SAMHSA
Substance Abuse and Mental Health Services Administration

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO # 25-004

RE: Best Practices for Implementing the Continuum of Crisis Services Under Medicaid and CHIP

September 5, 2025

Dear State Health Official:

Section 5124 of the Consolidated Appropriations Act, 2023 (CAA, 2023; P.L. 117-328) requires the Secretary of Health and Human Services, in coordination with the Administrator of the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS) Assistant Secretary for Mental Health and Substance Use, to issue guidance to states on the continuum of crisis services and how states may support implementation of this continuum through Medicaid and the Children's Health Insurance Program (CHIP).

1. Introduction[1]

This guidance, which was developed jointly by CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) with input from healthcare providers and other stakeholders, is intended to provide a practical guide for states and other stakeholders on effective practices in crisis services as well as the federal authorities under which states can finance and enhance the availability of crisis response services in Medicaid and CHIP. It highlights effective strategies for crisis response services, describes specific Medicaid and CHIP authorities and flexibilities to support the full continuum of crisis services, and provides an overview of strategies for measuring and monitoring crisis response services.

Recent data underscores the need for a comprehensive crisis care system that is integrated within the larger system of care and needed services. In 2024, 5.5 percent of adults ages 18 years or older (or 14.3 million people) had serious thoughts of suicide in the past year, and among adolescents ages 12 to 17 years, 10.1 percent (or 2.6 million people) had serious thoughts of

[1] This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, SAMHSA, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website and the opinions expressed may not necessarily reflect those of CMS, SAMHSA or HHS. Also, please be aware that the privacy protections generally provided by United States Government websites may not apply to third-party sites.

suicide in the past year.[2] In 2023, more than 49,000 people died by suicide.[3] Suicide is the second leading cause of death among people ages 10-34 years and the sixth leading cause among people ages 35-64 years. Rates are higher in rural areas. In 2023, suicide rates in rural areas were 20.2 per 100,000 for rural residents, compared to 13.8 per 100,000 in urban areas.[4] Additionally, more than 105,000 people died from drug-involved overdoses in 2023.[5]

Despite the fatalities and hospitalizations associated with the behavioral health crisis, access to services is often limited. Survey data collected in 2024 showed significant gaps in access to services. Among the 14.6 million adults with serious mental illness in the past year, roughly 30 percent did not receive mental health (MH) treatment. Among adults with any mental illness and a co-occurring substance use disorder (SUD), 41.2 percent did not receive any treatment in the past year. Additionally, only 19.3 percent of people aged 12 or older who needed substance abuse treatment received it.[6]

High levels of distress and lack of accessible MH and SUD services also can lead to an increased demand for support from other services and systems such as schools, primary care providers, hospital emergency departments (EDs), and public safety officials, many of which have challenges that hinder their ability to effectively meet these needs. These challenges point to the importance of prioritizing the improvement of MH and SUD services, including services and programs providing more appropriate and effective responses for individuals experiencing MH or SUD crisis.

2. Effective Continuum of Crisis Response Services

This section incorporates insights from SAMHSA's recently published National Guidelines for a Behavioral Health Coordinated System of Crisis Care (BHCSCC) and the companion document, Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services.

A behavioral health crisis system represents a set of three essential elements: someone to contact, someone to respond, and a safe place for help.

Essential Elements of a Continuum of Care

A behavioral health crisis system represents a set of three essential elements: someone to contact, someone to respond, and a safe place for help. This includes the 988 Suicide & Crisis Lifeline and other behavioral health lines, mobile outreach and crisis teams (MCTs), and emergency and crisis stabilization services that work together to coordinate care. These services address the acute behavioral health needs of people in crisis; are consistent with goals to decrease psychological distress, decrease substance use, and prevent suicide and overdose; and are linked to sub-acute and outpatient

[2] Substance Abuse and Mental Health Services Administration (2025) Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health (HHS Publication No. PEP25-07-007, NSDUH Series H-60).
[3] See Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System (WBISQRS), Injury Counts and Rates, 2023.
[4] See Centers for Disease Control and Prevention, WBISQRS, Injury Counts and Rates, 2023.
[5] Garnett M., Miniño A. (December 2024) Drug Overdose Deaths in the United States, 2003–2023. NCHS Data Brief, no 522. Hyattsville, MD: National Center for Health Statistics.
[6] Ibid (SAMHSA 2025 NSDUH).

services with a goal of ongoing engagement toward overdose prevention, treatment, and recovery and resilience.

There are a range of service types within these three essential elements that together make up a robust BHCSCC. These services, while complementary, are not interchangeable, have different staffing models, and address varying levels of complexity.

An important concept in the crisis delivery system is "emergency capable services" that function on par with the existing medical emergency system—that is, 24/7 services that are not referral-dependent.[7] Facilities in this emergency category receive people who are brought to the facility by public safety first responders. Among the services described in this section, the following are designated as emergency capable:

- Hospital-Based Behavioral Health Emergency Units, and
- High-Intensity Behavioral Health Emergency Centers.

Ideally, a crisis continuum should ensure that all community members have access to this full array of emergency capable services, in addition to the other critical services noted below, many of which can be less intensive and more inclusive alternatives to emergency care, provide stepdown linkages from emergency care, and/or prevent the need for more intensive emergency care.

Someone to Contact: 988 and Other Behavioral Health Lines

Crisis and other behavioral health lines are the first of three foundational programmatic elements that are essential to a BHCSCC. They fulfill a crucial role by offering free and easily accessible support to individuals experiencing an acute crisis, those facing barriers to accessing behavioral health care, and/or people who support help seekers. In addition, these lines are a critical component of an evidence-based, public health approach to suicide prevention.[8] Behavioral health lines can include:

- **988 Suicide & Crisis Lifeline**: The 988 Lifeline is the three-digit, nationwide phone number to connect directly (via call, chat, or text) to the network of crisis contact centers. 988 Suicide & Crisis Lifeline Contact Centers must meet minimum expectations as outlined in the SAMHSA *Saving Lives in America Plan*.[9] All states have at least one crisis center providing local 988 service.
- **Other Behavioral Health Crisis Hotlines**, such as the Disaster Distress Helpline or the HRSA's National Mental Health Hotline (833-TLC-MAMA for women before, during, and after pregnancy). These hotlines are not part of the 988 Lifeline network but also

[7] Emergency capable services also allow the seeking care as well as their family or other supporter to request the service. There is no pre-approval requirement for receiving the service and the service will not screen a person out but will connect someone to a different service (including more restrictive care) if they are unable to safely care for the help seeker.

[8] Hoffberg, A., Stearns-Yoder, K., Brenna, L. (2020) The Effectiveness of Crisis Line Services: A Systematic Review, *Frontiers in Public Health*.

[9] See Substance Abuse and Mental Health Services Administration (April 2024) Saving Lives in America Plan: 988 Quality and Services Plan for additional information on operational, performance, technology, security, training, and quality improvement.

provide support to people experiencing emotional distress and/or third-party callers who are concerned about another person in distress.

- **Peer-Operated Warmlines** are a phone and/or text service run by peers (individuals with behavioral health lived experience) that provides connection focused on wellness and support. These lines help people navigate the recovery process.
- **Emotional Support Lines** provide the same services as peer-operated warmlines but differ in that they are not necessarily staffed by individuals with personal lived experience of behavioral health conditions.

Someone to Respond: Mobile Crisis and Outreach Services

Mobile Crisis Team (MCT) services offer community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis. MCTs provide rapid, on-demand community-based responses that can include a risk assessment, clinical assessment and community-based stabilization supports to decrease emotional distress, improve mental wellbeing, and reduce any immediate risk of harm or danger to themselves self or others. MCTs can also facilitate linkages to higher levels of care if needed.

Communities may implement different models of mobile crisis teams, including:

- Behavioral Health Practitioner-Only response (only if there is no clear imminent risk or threat to health or public safety which warrants law enforcement presence);
- Co-Responder MCTs that utilize both law enforcement and/or Emergency Medical Services (EMS) and behavioral health practitioners; and
- Mobile Response and Stabilization Services (MRSS), a youth- and family-specific crisis intervention model.[10]

Best Practices for Mobile Crisis

It is recommended that Mobile Crisis Teams:

- Include a licensed and/or credentialed clinician on-site or via telehealth who is capable of conducting assessments;
- Have the ability to respond where the person is (home, school, work, park, etc.) throughout the entire service region, preferably 24/7;
- Connect to facility-based and community-based care as needed through warm hand-offs and coordinating transportation when situations warrant transition to other locations;
- Incorporate peers within the mobile crisis team;
- Have the capacity to assess for and respond to psychiatric treatment needs and the ability to refer people to crisis stabilization facilities;
- Be equipped to respond to people across the developmental lifespan; and
- Provide follow-up services including scheduling outpatient follow-up appointments to support connection to ongoing care.

[10] For more on best practices and the components of models, see Substance Abuse and Mental Health Services Administration (January 15, 2025) 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care.

All three MCT models can operate in the same geographic area and share triage and/or dispatch protocols. These protocols might also be coordinated between 988 and 911 Public Safety Answering Ports (PSAPs) to facilitate a clear, efficient process for determining which MCT model is best suited to respond to specific crisis events. In such cases, dispatch should consider defaulting to BHP-Only MCTs and minimize the use of Co-Responder MCT teams that incorporate law enforcement; however, physical health, safety or other factors may warrant response by a different MCT model or first responder type.

School districts have also utilized school crisis response teams. These teams generally consist of school administrators, nurses, teachers, and public safety personnel to provide support, guidance and resources to schools and students during and after a crisis event and/or to intervene with a child in crisis.[11]

In addition to the models outlined above, **Community Outreach Teams (COTs)** can support a variety of needs of individuals including behavioral health, physical care, housing, benefits, education, and employment. COTs do not provide on-demand crisis services. Instead, through outreach and engagement, COTs promote wellness, resilience, recovery, self-advocacy, development of supports, and maintenance of community living skills. COTs can work effectively alongside MCTs to prevent crisis and provide wraparound supports to those in need. Some rural and under-resourced communities have created teams with dual roles of mobile crisis services and COTs. COTs can be especially helpful for follow-up care and may provide warm hand-offs to crisis services.

A Safe Place for Help: Crisis Stabilization Services

A Safe Place for Help includes both emergency and crisis stabilization services across a continuum of care from no barrier, low barrier, to referral-based services. For example, there are some facility-based settings that will accept all individuals who present to the facility and provide access to a full range of clinical and non-clinical staffing support (no barrier or emergency settings). Other settings may accept most individuals who come to a facility-based service, but they may have less intensive staffing models, may not be able to accept people who are brought to the facility via an ambulance or law enforcement or who present with a level of acuity that cannot be safely supported (low barrier settings). Finally, some referral-based services may only provide services in accordance with a referral-based system that includes a triage and/or screening process that incorporates the use of pre-determined eligibility criteria. Services in this category also can be distinguished by the setting in which stabilization services are offered.

