Medi-Cal Mobile Crisis Services Benefit

Frequently Asked Questions (FAQ)

This document includes DHCS' responses to frequently asked questions from county representatives, providers, and other stakeholders related to the Medi-Cal Mobile Crisis Services benefit. Find additional information about mobile crisis services on the DHCS website, and submit questions to MCBHPD@dhcs.ca.gov.

Table of Contents

Medi-Cal Mobile Crisis Services

General Questions

1) When will mobile crisis services be available under Medi-Cal?

In July 2023, the Centers for Medicare & Medicaid Services approved DHCS' State Plan Amendment 22-0043 to cover qualifying community-based mobile crisis intervention services under Medi-Cal, effective January 1, 2023. The majority of counties will have the Mobile Crisis Services benefit implemented by December 31, 2023. Alpine, Amador, Colusa, Del Norte, Glenn, Inyo, Mariposa, Modoc, Mono, Plumas, Sierra, and Trinity have until June 30, 2024, to implement the benefit. All requirements for counties to begin implementing mobile crisis services are outlined in Behavioral Health Information Notice (BHIN) 23-025.

2) Why do some counties have a delayed mobile crisis implementation date of June 30, 2024?

DHCS used the Crisis Resources Need Calculator, a tool developed for the National Association of State Mental Health Program Directors (NASMHPD), as a data source to develop mobile crisis services rates for each county. This tool estimates the number of mobile crisis services encounters, travel time, and number of needed mobile crisis teams for each county.

DHCS created a rate methodology using data from the Crisis Resources Need Calculator to develop a mobile crisis encounter rate for each county. The methodology is designed to develop encounter rates that accounts for the following components of the benefit: travel time, face to face time with the member, follow up time, translation/interpretation services, and standby time. The Crisis Resources Need Calculator estimates 12 counties to have a low number of mobile crisis encounters, which is not enough to have at least one mobile crisis team. Because of this, DHCS was initially unable to develop an appropriate mobile crisis encounter rate for these counties. Therefore, DHCS announced a six-month delay, to June 30, 2024, for these 12 counties to implement the benefit and used this additional time to develop encounter rates for these 12 counties.

3) How do mobile crisis services differ from existing crisis services that are currently coverable under Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), and Drug Medi-Cal Organized Delivery System (DMC-ODS)?

DHCS is not making any changes to the existing crisis intervention services and substance use disorder (SUD) crisis intervention services benefits covered under SMHS, DMC, and DMC-ODS. Medi-Cal behavioral health delivery systems shall continue

covering these services in accordance with existing federal and state, and contractual requirements.

Medi-Cal mobile crisis services[1] provide rapid response, individual assessment, and community-based stabilization to individuals who are experiencing a mental health or substance use crisis. They are delivered by a multidisciplinary mobile crisis team at the location where an individual is experiencing a crisis, including at home, school, work, or on the street. Mobile crisis services provide relief to members experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reducing the immediate risk of danger and subsequent harm; and avoiding unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

4) Do mobile crisis services need to be coordinated across SMHS and DMC/DMC-ODS delivery systems?

Medi-Cal behavioral health delivery systems in each county shall collaborate with each other to implement mobile crisis services. All mobile crisis teams, regardless of delivery system, must meet the same set of requirements and a single encounter may be claimed only once through one delivery system. DHCS strongly encourages counties to implement a fully integrated approach across mental health and SUD delivery systems in which a single mobile crisis services infrastructure serves the entire county. A single integrated system may include multiple mobile crisis teams that are equipped to respond to members regardless of whether they otherwise are served by the county Mental Health Plan (MHP) or the county's SUD delivery system (DMC or DMC-ODS). If a county opts not to establish a single integrated system, it shall document, as part of its mobile crisis implementation plan, how it will ensure mobile crisis services are coordinated across the Medi-Cal behavioral health delivery systems in the county. All mobile crisis teams should be equipped to provide immediate coordination with other providers involved in the member's care and with other crisis receiving and stabilization facilities (e.g., sobering centers, crisis respite, crisis stabilization units, psychiatric health facilities, etc.).

5) What requirements do counties need to meet in advance of claiming for Medi-Cal mobile crisis services?

[1] SPA 22-0043 proposes to add qualifying community-based mobile crisis intervention services, as authorized by section 9813 of the American Rescue Plan Act of 2021, codified as Title 42 of the United States Code (U.S.C.), section 1396w-6, to the Medicaid State Plan as a Rehabilitative Mental Health Service, Substance Use Disorder (SUD) Treatment Service, and Expanded SUD Treatment Service.

