ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Frequently Asked Questions: Mobile Crisis Response (MCR) and Crisis Stabilization
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Helpful Links:

- Proposed revisions to 89 IL Admin Code 140 can be found here.
- Information on the IM-CAT crisis screening tool can be found here.
- IM+CANS Training Schedule can be found here.

PROVIDER ENROLLMENT

Q: Is the IMPACT system ready for providers to update their service array as a mobile crisis provider?
A: Yes.

Q: Can a provider apply for certification for crisis stabilization without being required to provide the mobile crisis response service?
A: Yes.

Q: How do we enroll in IMPACT to provide Mobile Crisis Response and Crisis Stabilization services?
A: To provide Mobile Crisis Response and Crisis Stabilization services, CMHCs and BHCs must obtain a Crisis Services Program Approval from HFS. The Crisis Services Program Approval process is initiated once a provider submits their initial enrollment application for review through IMPACT. To initiate this process, a provider must indicate which crisis services they intend to provide by selecting the appropriate Specialty/Subspecialty combinations for their Provider Type. Providers already enrolled with HFS may request to add Mobile Crisis Response and Crisis Stabilization services to their enrollment by modifying their application in IMPACT to add the necessary Specialty/Subspecialty combinations.

The table below identifies the Provider Type/Specialty/Subspecialty combinations for MCR and Crisis Stabilization services:

Service	Provider Type	Specialty	Subspecialty
Crisis Stabilization	Community Mental Health Center	Crisis Response	Crisis Stabilization
Crisis Stabilization	Behavioral Health Clinic	BHC Crisis Response	Crisis Stabilization
Mobile Crisis Response	Community Mental Health Center	Crisis Response	Mobile Crisis Response
Mobile Crisis Response	Behavioral Health Clinic	BHC Crisis Response	Mobile Crisis Response

Following completion of the initial application process in IMPACT, HFS will email a request to providers for additional documentation to demonstrate the provider's compliance with the Crisis Services Program Approval requirements outlined in 89 Ill. Admin. Code 140.Table N (c)(4). HFS will notify the provider of the outcome of its review.

Q: How do organizations who are not currently SASS providers become certified as a Mobile Crisis Response Provider? ***Added 10/1/2018***

A: Any BHC or CMHC interested in providing MCR services may seek to obtain a Crisis Services Program Approval from HFS consistent with the process outlined above. Any provider with an active Subspecialty of Mobile Crisis Response on their IMPACT enrollment may render MCR services to Medicaid eligible recipients.

REIMBURSEMENT

Q: With Crisis Stabilization (T1019), the fee schedule indicates a 1 hour unit as $50.00? Is this billed in units or as an event?

A: Crisis Stabilization is billed in one (1) hour units.

Q: Is Crisis Stabilization only to be provided in 1-hour increments?

A: The unit of reimbursement for Crisis Stabilization services is one (1) hour.

Q: Why would anyone bill Crisis Stabilization at that low rate?

A: Crisis Stabilization is a new component of Illinois' crisis services array available to clients following a Mobile Crisis Response event that includes: observing, modeling, coaching, supporting the implementation of the client's Crisis Safety Plan, performing crisis de-escalation, and responding to behavioral health crisis, when necessary. Other services in the MRO-MH service array require "active treatment," but Crisis Stabilization provides reimbursement for both active therapeutic interventions (e.g. coaching, client support, Crisis Safety Plan implementation, crisis de-escalation, etc.), and for passive event time (e.g., observation and modeling). The rate balances both the active and passive time in the event to ensure equitable reimbursement for the provider who is not required to be actively intervening with the client for the entire event.

Q: The MCR event rate does not account for the $7.00 add on-rate for crisis intervention, so the event rate is actually less than if we provided 4 unit of crisis intervention billing. Is there any conversation about bringing these two rates into alignment?

A: The service of T1023 – Crisis Intervention, Pre-hospitalization Screening was not subject to the enhanced rate add-on. Because MCR is an alternative service to the T1023, the enhanced rate add-on was not applied to the service. Altering the rates for MCR is not under consideration at this time. Since MCR is paid as an event, a provider has to perform the service to receive the full reimbursement (e.g., 15 minutes of MCR service time pays at the full event rate). Utilizing the crisis intervention rate upon which the original T1023 rate was established, a provider would have to complete a minimum of 53 minutes of crisis intervention to receive an equal reimbursement.

