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# BEHAVIORAL HEALTH CRISIS SERVICES BILLED TO COMMERCIAL INSURANCE, MEDICAID, AND MEDICARE

## KEY POINTS

- This study examined the extent to which commercial payors, Medicaid, and Medicare used specific crisis service billing codes. The study's findings provide insight into the use of claims-based reimbursement to support the delivery of crisis services outlined in the Substance Abuse and Mental Health Services Administration's National Guidelines for Behavioral Health Crisis Care.
- The rate of crisis service claims per 10,000 enrollees in 2020 was substantially higher for Medicaid enrollees than for people enrolled in commercial insurance or Medicare.
- Psychotherapy for crisis" was the most common Current Procedural Technology® (CPT) code associated with crisis service claims for Medicare and commercially insured populations. Medicaid crisis service claims included a wider range of Current Procedural Technology® and Healthcare Common Procedure Coding System codes.
- Consistent with wider use of codes than Medicare and commercially insured populations, Medicaid crisis service claims also included a broader range of providers. Differences in the use of these codes across payors could reflect both coverage policies and underlying differences in the insured populations. They also imply opportunities to expand claims-based reimbursement for crisis services, particularly among Medicare and commercial payors.

## BACKGROUND

The National Guidelines for Behavioral Health Crisis Care from the Substance Abuse and Mental Health Services Administration (SAMHSA) call for a sustainable infrastructure to respond to behavioral health crises, through crisis services that are accessible to anyone, anywhere, at any time [1]. States and communities use a variety of funding sources to support crisis services, such as public and commercial insurance, federal and state grants, and other state and local funds [2,3]. Having all health insurers cover crisis services can help promote more adequate, stable funding for a full continuum of these services [4]. The National Guidelines for Behavioral Health Crisis Care recommend Medicaid, Medicare, and commercial insurers adopt universal billing codes for crisis services. According to the national guidelines, establishing crisis service codes that every insurer should reimburse is important to fostering parity between coverage for medical and behavioral health care services [1].

Although some national and state codes exist to reimburse crisis services, not much is known about how providers use them in practice and the types of providers who use them. As of July 2022, 11 states and Washington, DC, covered three core crisis services (crisis call centers, mobile crisis teams, and crisis receiving and stabilization services) in their Medicaid fee-for-service plans [5], but the scope of crisis services coverage and Medicaid billing requirements vary across states [2]. Medicaid managed care plans, Medicare, and commercial insurance also reimburse crisis services, but coverage and billing guidelines vary across these payors. This exploratory analysis examined the extent to which commercial payors, Medicaid, and Medicare reimbursed services using specific national and state crisis services billing codes. We compared the rate of

crisis service claims across payors, state and geographic variation in the use of these codes, and the types of providers associated with the claims.

## METHODS

We used three data sources to examine crisis service billing in this study: 2020 Transformed Medicaid Statistical Information System Analytic Files for Medicaid claims, 2020 Medicare claims, and 2021 Merative™ MarketScan® Commercial data for commercial claims for privately insured beneficiaries. **Appendix A** includes more information about the data sources and populations included in the study and the methodological limitations. We conducted a targeted environmental scan of the literature and states' Medicaid documentation to identify crisis service codes aligned with the three core services described in SAMHSA's National Guidelines for Behavioral Health Crisis Care,[a] which resulted in the identification of a set of Healthcare Common Procedure Coding System (HCPCS) codes that are used nationally [6] (**Table 1**).

**Table 1. National procedure codes for crisis services**

| Code | Description | Billing Codes Permitted |
|---|---|---|
| H0007 | Alcohol and/or drug services; crisis intervention (outpatient) | Medicaid, Commercial |
| H0030 | Behavioral health hotline service (short description: Alcohol and/or drug hotline) | Medicaid, Commercial |
| H2011 | Crisis intervention service, per 15 minutes | Medicaid, Commercial |
| S9484 | Crisis intervention mental health services, per hour | Medicaid, Commercial |
| S9485 | Crisis intervention mental health services, per diem | Medicaid, Commercial |
| T2034 | Crisis intervention, waiver; per diem | Medicaid, Commercial |
| 90839 | Psychotherapy for crisis; 60 minutes (time range 30-74 minutes) | Medicaid, Medicare, Commercial |
| 90840 | Add-on code with 90839 for each additional 30 minutes beyond the first 74 minutes | Medicaid, Medicare, Commercial |

Source: Healthcare Common Procedure Coding System. Note that the billing codes permitted column reflects that there are no known restrictions for the payor to use the code. Billing codes permitted additionally depend on local Medicaid coverage policies and commercial payor policies and may not reflect actual use of billing codes by providers. There may be additional national billing codes permitted for covering crisis services that are not included in this list.

States have flexibility to use multiple national codes for Medicaid billing, and commercial insurance also has the flexibility to utilize any crisis codes they deem necessary. Medicare is limited to psychotherapy for crisis codes (90839 and 90840) and does not have flexibility to add codes without federal rulemaking.

