PROVIDER MANUAL: Community-Based Mobile Crisis Services

COMMUNITY-BASED MOBILE CRISIS SERVICES

Target Group: All Global Commitment to Health Enrollees

DEFINITION

Community-Based Mobile Crisis Services are provided 24 hours per day, seven days per week, and 365 days per year (24/7/365) to individuals experiencing a mental health, substance use or co-occurring mental health and/or substance use crisis. Services are delivered by a multidisciplinary two-person team in the community where the individual is experiencing a crisis (home, school, and other community settings) to individuals of all ages. Adults are defined as age 22+ and youth are defined as under age 22. These services are not delivered in a facility setting such as hospital emergency department, inpatient treatment facility, or nursing home. Services are delivered in the community whenever possible but may be delivered at the Mobile Crisis Team (MCT) office if clinically indicated and/or if requested by the individual seeking services. National Guidelines for Behavioral Health Crisis Care note that a key tenet of crisis services is they are for **anyone, anywhere, and anytime**. [1] "Crisis" means different things to different individuals and families; it is important to use the individual's/family's own definition, based on their own needs and strengths.[2]

MCTs must connect individuals to facility-based care as needed such as urgent care centers, crisis stabilization and hospital diversion programs, emergency department, and inpatient, through warm hand-offs and coordination of transportation to the appropriate levels of care determined for disposition. MCTs must refer to a Designated Agency for Inpatient Screenings for involuntary inpatient care. Screening for involuntary admissions shall be performed in accordance with the Qualified Mental Health Professional (QMHP) Manual.

MCTs must have the capability to facilitate access to mental health and/or substance use outpatient care. They must follow up to ensure that individuals' crises are resolved, or they have successfully been connected to ongoing services. For individuals who do not require inpatient mental health services or another 24-hour level of care, the MCT will provide post-stabilization follow-up (up to 3 days for adults and up to 7 days for youth) to connect the individual with needed supports and confirm transition to and engagement with aftercare.

MCTs must incorporate trauma-responsive, resilience-based programming that employs trauma-

[1] Substance Abuse and Mental Health Services Administration (SAMHSA), "National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation," SAMHSA.gov, 2020.
[2] Elizabeth Manley et al., "Making the Case for a Comprehensive Children's Crisis Continuum of Care," National Association of State Mental Health Program Directors (NASMHPD), August 2018. Available at: https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf

informed care principles in the design and delivery of services.[3] The MCT must meet the Health & Human Services (HHS) National Culturally and Linguistically Appropriate Services (CLAS) standards with appropriate access to interpreters. For more information visit: https://thinkculturalhealth.hhs.gov/CLAS/ The MCT must include a plan on how the agency will address Inclusion, Diversity, Equity, and Accessibility for staff and client.

Mobile Crisis Services are distinct from Designated Agency Emergency Services. Emergency services will continue to provide time-limited, intensive supports intended to resolve or stabilize the immediate crisis. Services will continue for crisis response (all locations including Emergency Departments), Inpatient screenings, Emergency Exam (EE) reassessments, court screenings, community disaster response, and mobile outreach, as appropriate.

MOBILE RESPONSE

The Mobile Crisis Team (MCT) is deployed in real time. The MC provider must have the ability to field referrals (via telephone), deploy and track community mobile teams 24/7/365 with the ability to respond in the community within sixty (60) minutes average response time per service area, with exceptions for rural locations that include travel time more than 45 minutes, from the time of the call. One of the two-person team members may be available via telehealth as clinically indicated; however, it is expected that the core model include an in-person response by the two-person team. One team member must be on site with the individual during the crisis screening and assessment. All mobile crisis services in the service area are accessed by phone through a toll-free number operated by the mobile crisis provider 24/7/365. Mobile Crisis providers must collaborate with 911 and 988 to accept direct telephone transfers.

