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POLICIES AND STRATEGIES TO STRENGTHEN THE CONTINUUM OF CRISIS SERVICES

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Brief overview of the problem

The demand for crisis response and other acute behavioral health services has been increasing. Age-adjusted suicide rates have increased by roughly a third from 1999-2019, with the largest increases in suicides for American Indian/Alaska Native men and women (Hedegaard et al., 2021; Curtin and Hedegaard, 2019). In addition, suicide rates were highest for individuals in rural counties and may be associated with limited access to mental health care, made worse by shortages in behavioral health care providers in these areas, and greater social isolation (Gale et al., 2019). Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) youth are over four times more likely to attempt suicide than their peers (Johns et al., 2020). An estimated 45% of LGBTQ youth seriously considered suicide in the past year, including more than one-half of transgender and non-binary youth (The Trevor Project, 2022).

A bellwether regarding the need for crisis services is directly related to the presentation of individuals at emergency departments (EDs) with behavioral health conditions and ultimately admissions to inpatient psychiatric and substance use disorder (SUD) units. ED visits for behavioral health conditions have increased since 2009 and have increased even more during the pandemic (ASPE, 2021; Stroever et al., 2021). The mean number of ED visits for suicide attempts and all SUD overdoses increased by 5% and 14%, respectively, in the post-pandemic period in 2020 compared to the same time frame in 2019 (Holland et al., 2021). Furthermore, the share of ED visits accounted for by suicide attempts and all SUD overdoses increased by 26% and 36% respectively over the same time period (Holland et al., 2021). Growth in behavioral health related ED visits has been highest for youth and particularly those of color (Hoge et al.,2022; Kalb et al.,2019). Most youth that present to an ED are *not* subsequently admitted to an inpatient setting and often need follow up-community behavioral health services. Once admitted, the length of stays for these individuals has increased, while the length of stays for medical conditions has not changed significantly (Hoge et al., 2022). EDs vary in their familiarity and relationship with behavioral health providers across the continuum which can present challenges in offering referrals to ongoing care (Child Health and Development Institute of Connecticut, 2022). This lack of familiarity with community resources may lead to inappropriate or unsuccessful linkages, which can potentially result in having individuals and caregivers continue to seek help from EDs or may lead EDs to continue to hold the individual until they stabilize or an inpatient bed becomes available.

Historically, behavioral health ED visits were twice as likely to result in an inpatient admission than ED visits for medical care (Nordstrom et al., 2019). Boarding of individuals with behavioral health conditions in EDs also continues to be problematic. Boarding is the process of holding individuals in an ED even after the decision is made to admit the patient. Increases in this practice for behavioral health patients has been fueled by the decrease in inpatient psychiatric beds, the increase in opioid use disorder cases, and inadequate community-based alternatives (ASPE, 2021). Boarding for individuals with behavioral health conditions is five times more common than for those with medical conditions (Nordstrom et al., 2019). In addition, 62% of individuals with a behavioral health condition boarded in EDs do not receive behavioral health

services while they are boarded. The lack of services in EDs has the unintended consequence of compromising outcomes and making stabilization more difficult.

There is a lack of capacity in place to appropriately respond to behavioral health crises. There are a significant number of jurisdictions that have made little to no investment in crisis infrastructure and, therefore, rely heavily on involvement of law enforcement and 911 that are often ill-prepared to address behavioral health crises (Pew Charitable Trusts, 2021). Individuals with untreated mental health conditions fare much worse when law enforcement is involved. For instance, police shootings, and deaths from those shootings, are 16 times higher for individuals with mental health conditions (Fuller et al., 2015). Nearly 1 in 4 people shot and killed by police officers between 2015–2020 had a mental health condition (National Alliance on Mental Illness, 2023). For individuals who are incarcerated and imprisoned after an arrest, 41% have a history of mental health issues and 16% have a serious mental illness (Torrey et al., 2010; Maruschak and Bronson, 2021).

Policy efforts to support crisis services

While all these data paint a daunting picture of the behavioral health crisis and access to behavioral health services in the United States, Congress has over time taken a series of steps to address the vulnerabilities of individuals and their caregivers who need access to immediate crisis care. The combination of the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) emphasized the importance of behavioral health services. The ACA requires non-grandfathered health plans in the individual and small group markets to cover essential health benefits (EHB), which include mental health and substance use disorder services (Patient Protection and Affordable Care Act, 2010).The MHPAEA generally prevents group health plans, health insurance issuers, and Medicaid managed care plans that provide mental health or substance use disorder (MH/SUD) benefits from imposing more restrictive benefit limitations on behavioral health services than on medical and surgical benefits (Mental Health Parity and Addiction Equity Act, 2008).

There are a number of other responses by Congress supporting crisis services that are worth noting:[1]

- The Protecting Access to Medicare Act (PAMA), which authorized a demonstration program to allow states to test new strategies for improving community behavioral health services, including crisis services, through Certified Community Behavioral Health Clinics (CCBHCs) [Protecting Access to Medicare Act, 2014].
- The Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, including Section 5022 which requires the Children's Health Insurance Program (CHIP) to include coverage of mental health services (including behavioral health) necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including SUDs (Substance Use-

[1] A summary of Congressional efforts in this area is provided in Appendix A.

Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, 2018).

- The National Suicide Hotline Designation Act of 2020 creating a new 988 dialing code to help people in emotional distress or experiencing a suicidal crisis. The Act also allows states to enact new state telecommunication fees to help support 988 operations (National Suicide Hotline Designation Act, 2020).
- The Bipartisan Safer Communities Act in 2022 which provided $50 million in supplemental grant funding to help states and territories expand and enhance the 988 start-up (Bipartisan Safer Communities Act, 2022).
- The American Rescue Plan Act (ARPA) which established a new state Medicaid option to incentivize states to provide or enhance community mobile crisis intervention services for individuals experiencing a mental health or substance use disorder crisis (American Rescue Plan Act, 2021). ARPA also provided a significant boost to the Mental Health Services Block Grant (MHBG) and workforce funding to support the 988 workforce for a two-year period beginning in July of 2022.
- The Consolidated Appropriations Act of 2021 requires the Substance Abuse and Mental Health Services Administration (SAMHSA) to set aside 5 percent in the MHBG for evidence-based crisis care programs (Consolidated Appropriations Act, 2020).
- The Consolidated Appropriations Act of 2023 sets forth several important provisions regarding federal action to expand the continuum of crisis services. The Act requires the Centers for Medicare and Medicaid Services (CMS), SAMHSA, and other federal partners to undertake major activities to identify, define, and underwrite these services (Consolidated Appropriations Act, 2022).