As part of the continuum of services, it is important to have a no barrier emergency facility, as an alternative to hospital emergency departments, that can respond to the highest level of acuity of MH and substance use needs, including those who need involuntary treatment and/or are dropped off by public safety first responders. Such high acuity settings should be community-based emergency stabilization facilities that:

[11] There are multiple resources available for school crisis teams. See for example guidance developed jointly by the U.S. Department of Education, U.S. Department of Justice, U.S. Department of Health and Human Services, U.S. Department of Homeland Security (September 2019) The Role of Districts in Developing High-Quality School Emergency Operations Plans.

- Accept all referrals;
- Offer walk-in services and public safety first responder drop-off options;
- Do not require medical clearance prior to admission but rather triage and support for medical stability of basic medical concerns while in the program;
- Have the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway to transfer the individual to more medically staffed services if needed;
- Design their services to both address MH and substance use-related crises including acute intoxication and withdrawal;
- Are staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the integrated health needs of individuals experiencing all levels of crisis in the community;
- Screen for suicide risk and complete comprehensive suicide risk assessments and safety planning when clinically indicated;
- Screen for violence risk and complete more comprehensive violence risk assessments and safety planning when clinically indicated;
- Screen for the risk of substance-related conditions including intoxication, overdose, and withdrawal and manage these conditions including the utilization of pharmacotherapy and overdose prevention support; and
- Engage in disposition planning that encourages the use of natural supports, existing service providers as appropriate, other services (including both higher and levels of care when clinically appropriate), and providing connection to other supports such as social service needs like facilitation of insurance coverage and connection to the local U.S. Department Housing and Urban Development Continuum of Care Program.

In addition to emergency capable stabilization services noted above, states and communities should consider additional settings and services equipped to address people of different ages and with different levels of need. A full range of low barrier and referral-based services to support those in crisis, may include:

- **Moderate-Intensity Behavioral Health Crisis Centers** generally provide the same range of services as the high intensity centers described above, but they serve lower acuity needs and do not provide services for individuals on involuntary holds.
- **Behavioral Health Urgent Care (BHUC)** provides short-term, voluntary, and timely alternative and diversion from the use of hospital emergency departments. Services occur in an ambulatory setting and typically do not include long-term behavioral health treatment. BHUCs can be free-standing or embedded with other services components.
- **Peer Crisis Respite** are voluntary, short-term residential services and peer support to individuals experiencing a behavioral health crisis operated and provided by trained peer support professionals who have lived experience with and recovery from behavioral health conditions.
- **Sobering Centers** are short-term (less than 24 hour) community-based facilities that typically operate 24 hours/7 days a week/365 days per year. Sobering Centers provide monitoring of adults with acute alcohol and/or other drug intoxication in a supervised environment.
- **Crisis Residential Services** are referral-based services provided in residential settings. The length of stay ranges from several days to two weeks. The focus is to support

rehabilitation, resilience, and recovery goals, to further stabilize persons in crisis, and to provide connections for wraparound care. Residential services may be low to moderate intensity, with moderate intensity facilities capable of providing higher levels of medical monitoring.

- **Community Crisis Respite Apartments** allow individuals to stay for a limited time to receive crisis prevention and post-crisis services, such as case management, medication administration, counseling, and skill building. There is up to 24-hour access to peer staff and clinical staff.
- **Youth and Family Crisis Respite** provides an alternative to hospitalization for youth experiencing a behavioral health crisis. These supportive home-like settings allow youth to recover when more support is needed than can be provided at home. These settings are tailored to prioritize family and natural supports. Services are provided to both the youth and their family.
- **In-Home Stabilization Services** may serve as a bridge for youth transitioning from immediate crisis services (e.g., mobile response, crisis facilities) to ongoing care in the community. Services may last for several weeks and may be provided by a therapist or clinician in partnership with a paraprofessional. Services may include assessment, parent education programs, peer support, coping and conflict management skills-building, behavior management training, and warm hand-offs to other resources and services.

Developing a crisis or suicide safety plan is vital for promoting both the immediate safety and long-term stability of people seeking behavioral health crisis care.

For a more detailed description of no barrier, low barrier services and referral-based services, see SAMHSA's Model Definitions for Behavioral Health Emergency, Crisis and Crisis-Related Services and the 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care.

Promoting Safety

Safety, for individuals experiencing a crisis, those providing the services, and the community as a whole, is a foundational element for all crisis service settings. The capacity to screen, assess, and respond to the varied needs of people in crisis, including those with suicidal or homicidal thoughts and plans, as well as people who are at risk of substance-related overdose or at risk of harm in a situation of interpersonal violence, is a key to crisis system design.

Services and systems should be designed in a way that people have a sense of both physical and emotional safety. Furthermore, the services should be operated in a physical setting (when applicable) and in a manner that promotes the safety of the service delivered through strong policies, procedures, protocols, training, respect for individual rights, and quality improvement activities that promote safer care and positive outcomes, while minimizing adverse outcomes, for both those receiving and providing care, as well as visitors. Providers of crisis services should also have adequate training and capacity specifically geared toward responding to those who may be experiencing psychosis as a means for prioritizing safety. Additionally, training should include approaches to screening and service support to people impacted by interpersonal violence (IPV).

Developing a crisis or suicide safety plan is vital for promoting both the immediate safety and long-term stability of people seeking behavioral health crisis care. CMS implemented several actions to support access to behavioral health, including measures to support safety planning interventions for patients in crisis. These steps included separate coding and payment under the Physician Fee Schedule (PFS) describing safety planning interventions for patients in crisis, including those with suicidal ideation or at risk of suicide or overdose. CMS also established payment for a monthly billing code that requires specific protocols in furnishing post-discharge follow-up contacts that are performed in conjunction with a discharge from the emergency department for a behavioral health or other crisis encounter. Safety plans should be brief, clear, and person- and family-centered. Safety planning can be done with any qualified crisis or health professional and should be made universally available to all individuals at high risk of or experiencing a behavioral health crisis.

Overdose Prevention

Overdose prevention is also critical. Crisis systems should be developed with the evolving understanding and responsivity to overdose trends in their service catchment area, including overdose trends. They should also be aware of overdose prevention and response principles and activities.[12]

Suicide Prevention and Postvention

The National Action Alliance for Suicide Prevention created a set of evidence-based actions known as Zero Suicide or Suicide Safer Care that healthcare organizations can apply through an implementation toolkit developed by the Suicide Prevention Resource Center (SPRC). The elements of Zero Suicide closely mirror the standards and guidelines of the 988 Suicide & Crisis Lifeline, which has established suicide risk screening and assessment standards, guidelines for help seekers at imminent risk, and protocols for follow-up contact after the crisis encounter. Zero Suicide also promotes collaborative safety planning, reducing access to lethal means, and incorporating the feedback of suicide loss and suicide attempt survivors into the service provided. This framework can also be used for overdose prevention as well.

Suicide postvention, or mental health care for people impacted by suicide, is another important component of the continuum of crisis response. Nationwide, 51 percent of adults have been exposed to suicide, and 35 percent have been bereaved by a suicide.[13] For both youth and adults, exposure to suicide is associated with negative health outcomes, including an increased risk of suicide.[14] Suicide postvention response can facilitate the healing of individuals from the grief and distress of suicide loss; mitigate other negative effects of exposure to suicide; and prevent suicide among people who are at high risk after exposure to suicide.[15]

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[12] See Substance Abuse and Mental Health Service's Overdose Prevention and Response Toolkit for guidance on how to prevent and respond to overdoses.
[13] Feigelman, W., Cerel. J. et. al. (February 2018) Suicide Exposure and Bereavement Among American Adults: Evidence from the 2016 General Social Survey *Journal of Affective Disorders* 227: 1–6.
[14] Pitman, A., Osborn, D. et. al. (June 2014) Effects of Suicide on Mental Health and Suicide Risk *Lancet Psychiatry* 1(1):86-94.
[15] See The U.S. Department of Veteran's Affairs (February 2022) Postvention-Mental Health Care Following a Death by Suicide.

Screening and Assessment

Completion of formal, comprehensive, biopsychosocial assessments should not be required prior to providing assistance to individuals experiencing a MH or substance use crisis. Often people in crisis are experiencing a high level of distress and alterations in their thought processes that would make it challenging, if not impossible in some cases, to participate in a formal diagnostic assessment. Although individuals with behavioral health conditions are more likely to be a victim of crime than a perpetrator, crisis services need to be aware of how to assess for the risk of both aggression or violence and risk of victimization of an individual who has a behavioral health condition(s). See Appendix A for more on available screening tools.

3. Strategies to Improve Access to and the Timely Provision of Crisis Response Services

This section highlights strategies states may consider for improving access to crisis response services.

Providing Crisis Response Services 24/7 in Rural and Remote Regions

There are challenges with improving access to MH and substance use services and crisis response services in rural and remote communities across the United States. Response times for mobile crisis and geographic accessibility for crisis stabilization services are significant challenges in rural areas. The physical distance and/or terrain can limit the ability of mobile crisis teams to reach individuals in need of a crisis stabilization service.

Telehealth has long been recognized for its ability to reach individuals in underserved areas, including rural and remote areas. This allows the individual to receive help without having to spend hours and possibly money on transportation to a health facility outside of their community and away from their support network.[16]

Telehealth may also be helpful to engage and support individuals in crisis in remote areas while they await responders. While 988 Suicide & Crisis Lifelines provide 24/7 access to someone to talk to, it may require one or more hours for mobile crisis response teams to reach someone in a rural or remote area, especially in remote regions like the Pacific Island Jurisdictions. Thus, during a crisis in a rural and remote area that cannot be resolved in a call to 988, telehealth can serve as a bridge to facilitate access to the clinical element of a mobile crisis response. Telehealth can also be a useful modality for crisis care follow-up services. If an individual is leaving a crisis stabilization facility or an inpatient setting, the availability of telehealth follow-up care can reduce the chance of a return visit to the ED or hospital.

[16] Federal Medicaid and CHIP laws and regulations for most benefits do not include specific requirements for delivering benefits via telehealth. Provided states cover and pay for services delivered through telehealth in the same way/amount that they cover and pay for face to-face services, states are generally not required to submit a state plan amendment (SPA) for coverage or payment of Medicaid coverable services delivered through telehealth. For additional information on coverage of telehealth in Medicaid and CHIP, see State Medicaid and CHIP Telehealth Toolkit.