In general, Medi-Cal behavioral health delivery systems shall undergo a comprehensive, standard implementation process prior to claiming for mobile crisis services. This implementation process includes submission of an Implementation Plan for review and approval by DHCS at least 30 days before the planned go-live date, but no later than the deadlines outlined in BHIN 23-025. Medi-Cal behavioral health delivery systems with experience providing mobile crisis services or that otherwise are prepared to implement mobile crisis services more expeditiously may use an expedited implementation process and begin services immediately following approval by DHCS. Additional information about the standard and expedited implementation processes are available in BHIN 23-025.

6) Do counties need to have 24/7 staffing in place to begin claiming Medi-Cal for mobile crisis services?

Per federal requirements, Medi-Cal behavioral health delivery systems are required to provide mobile crisis services 24 hours a day, 7 days a week, and 365 days a year in order to bill Medi-Cal for mobile crisis services. However, no single mobile crisis team must be available 24/7, and multiple shifts of multiple teams can be scheduled accordingly to ensure coverage throughout the 24/7 period.

7) Are there restrictions on the settings in which mobile crisis services can be delivered?

The initial mobile crisis response must be provided where the member is experiencing a crisis, or at an alternate location of the member's choosing. Mobile crisis services may **not** be provided in the following settings, due to restrictions in federal law and/or because these facilities and settings are already responsible for providing crisis services:

- Inpatient Hospital;
- Inpatient Psychiatric Hospital;
- Emergency Department;
- Residential SUD treatment and withdrawal management facility;
- Mental Health Rehabilitation Center;
- Psychiatric Health Facility;
- Special Treatment Program;
- Skilled Nursing Facility;
- Intermediate Care Facility;
- Settings subject to the inmate exclusion such as jails, prisons, and juvenile detention facilities;
- Other crisis stabilization and receiving facilities (e.g., sobering centers, crisis respite, crisis stabilization units, psychiatric health facilities, psychiatric inpatient hospitals, crisis residential treatment programs, etc.).

8) Can mobile crisis services be delivered at Short-Term Residential Therapeutic Program (STRTP) settings?

It is allowable for mobile crisis teams to respond to a crisis that is happening at an STRTP; however, it would likely be a rare occurrence as STRTPs are required to provide crisis intervention services.

9) Do all mobile crisis teams need to include a licensed behavioral health professional as part of the initial two-person response?

Mobile crisis teams must include at least two providers for the duration of the initial mobile crisis response. The two-person team must **include** or **have access to** a Licensed Practitioner of the Healing Arts (LPHA) or a Licensed Mental Health Professional, including a licensed physician, licensed psychologist, licensed clinical social worker, licensed professional clinical counselor, licensed marriage and family therapist, registered nurse, licensed vocational nurse, or licensed psychiatric technician. A mobile crisis team could consist of one LPHA and one peer support specialist. It also could consist of two peer support specialists who have access to a LPHA via telehealth or telephone for the initial mobile crisis response. Follow-up may be conducted by one mobile crisis team member. Additional information on mobile crisis team composition requirements for initial crisis response are available in BHIN 23-025.

10) Who can perform a crisis assessment?

All mobile crisis team members and service providers must complete a core training in crisis assessment. Any mobile crisis team member that has been trained to conduct a crisis assessment as part of required mobile crisis services training can deliver the initial face-to-face crisis assessment. At least one onsite mobile crisis team member shall be able to conduct a crisis assessment, and it must be done onsite.

11) Is a psychiatric advance directive (PAD) required as part of the crisis planning?

When appropriate, crisis planning may include, but is not required to include, the development of a written crisis safety plan. A PAD may be appropriate as a part of the crisis safety plan. The PAD may be drafted when a person is well enough to consider preferences for future mental health treatment. In some circumstances, this may occur during mobile crisis follow-up services or upon linkage to ongoing care.

12) Can a "co-response" team that consists of a behavioral health professional and law enforcement officer deliver qualifying mobile crisis services?

It is considered a national best practice for a mobile crisis team to respond without law enforcement accompaniment unless special safety concerns warrant inclusion.[2] A law enforcement officer may accompany a mobile crisis team for the initial mobile crisis response when necessary for safety reasons; however, the law enforcement officer does **not** qualify as a member of the mobile crisis team. This means that the mobile crisis team must include two or more qualified providers who participate in the initial mobile crisis response in addition to the law enforcement officer to be a qualifying mobile crisis service.

13) What is defined as a "timely response" for mobile crisis teams?

