



National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, Virginia 22314

Assessment #7

Financing Mental Health Crisis Services

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Robert Shaw, M.A.

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Introduction

Mental health crisis services are a critical component of the behavioral health service continuum. Comprehensive behavioral health crisis systems can reduce the time individuals in crisis are stuck in emergency rooms, can reduce unnecessary psychiatric hospitalization by diverting clients to appropriate levels of care, and reduce suicides and other negative outcomes. In this paper, I review information gleaned from interviews of representatives from State Mental Health Authorities (SMHAs). During these interviews, SMHAs described how they work to expand and improve their crisis services continuum.

States differ widely on the definition of a mental health crisis; the nature, extent and comprehensiveness of the crisis services available; and the organization and financing of such services. The Substance Abuse Mental Health Services Administration's (SAMHSA) *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit*ⁱ provides a model for states to organize their crisis services after. In most states, crisis services are largely funded by the state through the SMHA. In some states, that burden is shared with Medicaid, local governments, private insurers, and other funding sources. The Center on Budget and Policy Priorities estimates that Fiscal Year 2020 budget cuts resulting from the COVID-19 epidemic have been 10 percent and will rise to 25 percent in Fiscal Year 2021ⁱⁱ. Despite state mental health services being an essential state service, the recessions of the 2000s have shown that SMHAs are likely to experience targeted budget cuts as states balance their budgets. To support crisis services, SMHAs may have to expand crisis funding sources, including working with insurance leaders and others to include crisis services as essential benefits to be covered by all insurers.

Unlike a medical emergency, there is no official definition of a mental health crisis. In the *Best Practice Toolkit*, “crisis services are for anyone, anywhere and anytimeⁱⁱⁱ.” In the Crisis Now model that informs the *Toolkit*, crises are defined by the person experiencing the crisis; so long as he or she believes themselves to be in need of urgent support^{iv}. There are other definitions used across the country which will be described later. The lack of an official definition inhibits the billing of crisis services, in some states, to private insurance and Medicaid. If a state wants to increase funding by Medicaid and private insurance, it may be able to work with their SMHA, State Medicaid Agency, State Insurance Commissioners and private insurers to support including more crisis services as essential insurance services.

An earlier paper, *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*, found that

“The most frequently reported funding sources for crisis services are state and county general funds and Medicaid waivers. Although states finance crisis services in different ways, many are using multiple funding sources to ensure that a continuum of crisis care can be provided to all who present for services, regardless of insurance status.”

This paper discusses how mental health crisis services are funded in 2020 and how the burden of funding those services can be more broadly shared by Medicaid and private insurance. It will give an overview of mental health crisis service systems, show how the service systems are funded, and show how funding individual service types are funded.

Methodology

The 2020 National Association of State Mental Health Program Director’s (NASMHPD’s) Technical Assistance Coalition (TAC) papers focus on various aspects of mental health crisis services. The NASMHPD Research Institute (NRI) developed this paper on financing by reviewing the literature and available national data, and then conducting semi-structured interviews with key state staff about the organization and structure of their state’s crisis service systems. This methodology was used in the development and writing of the papers *Using Technology to Improve the Delivery of Behavioral Health Services in the United States* and *Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the United States*. Many of the responses informed other aspects of financing relevant to this paper. Similarly, prior interviews had taken place by NRI in a review of current trends in state’s development of inpatient bed registries, and information from those interviews was also used to inform this paper.

Information about crisis services and the relationship between the SMHA and the State Medicaid Agency was taken from the 2015 and, preliminary 2020 NRI State Profiles System data collection project.

The SMHAs that provided information for this paper were Alaska, Arizona, Colorado, Delaware, Florida, Kentucky, Maryland, Minnesota, Mississippi, Missouri, Nebraska, New Mexico, Ohio, South Dakota, and Utah. In the paper, a distinction is made between states, SMHAs, and State Medicaid Agencies. State refers to the entire state crisis service effort and state funding, which is not always SMHA directed, and non-Medicaid state funding. SMHA is the mental health agency. Medicaid refers to the State Medicaid Agency.

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Overview of States

A continuum of mental health crisis services is provided in all states; however, the organization and types of services provided are not the same from one state to another, and sometimes vary from one region in a state to another.

