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ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

# Financing Crisis Services Through Public and Commercial Insurance: Current Landscape and Future Opportunities

Prepared for
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by
**Mathematica**

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*This research was funded by the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation under contract and carried out by Mathematica. Please visit https://aspe.hhs.gov/topics/behavioral-health for more information about ASPE research on behavioral health.*

# FINANCING CRISIS SERVICES THROUGH PUBLIC AND COMMERCIAL INSURANCE: CURRENT LANDSCAPE AND FUTURE OPPORTUNITIES


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## Study Highlights

- Crisis services rely on a patchwork of funding, including federal, state, and local grants; public and commercial insurance; and other state and local funds. The Substance Abuse and Mental Health Services Administration recommends that all insurers cover three core crisis services – 24/7 clinically staffed regional crisis call centers, mobile crisis teams, and crisis receiving and stabilization facilities – and adopt a universal set of billing codes for claims-based reimbursement of these services.
- We conducted an environmental scan, key informant interviews, and case study interviews with providers and payors to better understand the current role of insurance in financing crisis services and identify opportunities to expand the use of insurance for these services. We also analyzed Medicaid claims data from 2020–2022 to examine billing for crisis services in the states corresponding with the case study communities.
- Coverage for crisis services varies across insurers. As of 2022, 33 state Medicaid programs covered mobile crisis teams, 28 covered crisis receiving and stabilization facilities, and 12 covered crisis call center (hotline) services; however, only 12 states covered all three of these services (KFF 2023). As of January 2024, Medicare only covered crisis psychotherapy services delivered by certain types of providers in hospitals, skilled nursing facilities, physician's offices, or patient's homes. These crisis billing codes may be used to bill for some core crisis services delivered in these settings. Commercial insurers vary in their coverage of crisis services even within the same state or region. When commercial insurance covers crisis services, the insurer often contracts directly with a crisis service provider and negotiates provider-specific billing codes and reimbursement rates.
- Across states corresponding with case study communities, insurance does not serve as the sole or primary source of funding for crisis services. Providers most often billed Medicaid for crisis services, but claims reflected few enrollees. For example, in most states where the case study communities are located, fewer than one percent of Medicaid enrollees had at least one claim for crisis services in any calendar year of the analysis. These Medicaid programs also vary notably in their authorization of specific crisis services billing codes. Case study communities also differ in the administration of crisis services, arrangements for reimbursing providers, and in the availability of technical assistance to help crisis service providers bill for services.
- Crisis service providers in this study vary in their organizational history and scale. Providers range from small, recently established community-based organizations with no billing experience to multi-regional behavioral health care organizations offering both crisis and non-crisis services with extensive billing experience. Larger, established organizations with existing billing infrastructure and designated billing staff expressed the fewest concerns about billing Medicaid for services but noted challenges billing commercial insurance.
- Providers and payors described several areas of misalignment between how crisis services are delivered on the ground and the processes required for claims-based reimbursement, including how the collection of insurance information from clients could present barriers to care and how billing code definitions may limit reimbursement for some crisis services. They also noted low reimbursement rates, as well as the administrative burden associated with billing for crisis services, as disincentives to participation in insurance.
- States and communities could support expanding the use of insurance for crisis services by aligning service definitions, for billing codes and associated reimbursement rates with state licensing and credentialing requirements and how services are delivered in practice. Many crisis service providers require support to develop their capacity to collect and submit data for reimbursement. Providers also encouraged billing strategies that align with low-barrier crisis care and minimize provider administrative burden.

## Abstract

The National Guidelines for Behavioral Health Crisis Care from the Substance Abuse and Mental Health Services Administration (SAMHSA) call for the availability of three core crisis services: (1) 24/7 clinically staffed regional crisis call centers, (2) mobile crisis teams, and (3) crisis receiving and stabilization facilities. Crisis services rely on a patchwork of funding, including federal, state, and local grants; public and commercial insurance; and other state and local funds. SAMHSA's National Guidelines urge all insurers to cover these services and adopt a universal set of billing codes to support reimbursement. Greater reliance on insurance to finance crisis services may support efforts to expand and sustain these services. This study consisted of an environmental scan, key informant interviews, and case study interviews with providers and payors to better understand the current role of insurance in financing crisis services and identify future opportunities to expand the use of insurance for crisis services. We also analyzed Medicaid claims data from 2020–2022 to examine billing for crisis services in the states corresponding with the case study communities. Across case study communities, insurance did not serve as the sole or primary source of funding for crisis services. Providers most often billed Medicaid for crisis services, but claims reflected few enrollees. For example, in most states where the case study communities are located, fewer than one percent of Medicaid enrollees had at least one claim for crisis services in any calendar year. Providers and payors described several areas of misalignment between how crisis services are delivered on the ground and the processes required for claims-based reimbursement, including how the collection of insurance information from clients could present barriers to care, and how crisis service coverage and billing code requirements and associated reimbursement rates may limit providers' ability to obtain reimbursement for some crisis services in some states. For example, crisis receiving and stabilization facilities often care for people with primary substance use disorders and co-occurring disorders, but in rare instances, states may designate these services and corresponding billing code definitions only for people with mental health diagnoses. States and communities could support expanding the use of insurance for crisis services by aligning billing codes across payors, ensuring billing code requirements and associated reimbursement rates are congruent with how services are delivered in practice (for example, by accounting for staffing models dictated by state licensure requirements), and ensuring their alignment with state licensing and credentialing requirements. Many crisis service providers require support to develop their capacity to collect and submit data for reimbursement. Providers also encouraged billing strategies to support low-barrier crisis care and minimize provider administrative burden.



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# Acronyms

The following acronyms are mentioned in this report.

| | |
|---|---|
| ARPA | American Rescue Plan Act |
| ASPE | Office of the Assistant Secretary for Planning and Evaluation |
| BH-ASO | Behavioral Health – Administrative Service Organization |
| BHA | behavioral health authority |
| CCBHC | Certified Community Behavioral Health Clinic |
| CHIP | Children's Health Insurance Program |
| CMS | Centers for Medicare & Medicaid Services |
| CPT | Current Procedural Terminology |
| DE | Demographics and Eligibility files |
| DQ Atlas | Data Quality Atlas |
| HCPCS | Healthcare Common Procedure Coding System |
| IP | Inpatient files |
| KFF | Kaiser Family Foundation |
| MCO | managed care organization |
| MHBG | Mental Health Block Grant |
| NAMI | National Alliance on Mental Illness |
| NASMHPD | National Association of State Mental Health Program Directors |
| OT | TAF RIF Other Services file |
| PII | personally identifiable information |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SMA | state Medicaid agency |
| SMI | serious mental illness |
| SUD | substance use disorder |
| TA | technical assistance |
| TAF-RIF | Transformed Medicaid Statistical Information System Analytic Files Research Identifiable Files |
| T-MSIS | Transformed Medicaid Statistical Information System |

# Executive Summary

The National Guidelines for Behavioral Health Crisis Care from the Substance Abuse and Mental Health Services Administration (SAMHSA) call for the availability of three core crisis services: (1) 24/7 clinically staffed regional crisis call centers, (2) mobile crisis teams, and (3) crisis receiving and stabilization facilities. For people in crisis, these services provide an alternative to interactions with law enforcement, seeking care from emergency departments, and unnecessary hospitalization. Crisis services rely on a patchwork of funding, including grants, state and local funds, and public and commercial insurance. SAMHSA's National Guidelines urge all insurers to cover these services and adopt a universal set of billing codes to support reimbursement. Greater reliance on insurance to finance crisis services may support efforts to expand and sustain these services.

This study consisted of an environmental scan, key informant interviews, and case studies with providers and payors of core crisis services to better understand the role of insurance in financing crisis services and identify opportunities to expand the use of insurance for such services. We also analyzed Medicaid claims data from 2020–2022 to examine billing for crisis services in the states corresponding with the case study communities.

**Role of insurance in financing crisis services.** Coverage for crisis services varies across insurers. As of 2022, 33 state Medicaid programs covered mobile crisis teams, 28 covered crisis receiving and stabilization facilities, and 12 covered crisis call center (hotline) services; however, only 12 states covered all three of these services (KFF 2023). Medicare and commercial insurance generally provide less generous coverage for crisis services relative to Medicaid. As of January 2024, Medicare only utilized two codes specific to crisis services: crisis psychotherapy services delivered by certain types of providers in hospitals, skilled nursing facilities, physician's offices, or patient's homes. It is possible that components of crisis services may be billed using more general codes (CMS 2024). Even within the same state or region, commercial insurers vary widely in their coverage of crisis services. When commercial insurance covers crisis services, the insurer often contracts directly with a crisis service provider and negotiates provider-specific billing codes and reimbursement rates. As a result, commercial coverage and allowable codes can vary between providers in the same state or community.

Across case study communities, insurance does not serve as the sole or primary source of funding for crisis services. Providers most often billed Medicaid for crisis services, but claims reflected few enrollees. For example, in most states where the case study communities are located, fewer than one percent of Medicaid enrollees had at least one claim for crisis services in any calendar year in the claims analysis between 2020-2022. These state Medicaid programs also vary in their use of specific crisis services billing codes, and in their arrangements for reimbursing providers. In most states, Medicaid reimburses crisis service providers through a managed care organization (MCO) or regional behavioral health authority (BHA) wherein the provider typically receives a prospective payment and then submits information about patient encounters to support these payments. In most of these arrangements, payments to providers are not directly tied to an individual patient encounter but instead the provider receives a fixed amount of funding to cover their operating expenses. These arrangements allow the BHA or MCO to take on much of the infrastructure costs, administrative burden, and financial liability of claims-based reimbursement. However, providers must still obtain some personally identifiable information (PII) about the clients they

serve and the billable services they provided (for example, name, MCO, presenting problem). None of the providers interviewed for the case studies billed Medicare for any of the core crisis services and only a few described negotiating contracts to bill commercial insurers for crisis receiving and stabilization services.

Crisis service providers vary in their organizational history and scale. For example, interviewed providers ranged from small, recently established community-based organizations offering one of the core crisis services with no billing experience to multi-regional behavioral health care organizations with extensive billing experience offering all of the core crisis services plus non-crisis services. Larger, established organizations with existing billing infrastructure and designated billing staff expressed the fewest concerns about billing Medicaid for services but noted that billing commercial insurance remains challenging.

**Alignment of crisis services with insurance**. Although providers and payors acknowledged the importance of insurance in supporting crisis services, they unanimously agreed on the need for other sources of funding to cover the costs of crisis services given the on-call and variable-volume nature of crisis service delivery. Traditional volume-based fee-for-service reimbursement requires a predictable number of clients to generate a dependable revenue stream for the provider. Most crisis services require maintaining adequate staffing levels to deliver on-call services in response to behavioral health emergencies. However, the volume of people who will experience such an emergency can vary from week to week or month to month, making it challenging for these providers to derive a predictable revenue stream from claims-based reimbursement alone.

