REPORT FROM

OFFICE OF THE CITY ADMINISTRATIVE OFFICER

Date: June 5, 2024

CAO File No. 0220 - 06215 - 0000
Council File No. C.F. 22-0037
Council District: Citywide

To: Honorable Members of the City Council

From: Matthew W. Szabo, City Administrative Officer

Subject: **REPORT ON THE IDENTIFICATION OF COMMUNITY CRISIS RESOURCE CENTERS AND UNARMED CRISIS RESPONSE FUNDING SOURCES**

RECOMMENDATION

That the Public Safety Committee receive and file this report inasmuch as the report is informational in nature.

SUMMARY

This report provides information responsive to C.F. 22-0037.

BACKGROUND

On January 11, 2022, Motion (Blumenfield, Harris-Dawson – Rodriguez, CF 22-0037), instructed the CAO to work with various partners to:

- Identify potential community spaces that can be transformed into a community crisis resource center where mobile crisis response teams can be deployed and report back on the cost to operate these centers
- Report on funding sources potentially available to the City of Los Angeles to support the implementation of the 9-8-8 mental health crisis hotline system and implementation and/or expansion of mobile crisis response teams.
- Report on models of and services provided by mobile crisis response teams that can qualify for Medicaid reimbursements and how they are supported by a county and/or State health, mental health, and homeless service programs

FINDINGS

Community Spaces for Mobile Crisis Response Team

The Office of the CAO worked in collaboration with the Mayor's Office of Community Safety to develop criteria for mobile response team deployment sites, as well as preliminary cost estimates for the operation of such sites.

Identification of Potential Sites
This Office requested that the General Services Department's Integrated Asset Services Division conduct an analysis of the City's assets to determine whether any available City properties would be appropriate for use as community crisis centers/mobile response team deployment sites. The criteria for appropriate spaces are outlined in Attachment 1. The criteria for these spaces were developed based on the facilities used by the CIRCLE program for similar purposes.

GSD conducted an extensive search of the City's real estate assets and could not identify any suitable spaces that are currently available. All potentially suitable locations are under existing or pending agreements with other organizations. GSD also informed this Office that while the CIRCLE program does occupy three City facilities for their operations, the number of city facilities available was insufficient for the full needs of the CIRCLE program, causing the program to enter into rental agreements with non-City facilities to supplement what the City could provide.

This Office also requested that DOT conduct a review of available commercial space, and it was reported that there were no available facilities.

Cost to Operate

This Office is currently developing a Request for Qualifications (RFQ) for the potential future expansion of the City's Unarmed Model of Crisis Response pilot.

Recognizing the evolving needs and nature of unarmed response, and the ongoing information gathering/data collection in the pilot, the forthcoming RFQ is being specifically designed to obtain additional, more detailed, and forward-looking information on proposers' facility requirements and associated costs.

This Office conducted a preliminary analysis of the potential costs to operate mobile crisis response team facilities. It was found that the cost of operating such a facility can vary significantly depending on the use, purpose, and geographical location of such a space. Current city contractors use either their own facilities and associated costs are included in City contracts, or they lease City or private facilities.

Lease Costs
Based on existing privately-held leases for similarly-staffed and equipped programs, a preliminary analysis found that rental costs could reasonably be expected to range from $3,000-$6,000 per month per facility. The General Services Department (GSD) can lease City facilities to non-profits for costs that are significantly below market rate, however such an arrangement hinges on property availability.

Maintenance Costs
When leasing City facilities, the contracted provider takes on maintenance and repair costs of the facility, which can vary, as some facilities require significant repairs and maintenance. The provider typically invoices for such costs through the City's contract, with the City ultimately assuming the cost of the maintenance and repairs.

Miscellaneous Costs
Additionally, there are regular ongoing expenses for operating a facility, such as utilities, internet, sanitation, custodial services and staff and guest parking.

The ultimate cost for the above expenses depends on the facility, the needs of the provider and the details of the lease.

Funding Sources for Mobile Crisis Response Teams

This office researched funding sources available for the implementation of mobile crisis response teams. While a variety of such funding sources exist, none are specifically designed for cities — and as such, the City's ability to directly benefit from these funding sources is limited.

California Assembly Bill 988

Background
AB 988 established the state 9-8-8 surcharge. The surcharge rate for the 2023 calendar year is $0.08. AB 988 requires counties to provide telephonic and in-person crisis services available to those who need it. The revenue generated from the 9-8-8 surcharge will be deposited into a state special revenue fund called the "988 State Suicide and Behavioral Health Crisis Services Fund" and will be administered by the State of California's Office of Emergency Services.

Eligibility Requirements
This fund is used solely for the operations of the 9-8-8 center and mobile crisis teams, as defined in the American Rescue Plan Act of 2021. To qualify, mobile crisis teams, made up of two behavioral health practitioners, must be available to Medi-Cal beneficiaries experiencing a behavioral health crisis 24/7, 365 days a year. The City does not have access to these funds, as it does not administer the 9-8-8 program or employ the teams that respond to calls from 9-8-8.

Medicaid

Background
Medicaid reimbursement opportunities were made possible by the American Rescue Plan Act of 2021. Counties will receive an enhanced 85% federal medical assistance percentage for qualifying community-based mobile crisis services for the first 12 fiscal quarters.

Medi-Cal is California's version of the Federal Medicaid program. Medi-Cal offers no-cost and low-cost health coverage to eligible people who live in California. The California Department of Health Care Services (DHCS) oversees the Medi-Cal program. Local county offices (including Los Angeles County) manage most Medi-Cal cases for DHCS.

Eligibility Requirements

To qualify for Medi-Cal reimbursement under the Medi-Cal mobile crisis services benefit, mobile crisis teams must meet all requirements outlined in Behavioral Health Information Notice (BHIN) 23-025 (Attachment 2). This includes having at least two providers on a mobile crisis team which may consist of clinicians and/or paraprofessionals (such as peer support specialists). Mobile crisis teams must be available to Medi-Cal members experiencing a behavioral health crisis 24/7, 365 days a year.

All claims are reimbursed by “encounter,” which is inclusive of all mobile crisis service components delivered by a mobile crisis team during the mobile crisis response, with the exception of service components that receive an add-on reimbursement. Each mobile crisis encounter must include an initial face-to-face crisis assessment, mobile crisis response, crisis planning, referrals to ongoing services and facilitation of warm handoffs (if appropriate), and a follow-up check-in. Additional requirements and information about Medi-Cal claiming for Mobile Crisis Services are outlined in BHIN 23-025.

The program is designed such that funding is provided through managed care entities via prepaid inpatient health plans. The state has contracted with the Los Angeles County Department of Mental Health (LACDMH) to be the prepaid inpatient health plan for these services in the LA area. Therefore, the LACDMH is the only entity which may access these funds directly from the State. Any entity providing the mobile crisis benefit under Medi-Cal may only do so under contract with the LACDMH.

Care First and Community Investment (CFCI) Funding

Background
On November 3, 2020, Los Angeles County voters approved Measure J, which dedicated no less than ten percent of the County’s locally generated unrestricted funding to address the disproportionate impact of racial injustice through community investments such as youth development, job training, small business development, supportive housing services and alternatives to incarceration.

On June 17, 2021, the Superior Court ruled that Measure J is constitutionally invalid. The court determined that the Measure interferes with the Board of Supervisors' authority under State law to establish the County's budget. Although Measure J was ruled unconstitutional, the Board of Supervisors has reaffirmed its commitment to continuing to support Measure J’s letter and spirit as a budgeting principle.

The Board voted to transform the Measure J Re-imagine LA Advisory committee into the Care First and Community Investment Advisory Committee, and a board policy on CFCI investments was established to ensure that provisions of the CFCI Program for ongoing funding for alternatives to incarceration and direct community investments are implemented in accordance with the Board's intent.

CFCI funds are allocated annually, with funds set aside for programming in 45 areas, none of which are currently directly focused on mobile crisis response.

Eligibility Requirements
Applicants for CFCI funds are required to be community based organizations that provide direct services to underserved individuals and families and are led, at least in part, by Black, Brown, Indigenous, People of Color, Transition-Age Youth, Transgender, Gender Nonconforming, Intersex, LGBQA+, and People with Lived Experience (particularly reentry).

Direct Funding from Federal and State Governments

Background
Oakland and the San Gabriel Valley Council of Governments (SGVCOG) have each received direct funding from the California State Budget and/or the federal government to implement unarmed response programs.

SGV Care
SGV CARE was initially launched using Measure H funding, a sales tax for homelessness programs in Los Angeles County. Through government relations and lobbying efforts, the SGVCOG also received $850,000 in state funding and $1.5 million in federal funding. These financial resources will sustain the program through early 2025 and allow the SGVCOG to provide SGV CARE at no cost to participating jurisdictions.