To inform the Medicaid analyses, we also identified and included state-specific crisis service codes based on Medicaid billing guidance documentation or provider manuals [6].[b] Inclusion of the state-specific codes could yield over-estimation of the number of crisis claims if applied nationally and to other payors, because certain state-specific codes that one state Medicaid office recommends using for crisis services may be used for non-

[a] We excluded codes that did not align with the SAMHSA definition (for example, codes that might have had a crisis component but also included services that went beyond acute crisis intervention) and limited the code list to specific codes that could be used to identify these services rather than applying a broader logic such as identifying emergency department visits that included diagnoses related to intentional self-harm.

[b] State-specific codes were either a state-created procedure code or a procedure or revenue code from a standard system that a state used in a particular way that we determined should not be included in the national code set

crisis services in other states, or may not have been allowable under Medicare.[c] For this reason, we only applied state-specific codes to Medicaid analyses when Medicaid billing guidance supported the inclusion of that code for crisis services in a given state.

For the Medicaid and commercial data sets, we identified provider types using the provider taxonomy, provider specialty code, and provider type code reported on outpatient claims for the provider who delivered the service.[d] The Medicare data set did not include provider type data, so we did not examine provider type data for Medicare for this brief.

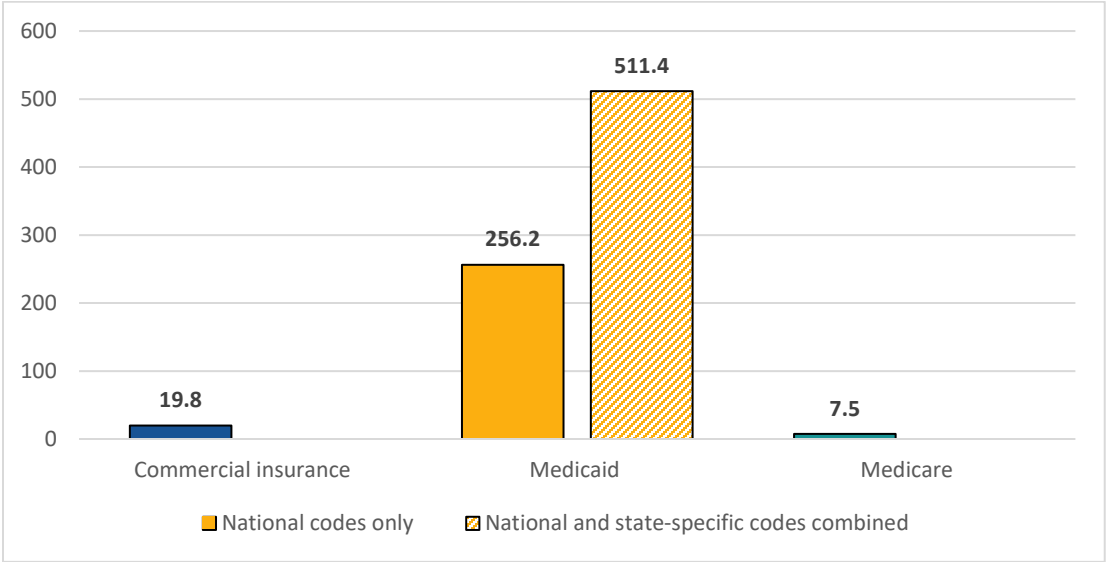
In addition to the differences in use of state-specific codes, there were several key differences in the analytic approach applied to each payor data set. First, the Medicare and Medicaid analyses used data from 2020, but commercial analyses used data from 2021. In addition, the Medicaid analyses excluded several states with substantial data quality concerns. Finally, the Medicare analyses did not include managed care encounters, whereas the Medicaid and commercial insurance did.

## FINDINGS

### Extent and Types of Crisis Service Claims

The rate of crisis service claims per 10,000 enrollees varied across the three payors (**Figure 1**). The rate of crisis service claims was more than 10 times higher among Medicaid enrollees than among commercial insurance or Medicare enrollees.