Q: If the MCR screening event takes longer than 1 hour, regardless of completion of the IM-CAT, we are to switch to crisis intervention for billing?

A: To be reimbursed for MCR, providers must complete the IM-CAT in full. The service is reimbursed as an event "not to exceed one hour," meaning that the service reimbursement is guaranteed to address the cost of the IM-CAT as an "event rate" if it is performed in less time than one hour. However, if the service requires a provider to spend more than one hour of time, the provider

should transition to billing additional service time as Crisis Intervention. Additionally, providers that are performing ancillary services to the MCR event, such as facilitating hospitalization, facilitating transportation, or providing direct crisis intervention, should bill those services utilizing the following rules:

1. Actual time spent performing activities should be billed accordingly,
2. Crisis Intervention should be billed if the client is present,
3. Case Management – Mental Health should be billed if the client is not present.

Q: If we are providing Case Management Client Centered Consultation for the purpose of obtaining hospitalization for a client following the MCR event, does each call with the hospital have to meet the 8 minute threshold in order to bill for this service? Or are we able to include a period of time and document the time each hospital is called (e.g., 12:58am-1:03am, call to Streamwood; 1:04am-1:08am, call to Hartgrove; 1:09am-1:14am, call to Riveredge) ***Added 10/1/2018***

A: HFS guidance provided in the MCR Webinars states that providers should seek reimbursement under the service of Mental Health Case Management for services rendered on behalf of a non-present recipient following a MCR event when the services rendered are for the purpose of further ameliorating the crisis episode (e.g. facilitating psychiatric hospitalization).

Under this guidance, provider billing activity should be reflective of the total time spent working on behalf of the recipient in crisis; providers should roll-up the total service time and convert the total service time spent into units. In the example provided in the question, the provider spent a total of 16 minutes across three (3) phone calls facilitating psychiatric hospitalization. The provider could seek to bill one (1) unit of Case Management Mental Health for these activities.

CRISIS SERVICES PROGRAM APPROVAL

Q: One of the stipulations for Crisis Services Program Approval is that "crisis services will be available to individuals in crisis, 24/7. If the CMHC does not have a service area designation, can the 24/7 crisis team availability be within a hospital (not mobile)? ***Added 10/1/2018***

A: No. A provider's crisis team may be housed or located in the setting the provider deems most appropriate, operationally or clinically, based upon the population served and the array of services provided. However, a crisis team nested within a hospital for the purpose of responding to individuals presenting at the hospital in behavioral health crisis would not satisfy the requirements of service delivery. The provider's crisis team would need to travel to the location of the crisis for individuals in need of MCR services, or provide services to the individual in their natural environment to provide Crisis Stabilization services.

The model proposed within this question would most likely be a better fit for the delivery of Crisis Intervention services or other, non-Medicaid Rehabilitation Option (MRO) services.

CRISIS INTERVENTION

Q: Crisis Intervention - will all adults with Medicaid/MCO payers be required to be referred to a SASS/CARES provider as of 08/01/2018? If so, does an agency have to be a SASS provider to serve that population? ***Added 10/1/2018***

A: Any enrolled CMHC or BHC may provide the service of Crisis Intervention to any Medicaid eligible recipient that presents in crisis. Referrals to the CARES line are only required for individuals seeking to participate in certain HFS crisis programs and for children seeking inpatient psychiatric hospitalization.

CRISIS STABILIZATION

Q: What is the intent of the crisis stabilization service? Can you give examples of why you'd provide one service versus the other?

A: Crisis Intervention and Mobile Crisis Response services are provided to clients who are experiencing a behavioral health crisis and require immediate intervention to stabilize and return to a normalized level of functioning.

Crisis Stabilization is designed to provide more options and flexibility for providers responding to the needs of individuals in crisis. Crisis Stabilization services are intended to mitigate the symptoms and causes of crisis through the provision of one-to-one, strengths-based, individualized supports over a longer term basis as situational stressors occur, reducing the need for additional crisis intervention and potential institutionalization.

