

# Improve Behavioral Health Crisis Systems

Cost Driver Targeted: Inpatient/emergency department utilization

## OVERVIEW

The United States has created an organized system of care to meet the needs of those experiencing a physical health crisis. Individuals may call a dedicated national number (9-1-1) that will dispatch an ambulance to take them to a hospital emergency department (ED), where a team of clinicians will be activated to immediately address their needs. The current system, however, often fails to serve those experiencing a behavioral health crisis. In this case, an individual may call 9-1-1 or one of hundreds of other behavioral crisis lines and may end up “boarded” in an ED or sent to a crowded jail. Either path often sustains or escalates the behavioral health crisis for the individual. This is not only harmful and ineffective but also unnecessarily costly.

As a better option, states could create a crisis response system for behavioral health that is as robust and effective as our physical health emergency response system. Congress has recently taken a series of legislative actions that create new opportunities for states to improve the behavioral health crisis infrastructure at the state level, including:

- In 2020, Congress designated 9-8-8 as the universal telephone number for the national suicide prevention and mental health crisis hotline system. This number will go live in July 2022.
- Also in 2020, Congress set aside 5 percent of the Mental Health Block Grant to advance crisis care in states, resulting in the recent award of \$75 million to states for this purpose.



- As part of the American Rescue Plan Act (ARPA) in 2021, Congress authorized an enhanced federal medical assistance percentage (FMAP) of 85 percent for Medicaid funding of mobile crisis response teams. Additionally, the Centers for Medicare and Medicaid Services (CMS) awarded \$15 million in grants to states to develop their mobile response capacity.
- The ARPA also increased funding for home- and community-based services that could be used by states to support crisis services development.

As a result, there is an extraordinary alignment of policies and investments to create a meaningful, functioning behavioral health crisis system. State efforts to strengthen behavioral health crisis systems have the potential to improve the patient experience of care, advance population health, and bend the cost curve for all state residents, including the commercially insured population. Although behavioral health crisis services have been financed primarily by public sources to date, privately insured individuals account for substantial proportions of [inpatient discharges for behavioral health conditions](#) (26.9% of discharges from community hospital psychiatric units and 30.2% of discharges from “scatter beds,” referring to beds serving patients with behavioral health conditions on general medical/surgical units). Privately insured individuals also comprise an estimated [34.5 percent of people](#) with serious mental illness, suggesting that commercially insured individuals make up a substantial portion of the population that would likely benefit from a crisis system.

As states design and implement programs to meet the emergent behavioral health needs of their residents, they should design programs [following guidelines](#) from the Substance Abuse and Mental Health Services Administration (SAMHSA). The guidelines were developed to serve anyone, anywhere, at any time, regardless of payer. They define the three major components for a crisis system, which include:

- regional crisis call center capacity that is clinically staffed 24/7 and can provide risk assessment, engage individuals at imminent risk of suicide, and coordinate crisis care in real time

- a crisis mobile response team that can provide emergency mental health evaluation and crisis services in the field
- crisis stabilization facilities that can provide short-term (under 24 hours) observation and stabilization services in a nonhospital environment.

## KEY STEPS IN DESIGN AND IMPLEMENTATION

**Secure sustainable, multipayer financing.** Historically, states have braided different public funding sources to develop and operate the crisis infrastructure. These resources typically included some combination of SAMHSA funds, Medicaid, local dollars, and private funds, with Medicare and commercial payers conspicuously absent. As of May 2021, bills had been [introduced in 20 states](#) to fund local crisis hotlines in the 9-8-8 network. [In Utah, legislation](#) was recently enacted requiring the Medicaid agency to submit a waiver or state plan amendment to allow payment for 9-8-8 services provided to Medicaid enrollees. As states develop their crisis system plans, they will need to evaluate strategies to include other payers, such as commercial plans, to support the infrastructure. This would help supplement federal block grant funds, which are very limited. (Nationally, only \$75 million of crisis care funding has been allocated for the first year. In comparison, Arizona alone had an annual funding commitment of \$163 million in 2019.)

**Define program and policy requirements for a comprehensive crisis infrastructure.** States provide the key guidance around payment policy and licensure to create viable crisis infrastructure. Leveraging key elements like peer supports and other nontraditional provider types are important in creating a viable structure. Such is the case with Arizona’s crisis program, which is frequently cited as a model of a comprehensive program. Arizona’s behavioral health crisis system is operated by the state Medicaid agency and administered by three regional behavioral health authorities that contract directly with community behavioral health providers. Crisis services include three regional 24-hour hotlines, mobile crisis response teams, and facility-based crisis stabilization. The state delineates the services provided and requirements for payments through its [provider billing manual](#).

**Ensure stakeholder engagement.** A successful crisis infrastructure depends on support from consumers, advocates, law enforcement, providers, and policymakers. The state of Washington recently enacted [comprehensive legislation](#) that provides funding for crisis call centers and 9-8-8 implementation. The legislation creates a Crisis Response Improvement Strategy Committee with broad stakeholder representation to provide recommendations to implement and monitor the progress of the 9-8-8 crisis hotline and to improve behavioral health crisis response and suicide prevention services statewide.