**Figure 1. Commercial insurance, Medicaid, and Medicare rate of claims with crisis service codes per 10,000 enrollees**



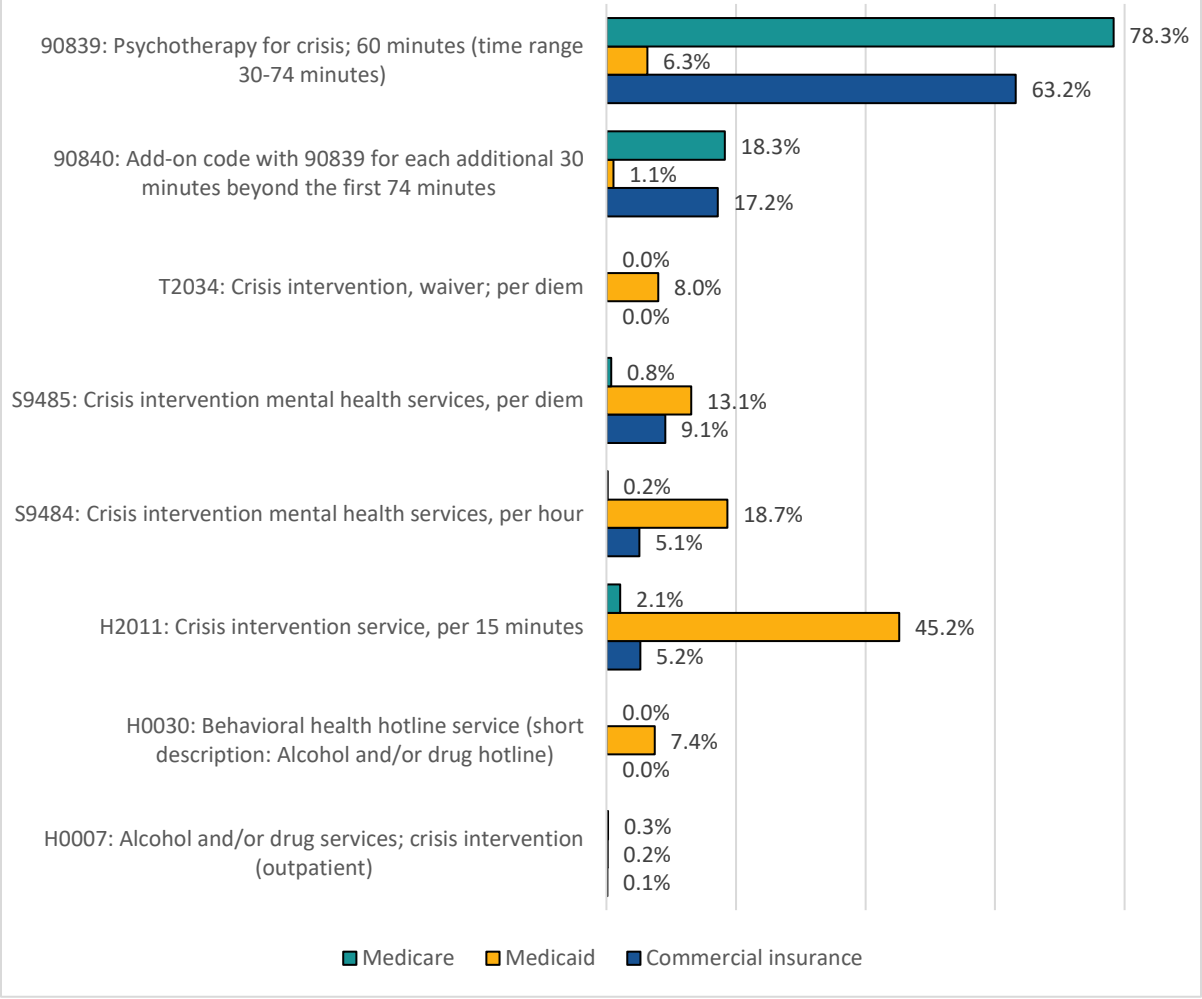

Note: The denominator includes all enrollees, not just those with crisis service claims.

[c] For example, Hawaii uses billing code W9083 for crisis intervention contact by phone, but Washington, DC, uses this same code for a nursing home podiatry examination.

[d] In cases in which provider specialty information was not available on outpatient claims, we determined provider type using the primary provider taxonomy obtained from the National Plan and Provider Enumeration System. The data sets exclude outpatient claims with missing or invalid provider IDs. Source: https://npiregistry.cms.hhs.gov/search.

The specific national procedure codes used for crisis services also varied by payor type. Among Medicaid crisis service claims, the most common HCPCS codes were for crisis intervention and hotline services (H0030, H2011, S9484, S9485, and T2034), whereas among commercial insurance and Medicare crisis-service claims, psychotherapy for crisis codes (90839 and 90840) were more common. The alcohol and/or drug services outpatient crisis intervention code (H0007) was rarely used in claims for any of the payors (**Figure 2**). Although the psychotherapy codes were used less commonly than crisis intervention codes among Medicaid claims, they were used in all states. The broader array of crisis service codes appearing in Medicaid claims could reflect differences in coverage of billing codes and/or billing guidance across payors.

**Figure 2. Percentage of all national crisis service procedure codes used for claims, by code and payor**




Note: The denominator for each payor analysis included is the total national crisis claims in each payor data set. In the data sets, some values were suppressed because of the small sample size; suppressed values were counted as zero and therefore these values may undercount true values. The number of claims for a specific crisis service code may be driven, in part, by the time unit associated with the claim (for example, H2011 is billed in 15-minute increments, and T2034 is billed per diem).

The origins and purposes of the different types of national crisis service procedure codes may help explain differences in their use across payors. The H2011, H0030, and T2034 codes were specifically established for Medicaid and while commercial payors can opt to use them, this likely explains why they are more commonly

used to obtain Medicaid reimbursement.[e] Other HCPCS codes (S codes) were specifically established for Blue Cross/Blue Shield and other private insurers. Managed care organizations also use S codes, which might explain their use by Medicaid and commercial providers in the sample. Commercial payors have greater flexibility than Medicare in the codes they can choose to accept. In addition to the HCPCS S codes (S9484 and S9485), commercial payors can accept Current Procedural Technology® (CPT) codes (i.e., 90839 and 90840, psychotherapy for crisis codes) for crisis service reimbursement.[f]

