Behavioral Health Crisis Response Stakeholder Coalition

9-8-8 Implementation Planning Meeting #3

South Dakota Department of Social Services

Stakeholder Coalition members:

Roundtable introductions of coalition members

- Department of Social Services
  - **Laura Ringling**
  - **Tiffany Wolfgang**
  - **Bre Baltzer**
  - **Tessia Johnston**
- Contracted Project Supports
  - **Nick Oyen**
  - **Rachel Oelmann**
- Individuals with lived experience
  - **Tara Johanneson**
  - **Rosanne Summerside**
  - **Matthew Glanzer**
  - **Penny Kelly**
- Lifeline Crisis Center
  - **Janet Kittams**
  - **Taylor Funke**
- State Suicide Prevention Coordinators
  - **Jana Boocock** (DSS)
  - **Kiley Hump** (DOH)
- Providers of crisis respite / stabilization services
  - **Thomas Otten** (Avera)
  - **Katherine Sullivan** (Monument Health)
  - **Jeremy Johnson** (Human Services Center)
  - **Teri Corrigan** (Behavior Management Systems)
- Mobile crisis service providers
  - **Kris Graham** (Southeastern Behavioral Health Care)
  - **Amy Iversen-Pollreisz** (Capital Area Counseling Service)

Introductions

Roundtable introductions of coalition members

- Law Enforcement
  - **Staci Ackerman** (SD Sheriffs Association)
  - **Don Hedrick** (SD Police Chiefs Association)
  - **Dave Kinser** (Rapid City PD)
- 911 Leaders
  - **Maria King** (Statewide 911 Coordinator)
- Peer support service providers
  - **Wendy Giebink** (NAMI)
- Mental health and suicide prevention advocacy
  - **Kelli Rumpza** (Human Service Agency)
- Other Stakeholders
  - **Tosa Two Heart** (Great Plains Tribal Leader's Health Board)
  - **Terry Dosch** (Council of Community BH Directors)
  - **Chairman Peter Lengkeek** (Crow Creek Sioux Tribe)
- Technical Assistance Providers
  - **Terresa Humphries-Wadsworth** (Educational Development Center on behalf of Vibrant Emotional Health)

Eight Core Planning Considerations

Overview | BHCRSC Coalition Charter in Summary

- **Background**
  - Nationwide
  - Will be launched by July 2022
  - Transition from current 10-digit crisis number towards 9-8-8
  - All states were awarded funds to support implementation planning for their specific state and response systems in place
  - South Dakota has one Lifeline Center – Helpline Center (some states of multiple Lifeline Centers)
  - Will require implementation of statewide chat and text services in addition to hotline
  - Planning template is forthcoming to guide the work of this coalition

- **Mission & Vision**
  - Coalition is a required activity of the implementation planning grant funding
  - Coalition formed to guide and inform the development of the 9-8-8 statewide implementation plan
  - Three key tasks:
    - Develop plans to address coordination, capacity, funding, and communication strategies to launch 9-8-8
    - Plan for long-term improvement of in-state answer rates for 9-8-8 calls
    - Provide initial considerations for expanded crisis center services and systems to support real-time inventory and dispatch

Eight Core Planning Considerations

Overview | BHCRSC Coalition Charter in Summary

1. Ensuring statewide coverage for 9-8-8 calls, chats, and texts
2. Funding structure for Lifeline Centers
3. Capacity building for Lifeline Centers
4. State/Territory support of Lifeline's operational, clinical and performance standards for centers answering 9-8-8
5. Identification of key stakeholders for 9-8-8 roll out
6. Ensure there are systems in place to maintain local resource and referral listings
7. Ensure ability to provide follow-up services to 9-8-8 users according to Lifeline best practices
8. Alignment with national initiatives around public messaging for 9-8-8

BHCRSC Workgroup Structure & Membership

Workgroup Membership

Crisis Response

This work group provides the coalition with leadership in the fields of crisis response. This group will take the lead in determining the best practices in immediate mobile crisis response and crisis stabilization in South Dakota. Members of this group include:

Bre Baltzer, DSS
Teri Corrigan, BMS
Kris Graham, SEBH
Katherine Sullivan, Monument
Thomas Otten, Avera
Dave Kinser, RCPD
Jeremy Johnson, HSC
Chief Don Hedrick, SD Police Chiefs Association
Staci Ackerman, SD Sheriffs Association

911 / 988 Intercommunication

This work group provides the coalition with operational expertise with crisis calls. This group will take the lead in recommending how 911 and 988 can partner together to best serve South Dakotans with a mental health or suicide crisis. Members of this group include:

Maria King, Statewide 911 Coordinator
Amy Chase, Metro Communications (Sioux Falls 911)
LeAnn Benthin (Watertown PD / 911)
Janet Kittams, Helpline Center
Stephanie Olson (Pennington Co. 911)
Tiffany Wolfgang, DSS

BHCRSC Workgroup Structure & Membership

Workgroup Membership

Diversity & Geographical Considerations

This work group provides the coalition with the crucially import perspective of diversity and geographical considerations. This group will take the lead in determining the important elements that are needed to best support the diversity across South Dakota in a crisis response system. Members of this group include:

Tosa Two Heart, GPTLHB
Tessia Johnston, DSS
Amy Iversen-Pollreisz, Capital Area
Erik Muckey, Lost & Found
Terry Dosch, Council of Community BH
Ellen Durkin
Deb Griffith, HSA & Watertown LOVE
Carissa Weddell

Lived Experience

This work group provides the coalition with the crucially import perspective of individuals with lived experience of suicide thoughts, attempts and loss directly or through a family member. This group will take the lead in determining what are the critical elements of a crisis response system to ensure that it can best serve South Dakotans in crisis. Members of this group include:

Tara Johanneson
Penny Kelley
Rosanne Summerside
Taylor Funke, Helpline Center
Jana Boocock, DSS
Matthew Glanzer
Kelli Rumpza, Human Service Agency
Kiley Hump, DOH
Wendy Giebenk, NAMI

Personal Perspective of Mental Health Crisis Response

First Person Accounts

Reflection on the Testimonials

From what you heard….

- What opportunities for process change or improvement could be taken?
- What could we do to continuously improve our response to crisis situations such as these?