Telehealth can be of limited utility if the person does not have access to the technology needed to use these services or understanding of how to use these tools. Some states have found solutions to this challenge. Oklahoma, for example, leveraged their Certified Community Behavioral Health Clinics (CCBHCs) to provide rapid access to telehealth services in the community through electronic tablets that are carried by law enforcement officers. Whether used by law enforcement or in other settings, this strategy can prevent tragedies and reduce the time for someone in crisis to receive services.[17]

Assuring Access to Crisis Response Services for People with Intellectual, Developmental Disabilities or Other Related Conditions

Services should be accessible to individuals with intellectual or developmental disabilities (IDD). Crisis staff should be trained to recognize individuals with IDD, to understand their unique needs, and to apply best practices for working effectively with individuals with IDD, their families, guardians, and/or caretakers. Considerations include potential cognitive limitations, medical co-morbidities, varying verbal skills, and/or differing social skills levels. Providers may wish to cultivate relationships with agencies and systems serving individuals with IDD (e.g., intellectual and disability-specific service systems, group homes, skilled nursing facilities and intermediate care facilities, assisted living and rehabilitation facilities, child welfare systems, and the educational system) and developing protocols for coordinating care and referrals to these agencies and systems.

Maximizing Capacity to Deliver Crisis Response Services

To develop an effective, coordinated crisis continuum, states and local communities may wish to consider maximizing existing resources.

Strategic Placement of Facilities

Repurposing existing buildings for crisis services, such as retrofitting prior healthcare delivery sites for crisis services, can be an effective strategy. The co-location and operational integration of a wide array of programming can be an efficient use of space and staff. It can also enable individuals to seamlessly move through multiple levels of care. For example, if a crisis stabilization unit is seamlessly coordinated with a crisis residential unit, then an individual can move to a lower level of care quickly and in a familiar place when clinically appropriate while allowing for the facility to receive higher acuity individuals and support community-based stabilization in a stepped approach. States should consider how such strategies might affect Medicaid payment for services provided in Institutions for Mental Disease (IMDs). An IMD is defined in section 1905(i) of the Act as a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." There is a general prohibition on Medicaid payment for services provided to most individuals under age 65 who reside in an IMD. This is commonly known as the "IMD exclusion." See discussion of

[17] The availability of broadband internet may be limited in rural and remote areas, posing a further limitation on a provider's ability to reach individuals remotely in the community. The USDA Rural Health program is a potential resource for rural and remote communities to support the healthcare infrastructure for these communities, including capital improvement funding in addition to funding that could support these telehealth services.

managed care flexibilities and section 1115 Demonstrations below for pathways to support treatment in an IMD when certain conditions are met.

Strategies to Expand Workforce Capacity

Behavioral health workforce shortages are common in communities across the U.S. and are of particular concern with professions that require a high level of specialized training, including psychiatrists and licensed clinical staff. [18] These shortages impact the entire behavioral health system, and they are expected to continue in the future.[19] It is important to identify and implement behavioral health crisis workforce strategies for recruitment, retention, and support, for the full range of crisis responders, including 988 and mobile crisis responders, care coordinators, counselors, and other crisis professionals with the appropriate training and/or certification. Addressing crisis workforce concerns and supporting crisis teams that reflect the communities they serve will help increase access and quality of crisis care for individuals and families.[20]

Another strategy to maximize capacity in the workforce is the use of peer support specialists, or people with lived experience with MH and/or substance use conditions. Peer support specialists can expand and enhance the workforce and complement the clinical team by providing a wide array of nonclinical services, including advocacy, system navigation and linkages to resources.[21]

Additionally, the workforce can be augmented by other MH and substance use crisis staff who are not licensed by their state, but meet the certification, skills, education, experience and training, and/or supervisory requirements as allowed under state law. Additionally, individuals with prescribing capacity who are not physicians, such as nurse practitioners and physician assistants, may be used to expand access to medications to treat MH conditions or SUDs. This is not only a way to alleviate the current behavioral health workforce shortage, but also a way to provide accessible, multidisciplinary care. These team members can perform key functions within their appropriate scope of practice. Programs can utilize the services provided by licensed individuals to provide supervisory and oversight roles to ensure quality of these multidisciplinary teams in addition to extending their reach through telehealth.

Locating crisis services near other human services buildings and emergency departments or near areas that are familiar or commonly used in a community can encourage utilization of needed services.

[18] Office of the Assistant Secretary for Planning and Education (ASPE). April 14, 2021. Crisis Services and the Behavioral Health Workforce Issue Brief.
[19] HRSA, National Center for Health Workforce Analysis (November, 2024) State of the Behavioral Health Workforce.
[20] In 2023, the National Action Alliance for Suicide Prevention (Action Alliance) convened the Crisis Workforce Task Force that was co-led by a representative from SAMHSA. A group comprised of national crisis workforce experts from the public and private sector to delineate the issues affecting the crisis workforce and developed recommendations for addressing them. In 2024, Action Alliance published *Sustaining the Crisis Workforce: A National Roadmap* based on input from the task force and results from key informant interviews across the nation examining the state of the crisis workforce. The Roadmap outlined the goals of behavioral health crisis workforce recruitment, retention, and support. SAMHSA supports these three goal areas and suggests this document as reference for state and community-based workforce development strategies.
[21] See SAMHSA, Peer Support Specialists: A Growing Mental Health and Addictions Workforce.

Coordination Across State Programs and Funding Streams

A high-quality BHCSCC requires providers, system partners, and payers to collaborate to ensure the coordination of services and the accountability of system components under the oversight of an "accountable entity." An "accountable entity" that provides an oversight role is a critical component of a well-functioning crisis response system. Functions of this entity include assessing the needs and specific population characteristics of a community as well as ensuring the coordination of a myriad of services with a focus on a systems-based approach (as opposed to a collection of services that are not interconnected). In addition, this accountable entity can set benchmarks for performance metrics for a community or catchment area.

An accountable entity that provides an oversight role is a critical component of a well-functioning crisis response system.

This entity may also have the role of developing a comprehensive funding strategy for the community that it serves that strategically optimizes the funding sources without waste, implementing the funding plan, and monitoring the expenditures and utilization of the crisis continuum services. Multiple funding sources including public payers, private payers, and funds from federal, state, and local grants should be coordinated in order to share both the fiscal responsibility and benefits of a comprehensive crisis system and to avoid duplication. Because crisis continuum services are required to have availability to serve a community as a whole, funding sources that are not based solely on fee-for-service revenue are likely to be necessary to ensure that crisis services have the availability to flexibly serve individuals in need at any time. An accountable entity should have the authority to fulfill these functions and have some mechanism by which the people who are served within the community can provide feedback and/or participate in the functions of this entity.

4. Strategies for Covering Crisis Response Services in Medicaid and CHIP

States have multiple options for covering all components of the continuum of crisis services described above—988 and crisis call centers, mobile crisis, crisis stabilization centers—in their Medicaid and CHIP programs. Payment for 988 call centers is described in section 5 below. Qualifying mobile crisis services may be eligible for the enhanced Federal Medical Assistance Percentage (FMAP) through March 31, 2027, under section 1947 of the Act, as added by section 9813 of the American Rescue Plan Act of 2021 (P.L. 117-2); this option has been described in detail in previous guidance. Below are other options available to states to cover crisis services.

State Plan Benefits

Medicaid

States are statutorily required to provide coverage of certain aspects of behavioral health in their Medicaid programs. For example, 1905(a)(29) of the Act requires states to cover medication-assisted treatment for opioid use disorder for all individuals eligible for Medicaid through a categorically needy eligibility group. The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for eligible children under age 21 requires states to provide coverage

of medically necessary services described in section 1905(a) of the Act (including services to treat SUD and mental illness) that are included within the categories of mandatory and optional services, regardless of whether such services are covered under the state plan for adults.[22] States must also comply with Mental Health Parity and Addiction Equity Act (MHPAEA) (Pub. L. 110-343) requirements applicable to Medicaid and CHIP.[23]

States may use multiple state plan benefits to cover crisis stabilization services and follow-up care. CMS has described many of these benefits in previous guidance.[24] The optional rehabilitative services benefit under 42 C.F.R. § 440.130(d) can be used to provide coverage for a wide range of behavioral health services when recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice under state law. States have used the rehabilitative services benefit to cover a wide range of crisis services, including mobile crisis, counseling, psychosocial rehabilitation, and care coordination. States may also utilize the rehabilitative services benefit to provide coverage of peer support services, an important component of crisis stabilization services. (For more on coverage for peer support services, see CMS guidance and Frequently Asked Questions on Medicaid and CHIP Coverage of Peer Support Services.) The optional other licensed practitioner (OLP) benefit at 42 C.F.R. § 440.60 allows states to provide coverage for services (other than physicians' services) of a licensed practitioner acting within their scope of practice under state law, as well as the services furnished directly by non-licensed practitioners working under the supervision of a licensed practitioner when certain conditions are met.[25] Services furnished by a physician within the scope of practice of medicine or osteopathy under state law, or furnished by or under the personal supervision of a person licensed under state law to practice medicine or osteopathy are covered under the mandatory Medicaid physician services benefit at 42 C.F.R. § 440.50.

States are statutorily required to provide coverage of certain aspects of behavioral health in their Medicaid programs.

The mandatory Federally Qualified Health Center (FQHC) services benefit is also an important mechanism to support the continuum of crisis services. The Medicaid FQHC services benefit is defined at section 1905(a)(2)(C) of the Act, and FQHCs and FQHC services are further defined at section 1905(l)(2) of the Act. An FQHC can function as a central hub for crisis services by coordinating with pharmacy, mental health, and substance use treatment providers, ensuring that crisis services are accessible and linked to the broader health care provider system.

States also have the option to provide state plan coverage for interprofessional consultation—when one treatment professional (such as a physician or a member of the MCT) consults with another practitioner (e.g., a psychiatrist) on a beneficiary's care—provided that the consultation is for the direct benefit of the beneficiary. Interprofessional consultation services may be covered under several Medicaid state plan benefits, including physician services (42 C.F.R. § 440.50),

[22] For more on EPSDT, see the CMS 2024 guidance, Best Practices for Adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Requirements.
[23] For more on parity, refer to https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/parity.
[24] See for example Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services and Opportunities for Improving Access to Mental Health and Substance Use Disorder Services for Medicaid and CHIP Enrollees Experiencing Homelessness.
[25] For more on the requirements of the other licensed practitioner benefit see CMS 2014 guidance, Clarification of Medicaid Coverage of Services to Children with Autism.

services of other licensed practitioners (42 C.F.R. § 440.60), and rehabilitative services (42 C.F.R. § 440.130(d)). Covering these services can help to improve access to behavioral health services for beneficiaries. For more on interprofessional consultation, see the 2023 CMS guidance.