FOLLOW-UP SERVICES

The MC service may be provided by mobile crisis teams, as clinically indicated, to individuals who are not admitted to a 24-hour treatment setting. Follow-up services link individuals to needed supports and confirm transition to and engagement with aftercare services. Follow-up services may be provided either in-person (in the community, office, other), via telehealth, or telephonically by appropriate staff.

Follow-up services may be provided up to three (3) days post-assessment for adults (age 22+) and up to seven (7) days post-assessment for youth (under age 22).

There is no requirement that follow-up encounters include more than one staff member. Staff providing follow-up services is determined by clinical necessity and may be a paraprofessional or a clinician.

[3] SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884

CONDITIONS OF COVERAGE

The established valuation for the cost to deliver community-based mobile crisis services includes costs for delivering the services on overnight and weekend shifts. An overnight shift is defined as hours between 11:00 PM – 7:00 AM and a weekend shift is defined as hours between Friday 11:00 PM and Sunday 11:00 PM. Community-Based Mobile Crisis Services may be provided face-to-face or through Telehealth[4]. Community-Based Mobile Crisis Services must be provided under the supervision of licensed staff. When not on the scene, licensed staff must be available "on call" 24/7/365 to provide consultation and higher-level interventions.

The Medicaid rate structure applies to all individuals enrolled in Vermont Medicaid. The rate structure does not apply to individuals with Commercial coverage only. Medicaid is a payer of last resort[5]. It is expected that mobile crisis providers pursue contracts with Commercial Health Plans for the provision of Community-Based Mobile Crisis Services.

DOCUMENTATION AND REPORTING REQUIREMENTS

Community-Based Mobile Crisis Services must be documented by the clinician and the paraprofessional. The clinician must use the crisis assessment form which will include the elements listed below.

Clinician documentation requirements:

- Identified issue or precipitant to crisis contact.
- Issues addressed or discussed.
- Collateral contact information as solicited or available
- Observations made by the clinician.
- The clinician's assessment of the issues/situation including mental status and lethality/risk potential.
- Disposition or plan resulting from the crisis intervention.
- Psychiatric consultation, as clinically indicated.

Paraprofessional documentation requirements:

- Services provided.

[4] See *Telemedicine*, *Section 5.3.53*, of the Vermont Medicaid General Billing and Forms Manual for specific requirements related to the provision of telemedicine services: http://www.vtmedicaid.com/assets/manuals/GeneralBillingFormsManual.pdf

[5] Vermont Medicaid Provider Manual (vtmedicaid.com), section 1.1.

- Guidance for follow-up services.

The MCT is responsible for the completion of an electronic encounter form for every crisis intervention provided. For each subsequent day in an intervention, the MCT is responsible for the completion and electronic submission of an abbreviated subsequent MCT follow-up encounter form. These subsequent encounters are connected to the full encounter by a unique encounter ID. The MCT ensures that encounter forms are electronically submitted to DMH within the timeframe established by DMH.

Billing Criteria	Minimum Clinical Documentation Required	Encounter Data to Support Clinical Documentation	Provider Qualifications
Community-Based Mobile Crisis Services - Community			
Target Population: All Medicaid Members and Global Commitment to Health Enrollees **Minimum Duration for Payment:** **1 unit (*15 min)** accumulated in one day	**Per Episode Documentation** - Identified issue or precipitant to crisis contact; - Issues addressed or discussed; - Collateral contact information as solicited or available; - Observations made by the clinician; - The clinician's assessment of the issues/situation including mental status and lethality/risk potential; - Disposition or plan resulting from the crisis intervention; - Psychiatric consultation, as clinically indicated - Paraprofessional's documentation will include services provided and guidance for follow-up services.	**Chronological Log of all Community-based Mobile Crisis Services Provided** All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service -Location of Service	Vermont Medicaid-enrolled provider consistent with their scope of practice; and is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a licensed qualified provider.
Community-Based Mobile Crisis Services – Office Setting			
Target Population: All Medicaid Members and Global Commitment to Health Enrollees **Minimum Duration for Payment:** **1 unit (*15 min)** accumulated in one day	**Per Episode Documentation** - Identified issue or precipitant to crisis contact; - Issues addressed or discussed; - Collateral contact information as solicited or available; - Observations made by the clinician; - The clinician's assessment of the issues/situation including mental status and lethality/risk potential; - Disposition or plan resulting from the crisis intervention; - Psychiatric consultation, as clinically indicated - Paraprofessional's documentation will include services provided and guidance for follow-up services.	**Chronological Log of all Community-based Mobile Crisis Services Provided** All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service - Location of Service	Vermont Medicaid-enrolled provider consistent with their scope of practice; and is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a licensed qualified provider.