Regional Planning for Crisis Response

Crisis Now Assessment Tool by Region

Crisis Response Planning by Region

Exercise 1

- Timelines will be placed around the room representing each region.
- Each Region will be reviewed on all goals from each level. Each goal will be classified as due by July 2022, in first year, after first year, or not presently a focus
- Review Region 1 and make recommendations as a group for goals of the Crisis Now process.
- Divide into three groups, each group will be assigned a region, either 2, 3, or 4
- Review Region 5 as a large group and complete the same process

Electronic Registry Project Overview

HMA

South Dakota Department of Social Services

Strong Families - South Dakota's Foundation and Our Future

HEALTH MANAGEMENT ASSOCIATES

Electronic Behavioral Health Services Registry Research Project

Stakeholder Meeting
June 24, 2021

OUR PEOPLE

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AGENDA

1. Project Overview/Timeline
2. Progress to date
3. Next Steps
4. Questions

1 PROJECT OVERVIEW

Establish and expand the use of a comprehensive, electronic **behavioral health services registry.**

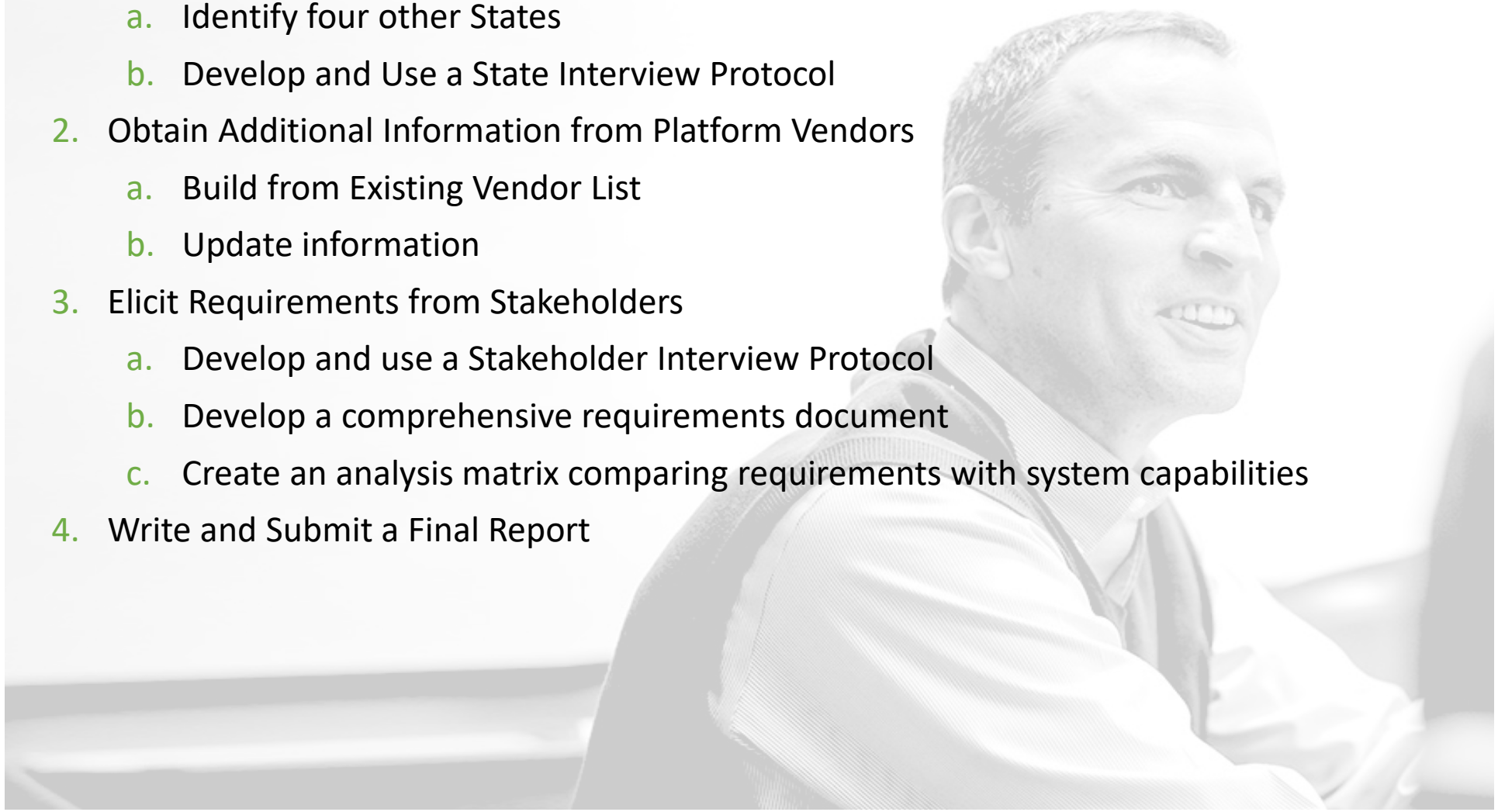
Goal is to collect and display **capacity information** for a comprehensive range of publicly and privately funded **behavioral health service** providers in the State. These providers include, but are not limited to:

- Crisis services
- Mobile crisis services
- Outpatient mental health and substance use disorder services
- Residential mental health and substance use disorder services
- Supportive and recovery housing
- Others to be determined

Review costs, capabilities; develop sustainability plan

1 PROJECT OVERVIEW

1. Research the Current Landscape of Electronic Behavioral Health Registries
    a. Identify four other States
    b. Develop and Use a State Interview Protocol
2. Obtain Additional Information from Platform Vendors
    a. Build from Existing Vendor List
    b. Update information
3. Elicit Requirements from Stakeholders
    a. Develop and use a Stakeholder Interview Protocol
    b. Develop a comprehensive requirements document
    c. Create an analysis matrix comparing requirements with system capabilities
4. Write and Submit a Final Report



2 PROGRESS TO DATE

1. State Interviews
   - ❑ Iowa--Scheduled
   - ❑ Oklahoma--TBD
   - ❑ Nebraska--TBD
   - ❑ Vermont--Scheduled
   - ❑ Possible Additions (time permitting)
     - ❑ Minnesota
     - ❑ Colorado

