Medicaid Section 1115 Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Demonstrations: State Actions to Deliver Crisis Stabilization Services

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RTI International

Introduction

Crisis stabilization services help an individual de-escalate their level of distress associated with a mental health disorder.[1] These services most often include 24-hour crisis call centers that provide immediate, telephonic de-escalation services with a trained mental health practitioner; mobile crisis teams that travel to an individual in crisis and provide in-person services; and crisis stabilization units,[2] small facilities where individuals can present in an emergency and receive in-person treatment. Crisis stabilization services are an integral component of the care continuum for individuals with serious mental illness (SMI)/serious emotional disturbance (SED). Successful stabilization can prevent psychiatric hospitalization, ensure referrals to community-based treatment providers, and avert arrest and incarceration for individuals engaging in unlawful behavior during a crisis.

The availability of crisis stabilization services varies across the United States. For example, according to the 2022 National Substance Use and Mental Health Services Survey, less than 10 percent of Maine's Medicaid-accepting mental health facilities offer a crisis intervention team whereas 75 percent of Arkansas' Medicaid-accepting mental health facilities offer these services.[3]

The Centers for Medicare & Medicaid Services (CMS) is focusing on improving access to high-quality crisis care for Medicaid beneficiaries. In 2018, CMS released the opportunity for states to apply for the section 1115 SMI/SED demonstration, which offers states flexibilities to design activities aimed at improving the continuum of care for individuals with SMI or SED, including increasing access to crisis stabilization services. In 2021, CMS awarded $15 million in planning grants to 20 state Medicaid agencies to develop a state plan amendment (SPA), section 1115 demonstration application, or section 1915(b) or 1915(c) waiver request (or an amendment to an existing waiver) to provide qualifying community-based mobile crisis intervention services.[4] Six section 1115 SMI/SED demonstration states (Alabama, Maryland, New Mexico, Oklahoma, Utah, and Vermont) were awarded planning grants for community-based mobile crisis intervention services. Additionally, states have the opportunity granted through the American Rescue Plan Act of 2021 to implement a state option to provide qualifying community-based mobile crisis intervention services for Medicaid beneficiaries and receive increased federal Medicaid matching funds of 85 percent for those services during a five-year period beginning in April 2022.[5]

This report is part of a series of rapid cycle reports intended to share early findings and insights about section 1115 SMI/SED demonstrations. This report uses state program documents and interviews with state Medicaid agency and behavioral health agency officials to summarize the strategies states are using to expand access to crisis stabilization services and the enabling factors and challenges states experience during implementation.

Specifically, this report addresses the following three objectives:

1. Describe state strategies to increase availability of crisis stabilization services.
2. Describe state-reported policies, programs, and contextual factors that enable expansion of crisis stabilization services.
3. Describe state-reported challenges to increasing crisis stabilization services and how states are addressing or plan to address these challenges.

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[1] Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *Crisis services: Effectiveness, cost-effectiveness, and funding strategies*. SMA-14-4848. https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4848.pdf

[2] National Alliance on Mental Illness (NAMI). (2015). *Crisis services*. https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/Crisis-Service-FS.pdf

[3] Author's analysis of the 2022 National Substance Use and Mental Health Services Survey (N-SUMHSS) data. Data available from https://www.datafiles.samhsa.gov/dataset/national-substance-use-and-mental-health-services-survey-2022-n-sumhss-2022-ds0001.

[4] Centers for Medicare & Medicaid Services. (2021). *State planning grants for qualifying community-based mobile crisis intervention services*. https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-community-based-mobile-crisis-intervention-services/index.html

[5] Centers for Medicare & Medicaid Services. (2021). *Medicaid guidance on the scope of and payments for qualifying community-based mobile crisis intervention services.* SHO 21-008. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf

About Section 1115 SMI/SED Demonstrations

Improving care for Medicaid-enrolled adults with SMI and youth with SED through innovative service delivery is a priority for CMS. Section 12003 of the 21st Century Cures Act directed CMS to develop section 1115 demonstration projects for this population. Section 1115 SMI/SED demonstrations allow states to receive federal financial participation (i.e., federal Medicaid matching dollars) for care delivered during short-term stays in institutions for mental disease (IMDs) as long as the state is taking action to ensure quality of care in IMDs and to improve access to mental health care at all levels of intensity as well as recovery support services for Medicaid beneficiaries with SMI or SED. States must also commit to maintaining funding levels for outpatient community-based mental health services and monitor and evaluate demonstration performance.

