

SHO # 21-008

**RE: Medicaid Guidance on the Scope of
and Payments for Qualifying
Community-Based Mobile Crisis
Intervention Services**

December 28, 2021

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing this guidance on the scope of and payments for qualifying community-based mobile crisis intervention services authorized by section 9813 of the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2).

Overview

Section 9813 of the ARP amends Title XIX of the Social Security Act (the Act) to add a new section 1947. Section 1947 authorizes a state option to provide 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. States that have approved coverage and reimbursement authority through the state plan, section 1915(b) waiver programs with corresponding authority, section 1915(c) home and community-based services waiver programs, or section 1115 demonstration projects may receive an 85 percent federal medical assistance percentage (FMAP) for expenditures on qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within the five-year period during which they meet the conditions outlined in statute to qualify for the increased match. Section 9813 of the ARP permits states to disregard Medicaid requirements for statewideness at section 1902(a)(1), comparability at section 1902(a)(10)(B), and free choice of provider at section 1902(a)(23)(A) of the Act as part of their submission. Additionally, the statute permits states to disregard the provider agreement requirements at section 1902(a)(27) of the Act that obligate states to enter into provider agreements with “every person or institution providing services under the State plan.”

Background

The Department of Health and Human Services (HHS) has long recognized the importance of providing access to qualified professionals who can respond in real-time to mental health and substance use disorder (SUD) crises. Community-based mobile crisis intervention services are a key element of an effective behavioral health crisis continuum of care. The main objectives of community-based mobile crisis intervention services are to provide rapid response, individual assessment and crisis resolution by trained mental health and substance use treatment professionals and paraprofessionals in situations that involve individuals who are presumed or

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known to have a mental health condition and/or SUD. With the provision of these intervention services, individuals can be linked to needed services, such that psychiatric hospitalizations, including hospitalizations that follow psychiatric emergency department (ED) admissions, can be reduced.¹ Additionally, mobile crisis teams can respond to situations that require their services rather than those of law enforcement.² Programs providing community-based mobile crisis intervention services in the United States have been operating since the late 1980s and early 1990s.³

Mobile Crisis Systems

The Substance Abuse and Mental Health Services Administration (SAMHSA) frames a successful mobile crisis system as one that: helps individuals experiencing a crisis event experience relief quickly and resolve the crisis situation when possible; meets individuals in an environment where they are comfortable; and provides appropriate care/support while avoiding unnecessary law enforcement involvement, ED use and hospitalization. In its National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit and its 2021 publication, Meeting Needs, Saving Lives, SAMHSA offered a set of minimum expectations and best practices to operate a mobile crisis team.^{4,5} The services should be provided where the person is experiencing a crisis (home, work, park, etc.) and not be restricted to select locations within the region or particular days/times. Mobile crisis services should connect individuals to facility-based care as needed, through warm hand-offs and coordinating transportation only if situations warrant transition to other locations.

The SAMHSA National Guidelines for Behavioral Health Crisis Care describe three core components of a robust crisis system where people do not fall through the cracks of a fragmented system, as follows: (1) a 24/7 clinically staffed call center that can serve as the hub of an integrated mental health crisis system; (2) mobile crisis response teams that can respond rather than law enforcement, and (3) crisis receiving and stabilization facilities that provide short-term services and can be accessed readily rather than relying on emergency departments or hospital environments. A crisis continuum that functions well is intentionally inclusive of all residents of a community, including those from under-resourced areas.

Best practices include incorporating trained peers who have lived experience in recovery from mental illness and/or SUD and formal training within the mobile crisis team; responding without law enforcement accompaniment, unless special circumstances warrant inclusion, in order to support justice system diversion; implementing real-time GPS technology in partnership with the region's crisis call center hub to support efficient connections to needed resources and tracking of engagement; and scheduling outpatient follow-up appointments and services to connect to ongoing care and home and community-based services and supports. Community-based mobile

¹ <https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4848.pdf>

² https://csgjusticecenter.org/wp-content/uploads/2021/04/Field-Notes_Mobile-Crisis-Team_508FINAL34.pdf

³ <https://www.vera.org/behavioral-health-crisis-alternatives?goTo=https://www.vera.org/behavioral-health-crisis-alternatives/case-study-tiles>

⁴ <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

⁵ <https://store.samhsa.gov/product/crisis-services-meeting-needs-saving-lives/PEP20-08-01-001>

crisis services use face-to-face professional and trained peer intervention, deployed in real time to the location of the person in crisis in order to achieve the best outcomes for that individual. Most community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff. For example, a Master's or Bachelor's level clinician may be paired with a trained peer support specialist and the backup of psychiatrists, psychologists or other Master's level clinicians who are on-call, as needed. Trained peer support workers often take the lead on client engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis. Teams should consider including representatives from recovery community centers and harm reduction initiatives in their composition or establishing formal relationships with such programs when they are locally available. Teams should consider linking individuals served with local recovery community centers, recovery community organizations, and other peer led organizations when these are locally available.