Providers and payors in the case study communities, as well as key informants, described misalignment between how crisis services are delivered on the ground and the processes required for claims-based reimbursement. This included four overarching issues:

- **Coverage and billing code definitions**. Providers noted instances in which the definitions and restrictions on billing codes prevented them from obtaining reimbursement. For example, in some states, the state Medicaid program requires some crisis services billing codes to include a primary mental health diagnosis for reimbursement, which prevents use of that billing code for people with a primary substance use disorder diagnosis. Providers also described how restrictive billing code requirements resulted in uncompensated care. For example, crisis receiving and stabilization facilities provide care to Medicaid enrollees who walk-in to the facility but do not meet program criteria for reimbursement. In these instances, the facility may still provide some case management or other immediate support but cannot bill Medicaid.
- **Reimbursement rates.** Some providers cited low reimbursement rates for crisis services as a disincentive to participation in insurance or investing in developing their billing infrastructure. Providers also described instances in which state staffing, accreditation, or licensing requirements increase the costs of care and necessitate higher reimbursement rates. For example, in a state that requires crisis service providers to employ a registered nurse (RN), one provider described how the Medicaid payment rates did not cover the high salaries of RNs, which are driven by the nursing shortage in their state.
- **Billing infrastructure and staffing.** Payors noted that crisis services providers, especially those organizations newer to crisis service delivery with limited healthcare billing experience and

infrastructure, may need support to increase their billing capacity. Crisis call centers and mobile crisis teams often operate outside of traditional health care settings and may require significant resources to establish the staffing and infrastructure required to adopt claims-based reimbursement. For most providers, the administrative burden associated with billing places additional stress on the already-taxed behavioral health workforce and may require additional staff to establish and maintain billing infrastructure.

- **Client and provider perceptions of PII collection for billing.** Some providers, particularly crisis call centers and mobile crisis teams, thought collecting insurance information or other PII from clients would limit their ability to build trust and engage clients in care. They also believed clients might be concerned about the potential costs of care or their ability to afford a co-pay (for those with commercial insurance).

In general, interviewees felt claims-based reimbursement was better suited for mobile crisis team and crisis receiving and stabilization services as opposed to crisis call centers because call centers have a service delivery model less compatible with obtaining PII.

Although commercial payors indicated support for crisis services, they also expressed concerns about the lack of standardization related to crisis services billing codes and service definitions. These payors emphasized the need to ensure covered services—particularly crisis receiving and stabilization facilities—meet quality standards, such as credentialing of crisis services staff. Some commercial and public payors also noted the challenges of aligning Healthcare Common Procedure Coding System (HCPCS) coding used for Medicaid with commercial claims reimbursement systems.

**Opportunities to expand the role of insurance to finance crisis services.** Findings from this study point to several opportunities to expand claims-based reimbursement for crisis services. Better alignment of billing requirements and codes across payors could encourage the use of insurance for crisis services. Efforts to increase the use of insurance and claims-based reimbursement for crisis services will likely require helping states, BHAs and MCOs, and providers develop their billing infrastructure and data collection processes, while ensuring crisis services remain accessible to anyone seeking care, regardless of insurance status. Strategies to reduce administrative burdens for providers related to billing are particularly important given the workforce pressures and limited financial resources these providers commonly face. States and communities also could consider developing insurance-based alternatives to traditional claims-based reimbursement. These could include prospective payments based on the projected costs of crisis services and the anticipated number of clients over time and the assessment of proportional payments to support crisis services based on their estimated share of costs.

# I. Introduction

## A. Background and purpose

The National Guidelines for Behavioral Health Crisis Care from the Substance Abuse and Mental Health Services Administration (SAMHSA) call for the availability of three core crisis services: (1) 24/7 clinically staffed regional crisis call centers; (2) mobile crisis teams; and (3) crisis receiving and stabilization facilities (Exhibit 1.1). For people in crisis, these services provide an alternative to interactions with law enforcement, seeking care from emergency departments, and unnecessary hospitalization. These crisis services rely on dedicated, behavioral health professionals who coordinate care with other behavioral health providers and first responders.

**Exhibit I.1.** Core elements of a crisis system

- **Crisis call centers** serve individuals, regardless of insurance status, by call, text, or chat with trained team members who assess and triage needs. Call centers also coordinate connections for the minority of callers who need higher levels of care. Call centers fully aligned with best practices have caller identification, GPS-enabled technology, real-time bed registry technology, and follow-up care processes to connect clients with follow-up appointments and ongoing care.
- **Mobile crisis teams** provide rapid response assessment intervention to individuals in crisis, responding to individuals wherever they are in the community and connecting them to ongoing care. Mobile crisis teams are usually comprised of two —including at least one licensed or credentialed clinician—and often incorporate peer support specialists without law enforcement accompaniment unless under special circumstances. Teams implement real-time GPS technology in partnership with their regions' crisis call center hub and schedule outpatient follow-up appointments to support ongoing care.
- **Crisis receiving and stabilization facilities** offer stays of 24 hours or less in 24/7 staffed facilities with a multidisciplinary team (for example, psychiatrists and psychiatric nurse practitioners, nurses, licensed and/or credentialed clinicians for assessments, and peers) that supports connections to higher levels of care and coordination with ongoing care.

Source: SAMHSA 2020b

Crisis services rely on a patchwork of funding, including federal, state, and local grants; public and commercial insurance; and other state and local funds (Exhibit I.2). With the 2022 implementation of the national 988 Crisis and Suicide Prevention lifeline, states have sought to maximize available funding to expand access to crisis services. Most states use general funds to support crisis call centers, mobile crisis teams, and crisis receiving and stabilization facilities (NRI 2023), although several states and communities also use other mechanisms such as tax levies to fund these services. Federal investments, such as SAMHSA's Mental Health Block Grant 5 percent set-aside for evidence-based crisis services, have also provided opportunities for states to enhance their crisis services (Beronio 2021). Both commercial and public insurers, including Medicaid and Medicare, play a minor role in funding crisis services. Insurers support the development of billing guidance and supports to facilitate claims billing and reimbursement for crisis services, which we refer to as "claims-based reimbursement" in the remainder of this report.

State Medicaid programs vary in their coverage for crisis services. In 2022, 33 state Medicaid programs covered mobile crisis teams, 28 covered crisis receiving and stabilization facilities, and 12 covered crisis call center (hotline) services; however, only 12 states covered all three of these services (KFF 2023). State

Medicaid agencies (SMAs) also differ in how they organize and reimburse crisis services. Most SMAs contract with regional behavioral health authorities (BHAs) or managed care organizations (MCOs) to administer all or most of their behavioral health services. These BHAs and MCOs pay providers for services rendered (reimbursement) and negotiate contracts that include reporting and billing requirements, which may vary from provider to provider. However, some state Medicaid programs also continue to reimburse at least some crisis services through traditional fee-for-service billing (Guth et al. 2023).

**Exhibit I.2.** Recent federal, state, and local actions to finance crisis services

- **American Rescue Plan Act (ARPA), 2021:** The ARPA provided $15 million in planning grants to 20 SMAs. States used this funding to develop a state plan amendment (SPA), section 1115 demonstration application, or section 1915(b) or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services. Upon approval of their SPA or waiver, states could claim a temporary 85 percent federal medical assistance percentage (FMAP) for expenditures for these services (CMS 2021a; CMS 2021b).
- **Medicaid 1115 SMI/SED Demonstration Waivers:** The state Medicaid programs of participating states (12 state demonstrations approved and 11 pending as of 2024) are allowed to overcome a long-standing payment exclusion, thus permitting them to use Medicaid funds to treat individuals with serious mental illness (SMI) in institutions for mental disease (IMD) if they use cost savings to strengthen access to and the quality of community-based behavioral health services, including crisis services (KFF 2024).
- **Medicaid Home and Community-Based Services (HCBS):** 1915(c) HCBS waivers and 1915(i) HCBS state plan option can be used to expand HCBS, which can include crisis services, for specific populations including people with behavioral health conditions (Wachino and Camhi 2021).
- **Medicaid Administrative Matching Funds:** States may access an administrative match for crisis call centers that offers federal Medicaid reimbursement for half of the costs for Medicaid enrollees (CMS 2018).
- **Mental Health Block Grant (MHBG) 5 percent Set-Aside, 2021:** Beginning in fiscal year 2021, Congress directed SAMHSA to dedicate 5 percent of total MHBG dollars for states and territories to evidence-based crisis services addressing the needs of individuals with SMI and children with serious mental and emotional disturbances (SAMHSA 2020a).
- **988 Telecom Service Fees:** As of 2024, 11 states have passed permanent telecom 988 taxes to fund crisis call center services (NAMI 2024). These fees are often small per service line per month, ranging from 8 cents in California to 60 cents in Delaware (NAMI 2024).
- **Local levies:** Various states, counties, and municipalities have passed tax levies to fund behavioral health services that support funding for crisis services, such as California's Mental Health Services Act, King County's (Washington State) Crisis Care Levy, and Missoula's (Montana municipality) Fire and Emergency Services Levy.
- **State general fund appropriation:** In a 2022 study of 40 states, 34 used state general funds for crisis call centers and 39 used state general funds for mobile crisis teams (NRI 2023).

Medicare and commercial insurers do not consistently cover a wide range of crisis services. As of January 2024, Medicare only utilized two codes specific to crisis services: crisis psychotherapy services delivered by certain types of providers in hospitals, skilled nursing facilities, physician's offices, or patient's homes. It is possible that,  components of crisis services may be billed using more general codes (CMS 2024). . Commercial insurers also vary in their coverage of crisis services. Since the launch of 988 in July 2022, the annual number of crisis calls, texts, and chats has increased every year (Saunders 2024), making it more likely that commercially insured individuals will use crisis services. However, many providers have not been

successful in billing commercial insurance (Shaw 2020). In response, some states have introduced legislation or invoked federal and state insurance parity laws to require commercial insurers to expand their coverage of crisis services (Hepburn 2023). States and providers are exploring ways to encourage commercial insurers to reimburse a greater share of crisis services, such as promoting use of service contracts and fee schedules between payors and crisis service providers and levying an assessment on insurers to cover their fair share of costs. However, these strategies are still under development and have not been widely implemented (Hepburn 2023; Shaw 2020).

> *"The crisis services [financing] landscape is fragmented, not sustainable, and not adequate for the volume of demand."*
>
> Key informant interviewee

Given variability in coverage for crisis services and broader concerns about reliable funding to sustain these services, SAMHSA's National Guidelines recommend all insurers adopt a universal set of Healthcare Common Procedure Coding System (HCPCS) billing codes (H0030, H2011, S9484/S9485) for crisis services that correspond with the three core crisis services (SAMHSA 2020b). SAMHSA and other groups, such as the National Alliance on Mental Illness (NAMI), have also recommended broader expansion of insurance coverage for crisis services to foster parity between coverage for medical and behavioral health care (NAMI 2024). Shifting a greater share of financing for crisis services to insurance would, however, require investment and buy-in from SMAs, state and local BHAs and MCOs, and crisis providers, many of whom have historically delivered crisis services outside of traditional claims-based reimbursement. In addition, coverage definitions and billing codes would need to align with the different types of crisis services and how they are delivered in practice. Crisis service providers may also need to adopt new processes to obtain insurance information from their clients and submit claims for reimbursement.

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) engaged Mathematica to examine the role of insurance in financing crisis services and opportunities for expanding claims-based reimbursement to sustain these services. We conducted an environmental scan, key informant interviews, and virtual case study interviews with crisis service providers and payors. We also analyzed Medicaid claims data from 2020–2022 to examine billing for crisis services in the states corresponding with the case study communities. The report provides a brief overview of our methods and then summarizes findings on how states and communities have used insurance for crisis services and the specific crisis services billing codes used for claims-based reimbursement. The report concludes with potential opportunities for expanding the use of claims-based reimbursement to support crisis services.

## B. Overview of methods

This report synthesizes findings from (1) an environmental scan of peer-reviewed and grey literature, (2) key informant interviews, (3) virtual case study interviews with crisis service providers and payors in eight communities, and (4) quantitative analyses of Medicaid claims data. Exhibit I.3 summarizes the data sources and methods (see Appendix A for additional details on data sources).