Oakland MACRO
In 2021, Oakland's City Council launched Mobile Assistance Community Responders of Oakland (MACRO) as an alternative to policing, based on Eugene, OR's CAHOOTS program. The MACRO program was supported by a $10M State of California grant.

Eligibility Requirements
There are no specific requirements for requesting direct funding for unarmed crisis response programs.

FISCAL IMPACT STATEMENT

There is no fiscal impact to the General Fund associated with the information provided in this report.

MWS:MCB:AEH:HMR:17240011H

Attachments
1. Facility Specifications for Community Crisis Resource Centers
2. Behavioral Health Information Notice 23-025

Specifications for Community Crisis Resource Centers (e.g. decompression centers)

Scope of Work: Centers to be operated 24/7 (though likely achieved in a phased approach) and where services will be provided, including, but not limited to: allowing clients/ patients to rest away from their encampment or reprieve from extreme weather or environmental conditions, de-escalating or de-compressing, and providing snacks and water.

Building Specifications: An ideal space is about 800-1,000 square feet and includes:

- A street entrance (bottom floor)
- Bathroom(s)
- A kitchen or small kitchenette
- Space for a couple of desks/workstations for staff *On average - locations should be able to accommodate at least 3-4 workstations and accommodate 4-5 staff members at a time*
- At least one private room/space for a person to lie down on a bed or cot
- Room for up to 10-15 employees in the entire facility at a time

Not required but helpful:

- Space for washer/ dryer hookup

Specifications for Deployment Centers for Mobile Crisis Response Teams

Scope of Work: Centers to be operated 24/7 (though likely achieved in a phased approach) and to act as central deployment facilities from which mobile crisis response teams will be dispatched to other areas of the city.

Building Specifications:

- Internet capabilities
- Team meeting space / Break room - for 6-10 at one time
- Parking to accommodate fleet vehicles used by mobile teams as well as staff's personal vehicles
- Space for file cabinets – teams will use paper in the field sometimes to create service plans with clients
- Large closet/small room for storage of supplies– i.e., first aid, hygiene kits, water, donated clothing, etc.

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: June 19, 2023

Behavioral Health Information Notice No.: 23-025
Supersedes Behavioral Health Information Notice No.: 22-064

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of
California County Drug & Alcohol Administrators

SUBJECT: Medi-Cal Mobile Crisis Services Benefit Implementation

PURPOSE: To provide guidance regarding implementation of the Medi-Cal Community-Based Mobile Crisis Intervention Services benefit by county mental health plans (MHPs), Drug Medi-Cal (DMC) counties and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties

REFERENCES: American Rescue Plan Act of 2021 Section 9813 (42 U.S.C. section 1396w–6); California Code of Regulations (CCR), Title 9, Sections 1810.405 and 1810.410; Centers for Medicare and Medicaid Services State Health Official (SHO) #21-008; DHCS Behavioral Health Information Notice (BHIN) No. 20-070, 21-003, 21-013, 21-071, 21-073, 23-001, 22-011, 22-013 and 22-019; DMH Information Notice No. 10-02 and 10-17; Social Security Act Section 1905(r) (42 U.S.C. § 1396d) SPA 20-0006-A, 21-0051, 21-0058, 22-0001 and 22-0043

BACKGROUND:
The American Rescue Plan Act (ARPA) of 2021 section 9813 (42 U.S.C. section 1396w–6) allows states to add qualifying community-based mobile crisis intervention services as a covered Medicaid benefit for a five-year period, beginning April 1, 2022, and ending March 31, 2027. In addition, ARPA provides an opportunity to receive an enhanced 85

percent federal medical assistance percentage (FMAP) for expenditures on qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within the five-year period during which a state meets the conditions outlined in statute.[1]

Pursuant to Section 14132.57 of the Welfare and Institutions Code (W&I), DHCS intends to seek all necessary federal approvals to provide qualifying community-based mobile crisis intervention services ("mobile crisis services") to eligible Medi-Cal beneficiaries experiencing a mental health and/or substance use disorder (SUD) crisis ("behavioral health crisis"). Accordingly, DHCS submitted to the Centers for Medicare and Medicaid Services (CMS) State Plan Amendment (SPA) 22-0043 that establishes mobile crisis services as a new benefit in the Medi-Cal program. DHCS is not making any changes to the existing crisis intervention services and SUD crisis intervention services benefits covered under the Specialty Mental Health Services (SMHS), DMC and DMC-ODS delivery systems. Medi-Cal behavioral health delivery systems shall continue covering these services in accordance with existing federal and state, and contractual requirements.

No sooner than January 1, 2023, and upon receiving approval from DHCS, county MHPs, DMC counties, and DMC-ODS counties (collectively, "Medi-Cal behavioral health delivery systems") shall provide, or arrange for the provision of, qualifying mobile crisis services in accordance with the requirements set forth in this BHIN. Mobile crisis services are an integral part of California's efforts to strengthen the continuum of community-based care for individuals who experience behavioral health crises, including through implementation of the 988 Suicide and Crisis Lifeline and the Crisis Care Mobile Units Program Grant.

POLICY:
Medi-Cal behavioral health delivery systems shall establish, or contract with providers to establish, qualifying mobile crisis teams as defined in SPA 22-0043 that meet DHCS' training and implementation requirements set forth in this BHIN.

Nothing in this BHIN limits or modifies the scope of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) mandate or otherwise supersedes any DHCS guidance addressing EPSDT services. For beneficiaries under age 21, a service is considered "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medicaid-coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, whether or not

[1] 42 U.S.C. § 1396w–6, subd. (c). Qualifying community-based mobile crisis intervention services provided to eligibility groups with a higher matching rate will continue to be reimbursed by the federal government at the higher FMAP.

such services are covered under the State Plan. Furthermore, federal guidance from the Centers for Medicare & Medicaid Services makes it clear that services need not be curative or restorative to ameliorate a health condition. Services that sustain, support, improve, or make more tolerable a condition are considered to ameliorate the condition and are thus medically necessary and covered as EPSDT services.

Medi-Cal behavioral health delivery systems in each county shall collaborate with each other to implement the mobile crisis services benefit. All mobile crisis teams, regardless of delivery system, shall meet the same requirements. Counties may, and 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 beneficiaries regardless of whether they otherwise are served by the MHP or the county's SUD delivery system. If a county opts not to establish a single integrated system, it shall document as part of its mobile crisis implementation plan (described in section VIII(c) how it will ensure mobile crisis services are coordinated across the Medi-Cal behavioral health delivery systems in the county, including, but not limited to, what coordinated information will be provided to beneficiaries on how to access mobile crisis services, and billing and payment policies.

As described in the Substance Abuse and Mental Health Services Administration's (SAMHSA) Best Practice Toolkit, mobile crisis services are a critical component of an effective behavioral health crisis continuum of care. A "behavioral health crisis" refers to any event or situation associated with an actual or potential disruption of stability and safety as a result of behavioral health issues or conditions. A crisis may begin the moment things begin to fall apart (e.g., running out of psychotropic medications or being overwhelmed by the urge to use a substance they are trying to avoid) and may continue until the beneficiary is stabilized and connected or re-connected to ongoing services and supports.[2]

I. Mobile Crisis Services Benefit

Mobile crisis services provide rapid response, individual assessment and community-based stabilization to Medi-Cal beneficiaries who are experiencing a behavioral health crisis. Mobile crisis services are designed to provide relief to beneficiaries experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. While mobile crisis services are intended to support an integrated approach to responding to both

[2] National Council for Mental Wellbeing, "Roadmap to the Ideal Crisis System" (2021) p. 14.

mental health and substance use related crises, and mobile crisis teams will be carrying, trained, and able to administer naloxone, this benefit is not intended to replace emergency medical services for medical emergencies.

