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FREQUENTLY ASKED QUESTIONS (FAQS): Recent State Medicaid Activity to Improve Access to Substance Use and Mental Health Crisis Intervention Services

Overview:

Often, when emergency medical services are requested for people who use drugs or alcohol (PWUD) or individuals experiencing mental illnesses, the response does not address the actual health emergency. The impacted person may be confronted by law enforcement entities whose presence or actions may agitate or harm the individual and fail to provide them with appropriate services. Moreover, because of existing racial inequities in health care and law enforcement systems and policies -- Black and brown people experiencing these health emergencies are more likely to receive punitive or fatal responses from law enforcement authorities, instead of obtaining crisis intervention services that address their emergent mental health or substance use conditions.

To help combat this issue, states have begun to apply for HHS Medicaid demonstration projects or 1115 waivers and state plan amendments to provide services that can offer a health care response to individuals' mental health, drug use, or overdose emergencies.

Q & A:

Q. How can requests from community residents for assistance with mental health and substance use disorder emergencies be better addressed through mobile crisis responses?

A. According to the Substance Abuse and Mental Health Services Administration (SAMHSA)'s National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit several approaches exist to aid individuals undergoing a mental health or substance use crisis. The Toolkit recommends that communities have access to a "no-wrong door" strategy for assisting people that include a regional crisis center, crisis mobile team response, and crisis receiving and stabilizing facilities. In addition, the National Association of State Mental Health Program Directors' report recommended that crisis response services also include 24 hour crisis phone lines, psychiatric urgent care services, hospital emergency departments that may include dedicated behavioral health sections for mental health or substance use disorder (SUD) services, and other resources.

Specifically, since this Q & A focuses on crisis intervention services, such as mobile crisis units -- SAMHSA's Best Practice Toolkit suggests that this type of service should have the following minimum requirements:

- Include a licensed and/or credentialed clinician capable of assessing the needs of individuals within the region of operation;
- Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or certain days or times; and
- Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations.

In addition, the guidance recommends that community-based mobile crisis services use face-to-face professional and peer intervention, dispatched in real-time to where the person in crisis is located to get the best outcomes for that individual. Also, among other goals -- the guidance urges that mobile crisis teams should:

- Incorporate peers within the mobile crisis team;
- Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion; and
- Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care.

Q. What is a Medicaid 1115 demonstration project or waiver?

A. The Medicaid program is a joint federal and state program that is operated by each state. A provision of the Social Security Act grants the Secretary of the Department of Health and Human Services (HHS) the authority to allow states the flexibility to design innovative health programs for their residents, known as Medicaid 1115 "demonstration projects" or "waivers." HHS, through the Centers for Medicare & Medicaid Services (CMS), then determines if the proposed state's 1115 waiver application meets the objectives of the Medicaid program (to provide health coverage to eligible low-income adults, children, pregnant individuals, elderly adults and people living with disabilities) through "experimental, pilot, or demonstration projects," while also waiving certain federal requirements of the Medicaid program.

Q. Has the federal government provided any guidance for states on Medicaid 1115 demonstration project opportunities for crisis intervention services?

A. Yes. As a part of the American Rescue Plan, which became law in March 2021, Congress gave CMS authority to develop a state option to provide qualifying community-based mobile crisis intervention services for a period of up to five years, during the period starting April 1, 2022, and ending March 31, 2027, and receive enhanced federal funding.

In December 2021, CMS released a Dear State Health Official letter, "Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention

Services." CMS' guidance on the new state mobile crisis opportunity detailed how states that have approved coverage and reimbursement authority through state plans, 1115 demonstration projects, and other Medicaid authorities can obtain an 85 percent federal medical assistance percentage (FMAP) financing for expenditures on qualifying community-based mobile crisis intervention services for a specified period under conditions. The guidance informed stakeholders that the main objectives of community-based mobile crisis intervention services are to provide rapid response, individual assessment and crisis resolution by trained mental health and substance use treatment professionals and paraprofessionals in situations that involve individuals who are presumed or known to have a mental health condition and/or SUD. Individuals are then connected to needed services.

