How States Leveraged Federal Funding Mechanisms in 2014–2024 to Expand and Enhance Mental Health Crisis Response and Stabilization Services

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Executive Summary

The Substance Abuse and Mental Health Services Administration (SAMHSA) has put forth three foundational elements that are essential within an integrated crisis care system, with the goal that anyone, anywhere, at any time should have access to: ***Someone to Contact***, meaning services like 988 and other behavioral health hotlines that provide immediate, accessible support; ***Someone to Respond***, which includes services like mobile crisis teams that deliver rapid, on-site interventions to de-escalate crises and connect individuals to care; and ***A Safe Place for Help***, which means a wide array of stabilization services for behavioral health emergencies where people can receive immediate treatment and support. Considerable advancement in each of these elements has occurred in recent years across the country.

In addition to state appropriations and the use of state and county/city funding streams, a major way in which crisis services can be expanded and enhanced is through federal funding opportunities, primarily made available by the Centers for Medicare and Medicaid Services (CMS) and SAMHSA. However, there is no existing detailed policy analysis in this area, and such an analysis could be useful for advocacy and policymaking. Understanding both commonalities and substantial differences across the states provides an in-depth national landscape that will be important for the upcoming decade of further advancement in crisis care. States learn from other states, and we hope that our comprehensive policy analysis will help government officials identify trends and opportunities to adopt policy and funding solutions.

This report addresses nine federal funding opportunities that states leveraged in variable ways during 2014–2024:

(1) Medicaid State Plan Amendments (SPAs)
(2) Children's Health Insurance Program (CHIP) SPAs
(3) Medicaid Section 1115 Demonstration Waivers
(4) Medicaid Home and Community Based Services (HCBS) Authorities under 1915(c)
(5) Certified Community Behavioral Health Clinics (CCBHCs)
(6) CMS Planning Grants for Crisis Services
(7) SAMHSA Cooperative Agreements for Innovative Community Crisis Response Partnerships
(8) SAMHSA Mental Health Services Block Grant and Supplemental Funds
(9) Bureau of Justice Assistance (BJA) Byrne State Crisis Intervention Program Grants

Scope and Limitations

While we aimed to be thorough and comprehensive, we acknowledge a number of limitations to our overarching approach. ***First***, we limited our focus to states' leveraging of federal funding streams rather than focusing on states' general appropriations for crisis services. ***Second***, we restricted our focus to the 11-year timeframe of January 1, 2014, through December 31, 2024; as such, our analysis does not address any state or federal actions before or after this period. ***Third***, we restricted our focus to the 50 states and the District of Columbia; as such, we do not cover the U.S. Territories or the sovereign tribal nations. ***Fourth***, our focus is on four types of crisis services: (1) mobile, community-based crisis responses embedded primarily in the behavioral health system, which is most commonly referred to as mobile crisis teams (MCTs) or a similar state-specific term; (2) facilities designed to receive, evaluate, and stabilize individuals in crisis, whether they be referred by mobile crisis teams, law enforcement, or others, which are most commonly referred to as crisis receiving and stabilization facilities or crisis stabilization units (CSUs); (3) short-term (usually several days and up to 14 days) out-of-home crisis respite and crisis residential facilities; and (4) crisis transportation, which includes new approaches to transportation aside from MCTs, EMS, and law enforcement. We do not cover the first of SAMHSA's three core elements of the crisis care continuum, regional crisis call centers including 988, as other research addresses funding of 988. ***Fifth***, we specifically focus on nine federal funding streams (which we refer to as "mechanisms") that states may have used during our time period of interest; yet, others might have been at play. ***Sixth***, the policy analysis approaches that we followed for each mechanism were selected to be both valid and replicable, though each approach has limitations. ***Seventh***, we report different types of information across the nine mechanisms, which makes an overall synthesis challenging. That is, for some, we could access details of how crisis services were expanded or enhanced but have no information on the dollar amounts that flowed from the federal government to the states. For other mechanisms, we could access details on dollar amounts provided to states by the federal government but have limited information on exactly how states used the funding to expand or enhance crisis services.

Putting the Report into Context

It should be emphasized that the 2014–2024 period was one of numerous events that shaped the evolution of crisis services and their funding. Federal legislation advanced and ultimately led to the implementation of 988. The COVID-19 pandemic occurred, as did ensuing federal legislation aimed at bolstering the mental health system, including the behavioral health crisis system. The police-related deaths of Daniel Prude and George Floyd—among countless others—solidified social pressure to transition mental health crisis response to the behavioral health system rather than law enforcement. The CCBHC model was signed into law and advanced substantially. The period was characterized by two extremely divergent presidential administrations; yet, some bipartisan actions advanced crisis services. State and federal executive actions, legislation, and court decisions occurring in 2025 are not considered, though such actions (e.g., H.R. 1 (referred to by the Trump Administration as the "One Big Beautiful Bill Act of 2025") and the July 2025 Executive Order titled "Ending Crime and Disorder on America's Streets") could have substantial adverse impacts on the crisis response and crisis care funding.

In addition to variability across time, it is important to recognize the wide variation across states—in mental health services delivery and thus crisis services capacity and delivery—that impact their leveraging of the nine federal funding opportunities. Such variation is highlighted in the opening portions of the report. Not only do states differ drastically with regard to geography, demography, population density, social norms, political ideologies, and policymaking, but they also differ in mental health funding and capacity.

Results of Our Policy Analysis

Nine chapters—very briefly summarized here—offer some ***Background*** material, then details of our ***Approach*** to the policy analysis for each mechanism, and finally our ***Findings*** along with some ***Tables and Figures***.

(1) Medicaid State Plan Amendments (SPAs). There were 10,951 SPAs during the 2014–2024 period (mean = 214.7±99.7 across states, ranging from 54 to 544). Among them, 115 were deemed of relevance to expanding or enhancing crisis services. We categorized 61 as "Low Impact" (meaning the SPA's potential effects on expanding or enhancing crisis services were likely to be relatively low and/or that the SPA was not intentionally designed to do so), 22 to be

"Medium Impact," and 32 to be "High Impact" (meaning that the SPA's potential effects on expanding or enhancing crisis services were likely to be relatively high and/or that the SPA was intentionally designed to do so). Among the latter 32 are SPAs that made MCT a billable service across the state and/or made CSU services billable.

(2) Children's Health Insurance Program (CHIP) SPAs. Among 694 CHIP SPAs with an effective date in 2014–2024, we identified two (in Indiana and Virginia) that made crisis services for CHIP recipients billable in the same way that they had been made billable to the adult population through Medicaid SPAs.

(3) Medicaid Section 1115 Demonstration Waivers. Among 159 1115 demonstration waivers scanned for relevance, eight were deemed relevant based on our criteria and approach, from the following states: Alaska, District of Columbia, Florida, Massachusetts, New Hampshire, Oregon, Rhode Island, and Texas.

(4) Medicaid Home and Community Based Services (HCBS) Authorities under 1915(c). Among 363 1915(c) waivers scanned for relevance, 12 were deemed relevant—again, based on our specific criteria and approach, from the following states: Indiana, Kansas, Louisiana, Maryland, Michigan, New York (which had three), South Carolina (which had two), Texas, and Wisconsin.

(5) Certified Community Behavioral Health Clinics (CCBHCs). Crisis behavioral health services are one of nine categories of services required of CCBHCs. We outline federal funding obtained from planning grants and cooperative agreements to states, as well as expansion grants to provider organizations within states—during the 2014–2024 period. As of January 2024, all but four states (North Dakota, South Dakota, South Carolina, and Delaware) had implemented one or more (up to 48 in Texas and 51 in New York) CCBHCs.

(6) CMS Planning Grants for Crisis Services. As part of the American Rescue Plan Act of 2021 (ARPA) 20 State Medicaid Agencies received 12-month planning grants from CMS to enhance their ability to offer community-based mobile crisis intervention services. A total of $15,000,000 was allocated, with an average of $750,000 per state. The funding led to the development of SPAs, 1115 demonstration waivers, or waivers under sections 1915(b) or 1915(c) that address community-based mobile crisis assistance.

(7) SAMHSA Cooperative Agreements for Innovative Community Crisis Response Partnerships. SAMHSA provided Cooperative Agreement to 25 jurisdictions or provider

organizations—in the amount of up to $750,000 in total costs per year, with project lengths of up to 4 years—to increase the capacity of MCTs while expanding access in high-need communities, increasing collaboration to improve crisis stabilization in the community, and improving equity in the continuity of care and post-crisis follow-up.

(8) SAMHSA Mental Health Services Block Grant (MHBG) and Supplemental Funds. MHBG funds are distributed to states annually based on formula calculations, and a 5% set-aside for crisis services began in 2021. ARPA allocated $1.5 billion in additional funds for the MHBG in 2021. We detail the block grant amount across the states (which accounts for approximately 0.44% to 5.30% of a state's total State Mental Health Agency (SMHA) expenditures, the average being about 1.67%), in addition to their crisis set-aside amounts (which represents about 0.04% to 0.41% of a state's total SMHA expenditures, the average being approximately 0.14%).

(9) Bureau of Justice Assistance (BJA) Byrne State Crisis Intervention Program Grants. As authorized by the Bipartisan Safer Communities Act of 2022, the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance (BJA) provides formula funds under the Byrne State Crisis Intervention Program (SCIP) to support the creation and implementation of extreme risk protection orders (also known as "red flag laws") as well as state crisis intervention court proceedings such as mental health courts, drug courts, and veterans' treatment courts. Related court-based and behavioral health deflection programs that can be covered by Byrne SCIP funds include the following: mobile crisis units (both co-responder and civilian only), regional crisis call centers, and crisis receiving and stabilization facilities, among others. Total amounts (summing FY 2022–2023 awards and FY 2024 awards) ranged from $1,014,905 in North Dakota, Vermont, and Wyoming to more than $20 million: $20,942,114 in New York; $23,925,501 in Florida; $33,571,333 in Texas; and $45,842,504 in California.

Summary/Synthesis

Our policy analysis examined nine federal mechanisms by which states, during 2014–2024, could leverage funding to expand and enhance (or just sustain) crisis services. This analysis revealed five major conclusions that inform a series of recommendations for local providers, state governments, and the federal government:

1. Medicaid Billing/Reimbursement Represents a Major Source of Funding for Crisis Services

2. Crisis Services Have Been Expanded through the Implementation of CCBHCs
3. Federal Planning Grants and Cooperative Agreements to States Have Helped in Expanding and Enhancing Crisis Services
4. The Annual SAMHSA Mental Health Block Grant Provides a Baseline, though Minimal, Level of Support for Crisis Services
5. Aside from CMS and SAMHSA, Other Federal Agencies Can Play a Role in Expanding and Enhancing Crisis Services

Overarching Recommendations

- ✓ Because Medicaid billing/reimbursement represents a major source of funding for crisis services that has not been fully optimized by some states, local providers and SMHAs/State Medicaid Agencies should optimize all Medicaid billing/reimbursement opportunities across the spectrum of crisis services.
- ✓ Because crisis services have been expanded through the implementation of CCBHCs and prospective payment opportunities, SMHAs should ensure optimal distribution/coverage of CCBHCs to serve population needs—as well as optimal approaches to billing—which will help to optimize crisis services coverage.
- ✓ Because federal planning grants and cooperative agreements to states have helped in expanding and enhancing crisis services, federal agencies should consider additional planning grant and cooperative agreement opportunities that prioritize areas of needed enhancement and sustainability of crisis services as the crisis service environment evolves. Grants and cooperative agreements for planning should shift to grants and cooperative agreements for implementation, evaluation, and sustainability.
- ✓ Because the annual SAMHSA Mental Health Block Grant provides relatively minimal support for crisis services, additional appropriations should be provided to further support states in expanding and enhancing crisis services.
- ✓ Because other federal agencies, aside from CMS and SAMHSA, have an interest in improving community safety and well-being by promoting effective crisis services, they should consider their role in funding the expansion and enhancement of crisis services.

Recommendations to Local Providers

- Local crisis programs should optimize Medicaid billing (with regard to billing codes, provider types, service requirements, etc.) across the full array of crisis services they provide (e.g., mobile crisis teams, crisis receiving and stabilization facilities, crisis respite, crisis residential services, and crisis transportation).
- Community mental health clinics interested in becoming CCBHCs should work with the SMHA for planning and to ensure that all criteria can be successfully accomplished, including the essential services pertaining to crisis behavioral health services.

Recommendations to State Governments

- SMHAs should work with State Medicaid Agencies to ensure that crisis services billing opportunities are optimized in the state plan for Medicaid-billing organizations. The full array of crisis services should be made reimbursable, including mobile crisis response, crisis receiving and stabilization, crisis respite, crisis residential services, and crisis transportation. Targeted state plan amendments may be needed.
- State governments should ensure or organize collaboration and coordination around advancing crisis services.
- As states develop and submit 1115 demonstration waivers, they should consider the ways in which the waiver might allow for innovation in crisis care delivery and payment. The same is true of other Medicaid waiver opportunities, including 1915(c) Home and Community Based Services for select patient populations at high risk of institutional care.
- In ensuring adequate coverage of crisis services, SMHAs should consider mapping crisis services delivered separately from CCBHCs, in conjunction with CCBHCs (through Designated Collaborating Organization agreements), and those provided directly by CCBHCs. Relevant state agencies in states without a CMS-approved permanent CCBHC initiative should pursue available Medicaid flexibilities—most likely through SPAs, but potentially also via Section 1115 demonstrations—to permanently establish the CCBHC model and a prospective payment system.

Recommendations to the Federal Government

- Because the enhanced FMAP for MCTs increased uptake and implementation, Congress should provide additional Medicaid FMAP enhancements, as an incentive for additional crisis services expansion, especially where crisis services are lacking. States should have the option to extend their SPAs for the increased Medicaid match for MCTs beyond the initial three-year period provided by ARPA.
- CMS should consider targeting crisis services as a 1115 demonstration waiver priority area that could then be taken up by multiple states.
- CMS and SAMHSA should consider additional rounds of planning grants and/or cooperative agreements that focus specifically on supporting states, counties, and local provider agencies for planning and implementation activities around expanding and enhancing crisis services, especially in areas where the availability of crisis response and crisis receiving/stabilization are limited.
- Congress should consider increasing SAMHSA's funding to further support states in expanding and enhancing crisis services; this might include increasing the current 5% set-aside to a minimum of 10%.
- Other federal agencies (e.g., Health Resources and Services Administration, National Institute of Justice, National Institute of Mental Health) should consider their role in funding the expansion and enhancement of crisis services.

Other Considerations

Finally, we briefly describe several other considerations as local providers, state governments, and the federal government look toward the next decade of expanding and enhancing crisis services.

1. Medicare and private health insurance plans have an untapped role in supporting crisis services.
2. Crisis services should be conceptualized and implemented with an explicit commitment to racial equity and other equity goals.
3. Financing innovations need to be considered for crisis services.
4. Additional innovation in crisis services may be needed for rural and remote areas.
5. Additional innovations are needed for children and adolescent crisis services.

6. More attention is needed on crisis transportation as an element of crisis services.
7. A competent, well-trained crisis response workforce is needed.
8. Research with a national landscape lens is warranted, across the array of crisis services.
9. Investments across the behavioral health continuum of care will reduce the need for crisis services.

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Commonly Used Abbreviations and Acronyms

Abbreviations and acronyms commonly used in this document are given below. A number of other state-specific abbreviations are used when referring to particular states' activities, though not listed here.

24/7 = availability 24 hours a day, seven days a week, every day of the year

ACA = Patient Protection and Affordable Care Act of 2010, also called the Affordable Care Act

ARPA = American Rescue Plan Act

CCBHC = Certified Community Behavioral Health Clinic

CHIP = Children's Health Insurance Program

CMS = Centers for Medicare and Medicaid Services

CSU = crisis stabilization unit

DCO = designated collaborating organization

EPSDT = early and periodic screening, diagnostic, and treatment

FMAP = Federal Medical Assistance Percentage

FPL = federal poverty level

FQHC = Federally Qualified Health Center

FY = fiscal year

HCBS = Home and Community Based Services

IMD = Institution of Mental Diseases

MACPAC = Medicaid and CHIP Payment and Access Commission

MCO = managed care organization

MCT = mobile crisis team

MHPAEA = Mental Health Parity and Addiction Equity Act

PPS = prospective payment system

PRTF = psychiatric residential treatment facility

SAMHSA = Substance Abuse and Mental Health Services Administration

SED = serious emotional disturbance

SMHA = state mental health agency

SMI = serious mental illness

SPA = (Medicaid) State Plan Amendment

SUD = substance use disorder

Background

American society is at a critical moment in terms of re-envisioning how individuals experiencing a mental health crisis or an acute exacerbation of a mental illness receive crisis care. Major momentum exists in cities and counties across the country, with much of the reform being driven by state agencies, including state mental health agencies (SMHAs). Public outcry and finally the resolve of both the mental health system and the criminal justice system have called for crisis response to now rest within the mental health and social services sector rather than with police/law enforcement.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines behavioral health crisis services broadly, referring to "immediately or rapidly responsive, intensive services that are provided to address or prevent behavioral health symptoms, situations, or events that, immediately or in the near term, may negatively impact an individual's ability to function within their current family/caregiver and living situation, school, workplace, or community" (SAMHSA, 2025a). SAMHSA has put forth three foundational elements that are essential within an integrated crisis care system—in which crisis services are accessible to anyone, anywhere, at any time—"with the goal that everyone should have access to:

Someone to Contact: Services like the 988 Lifeline and other behavioral health hotlines provide immediate, accessible support;

Someone to Respond: Services like Mobile Crisis Teams that deliver rapid, on-site interventions to de-escalate crises and connect individuals to care as well as Crisis Outreach Teams that provide complementary crisis prevention and postvention; and

A Safe Place for Help: A wide array of stabilization services for behavioral health crisis and emergencies where people can receive immediate treatment and support as well as services that can aid in crisis prevention and postvention." (SAMHSA, 2025b).

Progress and evolution of crisis service delivery during 2014–2024 has been remarkable. 988 (formerly the National Suicide Prevention Lifeline) was implemented nationwide in July 2022, and now there is a move toward enhanced on-scene crisis response (e.g., major expansion of mobile crisis teams to provide crisis response rather than police/law enforcement). This will undoubtedly result in a reduction in unwarranted criminal justice involvement for those experiencing a mental health crisis or an exacerbation of a mental illness. According to data from

NRI, “there was an increase of 301 non-child specialized MCTs operating in 2024 compared to 2023 (a 17 percent increase)” (NRI, 2025a). Additionally, “thirty-eight states (with data for all three years, 2022–2024) reported an increase of 423 MCTs operating in 2024 compared to 2022 (a 32 percent increase). These teams served 100,020 more individuals in crisis in 2024 than 2023 (a 14 percent increase in the 39 states with data for both years)” (NRI, 2025a). And “in 2024, 50 states and territories reported they currently have 2,448 MCTs, including 365 specialized Mobile Response and Stabilization Services, MRSS, programs for children, youth, and their families operating in 20 states” (NRI, 2025a). These data were accessed on November 3, 2025; the most recent version of the NRI report, with the latest numbers, is available at https://nri-inc.org/profiles.

If the national roll-out of 988 might be considered the first wave, and the expansion of MCTs the second, a third wave of expanding and enhancing crisis services might just be beginning: a move toward establishing recovery-oriented crisis stabilization and crisis respite services. Cities, counties, and states have used various funding streams to expand and enhance crisis response and crisis stabilization. Research is underway to understand the various funding approaches to 988 roll-out (Purtle et al., 2023; Purtle et al., 2024; Purtle et al., 2025), and prior policy analyses have begun addressing funding approaches to on-scene crisis response, crisis stabilization, and crisis respite (O’Brien, 2023; Johnson et al., 2024; Edmonds et al., 2025). Among the most impactful approaches to funding are those in which states leverage federal mechanisms available through the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA). This policy analysis addresses a gap in knowledge of how the 50 states and the District of Columbia have made use of CMS and SAMHSA mechanisms—in highly variable ways—to expand and enhance crisis response and crisis stabilization. This analysis is timely given the pace of efforts to improve crisis care in states across the country. The target audience of this work is policymakers, program planners and administrators, and researchers across all levels of government, but especially policymakers at the state level who are positioned to learn from a comprehensive analysis of all the states’ variable uses of CMS- and SAMHSA-related funding mechanisms during 2014–2024.

Scope and Limitations

Our approach also has several limitations, which we acknowledge here.

First, we limited our focus to states' leveraging of federal funding streams rather than focusing on states' general appropriations to expand and enhance—or simply sustain existing—crisis services. There is likely prominent variability in the extent to which states fund crisis services using general funds (see **Table A3** in the section on "Setting the Stage: An Overview of State Mental Health Agencies (SMHAs)" below), and this variability might be driven in part by—and/or might drive—their leveraging of the federal mechanisms detailed herein. Some dedicated state appropriations may stem from legislative initiatives including 988 telecommunication fees that can be used for crisis services beyond 988 implementation, as well as other state-specific legislative initiatives such as the Daniel's Law Task Force in New York and cannabis tax revenues dedicated for mental health services in Illinois, to name just a few. (It should be noted that while this report focuses on federal funding, and while Medicaid is a federal program, it requires states to match, and the decision to submit state plan amendments (SPAs) is state-driven. As such, the report does also to some extent cover state funding/investments in crisis services.) We also do not cover local (city/county) funding, foundation and philanthropic support, and private payers, including commercial health insurance plans. We do, however, discuss the potential role of both Medicare and commercial health plans in supporting crisis services in our "Other Considerations" section toward the end of the document.

Second, we restricted our focus to the 11-year timeframe of January 1, 2014, through December 31, 2024; as such, our analysis does not address any state or federal actions before or after this period. Agnostic to all crisis funding and expansion prior to 2014, our approach does not consider how states varied meaningfully in terms of what was already in place. For example, with regard to Medicaid State Plans—and thus the need for SPAs described in Chapter 1—for some states there may not have been any SPAs in the 11-year period because there could have been crisis-related services already added before 2014 that we do not account for. With regard to Medicaid SPAs—to keep using that mechanism as an example here—many states submitted SPAs in 2014–2024 that were updates of staffing/provider requirements (e.g., KY-23-003, NC-18-003), renaming or updating of service definitions (e.g., AR-23-0021, MT-20-0010), or simply modifications of rates and reimbursements (e.g., IL-22-0004, MN-15-14, UT-20-0012). As such,

those crisis services that were being amended existed before 2014 and were likely impactful in terms of Medicaid coverage for mobile crisis, crisis stabilization, etc. Thus, states that appear to have done little (e.g., submitting few or no crisis-related SPAs during our 11-year period) may not have needed such actions because they already had relatively robust services in place.

Similarly, our work does not consider any activity taking place after December 31, 2024. As such, we do not address ways in which changing local, state, and federal policy after that date might have impacted crisis services. This includes, for example, debated, planned, or implemented changes suggested or enacted by the second Trump Administration (which took office on January 20, 2025), such as suspensions or revocations of federal grants and contracts, reductions in Medicaid funding to states, and restructuring of federal agencies.

Third, we restricted our focus to the 50 states and the District of Columbia. As such, we do not cover the U.S. Territories (Puerto Rico, the U.S. Virgin Islands, American Samoa, the Northern Mariana Islands, Guam, and the minor outlying islands and claimed territories). Additionally, we do not include the sovereign tribal nations, except in Chapter 7 on SAMHSA Cooperative Agreements for Innovative Community Crisis Response Partnerships, where excluding sovereign tribal nation recipients would have painted an incomplete picture of the awarded Agreements. Additionally, of note, throughout this document, when we refer to the "states," we include the District of Columbia for sake of easier writing and reading.

Fourth, in defining mental health crisis services, our focus is on four types of crisis services. Those services are: (1) mobile, community-based crisis responses embedded primarily in the behavioral health system, which is most commonly referred to as *mobile crisis teams* or a similar state-specific term; (2) facilities designed to receive, evaluate, and stabilize individuals in crisis, whether they be referred by mobile crisis teams, law enforcement, or others, which are most commonly referred to as *crisis receiving and stabilization facilities* or related terms; (3) short-term (usually several days and up to 14 days) out-of-home *crisis respite* and *crisis residential facilities*; and (4) *crisis transportation*, which includes new approaches to transportation aside from mobile crisis teams, EMS, and law enforcement. As such, we do not cover the first of SAMHSA's three core elements of the crisis care continuum, *regional crisis call centers including 988*. (It should be noted, however, that it is often unclear how much of a lump of money earmarked for "crisis" goes to call centers versus other crisis services. This is due in part to a lack of specificity in the language used in budgeting. Thus, some of the dollars

covered in this report likely did go to supporting call centers.) Other researchers are documenting states' leveraging of federal funding for that core element (Purtle et al., 2023; Purtle et al., 2024; Purtle et al., 2025). We also do not cover "crisis intervention" evaluation, counseling, and therapy that occurs within outpatient behavioral health programs (typically for existing clinic clients) or crisis intervention expectations of other services with existing client caseloads like intensive outpatient programs, targeted case management, and assertive community treatment, as "crisis intervention" for those groups is different from (being part of the client's service provision and part of the provider's service expectations) from crisis intervention open to any community member. Finally, we do not consider crisis respite that is based solely in one's own home and crisis services focused specifically on individuals with intellectual and developmental disorders (as those services are designed and delivered differently from crisis intervention available to any community member). Regarding the decision to focus primarily on community-based rather than home-based crisis response, this is a substantial limitation in relation to youth given that the leading model of youth crisis response, which is considered a best practice—termed Mobile Response and Stabilization Services (MRSS)—often is delivered in the youth's home and can extend for weeks or longer until the individual and family are stabilized.

Fifth, we specifically focus on nine federal funding streams (which we refer to as "mechanisms") that states may have used during our time period of interest. Those nine mechanisms are: (1) Medicaid State Plan Amendments (SPAs), (2) Children's Health Insurance Program (CHIP) SPAs, (3) Medicaid Section 1115 Demonstration Waivers, (4) Medicaid Home and Community Based Services (HCBS) Authorities under 1915(c), (5) Certified Community Behavioral Health Clinics (CCBHCs), (6) CMS Planning Grants for Crisis Services, (7) SAMHSA Cooperative Agreements for Innovative Community Crisis Response Partnerships, (8) SAMHSA Mental Health Services Block Grant and Supplemental Funds, and (9) Bureau of Justice Assistance (BJA) Byrne State Crisis Intervention Program Grants. Importantly, as noted above, this means that we do not address state appropriations for crisis services, which, for some states, may be the predominant funding stream.

Focusing on these nine main federal funding streams means that other federal funding streams of potential relevance (though not as relevant as these nine) are not covered. For example, the Bureau of Health Workforce at the U.S. Health Resources and Services Administration (https://bhw.hrsa.gov) offers "scholarships and loan repayment to students and

clinicians," as well as "grants to organizations such as schools, hospitals, and health centers to improve health workforce training." Such mechanisms include, for example, the Behavioral Health Workforce Education and Training Program for Paraprofessionals (HRSA, 2025a), which aims to "develop and expand community-based experiential training such as field placements and internships to increase the skills, knowledge and capacity of students preparing to become mental health workers, peer support specialists, and other behavioral health paraprofessionals," and the Behavioral Health Workforce Development Technical Assistance Program (HRSA, 2025b), which supports Behavioral Health Workforce Development recipients and thus helps programs "expand the number of highly trained behavioral health providers across the nation."

There are also funding mechanisms from both CMS and SAMHSA that could have some impact on improving crisis services among states receiving awards, though they are not covered here. For example, in April 2020, SAMHSA issued a Notice of Funding Opportunity for Emergency Grants to Address Mental and Substance Use Disorders During COVID-19 (SAMHSA, 2020a). Its purpose—given expected increases in depression, anxiety, trauma, grief, and substance misuse—was to provide crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for children and adults impacted by the COVID-19 pandemic. Similarly, SAMHSA grant programs like the Community Mental Health Centers (CMHC) Grant Program in the Spring of 2021, "to enable community mental health centers to support and restore the delivery of clinical services that were impacted by the COVID-19 pandemic and effectively address the needs of individuals with serious emotional disturbances (SED), serious mental illnesses (SMI), and individuals with SMI or SED and substance use disorders" (SAMHSA, 2021a), could have been used in part to expand or enhance crisis services. And as a final example, Congressionally Directed Spending Projects (SAMHSA, 2024) could have potentially been used for crisis services, and at least one recipient (County of Contra Costa, California) received $1,061,548 between 2022 and 2024, which went toward MCT expansion (USASpending.gov, 2024)—other such projects may have existed in other years.

Sixth, the policy analysis approaches that we followed for each mechanism were selected to be both valid and replicable, though each approach has limitations. We relied to the largest extent possible on publicly available federal websites as our sources of information. These were deemed to provide more accurate and consistent information as opposed to other data sources (e.g., interviews with individuals, websites of State Mental Health Agencies, repositories of

private foundations or research institutions). This may have led to some loss of information given that federal websites provide some types of information but not other types. We also relied on targeted but carefully decided upon key word searches—as described in the "Approach" sections in the chapters that follow—to make the analysis manageable. While we sought to be comprehensive in our search strategies, some datapoints or specific states' leveraging of funds (e.g., Medicaid SPAs) might have been missed. We comment on any substantial shortcomings to specific analysis approaches and search strategies in the individual chapters.

Seventh, we report different types of information across the nine mechanisms, which makes an overall synthesis challenging. For some mechanisms (e.g., Medicaid SPAs, Medicaid Section 1115 Demonstration Waivers, Medicaid Home and Community Based Services Authorities under 1915(c)), we could access *details of how crisis services were expanded or enhanced but have no information on the dollar amounts that flowed from the federal government to the states*. For other mechanisms (e.g., SAMHSA Mental Health Services Block Grant and Supplemental Funds, SAMHSA Cooperative Agreements for Innovative Community Crisis Response Partnerships, Bureau of Justice Assistance Byrne State Crisis Intervention Program Grants), we could access *details on dollar amounts provided to states by the federal government but have limited information on exactly how states used the funding to expand or enhance crisis services*. For Certified Community Behavioral Health Clinics (CCBHCs), we provide a timeline of their evolution, along with dollar amounts received by states or by provider organizations within states across a number of federal funding opportunities, with the assumption of a relationship or correlation between CCBHC funding and subsequent enhancements in crisis services, given that community-based crisis services is one of nine core services of CCBHCs.

Our goal is to give an overview of states' use of these mechanisms during our eleven-year period, with no attempt to "rate" or "rank" the states. Other national landscape reports have compared the states in a more "head-to-head" fashion. For example, Inseparable's June 2024 report (Kimball et al., 2024) is accompanied by state "snapshots" that summarize, by state: call center capacity, estimated number of mobile response teams needed, estimated number of 23-hour crisis receiving chairs (and short-term crisis residential beds) needed, and current system financing (e.g., 988 telecommunications surcharge, enhanced Medicaid match for mobile crisis) and system accountability (e.g., crisis system advisory board, annual legislative reporting). As

other examples, NRI produces “State Profiles” reports (NRI, 2025a; NRI, 2025b; NRI 2025c), and KFF has made substantial resources available (e.g., Saunders et al., 2023).

Setting the Stage: Key Events During the 2014–2024 Timeframe

Before presenting the policy analysis, it is important to recognize key events during the 11-year period of interest that likely had an impact on expansion of crisis services. With regard to federal legislation, multiple enacted laws had a major impact, including the National Suicide Hotline Improvement Act of 2018 (August 14, 2018) and the National Suicide Hotline Designation Act of 2020 (October 17, 2020), both during the first Trump Administration, with the subsequent national go-live of the 988 Suicide and Crisis Lifeline on July 16, 2022, during the Biden Administration (Draper and McKeon, 2024). These efforts coincided with rising rates of suicide and opioid overdose deaths, which have been conceptualized as “deaths of despair,” as well as growing health-related inequities and an increasing recognition of the impact of the social determinants of health and health-related social needs.

The most significant global event during this period was the COVID-19 pandemic, declared by the World Health Organization on March 11, 2020. Federal legislation to address the massive societal impacts of the pandemic included the Coronavirus Aid, Relief, and Economic Security (CARES) Act on March 27, 2020, and the Coronavirus Response and Relief Supplemental Appropriations Act of 2021 (CRRSAA, which is Division M of the Consolidated Appropriations Act of 2021) on December 27, 2020, both during the first Trump Administration, and the American Rescue Plan Act (ARPA) on March 11, 2021 during the Biden Administration. ARPA arguably represents the most significant step forward in expanding and enhancing crisis services. It provided an influx of $825 million to states through the SAMHSA Mental Health Block Grant in response to the mental health tolls of the pandemic. It also established CMS incentives for states to establish qualifying mobile crisis team services (SAMHSA, 2021b). Specifically, through ARPA, CMS made available $15,000,000 in state planning grants (detailed in Chapter 6), a higher federal match rate for qualifying mobile crisis teams, and federal administrative matching funds for the development and implementation of technology to support the crisis continuum (Saunders, 2023). Other key federal acts include the Bipartisan Safer

Communities Act (BSCA) on June 25, 2022, and the Consolidated Appropriations Act of 2023 on December 29, 2022, both during the Biden Administration.

The 2014–2024 time period was also met with social upheaval—again highly relevant to the expansion and improvement of non-police-based crisis response—and the rise of the Black Lives Matter and related movements, especially after the police-related deaths of Daniel Prude in Rochester, New York (March 23, 2020) and George Floyd in Minneapolis, Minnesota (May 25, 2020), among countless others. Against this societal backdrop, Congress directed SAMHSA "to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. Congress specifically provided an increase to federal fiscal year (FY) 2021 MHBG appropriation over the FY 2020 level to help states meet this new requirement without losing funds for existing services" (SAMHSA, 2021c).

As detailed in Chapter 5, the CCBHC model was signed into law and implemented during the 2014–2024 period, with both CMS and SAMHSA releasing many millions of dollars toward this major mental health advancement. CCBHCs provide an array of services, including, by definition, crisis services (Mauri et al., 2024; Mauri et al., 2025a). Other sociopolitical movements have been at play. For example, following numerous Olmstead-related lawsuits (Olmstead v. L.C., 527 U.S. 581 (1999)) concerning unjustified institutionalization, states have been prompted to create more robust community crisis services—including mobile crisis teams, crisis walk-in centers, crisis stabilization units, and various types of community-based mental health and housing services—to prevent unnecessary institutionalization during mental health emergencies and to ensure that individuals with disabilities can live and receive care in their communities. (The Olmstead Supreme Court decision established that overly restrictive institutionalization of people with disabilities is illegal discrimination under the Americans with Disabilities Act (ADA) and requires states to provide community-based services in the most integrated setting appropriate to the individual's needs; U.S. Department of Health and Human Services, no date). As one example, in March of 2023, a DOJ investigation found that Louisville, Kentucky had violated the ADA by using police for mental health calls that posed no safety threat—calls that could have been addressed by a mobile crisis team instead of law enforcement (Saunders, 2023). Such investigations and impact litigation have pushed the field forward.

In summary, 2014–2024 was characterized by two extremely divergent presidential administrations, major societal strain and stress, and social unrest and upheaval. It was also a

period of relatively rapid advances in the mental health sector with regard to both CCBHCs and crisis system expansion, the latter perhaps spurred on in large part by the implementation of 988. As one considers the chapters that follow, all of these events must be remembered—if not considered explicitly—in understanding states' variable uses of federal funding mechanisms to expand and enhance crisis services during 2014–2024.

While our period of interest ended on 12/31/2024, it should be noted that subsequent policy actions (through state and federal executive actions, legislation, and court decisions) could have substantial impact on the funding of crisis services. Just two examples that are seen as very worrisome within the crisis services community are given here. First, H.R. 1 (referred to by the Trump Administration as the "One Big Beautiful Bill Act of 2025") is positioned to have major detrimental impacts on state Medicaid programs. For example, provisions pertaining to work requirements "are expected to reduce federal spending by $326 billion over 10 years. This is the largest share of federal Medicaid savings in the bill. And those savings come from coverage losses—that people won't be able to keep up with these requirements, and they'll lose Medicaid. This is estimated to lead to coverage losses exceeding 5 million people by 2034" (American Medical Association, 2025). Second, President Trump's July 24, 2025 Executive Order titled "Ending Crime and Disorder on America's Streets," is seen by many as representing "a major step backward in civil rights" after progress had been made in safeguarding constitutional protections, implementing the Americans with Disabilities Act (ADA) integration mandate, and investing in voluntary, community-based supports (Allbright, 2025). Such policy actions, among many others, could prominently impact the context in which crisis services are implemented going forward.

Setting the Stage: An Overview of State Mental Health Agencies (SMHSAs)

Before presenting the policy analysis, it is important to recognize the wide variation across states in mental health services delivery and thus crisis services capacity and delivery. The tables that follow provide details across the 51 states on a range of key variables related to clients served, service utilization rates, Medicaid funding status, and state expenditures on crisis services. To create **Tables A1, A2, and A3** below, we extracted variables from SAMHSA's Uniform Reporting System (URS) reports for the 50 states and the District of Columbia

(SAMHSA, 2023a). Fiscal Year 2023 URS reports (the most recently available reports at the time of our data collection) were compiled from the State Mental Health Agency (SMHA) reports under the Mental Health heading where a year and state can be selected (https://www.samhsa.gov/data/data-we-collect/urs-uniform-reporting-system). URS reports are constructed annually by SMHAs in support of the Community Mental Health Services Block Grant program. Data on utilization, outcomes, and the use of evidence-based practices are collected to provide an overview of state mental health delivery systems. (We acknowledge that there may be limitations in the validity of URS data because there is substantial between-state variability—especially for crisis services variables—and some of the variability may be an artifact of differences in how states interpret, track, and report on the different URS variables.) We rounded dollar figures and percentages to whole numbers. As shown, the reported data from the SMHAs varies considerably.

Table A1 provides an overview of the types of clients served by SMHAs. It shows that SMHAs report that as low as 14% (Maine, Vermont), one quarter (Nevada), and roughly one third (e.g., Arkansas, Kansas, Louisiana, New Jersey, West Virginia) of clients served meet the federal SMI definition, with 12 states reporting that 100% of clients served meet that definition. As few as 6–9% of adults served (Colorado, Wyoming, Wisconsin) are reported to have a co-occurring mental health and substance use disorder (SUD), to as many as 51–54% (Alaska, Connecticut, Missouri, Rhode Island). There is also substantial variability in clients served with access to supported housing and supported employment, and those who are employed. For the U.S. as a whole, 71% of clients served by SMHAs meet the federal SMI definition; 28% of adults have co-occurring mental illness and SUD; 2.3%, 3.3%, and 2.1% receive assertive community treatment, supported housing, and supported employment, respectively; and 28% of clients served are employed.