A literature review of studies focused on several local and state level community-based mobile crisis intervention services programs identified key elements in program design and demonstrated that the modality of mobile crisis response not only provides better treatment to people with mental health conditions and SUD, but also prevents or limits criminal justice involvement emanating from mental health or SUD crises.^{6,7} Additionally, in its 2020 Behavioral Health Crisis Care Best Practices Toolkit, SAMHSA cites several studies that demonstrate community-based mobile crisis intervention services' clinical effectiveness in treating people with mental health conditions and SUD, as well as cost effectiveness in preventing utilization of higher cost services, such as hospitalizations.⁸

Mobile Crisis Services

In a May 2013 Joint Center for Medicaid and CHIP Services (CMCS) and SAMHSA Informational Bulletin about mental health services for children, CMS and SAMHSA described Mobile Crisis Response as follows: "Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring. In most cases, a two-person crisis team is on call and available to respond. The team may be comprised of professionals and paraprofessionals (including trained peer support providers), who are trained in crisis intervention skills and in serving as the first responders to children and families needing help on an emergency basis."⁹

Mobile crisis services, including those for children and youth, can incorporate a range of staffing models, including both professional and paraprofessional staff, crisis intervention specialists, therapists, case managers and trained peer and family support workers. Service requests should be simple and coordinated, with preferred response times by the mobile crisis team under one hour. When not on the scene, licensed staff should be available "on call" to provide consultation

⁶ Mobile Outreach Crisis Services (MOCS) T D McCarley, W R Yates, Journal of the Oklahoma Medical Association. November, 1998.

⁷ North Carolina Medical Journal, May- June 2012, Doug Trantham, Anne Sherry.

⁸ <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

⁹ <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>

and higher-level interventions. Effective models also provide follow-up access to mental health providers within 48 hours either via telehealth or in-person services. Partnerships with schools—including those that assist with connecting students to school-based mental health services, helping to ensure special needs such as those identified in individualized education plans (IEPs) are met, and providing psychoeducation for school staff—are also critical to promote diversion and decrease arrests for youth in crisis. Additionally, it can be beneficial to establish agreements and partnerships with the courts, foster care and justice systems and community-based organizations that provide supports such as after-school recreational activities, mental health treatment, family and peer support, and mentorship. Services should be strengths-based, person-centered, trauma informed, culturally competent, coordinated and focused on outcomes (e.g., service engagement, decreases in arrest and emergency department boarding, etc.).

Mobile crisis teams should have the capability to make referrals to outpatient care and to follow up to ensure that the individual's crisis is resolved or they have successfully been connected to ongoing services. Some crisis interventions may also include the development of strategies for identification of triggers, safety planning, and related illness management to reduce future risk of crises.

Integration with Behavioral Health Crisis Continuum of Care

Within the Medicaid program, states currently cover various types of community-based emergency or mobile crisis response and intervention services, as well as a wide range of other mental health and SUD assessment and treatment services, medications and covered items. Key examples include the mandatory Medicaid benefit of physician services at 42 C.F.R. § 440.50, the optional rehabilitative services benefit at 42 C.F.R. § 440.130(d), and the services of licensed behavioral health practitioners (including unlicensed individuals with training and experience in behavioral health care who are under the supervision of licensed practitioners) through the optional state plan Medical or Remedial Care Provided by Licensed Practitioners benefit at 42 C.F.R. § 440.60. CMS specifically acknowledged the critical role of trained peers for people with mental health conditions and SUD in sub-regulatory guidance.¹⁰ Peer support services are coverable under the optional state plan rehabilitative services benefit. Prescribed drugs are an optional state plan benefit at 42 C.F.R. § 440.120(a). For many people with a mental health condition and/or SUD, medications are a critical component in effective treatment.¹¹ Section 1006(b) of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (Pub. L. 115-271) amends section 1902(a)(10)(A) of the Act to require state Medicaid plans to include coverage of medication-assisted treatment (MAT) for all individuals eligible to enroll in the state plan or waiver of state plan for the period from October 1, 2020 until September 30, 2025.¹² The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit for eligible children under 21 also provides for all 1905(a) benefits to treat or ameliorate health conditions, including mental health and SUD conditions. This means that states **must provide** coverage of all medically necessary services

¹⁰ <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd081507a.pdf>

¹¹ <https://www.apa.org/ptsd-guideline/patients-and-families/medication-or-therapy>

¹² <https://www.medicaid.gov/federal-policy-guidance/downloads/sho20005.pdf>

for children under 21 that are included within the categories of mandatory and optional services listed in section 1905(a) of the Act, regardless of whether such services are covered under the State plan for adults.¹³

Additionally, states may cover many of these types of services through other Medicaid authorities, such as section 1915(i) state plan home and community-based services benefits, section 1915(c) home and community-based services waivers, and section 1115(a) demonstration projects.