## EVIDENCE OF IMPACT

The costs of implementing a behavioral health crisis infrastructure are significant, but these services can lead to cost savings by reducing inpatient hospital and ED use, diverting individuals from the criminal justice system, and fostering more appropriate use of community-based behavioral health care. Apart from direct cost savings, delivering care in the most effective setting is important in its own right, an imperative underscored during the COVID-19 pandemic. Components of a comprehensive crisis system have been shown to improve outcomes and decrease cost. Most recently, the crisis system in Maricopa County, Arizona, which includes all three core components, was estimated to [reduce inpatient spending by \\$260 million](#) and to decrease ED boarding.

[Prior studies](#) have suggested that community-based mobile crisis services result in a lower rate of hospitalizations than hospital-based interventions. This was also found by a study of [mobile crisis services](#) in DeKalb County, Georgia, which estimated savings for mobile crisis services compared with police interventions. A small study of [crisis intervention services located at a single hospital](#) also found that intervention services reduced costs associated with inpatient hospitalization by approximately 79 percent in a six-month follow-up period after the crisis episode. Another study examining [mental health crisis stabilization programs in the east metropolitan area of the Minnesota Twin Cities region](#) assessed the costs associated with reduced inpatient hospitalization and found a return of \$2.16 for every dollar invested.

The previous studies did not primarily focus on commercially insured populations and, with the exception of the Twin Cities study that used Medicaid

claims data because of a lack of commercial claims data, did not specify the insurance coverage for the individuals served. As crisis services expand to serve all in need, additional research will be helpful to measure the impact on commercially insured individuals specifically.

## IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

To successfully develop comprehensive behavioral health crisis systems, states may opt to tackle each of the three major areas highlighted above: financing, policy, and stakeholder engagement. Ultimately, states need a financing strategy that can support the level of need in the state. Policymakers should assess how all payers should contribute to a strong crisis system that serves everyone in the state.

This approach is likely to have broad appeal across states with different political environments. It may be of particular interest to states that have:

- consensus about the need to improve behavioral health crisis services
- support from a lead payer-partner and/or a strong multistakeholder coalition on behavioral health issues.

## EQUITY CONSIDERATIONS

A comprehensive crisis system can be a very effective tool in addressing disparities in care and access to treatment for mental health or substance use disorders. A strong crisis system creates a different access point other than an ED or jail, avoiding the negative repercussions of these pathways.

Expanded crisis capacity also may reduce the stigma associated with behavioral health issues and further break down cultural barriers to behavioral health treatment that may exist in communities. The establishment and rollout of a national behavioral crisis telephone number will likely create educational and promotional opportunities that are often limited and fragmented today.

Thoughtful stakeholder engagement in the design and implementation of a comprehensive crisis system is important to ensure that these programs meaningfully improve access and outcomes for diverse populations.

Virginia's [Marcus-David Peters Act](#) is one example. The act takes a comprehensive approach to responding to behavioral health emergencies and has several specific goals related to equity, including analyzing and decreasing race-based and other health disparities in crisis services; cultivating a statewide, Black-led crisis coalition; and supporting additional projects to ensure that equity is a central consideration in the planning, oversight, and evaluation of the crisis system.

## POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

Ideally, a well-designed system would fully cover the state in both rural and urban areas, develop sustainable funding streams, and ensure continuity of care to create a clear path for the individual in crisis. The following examples illustrate potential unintended consequences that stem from design challenges:

- *Regional limits:* Some county leaders have developed a crisis infrastructure at the local level. Although creating local capacity is important, there may be challenges with how those local networks support individuals outside the county line. An approach that is too local can and will be fragmented and less effective.
- *Operational funding:* This is one of the most critical aspects that determines long-term viability. Often communities or states are eager to utilize new, but time-limited, resources. To have a sustainable infrastructure, it is essential to identify and secure permanent funding.
- *Continuum capacity:* As the crisis system evolves, having end-to-end visibility into system capacity is critical. Individuals may move from the call center to mobile response to stabilization and then to a poststabilization need. Managing this flow is important to care continuity and community support. Without it, stakeholders and the community may view the system as incapable of meeting their needs. For example, if significant effort is made to work and coordinate with law enforcement but they find inadequate access or responsiveness, they will begin to limit their use of the system.

## RESOURCES

Stuart Yael Gordon, *Building State Capacity to Address Behavioral Health Needs Through Crisis Services and Early Intervention* (Milbank Memorial Fund, Nov. 9, 2020).

Substance Abuse and Mental Health Services Administration, *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* (SAMHSA, 2020).

Ashley Traube, Patricia Boozang, and Jocelyn Guyer, *American Rescue Plan Provides a New Opportunity for States to Invest in Equitable, Comprehensive and Integrated Crisis Services* (State Health and Value Strategies, Apr. 30, 2021).

National Association of State Mental Health Program Directors, *Financing Mental Health Crisis Services* (NASMHPD, Aug. 2020).