

# A Safe Place for Help

## A Guide to Implementing High-Intensity, Place-Based Behavioral Health Crisis Care in Alaska



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*Disclaimer: This document was created for reference purposes and should not replace an organization’s review of source documents for licensing, regulatory and billing requirements. This document does not constitute legal advice or supersede the practices, policies or procedures for any operator of high-intensity stabilization services.*

# Purpose

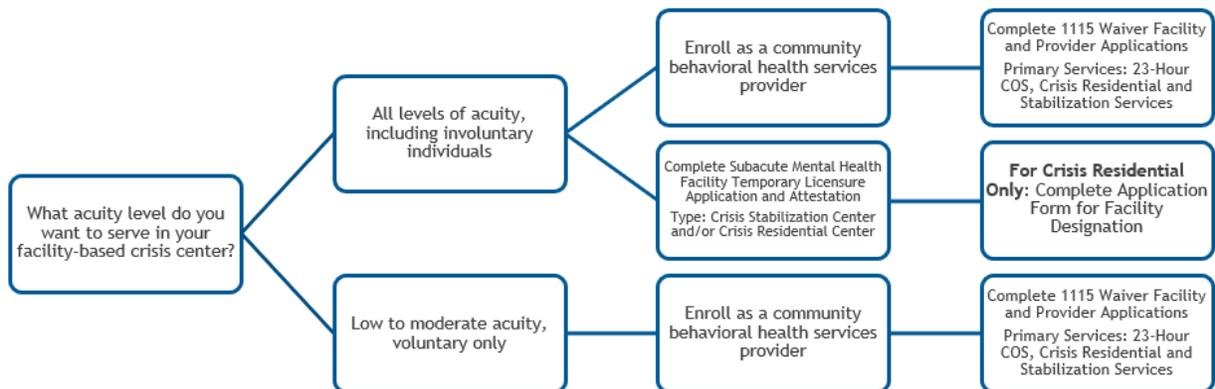
SAMHSA’s Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services (2025) introduced new terminology for place-based crisis care settings that operate under a “no-wrong-door” philosophy and are equipped to serve individuals in high-intensity crisis (but are not limited to serving only this highest-acuity population). SAMSHA’s definitions for community-based provision of this level of care include two components:

- **High-Intensity Behavioral Health Emergency Centers** “...operate with two functions: no barrier access and stabilization. High-Intensity Centers accept all arrivals, including those that are unplanned and unscheduled, without pre-screening or requirement to be “medically cleared” prior to arrival. These centers can provide immediate medical triage and ambulatory-level care for non-urgent medical issues and may transfer an individual requiring further medical work-up and/ or management to an ED with expectation of re-acceptance upon medical stabilization. These centers can provide withdrawal management services requiring 24-hour medical monitoring outside of an inpatient hospital setting.” This level of care typically uses recliners instead of beds and provides stabilization services for a period of less than 24 hours.
- **High-Intensity Behavioral Health Extended Stabilization Centers** “...are connected to the High Intensity [Emergency] Centers. These facilities offer extended behavioral health emergency care beyond the initial 24 hours and provide access to individual bed space. They typically offer services for an average of 3-5 days. They provide an additional period of stabilization, as may be necessary before the help seeker can return to the community or transfer to another setting based on the person’s unique needs and preferences. They can provide continued withdrawal management services requiring 24-hour medical monitoring outside of an inpatient hospital setting.”

This document describes what is known about the regulatory and funding landscape for **high-intensity, place-based behavioral health crisis care** in Alaska, as well as the barriers to implementation and outstanding questions related to the alignment of licensing, regulatory and funding requirements. This document attempts to clarify terminology and summarize the status of existing efforts. This document is intended to support place-based crisis services provided in settings outside of hospitals; however, components of this overview, such as the section on Designated Evaluation and Stabilization facilities and Mental Health Treatment Assistance Program, are applicable to hospital and non-hospital operators.

It is important to understand the divergent pathways for implementing place-based behavioral health crisis care in community settings in Alaska. Not all providers want to operate high-intensity services and not all communities have sufficient demand or workforce to sustain this level of service in a community-based setting. For providers who wish to operate place-based crisis services for individuals who are voluntary for treatment and present with low to moderate-acuity, the lower pathway in **Figure 1** is the most appropriate. For providers who wish to serve individuals with all levels of acuity, including those with the highest needs and those who are involuntary, the upper pathway of **Figure 1** provides an overview of the Medicaid billing and State of Alaska licensing and designation requirements. This document provides further detail for providers considering the high-intensity, high acuity pathway (upper pathway in **Figure 1**).

Figure 1: Pathways to implementing place-based behavioral health crisis care in community settings



## Systems Alignment Efforts

While the alignment of policy, regulation and funding streams to support “no wrong door” crisis care has long been a goal of systems leaders working in the behavioral health crisis care space, the alignment occurs incrementally and has not kept pace with community desire to see new opportunities for center-based behavioral health crisis care realized or with provider planning processes.

There are three areas where systems alignment efforts are underway or are needed: Service levels and billing, licensing and transportation.

## Service Levels and Billing

**Table 1 - Levels of Care and Alignment with Alaska Billing and Regulatory Terminology** highlights the differences in terms used to describe a level of place-based care as proposed by SAMSHA, Alaska Medicaid, and facility licensing and designation. Understanding the landscape of implementing place-based crisis services in Alaska is challenged because:

- 1) The same Medicaid service names, descriptions and rates are applied to multiple intensities of crisis care, and
- 2) The applicability of facility licensing and designation requirements (only for facilities that wish to provide high-intensity care to voluntary and involuntary individuals) is not well understood.

Table 1: Levels of Care and Alignment with Alaska Billing and Regulatory Terminology

	SAMSHA Level of Care	Alaska Medicaid Billing	Alaska Facility Licensing	Alaska Designation Requirements
Stay <24 hours	High-Intensity BH Emergency Center	1115 Waiver 23-Hour Crisis Observation and Stabilization	Subacute mental health facility: crisis stabilization center	n/a
	Moderate-Intensity BH Crisis Center	1115 Waiver 23-Hour Crisis Observation and Stabilization	TBD	n/a
Stay >24 hours	High-Intensity BH Extended Stabilization Center	1115 Waiver Crisis Residential and Stabilization Services	Subacute mental health facility: crisis residential center	Designated Evaluation and Stabilization (DES)
	Moderate-Intensity BH Extended Stabilization Center	1115 Waiver Crisis Residential and Stabilization Services*	TBD	n/a
	Moderate-Intensity Crisis Residential Low-Intensity Crisis Residential	<i>* Additional review needed to determine if this service is currently applicable to all three SAMSHA levels of care identified at left.</i>		

A glossary of terms is provided in Appendix A.