Goals of section 1115 SMI/SED demonstrations include reducing utilization and length of stay in emergency departments (Eds); reducing readmissions to acute care hospitals and residential settings; improving availability of crisis stabilization, intensive outpatient, psychiatric hospital, and residential treatment setting services; improving access to community-based services and integrated primary and behavioral health care; and improving care coordination and continuity of care after a hospitalization or residential treatment stay.

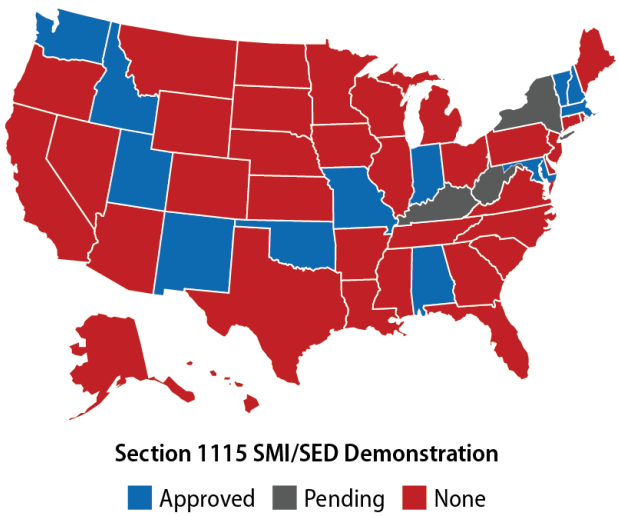
These demonstrations require the state to submit and carry out implementation plans that set forth how the state will meet the following four key milestones on its path to achieving demonstration goals:

1. Ensure quality care in psychiatric hospitals and residential settings.
2. Improve care coordination and transitions to community care.
3. Increase access to a continuum of care and crisis care.
4. Support early identification and engagement in treatment.

Achieving these milestones is expected to lead to successful performance on demonstration goals.

As of February 2024, 12 states and the District of Columbia had received approval for section 1115 SMI/SED demonstrations; 3 states have a pending application (**Figure 1**).

Figure 1. Section 1115 SMI/SED demonstration status as of February 2024



Overview of Findings

States pursued several common strategies to increase availability of crisis stabilization services. Many of these strategies were used prior to the section 1115 SMI/SED demonstration, and states expanded on these services as part of the demonstration. Strategies included:

- Implementing crisis bed tracking so that providers can more easily find an available bed for their beneficiaries.
- Expanding availability of mobile crisis services that travel to an individual in crisis for an onsite assessment.
- Expanding the number of crisis stabilization centers to provide an alternative to receiving crisis care in the ED.
- Incorporating peer supports in mobile crisis services and other crisis stabilization programs to provide treatment and assist in coordinating care.
- Integrating crisis care into criminal justice initiatives to improve law enforcement officers' encounters with individuals with SMI/SED, prevent arrest of individuals with mental illness, and connect individuals in crisis to treatment.
- Using behavioral health crisis call centers to deliver immediate crisis care and integrating state crisis support hotlines into the national 988 Suicide & Crisis Lifeline.
- Offering respite care and in-home support for vulnerable populations, such as children, who may benefit from receiving crisis care in the home rather than a crisis stabilization center.

State officials reported some common facilitators that supported increasing the availability of crisis stabilization services:

- Leveraging the national implementation of 988 the Suicide & Crisis Lifeline to re-assess local capacity to deliver crisis stabilization services.

- Using telehealth to deliver crisis stabilization services, particularly during the COVID-19 pandemic.
- Working with partners such as schools, behavioral health departments, and local law enforcement to coordinate the delivery of crisis stabilization services.
- Relying on existing crisis stabilization programs and existing funding to expand state crisis initiatives.

State officials identified a few common challenges to increasing the availability of crisis stabilization services:

- Experiencing shortages of providers to deliver crisis care throughout the state.
- Managing provider concerns about state policy changes and implications of those changes for beneficiaries.