Mobile crisis services include warm handoffs to appropriate settings and providers when the beneficiary requires additional stabilization and/or treatment services; coordination with and referrals to appropriate health, social and other services and supports, as needed; and short-term follow-up support to help ensure the crisis is resolved and the beneficiary is connected to ongoing care. Mobile crisis services are directed toward the beneficiary in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the beneficiary in addressing their behavioral health crisis and restoring the beneficiary to the highest possible functional level. For children and youth, in particular, mobile crisis teams shall work extensively with parents, caretakers and guardians, as appropriate and in a manner that is consistent with all federal and state laws related to minor consent, privacy and confidentiality.[3]

Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the beneficiary is experiencing the behavioral health crisis. Locations may include, but are not limited to, the beneficiary's home, school, or workplace, on the street, or where a beneficiary socializes. Pursuant to federal law, mobile crisis services claimed under this option cannot be provided in hospitals or other facility settings (described in section IV(i)).[4] Mobile crisis services shall be available to beneficiaries experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year.

a. <u>Existing Crisis Intervention Services</u>

DHCS is not making any changes to the existing crisis intervention services and SUD crisis intervention services benefits covered under the SMHS, DMC and DMC-ODS delivery systems. Medi-Cal behavioral health delivery systems shall continue covering these services in accordance with existing federal and state, and contractual requirements. To the extent already allowed, Medi-Cal behavioral health delivery systems may provide crisis intervention services in settings or in a manner not allowed under the mobile crisis services benefit. For example, a Medi-Cal behavioral health delivery system may allow mobile crisis teams to provide qualifying crisis intervention services in a hospital emergency department. However, these services shall not qualify for the enhanced

[3] Mobile crisis teams shall abide by all State and federal laws on minor consent. (See Fam. Code, §§ 6924, 6929; Health & Saf. Code, § 124260; 42 C.F.R. §§ 2.11, 2.12, 2.14.)
[4] 42 U.S.C. § 1396w–6(b)(1)(A).

matching rate available for mobile crisis services, and, as applicable, the Medi-Cal behavioral health delivery system would remain responsible for the county share of the cost.

b. Access Criteria for Mobile Crisis Services

Consistent with policies outlined in BHIN 22-011 and BHIN 22-013, and given the unique nature of behavioral health crises, mobile crisis services are covered and reimbursable prior to determination of a mental health or SUD diagnosis, or a determination that the beneficiary meets access criteria for SMHS, DMC and/or DMC- ODS services.[5] Counties should refer to BHINs 21-071, 21-073 and 23-001 for criteria for beneficiary access to the SMHS, DMC and DMC-ODS delivery systems.

II. Dispatch of Mobile Crisis Teams

Medi-Cal behavioral health delivery systems shall establish a system for dispatching mobile crisis teams and develop policies and procedures that shall include, but are not limited to:

- Identification of a single telephone number to serve as a crisis services hotline connected to the dispatch of mobile crisis teams to receive and triage beneficiary calls;
- A standardized dispatch tool and procedures to determine when to dispatch a mobile crisis team; and
- Procedures identifying how mobile crisis teams will respond to dispatch requests.

a) **Crisis Services Hotline**

Medi-Cal behavioral health delivery systems shall identify and post a single telephone number that Medi-Cal beneficiaries who may require mobile crisis services can call. This number can be the same as the county's 24/7 access line, or an existing crisis line, if the Medi-Cal behavioral health delivery system ensures the line has the capacity to respond to beneficiaries in crisis and to dispatch mobile crisis teams when appropriate.

Medi-Cal behavioral health delivery systems shall coordinate with the 988 Suicide and Crisis Lifeline, local law enforcement and 911 systems, the Family Urgent Response System (FURS), and community partners to ensure beneficiaries have information about mobile crisis services. Medi-Cal behavioral health delivery systems shall document their strategies for

[5] See also W&I, § 14184.402, subd. (f).

establishing a crisis services hotline for use by beneficiaries in crisis and their outreach plans in their mobile crisis services implementation plans (described in section VIII(c)).

b. Standardized Dispatch Tool and Procedures

Medi-Cal behavioral health delivery systems shall require county-operated or contracted mobile crisis services hotline operators to use a standardized tool and set of procedures to determine when a mobile crisis team should be dispatched versus when a beneficiary's needs can be addressed via alternative means (e.g., de-escalation by hotline operator, connection to other services, etc.). As part of the training and technical assistance process, DHCS will develop a template that Medi-Cal behavioral health delivery systems may use as the standardized dispatch tool. Counties may also select or develop their own standardized dispatch tool, subject to DHCS approval during the implementation process, that is used to screen beneficiaries and dispatch mobile crisis teams as appropriate. Whether the Medi-Cal behavioral health delivery system uses DHCS' template or develops its own dispatch tool, the Medi-Cal behavioral health delivery system shall use the tool consistently to dispatch mobile crisis teams.

c. Mobile Crisis Services Providers' Response to Dispatch Requests

Medi-Cal behavioral health delivery systems shall ensure that mobile crisis services providers have live staff to receive and respond to all calls from the mobile crisis services hotline. Mobile crisis services providers shall not use an answering service. If a beneficiary has been screened either directly, or through an individual calling on their behalf to request assistance, and the standardized dispatch tool (described in section II(b)) has been used to determine that the beneficiary requires mobile crisis services, the mobile crisis services provider shall dispatch a team to respond to the beneficiary. When it is dispatched, the mobile crisis team shall meet the beneficiary who is experiencing the behavioral health crisis in the location where the crisis occurs, unless the beneficiary requests to be met in an alternate location in the community or cannot be located.

III. Mobile Crisis Team Requirements for Initial Crisis Response

The initial mobile crisis response shall be provided at the beneficiary's location or at an alternate location of the beneficiary's choice in the community ("onsite") by a multidisciplinary mobile crisis team.

Mobile crisis teams shall meet the following standards:

- At least two providers listed in Table 1 below shall be available for the duration of the initial mobile crisis response. It is a best practice for at least two providers to be physically present onsite, but Medi-Cal behavioral health delivery systems may allow one of the two required team members to participate via telehealth, which includes both synchronous audio-only (e.g., telephone) and video interactions.[6] Mobile crisis teams may provide services in this manner only if the Medi-Cal behavioral health system determines that such an arrangement:
  - Is necessary because it otherwise would result in a marked delay in a mobile crisis team's response time; and
  - The use of such an arrangement poses no safety concerns for the beneficiary or the single mobile crisis team member who is physically onsite during the initial mobile crisis response.
- At least one onsite mobile crisis team member shall be carrying, trained, and able to administer naloxone;
- At least one onsite mobile crisis team members shall be able to conduct a crisis assessment; [7]
- The mobile crisis team providing the initial mobile crisis response shall include or have access to a Licensed Practitioner of the Healing Arts (LPHA) as defined in the "SUD Treatment Services" or "Expanded SUD Treatment Services" section of Supplement 3 to Attachment 3.1-A of the State Plan, 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.[8] For example, 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, which includes both synchronous audio-only (e.g., telephone) and video interactions.[9]

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[6] Information regarding telehealth policy for Medi-Cal behavioral health delivery systems is described in BHIN 23-018.

[7] Any 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 (described in section IV(a)).

[8] Clinical support may include those individuals authorized to take a beneficiary into custody for a 72-hour involuntary hold ("5150 hold") under W&I section 5150 or have expertise to determine if a beneficiary requires further treatment in a higher level of care.

[9] As outlined in BHIN 23-018 and BHIN 21-003, assessments under W&I sections 5150 and 5151 may be completed face-to-face via a mode of telehealth that uses synchronous audio and visual components. (See also W&I, §§ 5150.5, 5151, subd. (b).) An examination or assessment pursuant to W&I section 5150 may be conducted via synchronous audio and visual components, but not via telephone (i.e., audio-only).

Table 1. Qualified Mobile Crisis Team Members by Delivery System

Rehabilitative Mental Health Treatment Providers	SUD Treatment Providers	Expanded SUD Treatment Providers	Other Provider Types
• Physician • Psychologist • Waivered Psychologist • Licensed Clinical Social Worker • Waivered/Registered Clinical Social Worker • Licensed Professional Clinical Counselor • Waivered/Registered Professional Clinical Counselor • Marriage and Family Therapist • Waivered/Registered Marriage and Family Therapist • Registered Nurse • Certified Nurse Specialist • Licensed Vocational Nurse • Psychiatric Technician • Mental Health Rehabilitation Specialist • Physician Assistant • Nurse Practitioner • Pharmacist • Occupational Therapist	• LPHA as defined in the "Provider Qualifications" subsection of the "SUD Treatment Services" section of Supplement 3 to Attachment 3.1-A of the California Medicaid State Plan. • Alcohol and Other Drug (AOD) Counselor • Peer Support Specialist	• LPHA as defined in the "Practitioner Qualifications" subsection of the "Expanded SUD Treatment Services" section of Supplement 3 to Attachment 3.1-A of the California Medicaid State Plan. • AOD Counselor • Peer Support Specialist	• Community Health Workers as defined in the Community Health Worker Services preventive services benefit. • Emergency Medical Technicians. Emergency Medical Technicians must be certified in accordance with applicable State of California certification requirements. • Advanced Emergency Medical Technicians. Advanced Emergency Medical Technicians must be certified in accordance with applicable State of California certification requirements. • Paramedics. Paramedics must be licensed in accordance with applicable State