The Division of Behavioral Health recognizes the challenge presented by one service description and rate for a wide range of care intensities and is actively working to create additional service descriptions and billing rates that are aligned with varying intensities and types of care.

### Enhancements to Service Continuum

In September 2025, Milliman released the report [Potential Enhancements to Alaska’s Behavioral Health Crisis Continuum](#), which includes recommendations for a place-based continuum of crisis services and settings. If implemented, place-based crisis services available to bill under Alaska Medicaid would shift from one service each for under 24-hour and over 24-hour care to five services for under 24-hour care and four services for over 24-hour care. **Table 2** shows the alignment between current and proposed place-based crisis services.

Table 2 - Current and Potential Enhancements to Alaska’s Place-Based Crisis Service Array

	Under 24-Hour Services	Over 24-Hour Services
<b>Current Services</b>	23-Hour Crisis Observation and Stabilization Services	Crisis Residential and Stabilization Services

<b>Proposed Services</b>	High-Intensity Subacute Crisis Stabilization Center*	High-Intensity Subacute Extended Crisis Residential*
	Moderate Intensity Crisis Stabilization Center	Moderate Intensity Extended Crisis Residential
	Behavioral Health Urgent Care	Peer Crisis Residential Respite
	Sobering Center	Crisis Residential (referral-based)
	Peer Living Room	

\*Per Milliman, these services would align with Alaska’s current subacute mental health facilities requirements.

### ***Enhancements to Rates***

The second component of Division of Behavioral Health-led efforts is an evaluation of Medicaid payment rates. Guidehouse Inc. completed an evaluation of reimbursement for Medicaid community behavioral health services, including State Plan, 1115 Waiver and Applied Behavior Analysis services. Results were shared publicly in a September 2025 report: [Alaska Rate Evaluations - Community Behavioral Health Services](#). Guidehouse’s recommendation specific to crisis services was: “Alaska Medicaid should establish rates for expanded crisis service options that are thoroughly informed by provider costs and well-suited to the deliver models adopted by Alaska providers.” Guidehouse recommended increases in rates for 23-Hour Crisis Observation and Stabilization Services and Crisis Residential and Stabilization Services as currently written and continues work with the Division of Behavioral Health to identify rates and fiscal impacts of the service array proposed by Milliman.

## **Licensing Regulations**

The processes for developing licensing regulations for subacute mental health facilities is a multi-year process:

- July 2022: House Bill 172 was signed into law. HB 172 amended Title 47 to allow non-hospital entities to provide evaluations for civil commitment and created a subacute facility type.
- 2023: Health Care Services released interim licensing guidance for subacute mental health facilities.
- August 2024: Proposed final licensing regulations for subacute mental health facilities out for public comment
- December 2024: Public comment on subacute mental health facilities published
- June 2025: Proposed final licensing regulations for subacute mental health facilities re-released for public comment
- December 2025: Final subacute mental health facilities licensing regulations adopted
- January 8, 2026: Subacute mental health facilities licensing regulations effective date

Finalized licensing regulations give organizations implementing subacute mental health facilities the necessary clarity to design facilities, staffing patterns and processes that incorporate these requirements and align them with other requirements such as those from accrediting bodies, Medicaid and Medicare.

## **Transportation**

Understanding funding mechanisms that support transportation to and between crisis stabilization centers and crisis residential centers and from these settings to additional discharge options is identified as an area where further clarification is needed. The table below attempts to document what is known about the scenarios where Department of Family and Community Services (DFCS) funds are accessible for individuals who are involuntary and outstanding questions to review with Alaska Medicaid. The first table describes scenarios where an individual presents voluntarily for treatment and either has Medicaid, a commercial payer or is uninsured. The second table is for the scenarios applicable to individuals who are involuntary, either under a notice of emergency detention or a 72-hour ex parte order.

The scenarios below do not describe the full breadth of transportation challenges experienced during crisis situations. Rural, off the road system communities experience additional difficulties in coordinating transportation for individuals in behavioral health crisis due to weather, availability of aircraft or staff to respond, regional variations in process and available resources, coordination between local health clinics, law enforcement and Tribal behavioral health providers and hospitals and reimbursement for behavioral health crisis transports.

### Voluntary Individuals

Voluntary: Scenario	Payer: Medicaid	Payer: Commercial	Payer: Uninsured
For all scenarios, will the payer also cover the cost for secure transport of the individual?			
Individual presents to an emergency department, is identified with behavioral health needs and is appropriate for transportation to a 23-hour crisis stabilization center.	Unknown	Unknow what, if any, transportation scenarios will be covered by commercial payers. Conversations with providers indicated that transportation is typically not covered and the sending facility must cover the cost of travel.	No known payment mechanism.
Individual is receiving care at a subacute mental health facility (crisis stabilization or crisis residential) and requires treatment at a medical facility: Emergency treatment (ambulance) vs. non-emergency but necessary care.	Unknown		
Individual is at a subacute mental health facility (crisis stabilization or crisis residential) and needs additional treatment at an inpatient psychiatric hospital.	Unknown		
Individual is an adolescent traveling outside of their home community to receive care. Additional days needed for parent to support transition into a program.	Unknown		
Individual is ready to discharge from a subacute mental health facility (crisis stabilization or crisis residential) but needs transportation home or to their next level of care.	Unknown		

### Involuntary Individuals: Notice of Emergency Detention and Commitment Orders

[AS 47.30.870](#) states: “When a person is to be involuntarily committed to a facility, the department shall arrange, and is authorized to pay for, the person’s necessary transportation to the designated facility accompanied by appropriate persons and, if necessary, by a peace officer. The department shall pay return transportation of a person, the person’s escorts, and, if necessary, a peace officer, after a determination that the person is not committable, at the end of a commitment period, or at the end of a voluntary stay at a treatment facility...”

DFCS funds for the transport of involuntary individuals are only applicable when the receiving facility is a designated facility.

Involuntary: Scenario	Will DFCS cover transportation costs?
Individual presents to an emergency department, is identified with behavioral health needs and is under a NED, and is appropriate for transportation to the 23-hour crisis stabilization center.	Per 6/19/24 meeting: Transportation would not be paid for by DFCS because the receiving facility is not a designated facility.
Individual presents to an emergency department, is identified with behavioral health needs and is under a NED. ED staff file a petition for commitment at a crisis residential center and the petition is approved.	Per 6/19/24 meeting: Transportation to the subacute mental health facility - crisis residential center - would be paid for by DFCS as long as the crisis residential center is a designated facility.