The Administration has also taken parallel steps to augment some of these Congressional actions. For instance, SAMHSA has provided information to states, providers, and other stakeholders regarding crisis services. SAMHSA and the National Association of State Mental Health Program Directors (NASMHPD) developed a publication that provides guidance on efforts to develop and expand the continuum of crisis services (Pinals, 2020). SAMHSA also developed a toolkit that defines national guidelines in crisis care, provides tips for implementing care that align with those national guidelines, and suggests options for evaluating alignment of crisis systems to these national guidelines (SAMHSA, 2020).

CMS has also provided specific information or guidance to allow states to cover select services in the crisis continuum. This includes:

- Several informational bulletins on strengthening behavioral health crisis services (Tsai, 2022; Wachino et al., 2015; Mann and Hyde, 2013).
- Medicaid managed care regulations that allowed for states to include behavioral health crisis stabilization units provided in facilities with greater than 16 beds as an “in-lieu-of service” (Title 42, 2002).
- An 1115 Medicaid authority to improve access to services across the continuum of care including crisis stabilization services (CMS, 2018).
- A SHO letter augmenting the ARPA legislative crisis opportunities and providing states additional guidance on using Medicaid to reach these statutory provisions (Tsai, 2021).

These efforts have been useful in messaging the importance of and, in some instances, underwriting the cost of crisis services. While some states have taken advantage of these opportunities, there is still a need to not only define the continuum of crisis services but develop effective tools to allow states and their crisis providers to develop, implement, or modernize these services. As discussed in several sections of this brief, there are gaps in critical crisis services that have not received sufficient attention from the Administration that could round out the continuum. In addition, the infrastructure needed to support the crisis continuum and divert reliance on law enforcement to first responders would benefit from additional strategies and investment. For instance, efforts to support the 988-lifeline long term are underdiscussed and, even when they are discussed, provide only a fraction of the funding needed to support this important function. Workforce is a perennial issue and perhaps more acute for staffing crisis services. Supporting crisis workers to allow them to perform their jobs well has not been a significant focus of legislation or the Administration's actions. Most crisis response systems are locally developed and funded and need more than a national technical assistance effort to aid staff to perform their responsibilities. While SAMHSA has recognized the need for enhanced assistance to state and local law enforcement agencies to better address individuals experiencing a behavioral health crisis, it is unclear whether these efforts will have a lasting impact (SAMHSA, 2020). The issues and proposed strategies discussed below would provide more substantive and needed changes to ensure better uptake and promote greater access to these crisis services.

Issue: The continuum of crisis services is not well amplified in federal policies and not well deployed by payers (including state Medicaid programs).

Congress and various federal agencies have recognized the need for certain crisis services and have developed incentives to promote those services. SAMHSA and CMS have developed information and guidance to states regarding some, but not all, services in the crisis continuum and the infrastructure needed to support the continuum. Specifically, this information and guidance has focused on mobile crisis response. As discussed in more detail below, 23-hour crisis programs have also been referenced in various SAMHSA documents.

While this information has been tremendously helpful to states and crisis providers, the approach is incomplete as it does not address the full continuum of crisis care. Most state crisis systems are not fully aligned with SAMHSA's national guidelines and do not have crisis receiving and stabilizing facilities, or such facilities may be limited to serving only a particular region. In addition, crisis services have generally been organized on a sub-state basis (county or municipality level) and may not be available statewide.

Moreover, there are several services that are underrepresented in guidance but that are currently deployed by several states and would round out the crisis continuum. As discussed below, there are limited state efforts to define and fund these services. For instance, as of 2018, only 14 states had at least one peer respite, despite evidence regarding their effectiveness (LAPPA, 2021). More states have been underwriting behavioral health urgent care centers, but

these are more recent efforts and are not available in many states or not covered statewide even where they do exist.

At a minimum, the services that should be added to the crisis continuum are included below:

- **Ongoing community-based crisis stabilization services** are offered to individuals following an initial mobile crisis event or for individuals who may be stepping down from crisis stabilization units. Stabilization services offer ongoing stabilization and safety monitoring in the community for a specified period (2-6 weeks).
- **Urgent care centers**, sometimes referred to as Crisis Walk-In Centers, which offer face-to-face, 24/7/365 evaluation for those who are experiencing a mental health emergency. Designed to prevent emergency department visits and psychiatric hospitalizations, urgent care centers stabilize individuals and provide referrals to other needed services. Generally, these centers have the capacity to serve a set number of individuals (12-16) and provide stabilization services for up to 24 hours.
- **Peer crisis respite programs** that offer voluntary, short-term (usually less than 10 days) or overnight programs and provide community-based, non-clinical crisis support to help people who are experiencing a behavioral health crisis. Peer crisis respite programs are designed as psychiatric hospital diversion programs to support individuals experiencing or at-risk of a psychiatric crisis.

Where various crisis services exist, there is a lack of standardized definitions that set forth clear expectations, processes, and staffing for these services. For instance, the differences between crisis stabilization units (CSUs) and urgent care are sometimes blurred in federal and state language and better distinction is needed. The SAMHSA Crisis Toolkit contains some language regarding Crisis Receiving and Stabilization Facilities, noting crisis stabilization facilities were akin to urgent care centers and provided short-term (under 24 hours) observation (SAMHSA, 2020). CMS's Medicaid managed care regulations allow states to cover facility-based crisis stabilization services through "in-lieu-of" provisions that could be included in these managed care contracts (CMS, 2016). But while the regulations included these provisions, CMS did not define a CSU service.

Across states, CSUs have different definitions. For example, the California Department of Health Care Services has defined CSUs as those that provide behavioral health services (e.g., assessment, case management, and therapy) on an "urgent" basis for less than 23 hours (California Code of Regulations). However, in some other states, CSUs are defined as a time-limited short-term residential service that provides more intensive crisis services. Louisiana's new CSU service definition states that the service is a short-term, bed-based crisis treatment and support service for members who have received mobile crisis response and/or stabilization services but continue to be at risk of hospitalization or institutionalization, including nursing home placement (State of Louisiana, 2021). Georgia and Colorado have defined CSU services like Louisiana (State of Georgia, 2023; State of Colorado, 2021).

Having different definitions of crisis stabilization services is confusing to states and providers who may be interested in funding or seeking Medicaid coverage for these services. For instance, behavioral health urgent care is a community-based service and is not part of residential programs. There are multiple Medicaid options to cover this service for Medicaid beneficiaries. Residential CSUs, while operating in the community, are viewed as more institutional and, therefore, Medicaid will not cover room and board in these facilities or require states to seek additional Medicaid authority (e.g., "in-lieu-of" services in managed care contracts or 1115 authority) to seek reimbursement when these residential services are provided in facilities greater than 16 beds that may be considered an Institution for Mental Disease (IMD) and excluded from reimbursement for such services (MACPAC, 2023).