Q: How does Crisis Stabilization differ from Community Support-Individual? Can you provide some example activities that would qualify as Crisis Stabilization and how these activities differ from the activities of Community Support-Individual?

A: Crisis Stabilization and Community Support are distinct services with their own purpose and intent.

Crisis Stabilization is defined as:

- a time-limited, crisis-based service;
- authorized by an LPHA via an HFS approved Crisis Safety Plan completed after a MCR screening event;
- designed to provide ongoing stabilization supports to mitigate crisis symptoms;
- expands services available to clients to help stabilize the client in the home or community; and,
- may be provided prior to the completion of the client's Integrated Assessment and Treatment Plan (IATP).

Crisis Stabilization services may include:

- observing the client in their natural environment during periods of high stress,
- providing coaching to the client in the usage of their crisis safety plan;
- modeling positive coping skills and response patterns to the client's parent/caregiver;
- redirecting a client's behaviors when they begin to escalate;
- educating the client on reducing environmental stressors when the client is feeling overwhelmed, etc.

Community Support is a therapeutic service that is part of the client's broader treatment and is only authorized following the completion of the client's IATP. Community Support services are designed to promote skill building and the client's ability to self-monitor and self-manage their

symptoms and illness. Community Support services may include: engaging the client to have input into their service delivery and recovery process; developing relapse prevention strategies and plans with the client; assisting in development of functional, interpersonal and community coping skills (including adaptation to home, school, family and work environments); and skill-building related to symptom self-monitoring.

Q: We have added the recommendation of Crisis Stabilization to our safety plan to be reviewed by an LPHA. Can we start using these services or do we need to wait for the HFS approved safety plan?

A: HFS will establish a standardized Crisis Safety Plan in FY2019. Until the formal HFS Crisis Safety Plan is introduced, the Crisis Safety Plan utilized by providers will be accepted for the purposes of authorizing Crisis Stabilization services, so long as the Crisis Safety Plan includes the following elements:

1. An identification of diagnosis, need, or functional impairment;
2. A treatment recommendation of Crisis Stabilization Service accompanied by a recommendation for service Amount, Frequency, and Duration;
3. Documentation of which agency/provider is responsible for the delivery of service; and
4. Licensed Practitioner of the Healing Arts (LPHA) Authorization demonstrated by Printed Name, Signature, and Date.

Q: The FAQ on Crisis Stabilization states that a Crisis Safety Plan has to include "3. Documentation of which agency/provider is responsible for the delivery of service". Does this mean that a SASS agency could provide the mobile crisis response service, have an LPHA on the staff of the SASS agency approve crisis stabilization, and then another different CMHC or BHC agency could provide crisis stabilization based on that approval? ***Added 10/1/2018***

A: Yes, so long as the other CMHC or BHC is appropriately enrolled and credentialed with HFS to provide the service, and the Crisis Safety Plan clearly indicates which agency will be responsible for the Crisis Stabilization service for the individual.

MOBILE CRISIS RESPONSE

Q: Will this change have any impact on public schools? For example, if the LPHA works for a public school and handles a student/adult in crisis either on- or off-site. Would the school request reimbursement for the LPHA's service?

A: Only enrolled CMHCs and BHCs may be reimbursed for MRO crisis services.

Q: Is it accurate that staff certified in the CSPI is grandfathered in as certified in the IM-CAT?

A: Specific to SASS providers, HFS has provided guidance on transitioning from the usage of the IM-CSPI to the IM-CAT.

All providers of MCR services must utilize the IM-CAT as part of the face-to-face screening effective August 1, 2018. SASS crisis workers who were certified in the IM-CSPI as of July 31, 2018, will be considered qualified to deliver the IM-CAT through September 15, 2018. However, all SASS crisis workers were required to attend an in-person IM+CANS training during the month of July 2018, and must certify in the IM+CANS or the IM-CAT following attendance of the in-person training. SASS

agencies with specific questions or concerns about this transition guidance should address those questions to HFS.CBH@illinois.gov.

Q: Some SASS providers have expertise or prefer to work only with the C&A population. Are there additional providers coming aboard? Can current SASS providers opt out?

