Crisis Services

Presentation to the State Consumer and Family Advisory Committee (SCFAC)

April 8, 2026

BACKGROUND

- For years, Alliance Health and other LME/MCOs have created and managed a regionally-based behavioral health crisis system
- Crisis Service for this discussion include Facility-Based Crisis (FBC), Behavioral Health Urgent Care (BHUC), and Mobile Crisis Management (MCM)
- Under Medicaid Transformation, Standard Plans and LME/MCOs operating Tailored Plans are required by legislation and contract to offer crisis services
- Financing for most of Alliance crisis services is based on a “firehouse model” which requires flexible funding to ensure services are available regardless of daily utilization

Behavioral Health Crisis System Challenges

START-UP COSTS

LME/MCOs and counties responsible for investing in expanding/ improving crisis system

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OVERSIGHT

Multiple oversight and monitoring of the crisis system results in every health plan reviewing/ auditing crisis providers

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PAYMENT/ OPERATIONS:

- Other payers have not contracted for crisis services; or
- Contracted for services but are not paying the provider; or
- Contracted for the services but not paying a rate that is sufficient to support the cost of care

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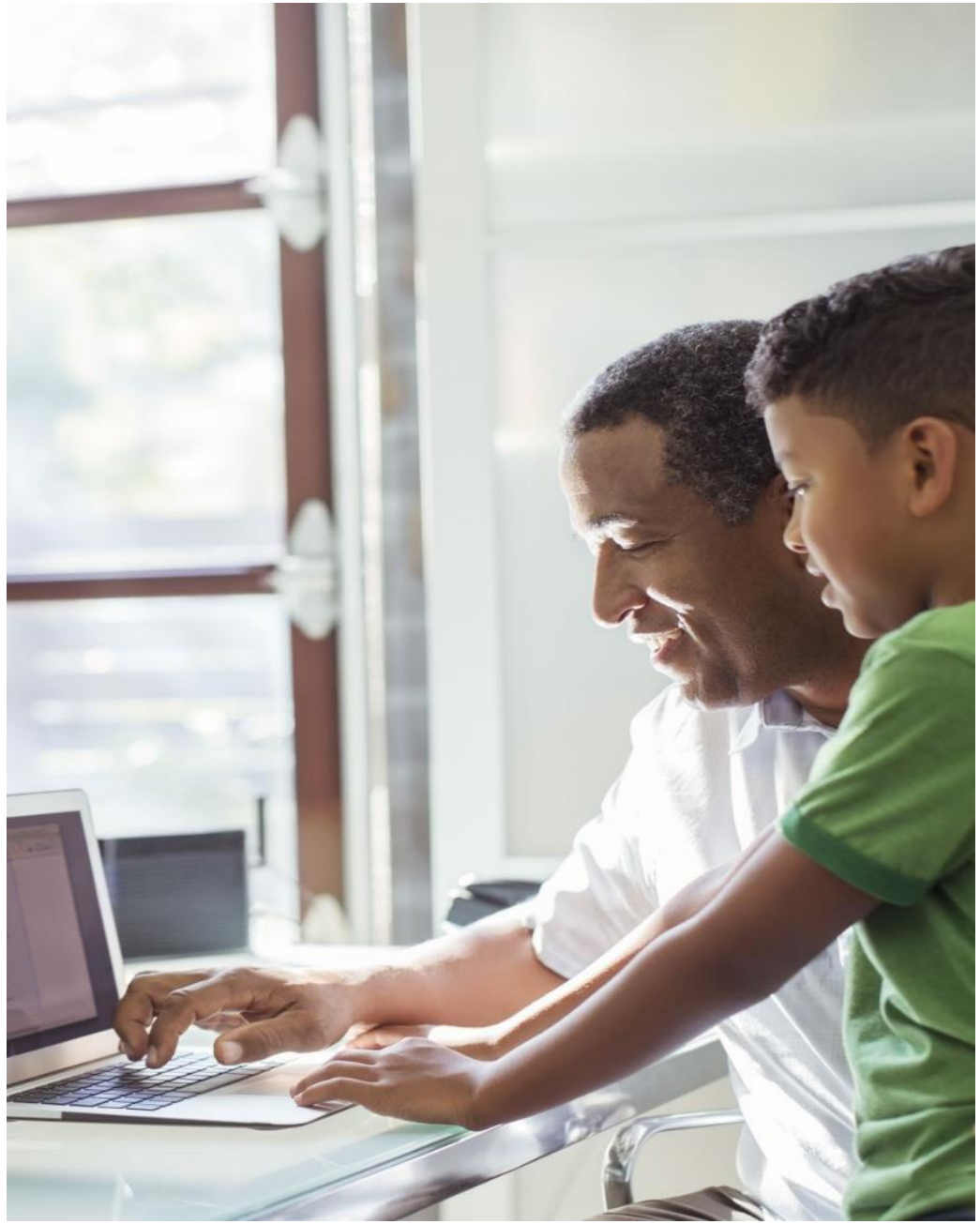
RESULT

Alliance/LME/ MCOs and counties default to make providers financially whole ($24 million for FY24)