Both quantitative and qualitative evidence indicates that services rendered by peer specialists have an important impact on outcomes. Multiple studies have concluded the presence of peers positively impacts the overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services, and by increasing the use of outpatient services. Peer support also improves an individual's quality of life, improves the likelihood of engagement in services, and increases self-management (Mental Health America, 2019). States include peers as part of a core continuum of crisis services that includes crisis call centers, mobile mental health teams, and facility-based care. The inclusion of peers also has the added effect of addressing workforce shortages by expanding staff capacity (Falkner et al., 2022).

Strategy: Expanding the continuum of crisis services

As discussed above, Congress requires SAMHSA to identify best practices that will define the continuum of crisis care. Congress and the Administration (including previous administrations) have already messaged and encouraged states and localities to develop mobile crisis response and CSUs. Therefore, the Administration should focus efforts on adding several important services to the crisis continuum. In addition, SAMHSA should coordinate efforts between various federal agencies including CMS, the Health Resources and Services Administration (HRSA), and the Department of Justice (DOJ), to develop standards for these services that identify the activities to be undertaken and the requisite qualifications of organizations and staff that would render these services. While the 2023 Consolidated Appropriations Act explicitly required SAMHSA to partner with CMS and HRSA, DOJ has been instrumental in efforts to expand community-based crisis services. For instance, in Louisiana, DOJ requires the state to explicitly build a crisis continuum including 24/7 crisis call centers and mobile crisis response, and recommends the state consider peer operated crisis settings (DOJ, 2018). As discussed above, services that should be added to the crisis continuum include:

Ongoing crisis stabilization services

Several states and jurisdictions have already developed this service for individuals (both children and adults) needing more than initial mobile crisis response services. Some states (e.g., Connecticut, Oklahoma, Ohio, Oregon, and New Jersey) have specifically designed mobile response and stabilization services (MRSS) to address youth experiencing a behavioral

health crisis. MRSS provides in-person crisis response that connects children, youth, young adults, and their families to rapid supports at home and in the community. MRSS de-escalates situations, often preventing unnecessary trips to emergency departments. MRSS has reduced ED and inpatient behavioral health hospital admissions among children and youth, decreased the average cost of care for Medicaid-enrolled children and youth, and reduced the trauma experienced by children who entered foster care (Connecticut 2-1-1 and United Way, 2022).

Louisiana has recently implemented Community Brief Crisis Support (CBCS) for adults participating in their Medicaid program. CBCS offers time-limited ongoing crisis intervention response "to provide relief, resolution, and intervention and maintains the individual in the community, further de-escalates behavioral health needs, develops referrals for treatment needs, and coordinates these referrals with local providers" (Louisiana Healthcare Connections, 2022). These states' efforts can provide important parameters for federal agencies to consider when developing these service definitions.

At a minimum, SAMHSA and its federal partners should require that the full array of the following activities be included in the definition of stabilization service activities across populations:

- Continued assessment and ongoing monitoring of the safety plan
- Solution-focused interventions
- Teaching new communication, problem solving, coping, and behavior management skills
- Psychoeducation
- System navigation
- Referral for psychiatric consultation and medication management if indicated
- Advocacy and networking by the provider to establish linkages and referrals to appropriate supports and services
- Coordination of specialized services to address the needs of youth and adults with unique needs (e.g., co-occurring intellectual or developmental disabilities and SUDs)
- Convening or participating in service planning meetings for the purpose of developing linkages to ongoing services and supports.
- Review of progress/gains made during stabilization, focusing on the individual's role in achieving those gains

There are several activities SAMHSA should specifically address in their service definition for youth who experience a crisis and their caregivers (including foster families). This includes caretaker support, advocacy, and empowerment, as well as a focus on ensuring crisis providers participate on child and family teams that are core to states that have implemented a high-fidelity wraparound approach to care coordination. The definition should clearly message the importance of ongoing community-based stabilization services as a preventative or early intervention approach for youth who were recently in custody and may experience significant

trauma. The purpose of such messaging is to provide increased support to children and resource parents (e.g., foster care) during the transition into their new home.

These definitions should contrast ongoing stabilization services with mobile crisis services and CSUs: the former being offered exclusively in community settings with a particular focus being provided in the youth or adult's home, the latter being in a residential or institutional setting. The primary focus of ongoing stabilization services offered in the community is to prevent removal from the home (including short-term crisis residential programs) or potential incarceration. The definition should ensure that staff that offer crisis stabilization services are separate and distinct from mobile crisis staff. When staff are combined and provide both services, ongoing stabilization services may take a back seat to mobile crisis response given the timeliness requirements for mobile crisis services. Teams that provide both services, without clear role delineation, will necessarily cancel "follow up" services to respond to crises in a timely fashion. The definition should clearly indicate that the service is to be provided in the home or other community setting versus CSUs or other facilities that are engaged in the treatment of behavioral health conditions.

The definition should establish general time parameters for the delivery of ongoing crisis services and create an evidence-based norm for the delivery of stabilization services. States such as Ohio, Connecticut, and Louisiana have recommended these services be offered on a time-limited basis (15-45 days) post the initial involvement with a mobile crisis team. However, it is not recommended that the definition establish a "hard limit" on the number of days post the initial involvement, which would be both clinically unwise and likely to violate Early Periodic Screening, Diagnosis and Treatment (EPSDT) and MHPAEA requirements.

Behavioral health urgent care centers (BHUCC)

SAMHSA's National Guidelines include an approach for Crisis Receiving and Stabilization Facility Services that is similar to the concept of behavioral health urgent care centers (BHUCC). BHUCCs would follow the same construct for medical urgent care centers but would be separate and distinct from these centers. The guidelines do refer to some activities to be offered by these providers but focus on the staff requirements and metrics. Therefore, SAMHSA and its federal partners should develop a service definition for BHUCC to include:

- Comprehensive evaluation and diagnostic formulation, including screening for suicide risk and risk of violence
- Brief physical examination
- De-escalation and stabilization, which are expected to be needed periodically throughout the length of stay
- Group and individual evidence-based treatments
- Engagement with the individual's support system (families, friends, etc.) in the individual's treatment, crisis, and safety plans
- Coordinated connections to ongoing care across the entire service array;
- Transportation to support flow between BHUCCs and EDs, as well as to CSUs (short-term) and inpatient hospitals, as needed

- Real-time bed and appointment tracking and registry systems (in collaboration with 988 and mobile crisis services) to support efficient connection, referral, and direct placement to needed services (Child Health and Development Institute of Connecticut, 2022).

Several states or jurisdictions have created BHUCCs as walk-in centers for individuals who are experiencing a mental health emergency (e.g., Arizona, Connecticut, California [San Diego], Louisiana, North Carolina [Guilford County]). The average length of stay in some urgent care centers is 4-6 hours. BHUCCs often have cross-disciplinary staff including doctors, nurses, licensed clinicians, and peer counselors.