Mobile crisis intervention services play an important role in a continuum of care for people with mental health conditions and SUD. Specifically, they can be used to improve the identification of need, treatment in the community, and diversion from inpatient services for individuals with mental health conditions and SUD. Mobile crisis intervention services are one component of a robust system of care for people with SUD and mental health conditions detailed in the CMS State Medicaid Director Letters (SMDLs), *Strategies to Address the Opioid Epidemic and Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance*.^{14,15} These two demonstration opportunities may be used to support and provide federal financial participation (FFP) for other pieces in the mental health and SUD service continuum that include residential crisis receiving and stabilization facility services and ongoing follow-up services to prevent future behavioral health crises and avoid inpatient psychiatric treatment.

On July 16, 2020, the Federal Communications Commission (FCC) adopted rules to establish 988 as the new, nationwide, easy-to-remember three-digit phone number for Americans in crisis to connect with suicide prevention and mental health crisis counselors. As of July 2022, the current National Suicide Prevention Lifeline will be accessible by dialing 988 from any landline or cell phone in the U.S. SAMHSA is actively engaged in efforts to strengthen the capacity of the Lifeline. Current planning includes developing a strategy to provide access to competent, specialized services for high-risk populations such as lesbian, gay, bisexual, transgender, and queer (LGBTQ) youth, minorities, and rural individuals. As described later in this letter, Medicaid matching funds are available to support state information technology (IT) systems integration activities to operationalize the transition from Lifeline to 988.

States are required to dedicate at least five percent of their SAMHSA Mental Health Block Grant (MHBG) allocation to support evidence-based crisis systems for adults with serious mental illnesses and children with serious mental and emotional disturbances. States and territories must use these resources to fund some or all of a set of core crisis care elements including: 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 state-wide crisis call centers that coordinate mental health services in real time.

¹³ https://www.medicaid.gov/sites/default/files/2019-12/epsdt_coverage_guide.pdf

¹⁴ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>

¹⁵ <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

The Certified Community Behavioral Health Clinic (CCBHC) model, which was established in the Protecting Access to Medicare Act of 2014, (PAMA), was designed to provide a comprehensive range of mental health and substance use disorder services. PAMA required crisis mental health services, as one of nine core CCBHC services. CCBHC crisis mental health services include 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization services.¹⁶ The CCBHC Certification Criteria, which all CCBHCs must adhere to, require provision of crisis management services that are available and accessible 24-hours a day and delivered within three hours.

Individuals served by the CCBHC must receive education about crisis management services, Psychiatric Advanced Directives, and how to access crisis services. CCBHCs must maintain a working relationship with local emergency departments (EDs), where protocols must be established for CCBHC staff to address the needs of CCBHC clients in psychiatric crisis who come to those EDs. Protocols to coordinate with law enforcement agencies must also be in place to reduce delays for initiating services during and following a psychiatric crisis. CCBHCs must also provide timely access to ongoing outpatient behavioral health services following a crisis, and adhere to standards for the timeliness of initial screening, evaluation, and treatment planning.

The new provision in ARP to allow increased Medicaid reimbursement for qualifying community-based mobile crisis intervention services will complement the resources available through the MHBG and existing CCBHCs to enable more robust support crisis intervention and management services.

As states consider how to incorporate mobile crisis intervention services into an overall crisis system of care for individuals with mental health conditions and SUD, they should be mindful to include underserved communities of color and tribal communities. Additionally, mobile crisis intervention services should be integrated with the national suicide prevention and mental health crisis hotline, state funding of core crisis care elements, and community-level efforts to implement CCBHC crisis management services.

Qualifying Services and Provider Qualifications

Qualifying community-based mobile crisis intervention services are defined under section 1947(b) of the Act as items and services for which medical assistance is available under the state plan or a waiver of the plan and that meet the conditions described in section 1947(b)(1) through (3).

First, under section 1947(b)(1), these services must be provided to individuals who are Medicaid eligible, either through the state plan or through a waiver of such plan, and who are experiencing a mental health or SUD crisis. Under section 1947(b)(1)(A), states need to ensure that services are provided to individuals outside of a hospital or other facility setting.

Second, under section 1947(b)(2), qualifying community-based mobile crisis intervention services must be delivered by a multi-disciplinary team that meets the conditions described in

¹⁶ https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

that provision. 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. Under section 1947(b)(2)(B), states must ensure that all members of the team are trained in trauma-informed care, de-escalation strategies and harm reduction. States should also consider how to meet the needs for language access for people with limited-English proficiency or those who are deaf or hard of hearing and comply with any applicable requirements under the Americans with Disabilities Act, Rehabilitation Act and Civil Rights Act. Under section 1947(b)(2)(C), states must also ensure that community-based mobile crisis intervention services teams are able to respond to crises in a timely manner. CMS is requiring states to establish and ensure training and timeliness standards. We encourage states to take into account additional travel time that may be needed for mobile crisis teams to respond in rural and remote areas when developing timeliness standards.