Table A1. Overview of Clients Served by SMHAs in FY 2023 (per SAMHSA URS)

STATE	Percent of Clients Who Meet the Federal SMI Definition	Adults With Co-Occurring MH/SUD	Assertive Community Treatment	Supported Housing	Supported Employment	Employed	Adults Arrested This Year
U.S.	**71%**	**28%**	**2.3%**	**3.3%**	**2.1%**	**28%**	
STATES REPORTING *	**57**	**55**	**43**	**34**	**39**	**58**	
ALABAMA	89%	19%	1%	1%	0%	22%	6%
ALASKA	54%	51%	2%	4%	5%	40%	4%
ARIZONA	59%	23%	2%	0%	9%	48%	11%
ARKANSAS	31%	15%	2%	0%	0%	27%	4%
CALIFORNIA	100%	21%	3%	1%	1%	13%	9%
COLORADO	72%	6%	31%	3%	4%	37%	2%
CONNECTICUT	78%	51%	3%	6%	6%	29%	-
DELAWARE	100%	18%	1%	0%	0%	29%	-
DISTRICT OF COLUMBIA	71%	15%	7%	4%	1%	17%	5%
FLORIDA	100%	11%	3%	2%	1%	30%	47%
GEORGIA	82%	31%	2%	5%	5%	18%	14%
HAWAII	100%	25%	-	10%	-	15%	-
IDAHO	100%	11%	2%	-	1%	4%	-
ILLINOIS	61%	43%	3%	-	19%	15%	-
INDIANA	100%	31%	1%	4%	1%	27%	-
IOWA	100%	14%	-	-	-	72%	-
KANSAS	33%	13%	-	18%	8%	38%	8%
KENTUCKY	56%	10%	1%	0%	1%	29%	2%
LOUISIANA	39%	34%	0%	-	0%	30%	1%

STATE	Percent of Clients Who Meet the Federal SMI Definition	Adults With Co-Occurring MH/SUD	Assertive Community Treatment	Supported Housing	Supported Employment	Employed	Adults Arrested This Year
U.S.	**71%**	**28%**	**2.3%**	**3.3%**	**2.1%**	**28%**	
STATES REPORTING *	**57**	**55**	**43**	**34**	**39**	**58**	
MAINE	14%	42%	8%	-	2%	22%	2%
MARYLAND	68%	40%	2%	25%	2%	28%	-
MASSACHUSETTS	83%	25%	9%	-	-	-	2%
MICHIGAN	100%	39%	3%	0%	3%	19%	-
MINNESOTA	100%	37%	62%	38%	-	30%	-
MISSISSIPPI	100%	11%	3%	1%	1%	19%	6%
MISSOURI	96%	53%	2%	4%	2%	20%	5%
MONTANA	90%	29%	4%	-	0%	33%	5%
NEBRASKA	55%	15%	1%	9%	8%	41%	4%
NEVADA	25%	17%	3%	13%	-	52%	-
NEW HAMPSHIRE	100%	24%	6%	3%	80%	37%	3%
NEW JERSEY	37%	22%	2%	5%	1%	28%	10%
NEW MEXICO	77%	30%	0%	0%	-	84%	-
NEW YORK	88%	23%	1%	5%	0%	28%	2%
NORTH CAROLINA	72%	32%	5%	-	-	29%	2%
NORTH DAKOTA	45%	46%	7%	-	2%	46%	9%
OHIO	40%	20%	-	-	2%	52%	6%
OKLAHOMA	60%	39%	2%	1%	4%	30%	2%
OREGON	-	30%	1%	-	2%	32%	3%
PENNSYLVANIA	59%	19%	1%	2%	0%	27%	2%

STATE	Percent of Clients Who Meet the Federal SMI Definition	Adults With Co-Occurring MH/SUD	Assertive Community Treatment	Supported Housing	Supported Employment	Employed	Adults Arrested This Year
U.S.	**71%**	**28%**	**2.3%**	**3.3%**	**2.1%**	**28%**	
STATES REPORTING *	**57**	**55**	**43**	**34**	**39**	**58**	
RHODE ISLAND	77%	53%	12%	3%	2%	27%	3%
SOUTH CAROLINA	96%	30%	-	-	-	23%	-
SOUTH DAKOTA	100%	-	-	-	-	52%	-
TENNESSEE	83%	29%	0%	1%	1%	30%	-
TEXAS	95%	30%	2%	2%	1%	32%	-
UTAH	57%	12%	1%	2%	2%	33%	-
VERMONT	14%	22%	-	-	17%	38%	-
VIRGINIA	69%	42%	4%	5%	2%	27%	-
WASHINGTON	79%	15%	1%	-	-	24%	3%
WEST VIRGINIA	36%	33%	3%	-	-	20%	-
WISCONSIN	58%	9%	-	-	-	29%	6%
WYOMING	42%	7%	-	-	-	53%	3%

* SAMHSA's URS report includes territories and DC alongside the 50 states, leading to totals such as 58 or 59 jurisdictions reporting, depending on data submission for that year.

As shown in **Table A2**, there is also meaningful variability across SMHAs' community utilization rate per 1,000 population (community services refer to all services provided in a community rather than inpatient setting; i.e., clients that receive publicly funded mental health services in community mental health settings per 1,000 population), state hospital utilization rate per 1,000 population, and other psychiatric inpatient utilization rate per 1,000 population (the latter meaning inpatient psychiatric services provided in a private psychiatric hospital, a psychiatric bed in a general hospital, or any other psychiatric inpatient bed that is not part of a state psychiatric hospital). The total clients served in community settings also varies considerably (spanning from just over 9,000 in Delaware and Hawaii to 596,053 in California and 774,445 in New York). The Medicaid Funding Status Percentage (the percentage of individuals served by the SMHA who had at least some of their services reimbursed through Medicaid during the reporting year, including both clients whose services were entirely paid by Medicaid ("Medicaid Only"), and those who received services financed by a mix of Medicaid and other funding sources) ranges from 24% in Wyoming, 34% in Georgia, and 41% in New Jersey and Texas, to ≥95% in the District of Columbia, Illinois, Maine, Maryland, Minnesota, New Mexico, Oregon, and Pennsylvania.

Table A2. Overview of Utilization Rates and Medicaid Funding Status, FY 2023 (per SAMHSA URS)

STATE	Community Utilization Per 1,000 Population Rate	Clients Served in Community Settings	State Hospital Utilization Per 1,000 Population Rate	Clients Served in State Hospitals	Other Psychiatric Inpatient Utilization Per 1,000 Population Rate	MEDICAID Funding Status	MEDICAID Only	Both MEDICAID and Other Funds	Non - MEDICAID
ALABAMA	18.08	91,731	0.13	651	0.24	59%	40%	20%	41%
ALASKA	30.29	22,199	0.76	557	0.28	79%	73%	6%	21%
ARIZONA	18.08	91,731	0.13	651	0.24	59%	40%	41%	21%
ARKANSAS	21.80	66,370	0.10	315	0.10	76%	76%	-	24%
CALIFORNIA	15.27	596,053	0.23	9,140	0.45	78%	59%	20%	22%
COLORADO	21.08	123,071	0.18	1,053	-	88%	47%	42%	12%
CONNECTICUT	25.57	92,733	0.33	1,198	0.04	69%	65%	4%	31%
DELAWARE	8.96	9,119	0.24	246	2.68	69%	64%	5%	31%
DISTRICT OF COLUMBIA	64.51	43,283	0.74	494	2.74	95%	93%	2%	5%
FLORIDA	8.27	183,983	0.23	5,179	0.13	-	-	-	100%
GEORGIA	10.41	113,638	0.19	2,127	0.69	34%	27%	7%	66%
HAWAII	6.48	9,334	0.47	677	0.04	65%	19%	46%	35%
IDAHO	6.11	11,851	0.99	1,916	2.77	-	-	-	-
ILLINOIS	2.08	26,151	0.30	3,791	-	100%	100%	-	-
INDIANA	20.98	143,342	0.19	1,281	0.07	78%	70%	8%	22%
IOWA	93.35	298,708	0.18	581	5.20	94%	89%	5%	6%
KANSAS	17.17	50,441	0.84	2,470	-	62%	22%	40%	39%
KENTUCKY	31.63	142,703	0.90	4,061	0.33	69%	56%	14%	31%
LOUISIANA	9.39	43,087	0.24	1,088	-	80%	34%	46%	20%
MAINE	46.70	64,681	0.27	369	4.03	99%	100%	-	1%

STATE	Community Utilization Per 1,000 Population Rate	Clients Served in Community Settings	State Hospital Utilization Per 1,000 Population Rate	Clients Served in State Hospitals	Other Psychiatric Inpatient Utilization Per 1,000 Population Rate	MEDICAID Funding Status	MEDICAID Only	Both MEDICAID and Other Funds	Non - MEDICAID
MARYLAND	41.91	258,323	0.27	1,650	1.94	97%	89%	9%	3%
MASSACHUSETTS	3.61	25,212	0.23	1,618	0.04	72%	28%	44%	28%
MICHIGAN	26.58	266,748	0.13	1,343	2.49	92%	92%	-	8%
MINNESOTA	65.65	375,338	0.63	3,612	3.94	95%	87%	8%	5%
MISSISSIPPI	26.04	76,549	0.65	1,914	-	58%	59%	-	42%
MISSOURI	10.70	66,071	0.24	1,471	-	80%	69%	11%	20%
MONTANA	67.83	76,101	0.75	847	2.08	93%	86%	7%	7%
NEBRASKA	9.18	18,065	0.26	514	1.15	69%	58%	11%	31%
NEVADA	4.74	15,049	0.31	989	-	45%	22%	23%	55%
NEW HAMPSHIRE	30.63	42,735	0.4	562	2.47	86%	49%	37%	14%
NEW JERSEY	35.36	327,456	0.18	1,702	1.97	41%	33%	8%	59%
NEW MEXICO	101.31	214,062	0.15	311	0.23	97%	94%	2%	3%
NEW YORK	39.36	774,445	0.35	6,824	3.72	59%	47%	12%	41%
NORTH CAROLINA	6.83	73,029	0.12	1,258	1.40	73%	72%	2%	27%
NORTH DAKOTA	13.30	10,364	0.97	759	1.03	-	-	40%	61%
OHIO	34.39	404,246	0.30	3,518	1.68	92%	88%	4%	8%
OKLAHOMA	31.36	126,049	0.62	2,479	0.65	49%	6%	44%	51%
OREGON	42.87	181,756	0.36	1,510	1.20	97%	94%	3%	3%
PENNSYLVANIA	38.99	505,788	0.17	2,239	2.98	97%	96%	0%	3%
RHODE ISLAND	25.62	28,001	0.18	193	-	66%	23%	44%	34%
SOUTH CAROLINA	17.93	94,707	0.19	980	-	54%	42%	12%	46%

STATE	Community Utilization Per 1,000 Population Rate	Clients Served in Community Settings	State Hospital Utilization Per 1,000 Population Rate	Clients Served in State Hospitals	Other Psychiatric Inpatient Utilization Per 1,000 Population Rate	MEDICAID Funding Status	MEDICAID Only	Both MEDICAID and Other Funds	Non - MEDICAID
SOUTH DAKOTA	12.77	11,610	0.96	873	-	-	-	-	-
TENNESSEE	57.39	404,629	0.71	4,991	3.51	86%	86%	1%	14%
TEXAS	15.09	453,066	0.61	18,248	0.23	41%	-	41%	59%
UTAH	17.66	59,690	0.16	532	0.59	67%	56%	11%	33%
VERMONT	39.88	25,802	0.09	60	0.73	66%	6%	60%	34%
VIRGINIA	13.88	120,547	0.60	5,250	2.30	79%	41%	38%	21%
WASHINGTON	38.97	30,3405	0.26	2,046	0.15	93%	92%	1%	7%
WEST VIRGINIA	14.12	25,066	0.89	1,575	0.56	60%	40%	20%	40%
WISCONSIN	11.34	66,809	0.92	5,400	0.09	72%	-	72%	28%
WYOMING	22.58	13,118	0.31	181	-	24%	15%	9%	77%

Table A3 shows State Expenditures from State Sources (i.e., excluding all federal sources and federal match funding, the rate thus indicating the percentage of mental health expenditures that come from state sources) range from $2,462,797 in Rhode Island (3% of SMHA expenditures being from state sources), $22,160,337 in Wyoming (33%), and $42,655,872 in Iowa (4%) to over $1 billion in Massachusetts (95%), Pennsylvania (19%), and Texas (85%), and over $2 billion in California (25%) and New York (29%). References to "state expenditures" pertain to mental health expenditures by the SMHA, not overall mental health spending in the state (which could include Medicare, commercial insurance, and out-of-pocket spending).

Importantly, this table also gives SMHAs' reports of *State Funds Used for Crisis Services* (dollar amounts), as well as SMHA *Crisis Services Spending as a Percentage of Total State Expenditures*, with crisis services defined as: "…centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or statewide crisis call centers coordinating in real time that connect people as soon as possible to care…Crisis services are for anyone who is in a behavioral health crisis regardless of their SMI or SED status. Crisis services should not be viewed as stand-alone resources operating independent of the local community mental health and hospital systems but rather as an integrated part of a coordinated continuum of care." (SAMHSA, 2022a). This figure spans from 0–2% (in California, Connecticut, Idaho, Indiana, Kansas, Kentucky, Louisiana, Maryland, Michigan, Montana, Nevada, New Jersey, New Mexico, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Washington, and Wisconsin) to ≥10% in six states: Delaware (10%), Mississippi (10%), North Dakota (10%), South Dakota (10%), Utah (13%), Minnesota (28%), Georgia (23%), and Arizona (66%). As noted previously, we acknowledge potential validity limitations of URS data given that states vary in how they interpret, track, and report on the different variables.

Table A3. Overview of SMHA Expenditures, FY 2023 (per SAMHSA URS)

STATE	State Expenditures from State Sources	State Expenditures from State Sources Rate	FY 2023 Per Capita Community MH Expenditures	FY 2023 Per Capita Total SMHA MH Expenditures	State MHBG Funds Used for Crisis Services	Crisis Services % of Total State Expenditures	Community Percent of Total SMHA Spending	Total SMHA MH Expenditures
ALABAMA	$522,603,629	77%	$113	$133	$47,717,286	7%	85%	$677,445,977
ALASKA	$54,036,554	25%	$193	$294	$7,711,096	4%	66%	$215,714,222
ARIZONA	$108,063,573	32%	$33	$46	$225,184,177	66%	72%	$339,921,322
ARKANSAS	$97,775,839	84%	$23	$38	$5,332,875	5%	59%	$116,730,461
CALIFORNIA	$2,093,927,000	25%	$145	$219	$27,769,241	0%	66%	$8,518,278,363
COLORADO	$283,565,577	76%	$27	$64	$25,062,793	7%	43%	$374,779,628
CONNECTICUT	$882,033,474	79%	$203	$308	$22,585,180	2%	66%	$1,113,273,014
DELAWARE	$120,993,145	76%	$90	$155	$15,825,704	10%	58%	$160,092,413
DISTRICT OF COLUMBIA	$211,037,779	78%	$165	$401	$18,157,266	7%	41%	$272,276,019
FLORIDA	$972,469,170	80%	$29	$54	$49,813,342	4%	55%	$1,212,453,551
GEORGIA	$837,697,728	92%	$53	$83	$211,656,698	23%	64%	$912,255,413
HAWAII	$196,334,823	93%	$63	$147	$11,201,253	5%	43%	$211,460,104
IDAHO	$103,175,097	73%	$43	$72	$1,195,636	1%	59%	$141,390,918
ILLINOIS	$490,961,977	49%	$54	$79	$79,255,192	8%	68%	$997,123,713
INDIANA	$286,589,215	38%	$80	$111	$386,080	0%	72%	$759,815,483
IOWA	$42,655,872	4%	$269	$313	$54,320,579	5%	86%	$1,003,106,415
KANSAS	$255,352,209	42%	$153	$208	$6,815,296	1%	73%	$611,317,595
KENTUCKY	$150,572,172	57%	$20	$59	$3,173,197	1%	34%	$265,216,878
LOUISIANA	$213,329,371	22%	$100	$210	$13,579,171	1%	48%	$962,473,047

STATE	State Expenditures from State Sources	State Expenditures from State Sources Rate	FY 2023 Per Capita Community MH Expenditures	FY 2023 Per Capita Total SMHA MH Expenditures	State MHBG Funds Used for Crisis Services	Crisis Services % of Total State Expenditures	Community Percent of Total SMHA Spending	Total SMHA MH Expenditures
MAINE	$84,827,268	25%	$173	$240	$20,101,196	6%	72%	$335,056,951
MARYLAND	$546,663,875	91%	$33	$97	$14,279,105	2%	34%	$599,979,380
MASSACHUSETTS	$1,094,996,637	95%	$122	$165	$38,884,630	3%	74%	$1,157,250,881
MICHIGAN	$554,095,865	78%	-	$70	$3,411,002	0%	1%	$706,461,260
MINNESOTA*	$234,251,938	26%	$111	$183	$11,152,934	28%	75%	$724,175,862
MISSISSIPPI	$116,934,934	40%	$55	$99	$28,750,807	10%	55%	$290,160,913
MISSOURI	$358,288,965	40%	$99	$143	$71,704,011	8%	69%	$886,257,048
MONTANA	$114,030,031	31%	$230	$322	$8,690,877	2%	71%	$365,274,086
NEBRASKA	$144,844,641	45%	$118	$164	$8,743,547	3%	72%	$324,200,791
NEVADA	$113,605,512	82%	$14	$43	$602,430	0%	31%	$138,140,121
NEW HAMPSHIRE	$113,653,223	25%	$265	$328	$16,823,066	4%	81%	$460,305,000
NEW JERSEY	$857,914,965	45%	$161	$207	$602,592	0%	78%	$1,923,923,133
NEW MEXICO	$64,561,957	15%	$168	$199	$1,500,000	0%	84%	$420,417,949
NEW YORK	$2,145,600,000	29%	$263	$376	-	-	70%	$7,359,865,217
NORTH CAROLINA	$304,709,171	26%	$69	$110	$1,925,971	0%	63%	$1,191,186,700
NORTH DAKOTA	$116,208,008	88%	$104	$169	$12,951,107	10%	62%	$132,539,327
OHIO	$411,714,438	15%	$215	$242	$10,727,002	0%	89%	$2,846,364,195
OKLAHOMA	$304,331,968	63%	$97	$119	$8,913,700	2%	82%	$484,072,693
OREGON	$619,430,596	27%	$447	$546	$49,867,363	2%	82%	$2,309,436,613
PENNSYLVANIA	$1,045,704,459	19%	$344	$423	$38,301,050	1%	82%	$5,478,691,973
RHODE ISLAND	$2,462,797	3%	$57	$77	$1,812,015	2%	74%	$84,842,574
SOUTH CAROLINA	$319,802,572	56%	$66	$107	$7,012,057	1%	62%	$573,117,798
SOUTH DAKOTA	$63,800,906	62%	$53	$112	$9,843,378	10%	47%	$103,104,357

STATE	State Expenditures from State Sources	State Expenditures from State Sources Rate	FY 2023 Per Capita Community MH Expenditures	FY 2023 Per Capita Total SMHA MH Expenditures	State MHBG Funds Used for Crisis Services	Crisis Services % of Total State Expenditures	Community Percent of Total SMHA Spending	Total SMHA MH Expenditures
TENNESSEE	$249,530,755	24%	$102	$148	$50,284,569	5%	69%	$1,058,220,930
TEXAS	$1,178,777,869	85%	$29	$46	$127,283,685	9%	63%	$1,390,387,856
UTAH	$147,672,494	44%	$71	$97	$42,209,964	13%	73%	$332,658,921
VERMONT	$11,188,797	4%	$364	$435	$8,614,129	3%	84%	$281,697,787
VIRGINIA	$888,874,628	74%	$70	$138	$41,467,584	3%	50%	$1,205,209,315
WASHINGTON	$832,955,618	36%	$201	$294	$12,773,459	1%	68%	$2,296,904,230
WEST VIRGINIA	$140,746,880	71%	$29	$111	$5,676,564	3%	26%	$197,033,010
WISCONSIN	$159,601,586	13%	$153	$201	$8,056,173	1%	76%	$1,189,043,772
WYOMING	$22,160,337	33%	$39	$115	$1,819,097	3%	34%	$66,900,909

* These figures (for Minnesota) are an average of 2018, 2019, and 2022 datapoints as the 2023 datapoints appear to have been incorrect (e.g., State Expenditures from State Sources reported to be $145,087). Crisis services funding amount was averaged for 2022 and 2023.

This background information about the states reminds us of the remarkable variability across states, which must be kept in mind when "comparing" the states on their variable leveraging of federal mechanisms to expand and enhance crisis services. Not only do states differ drastically with regard to geography, demography, population density, social norms, political ideologies, and policymaking, but they also differ in mental health funding and capacity (though, as noted above, the states could also differ in how they interpret URS questions and the data that they have available to answer the questions, prompting caution when interpreting URS data). The numbers of clients served varies drastically across states; among those clients, the percentage with Medicaid varies drastically across states; and total and per capita expenditures on mental health varies drastically across states. Because mental health and substance use services delivery and funding varies substantially across the states, it should be no surprise that behavioral health crisis services and their funding will also vary considerably. As one considers the chapters that follow, findings regarding specific states must be understood in this context of variability. It should also be noted that there is variation in how services are organized; for example, many SMHAs provide funding to counties, though others fund community service boards or related regional entities (which may serve one or multiple counties). There is also local, within-state variation that we are unable to capture in this project.

Structure of the Pages That Follow

Our policy analysis findings are reported in the nine "Chapters" on the nine federal mechanisms that follow. Each Chapter is structured in four sections: Background, Approach, Findings, and Table(s). The *Background* section provides a brief overview of the mechanism itself, with a focus on the mechanism's relevance with regard to crisis services. The *Approach* section details how we collected and tabulated data, providing sufficient detail for our analysis to be replicated. The *Findings* section gives an overview or summary of the policy analysis for that mechanism. One or two *Tables* are then provided with detailed numerical data or descriptive summaries of how states or organizations have leveraged mechanisms and spent funds for expanding and enhancing crisis services. The nine Chapters are presented in the following order:

(1) Medicaid State Plan Amendments (SPAs)

(2) Children's Health Insurance Program (CHIP) SPAs

(3) Medicaid Section 1115 Demonstration Waivers

(4) Medicaid Home and Community Based Services (HCBS) Authorities under 1915(c)

(5) Certified Community Behavioral Health Clinics (CCBHCs)

(6) CMS Planning Grants for Crisis Services

(7) SAMHSA Cooperative Agreements for Innovative Community Crisis Response Partnerships

(8) SAMHSA Mental Health Services Block Grant and Supplemental Funds

(9) Bureau of Justice Assistance (BJA) Byrne State Crisis Intervention Program Grants

After the nine Chapters, we provide a *Summary/Synthesis* of policy analysis findings across the nine mechanisms. We then offer *Recommendations to Local Providers, State Governments, and the Federal Government* based on everything we learned (with a focus especially on state government). Finally, we discuss a number of *Other Considerations* of importance to enhancing crisis services.

1. Medicaid State Plan Amendments (SPAs)

1. Medicaid State Plan Amendments (SPAs)

Background

The federal government and each state enter into a contract known as a Medicaid "state plan," which specifies how the Medicaid program will be administered in the state. The plan covers how providers will be reimbursed, what populations will be covered, and the exact services provided by the program. Any change that a state looks to make regarding its plan, such as in program policies and operational strategies, must be sent as an amendment to the Center for Medicare and Medicaid Services (CMS) for approval. Additionally, amendments can make large program changes, include new information on services, or make minor corrections. This Chapter presents states' SPAs, with an effective date within 2014–2024, that we deemed relevant to the expansion or enhancement of crisis services, as well as our rating of the level of impact of those SPAs.

Some SPAs are directly in response to new federal policies pertaining to Medicaid. For example, and importantly for our purposes, a new state Medicaid option was established for eligible community mobile crisis teams under Section 9813 of the American Rescue Plan Act (ARPA) passed in March 2021. States that choose to use this option can receive an 85% Federal Medical Assistance Percentage (FMAP) for Medicaid beneficiaries' mobile crisis response payments for the first 12 fiscal quarters within a period of up to five years: April 1, 2022, to March 31, 2027. Mobile crisis response services can be provided through either a fee-for-service (FFS) or managed care delivery system with additional documentation required for rate setting through FFS. Approved coverage could qualify through submission of a SPA, Section 1915(b) waiver, Section 1915(c) home and community-based services waiver, or Section 1115 demonstration project. States would need to apply separately for each type of waiver or demonstration used to receive the enhanced match (CMS, 2021a).

For example, if a state uses a 1915(c), they will need to outline the rate setting methodology and cost estimates in their application for any services the state wants an enhanced rate for (CMS, no date #1). However, in this example, states ultimately primarily use SPAs to obtain the enhanced match for mobile crisis response services. For states to have a SPA for enhanced mobile crisis rates approved, the services need to meet specific standards explained in

a CMS letter to state officials (CMS, 2021a). To continue with this example of a SPA, there are four main groupings of requirements needed to receive an enhanced match rate. First, community-based teams must be available 24/7, every day of the year, responding to crises in a timely manner. Second, all team members must be trained in trauma-informed care, de-escalation strategies, and harm reduction. Third, teams must include two professionals, with at least one behavioral health professional; the second team member may be a paraprofessional such as a peer support specialist. Specifically, the guidance states, "Under section 1947(b)(2)(A), the team must include at least one behavioral health care professional who is qualified to provide an assessment within their authorized scope of practice under state law, and should also include other professionals or paraprofessionals with expertise in behavioral health or mental health crisis intervention. These additional community-based mobile crisis intervention services team members may include nurses, social workers, trained peer support specialists and others with relevant experience and expertise as identified by the state in its state plan, waiver or Section 1115 demonstration." Generally, states at a minimum have two professionals, though the actual composition of these teams can vary state to state (Saunders, 2023). Lastly, mobile crisis teams must be connected to community partners. Other suggestions from CMS include teams carrying naloxone and being trained in its administration to reverse opioid overdoses. Teams can also consider using telehealth at the outset of a crisis or during follow-up.

An amendment or waiver may not be required if mobile crisis teams already meet standards. Furthermore, Medicaid reimbursement for mobile crisis is reserved for qualified participants. Providers can attempt to enroll an uninsured person in Medicaid if they require mobile crisis services and can submit claims with retroactive coverage so patients can receive follow-up care (Saunders, 2023).

A state submitting a SPA to obtain the enhanced match for mobile crisis response services is just one example of a SPA that could directly and intentionally expand or enhance crisis care. Other types of SPAs of relevance here establish mobile crisis response services or crisis stabilization unit services as a newly covered benefit, for example. Additionally, as detailed below, some SPAs that are not directly and intentionally focused on crisis services also have an indirect impact on expanding or enhancing crisis services. As we will show, states regularly and repeatedly submit SPAs, with some states being more active in amending their Medicaid state plans than others.

Approach

Medicaid SPAs relevant to this project were identified using the following methodology.

1. The search was conducted using this Medicaid.gov website: https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html.
2. At the time of our search, at "Refine Your Search" on the right side of the website, the "Filter by Effective Date" was used with these dates: 01/01/2014 and 12/31/2024, and "Filter by Approval Date" was set to blank.
3. Then, the specific state was selected using "Filter by State." The number of total SPAs for that state during our 11-year period was recorded (e.g., 110 for Alabama, 103 for Alaska, 224 for Arizona) and documented in the first table below, **Table 1a**.
4. A series of searches was then conducted using the main search bar (resetting filters between searches), which queries the "Summary" of the SPAs for that state for the 11-year period (again, for example, 110 for Alabama, 103 for Alaska, 224 for Arizona). In this series of searches, the following search words were used in an iterative fashion: "crisis," "mental," "behavior," "rescue" (pertaining to the American Rescue Plan Act), and "rehabilitative."
5. The total number of SPAs returned from that search was then recorded (of note, some search words generated duplicate results, which were reconciled). As an example, for Alabama, among 110 total SPAs during the 11-year period, 8 were identified as "Potentially Relevant" and thus warranting review. The number of "Potentially Relevant" SPAs for Alaska (from among 103 total) was 10, and the number of "Potentially Relevant" SPAs for Arizona (from among 224 total) was 14, as given in the **Table 1a**.
6. The Approval Document (available on the website) for each "Potentially Relevant" SPA was then reviewed, including a scan of the overall structure of the Approval Document, transmittal documentation between the State and CMS, a search of the PDF for "crisis" and related terms, comparisons with prior (superseded) SPAs, etc. Based on this review of the Approval Document, the SPA was deemed (1) Not Relevant, (2) Relevant, (3) Crisis-Related but Not Relevant, or (4) Uncertain and Needing Further Review.
7. That categorization led to the following actions:
    a. Not Relevant: the SPA was not considered further (e.g., 7 of 8 for Alabama, 10 of 10 for Alaska, 13 of 14 for Arizona).

b. Relevant: details of the SPA were included in a spreadsheet.
c. Crisis-Related but Not Relevant: there was some mention of crisis services, though the SPA did not rise to the level of importance to be deemed Relevant to the project; basic details of these SPAs were recorded.
d. Uncertain and Needing Further Review: a secondary review of the SPA was conducted by the PI (Compton) so that the Policy Analyst (Dua) and the PI could arrive at a consensus decision together. When a third opinion was desired, the SPA was taken to the full project team for review and discussion.

8. A subgroup of the research team (Compton, Pope, Dua) held multiple consecutive meetings for two purposes; one was to confirm that each SPA deemed Relevant above was in fact Relevant (or else to move it to the "Not Relevant" category), and then to rate each of the final 115 Relevant SPAs in terms of impact, as detailed below.

As shown in the **Table 1a** below, there were a total of 10,951 SPAs for the 2014–2024 period (mean = 214.7±99.7 across states, with a (low) range of 54, 77, and 82 in Tennessee, Hawaii, and West Virginia to a (high) range of 357, 421, and 544 in Ohio, California, and New York). There was a total of 888 "Potentially Relevant" SPAs (mean = 17.4±10.7 across states, with a (low) range of 2, 3, and 4 in Hawaii, Tennessee, and Florida to a (high) range of 42, 45, and 52 in New York, Minnesota, and Massachusetts). In terms of SPAs ultimately deemed relevant (mean = 2.3±2.2 across states), 12 states had 0, 11 states had 1, 10 states had 2, seven states had 3, three states had 4, three states (Arkansas, California, Idaho) had 5, three states (Kansas, Louisiana, Minnesota) had 6, Massachusetts had 8, and New York had 10.

Table 1a. Numbers of State Plan Amendments (SPAs) and Those Deemed "Not Relevant" and "Relevant," by State, 2014–2024

STATE	Total SPAs (Effective Date, 1/1/2014–12/31/2024)	Number of "Potentially Relevant" SPAs Returned by Key Word Search	Number of Those SPAs Reviewed and Deemed Not Relevant	Number of SPAs Deemed Relevant and Reviewed in Detail
Alabama	110	8	7	1
Alaska	103	10	10	0
Arizona	224	14	13	1
Arkansas	155	16	11	5
California	421	28	23	5
Colorado	356	19	18	1
Connecticut	351	22	22	0
Delaware	103	14	12	2
District of Columbia	152	17	14	3
Florida	129	4	4	0
Georgia	122	8	6	2
Hawaii	77	2	1	1
Idaho	119	15	10	5
Illinois	219	25	22	3
Indiana	156	25	23	2
Iowa	306	13	13	0
Kansas	272	24	18	6
Kentucky	178	13	9	4
Louisiana	289	36	30	6
Maine	228	26	24	2
Maryland	168	17	14	3
Massachusetts	346	52	44	8
Michigan	255	20	20	0
Minnesota	258	45	39	6
Mississippi	207	9	8	1
Missouri	192	17	15	2
Montana	307	21	17	4
Nebraska	159	8	7	1
Nevada	181	23	20	3
New Hampshire	281	14	11	3
New Jersey	189	18	16	2
New Mexico	132	10	8	2
New York	544	42	32	10
North Carolina	236	14	10	4
North Dakota	246	14	14	0
Ohio	357	22	21	1
Oklahoma	233	33	31	2
Oregon	189	18	17	1

STATE	Total SPAs (Effective Date, 1/1/2014–12/31/2024)	Number of "Potentially Relevant" SPAs Returned by Key Word Search	Number of Those SPAs Reviewed and Deemed Not Relevant	Number of SPAs Deemed Relevant and Reviewed in Detail
Pennsylvania	340	8	8	0
Rhode Island	154	9	9	0
South Carolina	184	14	13	1
South Dakota	109	13	13	0
Tennessee	54	3	3	0
Texas	327	11	11	0
Utah	204	15	14	1
Vermont	127	6	4	2
Virginia	183	21	19	2
Washington	355	32	29	3
West Virginia	82	6	3	3
Wisconsin	186	5	4	1
Wyoming	96	9	9	0
Total	10,951	888	773	115
Average	214.7	17.4	15.2	2.3
SD	99.7	10.7	9.3	2.2

As noted, each "Relevant" SPA (e.g., 1 for Alabama, 0 for Alaska, 1 for Arizona; 115 in total) was then reviewed by a subgroup of the research team to rate each of the 115 Relevant SPAs in terms of impact, as follows:

a. "Low Impact" meant that the SPA's potential effects on expanding or enhancing crisis services are likely to be relatively low and/or that the SPA was not intentionally designed to do so. This category is exemplified by SPAs that: allow clinic-based crisis intervention services to go out into the community for crisis intervention (though not as a MCT); increase rates that extend to all community-based mental health services (with crisis-related services being included among many); increase rates in response to the COVID-19 pandemic that are across the board and not specific to crisis services; increase rates for MCT and crisis stabilization unit services; provide for bundled payment rates for MCT; allow for temporary flexibilities in service provision due to the COVID-19 pandemic's restrictions; allow MCT services to extend into emergency rooms and urgent care settings; extend the billable length of CSU's lengths of stay from 96 hours to greater than 96 hours; add one or more additional types of service providers for MCT or crisis

stabilization; and add peer support workers as providers of MCT, crisis stabilization, and others services. With regard to the latter, the integration of peer perspectives into services could be considered a transformative change in services, but for our purposes here, we consider it "low impact" with regard to expanding services, equal to the addition of other types of service providers.

b. "Medium Impact" meant that the SPA's potential effects on expanding or enhancing crisis services is likely between those that are "Low Impact" (as described above) and those that are "High Impact" (as described below). This category is exemplified by SPAs that: make MCT a billable service in a high need population (like Alternative Benefit Plan eligible beneficiaries) or for youth specifically; make hospital-based (as opposed to community-based) crisis stabilization units billable; allow the State to receive the enhanced FMAP for mobile crisis services based on provisions of ARPA (as described in detail above in the Background section); and make CCBHC services billable using a prospective payment system.
c. "High Impact" meant that the SPA's potential effects on expanding or enhancing crisis services are likely to be relatively high and/or that the SPA was intentionally designed to do so. This category is exemplified by SPAs that: make MCT a billable service across the state; make CSU services billable; and make crisis transport a billable service.

The key limitation regarding our search strategy is that many SPAs deemed "Not Relevant" and "Crisis-Related but Not Relevant" could have had minimal but nonetheless cumulatively meaningful impacts on crisis services. These include small (e.g., 1–3%) increases in payments for mental health-related billing codes (which would include crisis-related billing codes), ARPA-related changes such as reduced requirements for in-person trainings or the use of telehealth services, and inflation-related rate increases. We view these as downstream ripple effects that may have impacted crisis services in small ways, though the focus was on the mental health system much more broadly. While it is possible that we may have missed some "Low Impact" SPAs in this way, it is unlikely that we would have failed to identify "High Impact" SPAs aside from those reported in **Table 1b** below. Another limitation is our relatively subjective approach at rating impact; for example, others might consider certain SPAs to be "Medium

Impact" or "High Impact," though we might have rated them as "Low Impact" or "Medium Impact," respectively. That said, the key limitation of our categorization into "Low," "Medium," and "High" impact is that the categorization was based on the subjective opinions of the three reviewers, who discussed each SPA and came to a consensus decision. Some of the "Low Impact" SPAs—like those increasing payment rates—might be deemed by others as potentially Medium Impact or High Impact, especially, for example, given workforce shortages that pose barriers to crisis expansion.

Another limitation, given the nature of our search strategy, is that we focused on approved SPAs with effective dates within our date range of 2014–2024. There may have been SPAs that were submitted and denied, which we would not have had access to (though they would have had no impact on expanding or enhancing crisis services). CMS can approve or deny a SPA, and states need to comply with federal regulations for successful approval. As such, it is possible that a state submitted a SPA with the intention of improving crisis services, it was denied, and thus never approved/implemented as part of the state's Medicaid plan, even though the state had attempted (unsuccessfully) to do so. It is probably very rare, however, that a state would submit a SPA that is not aligned with federal guidelines and thus not eligible for approval.

Findings

Among the 115 Relevant SPAs, 61 were deemed to be Low Impact, 22 to be Medium Impact, and 32 to be High Impact. The High Impact SPAs are briefly summarized in **Table 1b** below.

With regard to Low Impact SPAs, 61 were submitted by 33 states. Some made small adjustments to crisis services, and others made adjustments that were more expansive but would have had a small impact on crisis services in particular. Among other similar content areas, two updated provider qualifications; four added peers as providers of crisis services; eight added other types of providers of crisis services; several added clinic-based crisis intervention services that can go into the community; several revised the definitions of crisis response or crisis stabilization; five revised rates for Comprehensive Psychiatric Emergency Programs (CPEPs) and other crisis receiving (or crisis residential) services; and 14 pertained to provider payments and rates during COVID-19.

In terms of SPAs deemed to have a Medium Impact, 22 were submitted by 17 states. Among other similar content areas, two updated mobile crisis standards to meet the

qualifications for the enhanced FMAP made available by ARPA; five added coverage of CCBHCs, which include crisis services as one of their core services; and nine added children's crisis services (e.g., mobile crisis, crisis respite).

As is apparent from **Table 1b**, most of the SPAs deemed to be High Impact add MCT and/or crisis stabilization centers as a Medicaid-reimbursed benefit. Three add crisis transport (KY-23-0020, NV-21-0001-A, and OK-23-0021). A number of them, in addition to adding MCT as a benefit, provide documentation demonstrating eligibility for the enhanced FMAP made available by ARPA.