In a 2020 survey of SMHAs currently being conducted by NRI, out of 24 states that had already responded, most SMHAs (19) work with law enforcement to train crisis intervention teams (CITs); directly provide services, including 24-hour crisis hotline services (15), mobile crisis teams (16), and crisis stabilization beds (16). Crisis clinics are provided in half (12) of the responding states, while a few (3) supported behavioral health services in emergency departments.

The biggest difference between SMHAs is how direct their relationship is with the providers of crisis services. In states with the most direct relationship, services are either provided by state staff or by providers directly contracted by the state. Most states organize crisis services regionally but with varying degrees of control of services. In states with the least direct relationships, city/county /regionally based and/or tribal governmental organizations contract out the services to local providers based on standards mandated by the state. In some regionally organized states, the city or county governments in the regions provide funding for services to augment state, Medicaid, and other funding.

All states participating in the interviews are dedicated to providing high-quality and responsive crisis services to their populations to the best of their ability and resources. SMHAs are faced with the challenge of providing behavioral health crisis services in varied settings, including those with high and low population densities; disparities in broadband access; with variations in the amount of funding available to support these services; and disparities in available behavioral health workforce. Many SMHAs also provide services adapted to the linguistic and cultural differences within their state. In Delaware and Nebraska, Medicaid manages their own crisis service systems that cover their own patients. Arizona then braids Medicaid, SAMHSA block grant, state general and county funds into the crisis system to offer a resource that can accept all referrals. Arizona has reimbursement rates for services that represent their true costs.

All states interviewed are converging towards the same point but the paths they have to take to get there can be very different as is their pace. States with centralized control of services are not likely to change, nor are states with decentralized control. Expanding Medicaid under the Affordable Care Act (ACA) can lessen the burden states have in using state general funds for crisis services by decreasing the number of people uninsured, but not all states have expanded Medicaid.

Funding Sources

State Funding

State general funds are the primary way that mental health crisis services are funded and are often the funding of last resort. States typically pay for the 24/7 infrastructure critical to the functioning of a crisis system: crisis call lines, mobile crisis teams, crisis receiving and stabilization centers, and often for CIT training. State funds are especially important, even when services can be billed to Medicaid and private insurance or when there are local or other funds supporting services, because they are often used to fund the basic infrastructure of crisis services.

Crisis service systems have developed and evolved differently across the states. The services have to be established, staffed, and trained, and these start-up costs are often not billable to Medicaid, and rarely to private insurance because they do not define them as services. Effective crisis services are provided immediately when a person is in need^{vi}. In areas with a high population, crisis service providers across the spectrum of service types may have a high enough service volume that they are constantly providing direct services that could be billable. In areas with low populations the services still need to be available at all hours but there may be down time between crises leaving the staff unable to bill for services. As a result, state general funds, through the SMHA, are usually the primary source of funding for the establishment and availability of crisis services, especially call centers and mobile teams.

Medicaid

As with SMHAs, no two State Medicaid Agencies are alike. In 2018, most State Medicaid Agencies were part of a larger state agency (76 percent), more than a fifth (22 percent) were stand-alone agencies, and one reported to a board of directors. Half of the directors of State Medicaid Agencies were political appointees, and the other half were civil servants. The priorities of State Medicaid Agencies vary by state. For example, only thirteen directors reported that behavioral health changes, such as carving-in behavioral health services into managed care contracts and redesigning outpatient treatment, was a priority. With the average tenure of a State Medicaid Director only 21 months, and the states dealing with the current COVID-19 pandemic, by the time you are reading this report it is likely that the priorities of some Medicaid Agencies have changed^{vii}. There are major differences in the populations covered by Medicaid. As of July 1, 2020, 36 states have expanded Medicaid coverage, two states have approved but not yet implemented the expansion of Medicaid, and 13 states have not expanded Medicaid coverage under the Affordable Care Act (ACA)^{viii}. Medicaid expansion decreases the number of uninsured individuals by expanding Medicaid eligibility requirements.