Under section 1947(b)(2)(C), states must ensure that the multidisciplinary mobile crisis team can, where appropriate, provide screening and assessment, stabilization and de-escalation, and coordination with and referrals to health, social and other services and supports, as needed, and health services as needed. As described at section 1947(b)(2)(A), states have latitude in decisions about the composition of professionals and/or paraprofessionals on the community-based mobile crisis intervention team. These state decisions will impact the scope of services that may be provided to individuals with a mental health or SUD crisis as part of qualifying community-based mobile crisis intervention services.

States may opt to include as community-based mobile crisis intervention team members clinicians who can prescribe and administer medications on scene. CMS suggests that community-based mobile crisis intervention teams carry naloxone and have team members trained in its administration to reverse opioid overdoses. CMS also encourages states to equip their mobile crisis units with harm reduction supplies, including fentanyl test strips and suboxone. States may also choose to include highly trained and specialized practitioners, such as psychiatrists or psychiatric nurse practitioners, as part of the mobile crisis team that connect virtually via telehealth to other members of the mobile crisis team on scene to provide screening and assessment and/or to stabilize the beneficiary and de-escalate the crisis. Community-based mobile crisis intervention team members may need to initiate safety planning interventions, make follow-up referrals and engage in other coordination activities relating to the crisis both on scene and shortly following the crisis intervention with other community providers, including recovery centers. Additionally, telehealth may also be used at either the outset of the crisis as part of screening, assessment and stabilization, or in near term follow-up to the crisis with the beneficiary regarding coordination and referrals. These activities may also be considered items or services for which medical assistance is available under the state plan or a waiver of such plan as community-based mobile crisis intervention services.

To illustrate the interrelationship of community-based mobile crisis intervention services and other Medicaid services, the community-based mobile crisis intervention team may provide the beneficiary experiencing a mental health or SUD crisis in the community with medically necessary transportation¹⁷ to crisis receiving or stabilization settings to facilitate a warm handoff for ongoing care. Crisis receiving or stabilization settings, while not a component of qualifying community-based mobile crisis intervention services, are examples of other settings providing Medicaid services within a robust crisis continuum of care for many state mental health and SUD service systems.

States must ensure that community-based mobile crisis intervention services teams are maintaining relationships with relevant community partners, including medical and behavioral health providers, primary care providers, which would include pediatric providers for children, community health centers, crisis respite centers, and managed care plans (if applicable), as specified at section 1947(b)(2)(D). Under section 1947(b)(2)(E), states must also ensure that community-based mobile crisis intervention services programs maintain the privacy and confidentiality of beneficiary information consistent with federal and state requirements.

Third, under section 1947(b)(3), states must ensure that community-based mobile crisis intervention services are available 24 hours a day, every day of the year.

Under section 1947(d)(1), as a condition of receiving the increased FMAP available for qualifying community-based mobile crisis intervention services, states must demonstrate, to the satisfaction of the Secretary, that they will be able to support the provision of qualifying community-based mobile crisis intervention services. States may satisfy this requirement through one of the Medicaid authorities outlined in this letter to provide community-based mobile crisis intervention services.

Provider Payment and Delivery Systems

Qualifying community-based mobile crisis intervention services under section 1947 may be provided through either a fee-for-service (FFS) or managed care delivery system. If providers of qualifying community-based mobile crisis intervention services are being paid for providing such services authorized in the state plan through a FFS delivery system, states must have approved Attachment 4.19-B pages that comprehensively describe the rate-setting methodology used to pay providers of services. The rate-setting methodology for providers of community-based mobile crisis intervention services must be consistent with section 1902(a)(30)(A) of the Act, which requires Medicaid payments to be “consistent with efficiency, economy, and quality of care” and to be “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”

¹⁷ 42 C.F.R. § 431.53

If community-based mobile crisis intervention services are to be delivered through a section 1915(c) waiver, states must include the rate setting methodology and cost estimates in a CMS-approved 1915(c) waiver application. The requirements of 1902(a)(30)(A) apply to 1915(c) waivers.

Section 1115 demonstrations used to authorize community-based mobile crisis intervention services must be budget neutral, which means that the proposed demonstration cannot cost the federal government more than it would absent the demonstration. The requirements of 1902(a)(30)(A) also apply to 1115 demonstrations.

If these providers are delivering community-based mobile crisis intervention services in a managed care delivery system, in addition to an approved Medicaid authority, the services must be specified in the managed care plan contracts and included in the corresponding managed care capitation rates. As always, managed care capitation rates must be actuarially sound, and states must comply with the federal requirements in 42 C.F.R. §§ 438.4 through 438.7.

