HEALTH CARE AUTHORITY

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Letter of Direction #20

Date: **October 4, 2024**

To: **Turquoise Care Managed Care Organizations**

From: **Dana Flannery, Director, Medical Assistance Division**
Nick Boukas, Director, Behavioral Health Services Division

Subject: **Implementation of Mobile Crisis Intervention and Mobile Response and Stabilization Services**

Title: **Mobile Crisis Intervention and Mobile Response and Stabilization Services**

The purpose of this Letter of Direction (LOD) is to provide guidance to the Turquoise Care Managed Care Organizations (MCOs) for implementation of changes to mobile crisis intervention services and children's mobile response and stabilization services. Changes to mobile crisis intervention services are effective July 1, 2024. This guidance is being issued in advance of a rule promulgation of 8.321.2 NMAC and is effective immediately.

Mobile Crisis Intervention Services

Mobile crisis intervention services are intended to provide rapid response, individual assessment, evaluation, and treatment for individuals across the lifespan when a person is experiencing a behavioral health crisis. A behavioral health crisis is defined as a turning point in the course of anything decisive or critical in an individual's life, in which the outcome may decide whether possible negative consequences will follow. Services must be available where the individual is experiencing a behavioral health crisis 24 hours a day, 7 days a week, 365 days per year and may not be restricted to select locations within any region/designated response area(s), or on particular days or times and must address co-occurring substance use disorders, including opioid use disorder, if identified. Mobile crisis intervention services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available.

Mobile crisis intervention services include immediate response by a Mobile Crisis Team (MCT) or Mobile Response and Stabilization Services (MRSS) team to provide screening and assessment, stabilization, de-escalation, coordination and referral to health, social, and other services as needed to effect symptom reduction, harm reduction, and/or to safely transition person in acute crisis to the appropriate environment for continued stabilization. Services follow an integrated culturally, linguistically, and developmentally appropriate approach, are trauma informed, and may be provided prior to an intake evaluation for mental health services. Mobile crisis intervention services include

telephonic follow-up for up to 72 hours after the initial mobile response, which may include, where appropriate, additional intervention and de-escalation services and coordination with and referrals to health, social, emergency services and other services and supports, as needed.

MCTs:

MCTs must comply with the crisis requirements described in 8.321.2.20 NMAC and must:

a. Operate 24 hours per day, 7 days per week, and 365 days per year;
b. Provide community-based crisis intervention, screening, assessment, and referrals to appropriate resources;
c. Be able to administer naloxone and other harm reduction strategies, as warranted;
d. Coordinate to ensure appropriate transportation to a place of safety if clinically appropriate or to a higher level of care, if required by the situation;
e. Maintain relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, county health and human services, law enforcement. Certified Community Behavioral Health Clinics (CCBHCs), crisis care providers including -988, crisis triage centers and managed care organizations (as applicable);
f. Be certified by HCA/Behavioral Health Services Division (BHSD).

Children's MRSS

Children's MRSS is a child, youth, and family specific behavioral health crisis intervention and prevention service. It provides immediate, in-person response, screening and triage, to de-escalate crises that are defined by the child, youth, family or caregivers. MRSS provides ongoing stabilization services and supports, follow up, navigation and access to community supports across the system of care to prevent future crises or out of home placement. MRSS services are conducted through a cultural, linguistic, and developmentally appropriate, trauma-responsive framework.

Mobile response includes activities to de-escalate a crisis, address immediate needs that intensify the crisis, gathering of information from family and collateral contacts to complete the MRSS Crisis Assessment Tool (CAT), and collaborative completion of a crisis, safety or relapse prevention plan, as appropriate, with the child, youth, and their family or caregivers.

Following the initial mobile response, MRSS includes up to 56 days of stabilization services, a critical component of MRSS. To maintain care continuity, whenever possible stabilization services are conducted by a member of the MRSS team who initially responded. The stabilization period is meant to identify deeper reasons for safety and stability events, particularly when they are re-occurrent.

The MRSS stabilization process addresses the child and family's urgent and emergent needs through intensive care coordination. The MRSS eight-week stabilization process is not meant to be a limitation of the stabilization period but part of a continuum of care for stabilization, and the individual may at any time transfer to other long-term services and supports for continued care.