There are differences in how the care is organized because State Medicaid Agencies determine how care is delivered and paid for, within the bounds of federal rules. Most states (40) have Managed Care Organizations (MCOs) that organize care, usually with multiple MCOs organized regionally. Using risk-based contracting, the MCOs provide care at a set per-member, per-month payment. In many states with MCOs, not all Medicaid enrollees are covered under an MCO. Mental health and substance use disorder services are sometimes carved-out, meaning that mental health is not included in the MCO's coverage. In 2018, in 17 states carved-out outpatient mental health services and 15 states carved out inpatient mental health services in at least parts of the state^{ix}. Some MCOs are operated by large private insurance companies including UnitedHealth Group, Centene, Anthem, Molina, Aetna, and WellCare^x.

By using waivers or provisions, State Medicaid Agencies particularize the Medicaid rules under which they operate. There are a variety of waivers available, and states, through their waiver applications, particularize their waivers. A 1915(b) waiver permits states to implement service delivery models, such as MCOs, and to implement the terms of the waiver in specific parts of the state rather than statewide. A 1915(c) waiver permits states to use Home and Community-Based Services (HCBS) to provide care in a non-institutional setting. An 1115 waiver permits states to waive some Medicaid statutes related to program design as part of an experimental, pilot or demonstration project. These waivers have time limits, need to be approved by the Centers for Medicare and Medicaid Services (CMS), and states interested in continuing them must apply for renewal before they expire^{xi}.

The Mental Health Parity Act of 1996 required that the amount spent on mental health benefits be no less than those for medical and surgical benefits offered by insurance. The law exempted businesses that did not provide mental health coverage, businesses with fewer than 50 employees, and if implementing parity would increase premiums by at least one percent.^{xii} Parity did not expand to the level desired by Congress so this law was superseded by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 which requires that insurers guarantee that benefits for mental health and substance use disorder (MH/SUD) services are no more restrictive than those for medical and surgical benefits^{xiii}. The MHPAEA was amended through the ACA to have even broader application to include individual health insurance coverage.

There is ambiguity regarding coverage of certain key components of behavioral health as compared to medical services. For example, ambulance and paramedic services for primary healthcare are covered by Medicaid if it is a medical emergency and the provider is licensed by the state. Medical transportation for non-emergencies is covered if there is a statement by a doctor that the service is required^{xiv}. Medical emergencies are defined for Medicaid by §424.101 as being "inpatient or outpatient hospital services that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require use of the most accessible hospital available and equipped to furnish those services." In many states, there is a lack of transportation for behavioral health crisis services other than law enforcement. One state interviewed indicated that state general funds are used to reimburse law enforcement agencies when transporting individuals experiencing a behavioral health crisis.

One of the issues with Medicaid coverage is that there is no official definition of a mental health crisis rather definitions vary from place to place. Below are examples of definitions other than the Crisis Now definition related above.

- Arizona Complete Health, a Medicaid MCO, says “A crisis is defined by the person going through it. If a situation exceeds a person's coping skills, they are in crisis^{xv}.”
- Mississippi’s Department of Mental Health defines a mental health crisis as “any situation in which someone’s behavior puts them at risk of becoming unable to properly provide self-care, of functioning in the community, or maybe even of hurting themselves.^{xvi}”
- In Washington County, Pennsylvania, a mental health crisis is “an immediate stress-producing situation, which causes acute problems of disturbed thought, mood or social relationships requiring immediate intervention.^{xvii}”

The relationship between SMHAs and Medicaid does not follow one model. In a few states the SMHA is part of the Medicaid Agency. In the other states they are closely split between being in the same umbrella department or in different state departments^{xviii}. Medicaid is a significant payer of mental health services^{xix} but not necessarily for crisis services in all states. In Florida, Kentucky, and Nebraska, Medicaid, and private insurance, when possible, is billed first, and state general funds pay for the uninsured. Seven of the states interviewed had either Medicaid Managed Care Organizations (MCOs) or Accountable Care Organizations (ACOs) that organized Medicaid funded services. Of these, six used MCOs/ACOs to provide crisis services. In Delaware, Kentucky, and Nebraska there were parallel crisis service systems, one paid for by Medicaid, and one largely paid for by the state. In Kentucky, only behavioral health providers who are allocated state crisis funds must provide 24/7 crisis services to anyone who presents in need while the other providers may choose how and to whom they provide crisis services. In other cases, crisis service providers had difficulty getting Medicaid to reimburse for services rendered to patients covered by Medicaid.