As of 2020 (the year of the Medicare data included in this analysis), only two national crisis service CPT codes were reimbursable by Medicare (90839 and 90840); the H, S, and T codes were not included in the Medicare physician fee schedule [14]. This explains the near nonexistence of Medicare claims using the H, S, and T codes in our sample: Medicare billing for the H, S, and T codes was limited to a very small number of claims from providers in a handful of states, which may have been approved in error. The small number of available codes for Medicare fee for service could partially account for lower rates of crisis service code use by providers billing Medicare.[g]

## Variation in Crisis Service Claims by State and Rurality

The rate of crisis service claims per 10,000 enrollees was consistently low across states for commercial insurance and Medicare (**Figure 3**). The highest rate for commercial insurance was 129.2 crisis service claims per 10,000 enrollees in Washington, DC, and the highest rate for Medicare was 49.0 per 10,000 enrollees in New Hampshire; commercial insurance rates were higher than Medicare rates for most states. For all but two of the states (Florida, Maryland)[h] that had complete data,[i] the rate of crisis service claims per 10,000 enrollees was highest for Medicaid. Illinois had the highest rate of Medicaid crisis claims, with rates up to 1,623 claims per 10,000 enrollees in Illinois.[j]

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[e] HCPCS provides Level I and Level II codes; some Level II codes (H and T codes) were specifically established for Medicaid, which may explain why Medicaid providers in our sample use H2011, H0030, and T2034 much more frequently than commercial insurance and Medicare providers do.

[f] This may account for the predominant use of the psychotherapy for crisis CPT codes (90839 and 90840) for commercial insurance crisis service claims in our sample. To a more limited extent, commercial insurance providers also used the S codes (as might be expected because these codes were established at the request of private insurers) and the Medicaid H2011 crisis intervention code.

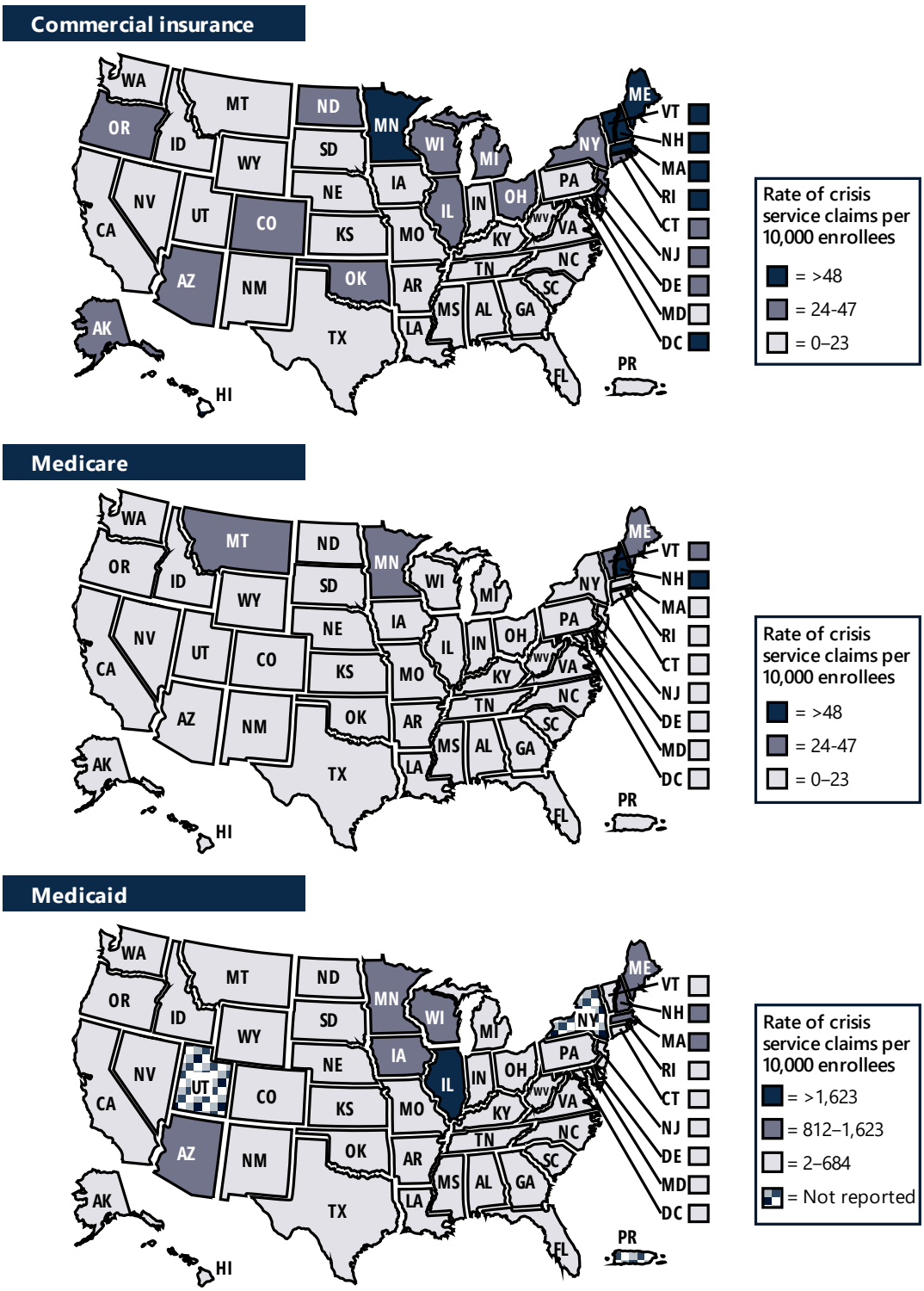
[g] Medicare billing for the H, S, and T codes in our analysis was limited to a very small number of claims from providers in a handful of states. These claims may have may have been approved in error.