Similar to MRSS, BHUCCs reduce expenditures for emergency departments and behavioral health inpatient stays. For example, it is estimated that nearly 40% of individuals who used BHUCC services would have otherwise sought care in an emergency department (Knapp and Alfieri, 2021). By handling some avoidable ED behavioral health visits at BHUCCs, the number of avoidable behavioral health ED visits in local hospitals actually decreased within the first year of implementation.

Peer crisis respite centers

Peer crisis respite centers are voluntary, short-term, overnight programs that provide community-based, non-clinical crisis support to help people find a path forward from crisis Peer crisis respite seeks to avoid psychiatric emergency services and can provide less coercive or intrusive supports in the community. Peer crisis respite programs operate 24 hours per day in a homelike environment. Individuals with psychiatric histories or who have experienced trauma and/or have a history of using mental health services staff these facilities. In some instances, these programs employ or contract with registered nurses who offer medical or behavioral health exams at entry, facilitate medication refills, and provide medication education (Thieling et al., 2022).

Service standards from states, such as New York, New Jersey, and Georgia, that had more mature peer crisis respite programs can be used to create federal standards or guidelines for these services. For instance, these states require:

- Individual peer crisis respite programs should be small and homelike (New York had an upper limit of 8 beds but are ensuring newer programs have 4-6 beds).
- Peer crisis respite programs provide separate rooms for everyone that participates in the program.
- Staffing requirements that management and staff delivering services in peer crisis centers have significant lived experience.
- Peer respite services are a completely voluntary alternative for people who would otherwise seek mental health crisis care through the emergency room and possibly be involuntarily committed to a hospital.

The most recent information from a national organization for these programs indicate that approximately 14 states have one or more peer crisis respite programs (LAPPA, 2021). Peer

respite centers have proven to be an effective diversion strategy from emergency department or inpatient behavioral health services (Bouchery et al., 2018).

Issue: Financing for crisis services by commercial plans, Medicaid, and Medicare

The creation of 988 is directly increasing the demand for crisis services. Over the past year, call volume has increased and the number of calls dropped has decreased (SAMHSA, 2023; Chatterjee, 2023). 988 and call centers are reliant on having crisis services immediately available for individuals to access. Without these services, and more importantly, the funding for these services, 988 and crisis call centers will be ineffective and will become less used.

Underwriting the continuum of crisis services has been challenging. One challenge is that private insurers, who cover over 50% of the population, generally do not cover behavioral health crisis services (KFF, 2022). Therefore, payment for crisis services may only allow individual practitioners to deliver crisis stabilization services in clinic or office settings, therefore limiting access to those practitioners to regular office hours (MACPAC, 2021).

Medicare, which insures approximately 14% of all individuals in the country, has a very limited benefit for behavioral health crisis services (KFF, 2022). The 2023 Consolidated Appropriations Act changes coverage of crisis services to only a very small extent. It requires CMS to amplify the procedure code for crisis psychotherapy, increases the rate for this service, and allows only certain licensed clinicians to provide this service in a non-office-based setting.

This leaves states and providers to rely on Medicaid to reimburse for a sliver of the population—Medicaid covers 21% of the population and must scramble for scarce federal, state, and local resources in an attempt to meet the demand for behavioral health crisis services (KFF, 2022).

While federal funding is available for these services, federal guidance does not fully address how states can use Medicaid and other federal funds to support crisis continuum. As indicated above, Medicaid has provided federal suggested coverage and payment for some, but not all, services in the crisis continuum in their informational bulletins. Even when CMS has created opportunities (e.g., enhanced federal match for crisis services), few states have taken advantage of these possibilities. Only one state has an approved state plan under this new program. This limited take-up may be due to states already covering some form of mobile crisis services under existing state plan authority (e.g., 1915(a)).

The SAMHSA Mental Health Block Grant has a 5% set-aside, resulting in an estimated $85 million for crisis services (SAMHSA, 2021). This is a relatively small amount of funding available to states to support developing or sustaining the crisis continuum. In addition, the set-aside does not specifically tie these funds to services in the continuum. CMS did not specifically address mental health crisis services in the 2020 CHIP SHO.

Even when information and guidance exist, it sometimes precludes or creates barriers for incentivizing states to cover services or settings that are part of the crisis continuum. For

instance, CMS has implied that ongoing stabilization services are not included in enhanced Medicaid reimbursement for mobile crisis response services. In addition, CMS, based on Congress' intent, precludes enhanced match for mobile crisis response services in inpatient settings—specifically emergency departments and other facilities.

Many states that cover crisis services in their Medicaid program offer this under Medicaid rehabilitative services which has been used by states for decades to create and sustain most of their community-based behavioral health services. The federal statutes and regulations governing rehabilitative services require services to be "recommended by a Licensed Practitioner of the Healing Arts (LPHA)" which is often synonymous with various behavioral health licensed clinicians (e.g., psychologists, marriage and family therapists, etc.). As discussed below, licensed clinicians are in short supply and may not be readily available to recommend services when an individual is in crisis. In addition, long-standing federal and state policies that operationalize medical necessity often require an individual to have a specific behavioral health diagnosis for a provider to be reimbursed through Medicaid. For many Medicaid beneficiaries, crisis services may be the first time they have contact with the behavioral health system and thus they do not have an existing and related diagnosis. While these policies may be sensible for routine care, they do not lend themselves well to individuals who need an immediate crisis response.

The addition of Medicare as a payment source for crisis counseling services is underwhelming. Expecting licensed clinicians, including psychiatrists, to offer these services, especially in a non-clinical setting will likely produce very little uptake for these beneficiaries. As discussed in the next section, there is an increasing number of counties experiencing a behavioral health workforce shortage, especially among psychiatrists and other licensed clinicians who Medicare beneficiaries would rely on for this service (Kalter, 2019; Ku et al., 2021).

The full continuum of crisis services cannot be supported solely by Medicaid or the MHBG. Many states use other state revenues, county and local monies, and donations to finance the delivery of these services. These funds are generally appropriated on a time-specific basis or have specific parameters and may not provide a long-term sustainable strategy for funding these services nor address the funding needed to make the necessary infrastructure investments in developing new or modernizing existing crisis services.

In very limited instances, commercial insurers have covered crisis services (Gordon, 2020). This is particularly problematic given approximately 175 million individuals were enrolled in commercial plans as of 2021 (KFF, 2022). This payment gap places undue pressure on states, localities, and crisis providers to find sustainable resources to underwrite the demand for crisis services for these individuals.

Strategy: Expand payer coverage of crisis services

Projecting the exact utilization and cost of crisis services for individuals covered by different payers is challenging given the variability of crisis definitions across state Medicaid programs

and the lack of historical coverage of crisis services in the Medicare and commercial insurance markets. However, a proxy for projecting potential utilization of crisis services would be behavioral health visits by individuals by payer. The table below provides information of ED utilization by various payers (Moore et al., 2017).

