Effective October 1, 2015 in New York City and July 1, 2016 in the rest of New York State, Medicaid Managed Care Organizations (MMCOs), which include Mainstream Medicaid Managed Care Plans, Health and Recovery Plans and HIV Special Needs Plans, must cover a new Crisis Intervention benefit. The services available in this new benefit are being offered as a demonstration under New York State’s 1115 Waiver, which also provides for the transition of Medicaid-funded behavioral health services into Medicaid Managed Care.

Reimbursement for this benefit is only available through MMCOs. It is not available in other managed care plans or products (e.g. MAP, MLTC, FIDA) or as a service reimbursed by Medicaid fee-for-service. MMCOs must reimburse for Crisis Intervention services as outlined in this guidance and include sufficient crisis intervention providers in their networks to meet the needs of their enrollees.

The State will use its demonstration authority to permit reimbursement for a range of Behavioral Health (BH) crisis services that serve children and adults, including mobile and telephonic crisis response, as well as follow up to crisis services.

This document outlines guidance for the mobile crisis component of the Crisis Intervention Benefit. NYS will release guidance on additional crisis services reimbursable under this benefit as it is developed.

Mobile Crisis Component of the Crisis Intervention Benefit:

The mobile crisis component of the Crisis Intervention Benefit includes the following services and corresponding activities. Each service is eligible for reimbursement separately when delivered in accordance with this guidance.

- Telephonic triage and crisis response
- Mobile crisis response
- Telephonic crisis follow up
- Mobile crisis follow up

The goals of these services are engagement, symptom reduction, and stabilization. These services are provided to an adult or child, who is experiencing or is at imminent risk of experiencing a psychiatric or substance use (BH) crisis. These services are designed to interrupt and/or ameliorate crisis by:

- Providing crisis services in the community where the individual is experiencing a crisis;
• Assisting the individual to utilize community and family/support systems with the intent of preventing the reoccurrence of similar events in the future;
• Assessing the immediate crisis and facilitating resolution and de-escalation;
• Engaging the individual to identify follow up services and assist the individual to access these services that are necessary to manage and/or prevent further BH crisis experiences;
• Engaging with the individuals’ caretaker and/or family members when appropriate.

**Behavioral Health Crisis Definitions**

**Behavioral Health Crisis**

A Behavioral Health crisis is an unplanned event that requires a rapid response. A BH crisis includes instances in which a person cannot manage his/her primarily psychiatric and/or substance use related symptoms without de-escalation or intervention. A BH crisis may also be defined as a situation in which the experience of challenges in daily life have resulted in, or are at risk of an escalation in psychiatric and/or substance use symptoms.

**Behavioral Health Crisis Intervention**

Behavioral Health Crisis intervention is defined as an activity which utilizes therapeutic communication, interactions and supporting resources to interrupt and/or ameliorate acute BH distress and associated behaviors.

**Behavioral Health Crisis Intervention Service Episode**

A qualifying episode of crisis intervention begins with the provider’s initial contact with the individual. The end of the crisis episode will be defined by the resolution of the individual’s presenting symptoms or if clinically indicated when the person is transferred to the recommended level of care.

Follow up crisis services may be provided within 14 days of a qualifying crisis episode.

**Mobile and Telephonic BH Crisis Service Component Definitions**

The Crisis Intervention benefit includes the following mobile and telephonic response service components:

**Telephonic Crisis Triage and Response**

Upon contact by the individual or referent, a provider will answer the call to determine the appropriate service response to the crisis. Referents may include families, providers, crisis hotlines, 911 operators, law enforcement or other sources, depending on what resources are available in the locality. Telephonic crisis triage and response coverage must be available 24 hours a day, 7 days a week and 365 days a year.

Telephonic crisis triage includes a preliminary assessment to determine the need for further evaluation, and to make treatment recommendations and/or referral to other health and/or behavioral
health services as clinically indicated. The expectation is that the assessment includes, but may not be limited to:

- Risk of harm to self or others, current mental status, current and recent history of substance use, assessment of intoxication and potential for serious withdrawal;
- History of psychiatric treatment and medical stability;
- Prescribed medications, including medical, psychiatric and medication assisted treatments for substance use;
- Presenting problem and review of immediate needs; and
- Identification of supports.