2. Review Platforms
   - ❑ Five Points
   - ❑ Open Beds
   - ❑ MyAvatar
   - ❑ State-developed (MN)

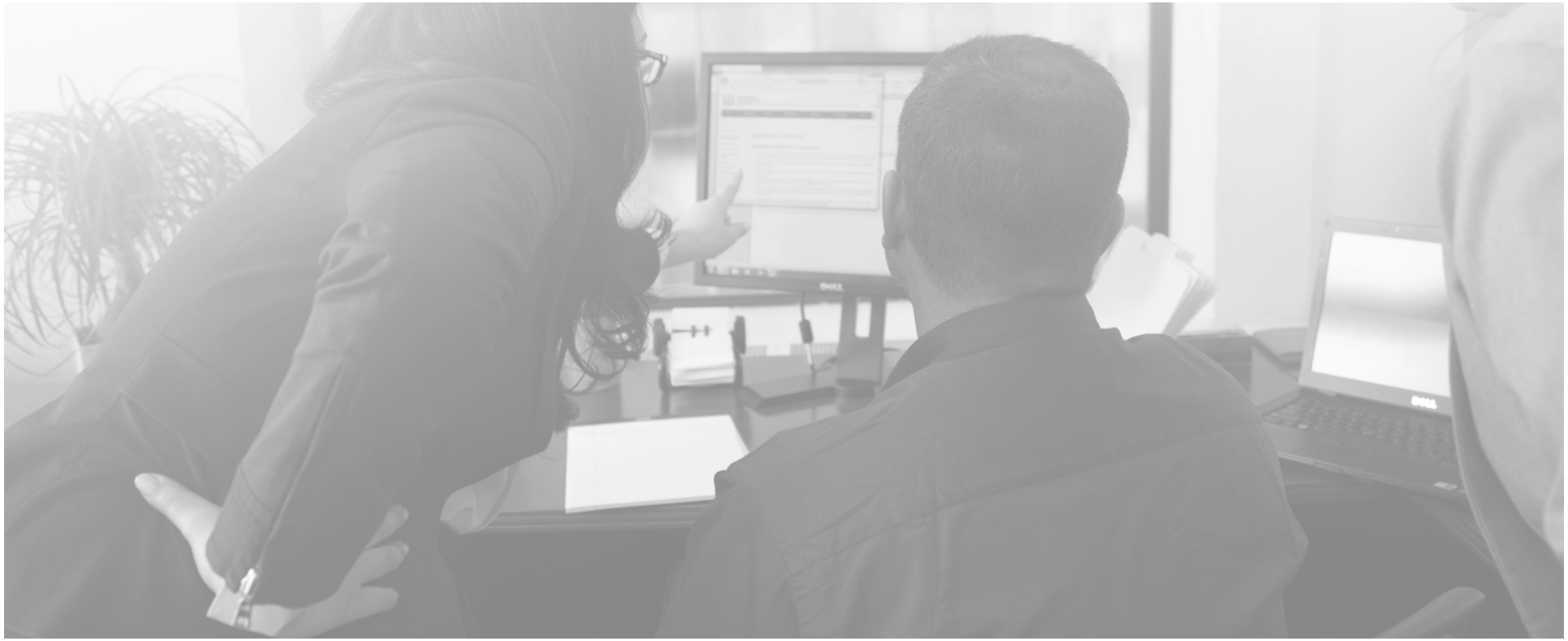
3. South Dakota Stakeholders
   - ❑ Nine Cohorts, 19 stakeholders
   - ❑ Completed three cohorts
     - ❑ Hospitals
     - ❑ Peer Support (SUD/MH)
     - ❑ Helpline
   - ❑ One scheduled for 6/25
   - ❑ Actively trying to schedule remaining meetings

Findings To Date

- ❑ Occasional cross-state use of facilities (MN, IA)
- ❑ IP and Crisis beds are hardest to find, especially for pediatric patients during the school year
- ❑ MH and SUD needs are not interchangable
- ❑ Several groups have their own data resources to use for referrals, but information is not standardized across agencies and largely do not reflect capacity
- ❑ Existing referrals are not an endorsement, just a listing of available service providers
- ❑ Referrals do not include any warm hand-off,
- ❑ If services cannot be located, not a lot of good options:
  - ❑ Crisis support
  - ❑ ER
  - ❑ Jail (last resort)
  - ❑ Availability also regionally specific
- ❑ Needed Information:
  - ❑ By age, and payor
  - ❑ Not all beds are equal—depends on other patients, staff compliment, etc.
- ❑ Ideally information is updated in real-time and via link with other electronic systems; no less frequent that by shift.

3 NEXT STEPS

- Interviews with remaining South Dakota Stakeholders (Please respond if someone reaches out!)
- Interview States
- Collect Information from Vendors
- Review/Discuss Findings




ANY
QUESTIONS?

Fiscal Modeling Project Overview

Guidehouse

988 Fiscal Planning Grant Research Project

State of South Dakota
Department of Social Services
Division of Behavioral Health

South Dakota Department of Social Services
Strong Families - South Dakota's Foundation and Our Future

June 24, 2021

988 Stakeholder Group - June 24th Meeting Presentation

1. State Legislation and Funding Research
2. Federal Guidance and National Funding Research
3. Preliminary Cost Modeling Categories
4. Questions

State Legislation and Funding Research

Guidehouse conducted research on 988 efforts and legislation in 10 states.

Comparable States

- DBH and Guidehouse agreed to focus research on five comparable states including **Alaska, Montana, North Dakota, Nevada, and Utah**.
- Like South Dakota, most comparable states have one Lifeline call center (except for Montana, which has two).
- Guidehouse reviewed 988 initiative-related materials from comparable states, including 988 legislation, press releases, and stakeholder coalition materials (if available).

Additional States

- Guidehouse also reviewed 988 legislation from five other key states, including **Arizona, Idaho, Indiana, Virginia, and Washington**.
- These states are either model states in crisis services or are further along in the 988-implementation process.

State Legislation and Funding Research

Guidehouse organized **funding approaches commonly outlined in 988 state legislation** into four categories:

- State General Funds & Other Non-Fee Approaches
- 988 End-User Fees
- 1115 Medicaid SMI / SED & Demonstration Waivers
- Medicaid Administrative Claiming

State Legislation and Funding Research Summary

Overall, states are at varying stages in 988 design and implementation. While several states have signed 988-related legislation into law, other states have not yet introduced 988-related legislation.

