

HB 2417 Report: Statewide Coordinated Crisis Services System



Oregon
Health
Authority

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EXECUTIVE SUMMARY

In 2021, through [HB 2417](#), the Oregon legislature appropriated \$15 million to the Oregon Health Authority (OHA) to establish 988 call centers and enhance mobile crisis services. The bill also directed OHA to identify an implementation plan for Crisis Receiving Centers as part of the state's behavioral health crisis system. Additionally, it required a comprehensive analysis of the existing crisis services in Oregon, with policy and funding recommendations for a continuum of crisis services that addresses the behavioral health needs of Oregonians in all stages of life while simultaneously addressing health inequity.

In order to report to the legislature on these important aspects of the design of the crisis care system, OHA contracted with RI International (RII), a national non-profit with expertise on the provision of crisis services, to conduct an analysis and make policy and funding recommendations. The full report by RII is attached. This report brings forward information from RI and input from key partners that are implementing and utilizing the system.

While RI International is providing expertise on how to design the regulatory, accountability, and financial infrastructure of the crisis system, OHA is simultaneously centering the perspectives of communities with lived experience in the behavioral health crisis system, as well as engaging with Community Mental Health Programs and 911 partners, to guide changes in policy, rules, and contracts. The overarching goal of the implementation planning process is to design an Evidence Based crisis system through consistent engagement with communities of color and other prioritized communities who have historically experienced unintended adverse outcomes of the crisis response due to social and historical injustice. OHA is also exploring all the potential avenues to leverage Medicaid for each component of the crisis system.

OHA aims to continue engaging with communities and state and federal partners through 2022, and to strengthen the existing foundation of 988 Call Center and enhanced Mobile Crisis System by end of 2022. OHA also will continue to explore what a system of facility-based crisis receiving capacity should look like in Oregon to meet individual and regional needs, led by RI and community recommendations. OHA anticipates the following resource needs:

1. Additional funding to sustain 988 call center operations, needed to support increasing call volume and to accommodate text and chat services
2. Funding to sustain enhanced mobile crisis model, if federal funding provisions expire after five years
3. Funding to support start-up and operational costs for Crisis Receiving Centers

INTRODUCTION

Legislative Direction

[House Bill 2417](#), passed by the Oregon legislature and signed into law by Governor Brown in 2021, directs the Oregon Health Authority (OHA) to:

Report to the interim committees of the Legislative Assembly related to mental or behavioral health, recommendations on policies, legislative changes, if any, and funding to implement the National Suicide Hotline Designation Act of 2020 (P.L. 116-172) and establish a statewide coordinated crisis services system. The report shall address and include:

- (1) The establishment of the crisis hotline center under section 2 (3) of this 2021 Act to receive calls, texts and chats from the 9-8-8 suicide prevention and behavioral health crisis hotline, including coordination with mobile crisis intervention teams and other crisis services and projected costs for the necessary technology and ongoing operations;*
- (2) Projections for increased crisis stabilization services to meet the needs of individuals accessing the 9-8-8 suicide prevention and behavioral health crisis hotline*
 - a. Policies and funding to provide access to adequate mobile crisis intervention teams statewide, addressing ongoing funding from Medicaid, commercial insurance or other funding sources, to coordinated mobile crisis response services between cities and counties and the appropriate number of teams and staffing;*
 - b. Policies and funding to provide statewide access to crisis stabilization centers, as defined in section 1 of this 2021 Act, addressing the statutory framework for such centers, licensing or regulatory structures, ongoing funding that maximizes Medicaid and commercial insurance, and a plan for the location and number of such facilities;*
 - c. Policies and funding to provide access to other crisis services, including peer respite centers, as defined in section 1 of this 2021 Act, behavioral health urgent care walk-in centers or other services for specific populations; and*
 - d. How the continuum of crisis services proposed in the report will:*
 - i. Address the needs of Oregonians in all stages of life who experience behavioral health crises; and*