Rehabilitative Mental Health Treatment Providers	SUD Treatment Providers	Expanded SUD Treatment Providers	Other Provider Types
• Other Qualified Provider • Peer Support Specialist			of California licensure requirements. • Community Paramedics. Community paramedics must be licensed, certified, and accredited in accordance with applicable State of California licensure requirements.

a. Use of Telehealth to Supplement Mobile Crisis Teams

The use of telehealth (which includes both synchronous audio-only (e.g., telephone) and video interactions) can offer an important avenue for expanding the expertise available to an onsite mobile crisis team. In addition to the staffing requirements listed above, mobile crisis teams may utilize telehealth to:

- Connect the beneficiary with highly trained and specialized practitioners, including psychiatrists and psychiatric nurse practitioners;
- Connect the beneficiary with a provider who can prescribe medications;
- Deliver follow-up services;
- Consult with appropriate specialists for beneficiaries who have intellectual and/or developmental disabilities (I/DD); and/or
- Engage translators or interpreters for beneficiaries who may need American Sign Language or other interpretation or translation services.

b. Role of Peer Support Specialists

It is considered a national best practice to include individuals with lived experience as members of mobile crisis teams. In December 2021, CMS approved SPA 20-0006-A, SPA 21-0058 and SPA 21-0051, which added Peer Support Services as a distinct service type and Peer Support Specialists as a Medi-Cal provider type in counties opting to implement these services. A Peer Support Specialist may participate as a mobile crisis team member if they have a current, State-approved Medi-Cal Peer Support Specialist certification, as

outlined in BHIN 21-041, provide services under the direction of a Behavioral Health Professional, and meet all other mobile crisis services requirements, including required mobile crisis services training.

Including Peer Support Specialists on mobile crisis teams may give beneficiaries experiencing behavioral health crises greater opportunity to see and interact with someone they can relate to while they are receiving services.[10] In many cases, Peer Support Specialists may be better equipped than other team members to lead client engagement, connect beneficiaries with ongoing supports, and follow-up.[11] Peer Support Specialists may establish a rapport, share experiences, and engage with family members or other significant support collaterals to educate them about self-care and ways to provide further support.

c. Role of Community Health Workers

In July 2022, CMS approved SPA 22-0001, which added Community Health Worker (CHW) services as a Medi-Cal benefit. CHWs may include individuals known by a variety of job titles, including promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals. A CHW that meets the minimum qualifications through the certificate pathway or the work experience pathway as set forth in the California State Medicaid Plan[12] and also completes required mobile crisis services training may provide mobile crisis services as part of a mobile crisis team contracted with a Medi-Cal behavioral health delivery system.[13]

Like Peer Support Specialists, CHWs are trusted members of their communities who may be best positioned to help serve as cultural liaisons or assist behavioral health professionals in developing a crisis plan or connecting a beneficiary to ongoing services and supports.[14]

d. Role of Emergency Medical Technicians, Paramedics, and Community Paramedics

Emergency Medical Technicians (EMTs), Advanced Emergency Medical Technicians (AEMTs), Paramedics, and Community Paramedics that are

[10] SAMHSA, National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (2020) p. 21.
[11] CMS, SHO #21-008 (Dec. 28, 2021).
[12] California Medicaid State Plan, sec. 3.1, Limitations on Attachment 3.1-A, pp. 18e-18g.
[13] DHCS, Community Health Worker (CHW) Preventive Services (July 2022).
[14] DHCS, Community Health Worker Medi-Cal Benefit (Feb. 4, 2022), slides 10-11.

licensed, certified, and/or accredited in accordance with applicable State of California requirements and who complete required mobile crisis services training may provide mobile crisis services as part of a mobile crisis team contracted with a Medi-Cal behavioral health delivery system. EMTs, AEMTs, Paramedics and Community Paramedics may be best positioned to support physical examinations, when needed, and provide individualized care to beneficiaries who are at risk of preventable hospital admission or re-admission due to chronic care or acute physical needs. These providers may also support a behavioral health professional's assessment to determine if a beneficiary requires emergency transport to an alternative setting for continued care.[15]

IV. Mobile Crisis Service Encounter

SPA 22-0043 covers the following mobile crisis service components:

- Initial face-to-face crisis assessment;
- Mobile crisis response;
- Crisis planning;
- Facilitation of a warm handoff, if needed;
- Referrals to ongoing services, if needed; and
- Follow-up check-ins.

Each mobile crisis services encounter shall include, at minimum:

- Initial face-to-face crisis assessment;
- Mobile crisis response;
- Crisis planning, as appropriate, or documentation in the beneficiary's progress note of the rationale for not engaging the beneficiary in crisis planning; and
- A follow-up check-in, or documentation in the beneficiary's progress note that the beneficiary could not be contacted for follow-up despite reasonably diligent efforts by the mobile crisis team.

When appropriate, each mobile crisis services encounter shall also include:

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

Mobile crisis teams shall be able to deliver all mobile crisis service components, even though there may be some circumstances in which it is not necessary or appropriate to provide all components (e.g., if the mobile crisis team can de-escalate a situation onsite, it may not be necessary to facilitate a warm handoff to a higher level of care).

[15] See A.B. 1544 (2019-2020 Reg. Sess.), as chaptered on September 25, 2020.

Medi-Cal behavioral health delivery systems shall not require prior authorization for the delivery of mobile crisis services. Consistent with the dispatch policies described in Section II, Medi-Cal behavioral health delivery systems may de-escalate and stabilize an individual via telephone and make a determination that mobile crisis services are not appropriate or necessary.

a. Initial Face-to-Face Crisis Assessment

The mobile crisis team shall provide a brief, face-to-face crisis assessment to evaluate the current status of the beneficiary experiencing the behavioral health crisis with the goal of mitigating any immediate risk of danger to self or others, determining a short-term strategy for restoring stability, and identifying follow-up care, as appropriate. The crisis assessment is distinct from a comprehensive SMHS or DMC/DMC-ODS assessment as described in BHIN 22-019 (or superseding guidance) or a non-specialty mental health assessment as described in APL 22-006. If a beneficiary is referred to SMHS and/or DMC/DMC-ODS services for further behavioral health treatment, the Medi-Cal behavioral health delivery system and its contracted providers, shall ensure the beneficiary receives a comprehensive SMHS or DMC/DMC-ODS assessment when required.

Any 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. When delivering a crisis assessment, mobile crisis teams shall use a standardized crisis assessment tool. As part of the training and technical assistance process, DHCS will develop a template that Medi-Cal behavioral health delivery systems may use as the standardized crisis assessment tool.

Medi-Cal behavioral health delivery systems may also select or develop their own standardized tool, subject to DHCS approval during the implementation process.

Medi-Cal behavioral health delivery systems shall ensure that the crisis assessment tool is responsive to youth and adult beneficiaries from culturally diverse backgrounds, including but not limited to tribal communities, LGBTQ+ youth and adults, beneficiaries with limited English proficiencies and beneficiaries with disabilities, including co-morbid disabilities, I/DD, serious mental illness, traumatic brain injury, and beneficiaries who are deaf or hard of hearing.

Consistent with the SAMHSA National Guidelines for Behavioral Health Crisis Care, the crisis assessment tool developed by DHCS and/or by Medi-Cal behavioral health delivery systems may include information available from the beneficiary or their significant support collateral(s) about:

- Causes leading to the crisis; including psychiatric, social, familial, legal factors and substance use;
- Safety and risk for the beneficiary and others involved, including an explicit assessment of suicide risk, and access to any weapons or firearms;
- Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports;
- Recent inpatient hospitalizations and/or any current relationship with a mental health provider;
- Medications prescribed as well as information on the beneficiary's use of prescribed medication;
- A rapid determination as to whether the crisis requires coordination with emergency medical services (EMS) or law enforcement; and
- Medical history as it may relate to the crisis.

b. Mobile Crisis Response

During the mobile crisis services encounter, the mobile crisis team shall intervene to de- escalate the behavioral health crisis and stabilize the beneficiary at the location where the crisis occurs, unless the beneficiary requests to be met in an alternate location in the community.

