

(iii) community health workers, translators, and other individuals with culturally-appropriate expertise; and

(B) be freestanding, virtual, or based at a children's hospital, hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity determined to be appropriate by the State and approved by the Secretary.

(7) Health team

The term “health team” has the meaning given such term for purposes of section 256a-1 of this title.

(Aug. 14, 1935, ch. 531, title XIX, § 1945A, as added Pub. L. 116-16, § 3, Apr. 18, 2019, 133 Stat. 853.)

Editorial Notes

REFERENCES IN TEXT

Section 5001 of Public Law 111-5, referred to in subsec. (c)(3)(B), is section 5001 of Pub. L. 111-5, div. B, title V, Feb. 17, 2009, 123 Stat. 496, which was formerly set out as a note under section 1396d of this title.

§ 1396w-5. Addressing health care disparities

(a) Evaluating data collection approaches

The Secretary shall evaluate approaches for the collection of data under this subchapter and subchapter XXI, to be performed in conjunction with existing quality reporting requirements and programs under this subchapter and subchapter XXI, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, sex, primary language, and disability status. In conducting such evaluation, the Secretary shall consider the following objectives:

- (1) Protecting patient privacy.
- (2) Minimizing the administrative burdens of data collection and reporting on States, providers, and health plans participating under this subchapter or subchapter XXI.
- (3) Improving program data under this subchapter and subchapter XXI on race, ethnicity, sex, primary language, and disability status.

(b) Reports to Congress

(1) Report on evaluation

Not later than 18 months after March 23, 2010, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status for the programs under this subchapter and subchapter XXI; and

(B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1395w-22(e)(3) of this title and other nationally recognized quality performance measures, as appropriate, on such bases.

(2) Reports on data analyses

Not later than 4 years after March 23, 2010, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for beneficiaries under this subchapter and under subchapter XXI based on analyses of the data collected under subsection (c).

(c) Implementing effective approaches

Not later than 24 months after March 23, 2010, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, sex, primary language, and disability status.

(Aug. 14, 1935, ch. 531, title XIX, § 1946, as added Pub. L. 111-148, title IV, § 4302(b)(2), Mar. 23, 2010, 124 Stat. 581.)

§ 1396w-6. State option to provide qualifying community-based mobile crisis intervention services

(a) In general

Notwithstanding section 1396a(a)(1) of this title (relating to Statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), section 1396a(a)(23)(A) of this title (relating to freedom of choice of providers), or section 1396a(a)(27) of this title (relating to provider agreements), a State may, during the 5-year period beginning on the first day of the first fiscal year quarter that begins on or after the date that is 1 year after March 11, 2021, provide medical assistance for qualifying community-based mobile crisis intervention services.

(b) Qualifying community-based mobile crisis intervention services defined

For purposes of this section, the term “qualifying community-based mobile crisis intervention services” means, with respect to a State, items and services for which medical assistance is available under the State plan under this subchapter or a waiver of such plan, that are—

(1) furnished to an individual otherwise eligible for medical assistance under the State plan (or waiver of such plan) who is—

(A) outside of a hospital or other facility setting; and

(B) experiencing a mental health or substance use disorder crisis;

(2) furnished by a multidisciplinary mobile crisis team—

(A) that includes at least 1 behavioral health care professional who is capable of conducting an assessment of the individual, in accordance with the professional's permitted scope of practice under State law, and other professionals or paraprofessionals with appropriate expertise in behavioral health or mental health crisis response, including nurses, social workers, peer support specialists, and others, as designated by the State through a State plan amendment (or waiver of such plan);

(B) whose members are trained in trauma-informed care, de-escalation strategies, and harm reduction;

(C) that is able to respond in a timely manner and, where appropriate, provide—

- (i) screening and assessment;
- (ii) stabilization and de-escalation; and
- (iii) coordination with, and referrals to, health, social, and other services and supports as needed, and health services as needed;

(D) that maintains relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care organizations (if applicable); and

(E) that maintains the privacy and confidentiality of patient information consistent with Federal and State requirements; and

(3) available 24 hours per day, every day of the year.

(c) Payments

Notwithstanding section 1396d(b) or 1396d(ff) of this title and subject to subsections (y) and (z) of section 1396d of this title, during each of the first 12 fiscal quarters occurring during the period described in subsection (a) that a State meets the requirements described in subsection (d), the Federal medical assistance percentage applicable to amounts expended by the State for medical assistance for qualifying community-based mobile crisis intervention services furnished during such quarter shall be equal to 85 percent. In no case shall the application of the previous sentence result in the Federal medical assistance percentage applicable to amounts expended by a State for medical assistance for such qualifying community-based mobile crisis intervention services furnished during a quarter being less than the Federal medical assistance percentage that would apply to such amounts expended by the State for such services furnished during such quarter without application of the previous sentence.

(d) Requirements

The requirements described in this subsection are the following:

(1) The State demonstrates, to the satisfaction of the Secretary that it will be able to support the provision of qualifying community-based mobile crisis intervention services that meet the conditions specified in subsection (b).

(2) The State provides assurances satisfactory to the Secretary that—

(A) any additional Federal funds received by the State for qualifying community-based mobile crisis intervention services provided under this section that are attributable to the increased Federal medical assistance percentage under subsection (c) will be used to supplement, and not supplant, the level of State funds expended for such services for the fiscal year preceding the first fiscal quarter occurring during the period described in subsection (a);

(B) if the State made qualifying community-based mobile crisis intervention services available in a region of the State in such fiscal year, the State will continue to

make such services available in such region under this section during each month occurring during the period described in subsection (a) for which the Federal medical assistance percentage under subsection (c) is applicable with respect to the State.

(e) Funding for State planning grants

There is appropriated, out of any funds in the Treasury not otherwise appropriated, \$15,000,000 to the Secretary for purposes of implementing, administering, and making planning grants to States as soon as practicable for purposes of developing a State plan amendment or section 1315, 1396n(b), or 1396n(c) of this title waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services under this section, to remain available until expended.

(Aug. 14, 1935, ch. 531, title XIX, §1947, as added Pub. L. 117-2, title IX, §9813, Mar. 11, 2021, 135 Stat. 213.)

§ 1396w-7. Supporting access to a continuum of crisis response services under Medicaid and CHIP

(a) Guidance

Not later than July 1, 2025, the Secretary, in coordination with the Administrator of the Centers for Medicare & Medicaid Services and the Assistant Secretary for Mental Health and Substance Use, shall issue guidance to States regarding Medicaid and CHIP that includes the following:

(1) Provides, in consultation with health care providers and stakeholders with expertise in mental health and substance use disorder crisis response services, recommendations for an effective continuum of crisis response services that—

(A) includes crisis call centers, including 988 crisis services hotlines, mobile crisis teams, crisis response services delivered in home, community, residential facility, and hospital settings, and coordination with follow-on mental health and substance use disorder services, such as intensive outpatient and partial hospitalization programs, as well as connections to social services and supports;

(B) promotes access to appropriate and timely mental health and substance use disorder crisis response services in the least restrictive setting appropriate to an individual's needs; and

(C) promotes culturally competent, trauma-informed care, and crisis de-escalation.

(2) Outlines the Federal authorities through which States may finance and enhance under Medicaid and CHIP the availability of crisis response services across each stage of the continuum of crisis response services.

(3) Addresses how States under Medicaid and CHIP may support the ongoing implementation of crisis call centers, including 988 crisis services hotlines, and how Medicaid administrative funding, including enhanced matching, and the Medicaid Information Technology Architecture 3.0 framework, may be used to establish or enhance regional or statewide crisis