Public Comments for Chapter 503, Appendix H Community-Based Mobile Crisis Intervention Services

Effective Date: February 1, 2024

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
001	11/30/2023	503H.12, page 7 and page 12	Clarification: What is the definition of "clinical staff"? It is confusing throughout the whole document. This specific appendix references the clinical supervisory staff but not clinical staff in general.	**No Change:** The Glossary defines clinical staff and it is defined at 503H.12, page 7
002	11/30/2023	Glossary, page 12 and 503H.10, page 6	this statement says teams are comprised of 2 people. In Section 503H.15/Pg.12 it states ": A group of trained staff comprised of at least three individuals including, at a minimum, one supervisory staff with experience in crisis response, and two direct care staff" What are these teams supposed to be comprised of? 2 members or 3 members?	**No Change:** Per 503H.10, a minimum of two staff must be present for face-to-face intervention services. Per 503H.12, teams must include a clinical resource. If the clinical staff resource was present on-site, the in-field team would consist of two individuals, practicing under the authority of a supervising clinician. Otherwise, the team would consist of three individuals in the field- two direct care workers, and one clinical resource via telehealth or on site.
003	11/30/2023	503H.13, page 8	Why does this peer mentor require an associates degree? All of the other peer mentors do not require anything but a HS diploma or GED.	**No Change:** This provider type may have either an associate degree or lived experience.
004	11/30/2023	503H.14, page 9	Clarification: What is "clinically appropriate" follow up?	**No Change:** BMS would anticipate that a clinical supervisor would determine the clinically appropriate follow-up within the specified timelines in this section.
005	11/30/2023	503H.1, page 2	Can this service be used in the jail setting if the agency is working with the courts on a jail diversion plan (treatment vs. incarceration) and they meet admission criteria?	**No Change:** No, this service may not be used within a jail setting per federal regulation.
006	11/30/2023	503H.1, page 2	Can this service be used in the ED setting if mental health and/or substance use treatment is being considered as or is the discharge plan?	**No Change:** This service may not be billed if the member has been admitted to an inpatient facility. However, the service may be utilized before admission.

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
007	11/30/2023	503H.10, page 6	Clarification: If one member is in-person and the other via telehealth, does this meet the two staff face-to-face requirement or do two staff have to be in-person?	**No Change:** A minimum of two staff must be present during in-person encounters. The clinical staff may participate by telehealth, in which case there could be two direct care workers on-site, with the clinical resource participating via telehealth, for example.
008	11/30/2023	503H.13, page 7	Clarification: Define "this population". Does this mean crisis level clients specifically or does this mean mental health/substance use populations.	**Change:** 503H.13, page 7 will be changed to more clearly define “population” to mean experience working with mental health and/or substance use disorder.
009	11/30/2023	503H.13, page 8	On page 8 under the same section, the Youth Peer is required to have either a lived experience of recovery from mental health disorders or an associate degree in behavioral health or related human services field. They will complete formal training or education in peer recovery support. There is no requirement with the associate's degree to have experience with the population. Consideration: Removal of the required "one-year experience working with the population" for the Crisis Specialists and replace it with more intensive supervision or consider the additional 2 years of education as the equivalent to the Youth Peer's "or education in peer recovery support".	**No Change:** The current wording is required per the federally approved State Plan Amendment.
010	11/30/2023	503H.14, page 9	Consider extending the 24 hour documentation requirement. If we have multiple calls and responses throughout a shift, this requirement will be significantly difficult to meet.	**No Change:** Page 5.1 of the State Plan Amendment as approved specifies 24 hours.
011	11/30/2023	503H.14, page 9	Many of the individuals we are responding to are homeless and do not have working phone numbers/addresses for follow up making it challenging to connect with them after crisis, despite us asking them the best way to reach them. Some also refuse further services. If this is the case, would it be sufficient to note this in the documentation as to why the follow up requirement was not met?	**No Change:** Yes.
012	11/30/2023	503H.14, page 9	Can you provide examples of evidence and documentation so we are positioned to produce this information in a timely manner?	**No Change:** We are unable to give examples of evidence or documentation in policy.