Section 209 of Division G, Title I, Subtitle B of the Consolidated Appropriations Act, 2024 (CAA, 2024; P.L. 118-42), enacted March 9, 2024, added a new Medicaid CCBHC optional state plan benefit at section 1905(a)(31) and (jj) of the Act. States can use this benefit to cover services provided by clinics that meet the CCBHC demonstration criteria, as certified by the state, including 24-hour mobile crisis teams and other crisis supports. This optional benefit took effect upon enactment.[26] The statutory language governing this benefit does not provide for an enhanced federal match for CCBHC services or dictate how states must pay providers for the provision of CCBHC services, unlike in the CCBHC demonstration (see section on CCBHC demonstrations below).

Some individuals who are in crisis due to an SUD or MH condition are in need of inpatient or residential treatment. The inpatient psychiatric hospital services for individuals under age 21 benefit (often called the psych under 21 benefit) provides inpatient or residential services to individuals under age 21 in psychiatric hospitals, psychiatric units of general hospitals, and Psychiatric Residential Treatment Facilities. There is also a state plan option available under section 1915(l) of the Act that gives states an option to receive federal financial participation (FFP) for expenditures for services furnished in settings not normally eligible for FFP. Specifically, 1915(l) permits states to pay for high quality, clinically appropriate services in residential and inpatient treatment facilities that qualify as an IMD. Under section 1915(l), states may receive FFP for items and services for which medical assistance is available under the state plan that are provided to eligible individuals aged 21 through 64 residing in an eligible IMD primarily to receive withdrawal management or SUD treatment services. Per section 1915(l)(2), FFP is available for a maximum of 30 days per 12-month period per eligible individual from the date an eligible individual is first admitted to an eligible IMD. CAA, 2024 made changes to section 1915(l) requirements including certain maintenance of effort requirements and utilization of evidence-based, SUD-specific individual placement criteria and utilization management approaches to ensure placement of eligible individuals in an appropriate level of care. Section 204 of Division G, Title I, Subtitle B of the CAA, 2024 also added a new section 1915(l)(4)(E) that requires states to have in place a process to review the compliance of eligible IMDs with nationally recognized SUD-specific program standards that are specified by the state. (See CMS guidance for additional information on CAA, 2024 updates).

CHIP

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act, P. L. 115-271) made behavioral health coverage a required benefit for separate CHIPs effective October 24, 2019, for both child and pregnancy-related coverage. As discussed in this CMS guidance, state CHIPs must cover "mental health services (including behavioral health treatment) necessary to prevent, diagnose, and treat a broad range of mental health symptoms and disorders, including SUDs." The statute also requires these services to be delivered in a culturally and linguistically appropriate manner. CMS also

[26] For additional information, see the SAMHSA CCBHC Certification Criteria.

encourages states to cover crisis intervention and stabilization under the CHIP state plan, and other types of services included in the full continuum of crisis stabilization services, such as intensive in-home services, intensive outpatient services, care coordination, and case management.

Home and Community-Based Services

Section 1915 of the Act provides states with several options to cover home and community-based services (HCBS) as part of their Medicaid programs to meet the needs of people who choose to receive services and supports in their home or community, rather than in an institutional setting. Sections 1915(c) and 1915(i) of the Act can be used to cover a continuum of crisis services for populations that may not otherwise be eligible for Medicaid and allow for more flexible service design than other state plan authorities.

Under section 1915(c) of the Act, states may cover part or all of the cost of HCBS (other than room and board) as approved by CMS to individuals who, but for provision of HCBS, would otherwise require the level of care provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). In addition, under section 1915(c), the Secretary of HHS may waive certain Medicaid requirements (i.e., statewideness, comparability, income and resource rules applicable in the community) to enable states to administer its HCBS program to, and cover HCBS for, a targeted subset of Medicaid-eligible individuals. States can then determine additional eligibility criteria for their section 1915(c) HCBS waiver program(s), including certain medical diagnoses (such as traumatic brain injury or autism spectrum disorder), age groups, and certain financial criteria. States also have broad latitude to determine the services to cover under their section 1915(c) HCBS waiver programs. States may include coverage of crisis services to the extent that they are consistent with the scope of section 1915(c) of the Act and do not duplicate services available in the state plan, including under EPSDT.

Forty-six states and DC are operating at least one section 1915(c) HCBS waiver program. Many section 1915(c) HCBS waiver programs cover provision of crisis intervention services in a home or community-based setting, such as mobile response, assessment, and therapeutic supports necessary for crisis stabilization and prevention of the need for more intensive services. Some section 1915(c) HCBS waiver programs also cover crisis respite and short-term crisis diversion beds. Continuum of crisis services are critical for addressing the immediate needs of individuals enrolled in a section 1915(c) HCBS waiver program who are at risk of hospitalization or institutionalization and help ensure they can continue to successfully remain in their homes and communities.

States have broad latitude to determine the services to offer under 1915(c) waiver programs, which may include the continuum of crisis services.

Section 1915(i) of the Act is an optional state plan benefit that allows states to cover HCBS for individuals who meet state-defined needs-based criteria and whose income does not exceed 150 percent of the federal poverty line. The state establishes the needs-based criteria for determining the individual's eligibility for Medicaid coverage of HCBS under the state's section 1915(i) state plan amendment. The state's needs-based criteria must assess the individual's support needs and capabilities and may take into account the inability of the individual to perform two or more activities of daily living or the need for significant

assistance to perform such activities. The needs-based criteria may also take into account other risk factors that the state determines to be appropriate, such as behavioral health risks or risk of social isolation for older adults with chronic conditions. The state's needs-based criteria must also be less stringent than the state's criteria for determining whether an individual requires the level of care provided in a hospital, a nursing facility, or an ICF/IID. The state must use an independent evaluation, meeting certain requirements (e.g., a face-to-face evaluation of the individual by an appropriately qualified and trained agent) to determine whether the individual meets the state's needs-based criteria for eligibility. States may also determine additional eligibility criteria for their 1915(i) HCBS state plan benefit, to provide coverage benefits to a specific population based on age, disability, diagnosis, and/or Medicaid eligibility group (e.g., pregnant women, individuals receiving Supplemental Security Income, children in foster care).

Similar to section 1915(c) HCBS waivers, states have considerable flexibility in designing the types of services that it will cover under a section 1915(i) state plan benefit, which also may include continuum of crisis services. For example, four states offer section 1915(i) coverage benefits targeted to children with serious emotional disturbance (SED) that include mobile crisis response, crisis stabilization, and/or crisis intervention as a component of care coordination. Unlike section 1915(c) HCBS waiver programs, states must ensure services covered by their section 1915(i) program are available statewide.

Health Homes

Under section 1945 of the Act, states have the option to offer a health home benefit to Medicaid-eligible beneficiaries with chronic conditions. Medicaid beneficiaries who receive coverage of health home services must fall within at least one of the categories defined in section 1945(h)(1)(A)(ii) of the Act[27]: individuals with two or more chronic conditions listed in the Act, individuals with at least one chronic condition listed in the Act who are at risk for a second, or individuals with at least one serious and persistent mental health condition. As defined in the statute, chronic conditions can include a MH condition or a SUD. Health home services include comprehensive care management and care coordination. The statewideness requirement at section 1902(a)(1) of the Act and the comparability requirement at section 1902(a)(10)(B) of the Act are not applicable to coverage of section 1945 health home services, and thus states can offer health home services only to individuals who are in the health home population. See CMS guidance[28] on Health Homes for Medicaid beneficiaries with chronic conditions for additional information.

Section 1945A of the Act gives states the option to cover health home services for Medicaid-eligible beneficiaries under 21 years of age with medically complex conditions, as defined in section 1945(i)(1)(A) of the Act.[29]

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[27] Categories include "a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight, as evidenced by a body mass index over 25."
[28] Refer to https://www.medicaid.gov/federal-policy-guidance/downloads/SMD10024.pdf and https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes.
[29] Refer to CMS guidance at https://www.medicaid.gov/federal-policy-guidance/downloads/smd22004.pdf.

Section 1115 Demonstration Projects

Section 1115 of the Act gives the Secretary of HHS the authority to approve experimental, pilot, or demonstration projects that are found by the Secretary of HHS to be likely to assist in promoting the objectives of the Medicaid program. States can seek section 1115 demonstration authority to offer a continuum of crisis services for CMS consideration.

There are several established demonstration types that can help to expand access to behavioral health services, including:

- **SUD demonstration**. This demonstration opportunity, outlined in the State Medicaid Director Letter (SMDL) #17-003, Strategies to Address the Opioid Epidemic, allows states to receive FFP for services delivered in institutions for mental diseases (IMDs) in exchange for a commitment to ensuring access to quality services across the continuum of care for SUD. Ordinarily such residential treatment services are not eligible for federal Medicaid matching funds due to the payment exclusion in the Medicaid statute of payment for services provided to most beneficiaries who are patients in IMDs. One goal of these demonstrations, as discussed in the SMDL, is: "Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services." Crisis stabilization is an important component of the SUD continuum of care and often can serve as the first point of contact for an individual in need of services. Crisis stabilization services can "divert individuals from unnecessary hospitalizations and ensure the least restrictive care option."[30]
- **Serious Mental Illness/Serious Emotional Disturbance demonstration**. Similar to the SUD demonstrations, this demonstration opportunity is outlined in SMDL #18-011, Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness and Children with a Serious Emotional Disturbance. Crisis stabilization is a key component of these demonstrations, as discussed in the SMDL, including a goal which indicates: "Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state." These services may also support earlier identification and engagement in treatment by serving as the entry point into treatment.
- **Reentry demonstrations**. States also have the option to seek section 1115 authority to ease the transition of incarcerated individuals back into the community. As discussed in CMS guidance, section 5032 of the SUPPORT Act allows for a section 1115 demonstration opportunity to improve care transitions for soon-to-be released incarcerated individuals who are otherwise eligible for coverage, with the aims of improving health outcomes and reducing ED visits and inpatient hospital admissions for both physical and behavioral health (MH and SUD) issues once they return to the community.

[30] See SAMHSA (2014) Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies.