Increased FMAP and Claiming

FFP associated with the increased FMAP of 85 percent is available for qualifying expenditures for community-based mobile crisis intervention services, including the costs of services otherwise covered under the state plan or waiver of the plan that are furnished as part of the qualifying services, on a quarterly basis, as described below.¹⁸ The increased FMAP of 85 percent is available for the first 12 fiscal quarters in which a state's community-based mobile crisis intervention services program complies with statutory requirements at section 1947(d), as long as the expenditures are incurred on or after April 1, 2022, and no later than March 31, 2027. CMS will be implementing changes to the Medicaid Budget and Expenditure/CHIP Budget and Expenditure System (MBES/CBES) to ensure that states will be able to accurately report budget estimates and expenditures related to the increased FMAP for qualifying community-based mobile crisis intervention services, consistent with the requirements of section 1947 of the Act. Community-based mobile crisis intervention services, including the costs of services otherwise covered under the state plan or waiver of the plan that are furnished as part of the qualifying community-based mobile crisis intervention services, that are matched at a higher FMAP than 85 percent will continue to be matched at the higher FMAP even when the conditions in section 1947(d) are met.

- **Obtaining FFP associated with the increased FMAP through the Form CMS-37 (Medicaid Program Budget Report; Quarterly Distribution of Funding Requirements):** CMS will provide FFP associated with the temporary increased FMAP to states based on budget estimates submitted on the quarterly Form CMS-37 as described in 42 C.F.R. § 430.30(b).

¹⁸ MBES/CBES reporting requirements described throughout this document also extend to state CMS-37 submissions via the Medicaid and CHIP Financial System (MACFin), which will begin with the February 15, 2022 budget submission.

- **Obtaining FFP associated with the increased FMAP through the Form CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program):** CMS will reconcile the advance FFP amounts associated with the temporary increased FMAP to states based on actual recorded expenditures submitted through the quarterly Form CMS-64 as described in 42 C.F.R. § 430.30(c).
- **MBES/CBES Modifications:** CMS will modify the MBES/CBES to reflect each state's increased FMAP. Once CMS completes the modifications to the MBES/CBES, the states will be able to enter expenditures at the temporary increased FMAP, and apply the increased FMAP to the actual claimed expenditures. The modifications to MBES/CBES may delay expenditure reporting associated with the temporary increased FMAP for the third quarter of the federal fiscal year 2022. In those cases, states can report expenditures associated with the increased FMAP through prior period adjustments in subsequent quarters.
- **Other Expenditure Reporting Information:** States should follow existing federal requirements regarding the applicability of a particular match rate available for a given quarter. The applicable FMAP is based on date of payment, not date of service for current quarter original expenditures. The FMAP applicable to expenditures for prior period adjustments should be the FMAP at which the original expenditure was claimed, for both private and governmental providers. All states are responsible for reporting Medicaid collections and overpayments on the CMS-64. States must report overpayments and collections at the same match rate at which the expenditures were originally claimed, including the temporary increased FMAP. Recoveries of FFP must be returned at the same match rate at which they were originally claimed. Therefore, if a Medicaid expenditure was claimed using the increased FMAP, the federal share of any recoveries associated with that expenditure would have to be returned using the same increased FMAP. Consistent with existing requirements, states must document expenditures to ensure a clear audit trail, by isolating expenditures that are matched at increased FMAP rates. CMS will conduct oversight to ensure that expenditures are allowable, accurate, and are claimed at the correct FMAP rate.
- **Claiming the Increased FMAP for Managed Care Expenditures:** In order for states to claim the temporary FMAP of 85 percent for amounts expended by a state in managed care for qualifying community-based mobile crisis intervention services, states must include section 1947 qualifying community-based mobile crisis intervention services in the managed care contract. The portion of the capitation rate that is attributable to community-based mobile crisis intervention services, including the costs of other state plan or waiver covered items and services provided by the multidisciplinary team during the qualifying community-based mobile crisis services being provided under the contract, and for which an increased FMAP may be claimed, should be determined based on the data utilized to develop the applicable capitation rates. States may utilize claiming methodologies to identify a reasonable estimate (e.g., proxy) of a portion of the capitation rate attributable only to qualifying community-based mobile crisis intervention services that are eligible for the increased FMAP. The use of this claiming methodology is solely

for FFP claiming purposes and does not negate the requirements that Medicaid capitation rates be actuarially sound and must be developed in compliance with federal requirements under 42 C.F.R. part 438. States have used similar claiming methodologies for FFP for services and populations such as family planning, section 1915(k) benefits, and the new adult group.

Administrative Claiming

Federal match may be available under section 1903(a)(7) of the Act and implementing regulations at 42 C.F.R. § 430.1 and 42 C.F.R. §431.15 for state Medicaid agency costs associated with establishing and supporting delivery of community-based mobile crisis intervention services for people with mental health conditions or SUD as well as call centers and other crisis stabilization services. Section 1903(a)(7) of the Act directs payment of FFP at 50 percent for amounts “found necessary by the Secretary for the proper and efficient administration of the State plan.” Allowable administrative activities could include operating state crisis access lines and dispatching mobile crisis teams as needed to assist Medicaid beneficiaries.