Table 1b. 32 State Plan Amendments (SPAs) Deemed to be Both "Relevant" and "High Impact" for Crisis Services, 2014–2024

State	State Plan Amendment #	Approval Date	Effective Date	Summary Directly from the CMS Website
Our Abbreviated Overview of the Most Relevant Aspects of the State Plan Amendment				
Alabama	AL-23-0009	11/20/2023	10/1/2023	This amendment will allow mobile crisis services to be offered throughout the state. The Alabama Department of Mental Health will be offering these emergency crisis services in order to help reduce unnecessary Emergency Room visits and/or arrests for individuals in mental health or substance use crisis.
Covers mobile crisis services to be offered throughout the state. MCTs are designed to specifically diffuse and mitigate a behavioral health crisis. MCT services offer community-based interventions to youth and adults and their families experiencing a behavioral health crisis in homes, schools, or communities. The MCT may be delivered in-person, in-home, and/or in community settings, and is available within a timely manner. Telemedicine and telephonic support may be provided until an in-person response arrives and/or as follow-up post-crisis regarding coordination and referrals. Up to nine services may be provided. Services may also include follow-up interventions for a period of up to 72 hours after the initial response that may include, where appropriate, additional MCT and/or behavioral health crisis intervention services, de-escalation, and coordination with and referrals to other social services. MCT team composition must include at least two licensed and/or credentialed clinicians in a supervisory role who have expertise and experience using evidence-based assessment tools with target populations. Two-person teams are available 24/7 and can travel throughout the state to respond on location.				
Arizona	AZ-22-0008	9/23/2022	4/1/2022	This amendment clarifies coverage of crisis intervention services.
Allows reimbursement for community-based MCTs outside of a hospital or facility setting, available 24/7, and staffed by a multidisciplinary team. Interventions include screening and assessment, stabilization and de-escalation, and coordination with, or referrals to, health, social, and other services. Arizona will claim increased ARPA FMAP only for two-person MCTs that meet requirements as described in section 1947(b)(2)(A) of the Act. Provider qualifications and requirements are listed.				
Arkansas	AR-16-008	3/19/2018	7/1/2017	Establishes the State's Medicaid Outpatient Behavioral Health Services Program.
Establishes the State's Medicaid Outpatient Behavioral Health Services (OBHS) Program. Before 2018, Arkansas Medicaid provided outpatient behavioral health services through the Rehabilitative Services for Persons with Mental Illness (RSPMI), Licensed Mental Health Practitioner (LMHP), and Substance Abuse Treatment Services (SATS) programs. These programs were gradually phased out starting in July 2017 and fully replaced by the OBHS Program by July 2018. The new program formalizes multiple services including: Crisis Stabilization Interventions, which are scheduled face-to-face treatment activities provided to a beneficiary who has recently experienced a psychiatric or behavioral crisis and serves as an alternative to 24-hour inpatient care; Crisis Care De-escalation, which provides temporary direct care for an individual in the community that is not facility-based with the goal of reducing the need for acute hospitalization or other higher levels of care; and Acute Crisis Units, which provide brief (96 hours or less) crisis treatment services to persons over the age of 17 who are experiencing a psychiatric- and/or substance abuse-related crisis and may pose an escalated risk of harm to self or others. Acute Crisis Units provide hospital diversion and step-down services with psychiatry and/or substance abuse services on-site as well as on-call psychiatry available 24 hours a day. This service does not include payment for room and board of the beneficiary and Acute Crisis Unit must be certified by Department of Human Services as an Acute Crisis Unit.				
California	CA-21-0049	12/15/2021	5/1/2020	CMS is approving this time-limited state plan amendment (SPA) to respond to the COVID-19 national emergency. The purpose of this amendment to add a provider type – State-Operated Mobile Crisis Team – and to add new rate methodologies for behavioral health providers serving the developmentally disabled population under the 1915(i) state plan home and community-based services benefit during the COVID-19 Public Health Emergency (PHE) period.

Adds State Operated MCTs as a new 1915(i) State plan HCBS provider type under Habilitation – Behavioral Intervention Services. Use of state-operated mobile crisis services are available for individuals continuing to experience crises after having exhausted all other available crisis services. Crisis teams are unique in providing partnerships, assessments, training, and support to individuals experiencing crisis. Provider types are listed.				
California	CA-22-0043	7/20/2023	1/1/2023	This state plan amendment clarifies coverage of crisis intervention services and service rates.
Adds mobile crisis intervention services authorized by Section 9813 of the American Rescue Plan of 2021 to the state plan. The service aims to provide relief, de-escalation, stabilization techniques, and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. These services are provided by a multidisciplinary team at the location where the individual is experiencing the behavioral health crisis, which can include their home, school, workplace, on the street, or where they socialize. Mobile crisis services cannot be provided in hospitals or other facility settings. The team must be available 24/7. Services are delivered by a multidisciplinary team and must include at least two behavioral health professionals from a specified list. At least one team member must be qualified to provide a crisis assessment. Eligible providers rendering these services will be reimbursed a bundled rate for each encounter.				
Colorado	CO-23-0008	12/4/2023	7/1/2023	This state plan amendment clarifies coverage of crisis intervention services and service rates.
Authorizes Colorado to reimburse for Mobile Crisis Response (MCR), which must be available 24/7, by providers enrolled with Colorado Medicaid and endorsed by the Behavioral Health Administration. MCR-covered services include screening, assessment, de-escalation, stabilization, safety planning, coordination with culturally responsive referrals to appropriate resources, and harm reduction interventions including naloxone administration. Covered services may be performed during the following episodes of care: initial face-to-face crisis response; initial follow-up consultation 24 hours after the initial crisis and for up to 5 days after to coordinate with and refer to services; and secondary follow-up to ensure warm handoff and to schedule appointments to referrals within 7 days of referral by the MCR provider. An initial MCR response must be a paired response by any two team members (provider credentials are defined); the second responder may appear via telehealth. MCR services are reimbursed at the lower of: submitted charges or a market-based fee schedule (determined as outlined in the amendment).				
District of Columbia	DC-21-0010	4/26/2022	1/1/2022	This amendment proposes to allow the District to transition its Section 1115 Behavioral Health Transformation Demonstration Program services to permanent State Plan authority in order to retain authority to provide Medicaid reimbursement.
Updates substance abuse crisis services from amendment #15-004. Adds detail about the 24/7 availability and specifies that providers must adjust their staffing for immediate response. It also adds detail about the role of the provider in ensuring access to necessary follow-up care. Crisis Intervention is defined in both Mental Health Rehabilitative Services (MHRS) and Adult Substance Use Rehabilitative Services (ASURS) as immediate face-to-face or telephonic responses available 24/7. For MHRS, it is provided by DBH-certified Core Services Agencies (CSAs) to their consumers involved in an active crisis and for ASURS, it is provided to clients involved in an active crisis, with the provider adjusting staffing to meet requirements for an immediate response. Adds Behavioral Health Stabilization Services as a new category of covered services including Comprehensive Psychiatric Emergency Program (CPEP covered services: brief and extended crisis psychiatric care), Adult Mobile Crisis and Outreach (covered services: mobile crisis intervention, behavioral health outreach services), Youth Mobile Crisis, and Psychiatric Crisis Stabilization. For crisis stabilization, individuals can have ongoing access to comprehensive nursing assessment and plan of care development; psychiatric consultation and assessment; crisis counseling; medication monitoring; and discharge planning. Consistent with EPSDT requirements: CPEP, Adult Mobile Crisis, and Crisis Stabilization are provided to individuals under 21, if medically necessary.				
Georgia	GA-17-0002	4/21/2017	1/1/2017	This state plan amendment adds to the scope of services to children, youth and families, modifies service modalities and revises reimbursement methodology for Community Behavioral Health Rehabilitation Services (CBHRS).
Introduces Crisis Stabilization as a new service covered, offering a structured, intensive residential alternative to psychiatric hospitalization or detoxification, with a focus on psychiatric stabilization and withdrawal management. The program provides medically monitored intensive psychiatric and/or substance abuse services that address the psychiatric, psychological, and behavioral health crisis needs of the individuals. The definition of Crisis Intervention Services is updated to include face-to-face interventions (in person or via telemedicine/telehealth), emphasizing brief situational assessment, de-escalation, crisis resolution, mobilization of support, and referrals to alternate services. Both Crisis Intervention Services and Crisis Stabilization are now provided by practitioners at Levels 1–5, as appropriate under their approved scope of practice, with Level 5 practitioners now defined as non-licensed, non-degreed, and trained paraprofessionals. Finally, the amendment introduces the use of bundled				

procedure codes, where multiple individual service codes (such as Behavioral Health Assessment, Service Plan Development, Diagnostic Assessment, etc.) are combined into a single comprehensive code for program services like Crisis Stabilization Unit Services and Assertive Community Treatment.				
Illinois	IL-16-0007	4/24/2018	7/1/2018	Mobile Crisis Response and Crisis Stabilization
Adds coverage of mobile crisis response (MCR) and crisis stabilization. MCR services may include face-to-face crisis screening, short-term intervention, crisis safety planning, brief counseling, consultation with other qualified providers to assist with the client's specific crisis, and linkage to other mental health services including higher levels of care. When the client is under 21 and the caregiver support is necessary, support is given to the caregiver as well. Crisis Stabilization is a time-limited, intensive intervention available immediately following an MCR event. Crisis stabilization requires a demonstrated need for ongoing stabilizing supports as documented in the client's crisis safety plan and authorized by a Licensed Practitioner of the Healing Arts. The service provides strengths-based, individualized, direct support on a one-on-one basis to clients in the home or community setting. Staff eligible to provide this service include Mental Health Professionals with access to a Qualified Mental Health Professional who is available for immediate consultation.				
Indiana	IN-23-0007	9/19/2023	7/1/2023	This amendment adds enhanced mobile crisis services to the Medicaid state plan.
Adds coverage of mobile crisis services. Face-to-face home- and community-based interventions that serve individuals experiencing a mental health or substance use-related crisis. Mobile crisis services must be recommended by a physician or other licensed practitioner and consist of a multidisciplinary team of trained providers who arrive and respond to mental health/substance use crises in the community operating 24/7. A variety of services include peer support, medication, and follow-up stabilization services through contacts in-person, via phone, or telehealth up to 14 days following the initial crisis intervention. Stabilization includes coordination/warm handoffs with identified resource needs (such as insurance navigation, housing, benefits and entitlements, physical health concerns, educational and/or vocational supports). Services must be provided to individuals outside of a hospital or other facility settings including community mental health centers. MCTs may include law enforcement-based co-responder behavioral health teams and must include a minimum of two individuals with one individual able to perform an assessment within their scope of practice under Indiana state law.				
Kentucky	KY-23-0016	7/20/2023	10/1/2023	This state plan amendment clarifies coverage of crisis intervention services and service rates.
Develops services for 23-hour crisis observation stabilization service, updates definitions of Crisis Intervention Service and Residential Crisis Stabilization Service, changes "Mobile Crisis" as a service to "Community Based Mobile Crisis Intervention Services" (MCIS) and updates definitions. Adds Certified Alcohol and Drug Counselor as a provider of "Crisis Intervention." Adds Behavioral Health Associate as a provider of "Residential Crisis Stabilization." "Residential Crisis Stabilization" is divided into two service types: 23-hour Crisis Observation Stabilization Service (COSS) and Residential Crisis Stabilization (as before).				
Kentucky	KY-23-0020	9/11/2023	10/1/2023	This amendment proposes to create a new provider type for Behavioral Health Crisis Transportation.
Creates a new provider type for Behavioral Health Crisis Transportation (BHCT). Behavioral health crisis transport service means the use of a motor vehicle, other than an ambulance or other emergency response vehicle, that is specifically designed, equipped, and staffed by a licensed crisis transportation provider to transport a Medicaid recipient alleged to be in a behavioral health crisis and needing transportation to a higher level of care. BHCT may be used to transport a recipient after a MCT assesses that the recipient requires a higher level of care that is the nearest Medicaid healthcare provider, or facility to facility transport including but not limited to transportation from emergency departments to behavioral health crisis treatment that is the nearest Medicaid healthcare provider. Provider qualifications are given (including annual staff trainings), and specifications for the BHCT vehicle (e.g., a driver's compartment that is separated from the passenger compartment, child lock feature) are given.				
Louisiana	LA-22-0007	8/1/2022	7/1/2022	The purpose of this SPA is to amend the provisions governing adult mental health services in order to add crisis stabilization as a covered service.
Establishes crisis stabilization as a covered service, defined as a short-term, bed-based crisis treatment and support services for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization. Services can be provided by licensed mental health professionals (LMHPs), unlicensed professional and peer support services. Defines core staffing requirements such that all crisis stabilization providers have an authorized licensed prescriber, LMHPs, nursing staff, unlicensed professionals, and credentialed peer support services.				
Louisiana	LA-23-0044	3/5/2024	4/1/2024	This amendment adds enhanced mobile crisis services to the Medicaid state plan.

Adds mobile crisis response (MCR) as an emergent crisis response intended to provide relief, resolution, and intervention through crisis supports and services during the first phase of a crisis in the community. The main objectives are to provide rapid response and individual assessment. Face-to-face and time limited services for people who are experiencing a mental health or SUD crisis. Defines MCR services as provided by a two-person team that includes one licensed professional and one unlicensed or peer support specialist. MCRs are available 24/7. Provider qualifications are outlined, as are staffing requirements/definitions.				
Maryland	MD-24-0001	4/15/2024	5/1/2024	This state plan amendment clarifies coverage of crisis intervention services and service rates.
Adds two behavioral health services to the state plan: MCT services and behavioral health crisis stabilization center services. The amendment outlines a service description for both types of care, as well as provider qualifications. MCTs have a team composition that includes two people, with at least one licensed mental health professional responding in person or via telehealth. Agencies operating MCT services must be able to operate 24/7.				
Massachusetts	MA-23-0015	9/29/2023	1/1/2023	This amendment adds enhanced mobile crisis services to the Medicaid state plan.
Adds new coverage for mobile crisis intervention. Mobile crisis intervention provides a short-term, on-site, face-to-face crisis assessment, intervention, and stabilization of individuals in crisis. Services are available 24/7 where the member is located, including community-based settings, at a designated Community Behavioral Health Center (CBHCs), or in emergency departments. Services provided in emergency departments and at designated CBHCs will not be eligible for enhanced FMAP under Section 1947 (ARPA). Phone contact and consultation may be provided as part of initial triage and intervention and services may be provided through telehealth, though services provided solely through telehealth will not be eligible for enhanced FMAP. Among services for those 21 and older are care coordination and safety planning. The team must be comprised of at least two individuals, including at least one clinician capable of completing a crisis assessment within their scope of practice under state law. Teams may include family partners in lieu of certified peer specialists when clinically indicated based on the needs of the member. Non-licensed clinicians (including peers) and trainees provide services under the supervision of a licensed clinician or a certified peer supervisor. Other provider types are listed.				
Montana	MT-22-0030	12/15/2022	10/1/2022	This amendment revises Rehabilitation services coverage and payment to enhance the continuum of care. The state has added a new service to the mental health and substance use disorder treatment continuum of care, identified the component services that are available under larger "umbrella" services, and updated practitioner/provider qualifications.
Differentiates between crisis stabilization and crisis receiving by creating tiers: Tier I (Crisis Receiving), Tier II (Crisis Stabilization), and Tier III (Crisis Receiving and Stabilization). Crisis Receiving Program is now defined as a community-based outpatient program that provides evaluation, observation, intervention, and referral for members experiencing a crisis due to behavioral health (i.e., mental health or a co-occurring mental health and SUD). It replaces what was previously known as outpatient crisis services and clarifies that it is an alternative, but not a replacement, to a community hospital emergency department, operating 24/7 and offers walk-in and first responder drop-off options. Crisis Stabilization Program is clarified and defined as a short-term and 24-hours or more, of supervised residential treatment in a community-based facility of fewer than 16 beds for adults with a mental health and/or mental health and co-occurring SUD. It also adds a new service: SUD psychotherapy for crisis, defined as an urgent assessment and history of a crisis state, a mental status exam, and a disposition. Treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. This service also includes after-hours crisis assessments.				
Montana	MT-23-0006	10/17/2023	7/1/2023	This state plan amendment clarifies coverage of crisis intervention services and service rates.
Adds coverage for Mobile Crisis Response Services. Services must be able to be dispatched without law enforcement and outside of a facility setting, 24/7. The mobile crisis team must have at least one team member respond in-person (one team member may respond via telehealth and remain connected throughout the duration of the response). The multidisciplinary team must include a clinical mental health professional in order to claim increased FMAP. In addition, Crisis Care Coordination services provide organization of member care activities for members who have recently experienced a behavioral health crisis and meet the medical necessity criteria. Crisis Care Coordination services facilitate information sharing among all the participants concerned with a member's care to achieve safer and more effective care. Crisis Care Coordination services must be provided by a provider that is approved by the department and enrolled in Montana Medicaid as a crisis provider.				
Nevada	NV-21-0001-A	4/9/2021	2/1/2021	This amendment proposes to add coverage for a new type of non-emergency medical transportation (NEMT) called Non-Emergency Secure Behavioral Health Transport as an

				optional medical service outside of the state's NEMT broker program to the state's Alternative Benefit Plan pages.
Adds a new service to the alternative benefit plan of non-emergency secure behavioral health transport services through the use of a motor vehicle, other than an ambulance or other emergency response vehicle, that is specifically designed, equipped and staffed by an accredited agent to transport a person alleged to be in a mental health crisis or other behavioral health condition, including those individuals placed on a legal hold. Non-emergency secure behavioral health transports do not require prior authorization.				
Nevada	NV-22-0005	7/29/2024	3/30/2022	This plan amendment updates the Crisis Services.
Adds Intensive Crisis Stabilization, Crisis Intervention, and Mobile Crisis as reimbursable services. Intensive Crisis Stabilization is a time-limited (24 hours) facility-based crisis treatment and stabilization service. Services include comprehensive assessment and observation; psychiatric and/or SUD treatment; safety planning; and referral to ongoing treatment, with an emphasis on services necessary for stabilizing the individual to avoid hospitalization. Crisis Intervention is a brief intervention that includes safety and risk screening, assessment, stabilization, de-escalation and coordination with, and referral to, health, social, and other services and supports as needed. Services may be mobile, responding to the location of the recipient and may be provided in a variety of settings, including, but not limited to, psychiatric emergency departments, homes, hospital emergency rooms, schools, child protective custody, and homeless shelters. Crisis intervention services include follow-up sessions, and all services may be provided telephonically for all levels of care, as long as the service meets the definition of crisis intervention. These services require utilization review according to the individual intensity of need and are time limited. Recipients may receive a maximum of four hours per day over a three-day period (one occurrence) without prior authorization. Recipients may receive a maximum of three occurrences over a 90-day period without prior authorization. All service limitations may be exceeded with a prior authorization demonstrating medical necessity. Finally, it adds mobile crisis services in accordance with Section 1947 (effective July 1, 2023). Provided to Medicaid beneficiaries outside of a hospital or other facility setting and are available 24/7. Mobile crisis teams under Section 1947 must meet team composition requirements.				
New Hampshire	NH-24-0021	9/12/2024	4/1/2024	This amendment adds enhanced mobile crisis services to the Medicaid state plan.
Introduces covered CRS services intended to provide rapid response for mental health crises. First, Crisis Stabilization is covered, which is an outpatient service providing up to 30-days of stabilization services per crisis episode (limits may be exceeded if prior authorization is granted by the Department based on medical necessity). Crisis Stabilization includes services that are designed to minimize an acute crisis episode or to prevent incarceration, emergency department, inpatient psychiatric hospitalization, or medical detoxification. Services included are crisis triage, screening and assessment, de-escalation and stabilization, brief intervention or psychological counseling, peer support, prescribing/administering medication, and referral to services (ambulatory withdrawal management may be included). Services can be delivered through telehealth, face-to-face in a clinic setting, and within the community in the least restrictive environment available. Crisis Stabilization Centers are included in this coverage. The facilities are either outpatient only (providing crisis stabilization as indicated above), or outpatient and residential, with no more than 16 beds. Minimum provider agency requirements for staffing are included including if a crisis stabilization center is run by a certified Community Mental Health Center, a FQHC, a Rural Health Clinic, or a licensed hospital. Second, Mobile Crisis Response and Stabilization Services (MCRSS) are covered consistent with section 1947 to claim enhanced FMAP for enhanced match availability. MCRSS will be available 24/7, and where the individual is experiencing a mental health crisis and shall not be restricted to select locations within any region, on particular days or times, and must address SUD, including opioid use disorder. Mobile teams must ensure language access for individuals with limited-English proficiency, or those who are deaf or hard of hearing, and comply with all applicable federal requirements. Services may include telephonic follow-up interventions within 48 hours after the initial mobile response and 30 days of follow-up stabilization services. Follow-up includes additional intervention, de-escalation services, and coordination with other social support services. Staffing for mobile teams is provided by a multidisciplinary MCT that includes at least two members of differing disciplines responding to the person in crisis in the community. The responding team includes at least one behavioral health care professional, and a responding team may include a member who is participating in the response via telehealth. Other requirements for staffing are given.				
New Jersey	NJ-24-0021	12/12/2024	12/23/2024	This amendment adds enhanced mobile crisis services to the Medicaid state plan.
Makes Community-Based Mobile Crisis Outreach Response Teams (MCORTs) now a covered Rehabilitation Service. MCORT are services providing timely response, individual assessment, crisis stabilization, and time-limited rehabilitative services/supports to individuals who are experiencing a mental health and/or SUD-related crisis.				

MCORTs are available throughout the State and are staffed 24/7. Services are provided at the individual's home, work, school, or community-based setting but may not be delivered to an individual admitted to hospital or other facility setting. The team is multidisciplinary with at least one MCORT team member physically present with the beneficiary experiencing crisis, and at least one member of the team must be qualified to perform assessments. Other provider requirements listed. Services can be delivered in-person and remotely with New Jersey only claiming increased FMAP for MCT services that meet the requirements as described in section 1947(b) of the Social Security Act.				
New Mexico	NM-19-0002	10/22/2019	1/1/2019	Proposes to add a Substance Use Disorder (SUD) Continuum of Services to the New Mexico State plan.
Introduces coverage for crisis stabilization services described as an outpatient service providing up to 24-hour stabilization of acute crisis conditions to prevent incarceration, emergency department, inpatient psychiatric hospitalization, or medical detoxification for SUD. Ambulatory withdrawal management may be included. Some Centers may also offer navigational services for individuals transitioning to the community from correctional facilities upon official release from custody/detention. Crisis Triage Centers are also now covered as community-based alternatives to hospitalization or incarceration authorized by 2014 NM HB212 Crisis Triage Center legislation. The facilities are either outpatient only (providing crisis stabilization as indicated above), or outpatient and residential, with no more than 16 beds. They serve youth and adults to provide voluntary stabilization of behavioral health crises including emergency mental health evaluation, withdrawal management, and care. May include ambulatory withdrawal management; and, if residential, all level 3 withdrawal management services. Staffing requirements are given.				
New Mexico	NM-23-0006	2/6/2024	7/1/2023	This state plan amendment clarifies coverage of crisis intervention services and service rates.
Adds mobile crisis services as a covered service but also makes updates to other crisis services on the continuum. Crisis stabilization services remain largely the same, but the definition adds specificity by adding telephone crisis services, face-to-face crisis intervention in a clinic setting, and outpatient crisis stabilization as services. Also adds the specific services that include crisis triage; screening and assessment; de-escalation and stabilization; brief intervention or psychological counseling; peer support; prescribing and administering medication; and referral to services. Crisis triage center services remain largely the same except they now allow for involuntary stabilization for individuals determined to be a danger to self or others due to mental illness. Charge nurses who are on duty 24/7 can be available via telehealth. For Adult Accredited Residential Treatment Centers (AARTC) for Adults with SUD, which offer low to high intensity residential services and withdrawal management, crisis services are added. Regardless of service level AARTCs must include interdisciplinary staff, available on a 24-hour basis to respond to a crisis and provide stabilization services. Finally, also adds mobile crisis and mobile response and stabilization services for children and adults provided consistent with section 1947 of the Social Security Act, allowing the state to claim at the enhanced FMAP for the duration of the enhanced match availability. This includes provision to individuals experiencing a mental health or substance use disorder crisis and furnished outside of a hospital or other facility setting. The MCT must include at least two members, including at least one behavioral health care professional able to conduct a mobile crisis screening and assessment in person or via telehealth.				
New York	NY-22-0026	6/29/2023	4/1/2022	This state plan amendment clarifies coverage of crisis intervention services.
Adds reimbursement for a variety of crisis services including Mobile Crisis, Crisis Stabilization, Children's Crisis Residence, Intensive Residential Crisis for adults, Residential Crisis Support for adults. It also expands access to crisis intervention services previously available to children and populations under the 1115 waiver only under the State Plan, including crisis stabilization now authorized for adults. Mobile Crisis Intervention offers 24/7 interdisciplinary response teams for immediate and follow-up care, including telehealth options. Services are typically comprised of two team members, with a member being a Crisis Intervention Professional. To qualify for enhanced FMAP, an initial response must be by the two-member team with one team member who may participate via telehealth. Other provider requirements listed. Crisis Stabilization Centers provide urgent assessment, treatment, and coordination of services for children and adults experiencing a mental health or SUD crisis. Crisis intervention services are provided on-site by Crisis Stabilization Centers licensed by New York. Children's Crisis Residence is short-term, voluntary, non-IMD, sub-acute crisis intervention for children under age 21 to stabilize a child's psychiatric or other behavioral health crisis symptoms. Children's Crisis Residences provide 24-hour monitoring and supervision, as well as treatment and support services in Crisis Residential facilities. Intensive Residential Crisis is a short-term, voluntary, non-IMD, sub-acute crisis intervention for individuals aged 18 and over who are experiencing an escalation of behavioral health symptoms and who may raise safety concerns for themselves and others without intensive services. Services allow 24-hour monitoring and treatment in Crisis Residential facilities. Lastly, Residential Crisis Support short-term, voluntary, non-IMD, sub-acute crisis intervention modality for individuals aged 18 and older to stabilize crisis symptoms, address the cause of the crisis, and avert or delay the need for acute psychiatric inpatient hospitalization/emergency services. Services provide respite, 24-hour supervision, treatment and support services in				

Crisis Residential facilities. Each modality includes assessments, crisis planning, counseling, medication management, and peer support, ensuring comprehensive crisis care.				
Oklahoma	OK-23-0021	9/5/2023	7/1/2023	This amendment proposes to add secure mental health transportation services to Oklahoma's Medicaid State Plan.
Adds coverage of secure behavioral health transportation for members presumed to be experiencing a behavioral health crisis who require transportation to a treatment facility for the purpose of examination, inpatient services, emergency psychiatric detention, or other emergency psychiatric actions. All transports must be made to the nearest appropriate treatment facility. Transports completed by law enforcement or transports to correctional facilities are not authorized under this Plan. Service providers must be Oklahoma Department of Mental Health and Substance Abuse Services designated Qualified Transportation Service Providers and meet the criteria. Vehicle drivers and vehicle descriptions are provided. The agency contracts with a broker to provide statewide curb to curb coverage for non-emergency transportation. Reimbursement for out-of-state transportation that is medically necessary is authorized through the agency when transportation exceeds 50 miles from the Oklahoma border.				
Oregon	OR-22-0012	9/12/2022	4/1/2022	This SPA approves Oregon's request for a state option to provide qualifying community-based mobile crisis intervention services.
Authorizes a state option to reimburse qualifying community-based mobile crisis intervention services for a period of up to five years, during the period starting April 1, 2022, and ending March 31, 2027. This service must address co-occurring substance use disorders, including opioid use disorder, if identified. At a minimum, it includes the initial response of conducting immediate crisis screening and assessment, providing mobile crisis stabilization and de-escalation, coordinating with and making referrals to other services, and harm reduction, all outside of a hospital or facility setting. Services may also include follow-up interventions for a period of up to 72 hours after the initial response. If continued stabilization services are identified after 72 hours, a stabilization plan must be developed for coordination with referrals for continued stabilization services through warm hand-offs and coordinating transportation if warranted. Mobile crisis services must maintain relationships with relevant community partners. Two-person multidisciplinary teams are required that include at least one qualified professional able to conduct a mobile crisis screening and assessment within their scope of practice under state law and one other professional or paraprofessional with expertise in mental health services.				
Virginia	VA-21-0023	12/15/2021	12/1/2021	Implement programmatic changes and reimbursement rates for the following: multisystemic therapy, functional family therapy, crisis intervention services, crisis stabilization services, and behavioral therapy.
Enhances, renames, and adds several crisis-related services. Crisis stabilization is now known as community stabilization. Core services from a previous amendment remain the same with additions of specific services like Peer Recovery Support Services and Individual, Family, and Group Therapy. Providers listed for each with the addition now in community stabilization of Certified Substance Abuse Counselors. Adds Mobile Crisis Response Services, available 24/7. Mobile Crisis Response activities include assessment, short-term counseling designed to stabilize the individual, crisis intervention, health literacy counseling, peer recovery support services, and care coordination for those with medical necessity. Services are provided in a variety of settings including community locations where the individual lives, works, attends school, participates in services, and socializes, and includes temporary detention order preadmission screenings. Adds coverage of Residential Crisis Stabilization described as a diversion from inpatient hospitalization by offering psychiatric stabilization in licensed crisis services provider units of less than 16 beds. It is short-term, 24/7 and includes residential crisis evaluation and brief intervention services that can also be provided as a 23-hour service if it is expected that it can be resolved in that timespan.				
Vermont	VT-24-0005	4/4/2024	1/1/2024	This amendment adds enhanced mobile crisis services to the Medicaid state plan.
Adds coverage for community-based mobile crisis services that provide rapid crisis response by a team of at least two Medicaid providers trained in trauma-informed care practices, de-escalation strategies, and harm reduction techniques, delivered per Section 1947 of the Social Security Act. Community-based mobile crisis services may include follow-up interventions for a period of up to three days for adults and up to seven days for children after the initial response. All services are provided outside of a nursing facility, hospital, or other inpatient treatment facility setting and are available to members 24/7. The community-based mobile crisis provider agency must have an				

active contract with Vermont Medicaid to deliver services. The team must include at least one mental health/substance use professional who can conduct an assessment within their scope of practice and the second provider may be a paraprofessional. Provider qualifications are listed.				
Washington	WA-23-0010	10/10/2023	1/1/2024	This state plan amendment clarifies coverage of crisis intervention services and service rates.
Updates and formalizes crisis services. A previous amendment mentions crisis counseling for children available 24 hours; now there are two services, crisis intervention and crisis stabilization. Crisis intervention includes screening, evaluation, assessment, and clinical intervention provided to all Medicaid enrolled persons experiencing a behavioral health crisis. Crisis intervention services are available on a 24/7 and may be provided prior to completion of an intake evaluation. In order to claim enhanced FMAP for services using the 'community-based mobile crisis intervention services' model, the requirements described in section 1947(b) of the Act must be met, including providing services to persons outside of a hospital or other facility setting, through a multidisciplinary team, trained in trauma-informed care, de-escalation strategies, and harm reduction. The team must include, at a minimum, at least one individual who may conduct an assessment within their authorized scope of practice and other professionals or paraprofessionals with appropriate expertise in behavioral health care. Crisis Stabilization Services includes follow-up after a crisis intervention. These services are provided in the person's own home, another home-like setting, or a setting which provides safety for the person and the Mental Health Professional. Crisis stabilization services may include short-term assistance with life skills training and understanding medication effects. It may also include providing services to the person's natural and community supports, as determined by a Mental Health Professional. Crisis stabilization services may be provided by a team of professionals, as deemed appropriate and under the supervision of a Mental Health Professional. Providers are listed for both services.				
West Virginia	WV-23-0003	9/5/2023	7/1/2023	This state plan amendment clarifies coverage of crisis intervention services and service rates.
Adds reimbursement for mobile crisis services for those experiencing a suspected mental health and/or SUD-related crisis. It includes a toll-free hotline and a Mobile Crisis Response Team. The team provides assessment, short term intervention, counseling, and safety planning among other services intended to achieve crisis symptom reduction. The toll-free crisis hotline services and Mobile Crisis Response Teams are available throughout the state and staffed 24/7. Community-Based Mobile Crisis Intervention Services will be provided at the home, work, school, group care, and/or other natural setting of the member. The Mobile Crisis Response Teams consist of Supervisory Staff, Clinical Staff, and Direct Care Staff who provide supervisory support, clinical support and direct crisis response services. The provider organization will be responsible for helping to ensure clinically appropriate follow-up occurs including documentation of follow-up with the member and/or family/caregiver/guardian within 24 hours of initial contact/response and up to four weeks post-contact/response. In the event that the member cannot be stabilized by the responding MCT, services may include facilitation of a safe transition to a higher level of care. Further descriptions of providers are given.				
Wisconsin	WI-23-0001	5/12/2023	1/1/2023	This amendment adds enhanced mobile crisis services to the Medicaid state plan.
Adds coverage of enhanced mobile crisis services. They are specialized mental health crisis intervention services that provide rapid in-person community-based mobile crisis intervention by a team of at least two Medicaid providers trained in trauma-informed care practices, de-escalation strategies, and harm reduction techniques. The team must include one behavioral health professional able to conduct an assessment within their scope of practice under state law. At least one practitioner must deliver services in-person with additional practitioners who can provide services in-person or via telehealth (providers are listed.) Enhanced mobile crisis services include individual assessment, de-escalation, and crisis resolution and may also include follow up interventions for a period up to 72 hours after the initial response, including additional mobile crisis intervention and referral to or arrangement for any additional behavioral health services. All services are provided outside of a hospital, psychiatric residential treatment facility, or nursing facility. Enhanced mobile crisis services are available to members 24/7. Wisconsin will only claim increased FMAP for mobile crisis services that meet the requirements as described in section 1947.				

2. Children's Health Insurance Program (CHIP) State Plan Amendments (SPAs)

2. Children's Health Insurance Program (CHIP) State Plan Amendments (SPAs)

Background

CHIP is an insurance program that is jointly financed by federal and state dollars and is administered by each state. CHIP provides health care coverage to uninsured children up to age 19 whose family income is too high for Medicaid, but less than state-specific income eligibility limits. (The child must also not have access to other insurance, such as through a parent's employer.) To keep insurance affordable for families, CHIP limits premiums and cost-sharing. Unlike Medicaid, CHIP is a block grant. The federal government makes a fixed allotment of funds available on a matching basis to each participating state each year. Eligibility for CHIP is dependent on the state. For example, persons under 190% of the federal poverty level (FPL) in Idaho are eligible while persons under 405% of the FPL are eligible in New York. A rate that is 15 percentage points higher than the Medicaid matching rate is provided to states as an incentive to invest in health insurance coverage for children (Peter G. Peterson Foundation, 2024). As such, for fiscal year 2023, the average CHIP match rate among states was 69%, compared to the average Medicaid match rate of 56% (U.S. Congress, 2025). The maximum eligibility level that states can set and still receive the higher federal matching rate that CHIP provides is 300% of the FPL. (States opting to expand coverage to children above 300% on or after FY 2009 receive the regular Medicaid match for their coverage; Georgetown University McCourt School of Public Policy, Center for Children and Families, 2017). Under federal guidelines, states can individualize the design of their CHIP program in terms of eligibility groups, benefit packages, reimbursement rates, and administrative and operating procedures (Code of Federal Regulations, 2025).

Federal law allows states to choose from three different program designs: (1) a *Separate CHIP* in which states design their programs within the statutes of the CHIP program (but children are screened during the application process to determine if they are eligible for Medicaid and, if so, are enrolled in Medicaid); (2) *Medicaid Expansion CHIP* in which states cover CHIP-eligible children through their Medicaid program; and (3) a *Combination CHIP* in which states use elements of a Separate CHIP and Medicaid Expansion CHIP models. There are benefits to the different program types. Medicaid Expansion CHIP programs generally offer robust benefits, as enrollees are entitled to EPSDT (Early and Periodic Screening, Diagnostic,

and Treatment) coverage and the same cost-sharing limits as those in Medicaid (MACPAC, 2021a). It also streamlines program administration and can prevent children from losing coverage during transitions from CHIP to Medicaid programs (Schneider et al., 2023). If CHIP is implemented separately, states have more flexibility in determining the program's structure. Stand-alone CHIP plans can charge up to 5% of household income for copayments, premiums, deductibles, and other fees to families with children (Peter G. Peterson Foundation, 2024). Separate CHIP also allows states to alter benefit packages and delivery systems. Most states use a combination of Medicaid expansion and separate CHIP programs to cover eligible children. This is due to the passage of the Affordable Care Act (ACA), which made two changes to CHIP. ACA required states to disregard the first 5% of a family's income when determining if a child qualifies for Medicaid or CHIP leading to more children qualifying for Medicaid rather than CHIP. Additionally, families with children ages 6–18 making between 100% to 133% FPL (stair-step children) were in separate CHIP programs but the ACA required states to move those children into Medicaid instead. Thus, more children post-ACA are eligible for Medicaid leading to most states running a combination program (MACPAC, 2021a).

Approach

For our policy analysis approach, we used a search strategy for CHIP SPAs very similar to that outlined in the prior chapter on Medicaid SPAs. The Medicaid.Gov website for CHIP SPAs (https://www.medicaid.gov/chip/state-program-information/chip-spa) documented (on 3/13/25) 950 total CHIP SPAs. During an Effective Date range of 01/01/2014 – 12/31/2024, there were 694 (on 3/13/25).

During that Effective Date range, using the key word "crisis" to search the Summaries of those 694 CHIP SPAs returned only 1 (IN-24-0002-CHIP), described below in **Table 2**. Using the key word "mental" to search the Summaries of the 694 CHIP SPAs returned only 39 CHIP SPAs, all but one of them to "demonstrate compliance with CHIP mental health parity regulations" (with the other one not being relevant to crisis services). Using the key word "behavior" to search the Summary of the 694 CHIP SPAs returned only 12 results. Only one was relevant to our purposes aside from the aforementioned IN-24-0002-CHIP. Specifically, Virginia's VA-22-0011 was relevant, and it is described in **Table 2**. We also used the key word "disturbance" (to capture serious emotional disturbances, or SED), though no additional relevant CHIP SPAs were identified.

As noted previously with regard to Medicaid SPAs, a key limitation in our analysis of CHIP SPAs is that some that we did not identify as relevant could have had minimal but nonetheless cumulatively meaningful impacts on crisis services (i.e., downstream ripple effects that may have impacted youth-related crisis services in small ways, though the focus was on the children's mental health system much more broadly).

Findings

As shown in **Table 2**, Indiana's IN-24-0002-CHIP adds mobile crisis services to the state's behavioral health benefits (Submitted on 02/28/2024; Approval Date: 05/13/2024; Effective Date: 07/01/2023). We had previously identified the Indiana Medicaid SPA (IN-23-0007) that adds mobile crisis services, also with an Effective Date of 07/01/2023. As such, the CHIP State Plan Amendment (the only one among 950 total, or 694 during 01/01/2014 – 12/31/2024 to include the word "crisis" in its brief summary) does not expand mobile crisis services above and beyond what the Medicaid State Plan Amendment had concurrently done, it simply allows for coverage of mobile crisis services for CHIP beneficiaries outside of the state's Medicaid program. On the other hand, by broadening the payor base, mobile crisis programs become more financially sustainable and new teams thus might become possible. As such, it may be as important as IN-23-0007, even though CHIP has fewer covered lives.

Virginia's VA-22-0011 adds mobile crisis response and residential crisis stabilization. We had previously identified the Virginia Medicaid SPA (VA-21-0023) that makes these additions to the state's Medicaid plan, also with an Effective Date of 12/01/2021. As such, this CHIP SPA does not make changes above and beyond what the Medicaid SPA had done. Nonetheless, the above points made for Indiana are applicable here; as such, this too represents an expansion.