- ii. *Improve health equity by addressing the preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by socially disadvantaged populations;*
- (3) *Proposed strategies and policies for coordination with 9-1-1 and law enforcement*
- (4) *Projections and proposed timeline for implementing the National Suicide Hotline Designation Act of 2020 (P.L. 116-172), and in particular for expanded service capacity and any proposed capital development, workforce needs or need for legislative changes or policies to remove barriers to the expansion of service.*
- (5) *Whether a fee should be proposed to pay expenses that the state is expected to incur for:*
 - a. *Ensuring the efficient and effective routing of calls made to the 9-8-8 suicide prevention and behavioral health crisis hotline to an appropriate crisis center and personnel; and*
 - b. *Providing acute behavioral health, crisis outreach and stabilization services by directly responding to the 9-8-8 suicide prevention and behavioral health crisis hotline;*
- (6) *If a fee is proposed:*
 - a. *The proposed fee amount;*
 - b. *The proposed mechanism for the fee, including the type of telecommunications lines or accounts on which the fee will be imposed;*
 - c. *The allocation of the fee revenue, including the crisis services to which the fee will be allocated, the estimated cost of those services, and whether any portion of the fee revenue will be eligible for Medicaid match; and*
 - d. *Whether the proposed fee revenue will supplant any existing funding;*
- (7) *An assessment of existing and proposed crisis response services and any recommendations for maximizing federal financial participation in the funding of the services.*
- (8) *An assessment of existing and proposed crisis response services and any recommendations for maximizing federal financial participation in the funding of the services.*

In accordance with HB 2417, this report summarizes OHA's progress and planning to implement the enhanced Behavioral Health Crisis system. Also

attached is the recommendation report from OHA’s independent consultant – RI International – which provides a roadmap to designing and implementing the enhanced crisis system in Oregon in alignment with national best practice.

Background

The National Suicide Hotline Designation Act was passed unanimously by Congress in October 2020. This act replaces the National Suicide Hotline number with the three-digit number – 988 – effective July 16, 2022. With this legislation, the federal government signaled its intent for legislation to be enacted in all 50 states and Washington DC to support 988 implementation and to establish a sustainable funding mechanism for the 988 crisis response system as allowed for in federal law. In addition, the act increased the scope of 988 to be the initial point where individuals can seek out behavioral health crisis services and be linked to community-based behavioral health treatment with the goal of diversion from emergency departments and jail. The federal National Suicide Hotline Designation Act includes language authorizing each state to pass their own legislation to fund 988 in the same manner as 911, through state-managed monthly customer service fees.

RII Role and Report

As part of its implementation of HB 2417, through federally funded grant monies intended for planning 988 implementation, OHA awarded a contract to RI International, an organization and national non-profit that specializes in consultation and the provision of crisis services. Along with the Substance Abuse and Mental Health System Administration, RII co-authored the national best practice for behavioral health crisis system, called the [Crisis Now Model](#). Crisis Now is led by the National Association of State Mental Health Program Directors and developed with the National Action Alliance for Suicide Prevention, the National Suicide Prevention Lifeline, the National Council for Behavioral Health, and RI International.

Under the Scope of Work for the contract with OHA, RII was tasked with developing a roadmap for 988 crisis system implementation in Oregon, to include system coordination, capacity, funding, and communication strategies in alignment with the Crisis Now Model. This roadmap report by RII is attached. It analyzes the existing crisis system in Oregon and provides funding and policy recommendations.

Overview of OHA’s process

Oregon’s planning for the 988 & the behavioral health crisis system is informed through community engagement. In January 2021, the Governor’s Office, with support from OHA, convened the 988 Governor’s Workgroup led by the Governor’s behavioral health policy advisor. This workgroup included

consumers, providers, and other relevant community partners such as law enforcement, telecom services providers, and the 911 Program.

Following the passage of HB 2417, OHA established the Crisis System Advisory Workgroup (CSAW), primarily comprised of individuals and families with lived experiences and from marginalized communities who experience potential adverse impacts of the crisis response system disproportionately, due to systemic and historical social injustice. The CSAW is driving policy decisions that will lead to changes in statutes, rules, and contracts to ensure Oregonian experience crisis services at a quality they recommend.

In addition, OHA is consulting with the Association of Community Mental Health Programs, and has convened a Community Mental Health Programs (CMHP) workgroup to plan implementation of enhanced mobile crisis services in each county. This CMHP workgroup is working closely with the CSAW to ensure they implement the quality of mobile crisis service that Oregonians want to experience.