Though mental health crisis has no Medicaid definition, there are billing codes that can be used for mental health crisis intervention services.

- H0030 – Behavioral Health Hotline Service
- H0031 - Mental Health Assessment, by Non-Physician
- H0035 - Mental Health Partial Hospitalization, Treatment, Less Than 24 Hours
- H2011 - Crisis Intervention Service, Per 15 Minutes
- S9484 - Crisis Intervention Mental Health Services, Per Hour
- S9485 – Per Diem Mental Health Crisis Services
- T1016 – Case Management, Each 15 Minutes – used by Arizona to bill Medicaid for crisis calls
- T2034 – Crisis Intervention, Waiver, Per Diem

In order to bill Medicaid for crisis services, it is not enough to assign a billing code to services provided. State Medicaid Agencies need to recognize the provider or service type that meets their definitions of a billable service and qualified provider. How comprehensively crisis services in a state can be billed to Medicaid is dependent on a variety of factors including the relationship between the SMHA and the providers of crisis services to Medicaid, the specific waivers in place in the jurisdiction and their provisions, as well as the capabilities of providers related to meeting the requirements for billing Medicaid. Within any given state, these factors can vary by region, making a comprehensive array of fundable crisis services through Medicaid challenging.

In states where Medicaid coverage has been expanded, the number of uninsured individuals is reduced, which can shift the funding burden from the SMHA and on to the State Medicaid Agency for those individuals covered by the expansion. The expansion of Medicaid did not determine whether or not states were able to bill Medicaid for specific crisis services since some states that have expanded Medicaid coverage to more people still do not bill Medicaid for these services and some that have not expanded do bill Medicaid for specific services.

If Medicaid is not currently supporting billing for behavioral health crisis services in a state, the SMHA, and their crisis service provider networks, can work with their state's Medicaid agency to build necessary rules and definitions required to allow for the billing of crisis services.

Private Insurance

Mental health crisis systems, in many states, have a problem passing Go and collecting their \$200 from private insurance. Some states remarked that they did not believe anyone was able to successfully bill private insurance. However, of fifteen states, nine reported that private insurance was successfully billed for some crisis services, but only two of those reported more than limited success in billing private insurance. Below are some specific findings gleaned from interviews with state experts. Below are some findings gleaned from interviews with the SMHAs.

- Arizona: Regional authorities that operate crisis services are required to coordinate third party liability/benefits and have had success albeit limited in collecting from private insurance.
- Colorado: Colorado is in the initial stages of gathering data in an effort to better work with the state's Division of Insurance on commercial providers becoming more responsible for the payment of crisis services.
- Florida: Providers are usually able to bill private insurance, including for crisis services.
- Maryland: Private insurance is billed, on a limited basis, for some services; however, coverage varies by insurance company and by region within the state. It is up to the provider to bill private insurance. When the insurance companies pay it is for a service and not for the infrastructure that makes the service possible.
- Minnesota: Private insurance does not pay for crisis services because they do not see them as emergency services. However it has happened that insurance has paid for

services because providers are supposed to bill private insurance first. The SMHA is having their Department of Commerce review the coverage refusals.

- Mississippi: Some providers certified by The Joint Commission are able to bill private insurance for crisis services.
- Nebraska: Regional Managed Care Organization (MCOs) are able to bill private insurance and have collected from them though sometimes the payment has been delayed.
- Ohio: It is the responsibility of providers to collect from private insurance.
- Tennessee: Providers have been able to collect from private insurance. They speculated that their success could be due to the provider being part of a larger provider group.

The ability to bill private insurance for crisis services is something that states can improve in collaboration with the SMHA, State Insurance Commissioners, insurance companies, and advocates. With insurers acting as MCOs/ ACOs in some states, their familiarity with the efficacy of crisis services may increase. Utah has not been able to bill private insurance but that may change now that two of their major insurers in the state are their MCOs/ACOs. They are also considering levying an assessment on private insurance to pay for crisis services. Another way is to have the state agency that governs insurance mandate the coverage for behavioral health crisis services, as a way to meet parity requirements. Continued advocacy in this arena is needed. Parity theoretically began in 1996, yet there is no uniform way to address private insurance coverage for MH/SUD crises similar to how these are addressed in medical and surgical types of crises.