For states which have already adopted a 988 funding approach, the approaches focus on state general funds and other non-fee funding options, end-user fees, and Medicaid reimbursement. Several reviewed states have not adopted a definitive 988 funding approach.

	Comparable States					Other States				
	AK*	MT*	ND*	NV*	UT*	AZ	ID	IN	VA*	WA*
Funding Approach										
State General Funds & Other Non-Fee Approaches**		X		X	X		X	X	X	X
End-User Fee		X		X			X		X	X
Medicaid Reimbursement					X					
To Be Determined	X		X		X	X				
Legislation Status										
None Introduced	X		X			X				
Unsuccessful		X								
Introduced							X			
Signed into Law				X	X			X	X	X

* As of 6/15/2021, legislature adjourned or in special session.[1]

**Includes state general funds; gifts, grants, and donations; interest earnings; and investment income.

Guidehouse

State General Funds & Other Non-Fee Approaches

988 legislation passed by states typically included **appropriations from state general funds**; **gifts, grants, and contributions**; and **investment earnings and interest**. 7 out of 10 states researched included one or all of these funding options in 988 legislation.

These approaches were often used in tandem with end-user fees and Medicaid-focused approaches, including waiver demonstrations and administrative claiming. However, the State of Indiana recently passed legislation that creates a 988 trust fund consisting of only general appropriations, federal funding, investment earnings, and other sources. [2]

Reimbursement from commercial insurers is rare – some insurers fund their own hotlines for members.[3] However, as more payers recognize behavioral health as a cost driver, opportunities for commercial payer reimbursement may emerge. [4]

End-User Fees

What Is An End-User Fee?

- End-user fees are collected fees from mobile and landline communications subscribers.
- End-user fees are imposed across mobile communication services, IP-enabled voice services (VoIP), and landline telephone services in the state.
- Similar to 911 end-user fees, 988 end-user fees may differ according to subscription package (e.g., prepaid vs. contract mobile services).

Research Findings

End-user fees were the second most common funding approach. 5 out of 10 states (ID, MT, NV, VA, WA) proposed end-user fees as a funding approach in 988 legislation.

Typically, states will deposit funds generated from end-user fees in a trust fund to earn interest, invest funds, and add funds from other sources (e.g., state appropriations; grants; gifts and donations).

End-User Fees: State Spotlights

- Imposes a surcharge of $0.10 /month/line for all access lines and $0.10 /transaction for prepaid wireless services.
- Requires communications providers to collect and submit fees to the Department of Revenue via a quarterly return.
- Establishes a statewide 988 account for deposit of all fees received from communications providers. Monies in the fund are used to offset costs associated with 988 implementation, operation, improvement, and expansion. [5]

Montana

- Imposes a surcharge on mobile communication services, IP-enabled voice services and landline telephone services not to exceed $0.35 /month/line.
- Establishes a Crisis Response Account within the State General Fund. Surcharges are collected from telecommunication companies and providers and transferred to the Account.
- Funds the Crisis Response Account with other approaches, including gifts, grants, donations, interest, and investment earnings. [6]

Nevada

End-User Fees: Comparing Fee Amounts – 988 vs. 911

Across most states, 911 end-user fees are a primary funding source for 911 services. The fee amount, distribution, and use vary by state. States also rely on other funding sources – some 911 program components are fully funded by fees, but there are no states that fund the entirety of their 911 system on 911 fees.

988 user fee amounts varied across states. **Proposed 988 user fees are substantially lower than most 911 user fees:**

State	Proposed 988 User Fee	911 User Fee [10]
Idaho [7]	• Amount not specified, but may not exceed 911 user fee	• $1.25 monthly fee maximum
Montana [5]	• $0.10 monthly fee, per line • $0.10 fee per transaction (prepaid wireless only)	• $1.00 monthly fee
Nevada [6]	• $0.35 monthly fee maximum, per line	• Varies by jurisdiction
South Dakota	• N/A	• $1.25 monthly fee • 2% Point of Sale (prepaid wireless only)
Virginia [8]	• $0.12 monthly fee, per line • $0.08 fee per transaction (prepaid wireless only)	• $0.82 monthly fee, per line • $0.55 fee per transaction (prepaid wireless only)
Washington [9]	• $0.24 monthly fee, per line (through 12/31/2022) • $0.40 monthly fee, per line (after 1/1/2023)	• $0.95 combined statewide and county fee

Medicaid Reimbursement: State Examples

States have used innovative methods to capture Medicaid matching funds as reimbursement for crisis call services, including for 988 implementation and operations.

988 example

Under recently passed 988 legislation, the Utah Department of Human Services will **pursue a waiver or State Plan Amendment to enable reimbursement for 988 services** delivered to Medicaid beneficiaries. [11]

Current crisis line examples

The Arizona Health Care Cost Containment System (AHCCCS) **reimburses crisis call center services as a form of telephonic case management**. The service must be delivered to Medicaid beneficiaries or those who are eligible to enroll in Medicaid. [12]

New Mexico's Behavioral Health Services Division was able to secure Medicaid reimbursement for calls to the state's crisis line. **Half of all callers self-identified as being enrolled in Medicaid**; enabling New Mexico to attain a 50 percent match on half of the callers, resulting in 25 percent of the call center's costs being subsidized by Medicaid. [3]

Federal Guidance and National Funding Research

Beyond state legislation on 988, Guidehouse reviewed relevant federal guidance, national publications, and other academic sources for 988-related funding options**. There are several more potential funding approaches to explore for supporting 988 implementation efforts.** Options include, but are not limited to the following:

- Medicaid Technology Claiming
- American Rescue Plan State and Local Recovery Funds
- SAMHSA Mental Health & SA Block Grant
- Medicaid Managed Care
- Commercial Insurers

