988 & Mobile Crisis Response Through CCBHCs

States Can Use the CCBHC Model to Streamline Mobile Crisis Response and Other Mental Health and Substance Use Services, Including 988

Two key paths were recently established to help reduce suicide and overdose rates by connecting people experiencing crisis to critical services: 1) The creation of a 5-year 85% enhanced match in Medicaid for mobile crisis response; and 2) The transition of the National Suicide Prevention Lifeline (NSPL) to a new three-digit dialing code (988), which will help expand access and promote systems of high-quality, community-based crisis response, similar to the medical, fire, and public safety emergency response systems associated with 911.

In establishing 988, Congress allowed states to collect a user fee through telecom companies to finance the management of the Lifeline. However, many states are looking for health care funding solutions – in addition to, or in lieu of, telecom fees – to ensure access to high-quality services for people utilizing 988. The Centers for Medicare and Medicaid Services (CMS) awarded planning grants to states to develop mobile crisis intervention services, and the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded planning grants to support states in developing capacity to respond to 9-8-8 calls. While these efforts will help to build crisis response infrastructure, there is a continued need for baseline funding for service delivery.

As states continue to work to build out their crisis response capacity and prepare for the July 2022 implementation of 988, CMS and SAMHSA have recommended implementation of **Certified Community Behavioral Health Clinics (CCBHCs).**

> "The CCBHC model is a useful approach that can link individuals in crisis with a network of services either performed on-site or through designated collaborating organizations." -- ***Report to Congress on 988 Resources***, SAMHSA, December 2021

CCBHCs Play a Key Role in a Comprehensive Crisis Response System

A CCBHC is a specially-designated clinic that is designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. CCBHC service selection is deliberate, expanding the range of care available to create access, stabilize people in crisis, and provide the necessary treatment for those with the most serious, complex mental illnesses and substance use disorders.

CCBHCs are required to provide 24-hour crisis response, including but not limited to mobile crisis teams, emergency crisis intervention services, and crisis stabilization. CCBHCs currently manage their own crisis hotlines – as of January 2021, every CCBHC either operates their own local crisis hotline themselves or refers individuals to a crisis hotline within the community, such as NSPL.

Moreover, the CCBHC model requires integrated mental health and substance use treatment, use of peers and person-centered planning, data sharing, outcome measures and expanded care coordination with local primary care providers, hospitals, other health care providers, social service providers, and law enforcement, with a focus on whole health and comprehensive access to a full range of medical, behavioral and supportive services.

How to Link CCBHC Financing Structures to 988

Medicaid is fundamental to states' 988 efforts, with additional funding streams (e.g., telecom fees, state-based grants, county-based budgets) to supplement and support areas that are not covered by Medicaid. The CMS *Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services* describes how states can connect the 85% enhanced Medicaid reimbursement for mobile crisis response with some elements for 9-8-8, specifically state information technology systems for integration of 9-8-8 with the continuum of care. CMS added, "*Mobile crisis intervention services should be integrated with the national suicide prevention and mental health crisis hotline, state funding of core crisis care elements, and community-level efforts to implement CCBHC crisis management services*."

- ***CCBHC Expansion grants offer one-time funding.*** Many CCBHCs are funded by expansion grant dollars through SAMHSA (i.e., CCBHC-E grants), which provide individual clinics with up-to $4 million dollars for a two-year period. These grant dollars can cover the costs of hiring staff, connecting technologies, and providing services, including mobile crisis response. To the extent clinics use grant funding to support the build-out of crisis response infrastructure or improve the clinic's ability to take on referrals from 9-8-8, they contribute to a state's readiness for 9-8-8 implementation.
- ***CCBHCs through Medicaid provide additional opportunities to utilize federal funding.*** Outside of the CCBHC-E grant, the financing model for CCBHCs is a Medicaid payment rate known as a prospective payment system (PPS)—piloted as a demonstration program in 10 states—that covers the costs associated with CCBHCs' heightened requirements and activities. PPS rates provide financial flexibility for CCBHCs to deliver a wide range of evidence-based services, implement innovative staffing models, and leverage technology for improved care. Crisis services and technologies, including mobile crisis response, are among the most commonly added types of services under the CCBHC demonstration, an indication of the model's potential to increase the availability of crisis response throughout a state. The CCBHC model has been particularly helpful in increasing access to crisis response in rural areas where prior financing models did not support the full costs of robust crisis intervention activities.

If a state, through legislation or executive action, **establishes CCBHC as a provider type within their state Medicaid program** and requires CCBHCs to coordinate with or **participate in the 988-lifeline network**, certain allowable costs (as outlined in CMS guidance) could be **funded through federal dollars with the 85% enhanced match** for mobile crisis response.

As such, the 85% mobile crisis match represents a pathway to finance a portion of the costs associated with CCBHC implementation, while the CCBHC model represents a way to ensure statewide availability of crisis response linked to a comprehensive continuum of care.

In states with a CCBHC PPS in place, if the CCBHC provides crisis services directly or contracts with another organization (e.g., a state-sanctioned crisis division) to provide 24/7/365 mobile crisis team services, states can work with CMS to understand how to properly segregate and claim eligible expenditures to secure the appropriate enhanced match for CCBHCs' mobile crisis services (including relevant technologies, overhead, and staffing per CMS guidelines). States can use the CCBHC cost reporting process—in which CCBHCs clearly delineate their direct and indirect expenditures, with state review and approval—to ensure transparency around CCBHCs' anticipated costs associated with crisis response and 9-8-8 lifeline services or referral coordination.

State-level Actions for 9-8-8, Mobile Crisis Response, and CCBHC Integration

Legislation to expand the 10-state CCBHC Medicaid demonstration to additional states—with an enhanced match rate for CCBHC services—has been introduced in Congress. Meanwhile, states can establish the CCBHC model independently through a State Plan Amendment (SPA) or Medicaid waiver (e.g., 1115). Four states (Illinois, Kansas, Maine and Texas) are currently moving forward with a SPA or waiver approach or have allocated funding to initiate a planning process. Additional states across the nation are considering how to link CCBHC activities with 9-8-8 implementation. For more information on the CCBHC implementation landscape and the role of CCBHCs in the crisis continuum, visit https://www.thenationalcouncil.org/ccbhc-success-center/