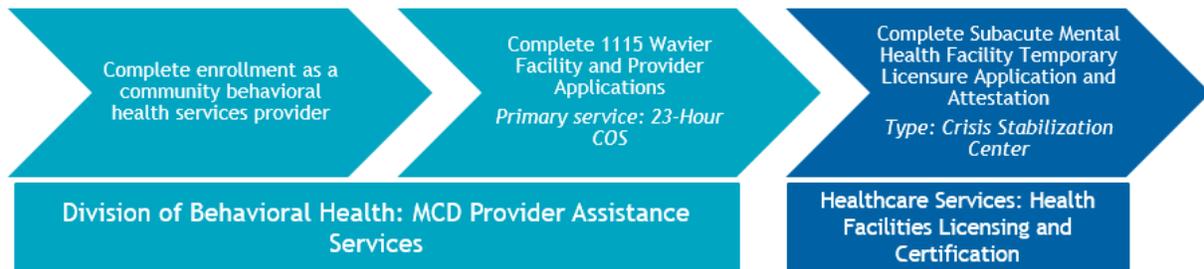
Individual is receiving care at a crisis stabilization center (crisis stabilization or crisis residential) and requires treatment at a medical facility.	Per 6/19/24 meeting: Transportation would likely not be covered by DFCS.
Individual is at a subacute mental health facility (crisis stabilization or crisis residential) and staff file for and are approved a petition for a 30-day commitment.	Per 6/19/24 meeting: Transportation to API or a DET facility would be paid for by DFCS.

## Implementation Overview and Outstanding Questions

### High-Intensity Behavioral Health Emergency Center<sup>1</sup>

Operating a high-intensity behavioral health emergency center in Alaska requires the steps outlined in Figure 2 below. These steps and the following tables apply to settings with stays typically less than 24 hours.

Figure 2: Implementing a community-based High-Intensity Behavioral Health Emergency Center



To operate a *high-intensity behavioral health emergency center* in Alaska that bills Medicaid, a provider will:

- Be **enrolled** with the Division of Behavioral Health as a Community Behavioral Health Services provider
  - Requires accreditation by CARF, COA or Joint Commission
- **Bill** 1115 MCD Waiver - 23-Hour Crisis Observation and Stabilization for Medicaid clients and adhere to program descriptions and requirements described in the Standards and Administrative Procedures
  - 23-Hour COS is the primary service, but other services may be billed in addition
- Be **licensed** as a sub-acute mental health facility - crisis stabilization center

### Regulatory Framework Overview

The following tables provide a side-by-side glance of the existing regulatory framework for billing and licensing of settings that wish to provide a level of care aligned with SAMHSA’s definition of a high-intensity behavioral health emergency center.

<sup>1</sup> SAMSHA terminology is used because Milliman recommendations and service titles are not yet finalized. This section aligns with Milliman’s proposed service “High-Intensity Subacute Crisis Stabilization Center”.

High-Intensity Behavioral Health Emergency Center	Billing (1115 Waiver 23-Hour Crisis Observation and Stabilization)	Licensing (Subacute Mental Health Facility, Crisis Stabilization Center)
<b>Description</b>	Services provided for up to 23 hours and 59 minutes in a secure environment to an individual presenting with acute symptoms of mental or emotional distress, and that must (A) be provided by a multidisciplinary team supervised by a physician, a physician assistant, or an advanced practice registered nurse; (B) result in prompt evaluation and stabilization of the individual's condition; and (C) ensure that the individual is safe from self-harm, including suicidal behavior.	“Subacute mental health facility” means a facility, or a part or unit of a facility, that has been designed to evaluate, stabilize, and treat, on a short-term, intensive, and recovery-oriented basis, and without the use of hospitalization, individuals experiencing an acute behavioral health crisis, including a crisis stabilization center and a crisis residential center; in this paragraph, “crisis stabilization center” means a subacute mental health facility that has a maximum stay of 23 hours and 59 minutes.
<b>Place of Service &amp; Patient Status</b>	Various, outpatient	Non-hospital
<b>Target Population</b>	Acute symptoms of mental or emotional distress who need a secure environment for evaluation and stabilization	Must be included in statement of center’s purpose (see 7 AAC 12.377)
<b>Assessment/ Screening</b>	<p>Must provide either co-occurring capable or enhanced evaluation.</p> <p>Prompt evaluation</p>	<p>7 AAC 12.384(c) A center shall conduct an initial evaluation of each patient who presents for treatment. The evaluation must</p> <ol style="list-style-type: none"> <li>(1) Be performed by a mental health professional [def. AS 47.30.915]</li> <li>(2) Be initiated not more than 30 minutes and completed not later than three hours after the patient’s arrival</li> <li>(3) Be used to determine the patient’s eligibility for and the appropriateness of services provided by the crisis stabilization center; and</li> <li>(4) Include <ol style="list-style-type: none"> <li>(A) An assessment of whether the patient is in imminent danger to self or others</li> <li>(B) An assessment of risk for imminent withdrawal</li> <li>(C) A breath analysis and urine drug screen...</li> <li>(D) A check of vital signs</li> <li>(E) Clinical assessment of the patient’s current condition to determine the patient’s primary medical problems...</li> <li>(F) A brief patient medical history</li> </ol> </li> </ol>

High-Intensity Behavioral Health Emergency Center	Billing (1115 Waiver 23-Hour Crisis Observation and Stabilization)	Licensing (Subacute Mental Health Facility, Crisis Stabilization Center)
<p><b>Services</b></p>	<p>Service components:</p> <ul style="list-style-type: none"> <li>• Assessment</li> <li>• Psychiatric evaluation</li> <li>• Nursing</li> <li>• Medication services (prescription, administration and management)</li> <li>• Crisis intervention services</li> <li>• ID and resolution of crisis' contributing factors</li> <li>• Stabilization of withdrawal symptoms</li> <li>• Linkage and referral to community-based services</li> </ul> <p>Service requirements include:</p> <ul style="list-style-type: none"> <li>• Ensuring individual is safe from self-harm</li> <li>• Prompt stabilization</li> <li>• Coordination with law enforcement</li> <li>• Coordination with crisis residential services</li> <li>• Co-occurring capable or enhanced service provision</li> </ul>	<p>Treatment services 7 AAC 12.387(a)(2)</p> <ul style="list-style-type: none"> <li>(A) Individual crisis assessment</li> <li>(B) Psychiatric evaluation services</li> <li>(C) Nursing services</li> <li>(D) Therapeutic interventions to decrease and stabilize a presenting crisis</li> <li>(E) Identification of a crisis's contributing factors</li> <li>(F) Withdrawal symptom stabilization, if applicable</li> <li>(G) 24-hour observation</li> <li>(H) Advocacy, networking and support to provide linkage and referral to community-based services; and</li> <li>(I) Medication services, including prescription, administration and management</li> </ul>
<p><b>Involuntary (emergency detention)</b></p>	<p>n/a</p>	<p>Initial evaluation initiated not more than 30 minutes and completed not later than three hours after arrival (7 AAC 12.384(c)(2))</p> <p><i>Statutory requirements:</i>          Except as provided in (b) of this section, when a crisis stabilization center admits a respondent under AS 47.30.705, the crisis stabilization center may hold the respondent at the center for a period not to exceed 23 hours and 59 minutes. A mental health professional shall examine the respondent within three hours after the respondent arrives at the center (AS 47.30.707(a))</p> <p>...a mental health professional may submit an ex parte application to the court under this section for detention at the crisis residential center or evaluation facility...the respondent may remain at the crisis stabilization center until admission to a crisis residential center or evaluation facility (AS 47.30.707(b))</p>