Approach

Findings in this report are based on interviews and a review of state documentation submitted to CMS by ten states with approved section 1115 SMI/SED demonstrations (Alabama, District of Columbia, Idaho, Indiana, Maryland, New Hampshire, Oklahoma, Utah, Vermont, Washington) as of November 2022.[6] Videoconference interviews were conducted between August and November 2022 with 32 Medicaid and behavioral health agency officials in the ten states. Interviews with Alabama, Maryland, and New Hampshire were conducted soon after their demonstration implementation plans were approved, and the states had not yet started demonstration activities. As a result, these interviews focused on planned activities and anticipated facilitators and challenges. **Appendix A** provides more information about the data collection methods used.

Results

Milestones 3c and 4c for the section 1115 SMI/SED demonstrations guided states to implement strategies to improve state tracking of available inpatient and crisis stabilization beds and to establish specialized settings and services, including crisis stabilization, for young people experiencing SED/SMI.[7] State officials and state documentation described a variety of strategies to enhance crisis stabilization services, and the most frequently reported are described here (**Exhibit 1**). In many cases, states used the demonstration to expand upon previously established crisis care initiatives.

Common State Strategies

Implementing Crisis Bed Tracking. Crisis beds provide short-term crisis stabilization services and serve as an alternative to psychiatric inpatient hospitalization.[8] Finding available crisis beds in hospitals and residential mental health treatment settings has been an ongoing challenge in the United States, leading to missed opportunities to deliver needed mental health treatment. In response, states began gathering and posting crisis bed availability as a resource to help providers, patients, and families.[9] Without a bed tracking system (otherwise known as a bed registry), individuals or providers often must call multiple facilities to find an available bed that fits the level of care needed.[10] With a bed registry, individuals can view locations of available beds, services provided (including crisis stabilization), and contact information to request a bed. In their implementation plans, eight of the ten states we interviewed reported tracking their crisis stabilization beds prior to the demonstration's implementation. Some state systems are public facing, whereas others are only accessible to providers. Four state implementation plans described plans to expand their use of bed tracking to better identify crisis stabilization beds through the demonstration. For example, before the demonstration Indiana's bed tracking portal focused on general inpatient and substance use disorder beds only; Indiana expanded its efforts to include psychiatric inpatient and crisis stabilization beds in their portal. Motivated by the demonstration's focus on expanding access to crisis care, Maryland created a bed registry advisory committee to evaluate how best to track crisis beds, and the District of

Exhibit 1. Summary of state strategies for expanding crisis stabilization services

- Implementing crisis bed tracking.
- Expanding mobile crisis services.
- Expanding the number of crisis stabilization centers.
- Incorporating peer supports in mobile crisis services and other crisis stabilization programs.
- Integrating crisis care into criminal justice initiatives.
- Using behavioral health crisis call centers to deliver immediate crisis care.
- Offering respite care and in-home support.

[6] For brevity, we refer to states and the District of Columbia as "states" and all respondents as "state officials."
[7] The state Medicaid Director Letter titled "Opportunities to Design Innovative Service Delivery for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance" can be found here: https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf
[8] DC Department of Behavioral Health. (n.d.). *Adult services*. https://dbh.dc.gov/service/adult-services
[9] Mark, T. L., Howard, J. N., Misra, S., & Fuller, L. (2019). Bed tracking systems: Do they help address challenges in finding available inpatient beds? *Psychiatric Services, 70*(10), 921-926. https://doi.org/10.1176/appi.ps.201900079
[10] Mark, T., Misra, S., Howard, J., Mallonee, E., & Karon, S. L. (2019). *Inpatient bed tracking: State responses to need for inpatient care*. Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/reports/inpatient-bed-tracking-state-responses-need-inpatient-care-0

Columbia planned to redesign electronic health records systems and referral practices for their mental health providers to more systematically track open inpatient and crisis stabilization beds to facilitate more timely referrals. Utah is implementing a search engine for providers to find open inpatient and crisis beds.