**Exhibit I.3.** Summary of data sources and methods

| Component | Objective | Data source | Analysis |
|---|---|---|---|
| Environmental scan | Describe the financing landscape for crisis services and the role of claims-based reimbursement and billing processes in crisis services. We also used the findings to identify potential case study communities. | Scan of English-language peer-reviewed and grey literature, focusing on the past five years (2018–2023), in addition to formative articles and reports before 2018 identified in supplemental searches; identified 44 sources that matched criteria and extracted information from 18 of the most relevant sources. | Reviewed articles and wrote analytic summaries; organized findings into synthesis of current state of claims-based reimbursement for crisis services. |
| Key informant interviews | Gather varying perspectives on the current landscape of claims-based reimbursement for crisis services and identify promising strategies for using insurance to finance crisis services. | Semi-structured interviews with four key informants with relevant expertise representing clinical practice and administration, research, advocacy, and policy perspectives. | Performed rapid qualitative thematic analyses. |
| Case studies | Examine how crisis services are financed and/or how crisis service providers bill Medicaid, Medicare, and commercial insurers for crisis call center, mobile crisis team, and crisis receiving and stabilization services. Describe strategies for greater alignment of claims-based reimbursement with crisis services delivery and promising approaches. | Semi-structured, recorded interviews with providers, as well as staff representing public and commercial payors in eight communities in eight states. | Performed rapid qualitative thematic analyses. |
| Quantitative analysis | Examine rates of claims for crisis services billed to Medicaid, overall, and by specific billing codes. Describe patterns over time and summarize diagnostic characteristics. | Medicaid T-MSIS Analytic File enrollment and claims data, eight states corresponding with case study communities, 2020–2022. | Performed quantitative descriptive analyses. |

## C. Case study communities

For the case studies, in the spring and summer of 2024, we interviewed providers and payors in eight communities (defined as counties or municipalities) across the United States (Exhibit I.4). We identified these communities through our environmental scan and key informant interviews. Each selected community had established crisis services and was located within a state with Medicaid coverage for at least one core crisis service.

For each community, we identified and recruited representatives from at least one crisis service provider organization. We also recruited at least one payor and/or the entity responsible for administrative services on behalf of the payor in each community. For the purposes of this study, "payor" refers to SMAs, BHAs, MCOs, and commercial insurers, depending on the community. To honor the confidentiality of provider organizations and payors participating in the case studies, this report only describes the states in which these communities are located.

## D. Crisis service provider organizations and populations served

The eight case study communities differed in population size and demographic composition but are all located in states in which Medicaid covers at least one of the three core crisis services (Exhibit I.4). Three of the case study communities are located in states where, as of 2022, Medicaid covered crisis call centers (Arizona, Montana, Washington), five in states where Medicaid covered mobile crisis team services (Arizona, Louisiana, North Carolina, Ohio, and Washington), and six in states where Medicaid covered crisis receiving and stabilization services (Arizona, California, Louisiana, Montana, North Carolina, and Washington).

Crisis services were financed in all case study communities through a combination of federal, state, and local funds. As of 2024, two states used state phone taxes to fund crisis call centers (California, Washington); one state earmarked opioid litigation proceeds for 988 crisis call center services (Utah); and communities in Montana and Washington used local crisis services tax levies, with funds earmarked to partially finance the crisis service continuum. Five of the states received ARPA funds to expand mobile crisis team services (Arizona, California, Montana, North Carolina, Washington). Three states enacted legislation to require commercial insurers to cover emergency behavioral health services (California, AB 988; Utah, SB 155; Washington, E2SHB 1688).

For most states corresponding with the case study communities, more than one in five people were enrolled in Medicaid as of 2022 and, for most states, more than one in five Medicaid enrollees had a behavioral health condition.[1]

**Exhibit I.4.** Delivery system context for case study communities

| State | Medicaid administration and coverage of crisis services[2] | Medicaid enrollees (2022)[a] | Percentage of overall state population enrolled in Medicaid [b] | Percentage of Medicaid enrollees with BH condition [c] |
|---|---|---|---|---|
| Arizona | The Arizona Health Care Cost Containment System contracts with MCOs that serve as regional behavioral health authorities providing and overseeing behavioral health service delivery, including all crisis services. Medicaid covers call center, mobile crisis team, and crisis stabilization and receiving services. | 2,609,315 | 21% | 19% |
| California | The California Department of Health Care Services covers crisis services (which are carved out of managed care) and counties deliver crisis services. County behavioral health authorities administer and deliver behavioral | 17,089,683 | 27% | 12% |

[1] Diagnosed behavioral health conditions were defined using the Chronic Conditions Data Warehouse (CCW) algorithm for mental health and substance use disorders.

[2] Medicaid coverage for crisis services were determined based on the Kaiser Family Foundation's Behavioral Health Survey of State Medicaid Programs, available at: "Medicaid Coverage of Behavioral Health Services in 2022: Findings from a Survey of State Medicaid Programs." https://www.kff.org/mental-health/issue-brief/medicaid-coverage-of-behavioral-health-services-in-2022-findings-from-a-survey-of-state-medicaid-programs/.

| State | Medicaid administration and coverage of crisis services[2] | Medicaid enrollees (2022)[a] | Percentage of overall state population enrolled in Medicaid [b] | Percentage of Medicaid enrollees with BH condition [c] |
|---|---|---|---|---|
| | health services and most offer mobile crisis team services. The state has invested significant state funding into crisis services infrastructure development. Medicaid covers mobile crisis team (as of calendar year 2023) and crisis stabilization and receiving facilities. | | | |
| Louisiana | The Louisiana Office of Behavioral Health coordinates with independent local governing entities that deliver behavioral health services locally. Medicaid covers mobile crisis team and crisis stabilization and receiving services. | 2,098,686 | 32% | 19% |
| Montana | The Montana Behavioral Health and Developmental Disabilities Division oversees a statewide system of behavioral health services. Medicaid covers call center, mobile crisis team (as of fiscal year 2023), and crisis stabilization and receiving services. | 345,312 | 21% | 28% |
| North Carolina | North Carolina Medicaid contracts with MCOs to coordinate behavioral health services. Medicaid covers mobile crisis team and crisis stabilization and receiving services. | 3,067,443 | 19% | 15% |
| Ohio | Eighteen Alcohol, Drug Addiction, and Mental Health Boards in Ohio administer behavioral health services. Medicaid covers mobile crisis teams. | 3,662,952 | 21% | 29% |
| Utah | Local mental health authorities administer behavioral health services; many contract for and pay a capitated monthly fee to prepaid mental health plans. Based on interviews, Medicaid presently covers mobile crisis team and crisis receiving and stabilization services. | 555,724 | 11% | 21% |
| Washington | The Washington State Health Care Authority contracts with county behavioral health administrative organizations (BH-ASOs), many of which are led by counties, to deliver crisis services. In turn, the BH-ASOs contract with providers and are reimbursed for services. Medicaid covers call center, mobile crisis team, and crisis stabilization and receiving services. | 2,414,012 | 21% | 20% |

[a] The count of Medicaid enrollees is based on Mathematica's analysis of Medicaid claims data.

[b] The percent of the overall state population enrolled in Medicaid is from Kaiser Family Foundation, available at: "Health Insurance Coverage of the Total Population, 2022." https://www.kff.org/other/state-indicator/total-population/

[c] Percentage of enrollees with behavioral health conditions represents enrollees identified with a mental health condition, substance use disorder, or co-occurring disorder using these data.

BH = behavioral health.

## E. Study limitations

This study provides insights into the use of insurance and claims-based reimbursement to support crisis services from the perspectives of a limited number of providers and payors. Our study focused on crisis call centers, mobile crisis teams, and crisis receiving and stabilization facilities and did not include short-term residential crisis and peer respite care services. The study examined the claims for crisis services between 2020–2022 with codes confirmed in interviews and billing guidance from 2024. Our analysis of Medicaid claims data intended to capture crisis services billed to Medicaid as opposed to such services used by Medicaid enrollees. The analysis time frame included the COVID-19 public health emergency, during which Medicaid programs relaxed re-eligibility determination requirements and service delivery was disrupted, and this could have influenced the findings.

# II. Provider and Payor Experiences with Claims-Based Reimbursement for Crisis Services

This chapter describes how the case study communities use insurance to support crisis services and highlights provider and payor perceptions of claims-based reimbursement.

## A. Use of insurance to support crisis services

**Role of insurance.** Insurance does not serve as the sole or primary source of funding for crisis services in any of the case study communities. Although providers and payors acknowledged the importance of insurance in supporting crisis services, they unanimously agreed on the need for other sources of funding to cover the costs of crisis services given the on-call and variable-volume nature of crisis service delivery. Traditional volume-based fee-for-service reimbursement requires a predictable number of patients to generate a predictable revenue stream for the provider. Most crisis services require maintaining adequate staffing levels to deliver on-call services in response to behavioral health emergencies. However, the volume of people who will experience such an emergency can vary from week-to-week or month-to-month, making it challenging for these providers to derive a predictable revenue stream from claims-based reimbursement alone. A crisis receiving and stabilization facility administrator described how their 16-bed facility would need to serve 14 reimbursable patients a day for claims-based reimbursement financing to be sustainable. Another provider remarked that an entirely fee-for-service claims-based reimbursement model would "collapse the crisis system" because there would be a higher risk of denying clients if they did not have coverage, and that payors would need to reimburse services at a much higher rate to cover the infrastructure costs of crisis care.

> *"We get lots of calls. But the concept [of the firehouse model] is that the funding has to be enough to support the infrastructure, whether you get calls or not."*
>
> *BHA administrator*

**Insurance coverage and use.** Crisis service providers in the case study communities most often billed Medicaid, but did not bill Medicare and infrequently billed commercial insurance. Public payors in a few communities have also used ARPA funding to increase Medicaid reimbursement rates for mobile crisis team and crisis receiving and stabilization services and support the expansion of mobile crisis team services to 24/7 service models. Although providers in the case studies do not bill Medicare for crisis services, several expressed interest in better understanding how to use Medicare reimbursement for such services.

Most providers in the case study communities do not bill commercial insurance for crisis services, which is consistent with previous findings (Shaw 2020). When commercial insurance covers crisis services, the insurer often contracts directly with an individual crisis service provider or behavioral health authority and negotiates the billing codes and reimbursement rates. Because agencies providing crisis services are committed to providing services regardless of

> *"We recognize that there may be local nuances but in terms of what these [crisis] services are and how they should be covered, we would like an off-the-shelf code set. We want uniformity, we want alignment. But we also think that paramount for payors in general, is quality control and balancing that need with access."*
>
> *Commercial payor*

insurance status, the provider or behavioral health authority may need to work with individual commercial plans to credential individual providers and establish the reimbursement rates for services; each insurer may have their own billing codes and reimbursement rates. As a result, commercial coverage and allowable codes can vary between providers in the same state or community. Providers in our study that routinely bill commercial insurance for mobile crisis team and/or crisis receiving and stabilization services are large, mature organizations (large-scale provider organizations and an academic medical center). They also have strong technological and administrative support for billing and the resources to independently negotiate contracts with commercial payors. Commercial payor interviewees remarked that commercial coverage "typically follows Medicare" and that expanded Medicare coverage and billing guidance could encourage and lay a groundwork for commercial insurers to do the same.

**Financing structure.** In states corresponding to the case study communities, the state Medicaid and/or behavioral health authority contracts with local BHAs or MCOs or works directly with crisis service providers to deliver services. These services are often administered on a county or regional level. MCOs typically receive a capitated rate from the state and then pay providers by using braided funds from Medicaid and other sources, including federal block grants and state and local funds.

**Indirect and direct billing arrangements.** Most providers interviewed use insurance through a system of indirect Medicaid billing wherein they receive a prospective payment from the local BHA or MCO and then submit information about patient encounters to support these payments. These arrangements allow the BHA or MCO to take on much of the infrastructure cost, administrative burden, and financial liability associated with claims-based reimbursement. In most cases, prospective payments to providers are not directly tied to individual patient encounters; rather, providers receive a fixed amount of funding to cover their operating expenses.