MRSS providers must be certified by CYFD BHS.

MCT/MRSS Staffing Requirements:

Mobile crisis intervention services are furnished by a multidisciplinary team that includes at least two members. The team includes at least one behavioral health care professional able to conduct a clinical assessment within their permitted scope of practice under state law and who may be available via telehealth. It is strongly recommended that Certified Family Peer Support Workers, Certified Youth Peer Support Workers, or Certified Peer Support Workers are included in the MRSS team whenever possible. Additional team members may include:

a. A licensed Mental Health Therapist;
b. Certified Peer Support Specialist;
c. Certified Family Peer Support Workers;
d. Certified Youth Peer Support Specialists
e. Community Support Worker;
f. Community Health Worker;
g. Community Health Representative;
h. Certified Prevention Specialist;
i. Registered Nurse;
j. Emergency Medical Service provider;
k. Licensed Alcohol and Drug Abuse Counselor (LADAC) or Certified Alcohol and Drug Addiction Consultant (CADAC);
l. non- independently licensed behavioral health professionals;
m. Emergency Medical Technician;
n. Licensed Practical Nurse; and
o. other certified and/or credentialed individuals.

MCT Specific Requirements

The MCT shall have a full-time clinical director who is an RLD board-approved clinical supervisor and/or a part-time medical director which may include a physician, psychiatrist, or advanced practice registered nurse.

The MCT shall ensure that prior to providing direct care to recipients, all individuals having direct contact with recipient shall have all applicable background checks and receive 25 hours of required training. Annually all individuals having direct contact with recipients must receive at least 20 hours of crisis related continuing education.

MRSS Specific Requirements

MRSS teams may include both licensed and non-licensed staff and must have a clinical supervisor who is an independently licensed, RLD board-approved clinical supervisor. It is recommended that Certified Family Peer Support Workers, Certified Youth Peer Support Workers, or Certified Peer Support Workers are included in the MRSS team. MRSS providers shall ensure that MRSS staff complete required training which includes:

- 30 hours of required MRSS training;
- CPR and de-escalation training provide through the behavioral health agency; and
- Any HCA/MAD required provider trainings.

Tribal 638 or IHS facilities may request waivers to the staffing requirements outlined above for MCTs by submitting their staffing plan to the HCA BHSD or for MRSS by submitting their staffing plan to the Children Youth and Families Department (CYFD) Behavioral Health Services (BHS).

MCT/MRSS Dispatch

Use of state approved tools will be used for dispatch protocols for crisis response services. MCT/MRSS teams may be dispatched by 988 Lifeline call centers, by the agency operating the MCT or MRSS team, or by local law enforcement/public safety systems, as outlined in a memorandum of understanding (MOUs). MOUs must be provided to the state, or its designee, as requested.

MCTs and MRSS responders cannot refuse a request for dispatch unless safety considerations warrant involvement of public safety. In those cases, MCT and MRSS providers must establish standardized safety protocols for community response and when public safety involvement is needed (e.g., in instances of serious injury, overdose, medical emergency, imminent risk of harm). Policies must appropriately balance a willingness to help those in crisis with the team's personal safety and not involve broad rules that would exclude whole populations (i.e., individuals actively using substances or those with a criminal history). In the case of simultaneous requests for dispatch, MCT and MRSS providers must use a triage system to prioritize acuity.

Telehealth is allowable, however in vivo MCT and MRSS response is preferred. MCTs/MRSS teams can use telehealth to ensure rapid response and clinical decision-making to ensure the crisis is resolved safely.

MCT and MRSS dispatch practices on Tribal lands may differ from MCT dispatch protocol off Tribal lands.

Program Implementation

MCTs must be certified by HCA BHSD. MRSS providers must be certified by CYFD BHS. In addition to this certification, the agency must be enrolled as one of the following provider agency types:

a. Federally Qualified Health Center;
b. Community Mental Health Center;
c. Hospital or affiliated clinic;
d. an IHS hospital or clinic;
e. Crisis Triage Center;
f. PL 93-638 tribally operated hospital or clinic;
g. a MAD designated CareLink NM Health Home;
h. Behavioral Health Agency;
i. Core Service Agency

MCTs will be identified with a provider specialty type of 149 and MRSS will be identified with a provider specialty type of 139.