A: Any enrolled CMHC or BHC may obtain a Crisis Services Program Approval to provide MCR and/or Crisis Stabilization services. Any provider with a Crisis Services Program Approval has the ability to provide MCR services to Medicaid-eligible clients who they determine to be in need of crisis screening and assessment.

However, only existing SASS providers and their subcontractors or partners will maintain a unique Service Area Designation in the IMPACT system, designating them as the State's safety net MCR provider. All referrals that go through the CARES line for MCR services will be dispatched to the provider with the Service Area Designation for the area where the individual in crisis is located.

SASS providers have the ability, with the approval of HFS, to subcontract the provision of adult MCR services to another local provider with a Crisis Services Program Approval. SASS providers may also give up their status as the State's safety net MCR provider and SASS provider for a given service area with 90 days of written notice to HFS to allow for the safe transition of crisis accountability for children and adults to another provider in their community.

Q: As a SASS Intake Supervisor from 2003 until 2011, one of the major challenges we encountered was informed consent during a crisis response. What are the expectations for the provider community to manage MCR calls for adults in crisis who are unaware or unwilling to participate in the process?

A: Based upon suggestions and feedback from SASS providers, HFS has updated the minimum data set the CARES line will be providing to crisis workers when making a MCR referral for an adult. This will include information from the referent on whether or not the adult in crisis is aware of the MCR referral. By adding this updated referral information, HFS is seeking to provide MCR providers with the information necessary to facilitate the engagement process with adults in need of crisis services. Adult clients have the right to refuse or decline MCR services. If this occurs, the provider should document on the IM-CAT form that the MCR screening was unable to be completed because the individual refused services.

Q: Will all adults with Medicaid/MCO payers be required to be referred to a SASS/CARES provider as of 08/01/2018? If so, does an agency have to be a SASS provider to serve that population?
Added 10/1/2018

A: In order to access certain crisis services, adults who are covered by one of the HFS full benefit Medical Assistance Programs must be referred through the CARES line, regardless of whether the service is being administered by an MCO or the fee-for-service delivery system.

Any provider with an active Subspecialty of Mobile Crisis Response on their IMPACT enrollment may render MCR services to eligible recipients. However, if a referral for MCR services is made through the CARES line on behalf of an eligible recipient in crisis, the CARES line will dispatch the

provider who maintains the Service Area Designation for the geographic location where the recipient in crisis is located.

Q: On the MCR webinar, it was stated that the MCR screening event may also include the completion of the following activities: short-term intervention; brief counseling; completion of a crisis safety plan; consultation with other qualified providers; and referral and linkage to community services or the appropriate next level of care. If an individual is assessed to need a higher level of care, such as a hospitalization, is it required that the MCR team facilitate the placement to a hospitalization, as described in the webinar scenarios? Or is it just allowable? ***Added 10/1/2018***

A: If, following the completion of an MCR screen, a provider determines that an HFS recipient cannot be successfully stabilized in the community, the provider must continue to meet the expectations of 89 Ill. Admin. Code 140.2(b): *"'Necessary medical care' is that which is generally recognized as standard medical care required because of disease, disability, infirmity or impairment."*

To that end, the MCR provider that determines that an individual (child or adult) cannot be stabilized in the community following a MCR screening must take sufficient action to ensure:

1) Service options are discussed with the individual or a parent or guardian;
2) The individual is hospitalized;
3) The individual is routed to a local emergency department;
4) The individual is admitted to a service setting as an alternative to acute inpatient treatment; or
5) The individual is referred to 9-1-1 for emergent service.

Any provider failing to take sufficient action to ensure the safety of the individual shall be referred to:

- The HFS Office of Inspector General;
- The Illinois Department of Financial and Professional Regulation (when an LPHA is involved);
- Any and all applicable licensure, certification, and funding agents for review; and
- The HFS Bureau of Behavioral Health Compliance Officer to trigger an immediate audit of the provider's Crisis Program and review of the provider's Crisis Program Approval.

Q: What operational / treatment requirements of the former SASS contracts will remain as expectations for providers? And, will these same expectations apply to adults being served through MCR services? ***Added 10/1/2018***

A: SASS providers should continue to comply with the policies and processes outlined in the Handbook for Providers of SASS Services for children who have an active HFS Social Services Segment and who are assigned to the provider.