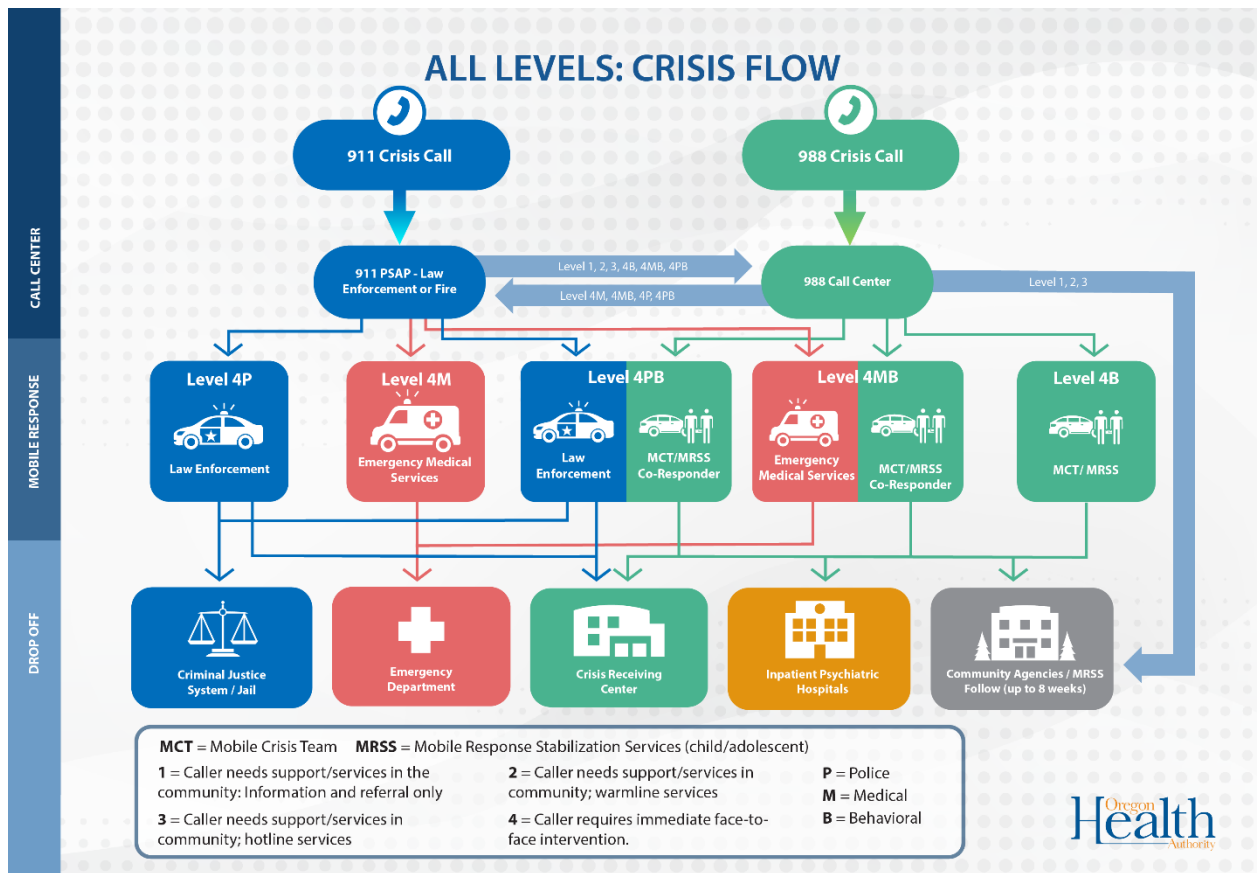
In addition, OHA is collaborating with Oregon’s Coordinated Care Organizations (CCOs) through the CCO Behavioral Health Directors group regularly. OHA has initiated engagement with Department of Consumer and Business Services (DCBS), in partnership with the Governor’s Office, to explore pathway to parity for Commercial Payers.

THE CRISIS RESPONSE SYSTEM

Continuum of Crisis Services

The graphic below depicts the proposed “Future State” of Oregon’s Crisis Response System, incorporated recommendations from RII as well as guidance from the Substance Abuse and Mental Health Services Administration. That agency defines a crisis stabilization service as:

A direct service that assists with de-escalating the severity of a person’s level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services. Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery.



988 Call Center

The cornerstone of 988 is a 24/7 Crisis Call Center. Only organizations that are certified affiliates of the National Suicide Prevention Lifeline center, administered by the non-profit Vibrant, and regulated by SAMHSA, can become 988 call centers. Oregon’s two Lifeline crisis call centers are operated by Lines for Life and Northwest Human Services. Lines for Life, cover the entire state. Northwest Human Services covers Marion and Polk county. In addition, each of Oregon’s 36 counties currently maintains its own crisis call center.

