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Financing Crisis Services Using Public and Commercial Insurance: Key Takeaways for State and Local Agencies

BACKGROUND AND METHODS

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, care from emergency departments, and unnecessary hospitalization. Crisis services are funded by a patchwork of grants, state and local funds, and public and commercial insurance. The National Guidelines for Behavioral Health Crisis Care urge all insurers to cover these services and adopt a universal set of Healthcare Common Procedure Coding System (HCPCS) billing codes (H0030, H2011, S9484, and S9485) to support reimbursement (SAMHSA 2020). Greater reliance on insurance to finance crisis services may support efforts to expand and sustain these services.

To better understand the current and future role of insurance in financing crisis services, we conducted an environmental scan, key informant interviews, and case study interviews with providers and payors in eight communities nationwide. The case study communities were located in Arizona, California, Louisiana, Montana, North Carolina, Ohio, Utah, and Washington. For each community, we interviewed crisis service providers representing the three core crisis services (crisis call centers, mobile crisis teams, and crisis receiving and stabilization facilities) for a given county, and at least one payor or the entity responsible for administrative services on behalf of the payor. For the purposes of this study, “payor” refers to state Medicaid agencies (SMAs), state and local behavioral health authorities (BHAs), managed care organizations (MCOs), and commercial insurers. To honor the confidentiality of provider organizations and payors participating in the case study interviews, we do not name interviewees or refer to the case studies by location.

Interviews with providers and payors in eight communities nationwide offered on-the-ground perspectives on how crisis services are financed and how crisis service providers use Medicaid, Medicare, and commercial insurance. We identified common themes across case study communities with a focus on opportunities to advance crisis services financing using insurance. This brief summarizes key takeaways relevant to state and local agencies interested in using public and commercial insurance to support crisis services. Please see the full report, *Financing Crisis Services Through Public and Commercial Insurance: Current Landscape and Future Opportunities* for additional findings from this study.

1. Support adequate public and commercial coverage for crisis services

Most state Medicaid programs cover at least one of the three core crisis services; however, coverage differs across states (***Exhibit 1***). State Medicaid programs also vary in their authorization of the four SAMHSA-recommended HCPCS billing codes for crisis services (H0030, H2011, S9484, and S9485) that correspond with the three core crisis services (call centers, mobile crisis teams, and crisis receiving and stabilization facilities), and some states authorize additional, state-specific codes to cover certain aspects of crisis service delivery. Medicare and commercial insurance provide less generous coverage for crisis services than Medicaid;

recognizing fewer crisis codes and reimbursing for fewer crisis service encounters per beneficiary. Both insurance types generally do not reimburse providers for the SAMHSA-recommended codes, though other codes are accepted by each payor for reimbursement of crisis services.

Exhibit 1. Medicaid, Medicare, and commercial insurance crisis services coverage

Medicaid	Medicare	Commercial Insurance
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 3 of these services (KFF 2023).	As of 2024, Medicare only recognized 2 crisis-specific codes. These were for psychotherapy Current Procedural Terminology (CPT) codes (90839 and 90840) delivered by certain types of providers (such as psychiatrists, psychologists, and clinical social workers) (CMS 2023).	Commercial insurers vary in their coverage of crisis services (Shaw 2020). 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.

Medicaid, which allows states considerable flexibility in how they cover and reimburse crisis services, is an important pathway to expanding coverage for crisis services (Beronio 2021; Wachino and Camhi 2021). In addition, recent policy changes offer states additional opportunities to leverage Medicaid to expand funding for crisis services; these include alternative payment models and demonstration waivers (***Exhibit 2***) (Beronio 2021).