States that are interested in claiming FFP for administrative costs associated with the delivery of qualifying community-based mobile crisis intervention services for people with mental health conditions or SUD should submit an amendment to their Public Assistance Cost Allocation Plan (PACAP), which is approved by HHS’ Division of Cost Allocation Services (CAS) with CMS concurrence. The timeframe for approval can vary based on a number of factors, however, we recommend that states submit the proposed administrative claiming methodology to CMS for review and approval in advance of, or concurrently with, submission to CAS in order to expedite the process. CMS will review the proposal using existing administrative claiming criteria, as well as federal cost allocation principles. Reported expenditures must be reasonable, allowable and allocable.¹⁹ For example, states could assess the appropriate allocation of costs to Medicaid beneficiaries by identifying the percent of residents with serious mental illness, SUD, and intellectual disabilities/ developmental disabilities who are enrolled in Medicaid since these populations are most likely to need crisis stabilization services.

CMS has consistently held that allowable claims under the 1903(a)(7) authority must not only be directly related to the administration of the Medicaid program, but must also directly benefit the health of Medicaid beneficiaries and the Medicaid program. As stated in our 1994 State Medicaid Director letter (SMDL) on administrative claiming²⁰, costs matched by CMS may not include funding for a portion of general public health initiatives that are made available to all persons, **unless** the campaign is explicitly directed at assisting Medicaid eligible individuals to access the Medicaid program. Other general principles from the 1994 SMDL also apply (e.g., an allowable administrative cost must be supported by a system which has the capability to isolate the costs which are directly related to the support of the Medicaid program from all other costs

¹⁹ See 2 C.F.R. § 200 (formerly known as OMB Circular A-87) to review time study proposals and determine cost allocability. The A-102 Common Rule and OMB Circular A-110 (2 C.F.R. part 215) require that non-Federal entities receiving Federal awards establish and maintain internal controls designed to reasonably ensure compliance with Federal laws, regulations, and program compliance requirements.

²⁰ <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD122094.pdf>

incurred by the agency). CMS is available to provide technical assistance to states regarding administrative claiming upon request.

Administrative Information Technology (IT) System Costs

- State Medicaid agency IT System costs may be eligible for enhanced FFP. Approval for enhanced match requires the submission of an Advanced Planning Document (APD). A state may submit an APD requesting approval for a 90/10 enhanced match for the design, development and implementation of their Medicaid Enterprise Systems (MES) initiatives that contribute to the economic and efficient operation of the program, including technology supporting implementation of crisis call centers, community-based mobile crisis intervention services, and crisis stabilization centers, including the maintenance and operations of these services.
- Interested states should refer to 45 C.F.R. Part 95 Subpart F – Automatic Data Processing Equipment and Services-Conditions for FFP for the specifics related to APD submission.
- States may also request a 75/25 enhanced match for ongoing operations of CMS approved systems. Interested states should refer to 42 C.F.R. Part 433 Subpart C – Mechanized Claims Processing and Information Retrieval Systems for the specifics related to systems approval.
- State Medicaid agency costs that may be eligible for this enhanced administrative match include, but are not limited to, the following examples:
 - Systems in support of establishing and/or improving crisis call centers that can enable Medicaid beneficiaries to access mobile crisis teams;
 - Systems integration activities in support of the 988 activities;
 - Providing cell phones or iPads to state staffed mobile crisis teams to facilitate telehealth services with a clinician at another location during a crisis intervention;
 - Developing and implementing software applications to facilitate communication between crisis call centers and mobile crisis providers and supervisory clinicians with mobile crisis team staff;
 - Implementing text and chat technologies that many beneficiaries, including youth, may be more comfortable using as part of the services offered by crisis call centers; and
 - Implementing accessible technologies for individuals with disabilities.

If there are questions related to these topics, CMS encourages states to contact their MES State Officer.

Data Reporting

CMS is committed to the completeness, accuracy and timeliness of Medicaid data quality as captured from states via the Transformed Medicaid Statistical Information System (T-MSIS). States that submit SPAs or waivers for qualifying community-based mobile crisis intervention services will be provided with T-MSIS technical instructions for data reporting. Data reported to

T-MSIS and MBES/CBES must be fully supported by FFS claims, managed care encounter records, capitation payments or other records associated with these services. The data is also expected to meet CMS' data quality reporting requirements.