Coordination with 9-1-1 and Law Enforcement

It is imperative that OHA, mobile crisis services, and facility-based crisis services in Oregon maintain an ongoing relationship between crisis call centers and 911 dispatch, to ensure prompt responses to critical situations as well as to identify and troubleshoot communication concerns. This priority is being addressed by a collaborative workgroup within OHA’s 988 implementation planning structure focused on 911 and 988 communication. The workgroup includes OHA, 911 regional Advisory Committee, Department of Public Safety Standards & Training (DPSST), and 988 Call Centers. This work group is gaining a uniform understanding of which calls warrant a 988 response versus a 911 response, taking into consideration safety, level of threat, mobile crisis

system capacity, and care of the individual. It also will be establishing communication transfer protocols. This workgroup is also evaluating training protocols for 911 dispatch in order to divert calls to 988 as needed. Once developed, a pilot testing of protocols will identify the technology and methodology for call transfer that limits the number of dropped calls and the number of errors in coordination to ensure smoother operations in advance of 988.

Oregon is home to 43 different 911 centers, known as Public Safety Answering Points (PSAP), which cover all 36 counties. Because Oregon will be operating with only two 988 crisis call centers, collaboration between 911 and 988 will be significantly different than working within a single jurisdiction. Both of Oregon's two 988 hubs must maintain protocols with all 43 PSAPs.

The physical co-location of 911 and 988 resources has been an attractive and progressive development to facilitate collaborative working relationships. However, given COVID-19 developments, it is questionable whether physical call centers will continue to exist in the same form. Many crisis call centers around the country, including those affiliated with NSPL, have been forced to operate remotely during the pandemic, and they are considering whether or not to maintain a virtual operation or some type of hybrid operation after the pandemic. In addition, 911 is undergoing its own independent changes, as discussed in further detail in the attached RII report (page 57).

Call Center Plan Overview

HB 2417 appropriated \$5 million for 988 call center capacity and workforce. Funding available through a federal grant to be awarded in April 2022, for \$2.1 million, will go towards training support and workforce capacity at 988 call centers, in Year One. However, to sustainably fund the 988 call center for call, text, and chat function, not just in year one, but over the next five years when call volume increases exponentially, the resource need is approximately \$13 million in year one and up to \$20 million in year five. Oregon's 988 call center projections for implementation are 118,000 calls¹ in year one, with a gradual increase to 240,750 annually after five years. The projected cost for year one is to support 51 counselors, 10 supervisors, and four quality assurance staff. Implementing a chat and text function is projected to require additional 6 staff.

¹ The call volume projection is provided by the National Lifeline Center, aka Vibrant, and assumes an 8% call transfer rate from 911.

988 Volume and Cost Projections		
	Volume	Expense
Implementation	118,216	\$ 13,161,268
Full Year 1	205,593	\$ 13,363,554
Full Year 2	234,304	\$ 15,229,774
Full Year 3	258,914	\$ 16,829,391
Full Year 4	283,523	\$ 18,429,009
Full Year 5	308,133	\$ 20,028,626

(RII Report, Page 54)

OHA plans to deploy the \$5 million appropriated by HB 2417 for 988 call centers no later than the first quarter of 2022. To achieve this goal, the CSAW and an additional workgroup focused on the Mobile Response and Stabilization Services (MRSS) model for children and families have provided a list of training recommendations for 988 call center staff and supervisors. OHA is also partnering with 911 programs across Oregon and with the Department of Public Safety and Standards Training (DPSST) to establish additional standards. This will ensure that Oregon 988 call centers hire the workforce needed by July 16, 2022, and train them appropriately to provide high quality service to Oregonians.

Mobile Crisis Services

Community-based mobile crisis teams (MCT) are an integral part of a crisis response system. MCTs typically use face-to-face professional and peer intervention teams, deployed in real time to the location of a person in crisis, to provide assessment, de-escalation, and referral services as needed.

Under Oregon Administrative Rules [309-019-0150](#), all Community Mental Health Programs (CMHPs) in Oregon must provide mobile crisis services 24/7. However, there is variability in the composition and staffing of MCTs from county to county. Some counties have a co-responder model with law enforcement, while several counties transition to a 100% law enforcement response after hours. Community Mental Health Programs (CMHPs) have first right of refusal for mobile crisis services. However, there are a few examples of non-CMHP entities who provide mobile crisis and outreach services independent of CMHPs, such as Portland Street Response and CAHOOTS.