Community-Based Mobile Crisis Follow Up Services			
Target Population: All Medicaid Members and Global Commitment to Health Enrollees **Minimum Duration for Payment:** **1 unit (*15 min)** accumulated in one day -	**Per Episode Hit Note** - Reason for follow-up support - Collateral contacts - Summary of major content or intervention - Individual's responses to interventions - Ongoing needs for continued intervention and plan	**Chronological Log of all Follow Up Community Support Services Provided** All encounter data must include: -Client Identification -Name of Service -Staff Providing Service -Date of Service -Duration of Service - Location of Service	Vermont Medicaid-enrolled provider consistent with their scope of practice; and is determined competent to provide the covered service by the Medical Director of the DA/SSA and whose work is directly supervised by a licensed qualified provider.

MEDICAID CLAIMS INFORMATION

Requirements for Participation

Community-Based Mobile Crisis services must be provided by providers directly enrolled in Vermont Medicaid. It is the responsibility of the MC providers to complete the Medicaid enrollment process which is available here: http://vtmedicaid.com/#/provEnrollDataMaint

MC providers who are not enrolled with Vermont Medicaid cannot submit claims for reimbursement.

Roles and Responsibilities

The following are approved Vermont Medicaid Provider Types and Provider Specialties for this program:

MCT Mental Health and Substance Use Care Professionals

Licensed Professionals

Provider Type:

019 - Masters Level Psychologist

Provider Specialties:

062 – Independently Billing Psychologist

079 – Addiction Medicine

080 – Licensed Psychologist / Social Worker

S70 – Licensed Clinical Mental Health Counselor

S71 – Marriage and Family Therapist

Bachelor's Level Mental Health Professionals

Provider Type:

T48 – Community Health Worker

Provider Specialties:

S95 – Mobile Crisis Mental Health Professional

MCT Mental Health and Substance Use Care Paraprofessionals

Credentialed Peer Support Providers

Provider Type:

T48 – Community Health Worker

Provider Specialties:

S92 – Adult Peer Support Worker

S93 – Family Peer Support Worker

S94 – Peer Recovery Coach

Community Support Workers / Case Managers

Provider Type:

T48 – Community Health Worker

Provider Specialty:

S26 - Case Management

Procedure Codes for Community-Based Mobile Crisis

Providers are responsible for correct coding practices, as required in the Vermont Medicaid Provider Manual.

Mobile Response Codes:

- H2011
- S9484

Follow Up Service Code:

- H2015

Allowable Modifiers

V2 – Interprofessional Collaboration
(Team of two MCT Mental Health and Substance Use Care Professionals)

HT – Multi-Disciplinary Team
(Team of MCT Professional and a MCT Paraprofessional)

XE – Separate Encounter

XP – Separate Practitioner

UJ – Services Provided at Night

TV – Services Provided on a Weekend

QUALITY MEASURES

The MCT adheres to the following Quality Performance Measures

Quality Measure	Target
Average response time *From time of readiness	60 minutes
Response Time - percent within 60 Minutes	85% of all interventions achieve a response time within 60 minutes
Location of intervention	Adult: 80% community-based/20% MCT office based
	Youth: 85% community-based/15% MCT office based
Follow up Services by MCT - Percent of individuals that receive follow up services by MCT who are not admitted to 24-hour level of care	75%
Disposition	Adult: 70% Diversionary service/30% inpatient (or referred for IP screening by DA ES)
	Youth: 80% Diversionary service/20% inpatient screening (or referred for IP screening by DA ES)

*The MCT begins a crisis intervention within 60 minutes of *time of readiness*. Readiness assumes that the individual is medically stable, awake, and sufficiently cleared from the effects of substances so that they may participate in the evaluation.