[h] Rates of commercial and Medicare claims were not particularly high in Florida and Maryland; Medicaid crisis service claims were just particularly low in both states. State-specific codes were not used in either state. National crisis service codes were used infrequently.

[i] For Puerto Rico, South Dakota, West Virginia, and Wyoming, the crisis service rates for commercial insurance claims were either 0 or suppressed because of low sample size and because the Medicaid and Medicare rates were low, missing, or suppressed, so we cannot determine which payor had the highest rate (thresholds for suppression in the data sets are not stated or unclear). For Puerto Rico, New York, and Utah, the Medicaid rates were not reported because of data quality issues.

[j] The Illinois rate of crisis service claims per 10,000 Medicaid enrollees (5,575.18) is an outlier attributable to high use of a single state-specific crisis service code (T1019: crisis stabilization unit = 1 hour). The code was used for a small number of beneficiaries (about 14,000) but quite frequently (at least 132 times per year) for half of them, suggesting that most people in crisis required considerably more than one hour in a crisis stabilization receiving and stabilization facility.

**Figure 3. Rates of crisis service claims per 10,000 enrollees, by state and payor**




Notes: The denominator includes all enrollees, not just those with crisis service claims. The rate of Medicaid crisis service claims includes either national or state-specific crisis service codes. The rates of crisis service claims in the commercial insurance and Medicare data sets are based only on claims that include national crisis service codes. In the aggregate commercial insurance data set, rates were suppressed if there were fewer than 30 crisis service claims for the state; in this figure, states for which commercial insurance rates were suppressed (Hawaii, Idaho, Puerto Rico, South Dakota, West Virginia, and Wyoming) are included in the 0-23 range. We visually inspected the distribution of rates across states to identify ranges.

For all payors, more than three-quarters of all? enrollees lived in urban areas, but a higher percentage of commercial insurance enrollees lived in urban areas than did Medicaid and Medicare enrollees (Table 2, row 1). For all payors, the percentage of enrollees with any crisis service claim was similar for those living in urban versus rural areas (Table 2, row 2), but the rate of crisis service claims per 10,000 enrollees was higher for those living in urban areas (Table 2, row 3). This suggests that, regardless of payor, people living in rural and urban areas are equally likely to have claims for crisis services, but the number of crisis services claims per person is higher among those living in urban areas than among those living in rural areas. While this finding could, in part, reflect different availability of crisis services in urban versus rural areas, lower rates of crisis service claims in rural areas do not necessarily reflect less access to these services. Since crisis services are commonly funded through state grants or other mechanisms, for various reasons (e.g., more telephone-based crisis services, non-billable time for mobile units to travel long distances), non-insurance financing could represent a larger proportion of crisis services in rural areas.

**Table 2. Variation in crisis service claims by rurality, by payor**

| Metric | Rurality[b] | Commercial insurance | Medicaid | Medicare |
|---|---|---|---|---|
| 1. Percentage of all enrollees living in urban versus rural areas | Urban | 89% | 78% | 76% |
| | Rural | 11% | 20% | 24% |
| 2. Percentage of enrollees with any crisis service claim[a] | Urban | 0.08% | 0.86% | 0.05% |
| | Rural | 0.07% | 0.95% | 0.03% |
| 3. Rate of crisis service claims per 10,000 enrollees[a] | Urban | 20.6 | 558.4 | 8.3 |
| | Rural | 13.2 | 367.0 | 5.3 |

Notes: Denominators include all enrollees, not just those with crisis service claims.

a. For Medicaid, the percentage of enrollees with any crisis service claim and the rate of crisis service claims per 10,000 enrollees is based on claims that include either national or state-specific crisis service codes. For commercial insurance and Medicare, these percentages and rates are based only on claims that include national crisis service codes.