Potential Funding Approaches

Short Term	**American Rescue Plan State and Local Recovery Funds**	South Dakota could allocate some portion of its $980 million in State Recovery Funds and $120 million in capital project funds, as well as coordinate and leverage county and municipal Local Recovery Funds for 988 implementation. U.S. Treasury Guidance of 5/10/21 supports use of funds for crisis hotlines and services.
Short Term	**SAMHSA Mental Health & SUD Block Grants**	South Dakota could consider allocating a portion of its Supplemental FY 21 MHBG and SABG awards (under ARPA) of $3.08 million and $4.89 million to 988 implementation.
Long Term	**1115 Medicaid Demonstration Waivers**	States may seek federal Medicaid reimbursement for behavioral health services, including crisis services. Waiver opportunities include SMI/SED IMD waivers, as well as broader delivery system transformation waivers. States may seek new payment models under these waivers, including bundled payment for crisis services with enhanced federal reimbursement.
Long Term	**Medicaid Administrative and System Claiming**	States may leverage federal reimbursement (generally at 50 percent FFP) for administering case management or wraparound crisis services to Medicaid populations. In addition, states should consider submitting APDs (advanced planning documents) to CMS for 75 percent and 90 percent reimbursement for Medicaid system buildouts for 988.
Long Term	**988 End-User Fees**	FCC 988 Final Report and Order permits states to impose fees on communication access lines (e.g., landline, mobile, VoIP) to support 988 implementation and operation.
Long Term	**State General Funds & Other Non-Fee Funding**	States may utilize state general funds, gifts, grants, investment income, to support 988 implementation and operations.
Longer Term	**Managed Care & Commercial Insurer Assessment**	In the longer term, states can leverage managed care contracts for delivery and payment of crisis services. States can require MCOs to help administer the 988 system, contract with any willing crisis provider, and cover 988 system costs. States should also consider how to leverage contribution from commercial insurers.

Preliminary Cost Modeling Categories

Several cost components will need to be considered for 988 implementation. Preliminary costs may include, but are not limited to, the following:

FCC Identified Costs

- Update Switches; replace legacy equipment
- Potential construction / reconfiguration costs to connect switches
- Texting capability to 988; Integrated text service
- Direct Video / TTY
- Crisis center funding and capacity

Vibrant Identified Costs

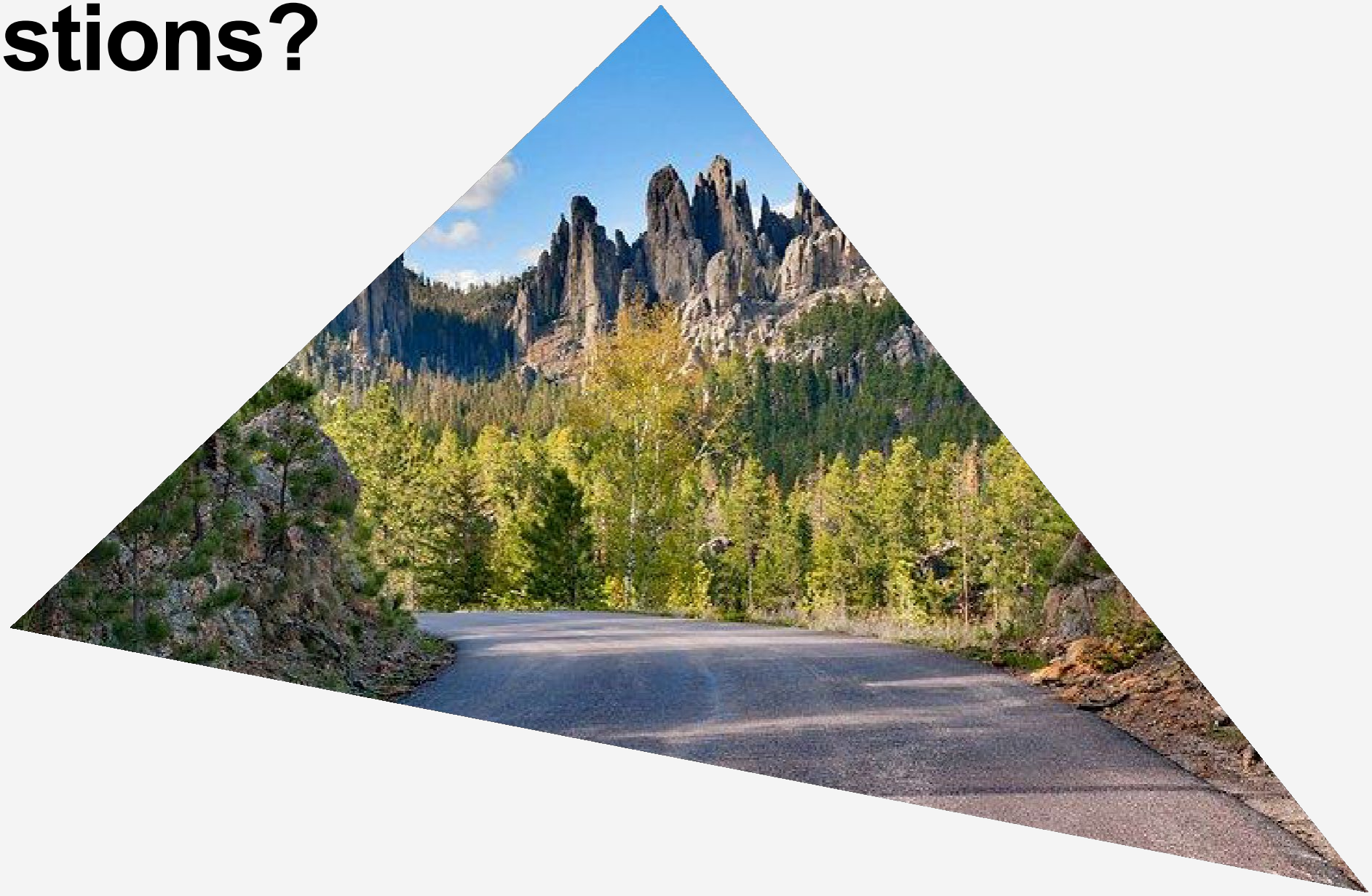
- Operational Expenses
  - *Dedicated and Shared Expenses for staffing*
  - *Hardware, software, HR oversight, network center fixed costs (e.g. rent, utilities)*
  - *Ongoing training & supervisions of staff tied to nature of crisis work*
  - *Technical IT support as needed*
- Service modality costs (Phone, Chat, Text)
- Service Drivers
  - *Service standards, workforce and logistics*
  - *Training and education*
  - *Network size, routing, key performance indicators that will drive staffing & training costs*

Other Costs to Consider and Factor in for Sustainable Model

- Changes in crisis services delivery capacity / payment models due to implementation of 988
- Medicaid MMIS system changes impacted by 988
- Organizational design costs for (i) Statewide Governing Board, (ii) Command Center, and (iii) Satellite Centers, including:
  - *GPS enabled Mobile Crisis Dispatch*
  - *Crisis bed management system*
  - *24/7 Outpatient scheduling*
  - *Data Collection/Outcome reporting*

Note: This is a preliminary list of relevant costs, not all of which will need to be incorporated into the final cost model. These costs may be incurred by telecommunications carriers, the State, or other parties.

