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FEDERAL POLICY BRIEFS

Crisis Response

Crisis Response Systems

Our country lacks a dedicated system for responding to behavioral health crises. People experiencing a mental health crisis are more likely to encounter law enforcement than to access treatment, and approximately 20% of police response calls involve mental health or substance use. Even when individuals can access medical care, they are often taken to emergency departments, which frequently lack specialized behavioral health services; one in eight visits to the emergency department in the United States is related to mental health or substance use.

Crisis reponse systems represent an alternative approach, preventing clinically inappropriate and costly stays in emergency rooms and jails. These systems have three core components: call centers, which provide remote crisis interventions, assess risk, and dispatch crisis teams or emergency services; mobile crisis teams, which quickly respond to crises in homes, workplaces, or the community; and crisis stabilization centers, which provide short-term interventions and connections to care in non-hospital settings. Together, these services can help ensure that a person experiencing a mental health or substance use-related crisis is connected to behavioral health care.

Crisis response systems include

- **Crisis call centers**
- **Mobile crisis teams**
- **Crisis stabilization centers**

Medicaid's Role in Crisis Response

Adults with mental illness who are covered by Medicaid are significantly more likely to be involved in the justice system than those who are privately insured, highlighting the need to build out robust crisis systems that serve Medicaid members. Recently, Congress has taken action to expand crisis response services, including creating a new Medicaid state option to fund mobile crisis teams, designating 988 at the nation's crisis hotline, and creating additional funding for crisis services through the Substance Abuse and Mental Health Services Administration (SAMHSA). The Centers for Medicare and Medicaid Services (CMS) also recently released guidance on the mobile crisis state option and clarified that Medicaid administrative claiming funds could be used to help fund crisis call centers.

These are important first steps, but states report ongoing regulatory, financial, and operational barriers to creating accessible, scalable, and well-coordinated 24/7 crisis response systems. 988 is set to "go live" in July 2022, adding urgency to states' efforts.

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Opportunities for Federal Action

- **Support state efforts to create crisis stabilization centers.** Congress has taken steps to build out mobile crisis teams and call centers, but crisis stabilization centers – which can offer short-term stabilization, observation, treatment, case management, and/or connections to care – are also crucial components of crisis continuums. To help increase access to stabilization centers, Congress could provide an enhanced federal match, as they did for mobile crisis teams. Congress should also be mindful of how the "institutions for mental diseases" (IMD) exclusion, which prevents Medicaid from covering most inpatient behavioral health services, limits the scalability of crisis stabilization centers; the IMD exclusion's 16-bed limit may be particularly challenging in rural communities with limited provider networks. Congress could exempt crisis stabliziation centers – which, by definition, provide short-term stays – from the IMD exclusion.
- **Create clear Medicaid reimbursement structures for 988 hotlines.** Although Medicaid members will undoubtedly utilize 988 hotlines, it is unrealistic to expect hotline workers to gather a person's insurance information while they are experiencing a behavioral health crisis. CMS recently released information on how Medicaid programs can use administrative claiming and allociation methodologies to be reimbursed for the portion of crisis call center services that are delivered to Medicaid members. This is an important first step, and CMS should work with states to quickly develop and approve these methodologies. Congress should also develop ways to ensure that commercial payers cover their fair share of call center operating costs, as telecommunications fees (which were authorized by the Federal Communications Commission to support 988 implementation) and Medicaid reimbursements are unlikely to cover the full costs of operating these hotlines.
- **Create ongoing federal investments in mobile crisis teams**. The American Rescue Plan created new opportunities for states to fund mobile crisis teams through their Medicaid programs. Congress and federal agencies should work with commercial payers and other stakeholders to develop sustainable funding models beyond Medicaid, along with ensuring long-term fiscal support for Medicaid's role in providing these services.

Supporting State Innovation

Many states have already launched efforts to develop robust crisis response systems. Arizona, for example, operates 24/7 crisis call centers to respond to people in need and dispatch mobile crisis teams. Tennessee has 13 mobile crisis teams that operate throughout the state; these teams are jointly funded by Medicaid and the state general fund. Rhode Island developed a special Medicaid rate for "BH Link," a center that provides crisis stabilization and connections to ongoing care. Scaling these types of services across the country, however, will require federal action.

You can read more about state actions to support crisis response in NAMD's Medicaid Forward: Behavioral Health report.

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The National Association of Medicaid Directors has developed the Federal Policy Briefs series to highlight federal opportunities to improve the accessibility, affordability, and quality of health care services delivered through the Medicaid program