Among other provisions, the guidance supported best practices for mobile crisis services, such as:

- involving trained peers who have lived experience in recovery from mental illness and/or SUD and formal training within the mobile crisis team;
- responding without law enforcement involvement, unless special circumstances warrant inclusion, to support justice system diversion;
- scheduling outpatient follow-up appointments and services to connect to ongoing care and home and community-based services and supports; and
- including representatives from recovery community centers and harm reduction initiatives in their composition or establishing formal relationships with such programs when they are locally available.

To be eligible for this enhanced federal financing, states' community-based mobile crisis services must already be included in their Medicaid state plan or 1115 demonstration project; provided to individuals who are Medicaid eligible (under the state plan or waiver) who are experiencing a mental health or SUD crisis; and qualifying services must be delivered by a multi-disciplinary team that meets certain conditions (e.g., the team must include at least one MH/SUD professional who is qualified to provide an assessment within their authorized scope of practice under state law, and should also include other professionals or paraprofessionals with expertise in behavioral health or mental health crisis intervention).

In addition, the guidance indicated that states may decide to include as community-based mobile crisis intervention team members clinicians who can prescribe and administer medications on scene. The guidance suggested that community-based mobile crisis intervention teams carry naloxone and have team members trained in its administration to reverse opioid overdoses. CMS also encouraged states to equip their mobile crisis units with harm reduction supplies, including fentanyl test strips and suboxone. Moreover, states could choose to include highly trained and specialized practitioners, such as psychiatrists or psychiatric nurse practitioners, as part of the mobile crisis team that connect virtually via telehealth to other members of the mobile crisis team on scene to provide screening and assessment and/or to stabilize the beneficiary and de-escalate the crisis.

States should also ensure that their community-based mobile crisis intervention services teams are maintaining relationships with relevant community partners, including medical and behavioral health providers, primary care providers, which would include pediatric providers for children, community health centers, crisis respite centers, and relevant managed care plans.

Q. Which states are planning to use 1115 demonstration projects or state plan amendments to address their mental health or substance use crisis intervention needs? Is there funding to support state planning?

A. In September 2021, CMS, through the Center for Medicaid and CHIP Services (CMCS), awarded $15 million in planning grants to 20 State Medicaid Agencies to support their development of a state plan amendment (SPA), section 1115 demonstration application, or section 1915(b) or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services.

The following State Medicaid Agencies were awarded planning grants: Alabama, California, Colorado, Delaware, Kentucky, Massachusetts, Maryland, Maine, Missouri, Montana, North Carolina, New Mexico, Nevada, Oklahoma, Oregon, Pennsylvania, Utah, Vermont, Wisconsin and West Virginia. Additional states are likely developing their own mobile crisis initiatives.

Q. What are some features of the state Medicaid mobile crisis initiatives?

A. The following sample of states have pending or approved 1115 waiver applications or SPAs to establish crisis intervention programs with a variety of features to meet the identified needs of its residents:

- District of Columbia: *Has an approved SPA to receive enhanced federal financing to provide community-based mobile crisis services for Medicaid eligible individuals (including those under age 21).* A key feature of this SPA are Adult Mobile Crisis and Outreach services -- acute behavioral health crisis interventions and behavioral health outreach services intended to minimize the individual's involvement with law enforcement, emergency room use, or hospitalizations. These services are available 24 hours per day, seven days per week and include rapid response, assessment, and treatment of behavioral health crisis situations. Services are delivered by a multidisciplinary team which consists of, at minimum, two people and must include at least one professional or paraprofessional with expertise in mental health services and the appropriate qualifications to conduct a mobile crisis screening and assessment. At least one member of the multidisciplinary team must be face-to-face with the individual. The SPA was approved on September 8, 2023.

- New Jersey: *Has an approved 1115 waiver for people under age 21 eligible for Medicaid that also focuses on individuals' health-related social needs.* In March 2023, CMS granted New Jersey the approval to extend and amend their

current 1115 waiver, "New Jersey FamilyCare Comprehensive Demonstration. For eligible children's behavioral health services not included in the benefit package, the demonstration now includes a behavioral health administrative service organization to provide services such as, dispatch of mobile response/crisis response, clinical telephone triage (performed by licensed clinicians), and behavioral health and primary care coordination. In addition, the demonstration offers housing health-related social needs assistance for those who are homeless or at risk of becoming homeless, transitioning from an institution to the community, being released from correctional facilities, at risk of institutionalization who require a new housing arrangement to remain in the community (including older adults, individuals with disabilities, and individuals with serious mental illness and/or SUD), and/or those who are transitioning out of high-risk or unstable housing situations. The waiver is effective from April 1, 2023, through June 30, 2028.