Maintenance of Effort (MOE) Requirements

In order to receive the increased FMAP for any fiscal quarter, states must meet the requirements at section 1947(d)(2) of the Act. By claiming FFP at the increased FMAP of 85 percent, the state is agreeing to meeting the MOE requirements, as noted below. Specifically, states must demonstrate to the satisfaction of the Secretary that additional federal funds for qualifying community-based mobile crisis intervention services that are attributable to the increased FMAP will supplement and not supplant the level of state funds expended for such services in the federal fiscal year prior to April 1, 2022. CMS interprets 1947(d)(2) to require that in order to demonstrate compliance with this requirement, states must:

- Not impose stricter standards for receipt of community-based mobile crisis intervention services than those in effect on the last day of the preceding federal fiscal year, September 30, 2021;
- Preserve or exceed the amount, duration, and scope of community-based mobile crisis intervention services in effect on the last day of the preceding federal fiscal year, September 30, 2021; and,
- Maintain community-based mobile crisis intervention services provider payments at a rate no less than those on the last day of the preceding federal fiscal year, September 30, 2021.

Additionally, if the state made qualifying community-based mobile crisis intervention services available in a region of the state in the federal fiscal year prior to April 1, 2022, the state must continue to make such services available in that region during each month in which the state claims the increased FMAP under section 1947.

The state must ensure that it will not make duplicate claims for community-based mobile crisis intervention services delivered consistently with section 1947 of the Act and other types of mobile crisis services provided during the period of April 1, 2022, through March 31, 2027. The state will need to ensure that it has data supporting its claims, which are to be made available to CMS upon request.

Planning Grants

CMS issued a Notice of Funding Opportunity (NOFO) for State Planning Grants for qualifying community-based mobile crisis intervention services required by section 9813 of ARP at section 1947(e). CMS awarded 12-month planning grants to 20 states for the purposes of developing a SPA, section 1115 demonstration, section 1915(b) waiver, or section 1915(c) waiver request (or an amendment to such a waiver) to provide coverage of qualifying community-based mobile

crisis intervention services.²¹ States that received planning grants may use planning grant funds to pay for infrastructure activities to ensure that they will be able to provide coverage of qualifying community-based mobile crisis intervention services as defined in section 1947(b) of the Act.

Medicaid Coverage, Payment and Service Delivery System Authority

If community-based mobile crisis intervention services are not currently covered in the state plan or a waiver of such plan (including a section 1115 demonstration) or a state needs to make changes to the benefit, payment or service delivery mechanism, states will need to submit a SPA under an existing 1905(a) benefit category, 1915(i) SPA, 1932(a) SPA, 1915(c) HCBS waiver application, 1915(b) waiver application and/or an 1115 demonstration in order to claim the increased FMAP through 1947 for qualifying community-based mobile crisis intervention services. Depending on the authority the state elects, states are expected to follow specific processes, formats and/or procedures for the selected Medicaid authority, as outlined below. CMS is available for technical assistance in determining how community-based mobile crisis intervention services could be incorporated into a state's program.

SPA Coverage

States wishing to add community-based mobile crisis intervention services to their state plan or modify coverage of existing community-based mobile crisis intervention services in their state plan will need to submit a coverage SPA under the appropriate benefit category or categories. States must conduct tribal consultation for SPAs, if required, under section 1902(a)(73)(A) before submission of a SPA. SPA effective date requirements outlined at 42 C.F.R. § 430.20 provide for an effective date retroactive to the first day of the quarter in which the SPA was submitted except for 1915(i) SPAs with substantive changes which may only take effect on or after the date CMS approves the amendment per 42 C.F.R. § 441.745(a)(2)(v). Under 42 C.F.R. § 430.20, for coverage SPAs that are not for 1915(i), states have until June 30, 2022, to submit a SPA for community-based mobile crisis intervention services that would take effect on April 1, 2022. Section 1915(i) SPAs in which states are requesting a substantive change, including the addition of a new service or revision to an existing service, can only have an effective date that is prospective of the date that CMS approves the SPA. States wishing to utilize a managed care delivery system under section 1932(a) of the Act should also submit a managed care SPA as appropriate.²² Information regarding other managed care authorities is provided later in the letter.

²¹ <https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-community-based-mobile-crisis-intervention-services/index.html>

²² Section 1932(a) of the Act allows states to mandatorily enroll many Medicaid beneficiaries into managed care organizations to receive care. There are some Medicaid populations that cannot be mandatorily enrolled under this authority, including children with special needs, Medicare beneficiaries, and American Indians/Alaska Natives.

SPA Payment (4.19-B Pages)

States wishing to add a rate setting methodology to authorize fee-for-service payment under Medicaid state plan authority for community-based mobile crisis intervention services or to modify payment of existing community-based mobile crisis intervention services already in their state plan will need to submit a separate payment SPA (4.19-B pages). In setting payment rates, states may include all medical service costs (e.g., salaries, fringe benefits, supplies, and equipment) associated with furnishing the community-based mobile crisis intervention services to Medicaid beneficiaries. The rate-setting methodology for payments for community-based mobile crisis intervention services must be a comprehensive written description consistent with 42 C.F.R. § 430.10.