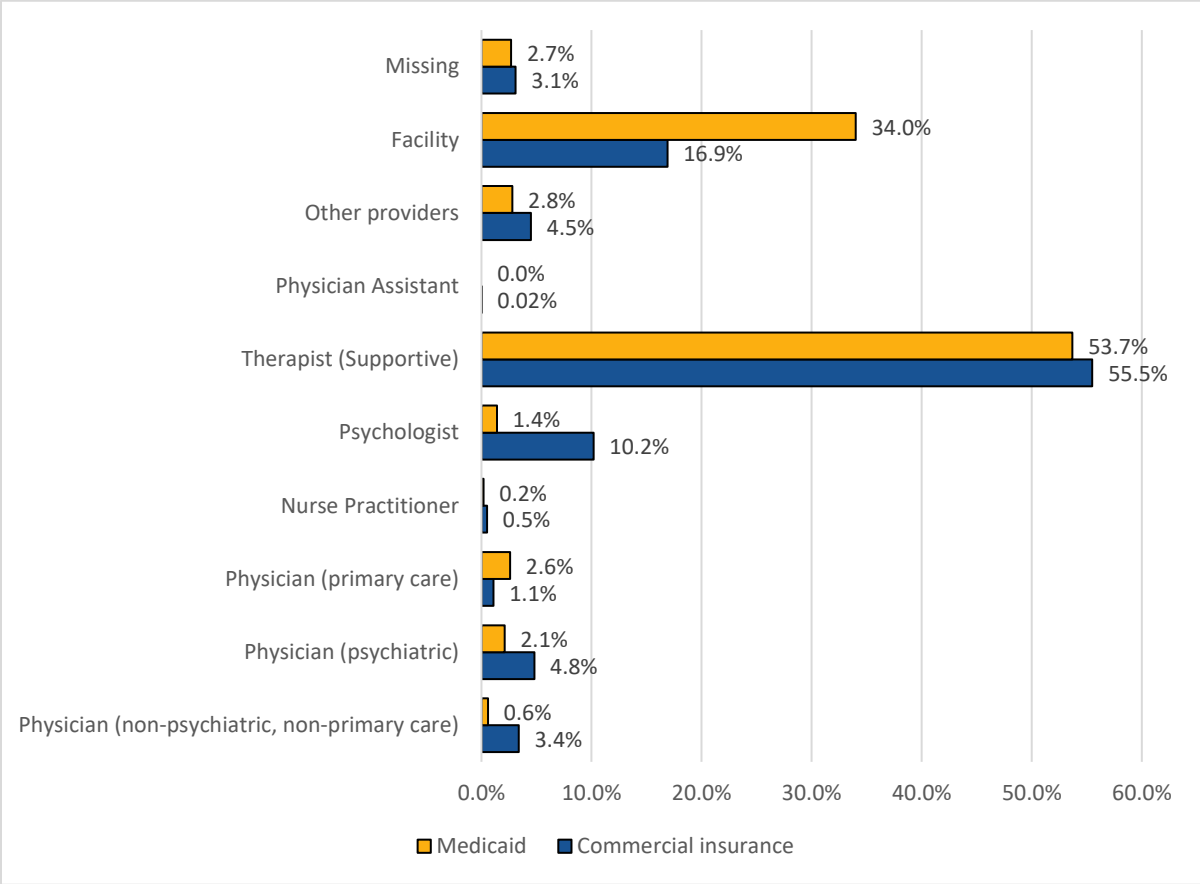
b. For Medicaid and Medicare, urban versus rural area was assigned based on the enrollee's zip code, using the U.S. Department of Education's Education Demographic and Geographic Estimates (EDGE) data. Urban location includes enrollees residing in areas designated as City, Suburban, Town (Fringe) and Rural (Fringe) by the EDGE data. Rural location includes enrollees residing in areas designated as Town or Rural (Distant or Remote) by the EDGE data. For commercial insurance, urban versus rural area was assigned based on the enrollee's zip code, using the Core Based Statistical Area designations used for the Medicare Inpatient Psychiatric Prospective Payment System.

## Provider Types Associated with Outpatient Crisis Service Claims, by Payor

The most common type of provider associated with crisis service claims for both Medicaid and commercial insurance was "Therapist (supportive)," which was associated with more than half of claims for each payor (**Figure 4**). There was some variation by payor in the extent to which Psychologists and the "Facility" provider category were associated with crisis service claims. Psychologists were associated with 10% of commercial insurance crisis service claims but only 1.4% of Medicaid crisis service claims.[k] Thirty-four percent of Medicaid crisis service claims were associated with "Facility" compared to 17% of commercial insurance crisis service claims. Few crisis service claims were associated with physicians, nurse practitioners, or physician assistants for either payor (**Figure 4**).

[k] These findings are consistent with the appearance of the "Psychotherapy for crisis" procedure code on 63.2% of commercial crisis service claims but only 6.3% of Medicaid claims (**Figure 2**).

**Figure 4. Percentage of total crisis service claims associated with each provider type, by payor**




Notes: The denominator for each payor comprises total Medicaid other services (OT) crisis services claim lines (using national or state-specific crisis service codes) or commercial insurance outpatient services claims (using national crisis service codes). The numerator is the number of those crisis service claim lines indicating each service provider type. The "Therapist (supportive)" category is defined differently by payor due to differences in the characteristics of the underlying data and construction of the analytic files. In the Medicaid data set, "Therapist (Supportive)" includes individual provider types such as counselors and marriage and family therapists, and non-individual provider types such as group practices, but does not include social workers. In the commercial data set, the category includes various providers such as counselors, marriage and family counselors, and social workers and may or may not include group practices. "Physician (primary care)," "Physician (psychiatric)," and "Physician (non-psychiatric)" are mutually exclusive categories in that "Physician (non-psychiatric, non-primary care)" includes all other specialties except primary care and psychiatry. "Other providers" refers to the provider type "Social Worker" in the Medicaid data set and includes a range of providers such as dieticians, midwives, and laboratories in the commercial data set. "Facility" refers to providers who are not classified as "Other" or as individual providers. Providers are included in a provider type category if they have at least one claim line that includes a particular servicing provider type; for this reason, providers may be assigned to more than one provider type category.

