting innovative approaches in Medicaid such as the Emergency Triage, Treat and Transport model, a CMS model to address emergency health care needs.⁴²

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). EPSDT, Medicaid's comprehensive pediatric benefit, guarantees children's access to all medically necessary optional and mandatory benefits, if the service is necessary to correct or ameliorate a child's physical or behavioral health condition. EPSDT therefore assures access to services, including crisis services, regardless of whether a state has elected specific optional benefits.⁴³ Many states authorize services for children in their state plan, relying on both optional benefits and EPSDT. Massachusetts, for example, covers mobile crisis services for children in a state plan amendment under EPSDT as covered rehabilitative services.⁴⁴

Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs provide a range of community-based behavioral health services.⁴⁵ They must provide nine core services, including crisis mental health services. These include 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.⁴⁶ Congress originally established

CCBHCs as an eight-state demonstration in 2014. Following several extensions and expansions, in 2020 there were CCBHCs operating in 40 states and the District of Columbia. Some states authorize CCBHCs through Medicaid state plan amendments or waivers, while others rely on grant funding.⁴⁷



BUILDING BLOCK 2: INCREASING ACCESS TO HOME AND COMMUNITY-BASED SERVICES (HCBS)

Home and community-based services (HCBS) offer some Medicaid beneficiaries the option of receiving care in their home or community rather than in an institutional setting.⁴⁸ HCBS can encompass a wide range of services and be authorized under several different Medicaid authorities, including 1915(i) state plan amendments and section 1915(c) waivers.⁴⁹ In HCBS programs, crisis services operate as part of a broader benefit package.

Section 1915(c) HCBS waivers. Using 1915(c) waivers, states can cover a set of services to seniors and people with disabilities who meet an institutional level of care, meaning that without services being provided in the community, a beneficiary would likely require care in an institutional setting such as a nursing facility.⁵⁰ 1915(c) waivers can be designed to serve specific populations and geographies within a state.⁵¹ HCBS authorized under 1915(c) waivers often serve people with physical and developmental disabilities, including people with mental health conditions. Services that states can cover under 1915(c) waivers include case management, habilitation services, and respite care. States are encouraged to have crisis plans in place for their HCBS participants.⁵²

Section 1915(i) programs. States can also cover HCBS under section 1915(i) authority. Under 1915(i), states can offer home and community-based services to populations that they specify, regardless of whether they meet an institutional level of care requirement.⁵³ Eleven states have established 1915(i) programs; many serve people with mental illness and substance use disorders.⁵⁴ Crisis intervention is one of the most commonly offered service categories in 1915(i) mental health SPAs. Maryland's 1915(i) program, part of a 2014 state plan amendment, serves seniors and people with disabilities and includes 24/7 mobile crisis response services.⁵⁵



BUILDING BLOCK 3: USING MANAGED CARE TO ORGANIZE SERVICE DELIVERY

Managed care is the dominant delivery system in Medicaid.⁵⁶

States can establish and organize managed care systems through several different authorities. These authorities are not specific to behavioral health or crisis services, but some states have used them to establish crisis services as part of a broader delivery system.⁵⁷ As described below, managed care offers some flexibility to cover nontraditional benefits. States can also use waiver authorities to tailor provider networks, and can use managed care contract requirements to ensure quality, access, and service provision standards.

“In lieu of” services. States and managed care organizations can authorize crisis services through Medicaid managed care contracts as an “in lieu of” service. In Medicaid, in lieu of services are alternative services and settings that are cost effective, clinically appropriate substitutes for services and settings that are authorized under a state plan.⁵⁸ MCOs have discretion on whether to offer them; if they do, a beneficiary cannot be required to use them. States’ ability to cover short-term crisis residential services as in lieu of services was codified by CMS in 2016.⁵⁹ In Florida and Oregon some MCOs are providing crisis services as in lieu of services.⁶⁰

Section 1915(a) waivers. Using these waivers, states can establish managed care programs that operate in specific geographies of a state.⁶¹ Some states have used this authority to design programs that serve populations with behavioral health needs, and include crisis services as part of a larger set of community-based behavioral health services. States can also use this authority to establish a limited provider network, which can be used to target a specific set of providers who have expertise and experience in providing community-based behavioral health services. Wisconsin’s ‘Wraparound

Milwaukee’ program, which serves youth with serious behavioral, emotional, and mental health needs, takes this approach.⁶² The program includes children’s mobile crisis teams, which can provide crisis intervention and case management to families. Wisconsin reported in 2014 that the program reduced use of residential treatment centers and inpatient psychiatric hospitalization.⁶³

Section 1915(b) waivers. States can also implement statewide Medicaid managed care systems through Section 1915(b) waivers.⁶⁴ As with 1915(a) waivers, states can establish a network of specific types of providers, such as those with behavioral health expertise. Michigan used a 1915(b) managed care waiver, along with other sources, to cover a continuum of services that includes crisis response. Residential and ambulatory services as well as mobile crisis teams and crisis call lines are covered.⁶⁵ New York offers a set of behavioral health services in a network that is limited to Certified Community Behavioral Health Centers through a 1915(b) waiver.⁶⁶



BUILDING BLOCK 4: STRENGTHENING SERVICE DELIVERY THROUGH SECTION 1115 DEMONSTRATION WAIVERS

Since 2018, CMS has encouraged states to strengthen service delivery for people who experience serious mental illness (SMI) or serious emotional disturbance (SED) through section 1115 demonstration waivers. Under section 1115 of the Social Security Act, Medicaid's authorizing law, CMS can authorize states to adopt policies that differ from federal law but serve the objectives of the Medicaid program. Over time, 1115 demonstrations have been used for different purposes, such as establishing delivery system innovations and permitting Medicaid to cover populations and services that are not otherwise authorized under federal law.