Questions?



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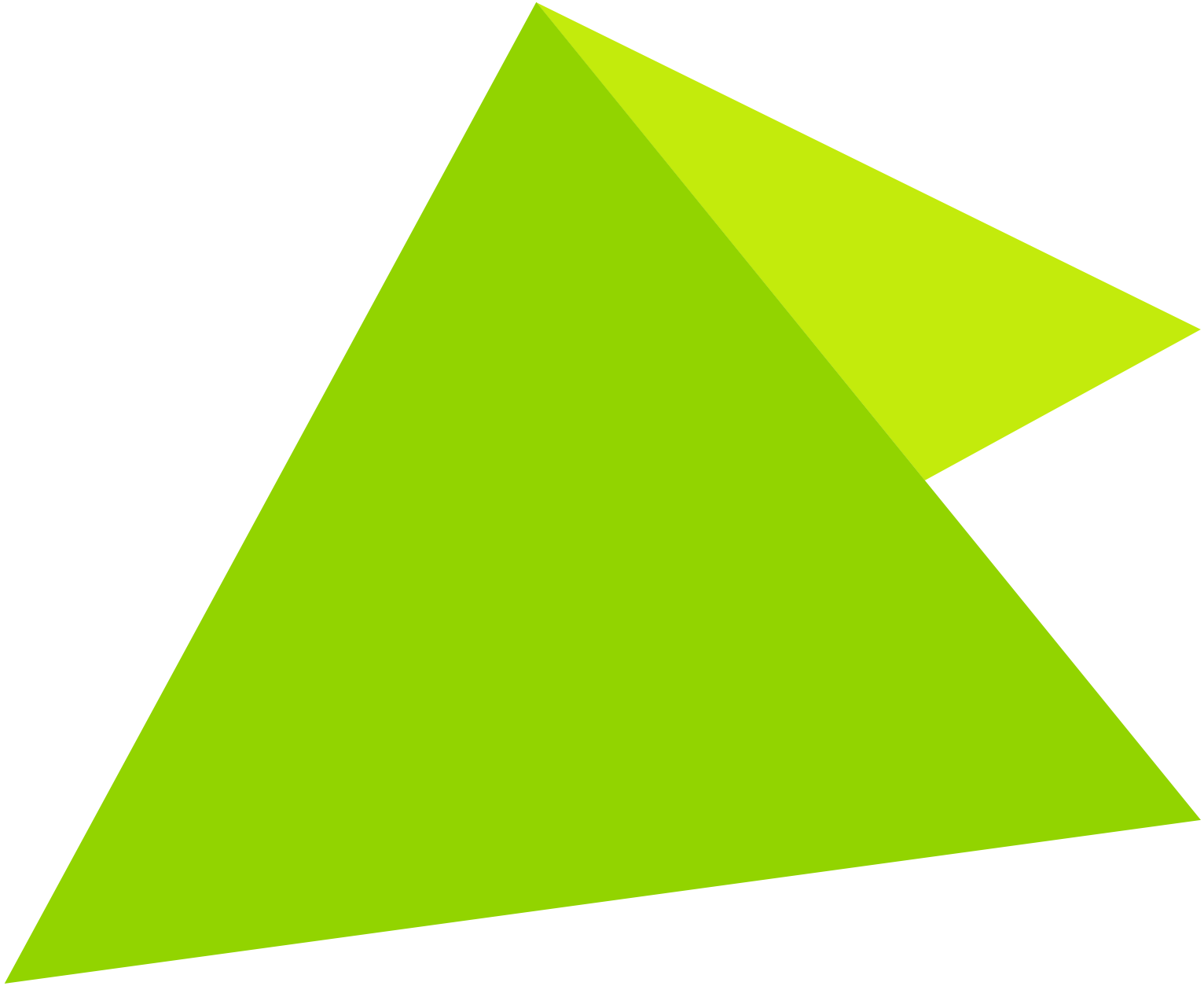