The mobile crisis response may include, but is not limited to:

- Trauma-informed on-site intervention for immediate de-escalation of behavioral health crises;
- Skill development, psychosocial education and initial identification of resources needed to stabilize the beneficiary;
- Immediate coordination with other providers involved in the beneficiary's care;
- Immediate coordination with other crisis receiving and stabilization facilities (e.g., sobering centers, crisis respite, crisis stabilization units, psychiatric health facilities, psychiatric inpatient hospitals, general acute care hospitals, crisis residential treatment programs, etc.); and
- Provision of harm reduction interventions, including the administration of naloxone to reverse an opioid overdose, as needed.

c. Crisis Planning

As appropriate during the mobile crisis services encounter, the mobile crisis team shall engage the beneficiary and their significant support collateral(s), if appropriate, in a crisis planning process to avert future crises. Crisis planning may include:

- Identifying conditions and factors that contribute to a crisis;
- Reviewing alternative ways of responding to such conditions and factors; and
- Identifying steps that the beneficiary and their significant support collateral(s) can take to avert or address a crisis.

When appropriate, crisis planning may include the development of a written crisis safety plan. As part of the training and technical assistance process, DHCS will develop a template that Medi-Cal behavioral health delivery systems may use as a standardized tool for writing a crisis safety plan. Medi-Cal behavioral health delivery systems may also select or develop their own standardized tool, subject to DHCS approval during the implementation process.

To the extent information is available and appropriate, the written crisis safety plan shall include, but is not limited to:

- A review of any immediate threats to the individual's or others' safety and well-being, such as accessible firearms or medications which could be used in a plan for self-harm or harm to others;
- Conditions and factors that contribute to a crisis;
- Alternative ways of responding to such conditions and factors;
- Additional skill development and psychosocial education;
- A psychiatric advanced directive;[16]
- Short and long-term prevention and strategies and resources the beneficiary can use to avert or address a future crisis, including harm reduction strategies.

A copy of the crisis safety plan, if one is developed, shall be documented in the beneficiary's clinical record, and provided to the beneficiary and to their

[16] A psychiatric advance directive is a legal document in which individuals living with mental illness may state their wishes for treatment or designate an individual who is empowered to make treatment decisions on their behalf if the individual is in crisis and unable to make decisions. A psychiatric advance directive may be appropriate as part of the crisis planning process in some circumstances, or as part of follow-up. See National Alliance on Mental Illness, Psychiatric Advance Directives, for additional information.

significant support collateral(s) if it is feasible and would benefit the beneficiary's treatment.

The mobile crisis team shall note in the beneficiary's progress notes if crisis planning was appropriate and if the beneficiary was or was not able to engage in crisis planning. The mobile crisis team may continue crisis planning and create or update a written crisis safety plan with the beneficiary as part of follow-up check-ins.

d. Facilitation of a Warm Handoff

In some cases, the beneficiary may need to be transported to a higher level of care, such as a sobering center, crisis respite, crisis stabilization unit, psychiatric health facility (PHF), psychiatric inpatient hospital, general acute care hospital, or crisis residential treatment program. If the beneficiary requires further treatment at a higher level of care, the mobile crisis team shall connect the beneficiary with the appropriate care option by facilitating a warm handoff.[17] The mobile crisis team shall also arrange for or provide transportation to effectuate the warm handoff, if needed. Additional guidance on transportation as part of the mobile crisis services encounter is described in section V(d).

e. Referrals to Ongoing Services

Medi-Cal behavioral health delivery systems shall ensure that mobile crisis teams refer beneficiaries, as appropriate, to available ongoing mental health and/or SUD treatment, community- based supports, social services, and/or other supports to help mitigate the risk of future crises. Mobile crisis teams shall identify appropriate services and make referrals or appointments during the initial mobile crisis response if appropriate, or as part of follow-up check-ins, as needed.

Referral sources may include, but are not limited to:

- Primary care providers;
- Outpatient behavioral health treatment providers, including providers that may offer further support with care coordination/case management;
- Prescribers for mental health or SUD medications;
- Indian Health Care Providers;

[17] A warm handoff includes coordination with other delivery systems to facilitate care transitions and guide referrals for beneficiaries, ensuring that the referral loop is closed, and the new provider accepts the care of the beneficiary. Such decisions should be made via a patient-centered shared decision-making process. See BHIN 22-011, p. 6.

- Providers serving individuals with disabilities, including individuals with I/DD, including but not limited to Regional Centers;
- Programs offering Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC) services;[18]
- Crisis receiving and stabilization facilities (e.g., sobering centers, crisis respite, crisis stabilization units, psychiatric health facilities, psychiatric inpatient hospitals, general acute care hospitals, crisis residential treatment programs, etc.);
- Community support and mutual aid groups (e.g., National Alliance on Mental Illness, Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery);
- Care coordination supports identified by the beneficiary's Managed Care Plan (MCP) or other sources (e.g., Enhanced Care Management (ECM) services); and
- Other housing and community supports for assistance with obtaining housing, utility, and rent (e.g., housing shelters and providers to facilitate coordinated entry, places of worship, food pantries, soup kitchens, recreation centers, community centers).

Mobile crisis teams shall document all referrals in the beneficiary's progress note. Mobile crisis teams shall coordinate with other providers serving the beneficiary in crisis when appropriate (described in section IV(h)).

f. <u>Follow-up Check-Ins</u>

Medi-Cal behavioral health delivery systems shall ensure that beneficiaries receive a follow-up check-in within 72 hours of the initial mobile crisis response. The purpose of the follow-up check-in is to support continued resolution of the crisis, as appropriate, and should include the creation of or updates to the beneficiary's crisis safety plan, or additional referrals to ongoing supports, as needed. If the beneficiary received a referral to ongoing supports during the initial mobile crisis response, as part of follow-up the mobile crisis team shall check on the status of appointments and continue to support scheduling, arrange for transportation, and provide reminders as needed.

Follow-up may be conducted by any mobile crisis team member who meets DHCS' core training requirements and may be conducted in-person or via telehealth, which includes both synchronous audio-only (e.g., telephone) and

[18] See DHCS and California Department of Social Services, Medi-Cal Manual for ICC, IHBS, and TFC Services for Medi-Cal Beneficiaries, (Jan. 2018).

video interactions. Follow-up may be conducted by a mobile crisis team member that did not participate in the initial mobile crisis response. If the mobile crisis team member conducting follow-up is not part of the mobile crisis team that provided the initial crisis response, the individual providing follow-up shall coordinate with the team members that participated in the initial mobile crisis response to gather information on the recent crisis and any other relevant information about the beneficiary. There may be times when the mobile crisis team is unable to engage the beneficiary in follow-up. Examples include but are not limited to the beneficiary is in inpatient treatment, otherwise incapacitated, unwilling to engage, or cannot be reached despite reasonably diligent efforts. The mobile crisis team shall document those instances where the beneficiary cannot be engaged for follow-up.

g. Documentation

Mobile crisis teams shall document problems identified during the mobile crisis services encounter on the beneficiary's problem list within the beneficiary's medical record, consistent with documentation requirements outlined in BHIN 22-019 (or superseding guidance). In addition, mobile crisis teams shall create a progress note that describes all service components delivered to the beneficiary, including any follow-up check-ins, referrals to ongoing supports, crisis planning, or facilitation of a warm handoff made as part of the mobile crisis services encounter.

h. Coordination with Other Delivery Systems

A mobile crisis response is a powerful indicator that a beneficiary needs additional services or that something is not working well with their current array of services; it warrants an alert to other providers who are involved in the beneficiary's care and coordinated follow-up.

During the implementation process, Medi-Cal behavioral health delivery systems shall establish policies and procedures to ensure mobile crisis services are integrated into a whole person approach to care. Policies and procedures may include, but are not limited to:

- Mobile crisis teams shall alert a beneficiary's Medi-Cal behavioral health delivery system within 48 hours of a mobile crisis response and provide basic information about the encounter (e.g., disposition of the mobile crisis call);
- The Medi-Cal behavioral health delivery system shall inform the mobile crisis team if they are aware if the beneficiary is receiving care

management through targeted case management, ICC, ECM, or any other benefit including non-Medi-Cal benefits such as Full-Service Partnership;
- The Medi-Cal behavioral health delivery system shall alert the beneficiary's MCP, if known, of the behavioral health crisis; and
- If a mobile crisis team receives information that a beneficiary is receiving services from a care manager, it shall alert the beneficiary's care manager(s) of the behavioral health crisis, as applicable, and coordinate referrals and follow-up consistent with privacy and confidentiality requirements.

Mobile crisis teams shall ensure that they have the beneficiary's consent for these disclosures in cases where consent is required by applicable law.[19]

i. <u>Service Setting Restrictions</u>

With the exception of the settings listed in the next paragraph, the initial mobile crisis response shall be provided where the beneficiary is in crisis, or at an alternate location of the beneficiary's choosing. Examples of settings include, but are not limited to:
- Houses and multi-unit housing;
- Workplaces;
- Public libraries;
- Parks;
- Schools;
- Homeless shelters;
- Outpatient clinics;
- Assisted living facilities; and
- Primary care provider settings.