A "timely response" is within 60 minutes of dispatch in urban areas and within 120 minutes in rural areas. Consistent with Alternative Access Standards for Medi-Cal Managed Care Health Plans, "rural" is defined to include all areas with less than 50 people per square mile. (See p. 345.) DHCS will provide ongoing technical assistance to Medi-Cal behavioral health delivery systems to review response times and adjust timeliness standards, as needed.

14) Will tribal areas be included or excluded from the definition of rural for the purposes of meeting timeliness standards?

Tribal areas will be evaluated and expected to meet the timeliness standards in the same way as other rural or urban areas as outlined in the Alternative Access Standards for Medi-Cal Managed Care Health Plans. A timely mobile crisis response is considered within 60 minutes of dispatch in urban areas and within 120 minutes in rural areas.

15) Does the crisis services hotline have to be able to dispatch directly, or can they warm transfer to another number for dispatch?

Counties must identify a single telephone number to serve as a crisis services hotline connected to the dispatch of mobile crisis teams to receive and triage member calls. The number can be the same as the county's 24/7 access line or an existing county crisis line, if the Medi-Cal behavioral health delivery system ensures the line has the capacity to respond to members in crisis and to dispatch mobile crisis teams when appropriate.

[2] SAMHSA national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (samhsa.gov).

16) When does the clock start running for the purpose of measuring a "timely response"?

The clock starts when a crisis line operator has determined a member requires a mobile crisis response. For example, a person may call 988 and then be transferred to a county's crisis line for further assessment. The crisis line operator may talk with the member and use a standardized tool and set of procedures to determine when a mobile crisis team should be dispatched. After the operator determines on-site help is required and dispatches the mobile crisis team, the mobile crisis team should arrive on-site within no more than 60 minutes for urban areas and 120 minutes for rural areas.

Training & Technical Assistance

17) What are the core training requirements for mobile crisis team members that conduct follow-up check-ins?

All members of mobile crisis teams, including those providing follow-up, must complete core training delivered by DHCS' training contractor(s) or by an outside source. Required core trainings include:

- Crisis intervention and de-escalation strategies;
- Harm reduction strategies;
- Delivering trauma-informed care;
- Conducting a crisis assessment; and
- Crisis safety plan development.

18) What other trainings and tools will be available to support mobile crisis services providers?

In addition to the core trainings described above, DHCS' training contractor(s) also developed a series of required enhanced trainings, recommended supplemental trainings, and technical assistance tools to support mobile crisis teams and county behavioral health delivery systems. Enhanced and supplemental trainings include, but are not limited to, training in provider safety, delivering culturally responsive crisis care, and crisis response strategies for special populations (e.g., children, youth and families, tribal communities, and members with intellectual and/or developmental disabilities (I/DD)).

19) Are other crisis continuum partners, such as law enforcement officers, able to participate in mobile crisis services trainings offered by DHCS?

It is a best practice for all entities working across the crisis care continuum to be trained in the core elements of mobile crisis services. Mobile crisis teams who will be implementing mobile crisis services under Medi-Cal will be given first priority in training

registration. If there are no space limitations, all entities that may be involved in the delivery of mobile crisis services are welcome and encouraged to participate in trainings, including law enforcement officers (note: even if trained, law enforcement staff do not count as team members for the qualifying Medi-Cal mobile crisis service). All trainings are recorded and training resources and registration for trainings are housed on the Medi-Cal Mobile Crisis Training and Technical Assistance Center's (M-TAC) website. To receive announcements for upcoming trainings/webinars, please subscribe to the M-TAC distribution list here.

20) Where can I find templates and tools?

Templates and tools for mobile crisis services providers and county behavioral health delivery systems can be found on the M-TAC website.

Reimbursement for Medi-Cal Mobile Crisis Services

21) What mobile crisis service components must be delivered for the service to be reimbursable under Medi-Cal?

To be reimbursable under Medi-Cal, each mobile crisis services encounter must include, at minimum:

- An initial face-to-face crisis assessment;
- Mobile crisis response;
- Crisis planning, as appropriate; and
- A follow-up check-in, or documentation that the member could not be contacted for follow-up.

When appropriate, mobile crisis services encounters should also include:

- Referrals to ongoing services; and/or
- Facilitation of a warm handoff to a higher level of care.

22) What service components are included in the bundled encounter rate?

DHCS has developed county-specific bundled encounter rates for mobile crisis services. The encounter rate is inclusive of the mobile crisis service components delivered by a mobile crisis team during the mobile crisis services encounter. DHCS made informed assumptions in establishing the encounter rate (e.g., duration of a service component).