Table 2. Two CHIP State Plan Amendments (SPAs) Deemed to be Relevant for Expanding and Enhancing Crisis Services, 2014–2024

State	CHIP State Plan Amendment #	Approval Date	Effective Date	Summary Directly from the CMS Website
Our Abbreviated Overview of the Most Relevant Aspects of the State Plan Amendment				
Indiana	IN-24-0002-CHIP	05/13/2024	07/01/2023	Adds mobile crisis services to the state's behavioral health benefits.
Crisis services include "mobile, face-to-face, home and community-based crisis interventions that serve individuals experiencing a mental health or substance use-related crisis…Crisis intervention is a short-term emergency behavioral health service, available 24 hours a day, 7 days a week. Crisis Intervention includes, but is not limited to, the following: Crisis assessment, planning, and counseling specific to the crisis; [and] Intervention at the site of the crisis (when clinically appropriate).				
Virginia	VA-22-0011	07/26/2022	07/01/2021	Adds several new behavioral health services.
Effective 12/1/2021, Mobile Crisis Response shall provide immediate behavioral health care, available 24 hours a day, seven days per week, to assist individuals who are experiencing an acute behavioral health crisis requiring immediate clinical attention. This service's objectives shall be to prevent exacerbation of a condition, to prevent injury to the client or others, and to provide treatment in the context of the least restrictive setting. Mobile Crisis Response is provided in a variety of settings including community locations where the individual lives, works, attends school, participates in services and socializes, and includes temporary detention order preadmission screenings. Effective 12/1/2021, Residential Crisis Stabilization services serve as a diversion from inpatient hospitalization by offering psychiatric stabilization in licensed crisis services provider units of fewer than 16 beds. Residential Crisis Stabilization shall not be provided in facilities that meet the definition of an Institution for Mental Diseases (IMD) as defined in 42 CFR 435.1010. Residential Crisis Stabilization provides short-term, crisis evaluation and brief intervention services to support an individual who is experiencing an abrupt and substantial change in behavior noted by severe impairment of functioning typically associated with a precipitating situation or a marked increase in personal distress. This service is also available as a 23-hour option.				

3. Medicaid Section 1115 Demonstration Waivers

3. Medicaid Section 1115 Demonstration Waivers

Background

To test new approaches within their Medicaid program that diverge from typical federal rules, states can use Section 1115 demonstration waivers that allow for experimentation (Hinton and Diana, 2025). (Of note, these waivers are sometimes referred to as "1115 waivers," "1115 demonstrations," or "1115 demonstration waivers;" here, we use the latter.) While there is great diversity in how states have used 1115 demonstration waivers over time, they generally reflect priorities identified by states and CMS. Some states have multiple waivers, and many waivers cover several different content areas. Section 1115 demonstration waivers are meant to allow states to test and experiment with new approaches for program design and implementation by waiving certain provisions of Medicaid and CHIP statutes. Waivers can range in scope from comprehensive waivers that cover many changes and populations, to narrow waivers that focus on a very specific pilot project. Via waivers, CMS allows states to use federal Medicaid funds in ways that would not otherwise be allowed (Hinton and Diana, 2025).

The changing priorities of presidential administrations are reflected in 1115 demonstration waivers approved, with each administration having discretion over which waivers to approve and support. Since the 1990s, the focus of demonstration waivers has evolved over time, starting from broad coverage expansion through the use of managed care organizations. In 2014, Delivery System Reform Incentive Payment (DSRIP) programs started to be prioritized (aimed at improving the quality of care while lowering costs), and in 2017 CMS was beginning to allow some care in Institutions for Mental Disease (IMD), or state psychiatric hospitals, to be paid for with federal Medicaid funds. Recently, a focus has been on health-related social needs such as housing and nutrition supports to improve health and ultimately reduce healthcare costs. Almost all states have an active 1115 demonstration waiver with many states running multiple initiatives through concurrent waivers or waivers spanning multiple service lines (Hinton and Diana, 2025).

For example, Massachusetts's 1115 demonstration waiver (MassHealth) has been a major avenue for federal funds to support the Massachusetts healthcare system, with federal funds supporting what previously was paid for solely by the state. A share of federal reimbursement goes toward providing benefits for MassHealth members in addition to subsidies for purchasing

coverage, direct support to safety-net providers, and payments for incentives to providers for higher quality care. MassHealth covers initiatives like Accountable Care Organizations (ACO) and Community Partners (CP), organizations that work with ACOs and managed care organizations (MCO) to provide extensive long-term services and support behavioral health needs. DSRIP payments are also covered by the waiver, which provide time-limited funding for the development of ACOs and CPs, funds to prepare for value-based payment approaches that underscore quality, and reimbursement to enhance care management, coordination, and patient navigation. Finally, the Flexible Services Program is supported by the waiver as a pilot program to address housing instability and food insecurity, which are health-related social needs that would not usually be covered by MassHealth (Massachusetts Foundation, 2023).

Florida, on the other hand, as another example, has multiple concurrent demonstration waivers that are focused on a variety of services. The 1115 Managed Medical Assistance demonstration waiver primarily provides behavioral health, dental, and acute medical care through selected health plans. The 1115 Family Planning Waiver provides family planning-related services to women of child-bearing age who have a family income at or below 191% of the FPL and would not otherwise be eligible for Medicaid or CHIP. A CHIP extension waiver can provide coverage for children with a family income above 200% of the FPL. And the Florida Health Care Workforce Sustainability 1115 demonstration waiver looks to implement new workforce recruitment and retention initiatives, especially in medically underserved areas, to address Medicaid workforce challenges (Florida Agency for Health Care Administration, 2025).

Demonstration waivers are approved for a five-year period with renewals at three-to-five-year periods. If an administration finds that a waiver does not meet its priorities, the administration can let the waiver expire without renewing or even withdraw approval at any time. The Biden Administration, for example, pulled waivers conditioning Medicaid coverage on meeting work and work reporting requirements for all states that had previous approval. States can appeal withdrawal decisions to the HHS Department Appeals Board and/or challenge rescissions in court (Hinton and Diana, 2025). States must submit quarterly and annual reports to CMS detailing changes within waivers that impact access, quality, and outcomes. Additionally, following the Affordable Care Act, public notice and comment periods are required to take place at the state and federal levels before CMS approves any new or extended Demonstrations (Hinton and Diana, 2025).

To be approved, CMS has a long-standing policy and practice of expecting that demonstration waivers be "budget neutral," which means that the federal costs of the state's Medicaid program with the demonstration cannot be greater than what the federal government's Medicaid costs in that state would have been if the demonstration had not taken place (Hinton and Diana, 2025). CMS's interest is in both not expanding the financial burden of the Medicaid program and facilitating state innovation through demonstration waivers (Hinton and Diana, 2025). It is reported that 52% of Medicaid spending is authorized through the Section 1115 demonstration waiver authority; however, much of the spending under Section 1115 goes toward populations and services that could have been covered without a waiver (MACPAC, 2021b). If state spending under its demonstration is below the intended baseline, the difference is considered savings. The state can then use any accumulated savings to finance spending on populations or services that are not covered by Medicaid, referred to as costs not otherwise matchable (CNOM). CNOM are certain types of expenditures that do not qualify for the regular federal Medicaid match under standard Medicaid funding rules. 1115 demonstration waivers must meet budget neutrality, but they still benefit from federal funding to try out experimental and expansion efforts such as new eligibility groups and service innovations that might otherwise be too expensive for the state to implement on its own (Hinton and Diana, 2025). Regarding 1115 "budget neutrality," it is important to note the concept of "hypothetical" expenditures that allows states to assume costs that could have been covered under different circumstances and therefore those costs do not have to be offset with savings to achieve budget neutrality (CMS, 2024a).

1115 demonstration waivers in certain states have functioned as a precursor to more permanent and sustainable options like SPAs. For example, DC's 1115 "DC Behavioral Health Transformation" waiver was initially used to cover CPEPs, mobile crisis intervention for youth and adults, and psychiatric residential crisis stabilization services. A SPA followed the waiver to formally incorporate these services into the District's Medicaid plan (CMS, 2022). Similarly, in Massachusetts, the "Diversionary Emergency Services Program" within the 1115 demonstration waiver covered 24/7 mobile crisis services. The program ultimately was renamed Mobile Crisis Intervention and included in the Medicaid State Plan in 2023 (CMS, no date #1). It is important to note a Section 1115 initiative by CMS in 2018 that encouraged states to build out comprehensive continua of care for adults with SMI or children with SED, which included

requirements that states take action to increase access to crisis response and stabilization services, as well as coverage for inpatient and residential treatment (CMS, 2018). While they are not covered here, it is reasonable to expect all of the states with these SMI-focused 1115 demonstration waivers would have expanded coverage, including for crisis stabilization services. The states implementing those SMI-focused 1115 demonstration waivers included: Alabama, Arkansas, California, Colorado, the District of Columbia, Idaho, Indiana, Kentucky, Maryland, Massachusetts, Missouri, New Hampshire, New Mexico, Oklahoma, Utah, Vermont, and Washington.

In addition to the CMS website given below in the Approach section, KFF maintains an up-to-date Medicaid Waiver Tracker of both approved and pending Section 1115 demonstration waivers by state. KFF describes pending waivers to "include new applications, amendments to existing waivers, and renewal/extension requests. State waiver renewals that do not propose changes and amendments that are technical in nature are excluded from this tracker and the accompanying tables. This tracker does NOT include/capture states mandating managed care through Section 1115 (since waiver authority is not generally required for these initiatives) and does not capture delivery system reform, behavioral health, or LTSS [Long-Term Services and Supports] initiatives that do not require Section 1115 expenditure authority/federal funds" (KFF, 2025).

Approach

Our goal was to document how some states have approached improving crisis care, often among other goals, through Section 1115 demonstration waivers above and beyond Medicaid state plan amendments (SPAs). Here, we describe our search strategy and policy analysis approach. Relevant 1115 demonstration waivers were identified using the following methodology.

1. The search was conducted using this Medicaid.gov website: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list.
2. Under "Advanced Search," the "Filter by Authority" box was used to select only "1115."
3. Every demonstration was scanned using three key search terms: "crisis respite" "crisis stabilization," and "mobile crisis."

4. If any of the terms or words within them (e.g., just "crisis" or just "respite") were found, the waiver was reviewed to determine relevance.
5. The waiver was recorded with *yes* or *no* depending on whether or not it had any of the search terms or key words.
6. Any demonstrations that were pending review of application or outside of the timeframe of the project were deemed not relevant.
7. It was noted if the waiver had a focus on re-entry or IMDs for mental health and substance abuse, which frequently included crisis terminology but were deemed not relevant given their focus.
8. Any demonstrations solely increasing eligibility were deemed not relevant as they were not expanding or enhancing crisis programming.
9. A waiver was deemed relevant if it: (1) increased federal funds to be pulled down by the state like Designated State Health Programs, (2) began a pilot or project with new crisis programming and services, or (3) incentivized funding crisis programming, such as that occurring as part of DSRIP.
10. Once a waiver was deemed relevant, a summary of the main points was recorded (in **Table 3**, below).

As noted previously with regard to Medicaid SPAs, a key limitation of our analysis of 1115 demonstration waivers is that some that we did not identify as relevant could have had minimal but nonetheless cumulatively meaningful impacts on crisis services (i.e., effects that may have impacted crisis services in small ways, though the focus was on the mental health system or the healthcare system more broadly).

Findings

159 waivers were scanned for relevance. Three waivers included part of the search term ("crisis" and "respite") and needed to be read and discussed further to clarify relevance, though were ultimately deemed not relevant. **29** waivers included a search term and were read further for relevance. **8** waivers were determined relevant, from the following states: Alaska, District of Columbia, Florida, Massachusetts, New Hampshire, Oregon, Rhode Island, and Texas. Though all are very complex, in **Table 3** we briefly summarize aspects of the waiver relevant to crisis services. Regarding their complexity, which is not captured herein, 1115 demonstration waivers are a necessary tool to advance Medicaid innovation; however, the time-intensive and lengthy

timeline to leverage the waiver demands considerable State Medicaid Agency resources and staffing. Depending heavily on U.S. Department of Health and Human Services discretion, state 1115 demonstration waiver applications can face long negotiations with CMS as each part of a proposal is reviewed for alignment with overall national policy goals or the goals of an administration. The process can take up to five years for a waiver to finally be implemented and impact Medicaid populations. Moreover, waivers can be broad or narrow in scope, thus requiring varying timeframes for implementation, depending on the extent of federal funding requested for different innovations (National Association of Medicaid Directors, 2024).

Table 3. Eight 1115 Demonstration Waivers Deemed to be Relevant for Expanding and Enhancing Crisis Services, 2014–2024

State	1115 Demonstration Title	Overarching Goals	Crisis-Related Activities, Briefly Summarized	Timeframe
Alaska	Alaska Behavioral Health Reform	Alaska has faced considerable difficulties in addressing the crises of opioid addiction and the state's expanding behavioral health demands. The original Demonstration aimed to lay the groundwork for a comprehensive continuum of high-quality, evidence-based, and reasonably priced SUD and behavioral health services. The Demonstration was centered around three overarching objectives: (1) rebalance the current behavioral health system of care to reduce Alaska's over-reliance on acute, institutional care and shift to more community- or regionally based care. (2) intervene as early as possible in the lives of Alaskans to address behavioral health symptoms before they cascade into functional impairments; and (3) improve overall behavioral health system accountability by reforming the existing system of care. This continuum comprises treatments that cover every level of care, including intense outpatient/partial hospitalization, residential treatment/inpatient, intensive inpatient, early intervention and prevention, and outpatient care.	**Peer-Based Crisis Services**: Covered for diversion from emergency department and psychiatric hospitalization use and delivered in community settings with medical support. **Mobile Outreach & Crisis Response Services (MOCR)**: Face-to-face services with the individual (or family member) provided in any location where the provider and the individual can maintain safety. **23-Hour Crisis Observation and Stabilization Services (COS):** Services for up to 23 hours and 59 minutes of care in a secure and protected environment—an unlocked facility designed to allow staff to stay in close contact with clients. **Crisis Residential/Stabilization Services:** A medically monitored, short-term, residential program in an approved (10- to 15-bed) facility that provides 24/7 psychiatric stabilization.	The Demonstration's implementation plans received approval in March 2019. The behavioral health component received approval in September 2019. Renewed through 2028.
District of Columbia	DC Behavioral Health Transformation	The main goal of the Demonstration is for the District to maintain and enhance access to mental health services, opioid use disorder and other SUD services; as well as continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid	**Comprehensive Psychiatric Emergency Program (CPEP):** This program provides 24/7 emergency psychiatric assessment and treatment to individuals presenting on involuntary and voluntary status. Covered services include brief psychiatric crisis/emergency visits, 23-hour psychiatric crisis/emergency visits,	Temporary services which were not currently Medicaid state plan-approved were authorized from January 1, 2020, through December 31, 2021. CMS approved an extension to provide

State	1115 Demonstration Title	Overarching Goals	Crisis-Related Activities, Briefly Summarized	Timeframe
		beneficiaries with SMI, SED, and/or SUD. Specific SMI/SED goals include: (1) reduced utilization and lengths of stay in hospital emergency departments among Medicaid beneficiaries with SMI or SED (2) reduced preventable readmissions to acute care and specialty hospitals and residential settings (3) 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 and psychiatric hospitals; (4) improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and (5) improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.	and extended observation psychiatric crisis/emergency visits. **Mobile Crisis Intervention (youth and adult):** These services provide clinical attention or treatment by mobile intervention and outreach staff in the community or via telephone to individuals experiencing a behavioral health crisis. Concurrent with this demonstration, in July 2019, the District initiated the Community Response Team (CRT), a multi-site, 24/7 model of care consisting of a multidisciplinary team of licensed clinicians, community behavioral health specialists, and individuals with lived experience. The CRT provides critical incident response, targeted community outreach, supportive behavioral health services, and community education. The Department of Behavioral Health's CRT recently merged the Department's Mobile Crisis, Homeless Outreach, and Pre-Arrest Diversion Pilot Programs into a single program. **Psychiatric Residential Crisis Stabilization Services**: Services are furnished outside of an IMD setting to eligible individuals needing treatment or recovery support.	authority for D.C. to receive federal financial participation for non-state plan services (inclusive of crisis services) through July 1, 2022. This extension was granted because D.C. needed additional time to work with CMS to submit approvable SPAs to formally incorporate these services into the District's Medicaid plan while preventing a gap in coverage. The demonstration itself had an overall approval period from January 1, 2020, through December 31, 2024.
Florida	Managed Medical Assistance	Florida's 1115 demonstration allows the state to operate a Medicaid managed care program and a Prepaid Ambulatory Health Plan (PAHP). Most Medicaid-eligible individuals are required to enroll in Managed Medical Assistance (MMA)	**The Behavioral Health and Supportive Housing Assistance Pilot** approved under the Demonstration is a voluntary pilot program for Medicaid recipients that offers additional behavioral health services and supportive housing	On March 26, 2019, The Behavioral Health and Supportive Housing Assistance pilot was approved. On January 15, 2021, the Demonstration

State	1115 Demonstration Title	Overarching Goals	Crisis-Related Activities, Briefly Summarized	Timeframe
		managed care plans, which are MCOs. Applicants can select a plan before receiving a Medicaid eligibility determination or be auto assigned into an MMA plan upon affirmative eligibility determination. MMA plans offer customized benefits, comparable to state plan benefits, and participants have access to the Healthy Behaviors Programs for healthy behaviors.	assistance services for persons aged 21 and older with SMI, SUD, or SMI with co-occurring SUD, who are homeless or at risk of homelessness due to their disability. The pilot program is approved to operate in two regions of the state. The goal of this pilot program is to provide additional tools to improve health outcomes and achieve stable tenancy, potentially reducing state costs related to unnecessary service utilization. The state is required to evaluate the pilot's effectiveness in improving service integration, care coordination, individual involvement in care, health outcomes, and reducing inefficient use of healthcare. **Mobile Crisis Management** is a specific service offered under the pilot. It is provided to enrollees participating in the pilot who are experiencing a behavioral health crisis. The service is delivered by a team of behavioral health professionals who are always available to prevent the need for emergency inpatient psychiatric services, when possible, and to prevent the loss of a housing arrangement. Services are provided at the Florida location in which the crisis occurs, even if that location is outside the region in which the managed care plan is operating. As part of its approved Quality Improvement Strategy, the state is mandated to create specific performance measures for mobile crisis management to track how well the program is functioning.	was extended through June 30, 2025.

State	1115 Demonstration Title	Overarching Goals	Crisis-Related Activities, Briefly Summarized	Timeframe
Massachusetts	MassHealth	MassHealth has been an essential tool in enabling Massachusetts to achieve and maintain near-universal coverage since 1997. The waiver has sustained the Commonwealth's safety net, expanded critical behavioral health services, and reformed the way that care is delivered. Behavioral health (BH), defined here as SMI, SED, and/or SUD/opioid use disorder (OUD), is a top priority in the 2022–2027 Demonstration period. The BH Demonstration domain has three main policy components: (1) diversionary BH services; (2) a full range of SUD/OUD treatment services, including residential and inpatient treatment; and (3) residential and psychiatric inpatient treatment for individuals with SMI or SED. Some of the main goals through the BH Demonstration include the following: 1. Strengthen the delivery of BH outpatient, urgent, and crisis care. 2. Increase rates of early identification, initiation, and engagement in BH treatment. 3. Increase access to community-based recovery support services to improve member health and increase rates of long-term BH recovery. In addition, The Delivery System Reform (DSR) includes the Commonwealth's efforts under the 1115 Demonstration authority to enact payment and delivery system reforms that promote member-driven, integrated, coordinated care and hold plans and providers accountable for the quality and total cost of care. The State	**Diversionary Behavioral Health Service:** Emergency Services Program (renamed Mobile Crisis Intervention as of January 2023 when included in the Medicaid state plan): Non-24-hour facility services provided through designated contracted emergency services providers / Mobile Crisis Intervention providers, and which are available 24/7 to provide treatment for any individual who is experiencing a mental health crisis. **SMI/SED Services that the Commonwealth will cover under the Demonstration:** MassHealth aims to ensure that members have access to the full range of services, including those provided in facilities that meet the definition of an IMD that will ensure smooth transitions to clinically appropriate levels of community BH care, physical health care, and social services. (1) Community crisis stabilization for adults and youth (CCS): 24/7 short-term, intensive behavioral health support in a community-based setting for individuals in crisis. (2) Community-based acute treatment for children and adolescents (CBAT): staff-secure, 24-hour care for children/adolescents needing acute stabilization due to serious emotional disturbance. **Delivery System Reform** Under the Massachusetts 2017–2022 renewal, MassHealth used $1.8 billion in federal DSRIP program funding to	The DSRIP program was primarily implemented during the previous Massachusetts Section 1115 period, 2017–2022. For the current demonstration period, which is effective from October 1, 2022, through December 31, 2027, no new DSRIP funding is authorized. The expenditure authority granted under this extension allows the state to use DSRIP funds remaining from the previous period, up to $253.2 million. Since 2014, Mobile Crisis and Crisis Stabilization services have been offered through the Demonstration; however, renaming and reorganization occurred with renewals of the Demonstration.

State	1115 Demonstration Title	Overarching Goals	Crisis-Related Activities, Briefly Summarized	Timeframe
		will use DSRIP funding to support investment in new or enhanced diversionary strategies or infrastructure to help place members with behavioral health needs in the least restrictive, clinically most appropriate settings and to reduce the incidence of members who are boarded in a hospital emergency department waiting for admission into acute inpatient treatment.	support infrastructure and capacity building. Strategies for investment include CBAT for adults, Mobile Crisis Intervention Teams with specific focus on placement in the Eds, Crisis Stabilization Services, and Peer Support models. A variety of providers including community mental health centers, acute care hospitals, community health centers, psychiatric hospitals, and advocacy organizations were eligible to get funding.	
New Hampshire	Building Capacity for Transformation	New Hampshire seeks to transform its behavioral health delivery system through: (1) integrating physical and behavioral health to better address the full range of beneficiaries' needs; (2) expanding provider capacity to address behavioral health needs in appropriate settings; and (3) reducing gaps in care during transitions through improved care coordination for individuals with behavioral health issues. DSRIP funding will enable the state to make performance-based funding to regionally based Integrated Delivery Networks (IDNs) that provide Medicaid services. The state will use the IDNs as a vehicle to foster relationships between behavioral health providers and other health care and community service providers that are necessary to achieve the state's vision for Medicaid system transformation. A 2019 amendment to this Demonstration further replaces an existing Designated State Health Program (DSHP) with three new programs and services. DSHP expenditures allow states to draw down federal funds for designated	**Designated State Health Programs Peer Support Services Programs** are face to face and telephone peer support; outreach includes crisis respite (24 hours, short-term, non-medical crisis program). **Mobile Crisis Teams** consist of clinicians and peer support specialists who are available 24/7 to respond to individuals experiencing an acute mental health crisis. **The Behavioral Health Crisis Treatment Center:** a treatment site that provides 24/7 intensive, short-term stabilization treatment services for individuals experiencing a mental health crisis, including those with co-occurring SUD. Accepts individuals for treatment on a voluntary basis who walk in, are transported by first responders, or as a step-down treatment site post emergency department visit or inpatient psychiatric treatment.	On January 5, 2016, New Hampshire secured a five-year, $150 million Medicaid 1115 waiver to transform the state's delivery system for Medicaid beneficiaries with mental health disorders and SUDs. The amendment of DSHPs focused on crisis was effective February 1, 2019, through December 2020. This Demonstration has since expired. The Demonstration preceded SPA NH 24-0021, which added mobile crisis response teams through the ARPA enhanced match, as well as crisis stabilization services (residential or

State	1115 Demonstration Title	Overarching Goals	Crisis-Related Activities, Briefly Summarized	Timeframe
		programs that provide or support the provision of health services that are otherwise state-funded.	**Community Mental Health Center Emergency Services:** emergency services that include an emergency assessment that is used to evaluate whether the individual needs hospital placement, crisis respite care, revocation of conditional discharge, or another out-of-home placement. **Integrated Delivery Networks** Over the 5-year initiative, New Hampshire had the authority to invest up to $30 million per year to support Integrated Delivery Networks (IDNs), formed by individual providers who come together to create regional coalitions. They are organized around seven service regions throughout the state and are expected to be built upon collaboration among a diverse range of partners such as federally qualified health centers and community health centers. The initiative includes a DSRIP program, under which the state makes performance-based funding available to IDNs for projects such as one titled Community Driven Projects. This project invests in capacity building to expand the mental health workforce, integrate behavioral health with social services and primary care, and care transition that looks to support individuals moving from institutional settings into the community The state can claim Federal Financial Participation (FFP) for DSRIP payments. One of the projects available for payments looked to, among other goals,	outpatient) to the state plan.

State	1115 Demonstration Title	Overarching Goals	Crisis-Related Activities, Briefly Summarized	Timeframe
			expand peer support workforce capacity, including peer-run Crisis Respite Centers, and peer workers on Assertive Community Treatment Teams and Mobile Crisis Response Teams.	
Oregon	Oregon Health Plan	Oregon Health Plan (OHP) began in phases in February 1994 and initially affecting Medicaid clients in the Aid to Families with Dependent Children (later replaced by Temporary Assistance for Needy Families) and Poverty Level Medical programs. The demonstration aims to offer a basic benefit package, encourage healthcare provider participation, implement clinical effectiveness and cost-effectiveness processes, structure benefits using a Prioritized List of Health Services, improve Medicaid delivery, and expand services through Indian Health Services and tribal health facilities.	**Designated State Health Programs (DSHPs)**: The state may claim federal financial participation for DSHPs. These programs are otherwise normally state-funded, and not otherwise eligible for Medicaid payment. Under DSHP approval, CMS makes these programs eligible for federal Medicaid matching of funds. States can then use the newly freed up state dollars for other Demonstrations or state programs. **DSHPs include**: **Non-Medicaid Mental Health – Crisis and Acute Transition Services (CATS)**: Services for youth and their families during transitions from emergency departments to community-based treatment and support services; an alternative for inpatient psychiatric admission when the child meets criteria to return home safely if support services are in place. **Non-Medicaid Mental Health – Community Mental Health Crisis Services for Adults and Children (adult mobile crisis)**: Limited-duration behavioral health crisis assessment, triage, and intervention for individuals/families experiencing sudden	In 2012, CMS approved an expansion of the hospital benefit under the OHP Standard plan for the expansion adult population and authorized expenditures on DSHPs. These have since been renewed until 2027.

State	1115 Demonstration Title	Overarching Goals	Crisis-Related Activities, Briefly Summarized	Timeframe
			onset of psychiatric symptoms or the serious deterioration of mental or emotional stability or functioning.	
Rhode Island	Rhode Island Comprehensive Demonstration	The Rhode Island Medicaid Reform Act of 2008 directed the state to apply for a Demonstration project under the authority of Section 1115 to restructure the state's Medicaid program with the goal of a "sustainable, cost-effective, person-centered, and opportunity-driven program utilizing competitive and value-based purchasing to maximize available service options" and "a results-oriented system of coordinated care." Under this demonstration, Rhode Island operates its entire Medicaid program aside from four exceptions. All Medicaid-funded services on the continuum of care–including those approved in the state plan—are subject to the requirements of the Demonstration. Rhode Island's previous Section 1115 Demonstration programs, Rite Care and Rite Share, were subsumed under this demonstration, in addition to the state's 1915(c) home and community-based services (HCBS) waivers.	**The Behavioral Health Link (BH Link) program** began in the first quarter of January 2019 as one triage center to support crisis stabilization and short-term treatment for Medicaid beneficiaries experiencing a behavioral health (mental health and/or SUD) crisis. As of January 2019, there is only one provider that can receive reimbursement for this service, which will operate 24/7 in person or through telemedicine. If at some point the state finds this program to be cost effective, the state will increase the number of BH Link triage centers. **BH Link triage center provides services such as** local mobile outreach, case management, assessment, treatment coordination, 23-hour observation beds, discharge planning, warm hand-offs to community providers, and medications. BH Link will receive a bundled rate that may be billed no more than once per client per 24-hour period. Bundles may include Crisis Management and Stabilization, Psychiatric Consultation Services, Connections to Treatment, Recovery Supports, Recovery Housing, Peer Support, and Mobile Crisis Response. For a provider to receive the total reimbursement of $598.50, they must perform a crisis assessment.	On July 11, 2018, the state requested expenditure authority to receive federal financial participation for services delivered to beneficiaries diagnosed with an opioid use disorder and other SUDs residing in an IMD. In its extension application, the state also requested authority for BH Link. It received approval for a renewal from January 1, 2019 through June 30, 2025.

State	1115 Demonstration Title	Overarching Goals	Crisis-Related Activities, Briefly Summarized	Timeframe
Texas	Texas Healthcare Transformation and Quality Improvement Program	Texas submitted its formal proposal for the Texas Healthcare Transformation and Quality Improvement Program (THTQIP) Section 1115(a) demonstration to CMS in 2011. THTQIP was originally designed to expand the existing Medicaid managed care programs (STAR and STAR+PLUS) statewide and to use savings from the expansion of managed care as well as the discontinuation of supplemental provider payments to finance a new safety net care pool to assist hospitals and other providers with uncompensated care costs and to promote health system transformation in preparation for new coverage demands that began in 2014. The demonstration was approved in December of 2011. Through this demonstration, the state aims to: 1. Expand risk-based managed care to new populations and services. 2. Support the development and maintenance of a coordinated care delivery system. 3. Improve outcomes while containing cost growth. 4. Transition to quality-based payment systems across managed care and providers.	The Delivery System Reform Incentive Payment (DSRIP) program was designed to provide incentive payments to Texas hospitals, physician practices, Community Mental Health Centers, and Local Health Departments for investments in delivery system reforms that increase access to health care, improve the quality of care, and enhance the health of patients served. DSRIP is multipronged in this demonstration. Projects within the DSRIP program include the following examples: Developing crisis stabilization services that serve as alternatives to settings like the emergency room, jail, or inpatient hospital beds. Service investment would be facilities such as sobering units, crisis residential settings, and crisis respite programs. DSRIP supports youth crisis centers in 21 rural counties in the state. Creating incentives for reducing the rate of Emergency Department visits for behavioral health and substance abuse and decreasing mental health admissions and readmissions to criminal justice settings such as jails or prisons. Incentives are based on meeting targeted improvement goals. Improving statewide reporting measures such as effective crisis response, crisis follow up, community tenure (adult and child/youth), reduction in juvenile justice involvement, and adult jail diversion.	The DSRIP program was authorized on December 12, 2011, with the approval of the THTQIP Demonstration. Healthcare providers began participating in DSRIP and earning funds starting in 2012. The first five demonstration years of the waiver, which included the initial phase of DSRIP (DSRIP 1.0), spanned from December 12, 2011 through September 30, 2016. The Renewal was approved December 21, 2017, authorized for five years through September 30, 2022. This renewal shifted the focus of delivery system transformation from individual provider projects to system-level performance measurement and improvement (DSRIP 2.0). The full Demonstration is renewed until September 2030.

4. Medicaid Home and Community Based Services (HCBS) Authorities under 1915(c)

4. Medicaid Home and Community Based Services (HCBS) Authorities under 1915(c)

Background

Home and Community Based Services (HCBS) waivers first became available in 1983 when Congress added Section 1915(c) to the Social Security Act, giving states the option to receive a waiver of Medicaid rules governing institutional care (CMS, no date #2). Before then, states primarily relied on Medicaid-funded facility-based care, with only limited home services under state plans or small, state-only community programs, since there was no federal authority to fund broad home- and community-based initiatives. In 2005, HCBS became a formal Medicaid state plan option. Forty-seven states and DC are operating at least one 1915(c) waiver. State Medicaid Agencies have several HCBS options: 1915(c) Home and Community Based Waivers, 1915(i) State Plan Home and Community Based Services, 1915(j) Self-Directed Personal Assistance Services Under State Plan, and 1915(k) Community First Choice (CMS, no date #2). Here we focus on 1915(c) waivers that might have had some impact toward improving crisis services (e.g., crisis stabilization and crisis respite), despite being available only to a select high-risk population at risk for needing institutional care.

Section 1915(c) HCBS waivers allow a capped number of individuals from specific populations with long-term service and support needs to receive specialized services as a substitute for institutional care. These individuals must meet the institutional level-of-care requirements. HCBS waivers allow states to waive certain Medicaid requirements. First, they can target geographic areas where the state has the highest need. Second, the waiver can target services to groups who are most likely at risk for institutionalization such as those with intellectual disabilities or the elderly. In addition, states can further target those with particular diagnoses like traumatic brain injuries or HIV/AIDs. Third, states can increase income eligibility thresholds for HCBS services to those who may otherwise be ineligible for institutional-level services due to income levels of parents or spouses. Generally, state plans include a spousal or parent income rule unless the individual is institutionalized, so 1915(c) waivers allow states to bypass this rule (CMS, no date #2).

Services may include, among others, habilitation, case management, and diversionary behavioral health services. HCBS waivers must also prove that waiver services will not cost more than providing these services in an institutional setting (CMS, no date #2). The initial

waiver is approved for a three-year period, after which states can continue waiver operation by submitting a waiver renewal request, which CMS generally approves for five-year increments (Colello and Saraswathula, 2025).

While we chose to focus on Section 1915(c) HCBS waivers, other waivers may also be relevant to enhancing crisis services. Section 1915(i), for example, was enacted in part to improve access to HCBS for individuals with mental illnesses or SUDs specifically due to challenges with meeting the cost neutrality requirements in 1915(c) for this population, for whom an institutional level of care includes IMDs that are generally excluded from Medicaid coverage. (Psychiatric residential treatment facilities for youth under 21 are an exception to the IMD exclusion, and therefore states have often been able to cover youth with behavioral health needs more readily under 1915(c).) According to MACPAC, the "most commonly offered service category in 1915(i) mental health SPAs was other mental health and behavioral services, including crisis intervention" (MACPAC, 2020).

Approach

1915(c) waivers relevant to our focus were identified using the following methodology.

1. The search was conducted using this Medicaid.gov website: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list
2. Waivers were filtered solely for 1915(c) on the website.
3. **363** waivers were scanned, and titles were read for relevance.
4. Any titles that were clearly about a narrowly defined group that is generally not relevant to our purposes (e.g., traumatic brain injury, elderly long-term care) were excluded.
5. Any waivers with a title that did not clearly identify its focus area were reviewed.
6. This document from the Arch National Respite Network and Resource Center was cross referenced to confirm content and focus of long-term waivers. https://archrespite.org/library/80edicaid-waivers-for-respite-support/
7. **12** waivers were deemed relevant based on searches using the terms "crisis" and "respite."

We did not review 1915(c) waivers that were not approved or that were still pending. We do not report on prior iterations of the same waiver that may have occurred within our 2014–2024 period (but rather only on the most recent waiver).

Like with the Medicaid SPAs and 1115 demonstration waivers, some of the 1915(c) waivers that we deemed "Not Relevant" to our purposes may have had some elements that would have improved crisis services for select groups of beneficiaries, though likely at an overall low impact. For example, some provide for "Respite" (which could be medical respite and not necessarily crisis respite) for specific populations, such as youth who would otherwise be in Residential Treatment Facilities (RTFs) or youth with medically complex needs in addition to behavioral health disorders.

Findings

The 12 waivers briefly described in **Table 4** below provide crisis respite services for targeted, high-risk youth populations. The 12 waivers here all focus on youth populations because most other populations that 1915c waivers address were excluded by our search strategy (i.e., narrowly defined groups that are generally not relevant to our purposes, including those with intellectual and developmental disabilities, elderly individuals who need long-term care, those with physical disabilities who need support to live in the community, traumatic brain injury and spinal cord injury, and medically fragile/technology-dependent children requiring advanced support at home). Some of the relevant waiver programs provide 24/7 crisis stabilization services, and even more commonly, they provide *respite* care to allow for stabilization in home or community settings in an effort to prevent an institutional level of care. As noted below in **Table 4**, these HCBS wavier services are provided to as few as 95 youth in a state per year (e.g., in South Carolina), to nearly 20,000 youth in a state per year (e.g., in New York and Wisconsin). The impact on the overall crisis care continuum is low (given the targeted and relatively small populations, as well as the focus on respite), though the impact of providing crisis respite for these individuals may be substantial for them during times of crisis. On the other hand, the impact on costs is presumably high, which is why the HCBS services are justified. HCBS waivers targeting the other high-risk groups are not addressed here, though they might also allow for crisis stabilization and crisis respite services that would be helpful for those groups.

Table 4. Twelve 1915(c) Home and Community Based Waivers Deemed to be Relevant for Expanding and Enhancing Crisis Services, 2014–2024

State	Waiver Title	Wavier Goals	Effective Date of the Most Recent Renewal *	Crisis-Related Activities	Unduplicated Number of Participants Served
Indiana	Psychiatric Residential Treatment Facilities (PRTF) Waiver	Indiana's fundamental transformation goal continues to ensure that children in community settings receive effective behavioral health services and support, at the appropriate level of intensity, based on their needs and the needs of their families. This PRTF Waiver maintains the re-balancing of resources between PRTF and intensive community-based services for children with SED and youth with SMI. The PRTF Waiver provides a means for: (1) offering specific services designed to reduce the need for out-of-home placements to support children with SED and youth with SMI; (2) controlling financial risk for those children who meet the PRTF level of care; (3) supporting the development of providers guided by the principles and values of a System of Care; and (4) bringing all agencies who serve children together through a System of Care. Participants are expected to stay on the waiver for a limited time, at which point most are expected to move to the use of non-waiver outpatient services during the 5-year Waiver.	Approval: 9/25/12 Expiration: 9/30/17	Crisis Respite Care may be provided in an emergency in response to a crisis situation in the family. A crisis situation is one where the individual's health and welfare would be seriously impacted in the absence of Crisis Respite Care. The Crisis Respite Care rate is based on the rates for Respite Care in Indiana licensed crisis shelters, which range from $90 to $150/day depending upon the child's needs. Crisis Respite Care is provided for a minimum of 8 to 24 hours billable at a daily rate. 24-hour Respite Care cannot exceed 14 consecutive days.	Year 1: 749 Year 2: 459 Year 3: 281 Year 4: 173 Year 5: 106
Kansas	Serious Emotional Disturbance (SED) Waiver	The SED Waiver is designed as a hospitalization diversion program. The goal of the SED waiver is to divert from psychiatric hospitalization through the	4/1/2022	Short-Term Respite Care provides temporary direct care and supervision. The primary purpose is to provide relief to the parents or caregivers of a	Years 1–5: 4,900 per year

State	Waiver Title	Wavier Goals	Effective Date of the Most Recent Renewal *	Crisis-Related Activities	Unduplicated Number of Participants Served
		provision of intensive home and community-based support services in an effort to maintain participants in their homes and communities. Participants eligible for the waiver are between the ages of 4 and 18. An age exception for clinical eligibility may be requested for participants under the age of 4 and over the age of 18 through age 21 who are experiencing a SED and are at risk for inpatient psychiatric hospitalization. Foster Care children on the SED waiver will not be able to access short term respite care or professional resource family care.		participant with a SED. The service is designed to help meet the needs of the primary caregiver, as well as the identified participant. Short-Term Respite Care can be provided in the participant's home or place of residence or provided in other community settings. Other community settings include Licensed Family Foster Homes, Licensed Emergency Shelters, and Out-Of-Home Crisis Stabilization Houses/Units/Beds. SED Waiver services are provided by 25 Community Mental Health Centers and two affiliated organizations.	
Louisiana	The Coordinated System of Care (CsoC) Waiver	The CsoC Waiver is designed to provide specialized home and community-based services to members with mental health needs who would otherwise require the level of care of an inpatient psychiatric hospital or nursing facility. Serves those with SED ages 5–17.	7/1/2022	Short Term Respite Care provides temporary direct care and supervision for the member in the member's home, a relative's home, or a community setting that is not facility-based (i.e., not provided overnight in a provider-based facility). The primary purpose is to provide relief to family members/caregivers, help de-escalate stressful situations and provide a therapeutic outlet for the child. Crisis Receiving Center is an agency type for short term respite.	Years 1–5: 5,557 per year Maximum Number of Participants Served at Any Point During the Year: 2,900
Maryland	Psychiatric Residential Treatment Facilities (PRTF) Waiver	The purpose of the PRTF Waiver is to provide community-based services and care management to youth with SED and their families in an efficient, therapeutic, and cost-effective manner. The waiver has the goal of providing these specialized services to youth who meet the Residential Treatment Center level of	Effective: 10/1/2012 Expired 9/30/2014	1. Out-of-Home Respite Services are temporary and arranged on a planned or unplanned basis. Respite provides stabilization and relieves a caregiver from the stress of caregiving. Unplanned respite may be provided on an emergency basis due to an unforeseen event, or to help mitigate a	Year 1: 130 Year 2: 60 Year 3: 1

State	Waiver Title	Wavier Goals	Effective Date of the Most Recent Renewal *	Crisis-Related Activities	Unduplicated Number of Participants Served
		care in their family's homes or in alternative community based residential settings. Objectives of the waiver are focused on assuring the development of an individualized plan of care designed to be flexible and address the rapidly changing needs of youth and families with quality services while assuring their health, safety, and improved functioning.		potential crisis situation. Out-of-home respite is provided in a facility that is appropriately licensed, registered, or approved, based on: (a) The age of individuals receiving services, and (b) Whether the respite has capacity to do overnight services. Maximum of 24 days per waiver year, with the maximum to be exceeded if the participant continues to meet medical necessity criteria for the service and total costs for all services for the participant under the waiver do not threaten the program's overall cost neutrality. 2. Crisis and Stabilization Services are interventions for participants and families that: (a) are offered in response to urgent mental health needs; (b) are available on an on-call basis, 24/7; (c) are coordinated through the Care Coordinator and Child and Family Team and are incorporated into the participant's Plan of Care; (d) are short-term, flexible services that assist in de-escalating crises and stabilizing children and youth in their home and community setting; (e) are designed to maintain the child or youth in his or her current living arrangements, to prevent movement from one living arrangement to another, and to prevent repeated hospitalizations; and (f) include the delivery of a variety of flexible services in accordance with a comprehensive, individualized plan for stabilization.	