CCBHC Demonstrations

Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA; P.L. 113-93) authorized CCBHC demonstrations to allow states to test a new strategy for covering and paying for a comprehensive array of services provided in certified CCBHCs. States must include behavioral health crisis services in the demonstration, including 24-hour mobile crisis teams and other crisis supports. CCBHCs receiving payment under the demonstration must adhere to the CCBHC Certification Criteria, which include a requirement that mobile crisis services must be available and accessible 24-hours a day and delivered within three hours. In addition to providing crisis services, CCBHCs are well positioned to provide comprehensive coordinated outpatient mental health and substance use care that is often necessary following a crisis and to provide the care coordination and support necessary to ensure the people receive these services. Some states have used CCBHCs in coordination with their 988 systems to ensure access to mobile crisis response and follow-up services for people who contact 988.

Under a CCBHC demonstration, states pay CCBHCs for CCBHC services in alignment with the direction outlined in the CCBHC PPS Guidance. The guidance outlines four prospective payment system (PPS) methodologies for CCBHC services, including two daily and two monthly PPS rates, in addition to rate components included in certain PPS methodologies allowing states to make quality bonus payments and set additional PPS rates for special populations and special crisis services. As noted above, states may now also elect to provide Medicaid coverage for CCBHC services outside of a CCBHC demonstration under a new, optional state plan benefit, in addition to their ability to cover similar services outside of a CCBHC demonstration under other benefits, such as the rehabilitative or clinic services benefit. The statutory language governing the new state plan benefit does not require states to pay for CCBHC services under Medicaid state plan authority using the demonstration PPS methodologies.

Presumptive Eligibility

As states seek approaches to connect individuals in crisis to care and coverage, states could consider the presumptive eligibility (PE) option to provide individuals with quick access to coverage. Under PE, individuals who are determined by a qualified entity to be "presumptively eligible," meaning they are likely eligible under a state's Medicaid eligibility requirements, are immediately enrolled into temporary coverage while their application is being fully processed. A full Medicaid eligibility determination is not immediately needed and cannot be required in order for PE to be approved. PE may be an important way for individuals to access coverage for crisis services quickly, as the nature of the crisis service encounter often limits the ability to engage in standard eligibility activities.[31]

[31] States have the option to provide PE to the following modified adjusted gross income (MAGI) Medicaid-eligible groups (see 42 C.F.R. § 435.1102 and § 435.1103): pregnant women; infants and children; parents and caretaker relatives; the adult group, if covered by the state; individuals above 133 percent of the Federal Poverty Level under age 65, if covered by the state; individuals eligible for family planning services, if covered by the state; former foster care children; and certain individuals needing treatment for breast or cervical cancer, if covered by the state. Covered benefits for pregnant women during a PE period are limited to ambulatory prenatal care, and benefits covered under family planning PE are limited to family planning services. See 42 C.F.R § 435.1103(a) and (c)(1)(ii).

Managed Care and the Continuum of Crisis Response Services

The volume of Medicaid beneficiaries enrolled in a managed care program in Medicaid has grown from 81 percent in 2016 to 85 percent in 2021.[32] Similarly, enrollment in managed care in CHIP has grown from 74.5 percent in 2016 to 84.8 percent in 2021.[33] With 74.6 percent of Medicaid beneficiaries and 80.9 percent of CHIP beneficiaries enrolled in managed care organizations (MCOs) in 2021, managed care plays an important role in establishing the continuum of crisis response services.

States have numerous options for developing, implementing, and operating managed care delivery systems. States can seek various forms of federal authority to implement managed care, to identify and procure the managed care plans[34] with which they contract, identify services delivered through managed care, and much more. Managed care offers states flexibilities to tailor their programs to best support the needs of their enrollees and each phase of crisis care delivery – from crisis response to crisis prevention and postvention.

Managed care offers states flexibilities to tailor their programs to best support the needs of their enrollees, and each phase of crisis care delivery – from crisis response to crisis prevention and postvention.

Managed Care Requirements and Flexibilities

Federal Medicaid managed care regulations include requirements and flexibilities which states can use to develop and support the continuum of crisis response services.

Transition and Coordination of Care. Managed care regulations include requirements related to transitions and coordination of care, which may help states manage a continuum of crisis response services across various delivery systems and payers. Effective implementation of these provisions is critical to ensuring a continuum of crisis response care for managed care enrollees, identifying enrollee needs, avoiding missed services, and maintaining continuity of care between programs, setting, and payers.

At 42 C.F.R. § 438.62(b)(1) for Medicaid and through a cross reference at 42 C.F.R. § 457.1216 for CHIP, states are required to have a transition of care policy in place for individuals moving to managed care from fee-for-service (FFS), or from one MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), primary care case manager (PCCM), primary

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Consistent with 42 C.F.R. § 435.1101, a state may designate as a qualified entity any other entity the state deems capable of making PE determinations. As such, states have the option to designate entities such as mobile crisis units or crisis stabilization centers as qualified entities, if the state deems these entities as capable of making PE determinations consistent with state and federal policies. States provide information on relevant state policies and procedures and information on how qualified entities should fulfill their responsibilities in making presumptive eligibility determinations for applicants. For more information, refer to https://www.medicaid.gov/medicaid/enrollment-strategies/presumptive-eligibility.

[32] For data on the volume of Medicaid beneficiaries enrolled in managed care, see Medicaid Managed Care Enrollment Reports.

[33] Based on state enrollment totals reported as ever enrolled within the fiscal year data from Statistical Enrollment Data System (SEDS) form CMS-21E for FY2016 and FY2021.

[34] "Managed care plan" is used to mean a managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, primary care case manager, or primary care case management entity, as defined in 42 C.F.R. § 438.2.

care case management entity (PCCM entity) to another when an enrollee without continued services would experience serious detriment to their health or be put at risk of hospitalization or institutionalization. States are required to include a requirement for a transition of care policy meeting the standards described in the regulation (and the state transition policy) in their MCO, PIHP, and PAHP contracts. Additionally, as specified at 42 C.F.R. §§ 438.208(b) and 457.1230(c) for Medicaid and CHIP respectively, MCOs, PIHPs, and PAHPs must implement procedures to deliver care to and coordinate services for all of their enrollees.

Value-Added Services. Under 42 C.F.R. § 438.3(e)(1) for Medicaid and through cross reference at 42 C.F.R. § 457.1201(e) for CHIP, an MCO, PIHP, or PAHP may voluntarily cover services that are in addition to those covered under the state plan, although the cost of these services cannot be included in the development of capitation rates. These services are often referred to as "value-added" services. These services can be important in crisis prevention and postvention. Examples of value-added services can include wellness and nutrition services, social supports and resources, and exercise programs. Managed care plans, who are well-positioned to identify the particular needs of enrollees in the geographic areas they serve, should collaborate with crisis response providers and other stakeholders in developing value-added services to ensure that these services truly complement and support the continuum of crisis response services. Effectively used, value-added services may reduce the need for, or intensity of, future crisis services.

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Searchable Provider Directories and Telehealth Delivery Option

Section 5123 of the CAA, 2023 amended section 1932(a)(5) of the Act, to require that the provider directories of Medicaid MCOs, PIHPs, PAHPs, and PCCM entities (when applicable) be searchable and include information on whether each provider offers services via telehealth. The provisions of section 1932(a)(5) of the Act apply to CHIP via a cross reference at section 2103(f)(3) of the Act. CMS has issued regulations implementing this requirement at 42 C.F.R. §§ 438.10(h)(1) and 457.1207. Given the prevalent use of telehealth to deliver MH and SUD services, requiring this information to be included in managed care provider directories will enable enrollees who prefer to receive services via telehealth to more easily identify providers that are more likely to meet their needs. Additionally, ensuring that managed care plan provider directories are searchable will help enrollees identify appropriate network providers much more easily and quickly. Facilitating easier and more effective use of provider directories contributes to managed care plans' ability to meet their enrollees' needs and can be especially important in crisis prevention and postvention as they receive services within the continuum of care. The requirement to include information regarding the provision of telehealth services in searchable provider directories will be applicable on July 1, 2025. For more information, please see State Health Official Letter #24-003, dated July 16, 2024.

5. Strategies for Payment of Crisis Response in Medicaid and CHIP

This section describes mechanisms available to states to support the continuum of crisis response services in their Medicaid and CHIP programs.

Medicaid Administrative Claiming

Pursuant to section 1903(a)(7) of the Act, FFP is available for expenditures for allowable administrative activities that support the provision of crisis response services covered under the Medicaid or CHIP state plan. Section 1903(a)(7) of the Act authorizes 50 percent federal match for expenditures for state Medicaid agency (SMA) administrative activities that are necessary for the proper and efficient administration of the Medicaid program, provided all administrative claiming conditions are satisfied. Allowable administrative activities:[35]

- Must be directly related to the proper and efficient administration of the state Medicaid program (section 1903(a)(7) of the Act and implementing regulations at 42 C.F.R. §430.1, 433.15(b)(7)). Allowable administrative activities do not include gaining access to or coordinating non-Medicaid-covered services even if such services are health-related and provided to Medicaid beneficiaries;
- Must be included (by reference) in the Public Assistance Cost Allocation Plan (PACAP) that is approved by CMS and the HHS Program Support Center Division of Cost Allocation Services (CAS) per Subpart E of 45 C.F.R. Part 95 (requirements for PACAPs are discussed above in subsection D of this section):
- Must be supported by adequate documentation (45 C.F.R. § 75.403(g));
- Cannot reflect any direct or indirect activities related to providing a direct medical service;
- Cannot be an integral part or extension of a direct medical service, such as patient follow-up, patient assessment, patient education, counseling (including pharmacy counseling), or other physician extender activities;
- May not generally include any cost of general public health initiatives that are made available to all people, unless the activities related to assisting Medicaid-eligible individuals are specifically identified;
- May not include any cost of activities related to the operation of a provider facility, such as the supervision and training of providers. Such services are properly paid for as part of the payment made for the medical or remedial service. Because Medicaid providers have agreed to accept service payment as payment in full, such providers may not claim an additional cost as administrative cost under the Medicaid state plan; and
- May not include activities related to the operation of an agency whose purpose is other than the administration of the Medicaid program, unless that agency directs some fraction of its efforts to Medicaid-allowable activities and accurately identifies that fraction.

The SMA is the only entity that may submit claims to CMS to receive FFP for allowable Medicaid administrative costs. Costs incurred for the provision of Medicaid services by qualified providers are typically paid through the state's payment methodology for covered services authorized under the Medicaid state plan. States may enter into interagency agreements or contractual arrangements for the performance of Medicaid administrative activities. If the state has entered into an interagency agreements or contractual arrangement with a provider to perform allowable administrative activities on behalf of the state, and those allowable administrative activities conducted by providers are not covered under the service payment

[35] See pages 74-75 of CMS' May, 2023 guidance: Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming.

methodology and/or are excluded from the payment methodology, it may be possible for the state to pay the provider for the performance of those activities and claim those expenditures for FFP at the applicable administrative matching rate.