Mobile crisis services shall not be provided in the following settings due to restrictions in federal law[20] and/or because these facilities and settings are already required to provide other crisis services:
- Inpatient Hospital;
- Inpatient Psychiatric Hospital;
- Emergency Department;
- Residential SUD treatment and withdrawal management facility;
- Mental Health Rehabilitation Center;

[19] For example, if 42 C.F.R. Part 2 applies, then consent may be necessary to alert the Medi-Cal behavioral health delivery system of the required response.
[20] 42 U.S.C. § 1396w-6(b)(1)(A).

- PHF;
- Special Treatment Program;
- Skilled Nursing Facility;
- Intermediate Care Facility;
- Settings subject to the inmate exclusion such as jails, prisons, and juvenile detention facilities;[21]
- 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.).

V. Standards

a. Response Times

Mobile crisis teams shall arrive at the community-based location where a crisis occurs in a timely manner.[22] Specifically, mobile crisis teams shall arrive:

- Within 60 minutes of the beneficiary being determined to require mobile crisis services in urban areas; and
- Within 120 minutes of the beneficiary being determined to require mobile crisis services in rural areas.[23]

Timeliness standards are not included in network adequacy requirements or certification. DHCS will provide ongoing technical assistance to Medi-Cal behavioral health delivery systems to review response times and adjust timeliness standards, as needed.

b. Community Partnerships

Medi-Cal behavioral health delivery systems shall maintain relationships with key community partners to support community engagement with mobile crisis services, coordination, and system navigation.[24] Medi-Cal behavioral health delivery systems shall ensure that:

- Community partners are aware of the availability of mobile crisis services as a community resource; and
- Community partners understand how to request mobile crisis services to assist beneficiaries experiencing behavioral health crises.

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[21] The Social Security Act (Sec. 1905(a)(A)) prohibits use of federal funds and services, including Medicaid, for medical care provided to "inmates of a public institution."
[22] 42 U.S.C. § 1396w–6(b)(2)(C); CMS, SHO #21-008, (Dec. 28, 2021) p. 7.
[23] Consistent with Alternative Access Standards for Medi-Cal Managed Care Health Plans, "rural" is defined to include areas with less than 50 people per square mile. (See p. 345.)
[24] 42 U.S.C. § 1396w–6(b)(2)(D); see CMS, SHO #21-008 (Dec. 28, 2021) p. 8.

Community partners may include, but are not limited to:

- Medical and behavioral health providers;
- Primary care providers (including pediatric providers for children);
- Social services providers;
- Community health centers;
- Federally qualified health centers;
- Indian health care providers;
- Crisis receiving and stabilization facilities (e.g., sobering centers, crisis respite, crisis stabilization units, psychiatric health facilities, psychiatric inpatient hospitals, crisis residential treatment programs, etc.);
- Hospitals;
- Schools;
- Regional Centers;
- MCPs;
- Local courts;
- Local departments of social services; and
- Law enforcement.

As part of their implementation plans, Medi-Cal behavioral health delivery systems shall describe how they will ensure mobile crisis teams establish community partnerships and engage community partners in sharing information and conducting outreach about the availability of mobile crisis services for Medi-Cal beneficiaries and how to request dispatch of a mobile crisis team for Medi-Cal beneficiaries.

c. Law Enforcement

When a mobile crisis team is dispatched, it is considered a national best practice for the team to respond without law enforcement accompaniment unless special safety concerns warrant inclusion.[25] When not required for safety reasons, law enforcement involvement in a behavioral health crisis can lead to an increase in unnecessary arrests and incarceration of beneficiaries living with acute behavioral health needs.[26]

Medi-Cal behavioral health delivery systems shall coordinate with law enforcement and share information with law enforcement officers about how to request or coordinate mobile crisis dispatch, when appropriate. Medi-Cal

[25] CMS, SHO #21-008 (Dec. 28, 2021) p. 2.
[26] DHCS, Assessing the Continuum of Care for Behavioral Health Services in California, (Jan. 10, 2022) p. 79.

behavioral health delivery systems shall also work with law enforcement to determine how mobile crisis teams and law enforcement can best work together to safely resolve and de-escalate behavioral health crises, minimizing the role of law enforcement except when necessary and appropriate for safety reasons. As part of their implementation plans, Medi-Cal behavioral health delivery systems shall describe strategies to avoid unnecessary law enforcement involvement in mobile crisis services and describe how they will ensure mobile crisis teams coordinate with law enforcement to safely resolve and de-escalate crises.

While law enforcement officers may accompany a mobile crisis team when necessary for safety reasons, they shall not qualify as a member of the mobile crisis team for purposes of meeting Mobile Crisis Team Requirements. Similarly, Crisis Intervention Teams (CIT), which include specially trained law enforcement officers who have undergone designated CIT training[27] may not provide or be reimbursed for mobile crisis services, unless they meet the mobile crisis team requirements described in section III.

d. Transportation

When needed, a mobile crisis team shall arrange for or provide transportation to an appropriate level of care or treatment setting. The mobile crisis team may transport the beneficiary directly as part of providing the mobile crisis service. If the mobile crisis team cannot provide transportation itself, or if there are outstanding medical or safety concerns, the mobile crisis team shall coordinate with non-medical transportation (NMT) providers, EMS, or law enforcement, if necessary, to arrange transportation and ensure the beneficiary is connected with appropriate care. If EMS, NMT, or law enforcement is utilized to transport the beneficiary directly to a higher level of care, the mobile crisis team shall remain onsite until the transportation provider arrives. At its discretion, the mobile crisis team may have one or more team members accompany the beneficiary inside the vehicle to the higher level of care.

If the mobile crisis team provides transportation or accompanies a beneficiary who is being transported by an NMT provider, EMS, or law enforcement, beginning July 1, 2023, it can receive an add-on reimbursement to reflect the expanded nature of its mobile crisis encounter in such circumstances.

[27] SAMHSA, Crisis Services: Meeting Needs, Saving Lives (Aug. 2020) p. 15.

e. Cultural Competency, Linguistic Appropriate Care and Accessibility

Medi-Cal behavioral health delivery systems shall comply with all applicable cultural competence and linguistic requirements in state and federal law, including those in W&I section 14684, subdivision (a)(9); CCR, Title 9, section 1810.410; the contract between the MHP and DHCS, contracts between DMC counties and DHCS, and contracts between DMC-ODS counties and DHCS;[28] BHIN 20-070 and 23-001; and DMH Information Notices 10-02 and 10-17. Medi-Cal behavioral health delivery systems shall explain how they will meet these requirements as part of their implementation plans.

f. Privacy and Confidentiality

Mobile crisis teams shall maintain the privacy and confidentiality of their patient's information in accordance with federal and state law.[29] Mobile crisis teams typically will be health care providers subject to the privacy and security rules under the Health Insurance Portability and Accountability Act (HIPAA). While mobile crisis teams and Medi-Cal behavioral health delivery systems will often be able to exchange protected health information in compliance with HIPAA, Medi-Cal behavioral health delivery systems shall be aware of HIPAA requirements that may limit mobile crisis teams' ability to share such information, such as HIPAA's minimum necessary requirement.

In addition, there may be circumstances where mobile crisis teams are subject to the federal substance use disorder confidentiality regulation, 42 C.F.R. Part 2. Medi-Cal behavioral health delivery systems shall inquire whether any of their mobile crisis teams are subject to 42 C.F.R. Part 2 and, if so, ensure that workflows are in place to ask beneficiaries for their consent when appropriate.[30]

If the beneficiary is being served through a CalAIM initiative, some additional data sharing is permissible that might otherwise have been restricted under California law.[31] For more information, Medi-Cal behavioral health delivery systems should consult the CalAIM Data Sharing Authorization Guidance.

[28] See DMC-ODS Contracts, the DMC Contract, and the 2022 – 2027 MHP Contract.
[29] 42 U.S.C. § 1396w-6(b)(2)(E).
[30] Mobile crisis teams should not attempt to obtain beneficiary consent while the beneficiary is in the midst of the crisis.
[31] W&I, § 14184.102(j).

VI. Other Considerations

a. Children and Youth

Mobile crisis teams shall respond to beneficiaries of all ages, including children and youth experiencing behavioral health crises. Through crisis de-escalation and resolution, mobile crisis teams may help children, youth and their families avoid hospitalization and emergency out-of-home placements in many circumstances. For some children and youth, accessing crisis services may be their first introduction to the state's behavioral health system, making it a critical moment for early identification of mental health conditions and engagement into treatment.

