



License and Fund 23-hour Behavioral Health Crisis Facilities

Background

Despite recent investments, Washington’s behavioral health system still cannot meet the existing demand of patients who experience a mental health or substance use disorder-related crisis. Unfortunately, the behavioral system has only grown more strained as demand has increased throughout the COVID-19 pandemic. Many patients in crisis increasingly end up in far-from-ideal settings, like emergency departments (EDs) through Single Bed Certification (SBC), which provides minimum care and does not address their needs.

E2SHB 1477 — the 2021 law establishing the “988” call line — refers to “23-hour crisis stabilization units based on the living room model” as one source of crisis stabilization services. This model has also been described and outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA).

However, there is currently no statutory structure for licensing or certification that organizations could use to establish these facilities, nor is there a payment model for this type of crisis center. Without sustainable payment rates from Medicaid — the most prominent payer for behavioral health services — these facilities will be limited in their development and services to patients.

WSHA Position

WSHA strongly supports the development of a licensing and certification process, as well as a payment model for 23-hour crisis facilities in Washington State. Washington hospitals and EDs are overwhelmed with patients in behavioral health crisis, and 23-hour crisis stabilization facilities may help mitigate the number of patients flooding hospital EDs and getting stuck in emergency departments on SBCs.

Budget Ask

\$20.7 million state (\$47.4 million total) to fund Medicaid payment for operation of six nine-recliner facilities for the biennium.

SAMHSA and Crisis Now have developed guidance for how to provide Medicaid payment for a living room model 23-hour crisis service facility, included in this [Sustainable Funding for Mental Health Crisis Services: Healthcare Crisis Service Coding Guidelines to Support Standardized Billing and Access to Coverage from All Insurers](#) document (starting on page 12).

Both the document above and the SAMHSA [National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit](#), suggest using existing Healthcare Common procedure Coding System (HCPCS) codes for Crisis Intervention Mental Health Services to bill for these services: s9484 (hourly) for the first four-and-a-half hours and s9485 (per diem) for four-and-a-half hours to 23 hours and 59 minutes.

WSHA used information from a payment model developed by independent consultants from Mercer for the state of Virginia and discussions with members to build an estimated per diem Medicaid rate for these facilities in Washington State. We then applied that rate to the number of recliners in each facility, the number of days in a biennium, and the number of facilities we expect to be operating in this biennium.

Assumptions include (though are subject to change):

- 56.2% Federal Medical Assistance Percentage (FMAP) for FY 2023. This is essentially the federal matching rate for Washington's Medicaid spending.
- Six facilities
- \$1,200 per diem for HCPCS Code S9485 with a 23-hour facility modifier
- Nine recliners per facility

$\$1200/\text{day} \times 730 \text{ days} \times 9 \text{ recliners} = \$7,884,000$ per facility per biennium

$\$7.9 \text{ million} \times 6 \text{ facilities} = \47.4 million

$\$47.4 \text{ million} \times 56.2\% = \26.6 million federal portion.

More information is available about how we arrived at a \$1,200 per diem suggested Medicaid rate.

Key Messages

- Washington State's behavioral health crisis system is over-capacity and many patients in crisis end up boarding in hospital EDs, which are not an appropriate placement.
- Many of these patients would benefit from an outpatient, 23-hour crisis facility, designed specifically for behavioral health patients. This facility would create extra capacity in the state's behavioral health crisis system and be better equipped than an ED to meet patients' behavioral needs.
- Diversion of patients to behavioral health facilities could allow for de-escalation and discharge for some patients, instead of continued escalation and involuntary admission, allowing patients to stay in their communities for care.
- Without a proper payment methodology and adequate funding, behavioral health organizations will not take the risk of opening this type of facility and not being able to operate it.

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