Local Funds

All SMHAs interviewed organized crisis services regionally. Many states organized the provision of care through MCOs/ACOs with the bulk of the direction coming from the SMHA and the funding coming from state general funds and or Medicaid. In half of these states, local governments, which can be counties or groups of counties, were required to pay for a portion of the services. In South Dakota, services are organized, funded and provided locally with state general funds used to provide training. In Ohio and South Dakota counties and regions have the responsibility for providing crisis services and contribute some of the funding. In all states with local funding, there can be great regional differences in the services provided. Regional differences in access to services can also exist in states with limited or no regional funding since the needs and population densities of regions can vary greatly within a state.

Other Funding Sources

While most funding for SMHA crisis services comes from state general funds, Medicaid and local funds, states have also found other ways to pay for these services. Six of the SMHAs used SAMHSA Mental Health Block grants to help fund services, often to support service infrastructure. Other funding sources included the Indian Health Service, Tricare, NAMI, the United Way, self-pay, and private grants.

Crisis Services

Hotlines and Warm Lines

Crisis hotlines are an essential element of a mental health crisis service system. For people in crisis, hotlines connect them with care directly from hotline staff, are often able to dispatch a mobile crisis team, or make a referral to a community service based on the needs of the individual. In some states, the hotlines can make appointments for outpatient treatment. Hotline services are usually organized regionally, with service areas corresponding to the service areas of regional community provider systems. In some states, the hotlines are the same provider as the National Suicide Prevention LifeLine provider in the area but not in all cases. In one state, the hotlines funded by the state were only for people aged twenty-five and under. In another state, the call center staff also staff the mobile crisis teams.

Funding for these services has two components, infrastructure and services. Hotlines need to be available all the time but the service may not be used all the time. They also are usually available to anyone regardless of insurance and age. All the SMHAs used state general funds to support some or all of the cost of their hotlines. In seven states, hotlines received funding from Medicaid, though in two of the states, Medicaid operates separate hotlines for their beneficiaries. The ability of SMHAs to engage Medicaid in supporting the infrastructure costs of having hotlines available 24/7 varies greatly with seven states receiving no Medicaid funding, to states that rely heavily upon Medicaid funding. In Tennessee, TennCare (the named Medicaid program) provides most of the funding hotline funding. Private insurance did fund some centralized hotline services. In Ohio, some insurers operated their hotlines only for their own beneficiaries within their insurance plans. Other sources of funding were local funds in three states, mental health block grant funds in three states and the United Way in one state.

Warm lines are phone lines, usually operated by peers, which provide early intervention and emotional support. Warm lines exist in eight of the states interviewed, not always with statewide coverage and are usually funded by the SMHA though one state indicated that federal funds were also used to support this service. When necessary, callers to warm lines should be transitioned to a hotline.

Mobile Crisis Teams

Mobile crisis teams are a community-based service that travels out to meet an individual in crisis wherever they are. Model teams include a licensed and/or credentialed clinician who assesses the person in crisis and connects them to appropriate treatment^{xx}. Ideally, the teams are available at all times statewide and to anyone, but that is not always the case. Coverage can be difficult to provide in rural and frontier areas because of distances teams must traverse and the difficulty in staffing teams. Many states reported mobile crisis teams involved two individuals, a licensed behavioral health clinician and a peer specialist (often with state sponsored training/certification).

To provide services in rural areas in Colorado, some places use paramedics who are trained to do an initial screening and then, if appropriate and with the consent of the patient, connect the patient, via a tablet, with a telehealth provider who interacts with the patient and then informs the paramedic about

the next treatment steps. Minnesota also uses similar, web-based mobile crisis counselors. In Delaware, the teams have access to OpenBeds, a treatment referral website that allows the teams to make appointments for follow-up services at all levels of care. In Delaware mobile team staff are also the call center staff and it is often the case that the staff providing the mobile service took the crisis call. Delaware also has a separate and parallel service for Medicaid patients. Florida's mobile crisis services are targeted at people twenty-five and younger.