Exhibit 2. Opportunities to support crisis services financing through Medicaid

- **American Rescue Plan Act (ARPA), 2021**. The act provided $15 million in planning grants to 20 states and the District of Columbia. States used this funding to develop a state plan amendment, 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. On approval of their state plan amendment or waiver, states could claim a temporary 85% federal medical assistance percentage for expenditures for these services (CMS 2021).
- **Medicaid 1115 serious mental illness and serious emotional disturbance 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 in institutions for mental disease. To participate, CMS must determine the state's demonstration will promote objectives, including but not limited to improved access to services across the continuum of care, including crisis services (KFF 2024; CMS 2018).
- **Medicaid home and community-based services**. 1915(c) home and community-based services waivers and the 1915(i) home and community-based services state plan option can be used to expand these services, which can include crisis services for specific populations, including people with behavioral health conditions (Wachino and Camhi 2021).

States and local agencies can also support commercial coverage of crisis services by using their data to help commercial payors understand the potential financial benefits of covering crisis services. As described in ***Exhibit 3***, providers have used such analyses to persuade commercial insurers to cover crisis services.

Exhibit 3. Strategies to demonstrate the value of expanding coverage for crisis services

One provider interviewed 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 presented 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.

State and local agencies can also consider supporting state legislation to compel commercial coverage of crisis services. As of 2024, three of the eight states represented in our study have enacted legislation to require commercial insurers to cover emergency behavioral health services (California, AB 988; Utah, SB 155; Washington, E2SHB 1688) (NAMI 2024). For example, Washington's statute requires commercial insurers to cover emergency behavioral health services and protect clients from out-of-network charges for these emergencies.

Crisis services payors also remarked that commercial coverage "typically follows Medicare" and noted how expanding Medicare coverage for crisis services could help support financing of crisis services for people with Medicare and set precedent and groundwork for commercial insurance to also cover these services. Although Medicare is not in the purview of state and local agencies, meaning these agencies have less ability to influence changes to how Medicare covers or reimburses for crisis services, there may be opportunities to expand coverage of these services for Medicare enrollees beyond the currently available Psychotherapy for Crisis CPT codes. For example, providers could be encouraged to use other allowable Medicare billing codes, such as evaluation and management (E/M) codes for psychiatric diagnosis interview examination or CPR codes for general psychiatric diagnostic evaluation or individual psychotherapy to receive reimbursement for components of a crisis encounter.

2. Align Medicaid-authorized billing codes and reimbursement rates with state service standards and licensure requirements

Providers tend to encounter more challenges using Medicaid for crisis services when billing codes and reimbursement rates do not align with crisis service standards, licensure requirements, and costs of care. To ensure alignment and to identify challenges and common solutions, state and local agencies can support coordination between SMAs; BHAs; MCOs; state regulatory bodies that govern staffing, accreditation, and licensing requirements; and provider organizations (***Exhibit 4***). Increased collaboration could help states customize and standardize crisis service definitions and refine Medicaid billing codes, reimbursement rates, and reimbursement structures to meet local provider needs and contexts.

> *"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

Exhibit 4. Coordination across partners to implement Medicaid billing for crisis services

One BHA interviewed held 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 learned that reimbursement rates were insufficient to cover the cost of crisis services delivered by providers**. BHA staff also met regularly with state licensing 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.

Similarly, state and local agencies can coordinate with commercial payors. Although some commercial payors have indicated support for crisis services, they may also be concerned about the lack of standardization related to crisis services billing codes, service definitions, and quality standards such as credentialing of crisis services staff. Aligning the coding from the HCPCS used for Medicaid with commercial claims reimbursement systems might also pose a challenge. States and localities could support commercial payors in establishing a set of universal codes more compatible with commercial insurer billing systems than HCPCS and streamlining credentialing processes to support provider contracts with multiple commercial health plans. However, it

would be important to consider ways to minimize additional administrative burden among providers billing both commercial and public insurers.