High-Intensity Behavioral Health Emergency Center	Billing (1115 Waiver 23-Hour Crisis Observation and Stabilization)	Licensing (Subacute Mental Health Facility, Crisis Stabilization Center)
Facility Licensing	n/a	Subacute mental health facility, <a href="#">AS 47.32.900</a> (21)
Accreditation	Joint Commission, COA, CARF or alternative approved by the department (7 AAC 70.150)	7 AAC 12.379(k) A center...may request a waiver of a biennial inspection...if the center holds a current accreditation from a nationally recognized organization that meets the standards of AS 47.32 and 7 AAC 12.375 - 7 AAC 12.399, as determined by the department.
Medicaid Reimbursement	S9484 V1/V2: \$126.89 per hour, up to 23-hours and 59 minutes	n/a
Staffing	<p>Multidisciplinary team supervised by a physician, physician assistant, or advanced practice registered nurse</p> <p>At least one service component per episode must be provided by a medical professional with prescribing privileges (telehealth may be used).</p>	<p>7 AAC 12.383. Staffing</p> <ul style="list-style-type: none"> <li>• Full-time center administrator; may be shared with collocated CSC</li> <li>• Clinical director (Physician, PA or APRN); may function as the licensed prescriber may be shared with collocated CSC</li> <li>• Licensed prescriber (Physician, PA or APRN)</li> <li>• RN; may be shared in a collocated center if combined census is 16 patients or fewer</li> <li>• Mental health professionals</li> <li>• Non-licensed/non-certified staff</li> </ul>
Transportation	n/a	<p>7 AAC 12.384. Admission, transfer, and discharge</p> <p>(e) A center shall have a written discharge plan for each patient to provide continuity of services that includes</p> <p>(1) The patient’s transfer or referral to outside resources, continuing care appointments and crisis intervention assistance...</p> <p>(h) A center that transfers a patient shall</p> <p>(1) request and receive approval from the receiving facility before the patient may be transferred...</p>

## ***Outstanding Questions***

- How will 23-hour facilities that have the capability to accept individuals under a notice of emergency detention communicate these capabilities compared with 23-hour facilities that do not?
- Are there opportunities to make funds available for individuals who are awaiting a bed at a crisis residential center, evaluation facility or treatment facility who must stay in the 23-hour COS setting past 23-hours and 59 minutes?
- For those without a payer, the mental health commitment clock starts in the 23-hour setting. This setting is not eligible for designation and therefore not eligible for associated funds, how will providers be compensated for these admissions?
- Will Medicaid cover the cost of transportation in any of the following scenarios for voluntary individuals:
  - Individual presents to an ED, is identified with BH needs and is appropriate for transportation to a crisis stabilization center.
  - Individual is receiving care at a crisis stabilization center and requires treatment at a medical facility that is not an emergency but cannot be provided on-site.
  - Individual is at a crisis stabilization center and needs transportation to ongoing care: Inpatient, residential, ALF, etc.

## High-Intensity Behavioral Health Extended Stabilization Center<sup>2</sup>

Operating a high-intensity behavioral health extended stabilization center in Alaska requires the steps outlined in Figure 3 below. These steps and the following tables apply to settings with stays typically greater than 24 hours.

Figure 3: Implementing a community-based High-Intensity Behavioral Health Extended Stabilization Center



To operate a *high-intensity behavioral health extended stabilization center* in Alaska that bills Medicaid, a provider will:

- Be **enrolled** with the Division of Behavioral Health as a Community Behavioral Health Services provider
  - Requires accreditation by CARF, COA or Joint Commission
- **Bill** 1115 MCD Waiver - Crisis Residential and Stabilization Services (CSS) for Medicaid clients and adhere to program descriptions and requirements described in the Standards and Administrative Procedures
  - CSS is the primary service, but other services may be billed in addition
- Be **licensed** as a sub-acute mental health facility - crisis residential center
- Be **designated** by the Department of Family and Community Services as a Designated Evaluation and Stabilization Center

### *Facility Designation Process*

Because becoming a Designated Evaluation and Stabilization (DES) facility is a new process for all community behavioral health providers, additional information is included here about how to become a designated facility.

The Department of Family and Community services requested public input related to 7 AAC 72 Designated Facilities in late 2025. Following the public comment period, designated facilities regulations are currently under review by the department. This section will need to be reviewed and updated once new regulations designated facilities are effective.

<sup>2</sup> SAMSHA terminology is used because Milliman recommendations and service titles are not yet finalized. This section aligns with Milliman’s proposed service “High-Intensity Subacute Extended Crisis Residential”.

Figure 4: Designated Facility Application Requirements<sup>3</sup>

Licensed Facility must submit:	Facility Exempt from Licensure must submit:
<ul style="list-style-type: none"><li>• Application for Designation (form supplied by the department)</li><li>• A copy of the facility's license</li><li>• Facility Certification of Compliance for Designation (form supplied by the department)</li><li>• A copy of the table of contents for the hospital's behavioral health policies and procedures</li></ul>	<ul style="list-style-type: none"><li>• Application for Designation (form supplied by the department)</li><li>• A copy of the facility's current accreditation</li><li>• Facility Certification of Compliance for Designation (form supplied by the department)</li><li>• A copy of the most recent accreditation report</li><li>• A copy of the table of contents for the hospital's behavioral health policies and procedures</li></ul>

Changes to [7 AAC 72. Civil Commitment](#) include the addition of a new subsection (c) to [7 AAC 72.015](#) to include licensed hospitals, crisis residential centers licensed as subacute mental health facilities and facilities exempt from state licensure that meet specified criteria as facilities that can operate as designated evaluation facilities. This proposed change, and other changes to 7 AAC 72, aligns this chapter with HB 172 and will create a clearer pathway to designation for crisis residential centers licensed as subacute mental health facilities. Regulation changes were filed on March 26, 2025 with an effective date of April 25, 2025.

To request designation application forms, learn more about the designation process, or request updates on regulatory changes, reach out to the Health Program Manager at [fcs.des.det@alaska.gov](mailto:fcs.des.det@alaska.gov). Additional information, including the Designated Facility Manual can be found on the Department of Family and Community Services webpage: <https://dfcs.alaska.gov/Commissioner/Pages/Complex-Care/Civil-Commitment/Designated-Facilities.aspx>.