Reimbursement for each mobile crisis services encounter is considered all-inclusive (with the exception of transportation, see Question 24 below), and Medi-Cal behavioral health delivery systems must not submit separate claims on behalf of individual members of the mobile crisis team for services delivered as part of the individual encounter (e.g.,

separate claims for peer support services when a peer support specialist is acting as a member of a mobile crisis team).

If services are provided to members after the mobile crisis response (and not as part of required follow-up), counties should claim separately for those additional services (e.g., if a Medi-Cal member is connected with a peer support specialist who provides peer support services on an ongoing basis after the initial mobile crisis response).

23) How did DHCS calculate the hourly rate for a team of two mobile crisis services providers?

The hourly labor rate for two mobile crisis service providers includes a county-specific outpatient services rate for one LPHA or Licensed Mental Health Professional and one other qualified provider. The hourly labor rate for one mobile crisis team member to provide follow-up is an average of the two-person rate. Providers on the same mobile crisis team should not claim separately for the same encounter.

24) How will mobile crisis teams be reimbursed for transportation?

If the mobile crisis team provides transportation or accompanies a member who is being transported by a non-medical transport (NMT) provider, emergency medical services (EMS), or law enforcement, the mobile crisis services provider may receive an add-on reimbursement in addition to the county encounter rate.

The circumstances under which this add-on reimbursement could occur are:

- If a mobile crisis team member drives the member to an alternate setting such as an emergency department, the county may claim for transportation mileage using code A0140.
- If a mobile crisis team member spends staff time during the journey stabilizing the individual or assists the member by waiting with them for the next level of care (e.g., waits until they can be admitted), the county may claim for staff time using code T2007.

25) What administrative costs are covered and how do counties receive reimbursement for administrative costs?

Administrative costs related to mobile crisis services should be claimed through the existing administrative claiming process and include activities outlined in Mental Health Plan Letter 05-10.

26) How should a county claim for mobile crisis activities that occur outside of the initial mobile crisis response?

All activities that occur as part of the mobile crisis services encounter, including follow-up and connections with ongoing services and supports, are included in the all-inclusive mobile crisis services encounter rate. Transportation to another level of care and staff time spent assisting the individual during or after the transportation time are the only components of mobile crisis services that are claimed as add-ons to the all-inclusive rate (See question 24).

27) If a mobile crisis team that includes a Community Health Worker (CHW) delivers a service that cannot be claimed under the new benefit (e.g., responds to a hospital emergency department and ends up providing crisis intervention), does the CHW then need to meet qualifications for a SMHS "other qualified provider" for that service to be reimbursable as a SMHS?

If a crisis response is provided in a restricted setting, as outlined in BHIN 23-025, it would not meet the requirements of a qualifying mobile crisis services encounter. If a CHW provided crisis intervention services during the response, the crisis intervention services would be reimbursable if the CHW meets the qualifications of "other qualified provider" and is employed by the MHP or works for a Medi-Cal provider contracted with the MHP to provide crisis intervention services.

28) How should a county behavioral health delivery system claim for more than one response to the same member in a short period of time (e.g., in a 24, 48, or 72 hour period)?

The mobile crisis team should claim separately for each mobile crisis services encounter that includes the required elements of a mobile crisis response outlined in Question 21 above. A member may experience more than one behavioral health crisis in one day. For example, a member may experience an initial crisis that is resolved by a mobile crisis team, and then experience a subsequent crisis later that day or within the following days. In those cases, it may be appropriate for a mobile crisis team to engage in multiple mobile crisis services encounters with the same member over a short period of time.

29) What if there are multiple crises within a period of a few days? Can there be one follow up for multiple mobile crisis responses?

Follow-up is a key component of the mobile crisis services encounter to support continued resolution of the crisis, make referrals to ongoing supports, and create or update a crisis safety plan. Mobile crisis teams are expected to conduct a follow-up check-in within 72 hours of each initial mobile crisis response. If multiple mobile crisis

services encounters occur within a short period of time, mobile crisis teams are expected to coordinate follow-up to ensure the member is receiving appropriate services and supports. However, mobile crisis teams should ensure that any follow-up check-ins include outreach on the specific issues that arose during each crisis.

30) Can crisis planning be done as part of a follow-up check-in?

Crisis planning, which may include the development of a written crisis safety plan, can help a member avert future crises, including through identifying conditions and factors that contribute to a crisis, reviewing alternative ways of responding to such conditions and factors, and identifying steps the member can take to avert or address a crisis. In some cases, it may not be appropriate to engage a member in crisis planning during the initial mobile crisis response if they are in distress or need to be transported to a higher level of care. In those cases, it may be appropriate to conduct crisis planning as part of a follow-up check-in.