Expanding Mobile Crisis Services. Mobile crisis units, otherwise known as mobile response stabilization services (MRSS), consist of trained health professionals—typically nurses, mental health therapists, or social workers—who travel to an individual in crisis for an onsite assessment. When possible, mobile crisis units attempt to de-escalate and stabilize the patient at the site. If needed, mobile crisis units will transport patients to an appropriate destination (i.e., crisis stabilization center, a psychiatric hospital ED, a psychiatric inpatient unit, or a general hospital ED). In some demonstration states, mobile crisis services are provided by a community or crisis response team (CRT). CRTs are generally defined as multidisciplinary direct service teams available 24 hours a day, 7 days a week to deliver mobile crisis services, pre-arrest diversion, psychiatric assessments, referrals to community-based care, and short-term care management.[11] Over three-quarters of demonstration states reported having established mobile crisis services prior to the implementation of the demonstration using various funding mechanisms, including Substance Abuse and Mental Health Services Administration (SAMHSA) block grants, CMS's state planning grant for qualifying community-based mobile crisis intervention services, and other grant opportunities available to local governments to implement crisis care. The demonstration allowed these states to expand upon or rethink the design of their current mobile crisis unit initiatives to improve access. For example, the District of Columbia's and Alabama's state documentation discussed plans to merge their mobile crisis units with their CRTs to streamline mobile crisis service delivery. To support these changes, the District of Columbia mentioned a new Medicaid reimbursement method for CRT mobile crisis services. Children and youth may need different approaches to crisis stabilization compared to adults, and the District of Columbia and Oklahoma specifically mentioned operating mobile crisis units for adolescents prior to the implementation of the demonstration in their documentation. Two other states (Indiana and Vermont) reported in state documentation that they will use the demonstration period to explore developing MRSS for youth.

Expanding Crisis Stabilization Centers. Crisis stabilization centers are small facilities or departments within a larger facility (e.g., a wing of a community mental health center [CMHC]) that provide stabilization, evaluation of the presenting mental health disorder, and treatment. The centers provide an alternative to receiving crisis care in the ED of an acute care hospital or in jail. Many centers are designed to admit patients on a voluntary or involuntary basis. Mobile crisis teams, case managers, and police officers can bring individuals to a center or patients can voluntarily walk in and receive help. The goal of crisis stabilization is to divert admissions from inpatient psychiatric units and help an individual de-escalate the psychiatric crisis in a less restrictive environment than a hospital. Crisis centers are effective in diverting patients from a psychiatric admission to a hospital.[12] Most demonstration states already provided crisis stabilization services through crisis centers, and some used the demonstration's goal to increase availability of crisis stabilization services as motivation to add more. Some state officials planned to open additional crisis centers; other state officials planned to increase the number of crisis beds within existing facilities. The demonstration allowed states with crisis centers that qualify as an IMD to receive federal Medicaid matching funds for crisis stabilization services provided to Medicaid beneficiaries in these facilities.

Incorporating Peer Supports in Mobile Crisis Services and Other Crisis Stabilization Programs. Peer support workers (or peers) are individuals with the lived experience of mental health disorders and who have sustained recovery; they join clinical staff in delivering crisis care.[13] Peers promote shared understanding with individuals in crisis,[13] model recovery, offer positive coping strategies, and provide information on available treatments. Peers are often embedded in mobile crisis units, CRTs,[14] or crisis stabilization centers. According to state documentation, a few states (e.g., Washington, Vermont) operated peer-run crisis stabilization centers; a few states (e.g., Alabama, the District of Columbia) reported reimbursing peer counseling or peer recovery offered to Medicaid beneficiaries within crisis stabilization centers, CRTs, and/or mobile crisis teams prior to the demonstration. As a result of the demonstration, Vermont and Maryland reported in state documentation plans to explore expansion of peer supports, including implementing more peer-run crisis stabilization centers, integration of peer supports into the care coordination process for individuals experiencing a psychiatric crisis, and inclusion of peer supports in crisis walk-in centers and behavioral health urgent care centers.

Integrating Crisis Care into Criminal Justice Initiatives. Crisis intervention teams (CIT) are community-based, diversion programs that have the goal of improving law enforcement officers' encounters with individuals with SMI/SED, preventing arrest of individuals with mental illness, and connecting individuals in crisis to treatment.[15] A few states (e.g., District of Columbia, Vermont) already had CITs or criminal justice-based initiatives in place prior to the demonstration. At least one other state, Indiana, planned to pilot a partnership between their MRSS program and their juvenile justice agency during the demonstration period. This pilot program will provide de-