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
013	11/30/2023	503H.15, page 11	Clarification: Define "24-hour/calendar day". Is this a true 24 hours or is the this an actual calendar day? If the initial service begins at 11pm on December 1st extends into December 2nd at 4am, do we bill Procedure Code S9485 until 11:59pm on December 1st and then bill Procedure Code S9494 for the additional time, or do we bill Procedure Code S9485 for the first 3 hours and then bill the remaining hour as Procedure Code S9494?	**Change:** BMS will clarify page 11 to reflect more clearly that within a 24-hour period, there is the initial 3-hour increment, then the optional one-hour increment per S9494 for up to 21 hours for a total maximum combined of 24 hours, and that a discharge would then need to occur. After the 24-hour period, another per diem would then need to be billed after a qualifying encounter.
014	11/30/2023	503H.15, page 11	Clarification: Define "24-hour/calendar day". Is this a true 24 hours or is this an actual calendar day? If the initial service begins on December 1st and meets discharge criteria on December 1st and then meets admission criteria again on December 2nd (within the same 24 hour period), do we submit reimbursement for Procedure Code S9485 for the initial 3 hours on December 2nd or do we submit reimbursement for Procedure Code S9494?	**Change:** Please see the response to item 13.
015	11/30/2023	503H.15, page 11	Clarification: Does the 24-hour clock start at the beginning of the qualifying event or the completion of the event?	**Change:** Please see the response to item 13.
016	11/30/2023	503H.1, page 2	B. Suggest adding children as a population served.	**No Change:** Any member is eligible, regardless of age**.**
017	11/30/2023	503H.1, page 2	C. Not needed. Services must be provided 24/7. No need to list business hours.	**No Change:** Thank you for your comment.
018	11/30/2023		On Page 5 the second paragraph states: “Peer parent support services designed to offer support to the parent/ legal representative with a SED.” This statement makes it sound as though the parent/representative is the one with the SED.	**Change:** Changes were incorporated to clarify this applies to parent/legal representative who had a child with SED.

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
019	11/30/2023	503H.10, page 6	First, this paragraph states that all Mobile Crisis Response requires a minimum of two people. Should this be adjusted if the response is to a location where other providers are already present? For example, when responding to a school would they need two people as there are teachers, and counselors there. Second, this paragraph states the team is comprised of one Clinical Staff and one direct care staff. Clinical staff are define in Appendix H as Master's level, as needed resource. SAMSHA's National Guidelines state the following in regards to crisis teams: "Mobile Team Staffing Community-based mobile crisis services use face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis, in order to achieve the needed and best outcomes for that individual. Most community-based mobile crisis programs utilize teams that include both professional and paraprofessional staff. For example, a Master's or Bachelor's-level clinician may be paired with a peer support specialist with backup by psychiatrists or other master's-level clinicians who are typically accessed for on-call support as needed. Peer support workers often take the lead on engagement and may also assist with continuity of care by providing support that continues beyond the resolution of the immediate crisis. In this model, almost half of the mobile team system workforce would be filled by peers who are more broadly available to fill roles that their licensed and/or credentialed clinician team partners may not be available to fill." This indicates that it would be appropriate for Bachelor's level crisis specialists to be teamed with peers for mobile response. It is highly unlikely that a Master's Level position would be filled in a crisis response team other than as a supervisory role.	**No Change:** The existing wording in pursuant to the federally approved State Plan Amendment.
020	11/30/2023	503H.13, page 7	Also on page 7 under 503H.13 Direct Care Staff it states A clinical supervisor or a master's level clinical resource may directly provide Community Based Mobile Crisis Intervention Services." This appears to be in contrast to the previous section that stated the response team must consist of a masters level.	**No Change:** The teams must work under a clinical supervisor; the supervisor may be present and directly provide care, or the team would just need to have access to the supervisor. The teams must consist of at least one masters level resource.

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
021	11/30/2023	503H.13, page 8	On page 8 there is provided a definition of a Peer Parent Support However, currently there is no identified certification for such a position. Also on page 8 under Youth Peer Mentor it states “youth peer mentor must be 18 years of age or older.” There is no identified cut off age which makes a Youth Peer Mentor and an Adult Peer Mentor the same.	**No Change:** Thank you for your comment.
022	11/30/2023	Glossary, page 12	On page 12 the Clinical Staff is identified as “Members of the mobile response team on an as-needed basis.” Again this is contradictory to previous statements. On page 12 under Mobile Crisis Response Team, it states “at least three individuals” as previously noted above this conflicts with stating teams of two.	**Change:** BMS will clarify page 12 by clarifying the teams could consist of two or three individuals depending on the make-up of the team. The teams must practice under the authority of the clinical supervisor. The teams must also have access to a clinical staff member.
023	12/1/2023	503H.1, page 2	General Comments: Language should recognize the unique needs of children, youth, and families. An example: Mobile Crisis deliver services to youth vulnerable to or experiencing stressors, coping challenges, emotional or behavioral symptoms, difficulties with substance use as a coping strategy, or traumatic circumstances that may compromise the youth’s ability to function optimally and thrive within their family/living situation, school and/or community environments. Policy should include the requirement to refer and/or link to necessary longer on-going services during or after the stabilization phase. Use of the word acute in background statement suggests sudden onset and higher levels of severity. This is counter to broadening eligibility and promoting upstream access. Language should reference immediacy and access over acuity.	**No Change:** Thank you for your comment.