State	Waiver Title	Wavier Goals	Effective Date of the Most Recent Renewal *	Crisis-Related Activities	Unduplicated Number of Participants Served
Michigan	Waiver for Children with Serious Emotional Disturbance	The purpose of the Waiver for Children with Serious Emotional Disturbance (SEDW) is to provide home and community-based services to children, youth, and young adults under age 21 who, if not for the availability and provisions of SEDW services, would otherwise require hospitalization in a state psychiatric hospital. The goal of the SEDW is to enable beneficiaries with SED who have significant needs and who meet the SEDW eligibility requirements to live in their home and community instead of receiving hospital level of care. The objective is to provide regular Medicaid State Plan services and waiver services that address the participant's identified needs.	10/1/2024	Out-of-Home Respite: Respite care services are provided to beneficiaries on a short-term basis because of the need for relief of those persons normally providing care. The purpose of respite care is to relieve the beneficiary's family from daily stress and care demands. "Short-term" means the respite service is provided during a limited period of time (e.g., a few hours, a few days, weekends, or for vacations). Decisions about the methods and amounts of respite are decided during the person-centered planning process and are specified in the individual plan of service. Paid respite care may not be provided by a parent or legal guardian of a beneficiary. Respite care can be provided in the following locations: the beneficiary's home or place of residence, the home of a relative or a family friend, Licensed Foster Family Home, Licensed Foster Family Group Home, Licensed Children's Camp, or Licensed Children's Therapeutic Group Home.	Years 1–5: 969 per year
New York	Bridges to Health (B2H) for Children with Serious Emotional Disturbance	The purpose of the Bridges to Health for Children with Serious Emotional Disturbances (B2H SED) Medicaid waiver is to address the health-related needs of youth in foster care up to age 21. Participants' disabilities are sufficiently severe to require placement in a medical institution. However, the B2H waiver allows the State to	10/1/2017 (April 1, 2019: Consolidated into Children's Waiver; see below) Expired: 9/30/2022	(1) Out-of-Home Respite: Crisis respite provides emergency short-term relief for family/caregivers (non-shift staff) needed to resolve a crisis and segue back to the child's successful functioning and engagement in Individualized Health Plan activities. Crisis respite assists the family/caregivers in supporting the	Years 1–5: 3,340 per year

State	Waiver Title	Wavier Goals	Effective Date of the Most Recent Renewal *	Crisis-Related Activities	Unduplicated Number of Participants Served
		supplement the Medicaid State Plan and other supports with an array of services tailored to address the unmet health care needs of this complex population in the least restrictive, most home-like, and integrated setting appropriate to their needs. The services may continue to be available to the child upon discharge from foster care.		child's disability and/or health care issues. Crisis respite may be provided on an hourly, daily, or overnight basis (in-home or out-of-home) by an approved respite care and services provider. (2) Immediate Crisis Response Services are 24-hour services designed to respond immediately to crises that threaten the stability of the child's placement and the child's ability to function in the community. This service is intended to be of very short duration and primarily to engage/link to other services and resources, e.g., intensive in-home supports and services. This service may only be delivered in an individual, one-to-one session. The service includes crisis de-escalation, crisis resolution support, and the development of a crisis stabilization plan. This service also consists of the Immediate Crisis Response Specialist making recommendations for revisions to the Service Plan that is developed by the Crisis Avoidance, Management, and Training Specialist. A residence of 12 beds or less in the community is considered a qualified setting for receiving waiver services.	
New York	The Office of Mental Health (OMH) HCBS comprehensive waiver for children and	This waiver provides a community alternative for children with complex mental health needs who otherwise would require institutionalization. The waiver is targeted to ages 5–21. The goals of the waiver include: serving	9/1/2017 (April 1, 2019: Consolidated into Children's	Respite is a short-term intervention but also allows for a wide range of flexibility based on family need. This may include on a planned or emergency (crisis) basis, during the day or night (including overnight), and taking place	Year 1: 2,004 Year 2: 3,507 Year 3: 3,660 Year 4: 3,812 Year 5: 3,812

State	Waiver Title	Wavier Goals	Effective Date of the Most Recent Renewal *	Crisis-Related Activities	Unduplicated Number of Participants Served
	adolescents with SED	children with complex health or mental health needs in their homes and communities; decreasing the need for placements in psychiatric inpatient levels of care, including Residential Treatment Facilities; increasing the array of Medicaid reimbursable community-based services available to these children/adolescents and their families; and demonstrating an integrated model of partnership with the family, treatment provider, waiver services, and natural supports that are involved with the child and family.	Waiver; see below) Expired: 8/31/2022	in the child's home or community. For each of the types of respite provided, the service must be face-to-face with a minimum of 30 minutes with billing limitations of 6 hours a day, which allows for flexibility while maintaining it as a short-term service. This allows for children to receive planned respite, such as two hours a week in a group as part of their service plan, or overnight crisis respite in an emergency situation according to their safety alert plan.	
New York	Children's Waiver	The New York State Department of Health Children's Waiver operates concurrently with the State's 1115 Medicaid Redesign Team demonstration waiver and a 1915(b)(4) waiver. The Children's Waiver program went into effect on April 1, 2019. HCBS services are provided by Managed Care Organizations (MCOs) for children in managed care beginning October 1, 2019. Children in fee-for-service will continue to receive HCBS via the fee-for-service delivery system. The Children's Medicaid waiver incorporates the SED, Medically Fragile, and foster care and medically fragile Developmental Disability (DD) target populations. As part of ongoing redesign efforts, New York State proposed, and CMS approved, concurrent amendments to the existing six 1915(c) waivers and the	4/1/2022	Planned Day Respite, Planned Overnight Respite, Crisis Day Respite, Crisis Overnight Respite: These four types of services may be delivered with support of staffing ratios necessary to keep the child, and other children in the environment, safe, overseen by the respite provider. Planned respite services provide planned short-term relief for the child or family/primary caregivers that are needed to enhance the family/primary caregiver's ability to support the child/youth's functional, developmental, behavioral health, and/or health care needs. Crisis respite is a short-term care and intervention strategy for children/youth and their families that helps to alleviate the risk for an escalation of symptoms, a loss of functioning, and/or a disruption in a stable living environment. It may be	Year 1: 17,379 Year 2: 17,379 Year 3: 17,379 Year 4: 17,379 Year 5: 17,379

State	Waiver Title	Wavier Goals	Effective Date of the Most Recent Renewal *	Crisis-Related Activities	Unduplicated Number of Participants Served
		1115 Medicaid Redesign Team waiver. To streamline care for children and youth under age 21 who have needs for physical and behavioral health services and home- and community-based services, the State consolidated the existing six 1915(c) waivers into a new 1915(c) waiver in April 2019. The 1115 waiver amendment, implemented in October 2019, allows the state to move the services covered by the consolidated 1915(c) waiver from fee for service to Medicaid managed care and to target eligibility to medically needy children (Liu et al., 2021).		used when challenging behavioral or situational crises occur, which the child/youth and/or family/caregiver is unable to manage without intensive assistance and support. Crisis Respite can also be used as a result of crisis intervention or from visiting the emergency room.	
South Carolina	PRTF Alternative CHANCE (Children's Health Access in Community Environments) Waiver	The purpose of this waiver is to provide home and community-based supports and services to children with mental illness who would otherwise be served in Psychiatric Residential Treatment Facilities (PRTF). Families and youths are offered the choice of behavioral health services and supports to permit the youths to remain in, or return to, the least restrictive environment, preferably their homes. To be eligible, a potential waiver participant must meet the PRTF level of care and meet all Medicaid financial requirements.	Effective: 10/2/2012 Expired: 9/30/2017	Respite services are provided to participants who are unable to care for themselves on a short-term basis, to assist the primary caregiver by providing relief from the stress of care giving. Out-of-Home respite is provided in a Therapeutic Foster care setting and can include the administration of medication.	Years 1–5: 95
South Carolina	Palmetto Coordinated System of Care for Children (PCSC) Home	The state is developing the PCSC for South Carolina's youth with significant behavioral health challenges or co-occurring conditions in or at imminent risk of out-of-home placement. PCSC is an evidenced-based approach that is part	8/01/2020	Out-of-Home Respite Care includes services provided on a short-term, planned or emergency basis, and offers relief to a beneficiary's unpaid caregiver who is unable to provide services to the participant. Respite may	Year 1: 240 Year 2: 290 Year 3: 360 Year 4: 420 Year 5: 480

State	Waiver Title	Wavier Goals	Effective Date of the Most Recent Renewal *	Crisis-Related Activities	Unduplicated Number of Participants Served
	and Community Based Waiver	of a national movement to develop family-driven and youth-guided care, and keep youth at home, in school, and out of the child welfare and juvenile justice systems. The purpose of this waiver is to provide home and community-based supports and services to youth with mental illness(es) who would otherwise be served in inpatient psychiatric hospitals. Families and youth are offered the choice of behavioral health services and supports to permit the participant to remain in, or return to, the least restrictive environment, preferably their homes.		be provided in an emergency to prevent hospitalization. Respite is a face-to-face service, no longer than one week per episode, not more than 21 days per year. Stays of greater than 72 hours require prior authorization. Youth requiring crisis respite for longer periods may be evaluated on an individual basis. Respite provided in a certified residential care facility, substance use disorder residential facility, or public or private child service entity shall not replace or relocate a youth's primary residence.	
Texas	Youth Empowerment Services (YES)	The Texas Health and Human Services Commission (HHSC) was authorized by the Texas Legislature to develop and implement a plan to prevent custody relinquishment of youth with SED. To this end, HHSC was authorized to seek any necessary waivers or authorizations from the federal government. After review of various options, HHSC, in collaboration with stakeholders, requested Youth Empowerment Services (YES) 1915(c) Medicaid waiver to improve access to services and allow more flexibility in providing intensive community-based services and supports for youth with SED and their families. The goals of the waiver include: Reducing out-of-home placements and inpatient psychiatric treatment by all child-serving agencies, providing a more complete continuum of community-	4/1/2023	Out-of-Home Respite is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the waiver participant. Respite may be provided in: a private residence of a respite care provider; foster home verified by a HHSC licensed child placing agency; General Residential Operations licensed by HHSC; day or overnight camps accredited by the American Camping Association; day or overnight camps licensed by DSHS; childcare centers or homes licensed by HHSC; and childcare homes registered with HHSC.	Years 1–5:3,591

State	Waiver Title	Wavier Goals	Effective Date of the Most Recent Renewal *	Crisis-Related Activities	Unduplicated Number of Participants Served
		based services and supports for waiver participants with SED and their families to ensure families have access to parent partners and other flexible non-traditional support services as identified in a family-centered planning process, prevent entry and recidivism into the foster care system and relinquishment of parental custody, and improve the clinical and functional outcomes of children and adolescents. The waiver serves youth ages 3–18.			
Wisconsin	Children's Long Term Support Waiver	The purpose of this waiver is to provide necessary supports and services to children and youth from birth through age 21 in Wisconsin who have substantial limitations in their daily activities; need support to remain in their home communities; meet functional, Medicaid financial and non-financial requirements; and reside in allowable living situations within the community. The goal of the waiver program is to support children with substantial needs, as well as their parents/guardians, by delivering services to assure the child's health, safety, and welfare needs in an inclusive home and community settings.	1/1/2022	Respite care services maintain and strengthen the child's or youth's natural supports by easing the daily stress and care demands for the family, or other primary caregiver(s), on a short-term basis. These services provide a level of care and supervision appropriate to the child's or youth's needs while the family or other primary caregiver(s) are temporarily relieved from daily caregiving demands. Respite care may take place in a residential setting, institutional setting, the home of the child or youth, the home of a caregiver, or in other community settings. It can also be provided in Group Homes for Children, a Community-Based Residential Facility, Family Child Care Center, Shelter Care Facilities, and Foster Homes.	Year 1: 17,115 Year 2: 18,192 Year 3: 19,147 Year 4: 19,996 Year 5: 20,750

* The effective date of the most recent renewal is given, unless there has not yet been a renewal, in which case the original effective date is given. An expiration date is given only if the waiver expired during 2014–2024 and was not renewed.

5. Certified Community Behavioral Health Clinics (CCBHCs)

5. Certified Community Behavioral Health Clinics (CCBHCs)

Background

Although the first major CCBHC initiative began as an 8-state Medicaid Demonstration in 2017, the first CCBHCs opened in Texas in 2016. While Texas was one of 24 states awarded a Section 223 planning grant and was not selected for the 8-state demonstration, the state chose to independently implement the CCBHC model. Texas CCBHCs operate under an alternative payment model that differs from the Section 223 prospective payment system (PPS) but must still meet criteria closely aligned with federal requirements (Texas Health and Human Services, 2025).

To be recognized as a CCBHC, clinics must adhere to criteria that provide high-quality safety-net services for mental health and substance use crises, in addition to serving the overall behavioral health needs of communities. Eight state Medicaid Demonstrations initiated the CCBHC model. Twenty-four states were awarded planning grants by SAMHSA followed by 66 clinics qualifying to be part of the inaugural CCBHC model using a PPS. PPS was chosen to support the CCBHC model in anticipation for the costs of expanding services to new populations. Another goal of the PPS was to address the longstanding reimbursement gaps in Medicaid payments to community mental health providers, because, historically, Medicaid reimbursement rates have substantially underpaid the true cost of delivering community mental health services. Because the CCBHC PPS is calculated using a formula that accounts for the anticipated or historical costs of meeting program requirements—including costs associated with expanding and retaining a workforce, initiating or strengthening community partnerships, expanding care coordination functions, and launching new service lines—CCBHCs that participate in their state's Medicaid Demonstration typically have a more robust financial foundation for engaging in these activities than their grantee peers, whose funding is more circumscribed and time-limited.

With the success of the Demonstration, the CCBHC model was extended and expanded by Congress over the years. The SAMHSA-administered CCBHC Expansion Grant program has been implemented since 2018 to aid clinics in meeting the standards of a CCBHC. Grants are given for a limited time and with capped funds to assist clinics in adopting the CCBHC model's

nine required service categories including crisis services. Funds are also expected to be used towards enhancing current services, adding new services, and quality improvement that reflect the needs of the communities served. Resulting from the success of the CCBHC model, a number of states have added a CCBHC certification with PPS to their Medicaid State Plan with more states working to do so. This means that clinics can be certified by the state itself and then qualify for the enhanced Medicaid funding. Between state certification and grantees there are now more than 500 CCBHCs and growing in 48 states and territories. Billions of federal dollars have been poured into the CCBHC model over the lifetime of the program. By having access to PPS funding, CCBHCs can sustainably enhance their capacity, leading to a greater impact on the behavioral health crisis system.

PPS ensures that CCBHCs can be sufficiently funded to construct a comprehensive crisis system and crisis continuum partnership. The PPS formula includes the cost of ensuring all program requirements are met such as expansion or retention of clinic workforce, support of current or budding community partnerships, strengthening of care coordination, or initiation of new services. States have three main avenues to engage in CCBHC implementation, through a Medicaid Demonstration, adoption of state legislation, or submission of a state plan amendment (SPA) for formal inclusion into the Medicaid state plan. The expectation is that states will do their best to align CCBHCs with the 988 Lifeline and other crisis systems already in place to hopefully create standards and metrics that are statewide. By becoming a CCBHC, clinics can serve more than pre-certification. A 33% increase in the number of people served was reported specifically by Medicaid CCBHCs (National Council for Mental Wellbeing, 2024a). They can serve more people because of their flexible funding model (i.e., cost-based reimbursement instead of the traditional fee-for-service model, which reimburses for non-billable activities like community outreach), broader scope of services such as availability of same-day appointments and expanded hours of operation, concerted efforts to conduct outreach to underserved groups, and required partnerships with other community organizations to create a “one-stop-shop” model. By design, CCBHCs remove barriers to care, allowing them to serve larger and more diverse populations, including those who are uninsured or underinsured (National Council for Mental Wellbeing, 2024a).

The nine required CCBHC service categories, which must be provided directly or through formal partnerships, include: (1) Crisis Services, (2) Outpatient Mental Health and

Substance Use Services, (3) Person- and Family-Centered Treatment Planning, (4) Community-Based Mental Health Care for Veterans, (5) Peer Family Support and Counselor Services, (6) Targeted Care Management, (7) Outpatient Primary Care Screening and Monitoring, (8) Psychiatric Rehabilitation Services, and (9) Screening, Diagnosis and Risk Assessment (SAMHSA, no date #1).

The first, *crisis behavioral health services*, must provide crisis services directly or through a Designated Collaborating Organization (DCO) agreement with an existing state-sanctioned, certified, or licensed system or network for the provision of crisis behavioral health services. The U.S. Department of Health and Human Services (HHS) recognizes that state-sanctioned crisis systems may operate under different standards than those identified in these criteria. If a CCBHC would like to have a DCO relationship with a state-sanctioned crisis system that operates under less stringent standards, they must request approval from HHS to do so (National Council for Mental Wellbeing, 2024a; Mauri et al., 2025a). The three elements of crisis behavioral health services include the following (SAMHSA, 2023b):

First, *emergency crisis intervention services*, such as telephone, text, or chat options are offered through CCBHCs or through call centers. Partner call centers must meet 988 Suicide and Crisis Lifeline standards to provide appropriate risk assessments of suicidal individuals. Second, 24-hour *mobile crisis teams* serve adults, children, youth, and families. Teams must be available to dispatch 24/7 anywhere in their service area such as a workplace, home, or other location of a behavioral health crisis. Response time differs by location with standard areas requiring arrival within one hour of dispatch while rural areas require arrival within two hours. Overall response time cannot be over three hours. Telemedicine can be used to connect those in crisis with qualified mental health providers during travel time or if a location is too remote to make the arrival time requirements feasible. Regardless of the telemedicine option, in-person response must always be made available when safety is in question.

Third, *crisis receiving/stabilization* provides voluntary urgent care/walk-in mental health and SUD services to individuals by attempting to de-escalate a crisis and connecting those in crisis to ongoing care in the least-restrictive setting possible. CCBHCs can coordinate with peer-run crisis respite programs when appropriate. In ideal circumstances, crisis stabilization should be available 24/7 to the individual themselves, a concerned family member, and/or law enforcement following state and local laws. Community needs inform the hours of urgent care

with CCBHCs looking to extend operating hours when achievable. All levels of acuity are seen but services might not be enough for high-acuity individuals.

It should be noted that the crisis services-related criteria for CCBHCs are intentionally broad, allowing substantial discretion in how organizations operationalize these requirements—from the specific modes of service delivery to whether they provide none, some, or all of the required service categories directly versus through another organization. As a result, we should not expect uniformity in how CCBHCs offer crisis services. Other crisis services-related CCBHC requirements are noteworthy as well. For example, they are required to establish relationships with juvenile and criminal justice agencies, along with a recommendation to build relationships with law enforcement agencies, as outlined in Criterion 3.c.3 of the CCBHC criteria. This element is central to understanding how CCBHCs coordinate and interact with other entities within the crisis continuum. CCBHCs allow for the integration and co-location of the entire crisis continuum of care under one roof. This can happen without the presence of a CCHBC, but is much less likely due to disparate funding streams and infrastructure needs.

The CCBHC model was encoded into federal statute in 2014, and CCBHCs have evolved over the past decade. In April 2014, the Protecting Access to Medicare Act (PAMA) was passed. The new law included "Demonstration Programs to Improve Community Mental Health Services," which is a component of Section 223 of the Act. The demonstration program had three main goals: (1) defining basic federal requirements for a CCBHC and requiring the Secretary of HHS to publish more detailed criteria; (2) mandating the Secretary of HHS to issue guidance on the establishment of a PPS as a way to pay clinics a fixed amount each time a qualifying encounter occurs (daily or monthly PPS-1 and PPS-2), with the payment being based on average costs reported by the clinic and not changing based on how many or how intensive the services are within that one encounter; and (3) awarding states planning grants for preparation to join a two-year demonstration program. These funds were intended to support the development and submission of the state's proposal to participate in the time-limited pilot demonstration, which involved gathering stakeholder input, certifying organizations as CCBHCs, and establishing a PPS. Section 223 looked to assess demonstration programs in up to eight states that established CCBHCs based on a federal framework. States participating in the Section 223 Demonstration receive an enhanced FMAP; the enhanced FMAP is tied to participation in the Demonstration itself (SAMHSA, 2017).

While the Section 223 Demonstration program is run federally, state entities certify organizations as CCBHCs. Receiving a higher Medicaid reimbursement via PPS allows states to both provide comprehensive behavioral health services and reimburse clinics at rates that adequately cover the cost of care (SAMHSA, 2023b). CCBHCs were seen as a pivotal next step in the progression of states to more effectively address the behavioral health needs of communities. The demonstration programs were developed so states had an opportunity to enhance the breadth, quality, and funding mechanisms of community-based mental health and substance use disorder services (SAMHSA, 2023b).

In February 2024, CMS updated guidance to include two new rate options, PPS-3 and PPS-4. PPS-3 mirrors PPS-1 daily rates except that PPS-3 now requires daily Special Crisis Services (SCS) rates, which allows states to set separate PPS rates for crisis services. SCS rates may be set for one or more of the following: (1) mobile crisis services that meet the criteria as authorized under section 9813 of ARPA, (2) mobile crisis services that do not meet the qualifying criteria of section 9813, and (3) on-site crisis stabilization services. PPS-4 is similar but now also requires the new separate monthly SCS rates (CMS, 2024b). In March 2024, Congress passed section 209 of the Consolidated Appropriations Act (CAA), which created a permanent state plan option 1905(a)(31) for Medicaid agencies to implement CCBHCs under state plan authority. Of note, states that used SPAs previously did not have a permanent option and used other Medicaid mechanisms. Finally, in June 2024, 10 states were officially added through the BSCA expansion: Alabama, Illinois, Indiana, Iowa, Kansas, Maine, New Hampshire, New Mexico, Rhode Island, and Vermont (CMS, 2024c). In total, 20 states were now part of the official demonstration program with 10 more to be added in 2026 under BSCA rules (CMS, 2025).

While federal funding has primarily supported development of CCBHCs, some states have passed their own legislation during this time to state-certify their CCBHCs, such as Illinois, Indiana, and Kansas. Additionally, Texas has used DSRIP funding through their 1115 demonstration waiver to fund the Texas Certified Community Behavioral Health Clinic (T-CCBHC) initiative, which does not use the PPS methodology (Kelly and Brykman, 2023; Texas Health and Human Services, 2023).

Approach

We accessed data in June 2025. Using the SAMHSA Grants Dashboard, CCBHC-related grants were identified using the Medicaid website titled "CCBHC-Expansion Grant Program Funding Announcements." Seven federal funding opportunities—including planning grants, expansion grants, and cooperative agreements—were tabulated. Each funding opportunity was analyzed to determine the number of grants awarded per state, including those to individual organizations and to State Medicaid Agencies. Findings are summarized in **Table 5a**. Total number of grants were calculated for each funding opportunity, and total funding was calculated for each grant cycle as well as total funding across all seven grant categories. While **Table 5a** documents total federal expenditures (in terms of planning grants, expansion grants, and cooperative agreements) for CCBHCs, it is not possible to know what portion of those grants and agreements were dedicated to activities pertaining directly to crisis services.

We chose to approach the analysis from a state-level perspective, given the goal of understanding variation in the financial impact of CCBHC initiatives across states (as those receiving greater CCBHC investment may experience more substantial impacts on crisis services than those with fewer resources). However, there are also important limitations to this approach. First, states play a minimal role in one of the two federal CCBHC initiatives: the Expansion Grants, which go directly to provider organizations. Second, our analysis cannot capture the total Medicaid funding that flows into states. States participating in the Section 223 Demonstration receive an enhanced FMAP, and organizations may adjust their billing practices as a result of adopting a PPS.

Table 5b was created by compiling the number of organizations who are either designated as a CCBHC by the state/through a demonstration or are grant funded by SAMHSA based on the "List of Certified Community Behavioral Health Clinics (CCBHCs) By State" Report from the National Council for Mental Wellbeing. The report was updated in January 2024 and lists all CCBHC organizations per state (National Council for Mental Wellbeing, 2024b).

Findings

The funding to states and organizations, as detailed in **Table 5a**, must be understood in terms of the evolution of CCBHCs, including additional Congressional actions after PAMA. SAMHSA released a notice of funding in May 2015 to award planning grants to states so they could begin developing proposals for the new demonstration program that would support

certification of CCBHCs, which included establishment of Section 223 PPS reimbursement methodology, stakeholder input, and collection of a data. Adults with serious mental illnesses (SMI), children with serious emotional disturbances (SED), and those with long-term and serious substance use disorders (SUD) were the target population expected to be served. By October 2015, $22.9 million in planning grants were given to 24 states who received funding at an average of $956,659 (column **1** in **Table 5a**). Grant funding was broken down by hiring actuarial firms (27%), training staff and providing other supports (26%), and data collection and reporting specifically for quality measures (21%); the latter was primarily to enhance information technology capabilities for reporting on quality measures and other information required of the states participating in the demonstration. 12% of planning grant funds were used to engage stakeholders and coordinate statewide efforts during the planning grant year (SAMHSA, 2017). In December of 2016, of those 24 states, Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania were chosen to be part of the inaugural demonstration. Starting in 2017, 67 CCBHCs were established in these eight states through the Section 223 CCBHC Medicaid Demonstration.

In 2018, CCBHC Expansion Grants were created through $100 million in appropriated funds to SAMHSA (SAMHSA, no date #2). 64 organizations within 21 of the 24 states that received planning grants were awarded expansion funds to support implementation of the CCBHC model (SAMHSA, 2018). (Expansion grants were awarded to individual organizations, not to states, even though the distribution can be summarized at the state level). Over a two-year period, organizations within 21 states received an average of $3,347,816 (column **2** in **Table 5a**). These grants provided each recipient (behavioral health providers) up to $2 million per year in funding over a two-year grant period.

In 2019, Congress provided SAMHSA $150 million in annual appropriations to continue to support the CCBHC expansion grants and funding for previous grantee cohorts (SAMHSA, no date #2). Additionally, CMS approved the first CCBHC Medicaid State Plan Amendment (SPA) for Missouri, guaranteeing the model's viability after the demonstration. Nevada, Oklahoma, and Minnesota followed suit. All states that were part of the original demonstration secured permanent Medicaid funding through SPA approval, harnessing the CCBHC model to bundle services that may have been previously covered separately in different parts of the state plan. For example, in a Nevada SPA, individual services previously under the rehabilitative title were

bundled into the CCBHC model. Another example is Oklahoma's SPA which created two separate PPS rates, one for people with frequent inpatient or emergency department use who had previously received mental health or SUD services, and one for the general population. Each CCBHC was expected to receive a list of target patients in its service area with monthly payment rates set under the assumption that a certain percentage of those patients would be engaged in care. If a clinic did not meet those engagement benchmarks, it would face financial penalties, incentivizing clinics to shift patients away from costly emergency or crisis services. Overall, each of these SPAs allowed the select states to certify new CCBHCs and sustain the CCBHC model without a federal demonstration grant (National Council for Mental Wellbeing, 2022, 2023).

In 2020, a second set of expansion grants were awarded (column **3** in **Table 5a**). The Coronavirus Aid, Relief, and Economic Security (CARES) Act, passed in response to the COVID-19 pandemic, gave SAMHSA $450 million in COVID-19 relief for the behavioral health sector, including $250 million in earmarked funds to CCBHCs. This funded the second set of expansion grants (National Council for Mental Wellbeing, 2020). This second iteration of the CCBHC Expansion Grant program now required states and organizations to provide access to core services including 24/7 crisis intervention services for individuals with SMI or SUD including opioid use disorders, children and adolescents with SED, and individuals with co-occurring mental and substance disorders. The expectation was for CCBHCs to provide comprehensive 24/7 access to community-based mental health and SUD services alongside coordinating physical health care in one location (SAMHSA, 2020b). A total of 165 grants were awarded to 32 states over the two-year period with an average of $3,857,887 for up to two years. During this expansion period, certain states' organizations were more aggressive in applying for and receiving these grants, with agencies in New York being awarded 29 grants, Michigan awarded 18 grants, Texas awarded 11 grants, and Massachusetts awarded 10 grants. As expansion grants were awarded, the original two-year demonstration for the eight states was set to end on June 30, 2019. Through a series of congressional extensions (Continuing Appropriations Act of 2020, and Health Extenders Act of 2019) the demonstration was initially extended to May 22, 2020 (MACPAC, 2022). The CARES Act then further extended it to November 30, 2020, and added to the demonstration two additional states, Kentucky and Michigan until 2027 (MACPAC, 2022; SAMHSA, no date #2).

In 2021, CCBHC expansion grants continued through the use of $1.2 billion from COVID-19 relief, the American Rescue Plan Act (ARPA) and annual appropriations (SAMHSA, no date #2). 99 grants were awarded at an average of $3,913,573 during the two-year period in 32 states (column **4** of **Table 5a**). States with agencies receiving the most grants included Massachusetts and New Jersey (both receiving six); Texas, which received nine; and Michigan and New York (both receiving ten). Notably, Idaho, one of the states that never received an expansion grant or any prior funding, developed its CCBHC model using $12 million in ARPA funding (Becker, 2022).

The Bipartisan Safer Communities Act (BSCA) was then passed by Congress in 2022, amending PAMA to further extend the original CCBHC demonstration eight-state program through September 2025. Kentucky and Michigan were also authorized to stay in the program for up to six years (24 fiscal quarters). Moreover, every two years, HHS is authorized to add 10 additional states to the CCBHC Medicaid demonstration program under BSCA. Each of the states had to have received planning grants and states that joined later through BSCA would now be allowed to participate for up to four years (16 fiscal quarters), starting from the date each state chose to begin (CMS, 2023). SAMHSA developed two tracks in 2022 for CCBHC expansion through $315 million in appropriations (SAMHSA, no date #2). Specifically, new CCBHCs are established through *Planning, Development, and Implementation* (PDI) grants, while existing CCBHCs are expanded through *Improvement and Advancement* (IA) grants. Grants increase in time frame from two years to four years, up to $1 million a year. The PDI Grants were created to assist organizations in developing CCBHCs that meet the CCBHC certification criteria and the organization's needs assessments, with a focus on delivering a variety of outreach, screening, assessment, treatment, care coordination, and recovery supports regardless of an individual's financial situation (SAMHSA, no date #3). 147 organization—in 42 states—over three years (2022–2024) received on average $3,178,288 in funding (column **5** in **Table 5a**). IA grants are awarded to existing demonstration sites, expansion grant recipients, or an organization state certified as a CCBHC to enhance and improve CCBHCs. The intent of the grant program was to continue improving access to community-based mental health including 24/7 crisis services to anyone in the service area regardless of someone's ability to pay or place of residence. SAMHSA set an expectation for applicants to include a focus on groups facing health disparities as identified through a community needs assessment (SAMHSA, no date #3). Over the three-

year funding period (2022–2024), 148 organizations—in 36 states—received on average $3,097,104 in funds (column **6** of **Table 5a**). CMS also approved for the first time a SPA to operationalize CCBHCs outside a demonstration state, in Kansas.

In 2023, one-year Cooperative Agreements for CCBHC planning were awarded to prepare states for an application to a four-year CCBHC demonstration program (column **7** of **Table 5a**). As a cooperative agreement, SAMHSA provided continuing technical assistance, consultation, and coordination throughout the project period of the agreement (Health Management Associates, 2022). The grant looked to engage the community at large including youth, family members, and consumers in developing CCBHCs. Applicants were SMHAs, Single State Agencies, or State Medicaid Agencies (SAMHSA, 2022b). 15 Cooperative Agreement Planning Grants were awarded with states receiving on average $996,836.

The final column of **Table 5a** shows that three states secured no funding through the seven funding opportunities shown in columns 1–7: North Dakota, South Carolina, and South Dakota. Delaware has only received a Cooperative Agreement for planning, and the District of Columbia, Hawaii, and Wyoming have each only received one planning grant. States with the largest amount of total funding (exceeding $100 million) include: New York ($307,134,333), Michigan ($192,782,363), Texas ($127,101,179), New Jersey ($115,060,082), and Massachusetts ($110,936,560). The total number of CCBHCs per state—as of January 2024— is given in **Table 5b**. Of note, as of that time, four states (not shown in **Table 5b**) had no CCBHCs: Delaware, North Dakota, South Carolina, and South Dakota.

Table 5a. Dollar Amounts of Seven CCBHC-Related Funding Opportunities, by State, 2014–2024

Mechanism	1. 2016 Planning Grants	2. 2018-2019 Expansion Grants		3. 2020-2021 Expansion Grants		4. 2021-2022 Expansion Grants		5. Planning, Development, and Implementation Grants, 2022-2024		6. Improvement and Advancement Grants, 2022-2024		7. Cooperative Agreements, 2023	Total Within the State
Number Awarded	24	64		165		99		147		148		15	
State	Amount	n	Total Funding	n	Total Funding	n	Total Funding	n	Total Funding	n	Total Funding		
AK	$769,015	0		2	$8,000,000	0		1	$3,000,000	1	$4,000,000		$15,769,015
AL		0		0		2	$7,988,404	1	$2,976,523	0		$1,000,000	$11,964,927
AR		0		3	$11,999,998	3	$12,000,000	1	$3,000,000	1	$3,000,000		$29,999,998
AZ		0		0		1	$4,000,000	1	$2,931,355	0			$6,931,355
CA	$982,373	0		5	$19,598,609	5	$16,000,000	11	$32,336,823	5	$18,000,000		$86,917,805
CO	$982,372	1	$4,000,000	2	$8,000,000	1	$4,000,000	4	$12,780,757	2	$4,999,902		$34,763,031
CT	$982,372	1	$3,816,087	7	$27,995,541	1	$4,000,000	1	$3,000,000	4	$17,000,000		$56,794,000
DC		0		0		0		1	$2,955,151	0			$2,955,151
DE		0		0		0		0		0		$1,000,000	$1,000,000
FL		0		4	$15,782,546	3	$10,000,000	11	$35,418,583	7	$23,999,996		$85,201,125
GA		0		1	$4,000,000	1	$4,000,000	5	$15,997,098	0		$989,667	$24,986,765
HI		0		0		0		1	$2,999,823	0			$2,999,823
IA	$982,372	2	$5,995,754	6	$19,053,027	2	$7,862,163	2	$5,901,030	4	$11,993,140	$1,000,000	$52,787,486
ID		0		0		0		3	$10,000,000	0			$10,000,000
IL	$982,373	1	$4,000,000	5	$19,337,719	3	$16,000,000	9	$31,231,555	4	$12,999,937		$84,551,584

Mechanism	1. 2016 Planning Grants	2. 2018-2019 Expansion Grants		3. 2020-2021 Expansion Grants		4. 2021-2022 Expansion Grants		5. Planning, Development, and Implementation Grants, 2022-2024		6. Improvement and Advancement Grants, 2022-2024		7. Cooperative Agreements, 2023	Total Within the State
Number Awarded	**24**	**64**		**165**		**99**		**147**		**148**		**15**	
State	**Amount**	**n**	**Total Funding**	**n**	**Total Funding**	**n**	**Total Funding**	**n**	**Total Funding**	**n**	**Total Funding**		
IN	$982,373	2	$7,487,309	6	$23,894,979	2	$8,000,000	1	$5,485,581	7	$21,947,821		$67,798,063
KS *		0		1	$4,000,000	1	$4,000,000	10	$30,893,744	4	$8,989,039	$1,000,000	$48,882,783
KY *	$982,373	2	$8,000,000	5	$19,449,314	0		3	$8,864,049	3	$8,647,988		$45,943,724
LA		0		0		0		4	$11,383,442	0			$11,383,442
MA	$982,373	5	$13,815,812	10	$39,046,184	6	$23,273,487	4	$12,988,315	7	$20,830,389		$110,936,560
MD	$982,373	2	$7,369,546	1	$4,000,000	2	$7,682,903	2	$7,000,000	2	$4,982,934		$32,017,756
ME		0		0		2	$7,419,756	2	$5,983,933	2	$5,998,084	$998,247	$20,400,020
MI *	$982,373	9	$30,810,057	18	$70,072,740	10	$36,201,817	5	$16,925,497	12	$37,789,879		$192,782,363
MN *	$982,373	2	$6,698,384	2	$8,000,000	2	$7,881,680	1	$3,000,000	2	$6,979,175		$33,541,612
MO *	$982,373	3	$10,705,359	5	$19,984,666	1	$4,000,000	0		2	$7,000,000		$42,672,398
MS		0		0		1	$4,000,000	3	$10,000,000	2	$3,998,848	$1,000,000	$18,998,848
MT		0		0		0		2	$5,973,232	1	$2,999,998	$999,999	$9,973,229
NC	$978,401	1	$3,122,602	4	$14,243,220	3	$11,994,948	1	$665,180	2	$4,000,000	$971,074	$35,975,425
ND		0		0		0		0		0			$0
NE		0		2	$7,173,269	1	$4,000,000	3	$8,809,900	2	$6,000,000		$25,983,169
NH		0		0		0		2	$6,902,120	0		$1,000,000	$7,902,120
NJ *	$982,372	6	$21,659,768	9	$35,556,361	6	$24,000,000	3	$12,882,823	6	$19,978,758		$115,060,082
NM	$982,373	0		0		0		1	$2,811,309	0		$1,000,000	$4,793,682

Mechanism	1. 2016 Planning Grants	2. 2018-2019 Expansion Grants		3. 2020-2021 Expansion Grants		4. 2021-2022 Expansion Grants		5. Planning, Development, and Implementation Grants, 2022-2024		6. Improvement and Advancement Grants, 2022-2024		7. Cooperative Agreements, 2023	Total Within the State
Number Awarded	24	64		165		99		147		148		15	
State	Amount	n	Total Funding	n	Total Funding	n	Total Funding	n	Total Funding	n	Total Funding		
NV *	$933,067	1	$4,000,000	0		2	$10,000,000	0		1	$3,000,000		$17,933,067
NY *	$982,373	8	$23,175,329	29	$110,641,530	10	$35,906,044	15	$51,750,097	27	$84,678,960		$307,134,333
OH		0		2	$7,984,129	4	$15,410,354	7	$24,800,725	2	$7,000,000	$1,000,000	$56,195,208
OK *	$982,373	4	$14,974,116	5	$19,601,752	3	$18,243,454	0		7	$21,993,628		$75,795,323
OR *	$728,054	2	$6,861,840	3	$10,623,194	1	$3,156,442	0		2	$5,872,962		$27,242,492
PA *	$886,200	3	$8,212,845	6	$23,391,900	4	$15,456,775	3	$8,699,055	3	$8,850,373		$65,497,148
RI	$982,373	1	$2,000,000	2	$7,985,649	2	$7,999,824	2	$5,927,992	2	$5,000,000	$993,549	$30,889,387
SC	-	0	-	0	-	0	-	0	-	0	-	-	$0
SD		0		0		0		0		0			$0
TN		0		1	$3,706,202	0		1	$4,000,000	2	$8,000,000		$15,706,202
TX *	$982,373	6	$21,830,701	11	$41,623,476	9	$34,412,335	2	$4,976,396	8	$23,275,898		$127,101,179
UT		0		0		0		3	$6,733,752	1	$2,995,548		$9,729,300
VA	$982,373	2	$5,724,687	2	$7,999,688	0		0		3	$8,797,969		$23,504,717
VT		0		0		0		3	$7,854,409	1	$3,000,000	$1,000,000	$11,854,409
WA		0		3	$11,997,960	2	$6,553,349	8	$22,724,739	5	$15,770,094		$57,046,142
WI		0		1	$3,807,766	0		2	$2,999,914	0			$6,807,680
WV		0		2	$8,000,000	3	$12,000,000	1	$4,000,000	2	$4,000,000	$1,000,000	$29,000,000
WY		0		0		0		1	$3,000,000	0			$3,000,000

Mechanism	1. 2016 Planning Grants	2. 2018-2019 Expansion Grants		3. 2020-2021 Expansion Grants		4. 2021-2022 Expansion Grants		5. Planning, Development, and Implementation Grants, 2022-2024		6. Improvement and Advancement Grants, 2022-2024		7. Cooperative Agreements, 2023	Total Within the State
Number Awarded	**24**	**64**		**165**		**99**		**147**		**148**		**15**	
State	**Amount**	**n**	**Total Funding**	**n**	**Total Funding**	**n**	**Total Funding**	**n**	**Total Funding**	**n**	**Total Funding**		
Number of States Receiving Funding	24		21		32		32		42		36	15	48
Average	$956,659		$3,347,816		$3,857,887		$3,913,573		$3,178,288		$3,097,104	$996,836	
Total	$22,959,820	64	$214,260,196	165	$636,551,419	99	$387,443,735	147	$473,564,902	148	$458,371,320	$14,952,536	$2,176,103,928

* Indicates states with a CMS-approved CCBHC initiative.

