A Hybrid Funding and Coverage Model to Ensure Universal Access to Mobile Crisis Services

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STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

October 2021

Introduction

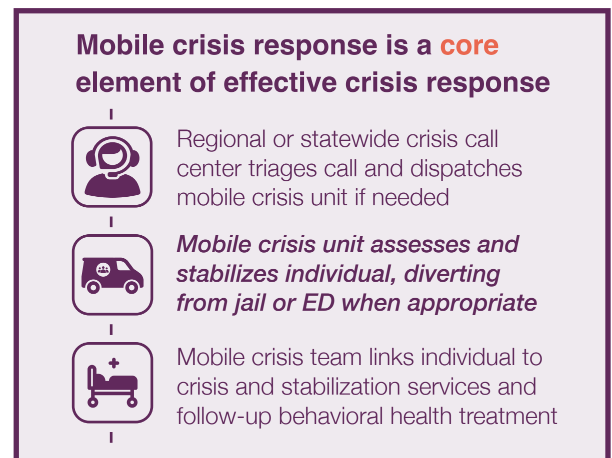
COVID-19, the resulting behavioral health crisis (including those related to mental health and substance use disorders (SUD)), and calls for law enforcement reform related to behavioral health crisis response have heightened the urgency among federal, state, and local policymakers to expand access to behavioral health crisis services. Recently, the federal government has provided new funding opportunities to states to improve access to behavioral health crisis services, including mobile crisis services. The American Rescue Plan Act of 2021 (ARP) gives states the option of covering community mobile crisis intervention services in Medicaid for five years beginning in April 2022 (see here for additional information on the ARP mobile crisis option).

As states review the opportunities available to begin, enhance, or expand mobile crisis intervention services under ARP, policymakers may further consider a hybrid funding model that provides mobile crisis providers with a consistent and steady stream of funding to ensure they are able to maintain 24/7 availability and respond in a timely manner to all individuals in crisis, regardless of insurance status. Such a new model for funding mobile crisis services could also be designed to hold payers accountable for covering mobile crisis services when their enrolled members use this essential resource. This issue brief presents a sustainable, hybrid coverage and funding approach for mobile crisis services where mobile crisis providers would obtain:

- A set amount or base funding that allows them to maintain continuous coverage; and
- Third-party insurance reimbursement for services rendered to commercially covered individuals and Medicaid enrollees.[1]

Background

The COVID-19 pandemic brought America's behavioral health needs into sharp relief. Drug-related overdoses increased by more than 30 percent from January 2020 to January 2021 across all demographic groups, with COVID-19 exacerbating worsening trends. Throughout the pandemic, 40 percent of adults reported symptoms of depression and anxiety compared to 10 percent who reported these symptoms from January to June 2019. Inadequate supports for individuals experiencing behavioral health crises lead to sometimes tragic encounters with law enforcement, unnecessary incarceration, inappropriate usage of the emergency department (ED) and unnecessary, lengthy psychiatric hospitalizations and readmissions. For example, in 2017, behavioral health-related ED visits totaled $5.6 billion.



Behavioral health crisis services are funded through a patchwork of sources – primarily Medicaid, federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant funding, and local and state funds. Despite the universal and growing need, most payers, including commercial insurers, Medicare, TRICARE, and large group plans do not generally cover or pay for mobile crisis services.[2] As a result, coverage and sustainable funding for universal mobile

1 Medicare and TRICARE are outside of the scope of this expert perspective because they are regulated by the federal government rather than states. A previous expert perspective available here focused on strategies states can use to increase Medicaid financing for mobile crisis services.

2 Medicare and TRICARE cover psychotherapy for individuals in crisis, but not mobile crisis services, specifically. Commercial insurance has a very limited role in funding mobile crisis services.

crisis services, even with new federal resources, remain inadequate. The funding gap is expected to widen once 988, the national suicide prevention and mental health crisis hotline, goes live in July 2022 and states are required to route and respond to calls. Experts estimate more than 40 million annual crisis calls coming in through 988 calls will be diverted from 911, local, and state crisis lines.

A Proposed Hybrid Approach to Mobile Crisis Coverage and Payment

In the context of a growing need for mobile behavioral health crisis services and new federal funding that will partially support development and maintenance of these services, state policymakers have the opportunity to consider a broader, hybrid solution for universal mobile crisis service coverage and funding. Table 1, below, summarizes strategies to both generate base funding for mobile crisis providers, as well as expand insurance coverage and payment beyond Medicaid for mobile crisis services.