To claim FFP for administrative expenditures, states must include cost identification procedures in a PACAP in accordance with 45 C.F.R. Part 95 Subpart E, which may be further supplemented by a Medicaid administrative claiming plan. The PACAP outlines all functions performed by the state related to the public assistance program and how it assigns the costs of performing these functions to all relevant entities within the state, including vendors and contractors. The PACAP submission includes both a narrative section as well as financial documents that are used to allocate costs from the aggregate costs incurred from running the entire program to each entity that performs specific activities and incurs costs. CMS recommends that states supplement their PACAP by obtaining CMS approval for a Medicaid Administrative Claiming (MAC) Plan describing their Medicaid administrative claiming allocation methodology in support of such expenditures.

The guidance below is specifically applicable to allowable state program administrative activities performed by the SMA, or an entity performing functions on behalf of the SMA via a contract or an interagency agreement.

Mobile Crisis Intervention Services and Call Centers

CMS issued "Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services".[36] which clarified that states may claim administrative match for SMA crisis response costs provided the state has an appropriate claiming mechanism and cost allocation methodology. This includes but is not limited to:

- Establishing and supporting delivery of community-based crisis intervention services for people with MH conditions or SUD; and
- Dispatching mobile crisis teams as needed to assist Medicaid beneficiaries.

States may be able to claim Medicaid administrative FFP for staff costs associated with the support of local crisis services.

States may be able to claim Medicaid administrative FFP for staff costs associated with the support of local crisis services and crisis call response functions, including some administrative costs associated with 988 crisis call centers. Medicaid can support crisis call response functions ***only to the extent and proportion that these functions serve Medicaid beneficiaries.*** CMS discussed the possibility of administrative FFP for associated costs, including allocation requirements, in a previous all-state call.[37]

CMS is available to provide assistance to states to discuss options for meeting the regulatory requirements and the availability of FFP for associated administrative costs.

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[36] See State Health Official letter # 21-008; Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services.

[37] CMS discussed the possibility of administrative FFP for associated costs during the Mobile Crisis Intervention Centers Administrative Claiming portion of the January 25, 2022 All-State Medicaid and CHIP Call.

Medicaid Mechanized Claims Processing Enhanced Funding

Under section 1903(a)(3) of the Act, SMA expenditures may be eligible for enhanced federal matching rates where CMS determines that an enhancement to the state's Mechanized Claims Processing and Information Retrieval Systems (MCPIRS) that make up the state's Medicaid Enterprise System (MES) is likely to provide more efficient, economical, and effective administration of the Medicaid state plan. MCPIRS is inclusive of, but not limited to, the Medicaid Information Management System (MMIS), the Eligibility and Enrollment system (EE), and the Data Warehouse/Decision Support System (DW/DSS).

SMAs may request enhanced funding to enhance the MCPIRS to offer services to support the implementation of 988 crisis call centers, hotlines, and mobile crisis stabilization.[38] MCPIRS updates, changes, or enhancements for services to support the implementation of 988 crisis call centers, hotlines, and mobile crisis response framework could include but are not limited to:

- Modify the MMIS to enroll eligible 988 crisis center responders, counselors, and providers authorized by the Medicaid state plan;
- Add new providers to the MMIS based on new crisis services provider types and evolving credentials as authorized by the Medicaid state plan;
- Establish functionality in the MMIS to receive and respond to requests for Medicaid-enrolled provider information from 988 crisis center providers, responders, and crisis counselors;
- Modify the MMIS to receive and respond to crisis call center or 988 crisis services hotline requests for prior authorization of services for Medicaid-enrolled members;
- Update the MMIS to respond to Medicaid-enrolled 988 crisis center provider requests for payment status with a x12 277 Health Care Information Status Notification transaction;
- Change the MMIS or E&E system to receive eligibility inquiry from Medicaid enrolled 988 crisis center providers via x12 Health Care Eligibility Benefit Inquiry and Response (270/271) inquiry transactions using CAQH CORE Rules;
- Add new Healthcare Common Procedure Coding System (HCPCS) codes to the MMIS specific to mobile crisis services and the 988 crisis services hotline as authorized by the Medicaid state plan;
- Modify the MMIS to receive eligibility inquiry from Medicaid enrolled 988 crisis center providers via National Council for Prescription Drug Programs (NCPDP) Retail Pharmacy Eligibility transaction;
- Establish a real time service in the MMIS to receive claims x12 837 Health Care Claim fee-for-services claims transactions from Medicaid enrolled 988 crisis center providers;
- Make other changes or enhancements to the MMIS or E&E systems related to paying Medicaid-enrolled crisis center providers for Medicaid-covered services or enrolling individuals into Medicaid; and
- Develop the required CMS outcomes, metrics, data, and necessary for continued reporting.

Authorization for enhanced funding for the MCPIRS systems requires the submission and prior approval of an Advance Planning Document (APD), acquisition solicitation documents, and

[38] For more information on the CMS initiative to foster integrated business and information technology transformation across Medicaid, see Medicaid Information Technology Architecture Framework.

contracts in accordance with 45 C.F.R. 95.610 and 95.611[39] respectively. An SMA may submit an APD requesting prior approval of enhanced federal funding for the design, development, and installation (including planning), as well as the operation (including maintenance), of their MCPIRS. The APD request must describe the Medicaid requirements, outcomes,[40] conditions for enhanced funding, measures, metrics and reporting that will be provided on an on-going basis to CMS. CMS defines the conditions for enhanced funding in 42 C.F.R. §433.112 for design, development, and installation activities and 42 C.F.R. 433.116 for operations activities.[41] Interested SMAs should refer to 45 C.F.R. Part 95 Subpart F,[42] Streamlined Modular Certification guidance,[43] and 42 C.F.R Part 433 Subpart C[44] for more information.

Not all costs associated with the 988 crisis service, hotline, and mobile crisis response are eligible for enhanced Medicaid funding. States may reference SMDL #16-004[45] for a general reference of allowable costs. Costs must be determined allowable, necessary, reasonable, and support the Medicaid outcomes that benefit the SMA, to include cost allocation if necessary. Federal regulations will require state Medicaid agencies to properly allocate the costs of changes or enhancements to MMIS and E&E between Medicaid and CHIP if they are both benefiting programs in accordance with 45 C.F.R. 95.631.[46]

Systems directly supporting 988 crisis call centers, hotlines, and mobile crisis services that do not meet the definition of MCPIRS as defined under 42 C.F.R. 433.111 are not eligible for the enhanced Medicaid funding under section 1903(a)(3) of the Act.[47] Certain functionality that supports Medicaid programs such as data sharing and interfaces to support care coordination for Medicaid beneficiaries may qualify with the appropriate cost allocation. CMS did not receive new appropriations authority under the CAA for 988 systems; current appropriations are limited to MCPIRS and electronic visit verification. States should allocate 988 systems costs to other funding sources such as the SAMHSA grant.

States should contact their MES State Officer for more information.

Financing of Crisis Response, Mental Health, and Substance Use Disorder Services through Fee-for-Service Delivery Systems

State Medicaid/CHIP agencies have multiple options regarding how to fund the non-federal, or state share, of Medicaid and CHIP payments for crisis response, MH, and SUD services provided to Medicaid/CHIP beneficiaries. Allowable funding sources of the non-federal share for these services may come from state legislative appropriations, Intergovernmental Transfers (IGTs), and Certified Public Expenditures (CPEs). State legislative appropriations are general revenue funds appropriated by the state legislature directly to the state Medicaid/CHIP agency to pay for

[39] See 45 C.F.R. Part 95 Subpart F.
[40] See Centers for Medicare & Medicaid Services Streamlined Modular Certification.
[41] See 42 C.F.R. Part 433 Subpart C.
[42] See 45 C.F.R. Part 95 Subpart F.
[43] Centers for Medicare & Medicaid Services (April 14, 2022) SMD #22-001 Updated Medicaid Information Technology Systems Guidance: Streamlined Modular Certification for Medicaid Enterprise Systems.
[44] See 42 C.F.R. Part 433 Subpart C.
[45] Centers for Medicare & Medicaid Services (March 31, 2016) SMD #16-004 Mechanized Claims Processing and Information Retrieval Systems-Enhanced Funding.
[46] See 45 C.F.R. §95.631.
[47] See 42 C.F.R. §433.111.

Medicaid/CHIP expenditures. IGTs are a transfer of governmental funds from a unit of government to the Medicaid state agency for use in the Medicaid program. CPEs allow units of government to certify that they have expended amounts during a defined period that constitute a Medicaid expenditure for Medicaid-covered services and allowable activities. The SMA must provide the non-federal share of the payment for Medicaid services from a permissible source of funding consistent with sections 1903(a) and 1903(w) of the Act and implementing regulations in 42 C.F.R. Part 433, Subpart B. These provisions extend to sources of the non-federal share of financing for CHIP through 42 C.F.R. § 457.628. The SMA, and providers, are responsible for maintaining auditable documentation of services to support claims for FFP.[48]

As the Medicaid program is generally the payer of last resort, states can only claim Medicaid expenditures for covered services provided to Medicaid beneficiaries after applying the Coordination of Benefits and Third- Party Liability requirements to Medicaid beneficiaries' claims. In addition, the definition of medical assistance at section 1905(a) of the Act would preclude FFP from being paid on expenditures for services provided to non-Medicaid beneficiaries.

Methods of Medicaid and CHIP FFS Rate Setting for Crisis Response, Mental Health, and Substance Use Disorder Services

In general, state Medicaid agencies have considerable flexibility in establishing FFS payments for providers of Medicaid services as long as the payments are in alignment with section 1902(a)(30)(A) of the Act that requires state Medicaid agencies to "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Federal funds for Medicaid services, including crisis response, MH, and SUD services, are only available for services rendered to individuals enrolled in Medicaid[49] that receive covered Medicaid service(s), which are furnished by qualified providers enrolled in Medicaid in accordance with the approved Medicaid state plan.

States wishing to add or modify a payment methodology for existing crisis response, MH, and SUD services in their state plan will need to conduct public notice consistent with 42 C.F.R. § 447.205 and submit a state plan amendment requesting to amend the appropriate payment pages (for example Medicaid FFS, non-institutional payments would be updated in the Medicaid state plan Attachment 4.19-B pages). States may make their payment methodology effective no earlier than one day after public notice is issued, and no earlier the first day of the quarter the state plan amendment is submitted. If required, states must also conduct tribal consultation, under section 1902(a)(73)(A), before state plan amendment submission.