## DISCUSSION

Overall, the rate of behavioral health crisis service claims per 10,000 enrollees was highest for Medicaid, followed by commercial insurance, and lowest for Medicare. With few exceptions, this pattern was consistent across states. There were also substantial differences across payors in the use of national billing codes for crisis services, with a wider variety of these codes being used for Medicaid claims than commercial insurance and Medicare claims, which predominantly reimbursed for two CPT psychotherapy crisis codes.

Several factors could help explain the observed variation in crisis service codes across payors. First, variability in coverage policies or the guidance that payors give providers on use of billing codes might have contributed to differences in providers' use of codes across payors. For example, Medicare only reimburses two of the

crisis codes included in this analysis whereas commercial insurers can accept more codes. Second, the Medicaid, Medicare, and commercially insured populations differ in their demographic characteristics and potential need for crisis services. For example, differences in average age of enrollees, prevalence of behavioral health conditions, and likely differences in disability status and income levels across payors could influence the need for crisis services.

While across payors, providers might have underused the codes included in this analysis or billed for crisis services using behavioral health procedure codes not specific to crisis services, such as general or intensive outpatient therapy codes, it is likely that lack of uptake in crisis codes represents an obstacle to equitable, sufficient, and sustainable crisis service reimbursement. As a result, states, block grant funds, and Medicaid serve as significant sources of funding for these services [8]. Mobile crisis services, for example, require on-call services, and in many cases the use of peers, outreach, or coordination. These components are not always billable under a standard fee-for-service arrangement requiring a client-provider interaction with a practitioner who is allowed to bill [8]. Medicaid has resolved many of these obstacles by developing bundled payment codes state Medicaid programs can adopt to allow providers to bill for bundled sets of services, but this has not been consistently taken up by Medicare or commercial payors.

Promoting the use of standardized coding guidelines, such as those published by the National Association of State Mental Health Program Directors [4], could support a comprehensive crisis response system aligned with the SAMHSA National Guidelines. Nonetheless, not all crisis services may be funded through claims. Crisis call centers are especially likely to be funded by other sources because of the challenges of collecting patient identifiers and insurance information from people using these services [2,3]. In addition, although some funding for crisis call center services may be financed in some states by Medicaid administrative funds through use of an algorithm based on prevalence [4], these funds are not attached to specific claims.

Differences among payors in use of national crisis service codes suggest potential opportunities to increase claiming for and reimbursement of crisis services, particularly for Medicare and commercial insurance. There are some promising developments that are likely to increase both billing for crisis services directly to allow for better monitoring of crisis utilization and improve the equitable coverage of these services. Medicare may soon expand coverage for mobile crisis services based on CMS' November 16, 2023, release of a final rule creating two new Medicare procedure codes (G0017 and G0018) to allow billing for psychotherapy services for crisis that take place in locations outside a physician's office [7]. While in theory, commercial payors can reimburse providers for a variety of billing codes, not all do so. Some states are beginning to explore requiring commercial insurers to cover certain crisis services to ensure more consistent coverage across payors. For example, in January 2024, Virginia began requiring commercial insurers to cover mobile crisis teams (using code H2011) [9]. Finally, there are opportunities for expansion of billing for crisis services under Medicaid, both through existing 1115 Medicaid demonstrations [10], and new options provided in the American Rescue Plan Act of 2021 (Pub. L. 117-2) which allow for enhanced funding of community-based mobile crisis intervention services [11].

## Caveats and Limitations

The impact of the COVID-19 public health emergency on demand for behavioral health care services likely influenced the overall rate of crisis services observed because the study used data from 2020 and 2021, the earliest years of the pandemic. In addition, the years of data included in the analyses coincided with Congress' 2020 enactment of 988 legislation but predate the July 2022 national launch of the three-digit 988 Lifeline, which may have influenced payors' and providers' awareness of crisis service demand and knowledge of relevant billing codes.

Furthermore, the Medicaid, Medicare, and commercial insurance data and analyses differed in several ways that could affect findings. Such differences include whether the analyses included state-specific crisis service codes,[l] the states excluded from the analyses,[m] the years of data included,[n] whether managed care encounters were included,[o] the distribution of provider types and place of service codes associated with outpatient claims, and enrollee characteristics. For this reason, readers should exercise caution in interpreting the meaning of differences in crisis service claims across payors.

In addition, the analysis was specifically focused on crisis services described in the National Guidelines posited as alternatives to hospital emergency departments. Therefore, traditional use of emergency departments to address behavioral health crises was not included in the data sets. Use of emergency departments to address behavioral health crises has been previously documented in the literature [12].

Finally, the findings are based on crisis service claims filed with insurers and should not be interpreted as representing all crisis services used by enrollees. The rates of behavioral health crisis service claims per 10,000 enrollees may undercount crisis services used, especially for commercial insurance and Medicare enrollees, because of restrictions on the use of certain codes or underuse of allowable codes, use of services paid by other funding sources, and other reasons described in **Appendix B**.