If crisis triage indicates the need for further evaluation and/or crisis response, then telephonic crisis response may include:

- Therapeutic communication and interaction to alleviate psychiatric or substance use symptoms;
- Development of a safety plan or crisis prevention plan;
- Referral and linkage to appropriate behavioral health community services as an alternative to more restrictive levels of care;
- Facilitating timely access to services required to address the crisis related needs of the individual, including mobile crisis response, stabilization, withdrawal and stabilization service, respite, or psychiatric or Substance Use Disorder (SUD) inpatient hospitalization.

**Mobile Crisis Response**

Mobile crisis teams are dispatched to an individual’s home or any community setting where a crisis may be occurring to provide brief intervention and facilitate access to other crisis/behavioral health services. They provide appropriate care/support while avoiding unnecessary law enforcement involvement, emergency department use and hospitalization. However, mobile crisis response may include co-response with local law-enforcement, if possible given local arrangements.

Mobile crisis response *may* include:

- Initial assessment and ongoing assessment of behavioral health symptoms and crisis related needs;
- Involvement of identified family and friends to resolve the individual’s crisis;
- Therapeutic communication and interaction to alleviate psychiatric or substance use symptoms;
- Development of a safety plan or crisis prevention plan;
- Psychiatric consultation and urgent psychopharmacology intervention;
- Referral and linkage to appropriate behavioral health community services as an alternative to more restrictive levels of care, including crisis respite;
- Linkage to stabilization and/or SUD 24/7 access centers;
- Secure access to higher levels of care if required; and
- Certified Peer services, including:
  - Engagement;
  - Assistance with developing crisis diversion plans or relapse prevention plans;
• Assistance with the identification of natural supports and access to community services during and after a crisis.

Mobile and Telephonic Follow Up Services

Crisis intervention service providers may bill MMCOs for mobile and telephonic follow up services provided to a recipient of a qualifying crisis service. Follow up services are eligible for reimbursement if provided within 14 days of the qualifying crisis episode¹. Follow up services may be delivered face to face or through telephonic contact and may include but are not limited to the following types of activities:

• Therapeutic communication and interactions to maintain stabilization following a crisis episode and prevent escalation of BH symptoms.
• Facilitation of engagement in outpatient BH services, care coordination, medical health or basic needs related to the original crisis service.
• Confirmation with service providers of connections to care and support to the recipient in the community while he or she is awaiting initiation or resumption of services;
• Contacts with the individual’s existing primary care and BH treatment providers, adult or children’s SPOA where applicable, and and/or care coordinator of the developed crisis plan. Contact with the individual’s natural support network with consent.
• Referral and engagement/re-engagement with health homes and appropriate BH community and certified peer services to avoid more restrictive levels of treatment, including crisis respite.
• Follow-up with the individual and the individual’s family/support network to confirm that enrollment in care coordination, outpatient treatment or other community services has occurred or is scheduled.

Standards

• Deliver person-centered, trauma informed, culturally and linguistically competent services.
• Mobile and Telephonic Crisis Response Services will be available 24 hours per day, seven days per week, and 365 days per year.
• Mobile Crisis Response will provide an in-person intervention within 3 hours of determination of need.
• Services will be provided upon the recipient’s presentation for the service, face to face or telephonically.
• Depending on local conditions, Mobile and Telephonic Crisis Response Services should be integrated with local emergency systems (e.g., 911, local crisis hotlines) and law enforcement, up to and including co-response, to be able to provide the safest and best-coordinated crisis response.
• With the recipient’s permission and whenever possible, contact should be made with family members, adult and children’s SPOA, where applicable and or other collaterals with pertinent information to inform the assessment. Follow-up activities and efforts to enroll the recipient and/or family/caregiver to supports and/or services will be documented.