As part of required training for mobile crisis teams, mobile crisis teams shall participate in training on strategies to work effectively with children, youth and young adults experiencing behavioral health crises. Training may include, but is not limited to, delivering culturally responsive care, particularly when working with children, youth and young adults who are LGBTQ+, Black, Indigenous, and People of Color, involved in the child welfare system, or living with I/DD. In addition, mobile crisis teams shall abide by all state and federal minor consent laws.[32] Required training shall also include an overview of existing minor consent obligations and appropriate protocols for communicating with parents, guardians and other responsible adults who may or may not be present at the time of the crisis.

As part of their implementation plans, Medi-Cal behavioral health delivery systems shall describe how mobile crisis teams will coordinate with the FURS,[33] Regional Centers and other dispatch lines to ensure the most appropriate systems are responding to a crisis. Medi-Cal behavioral health delivery systems shall also describe how mobile crisis services providers will collaborate with and conduct outreach to schools (e.g., attending school health fairs to provide information on mobile crisis services, serving as a resource for school counselors and resource officers, etc.).

b. Tribal Communities

The mobile crisis team shall make a good faith effort to identify if the beneficiary is a Tribal member, has seen an Indian Health Care Provider (IHCP) in the previous 12 months, or has a preference to receive follow-up care from an IHCP. The mobile crisis team may check with the beneficiary or their significant support collateral(s), if appropriate; the beneficiary's MCP; or the

[32] See Fam. Code, §§ 6924, 6929; Health & Saf. Code, § 124260; 42 C.F.R. §§ 2.11, 2.12, 2.14.
[33] See BHIN 21-013.

local IHCP to determine if the beneficiary is a current IHCP patient or prefers to receive follow-up care from an IHCP. If the beneficiary is an IHCP patient or prefers to be seen by an IHCP for follow-up care, the mobile crisis team shall make a good faith effort to connect the beneficiary with the IHCP where they are a current patient or an IHCP that provides Medi-Cal-covered behavioral health services for follow-up care. If the beneficiary sees a non-IHCP for follow-up care, the mobile crisis team shall make a good faith effort to share follow-up care information with the beneficiary's IHCP, provided the mobile crisis team has the beneficiary's consent to make such disclosure when required by applicable law.[34]

c. <u>Individuals with Intellectual and/or Developmental Disabilities</u>

Beneficiaries experiencing behavioral health crises may have co-occurring needs which require additional considerations in the provision of mobile crisis services. People with I/DD and co-occurring mental health conditions may experience sensory or communication challenges that may complicate de-escalation of a behavioral health crisis. Mobile crisis teams responding to a beneficiary with I/DD shall ensure that natural supports (e.g., familial caregivers, personal attendants) are involved and consulted in the crisis response, if appropriate.[35] To the extent possible, mobile crisis teams are encouraged to include a team member with I/DD expertise or have access to an individual with I/DD expertise (e.g., a Board-Certified Behavioral Analyst) via telehealth, which includes both synchronous audio-only (e.g., telephone) and video interactions.

All members of mobile crisis teams shall participate in training on crisis response for beneficiaries with I/DD, which may include, but is not limited to general characteristics of people with intellectual disability and autism spectrum disorder, co-occurrence of I/DD and mental health conditions, and crisis intervention strategies for serving this population (e.g., communication tactics and techniques, strategies to involve caregivers, etc.).

Additionally, county mental health agencies are currently required to develop MOUs with Regional Centers to coordinate services, identify dually diagnosed beneficiaries, and develop procedures for Regional Center staff and county

[34] If the IHCP needs information on follow-up care for treatment purposes, then HIPAA would permit the disclosure without the beneficiary's consent. (See 45 C.F.R. § 164.506(c)(2).) However, if the mobile crisis team is subject to 42 C.F.R. Part 2, then consent likely would be required.
[35] See SAMHSA, National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (2020), p. 27.

mental health staff to collaborate in responding to beneficiaries with co-occurring I/DD and mental health conditions.[36]

As part of the implementation process, Medi-Cal behavioral health delivery systems shall describe how their mobile crisis teams will meet the needs of beneficiaries with I/DD who are experiencing behavioral health crises. Medi-Cal behavioral health delivery systems are encouraged to conduct outreach to Regional Centers to promote communication and collaboration (e.g., provision of trainings for county mobile crisis teams, direction of people with I/DD in immediate crisis who contact regional center warmlines to county mobile crisis teams for support).[37] Medi-Cal behavioral health delivery systems are also encouraged to also seek supplementary training from local regional centers and/or the State Council on Developmental Disabilities.

VII. Medi-Cal Claiming for Mobile Crisis Services

The Short Doyle Medi-Cal claiming system will be updated to add Community-Based Mobile Crisis Intervention Services by January 1, 2023. All claims will be reimbursed by "encounter," which is inclusive of all mobile crisis service components delivered by a mobile crisis team during the mobile crisis response (described in section IV), with the exception of service components that receive an add-on reimbursement (described in section V(d)). Medi-Cal behavioral health delivery systems shall claim using HCPCS procedure code H2011 and place of service code 15. As determined by the Medi-Cal behavioral health delivery system, services can be identified as SMH mobile crisis services using modifier HE, or DMC-ODS mobile crisis services using level of care modifier U, or DMC mobile crisis services using no modifier. Medi-Cal behavioral health delivery systems shall submit one claim per mobile crisis services encounter, which must include the four minimum components of a Medi-Cal reimbursable encounter (described in section IV). Because this is a new benefit, the non-federal share of qualifying mobile crisis encounters will be reimbursed with state general funds.

Reimbursement for the encounter is considered all-inclusive, and Medi-Cal behavioral health delivery systems shall not submit separate claims on behalf of individual members of the mobile crisis team for services delivered as part of the mobile crisis services encounter (e.g., Medi-Cal behavioral health delivery systems shall not submit a claim for Peer Support Services when a Peer Support Specialist is acting as a member of a mobile crisis team and the team is submitting a claim for a mobile crisis encounter). The date of the mobile crisis service encounter is

[36] See W&I, § 4696.1, subd. (b).
[37] See, generally, Assembly Committee on Human Services, A.B. 823 Analysis (Jan. 2020).

the day the beneficiary received a mobile crisis response. A beneficiary may receive more than one mobile crisis service encounter on the same day.

a. <u>January – June 2023</u>

From January 1, 2023, through June 30, 2023, mobile crisis services will be reimbursed using a cost-based reimbursement methodology. For each SMHS encounter, the interim payment will be based on the Schedule of Maximum Interim Rates (SMIR) for mobile crisis services, which is equal to the SMIR for crisis intervention services multiplied by six hours.[38] For each DMC-ODS encounter, the interim payment will be based on the rate the county submits to DHCS. For each DMC encounter, the Statewide Maximum Allowance will be equal to the median rate submitted by DMC-ODS counties.

Medi-Cal behavioral health delivery systems shall submit claims for mobile crisis encounters as they would any other SMHS, or DMC/DMC-ODS service.

These interim reimbursement rates will be reconciled to actual allowable costs in accordance with the cost-based reimbursement principles applicable to the behavioral health delivery system. Allowable costs include all components of the mobile crisis services encounter (described in section IV), including the provision of transportation by the mobile crisis team, as needed.

b. <u>July 2023 Onwards</u>

Beginning July 1, 2023, in alignment with the CalAIM Behavioral Health Payment Reform initiative, Medi-Cal behavioral health delivery systems shall transition from cost-based reimbursement for mobile crisis services to a prospective fee scheduled based reimbursement for each mobile crisis encounter funded via Intergovernmental Transfers, eliminating the need for reconciliation to actual costs.[39] Beginning July 1, 2023, the encounter rate for mobile crisis services will be a county-specific bundled rate, which will be established in the Medi-Cal State Plan. DHCS intends the methodology for determining the encounter rate to include, but not be limited to, assumptions regarding the:

- Hourly cost of deploying a mobile crisis team (comprised of at least two providers, as described in section III);
- Time for a mobile crisis team to travel to the location of the Medi-Cal beneficiary in crisis where services will be provided;

[38] See SPA 22-0043 for additional information about reimbursement for mobile crisis services between January 1, 2023 and June 30, 2023.
[39] See BHIN 22-046.

- Time per direct mobile crisis response;
- Time per follow-up check-in;
- "Stand by" time per team per day.

If the mobile crisis team provides transportation, the mobile crisis services provider may receive an add-on reimbursement to reflect the expanded nature of its mobile crisis encounter in such circumstances.