Funding for these services has two components, infrastructure and services. Infrastructure consists of establishing and training the teams, as well as providing (and funding) the transportation operational elements. Teams need to be available even when they are not on a call and this is difficult in rural and frontier areas with low crisis volumes. Teams are organized regionally and often consist of staff dedicated to this task, often with a peer as part of the mobile team. In areas with staffing shortages and low volumes of crisis, the teams may be local clinicians who volunteer their services, much like members of a volunteer fire department or the crisis providers are on-call and are paid when they provide services.

State funding is essential to the provision of mobile crisis services, especially for infrastructure. Medicaid pays for mobile crisis services, in some way, in all states interviewed for this review, except for South Dakota. A limitation in almost every state in billing for mobile crisis services was that reimbursements are usually limited to the time the crisis team is actually with the client and does not include time traveling to or from the client nor the time between responding to clients. Many states have Medicaid 1115 waivers but only Alaska and Arizona reported that they use their waiver to fund mobile crisis services. Five states reported that counties provide funding for these mobile crisis services, especially in Ohio and South Dakota where the counties and regions have primary responsibility for the provision of crisis services. Private insurance did not play a great role in the funding of mobile crisis services especially for the infrastructure. Where private insurance did pay, it was usually because the state made an effort to try to collect or there was a special arrangement in one region with a local insurance company. In Minnesota, private insurance does not pay for mobile crisis services because they do not deem them to be emergency services.

Crisis-Receiving and Stabilization Services

Interviewed states tended to have one of two models of crisis-receiving or stabilization services, under-24 hours receiving and stabilization services, or short-term crisis residential programs that typically have a few beds that serve individuals in crisis for up to 72 hours. The labeling of these service types can be confusing in cross-state comparisons as CMS allows states to develop their own definitions for the crisis service array.

The *Toolkit* recommends the crisis-receiving model developed as part of the Crisis Now model with facilities that provide under-24 hour services staffed by multidisciplinary teams. These facilities offer no-wrong door access and accept all walk-ins and drop-offs by first responders and mobile crisis teams^{xxi}. Many states with crisis stabilization facilities do not follow the Crisis Now model and instead support crisis residential programs that have beds that provide crisis stabilization services for up to 72 hours

All the states interviewed have at least one facility providing some version of crisis stabilization services. Eight of the states have at least one facility that followed the Crisis Now model, which is a comprehensive crisis service system comprising and coordinating crisis services at all levels of intensity, and two states are working to establish such facilities, which provide comprehensive crisis services, while five states have crisis stabilization facilities with beds that provide more than 24-hour services. Missouri has an under-24-hour facility in Kansas City that is connected to the local court system but otherwise depends on hospitals emergency rooms with enhanced capabilities for serving people in crisis. Utah has one pilot facility that is similar to the Crisis Now model but with no walk-ins, otherwise there are units attached to hospitals which often do not accept Medicaid patients.

Funding for stabilization facilities of any type varied not always following the *Toolkit* model. Medicaid provided funding for this service in fourteen of fifteen states and the state general funds in eleven states. In five states, local funds were used to support services. Private insurance provided funding in six states though not always much. In Florida and Kentucky, crisis providers are required to bill private insurance and Medicaid first and only bill the state as a last resort.

Crisis Intervention Teams (CIT) Focused on Training

Crisis Intervention Teams (CIT) began in 1988 with a partnership between the Memphis Police Department and the local chapter of National Alliance for the Mentally Ill (NAMI) to provide training for a police unit to specialize in responding to people with mental illness. CIT guides the interaction between law enforcement and people with mental illness^{xxii}. The training and the establishment of teams has expanded across the country, but is not universally available. The University of Memphis' CIT center reports that there are 2,645 local CIT programs and 351 regional programs^{xxiii}. CIT programs are in all but four states, but, within those states where it is available, many counties and municipalities do not have any CIT programs. Only in Maine does every county have a program. In Ohio, all but one county has a program^{xxiv}. Law Enforcement is organized very locally on a municipal level so, even in counties with CIT programs; it is very possible that not all jurisdictions within a county have teams.