### ***Designated Facility Reimbursement***

Another area where significant questions have emerged is regarding if and how designated crisis residential centers can be compensated for services provided to individuals who are non-resourced but meet involuntary commitment criteria.

The Mental Health Treatment Assistance Program (MHTAP) is the established statutory and regulatory program for reimbursing designated facilities as the payer of last resort for uncompensated care for patients who meet involuntary commitment criteria, have no other payer source, and meet the low-income threshold set out in regulation. MHTAP funds are only available to patients who have received evaluation or treatment at a designated facility that is not a state-operated hospital. The figure below provides an overview of the program elements defined in statute and regulation.

<sup>3</sup> Alaska Department of Family and Community Services. What is a designated facility? Accessed April 4, 2025 at: <https://dfcs.alaska.gov/Commissioner/Pages/Complex-Care/Civil-Commitment/Designated-Facilities.aspx>.

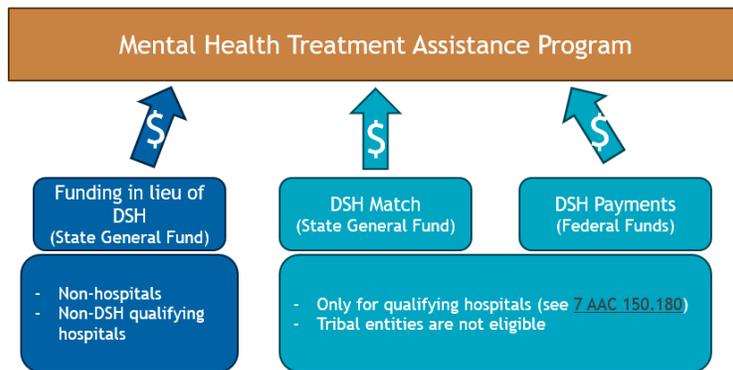
**AS 47 Chapter 31 Mental Health Treatment Assistance Program (AS 47.31) establishes:**

- Eligibility for assistance
- Application process
- How decisions about eligibility are determined
- How payment is made
- Process for appealing eligibility decisions

**7 AAC 72 Article 10 Mental Health Treatment Assistance Program (7 AAC 72 .500 - 7 AAC 72.540) establishes:**

- Rates to be paid for certain mental health services
- Types and levels of mental health services for which financial assistance is available
- Standards for verifying eligibility
- Standards to interpret or implement AS 47.31

MHTAP brings together funding from the State General Fund and Medicaid Disproportionate Share Hospital (DSH) Payments<sup>4</sup>. Federal DSH funds require a state match, which comes from state general funds. As the name implies, DSH is only available to hospitals and not all hospitals are eligible. Tribal entities and hospitals that do not meet state requirements as identified in [7 AAC 150.180](#) are not eligible. <sup>5</sup> Examples of hospitals that currently receive Behavioral Health DSH funds for qualifying services and individuals include: Bartlett Regional Hospital DET, Fairbanks Memorial Hospital DET and PeaceHealth DES.



Recognizing that Tribal entities (hospital and non-hospital) and DES programs established outside of hospitals are not eligible for DSH funding, the HB 172 fiscal note included additional undesignated general funds (UGF) for: the state match for DSH-eligible entities and funding for facilities in lieu of DSH.

<i>Table adapted from HB172CS(FIN)am-DFCS-DET-5-11-2022</i>	FY23	FY24	FY25	FY26	FY27	FY28
# of DSH qualifying facilities	1	2	2	2	2	2
Fed DSH (in MCD Services Fiscal Note)	\$150K	\$300K	\$300K	\$300K	\$300K	\$300K
UGF for DSH (HB 172 Fiscal Note)	\$150K	\$300K	\$300K	\$300K	\$300K	\$300K
# of Non-DSH qualifying facilities	1	3	7	7	7	11
UGF funding for facilities in lieu of DSH (HB 172 Fiscal Note)	\$300K	\$900K	\$2.1M	\$2.1M	\$2.1M	\$3.3M

<sup>4</sup> There are additional service types that receive DSH funding, but the MHTAP reimbursement application process only applies to facilities with the DSH classification type of Designated Evaluation and Treatment or Designated Evaluation and Stabilization.

<sup>5</sup> Example: Mat-Su Regional Medical Center is a designated facility but is not eligible for DSH.

The pathway for designated crisis residential centers to receive funds via the MHTAP program is further clarified by Department of Family and Community Services (DFCS) staff responses to questions regarding MHTAP statute and regulation:

- Point of clarification: [AS 47.31.010](#)(b)(1) still references inpatient evaluation or treatment and [AS 47.31.100](#)(4) uses an old definition of evaluation facility that does not include crisis residential centers.
  - **Resolution:** Per DFCS, “DFCS has worked with the Department of Law regarding the interpretation of this statute to ensure that CRCs can access MHTAP funds if they are designated”.<sup>6</sup>
- Point of clarification: The description of payment rates and services in [7 AAC 72.500](#) appear to be most applicable to hospitals. Is there enough flexibility to include reimbursement for behavioral health driven services under [7 AAC 72.520](#)(10) other services directly related to the admission being billed as determined by the department on a case-by-case basis?
  - **Resolution:** Per DFCS, “Yes, this fits under (10) if the patient qualifies for MHTAP.”<sup>7</sup>

The DES/DET Manual provides additional detail on the procedures, information and forms required to access MHTAP funds for qualifying individuals (see pages 14-23). The manual states that the DES/DET Program Manager and DES/DET Coordinator will assist the designated facility administrator in understanding the facility’s responsibilities and train facility staff on how to complete and submit an MHTAP application.

### ***Regulatory Framework Overview***

The following tables provide a side-by-side glance of the existing regulatory framework for billing and licensing of settings that wish to provide a level of care aligned with SAMHSA’s definition of a high-intensity behavioral health extended stabilization center.

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<sup>6</sup> Email communication, Julia McMullen. April 29, 2025.

<sup>7</sup> Ibid.