[11] DC Department of Behavioral Health. (n.d.). *Community response team*. https://dbh.dc.gov/service/community-response-team
[12] Pinals, D. A. (2020). *Crisis Services: Meeting Needs, Saving Lives.* National Association of State Mental Health Program Directors. https://store.samhsa.gov/sites/default/files/pep20-08-01-001.pdf
[13] Substance Abuse and Mental Health Services Administration (SAMHSA). (2022). *Peer support services in crisis care*. PEP22-06-04-001. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP22-06-04-001.pdf
[14] Hajny, J., Miccio, S., Bergeson, S., Rae, H., & Lyons, P. (2015). *Peers as crisis service providers.* https://www.nasmhpd.org/sites/default/files/Peers%20as%20Crisis%20Service%20Providers_SAMSHA_6.10.15.pdf
[15] National Alliance on Mental Illness (NAMI). (n.d.). *Crisis intervention team (CIT) programs*. https://www.nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs

escalation services and short-term follow-up and support for youth and their families with a goal of preventing re-escalation, ED use, reincarceration, and/or inpatient psychiatric admissions for youth.

Using Behavioral Health Crisis Call Centers to Deliver Immediate Crisis Care. The Federal Communications Commission (FCC) recently implemented a 3-digit national, suicide prevention and crisis hotline number—988—to make it easier for people to access help during a suicidal or emotional distress crisis. Many states also had their own hotlines prior to the rollout of 988, and several demonstration states reported using their state crisis hotlines to deliver crisis care as a demonstration activity. Some states staffed their hotlines with behavioral health professionals; others used peers. Still others incorporated two-way, real-time text messaging in addition to telephonic support. Only one state official specifically mentioned plans to integrate 988 with their state hotline to ensure that any 988 calls made by individuals in their state are referred to local crisis and mental health treatment services, but other demonstration states likely undertook a similar integration given the expected increase in crisis calls following implementation of the 988 hotline number.

Offering Respite Care and in-Home Support. Crisis respite and in-home support can help a person de-escalate from a psychiatric crisis in a more comfortable residential environment as opposed to an urgent care or institutional facility.[16] Four demonstration states (Alabama, Washington, Idaho, and Vermont) reported—through state interviews and state documentation—plans to continue offering crisis respite and/or in-home support services that were in place prior to the demonstration. Crisis respite centers provide 24-hour observation and support delivered by volunteers and peer supporters; services are typically not provided by clinical mental health practitioners. In-home supports include individual or family counseling, crisis intervention, mental health consultation, family support, and case management provided in a beneficiary's home when separation from the individual's everyday environment is not necessary or would cause additional distress. In-home supports are most commonly used for children and adolescents, although one state's documentation (Alabama) mentioned these services for adults as well.

State-Reported Policies, Programs, and Context That Support Expanding Availability of Crisis Stabilization Services

Leveraging the Federal 988 Suicide & Crisis Lifeline. As previously mentioned, the FCC implemented the 988 national suicide prevention and crisis hotline number to improve access to mental health care. Known as the 988 Suicide & Crisis Lifeline, the hotline began in summer 2022 and includes a national network of local crisis centers that provide free and confidential support to those in suicidal crisis or emotional distress. The hotline is available 24 hours a day, 7 days a week.[17] Several demonstration state officials and documentation noted that the rollout of this national resource motivated them to re-examine their local capacity to deliver crisis services.

Using Telehealth to Deliver Crisis Stabilization Services. Federal Medicaid policy changes were made during the COVID-19 pandemic to facilitate use of telehealth in lieu of in-person visits, and a couple of state officials mentioned how these changes made it easier to deliver crisis stabilization services. For example, one state official mentioned that their crisis providers could deliver mental health services via telehealth even when a beneficiary was quarantined for the COVID-19 pandemic or was apprehensive to leave their home to receive needed care. Another state official reported that crisis services providers were permitted to conduct psychiatric diagnostic assessments via audio only because of telehealth flexibilities. (This policy had changed at the time of the interview from allowing audio only to requiring at least a video assessment.) Even though they mentioned the benefits of telehealth during the COVID-19 pandemic, state officials in both states were unsure if telehealth for crisis care was as effective as in-person care.

Working with Partners to Deliver Crisis Stabilization Services. Every state relied on partners to provide crisis stabilization services; CRTs and CITs, in particular, depended on strong partnerships between state Medicaid agencies, state behavioral health departments, and local law enforcement. Almost every state (through interviews and/or documentation) mentioned partnerships with schools, the foster care system, behavioral health departments, local law enforcement, and/or the judicial system to support initiatives aimed at providing assessment and referrals during a time of crisis for a beneficiary with SMI/SED. State officials and state documentation also mentioned partnerships with substance use disorder providers, federally qualified health centers, and community-based providers to coordinate care for beneficiaries.