The MCOs will contract for these mobile crisis intervention and stabilization services only with those providers who have been approved by BHSD or CYFD. MCOs may request a copy of the BHSD or CYFD approval letter from the provider.

MCO's are directed to configure their systems accordingly to reimburse for mobile crisis intervention and children's mobile response and stabilization services.

All rates described in this LOD have been calculated and considered as a component of the MCO capitations rates.

Billing and Reimbursement

Mobile crisis and stabilization will use the following procedure codes and modifiers:

SERVICE	PROCEDURE CODE	MODIFIER(S)	MRSS Modifier	Unit
Mobile Crisis Intervention Services – Per Diem for response over 4 hours in duration				
MOBILE CRISIS — LICENSED RESPONSE	S9485	HO	HA	Per Encounter
MOBILE CRISIS — NON-LICENSED RESPONSE	S9485		HA	Per Encounter
MOBILE CRISIS – LICENSED RESPONSE WITH PEER	S9485	HT	HA	Per Encounter
TEAM RESPONSE WITH TELEHEALTH	S9485	GT	HA	Per Encounter
Mobile Crisis Intervention Services Unit – For responses 4 hours or less in duration				
LICENSED RESPONSE – CRISIS LICENSED & CRISIS LEVEL 1 NON-LICENSED	H2011	HO	HA	15 minutes Max units: 16
NON-LICENSED	H2011		HA	15 minutes

RESPONSE – CRISIS LEVEL 2 NON-LICENSED & CRISIS PEER/YOUTH & FAMILY SUPPORT				Max units: 16
LICENSED RESPONSE – CRISIS LICENSED & CRISIS PEER/YOUTH & FAMILY SUPPORT	H2011	HT	HA	15 minutes Max units: 16
TEAM RESPONSE WITH TELEHEALTH	H2011	GT	HA	15 minutes Max units: 16
TELEPHONIC				
MOBILE CRISIS FOLLOW-UP - TELEPHONE	H0030		HA	15 minutes
STABILIZATION SERVICES – for individuals age 21 and under				
STABILIZATION SERVICES – LICENSED & PEER	S9482	HA, HT		15 minutes
STABILIZATION SERVICES – LICENSED & NON-LICENSED	S9482	HA, HT		15 minutes
STABILIZATION SERVICES – NON-LICENSED ONLY	S9482	HA		15 minutes
STABILIZATION SERVICES – LICENSED ONLY	S9482	HA, HO		15 minutes

Please refer to the Behavioral Health Fee Schedule located on the HCA website for additional information. https://www.hca.nm.gov/providers/fee-schedules/.

Billing Guidance

- Crisis providers cannot bill a mobile crisis unit code (H2011), mobile crisis per diem (S9485) and/or MRSS stabilization (S9482) rate on the same day. Crisis providers cannot bill a mobile crisis per diem (S9485) and a telephonic follow-up call (H0030) in the same day.
- Mobile crisis intervention services (e.g., H2011 and S9485) by their nature are crisis services and are not subject to prior approval. Mobile crisis intervention is authorized for no more than 72 hours per episode. Mobile crisis intervention is authorized for no more than 72 hours per episode. Activities beyond the 72-hour period must have prior authorization by the State of its designee. The beneficiary's clinical record must reflect resolution of the crisis which marks the end of the current episode.
- Authorization for Telephonic Follow-up (H0030) is not required if it follows a mobile crisis intervention service.
- MRSS stabilization is authorized for no more than 8 weeks. For children or/youth in need of regular care beyond 72 hours who have been seen by an MRSS crisis team, use of MRSS stabilization services will be determined in conjunction with the caregiver and are based on risk factors identified in the MRSS CAT screening including, but not limited to, housing and economic stability, potential for harm to self or others, substance use and/or behavioral health challenges, school behavioral and attendance challenges. The goal of stabilization should be to stabilize the child or youth, to address immediate de-stabilizing economic factors and address immediate family needs and transition the youth to a longer-term community behavioral health service or support as appropriate.
- In the event the recipient has an existing provider and treatment plan, the crisis provider should coordinate with the existing provider and notify the provider of the individual's engagement with crisis services. The members' provider should work to provide continuity and support to re-establish and/or provide community-based care as soon as possible. The existing provider could advise the crisis team to provide input, etc. However, the crisis provider should ensure that the existing treatment plan is sufficient and does not need to be modified as a result of the crisis being experienced by the individual.
- Evidence-based practice (EBP) teams such as Assertive Community Treatment (ACT), Dialectical Behavioral Therapy (DBT), Multisystemic Therapy (MST), and Functional Family Therapy (FFT) should provide initial crisis services for their caseload and not bill for Mobile Crisis Intervention Services and Stabilization services separately. However, If the MCT/MRSS teams are dispatched to a member receiving ACT, DBT, MST, or FFT, the MCT/MRSS team can bill for the crisis response, as applicable, until the EBP team relieves them.
- MCT or MRSS should collaborate with ACT, DBT, MST, FFT, New Mexico High Fidelity Wraparound (HFW), or other existing care teams and ensure seamless care transition for individuals served.