- New York: *Has a pending amendment to its Medicaid Redesign 1115 Demonstration to authorize federal Medicaid matching funds for inpatient, residential, and other services provided to Medicaid enrolled individuals with behavioral health diagnoses including serious mental illness, serious emotional disturbance (SED), and SUD.* Key features of this amendment would permit New York to fund a complete continuum of SUD services (including reintegration), as well as the enhancement of services that are currently not Medicaid funded (e.g., expansion of telehealth access, the creation of mobile MAT units, and allowing all outpatient programs to do methadone treatment, among other initiatives).
- Rhode Island: *Has a pending 1115 waiver application to extend its Rhode Island Comprehensive Demonstration, that includes focusing on addressing the overdose crisis, providing health equity, and offering additional assistance to justice-involved individuals.* Some features of this demonstration project include addressing the state's opioid overdose crisis by implementing hotline and mobile outreach, and increasing access to peer recovery coaches; improving health equity through strong community--clinical linkages that support Medicaid enrollees in addressing these social determinants of health, including ensuring access to stable housing; supporting people who are transitioning back to the community following release from custody (with a focus on individuals with SUD or mental illness) by requesting the authority to provide Medicaid coverage 30 days prior to their release from state custody, including the provision of "reach-in" services provided by managed care organizations.

Q. How can states apply for and obtain federal Medicaid funding for crisis intervention services?

A. A state's Medicaid agency can receive federal matching funds for their Medicaid program through two methods - - a state plan amendment or a demonstration project/ waiver. The first method consists of submitting and receiving approval from the Secretary of the Department of Health and Human Services (HHS) for their state plan that is an agreement between the federal government and the state. The state plan describes the nature of their program and how the state will adhere to the objectives of the Medicaid program. Once the state plan is approved, if a state wishes to permanently change its program policies or operational approach, it must file a state plan amendment (SPA) with CMS which updates their original state plan. Moreover, a SPA also must be submitted if there is a change in federal law, regulations, court decisions, or policy interpretations, or if a state seeks to materially alter state law or operation of their Medicaid program.

Although a SPA application generally does not require a formal public comment period (unless the Medicaid agency is seeking a change in Medicaid provider payment rates), local advocates could consider contacting their state Medicaid agency to express support for and input on the need for mental health and SUD crisis intervention services in their state. Also, if the proposed SPA would impact the provision of health care to Native Americans, the Indian Health Program, or Urban Indian Organizations, then the state must obtain input from these individuals or entities. Lastly, unless Congress authorizes an expiration date or the state withdraws or updates the SPA, the SPA does not expire.

Secondly, the Medicaid 1115 demonstration project or waiver is the other method for states to obtain federal funding for mental health and SUD crisis intervention services. Before the demonstration project's application is submitted to CMS, a state Medicaid agency must provide at least a 30-day notice and comment period of the initial application or request for renewal of the application. Again, if the proposed demonstration project impacts Native American populations, the Indian Health Program, or Urban Indian Health programs, the Medicaid agency must consult with these individuals or entities.

For any 1115 demonstration project application, the state Medicaid agency must also demonstrate that federal spending for the proposed waiver would not be more than it would be if the waiver was not in place (budget neutrality). CMS then determines whether the proposed 1115 demonstration meets the objectives of the Medicaid program (to provide health coverage to eligible low-income adults, children, pregnant individuals, elderly adults and people living with disabilities) through a novel or experimental approach, while also waiving certain federal requirements of the Medicaid program.

Q. Can advocates play a role in reviewing and commenting on pending 1115 demonstration applications for crisis intervention services?

A. Yes, advocates play an important role in providing input on potential waiver applications in their communities and ensuring that demonstration projects reflect and address the lived experiences of Medicaid enrollees. Local advocates should be aware of and submit comments on pending waiver applications in notice and comment and public hearing opportunities. According to a 2012 CMS Final Rule, Medicaid agencies seeking

approval for their pending 1115 demonstration applications must publish the following information online: the demonstration application, public hearing announcements, a description of the objectives of the demonstration, and key program features, and an estimated impact on enrollment and spending. A subsequent federal regulation provision explains that states must have a 30-day public notice period, and also publish the public notice in either their states' administrative record or in newspapers with the widest circulation in each city with a population of 100,000, or more, and maintain an email mailing list or similar mechanism to notify interested parties of the demonstration applications.