*"We do not bill [Medicaid] directly. We submit to the county. The county bills Medi-Cal. Medi-Cal pays the county. The county pays us. We do not do any direct billing."*

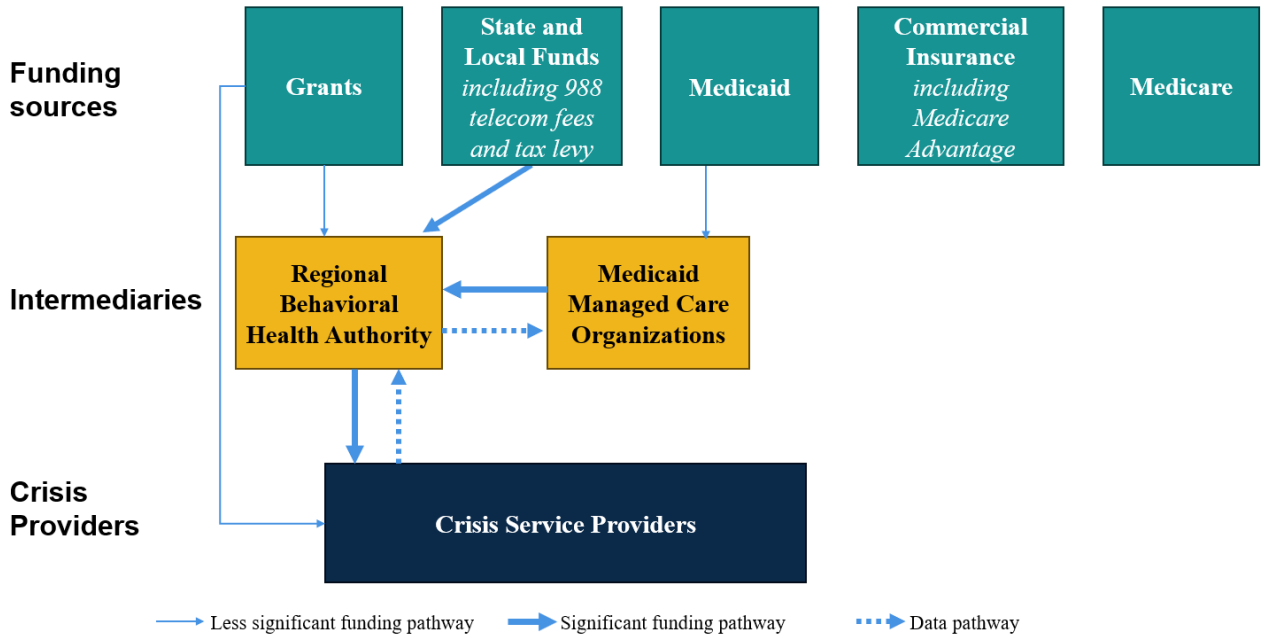
*Provider, California*

*"The big thing… [needed to facilitate insurance billing] is an allowance for advance payments to providers because they have not built up infrastructure for doing this work. And they don't want to make investments in building up the infrastructure for doing claims-based work."*

*BHA payor, California*

To submit claims for reconciliation, providers using indirect billing arrangements must still obtain some personally identifiable information (PII) about the clients they serve and the billable services they provided (for example, name, MCO, presenting problem). Collection of these data can be time consuming and pose logistical challenges. For example, one crisis call center provider participating in an indirect billing arrangement with a local BHA obtains and reports PII for only a fraction of overall crisis calls due to a high proportion of dropped calls and its limited capacity for data collection. BHAs and MCOs in several states reported using advanced data clearinghouses to match incomplete PII data from providers to Medicaid enrollment information to facilitate billing and even back billing (using new PII information to correct those records missing billable information to recoup already incurred costs). Exhibit II.1 provides an example of how braided funding flows from multiple sources through a BHA to pay crisis service providers in one case study community.

**Exhibit II.1.** Example: Crisis services funding and data pathways in one community




Note: This exhibit provides an example of how indirect billing works in one case study community. This example is not comprehensive, nor does it illustrate indirect billing arrangements in all communities.

It was unclear from case study interviews how closely payors and administrators enforce the collection of PII to maintain their payments to crisis service providers in these indirect billing arrangements, and what proportion of the payments to providers using braided funds are attributable to Medicaid. For some providers, payments from the BHAs or MCOs fully cover their operating expenses, whereas others rely on supplemental private donations, grants, or additional contracts with other counties or municipalities. Differences in funding approaches may reflect varying levels of state and local resources for crisis services. For example, although some states and communities have tax income earmarked to fund mental health services, others do not have any of these supplemental mechanisms and instead depend on less stable sources, such as state general funds.

Only one state included in this study currently requires providers to bill directly for mobile crisis team and crisis receiving and stabilization services. Providers submit claims directly to Medicaid and generate revenue from individual encounters or claims (as in traditional fee-for-service arrangements). Those providers also receive additional funds, such as block grants to cover services for people who are uninsured and underinsured and cover co-pays for people with commercial insurance. One crisis receiving and stabilization facility in this state uses a sliding-scale fee schedule for people without Medicaid or when other forms of insurance do not fully cover the costs of care. Providers using direct billing arrangements may face greater challenges related to billing due to lack of support from an intermediary to match PII with insurance records and navigate billing-related challenges, as described above.

**Billing guidance from payors.** State SMAs, BHAs, and/or MCOs in all case study communities publish provider manuals related to coverage and billing codes on their websites. In several states, BHAs or MCOs also host trainings and coaching sessions on billing practices. In a few states, payors described working to

convene coalitions of providers, payors, health plans, and other invested parties to troubleshoot policy and billing issues together.

## B. Alignment of crisis services with claims-based reimbursement

Providers and payors in the case study communities, as well as key informants, described misalignment between how crisis services are delivered on the ground and the processes required for claims-based reimbursement. Provider and payor interviewees described four overarching issues related to claims-based reimbursement: (1) inconsistent definitions and restrictions on billing codes; (2) low reimbursement rates; (3) infrastructure and staffing needed to support billing; and (4) challenges collecting PII needed for billing.

**Coverage and billing code definitions**. Coverage and billing code definitions do not always align with the delivery of crisis services or allow providers to obtain reimbursement for all of the services they provide or populations they serve. Providers noted instances in which billing codes are defined in ways that prevent them from billing crisis services for some populations. For example, a Medicaid beneficiary may seek walk-in services from a crisis receiving and stabilization facility, but the person may not meet program criteria for crisis receiving and stabilization facility reimbursement. In these cases, the facility may still provide case management or other immediate support but not bill Medicaid. In likely rare cases in two states, some types of claims submitted for crisis receiving and stabilization services were only Medicaid reimbursable for clients with a primary mental health diagnosis or receiving mental health services; in these states, providers would not be reimbursed for crisis services involving substance use disorder care.

Although commercial payors indicated support for crisis services, they also expressed concerns about the lack of standardization related to crisis services billing codes and service definitions. These payors emphasized the need to ensure covered services—particularly those provided by crisis receiving and stabilization facilities—met quality standards, such as credentialing of crisis services staff. Some commercial and public payors also noted challenges associated with aligning HCPCS coding used for Medicaid with commercial claims reimbursement systems.

**Reimbursement rates.** Some providers cited low reimbursement rates for crisis services as a disincentive to participation in insurance or investing in developing their billing structure. Inadequate rates may disincentivize existing and new behavioral health organizations from offering crisis services if they will be operating crisis services programs at a loss due, in part, to low reimbursement rates. Providers also described instances in which states have unique staffing, accreditation, or licensing requirements for crisis service providers that increase the costs of care and necessitate higher reimbursement rates. For example, in a state that requires crisis service providers to employ a registered nurse (RN), one provider described how the Medicaid rates do not cover the high salary of RNs, which is driven by nursing shortages in the community. As a result, the provider needed to offer a salary that exceeded the Medicaid payment rate for crisis services. Similarly, a key informant elaborated on the mismatch between provider salaries and

> *"Federal funding for increased rates [for crisis service providers] would be phenomenal... historically low rates are a reason for lack of uptake [of claims-based reimbursement] and a severe lack of providers in the area."*
>
> *State Medicaid payor*

reimbursement rates, explaining that hazard pay is often built into compensation packages as a hiring incentive but is not covered by standard fee schedules. Providers and payors reported that low reimbursement rates disincentivize billing for crisis services; one payor remarked that these rates also shape the availability of crisis service provider organizations. As another example, in one rural community, a provider noted funding constraints prevent them from updating their service delivery model to two-person 24/7 mobile crisis team services to align with ARPA requirements for the temporary 85 percent federal medical assistance percentage (FMAP). These providers would have to update their service delivery model to receive the higher reimbursement rate.

**Staffing and infrastructure.** Payors noted that many crisis services providers, especially from organizations newer to crisis service delivery with limited healthcare billing experience and infrastructure, need support to increase their billing capacity. Crisis service providers vary in their organizational history and scale, ranging from small, recently established community-based organizations to multi-regional behavioral health care organizations offering both crisis and non-crisis services with extensive billing experience. Larger, established organizations with existing billing infrastructure and designated billing staff expressed the fewest concerns about billing Medicaid for services but noted that billing commercial insurance remains challenging.

Crisis call center providers and more recently established mobile crisis team providers that operate outside of traditional health care settings voiced significant concerns about the staffing and infrastructure required to adopt claims-based reimbursement. These included the high up-front costs of adopting electronic health record technology, time and resources associated with training staff on how to collect and report PII and other billing information, and challenges recruiting additional staff to support this work amid broader workforce shortages. Additionally, some mobile crisis team and crisis receiving and stabilization facility providers who are currently billing for services expressed the need for additional technical assistance, for example, to address confusion around denied Medicaid claims and clawbacks.

*"You submit a claim [one way] today and the same exact way, tomorrow, one might be accepted and one might be denied for a totally random reason.... There is zero guidance [from payors]. If you call today [then] tomorrow, you get two different answers on what's allowable."*

*Crisis services provider*

Providers also emphasized the burden of billing on the crisis behavioral health workforce given broader workforce shortages that have resulted in challenges with provider recruitment and turnover. One provider explained how limited staff capacity and familiarity with billing would make it extremely difficult to implement claims-based reimbursement. Another described how crisis call centers new to billing would need to hire staff to maintain technology, run data reports, and batch and submit claims. Providers in rural communities expressed concerns about their ability to hire and retain sufficiently trained personnel to support crisis services delivery, let alone billing.

Providers already engaged in billing expressed fewer concerns about having the staff and infrastructure to support billing relative to providers participating in direct billing arrangements than those currently not billing for services. Some providers receive robust technical assistance from BHAs or MCOs that leverage their back-end billing warehouses or clearinghouses to reduce the administrative burden associated with billing. However, not all BHAs and MCOs are equipped with this infrastructure. One BHA explained how

their state's lack of infrastructure to support the provider claiming process has made establishing commercial coverage of mobile crisis team services less feasible.

Finally, only the most established crisis services providers interviewed had successfully negotiated with commercial payors to bill for mobile crisis team and crisis receiving and stabilization services. These providers devoted substantial time and resources to meet commercial payor standards and credential-based requirements (which often differ across different commercial payors). In some cases, providers reported that many commercial insurers were reluctant to cover some crisis services, and even in cases where commercial insurance may be amenable to covering crisis services, most crisis services providers may be considered out-of-network and would therefore receive limited guidance on how to bill commercial payors for crisis services or how to establish these relationships. The need for providers and BHAs to initiate billing with commercial payors, which may have differing requirements, may discourage billing of commercial payors, overall. According to one crisis receiving and stabilization facility provider, their facility serves too few people with commercial insurance to justify the administrative burden of billing commercial insurance.