Mobile Response and Stabilization Services (MRSS) Overview

Mobile Response Stabilization Services (MRSS) are intended to assist youth, young adults, parents and/or caregivers, and are initiated through the 988 centralized referral system. MRSS link youth, young adults, and their families or other caregivers to local services, supports, and resources appropriate to the

concerns identified during the mobile crisis response intervention. MRSS aims to stabilize a youth or young adult during a crisis, averting unnecessary Emergency Department visits, out-of-home placements, placement disruptions, homelessness, arrests/incarceration, or other adverse outcomes. Youth is defined as persons ages infant to 17, regardless of their developmental progression. Young Adult is defined as persons ages 18-21.

While ideally each CMHP would have a dedicated team for MRSS, practical considerations, including workforce availability, may not make that possible in all areas of the state. When MST and MRSS are combined, mobile teams will have to cross train and provide age appropriate services depending on the nature of each deployment. Funding distributed to CMHPs to plan for the implementation of enhanced mobile crisis services will also include MRSS planning in 2022 as the transitional year.

MCT and MRSS Plan Overview

The American Rescue Plan (ARP) Act, enacted on March 11, 2021, establishes a state option to provide enhanced community mobile crisis intervention services funded through Medicaid beginning in April 2022. As an incentive to state adoption, the law provides for an 85% enhanced federal matching rate for qualifying services for the first three years of state coverage. The state option for qualifying community mobile crisis intervention services represents a promising opportunity for Oregon to adopt a more robust and consistent system of mobile crisis services and to better leverage federal funds to sustain these enhanced services.

The federal Center for Medicare and Medicaid Services (CMS) plans to align with the 988 roll out and the Crisis Now model. CMS, through the Center for Medicaid and CHIP Services (CMCS), awarded \$15 million in planning grants to twenty State Medicaid Agencies for the purpose of developing a state plan amendment (SPA), section 1115 demonstration application, or section 1915(b) or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services. Oregon received approximately \$953,000 from this Planning Grant.

In preparation for meeting the expectations for this CMS grant, an OHA/AOCMHP Crisis Workgroup that includes CMHP directors and relevant staff that are geographically representative of each type of county in the state (urban, rural, remote) has been convened. The workgroup is identifying a funding formula to distribute \$21 million for mobile crisis to CMHPs; this amount includes \$10 million appropriated under HB 2417 plus funds set aside from other federal resources by OHA. The workgroup will use requirements from CMS and recommendations from the Crisis System Advisory Workgroup (CSAW) to inform policy decisions and ongoing quality improvement for statewide crisis services. OHA is currently in the process of distributing the \$10

million appropriated under HB 2417 based on a formula identified by the above mentioned Workgroup. The remaining \$11 million one-time federal funding will be used to fund start-up costs for CMHPs to build up and/or enhance their mobile crisis teams. The above \$21 million in addition to existing \$10 million in General Funds that CMHPs already receive. This brings up the total to \$31 million, of which \$20 million will be ongoing funding.

Crisis Receiving Centers

In addition to the 988 centralized call center and robust mobile crisis services, the Crisis Now model includes establishing dedicated facility-based crisis service centers to support people who need specialized care in a safe and supportive environment. According to the Crisis Now model, facility-based crisis services are usually provided in relatively small structures that provide stabilization services for no more than 23 hours. They follow a “no wrong door” approach, and are therefore required to receive everyone who needs crisis services whether voluntary or involuntary and regardless of ability to pay. Often these facilities are more home-like than institutional. They are staffed with a mix of professionals and paraprofessionals. They may operate as part of a community mental health center, in affiliation with a hospital, or a stand-alone facility operating by a non-profit provider organization.

Crisis stabilization facilities function best when the facilities:

- Function as an integral part of a regional crisis system serving a whole population, rather than as an offering of a single provider
- Operate in a home-like environment
- Utilize peers as integral staff members, and
- Have 24/7 access to psychiatrists and/or Master’s-level BH clinicians.

Crisis Stabilization Centers (CSCs) are often under the same roof as a 23-hour CRC. CSCs (also known as short-term crisis stabilization units, crisis triage centers, and crisis response centers or recovery centers) are also typically designed to reflect home-like environments and address behavioral health crises in a community-based provider setting, or in some instances are affiliated with and could be operated by a hospital. This model is found in Arizona, Arkansas, Georgia, North Carolina, and New Mexico. Unlike CRCs, CSCs are bedded units that range from 6-16 beds and are staffed by licensed clinical staff as well as peer support specialists. Services are provided on a 24-hour basis to address immediate safety needs, to develop resiliency, and to create a plan to integrate the individual back in community where they can access long term community-based services.