Funding for CIT training most often came from state general funds (nine states) followed by local funds (three states). Other funding sources included local NAMI chapters, private grants, a state university and federal funds. The CIT training also often has volunteer educators who contribute to the training elements. The infrastructure of CIT extends beyond training to include partnerships, policies, and practices, generally stems from the originating law enforcement department.

Policy Implications

Crisis services are essential to the health of people with mental illness, substance use challenges, and those with no prior histories but who find themselves in suicidal crisis or extreme emotional distress. Crisis services divert individuals from hospitalization and ensure the least restrictive treatments are available to people experiencing crises. Fewer hospitalizations reduce costs for states^{xxv}. These labor and resource intensive services most often rely on state general funding through SMHA, local funds, and, to

a lesser degree, Medicaid funding. Where the services exist, they should be, and most often are, available to everyone regardless of their insurance status.

States that do not have funding from Medicaid or private insurance proportionate to the coverage of the persons served by crisis services can choose to have the burden shared more fairly. The Parity Acts of 1996 and 2008 declare that this burden sharing is legally correct. Each state, with their unique characteristics, will have to take different paths towards greater burden sharing. What is politically possible in one state may be anathema in another.

There are billing codes that can be used to bill Medicaid for crisis services and Medicaid is billed for the provision of some crisis services in some states. The crisis service providers need to be certified to bill Medicaid. The State Medicaid Agency and the SMHA could agree to plans that move states towards greater Medicaid funding (including helping support the 24/7 infrastructure of the crisis system) such as a bundled rate that would cover infrastructure costs. Achieving this may require changes in the provider service system, regulations, or a new Medicaid waiver. In states where the SBHA has direct control over their provider system and those with a more direct relationship with their Medicaid Agency, there may be greater facility in transitioning towards enhanced Medicaid funding. This may be more challenging in other states with indirect control of provider systems or a less integrated and collaborative relationship between the SBHA and Medicaid.

Private insurance covers the majority of the population, yet provides only a spotty minority of the funding for crisis services. The Parity Acts indicate that this should not be so. Private insurance usually pays for face-to-face treatment and not for transportation, which in a rural state can be significant for a mobile crisis team. They also usually do not pay for the time a crisis call team might spend waiting for a call. Utah is considering levying an assessment on private insurance to fund crisis services.

States govern how private insurance operates within their state. This governance is generally not in the same agency as the SMHA or Medicaid and so any changes to the rules governing private insurance necessarily means collaboration with another state agency and possibly the support of the Governor and Legislature. There are complex federal and state rules that can make such policy shifts difficult. There also might be political pressure exerted by insurance companies to inhibit changes that will cost them money. In some states with Medicaid Managed Care and where Medicaid funds crisis services, the MCOs/ACOs are operated by divisions of private insurance companies that often do not pay for crisis services for their customers not covered by Medicaid.

That mental health crisis services are not considered emergency medical services remains an explanation used by some private insurers to deny reimbursement. Nevertheless, services that are not reimbursed by Medicaid or private insurance are largely paid for by state general and local funds. It is appropriate that crisis services have a broad definition: if a person feels they are in crisis then they are in crisis. It is not necessary that the clinical definition and a more restrictive insurance definition be the same. If there are two definitions, states may be able to more successfully pursue reimbursement for crisis services, albeit not all services provided, and thereby shift more of the burden for funding crisis

services onto private insurers when appropriate. Alternatively, one state is exploring levying a fee on private insurers to fund a portion of the crisis service system.

Conclusion

In the context of the COVID-19 pandemic, there is increased awareness of the need to consider emotional well-being as a critical element that requires support and often immediate attention. It is timely that the SAMHSA Crisis Services Toolkit brought further attention to the need for crisis services even prior to the pandemic. Every state has a different service system, political structure and traditions. They are not starting at the same place, nor are they changing at the same pace. If one state can have Medicaid and private insurance share the burden, and the Parity Acts indicate that they should be doing so, then all states can. Any plan that increases the burden sharing for crisis services must be particular to a state and may require systemic reorganization and not just regulatory changes.

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ⁱ Samhsa.gov. 2020. [online] Available at: <<https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>> [Accessed 24 August 2020].

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