High-Intensity Behavioral Health Extended Stabilization Center	Billing (1115 Waiver Crisis Residential and Stabilization Services)	Licensing (Subacute Mental Health Facility, Crisis Residential Center)	Designation (Designated Evaluation and Stabilization)
<b>Description</b>	Services provided to an eligible individual under this chapter presenting with acute mental or emotional disorders requiring psychiatric stabilization and care...The crisis residential and stabilization services must be (1) provided (A) as a short-term residential program with 16 or fewer beds; (B) as a medically monitored stabilization service designed to restore the individual to a level of functioning that does not require inpatient hospitalization; and (C) to assess the need for medication services and other post-discharge treatment and support services...	“Subacute mental health facility” means a facility, or a part or unit of a facility, that has been designed to evaluate, stabilize, and treat, on a short-term, intensive, and recovery-oriented basis, and without the use of hospitalization, individuals experiencing an acute behavioral health crisis, including a crisis stabilization center and a crisis residential center; in this paragraph, “crisis residential center” means a subacute mental health facility that has a maximum stay of 7 days for an involuntary admission.	“Evaluation facility” means a hospital or crisis residential center that has been designated or is operated by the department to perform the evaluations described in AS 47.30.660 – 47.30.915, or a medical facility operated under 25 U.S.C. 5301 – 5423 (Indian Self-Determination and Education Assistance Act), as amended, that performs evaluations
<b>Place of Service &amp; Patient Status</b>	Various, outpatient	Non-hospital, outpatient	Subacute mental health facility (non-hospital)  Hospital, outpatient or inpatient
<b>Target Population</b>	Acute mental or emotional disorders requiring psychiatric stabilization and care	Must be included in statement of center’s purpose (see 7 AAC 12.377)	Individuals experiencing a mental or behavioral health crisis who are admitted voluntarily or under an involuntary court order
<b>Assessment/ Screening</b>	Must be seen by a physician, PA, psychiatrist or APRN within 24 hours of admission to conduct an assessment, address issues of care and write orders	7 AAC 12.384(c) A center shall conduct an initial evaluation of each patient who presents for treatment. The evaluation must (5) Be performed by a mental health professional [def. AS 47.30.915] (6) Be initiated not more than 30 minutes and completed not later than three hours after the patient’s arrival (7) Be used to determine the patient’s eligibility for and the	<a href="#">7 AAC 72.250</a> <b>Physical Examination</b> (b) The physical examination required by <a href="#">7 AAC 72.240</a> must include (1) an examination of the patient’s chief complaint; (2) a review of the patient’s history; (3) a review of systems; (4) a routine physical examination; (5) a diagnosis; and (6) the physician’s recommendations.

High-Intensity Behavioral Health Extended Stabilization Center	Billing (1115 Waiver Crisis Residential and Stabilization Services)	Licensing (Subacute Mental Health Facility, Crisis Residential Center)	Designation (Designated Evaluation and Stabilization)
		<p>appropriateness of services provided by the crisis stabilization center; and</p> <p>(8) Include</p> <ul style="list-style-type: none"> <li>(A) An assessment of whether the patient is in imminent danger to self or others</li> <li>(B) An assessment of risk for imminent withdrawal</li> <li>(C) A breath analysis and urine drug screen...</li> <li>(D) A check of vital signs</li> <li>(E) Clinical assessment of the patient's current condition to determine the patient's primary medical problems...</li> <li>(F) A brief patient medical history</li> </ul>	<p><a href="#">7 AAC 72.260</a> <b>Mental Health Evaluation</b></p> <p>(b) A mental health evaluation required by <a href="#">7 AAC 72.240</a> must, when reasonably possible, include</p> <ul style="list-style-type: none"> <li>(1) an interview with the peace officers who brought the patient to the facility for the examination;</li> <li>(2) a brief history of the patient, including observations or information obtained by other persons relating to the background, development, and circumstances of the patient's current problems;</li> <li>(3) a brief evaluation of the patient's mental status;</li> <li>(4) a history of the patient's previous treatment and medication;</li> <li>(5) a diagnosis; and</li> <li>(6) a determination of whether the patient meets the involuntary commitment criteria established in <a href="#">AS 47.30.730</a>.</li> </ul>
<b>Services</b>	<p>Service components:</p> <ul style="list-style-type: none"> <li>• Crisis assessment</li> <li>• Psychiatric evaluation</li> <li>• Nursing</li> <li>• Medication services (prescription, administration and management)</li> <li>• Crisis intervention services</li> <li>• ID and resolution of crisis' contributing factors</li> <li>• Stabilization of withdrawal symptoms</li> <li>• Linkage and referral to community-based services</li> </ul> <p>Service requirements include:</p>	<p>Treatment services <a href="#">7 AAC 12.387(a)(2)</a></p> <ul style="list-style-type: none"> <li>(A) Individual crisis assessment</li> <li>(B) Psychiatric evaluation services</li> <li>(C) Nursing services</li> <li>(D) Therapeutic interventions to decrease and stabilize a presenting crisis</li> <li>(E) Identification of a crisis's contributing factors</li> <li>(F) Withdrawal symptom stabilization, if applicable</li> <li>(G) 24-hour observation</li> <li>(H) Advocacy, networking and support to provide linkage and referral to community-based services; and</li> </ul>	<p><a href="#">7 AAC 72.280</a> Procedures:</p> <ul style="list-style-type: none"> <li>(1) perform routine laboratory studies ordered by the attending physician;</li> <li>(2) follow-up and further evaluate physical problems noted at the time of the patient's emergency examination, if any;</li> <li>(3) obtain available background information relating to the patient's present condition, including relevant developmental, family, social, and occupational history;</li> <li>(4) develop an initial treatment plan appropriate to the patient's target symptoms and behavior;</li> <li>(5) note and record pertinent behavioral manifestations that indicate whether the patient continues to meet the involuntary</li> </ul>

High-Intensity Behavioral Health Extended Stabilization Center	Billing (1115 Waiver Crisis Residential and Stabilization Services)	Licensing (Subacute Mental Health Facility, Crisis Residential Center)	Designation (Designated Evaluation and Stabilization)
	<ul style="list-style-type: none"> <li>• Medically monitored stabilization services</li> <li>• Assessment for medication services</li> <li>• Assessment for post-discharge and support services</li> <li>• Crisis assessment based on an evidence-based risk assessment tool</li> <li>• Crisis treatment plan</li> <li>• Daily documentation of progress towards crisis resolution</li> </ul>	<p>(l) Medication services, including prescription, administration and management</p> <p>(b) A crisis residential center shall develop patient-specific centered treatment plans</p>	<p>commitment criteria established in AS 47.30.730; and</p> <p>(6) record progress notes that document the effectiveness of treatment interventions, untoward incidents, complications, and adverse effects.</p>
<p><b>Involuntary</b></p>	<p>n/a</p>	<p>Initial evaluation initiated not more than 30 minutes and completed not later than three hours after arrival (7 AAC 12.384(c)(2))</p> <p><i>Statutory requirements:</i>  AS 47.30.708(a) A respondent who is delivered to a crisis residential center for emergency examination and treatment shall be examined and evaluated as to mental and physical condition by a mental health professional within three hours after arrival at the facility.</p> <p>...a mental health professional may admit the respondent to the crisis residential center... (AS 47.30.708(b))...(c) If a mental health professional admits a respondent to a crisis residential center and a judicial order has not been obtained..., the mental health professional may apply for an ex parte order...</p> <p>(d) When, under (c) of this section, the court grants an ex parte application...the court shall set a time for a hearing, to be held if needed within 72 hours after the</p>	<p>Must meet the following criteria for admission under an involuntary commitment order:</p> <ol style="list-style-type: none"> <li>1. Determined to be mentally ill</li> <li>2. Presents a likelihood of serious harm to self or others or is psychologically gravely disabled</li> <li>3. Cannot be treated in a less restrictive environment</li> </ol>

