ROADMAP TO THE IDEAL CRISIS SYSTEM

LEGISLATIVE ADVOCACY PAPER – PARITY FOCUS

Ken Minkoff – January 14, 2022

Vision of the Behavioral Health Crisis System

Every person with a mental health and/or substance use disorder crisis will have the right response in the right place at the right time with the right result.

This is a parity vision. We expect the same for our response to medical crises. And while we are never perfect, we work toward that goal at every level of society: federal, state, and local; public and private.

This is not true for BH crises. There has been significant new federal funding for BH crisis response, attached to the development of the 988 crisis line. New Medicaid rules have opened access to increased FMAP for mobile crisis in states that choose to go in that direction.

However, from the perspective of parity response, there is more that needs to be done by legislators simply to match access to BH crisis response to what we normally achieve for medical crisis response.

EXAMPLES

RESPONSE TO CRISIS	For medical crises, ambulance districts nationwide are responsible for assuring universal response. For BH Crises, ambulances are not always needed, and may be better served by mobile crisis teams with less expensive transport. Similar local accountability for the full continuum of response is needed.
TRANSPORT TO HELP	For medical crises, ambulances can be paid for transport to medical ERs. For BH crises, non-hospital crisis centers are a best practice, but are not eligible for reimbursement for transport, by ambulance or by other less expensive options.
GETTING HELP: CRISIS STABILIZATION	For medical crises that involve brain injury (e.g. stroke), it is common for there to be a brief hospitalization followed by access to subacute rehabilitation, both residential and in-home. This is supported by all payers. For BH crises, individuals with serious acute brain events (psychosis) may receive brief hospitalization but rarely have access to the extended rehabilitation they may need for their subacute symptoms and disability. Subacute residential rehab is not routinely available. Most insurers, including Medicare, do NOT pay for a continuum of subacute crisis stabilization services. Legislation requiring payment for the continuum across all payers is needed.
CONTINUING HELP & ONGOING CRISIS INTERVENTION	Following return home, individuals with medical crises commonly have access to home health care, with a range of nursing, health aide and case management services. Similar services are often needed for individuals with BH crisis who can return home but are still too unstable to participate in routine outpatient care. Intensive home "behavioral health" care is needed. However, the rules governing home health services and payment are NOT designed to include comparable (parity) services for people with BH needs. BH needs may not meet eligibility for "home health aide" but do require in home peer support or in home therapy. Legislation is needed to revise home health rules to include provision for appropriately comparable (parity) services for BH crises.