Table 1. ED Utilization by Payer

Medicare	20.1%
Medicaid	32.0%
CHIP	3.0%
Commercial	22.5%
Uninsured	18.5%

As this table indicates, Medicaid and CHIP, which generally cover at least some crisis services, represent 35% of individuals who utilized EDs for behavioral health issues. CHIP calculations were based on CMS enrollment data for youth in Medicaid and the CHIP program separately. Medicare and commercial insurers accounted for approximately 43% of behavioral health ED visits which represent a significant proportion of ED visits and generally do not cover crisis services. Therefore, strategies are needed to require payers to cover the crisis continuum or modernize their requirements for existing crisis services based on likely utilization of crisis services.

Centers for Medicaid and CHIP Services (CMCS)

There are several strategies CMCS should consider in order to expand access to the continuum of crisis services. Of import are the provisions that incentive Medicaid State Agencies to develop or modernize their approach to mobile crisis services. As mentioned earlier, CMCS has included some crisis services in information bulletins, regulations, and the 2018 1115 SHO. These efforts provided strategies for states to cover mobile crisis services or crisis residential services in a CSU through various Medicaid authorities. These previous strategies continue to exist for states to provide coverage for some, but not all, of the crisis continuum. Recently, the CMCS SHO augmented opportunities under ARPA for states to develop or make changes to their mobile crisis services to receive enhanced federal Medicaid match (Tsai, 2021). CMCS should consider revising current messaging regarding ongoing time-limited stabilization services to be eligible for enhanced matching rates offered through ARPA. As indicated above, several states have included stabilization services as part of their overall crisis services. While Congress and CMCS guidance focused mainly on creating incentives for states to add or enhance their mobile crisis response effort, stabilization was specifically included in the statute. CMS could consider leveraging this language to allow states to include their proposed or current crisis stabilization efforts to receive enhanced match under ARPA.

In addition, CMCS may want to consider several parameters that have been communicated to states regarding allowable activities to receive enhanced match. One such parameter is the disallowance for enhanced match for mobile crisis services provided to individuals that present in an emergency department. This disallowance corresponds to Congress' intent for mobile crisis services be provided "outside of a hospital or other facility setting." CMCS has messaged

and states have precluded mobile crisis teams from receiving enhanced match for these services provided in an ED setting. It is less clear that CMS or state Medicaid policy would prevent mobile crisis teams from providing these services in an ED setting, and additional guidance would be helpful to clarify if this is an allowable strategy under Medicaid. A higher percentage of individuals in rural areas who utilize the ED for mental health services are insured by Medicare or Medicaid than their urban counterparts (Schroeder and Peterson, 2018). CMCS and SAMHSA should develop guidance that provides specific parameters for mobile crisis providers who are dispatched to address the behavioral health crisis needs of individuals in EDs. SAMHSA already requires CCBHCs to establish protocols to address the needs of clients in psychiatric crisis who come to EDs and for the involvement of law enforcement during and following a behavioral health crisis (SAMHSA, 2023). SAMHSA and CMCS can use these examples to create recommended protocols. This guidance should address how inpatient and crisis providers can ensure these interventions are not violating the Emergency Medical Treatment and Labor Act (EMTALA) and strategies to ensure mobile crisis providers are not staff extenders for EDs that have no or limited behavioral health staff and resources.

In addition, CMCS and SAMHSA guidance should explicitly address how states and providers should address the role of licensed clinicians delivering crisis services including federal statutory requirements for LPHAs to "recommend rehabilitative services" which state Medicaid authorities use to cover various crisis services. The guidance should address:

- Exemplary policies states can consider for meeting the requirements for LPHA recommending crisis services. This may include the use of licensed clinicians in overseeing call center staff that often triage and make decisions for dispatching mobile crisis. These changes would allow LPHAs to be used on a more thoughtful basis such as supervision and clinical consultation rather than assigning a diagnosis or signing off on countless treatment plans.
- Overall supervision roles of LPHAs to meet the statutory requirements and to ensure the best use of the limited and shrinking pool of licensed clinicians. The guidance could specifically clarify states can meet the "recommended" requirements through supervision of non-licensed staff who often have to make split-second decisions on delivering crisis services.

In addition to long-standing policies related to the LPHA requirement, CMCS should provide strategies to states on how to address medical necessity to respond to Congressional intent and some states' current efforts to remove the diagnosis requirement to receive crisis services. CMCS recently recommended that states avoid requiring a behavioral health diagnosis for the provision of EPSDT services to improve prevention, early identification, and engagement of children in treatment. Similar messaging is needed for adults and children seeking crisis services that do not have an existing diagnosis.

CHIP

Congress specifically required CMS to release additional CHIP guidance for states to address how to pay for a crisis continuum (including 988) for children. For example, CHIP allows states

to use some of their CHIP funding to implement health services initiatives (HSIs) focused on improving the health of eligible children (MACPAC, 2019). Permissible HSI activities include public health programs or the provision of certain services, including preventive care and other interventions, to improve the health of low-income children eligible for CHIP or Medicaid as well as other low-income children. Specifically, a state may use a portion of their administrative funds for HSIs. Currently CMS caps state CHIP administrative expenses at 10%. Some states such as Arkansas, New Jersey, New York, and Oklahoma have HSIs that have behavioral health specific HSIs (MACPAC, 2019). HSIs can conceivably be used to support the crisis continuum, including crisis hotlines, mobile crisis services, crisis receiving and stabilizing facilities, and other suicide prevention initiatives. To date, however, there has been relatively little guidance on the appropriate use of HSIs for crisis services.

Roughly one-half of the states have used their authority under CHIP to fund HSIs (MACPAC, 2019). HSIs focus on assisting particular populations or addressing acute public health issues, such as the opioid crisis (e.g., purchasing naloxone kits, administering naloxone, etc.) and other activities including supporting hotlines for child abuse and neglect (MACPAC, 2019).

Medicare

The current statutory provisions that allow Medicare to cover crisis services are insufficient. Allowing only certain licensed practitioners to deliver crisis psychotherapy to Medicare beneficiaries is contrary to the approach required under ARPA for mobile crisis providers and messaged by SAMHSA in its national guidelines. It is almost certainly the least cost-effective approach given the supply of well-trained lower cost psychotherapists. A recent report on integration of behavioral health care with other medical care by the Bipartisan Policy Center recommended that CMS should clarify that peers and paraprofessionals be considered "auxiliary personnel" within the Medicare Physician Fee Schedule (Gilbert et al., 2023). It also suggested CMS provide examples of auxiliary behavioral health services that other providers can furnish alongside other licensed professionals included in the Physician Fee Schedule.