- MRSS stabilization should not be billed when a child or /youth is under the care of a DBT, MST, HFW or other existing FFT team.

Billable Services

Face-to-face contacts with children, youth, and adults and relevant family and kinship network members and collateral contacts are billable. The rates set include costs for the following:

- Direct contacts with individuals and relevant family, caregivers and kinship network members
- Direct contacts with clinically relevant collateral contacts such as teachers, school administrators, child welfare workers, juvenile justice workers, social workers, probation officers and some social network contracts when clinically indicated.
- Indirect contacts, such as phone calls, with both individuals, caregivers, and relevant family and kinship network members, and collateral contacts.
- Costs of certification, training and data documentation as well as the time spent performing these tasks.
- Face-to-face contacts with individuals, caregivers, and relevant family and kinship network members and collateral contacts.

The following activities **may not be billed**:

- Mobile crisis intervention services are subject to the coverage limitations that exist for the other HCA/MAD covered behavioral health services. See Subsection G of 8.321.2.9 NMAC for general HCA/MAD behavioral health non-covered services or activities. HCA/MAD does not cover the following services billed in conjunction with mobile crisis intervention services to an eligible recipient:
    - Services past the initial crisis response for individuals receiving ACT, DBT, MST, High Fidelity Wraparound and FFT.
    - Inpatient services (can be billed on the same day if the recipient requires transfer, however the same provider may not bill for both MCT/MRSS and inpatient services on the same day).
    - Residential services.
- Services that are primarily recreational or diversional in nature.
- Services provided to teach academic subjects or as a substitute for educational personnel such as, but not limited to, a teacher, teacher's aide, or an academic tutor.
- Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.

- Respite care.
- Client Transportation: Rates include staff travel to and from the site of the crisis. If the staff is traveling back to the office, the individual may ride with the staff member. However, there is no adaptive or secure transportation costs included in the mobile crisis rate. If adaptive or secure transportation for the individual or family is needed, then those additional medical transportation costs for service needs are not considered part of the response. Crisis Services may be covered by the transportation service through the State Plan. Services provided in the car are considered Transportation and time may not be billed for Crisis.
- Covered services that have not been rendered.
- Services not in compliance with the crisis service definition within the Behavioral Health Policy and Billing Manual or licensure standards.
- Services provided to children, spouse, parents, or siblings of the eligible beneficiary under treatment or others in the eligible beneficiary's life to address problems not directly related to the eligible beneficiary's issues and not listed on the eligible beneficiary's Crisis participant-directed care coordination plan.
- Services provided that are not within the provider's scope of practice.
- Any art, movement, dance, or drama therapies.
- Anything not included in the approved Crisis service description.
- Any intervention or contact not documented or consistent with the goals, objectives, and approved services of the provider contract, service manual, or licensure standards will not be reimbursed.

Implementation

MCOs are directed to implement changes associated with these instructions, including system changes and provider contract negotiations as needed no later than 90 days from the date of issuance of this directive. For any claims submitted after July 1, 2024, but not paid based on these parameters, the MCOs are directed to adjust payments retroactive to July 1, 2024. The deadline to reprocess claims is December 2, 2024. HCA directs the MCOs to provide biweekly updates to HCA on the status of implementation every other Friday beginning October 11, 2024, until otherwise directed by HCA.

This LOD will sunset upon incorporation into 8.321.2 NMAC and the Behavioral Health Policy and Billing Manual.