Implementing regulations at 42 C.F.R. § 430.10 require that the state plan be a comprehensive written statement containing "all information necessary for CMS to determine whether the plan can be approved as a basis for FFP in the state program." To be comprehensive, payment methodologies should be understandable, clear and unambiguous. In addition, because the plan is the basis for FFP, it is important that the plan language provides an auditable basis for

[48] 42 C.F.R § 431.107; 42 C.F.R. § 431. 17.
[49] Sections 1902(a)(10), 1903(a), and 1905(a) of the Act.

determining whether payment is appropriate. All claims for FFP to the federal government must be adequately supported by underlying documentation that allows CMS and relevant oversight bodies to verify the expenditures associated with the claim.
States may use the following types of payment methodologies in the state plan.

1. Actual rates paid to providers (i.e., fee schedule rates or actual rates listed in state plan pages);
2. A methodology that details the precise formula explaining how rates are set (e.g., bundled payment, cost-based rate calculated using cost reports, payment at a percentage of specified fee schedule rate, published Medicare rates, a base rate with an annual inflation factor applied); or
3. Payment at actual, reconciled cost through settlement of a cost report.

Rates for telehealth services can consider additional costs incurred by providers to deliver services through telehealth, costs associated with the time and resources spent facilitating care where the beneficiary is located, and appropriate ancillary costs, such as technical support, transmission charges, and equipment necessary for delivering services via telehealth.

When setting payment rates for crisis response, MH, and/or SUD services, states may consider all costs associated with the provision of the medical service (e.g., salaries, fringe benefits, supplies, and equipment). States will only receive FFP for payments made for services provided to eligible Medicaid beneficiaries. When developing a rate-setting methodology for crisis response and related services, a state should consider their existing infrastructure, services, and provider network in addition to their desired goals, population, and outcomes for their programs. For example, crisis services are often more expensive than routine behavioral health services because of the additional challenges of recruitment of an already limited workforce for an intense and primarily in-person service in the era of telehealth and significant market competition. Other factors such as the geography and the impact on staffing patterns should also be considered.

FFS Bundled Payments for Crisis Response, Mental Health and Substance Use Disorder Services

States have used bundled payments as a mechanism to pay for crisis response, MH, and SUD services provided to Medicaid beneficiaries. Bundled payments can be developed to pay for multiple units of a single service delivered over a period of time (e.g., personal care services), multiple services within a single benefit category (e.g., assertive community treatment rehabilitative services), or multiple services across benefit categories delivered over a period of time (e.g., CCBHCs). CMS has issued detailed guidance on bundled and comprehensive payment methodologies on Medicaid.gov.[50] Given the flexibility states have around setting payment for Medicaid services, CMS is available to provide assistance to states as they develop payment proposals for crisis response, MH, and SUD services in their state.

[50] See Bundled Payments and Federal Requirements for Comprehensive State Plan Payment Methodologies.

FFS Payments for Crisis Response, Mental Health, and Substance Use Disorder Services Provided Via Telehealth

States have broad flexibility under Medicaid statutes and regulations in designing payment requirements for crisis response, MH, and SUD services delivered via telehealth and should consider whether they will pay the same rate for services delivered via telehealth or in person. Rates for telehealth services can consider additional costs incurred by providers to deliver services through telehealth, costs associated with the time and resources spent facilitating care where the beneficiary is located, and appropriate ancillary costs, such as technical support, transmission charges, and equipment necessary for delivering services via telehealth. States must submit a state plan amendment with Attachment 4.19-B payment pages if they want to provide payment for services or components of services delivered through telehealth differently than what they currently pay for face-to-face services or if they want to pay for ancillary costs. States paying for ancillary costs would need a payment methodology that specifies the ancillary costs and circumstances when those costs are payable. The ancillary costs must be directly related to a covered Medicaid service provided via telehealth and properly allocated to the Medicaid program. Further detail on paying for services provided via telehealth can be found in the Medicaid and CHIP Telehealth Toolkit.[51]

General Methods of Medicaid and CHIP Managed Care Rate Setting for Crisis Response, Mental Health, and Substance Use Disorder Services

In a Medicaid managed care delivery system, states contract with managed care plans to provide or arrange for a specified package of Medicaid services for enrollees. Managed care plans are typically paid capitation payments, which are fixed amounts paid to the managed care plans, usually on a monthly basis. Capitation rates are typically established prospectively and remain in effect for a 12-month rating period.[52] States have considerable flexibility in developing capitation rates, and federal oversight includes a review for actuarial soundness and that they are developed in such a way that managed care plans can reasonably meet minimum medical loss ratio requirements. Managed care plans are responsible for developing provider networks and negotiating provider payment rates for the covered services in their contract.

There are a variety of mechanisms that states may use to promote continuum of crisis services within a Medicaid managed care delivery system. For example, states can use contract provisions, such as an incentive or withhold arrangement[53] to encourage plans to implement care coordination across medical and nonmedical contexts, contract with community-based organizations with expertise in delivering a continuum of crisis services. States can also organize regular meetings to facilitate their managed care plans working collaboratively with each other to share promising practices and initiatives to encourage broader adoption.

[51] For more information, see the Medicaid & CHIP Telehealth Toolkit.
[52] 42 CFR 438.2.
[53] 42 CFR 438.6(b)(2)-(3).

6. Coordinating Medicaid and CHIP Funding with Other Payors and Sources of Federal Funding Crisis Response Services

There are multiple ways states can utilize multiple sources of funding to increase the supply, quality, and access to their programs that provide crisis response, MH, and SUD services. States should consider their goals, populations they plan to serve, and desired outcomes of their programs to identify funding sources that align with their objectives and desired framework for providing these services. States should consider all available funding sources, including those outside of Medicaid, to develop a robust and sustainable funding mechanism to support the provision of these services in their state. States that design programs to address the crisis, MH, and SUD needs of their state that is beyond what is coverable in Medicaid may do so by utilizing other funding sources outside of Medicaid, such as funding from federal, non-federal, and state grants, other federal agencies, or state-only, funds. For the portion of their programs that are coverable under Medicaid, states may claim Medicaid and CHIP expenditures for covered services provided to Medicaid beneficiaries (including state plan, waiver, and demonstration services), and associated administrative activities. Please note, as Medicaid is generally the payer of last resort, states must have requirements in place to ensure that payment is sought from any responsible third party where services are furnished to a Medicaid beneficiary. Payments from liable third parties that offset a state's Medicaid expenditures must be properly accounted for when claiming FFP. In addition, federal funds may not be used as non-federal share to draw down additional federal matching funds for Medicaid and CHIP program expenditures, as specified by federal regulations in 42 C.F.R. § 433.51(c).

7. Strategies and Best Practices for Measuring and Monitoring Utilization and Outcomes of Crisis Response Services

Data collection and evaluation of behavioral health crisis services is essential to developing and maintaining a BHCSCC that is responsive to the unique and evolving needs of the community. Evaluation also adds to the field of knowledge on evidence-based and evidence-informed practices and the degree of their effectiveness in different communities and contexts.

Data metrics for behavioral health crisis services should be identified based on their utility in supporting continuous quality improvement efforts. Communities should use data for early identification of community service needs and gaps, to develop an inventory of existing resources and assets, and to guide system improvement. Communities should select and apply an evaluation framework that will help achieve evaluation goals and provide results that can inform evidence-based decision-making. In addition to identifying local capacity and need, long-term outcomes and impacts should focus on the impact on health, reduced costs, care experience, implications on workforce, and the impact on advancing access to care.

Standardized definitions are essential. It is important for there to be alignment both on how services are defined, and on the key operational and quality metrics that can support performance monitoring and evaluation of services. Introducing variability into data definitions and standards creates barriers to making cross-site comparisons or to evaluate the system in its entirety at the national level.

Guiding Principles for Evaluating Crisis Response Services

Crisis services in behavioral health rely upon strong ethical and practice standards. Thorough, methodological evaluations and data collection approaches are crucial for improving public health actions. These evaluations should be useful, realistic, ethical, and accurate. To achieve this, evaluators should use the scientific method and have proper training to ensure their findings are credible and trustworthy. Stakeholder involvement is vital at every stage of the evaluation process, including conceptualizing the evaluation and selecting the approach.

In addition, evaluation data collection efforts should seek to understand the broader context in which services are provided. This includes assessing both the intended outcomes of crisis services and any unexpected effects. It should involve input from stakeholders, including those with lived experience, to ensure that the information is relevant and useful. This approach leads to better service delivery and health outcomes for diverse communities.

Transparency is also an important consideration; evaluators should identify the needs of service users early in the process and encourage open communication. When reporting results, it is essential to present a full picture, including positive and negative findings, while being clear about any conflicts of interest.

Steps in Evaluation

The six connected steps of the framework provide a starting point to tailor an evaluation for a particular program, at a particular point in time. The steps are as follows:[54]

1. Assess the context.
2. Describe the program.
3. Focus the evaluation question design.
4. Gather credible evidence.
5. Generate and support conclusions.
6. Act on findings.

Logic Models

Logic models are visual representations of the relationships among system or program inputs, activities, outputs, outputs, outcomes, and impacts.[55] They communicate the purpose of the system or program, who the contributors and partners are, the desired outcomes and impacts, and the specific mechanisms by which the goals will be achieved.

Evaluation of the BHCSCC and crisis services should begin with a logic model to provide a visual overview of the system or program depicting its resources, planned activities, and intended outcomes. This provides an invaluable resource to which leaders and evaluators can refer during implementation and continuous quality improvement.[56]

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[54] Centers for Disease Control and Prevention. (2024). CDC Program Evaluation Framework.
[55] Centers for Disease Control and Prevention. (n.d.). State Heart Disease and Stroke Prevention Program Evaluation Guide: Developing and Using a Logic Model.
[56] Centers for Disease Control and Prevention. (n.d.). State Heart Disease and Stroke Prevention Program Evaluation Guide: Developing and using a logic model.

Data Governance

Data governance refers to the necessary frameworks, policies, and protocols developed by an agency or organization to manage all aspects of data collection. Evaluation data collection should be anchored by a detailed data governance plan that should account for the following aspects:[57]

- **Data Quality:** Processes to ensure data is collected in an accurate and uniform manner.
- **Data Security:** Protocols in place to ensure data will be protected and only accessed by authorized individuals, including the handling of protected health information (PHI).
- **Data Sharing/Transparency:** List of audiences for each type of data and necessary considerations for each; processes and mechanisms for data sharing and data access; and routine measures in place to ensure data collection efforts are known and accessible to all relevant stakeholders/community members. This may include data type, standards, and access/reuse considerations.[58]
- **Data Integration:** List of any external data sources and processes for data aggregation and usability.
- **Compliance:** List of any legal/regulatory requirements pertinent to data collection, storage, and sharing, and the measures taken to meet these requirements.

