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OFFICE OF
INSURANCE COMMISSIONER

June 21, 2022

Commissioner Jim L. Ridling
Alabama Department of Insurance
PO Box 303351
Montgomery, AL 36130-3351

RE: Behavioral Health Crisis Services

Dear Commissioner Ridling,

The new "988" suicide prevention line takes effect this July. With implementation of this system, states are taking on the challenge of developing and strengthening our behavioral health crisis response systems. I wanted to share some of the recent experiences and successes we have achieved in Washington state and offer our assistance.

Having a unified suicide prevention call line is critical, but so is increasing access to crisis behavioral health services beyond that critical call line. Washington state recently passed legislation to create a more effective behavioral health crisis response system in our state any my office is part of that implementation effort.

In 2020, the federal Substance Abuse & Mental Health Services Administration released National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit. The guidelines include core behavioral health crisis services and guidelines for care. Beyond crisis call services, follow-up services to respond to behavioral health crises should include mobile crisis team services and crisis receiving and stabilization services.

This statement from the toolkit illustrates the compelling need to improve our behavioral health crisis response system:

> Many communities across the United States have limited or no access to true "no wrong door" crisis services; defaulting to law enforcement operating as community-based mental health crisis response teams with few options to connect individuals experiencing a mental health crisis to care in real time… Unacceptable outcomes of this healthcare gap are (1) high rates of incarceration for individuals with mental health challenges, (2) crowding of emergency departments that experience lost opportunity costs with their beds and (3) higher

> rates of referral to expensive and restrictive inpatient care with extended lengths of stay because lower levels of intervention that better align with person's needs are not available. For many others in crisis, individuals simply fail to get the care they need; contributing to mental illness's designation as the most prevalent disability in the United States and one of the greatest causes of lost economic opportunity in communities throughout the nation.

In response to these challenges, I proposed legislation that took effect this March. The new law protects consumers from charges for out-of-network health care services by addressing coverage of emergency services and aligning the Washington state Balance Billing Protection Act and the federal No Surprises Act (NSA). Sections 2 and 3 of this legislation amend current law, including provisions related to coverage of emergency services, to clarify the role of behavioral health crisis services providers in meeting the needs of individuals enrolled in fully insured individual and group health plans when they experience a behavioral health emergency.

Washington state law defines an emergency medical condition to encompass "a medical, mental health or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress…" according to a prudent layperson standard, which is consistent with CMS's interpretation of the EMTALA statute.[1] The new law designates "behavioral health emergency services providers" as providers of emergency services. Under the act, "behavioral health emergency services providers" include facilities licensed to provide behavioral health crisis services, such as evaluation and treatment facilities, crisis triage facilities, medical withdrawal management services facilities, and mobile rapid response crisis team services.[2] These behavioral health emergency services providers are equivalent to the full range of emergency and crisis services for medical and surgical conditions including hospital emergency rooms, ambulance (mobile outreach), and urgent care centers.

Hospital emergency rooms often lack the staff and capacity to immediately address a behavioral health crisis, while behavioral health emergency services providers are designed and licensed for this purpose. Our new law incorporates these essential, behavioral health-specific providers and services as part of the full range of behavioral health emergency and crisis care, just as the full range of medical/surgical emergency care is covered.

A health plan enrollee may seek and obtain any type of emergency care (screening, stabilization and post-stabilization services) for a medical/surgical condition at a hospital emergency room, via ambulance (mobile) or urgent care center; or for a behavioral health condition, at the facilities and providers designated as behavioral health emergency services providers. Under the act, health plans must cover "emergency services" provided to a consumer in an out-of-network (nonparticipating)

[1] See 86 Fed. Reg. at p. 36879 (July 13, 2021)
[2] See Sec. 2(48) of E2SHB 1688 for additional detail regarding these settings.

hospital emergency department or by a behavioral health emergency services provider.[3] The health insurer cannot require prior authorization for the emergency services. The act also brings behavioral health emergency services into the state's balance billing protections and into our network access standards.[4]

This clarification in our new law regarding emergency behavioral health services providers brings Washington state law into alignment with provisions of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) and the federal No Surprises Act. Ultimately, a federal solution to this issue would be best so that enrollees in self-funded group health plans could have the same access to behavioral health crisis services as enrollees in fully insured health plans issued in Washington state. My office has made this request to members of Washington state's Congressional delegation, as well as the Department of Labor and CMS/CCIIO.

Until that happens, I encourage you to explore this approach for the regulated health plans in your states. Many of us have undertaken or increased behavioral health parity enforcement efforts in response to the compelling need for consumers to access behavioral health services. Our approach shows the clear role commercial health plans can play to help ensure access to, and financing for, critical behavioral health crisis services for people in our states.

If you would like more information about our efforts, please feel free to contact Jane Beyer, Senior Health Policy Advisor at jane.beyer@oic.wa.gov or (360) 725-7043 with any questions.

Sincerely,

Mike Kreidler

Mike Kreidler,
Insurance Commissioner

[3] See RCW 48.43.093, as amended by section 3 of E2SHB 1688.
[4] See Behavioral Health Crisis Providers memorandum