Table 5b. Total Number of CCBHCs, By State, as of January 2024

State	Number of CCBHC Organizations Grant Funded*	State-Certified or Demonstration CCBHCs**
Alabama	2	-
Alaska	3	-
Arizona	4	-
Arkansas	4	-
California	20	-
Colorado	7	-
Connecticut	7	-
District of Columbia	1	-
Florida	21	-
Georgia	9	-
Hawaii	1	-
Idaho	4	-
Illinois	17	-
Indiana	10	-
Iowa	8	-
Kansas	24	21
Kentucky	8	4
Louisiana	6	-
Maine	5	-
Maryland	5	
Massachusetts	14	-
Michigan	41	30
Minnesota	18	16
Mississippi	8	-
Missouri	20	20
Montana	4	-
Nebraska	4	-
Nevada	6	8
New Hampshire	3	-
New Jersey	17	7
New Mexico	3	
New York	51	13
North Carolina	1	-
Ohio	15	-
Oklahoma	13	13
Oregon	12	12
Pennsylvania	10	7
Rhode Island	6	-
Tennessee	4	-
Texas	48	43
Utah	3	-
Vermont	5	-
Virginia	1	-
Washington	12	-

State	Number of CCBHC Organizations Grant Funded*	State-Certified or Demonstration CCBHCs**
West Virginia	6	-
Wisconsin	2	-
Wyoming	2	-

* The above states grant-funded by SAMHSA can represent individual clinics that may have more than one grant accounted for in the number of grants column. The National Council for Mental Wellbeing only counts federal grants as of 2024.

** The National Council for Mental Wellbeing defines State-Certified or Demonstration CCBHCs as either states participating in Section 223 Medicaid Demonstrations or as representing clinics that have been certified by their states under a CMS-approved Medicaid CCBHC initiative.

6. CMS Planning Grants for Crisis Services

6. CMS Planning Grants for Crisis Services

Background

Individuals in crisis have historically been served by emergency rooms, not uncommonly with law enforcement involvement as part of the pathway to care, due to the lack of a comprehensive and effective system in place for mental health crises. Medicaid, the largest payer of behavioral health care, is working to help states improve and modernize their response to substance use and mental health emergencies, in part with the hope that these services will help reduce incarceration rates for persons with SMI and SUD. Twenty State Medicaid Agencies received 12-month planning grants from CMS as part of the American Rescue Plan Act of 2021 (ARPA) to enhance their ability to offer community-based mobile crisis intervention services (CMS, 2021b). Sixteen of those states received one year, no-cost extensions to make use of grant funds (CMS, 2021a). A total of $15,000,000 was allocated (CMS, 2021b). The funding led to the development of SPAs, Section 1115 demonstration waivers, or waivers under sections 1915(b) or 1915(c) that address community-based mobile crisis assistance. The planning grants provided financial support to State Medicaid Agencies so that they could assess the needs of their communities and create sustainable mobile crisis services. To prepare for implementation, states made sure to guarantee that mobile crisis services met the requirements detailed below. Additionally, they looked to train multidisciplinary teams, enhance capacity, improve information systems, and pursue technical support to develop applications for amendments, demonstrations, and waivers. The period of performance for the grant was from September 30, 2021, to September 29, 2022 (CMS, 2021b). Planning grants were given so that states could prepare for the requirements under ARPA that would allow for a temporary enhanced Medicaid match rate of 85% for community-based mobile crisis services between the period April 1, 2022, and March 31, 2027 for up to 12 fiscal quarters (CMS, 2021a).

For states to have a Medicaid SPA for mobile crisis services approved, the services need to meet specific standards explained in a CMS letter to state officials (CMS, 2021a). There are four main groupings of requirements that states need to meet to get an enhanced match rate. First, community-based teams must be available 24/7, every day of the year, responding to crises in a timely manner. Second, all team members must be trained in trauma-informed care, de-escalation strategies, and harm reduction. Third, teams must have at least one behavioral health

professional but may also include a paraprofessional, such as peer support specialists. Fourth, mobile crisis teams must be connected to community partners. Other suggestions for services are given by CMS, including teams carrying naloxone and being trained in its administration to reverse opioid overdoses as well as using telehealth at the outset of a crisis or during follow-up. An amendment or waiver may not be required if mobile crisis teams already meet standards. Furthermore, Medicaid reimbursement for mobile crisis is reserved for qualified participants. Providers can attempt to enroll an uninsured person in Medicaid if they require mobile crisis services and can submit claims with retroactive coverage while also being able to provide patients with follow-up care.

Approach

Planning grant amounts were compiled using the Assistance Listing 93.639 titled Section 9813: State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services. The listing number was searched on the Department of Health and Human Services "HHS TAGGS" (Tracking Accountability in Government Grants System, 2025), an official open data source of federal spending information that includes data about federal grant awards. 20 states received grants (**Figure A** below) and total amounts awarded to each was identified. The planning grants were then matched with the SPAs flagged as those submitted for the ARPA mobile crisis enhanced match by Medicaid on the website titled "State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services" (CMS, no date #3c).

Findings

The 20 states highlighted in Figure A received planning grant funding in 2021 specifically to expand and improve mobile crisis services. As shown in **Table 6** below, planning grant amounts ranged from $381,331 (Oklahoma), $382,601 (Utah), and $476,665 (New Mexico) to $952,951 (Oregon) and $953,336 (Alabama and Vermont).

Figure A. Map Showing States that Received CMS Planning Grants for Crisis Services

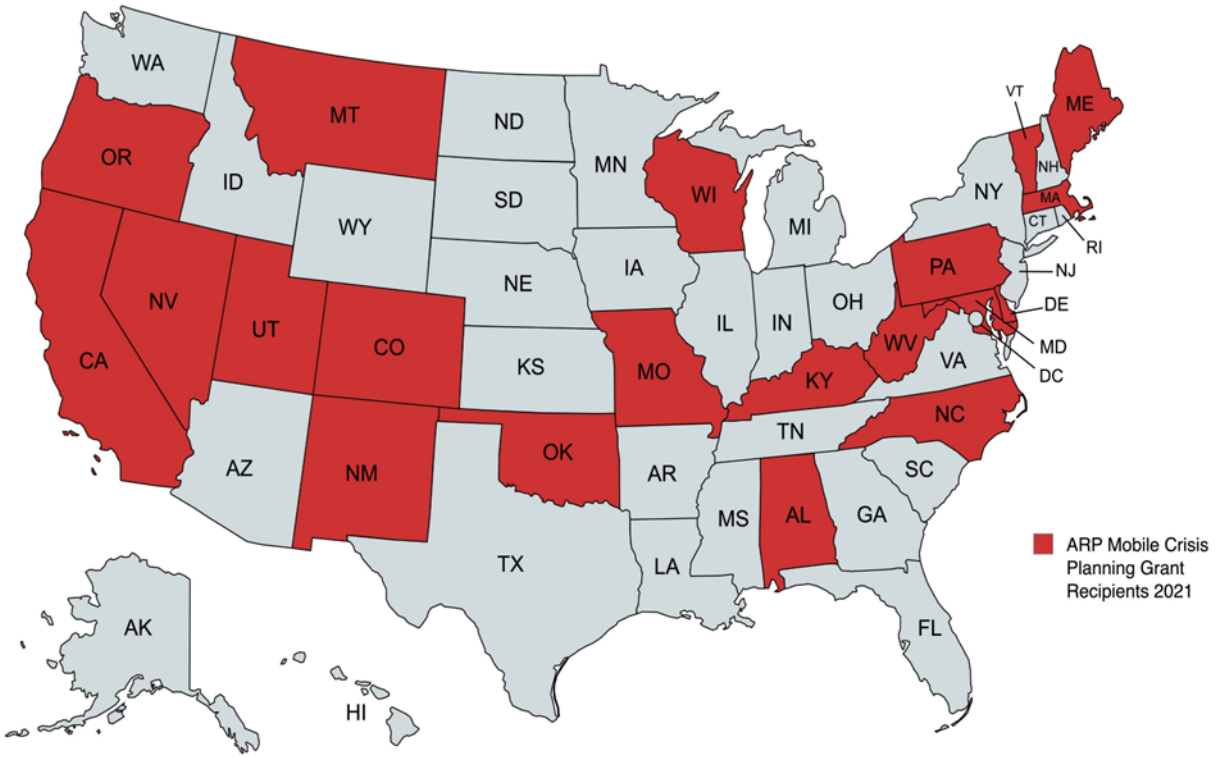


Table 6. Twenty States Receiving CMS Planning Grants for Crisis Services

State	Grant Amount	SPA Approval for Mobile Crisis
Alabama	$953,336	November 2023
California	$853,238	July 2023
Colorado	$818,278	December 2023
Delaware	$536,357	
Kentucky	$796,894	September 2023
Maryland	$800,365	April 2024
Massachusetts	$888,264	September 2023 and November 2023
Maine	$929,502	
Missouri	$653,765	
Montana	$585,609	October 2023
North Carolina	$948,335	October 2022
New Mexico	$476,665	February 2024
Nevada	$615,937	July 2024
Oklahoma	$381,331	
Oregon	$952,951	September 2022
Pennsylvania	$772,205	
Utah	$382,601	
Vermont	$953,336	April 2024
Wisconsin	$853,504	May 2023
West Virginia	$847,527	September 2023
TOTAL	$15,000,000	
AVERAGE	$750,000	

7. SAMHSA Cooperative Agreements for Innovative Community Crisis Response Partnerships

7. SAMHSA Cooperative Agreements for Innovative Community Crisis Response Partnerships

Background

SAMHSA's Notice of Funding Opportunity (NOFO) No. SM-22-016 (FY 2022 Cooperative Agreements for Innovative Community Crisis Response Partnerships) allowed for an estimated $9,000,000 for 12 awards, with an application due date of July 25, 2022 (SAMHSA, 2022c). The cooperative agreement opportunity was designed to create or enhance existing mobile crisis response teams to divert adults, children, and youth experiencing mental health crises from law enforcement in high-need communities (i.e., a community where mobile crisis services are absent or inconsistent, where most mental health crises are responded to by first responders, and/or where first responders are not adequately trained or equipped to diffuse mental health crises) (SAMHSA, 2022c). Grant recipients were expected to use SAMHSA's *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* (SAMHSA, 2022c) as a guide for best practices in mobile crisis services. Eligible applicants were States and Territories, including the District of Columbia, political subdivisions of States, Indian tribes, or tribal organizations, health facilities, or programs operated by or in accordance with a contract or grant with the Indian Health Service, or other public or private nonprofit entities (SAMHSA, 2022c). It was anticipated that Cooperative Agreements would be in the amount of up to $750,000 in total costs (direct and indirect) per year, with project lengths of up to 4 years. Annual continuation awards were noted to depend on the availability of funds, grantee progress in meeting project goals and objectives, timely submission of required data and reports, and compliance with all terms and conditions of award (SAMHSA, 2022c). Although we focus on NOFO SM-22-016, there are multiple additional cooperative agreements for 988 that included requirements for linkage with mobile crisis and/or crisis stabilization.

Approach

Using the SAMHSA Grants Dashboard, the NOFO SM-22-016 was used to search for all Cooperative Agreements for Innovative Community Crisis Response Partnerships given to states in 2022 and 2023. Abstracts submitted by organizations and state agencies describing how grant money will be utilized through the project period were reviewed. A total of 25 Cooperative

Agreements were funded, 12 in FY 2022 (for 9/30/2022 through 9/29/2026) and an additional 13 in FY 2023 (for 9/30/2023 through 9/29/2027).

The below **Table 7** was constructed using data available on the SAMHSA Grants Dashboard. In that table, *State*, *Organization*, *City*, *Project Period*, and *Funding Amount* (funding for fiscal years 2022, 2023, and 2024, as applicable; funding beyond 2024 was not yet available at the time of data collection) were extracted directly from the website. The *Brief Description* provided in **Table 7** is a shortened/paraphrased summary of the more detailed abstract given on the website. *Counties Targeted* in the table below were determined from the projects' detailed abstracts. The map (**Figure B**) below shows the counties noted in the various projects' detailed abstracts (in yellow). Cities receiving grants are noted on the map by highlighting the respective counties (in red) in which the cities are located. Three tribal organizations receiving grants are noted on the map by highlighting the counties (in blue) in which or around which those organizations are located. Finally, because South Dakota's award did not have specific counties listed and appears to have covered portions of the state, the entire state is highlighted (in gray).

Findings

The goals of this Cooperative Agreement program are to "Increase the capacity of mobile crisis response teams while expanding access in high-need communities; Increase collaboration to improve crisis stabilization in the community for adults, children, and youth; and Improve equity in the continuity of care and post-crisis follow-up, including for those with suicidal ideation and/or a previous suicide attempt" (SAMHSA, 2022c). SAMHSA set expectations that Cooperative Agreement recipients "use grant funds to implement high quality programs, practices, and policies that are recovery-oriented, trauma-informed, and equity-based as a means of improving behavioral health" (SAMHSA, 2022c). As detailed in the **Table 7**, many of the stated goals of these 25 projects pertained to: establishing MCTs in previously un-served or remote areas, expanding co-response programs between county sheriff's offices and local mental health service providers, enhancing 911 dispatch call coding, training community members in crisis response techniques, applying a community crisis mapping model to identify service needs, and enhancing data collection and data sharing. Many of the communities that were awarded this grant are defined as Medically Underserved Areas (MUA) or Health Professional Shortage Areas (HPSA). MUAs are defined as geographic areas where there is a lack of access to primary care

services and HPSAs are areas and population groups within the United States that are experiencing a shortage of health professionals based on federally defined population-to-provider ratios (Health Resources and Services Administration, no date). Project abstracts also highlight specific populations as targets of focus with respect to improving equity in the provision of crisis care, including Tribal communities, rural communities, and communities with high rates of suicide.

Table 7. Twenty-five Recipients of SAMHSA Cooperative Agreements for Innovative Community Crisis Response Partnerships

State	Organization	Agency Location	Counties Targeted	Brief Description	Funding Amount *	Project Period
California	Pala Band of Mission Indians	Pala	N/A, Tribal Nation	Pala Community Crisis Response Partnerships will serve 1,260 tribal members for 48 months. The project plans to create a 24/7 Mobile Crisis Response Team for the community, focusing on culturally responsive training for first responders. The model will address fragmentation in the care system on the Pala reservation and will be developed in collaboration with mental health, law enforcement, first responders, GIS, and healthcare. Post-crisis follow-up and safety protocols will be planned. By the end of the project, 24/7 services will be provided, including tribal member-filled peer support roles.	$750,000 $750,000 $750,000	9/30/22– 9/29/26
California	Imperial County	El Centro	Imperial	The Mobile Triage Response Team (MTRT) program proposed by Imperial County Behavioral Health Services will allow development of a new mobile crisis response team that will address service gaps for those experiencing behavioral crisis emergencies. Imperial Couty is located on the southern border of California with 4,175 square miles adjacent to the United States–Mexico Border. The program will provide services to 150 individuals annually and 600 throughout the project. MTRT will increase capacity firstly by integrating an additional mental health professional staff that will provide crisis call de-escalation, respond to dispatch requests, and provide continuum of care resources. Highlighted goals of the program include reducing the percentage of individuals requiring an application for involuntary detention for assessment and treatment completed by emergency responders, reducing the percentage of cancelled crisis response requests by community agencies, and decreasing the average response time for urgent requests.	$750,000 $750,000	9/30/23– 9/29/27

State	Organization	Agency Location	Counties Targeted	Brief Description	Funding Amount *	Project Period
Florida	Centerstone of Florida, Inc.	Bradenton	DeSoto, Manatee	Centerstone's Community Crisis Response Partnerships in Florida (C-CCRP) project will enhance infrastructure to expand mobile crisis response teams (MCRTs) in high-need geographic counties where up to 38% of the 387,000+ calls to law enforcement are behavioral health-related. C-CCRP will enhance cooperation with law enforcement, 988, and call centers. Mental health/substance use-related hospitalizations in Manatee were 56% higher than the state, and DeSoto exceeded Florida's average in non-fatal suicide attempts by 122%. The project will expand the capacity of and prompt access to round-the-clock, two-person MCRTs, advance equity in post-crisis follow-up continuity of care, and develop a documented service model for statewide and national replication. To identify service gaps and needs, the project will map the community, train people in crisis intervention, create protocols to better coordinate with community providers/first responders, and put in place a data system to monitor results. As a result of these goals, the project will achieve highlighted objectives of screening 100%, referring 100% to needed services, increase access to services by 60%, and decreasing arrest/detention by 30%. C-CCRP will serve 1,050 individuals (150 in Year 1; 300/year in Years 2–4).	$750,000 $750,000 $750,000	9/30/22– 9/29/26
Georgia	Highland Rivers Community Service Board	Dalton	Cherokee	Highland Rivers Behavioral Health (HRBH), the Cherokee County Sheriff's Office, and the Georgia Statistical Analysis Center (GASAC) are collaborating on the Cherokee PATH initiative (Partnership for Assistance, Treatment and Health), which pairs a licensed mental health clinician with a uniformed sheriff's officer to respond to 911 behavioral crisis calls. HRBH is expanding this model from previous successes into Cherokee County. The grant will help establish two co-response crisis units to divert individuals (adults, children, and youth) experiencing mental health crises from jail or unnecessary inpatient stays. Goals are to increase 24/7 access to crisis response and devise a strategy to support a newly established data program. Cherokee is Georgia's 8th largest county and among the fastest growing with a projected 2050 population of 401,622, a 52.8% increase from current numbers, showing a need for greater capacity. 825 individuals are expected to be served over four years.	$678,314 $746,017 $683,417	9/30/22– 9/29/26

State	Organization	Agency Location	Counties Targeted	Brief Description	Funding Amount *	Project Period
Indiana	Centerstone of Indiana, Inc.	Columbus	Bartholomew Brown, Decatur, Jackson, Jennings, Johnson, Lawrence, Monroe, Morgan, Owen	Centerstone's Community Crisis Response Partnerships (C-CCRP) project will improve infrastructure to expand mobile crisis response teams (MCRTs) in a high-need geographic area of ten South Central Indiana counties. C-CCRP will serve 925 unduplicated individuals (175 in Year 1; 250/year in Years 2–4). Centerstone has the only MCRT in the 3,972 square mile geographic area. Thus, there is a great need to increase the capacity of and timely access to 24/7 two-person MCRTs, increase collaboration with law enforcement/988/call centers, and improve equity in continuity of care and post-crisis follow-up. C-CCRP aims to build a strong crisis response system that delivers culturally appropriate care for all age groups and diverts individuals from law enforcement to community-based support. To achieve this, the following are project objectives: 70% of MCRT responses resolved in the community, 40**%** of crisis encounters diverted from law enforcement, 50% increase in referrals to MCRT, and 60% of first responders trained will show increased knowledge of effective crisis response.	$750,000 $750,000 $750,000	9/30/22– 9/29/26
Indiana	Indiana Family and Social Services Administration	Indianapolis	St. Joseph, Lake, Sullivan	Indiana Innovative Community Crisis Response Partnership will create a streamlined mobile crisis response. This project will operate through the 988 system and will serve the entire constituencies of each county, a total population of about 599,122 people. St. Joseph, Lake, and Sullivan counties are all high-need counties due to elevated poverty rates and minimal or absent mobile crisis response. These three counties represent diverse and high-need communities that would benefit from mobile crisis services that are culturally responsive. Main goals of the project include the following: (1) create and enhance mobile crisis teams using culturally and developmentally appropriate services, (2) implement a streamlined system with dispatch functionality through 988 and post-crisis follow-up protocols, and (3) prioritize the use of data and evidence-based practices and measurement.	$750,000 $750,000	9/30/23– 9/29/27
Michigan	Genesee Health System	Flint	Genesee	The Genesee Health System (GHS) recently launched a co-responder program in partnership with the Sheriff's department that needs further development and funding. Current crisis services are offered in a disintegrated fashion that has been found to confuse community members leading to low utilization. GHS looks to strengthen its mobile crisis services across Genesee County which serves around 400,000 residents and target those that are most under resourced. To increase service utilization the project aims to develop a mental health-specific dispatch code in collaboration with the 911 communications center. Crisis calls	$731,359 $730,450	9/30/23– 9/29/27

State	Organization	Agency Location	Counties Targeted	Brief Description	Funding Amount *	Project Period
				will route to GHS's main phone line or urgent care. GHS has begun partnering with 988 to receive referrals for behavioral health crisis care. A clear objective is for staff to be trained to use a decision tree to determine if law enforcement is needed or if a mobile crisis team can respond alone.		
Minnesota	Hennepin County	Minneapolis	Hennepin	The project in Hennepin County Behavioral Health is a 911 Alternative Mental Health Response (ALT) pilot in Brooklyn Park, Minnesota. A significantly more racially diverse city than the city of Minneapolis, 60% of residents identify as BIPOC. Police officers responding to 911 mental health calls are found to be exacerbating racial disparities in justice system involvement. ALT teams will have a senior social worker and a community paramedic responding to low-risk 911 behavioral health calls instead of Brooklyn Park Police Department (BPPD) officers. Throughout the 45-month implementation period, ALT teams will respond to 4,500 911 mental health calls, decreasing the number of calls currently responded to by BPPD officers by 95%. Goals include a 30% increase in connections to stabilizing services for residents involved in 911 mental health calls and a 30% decrease in repeat 911 mental health calls.	$735,353 $742,245	9/30/23– 9/29/27
Missouri	Mid-America Regional Council	Kansas City	Clay, Jackson, Platte, Ray	To improve current mobile crisis response teams in a cohesive, coordinated effort, Mid-America Regional Council (MARC) is proposing to collaborate with five community care behavioral health organizations (CCBHOs): Rediscover, Swope Health, University Health Behavioral Health, Burrell Behavioral Health, and Tri-County Mental Health Services, across four counties in the greater Kansas City region. This project will be the first cross-county collaboration to address mobile crisis services in the region, serving a combined population of 1,062,289 individuals. In line with current state initiatives, the project will look to enhance current mobile crisis response teams by designing a standardized crisis response system that can increase the number of individuals served, decrease response time, and increase warm handoffs to partner agencies. MARC hopes to accomplish project objectives by implementing staff trainings, data coordination, and mapping community crisis intercepts. The CCBHOs will improve current mobile crisis teams by creating a cooperative model that provides coverage 24/7, increases staff safety with technology and safety gear, and engages in work groups with other CCBHOs and technical advisors (such as emergency services, law enforcement) to analyze current procedures.	$747,773 $732,771 $732,907	9/30/22– 9/29/26

State	Organization	Agency Location	Counties Targeted	Brief Description	Funding Amount *	Project Period
Nebraska	Winnebago Comprehensive Healthcare System	Winnebago	N/A, Tribal Nation	Twelve Clans Unity Hospital (TCUH) and Winnebago Public Health Department, part of the larger Winnebago Comprehensive Healthcare System, will partner with the Winnebago Police Department (WPD) to establish the Community Crisis Response (CCR). CCR hopes to reduce and redirect law enforcement involvement whenever appropriate by having police dispatchers trained in identifying when a CCR Team response is needed. 1,750 enrolled Winnebago Tribal members live on the reservation with as many as 5,500 total members regularly returning home, increasing the demand for crisis response services. Teams may be the sole response, respond with WPD, or be called in after WPD arrives. A mobile crisis first-response model that incorporates Tribal values and Indigenous cultural sensitivity in all follow-up services will be the first choice whenever possible. In addition, WPHD Mental Health Therapists will deploy alongside EMS at any crisis scenes. CCR Case Managers will engage with individuals, including those who are incarcerated, to develop a personalized safety plan aimed at preventing future crisis calls. A CCR Task Force will be formed, made up of Winnebago Tribe of Nebraska stakeholders, and members of the population.	$731,119 $750,000 $750,000	9/30/22– 9/29/26
New Jersey	City of Newark	Newark	Essex	The City of Newark's Community Crisis Response Partnership looks to improve access to community-based behavioral health crisis services in Newark by enhancing the capacity of existing teams to respond within one hour of dispatch, enhancing responsiveness to homeless individuals, and creating an integrated city-wide crisis response system. This will involve increasing collaboration between Newark's crisis care and homeless services; enhancing data sharing; and formalizing partnerships with community-based organizations, hospital emergency departments, crisis receiving programs, and the Rutgers University Behavioral Health Care 988 Lifeline/Crisis Call Center. A collaborative effort across nine partners, the has multiple aims, including the following: hire three additional social workers on co-responder teams at Newark Police Department precincts, recruit 100% racially and ethnically diverse crisis responders, provide evidence-based crisis intervention training to all staff (officers, social workers, etc.), and integrate a licensed clinical social worker into homeless outreach teams. The project anticipates screening at least 2,000 new individuals for behavioral health issues and training 1,113 professionals across the behavioral health crisis care system by 9/29/2026.	$727,740 $724,087	9/30/23– 9/29/27
New York	Behavioral Health	Plattsburgh	Clinton, Warren, Washington	The Mobile Crisis Expansion Project spearheaded by Behavioral Health Services North (BHSN) is focusing on three counties that have rural designations as Mental Health Professional Shortage Areas. There is a need for expansion of	$746,744 $746,744 $746,744	9/30/22– 9/29/26

State	Organization	Agency Location	Counties Targeted	Brief Description	Funding Amount *	Project Period
	Services North, Inc.			mobile crisis teams as BHSN is the only licensed 24/7 crisis response in Clinton County. Furthermore, Warren and Washington counties have mobile crisis providers that operate mostly during daytime hours. BHSN handles an average of four mobile crisis responses a week, while combined law enforcement, EMS pickups, and ER visits across the counties averaged over 10–15 times this amount. Highlighted goals of the project include enhancing capacity by adding two mobile crisis teams to increase client volume by 250% and reducing involuntary pickup by Plattsburgh City Police Department by 25%. To achieve this, BHSN has partnered with Champlain Valley Family Center, a new local intensive crisis stabilization center, Plattsburgh City Police (Clinton County), and Morrisonville-Schuyler Falls Volunteer Ambulance Service (Morrisonville EMS).		
New York	The Neighborhood Center, Inc.	Utica	Oneida, Herkimer	The Neighborhood Center, Inc.'s (TNC) Mobile Crisis Assessment Team (MCAT) provides 24/7 crisis intervention services to children and adults in a six-county region of New York State. The project aims to have MCAT staff and peer advocates in Oneida and Herkimer Counties provide access to services on a 24/7 basis, with a minimum of two providers responding. The project further looks to establish co-response programs in both counties. Examples of some of the objective include: (1) within the first six months 75% of in-person crisis response requests will consist of two MCAT staff or a crisis response team, (2) 80% of assessment requests will dispatch a crisis response team for either virtual or in-person response within 10 minutes, and (3) 100% of Peer Advocate staff will serve as second providers at in-person assessments/engagements with MCAT staff.	$749,902 ** $750,000	9/30/22– 9/29/26
Ohio	ADAMHS Board for Montgomery County	Dayton	Montgomery	Montgomery County Crisis Care Expansion looks to serve a population of 535,000 individuals. Services will expand to a second location with four additional clinical and behavioral health professionals hired. Goals are to improve call response rates, increase community-resolved rates, reduce justice system involvement, and train community members in crisis intervention techniques. The program will be fully staffed after March 2023, with the response time maintained or decreased from 20 minutes. Highlighted objectives are increasing the community resolved rate from the current 85% to 90% by Year 2 and implementing updated referral policies in the first year.	$750,000 $750,000	9/30/23– 9/29/27
Oklahoma	Oklahoma Department of Mental Health	Oklahoma City	Oklahoma, Tulsa	Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) is looking to expand mobile crisis team capacity as part of the Oklahoma Comprehensive Crisis Response (OCCR) in Oklahoma and Tulsa County, two of the most populous in the state. All regions in Oklahoma currently	$750,000 $750,000	9/30/23– 9/29/27

State	Organization	Agency Location	Counties Targeted	Brief Description	Funding Amount *	Project Period
	and Substance Abuse			have 24/7 operational teams with 988-dedicated mobile crisis teams launched statewide on July 5, 2022**,** alongside a 988 crisis call center. Five additional flexible teams provide statewide support for surges or unexpected demand. Two main goals are to increase 988 mobile crisis team capacity in Oklahoma and provide technical assistance, training, and evaluation for these teams with the grant money.		
Oregon	Western Lane Fire and EMS Authority	Florence	Lane	Western Lane Mobile Crisis Response (MCR) will establish the first rural 24/7/365 mobile mental health crisis response program in the western section of Lane County. The program will serve 19,128 residents in a 980-square mile catchment area bound on the east by a coastal mountain range and the west by the Pacific Ocean. Struggles with rural health disparities are rampant with remoteness, isolation, lack of social support, and stigma all adding to suicide mortality rates that are close to three times higher than the total county average. The project looks to create a new model where staff are multi-role, conduct community outreach to frequent users, provide voluntary transport, and collaborate with external partners. Some examples of objectives are achieve "adequate staffing levels within year one and sustaining at 80% through the end of project period; creating joint protocols with law enforcement and first responder agencies for response without law enforcement accompaniment with year one, reducing law enforcement accompaniment by 50% within year one and 60% within city limits by year 3," as well as to onboard eight frequent users into the community outreach program in Year 1, and achieve a 50% reduction in 911 calls.	$422,961 $375,966	9/30/23– 9/29/27
Pennsylvania	Thomas Jefferson University	Philadelphia	Monroe	Thomas Jefferson University and Monroe county's mobile crisis provider, Resources for Human Development (RHD), is partnering with the local 911 Public Safety Answering Point (PSAP) and police departments to establish an alternative dispatch program and enhance RHD's infrastructure to respond. Monroe County, a high-need service area in rural Pennsylvania, hopes to divert unneeded response from law enforcement for behavioral crisis through this project. Three borough police departments, the Pennsylvania Office of Mental Health and Substance Abuse Services, and the local PSAP have all come together to support the project's operations and help gather all pertinent key performance indicators such as average number served per 8-hour shift. Objectives include maintaining countywide metrics for behavioral health calls, applying a community crisis mapping model to identify service needs, and increasing the qualified workforce through evidence-based training opportunities.	$750,000 $749,995 $745,758	9/30/22– 9/29/26

State	Organization	Agency Location	Counties Targeted	Brief Description	Funding Amount *	Project Period
Pennsylvania	The Devereux Foundation	Villanova	Orange	Behavioral Response Unit (BRU) is a partnership between Devereux Advanced Behavioral Health and Orange County Sheriff's Office to provide community-based mental health crisis intervention. 911 dispatchers and first responders can request BRU support for mental health-related calls. Each team includes a Crisis Intervention Team (CIT)-trained deputy and a licensed mental health therapist or clinical social worker. Orange County's population is around 1.4 million with the Sheriff's Office responding to 8,000 mental health-related calls per year (around 22 per day). Since 2021, BRU has responded to nearly 6,000 calls with a stabilization rate of 86% which means individuals have not been arrested or hospitalized post-intervention. BRU hopes to add two more teams on top of the three current teams with the funding to increase capacity to 1,600 calls annually or 6,600 calls over the grant period. A highlighted goal is to reduce cycles of arrest and involuntary hospitalizations by strengthening supports and external community connections.	$750,000 $750,000 $750,000	9/30/22– 9/29/26
Rhode Island	Newport County Community Mental Health	Middletown	Newport	The Newport County Community Mental Health Center (NCCMHC) project aims to expand its existing mobile crisis intervention initiatives to create a partnership that achieves 24/7 emergency response coverage across the county. The four-year funding period will serve 600 individuals, 150 a year, with serious mental illness or substance use disorders. Some highlighted goals include increasing capacity to respond by hiring four additional crisis clinicians, establishing post-crisis follow-up for all service recipients, improving equity by having 95% of crisis services provided in the client's primary language, and reducing inpatient hospitalizations by 95%.	$750,000 $750,000 $750,000	9/30/22– 9/29/26
South Carolina	South Carolina State Department of Mental Health	Columbia	Aiken, Anderson, Chesterfield, Newberry, McCormick, Saluda, Edgefield, Abbeville, Greenwood, Laurens	South Carolina State Department of Mental Health (SCDMH) Mobile Crisis project's main focus is to expand the capacity of existing MCTs in 10 high-need counties based on suicide and poverty rates. SCDMH Mobile Crisis Expansion will work with law enforcement agencies, hospital systems, and social service organizations to reach some of the highlighted objectives: (1) develop community crisis maps to identify barriers and continuity of care disparities, (2) hire, train, and credential 20 Peer Support staff to serve as co-responders on MCTs, (3) partner with at least one law enforcement agency in each of the identified high-need counties to provide an iPad with data plan to support implementation of telehealth services, and (4) create Mobile Crisis Advisory Boards comprised of partners and consumers of mental health services and their family.	$750,000 $749,992 $749,996	9/30/22– 9/29/26
South Dakota	South Dakota State	Pierre	Not Specified	South Dakota's Rural Mobile Crisis Response project aims to implement innovative rural mobile crisis response in partnership with three Community Mental Health Centers. The project will serve over 115,000 South Dakotans in	$737,788 $750,000	9/30/23– 9/29/27

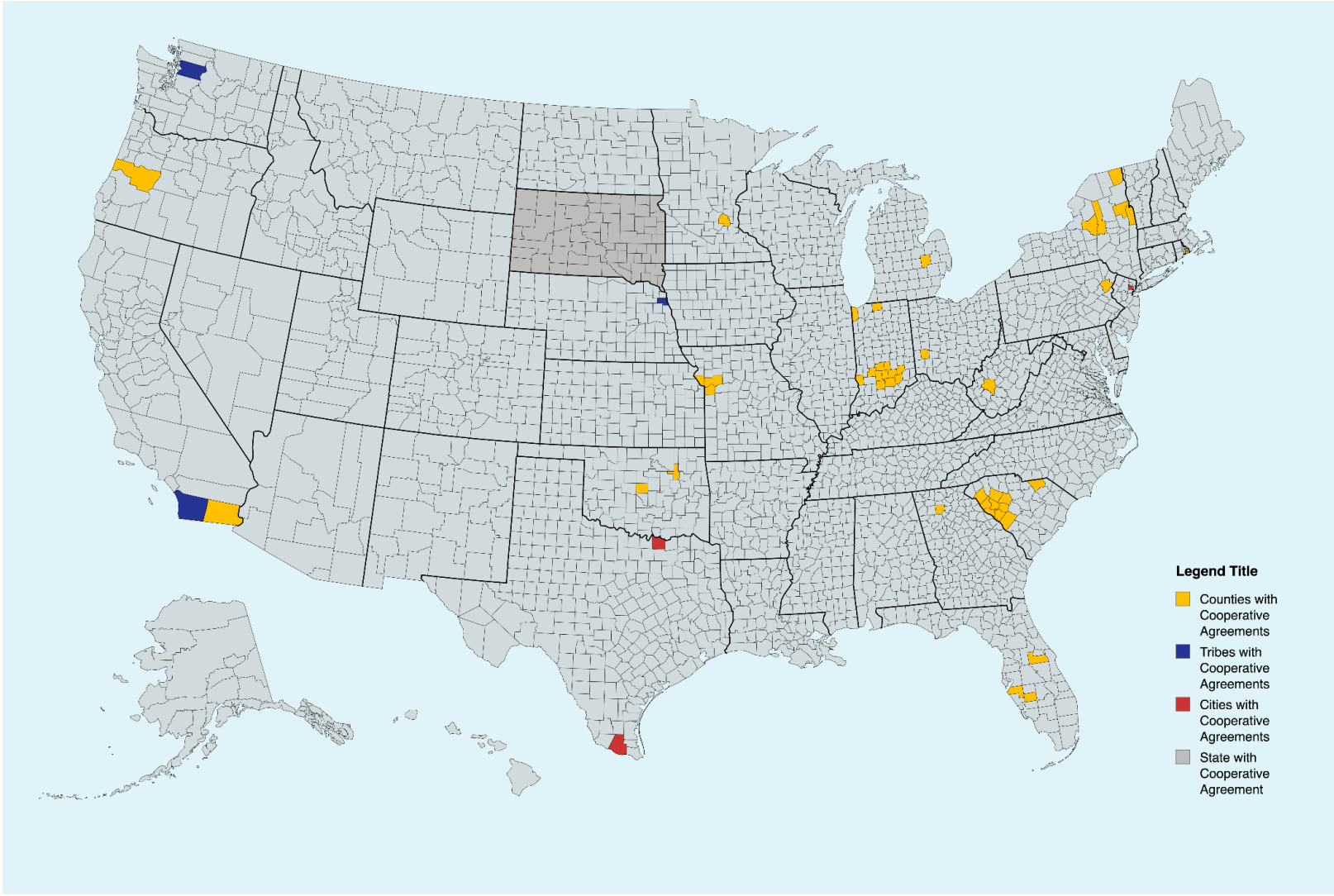
State	Organization	Agency Location	Counties Targeted	Brief Description	Funding Amount *	Project Period
	Department of Social Services			regions with limited to no mobile crisis response service availability. Every region will develop response protocols using a flexible approach relative to the level of need within the catchment area, supported by existing resources and newly developed co-responder teams. The project will align workforce capacity building efforts with recent telehealth enhancements provided to EMS services throughout the state. In addition, dedicated staff at the CMHC level will allow for adequate staffing to develop a strong continuum of care from response to follow-up care.		
Texas	Texoma Community Center	Sherman	Grayson	Texoma Community Center (TCC) is in North Central Texas, near the Oklahoma border. As the leading local mental health authority, the center has a longstanding collaborative relationship with local law enforcement agencies and has been operating a Mobile Crisis Outreach Team (MCOT) since 2007. TCC, having been involved in jail diversion, hopes to both improve the crisis care continuum in the region and reduce the burden on law enforcement through expanded services. This includes primarily developing a co-responder model with the City of Sherman, identified as the area of highest need, and extending the model to other towns in the largely rural region.	$730,710 $725,430	9/30/23– 9/29/27
Texas	Tropical Texas Behavioral Health	Edinburg	Hidalgo	Tropical Texas Behavioral Health (TTBH) will establish the TTBH-Edinburg Police Department (PD) Mental Health Unit (MHU) in Edinburg, Texas titled the TTBH-Edinburg PD Community Crisis Response Program. The service area is designated as a high-poverty area, with Edinburg experiencing a rate of 22.6% poverty, an average almost twice that of Texas. The county also identifies as both Medically Underserved and a Health Professional Shortage Area. TTBH will serve 500 persons annually through referrals by police department service calls that indicate behavioral health needs, with a total of 2,000 persons served through the lifespan of the grant. The first collaborative crisis responder team developed with the Edinburg PD, TTBH-Edinburg PD MHU is a ride along-respond service model providing immediate services to adults and adolescents experiencing a mental health crisis. TTBH will further provide triage services to individuals 24/7 by a qualified mental health professional.	$750,000 $750,000	9/30/23– 9/29/27
Washington	Health Care Authority	Olympia	N/A, Tribal Nation	Health Care Authority has identified the Tulalip Tribes as a partner to pilot one 24/7 tribal MCR program. An overarching goal is to document best practices so the state can further support expansion of other tribal MCR teams. Demonstration of relief and the positive impacts Tribal MCRs can have on the regional and statewide crisis system is a major aim of the pilot.	$727,221 $727,130	9/30/23– 9/29/27
West Virginia	West Virginia State	Charleston	Kanawha	West Virginia Bureau for Behavioral Health Cooperative Agreement for Innovative Community Response Partnerships Program will establish mobile	$732,261 $749,064	9/30/23– 9/29/27

State	Organization	Agency Location	Counties Targeted	Brief Description	Funding Amount *	Project Period
	Department of Health and Human Resources			crisis teams targeting adults, children, and youth in Kanawha County, West Virginia, who are experiencing a behavioral health crisis. Together with the launch of 988, the formation of these teams will accelerate the growth of crisis services in West Virginia, enabling better coordination in the program's development with 911 Public Safety Answering Points and local law enforcement resources. The advancements made in this program will be scalable.		