**Client and provider perceptions of PII collection for claims billing.** Some providers, particularly crisis call centers and mobile crisis teams, expressed concerns about collecting PII from clients and described how doing so would limit their ability to build trust and engage clients in care. They viewed obtaining this information as contradicting their mission to provide low-barrier care. Asking clients for insurance information could also raise concerns about costs of care or their ability to afford a co-pay (if commercially insured) or even deter mobile crisis team clients, who often do not place calls for help for themselves, from accepting care. However, some interviewees were less concerned about collecting PII; one BHA administrator described how collecting PII could be used effectively as a de-escalation technique and built into routine crisis services.

> *"People in crisis don't want to provide insurance information—they are in pain. Asking for insurance creates a barrier to providing services."*
>
> *"Asking for insurance information can trigger more stress. People sometimes call because their insurance is not working and they feel overwhelmed. Those individuals are looking for a free resource."*
>
> *Crisis call center providers*

In general, most interviewees thought claims-based reimbursement was better suited for use within mobile crisis teams and crisis receiving and stabilization facilities as opposed to crisis call centers. These call centers have a service delivery model less compatible with collecting PII for billing given their often short interactions with clients as they address immediate needs and quickly connect clients to care. They also may not have staff trained to support data collection and billing for services. Several key informants also perceived insurance could have a larger impact on the financial sustainability of crisis receiving and stabilization services because they felt these services have received less federal grant support and attention in recent years relative to crisis call centers and mobile crisis teams.

# III. Billing for Crisis Services

During our case study interviews, we discussed provider and payor experiences using billing codes, including SAMHSA-recommended codes, for claims-based reimbursement of crisis services. We shared a list of known billing codes to facilitate discussions about how providers currently use these codes for crisis services and to identify all billing codes authorized by payors to bill for crisis services and used in practice by interviewed providers. These discussions focused mostly on billing codes authorized by SMAs, given the limited role of Medicare and commercial insurance in supporting crisis services. For each of the eight states corresponding to case study communities, we conducted a claims analysis using authorized codes to examine patterns such as the percent of Medicaid enrollees with claims for crisis services, the overall rates of claims for crisis services billed to Medicaid, the least and most commonly billed codes, and diagnostic characteristics.[3] In this chapter, we summarize key findings from the case study interviews related to billing codes (Section A) and then present a high-level summary of the Medicaid claims analyses complemented, where feasible, with state context from case study interviews (Section B).

## A. Codes used to bill for crisis services

Medicare and commercial insurers generally do not reimburse providers for the SAMHSA-recommended universal HCPCS billing codes (H0030, H2011, S9484, S9485). However, as described in chapter I, Medicare recognizes two crisis psychotherapy Current Procedural Terminology (CPT) codes (90839 and 90840) (CMS 2024). Commercial health plans vary in their use of codes to reimburse crisis services. Commercial payors interviewed negotiate with providers on the use of specific codes for crisis services. For example, one large commercial health plan uses an hourly crisis intervention code (S9484) to reimburse for crisis receiving and stabilization delivered by a California-based provider, whereas another commercial plan in Utah reimburses these services for a specific provider using a per diem crisis intervention code (S9485). In both states, the commercial plans reimburse for codes only after authorizing specific providers.

State Medicaid programs vary in their authorization of SAMSHA-recommended HCPCS codes for crisis services (Exhibit III.1). Among the eight states corresponding with case study communities, six state Medicaid programs reimburse services using H2011 and S9484/S9485 and five reimburse for "psychotherapy for crisis" (90839 and 90840). State Medicaid programs also authorize additional, state-specific HCPCS and CPT codes to reimburse for other aspects of crisis service delivery. These additional codes are for services such as assessments, nursing, case management, transportation, and psychotherapy delivered during a crisis encounter and may reflect state efforts to ensure comprehensive billing code coverage of crisis services. Arizona designates six additional codes for crisis services; Ohio designates five additional codes; California, North Carolina, and Washington each designate two additional codes; and Louisiana and Utah each designate one additional code. Through interviews and reviews of billing guidance, we also learned that four of these state Medicaid programs require providers to submit some codes with modifiers or place-of-service codes to indicate the delivery of crisis services as opposed to services delivered in non-crisis encounters (see Exhibit III.1 for modifiers). Codes do not always map to specific crisis service providers; for example, some codes could be used by both mobile crisis teams and

[3] Because of small cell sizes and the need to maintain the confidentiality of each case study community, this report does not present findings for the county or jurisdiction served by the case study providers.

crisis receiving and stabilization facilities.

**Exhibit III.1.** Medicaid-approved billing codes for crisis services in case study states

| Code | CPT/HCPCS description | States using code and state-specific definitions |
|---|---|---|
| 90839 | Psychotherapy for crisis; 60 minutes (time range 30-74 minutes) | Authorized by 5 states (California, Montana, North Carolina, Ohio, Utah); no modifier required |
| 90840 | Psychotherapy for crisis; add-on code with 90839 for each additional 30 minutes beyond the first 74 minutes | Authorized by 5 states (California, Montana, North Carolina, Ohio, Utah); no modifier required |
| H2011* | Crisis intervention service, per 15 minutes | Authorized by 6 states (Arizona, California, Louisiana, Montana, North Carolina, Washington); modifier required by 2 states (ET, GT, H9, or U8 in Arizona; TG in Washington); place of service required by 1 state (15 in California)<br>Arizona: Crisis intervention service, per 15 minutes – multi-disciplinary mobile team |
| S9484* | Crisis intervention mental health services, per hour | Authorized by 8 states (Arizona, California, Louisiana, Montana, North Carolina, Ohio, Utah, Washington; modifier required by 2 states (32, ET, GT, H9, or U8 in Arizona; TG in Washington)<br>Arizona: Crisis intervention mental health services, per hour – (stabilization) – up to 5 hours in duration; billing unit: 1 hour |
| S9485* | Crisis intervention mental health services, per diem | Authorized by 7 states (Arizona, Louisiana, Montana, North Carolina, Ohio, Utah, Washington); modifier required by 2 states (32, ET, GT, H9, or U8 in Arizona; TG in Washington)<br>Arizona: Crisis intervention mental health services, per diem – (stabilization) – more than 5 hours and up to 24 hours in duration |
| 90791 | Psychiatric diagnostic evaluation | Authorized by 1 state (Arizona); modifier required by state (32, ET, GT, H9, or U8) |
| 90832 | Psychotherapy, 30 minutes with patient | Authorized by 1 state (Ohio); modifier required by state (KX) |
| A0140 | Non-emergency transportation and air travel (private or commercial) intra or inter state | Authorized by 1 state (California); no modifier required<br>California: Transportation mileage via telehealth in 24 hour or day facilities or as part of mobile crisis services |
| H0004 | Behavioral health counseling and therapy, per 15 minutes | Authorized by 1 state (Ohio); modifier required by state (KX) |
| H0030* | Behavioral health hotline service (short description: Alcohol and/or drug hotline) | Authorized by 2 states (Arizona, Washington); modifier required by both states (ET in Arizona; TG in Washington)<br>Arizona: Behavioral health hotline service |
| H0031 | Mental health assessment, by non-physician | Authorized by 1 state (Arizona) for "crisis services within first 24 hours" when submitted with modifiers 32, ET, GT, H9, or U8 |

| Code | CPT/HCPCS description | States using code and state-specific definitions |
|---|---|---|
| H0038 | Self-help/peer services, per 15 minutes | Authorized by 1 state (Arizona); modifier required by state (32, ET, GT, H9, or U8) |
| H0045 | Crisis stabilization – individual, per day | Authorized by 1 state (Louisiana); no modifier required |
| H2000 | Comprehensive multidisciplinary evaluation | Authorized by 1 state (Utah); no modifier required<br>Utah: Crisis mobile response |
| H2017 | Psychosocial rehabilitation services, per 15 minutes | Authorized by 1 state (Ohio); modifier required by state (KX)<br>Ohio: Nursing services – individual |
| H2019 | Therapeutic behavioral services, per 15 minutes | Authorized by 2 states (Ohio, Washington); modifier required by both states (KX in Ohio; TG in Washington) |
| T1002 | RN services, up to 15 minutes | Authorized by 2 states (Arizona, Ohio); modifier required by both states (32, ET, GT, H9, or U8 in Arizona; KX in Ohio) |
| T1016 | Case management, each 15 minutes | Authorized by 1 state (Arizona); modifier required by state (32, ET, GT, H9, or U8) |
| T2007 | Transportation waiting time, air ambulance and non-emergency vehicle, half hour increments | Authorized by 1 state (California); no modifier required<br>California: Transportation staff time via telehealth in 24 hour or day facilities or as part of mobile crisis response |
| T2025 | Waiver services, not otherwise specified | Authorized by 1 state (North Carolina); modifier required by state (U3)<br>North Carolina: Crisis intervention, waiver; per diem |
| T2034 | Crisis intervention, waiver; per diem | Authorized by 1 state (North Carolina); no modifier required |

Source: Provider and payor case study interviews and reviews of state provider billing guidance, 2024.

Notes: This exhibit shows known billing codes authorized by SMAs. In column 2, we indicate state-specific definitions if they do not agree with the national CPT/HCPCS definition. HCPCS provides Level I CPT codes and Level II HCPCS codes; some Level II codes (H and T codes) were specifically established for Medicaid. Other HCPCS codes (S codes) were specifically established for Blue Cross/Blue Shield and other private insurers. MCOs also use S codes.

*Recommended by SAMHSA as a part of a universal code set for crisis services claims-based reimbursement

Providers in several case study communities bill Medicaid for additional services – such as case management, evaluation, counseling, and peer services – during crisis encounters. However, the codes they use are also commonly used for non-crisis encounters in that are not specifically designated or defined for crisis services in their states. Associated codes for these services are detailed in Exhibit III.2. Use of these codes in our Medicaid analysis would likely overstate claims for crisis services. For this reason, our Medicaid claims analysis used only the codes specific to crisis services (Exhibit III.1).

**Exhibit III.2.** Additional billing codes used during crisis encounters

| Code | CPT/HCPCS description | Case study state(s) where provider reported using code for crisis services |
|---|---|---|
| 90791 | Psychiatric diagnostic evaluation, 30 minutes | Montana |
| 90832 | Psychotherapy, 30 minutes | Montana |

| Code | CPT/HCPCS description | Case study state(s) where provider reported using code for crisis services |
|---|---|---|
| H0007 | Alcohol and/or drug services; crisis intervention | Ohio |
| H0038 | Self-help/peer services, per 15 minutes | California and Montana |
| H2017 | Psychosocial rehabilitation services, per 15 minutes | North Carolina |
| T1016 | Case management for mental health/SUD/intellectual and developmental disabilities, each 15 minutes | North Carolina |
| T1017 | Targeted case management, each 15 minutes | California |

Source: Provider case study interviews.

Notes: There may be additional billing codes used during crisis encounters not included in this list, which was generated based on interviews with a select group of providers in each state. Additional billing codes used during crisis encounters may not reflect actual use of billing codes by providers.

[a] This code is also used by specialized SUD intervention teams in emergency department settings.

## B. Analysis of Medicaid claims for crisis services

In this section, we summarize findings from our analyses of Medicaid claims for each of the eight states corresponding with case study communities. For these analyses, we used the codes in Exhibit III.1 compiled from findings from provider and payor case study interviews and reviews of state provider billing guidance. Select detailed findings from the claims analysis are shown in Appendix C.