Table 1: Summary of Hybrid Financing Approach for State to Use for Mobile Crisis Providers

Approach	Strategy
Base funding strategies to enable mobile crisis providers to maintain continuous coverage	Implementing 988 fees on telecommunication lines, similar to 911 fees
	Imposing insurer assessments
Strategies for expanding insurance coverage and payment for mobile crisis services	Adding mobile crisis services to the essential health benefit (EHB) benchmark plan
	Enforcing the federal Mental Health Parity and Addiction Equity Act (MHPAEA)
	Ensuring network adequacy for mobile crisis services

"Base" Funding Strategies

States can make base payments to mobile crisis providers to maintain continuous coverage in between calls for assistance by allowing them to use funds to:

- Cover fixed operating, personnel, and administrative costs;
- Support training and workforce development;
- Purchase tablets and other technology; and
- Subsidize the cost of providing services to uninsured individuals.

There are a range of funding sources that states and localities can use separately or in combination to finance base payments to mobile crisis providers; some, like state general fund dollars and federal grants are common funding sources for mobile crisis providers today. Two additional and sustainable sources of base funding for mobile crisis services include 988 fees and revenue generated by insurer assessments.

Implementing 988 Fees on Telecommunication Lines

Federal statute allows states to impose a fee per line on wireless, wireline, and voice over internet protocol services for 988-related services. These fees are similar to 911 fees in which phone providers charge these fees to subscribers on their monthly bills and then transfer fee-related revenue to the jurisdiction charging the tax. All states and territories impose 911 fees on phone service providers as a funding mechanism for 911 services, which resulted in approximately $3 billion in fees collected nationally in 2019. Fees across states in 2019 ranged from $0.20 to $3.86 depending on whether the line was wired or wireless. States generally use 911 fees to cover personnel, administrative, and dispatch costs.

Similarly, federal statute allows states to impose telecommunication fees to cover costs for:

- Routing calls made to 988 to an appropriate crisis call center; and,
- Personnel and the provision of acute mental health, crisis outreach, and stabilization services by responding to 988 calls.

States are beginning to enact legislation to ready and upgrade their crisis call center capabilities for 988 implementation, and some have imposed a 988 fee to support the hotline and expand access to behavioral health crisis response. Virginia was the first state to establish a 988 fee ($0.08 per line for consumers with prepaid wireless services and $0.12 per line for consumers with subscription wireless plans) to support all crisis services, including mobile crisis teams. Washington has also enacted a fee on telecom lines that increases from $0.24 in October 2021 to $0.40 in January 2023 to route the calls to 988 to crisis call centers and to provide acute behavioral health, crisis outreach, and crisis stabilization services. 988 implementation legislation, including those that impose fees, are pending in a number of other states.[3]

Imposing Insurer Assessments

States can also explore imposing or increasing insurer assessments (or allocating revenue generated from existing state assessments on healthcare insurers) to support base funding to mobile crisis providers. Such assessments are used by states to fund a variety of state priorities, including state Departments of Insurance and state-based Marketplace operations, coverage for uninsured or underinsured people, and covering the non-federal share of Medicaid program costs, and can be used to fund other state priorities, like crisis services. These assessments generally can apply to both Medicaid and commercial insurance revenues. Notably, federal Medicaid regulations stipulate that an assessment imposed on Medicaid managed care organizations (MCOs) meet certain criteria for approval, including that the assessment be "broad-based" or apply to all MCOs rather than limited to Medicaid MCOs.[4]

States can apply an assessment universally to all state-regulated healthcare payers, including Medicaid, the state employee health plan, individual, small and large group insurers, as all their covered enrollees may experience behavioral health crises. States can also limit the assessment to commercially insured health plans and exclude Medicaid managed care plans. In addition, states have flexibility regarding the design of the assessment, and depending on how the assessment is structured, states may be able to extend it to self-insured plans regulated by the Employee Retirement Income Security Act (ERISA). Many states impose an assessment on a percentage of premium like Maryland, which charges health insurers a one-percent assessment on premium. However, self-insured plans are excluded from these assessments.[5] Alternatively, states can impose an assessment on covered lives or claims on all insurance plans, including self-insured plans. For example, New York imposes an annual covered lives assessment on health claim payers, including self-insured plans, that is based on the number of covered individuals who reside in the state.