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
024	12/1/2023	503H.1, page 2	503 H.1 Medical Necessity Criteria: Language should shift from “member who is experiencing a suspected mental health and/or substance use disorder-related crisis” to “a member who is experiencing an escalating behavioral health crisis as defined by the member or when under the age of 18 defined by the parent/caregiver.” See NJ: Mobile Response Stabilization Services – Initial 72 hours – (Youth) - PerformCare NJ Mobile Response and Stabilization Services (MRSS) - PerformCare (performcarenj.org)	**No Change:** Thank you for your comment.
025	12/1/2023	503H.1, page 2	503 H.2 Admission Criteria: Language specific for youth for youth should be added. For example, Crisis is defined by the youth and/or parent/caregiver. The youth is experiencing stressors and/or exhibits emotional and/or behavioral needs, that threaten to or are adversely impacting a youth’s ability to function in one or more life domains (family, living environment, school, or community). Youth may also meet these criteria if considered to be “at risk” of or experiencing emotional or behavioral challenges because of contextual environmental factors including living arrangement, psychosocial stressors or traumatic circumstances, factors, events. In the first bullet, use of the word acute leans towards screening around severity/urgency by professionals over offering immediate face to face responses for all service requests. While the second may cover most requests, the sub-bullets do not incorporate “at risk” criteria referenced above. Another sub-bullet should be added stating “any other crisis as defined by the person or their caregiver.”	**No Change:** Thank you for your comment.

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
026	12/1/2023	503H.3, page 3	H.3 Discharge Criteria: Criteria 2 should be edited to read: “The member has been to an admitted inpatient facility, hospital, or emergency room or other appropriate community-based intervention.” Discharge should not be limited to admission to inpatient facilities. Recommend: • Connection to stabilization services/other services to continue to work towards stabilization/resolving symptoms and/or challenges in a community setting could meet criteria for discharge without full resolution of crisis/distress leading to initial mobile response (given safety has been addressed). For youth discharge language should include connections to intensive care coordination as an alternative to inpatient hospitalization and/or residential interventions, as determined necessary. It is also noted that discharge to an emergency room is a temporary “treatment” option. MRSS is designed to divert and/or discharge from emergency departments.	**No Change:** Thank you for your comment.
027	12/1/2023	503H.3, page 3	Community-Based Mobile Crisis Intervention Services: Language for youth should be incorporated: • Developmentally appropriate child and family assessment • Crisis de-escalation • Facilitates the return to school, vocational activities, and extracurricular activities. • Evidenced informed care coordination that is inclusive of community engagement.	**No Change:** Thank you for your comment**.**

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
028	12/1/2023	503H.5, page 3	Screening and Assessment: This section is very clinical. Assessment should recognize factors contributing to the crisis beyond behavioral health diagnosis to include focus on safety/risk, strengths and needs in addition to and/or over diagnostic impression. Recommend inclusion of social determinants of health and specific consideration of a more comprehensive assessment of needs. Screening and assessment requirements for youth need to be: • Clinically indicated and developmentally appropriate child and family assessment to include: o Caregiver stress o Developmental delays o Education: academic, attendance and behavior changes o Suicidal ideation, history, and interventions o Trauma history o Support system SUD language should be broader than “intoxication”.	**No Change:** Thank you for your comment.
029	12/1/2023	503H.6, page 3	Crisis Planning and Brief Counseling: Brief counseling is named in this area but then defined and outlined in 503 H.7. Crisis planning for youth should include: • In-home stabilization services are made available up to 8 weeks for the youth and family, as indicated by need, and includes access to: o Evidenced informed care coordination with a focus on community connections o Clinical brief family interventions • In coordination with youth and family, ensure that developmentally appropriate assessment is reviewed, updated and implementation strategies are developed. • Care plan is updated implemented and updated.	**No Change:** Thank you for your comment.

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
030	12/1/2023	503H.7, page 4	Crisis Resolution and Debriefing: Crisis resolution for youth should include: • In-home stabilization services are available up to 8 weeks for the youth and family, as indicated by need. • Use of evidenced informed care coordination. • In coordination with youth and family, ensure that developmentally appropriate assessment is reviewed, updated and implementation strategies are developed. • Care plan is updated implemented and updated.	**No Change:** Thank you for your comment.
031	12/1/2023	503H.8, page 5	H.8 Crisis Coordination: An essential consideration for youth in crisis de-escalation is the focus on community connection and re-engagement in school and other developmentally appropriate activities as the main activities. Sequencing the connection to formal interventions such as outpatient and intensive outpatient interventions requires the teams to be intentional in working with the young person. This coordination takes place in an evidenced informed care coordination model. Stabilization services are available within the home inclusive of evidenced informed care coordination, clinical support for the young person. Care coordination includes development of Plans of Care based on the individual's strengths and needs across multiple domains, to include a strengths discovery as part of the assessment. Identification of strengths contributes to the stabilization and Plan of Care development. Emphasis on developing natural supports and engagement in community such as recreational and social activities is included in addition to consideration of clinical and formal supports.	**No Change:** Thank you for your comment.
032	12/1/2023	503H.9, page 6	Provider Qualifications: Are these three provider types inclusive of all providers who might be able and willing to provide the service. The SPA also lists CCBHCs, should they be added?	**No Change:** Thank you for your comment.