Of the three core service elements in the crisis care continuum as specified in the National Guidelines, Oregon’s most significant gap is facility-based crisis

services. As a result, a priority for 988 implementation planning – following initial establishment of the 988 call system capacity and development of enhanced mobile crisis and mobile response services – involves standing up facility-based capacity throughout the State.

Unity Center located in Portland was the first alternative setting for psychiatric emergencies in Oregon. Since the launch of Unity Center, Oregon has established three additional facility-based crisis services:

1. Deschutes County Stabilization Center in Bend operated by Deschutes County Health Services
2. Klamath Link Access Center in Klamath Falls, a collaborative project between Klamath Basin Behavioral Health and Sky Lakes Medical Center, and
3. Multnomah Crisis Assessment and Treatment Center (CATC), operated by Telecare Corporation.

Crisis Receiving Centers Status Overview

HB 2417 did not appropriate funding for Crisis Receiving Centers. This is a resource need that still exists. Under existing Oregon administrative rules and licensure, in order for a 24/7 crisis stabilization facility with beds to operate, it would have to be licensed by OHA as either Psychiatric Emergency Services (PES) under OAR 309-023-0100 or Secure Residential Treatment Facility (SRTF) under ORS 309-035-0100. The core elements that define a crisis facility are captured within the PES Rules. Both PES and SRTF licenses require the additional designation for the Civil Commitment Process to fully accept both voluntary and involuntary status individuals. Since it is expected that, under the National Guidelines, facility-based crisis services also provide detoxification, OHA is exploring whether a separate SUD facility license will be required for Crisis Stabilization Centers. Alternatively, new Rules for Crisis Receiving Centers as a new kind of BH facility can also be drafted to include both mental health and substance use disorder services. OHA will conduct rule-making in the last quarter of 2022.

Peer Respite Centers

Peer respites are peer-run, voluntary, short-term (typically up to two weeks), overnight programs that provide community-based, non-clinical support for those experiencing or at risk of experiencing an acute behavioral health crisis. Peer respite facilities operate 24/7 in a homelike environment and can provide a “step-down” from facility-based crisis services, where peer navigation services are provided to assist with transition back to the community. Peer respites also allow users to take a break from stressful life circumstances, while building a community of support with other peers.

House Bill 2980, passed by the Oregon legislature in 2021, provides funding for four peer-run organizations, in the Portland metropolitan area, southern Oregon region, and eastern and central Oregon region. The organizations are to operate peer respite centers that provide peer respite services to individuals with mental illness who experience acute distress, anxiety, or emotional pain. The bill also requires OHA to adopt criteria for peer respite centers that receive funding and to monitor compliance. It included an appropriation to OHA, for the 2021-2023 biennium, of \$2.25 million, which is intended to provide \$750,000 to each of the three peer respite centers. As these organizations come on line in late summer to early fall of 2022, they will be integrated into the crisis service responses in their respective jurisdictions for those experiencing acute crisis.

RII RECOMMENDATIONS

RII Recommended Location and Number of Facilities

The National Guidelines propose two types of crisis facilities:

- Crisis Receiving Centers (CRC) with stays of up to 23 hours for voluntary and involuntary admissions utilizing recliners instead of beds, and
- Crisis Stabilization Centers (CSC) with stays of to 14 days for voluntary and involuntary admissions utilizing beds

RII has provided by county capacity projections resulting in a recommendation for a total of 275 recliners and 175 beds. A by county breakdown and cost projection is available in Appendix C: County Capacity Projections of the attached report. (page 127) The report details that most of the 13 counties with the largest population density, have sufficient crisis service demand to either expand the capacity of existing facility-based crisis services or establish facility-based crisis services within the county limits. However, it is noted that facility-based crisis services may not be financially sustainable for all counties and therefore it is recommended that OHA facilitate the ability to opt to collaborate with other counties in establishing crisis facility assets that will serve a regionally defined service area.

Fee Analysis by RII

RII has provided the following recommendations regarding a potential telecom fee. Further analysis, methodology and recommendations are provided within the full RII report (page 104).