Implementing, increasing, or setting aside revenue from an assessment on insurers to fund base payments to mobile crisis providers likely requires state legislative and regulatory action. States may also need to consider the likelihood that commercial insurers will incorporate the cost of the assessment into the premiums they charge employers and individuals.

Strategies to Expand Insurance Coverage and Payment for Mobile Crisis Services

States can utilize several tools to require commercial insurance coverage of mobile crisis services to provide sustainable funding for and ensure access to mobile crisis services. These strategies include:

- Adding mobile crisis services to the essential health benefit (EHB) benchmark plan;
- Enforcing the federal Mental Health Parity and Addiction Equity Act (MHPAEA); and
- Ensuring network adequacy for mobile crisis services.

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3 For example, 988 legislation is pending in Kentucky, New York, and Massachusetts.

4 States can and often do receive federal waivers of the broad-based and uniform requirement to tax Medicaid-related revenue at a higher amount than non-Medicaid revenue. Federal approval of a Medicaid MCO assessment is only needed for a waiver of broad based and/or uniformity requirements.

5 Self-insured group health plans are not subject to a state premium assessment because there are no premiums to tax. In a self-insured plan, the plan does not buy health insurance from an insurer. Instead, the employer generally funds the claims as they come due from the general assets of the employer. As a result, state assessments on self-insured plans have focused on covered lives or claims.

States have long had the authority to require state regulated insurers to cover certain services, such as mobile crisis services, or include certain providers, such as mobile crisis providers, in their plan networks within certain federal parameters. States can regulate individual, as well as small and large group insurance plans. However, ERISA preempts states from imposing mandates on self-insured employer plans. Nationally, approximately 67 percent of covered employees are in these self-insured plans, which limits the applicability of benefit mandates to the privately insured.

Adding Crisis Services to the EHB Benchmark Plan

The Patient Protection and Affordable Care Act (ACA) requires insurers that sell fully insured individual and small employer health plans to cover a minimum set of 10 essential health benefits (EHBs), including emergency, mental health, and SUD services. In implementing this requirement, the U.S. Department of Health & Human Services (HHS) largely delegated this responsibility to the states, but required each state to select an existing health plan from one of 10 different group plan options to serve as a "benchmark" plan. These 10 options include:

- The largest three small-group plans available in the state;
- The largest three state employee health plans;
- The three largest national Federal Employees Health Benefits Program plan options; or
- The state's largest commercial health management organization (HMO).

If a state requires insurers to cover a benefit that is in addition to the benefits covered by a state's EHB benchmark plan, the state must defray any additional premium cost associated with that benefit mandate. This means that states must pay the cost to the enrollee of covering the additional service. However, several states have found that the annual process for updating the EHB benchmark plan can serve as a safe harbor for adding new benefits without triggering the ACA's defrayal requirement.

HHS laid out the parameters for states to update or change the EHB benchmark plan. To limit states' ability to add benefits (and potentially increase premium costs), states that wish to make changes must demonstrate, through an actuarial analysis, the following:

1. The scope of benefits is equivalent to those in a "typical" employer plan; and
2. The new benchmark plan does not "exceed the generosity" of either the benchmark plan in place in 2017 or any of the 10 benchmark plan options the state had available for 2017. The state must also offer an opportunity for public comment on the proposed new benchmark plan.

Five states have updated their EHB benchmark plans in recent years, and all five were able to add benefits in the process, including, for example, new requirements to cover opioid-related treatment, autism services, and chiropractic services. In each case, the state provided HHS with actuarial analyses demonstrating that their new benchmark plan was not more generous than the most generous of the 10 benchmark plan options listed above. States can leverage a similar strategy to add mobile crisis services to the EHB benchmark plan, as long as doing so would not result in the plan's generosity exceeding the generosity of the 10 available plan options. This, of course, requires that the state's existing benchmark plan is not already the most generous plan available.