Alliance Action Steps

- The financial model that compensates providers for operating a firehouse model is not sustainable
- Alliance has been working with counties, providers, other LME/MCOs and DHHS to find solutions
- Alliance:
  - Identified best practice in financing crisis systems across the country
  - Recommend alternative funding models should the state not act on a solution



Comparison of Funding & Oversight for Crisis Services

Oversight and Funding	Massachusetts	Arizona	Washington	North Carolina
ADMINISTRATION, OVERSIGHT & STANDARDIZATION	A single statewide entity is responsible for oversight, network adequacy, and monitoring compliance and quality	Regional BH authorities are responsible for oversight, and monitoring compliance and quality	Regional BH ASOs are responsible for oversight, and monitoring compliance and quality	No standardized approach to administration and oversight. Every payer is responsible for oversight, network adequacy, and monitoring compliance and quality. DHHS requirements differ by 9 different payers/plans
PAYMENT/RATE FOR UNINSURED	A surcharge on certain payments made to acute hospitals and ambulatory surgical centers funds the "BH Trust" which pays for uninsured A single statewide entity is responsible for all payments for uninsured	Mental Health Block Grant, state appropriation, one-time funds, and city/county financial supplements. Regional BH Authorities are responsible for payments for uninsured.	BH-ASOs braid state, local tax, and federal block grant dollars; gaps in funding still exist that the BH-ASOs must cover. The regional BH-ASOs are responsible for payments for uninsured	LME /MCOs receive state dollars to pay for the uninsured. Some Counties contribute at their discretion.
MEDICAID	Medicaid plans are required to reimburse at a standardized rate for crisis services (MCM and FBC) *MCM rate includes a 2-person team	All crisis Medicaid dollars go to RBHA's. Rates vary across RBHAs, and they can negotiate rates across plans	Medicaid plans are required to reimburse at a standardized rate for MCM	Standard Plans and Tailored plans are equally responsible for payment. Rates vary across plans. BHUC model varies across plans. *(an in lieu of service)*
COMMERCIAL PAYERS	State regulated Commercial plans are required to cover MCM and FBC services	Commercial payers are required to cover MCM and FBC services after first 24 hours	Commercial plans are required to cover MCM and FBC services	Commercial payers are not required to cover MCM, FBC and BHUC (no requirement to reimburse these crisis codes)

Crisis Continuum

- 988 and Medicaid Health Plan Behavioral Health Crisis Lines
- Mobile Crisis Management (MCM) and county co-responder models
- Mobile Outreach Response Engagement and Stabilization (MORES)
- Behavioral Health Urgent Care (BHUC)
- Facility-Based Crisis Services (FBC)/Non-Hospital Detox
- NC Systemic, Therapeutic, Assessment, Resources and Treatment (NC START)

MCM

- Mobile Crisis is considered a team service, however, only one member of the team typically provides the direct intervention with the member
  - The team member providing the assessment is not typically a licensed clinician
- Mobile Crisis Management is a core Medicaid benefit and must be covered by both Standard and Tailored plans.
- Currently Medicare and commercial insurance does not reimburse for these services
- LME/MCOs use state funding to pay for the uninsured and underinsured
- Service must be available 24/7 regardless of utilization and mobile crisis providers cannot refuse care to individuals based on insurance coverage.

MORES

- 24/7 Mobile crisis and stabilization services specifically designed for youth and families
- Provides for a 45-minute response time
- Assess child and family needs
- Provides immediate crisis stabilization and resolution
- Links youth and families to ongoing services and supports
- May stay engaged with youth and family for up to 8 weeks
- Covered by the Tailored Plans

BHUC

- Emergency department alternative walk-in crisis and evaluation centers staffed with licensed behavioral health professionals able to provide immediate care.
- BHUCs either operate as standalone facilities or are connected to facility-based crisis facilities
  - Tier III are open 1t least 12 hours per day
  - Tier IV are open 24/7
- Services include triage, evaluation and up to 23 hours of observation
- Can provide first level IVC evaluations when appropriately credentialed staff are employed by the facility and the facility is listed in the county crisis transportation plan
- An in lieu of service (optional) not covered by Medicare or private insurance
- LME/MCOs pay for the service for under and uninsured individuals

FBC

- Licensed 24/7 16-bed facilities designed to address the needs of individuals experiencing a behavioral health crisis
  - Adult and Child specific facilities are located throughout the state
- Can be designated to provide treatment to individuals that are on involuntary commitment status
- Typical length of stay is 4-7 days focused on individuals that need 24/7 observation and care that may not require psychiatric inpatient level of care
- Core state Medicaid service covered by Standard and Tailored Plans at a reimbursement rate set by the state.
- Not covered by Medicare and private insurance
- LME/MCOs pay for care at these facilities for individuals that are under and uninsured

NC START

- Community-based crisis support for individuals with intellectual/developmental disabilities who also have complex behavioral or mental health challenges
- Includes:
  - 24/7 Crisis response and clinical consultation
  - Therapeutic coaching
  - Training and education
  - Respite
- Available to individuals age 6 and up
- Intended to be short-term (12-18 months)
- Funded by the state through the LME/MCOs

Questions?

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