Additionally, all providers of MCR services must comply with the specific Provider Enrollment Terms and Conditions identified for MCR in addition to the policies related to MCR outlined in 89 Ill. Admin. Code 140.453 and the Handbook for Providers of Community-Based Behavioral Services.

Q: Why is CARES allowed to dispatch referrals on individuals who are known to be intoxicated? What is the expectation of providers who receive a referral from the CARES line for an adult who is intoxicated? Crisis workers cannot complete an assessment on an individual while they are intoxicated. The individual would receive help quicker if they were sent to the ER first. ***Added 10/1/2018***

A: While the presence of substances may contribute to the overall risk assessment a provider conducts as part of their crisis assessment, reported intoxication should not automatically be considered an emergent issue requiring medical intervention without a face-to-face assessment from a crisis worker.

If, in the course of conducting an MCR assessment, a crisis worker assesses the individual to be intoxicated such that the crisis assessment cannot be completed, the crisis worker shall implement the appropriate course of action to ensure the safety of the individual until a crisis assessment can be completed.

In order to be reimbursed for MCR in these instances, the provider must complete the following actions:

- Minimally score the Substance Use item on the IM-CAT;
- Document on the IM-CAT form that the assessment is being pended due to intoxication;
- Initiate a Crisis Safety Plan for the individual, minimally identifying the plan to ensure the immediate safety of the individual and for follow-up with the provider in order to complete the crisis assessment and the appropriate phone numbers to access crisis services; and
- Make every attempt to complete the MCR assessment within 72 hours.

Providers shall not bill an additional unit of MCR for the completion of a crisis assessment if the initial crisis assessment was pended due to intoxication.

INTERFACE WITH THE CARES LINE

Q: Can adults call when they are in crisis or does the call have to come from a family member or referral agency? ***Added 10/1/2018***

A: Anyone can call the CARES line to make a referral on behalf of an individual experiencing a behavioral health crisis, including the individual themselves.

Q: Will hospitals call the CARES line for unfunded individuals?

A: Anyone with a concern about an individual experiencing a behavioral health crisis may call the CARES line to make a referral for MCR services. However, CARES will only dispatch a local crisis worker to provide a face-to-face MCR screening if the individual in crisis is eligible to receive MCR services as follows:

- Medicaid eligible individuals;
- Uninsured children under the age of 18; and
- DCFS Youth in Care.

Q: What is the plan for using CARES for adults? What should we be telling our hospital partners and what is being communicated to them by the state?

A: The CARES line began accepting crisis calls for adults on August 1, 2018. While any provider with a Crisis Services Program Approval may deliver MCR services as they determine it to be medically necessary, there are certain instances in which CARES interface is required as follows:

- Prior to admission to psychiatric hospitalization for children (under age 21); and
- For Medicaid eligible individuals:
  - Prior to admission to a Crisis Intervention: Triage and Stabilization Site funded through the 1115 waiver; or
  - Prior to the provision of Crisis Stabilization services.

At this time, the fee-for-service system does not require that hospitals contact the CARES line for MCR services prior to admitting an adult client (age 21+) for psychiatric treatment. Hospitals with additional questions regarding about the usage of CARES for the adult population are encouraged to email HFS at HFS.CBH@illinois.gov.

Q: Will adults needing hospitalization always require a call through CARES because it is a level of care change?

A: No. At this time, it is not required that adults (age 21+) have a MCR screening prior to being admitted to a psychiatric hospitalization. However, hospitals may choose to call the CARES line to make a referral for MCR services if they wish.

Q: Can you clarify, for a change in level of care for adults, does CARES need to be called? If CARES only needs to be called for adults for crisis beds under the 1115 waiver, can you clarify what beds "1115 waiver crisis beds" is referring to? ***Added 10/1/2018***

A: For Medicaid eligible adults (age 21+), the CARES interface is required in the following instances:

- Prior to admission to a Crisis Triage and Stabilization Service sites funded through the 1115 waiver; or
- Prior to the provision of Crisis Stabilization services.

The terminology of "1115 waiver crisis beds" refers to the pilot program authorized by federal CMS under the State's 1115 Waiver; the formal name for this pilot program is Crisis Triage and Stabilization Services.