CMS policy on 1115 demonstrations to strengthen service delivery for people with SMI and SED encourages states to establish a continuum of care that encompasses both community-based and residential services. Under the waivers, states receive federal Medicaid matching funds for services provided to beneficiaries residing in institutions for mental disease (IMDs). These services are otherwise excluded from Medicaid coverage. States with these waivers are expected to expand community-based mental health care, using state savings that accrue as a result of federal matching payments for IMD services. CMS guidance prioritizes expanding crisis stabilization services for people with SMI and SED, noting the potential for these services to help reduce hospitalizations and criminal legal involvement.⁶⁷

A number of states have used this waiver approach to advance crisis services as part of implementing new service delivery systems. New York's section 1115 waiver demonstration covers crisis intervention services for some people enrolled in managed care.⁶⁸ Washington, DC increased the availability of call centers and mobile crisis units, intensive outpatient services, and some inpatient stabilization services in its 1115 demonstration.⁶⁹ Alaska finances a broad range of crisis services, including crisis peer support and stabilization services, through its 1115 demonstration.⁷⁰



BUILDING BLOCK 5: FINANCING CRISIS-RELATED ADMINISTRATIVE SPENDING

In addition to advancing service provision, Medicaid can support some state and local administrative costs associated with providing crisis services. These approaches can help support 988 and other crisis call lines.

The federal government matches state spending on administration at a 50 percent matching rate in all states. Medicaid can match state spending on the share of the call line that is attributable to Medicaid and CHIP beneficiaries.⁷¹ Under some conditions, crisis call line services can be billed as services rather than administrative spending, which can provide a higher matching rate.⁷² An enhanced matching rate for Medicaid systems is also available for developing call centers and technologies that connect people with behavioral health conditions to mobile crisis call centers.⁷³

Conclusion

Crisis response services are critical to effectively meeting the needs of many people with behavioral health conditions. Recent federal laws have created new options for states and localities to strengthen existing and build additional crisis response systems. These laws respond to the growing recognition in communities that redesigning crisis response can lead to better health outcomes and help advance racial equity. As state and local officials redesign crisis response programs to expand the role of behavioral health services, they can rely on a broad array of Medicaid policy pathways to cover crisis services for low-income people. In this way, Medicaid offers key building blocks states can use to build robust crisis systems, and ultimately to establish a continuum of care to support the health and well-being of people and the communities in which they live.

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A SNAPSHOT: MEDICAID BUILDING BLOCKS TO ADVANCE CRISIS SERVICES

Authority	Key Elements
Building Block 1: Expanding Benefits to Cover Crisis Services	
Rehabilitative services option	The rehabilitative services option can cover diagnostic, screening, preventive, and rehabilitative services to address physical or mental conditions and restore individual functioning. It is commonly used by states to cover a range of community mental health services, including crisis services.
Clinic option	The clinic option covers services that are furnished on-site at a clinic or off-site to people who are homeless. It is often used to provide outpatient behavioral health services, and can be used to cover crisis services.
Services of other licensed practitioners	States can cover remedial and medical services provided by licensed practitioners, such as paramedics and addiction counselors.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Medicaid's comprehensive pediatric benefit, EPSDT, requires states to cover medically necessary services to children. Many states authorize services for children under optional benefits authorities, but EPSDT ensures access to needed services, including crisis services, for children even if a state has not elected optional benefits.
Building Block 2: Increasing Access to Home and Community-Based Services (HCBS)	
1915(c) HCBS waivers	HCBS provide some Medicaid beneficiaries with the option to receive care at home or in the community. States can target specific geographies and populations. HCBS authorized via 1915(c) waivers serve seniors and people with physical and developmental disabilities.
1915(i) HCBS state plan option	Under 1915(i) authority, states can cover HCBS for specific populations of people, such as people with behavioral health conditions.
Building Block 3: Using Managed Care to Organize Delivery of Services	
"In lieu of" services	"In lieu of" services are alternative services and settings that are cost effective, clinically appropriate substitutes for those that are explicitly authorized under a state Medicaid plan. States and managed care plans can use this authority to cover some crisis services.
1915(a) waivers	Section 1915(a) waivers enable states to create managed care programs that operate on a regional basis and establish a specific provider network. These managed care programs can focus specifically on behavioral health services, or provide a broader set of services.
1915(b) waivers	Through section 1915(b) waivers, states can implement statewide Medicaid managed care systems and establish a specific provider network. These managed care programs can focus specifically on behavioral health services, or provide a broader set of services.
Building Block 4: Strengthening Service Delivery Through Section 1115 Demonstration Waivers	
Section 1115 SMI/SED service delivery waivers	States can strengthen service delivery for people with serious mental illness or serious emotional disturbance through 1115 demonstrations that prioritize expanding access to crisis services as part of a broader continuum of care.
Building Block 5: Financing Crisis-Related Administrative Spending	
Administrative matching	Federal administrative matching funds can support state spending on administration of crisis service programs, including crisis call lines.

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