- **Crisis call center services.** Of the three states in which Medicaid covered crisis call center services as of 2022,[4] two (Arizona and Washington) authorize use of the H0030 (behavioral health hotline service) code to bill Medicaid for crisis call center services. H0030 was one of the most frequently billed codes in Arizona (212 to 437 services per 10,000 enrollees from 2020 to 2022) but was billed less frequently in Washington (1.6 to 2.8 services per 10,000 enrollees from 2020 to 2022), perhaps due to additional state funds, such as the state's 988 behavioral health crisis response and suicide prevention line phone tax, designated for Washington crisis call centers.[5]
- **Mobile crisis team services.** As of 2022, Medicaid covered mobile crisis team services in all but one of the eight states considered in this analysis.[6] Six states authorize H2011 (crisis intervention service, per 15 minutes) to be used for mobile crisis team services. However, this code was billed infrequently in some states likely due in part to when Medicaid coverage was expanded in these states (California, Montana), and more frequently in others (Arizona, Louisiana, North Carolina, and Washington). Two states do not authorize use of the H2011 code and instead use state-specific codes for mobile crisis team services: Utah authorized H2000 for mobile crisis team services and Ohio authorized H2019 for these services.
- **Crisis receiving and stabilization services.** As of 2022, Medicaid covered crisis receiving and stabilization services in all but one (Ohio) of the eight states considered in this analysis.[7] All seven

[4] Montana covered crisis call center services as of 2022, but this coverage was not reflected in lists of authorized billing codes.

[5] Beginning in October 2021, Washington implemented a new excise tax on every telephone line and prepaid wireless retail transaction in the state to fund the new statewide 988 line.

[6] See Exhibit 1.3 for Medicaid coverage summary. Medicaid covered mobile crisis team services beginning in calendar year 2023.

[7] See Exhibit 1.3 for Medicaid coverage summary.

states that cover these services authorize providers to bill S9484 or S9485 (crisis intervention mental health services, per hour or per diem, respectively) for crisis receiving and stabilization services. The per diem code (S9485), which provides a daily bundled rate for all crisis receiving and stabilization services, was used more frequently than the per hour code (S9484) in five states (Arizona, Louisiana, Montana, Utah, Washington). Multiple providers from these states indicated that per diem codes facilitate simplified billing and more accurately capture the costs of delivering care.

We then examined the percent of Medicaid enrollees with claims for crisis services, the overall rates of claims for crisis services, the least and most commonly billed codes, and breakdown of diagnostic characteristics across enrollees and crisis claims in 2022.[8]

**Few Medicaid enrollees had claims for crisis services, but there was some variation across states.** Across the eight case study states, about 20 percent of Medicaid enrollees had a behavioral health condition between 2020 and 2022. However, in most states, the rate of claims for crisis services were quite low – fewer than one percent of enrollees had at least one claim for a crisis service during this period. Arizona represented an exception: between 5 and 6 percent of enrollees in the state had at least one claim for crisis services, depending on the year. The highest proportion of Arizona's crisis claims were for mobile crisis team services and other non-crisis receiving and stabilization services provided within the first 24 hours using the "case management services for crisis services for up to 15 minutes" code (T1016). Over the past three decades, Arizona has developed and refined its Crisis Now model to deliver coordinated community-based crisis care, and now has one of the most well-established crisis systems in the nation. According to interviewees, this system was designed to serve Medicaid enrollees due to the higher need among this population and stability of Medicaid reimbursement for these services. Across the state, most crisis providers are longstanding organizations familiar with the process of submitting billing data to MCOs for crisis services as a condition of their contract.

**Across states, claims for mobile crisis team and crisis receiving and stabilization services were more common than claims for crisis call center services among Medicaid enrollees with crisis claims.[9]** Claims for crisis receiving and stabilization services (T1016, S9484 or S9485) were most common in three states (Arizona, North Carolina, Washington) and claims for mobile crisis team services were most common in two (H2011 for Louisiana; H2000 in Utah). In Montana and Ohio, claims for psychotherapy for crisis were more common than all other types of claims. The most common type of crisis service claim in California (T2007) could apply to both mobile crisis team and crisis receiving and stabilization services.

The least common crisis codes billed among Medicaid enrollees also differed across states. However, the T1002 code (RN services up to 15 minutes), which is used by Arizona and Ohio, was the least-used code in both states. An Ohio payor suggested that these types of crisis-specific billing codes were developed to allow for reimbursement of expensive staff, like RNs, at enhanced rates that better account for the challenges of recruiting and paying in-demand staff for crisis services. It was not clear from interviews why

[8] For most analyses, we provide findings on an enrollee level (among enrollees with at least one crisis claim in 2022), as a given enrollee could have multiple crisis episodes within a given year and multiple codes billed for a single crisis encounter (for example, many billing codes were for small time increments).

[9] Medicaid enrollees with crisis claims were defined as those who had at least one crisis claim in the reference year.

this code was billed so infrequently in both states.

**Most Medicaid enrollees who had a claim for crisis services had a behavioral health condition.** In 2022, the majority (between 82 and 97 percent, depending on the state) of Medicaid enrollees with crisis services had a mental health condition, substance use disorder condition, or co-occurring disorder ; behavioral health conditions were defined using a standardized approach used by CMS.[10] These findings, and statements from case study interviewees, reflect some states' requirement that a primary mental health and/or substance use disorder diagnosis be present to bill Medicaid for crisis services. However, states vary in their guidance; some crisis codes cannot be billed for enrollees with a primary substance use disorder diagnosis. Across the eight case study states combined, 85 percent of enrollees with a crisis claim in 2022 had a mental health condition. Specifically, these enrollees had one or more of the following conditions: anxiety disorder (54 percent), mood disorder (58 percent), other mental health disorder (43 percent), personality disorder (8 percent), schizophrenia or other psychotic disorder (28 percent), or co-occurring disorder (11 percent). Across the eight case study states combined, more than one out of three enrollees with a crisis claim in 2022 had a substance use disorder; among these enrollees, 45 percent had an alcohol use disorder, 20 percent had an opioid use disorder, and 81 percent had another drug use disorder.

Diagnostic characteristics on a claims level are shown in Appendix Exhibit C.1. Only a small proportion of overall claims for crisis services across case studies in 2022 (between 2 and 52 percent of claims, depending on state) did not have a behavioral health diagnosis. More than half of these claims had a primary diagnosis codes related to a combination of the following: unspecified illness (14 percent), end-stage renal disease (11 percent), uncomplicated opioid dependence (10 percent), unspecified non-SUD related psychosis (10 percent), and attention deficit hyperactivity disorder (8 percent).[11]

**From 2020 to 2022, the overall rate of claims for crisis services per 10,000 Medicaid enrollees increased in two states (California and North Carolina), decreased in four states (Ohio, Louisiana, Utah, and Montana), and changed minimally in two states (Arizona and Washington).** Detailed findings are in Appendix Exhibit C.2.

- In **California and North Carolina**, the overall rate of claims for crisis services per 10,000 Medicaid enrollees increased from 2020 to 2022. Both received APRA planning grants to implement qualifying community-based mobile crisis intervention services. An interviewee from one of these states relayed that increased payment rates due to ARPA funding increased use of Medicaid for mobile crisis team

[10] To identify enrollees with behavioral health condition in claims data, we adopted the standardized approach that CMS uses, which is available from the Chronic Conditions Data Warehouse (CCW). This algorithm aims to classify enrollees in treatment for specific conditions. For most behavioral health conditions, the CCW algorithm requires "at least 1 inpatient claim or 2 other non-drug claims of any service type" during a two-year reference period to identify enrollees considered to have a behavioral health condition during a particular year. For example, an enrollee identified as having ADHD in 2020 had either one inpatient claim with an ADHD diagnosis code or two outpatient claims with an ADHD diagnosis code during 2019 or 2020. The analysis included mental health conditions (anxiety disorders; mood disorders; other mental health disorders; personality disorders; schizophrenia other psychotic disorders), substance use disorder conditions (alcohol use disorder; opioid use disorder; other drug use disorders), co-occurring conditions (identified by mental health diagnosis code and substance use disorder diagnosis code in any diagnosis position), and no behavioral health conditions (instances where no qualifying behavioral health condition was identified in claims data).

[11] These and other diagnoses did not meet the definition of behavioral health diagnosis codes established by the CMS's approach.

services; however, this funding did not go into effect until July 2022 in North Carolina and January 2023 in California, so ARPA may not explain the observed patterns (Saunders 2023).

- In **Ohio, Louisiana, Utah, and Montana**, the overall rate of claims for crisis services per 10,000 Medicaid enrollees decreased from 2020 to 2022. Interviewees pointed to several changes and challenges related to Medicaid billing during this period. The SMA payor in one of these states noted that providers were unable to bill Medicaid for both 90839 and 90840 due to billing systems issues. In another, respondents cited low reimbursement rates as impeding use of claims-based reimbursement for crisis services but noted ongoing efforts by the SMA to revisit coverage and payment rates for these services. Finally, a payor in one of these states speculated that many providers in the state lack the infrastructure and experience with Medicaid billing to submit claims.
- In **Arizona and Washington**, the overall rate of claims for crisis services per 10,000 enrollees stayed relatively constant from 2020 to 2022. In Arizona, where rates of claims began and stayed very high relative to other states, interviewees reported that most crisis providers are longstanding organizations familiar with the process of submitting billing data to MCOs for crisis services as a condition of their contract. Although Washington providers receive billing guidance, training, and support to manage and submit their billing data, rates of claims for crisis services billed to Medicaid were the lower than all other states.

Overall, findings from our claims analysis and corresponding interviews suggest that the billing landscape for crisis services varied across states. Findings also illustrate the challenges of using the SAMHSA-recommended set of recognized billing codes to track claims for crisis services given state differences in coverage, billing, and authorized billing codes. For example, providers may also opt to use other established non-crisis billing codes (for example, CPT codes for psychiatric diagnostic evaluation or individual psychotherapy) when billing for crisis services that are not reflected in the list of crisis-specific codes in this analysis. While trends in Medicaid claims for crisis services may reflect states' experiences with billing Medicaid for crisis services, these findings need to be interpreted cautiously – findings should not be interpreted as the volume of overall crisis services delivered between 2020 and 2022 to Medicaid enrollees due to uncertainty about the extent to which Medicaid-eligible services are billed. In addition, it is possible that other unidentified billing codes were used between 2020 and 2022 and other factors could have potentially contributed to observed trends, such as increased demand for crisis services during the COVID-19 pandemic or changes in the availability of non-claims funding for crisis services over this time period.

# IV. Opportunities to Expand Claims-Based Reimbursement for Crisis Services

Findings from this study point to several opportunities to expand claims-based reimbursement for crisis services and better align billing codes with crisis service delivery models. Efforts to expand the role of insurance for crisis services will likely require support for providers to develop their capacity to collect PII for billing. These findings also underscore the importance of limiting provider administrative burden and ensuring that financing strategies maintain low-barrier crisis services. This chapter summarizes recommendations derived from key informant, payor, and provider interviews.

## A. Key opportunities

**Expand Medicaid, Medicare and commercial insurance coverage and align billing and reimbursement processes across payors.** Medicaid already covers crisis services in many states and allows states considerable flexibility in how they cover and reimburse these services. Medicaid could serve as the most immediate pathway to expanding coverage for crisis services and could provide a stable source of funding. Providers also encouraged expanding Medicare coverage for crisis services, which they felt would both help Medicare enrollees and set a precedent for commercial insurance to cover these services, since commercial coverage "typically follows Medicare." Some key informants pointed to state laws as an avenue to compel commercial coverage of crisis services. For example, Washington's E2SHB 1688 requires commercial insurers to cover emergency behavioral health services and protect clients from out-of-network charges for these emergencies. Some providers have also used claims data to persuade commercial insurers to cover crisis services (Exhibit IV.1). Providers and payors encouraged greater alignment across payors in crisis service standards and definitions, licensure requirements, and billing codes to reduce provider burden associated with navigating multiple payors and promote equitable access to care. For example, commercial payors could establish codes more compatible with commercial insurer billing systems than HCPCS and streamline credentialing processes to support provider contracts with multiple commercial plans.