By RII’s calculations, if the Medicaid Administrative Claiming is applied to support 988 crisis call center services, it is projected that Oregon would need a \$0.20 phone surcharge fee in Year One and a \$0.24 charge by Year Five to fully support this service. Without the Medicaid Administrative Claiming (MAC)², the fee for Years One and Five would need to increase to \$0.25 and \$0.32 respectively.

RII has completed scenario cost modeling, and associated phone surcharge fee calculations, for each of the core components of the crisis response system that include both operational costs and capital costs. RII is available to assist OHA with the information necessary to make informed policy recommendations related to structuring phone surcharge fees.

RII Recommendations for Maximizing Federal Financial Participation

The American Rescue Plan (ARP) Act, enacted on March 11, 2021, establishes the state option to provide community mobile crisis intervention services for a five-year period beginning in April 2022. As an incentive to state adoption, the law provides for an 85% enhanced federal matching rate for qualifying services for the first three years of state coverage. Currently, funding for state crisis response systems is pieced together across funding sources and payers. Funding is also largely inadequate to sustain the crisis system using a “firehouse model,” which refers to mobile crisis services providers who are “on-call” and able to be dispatched at all times to anyone in crisis regardless of insurance status. Medicaid can reimburse for crisis services delivered to Medicaid-covered individuals only. Many private insurers may not cover crisis services. Taken together, these factors force states and localities to subsidize crisis services for insured and uninsured individuals using limited state and local funds, which inhibits the access and availability of mobile crisis services across Oregon in the existing model.

The state option for qualifying community mobile crisis intervention services for Medicaid reimbursement represents a promising opportunity for Oregon to better leverage federal funds to sustain its crisis response systems and crisis providers. However, Oregon will be able to claim 85% enhanced federal match on these services for the first three years of the option, and in addition, Oregon should consider developing or enhancing crisis provider reimbursement rates to reflect the cost of making “on call” mobile crisis services available to Medicaid

² Medicaid Administrative Claiming (MAC) means the program allowing partial federal reimbursement for administrative activities that support the goals of the Medicaid state plan.

enrollees. Should Oregon choose to do so, the state will experience significant relief from assuming the majority of MCT costs; and its crisis providers will experience a financing model that makes this service highly sustainable.

TIMELINE, RESOURCE NEEDS, AND CHALLENGES

Proposed Timeline

The following is the tentative timeline for next steps in the planning process, rulemaking, and distribution of the funds for crisis services expansion and implementation:

Dates	Activities
Sept-Nov 2021	<ul style="list-style-type: none"> • OHA engages with 988 Crisis System Advisory Workgroup (CSAW) to collect recommendation from individuals and families with lived experiences • AOCMHP convenes County Mental Health Programs workgroup with geographically representative CMHPs to plan mobile crisis fund distribution formula in partnership with OHA
Nov 2021-Jan 2022	<ul style="list-style-type: none"> • CMHP workgroup, in partnership with OHA, finalizes formula to distribute mobile crisis funds • OHA finalizes additional minimum requirements (MQ) for CMHP plans for mobile crisis implementation. MQs will be based on recommendations from the Crisis System Advisory Workgroup (CSAW) and federal requirements for Medicaid funding
Jan-March 2022	<ul style="list-style-type: none"> • OHA awards \$10M funding (HB 2417 appropriation) for mobile crisis to CMHPs to fill workforce and services gaps in mobile crisis teams and services via MHS 37 • OHA initiates OAR change process to align with federal requirements for Medicaid funding for Mobile Crisis services • OHA initiates SPA planning process internally and with external stakeholders
Mar-Apr 2022	<ul style="list-style-type: none"> • Rules Advisory Committee (RAC) process starts
April-May 2022	<ul style="list-style-type: none"> • CMHPs, in coordination with CCOs and other local existing mobile crisis services programs, submit their plan and timeline to establish mobile crisis services and teams to meet ARPA requirement for Medicaid funding

	<ul style="list-style-type: none"> • AOCMHP workgroup identifies any changes needed in funding formula, in partnership with OHA
May-Jun 2022	<ul style="list-style-type: none"> • OHA reviews and approves CMHP plans • OHA distributes additional \$11M Block Grant funds to CMHPs to implement mobile crisis teams and services meeting requirement for Medicaid funding • OHA continues to monitor CMHP progress and resource needs for mobile crisis services implementation
Jul 22, 2022	<ul style="list-style-type: none"> • 988 goes live
Aug-Oct 2022	<ul style="list-style-type: none"> • CMS Planning Grant ends • State Plan Amendment submitted to CMS • Permanent OAR changes to go into effect
Oct-Dec 2022	<ul style="list-style-type: none"> • CMS potentially approves SPA • All CMHPs comply with OAR, i.e. meet requirements for Medicaid funding • Rule making process for CRCs initiated • Potential pilot sites for CRCs identified