The MCT utilizes monthly performance/quality data provided by DMH to develop MCT-specific goals including strategies to improve patient satisfaction. The MCT leadership participates in meetings with DMH to review performance.

STAFF QUALIFICATIONS

The MCT can incorporate a range of staffing models, including both professional and paraprofessional staff, crisis intervention specialists, therapists, case managers, and trained peer and family support workers.

At minimum, the initial Community Mobile Crisis Service teams dispatched in the community must be delivered by a multi-disciplinary team comprised of professionals and paraprofessionals (including trained peer support providers), who are trained in crisis intervention skills that can meet the needs of individuals across the lifespan. This includes:

- **at least one mental health and substance use care professional**[6] who is qualified to provide an assessment within their authorized scope of practice under state law, and
- **one paraprofessional** (including trained peer support providers), with expertise in substance use or mental health crisis intervention.[7]
    - While the above multi-disciplinary team is the minimum requirement, deploying two mental health and substance use care professionals is allowable.

Core required program staffing includes:

i. Medical Director – Board-certified or board-eligible psychiatrist shall be responsible for clinical and medical oversight and quality of care across all Mobile crisis service components. May also be the Medical Director in other program(s) within the organization. The percentage FTE should be commensurate with client volume.
ii. Program Director – The clinical program director shall be a full-time position. This independently licensed mental health clinician shall share responsibility with the medical director for the clinical and administrative oversight and quality of care. The Program Director can be the person who provides direct supervision to all direct service staff.
iii. Mental Health and Substance Use Professional – At minimum a bachelor's level mental health clinician with experience and/or training in mental health or substance use under the supervision of a licensed mental health professional.
iv. Independently licensed clinical supervisor(s) – Licensed staff available to provide consultation as clinically indicated. The Program Director may function as the clinical supervisor.
v. Trained Peers and or other paraprofessionals, including:
    a. Credentialed Peer Support Workers (i.e., Adult Peer Support Workers and Family Peer Support Workers)[8]
    b. Certified Peer Recovery Coaches
    c. Case Managers (aka Community Support Worker)

Exclusions: a member of the two-person team cannot be a law enforcement professional. This does not preclude law enforcement accompanying the MCT on the mobile crisis response.

The MCT must refer to a Designated Agency for Inpatient Screenings for involuntary inpatient care. Screening for involuntary admissions shall be performed in accordance with the Qualified Mental Health Professional (QMHP) Manual.

[6] CMS uses the term *behavioral health care professional*. Vermont does not use the term behavioral health, instead the phrase *mental health and substance use* is used.
[7] Mental Health Provider Manual (vermont.gov) (P.23-24)
[8] Until Vermont has a Peer Support Worker credential, the Department of Mental Health will establish an interim certification process.

PROVIDER RESOURCES

Contact your Gainwell Provider Representative:
https://vtmedicaid.com/assets/resources/ProviderRepMap.pdf

The Vermont General Provider Manual:
https://vtmedicaid.com/assets/manuals/GeneralProviderManual.pdf

The Vermont Medicaid portal that contains further resources, manuals, etc. can be found at:
https://vtmedicaid.com/#/home or https://vtmedicaid.com/#/resources

Revalidation of provider enrollment occurs every 5 years. You will receive notices 90 and 45 days prior to the expiration of your enrollment with all necessary information to revalidate. Once you have received this information, you may visit the Provider Management Module homepage. Click Menu on the top right-hand corner of the screen. Select Provider Enrollment and then Resume/Revalidate Enrollment. For more information and instructions on using the Provider Management Module, please visit https://vtmedicaid.com/#/provEnrollResources.

If you are unable to complete the online application, contact the Gainwell Enrollment Department at vtproviderenrollment@gainwelltechnologies.com for assistance.