31) Will mobile crisis teams be reimbursed for "no shows"?

In some cases, a mobile crisis team may be dispatched to respond to a crisis and when they arrive onsite, the member is no longer able to be reached. If a mobile crisis team does not deliver all required components of the mobile crisis services encounter, they will not be reimbursed for services.

32) What happens if counties operationalize their mobile crisis teams differently than what the rate methodology accounts for? Can a county have a unique and distinct rate methodology?

Rate setting and operationalization of the Medi-Cal Mobile Crisis Services benefit are different issues. Counties may not request to have a unique rate methodology; however, Medi-Cal behavioral health delivery systems shall be prepared to work with DHCS to review the appropriateness of the assumptions for any given county. DHCS made informed assumptions and accounted for county variability in establishing encounter rates (e.g., county size and geography, anticipated volume of encounters/year, estimated stand by time, hourly provider rates). Counties do, however, have discretion in determining how best to operationalize the benefit and deliver the required services outlined above in Question 21. For example, counties can determine the team composition (based on the qualified providers outlined in BHIN 23-025) used to respond to a crisis (e.g., a peer support specialist and a LPHA, or two peer support specialists with back up from a LPHA via telehealth) regardless of the provider team assumptions used by DHCS when establishing rates.

33) Are counties able to claim for mobile crisis services through either the SMHS or DMC/DMC-ODS delivery systems?

Yes, counties may claim for mobile crisis services through either the SMHS or DMC/DMC-ODS delivery systems. However, claims should only be submitted to one delivery system per encounter. Oversight will be the same for both systems. In addition, each county's mobile crisis services implementation plan should include information about how a county intends to coordinate mobile crisis services across delivery systems. DHCS will conduct regular monitoring and oversight of mobile crisis services to ensure mobile crisis teams are not "double billing" for mobile crisis services in both delivery systems.

34) How does the encounter rate calculate standby time per team per day?

Under federal requirements, teams must be available 24/7, 365 days per year, which means there will inevitably be times when teams are on call, but not needed to respond to a crisis. The amount of stand-by time, however, will vary based on demand for mobile crisis services. To account for this, DHCS used a county-specific average hourly wage for two providers (one LPHA and one other qualified provider) and multiplied this two-person wage by the amount of standby time per shift.

Specifically, for rate setting purposes, the amount of standby time for mobile crisis teams in each county was estimated by multiplying the county's predicted average daily encounters per team by the total estimated time per encounter (including travel time, direct service, and follow-up time) for a total number of hours of active labor time per team on an 8-hour shift. The formula subtracts this total active labor time from an 8-hour shift and the remaining time is estimated to be the required stand-by time based on demand. Note, however, that DHCS also assumed that regardless of demand, each mobile crisis team will require at least one hour of standby time per 8-hour shift. Thus, a county's rate reflects a standby time of one hour per 8-hour shift or a longer period based on expected demand, whichever is higher.

35) How does the encounter rate incorporate the time that mobile crisis team members must spend getting to the site of a member's crisis?

DHCS' rates take into account that mobile crisis team members must travel to where members are in crisis. To build this travel time cost into the encounter rate, DHCS looked at one way travel time according to the Crisis Resource Need Calculator developed for the NASMHPD. The encounter rate formula multiplies this estimate by two to account for a round trip to and from the site. Travel time is multiplied by an average two-person hourly rate for one LPHA and one other qualified provider, inclusive of clinic overhead.

36) How does a mobile crisis team claim for a consultation with a specialist via telephone/telehealth?

If a consultation with a specialist is required during the mobile crisis response, the mobile crisis team would not submit a claim for those services. The clinician providing the specialist consultation would bill for the telehealth services provided, using the appropriate modifier (93 audio only or 95 audio and video).

37) How will counties claim if additional follow-up occurs after the 72-hour follow-up time frame? For example, there are three additional follow-ups over the course of the next two months to engage the individual in services.

Follow-up is required to take place within 72 hours of providing on-site services. Follow-up that occurs within this 72-hour window is part of the encounter rate – whether it results in multiple calls, one call, or the individual is unable to be reached. It is expected counties will have a mix of these outcomes in providing follow up services. Outreach to the member after the follow-up requirements that are part of the encounter have been met can be claimed separately as in accordance with the service that is provided, e.g., mental health services, crisis intervention services, etc.