> *"The demonstration is part of a bigger picture…[we have been] making investments in the state with respect to mobile crisis, critical time interventions, 988, structuring our managed care contracts with our community mental health centers, making sure that they're adequately funded, all those things… where we see the SMI demonstration fitting in is allowing us to sustain and expand upon those investments by being able to draw that extra federal matching percentage."*
>
> -State official

Relying on Existing Crisis Stabilization Programs and Existing Funding. Every state's implementation plan mentioned that the section 1115 SMI/SED demonstration builds on systems of mental health care already in place for Medicaid beneficiaries. State officials noted existing crisis programs or funding. Many of the demonstration states received a state planning grant to develop a

[16] National Alliance on Mental Illness (NAMI). (2015). *Crisis services*. https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/Crisis-Service-FS.pdf

[17] Zeller, S., & Kircher, E. (2020). Understanding crisis services: What they are and when to access them. *Psychiatric Times.* https://www.psychiatrictimes.com/view/understanding-crisis-services-what-they-are-when-access-them

SPA, section 1115 demonstration application, or section 1915(b) or 1915(c) waiver to provide qualifying community-based mobile crisis intervention services. State officials mentioned other adjacent crisis care initiatives funded by SAMHSA or the American Rescue Plan Act. These other funding streams, in addition to Medicaid reimbursement for crisis care, allowed the states to expand or enhance crisis services over the demonstration period.

State-Reported Challenges to Expanding Availability of Crisis Stabilization Services

Experiencing Shortages of Providers Who Can Deliver Crisis Care. Some state officials reported that provider shortages of behavioral health providers are a barrier to providing crisis stabilization services. One state official commented that the COVID-19 pandemic increased the number of Medicaid beneficiaries with SMI/SED in crisis, in turn creating a need for more crisis stabilization services. As the demand for crisis stabilization services has increased, the state is struggling to increase the number of providers available. Another state official discussed challenges that CMHCs have finding enough providers to staff their mobile crisis services.

Managing Provider Concerns about State Policy Changes. A few state officials reported providers' concerns with current policies that affect crisis care delivery. For example, one state now requires their mobile crisis and crisis stabilization programs to serve justice-involved populations, and several of their crisis providers have pushed back on this requirement because of the challenges serving this population. Another state official spoke of planned rollbacks of telehealth flexibilities adopted during the COVID-19 pandemic that allowed providers to conduct psychiatric diagnostic evaluations using audio-only (e.g., telephone) platforms. When the national public health emergency expires, providers will be required to do such evaluations via video instead of audio, and the state anticipates this will not be well-received by providers who appreciated the audio-only allowance. In preparation for this, the state is developing communications explaining why the state's preference is for the video option.

Conclusions

Demonstration states are expected to improve access to community-based mental health care that meets the care continuum needs of beneficiaries with SMI/SED. Through their demonstration documentation, states reported that their efforts to do so were often already in place at the start of the section 1115 SMI/SED demonstration. However, crisis stabilization services emerged as an area in which states expanded or continued previously established initiatives. As a result, states may make additional progress on these demonstration milestones. States gave mobile crisis care and crisis bed tracking particular attention. Although many factors contribute to states' expansion efforts around crisis care, the CMS state planning grants to expand mobile crisis and the national rollout of the 988 Suicide & Crisis Lifeline seemed to be significant supporting factors. Expanding crisis services led to a commensurate state focus on bed tracking to make it easier for providers and beneficiaries to find open crisis care beds.

Notably, through their efforts to improve access to crisis services, demonstration states are tailoring crisis programs to meet the needs of two special populations that are heavily represented among Medicaid beneficiaries: youth/adolescents and individuals at risk of being involved with law enforcement. For example, some states discussed plans to expand in-home crisis services for youth, and other states discussed initiatives aimed at diverting arrest of individuals with SMI/SED exhibiting unlawful behavior while experiencing a psychiatric crisis. With these efforts, states are addressing disparities in care that arise when vulnerable groups of individuals need unique approaches to service delivery.

All ten states we interviewed began demonstration activities during the COVID-19 pandemic. Three demonstrations were approved in early 2020, several months before the start of the pandemic, and the rest were approved after. The COVID-19 pandemic did not surface as a major implementation challenge during our interviews with state officials. In fact, some state officials reported the temporary changes in Medicaid telehealth rules during the pandemic were an important enabling factor to delivering more mental health care, including crisis care.