¹ See definition section for definition of qualifying crisis episode.
• Crisis service providers approved by the State will be eligible to bill using this benefit. These providers must be enrolled in the Medicaid program and under contract with MMCOs. See Approval of Mobile and Telephonic Crisis Response Providers section below for details.

**Staffing**

Mobile and Telephonic Crisis Response Services must be provided by one of the following individuals licensed in New York State as follows:

- Physician (MD), including Psychiatrist and Addictionologist/Addiction Specialist
- Nurse Practitioner in Psychiatry (NPP),
- Licensed Psychologist,
- Unlicensed Psychologist employed by State or County Government
- Licensed Psychoanalyst,
- Licensed Social worker (LMSW, LCSW),
- Licensed Marriage & Family Therapist,
- Licensed Mental Health Counselor.
- Licensed Creative Arts Therapists
- Physician Assistant- physical health procedures only or mental health if OMH approved training
- Registered Nurse /Licensed Practical Nurse
- Clinical Nurse Specialist

Non-licensed staff and qualified peers are eligible to provide crisis intervention services within their scope of practice and the under supervision of an LMSW, LCSW, licensed Psy.D, Ph.D, and MDs. Unlicensed and qualified/certified providers include:

- Limited Permit staff
- Students within approved SED programs
- Qualified non-licensed staff
- CASAC, CRPA
- Qualified peer advocates, family peer advisors and certified peer specialist may assist with developing crisis diversion plans or relapse prevention plans, provide support during and after a crisis and assist with connecting an individual with natural supports and linkages to community services and may accompany a licensed practitioner providing mobile crisis response.
NYS Crisis Provider Standards

- All staff providing crisis services at a provider agency must undergo and clear a Staff Exclusion List, NYS criminal background check and State Central Register.
- Must adhere to all Medicaid enrollee exclusion requirements
- Provider agencies and staff must be enrolled in NYS Medicaid program as directed by NYS DOH.
- All staff working on Mobile Crisis Teams must obtain training on the administration of Naloxone (Narcan).

Approval of Mobile and Telephonic Crisis Response Providers

Counties and the City of New York will submit plans that identify existing and developing crisis services systems, including implementation of the Crisis Intervention Benefit. County Plans will specifically identify providers eligible to contract for services. NYS OMH in consultation with OASAS, counties and the City of New York will approve the plan and Crisis Intervention providers. The State will inform MMCOs of providers approved by the State for each county. These providers will be offered contracts for the appropriate crisis intervention service(s), by the MMCOs.

Documentation of Mobile and Telephonic Crisis Response services

Mobile and Telephonic Crisis Response services must meet medical necessity criteria established by the State.

Crisis intervention services must be documented in the individual's chart in accordance with Medicaid regulations. This is necessary to identify discrete billable crisis response services delivered in a qualifying episode and/or 14 day follow up.

Oversight

OMH and OASAS will have shared oversight of the Crisis Intervention benefit and will coordinate with other NYS agencies as applicable. Counties and the City of New York will provide oversight of those agencies/providers consistent with current operations (e.g. could include site visits or outcome reports). Counties and the City of New York will ensure coordination of crisis services.

Network Access

MMCOs must ensure accessibility to crisis intervention services for enrolled children and adults as outlined in this guidance, and must ensure appropriate reimbursement is made for claims submitted by any providers of Crisis Intervention services in accordance with billing guidelines.

Utilization Management
Prior Authorization for Mobile or Telephonic Crisis Response Services is not required and coverage may not be denied. Retrospective reviews may be completed by MMCOs using state-approved medical necessity criteria.

**Rates**

Reimbursement for this service will be based on negotiated rates between MMCOs and providers. NYS calculated rates have been provided in order to guide these negotiations. OMH will conduct ongoing reviews for network adequacy for these services. In the event there is not adequate access, NYS would exercise authority to establish government rates.

**Billing**

Crisis intervention service providers may bill for mobile and telephonic follow up services provided to a recipient of a qualifying crisis service. Follow-up services are eligible for reimbursement if provided within 14 days of the qualifying crisis episode\(^2\).

\(^2\) See definition section for definition of qualifying crisis episode.