By maintaining an effective data governance plan, BHCSCCs can ensure transparent, effective, and safe data collection, sharing, and storage.

Quality Improvement

In addition to collecting data on program outcomes and impact, a key application of data in a BHCSCC is to drive continuous quality improvement. This involves collecting and analyzing data to pinpoint both strengths and weaknesses within services and operations, allowing for real-time corrections. Quality improvement evaluation processes should include the collection of both quantitative and qualitative data. In addition, it is important to assess how processes and procedures affect the overall BHCSCC and critical partners, including individuals with lived experience, crisis services workers across the three essential elements, EDs, law enforcement, and others.

Data and Evaluation Workforce Challenges

Difficulties in hiring trained evaluators and facilitating effective data management can lead to an absence of evaluation and data collection efforts. Alternatively, using individuals who lack sufficient expertise could lead to efforts that are not rooted in evidence-based practices or that render inaccurate or incomplete data, all of which could contribute to programmatic decisions and management practices that are inconsistent with accurate evidence. Some agencies and organizations address this workforce challenge by partnering with local universities, which can offer expertise in data collection and provide the necessary infrastructure. These partnerships can help ensure that data are collected, managed, and analyzed in accordance with evaluation best practices and that data and evaluation results are made accessible to all participating entities.

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[57] Ladley, J. (2019). Data Governance: How to Design, Deploy, and Sustain an Effective Data Governance Program. Academic Press.
[58] See National Institutes of Health. (n.d.). Complying with the HEAL Data Sharing Policy.

Additional Resources

The following tools and resources can be used to support and inform data collection and evaluation efforts.

- The Centers for Disease Control and Prevention's Program Evaluation Framework is a guide for conducting evaluation for public health professionals. It is a nonprescriptive, practical tool, designed to summarize and organize the essential elements of program evaluation.[59]
- National Council for Mental Wellbeing's Quality Measurement in Crisis Services offer options for crisis services metrics from a human engineering, systems-level, performance improvement perspective. This resource provides a helpful framework for a person-centered approach to data collection.

8. Conclusion

CMS and SAMHSA are available to work with states seeking to implement evidence-based crisis response services.[60] Technical assistance (TA) is available through the National TA Center or through the mailbox (CrisisTACenter@cms.hhs.gov). States may also request technical assistance through their CMS State Lead.

Sincerely,

/s/

Caprice Knapp, PhD
Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services

/s/

Arthur Kleinschmidt, Ph.D., MBA
Principal Deputy Assistant Secretary
Substance Abuse and Mental Health
Services Administration

[59] Centers for Disease Control and Prevention (2024, August 20) CDC Program Evaluation Framework.
[60] See: https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance.

Appendix A: Essential Services and Supports

Essential Services and Supports	Description	Resources to Inform Services and Supports
Triage and screening	○ Determine the needs and level of risk of the person in crisis. ○ Assess for the most appropriate response options by balancing person-centered care, autonomy, culture, psychosocial needs, safety considerations and available resources. ○ Decide whether support from law enforcement, emergency. medical services (EMS), or other public safety first responders are needed (but minimizing their involvement unless truly warranted). ○ Screen for suicide using a validated screening measure, such as the Columbia Suicide Severity Rating Scale—Screen Version. ○ Screen for problematic substance use and active substance intoxication and/or withdrawal. ○ Identify communication barriers and provide needed adaptations for quality, equitable service access. ○ Gain awareness of other factors to be considered in response (e.g., people with intellectual and developmental disorders, physical or sensory needs) and any needed assistive technology.	○ Columbia Suicide Severity Rating Scale—Screen Version ○ National Institute of Mental Health's Ask Suicide-Screening Questions Toolkit ○ Zero Suicide (includes toolkits and resources on suicide screening, prevention, and safety planning) ○ The University of New Mexico's Mobile Crisis Team Screening and Assessment Tools and Procedures, which includes triage scales and MH screeners ○ Clinical Opiate Withdrawal Scale ○ Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised ○ Patient Health Questionnaire (example questions)

Essential Services and Supports	Description	Resources to Inform Services and Supports
Clinical Assessment with the support of evidence-based screening and decision-support tools	○ Conduct an assessment tailored to the specific crisis situation. If ongoing services are planned, a more comprehensive assessment, performed by a behavioral health professional and possibly using evidence-based, validated assessment tools may be helpful, if time allows. However, an abbreviated assessment may be more appropriate during an acute crisis. At a minimum, an assessment should cover the following): ▪ Information leading up to the crisis situation and clarification of the presenting crisis; ▪ A safety and risk assessment (e.g., suicide, harm to others); ▪ The person's psychiatric history (including history of suicide attempts, overdose, violence) and current functioning; ▪ History of trauma; ▪ Current and previous medication use (especially psychiatric medication); ▪ History of inpatient and outpatient behavioral health care; ▪ Situations that could initiate or exacerbate a behavioral health crisis; ▪ Strengths, resiliencies, and coping skills; ▪ Available resources and supports (natural and professional); ▪ Whether they have a Psychiatric Advance Directive (PAD), Wellness Recovery Actions Plan (WRAP), or other self-directed recovery management tool and its contents; ▪ Relevant legal history (on probation or parole); ▪ Medical history, as relevant; and ▪ Relevant personal considerations. ○ History from family, other trusted supporters, peer support providers, as relevant and/or appropriate.	○ Crisis Assessment Tool (CAT) – Praed Foundation ○ Clinical Practice Guidelines for Assessment and Management of Patients Presenting with Psychosocial Crisis ○ The University of New Mexico's Mobile Crisis Team Screening and Assessment Tools and Procedures, which includes MH assessment tools for adults, children, and youth ○ SAFE-T Suicide Assessment Five Step Evaluation and Triage ○ Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) ○ Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) ○ Consider supplemental documents that can be left with the person and their family to gather additional information for the follow-up meeting on things such as situations to avoid, strengths, resiliencies and available resources and supports.

Essential Services and Supports	Description	Resources to Inform Services and Supports
De-escalation/ conflict resolution	○ Utilize therapeutic and trauma-informed de-escalation techniques to help the person feel calm, promote everyone's safety, and avoid unnecessary utilization of services at a higher level of care.	○ A full-text journal article, "Psychiatric Emergencies: Empowering Connections to De-escalate Aggression" ○ Texas Medical Library Trust's de-escalation techniques and resources, which includes videos demonstrating techniques ○ University of Memphis's presentation, "Crisis Intervention and De-escalation Techniques" ○ Crisis Prevention Institute's resources on crisis de-escalation training
Peer support	○ Include trained and experienced peer support and family peer support providers with lived experience of behavioral health disorders. This can help the person in crisis, the family, or primary caregiver feel understood, supported, and respected. ○ Peer and/or family peer support workers can also help people engage with family or other supports they choose, and advocate for the wishes of the person in crisis. ○ Peer support services are always voluntary for the people in crisis.	○ SAMHSA Advisory, "Peer Support Services in Crisis Care" ○ NASADAD issue brief, "Integrating Peer Recovery Support Services Into Substance Use-Related Crisis Care: A Brief for States" ○ SAMHSA brochure, "Family, Parent and Caregiver Peer Support in Behavioral Health" ○ SAMHSA's "Core Competencies for Peer Workers"
Overdose prevention and response	○ Training, distribution, and administration of opioid overdose reversal medications; ○ Access to drug-checking supplies; ○ Access to and coordination with sobering centers; and ○ Communicable disease screenings.	○ SAMHSA Toolkit, "Overdose Prevention and Response"

Essential Services and Supports	Description	Resources to Inform Services and Supports
Coordinated care for needed follow-up services (e.g., MH disorder and SUD treatment, medical, social)	○ Coordinate access to community-based and/or in-home services post-crisis to provide care and prevent future events. Services and supports can include: ▪ General somatic health care (including both primary care, specialized care, and Tribal and urban Indian health services), when possible and applicable; ▪ Intensive behavioral health treatment programs such as Assertive Community Treatment (ACT) and Partial Hospitalization Programs; ▪ Community outpatient mental disorder and/or SUD treatment (with connections made as soon as possible, ideally in 48 hours or less); ▪ For people experiencing a withdrawal-related SUD crisis, withdrawal management facilities, ambulatory and inpatient withdrawal management, opioid treatment programs, and sobering centers; ▪ Access to programs that provide medications for SUD treatment (including both opioids and alcohol use disorders); ▪ Family support services; and ▪ Application for health insurance and basic needs. ○ Enrollment in other recovery support services the person desires	○ Sample coordinated care referral form from the Connecticut State Department of Children and Families ○ The Council of State Governments Justice Center, "Building a Comprehensive and Coordinated Crisis System"

Essential Services and Supports	Description	Resources to Inform Services and Supports
Crisis planning, stabilization, and follow-up	○ Provide follow-up care that addresses factors potentially leading to recurrence of a crisis event, such as: ▪ Creating a suicide safety plan for people experiencing suicidal ideation and behavior (specifically address access to lethal means and, if needed, protocols for securing Extreme Risk Protection Orders (ERPOs) ▪ Engaging the person in crisis planning, such as creating a Wellness Recovery Action Plan that can be used to avoid or address a crisis; and ▪ Developing safety plans to address potentially dangerous situations (e.g., potential violence in the home, access to medications, opioid education and distribution of opioid overdose reversal medications). ○ Where possible, provide in-person, appropriate follow-up to assess the person's safety, determine whether they have engaged in needed services, and evaluate whether they need help accessing additional supports (childcare, caregiving role coverage, and pet care). ○ Explore with the person a preferred response in the event of a future crisis, including advance permission or advanced directives for communication between responders, providers, family, and other support entities, or alert information they would like added for contact center and crisis responders' awareness (e.g., a person with autism who is uncomfortable with any loud noises).	○ The Suicide Prevention Resource Center's Safety Planning Guide Quick Guide for Clinicians ○ Stanley-Brown Safety Planning Intervention ○ Sample Wellness Recovery Action Plan ○ SAMHSA's "Safety Plans Work," a fillable safety plan form ○ The National Wraparound Initiatives' Wraparound Basics: Frequently Asked Questions for families and children and youth with MH - or SUD-related needs ○ National Association of State Mental Health Program Directors' brief, "A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth" ○ Sample crisis services follow-up survey tool from the University of Wisconsin–Green Bay ○ Presentation from Medi-Cal (California's state Medicaid program), "Best Practices for Aftercare and Follow-Up Strategies in Mobile Crisis Services" ○ SAMHSA's guide, "A Practical Guide to Psychiatric Advance Directives"