Beginning July 1, 2023, the encounter rate for each county will be set based on the assumptions listed above. Medi-Cal behavioral health delivery systems shall be prepared to work with DHCS throughout 2023 to review the appropriateness of the assumptions for any given county. For example, DHCS may adjust rates if a county relies more heavily than assumed upon teams that consist of two Peer Support Specialists, with backup from a licensed provider via telehealth, which includes both synchronous audio-only (e.g., telephone) and video interactions.

In addition to the encounter rate, DHCS recognizes there are administrative activities associated with implementing mobile crisis services. Administrative costs should be billed through the existing administrative claiming process. Administrative activities associated with mobile crisis services include, but are not limited to:

- Time to coordinate with other Medi-Cal behavioral health delivery systems;
- Time to coordinate with community partners;
- Time to coordinate with law enforcement;
- Time to conduct dispatch activities;
- Time to complete data reporting; and
- Time to develop a mobile crisis implementation plan and other required policies and procedures.

VIII. Implementation Process

No sooner than January 1, 2023, and upon receiving approval from DHCS, Medi-Cal behavioral health delivery systems shall provide, or arrange for the provision of, qualifying mobile crisis services in accordance with the requirements set forth in this BHIN. Medi-Cal behavioral health delivery systems in the following counties shall have the benefit fully implemented by June 30, 2024:

- Alpine
- Amador

- Colusa
- Del Norte
- Glenn
- Inyo
- Mariposa
- Modoc
- Mono
- Plumas
- Sierra
- Trinity

Medi-Cal behavioral health delivery systems in all other counties shall have the benefit fully implemented by December 31, 2023.

A DHCS contractor(s) with expertise in culturally responsive mobile crisis services will deliver required trainings and ongoing technical assistance to support Medi-Cal behavioral health delivery systems in the implementation of the mobile crisis services benefit. In general, Medi-Cal behavioral health delivery systems shall undergo a comprehensive, standard implementation process prior to claiming for mobile crisis services. However, Medi-Cal behavioral health delivery systems with experience providing mobile crisis services or that otherwise are prepared to implement the mobile crisis services benefit more expeditiously may use an expedited implementation process and begin claiming for services.

a. <u>Standard Implementation Process</u>

In general, each Medi-Cal behavioral health delivery system shall:

- Submit a written mobile crisis implementation plan (described in section VIII(c)) to DHCS outlining its mobile crisis services policies and procedures. The Medi- Cal behavioral health delivery system shall submit the implementation plan at least 30 days prior to their proposed launch date, no later than April 30, 2024, for counties who are required to have the benefit fully implemented by June 30, 2024, and no later than October 31, 2023, for all other counties;
- Receive approval from DHCS of its mobile crisis implementation plan prior to delivering mobile crisis services for Medi-Cal reimbursement pursuant to this guidance; and
- Require all mobile crisis services providers to complete a core training curriculum (described in section VIII(d)).

b. Expedited Implementation Process

To accommodate counties that are prepared to offer mobile crisis services as early as January 1, 2023 (e.g., if they already operate a mobile crisis program), a Medi-Cal behavioral health delivery system may use an expedited implementation process. Under the expedited process, a Medi-Cal behavioral health delivery system shall:

- Submit a written Attestation to DHCS (included as Enclosure 1) confirming mobile crisis services providers meet minimum program requirements;
- Receive DHCS approval of the written Attestation; and
- Ensure mobile crisis services providers complete a core training curriculum (described in section VIII(d)). Mobile crisis services providers within Medi-Cal behavioral health delivery systems that use the expedited implementation process may complete core training that is delivered by DHCS' contractor(s) or by an outside source.

Medi-Cal behavioral health delivery systems that initially implement mobile crisis services through the expedited implementation process shall also submit, and receive approval from DHCS on, a written mobile crisis implementation plan.

c. Implementation Plan

All Medi-Cal behavioral health delivery systems shall submit a written implementation plan to DHCS outlining their comprehensive mobile crisis services policies and procedures. As described above, Medi-Cal behavioral health delivery systems that use the standard implementation process shall submit their implementation plans at least 30 days prior to their proposed launch date and no later than October 31, 2023, in most counties, and no later than April 30, 2024, for counties who are required to have the benefit fully implemented by June 30, 2024. Medi-Cal behavioral health delivery systems that use the expedited implementation process must submit their implementation plans by October 31, 2023, regardless of when they begin claiming for services.

DHCS will issue a template for the mobile crisis services implementation plan. Counties that intend to operate a coordinated mobile crisis services program administered jointly by multiple Medi-Cal behavioral health delivery systems may submit a single implementation plan. DHCS will provide a template for Medi-Cal behavioral health delivery systems to use to develop the mobile crisis implementation plan.

Mobile crisis implementation plans may include, but are not limited to, information about the:

- Medi-Cal behavioral health delivery system's mobile crisis services provider network;
- Coordination strategies across the county's MHP and DMC/DMC-ODS delivery systems;
- Participation of mobile crisis teams in required training;
- Dispatch policies and procedures, including an identified mobile crisis services hotline and standardized dispatch tool;
- Crisis assessment tool;
- Community engagement activities;
- Coordination with law enforcement, and strategies to reduce unnecessary law enforcement involvement;
- Coordination with the local EMS agency;
- Transportation policies and procedures;
- Oversight policies and procedures;
- Mechanisms to ensure culturally responsive and accessible care;
- Coordination with FURS and child welfare;
- Strategies for responding to children and youth;
- Engagement of 911, 988, and MCPs to engage in planning for Data exchange and develop related policies and procedures;
- Outreach to advise Medi-Cal beneficiaries on availability of the service and how to access it; and
- Other topics to be identified by DHCS and DHCS' training and technical assistance contractor.

If DHCS does not approve a Medi-Cal behavioral health delivery system's implementation plan, the Medi-Cal behavioral health delivery system shall work with DHCS to secure approval. If a Medi-Cal behavioral health delivery system still cannot secure approval, DHCS may require corrective action plans and, ultimately, may disallow mobile crisis services claims if a Medi-Cal behavioral health delivery system operates without an approved implementation plan.

d. <u>Training and Technical Assistance</u>

As described above, all mobile crisis team members shall meet the State's training requirements. Trainings may be provided either in-person or virtually. In addition, Medi-Cal behavioral health delivery systems and mobile crisis services providers shall participate in ongoing technical assistance to address ongoing implementation concerns and to continue to strengthen the delivery of mobile crisis services.

DHCS contractor(s) will develop both core and enhanced training curricula. The core training curriculum will include crisis intervention and de-escalation strategies, harm reduction strategies, delivering trauma-informed care, conducting a crisis assessment, and crisis safety plan development. Mobile crisis team members must meet core training curriculum requirements before delivering qualifying mobile crisis services.

DHCS contractor(s) will also develop an enhanced training curriculum. The enhanced training curriculum will include, but is 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 beneficiaries with I/DD).

DHCS may issue additional guidance on training and technical assistance requirements.

IX. Reporting

Medi-Cal behavioral health delivery systems shall provide demographic, process, and outcomes data to DHCS on a periodic basis. DHCS will use this information to monitor and oversee Medi-Cal behavioral health delivery systems' implementation of the mobile crisis services benefit.

Medi-Cal behavioral health delivery systems shall provide DHCS with data about each mobile crisis services encounter. The data shall include, but are not limited to:

- Beneficiary demographics (e.g., age, race, ethnicity, sexual orientation, and gender identity, etc.);
- Crisis location;
- Response times;
- Disposition of encounter (e.g., de-escalated in community-based setting, transported to crisis stabilization unit, etc.);
- Professional titles of each team member participating in the mobile crisis response;
- Use of telehealth;
- If transportation was needed, and if so, what type of transportation was provided;
- Law enforcement involvement; and
- Information about follow-up check-ins.

Counties shall conduct beneficiary satisfaction surveys. DHCS will issue additional guidance on data metrics, reporting processes and methods, and reporting frequency.

X. Medi-Cal Behavioral Health Delivery Systems' Required Oversight
Medi-Cal behavioral health delivery systems shall administer the mobile crisis services benefit in accordance with DHCS policies and oversee mobile crisis services providers as part of existing oversight responsibilities. Medi-Cal behavioral health delivery systems shall oversee mobile crisis services providers to ensure quality and adequate service delivery, and to ensure mobile crisis service providers comply with federal and state law requirements, and contractual obligations. As part of their implementation plans, Medi-Cal behavioral health delivery systems shall describe how they will oversee mobile crisis services providers.

Questions about this BHIN may be directed to MCBHPD@dhcs.ca.gov. Questions about claiming for or reimbursement of mobile crisis services may be directed to MEDCCC@dhcs.ca.gov.

Sincerely,

Original signed by

Ivan Bhardwaj, Chief
Medi-Cal Behavioral Health Policy Division