3. Promote billing practices that minimize burden on providers, including alternatives to traditional claims-based reimbursement

Crisis services providers, especially organizations newer to crisis service delivery with limited health care billing experience and infrastructure, may require significant resources to establish the staffing and systems to support traditional claims-based reimbursement. For many providers, the administrative burden associated with billing places additional stress on the already-taxed behavioral health workforce and would require hiring additional staff to support billing. In general, interviewees felt claims-based reimbursement was better suited to mobile crisis team and crisis receiving and stabilization services than crisis call centers because call centers have a service delivery model less compatible with obtaining personally identifiable information (PII). Some providers, particularly crisis call centers and mobile crisis teams, perceive that collecting insurance information or other PII from clients may limit their ability to build trust and engage clients in care. They also believed that clients might be concerned about the potential costs of care or their ability to afford a co-pay (for those with commercial insurance) if asked for insurance information and were concerned about discouraging people from using these 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

Respondents from multiple case study communities referenced use of indirect billing strategies that could serve as examples for other state and local agencies. For example, in some communities, providers receive payments from the BHA or an MCO[a] to cover their operating costs, though providers are required to obtain and submit some PII about the clients they serve and billable services they provided (for example, client identifiers, presenting problem) to the payor. The payor then leverages their clearinghouse and other data infrastructure to submit claims for reconciliation. By taking on much of the infrastructure cost, administrative burden, and financial liability associated with claims-based reimbursement, indirect billing processes reduce provider administrative burden. Providers and payors in case study communities also recommended other strategies to reduce provider burden associated with billing, including the use of bundled payments to generate a predictable revenue stream while supporting the on-demand nature of crisis services (***Exhibit 5***).

> *"The big thing… [needed to improve 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*

[a] Two communities included in our study were in states where MCOs are responsible for coordination and financing responsibilities and take on behavioral health authority functions.

Exhibit 5. Approaches to financing crisis services that reduce provider burden associated with billing

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 be paid based on the estimated proportion of crisis services used by people with commercial insurance 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).

4. Support BHAs, MCOs, and crisis services providers implementing claims-based reimbursement

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

Crisis services provider

Many crisis services providers, especially from organizations newer to crisis service delivery with limited health care billing experience and infrastructure, need support to increase their billing capacity. For example, providers may benefit from training on topics such as how to incorporate the collection of insurance information and other PII into clinical workflows without impeding care and troubleshooting reimbursement-related issues. They also cited the need for clarity in billing guidance and ongoing support to implement and adhere to billing requirements (***Exhibit 6***).

Not all BHAs and MCOs have established data systems to collect and reconcile client information from providers to support efficient and accurate claims processing for indirect billing. BHAs and MCOs may benefit from learning about strategies for financing crisis services, organizing coalitions of state and local partners to collaborate and strengthen crisis systems, and providing billing-related guidance and technical assistance. States might invest in these efforts by taking advantage of federal initiatives to provide technical assistance and support on these topics. For example, CMS's forthcoming national technical assistance center to support states in implementing the continuum of crisis services for Medicaid and Children's Health Insurance Program enrollees will provide opportunities for peer-to-peer learning as SMA staff, providers, BHAs, and MCOs work to address challenges related to all aspects of establishing a crisis system, including expanding Medicaid reimbursement of these services.

Exhibit 6. Billing guidance for providers to support Medicaid billing

To facilitate billing for crisis services, many BHAs and SMAs develop a provider manual with service standards, such as staffing requirements, definitions, and authorized billing codes and instructions. However, some described also offering providers considerable technical assistance to implement the billing guidance, such as regular one-on-one meetings. One state even engaged a public health institute to support the development of best practices related to crisis services delivery and financing responsive to provider needs.

CONCLUSIONS

Public and commercial insurance could play a greater role in financing crisis services. Findings from our study highlighted a variety of strategies for states and localities to consider and match to their unique needs and policy contexts. Improving public and commercial insurance coverage of crisis services and alignment of billing requirements across payors could lay a strong foundation for using public and commercial insurance to fund crisis services. To increase provider uptake of billing for crisis services covered by insurance, communities could also look for ways to reduce provider burden related to billing, including use of insurance-based strategies such as indirect billing or proportional or bundled payments. Amidst ongoing behavioral health workforce shortages and provider resource constraints, states and localities could also enhance billing-related implementation support for both providers and payors.

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