SAMHSA

As discussed above, Congress requires SAMHSA to set-aside 5% of the MHBG for crisis services. Neither Congress nor SAMHSA has explicitly developed specific parameters for states to use the set-aside for developing or sustaining the continuum of crisis services. Based on the current appropriation in the 2023 Omnibus Act, SAMHSA would be required to ensure states expended approximately $85 million on supporting the crisis continuum. There are several options, which are not mutually exclusive, for developing requirements for states to use their crisis set-aside under the MHBG. These include:

- Obligating a portion of the set-aside for start-up, including sustaining funding during the initial period immediately after implementation when providers may not have the initial utilization to generate revenues to initially support the program in total. This could include underwriting PAMA's CCBHC requirement that no individual is denied crisis

management services because of an individual's inability to pay for such services (PAMA, 2014).

- Allowing states to finance centralized training efforts (discussed in more detail in the last section) to ensure a consistent curriculum is offered across crisis providers and to provide crisis providers ongoing support to implement crisis services consistent with standards created by SAMHSA and federal partners.
- Ensuring the capacity of state 988 efforts to interface with mobile crisis providers and other crisis providers in the continuum to ensure safe and timely dispatches to individuals experiencing a behavioral health crisis.
- Requiring states to have a specific funding plan for their 988 hotline that addresses funding beyond the initial start-up funds in ARPA.

Commercial Plans

Most commercial plans do not explicitly include behavioral health crisis services in their benefit package. Congress has introduced legislation that would require commercial payers to cover crisis services for their enrollees. The Behavioral Health Crisis Services Expansion Act proposed to expand health insurance coverage (including commercial coverage) of behavioral health crisis services along a continuum of care. Unfortunately, this legislation did not pass, and the Congressional Appropriations Act remained silent regarding requirements for commercial plans.

The Administration released a Request for Information (RFI) in December 2022 to gather information related to gaps in service coverage with a specific question regarding coverage of mobile crisis and stabilization services. The comment period on this RFI has closed and information on the impact of responses is unknown (HHS, 2022).

In lieu of a Congressional mandate, there are several actions that can be taken by the Administration to increase the likelihood of crisis services being offered by commercial plans. However, without legislation, these actions taken in total will likely only marginally increase the uptake of crisis services covered but may be a toe in the water of getting commercial payers to cover these services.

One strategy that has been included in various briefs is the possibility of Including crisis services as part of the states' definitions of Essential Health Benefits (EHBs; Boozang et al., 2021). The ACA requires individual and small group health plans to offer ten EHBs, including emergency services, to their enrollees. Federal policy provides parameters for states to define their EHBs using benchmark plans that include existing plans within the State and Federal Employee Health Benefits Program. Given that most of these benchmark federal plans cover crisis services for behavioral health conditions, states would need to amend their EHB definition to include this service. States can amend their EHBs on an annual basis. Federal policies provide specific parameters for states seeking to add services to their EHBs. States are either required to defray the cost of the additional benefit or prove the additional service does not actuarially "exceed the generosity" of the benchmark plan (45 CFR 156.11 (a)(3)). The Administration

could provide additional messaging (e.g., through additional Frequently Asked Questions) to states' authorities that oversee commercial insurance specifically on how either or both parameters can be addressed for crisis services.

There are several arguments that can be made for both strategies. First, many states and jurisdictions have long histories of reimbursing providers to offer crisis services to individuals who are uninsured or whose insurance does not include this benefit. Some states that offer crisis services to this population have information that would allow them to predict and budget for defraying the cost of these services. Other states may not have the information to forecast utilization and costs and may not see defrayment as an option.

The second option would involve adding behavioral health crisis services to a state's EHBs based on a sound actuarial analysis. There exists some information regarding the impact of various crisis services on the costs of health and behavioral health services for health plans' enrollees. In 2014, SAMHSA published information regarding the cost-effectiveness of crisis services (SAMHSA, 2014). Information included in this document provided quantitative information on the impact of mobile crisis response and urgent care on behavioral health inpatient admissions. The report found psychiatric emergency services that included an emergency evaluation unit had a significantly lower rate of hospital admissions (36%) compared to ones without the unit (52%). Provider reported information indicates that nearly one-half of individuals served in the organization's urgent care program would have been admitted to the hospital if urgent care services had not been available (Gillig et al., 1989). The document also referenced several studies that provided empirical evidence on the effectiveness of mobile crisis for diverting individuals with a behavioral health crisis from inpatient psychiatric services (SAMHSA, 2014; Vermont State Legislature, 2020).

There have been other studies using health care claims that quantify the cost impact of various crisis services. Some evidence suggests that crisis services could be net cost-saving, implying that a state could include them in its EHB without triggering additional payments (SAMHSA, 2014). For example, a study in Minnesota regarding Medicaid beneficiaries identified a significant decrease in emergency department utilization post-crisis stabilization for all patients (Bennett and Diaz, 2013). The study found a 23% decrease in ED visits for individuals who received crisis stabilization over the course of two years. All cause inpatient hospital spending for these individuals was reduced from $2.9 million prior to stabilization to $1.7 million post-stabilization, and total costs for mental health hospitalization decreased from $2.0 million to $1.1 million. The calculated return on investment of the crisis stabilization unit program was approximately $0.3 million, or $300,000. These findings indicate that further research and actuarial analyses might usefully be conducted to provide information that could make the case that the addition of crisis services to a state's EHBs may not exceed the generosity standard set through ACA.

Another strategy would be to leverage current federal regulations to expand the availability of CSUs. Currently the Tri-Department regulations provide for the coverage of emergency services for individuals in commercial plans (29 CFR 2590.715-2719A). These regulations explicitly

require a health insurance issuer offering group health insurance coverage to cover emergency services if the plan "provides any benefits with respect to services in an emergency department of a hospital." They also define emergency medical conditions to include "acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition […] placing the health of the individual […] in serious jeopardy." An argument can be made that an individual experiencing a behavioral health crisis would likely meet the definitions of an emergency medical condition.

In addition, the regulation sets forth definitions of emergency services and stabilization. Emergency services include treatment, to the extent it is within the capabilities of the staff and facilities available at a hospital, to stabilize the patient. Stabilization includes "medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition." Following these regulations (and statutes referenced in the regulation), commercial plans could be required to cover stabilization services that were offered in a CSU if licensed as an inpatient provider or if an existing hospital were to offer crisis stabilization services.

A third strategy would require coverage of urgent care for behavioral health conditions to be on par with similar urgent care coverage of physical health conditions. States and the American College of Emergency Physicians (ACEP) have set forth similar definitions of emergency services. For instance, ACEP defines an emergency service as "any health care service provided to evaluate and/or treat any medical condition such that a prudent layperson possessing an average knowledge of medicine and health, believes that immediate unscheduled medical care is required" (2021). States' definitions vary, but most include language that references a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy or risk serious impairment of bodily functions.

The current MHPAEA regulatory language does not define emergency or the other service categories governing parity. The regulation specifically cites that "these terms are subject to plan design and their meanings may differ from plan to plan." Therefore, an argument can be made that emergency services include both ED type services and emergency services are analogous to the definitions currently used by ACEP and states. Applying the MHPAEA test to emergency services, there would be an expectation that comparable coverage should exist for both behavioral health crisis urgent car and stabilization services.