High-Intensity Behavioral Health Extended Stabilization Center	Billing (1115 Waiver Crisis Residential and Stabilization Services)	Licensing (Subacute Mental Health Facility, Crisis Residential Center)	Designation (Designated Evaluation and Stabilization)
		<p>respondent's arrival at the crisis stabilization center or the crisis residential center, whichever is earlier...</p> <p>(e) In the course of the 72-hour period, a petition for a 30-day commitment or for seven-day detention at a crisis residential center may be filed in court...</p>	
<b>Facility Licensing</b>	n/a	Subacute mental health facility, AS 47.32.900(21)	<p>7 AAC 72.015 (c) The department will approve the following facilities under this chapter...to operate as a designated facility:</p> <ol style="list-style-type: none"> <li>(1) A hospital that is licensed under AS 47.32.010 and 7 AAC 12.610</li> <li>(2) A crisis residential center licensed under AS 47.32.010 as a subacute mental health facility; and</li> <li>(3) A facility that               <ol style="list-style-type: none"> <li>(A) Is exempt from state licensure</li> <li>(B) Is operated under 25.U.S.C. 5301 - 5423...; and</li> <li>(C) Complies with the requirements for an evaluation facility...</li> </ol> </li> </ol>
<b>Accreditation</b>	Joint Commission, COA, CARF or alternative approved by the department (7 AAC 70.150)	7 AAC 12.379(k) A center...may request a waiver of a biennial inspection...if the center holds a current accreditation from a nationally recognized organization that meets the standards of AS 47.32 and 7 AAC 12.375 - 7 AAC 12.399, as determined by the department.	Accreditation requirements appear to only apply to designated <u>treatment</u> facilities that are exempt from state licensure and are operated under the Indian Self-Determination and Education Assistance Act (see 7 AAC 72.020(4) and 7 AAC 72.050(2)(A).

High-Intensity Behavioral Health Extended Stabilization Center	Billing (1115 Waiver Crisis Residential and Stabilization Services)	Licensing (Subacute Mental Health Facility, Crisis Residential Center)	Designation (Designated Evaluation and Stabilization)
<p><b>Reimbursement</b></p>	<p>S9485 V1/V2 \$982.82 per day, up to 7 days before service auth needed</p>	<p>n/a</p>	<p>The Mental Health Treatment Assistance Program (MHTAP) reimburses <b>designated facilities as the payer of last resort for uncompensated care for patients who meet involuntary commitment criteria</b>, have no other payor source (non-resourced), and meet the low-income threshold set out in regulation.</p> <p>Designated facility administrators work with the DFCS Health Program Manager to access MHTAP reimbursement funds by submitting:</p> <ul style="list-style-type: none"> <li>• An application for each patient verifying eligibility for the program and the need for funds</li> <li>• Patient certificate of need</li> <li>• Certification that the patient meets involuntary commitment criteria</li> <li>• The hospital's<sup>8</sup> billing form</li> <li>• Patient discharge summary</li> </ul> <p>The Department will reimburse a DES facility for no more than seven (7) days for evaluation and stabilization or for transition to community-based services</p>
<p><b>Staffing</b></p>	<p>Multidisciplinary team supervised by a physician, physician assistant, or advanced practice registered nurse; At least one service component per episode</p>	<p>7 AAC 12.383. Staffing</p> <ul style="list-style-type: none"> <li>• Full-time center administrator; may be shared with collocated CSC</li> <li>• Clinical director (Physician, PA or APRN); may function as the licensed</li> </ul>	<p>7 AAC 72.012 is repealed. Remaining references to staffing include:</p> <p>7 AAC 72.080</p>

<sup>8</sup> Communication with DFCS indicates DES/DET manual will be updated to reflect language appropriate to non-hospital entities applying for designation.

High-Intensity Behavioral Health Extended Stabilization Center	Billing (1115 Waiver Crisis Residential and Stabilization Services)	Licensing (Subacute Mental Health Facility, Crisis Residential Center)	Designation (Designated Evaluation and Stabilization)
	must be provided by a medical professional with prescribing privileges (telehealth may be used).	<p>prescriber may be shared with colocated CSC</p> <ul style="list-style-type: none"> <li>• Licensed prescriber (Physician, PA or APRN)</li> <li>• RN; may be shared in a colocated center if combined census is 16 patients or fewer</li> <li>• Mental health professionals</li> <li>• Non-licensed/non-certified staff</li> </ul>	<p>(1) staff members receive training to develop appropriate interactions with patients</p> <p>(2) properly trained and qualified staff handle the protection, security and observation of patients</p> <p>Mental health component of evaluation must be conducted by a mental health professional; Physical component of evaluation must be conducted by a physician, PA or APRN (added in regulatory update)</p>
Transportation	n/a	Written discharge plan to include patient's transfer or referral to outside resources, continuing care appointments and crisis intervention assistance (7 AAC 12.384(e)(1))	<p>When a person is involuntarily committed and accepted into a designated facility, the facility shall work with the Department to arrange for the person's necessary transportation to the designated facility accompanied by appropriate persons and, if necessary, by a peace officer. The Department is authorized to pay for transport services upon approval. Secure transport and escort services require prior authorization by the CBHSP for transportation to a hospital<sup>9</sup>. The escort must have a current and approved provider agreement and be on the list of current providers with the State of Alaska.</p> <p>The Department shall pay for return transportation for eligible patients under AS 47.30.870 - Transportation and may include the person's escorts, after a determination that the person is not</p>

<sup>9</sup> Communication with DFCS indicates DES/DET manual will be updated to reflect language appropriate to non-hospital entities applying for designation.

High-Intensity Behavioral Health Extended Stabilization Center	Billing (1115 Waiver Crisis Residential and Stabilization Services)	Licensing (Subacute Mental Health Facility, Crisis Residential Center)	Designation (Designated Evaluation and Stabilization)
			committable, at the end of a commitment period, or at the end of a voluntary stay at a treatment facility following an evaluation conducted in accordance with AS 47.30.715 - Procedure after order

**Outstanding Questions**

- Will Medicaid cover the cost of transportation in any of the following scenarios for voluntary individuals:
  - Individual presents to an ED, is identified with BH needs and is appropriate for transportation to a crisis residential center
  - Individual is receiving care at a crisis residential center and requires treatment at a medical facility that is not an emergency but cannot be provided on-site.
  - Individual is at a crisis residential center and needs transportation to ongoing care: Inpatient, residential, ALF, etc.