States can also update their EHB benchmark without triggering the ACA's defrayal requirement if they are doing so to comply with federal law. Under this safe harbor, a state may argue that it is revising the definition of emergency services to include mobile crisis services in order to comply with MHPAEA, which is cited in federal regulations as being integral to the "provision of EHB." If a state were to do this, they might redefine emergency services to include crisis services needed to respond to and stabilize a patient in an acute or with an emergent behavioral health condition, and require that they be covered in the same manner in which other medical services are covered for an acute or emergent medical condition. This approach would not necessarily ensure that insurers cover behavioral health crisis services under the emergency services requirement of EHB, since it will depend on how other medical and behavioral crises are defined.

For example, a health plan may define emergency services as services furnished in an emergency setting, which may exclude some mobile crisis service providers. States would therefore need to also review insurer offerings (in form review) and coverage of claims (as with a market conduct exam) to ensure the emergency services are being covered in compliance with MHPAEA.

Enforcing Mental Health Parity Requirements

A state could also consider including mobile crisis services in its broader assessment of whether insurers are complying with MHPAEA. The federal MHPAEA requires both self-insured group health plans and state-regulated insurance plans to cover mental health and SUD services at parity with coverage of other medical services. States use MHPAEA to determine whether state regulated insurers are applying any coverage limits more stringently to behavioral health emergency services than to other medical benefits, taking into account the processes, strategies, evidentiary standards, or other factors used in applying the limitation. Because states are preempted from regulating self-insured employer plans, only the U.S. Department of Labor can conduct the assessment of whether such ERISA plans are compliant with MHPAEA.

Ensuring Network Adequacy for Mobile Crisis Services

For enrollees to have access to covered mobile crisis services when they are experiencing behavioral health crises, their insurers must maintain sufficient networks of mobile crisis services providers. Many states require their state-regulated health plans to maintain network adequacy. This generally means that the plan must contract with a sufficient mix of providers to ensure that its enrollees can receive covered services without unreasonable delay and within a reasonable distance of the enrollee's home or workplace. If mobile crisis services become a covered benefit through one of the strategies discussed above, a state could presumably require plans to include crisis service providers within their contracted network in order to meet the network adequacy standard. States can require plans to contract with all mobile crisis providers, and establish quantitative standards for mobile crisis services, including geographic distance, appointment wait time, and provider-enrollee ratios.

Another critical issue for states to consider is that mobile crisis providers have not historically been included in plan networks of private health insurers. Many crisis service providers may be unwilling or unable to contract with health plans because of credentialing and reporting requirements, billing expectations, and regulatory compliance burdens. In those cases, even though the mobile crisis benefit may be covered by a health plan, if the patient is treated by an out-of-network provider, they may be expected to pay out-of-pocket for all or a large portion of the cost. In such cases, states have two main options. They could either (1) establish a fee schedule for these providers and require commercial payers to pay the state-mandated rates; or (2) include mobile crisis provider services among those protected under state and federal surprise medical billing protections. The federal No Surprises Act, which goes into effect on January 1, 2022, protects patients from unexpected out-of-network medical bills in two situations: (1) when receiving emergency services; and (2) when receiving services from out-of-network physicians working within an in-network facility. The federal law defers to state surprise billing laws that are more protective than the federal standard.[6] A state may include mobile crisis services in its definition of "emergency services" under either its own surprise billing law or by expanding on the federal standard. Such an action would prohibit the out-of-network mobile crisis service provider from billing the patient for its services, and would have to seek reimbursement directly from the patient's health plan. The federal law and many state laws establish a process for resolving payment disputes between the provider and the insurer, but the patient cannot be liable for any more than standard in-network cost-sharing for the services.

6 An expert perspective published by SHVS provides additional information to states on the No Surprises Act is available here.

Conclusion

A hybrid coverage and financing approach for mobile crisis providers consistent with the strategies presented in this issue brief can bring states one step closer to creating a more equitable, universal, and sustainable behavioral health crisis system that can serve all individuals in the state. States can use 988 fees, increased federal Medicaid and grant funding, and insurer assessment revenues to fund base and infrastructure costs, and leverage existing federal tools such as MHPAEA and EHB to require state-regulated commercial insurers to assume responsibility for covering behavioral health crisis services for their enrolled members. While implementing these recommendations would move states closer to a universal, all-payer crisis system, federally-regulated insurers, such as self-insured employer plans governed by ERISA, Medicare, and TRICARE would remain outside of this funding and coverage rubric. States should look to federal leaders and large, self-insured state employers to collaborate on strategies to ensure establishment of a true universal and all-payer mobile crisis services infrastructure in the United States.

Support for this issue brief was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

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