* For the funding amount, where three amounts are given, they represent 2022, 2023, and 2024 amounts (as those Cooperative Agreement was initially granted in 2022). Where two amounts are given, they represent 2023 and 2024 amounts (as those Cooperative Agreement was initially granted in 2023). Funding amounts for out-years (2025, 2026, 2027) are not known and thus not provided.

** Although this Cooperative Agreement was initially granted in 2022, funding amounts are provided (on the SAMHSA website) for 2022 and 2024 only (with no funding amount shown for 2023).

Figure B. Map Showing Locations Noted in Projects' Detailed Abstracts, SAMHSA Cooperative Agreements for Innovative Community Crisis Response Partnerships



8. SAMHSA Mental Health Services Block Grant and Supplemental Funds

8. SAMHSA Mental Health Services Block Grant and Supplemental Funds

Background

Mental Health Block Grant (MHBG) funds are distributed to states annually; states may directly administer programs or sub-grant the funds. SAMHSA's Center for Mental Health Services' Division of State and Community Systems Development administers MHBG funds. States can be flexible in the use of funds for both new and unique programs or to supplement their current programs covered by Medicaid, Medicare, and private insurance (SAMHSA, no date #4). It can also be used to fund treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time, and to fund priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery (SAMHSA, no date #5).

The MHBG formula calculates each state's share of funding based on three components: (1) the size of the population needing services, (2) the cost of services, and (3) the state's fiscal capacity (Ashwood et al., 2019). First, the MHBG formula estimates population need based on weights given to the number of people in different age groups to reflect higher risk for mental disorders for certain ages. The weights used to indicate population need are based on a 1986 Institute for Health and Aging study, as well as annual state population counts by age. These counts are weighted according to the formula to estimate the level of need (Ashwood et al., 2019). The formula relies on this indirect estimate of the level of need instead of direct estimates provided by survey data. Second, the current MHBG formula uses a cost index designed to reflect state variations in the inputs or resources required to deliver services. The cost index is based on a 1990 report and includes three components: state-level costs of labor (currently measured as median hourly wages for occupations involved in providing mental health treatment services), rent ("fair market" apartment rental prices), and other supplies (assumed to be constant across states) (Ashwood et al., 2019). Third, the current MHBG allocation formula also uses the annual estimates of states' "total taxable resources" from the U.S. Department of the Treasury as an indicator of state fiscal capacity (Ashwood et al., 2019). Thus, the MHBG formula combines an estimate of the quantity of services that need to be funded in the state, an estimate of the costs of providing those services in the state, and an estimate of the state's ability to fund services through other mechanisms. All three formulas have a minimum allotment so that each state and

territory is guaranteed a minimum amount of funding each year (Ashwood et al., 2019). The minimum allocation for the MHBG program is the amount received by the state in fiscal year 1998 (territories are subject to different minimum allotment rules) (Ashwood et al., 2019). The total amount gets re-calculated each year; total funding for the MHBG program is set by the annual federal budget, with Congress deciding how much money is allocated to the MHBG within the broader budget of SAMHSA each year.

Targeted populations of the MHBG include: (1) adults with serious mental illnesses (SMI) and (2) children with serious emotional disturbances (SED) (SAMHSA, no date #4). The former includes persons ages 18 and older who have a diagnosable behavioral, mental, or emotional condition—as defined by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. Their condition substantially interferes with, or limits, one or more major life activities, such as: basic daily living (e.g., eating or dressing), instrumental living (e.g., taking prescribed medications or getting around the community), and participating in a family, school, or workplace (SAMHSA, no date #4). Children with SED includes persons up to age 18 who have a diagnosable behavioral, mental, or emotional issue (again, as defined by the DSM). This condition results in a functional impairment that substantially interferes with, or limits, a child's role or functioning in family, school, or community activities (SAMHSA, no date #4).

Each grantee has a designated unit of the executive branch that is responsible for administering the MHBG (for example, in the State Mental Health Agency). SAMHSA expects block grant recipients to satisfy the following performance requirements (SAMHSA, no date #4):

- They must submit a plan explaining how they will use MHBG funds to provide comprehensive community mental health services to adults with SMI and children with SED.
- They must provide annual reports on their plans.
- They may distribute funds to local government entities and non-governmental organizations.
- They must ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs.

- They must comply with general federal requirements for managing grants. They must also cooperate in efforts by SAMHSA to monitor use of MHBG funds. For example, each year, SAMHSA's Center for Mental Health Services conducts investigations (site visits) of at least ten grantees receiving MHBG funds. This is to assess how they are using the funds to benefit the population. These evaluations include careful review of how the grantees are tracking use of MHBG funds for their adult and child mental health programs, data and performance management systems, and collaboration with consumers and the grantees' mental health planning council (SAMHSA, no date #4).

A number of eligibility requirements pertain to the MHBG. Funding can be used for non-Medicaid eligible children with SED and non-Medicaid eligible adults with SMI, and for services and activities that are not covered by Medicaid for Medicaid enrollees who have SED or SMI (Washington State Health Care Authority, 2024). The grant does not require a state match. However, it requires a statutory maintenance of effort to document that the state has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the state for the two-year period preceding the fiscal year for which the state is applying for the grant. Federal law requires that the funds awarded to states be obligated and expended within two years. SAMHSA operates on a federal fiscal year (October to September) while some states operate, for example, on a July through June state fiscal year (and block grant funds awarded in October cannot be allocated until the state budget is approved the following year) (Washington State Health Care Authority, 2024). Not less than 10% of the MHBG is to be used for services for children, based on 1994 expenditures. More recent stipulations include a 10% set-aside for early intervention services (e.g., coordinated specialty care for first-episode psychosis), and a 5% set-aside for crisis services, which began in 2021 and has been stipulated in each annual federal appropriations law since then thus far. Aside from these services that might be considered prevention-oriented, MHBG funds cannot be used for prevention.

Block grant funds cannot be used to: provide inpatient hospital services; make cash payments to intended recipients of health services; purchase or improve land; purchase, construct, or permanently improve buildings or other facilities; purchase major medical equipment costing over $5,000; satisfy any requirement for the expenditure of non-federal funds

as a condition for the receipt of federal funds; or provide financial assistance to any entity other than a public or nonprofit private entity (Washington State Department of Social and Health Services, 2016). Additionally, states cannot expend more than 5% of MHBG funds to administer the grant.

States and jurisdictions are required to prepare and submit reports for the last completed state fiscal year (SFY), addressing the purposes for which the MHBG funds were expended, the recipients of grant funds, the authorized activities conducted, and services purchased (SAMHSA, no date #6). In this reporting, particular attention must be given to the progress made toward accomplishing the goals and performance indicators identified in the states' plans. States are required to prepare and submit their respective reports using SAMHSA's Web Block Grant Application System (BGAS) (SAMHSA, no date #6).

The American Rescue Plan Act of 2021 (ARPA), signed by President Biden on March 11, 2021, directed SAMHSA to provide additional funds to support states through Block Grants to address the effects of the COVID -19 pandemic for Americans with mental illnesses and SUD (SAMHSA, 2021d). ARPA allocated $1.5 billion each for the MHBG and the Substance Abuse Prevention and Treatment Block Grant (SABG) to the states. States had until September 30, 2025 to expend these funds (SAMHSA, 2021d).

With regard to the aforementioned 5% set-aside for crisis services, in 2021, SAMHSA was directed by Congress through the Consolidated Appropriations Act of 2021 and its Division M—which is the Coronavirus Response and Relief Supplemental Appropriations Act of 2021—to set aside 5% of the MHBG allocation for each state to support evidence-based crisis systems. Additional funding was included in the FY 2021 appropriations law in order to support implementation of the new set-aside without losing funds for existing services (SAMHSA, 2021d), and the set-aside has been stipulated in each annual appropriations law thus far since then. States are required to provide services to those in crisis through three core services (i.e., call centers including 988, 24/7 MCTs, and crisis receiving/stabilization programs). Nothing precludes states from utilizing more than 5% of their MHBG funds for crisis services for individuals with SMI or children with SED (SAMHSA, 2021c). If states have other investments for crisis services, they are encouraged to coordinate those services with programs supported by the 5% set-aside. States may address the three core services either through enhancing existing

program activities or through developing a set of new activities (SAMHSA, 2021c) based on SAMHSA's National Behavioral Health Crisis Care Guidance (SAMHSA, 2025b).

Approach

The "Awards by State" tab and associated map on the SAMHSA Grants Dashboard was used to gather the dollar amounts of the MHBG given to each state every year from 2014 through 2024. Each year was filtered using "Award Fiscal Year." Going alphabetically through the summary tab of each state, the "Community Mental Health Services Block Grant" number under "Non-Discretionary Funding" was noted. These dollar amounts included all supplementary funds such as the two rounds of ARPA funds and one round of CRRSSA funds in 2021 and the Bipartisan Safer Communities Act funds in 2023; supplementary funds were added to the normally calculated MHBG amount per state.

As given in the **Table 8** below, an average of the total amount from 2014 through 2024 was calculated for each state, excluding 2021 when there was a substantial influx of funding. Similarly, percentages of the total block grant pool for every year were calculated for each state to compare what percent each state received from total SAMHSA MHBG funds to all 50 states and the District of Columbia (again, excluding 2021). The 2021 MHBG amounts per state are given separately. Finally, the calculated amount of the 5% set-aside for crisis services are given for fiscal years 2021, 2022, 2023, and 2024.

Findings

Given its non-discretionary nature and the formulas by which it is calculated, the MHBG levels the playing field in terms of supplementing SMHA's funds for community-based mental health services for people with SMI or SED. Relatedly, the 5% crisis services set-aside (2021–2024) provided each state a relative share of dedicated funds to focus on improving and expanding crisis services. For some states, such as those receiving ≤0.25% of total SAMHSA MHBG funds (Wyoming, North Dakota, Vermont, Alaska, South Dakota, DC, and Delaware, as shown in **Table 8**), this crisis set-aside amount may only range from $64,802 (Wyoming, in 2024) to $127,464 (Alaska, in 2024). For more populous states that receive a higher proportion of the total SAMHSA MHBG funds (e.g., >5% of funds going to California, Texas, Florida, and New York), the crisis set-aside amount is as high as $4,249,654 (Texas in 2024) and $6,726,982 (California in 2024).

These figures must be considered in the context of states' overall mental health expenditures, as reported earlier in **Table A3**. Here, we give just three examples from three states, Kansas, North Carolina, and Wisconsin. For Kansas, SMHA expenditures from state sources (FY 2023) are $255,352,209 and total SMHA expenditures are $611,317,595; as such, 42% of SMHA expenditures come from state sources. 73% of SMHA expenditures go toward community (as opposed to inpatient) services, and 1% go toward crisis services. Kansas receives approximately $5,222,476 in SAMHSA MHBG funds (average, 2014–2024, excluding 2021), which represents ***0.85%*** *of total SMHA expenditures* in FY 2023. The 5% crisis set-aside in the MHBG in FY 2023 was $404,180, which represents ***0.07%*** *of total SMHA expenditures*.

Taking North Carolina as another example, SMHA expenditures from state sources (FY 2023) are $304,709,171 and total SMHA expenditures are $1,191,186,700; as such, 26% of SMHA expenditures come from state sources. 63% of SMHA expenditures go toward community (as opposed to inpatient) services, and <1% go toward crisis services. North Carolina receives approximately $20,107,277 in SAMHSA MHBG funds (average, 2014–2024, excluding 2021), which represents ***1.69%*** *of total SMHA expenditures* in FY 2023. The 5% crisis set-aside in the MHBG in FY 2023 was $1,577,869, which represents ***0.13%*** *of total SMHA expenditures*.

Finally, looking at Wisconsin as a third example, SMHA expenditures from state sources (FY 2023) are $159,601,586 and total SMHA expenditures are $1,189,043,772; as such, 13% of SMHA expenditures come from state sources. 76% of SMHA expenditures go toward community (as opposed to inpatient) services, and 1% go toward crisis services. Wisconsin receives approximately $11,340,310 in SAMHSA MHBG funds (average, 2014–2024, excluding 2021), which represents ***0.95%*** *of total SMHA expenditures* in FY 2023. The 5% crisis set-aside in the MHBG in FY 2023 was $854,082, which represents ***0.07%*** *of total SMHA expenditures*. These examples show us that the SAMHSA MHBG represents a very small percentage (in these three examples, approximately 1–2%) of a state's total mental health spending. Furthermore, the 5% set-aside for crisis services represents a remarkably small percentage of total mental health spending (in these three examples, 0.07–0.13%).

When these same calculations are performed across the states, the SAMHSA MHBG accounts for approximately 0.44% to 5.30% of a state's total SMHA expenditures (with the average across the 51 states being approximately 1.67%). Furthermore, the 5% crisis set-aside in

the MHBG in FY 2023 represents about **0.04% to 0.41%** of a state's total SMHA expenditures (with the average across the 51 states being approximately **0.14%**).

Table 8. SAMHSA Mental Health Block Grant Funding Figures, by State

STATE	Average MHBG, 2014–2024 (Excluding 2021)	2021 MHBG	Average Percentage of the Total MHBG, 2014-2024 (Excluding 2021)	2021 MHBG Crisis Set-Aside	2022 MHBG Crisis Set-Aside	2023 MHBG Crisis Set-Aside	2024 MHBG Crisis Set-Aside
Alabama	$10,212,987	$43,681,061	1.46%	$2,184,053	$598,503	$790,502	$780,653
Alaska	$1,538,122	$6,849,601	0.21%	$342,480	$100,466	$127,780	$127,464
Arizona	$17,096,884	$83,052,859	2.46%	$4,152,643	$1,015,452	$1,298,207	$1,235,716
Arkansas	$6,189,730	$26,436,610	0.89%	$1,321,831	$361,322	$477,280	$434,836
California	$92,961,574	$395,844,100	13.35%	$19,792,205	$5,350,819	$6,968,215	$6,726,982
Colorado	$12,627,733	$59,388,925	1.78%	$2,969,446	$803,894	$1,032,110	$1,003,262
Connecticut	$7,225,180	$29,300,543	1.03%	$1,465,027	$420,962	$562,853	$553,494
Delaware	$1,731,800	$7,053,149	0.25%	$352,657	$86,328	$120,348	$117,661
D.C.	$1,631,730	$7,162,953	0.23%	$358,148	$99,476	$132,528	$115,177
Florida	$46,734,082	$200,719,072	6.70%	$10,035,954	$2,798,689	$3,551,830	$3,441,764
Georgia	$21,966,325	$96,686,608	3.17%	$4,834,330	$1,254,524	$1,612,722	$1,581,788
Hawaii	$3,669,911	$15,218,126	0.52%	$760,906	$205,824	$267,050	$273,150
Idaho	$3,945,403	$17,821,254	0.54%	$891,063	$222,453	$289,853	$296,398
Illinois	$24,510,381	$106,315,717	3.57%	$5,315,786	$1,289,674	$1,752,565	$1,679,460
Indiana	$13,210,992	$54,149,389	1.86%	$2,707,469	$816,719	$1,102,405	$1,060,806
Iowa	$5,649,807	$23,708,539	0.80%	$1,185,427	$327,601	$449,166	$431,152
Kansas	$5,222,476	$22,071,091	0.75%	$1,103,555	$301,985	$404,180	$388,039
Kentucky	$9,231,259	$39,255,580	1.32%	$1,962,779	$536,011	$712,403	$688,213
Louisiana	$9,134,854	$43,792,301	1.30%	$2,189,615	$535,711	$727,250	$692,200
Maine	$2,830,234	$11,854,377	0.40%	$592,719	$162,389	$219,989	$212,317
Maryland	$12,623,383	$58,876,742	1.83%	$2,943,837	$692,981	$940,307	$924,133
Massachusetts	$14,681,384	$60,526,529	2.08%	$3,026,326	$876,197	$1,165,315	$1,138,996
Michigan	$21,149,116	$88,736,574	3.03%	$4,436,829	$1,191,583	$1,642,891	$1,578,928
Minnesota	$10,918,570	$45,776,732	1.55%	$2,288,837	$664,618	$878,294	$854,964
Mississippi	$6,407,241	$27,633,313	0.92%	$1,381,666	$376,090	$495,235	$474,855
Missouri	$11,858,198	$50,880,859	1.69%	$2,544,043	$700,421	$929,984	$893,249
Montana	$2,329,001	$9,256,088	0.32%	$462,804	$148,863	$195,325	$194,632
Nebraska	$3,251,090	$13,879,219	0.46%	$693,961	$191,667	$253,971	$237,993
Nevada	$7,030,559	$31,974,582	0.96%	$1,598,729	$465,334	$0	$581,421

STATE	Average MHBG, 2014–2024 (Excluding 2021)	2021 MHBG	Average Percentage of the Total MHBG, 2014-2024 (Excluding 2021)	2021 MHBG Crisis Set-Aside	2022 MHBG Crisis Set-Aside	2023 MHBG Crisis Set-Aside	2024 MHBG Crisis Set-Aside
New Hampshire	$2,524,437	$10,652,264	0.36%	$532,613	$137,159	$188,579	$178,034
New Jersey	$20,387,528	$82,824,842	2.89%	$4,141,242	$1,128,285	$1,513,359	$1,545,805
New Mexico	$4,243,074	$18,382,358	0.61%	$919,118	$252,006	$328,074	$314,352
New York	$41,788,615	$169,455,960	5.98%	$8,472,798	$2,382,608	$3,127,922	$3,090,713
North Carolina	$20,107,277	$87,935,329	2.86%	$4,396,766	$1,216,324	$1,577,869	$1,517,797
North Dakota	$1,247,531	$5,287,653	0.18%	$264,383	$73,517	$98,280	$94,434
Ohio	$22,368,594	$94,248,587	3.19%	$4,712,429	$1,288,384	$1,799,466	$1,707,648
Oklahoma	$7,668,763	$33,255,919	1.09%	$1,662,796	$458,186	$611,801	$590,917
Oregon	$10,244,839	$47,933,257	1.44%	$2,396,663	$651,790	$837,143	$822,269
Pennsylvania	$24,129,982	$99,171,696	3.44%	$4,958,585	$1,386,038	$1,892,281	$1,839,872
Rhode Island	$2,587,624	$11,226,405	0.37%	$561,320	$143,903	$189,374	$187,342
South Carolina	$10,461,594	$45,477,505	1.49%	$2,273,875	$626,870	$818,315	$786,577
South Dakota	$1,539,231	$6,537,458	0.22%	$326,873	$89,737	$119,078	$114,797
Tennessee	$14,123,375	$57,756,122	1.82%	$2,887,806	$861,152	$1,121,903	$1,103,059
Texas	$57,041,004	$272,731,530	8.22%	$13,636,577	$3,352,058	$4,328,721	$4,249,654
Utah	$6,552,034	$27,277,972	0.90%	$1,363,899	$460,340	$578,270	$583,072
Vermont	$1,280,921	$5,218,374	0.18%	$260,919	$70,867	$97,484	$94,415
Virginia	$17,113,273	$75,764,369	2.43%	$3,788,218	$1,042,802	$1,366,771	$1,328,789
Washington	$18,080,162	$70,293,392	2.54%	$3,514,670	$1,002,653	$1,307,357	$1,265,075
West Virginia	$3,924,870	$16,468,613	0.56%	$823,431	$222,231	$301,881	$284,633
Wisconsin	$11,340,310	$52,146,181	1.63%	$2,607,309	$630,895	$854,082	$830,371
Wyoming	$893,153	$3,897,380	0.13%	$194,869	$53,880	$72,150	$64,802
Total	**$687,218,197**	**$2,971,845,659**		**$148,592,284**	**$40,128,241**	**$52,230,718**	**$51,314,130**

9. Bureau of Justice Assistance (BJA) Byrne State Crisis Intervention Program Grants

9. Bureau of Justice Assistance (BJA) Byrne State Crisis Intervention Program Grants

Background

The Bipartisan Safer Communities Act of 2022 was signed into law on June 25, 2022 by President Biden. One of the overarching aims of the law is to reduce gun violence and keep guns away from individuals who may be dangerous. To do so, the law directs the federal government to invest in anti-violence programs that seek to engage individuals most likely to commit or be a victim of gun violence. The funding largely supports implementation of extreme risk protection orders (ERPOs), also known as "red flag laws," which temporarily prevent the purchase or possession of guns by individuals who are thought to pose a risk to themselves or others. ERPOs allow health care providers, school officials, or law enforcement officers to petition a court to temporarily prevent firearm access, with constitutional safeguards and due process protections included for persons subject to the order (Department of Justice, 2021).

As authorized by the Bipartisan Safer Communities Act of 2022, the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance (BJA) provides formula funds under the Byrne State Crisis Intervention Program (Byrne SCIP) to support the creation and implementation of ERPO programs as well as state crisis intervention court proceedings such as mental health courts, drug courts, and veterans' treatment courts. Related court-based and behavioral health deflection programs that can be covered by Byrne SCIP funds include the following: assertive community treatment, triage services, mobile crisis units (both co-responder and civilian only), regional crisis call centers, crisis receiving and stabilization facilities, peer support specialists, behavioral threat assessment programs and related training, technological supports (e.g., smartphone applications to help families and patients navigate mental health services), telehealth initiatives, and specialized training for those who serve, or are families of, individuals in crisis (BJA, 2022).

To apply for Byrne SCIP funds, a state has to form a Crisis Intervention Advisory Board to aid in guiding its related gun violence reduction programs/initiatives. The Board must include representatives from the community, behavioral health providers, law enforcement, courts, victim services, prosecution, and legal counsel. Budget or program plans need to be approved by

that Board. The grants have a local pass-through requirement. States are required to pass 40% to local governments such as counties, cities, towns, townships, or federally recognized Native American tribes. Sixty percent of funds go to the State Administration Agency (SAA), which the agency can maintain with no pass-through. The mandatory pass-through handled by the SAA can also be given to a prosecutor's office, public defender's office, law enforcement agency, public health agency, or court system. States have discretion in how the funds are passed through to units of local government, as informed by their Crisis Intervention Advisory Board. Some small-sized units of local government known as "less-than-$10,000 jurisdictions" are not qualified to receive direct Justice Assistance Grants. However, under Byrne SCIP, states are mandated to fund state courts with criminal or civil justice services that cover the "less-than-$10,000 jurisdictions" or provide subawards for those jurisdictions (BJA, 2022). Congress directed the Bureau of Justice Statistics to determine a funding formula for states, with 50% being based on the share of the U.S. population and the other half based on the state's share of the average number of reported violent crimes in the U.S. For FY 2022 and FY 2023, the BJA awarded over $253,579,481 to states through Byrne SCIP (BJA, 2023). In FY 2024, BJA awarded an additional $145,797,751.

Approach

Data in **Table 9a** were obtained directly from two BJA documents: (1) BJA FY 2022 – FY 2023 Byrne State Crisis Intervention Program (SCIP) Formula Allocations (https://bja.ojp.gov/funding/fy-2022-2023-byrne-scip-allocations.pdf), and (2) BJA FY 2024 Byrne State Crisis Intervention Program (SCIP) Formula Allocations (https://bja.ojp.gov/funding/fy-2024-byrne-scip-allocations.pdf).

Findings

Table 9a displays BJA Byrne SCIP funding by state for FY 2022–2023 and for FY 2024. Total amounts over the three years (summing the two award periods shown in **Table 9a**) ranged from $1,014,905 in North Dakota, Vermont, and Wyoming to more than $20 million: $20,942,114 in New York; $23,925,501 in Florida; $33,571,333 in Texas; and $45,842,504 in California. The average award amount in FY 2022–2023 was $4,972,147, and the average award amount in FY 2024 was $2,858,779.

Because states used funds in variable ways, here we selected just one state, Pennsylvania, as an example. For years 2022–2023, Pennsylvania received $8,548,557. Pennsylvania's FY

2022-23 SCIP Funding Plan identified three priority areas with underlying objectives and approaches: "(1) improve crisis intervention services and supports across behavioral health, civil legal, and other settings, with a focus on reaching people and communities experiencing gun violence; (2) improve coordination of services and responses to gun violence victimization; and (3) address the intersections of domestic violence and intimate partner violence with gun violence" (Pennsylvania Commission on Crime and Delinquency, 2025). In terms of mental health crisis activities, one of the main projects addressed with the funding was Crisis Intervention Team (CIT, which is a law enforcement-based program to improve behavioral health crisis response) and Crisis Intervention Services Landscape Analysis. Pennsylvania's plan also outlined Local-Share and Less-than-$10,000-Share subgrants awarded to eight local units of governments to support a variety of activities, including co-responder initiatives pairing law enforcement with behavioral health clinicians, suicide prevention activities, CIT training for law enforcement officers, and behavioral health training for court officials.

Pennsylvania's Commission on Crime and Delinquency conducted a Gun Violence Prevention Stakeholder Feedback in late 2024 that included asking how funding should be prioritized to prevent and reduce gun violence. Notably, among 812 respondents 60% of those who identified as social service professionals regarded crisis response as a key priority, as did 50% of those who identified as gun owners. The below list is a more detailed breakdown of projects funded with FY 2024 Byrne SCIP funds in Pennsylvania, totaling $4,991,633 (Pennsylvania Commission on Crime and Delinquency, 2025):

1. Pennsylvania Crisis Intervention Team (CIT) Technical Assistance Center: $1,095,816 (The Council of State Governments (CSG) Justice Center and CIT International will be directly partnered with the Pennsylvania CIT Technical Assistance Center to create this statewide center. An emphasis on behavioral health and law enforcement collaborations will be promoted through the development and execution of services, such as deflection/diversion programs, crisis response models, and preventative initiatives.)
2. Sequential Intercept Model (SIM) Mapping Initiative: $50,000 (This is for expanding SIM Mapping training for justice system facilitators. Facilitators, who are county-based, would identify gaps, barriers, and opportunities for diversion with intercept 0, community services, being identified in prevention efforts such as crisis service,

outreach teams, community mental health programs, and crisis hotlines, including 988.)

3. SCIP Data, Research, and Evaluation Support – Pennsylvania Commission on Crime and Delinquency, Office of Research, Evaluation, and Strategic Policy Development: $350,000
4. Firearm Suicide Prevention, Intervention, and Postvention: $1,000,000
5. Direct Administrative Costs (Pennsylvania Commission on Crime and Delinquency), 10%: $499,163
6. Local Share: Direct Local Pass-Through Project: Competitive Funding Announcement (Local Share Initiatives): $1,449,306
7. Local Share: Under $10K Share Project: Other Under $10K Supported Initiatives: $547,348

The two Local Share funding streams will prioritize funding mobile crisis teams (co-responder and civilian), crisis stabilization services (regional crisis call centers, crisis receiving and stabilization facilities for individuals in crisis, triage services), and community-based programming (non-law enforcement responses like wraparound supports for people who are experiencing a behavioral health crisis). Additionally, recognizing the ongoing behavioral health workforce shortages, funds will be directed toward investing in "efforts to embed advocates and peer navigators within the justice system" (Pennsylvania Commission on Crime and Delinquency, 2025) through the hiring of peer navigators, social workers, and client advocates amongst other positions throughout the justice system.

Three other examples of states' overarching goals for Byrne SCIP awards are given in **Table 9b** (with information pulled from USA Spending, searching for Byrne State Crisis Intervention Program, with some paraphrasing in the descriptive abstracts). As shown, some states have a focus on the courts and ERPOs, and others address a broader array of court-based and mental health-based goals.

Table 9a. Bureau of Justice Assistance (BJA) Byrne State Crisis Intervention Program Funding Amounts, by State

State	2022-2023 Byrne SCIP Funding Amounts	2024 Byrne SCIP Funding Amounts
Alabama	$4,489,140	$2,555,663
Alaska	$1,449,121	$828,934
Arizona	$6,111,652	$3,493,824
Arkansas	$3,210,628	$1,869,465
California	$29,231,074	$16,611,430
Colorado	$4,564,438	$2,650,316
Connecticut	$2,470,247	$1,406,812
Delaware	$1,343,782	$773,651
District of Columbia	$1,503,447	$858,918
Florida	$15,177,934	$8,747,567
Georgia	$7,488,436	$4,348,578
Hawaii	$1,445,832	$828,728
Idaho	$1,634,585	$954,956
Illinois	$9,527,496	$5,427,421
Indiana	$5,116,765	$2,917,156
Iowa	$2,478,792	$1,433,585
Kansas	$2,698,339	$1,551,669
Kentucky	$3,038,438	$1,754,550
Louisiana	$4,501,897	$2,604,221
Maine	$1,234,695	$710,927
Maryland	$5,124,825	$2,887,797

Massachusetts	$4,983,728	$2,831,825
Michigan	$7,945,884	$4,573,367
Minnesota	$3,723,326	$2,157,199
Mississippi	$2,340,019	$1,339,578
Missouri	$5,459,025	$3,136,343
Montana	$1,387,530	$812,352
Nebraska	$1,813,568	$1,046,684
Nevada	$3,088,478	$1,755,528
New Hampshire	$1,306,219	$746,744
New Jersey	$5,317,826	$3,048,279
New Mexico	$2,853,074	$1,633,050
New York	$13,313,053	$7,629,061
North Carolina	$7,619,902	$4,442,690
North Dakota	$644,469	$370,436
Ohio	$7,621,174	$4,376,094
Oklahoma	$3,557,418	$2,045,942
Oregon	$3,127,544	$1,798,179
Pennsylvania	$8,548,557	$4,991,633
Rhode Island	$1,213,223	$698,613
South Carolina	$4,676,129	$2,709,287
South Dakota	$1,268,512	$736,391
Tennessee	$6,722,537	$3,891,486
Texas	$21,246,509	$12,324,824
Utah	$2,421,967	$1,411,492
Vermont	$644,469	$370,436

Virginia	$5,081,671	$2,919,856
Washington	$5,245,397	$3,019,496
West Virginia	$1,755,887	$1,002,234
Wisconsin	$4,166,354	$2,392,048
Wyoming	$644,469	$370,436
TOTAL	$253,579,481	$145,797,751

Table 9b. Three Examples of States' Overarching Goals for Their FY 2022–2023 Byrne SCIP Awards

Colorado Department of Public Safety: $4,564,438
Project description goals for Colorado's Byrne SCIP grant funded activities are: Colorado's SCIP funded activities will increase professional petitioner use and understanding of the appropriate use of ERPOs across Colorado from 60 per year to 240 per year (+400%), by September 30, 2026; Colorado's SCIP-funded activities will mitigate gun violence in the most impacted communities in Colorado by increasing the capacity of at least 40 community-based organizations, specialized court programs, and law enforcement agencies to implement community violence intervention, crisis intervention, behavioral health deflection, treatment services, and gun safety programs or initiatives, by September 30, 2026. Colorado will use most of the 60% "state share" of its SCIP award for noncompetitive subawards to the Office of the Attorney General for two ERPO projects: (1) law enforcement ERPO training and curriculum, and (2) preventing gun deaths through ERPO expansion and education; to the Office of Gun Violence Prevention for crisis intervention, awareness, education, and training, and to increase access to and utilization of mental health services and ERPOS: SERVE (strengthening education, response, and violence-prevention efforts).
Michigan Department of State Police: $7,945,884
To reduce the prevalence of gun violence in the state of Michigan, the Michigan State Police (MSP), Grants and Community Services Division (GCSD) will administer the Byrne SCIP through awards focusing, at a minimum, on the following topics: (1) parent, youth, and victim services firearm violence reduction education and outreach; (2) judicial threat assessment training; (3) healthcare behavioral threat assessment training; and (4) ballistic identification technology projects with law enforcement, prosecutor, healthcare, behavioral health, and community partners. Spurred by the tragedy of the fatal shooting at the Oxford Community Schools late in 2021, Michigan students, families, and those within the educational, public safety, and mental health communities have engaged in a number of efforts designed to prevent, respond, and recover from firearm violence. The MSP will initiate FY 2022–2023 Byrne SCIP projects in two subgrant phases to fund the first three of these. Phase 1 of the subgrant process coincides with MSP'S initial application and includes early proposals for sub-awardees for BJA approval to streamline project implementation. Specifically, MSP solicited project proposals for some of its intended sub-awardees with an established presence in gun violence harm reduction throughout the state in preparation for the FY 2022–0223 Byrne SCIP application package. These initial proposals were reviewed for alignment with the BJA'S program solicitation and the project's scope of work. In Phase 2, additional awards will be solicited through follow-up work with the evaluator and identification of community organizations ready and prepared to develop and implement a program focusing on identified needs. Organizations will be asked to look into comprehensive programs with multidisciplinary and multi-agency partnerships that address gun violence issues specific to their communities. Community agencies will be asked to form partnerships with their local government to serve as the fiduciary and ensure buy-in for the proposed initiatives.
Texas Office of the Governor: $21,246,509
In accordance with the Bipartisan Safer Communities Act established by S. 2938, the Public Safety Office (PSO) of the Texas Office of the Governor will utilize Byrne SCIP funds to further its mission of administering needed resources to those who are committed to interpersonal violence intervention, crisis intervention, and those who provide essential crisis and support services to at-risk populations within our communities. Through this mission, PSO will bolster programs that utilize evidence-based approaches to expand mental health services and address behavioral health system and service gaps, especially within the most rural communities, to help make the State a safer place for all Texans. The State of Texas' Byrne SCIP funds will be directed towards the following funding priorities: interpersonal violence prevention and intervention programs. State priority areas include: (1) domestic violence courts that hold individuals accountable (pre- and/or post-adjudication) and domestic violence high-risk teams; (2) training for investigators, prosecutors, and judges on the dynamics of interpersonal violence, and the enhancement of current domestic violence protection order infrastructure; (3) crisis intervention programs including crisis screening response services for individuals experiencing a mental health crisis or psychiatric episode; (4) community-based crisis facilities that offer assessment, support, and services to individuals with behavioral health needs to reduce emergency room or jail utilization, and specialized services for youth with trauma and serious mental illness and their families; and (5) expansion of mental health services to include mobile crisis outreach teams, crisis facilities, specialized counseling approaches, and peer support specialists.

Summary/Synthesis

Our policy analysis examined nine federal mechanisms by which states, during 2014–2024, could leverage funding to expand and enhance (or just sustain) crisis services. This analysis revealed five major conclusions that inform a series of recommendations for local providers, state governments, and the federal government.

1. Medicaid Billing/Reimbursement Represents a Major Source of Funding for Crisis Services

Medicaid billing is a key funding stream of many crisis services. Although crisis intervention and hotline services billing codes such as H0030 exist, claims-based reimbursement is largely not relevant to the first foundational element of an integrated crisis care system (*Someone to Contact*, meaning services like 988 and other behavioral health hotlines that provide immediate, accessible support) because anonymity is generally a core element of crisis lines. However, it is increasingly relevant to the second (*Someone to Respond*, primarily meaning MCTs that deliver rapid, on-site interventions to de-escalate crises and connect individuals to care) using codes like H2011 and S9484, and it is essential to the third (*A Safe Place for Help*, meaning a wide array of stabilization services for behavioral health crisis and emergencies where people can receive immediate treatment and support; namely, crisis receiving and stabilization facilities) using codes like S9485 (Blyler et al., 2025). As several Medicaid state plan amendments (SPAs) have shown, Medicaid billing is also increasingly pertinent to *crisis respite* (which is featured in a number of Medicaid Section 1915(c) HCBS waivers) and *crisis residential services*, and even *crisis transportation*.