## Appendix A: Glossary

Term	Definition	Source
<b>23-Hour Crisis Observation and Stabilization Services (COS)</b>	Services provided for up to 23 hours and 59 minutes in a secure environment to an individual presenting with acute symptoms of mental or emotional distress, and that must (A) be provided by a multidisciplinary team supervised by a physician, a physician assistant, or an advanced practice registered nurse; (B) result in prompt evaluation and stabilization of the individual's condition; and (C) ensure that the individual is safe from self-harm, including suicidal behavior.	<a href="#">7 AAC 138.450(a)(3)</a> <a href="#">7 AAC 139.350(a)(3)</a>
<b>Crisis Residential and Stabilization Services (CSS)</b>	Services provided to an eligible individual under this chapter presenting with acute mental or emotional disorders requiring psychiatric stabilization and care...The crisis residential and stabilization services must be (1) provided (A) as a short-term residential program with 16 or fewer beds; (B) as a medically monitored stabilization service designed to restore the individual to a level of functioning that does not require inpatient hospitalization; and (C) to assess the need for medication services and other post-discharge treatment and support services; and (2) supported by documentation that includes (A) an individualized crisis assessment based on an evidence-based risk assessment tool; (B) an individualized crisis treatment plan; and (C) daily documentation in the clinical record of the recipient's progress toward resolution of crisis.	<a href="#">7 AAC 138.450(c)</a> <a href="#">7 AAC 139.350(c)</a>
<b>Crisis residential center</b>	A subacute mental health facility that has a maximum stay of seven days for an involuntary admission	<a href="#">AS 47.32.900(21)(A)</a>
<b>Crisis stabilization center</b>	A subacute mental health facility that has a maximum stay of 23 hours and 59 minutes	<a href="#">AS 47.32.900(21)(B)</a>
<b>Designated Evaluation and Stabilization (DES)</b>	A hospital or crisis residential center that has been designated or is operated by the department to perform the evaluations described in <a href="#">AS 47.30.660</a> – 47.30.915, or a medical facility operated under 25 U.S.C. 5301 – 5423 (Indian Self-Determination and Education Assistance Act), as amended, that performs evaluations;	<a href="#">AS 47.30.915(9)</a>
<b>Designated Evaluation and Treatment (DET)</b>	A hospital, clinic, institution, center, or other health care facility that has been designated by the department for the treatment or rehabilitation of mentally ill persons under <a href="#">AS 47.30.670</a> – 47.30.915 but does not include correctional institutions;	<a href="#">AS 47.30.915(7)</a>

Term	Definition	Source
<b>High-Intensity Behavioral Health Emergency Center</b>	Operate with two functions: no barrier access and stabilization. High-Intensity Centers accept all arrivals, including those that are unplanned and unscheduled, without pre-screening or requirement to be “medically cleared” prior to arrival. These centers can provide immediate medical triage and ambulatory-level care for non-urgent medical issues and may transfer an individual requiring further medical work-up and/ or management to an ED with expectation of re-acceptance upon medical stabilization. These centers can provide withdrawal management services requiring 24-hour medical monitoring outside of an inpatient hospital setting.	SAMHSA. Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services (2025)
<b>High-Intensity Behavioral Health Extended Stabilization Centers</b>	Connected to the High Intensity [Emergency] Centers. These facilities offer extended behavioral health emergency care beyond the initial 24 hours and provide access to individual bed space. They typically offer services for an average of 3-5 days. They provide an additional period of stabilization, as may be necessary before the help seeker can return to the community or transfer to another setting based on the person’s unique needs and preferences. They can provide continued withdrawal management services requiring 24-hour medical monitoring outside of an inpatient hospital setting.	SAMHSA. Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services (2025)
<b>Low-Intensity Crisis Residential Program</b>	Low-Intensity Crisis Residential facilities (hereafter referred to as Low-Intensity Residential) provide similar services as Moderate-Intensity Residential facilities; however, Low-Intensity Residential facilities have lower levels of medical/nurse monitoring and less staffing per client. The primary focus is on connecting to and utilizing community resources for treatment services to facilitate the resolution of a crisis. Low-Intensity Residential only accepts individuals on a voluntary basis. Low-Intensity Residential can provide withdrawal management services for mild symptoms.	SAMHSA. Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services (2025)
<b>Moderate-Intensity Behavioral Health Crisis Center</b>	Provide similar services as High-Intensity Centers; however, they are considered low barrier and only accept voluntary individuals and often individuals presenting with a lower level of acuity than High-Intensity Centers. These centers may provide law enforcement and/or EMS drop-offs; however, they are not required to. They may not have onsite pharmacy or medication dispensing equipment but do have access to local pharmacy services that can enable access to medications for people who need this service while at the Moderate-Intensity Center. These centers offer the management of moderate symptoms of intoxication and withdrawal.	SAMHSA. Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services (2025)

Term	Definition	Source
<b>Moderate-Intensity Behavioral Health Extended Stabilization Centers</b>	<p>Connected to Moderate-Intensity Centers. These facilities offer extended behavioral health crisis care beyond 23 hours and provide access to individual bed space. These units typically offer services for an average of 3-5 days. They provide an additional period of stabilization, as may be necessary before the help seeker can be transferred to a setting or service that offers an appropriate next level of treatment and support. Moderate-Intensity Extension can provide continued moderate withdrawal management services.</p>	<p>SAMHSA. Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services (2025)</p>
<b>Moderate-Intensity Crisis Residential Program</b>	<p>Residential crisis programs with daily access (can be virtual), as needed, to psychiatric services; these also provide nursing services. Moderate-Intensity Residential programs are non-hospital-based programs with lengths of stay that typically range from a few days to two weeks and allow for relatively intensive 24/7 monitoring and support as well as provision of medical, nursing, and crisis intervention. These facilities are often in secured settings permitting admission of individuals who may need more intensive services. Admissions are typically voluntary; though depending on local regulations and laws, individuals may be legally mandated to this level of care. Moderate-Intensity Residential facilities can provide withdrawal management for mild to moderate withdrawal symptoms.</p>	<p>SAMHSA. Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services (2025)</p>
<b>Subacute mental health facility</b>	<p>A facility, or a part or unit of a facility, that has been designed to evaluate, stabilize, and treat, on a short-term, intensive, and recovery-oriented basis, and without the use of hospitalization, individuals experiencing an acute behavioral health crisis, including a crisis stabilization center and a crisis residential center</p>	<p><a href="#">AS 47.32.900(21)</a></p>