In addition, federal public notice regulations require states to conduct a minimum of two public hearings, at least 20 days before submitting an application for a new demonstration project or extension of an existing demonstration project to CMS for review. These hearings must have been held on separate dates and in separate locations, so that members of the public throughout the state have an opportunity to provide comments. Moreover, the State must use telephonic and/or Web conference capabilities for at least one of the two required public hearings to ensure statewide accessibility to the public hearing, unless it can document it has provided the public (throughout the state) the opportunity to provide comment, such as holding the two public hearings in geographically distinct areas of the state. The state public notice process for public hearings indicate that the hearings must take place in at least two of the following settings:

- States' Medical Care Advisory Committees (MCACs) - MCACs are charged with advising the state Medicaid agency about health and medical care services.[1]
- A commission or other similar process, where meetings are open to members of the public;
- A state legislative process, which would provide an interested party the opportunity to learn about the contents of the demonstration application, and to comment on its contents; or
- Any other similar process for public input that would afford an interested party the opportunity to learn about the contents of the demonstration application, and to comment on its contents.

Q. How can states design demonstration projects for certain populations, to meet special health needs, or to address unmet health-related social needs (HRSN), in order to address social determinants of health?

[1] U.S. Dep't of Health & Human Services, Centers for Medicare & and Medicaid Services, Proposed Rule: Medicaid Program; Ensuring Access to Medicaid Services, 85 Fed. Reg. 27960 (May 3, 2023), *available at* *https://www.govinfo.gov/content/pkg/FR-2023-05-03/pdf/2023-08959.pdf*. The Proposed Rule recommended changes to MCACs to increase their scope and provide more meaningful engagement with its committee members, that include Medicaid enrollees. The Proposed Rule also recommended renaming MCACs to "Medicaid Advisory Committees (MACs) that also have a Beneficiary Advisory Group (BAG). *Id.* at 27967.

A. States have used and are using the 1115 demonstrations to create new ways to help meet various health and health-related needs of certain populations, such as providing:

- expanded Medicaid eligibility in 2012 for adults without dependent children with incomes at or below 10 percent of the 2012 Federal Poverty Level (FPL) in Colorado;
- health care coverage and services during the nation's COVID-19 public health emergency, such as Arizona's dental benefit for individuals up to age 21 years old through Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit; expanded Medicaid coverage to all pregnant women and children up to age 21 with incomes up to and including 400 percent of the FPL in Michigan, who are currently served by the Flint water system or were served by the Flint water system between April 2014 and the date on which the Flint water system is determined safe by the appropriate state authorities; and
- HRSN benefits of housing supports and nutrition services for individuals and families experiencing critical life transitions, such as youth who are involved with child welfare entities, adults and youth leaving criminal legal system involvement, and people experiencing homelessness or at risk of homelessness in Oregon.

Q. How have states used Medicaid 1115 demonstrations to assist people living with substance use disorder and/or mental health issues?

A. CMS has approved several different Medicaid 1115 innovative demonstrations in several states to provide mental health and/or SUD care that reflect the health priorities of their residents. For example, in:

- Minnesota – Among other provisions, the state's demonstration project implements a new provision that medication assisted treatment (MAT) must be offered as part of the continuum of care and that providers have at least one medical professional with prescribing authority within their networks.
- Pennsylvania – The goals of this demonstration are to increase and strengthen coverage of former foster care youth and improve health outcomes for this population as well as provide access to high quality, evidence-based SUD treatment services covering critical levels of care including outpatient, intensive outpatient, MAT, residential, inpatient, and medically supervised withdrawal management.
- Oklahoma – The state provides medically necessary residential treatment, facility-based crisis stabilization, and inpatient treatment services within qualified Institutions for Mental Diseases (IMD) for Medicaid beneficiaries with serious mental illness (SMI), serious emotional disturbance (SED) and/or SUD diagnoses. The demonstration will test whether this authority

will increase access to evidence-based treatment services and improve overall health and long-term outcomes for those with SMI, SED, and SUD when a full continuum of care is provided.

For more information, please contact Deborah Reid (dreid@lac.org).

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