Most, but not all, state Medicaid programs offer some form of coverage for MCTs, though specific MCT services reimbursed by Medicaid vary widely across states, influenced by factors like crisis service definitions, provider qualification criteria, and state-specific Medicaid billing policies (Anderson and Jorem, 2025). Codes for billing (e.g., 15-minute codes like H2011) are unlikely to cover all costs (uniforms, vehicles, gas for vehicles, etc.). Partly for this reason, local/county mental health authorities sometimes cover the cost entirely. However, there are codes for crisis intervention with transportation and crisis intervention without transportation. Further, some states use per diem rates with follow-up for up to 60–90 days. Some states code up to 3 hours.

According to a report from the Assistant Secretary for Planning and Evaluation, "as of 2022, 33 state Medicaid programs covered mobile crisis teams, 28 covered crisis receiving and stabilization facilities, and 12 covered crisis call center (hotline) services; however, only 12 states covered all 3 of these services" (Edmonds et al., 2025). As detailed in Chapter 1, Medicaid SPAs represent an important approach to expanding and enhancing crisis services by better leveraging Medicaid claims-based reimbursement. The impact will vary based on the state's characteristics. That is, the extent of the impact of two SPAs that might look very similar, in two different states, varies by state-specific factors including the percentage of individuals served by the SMHA that have Medicaid coverage, the extent to which crisis services are embedded within Medicaid-billing organizations (as opposed to, for example, co-response programs embedded in law enforcement agencies), whether or not MCT and CSU services are already established in the state plan as a Medicaid benefit, and if so, the extent to which mobile teams and CSU staff provide billable services (e.g., by staff who can bill). SMHAs have to rely on the State Medicaid Agency to prepare and submit a SPA, and it is likely that State Medicaid Agencies have varying levels of bandwidth to prepare SPAs, especially for small enhancements that might have a relatively low impact. Additionally, stability of federal Medicaid policy will be important for continued implementation (i.e., states will be reluctant to take on new responsibilities if federal support is inconsistent/unreliable). Also importantly, it must be acknowledged that expanding Medicaid and CHIP payment for services still excludes a large portion of the population who are not eligible for Medicaid or are not covered by Medicaid. Nonetheless, fully optimizing Medicaid billing is one approach to expand and enhance crisis services, especially given that a survey of MCTs suggested that only 63% reported billing, with 37% relying solely on non-insurance funding (Odes et al., 2024).

We identified 115 SPAs during 2014–2024 that likely positively impacted crisis services by expanding or enhancing the way that crisis services can be billed and reimbursed by Medicaid. Some crisis services-related SPAs were deemed "Low Impact" (61 submitted by 33 states), which made small adjustments to crisis services or made broader adjustments that would have had a small impact specific to crisis services. Other important but relatively "Low Impact" SPAs amended the state's Medicaid plan by, for example: updating provider qualifications, adding peers or other types of personnel as billing providers of crisis services, adding clinic-based crisis intervention services that can go into the community, revising the definitions of

crisis response or crisis stabilization, and revising rates for crisis receiving or crisis residential services. An additional 22 SPAs, submitted by 17 states, were deemed to have a "Medium Impact" by, for example, updating mobile crisis standards to meet the qualifications for the enhanced FMAP made available by ARPA, adding coverage of CCBHCs (which have a mandate for crisis services among their array of services provided), and adding children's crisis services.

Some 32 SPAs, submitted by 26 states, were deemed "High Impact" by adding MCT and/or crisis stabilization centers as a Medicaid-reimbursed benefit during the 2014–2024 timeframe; three added crisis transportation. These "High Impact" SPAs are the essential first step toward Medicaid billing, with subsequent Medium or Low Impact SPAs making further enhancements to billing processes by adding more provider types, revising rates, and the like. As described in Chapter 2, we did not identify specific Children's Health Insurance Program (CHIP) SPAs that had a system impact above and beyond Medicaid SPAs enacted concurrently, though two did expand coverage of crisis services for CHIP beneficiaries.

In addition to amending a state Medicaid plan to optimize billing opportunities for crisis services, CMS also provides the opportunity for states to innovate around service delivery through 1115 demonstration waivers. We identified eight 1115 demonstration waiver programs that expanded or enhanced crisis services, summarized in Chapter 3. For example, Alaska's Behavioral Health Reform 1115 demonstration waiver, aiming to reduce over-reliance on acute, institutional care and shift to more community-based services—and the District of Columbia's Behavioral Health Transformation 1115 demonstration waiver—provided for mobile crisis services, crisis observation and stabilization, and crisis residential services. District of Columbia SPA DC-21-0010 allowed the District to transition its 1115 program services to permanent State plan authority. Oregon's 1115 used Designated State Health Programs to bring federal dollars into its crisis system, while also applying for the ARPA enhanced FMAP for mobile crisis services to enhance its mobile crisis response. Other examples are given in Chapter 3.

Finally, 1915(c) HCBS opportunities allow states to focus on the health needs of distinct patient populations at risk of institutional care. We identified 12 such state HCBS waivers, described in Chapter 4, focused in this case on youth at risk of psychiatric hospitalization or Psychiatric Residential Treatment Facility (PRTF) admission. With HCBS services such as crisis respite, states can strive for hospital and PRTF diversion—lower-cost care in a less restrictive setting—through stabilization in the community.

While additional recommendations are given in the pages that follow, an overarching recommendation in this area is: *Because Medicaid billing/reimbursement represents a major source of funding for crisis services that has not been fully optimized by some states, local providers and SMHAs/State Medicaid Agencies should optimize all Medicaid billing/reimbursement opportunities across the spectrum of crisis services.*

2. Crisis Services Have Been Expanded through the Implementation of CCBHCs

The establishment and dissemination of Certified Community Behavioral Health Clinics (CCBHCs) represents a major move forward for community mental health services in the U.S. Given that one of nine required CCBHC service categories is *crisis behavioral health services* (including MCT and crisis receiving/stabilization access), states' and provider organizations' leveraging of federal (SAMHSA and CMS) funding streams for CCBHC expansion undoubtedly has improved crisis services accessibility. Taken together, there are now more than 500 CCBHCs across state certification and grantee programs (i.e., some are certified by the state and receive special Medicaid payments through their state's CCBHC Medicaid initiative, some receive only expansion grant funds, and some are both state certified and expansion grantees), in 48 states and territories, with billions of federal dollars invested over the lifetime of the Demonstration and expansion grant programs.

Research has shown that CCBHCs are significantly more likely than non-CCBHC outpatient mental health facilities to offer crisis services (Wishon and Brown, 2023). Other work finds that CCBHCs receiving special Medicaid payments—compared with those solely designated as CCBHCs through one or multiple expansion grants—were more likely to have added mobile crisis response and crisis stabilization services, suggesting that these payment mechanisms may serve as a lever for expanding such crisis services (Mauri et al., 2025a). At the same time, research demonstrates that CCBHCs frequently rely on DCOs and other partnership arrangements to coordinate with existing providers within the crisis continuum. For instance, studies have found that CCBHCs often collaborate with law enforcement (Mauri et al., 2025b), and that DCOs are most commonly used in the area of crisis services relative to the eight other required CCBHC service categories among Section 223 CCBHCs (Brown et al., 2022).

Some states have leveraged more CCBHC funding across the 2014–2024 time period than others, which is detailed in Chapter 5. For example, California, Colorado, Connecticut,

Florida, Iowa, Illinois, Indiana, Kansas, Kentucky, Massachusetts, Maryland, Michigan, Minnesota, Missouri, North Carolina, New Jersey, New York, Ohio, Oklahoma, Pennsylvania, Texas, and Washington—and provider organizations in those states—have received multiple grants, ranging in total funding from $32,017,756 in Maryland to $307,134,333 in New York. Five states leveraged more than $100 million in funding for CCBHC expansion: Massachusetts ($110,936,560), New Jersey ($115,060,082), Texas ($127,101,179), Michigan ($192,782,363), and New York (as noted, $307,134,333). Obviously, these numbers do not include actual Medicaid billings via PPS and other payments. Other states and provider organizations in states have received grants only in more recent years (e.g., Arizona, the District of Columbia, Delaware, Hawaii, Idaho, Louisiana, Montana, New Hampshire, Utah, Wyoming), or not at all (North Dakota, South Carolina, and South Dakota).

Unlike most state-licensed community mental health centers and related mental health clinics, "CCBHCs must meet rigorous criteria for providing a comprehensive range of high-quality, safety net services for mental health and substance use crises and continuing care, to support their communities and community crisis systems" (National Council for Mental Wellbeing, 2024a). As such, crisis services are "baked into" the CCBHC model. Thus, as CCBHCs expand in reach, so too will their crisis services.

The advent and evolution of CCBHCs also represents an approach to optimizing Medicaid billing/reimbursement of crisis services, consistent with the prior point about Medicaid being a major source of funding for crisis services. Under the CCBHC Demonstration, participating states must select from among four prospective payment system (PPS) rate methodologies to reimburse CCBHC providers a clinic-specific rate that pays the expected cost of delivering CCBHC services (CMS, 2024b). Moving away from the traditional fee-for-service model, PPS-1 pays the expected cost of providing CCBHC services on a daily basis with optional quality bonus payments (QBPs). PPS-2 pays the expected cost of providing CCBHC services on a monthly basis, with required outlier payments and QBPs, and optional special population rates. The new PPS-3 option mirrors PPS-1 daily rates except that PPS-3 now requires daily Special Crisis Services (SCS) rates, which allows states to set separate PPS rates for crisis services. SCS rates may be set for one or more of the following: (1) mobile crisis services that meet the criteria as authorized under section 9813 of ARPA, (2) mobile crisis services that do not meet the qualifying criteria of section 9813, and (3) on-site crisis

stabilization services. PPS-4 is similar to PPS-2, but now also requires the new separate monthly SCS rates (CMS, 2024b).

An overarching recommendation in this area is: *Because crisis services have been expanded through the implementation of CCBHCs and prospective payment opportunities, SMHAs should ensure optimal distribution/coverage of CCBHCs to serve population needs—as well as optimal approaches to billing—which will help to optimize crisis services coverage.*

3. Federal Planning Grants and Cooperative Agreements to States Have Helped in Expanding and Enhancing Crisis Services

As part of the American Rescue Plan Act of 2021 (ARPA), CMS provided 20 states with planning grants for crisis services. A total of $15,000,000 was allocated—an average of $750,000 per state—with grants ranging from $381,331 to $953,336, as detailed in Chapter 6. The goal of the planning grants was to expand states' ability to offer community-based mobile crisis intervention services. The funding supported State Medicaid Agencies in assessing the needs of their communities and creating sustainable mobile crisis services. This could be done through the development of state plan amendments, Section 1115 demonstration waivers, or waivers under Section 1915 that address community-based mobile crisis assistance. The planning grants helped states prepare for the requirements under ARPA that would allow for a temporary enhanced Medicaid match rate of 85% for community-based mobile crisis services between the period April 1, 2022 and March 31, 2027 for up to 12 fiscal quarters.

Similarly, in terms of the federal government supporting planning and crisis expansion efforts, SAMHSA's 2022 Cooperative Agreements for Innovative Community Crisis Response Partnerships allowed for an estimated $9,000,000 for 12 awards to states, counties, tribal organizations, health facilities, or other public or private non-profit entities (SAMHSA, 2022c) "to create or enhance existing mobile crisis response teams to divert adults, children, and youth experiencing mental health crises from law enforcement in high-need community(ies). This program recognizes a high-need community as a community where mobile crisis services are absent or inconsistent, where most mental health crises are responded to by first responders, and/or where first responders are not adequately trained or equipped to diffuse mental health crises" (SAMHSA, 2022c). As summarized in Chapter 7, a total of 25 Cooperative Agreements

were funded, most at about $750,000, 12 in FY 2022 (for 9/30/2022 through 9/29/2026) and an additional 13 in FY 2023 (for 9/30/2023 through 9/29/2027).

These planning grants (like the ones from CMS) and cooperative agreements (like the ones from SAMHSA) that focus specifically on expanding and enhancing crisis services provide states, counties and local communities, and local provider agencies with funding to carry out the due diligence of planning, as well as actual implementation and expansion, all of which are key to a comprehensive crisis care continuum.

An overarching recommendation in this area is: *Because federal planning grants and cooperative agreements to states have helped in expanding and enhancing crisis services, federal agencies should consider additional planning grant and cooperative agreement opportunities that prioritize areas of needed enhancement and sustainability of crisis services as the crisis service environment evolves. Grants and cooperative agreements for planning should shift to grants and cooperative agreements for implementation, evaluation, and sustainability.*

4. The Annual SAMHSA Mental Health Block Grant Provides a Baseline, though Minimal, Level of Support for Crisis Services

SAMHSA provides a yearly Mental Health Block Grant (MHBG) to states—the amount computed annually based on a formula that takes into account the size of the state's population needing services, the cost of services in the state, and the state's fiscal capacity—for spending on community-based mental health services for those with SMI and SED. States can be flexible in the use of funds for both new and unique programs or to supplement their current programs. As detailed in Chapter 8, the SAMHSA MHBG represents a very small percentage of a state's total mental health spending: approximately 0.44% to 5.30% across the states, with the average across the 51 states being approximately 1.67%.

The MHBG was much larger in 2021 because ARPA directed SAMHSA to provide an additional $1.5 billion in funding to support states in addressing the effects of the COVID-19 pandemic for Americans with mental illnesses and SUD. Furthermore, SAMHSA was directed by Congress through the Consolidated Appropriations Act of 2021 and the Coronavirus Response and Relief Supplemental Appropriations Act of 2021, to set aside 5% of the MHBG allocation for each state to support evidence-based crisis systems, though nothing precludes states from utilizing more than 5% of their MHBG funds for crisis services for individuals with SMI or

children with SED. It should be recognized, however, that the 5% set-aside for crisis services, while a promising step forward in terms of dedicated crisis services funding, represents a remarkably small percentage of total mental health spending: about 0.04% to 0.41% across the states, with the average across the 51 states being approximately 0.14% (Chapter 8). States' spending on mental health services goes disproportionately toward high-cost interventions like psychiatric hospitalization, costs that deeper investments in crisis services could reduce.

An overarching recommendation in this area is: *Because the annual SAMHSA Mental Health Block Grant provides relatively minimal support for crisis services, additional appropriations should be provided to further support states in expanding and enhancing crisis services.*

5. Aside from CMS and SAMHSA, Other Federal Agencies Can Play a Role in Expanding and Enhancing Crisis Services

The Bipartisan Safer Communities Act of 2022 was signed into law on June 25, 2022 by President Biden. The U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Assistance (BJA) created a fund under the Byrne State Crisis Intervention Program (Byrne SCIP) primarily to help support the creation and implementation of extreme risk protection order programs (or "red flag" laws) as well as state crisis intervention court proceedings such as mental health courts, drug courts, and veterans' treatment courts. The grant to states aligns with the Department of Justice mission, at that time, to address gun violence and target risk factors that lead to violence. Crisis-related programs and initiatives that can be covered by the grant include, among others, mobile crisis units (both co-responder and civilian only), regional crisis call centers, crisis receiving and stabilization facilities, and specialized training for law enforcement officers responding to those in crisis. As a federal agency whose primary goal is not one pertaining to health services (but rather to strengthen "the Nation's criminal justice system and helps America's state, local, and tribal jurisdictions reduce and prevent crime, reduce recidivism, and promote a fair and safe criminal justice system;" BJA, 2025), BJA is likely interested in crisis response primarily because the responsibility has too commonly, for too many decades, been relegated to law enforcement rather than the mental health and social services sectors. BJA may also be interested in crisis response because people see SMI as a public safety issue (e.g., the Bipartisan Safer Communities Act was the result of school shootings).

The Byrne SCIP program provided formula funds to implement state crisis intervention court proceedings and crisis-related programs or initiatives: a total of $253,579,481 to states in FY 2022–2023 and an additional $145,797,751 in FY 2024. As detailed in Chapter 9, total amounts (summing grants given in FY 2022–2023 and in FY 2024) spanned from $1,014,905 in North Dakota, Vermont, and Wyoming to more than $20 million: $20,942,114 in New York; $23,925,501 in Florida; $33,571,333 in Texas; and $45,842,504 in California. Although states had flexibility in the spending of funds, some states used funds to bolster crisis response services while also attending to gun-related violence reduction activities.

An overarching recommendation in this area is: *Because other federal agencies, aside from CMS and SAMHSA, have an interest in improving community safety and well-being by promoting effective crisis services, they should consider their role in funding the expansion and enhancement of crisis services.*

Overarching Recommendations

By way of summary, we restate the following overarching recommendations, with more detailed recommendations given below.

Because Medicaid billing/reimbursement represents a major source of funding for crisis services that has not been fully optimized by some states, local providers and SMHAs/State Medicaid Agencies should optimize all Medicaid billing/reimbursement opportunities across the spectrum of crisis services.

Because crisis services have been expanded through the implementation of CCBHCs and prospective payment opportunities, SMHAs should ensure optimal distribution/coverage of CCBHCs to serve population needs—as well as optimal approaches to billing—which will help to optimize crisis services coverage.

Because federal planning grants and cooperative agreements to states have helped in expanding and enhancing crisis services, federal agencies should consider additional planning grant and cooperative agreement opportunities that prioritize areas of needed enhancement and sustainability of crisis services as the crisis service environment evolves. Grants and cooperative agreements for planning should shift to grants and cooperative agreements for implementation, evaluation, and sustainability.

Because the annual SAMHSA Mental Health Block Grant provides relatively minimal support for crisis services, additional appropriations should be provided to further support states in expanding and enhancing crisis services.

Because other federal agencies, aside from CMS and SAMHSA, have an interest in improving community safety and well-being by promoting effective crisis services, they should consider their role in funding the expansion and enhancement of crisis services.

Recommendations to Local Providers, State Governments, and the Federal Government

Here we offer a series of recommendations looking toward the next decade of expanding and enhancing crisis services.

Local Providers

1. Local crisis programs should optimize Medicaid billing (with regard to billing codes, provider types, service requirements, etc.) across the full array of crisis services they provide (e.g., mobile crisis teams, crisis receiving and stabilization facilities, crisis respite, crisis residential services, and crisis transportation). This may require seeking guidance from the SMHA or State Medicaid Agency. SAMHSA funds the Crisis Systems Response Training and Technical Assistance Center (CSR-TTAC), which can also provide support (https://988crisissystemshelp.samhsa.gov/about).
2. Community mental health clinics interested in becoming CCBHCs should work with the SMHA for planning and to ensure that all criteria can be successfully accomplished, including the essential services pertaining to crisis behavioral health services. CCBHCs should fulfill their crisis service requirements in ways that align with the existing crisis continuum within their service area, ideally informed by the community needs assessment. Because the CCBHC criteria allow considerable flexibility in how organizations meet crisis services-related requirements, CCBHCs should be encouraged to tailor their crisis services to address gaps in the local continuum or to support and complement organizations already serving their client populations. SAMHSA funds a National Training and Technical Assistance Center for CCBHCs though the National Council for Mental Wellbeing (https://www.thenationalcouncil.org/program/ccbhce-training-technical-assistance-center/).

State Governments

3. SMHAs should work with State Medicaid Agencies to ensure that crisis services billing opportunities are optimized in the state plan for Medicaid-billing organizations. The full array of crisis services should be made reimbursable,

including mobile crisis response, crisis receiving and stabilization, crisis respite, crisis residential services, and crisis transportation. Targeted state plan amendments may be needed. Similarly, for youth, CHIP state plan amendments may be warranted for children's services requiring updates not captured by the state's Medicaid plan. As reported by Anderson and Jorem (2025), by September of 2024, only 21 states had opted into the enhanced match under ARPA. They note that one potential barrier is variations in volume (which could make it difficult to meet the 24/7 availability requirement for enhanced ARPA funding) as well as billing practices among MCTs both within and between states, which may challenge the sustainability of a fully fee-for-service reimbursement model. Workforce issues are also at play. To move toward more complete billing, SMHAs may need to formalize not only MCTs, but also crisis receiving and stabilization facilities. For example, New York's crisis stabilization centers, crisis respite, and crisis residential services are jointly overseen and licensed by the New York State Office of Mental Health and the New York State Office of Addiction Services and Supports. Two types of crisis stabilization centers are now being established: *Supportive Crisis Stabilization Centers* (SCSCs), which provide a supportive environment for individuals who are experiencing a mental health or substance use crisis but do not require immediate hospitalization; and *Intensive Crisis Stabilization Centers* (ICSCs), which offer all the services of an SCSC, plus access to medication and services for acute symptoms to stabilize the individual and potentially divert them from higher levels of care (New York State Office of Mental Health, 2022).

4. State governments should ensure or organize collaboration and coordination around advancing crisis services. The Office of the Assistant Secretary for Planning and Evaluation recommended that, "To ensure alignment and to identify challenges and common solutions, state and local agencies can support coordination between SMAs; BHAs; MCOs; state regulatory bodies that govern staffing, accreditation, and licensing requirements; and provider organizations. Increased collaboration could help states customize and standardize crisis service definitions and refine Medicaid billing codes, reimbursement rates, and reimbursement structures to meet local provider needs and contexts" (Edmonds et al., 2025).

5. As states develop and submit 1115 demonstration waivers, they should consider the ways in which the waiver might allow for innovation in crisis care delivery and payment. The same is true of other waiver opportunities, including 1915(c) Home and Community Based Services for select patient populations at high risk of institutional care. The 1915(c) waivers that we reviewed expanded access to crisis respite services. (Crisis respite is a short-term intervention strategy for children/youth and their families that helps to alleviate the risk for an escalation of symptoms, a loss of functioning, disruption in a stable living environment, and hospitalization or PRTF admission.)
6. In ensuring adequate coverage of crisis services, SMHAs should consider mapping crisis services delivered separately from CCBHCs, in conjunction with CCBHCs (through Designated Collaborating Organization (DCO) agreements), and those provided directly by CCBHCs. Relevant state agencies in states without a CMS-approved permanent CCBHC initiative should pursue available Medicaid flexibilities—most likely through SPAs, but potentially also via Section 1115 demonstrations—to permanently establish the CCBHC model and a prospective payment system, though the payment could come in another form (e.g., in Texas). Additionally, states implementing a CCBHC special Medicaid payment option should allow participating organizations to include crisis service transportation costs within their cost reports.

The Federal Government

7. Because the enhanced FMAP increased uptake and implementation, Congress should provide additional Medicaid FMAP enhancements, as an incentive for additional crisis services expansion, especially where crisis services are lacking. As recommended by Anderson and Jorem (2025), "states should have the option to extend their state plan amendments for the increased Medicaid match for MCTs beyond the initial three-year period provided by ARPA. Extending this match would secure funding streams and help states develop sustainable infrastructures" (Anderson and Jorem, 2025).

8. Although crisis services are highlighted as a priority in the SMI-focused 1115 initiative established in 2018, CMS should consider targeting crisis services as a 1115 demonstration waiver priority area that could then be taken up by multiple states.
9. CMS and SAMHSA should consider additional rounds of planning grants and/or cooperative agreements that focus specifically on supporting states, counties, and local provider agencies for planning and implementation activities around expanding and enhancing crisis services, especially in areas where the availability of crisis response and crisis receiving/stabilization are limited.
10. Congress should consider increasing SAMHSA's funding to further support states in expanding and enhancing crisis services; this might include increasing the current 5% set-aside to a minimum of 10%.
11. Other federal agencies should consider their role in funding the expansion and enhancement of crisis services. Given the fact that much of community-based crisis response still resides within law enforcement, the Bureau of Justice Assistance (BJA) has a role in funding the expansion and enhancement of crisis services that reside squarely in the behavioral health sector, such as mobile crisis teams. Because of widely recognized workforce shortages impeding the expansion of mobile crisis teams and other crisis services (Compton et al., 2024; Watson et al., 2025a), the Health Resources and Services Administration (HRSA) should provide funding opportunities specific to this shortage area. In light of the need for health services research, implementation/effectiveness research, and comparative effectiveness research, the National Institute of Justice (NIJ) and the National Institute of Mental Health (NIMH) should establish dedicated funding streams and research portfolios to advance rigorous research in the area of crisis services.

Other Considerations

Here we briefly describe several other considerations as local providers, state governments, and the federal government look toward the next decade of expanding and enhancing crisis services.

1. Medicare and private health insurance plans have an untapped role in supporting crisis services.

With regard to CMS, we have focused exclusively on Medicaid and not Medicare. Nonetheless, both Medicare and commercial insurance represent opportunities to expand claims-based reimbursement for crisis services (Blyler et al., 2025). Approximately one in five Americans are covered by Medicaid, though it varies significantly by state (Burns et al., 2025). Whereas Medicaid billing makes use of a number of national procedure codes for crisis services (e.g., H2011: crisis intervention service, per 15 minutes; S9484: crisis intervention mental health services, per hour; S9485: crisis intervention mental health services, per diem, such as for crisis stabilization units) in addition to some state-specific codes, Medicare is limited to two crisis psychotherapy codes (90839 for 60 minutes, with a time range of 30–74 minutes; 90840 add-on code with 90839 for each additional 30 minutes beyond the first 74 minutes). While commercial insurers have the flexibility to use any of the crisis procedure codes, use of the psychotherapy codes (90840 and 90839) is the most common (80.4% of crisis services claims in 2021) (Blyler et al., 2025).

Billing for crisis services is estimated to be more than 10 times higher among Medicaid enrollees than among commercial insurance or Medicare enrollees (approximately 511 claims per 10,000 enrollees in Medicaid, when combining national and state-specific codes, as compared to 19.8 per 10,000 commercial insurance enrollees and only 7.5 per 10,000 Medicare enrollees, excluding Medicare Advantage claims) (Blyler et al., 2025). As such, promoting the use of standardized coding guidelines and requirements for commercial plans to cover crisis services could support a comprehensive, equitable, and sustainable crisis response system.

Commercial insurance coverage of crisis services is limited in scope. With private insurers not generally covering crisis services, states are forced to look to local or state funds to cover those uninsured, or insured but not by Medicaid. Some states have begun to require private

insurance coverage of crisis services through mental health parity legislation or regulatory requirement. Reliance on Medicaid funding alone severely hinders the financial sustainability of services such as MCTs, and braiding from other funding sources can vary from year-to-year due to political shifts, grant expirations, and changes in state appropriations. Additionally, development of local and state agency infrastructure for operating such services may pose additional costs borne only through Medicaid. A sustainable crisis system requires predictable reimbursement, which the current structure does not provide. Despite Medicaid being the primary insurance financer of MCTs, patients covered by commercial insurance or Medicare can still receive equivalent service without equivalent reimbursement (Huber et al., 2023), again with costs borne by Medicaid or other public funding sources. Commercial insurers, Medicare, TRICARE (active duty and retired service member insurance), and large group plans do not regularly cover mobile crisis services, only covering "Psychotherapy for Crisis." Gaps in funding are expected to increase with more calls to 988 and with MCTs needing to respond to some of those calls (State Health and Value Strategies, 2021).

Commercial insurance coverage generally follows the lead of Medicare. If Medicare were to increase the number of crisis billing codes, such as bundled payment codes (e.g., S9485, as above) or specific crisis codes used in Medicaid (e.g., S9484 or H2011), it would set a precedent for commercial insurance to then be positioned to cover crisis services in their plans. The larger issue is that Medicare is not within the influence of state or local agencies to enact meaningful change or influence what services are reimbursed. But there are ways for Medicare to increase coverage beyond the currently limited "Psychotherapy for Crisis" CPT codes. (CPT (Current Procedure Terminology) codes are five-digit numeric billing codes used for medical procedures and services performed by healthcare professionals.) New Medicare billing codes are needed, beyond codes for general psychiatric diagnostic evaluation and Evaluation and Management (E/M) codes used for outpatient psychiatry visits.

State and local agencies can engage commercial plans to support crisis services through advocating for the development of universal codes that align better with commercial billing than the Healthcare Common Procedure Coding System (HCPCS) used by Medicare and Medicaid. (HCPCS codes are alphanumeric codes used for medical supplies, products, and services not covered by CPT, such as durable medical equipment, ambulance services, and drugs. Level I codes are identical to CPT, whereas Level II identifies services not in the CPT system, which is

often used for Medicaid billing. HCPCS is used by CMS to provide a systematic way of identifying and classifying services for billing purposes.) Another issue pertains to the need to simplify the credentialing process so providers of crisis services can contract with more commercial plans. SMHAs should provide agencies that offer crisis services with technical assistance on how to join commercial insurance networks and how to submit claims. Agencies that offer mental health services may only have experienced credentialing with government payors. The processes can be quite different and many agencies may not have back-office sophistication without technical assistance and support.

In order to force commercial plans to cover crisis services, states such as Utah, California, and Washington have passed legislation that makes it necessary for commercial insurers to cover emergency behavioral health services. California's landmark Senate Bill 855 adds MCTs and crisis stabilization centers within mental health parity requirements. This means that crisis services are covered like they are for other types of medical emergencies (Steinberg Institute, 2025). Washington's E2SHB 1688 Bill requires private health plans to cover emergency behavioral health services with no prior authorization, including MCTs and crisis stabilization units or crisis triage facilities (Washington State Health Care Authority, 2022). In Michigan, Blue Cross Blue Shield and the Blue Care Network expanded coverage for crisis care services to commercial members in November 2022 and Medicare Advantage members in January 2024. These services include psychiatric urgent care, mobile crisis assessment for adults and children (with a mobile unit that can route to a home, office, or emergency department), crisis stabilization (24/7 recovery-oriented crisis center) and residential crisis treatment (short-term residential crisis treatment for adults) (MI Blue Daily, 2023).

Policy approaches—like including crisis services as part of states' definitions of essential health benefits (Purtle et al., 2025)—should be considered. State Health and Value Strategies (2021) recommended a hybrid funding model—more precise than the common "braided" or "patchwork" approach—"that provides mobile crisis providers with a consistent and steady stream of funding to ensure they are able to maintain 24/7 availability and respond in a timely manner to all individuals in crisis, regardless of insurance status." Specifically, mobile crisis providers would receive: "a set amount or base funding that allows them to maintain continuous coverage; and third-party insurance reimbursement for services rendered to commercially covered individuals and Medicaid enrollees" (State Health and Value Strategies, 2021). States

could make “base payments to mobile crisis providers to maintain continuous coverage in between calls for assistance by allowing them to use funds to: cover fixed operating, personnel, and administrative costs; support training and workforce development; purchase tablets and other technology; and subsidize the cost of providing services to uninsured individuals” (State Health and Value Strategies, 2021). States may need to impose assessment charges on insurers and/or implement 988 telecommunication fees. (Regarding the latter, as of January 2025, 10 states had adopted a 988 telecommunication fee: Washington, Oregon, California, Nevada, Colorado, Minnesota, Virginia, Maryland, Delaware, Vermont (Purtle et al., 2025), and this number is expected to rise.) With regard to reimbursement, states would need to add crisis services to the essential health benefit, as detailed by State Health and Value Strategies (2021), enforce mental health parity, and ensure network adequacy for mobile crisis services.

Commercial insurance should be paying for crisis services, under any credible application of the Mental Health Parity and Addiction Equity Act (MHPAEA). Almost all commercial insurance pays for crisis care in physical health, so it would be very difficult to imagine how they would be complying with the law while not reimbursing for mental health crisis care. HCPCS codes—and even some CPT codes—for crisis mental health care are available. Perhaps the biggest challenge is that many mental health crisis providers are not accustomed to billing commercial insurance, so they would need to get in networks and get used to billing. To ensure that crisis services are billed and reimbursed accurately and fairly, more training and technical assistance are needed for providers and health plans in both public and private sectors.

MHPAEA also applies to reimbursement rates, and MHPAEA-compliant coverage and reimbursement for crisis services could pay substantially more than what Medicaid pays; as such, mental health crisis care could be not only sustainable, but actually result in a bit of profit allowing for further expansion. Ultimately, mental health crisis care should be financed in the same way as physical health emergency care. It should be noted that there are some legislative proposals that seek to create better coding and reimbursement schemes for crisis care in Medicare, which would make it easier for commercial insurers and Medicaid to follow suit than with HCPCS codes alone. Researchers and policymakers focusing on Medicare and commercial insurance should address these and other potential opportunities to increase claims and reimbursement for crisis services.

It should be noted that the implementation of H.R. 1 under the second Trump Administration will result in significant cuts to Medicaid for states and many people losing insurance; thus, programs will need to provide more unreimbursed care. Expanding Medicare and commercial coverage for crisis services will help mitigate this very significant new challenge to programs that offer crisis services as states have to absorb the decrease in Federal funding.

2. Crisis services should be conceptualized and implemented with an explicit commitment to racial equity and other equity goals.

While our focus is policy analysis at the state level rather than research involving individuals or groups of individuals in programs or communities, this work is inherently tied to efforts to advance health equity for all Americans, including Black Americans and other racialized or minoritized groups who have suffered prominently at the hands of police/law enforcement, especially when law enforcement has functioned in the role of crisis response (Rafla-Yuan et al., 2021; Balfour et al., 2022). The complex societal re-imagining and restructuring that will nearly completely shift crisis response from the criminal justice sector to the mental health and social services sector will advance racial equity and health equity. There is promise, now, to reduce mass incarceration of Black Americans, and in particular those experiencing a mental health crisis or an exacerbation of a mental illness; there is promise, now, as well to reduce mass incarceration of individuals with mental illnesses in general. The promise can only be fully realized when states—every state—fully expand and enhance crisis response services and systems leveraging the available federal mechanisms among other funding streams. As programs are put into place, they should be conceptualized and implemented with an explicit commitment to racial equity (e.g., conducting racial equity impact assessments before implementing interventions to determine the potential to worsen disparities or cause unintentional harm) (Balfour et al., 2022; Goldman and Vinson, 2022; Jackson and Edwards, 2025). Additionally, other equity commitments should focus on individuals with disabilities, universal language access, deaf/hard of hearing, intellectual and developmental disabilities, veterans, tribal communities, and LGBTQ+ communities. Finally, the specific needs of immigrants must be considered, especially in a context in which contact with police could result

in U.S. Immigration and Customs Enforcement (ICE) involvement and deportation, even if the individual has a legal status.

3. Financing innovations need to be considered for crisis services.

Value-based payment models (which tie a portion of reimbursement to quality measures) have not been applied to crisis services in the way they have for other healthcare services. Agreed-upon quality metrics would be needed to evaluate whether crisis systems are achieving their goals and to identify opportunities for improvement (Purtle et al., 2025). And while fee-for-service remains the "dominant financing model for crisis services in Medicaid, some states have adopted alternative payment models for crisis care that tie payment to specific conditions, care episodes, populations, and/or quality measures" (Purtle et al., 2025).

4. Additional innovation in crisis services may be needed for rural and remote areas.

There has been a prominent increase in MCTs during the past decade, but not all areas have access, and not all teams are 24/7. Similarly, there has been an increase in crisis receiving and stabilization facilities, but there remains limited access especially in rural and remote areas where long travel distances and low population density create challenges in comparison to urban areas. Targeted planning, innovation, and demonstrations should be supported in order to ensure that crisis services are available and accessible across all parts of the country. Telehealth may be particularly important in such areas (SAMHSA, 2025c).

5. Additional innovations are needed for children and adolescent crisis services.

New approaches have been developed for youth crisis services, generally with a focus on stabilizing in the home/at school rather than removal to crisis stabilization. Mobile Response and Stabilization Services (MRSS) is "a specific kind of mobile crisis service and stabilization service for children and youth with behavioral health conditions. It is an upstream intervention for children and youth that are beginning to experience an acute behavioral health issue and are in crisis. This evidence-based service can help prevent unnecessary emergency department utilization and hospitalization" (Lav and Lewis, 2022). The model has "goals, standards, metrics, and expected outcomes. It is essential to have the infrastructure necessary to support high-quality

MRSS implementation" (Vanderploeg et al., 2023). Additional evolution of youth crisis services is needed, as exemplified by increasing flexibility for MCTs to provide extended wrap-around services.

6. More attention is needed on crisis transportation as an element of crisis services.

Law enforcement historically has been heavily involved in transportation stemming from a community-based crisis response. Even when the mobile crisis response is provided by behavioral health providers, it is not uncommon for law enforcement to be the sole provider of transportation to an emergency department or other crisis receiving and stabilization facility (in particular, when the client is being considered for involuntary civil commitment). This means that crisis clients are placed in the back of a police car, often handcuffed (Balfour et al., 2022). Even when no criminal charges are laid, this represents an unjust facet of criminalization of individuals with mental illnesses, heavily associated with stigma, as well as fear, embarrassment, lack of dignity, and even potential for injury. Although we identified three Medicaid SPAs that made crisis transportation (by crisis transportation professionals rather than law enforcement) a Medicaid reimbursable service, we rarely encountered crisis transportation cited as a key element of crisis services across the other federal funding mechanisms.

While using law enforcement for transportation during involuntary civil commitment is commonly assumed to be required by state law, only seven states bar non-law enforcement transportation under any circumstance during the process (Swartz et al., 2025). In the other 43 states and the District of Columbia, non-law enforcement entities may transport in at least some circumstances. Statutory amendments may be needed, budgetary issues would need to be considered, and in most places, and a cultural change would need to take place (Swartz et al., 2025).

7. A competent, well-trained crisis response workforce is needed.

There is a need for more providers (e.g., people to staff MCTs). The potential impacts of additional funding will not be realized without a sufficient workforce (this is also a major issue in the 988 call center space). The need for program and policy strategies to enhance the workforce in crisis care have been detailed (Compton et al., 2024, Watson et al., 2025b), and ongoing work has elaborated the values, competencies, and skills needed for a community

behavioral health crisis response workforce (Watson et al., 2025a), with many workers not necessarily requiring a master's (or even bachelor's) degree or a clinical licensure. Strategies for recruitment, retention, and support are needed (SAMHSA, 2025c).

8. Research with a national landscape lens is warranted, across the array of crisis services.

More information is needed on the exact models of mobile crisis response, how they are funded, how much they cost, core interventions, staffing, what is the gold standard in terms of quality metrics, and the regulatory/policy framework of SMHAs. An initial national survey of mobile crisis teams has been conducted (Goldman et al., 2023), several national reports have been produced by NRI (NRI, 2025a; NRI, 2025c), and a second national survey of mobile response programs is currently underway (Pope et al., 2025). Ongoing research will be needed as MCTs continue to be expanded and enhanced across the nation. Similar work will then be needed to understand the national landscape with regard to crisis receiving and stabilization facilities, crisis respite, crisis residential services, and crisis transportation.

9. Investments across the behavioral health continuum of care will reduce the need for crisis services.

If the goal is to both address and prevent crises, then policymakers, program planners, and funders need to ensure that everyone has access to a full continuum of behavioral health services, including but not limited to crisis services, for both youth and adults.

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