**Exhibit IV.1.** Using data to demonstrate the value of expanding coverage for crisis services

One crisis service provider tracked the types of crisis services clients received, the frequency of those services, and monitored clients' receipt of follow-up care after crisis services. Through client-level monitoring, they ultimately sought to deliver care in a way that could prevent subsequent behavioral health crises. Another provider in a different community used Medicaid claims data to examine the outcomes of clients who received crisis receiving and stabilization facility services, as compared to emergency department care. The provider used the results from the analyses to demonstrate cost savings for the commercial payor, which resulted in the payor choosing to reimburse crisis receiving and stabilization services.

**Adopt billing practices to minimize burden on providers and explore alternatives to traditional claims-based reimbursement.** Indirect billing arrangements facilitated a steady source of revenue for providers and placed much of the administrative burden associated with claims-based reimbursement on the BHAs or MCOs. This helps providers remain focused on delivering low-barrier, high-quality care. Some BHAs and MCOs reimbursed providers through prospective payments to cover their operating costs, which reduced providers' financial risk. Providers participating in these indirect billing arrangements did,

however, need to invest staff time and resources into developing new processes for obtaining insurance information and other PII from clients, and routinely submitting this information to the BHAs or MCOs to maintain their payments. This was no small undertaking for many providers, particularly those without much experience with these activities. These providers benefited from support from the BHA and/or MCO to develop their capacity to participate in insurance. In some cases, BHAs and MCOs could leverage their clearinghouse and other data infrastructure to streamline billing processes. In addition, several key informants and payors suggested alternatives to traditional claims-based reimbursement (Exhibit IV.2). For example, states might consider levying a fee on insurers to fund a portion of crisis services as opposed to reimbursing for individual claims, which requires provider to submit information about individual client encounters. Several providers also saw promise in the Certified Community Behavioral Health Clinic reimbursement model, which includes crisis services in the prospective payment.

**Exhibit IV.2.** Alternative insurance-based strategies to support crisis services

**Proportional payments.** Several providers suggested that commercial insurers could cover their share of crisis services through a proportional payment to providers or intermediaries (behavioral health authorities or managed care). In this arrangement, providers would receive a payment based on the estimated proportion of crisis services used by commercially insured individuals in a community. None of the case study communities were actively using this strategy, but Senate Bill 5187 Proviso 19(b) has been introduced in Washington State to address this issue. It requires the SMA to examine gaps in the current funding model for crisis services and recommend options to address these gaps, including examining alternate funding models for crisis services and identifying the proportional share of program costs among public and commercial payors.

**Bundled payment rates inclusive of crisis services.** Bundled rates can provide a predictable source of revenue and reduce the administrative burden of submitting separate claims for every procedure. For example, several providers pointed to the payment model used for the Certified Community Behavioral Health Clinic (CCBHC) Demonstration as a promising alternative to traditional fee-for-service reimbursement. In the CCBHC model, clinics receive a fixed daily or monthly payment (depending on the state) inclusive of the costs of 24/7 crisis services irrespective of the bundle of services the client receives during the day or month. CCBHCs submit a single daily or monthly claim to receive this Medicaid payment. In 2024, the Centers for Medicare and Medicaid (CMS) gave state Medicaid programs the option of establishing separate CCBHC rates for mobile crisis and crisis stabilization services (CMS 2024).

**Enhance support to encourage the use of insurance for crisis services.** Providers and payors cited several examples of efforts to encourage the use of insurance for crisis services:

- **Support for BHAs and MCOs.** Not all BHAs and MCOs have established data systems to collect and reconcile client information from providers needed to support the indirect billing practices described in this report. Some payors expressed interest in adopting these systems to support efficient and accurate claims processing. Payors may also benefit from learning about strategies for financing crisis services, organizing coalitions of state and local partners to collaborate to strengthen crisis systems, and providing billing-related guidance and technical assistance.
- **Support for crisis services providers.** Providers would benefit from assistance to develop their internal capacity to collect the client information necessary to obtain reimbursement from insurers. This could include staff training on how to incorporate the collection of insurance information and other PII into clinical workflows without impeding care, submission of this information to insurers, and troubleshooting reimbursement-related issues. Providers also cited the need for clarity in billing guidance and ongoing support to adhere with billing guidance. Exhibit IV.3 outlines such support.

**Exhibit IV.3.** Support to implement billing for crisis services

To facilitate billing for crisis services, a BHA developed a provider manual with service standards, such as staffing requirements, definitions, and authorized billing codes and instructions, and offered providers considerable technical assistance to implement the billing guidance. This BHA had weekly one-on-one meetings with providers and convened groups of providers to identify common billing issues and develop solutions. Based on these meetings, the BHA realized reimbursement rates were insufficient to cover the costs of the crisis services and motivated them to increase rates. BHA staff also met regularly with the state licensing office and MCO credentialing offices to align requirements of these offices with billing guidance. This BHA emphasized the importance of developing strong interpersonal relationships with all parties and remaining accessible to providers.

There may be opportunities to leverage existing federal initiatives led by SAMHSA (NASMHPD n.d.) and CMS to provide TA and support on these topics. For example, CMS's forthcoming national TA center to support states in implementing the continuum of crisis services for Medicaid and Children's Health Insurance Program (CHIP) enrollees will provide opportunities for TA and peer-to-peer learning as SMA staff, providers, and BHAs and MCOs work to address challenges related to all aspects of establishing a crisis system, including expanding Medicaid reimbursement of these services.

Providers and payors also emphasized the importance of community collaboration to ensure payment models and billing codes support the delivery of services and remove barriers to care. This includes collaboration across state regulatory bodies that govern staffing, accreditation, and licensing requirements. These collaborations could help states customize and standardize crisis service definitions and standards and refine Medicaid billing codes, reimbursement rates, and reimbursement structures to meet local provider needs and contexts. These collaborations could follow models used in other communities, including those led by BHAs (Exhibit IV.4).

**Exhibit IV.4.** Community-centered services planning approaches

To strengthen and support crisis services delivery and financing, one BHA serving many rural communities developed cross-sector coalitions within communities to advise on crisis services delivery and financing. This BHA hired coalition coordinators who planned and organized regular meetings to build engagement and consensus within communities. These meetings helped it identify and address billing and workforce challenges faced by communities and supported the BHA in aligning SMA crisis services billing guidelines with state licensing policies. The BHA also engaged a public health institute to support the development of best practices related to crisis services delivery and financing responsive to provider needs.

## B. Conclusions

Public and commercial insurance could play a greater role in financing crisis services. Crisis service providers tend to rely on Medicaid more than Medicare or commercial insurance. Better alignment of billing definitions and codes across payors could encourage the use of insurance for crisis services. Efforts to increase the use of insurance and claims-based reimbursement for crisis services will likely require helping states, BHAs and MCOs, and providers develop their billing infrastructure and data collection processes, while ensuring crisis services remain accessible to anyone seeking care, regardless of insurance status. Strategies to reduce administrative burdens for providers related to billing are particularly important given the workforce pressures and limited financial resources these providers commonly face.

State and communities could also consider developing insurance-based alternatives to traditional claims-based reimbursement.

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# Appendix A

## Detailed Summary of Methods

## A. Quantitative data analysis

We used the 2020–2022 Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) Research Identifiable Files (RIF) to measure Medicaid enrollee characteristics and claims for crisis services across case study states. We measured Medicaid enrollee demographic information (age, sex, race/ethnicity, urbanicity, disability status, and Medicaid managed care enrollment) using the TAF RIF demographics and eligibility (DE) files, and we measured service use and diagnostic information using the TAF RIF Other Services (OT) and Inpatient (IP) files. We included all Medicaid enrollees (both adults and children/adolescents) in the states corresponding with case study communities. Based on data quality assessments from the DQ Atlas, we excluded 2020 data from Utah due to concerns about the completeness of the procedure code fields required for the analysis.[12] We also did not report race/ethnicity information for Arizona, Louisiana, and Utah in 2020 and 2021 due to concerns about the quality of information in those fields.

We identified claims for crisis services using both the SAMHSA recommended and state-specific crisis services codes confirmed during case study interviews and reviews of billing guidance in 2024. We then created counts of the number of claims overall and with each crisis service code and counts of the number of enrollees with claims with these codes, overall and by code. We also calculated the rate of claims for crisis services per 10,000 Medicaid enrollees, overall and by code, and the percentage of enrollees with crisis services, overall and by code.

We summarized the findings in tables to describe the characteristics of enrollees in each case study community state. We then further limited the population to those with at least one crisis service claim in each year of the analysis and created tables to describe the demographic and diagnostic characteristics of those enrollees by state. We also reported the counts, rates, and percentages by enrollee demographic characteristics, presented separately by state. We calculated the percentage of crisis service claims with (1) a primary mental health diagnosis code, (2) a primary substance use disorder diagnosis code, (3) a co-occurring mental health and substance use disorder (as identified using all diagnosis code fields for a claim), and (4) a nonbehavioral health diagnosis code (that is, no mental health or substance use disorder diagnosis code in any diagnosis code field for a crisis service claim). We present select findings from the analysis in this report.

## B. Environmental scan

We conducted an environmental scan to examine how states and communities use claims-based reimbursement to fund crisis services. These findings supported the development of questions for our key informant interviews and case studies. We gathered information through searches of the English-language peer-reviewed and grey literature, focusing on the past five years (2019–2023). We also included formative articles and reports before 2019 from supplemental searches to provide a more comprehensive review of the literature. Based on this search strategy, we reviewed titles and abstracts of peer-reviewed and grey literature through searches of Google, Google Scholar, and PubMed. The scan drew heavily on prior work related to crisis services financing led by SAMHSA, the National Council for Mental Wellbeing, and the National Association of State Mental Health Program Directors. Once we identified relevant

[12] For more information, see the DQ Atlas: https://www.medicaid.gov/dq-atlas/welcome.

literature and resources, we assigned a relevance rating based on how directly the resource focused on claims-based reimbursement to inform full article extraction. The extraction template included various categories of analysis, including the source's focus (objective, crisis services discussed, and financing mechanisms discussed), use of claims-based reimbursement (relevant examples, crisis services not funded via claims, and administrative and legislative actions to expand claims-based reimbursement), and claims-based reimbursement practices and specific codes used. Additionally, based on our findings from the initial search stage, our team conducted a forward and backward snowball search based on the most relevant sources identified in the initial search and our key initial source list.

We found 44 sources that matched our search criteria and identified 18 highly relevant resources to include in the literature extraction table. Sources most frequently discussed 988 crisis response, mobile crisis services, crisis call centers, and crisis receiving and stabilization facilities. Sources discussed funding sources including Medicaid, SAMHSA block grants and other grant-based funding, 988 fees on telecommunication lines, commercial claims, local government funding, state funding, and Medicare.

## C. Key informant interviews

We conducted four interviews with individuals who have expertise in crisis service research, delivery, and policy. Our environmental scan findings and consultation with ASPE and Mathematica's internal experts helped us identify and propose 10 interviewees. We recommended four candidates and several alternates based on their areas of expertise and recruited selected key informants by email. We then developed an interview protocol with general questions appropriate for all interviewees, as well as separate sections tailored to the expertise of each key informant. To thank them for their participation, we offered each nongovernmental interviewee a $100 gift card. For each interview, we took notes and audio-recorded the conversation to ensure the accuracy of our high-level notes. From our high-level notes, we compiled findings into a table of key takeaways, including recommendations for candidate case study communities to inform the next stage of the study.