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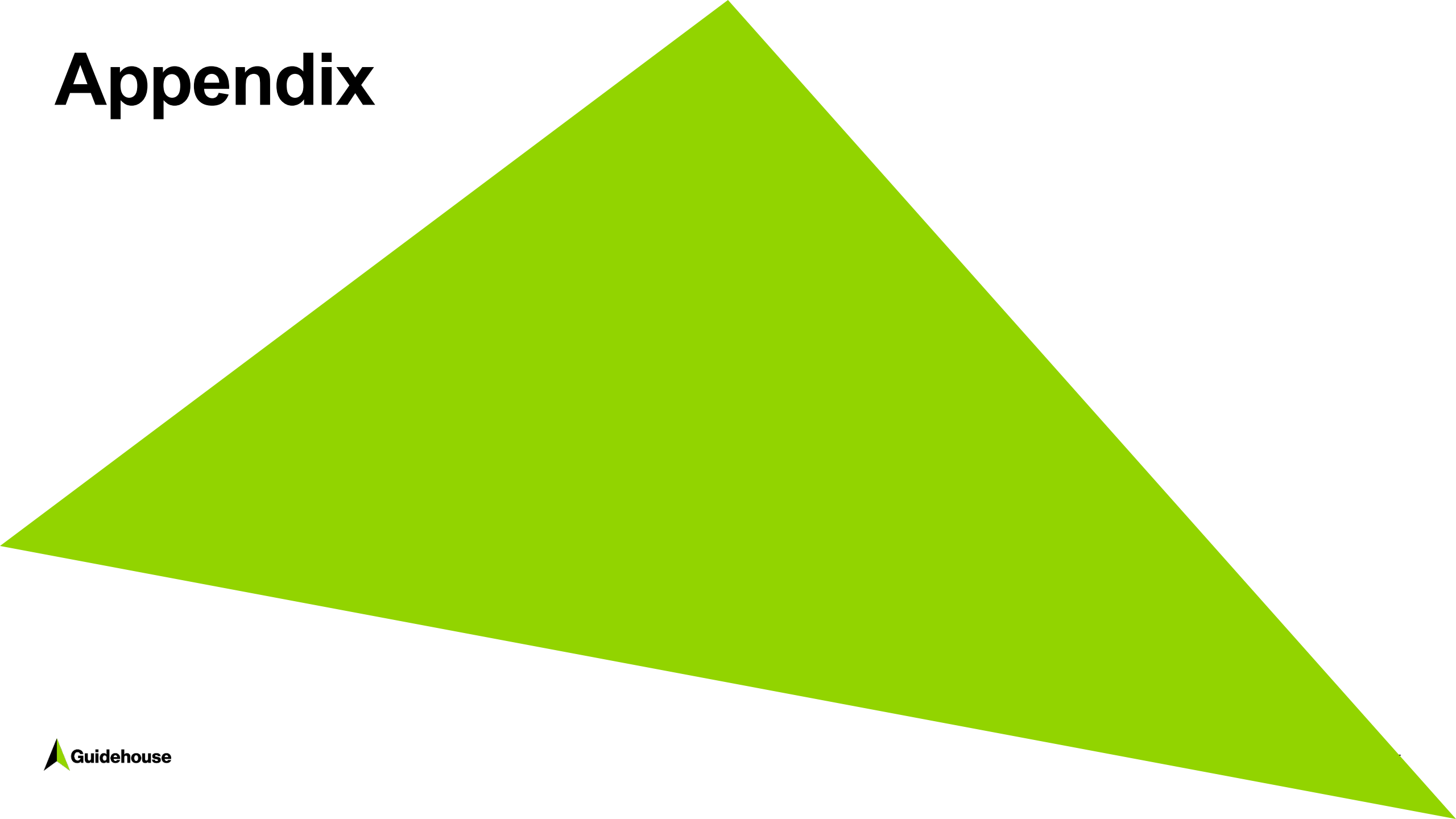
Appendix



988 End-User Fees

- The Federal Communications Commission (FCC) permits states to assess a fee on access lines to fund call routing, personnel, and provision of mental health and crisis outreach services in response to 988 calls.
- States must pass legislation to enact the small monthly fee on phone bills. As discussed previously, several states are enacting legislation to assess 988 end-user fees.

What Is An End-User Fee?

- End-user fees are collected fees from mobile and landline communications subscribers.
- End-user fees are imposed across mobile communication services, IP-enabled voice services (VoIP), and landline telephone services in the state.
- Similar to 911 end-user fees, 988 end-user fees may differ according to subscription package (e.g., prepaid vs. contract mobile services)

911 End-User Fees

Across most states, 911 fees are a primary funding source for 911 services. The fee amount, distribution, and use vary by state. States also rely on other funding sources – some 911 program components are fully funded by fees, but there are no states that fund the entirety of their 911 system on 911 fees.

Section 1115 SMI / SED IMD Medicaid Waiver Authority

Section 1115 waivers are intended for experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program and better serve Medicaid populations.

History of Crisis Call Center Inclusion in 1115 SMI / SED IMD Demonstrations

In SMD # 18--011 "*Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance*", CMS outlined goals and milestones for states to include within 1115 SMI / SED waiver applications: [13]

1. Reduced utilization and lengths of stay in EDs among Medicaid beneficiaries with SMI or SED while awaiting mental health treatment in specialized settings;
2. Reduced preventable readmissions to acute care hospitals and residential settings;
3. **Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;**
4. Improved access to community-based services to address the chronic mental health care needs of beneficiaries with SMI or SED including through increased integration of primary and behavioral health care; and
5. Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Section 1115 SMI / SED IMD Medicaid Waiver

State Spotlights

Alaska

Alaska's Substance Use Disorder and Behavioral Health Program 1115 IMD Demonstration authorized federal matching of costs for "crisis stabilization services designed to stabilize and restore the individual to a level of functioning that does not require inpatient hospitalization." The demonstration included establishing a 1-800 crisis support line for substance abuse. [14]

Idaho

In April 2020, Idaho was approved for a Section 1115 SMI / SED IMD Demonstration, enabling the state to receive federal financial participation (FFP) to improve access to a continuum of behavioral health services. The demonstration encompassed "services made available through crisis call centers, mobile crisis units, coordinated community response services that include law enforcement and other first responders, and observation/assessment centers." [15]

Utah

Utah's Primary Care Network (PCN) 1115 demonstration enables the State to receive FFP for services delivered to Medicaid beneficiaries with SMI, including crisis stabilization services. The demonstration includes a plan to increase the availability of services made available through crisis call centers. [16]

Medicaid Claiming

Background

Components of crisis call centers can be covered under Medicaid as **administrative costs** or **technology costs**.[17, 18]

Administrative Claiming

- Administrative claiming enables states to match at least 50 percent of costs. **In South Dakota, FMAP percentage is 58.69% percent**. [19]
- Current CMS guidance notes that states may be able to access Medicaid administrative match for crisis call centers as long as they **use an appropriate methodology to allocate costs to Medicaid.**

Technology Claiming

- States may also be able to obtain an enhanced administrative match of up to **90 percent** under Medicaid Information Technology Infrastructure (MITA) 3.0 to help support the crisis continuum.
- Enhanced funding under MITA 3.0 may be used to establish crisis call centers to connect Medicaid beneficiaries with treatment and develop technologies to link beneficiaries with serious mental illness to mobile crisis care.[17]

Medicaid Administrative Claiming

Current CMS guidance on administrative claiming for crisis services / call centers does not outline an appropriate methodology for allocating costs to Medicaid, but refers to guidance on tobacco quit lines.