This report is meant to share early insights about states' section 1115 SMI/SED demonstration efforts to deliver crisis stabilization services. The meta-evaluation will continue to monitor changes in service delivery as the demonstrations mature. The findings from these interviews may help to contextualize state-specific results from the impact analysis and meta-analysis or may support operationalization of new variables for those analyses.

Authors and Acknowledgments

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The Federal Meta-Analysis Support Contract

In 2018, the Centers for Medicare & Medicaid Services (CMS) commissioned the Federal Meta-Analysis Support contract (HHSM-500-2014-00037I) to learn from each Medicaid section 1115 demonstration and the groups of such demonstrations with similar features. Under this contract, RTI International is conducting meta-evaluations of selected groups of Medicaid section 1115 demonstrations.

Rapid cycle reporting is central to the Federal Meta-Analysis Support contract, providing CMS with timely, practical findings, and supporting dissemination of findings to key stakeholder audiences. This report is one of several rapid cycle reports prepared by RTI International under the contract.

Appendix A: Data, Methods, and Limitations

Findings in this report are based on interviews with 10 states (Alabama, District of Columbia, Idaho, Indiana, Maryland, New Hampshire, Oklahoma, Utah, Vermont, Washington) and a review of the 10 states' implementation plans, midpoint assessments for two states (District of Columbia and Vermont), and quarterly monitoring reports for five states (District of Columbia, Idaho, Oklahoma, Utah, and Washington). Videoconference interviews were conducted between August and November 2022 with 32 Medicaid and behavioral health agency officials in the ten states. Respondents included state Medicaid directors, state Medicaid program staff, and state behavioral health agency staff familiar with the section 1115 SMI/SED demonstration. One interview was conducted per state, and almost all states had multiple program staff attending the interview.

Interviews with Alabama, Maryland, and New Hampshire were conducted soon after their demonstration implementation plans were approved, and the states had not yet started demonstration activities. As a result, interviews in these states focused on planned activities, enabling factors, and challenges.

Interviews used a common, semi-structured protocol that covered multiple topics, including perspectives on the state's most important demonstration activities and activities around section 1115 SMI/SED demonstration Milestones 1 through 4. This report drew upon interview questions and responses related to implementation of Milestone 3c, strategies to improve state tracking of availability of crisis stabilization beds, and Milestone 4c, establishment of specialized settings and services, including crisis stabilization, for young people. Interviews were 60 minutes in length.

Interviews were audio recorded with state officials' permission and transcribed. RTI analyzed the transcripts using NVivo 12.0. The initial analysis phase entailed a deductive coding process with prescribed codes for topics that aligned with the interview protocol. After this initial phase, the analysis team initiated an inductive coding process to identify and synthesize strategies, enabling factors, and challenges across states. The team held regular coding reviews and debriefings and conducted intercoder reliability assessments to ensure quality control.

In the report, we use quantifying language (e.g., "all state officials" or "some state officials") to give readers a sense of the number of state officials who mentioned a topic during an interview and therefore the prevalence of topics that state officials raised or addressed. We do not provide exact counts of state officials who mentioned a topic because the interviews were semi-structured in nature. Unlike the case of a structured survey with identical questions and response sets, we cannot conclude from semi-structured interviews that a particular topic was or was not relevant or meaningful to state officials who did not mention a particular topic. Also, when data come from publicly available documents, we provide state names and counts, as well as note the documentary source. We avoid naming states when data come solely from interviews to minimize risk to confidentiality.

This analysis has several limitations. State officials may report strategies; state-reported policies, programs, and contextual factors; and challenges that are most important to them—as such, there may be some inherent bias in the information they report. Additionally, states' perspectives may have varied depending on how far along they were in implementation. At the time our interviews were conducted, some states had been engaged in demonstration implementation for close to two years while others were only recently approved to begin demonstration activities. Perspectives about the importance of a strategy in meeting a demonstration milestone may reasonably be expected to change over time. Moreover, this report is not designed to provide an exhaustive list of strategies, enabling factors, and challenges; we present those that were frequently mentioned. Finally, interviews lasted 60 minutes and covered multiple topics, which limited in-depth discussion on any one topic.