[l] Thirty-four state-specific codes were included in the Medicaid but not commercial insurance or Medicare datasets.
[m] The U.S. Virgin Islands were excluded from the commercial insurance dataset, and New York, Puerto Rico, and Utah were excluded from the Medicaid dataset.
[n] 2021 data were included in the commercial insurance dataset, and 2020 data were included in the Medicaid and Medicare datasets.
[o] Managed care encounters were included in the Medicaid and commercial insurance datasets but not the Medicare dataset.

## APPENDIX A

**Table A.1. Description of Medicaid, Medicare, and Commercial insurance data sources**

| | Medicaid | Medicare | Commercial insurance |
|---|---|---|---|
| Data source | 2020 Transformed Medicaid Statistical Information System Analytic Files (TAF) Research Identifiable Files (RIF). | 2020 Centers for Medicare & Medicaid Services' (CMS') Medicare Administrative Research Files (also known as "carrier" files). | 2021 Merative™ MarketScan® data. |
| Data source description | The TAF RIF are research-optimized versions of national data on Medicaid enrollment, demographics, service utilization, and payments.[1] Demographic and enrollment data are from the 2020 TAF RIF demographics and eligibility (DE) file.[2] Claims are from the 2020 TAF RIF other services (OT) and inpatient (IP) claim files, which include fee-for-service claims and managed care encounter records. | Fee-for-service claims from the 2020 CMS Medicare Administrative Research Files (also known as "carrier" files), including the IP, outpatient (OP), skilled nursing facility (SNF), home health (HHA), hospice (HSP), and professional (PHY) files. The analysis also includes demographic and enrollment data from the 2020 Master Beneficiary Summary File. | A convenience sample of commercial insurance plans for people with employer-sponsored insurance and includes fee-for-service claims and managed care encounters [13]. Demographic and enrollment data are from the 2021 MarketScan® Annual Enrollment file. Crisis service claims were identified in the IP and OP services files. |
| Population | Includes data from most states; Washington, DC; and the U.S. Virgin Islands. Includes all people who were eligible for full, comprehensive, or limited Medicaid benefits for at least one day of 2020. New York, Puerto Rico, and Utah were excluded because of data quality concerns regarding the procedure code variables used in the study [6]. Although some behavioral health claims for California are missing, which might include some crisis service claims, we did not exclude California because we do not expect the missing claims to significantly affect the analysis [6]. People who are dually eligible for Medicare and Medicaid were not excluded from this analysis [6]. | Includes data from all states; Washington, DC; Puerto Rico; and the U.S. Virgin Islands. Includes all people enrolled in Medicare Part A, Part B, or both for at least one month of 2020 who were not enrolled in Medicare Advantage or a health maintenance organization for the full year. Medicare Advantage plans are managed care plans, for which service encounters are not included in the fee-for-service claims files. | Includes data from all states; Washington, DC; and Puerto Rico. Includes people with any enrollment in 2021, regardless of length of enrollment. |
| Notes | | | Not nationally representative. Differences in enrollee characteristics and representation of plan and benefit type between it and the universe of all privately insured people has not been assessed. Therefore, results may differ substantially from what would be found using a representative sample of privately insured people, particularly in some smaller states in which limited insurers participate in the MarketScan® system.[3] |

1. More information about the contents of these files is available from the Research Data Assistance Center at https://resdac.org/cms-data?tid_1%5B2%5D=2.
2. DE records representing enrollee IDs that were present on claims but not included in the eligibility records submitted by the state are excluded from the analysis [6].
3. See https://www.cdc.gov/visionhealth/vehss/data/claims/marketscan.html.

## APPENDIX B. METHODOLOGICAL LIMITATIONS

The rates of behavioral health crisis service claims per 10,000 enrollees likely undercount crisis services used, especially for commercial insurance and Medicare enrollees, for the following reasons:

- State-specific crisis service codes were only identified and included for the Medicaid analyses.

- The data sets include people who might have been enrolled for a limited portion of the year. Claims for such people do not reflect service use during periods when they were not enrolled. Moreover, the Medicare population included in this study (that is, the denominator for the Medicare analyses) includes enrollees who may have been enrolled in Medicare Advantage for much of the year, but the Medicare data set includes only fee-for-service claims (and not Medicare Advantage claims).[p]
- Medicaid, Medicare, and commercial enrollees may have also used crisis services funded by other mechanisms, including SAMHSA block grants, state general funds, local government funds, foundations, other grants, or charitable contributions. Use of crisis call centers are especially likely to be funded by other sources because of the challenges of collecting patient identifiers and insurance information from people using these services [2,3]. In addition, although some funding for crisis call center services may be provided through Medicaid administrative funds in some states through use of an algorithm based on prevalence [4], these funds are not attached to specific claims and, therefore, are not represented in our data set.
- The analysis was specifically focused on crisis services described in the National Guidelines posited as alternatives to hospital emergency departments. Therefore, traditional use of emergency departments to address behavioral health crises was not included in the data sets. Use of emergency departments to address behavioral health crises has been previously documented in the literature [12].

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[p] Medicare Advantage plans are managed care plans, for which service encounters are not included in the fee-for-service claims files.

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