CMS Guidance (SMD # 18—011)

"…**States may be able to access administrative match for crisis call centers as some states have done for tobacco quit lines.** However, in order to access administrative match for crisis call centers, a state would have to **justify in a reasonable manner how many callers are Medicaid beneficiaries in order to properly allocate costs to Medicaid**…" [13]

In accordance with federal requirements for Medicaid matching funds for tobacco quit lines, states would be required to "document the extent to which the call center provides services to Medicaid beneficiaries." This may require surveying callers for Medicaid eligibility; however, **federal guidance also permits calculating a Medicaid eligibility ratio to determine the approximate percentage of Medicaid-eligible callers in the total universe of callers served by the call center** or using an existing plan from the State Medicaid Agency as a model. [20]

ARPA State & Local Recovery Funds for South Dakota

Funding and Guidelines

State of South Dakota $974 Million Direct Payment

SD Cities Rapid City/Sioux Falls $38.4 Million Direct Payment

SD Counties $170 Million Direct Payment

SD Non-Entitlement Areas $65.2 Million

- Funding Amounts are rounded
- Source: US Treasury, State & Local Recovery Funds

Allowable Uses of State and Local Funding *Through December 31, 2024**

1. To respond to COVID Public Health Emergency, or its negative economic impacts, including assistance to households, small business, & non-profits, or aid to impacted industries such as tourism, travel and hospitality
2. To respond to workers performing essential work during COVID by providing premium pay to eligible workers of the state, territory, or Tribal government
3. For provision of government services to the extent of reduction in revenue of the state (or territory/Tribal govt) due to COVID relative to revenues collected in the most recent fiscal year
4. For necessary investments in “water, sewer, and broadband”

* Funds Obligated by 12/31/24 may be expended through 12/31/26

ARPA Behavioral Health Funding

Funding for Block Grants for Community Mental Health Services

For use by SAMHSA to allocate via MH state block grant program

$1.5B

Funding for Block Grants for Prevention and Treatment of Substance Abuse

For use by SAMHSA to allocate via SUD state block grant program

$1.5B

Funding for Block Grants for Prevention and Treatment of Substance Abuse

Grants to communities and community mental health providers that meet the criteria for Certified Community Mental Health Centers

$400M

Funding for Behavioral Health Workforce Training

Grants to educational institutions for recruitment and training of clinical BH workforce

$100M

Funding for Mental and Behavioral Health Training for healthcare professionals, para-professions and public safety officers

HRSA grants/contracts to public or private nonprofit entities to plan, develop, operate, or participate in health professions and nursing training in evidence-informed strategies for reducing and addressing suicide, burnout, and mental and behavioral health conditions (including substance use disorders)

$80M

Funding for Pediatric Mental Healthcare

To expand statewide or regional pediatric mental health care telehealth access programs

$80M

Funding for Local Community Based BH Needs

Grants to states, tribes and non-profits to address increased community behavioral health needs worsened by the COVID–19 public health emergency

$50M

Funding for Local Community Based SUD Services

Grants to states, Tribes and non-profits to support community-based overdose prevention programs, syringe services programs, and other harm reduction services exacerbated by the COVID–19

$30M

Youth Suicide Prevention

For carrying out sections 520E and 520E–2 of the Public Health Service Act (42 U.S.C. 290bb–36, 290bb–36b).

$20M

Guidehouse

Community Mental Health Services Block Grant (MHBG)

Authorized by the Public Health Service Act

Administered by SAMHSA's Center for Mental Health Services (CMHS) Division of State and Community Systems Development (DSCSD)

MHBG Target Populations

- Adults with Serious Mental Illness
- Children with Serious Emotional Disturbances

Requirements for States and Territories

- Submit plan and annual reports
- Ensure Community Mental Health Centers (CMHCs) provide essential services
- Comply with federal grant management requirements
- Form and support a mental health planning council

American Rescue Plan – MHBG Supplemental Awards

State	Award Amount	State	Award Amount
Nevada	$15,102,828	Rhode Island	$5,302,664
New Hampshire	$5,031,475	South Carolina	$21,480,779
New Jersey	$39,121,366	South Dakota	$3,078,898
New Mexico	$8,682,696	Tennessee	$27,280,443
New York	$80,040,583	Texas	$128,821,616
North Carolina	$41,535,246	Utah	$12,884,438
North Dakota	$2,478,813	Vermont	$2,445,549
Northern Mariana Islands	$286,951	Virgin Islands	$590,398
Ohio	$44,517,241	Virginia	$35,786,432
Oklahoma	$15,708,052	Washington	$33,202,279
Oregon	$22,640,725	West Virginia	$7,778,761
Palau	$118,745	Wisconsin	$24,630,652
Pennsylvania	$46,842,615	Wyoming	$1,811,283
Puerto Rico	$18,182,788		

Source: GFAO

American Rescue Plan – SABG Awards

State	Award Amount	State	Award Amount
Nevada	$13,764,133	Red Lake Indians	$480,861
New Hampshire	$5,640,385	Rhode Island	$6,150,916
New Jersey	$38,907,646	South Carolina	$19,199,380
New Mexico	$7,742,896	South Dakota	$4,890,725
New York	$90,525,693	Tennessee	$25,886,179
North Carolina	$36,420,651	Texas	$117,140,711
North Dakota	$5,288,864	Utah	$13,428,346
Northern Mariana Islands	$286,951	Vermont	$5,229,225
Ohio	$52,241,251	Virgin Islands	$590,398
Oklahoma	$13,882,277	Virginia	$33,982,454
Oregon	$16,658,035	Washington	$30,586,435
Palau	$118,745	West Virginia	$6,826,198
Pennsylvania	$47,841,221	Wisconsin	$22,016,587
Puerto Rico	$18,182,788	Wyoming	$3,397,896

Source: GFAO

Potential Strategies for Use of ARPA FY 21Supplemental Funding for MHBG

Supplemental Block Grant funding can be used for many purposes, including but not limited to:

- Supporting needs assessment activities
- Build out the crisis services continuum
- Connect patients to telehealth and technology resources
- 24/7 access systems for youth and other populations
- Develop local partnerships
- Workforce development

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9-8-8 Planning

Workgroup Breakout Sessions to Refine the Plan

Workgroup Break-Out Sessions

Key Questions to Consider

- What work elements are missing?
- What pieces of information do we not know, or what do we not yet understand to inform an action plan?
- What are the top priority (big rock) issues that we need to address first, before others can be addressed?
- What partners would you recommend be at the table to implement these action steps?

Reminders

- This coalition is charged with identifying opportunities, and making recommendations, not solving the problem today.

Thank You