<u>Issue: Lack of sustainable supports for 988</u>

988 was established to improve access to crisis services in a way that the growing suicide and mental health crisis requires. Since its inception in July 2022, the volume of calls to 988 has increased and the speed which these calls have been answered has improved (SAMHSA, 2023). In some states, 988 and existing statewide call centers are combined to provide an important infrastructure for the crisis system. Crisis providers rely on these call centers to

dispatch mobile crisis teams or make referrals to other crisis services such as BHUCCs or CSUs. An estimate of the projected first year costs of a fully operational 988 system was $441 million in 2022 (Vibrant Emotional Health, 2021).

Funding for 988 is underwritten through SAMHSA funds and state funds, including funds that can be leveraged through telecommunication fees that were cited in the 988-enabling legislation. These funds have been used to:

- Recruit, hire, and train behavioral health workforce to staff local 988/lifeline centers to respond, intervene, and provide follow-up to individuals experiencing a behavioral health crisis;
- engage lifeline crisis centers to unify 988 responses across states/territories; and
- expand the crisis center staffing and response structure needed for the successful implementation of 988.

However, ongoing funding for 988 in many states is limited or non-existent. To date, only five states have enacted legislation to create telecommunication fees to sustain 988 efforts (NASHP, 2022). Other states have established a separate fund for underwriting a 988 trust fund. For instance, Connecticut passed legislation establishing a 988 Suicide Prevention and Mental Health Crisis Lifeline Fund within the state's General Fund to cover 988 call management and response services (NASHP, 2022). While these and similar efforts are admirable, they often do not provide enough funding for sustaining these efforts. Even if one-half of the states provide sufficient funding for 988, there is still at least a $165 million gap in fully funding these call centers.[2]

CMS did indicate allowable administrative activities could include operating state crisis access lines and dispatching mobile crisis teams as needed to assist Medicaid beneficiaries (SAMHSA, 2020; Tsai, 2021). In some jurisdictions, Medicaid beneficiaries represent a significant percentage of individuals who call crisis lines and seek behavioral health services. For instance, in Arizona, 58% of the call volume to their crisis call center is comprised of Medicaid enrollees (Crisis Response Network, n.d.). Despite this prevalence and the messaging from CMS, few states have used or are currently planning on underwriting some of their 988 efforts with Medicaid funding. Even if they do pursue this option, additional long-term funding is needed for individuals with no insurance or other payer sources which do not cover crisis hotlines or 988 activities.

<u>Strategy: Develop a long-term strategy that sustains 988</u>

States will need a longer-term financing strategy for 988 given that initial start-up funding from Congress will expire in June 2024. Twenty-six states have passed legislation to establish ongoing state funding or enacted legislation to allow for telecommunication fees to underwrite

[2] Author's calculations.

ongoing operations of 988 activities (NASHP, 2022). Therefore, half of the states may not have a longer-term strategy for sustaining 988.

There are several options Congress and the Administration should consider for a longer-term financing strategy for 988. These include leveraging current Medicaid and CHIP opportunities as well as changes to the set-aside in both SAMHSA block grants.

Medicaid and CHIP can provide sustainable funding sources that should be promoted by CMS. As indicated above, 21% of individuals are covered by Medicaid and a significant portion (almost 60%) of crisis callers in one state were enrolled in Medicaid (Crisis Response Network, n.d.). While the CMS SHO on payments for community-based crisis intervention services refers to administrative strategy changes to reach the costs of crisis lines, it does not provide detail that is specific to how these strategies could specifically underwrite 988 or crisis lines. CMS may want to highlight additional strategies and provide examples for states to pursue the current approach mentioned in the SHO. Specifically:

- Including services provided by crisis call centers as an allowable service as part of a state's Medicaid plan (including 1905a and other Medicaid authorities). For instance, Arizona has created case management codes for their statewide crisis call center. This allows their call center to submit claims for reimbursement for care coordination and referral services similar to other behavioral health services and obtain the federal matching rate for services versus administrative rate (AHCCCS, 2022). This would require the necessary infrastructure for crisis call centers to gather information regarding the insurance status of a caller which requires sophisticated back-office call center processes given it would be imprudent to have call center staff request payer coverage during triage and de-escalation.
- Clarifying that 988 responsibilities can be included in the Medicaid payment methodology for CCBHCs set forth in PACA. Several states require their CCBHCs to act as a back-up for call centers and several are considering adding 988 responsibilities to their CCBHCs.
- Messaging that states can leverage CHIP to cover a portion of the costs of 988 through HSIs. As indicated above, state CHIP authorities have used HSIs for behavioral health objectives and has used these initiatives to underwrite the cost of other hotlines such as child abuse hotlines.

Additionally, CMS should provide an example or strawman for states to submit revisions to their Advanced Planning Document (APD) which is an automated data processing planning document each state develops for its infrastructure to support their Medicaid program. States would need to revise and get approval from CMS for changes to their APD, providing an example or strawman for states to submit revisions to their ADP which would include detailed information regarding what specifically will qualify for the:

    - 90/10 match for the design, development, and implementation of their Medicaid Enterprise Systems (MES)

- 75% match for ongoing operations of a state's approved information system.

It may be helpful for this example to be provided in the larger context of making reforms to state crisis systems more broadly. This would include changes in service coverage through a proposed Medicaid authority, including alignment with the ARPA requirements, changes to APDs, and specific reimbursement changes.

Over the past two years, states have been required to set aside 5% of their MHBG for crisis services. SAMHSA does not explicitly require states to use these set-aside funds for 988 and it is likely that states may have already committed the set-aside for other crisis services and infrastructure. There are no set-aside requirements in the Substance Use Prevention, Treatment, And Recovery Services (SUPTRS) Block Grant, even though 38% of adults in with an SUD have a co-occurring mental health condition (NIDA, 2018). In addition, there have been marked increases in the number of individuals who have misused or abused pharmaceuticals and visited EDs (NIDA, 2018; CDC, 2021). Therefore, Congress would need to do undertake several legislative activities. Specifically:

- Create a 10% set-aside for crisis services in the SUPTRS similar to the current set-aside language in the MHBG;
- Increase the crisis set-aside for the MHBG by 5% (to a total of 10%); and
- Require 50% of the set-aside to be earmarked for underwriting the costs of 988.

This would create the necessary longer-term funding for 988 and get Congress out of the cycle of small legislative add-ons for 988 that are helpful but insufficient to meet the increasing demand from callers to 988.