As with any SPA submission, CMS expects states to comply with all SPA requirements that are not waived or modified, including those found in 42 C.F.R. § 440.200, et seq. When submitting a SPA that authorizes payment for community-based mobile crisis intervention services, states will need to conduct public notice consistent with 42 C.F.R. § 447.205. Per the regulation, states may make their methodology for payment to providers of community-based mobile crisis intervention services effective no earlier than one day after public notice is issued and the first day of the quarter in which the state submits the SPA. States must conduct tribal consultation, if required, under section 1902(a)(73)(A) before submission of section 1947 SPAs. Consistent with section 1902(a)(2) of the Act, states must assure that adequate funding is available for the non-federal share of community-based mobile crisis intervention services payments from state or local resources. Consistent with section 1902(a)(30) of the Act, states must have documentation to support any claims for FFP of the payments to providers for qualifying section 1947 services delivered to Medicaid eligible beneficiaries.

To assist states with developing payment methodologies, CMS has issued guidance that can be accessed on Medicaid.gov.^{23,24} As states have a variety of options to choose from in how they pay for qualifying community-based mobile crisis intervention services, CMS is available to provide assistance to states as they develop SPA proposals.

Section 1915(c) Home and Community-Based Services Waivers

State Medicaid agencies wishing to use section 1915(c) waiver authority to add or modify qualifying community-based mobile crisis intervention services will need to submit a waiver action to CMS that meets all requirements for section 1915(c) using the web-based waiver management system available at <https://wms-mmdl.cms.gov/WMS/faces/portal.jsp>. Section 1915(c) waiver actions with substantive changes, such as revisions to services available under the waiver, can only have an effective date that is on or after the date that CMS approves the waiver in accordance with 42 C.F.R. § 441.304. Therefore, states that are adding community-

²³ <https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/fed-req-pymt-methodologies.docx>

²⁴ <https://www.medicaid.gov/state-resource-center/downloads/spa-and-1915-waiver-processing/bundled-rate-payment-methodology.pdf>

based mobile crisis intervention services under section 1915(c) should submit the waiver action no later than December 31, 2021. More information about section 1915(c) waivers is available at <https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html>.

Section 1915(b) Waivers

States interested in providing community-based mobile crisis intervention services in a managed care delivery system will need a managed care authority as well as a concurrent Medicaid coverage authority for the services. States may utilize one or more managed care authorities, including a section 1932(a) SPA (described above), section 1915(b) waiver, and/or section 1115(a) demonstration. A section 1915(b) waiver can be utilized to mandate enrollment of all Medicaid beneficiaries into a managed care organization (MCO), prepaid inpatient health plan (PIHP), or a prepaid ambulatory health plan (PAHP) in order to receive section 1947 services. A section 1915(b) waiver may only be approved prospectively after a CMS review period. Therefore, states interested in utilizing a section 1915(b) waiver should submit a complete waiver application request no later than December 31, 2021. More information about section 1915(b) waivers is available at <https://www.medicaid.gov/medicaid/managed-care/managed-care-authorities/index.html>. States may request technical assistance at <https://www.medicaid.gov/medicaid/managed-care/technical-assistance/index.html>.

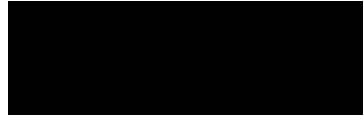
Section 1115 Demonstration Authority

States that seek to use section 1115 demonstration authority to add or modify qualifying community-based mobile crisis intervention services will need to submit an application consistent with the federal requirements applicable to the type of section 1115 demonstration submission to CMS. For new demonstration applications, states must comply with the public notice process set forth in 42 C.F.R. § 431.408 and the application procedures set forth at 42 C.F.R. § 431.412(a) prior to submission to CMS. States may choose to include a request to make qualifying community-based mobile crisis intervention services available through a demonstration in an application to extend an existing demonstration. For demonstration extension applications, states must comply with the public notice process set forth in 42 C.F.R. § 431.408 and the application procedures set forth at 42 C.F.R. § 431.412(c) prior to submission to CMS. States may refer to the “1115 Application Process” webpage on Medicaid.gov for more information on submitting an application for section 1115 demonstration authority (<https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-application-process/index.html>). For amendments to existing section 1115 demonstrations, states must follow the requirements outlined in their approved Special Terms and Conditions (STCs) for public notice and application submission. Section 1115 demonstrations must be budget neutral. CMS will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary. States may submit completed applications to 1115demorequests@cms.hhs.gov.

Conclusion

CMS is eager to work with states to facilitate the implementation of qualifying community-based mobile crisis intervention services that can improve the health of beneficiaries with a mental health condition or SUD through providing timely access to care and treatment. If you have any questions regarding this letter or would like to request technical assistance, please contact your respective CMS state lead.

Sincerely,



Daniel Tsai
Deputy Administrator and Director