Potential resource needs in 2023

988 Call Center

Oregon has received \$5 million from HB 2417 for the 988 Call center. However potential call volume increase in year one combined with chat and text services project year one cost of approximately \$13 million. In addition, over time, as 988 becomes more well-known and call volume rises, additional resources will be necessary to provide capacity coverage. While OHA is planning to leverage Medicaid Administrative Claiming and/or reimbursement based on federal and consultant recommendations, additional resources may still be needed for the following:

- To sustainably fund the 988 call center, not just in year one, but over the next five years when call, text, and chat volume increase exponentially, the resource need is approximately \$13 million in year one up to \$20 million in year five.
- In addition, CSAW recommends 988 call center staff remain in constant contact with callers until a mobile crisis team arrives on the scene. This will require additional \$3 million to accommodate greater staff time per call.

MCT and MRSS

To ensure that CMHPs can financially sustain the delivery of the enhanced mobile crisis model, OHA is procuring an actuarial firm to develop a financial model that will identify the rates to be set for the Fee for Service Population and for CCO capitation. CMHPs and RI International have both identified the cost of enhanced mobile crisis per year to be \$30 million at least. Therefore, OHA will need \$ 30 million each year to sustainably fund the enhanced mobile crisis services. Currently, OHA has received \$10 million from HB 2417 and added another \$11 million from one- time federal grant funds to make up \$30 million. OHA plans to submit Oregon’s Medicaid State Plan Amendment to CMS no later than June 3, 2022. OHA will change its administrative rules to reflect the State Plan Amendment within that same timeline.

Multiple states are advocating that Congress permanently increase the Medicaid match for mobile crisis services. However, if that effort is not successful, legislatively appropriated funds will be required to sustain the enhanced mobile crisis model.

Crisis Receiving Centers

At this time, no dedicated funding has been appropriated for Crisis Receiving Centers. However, HB5024 of 2021 provided 130 million dollars for capital, start-up, and operational costs related to increasing statewide capacity of licensed residential facilities and housing serving people with behavioral health conditions. This funding is currently being distributed via a series of requests for proposals and these proposals could include Crisis Receiving Centers. At this time OHA is receiving responses to this solicitation though a dedicated funding stream is expected to be needed to successfully implement the proposed model. The projection to start up Crisis Receiving Centers across the state via a regional approach would be \$163 million. Currently, some counties such as Klamath, Multnomah, Deschutes, Lane, and Umatilla are at various stages of readiness to be able to participate in a pilot if given the resources and opportunity.

Challenges

988 Call Center

It is imperative that 988 crisis call centers and 911 dispatch centers develop coordination and training standards to identify and troubleshoot communication concerns, as well as to ensure prompt responses to critical situations. This priority is being addressed by a collaborative workgroup within OHA’s 988 implementation planning structure, in partnership with Oregon’s chapter of the Association of Public Safety Communications-National Emergency Number Association. Coordination is specifically needed regarding telephony technology, addressing, and developing shared training curriculum. However,

there is no common governance structure for 911 programs across the state to enforce uniform standards for all 911 sites. It will take multiple years of coordination, additional resources, and pilot exemplars to slowly roll out coordination standards for 911 and 988 in Oregon.

MCT and MRSS

Under current Oregon administrative rules, CMHPs have the right to assess and decide whether mobile crisis teams should be dispatched. Oregon's 988 call centers will not have the capability or authority to directly dispatch mobile crisis teams. OHA is planning to make changes in relevant rules to ensure that if a 988 call center's clinical supervisor requests a CMHP to dispatch a mobile crisis team, the CMHP will promptly do so without further assessment. This is in alignment with recommendation from CSAW, National Best Practice, and OHA's consultant.

Document accessibility: For individuals with disabilities or individuals who speak a language other than English, OHA can provide information in alternate formats such as translations, large print, or braille. Contact the OHA Communications Unit at 1-971-673-2411, 711 TTY or COVID19.LanguageAccess@dhsoha.state.or.us.