Issue: Supporting the behavioral health crisis workforce

It has been well documented that there have been persistent behavioral health workforce challenges. In 2021 alone, direct support organizations that serve different populations saw a turnover rate of 43% (Baker, 2021). Turnover rates across various job classifications in behavioral health programs range from an average of 17.4% for supervisors to 37.2% for mental health workers/psychiatric aides (Open Minds, 2022). This is higher than other health care professionals. For instance, the average turnover rate for nurses was 18.7% in 2020, with behavioral health nurses having one of the highest turnover rates (Advisory Board, 2022). Turnover rates are directly impacted by staff experiencing "burn-out" caused by overwork or stress. Studies estimate that anywhere between 21% and 61% of mental health practitioners experience signs of burnout (APA, 2018). Burnout has been associated with workplace climate, caseload size, and severity of an individual's symptoms. The latter factor, severity of symptoms, is likely to impact turnover and burn-out among staff who render crisis services given the likely ongoing presence of individuals in crisis having significant and acute symptoms of behavioral health conditions.

Provider shortages vary by geographic area, payment context, and profession; however, shortages are more prominent for certain staff that require higher levels of training or credentials, such as psychiatrists and certain types of licensed professionals in publicly financed

programs (Pietras and Wishon, 2022). States and crisis providers often rely on these higher credentialled staff to offer or oversee crisis services. Federal statutory requirements and policies from CMS often drive state requirements regarding staff credentials for delivering crisis services. As previously discussed, current federal policy often requires that many behavioral health services be "recommended by a physician or other licensed practitioner of the healing arts" which states have interpreted as licensed clinicians (Social Security Act, 2023). More recently, ARPA legislation requires a mobile crisis team include at least one "behavioral health care professional who is capable of conducting an assessment of the individual" in order to receive enhanced match (American Rescue Plan Act, 2021). Not surprisingly, many states are interpreting this requirement as having a licensed clinician to render mobile crisis services. These provisions impact mobile crisis providers who may struggle to find licensed clinicians who are willing to do this work at a time when many such clinicians are migrating to less demanding and more generously compensated environments such as on-line counseling businesses.

Lastly, training requirements and training approaches of community providers offering services in the crisis continuum are variable. While federal resources are available for crisis providers, they often provide limited reference or remain silent on strategies for populations that are more likely to experience a behavioral health crisis. SAMHSA has recently contracted with the Trevor Project to develop training and technical support for the LGBTQ population for 988 staff (The Trevor Project, 2022). However, this training is not explicitly available for providers of crisis services.

Most states have developed a core set of competencies and related trainings for their crisis workforce. Some states have developed a centralized approach for rendering this training. In other states, providers are responsible for ensuring staff delivering crisis services receive the required training which can produce significant variability in training topics and affect the quality of the training. Depending on the state's training requirements, staff may be required to participate in upwards of ten hours of training per year, diverting time and resources from direct care. States do not have consistent strategies to pay providers for staff who are required to participate in training.

<u>Strategy: Create opportunities for states and their academic partners to support the workforce that delivers crisis care</u>

Caring for the workforce that provides crisis care is critical to successfully establishing the crisis continuum. While developing national technical assistance will be helpful, having state-specific strategies to provide technical assistance will be necessary to blend information on best practices developed by federal agencies with the unique requirements that exist in state policy (including Medicaid) and practice. In addition, states have a long history of providing crisis services and may best benefit from technical assistance that is tailored to their existing or envisioned provider network. States are more likely in a position to facilitate community partnerships to assist with diversion from less appropriate settings and increase awareness of crisis services. (Pietras and Wishon, 2021). States may be in a better position than a national technical assistance center to facilitate strong partnerships between the crisis system, law enforcement, emergency departments, first responders, jails, the broader behavioral health

system, health plans, schools, and judges to facilitate more widespread adoption of the crisis continuum.

Several states have developed strategies that specifically focus on developing and sustaining the competencies of the workforce providing crisis services. These states have underwritten efforts to develop statewide Centers of Excellence (COE) to support crisis providers to respond to individuals experiencing a behavioral health crisis. State-specific COE offer a wide range of assistance to crisis providers including:

- Identifying and recruiting the crisis response workforce
- Developing a training curriculum inclusive of a process for ongoing coaching for the crisis response workforce
- Developing and implementing an approach to assess the readiness of providers to offer crisis services and identifying assistance needed to address challenges identified though the readiness review process
- Evaluating the implementation of the crisis services to inform the state regarding the quality of the process, and the sustainability and outcomes associated with crisis services
- Implementing a process for collaborating with local communities to create awareness, resources, key partners, and benchmarks for crisis services provided in their communities

As indicated above, several states have developed COE or COE-like organizations. For instance, the Louisiana Department of Health (LDH) has contracted with Louisiana State University (LSU) to assist the state and the crisis workforce to establish their crisis continuum. These efforts are embedded in their Center for Evidence to Practice which supports LDH, organizations, communities, and providers in the selection and implementation of evidence-based interventions to promote youth and family well-being, improve behavioral health outcomes, and to address challenges related to sustaining quality practice (Center for Evidence to Practice, 2023). Ohio has developed a Child and Adolescent Behavioral Health Center of Excellence “to assist the state in system transformation efforts by providing technical assistance, training, professional development, coaching, consultation, evaluation, fidelity monitoring, and continuous quality improvement to build and sustain capacity in delivering evidence-based practices to fidelity within a system of care framework” (Wraparound Ohio, 2021). A major focus of Ohio’s COE is crisis services. Finally, the Connecticut Child Health and Development Institute (CHDI) offers consolidated state-wide training and technical assistance to their mobile response and stabilization providers. The Connecticut Department of Children and Families (DCF) contracts with CHDI to serve as the Performance Improvement Center for the state’s mobile crisis services. The Mobile Crisis Intervention Services Performance Improvement Center (PIC) carries out various functions for mobile crisis providers, DCF, and others to improve mobile crisis service quality and outcomes (CHDI, 2023).

COEs can play an important role in shaping education for crisis services providers that serve individuals and communities that have higher-risk populations. This includes crisis services

provided to youth, especially focusing on youth in the state's American Indian/Alaska Native population, youth of color more broadly, and youth who are LGBTQ.

Conclusion

We are encouraged that the Administration and Congress have, on a bipartisan basis, raised to prominence the need for a full continuum of crisis services, standardization across these services, and the importance of sustainable funding for these efforts. However, there is much to be done over the next several years and beyond given the statutory requirements of the Consolidated Budget Act. SAMHSA, CMS, and other federal partners should develop a coordinated strategy now to ensure that states receive the information and support needed to ensure there is a comprehensive array of crisis services. Without this coordinated strategy, the vision of the Act will not be realized, and federal agencies will have missed a once in a lifetime opportunity to create and sustain crisis services. While we are heartened by Congress and the Administration's efforts to support crisis services, it will also be critical to support the development and sustainability of "upstream" behavioral health services and supports to divert individuals from crisis services. Similar to other health care services, prevention and early intervention efforts will be key to create these diversionary strategies.

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