## D. Case study interviews with providers and payors

In consultation with ASPE, we conducted eight case studies to gather more detailed information on how crisis care providers fund crisis services and bill Medicaid, Medicare, and commercial insurers for crisis call center, mobile crisis team, and crisis receiving and stabilization services. In selecting candidate case study communities, we sought to recruit a diverse group that could offer various perspectives on claims-based reimbursement and its implementation. We identified a list of case study communities using recommendations from key informants and based on the results of the environmental scan and website searches. For each case study community, we initially identified at least two providers and a commercial and public payor representative for email outreach. We recruited interviewees by email using an email outreach protocol with prompts for up to three engagement attempts via email and phone and offered each nongovernmental interviewee a $100 gift card to thank them for their time. We created four separate interview protocols to gather provider and payor perspectives, with tailored protocols for each type of crisis service provider, as we anticipated that different types of providers would have different crisis services delivery and financing strategies. For each interview, we took notes and audio-recorded the conversation to ensure the accuracy of our high-level notes. After each interview, we used a rapid qualitative analysis approach. For this approach, the lead interviewer populated a comprehensive table

with key information, such as provider or payor use or support of claims-based reimbursement, billing codes used, infrastructure needed, and barriers and opportunities to using claims-based reimbursement to finance the crisis services continuum. We also developed additional analytic tables to summarize case study interview findings across communities and across provider and payor types.

# Appendix B

## Use of Claims-Based Reimbursement and Variation in Service Delivery Across Core Crisis Services

| Core crisis service | Experiences with billing and claims-based reimbursement | Variation in service delivery |
|---|---|---|
| Crisis call centers | All four of the crisis call centers we interviewed are funded through contracts comprising braided state-level appropriations, county block grants, and tax levy funds. Two crisis call center providers reported not billing any services to Medicaid due to limited staff capacity and existing state block grant funding. However, in one community, the crisis call center provider uses indirect billing. | Staffing models across case study communities differ and are aligned to make the most of existing resources. In one community, a large crisis call center affiliated with an academic medical center deploys only master's-level clinicians, while in another, the crisis call center provider uses a mix of bachelor's and master's-level staff, in addition to more than 300 trained volunteers; the level of education and credentialing varies across lines, and much of the work is done by entry-level to bachelor's-level staff. To maximize time efficiency, a large crisis call center provider cross-trained its crisis line staff to provide additional call line services, such as its MCO call line and 2-1-1 line. Two crisis call centers interviewed mentioned ongoing efforts to update licensing requirements for crisis call services. For example, one center engaged its SMA to expand the crisis worker certification process and allow bachelor's-level crisis providers to staff crisis lines to address the growing workforce shortage. |
| Mobile crisis teams | Across case study communities, all mobile crisis team providers bill indirectly and one does not bill at all. Mobile crisis providers across case study communities vary in their use of claims-based reimbursement due to a range of factors, including community rurality (for example, limited access to care, limited behavioral health workforce), infrastructure, workforce capacity, and the availability of resources and TA to train staff sufficiently. | The delivery of mobile crisis team services across case study communities varied. For example, one case study community follows the Crisis Intervention Team (CIT) model, a program designed to promote partnerships among law enforcement, behavioral health providers, and people with mental and substance use disorders (SAMHSA 2018), using motivational interviewing and de-escalation techniques to build rapport with individuals in crisis and prevent the need for higher levels of care. Staffing models also differed. In some communities, mobile crisis teams comprise a licensed clinician and peer support specialist who provide services to the community in partnership with law enforcement; others mobilize emergency service providers, such as firefighters or emergency medical technicians (EMTs) in their mobile crisis teams, along with clinicians, to provide medical care and assess needs. |
| Crisis receiving and stabilization facilities | All crisis receiving and stabilization facility providers, many of whom also run mobile crisis team services, reported billing for services. All except one provider, billed indirectly. | Across case study communities, crisis receiving and stabilization facilities reported multidisciplinary staffing models; many of these facilities also use peers within their model of care. At one facility, peers are responsible for supporting individuals with the |

| Core crisis service | Experiences with billing and claims-based reimbursement | Variation in service delivery |
|---|---|---|
| | | case management work of the facility, specializing in addressing unmet social needs, discharge planning, and connecting individuals to resources. Several facilities offer crisis stabilization services of more than 24 hours within the same facility to support connection to a higher level of care. |

Notes: Crisis call center, mobile crisis team, and crisis receiving and stabilization facility providers across case study communities varied in their organizational histories and scale. This table presents the difference across providers in case study communities related to experiences with billing and service delivery.

# Appendix C

## Supplemental Exhibits

**Exhibit C.1.** Medicaid claims analysis key findings

| State and authorized codes | Rate of claims for crisis services per 10,000 enrollees (2020–2022) | Percent of enrollees with claims for crisis services | Most common code among enrollees with a crisis service claim in 2022 | Least common code among enrollees with a crisis service claim in 2022 | Percent of claims for crisis services with each diagnosis category in 2022 |
|---|---|---|---|---|---|
| Arizona<br>90791*<br>H0030*<br>H0031*<br>H0038*<br>H2011*<br>S9484*<br>S9485*<br>T1002*<br>T1016* | 2020: 2,530<br>2021: 3,123<br>2022: 2,479 | 2020: 5.1<br>2021: 5.9<br>2022: 5.6 | T1016*: Case management, up to 15 minutes; AZ requires this code to be used with modifiers 32, ET, GT, H9, or U8 to indicate crisis services | T1002*: RN services, each 15 minutes; AZ requires this code to be used with modifiers 32, ET, GT, H9, or U8 to indicate crisis services | Primary MH: 72<br>Primary SUD: 10<br>Co-occurring: 3<br>Non-BH: 14 |
| California<br>90839<br>90840<br>A0140<br>H2011*<br>S9484<br>T2007 | 2020: 97<br>2021: 107<br>2022: 109 | 2020: 0.35<br>2021: 0.38<br>2022: 0.38 | T2007: Transportation waiting time, air ambulance and non-emergency vehicle, half-hour increments (CA definition: Transportation staff time via telehealth in 24 hour or day facilities, or as part of mobile crisis) | A0140: Non-emergency transportation and air travel (private or commercial) intra- or inter-state (CA definition: Transportation mileage via telehealth in 24 hour or day facilities, or as part of mobile crisis) | Primary MH: 46<br>Primary SUD: 1<br>Co-occurring: 3<br>Non-BH: 52 |
| Louisiana<br>H0045<br>H2011<br>S9484<br>S9485 | 2020: 205<br>2021: 77<br>2022: 77 | 2020: 0.24<br>2021: 0.16<br>2022: 0.16 | H2011: Crisis intervention service, per 15 minutes | S9484: Crisis intervention mental health services, per hour | Primary MH: 85<br>Primary SUD: 5<br>Co-occurring: 11<br>Non-BH: 8 |
| Montana<br>90839<br>90840 | 2020: 183<br>2021: 186<br>2022: 136 | 2020: 0.92<br>2021: 0.85<br>2022: 0.75 | 90839: Psychotherapy for crisis; 60 minutes (time range 30–74 minutes) | H2011: Crisis intervention service, per 15 minutes | Primary MH: 85<br>Primary SUD: 5<br>Co-occurring: 4 |

| State and authorized codes | Rate of claims for crisis services per 10,000 enrollees (2020–2022) | Percent of enrollees with claims for crisis services | Most common code among enrollees with a crisis service claim in 2022 | Least common code among enrollees with a crisis service claim in 2022 | Percent of claims for crisis services with each diagnosis category in 2022 |
|---|---|---|---|---|---|
| H2011<br>S9484<br>S9485 | | | | | Non-BH: 7 |
| North Carolina<br>90839<br>90840<br>H2011<br>S9484<br>S9485<br>T2025*<br>T2034 | 2020: 139<br>2021: 141<br>2022: 144 | 2020: 0.43<br>2021: 0.40<br>2022: 0.38 | S9484: Crisis intervention mental health services, per hour | S9485: Crisis intervention mental health services, per diem | Primary MH: 57<br>Primary SUD: 23<br>Co-occurring: 4<br>Non-BH: 18 |
| Ohio<br>90832*<br>90839<br>90840<br>H0004*<br>H2017*<br>H2019*<br>S9484<br>S9485<br>T1002* | 2020: 222<br>2021: 199<br>2022: 188 | 2020: 0.97<br>2021: 0.91<br>2022: 0.88 | 90839: Psychotherapy for crisis; 60 minutes (time range 30–74 minutes) | *T1002: RN services, up to 15 minutes; used with "KX" modifier to indicate RN nursing service provided when a patient is experiencing a crisis, as allowable within the practitioner's scope of practice. KX is not allowable with group RN nursing services. | Primary MH: 71<br>Primary SUD: 15<br>Co-occurring: 5<br>Non-BH: 9 |
| Utah<br>90839<br>90840<br>H2000<br>S9484 | 2021: 151<br>2022: 133 | 2021: 0.75<br>2022: 0.67 | H2000: Comprehensive multidisciplinary evaluation (UT definition: crisis mobile response) | S9484: Crisis intervention mental health services, per hour | Primary MH: 70<br>Primary SUD: 7<br>Co-occurring: 1<br>Non-BH: 22 |

| State and authorized codes | Rate of claims for crisis services per 10,000 enrollees (2020–2022) | Percent of enrollees with claims for crisis services | Most common code among enrollees with a crisis service claim in 2022 | Least common code among enrollees with a crisis service claim in 2022 | Percent of claims for crisis services with each diagnosis category in 2022 |
|---|---|---|---|---|---|
| S9485 | | | | | |
| Washington<br>H0030*<br>H2011*<br>H2019*<br>S9484*<br>S9485* | 2020: 13<br>2021: 16<br>2022: 14 | 2020: 0.05<br>2021: 0.05<br>2022: 0.04 | *S9485: Crisis intervention mental health services, per diem; WA requires this code to be used with modifier TG to indicate crisis services | *H2019: Therapeutic behavioral services, per 15 minutes; WA requires this code to be used with modifier TG to indicate crisis services | Primary MH: 93<br>Primary SUD: 4<br>Co-occurring: 8<br>Non-BH: 2 |

Source: Mathematica analysis of Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) Research Identifiable Files (RIF), 2020-2022; key informant interviews; and case study interviews.

Notes: This table presents 1) the procedure codes used by each case study state to bill for crisis services, 2) the rate of claims for crisis services (as identified using the codes for each state) per 10,000 Medicaid enrollees, 3) the percent of enrollees with crisis services (as identified using the codes for each state) in 2022, 4) the most common and least common procedure code in each state (as indicated by the highest and lowest rate of claims for crisis services for a code in each state), and 5) the percent of crisis claims in 2022 in each state that had an associated diagnosis code that indicated a primary mental health diagnosis, primary SUD diagnosis, co-occurring diagnosis, or did not have a behavioral health-related diagnosis code. See footnote 9 for a description of diagnosis categories. The denominator for rate of claims for services per 10,000 Medicaid enrollees and percent of enrollees with services is all Medicaid enrollees, not just those with a crisis services procedure code.

* Indicates modifier or place of service is required with the procedure code to bill for a crisis service.

## **Exhibit C.2.** Rate of claims for crisis services per 10,000 Medicaid enrollees

| | 2020 | 2021 | 2022 |
|---|---|---|---|
| Arizona | 2,530 | 3,123 | 2,479 |
| California | 97 | 107 | 109 |
| Louisiana | 205 | 77 | 77 |
| Montana | 183 | 186 | 136 |
| North Carolina | 139 | 141 | 144 |
| Ohio | 222 | 199 | 188 |
| Utah | DQ | 151 | 133 |
| Washington | 13 | 16 | 14 |

Source: Mathematica analysis of Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) Research Identifiable Files (RIF), 2020-2022.

Note: The denominator for rate of claims for crisis services per 10,000 Medicaid enrollees is all Medicaid enrollees, not just those with a crisis services procedure code. The codes used to identify crisis services are those used in each state as listed in Exhibit III.1.

DQ = Data not reported due to data quality concerns.