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
033	12/1/2023	503H.10, page 6	H.10 Staff Qualifications: Both mobile response services and care coordination services can be performed bachelor's prepared staff, trained peers, master level, non-licensed staff. More important than licensure or degree are training, skills, and value base. Requiring a licensed clinician for every response challenges an already taxed workforce and results in vacancies and lack of capacity to do work. It is sufficient to have a clinician available to teams to provide support by phone, telehealth, or in person as the situation requires. Similarly, while responses in pairs may be more desirable in many cases (for worker safety, managing multiple family members in crisis etc.). In other instances, it may be unnecessary and a poor use of resources as they could be used in response to other callers. One example is responding to schools or other locations where additional professionals and supports are already onsite. Some discretion on the part of providers allows for more flexible and individualized service delivery. The two-person team requirement could be met by having the second party connecting via telephonic or virtual telehealth for part of the assessment process. For youth consider allowing teams to include paraprofessionals and peer partners as the mobile team with clinicians available. Teams who work with children, youth and families need to have expertise to meet their unique needs.	**No Change:** The current wording is pursuant to federally approved State Plan Amendment.
034	12/1/2023	503H.11, page 7	Supervisory Staff: These standards, as written, appear to only allow for Master prepared and licensed individuals MFTs Professional Councilors for the use in the intervention and not in a supervisory role.	**No Change:** Thank you for your comment.
035	12/1/2023	503H.13, page 7	Direct-Care Staff: Rather than requiring one year of experience for direct care staff, consider specific training requirements or standards.	**No Change:** The wording is pursuant to federally approved State Plan Amendment.

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
036	12/1/2023	503H.14, page 8	Documentation: The unique needs of youth and families in policy and documentation should be recognized, especially in coordination and engagement with law enforcement. Best practice for youth requires that law enforcement is only engaged at the request of the family. For youth and their families, criteria for face-to-face responses should be broad, encouraging mobile responses for any youth or family defined crisis and not limited to high acuity or risk scenarios. Broader language is needed to allow for the "just go" set forth in the National MRSS Best Practices. For children and their families, follow-up stabilization care coordination services should be available for up to 8 weeks (currently says 4) as outlined in current BBH contracts.	**No Change:** The wording in this section is pursuant to federally approved State Plan Amendment.
037	12/1/2023	503H.15, page 10	Billing Procedures: Allow for follow-up billing for up to 8 weeks per current (and best) stabilization services practices for children and their families. Glossary: Same comment as above regarding Supervisory Staff. Should this include a broader array of Master-prepared, and licensed supervisory staff?	**No Change:** The wording in this section is pursuant to federally approved State Plan Amendment.

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
038	12/1/2023	503H.13 page 7	Is there a certification protocol for the peers other than the current SUD PRSS process? Are there any required trainings? For the Peer Parent staff, will BMS develop the specialized training requirements of this program and how will the qualified individuals be maintained (e.g. with BMS keep a list of those that have completed the requirements)? What frequency does this training need to be completed? Will these individuals have an NPI? Direct Care Staff, Section 503H.13: Can additional clarification be given on the Crisis Specialist as Direct Care? Why separate the Crisis Specialist if allowing two mentors to be a "team"? Mobile Crisis Support Response Team requires two direct care staff, however, it does not appear that a Crisis Specialist be one of the two staff people. We would encourage the team to require, at a minimum, one Crisis Specialist and one Direct Care staff (peer mentor), and unbundle the crisis specialist from the direct care definition. Define "access to" MA clinical staff for the team. Define "under the supervision of" the clinical supervisor. Define "attestation to support credentialing" for peers. Suggestion that required documentation have start and stop times listed, rather than duration.	**No Change:** Requirements for these provider types are described in 503H.13 and the glossary.
039	12/1/2023	503H.1, Page 2	Page 2 – 503H.1 Medical Necessity Criteria – It would be helpful for the issue of services such as CRU, Crisis shelter, etc. to be addressed. It currently states the services are not available when an individual is admitted to an inpatient facility only.	**No Change:** Thank you for your comment.
040	12/1/2023	503H.4, page 3	503H.4 Community-Based Mobile Crisis Intervention Services – What about activities that occur prior to a provider actually being able to establish a medical record?	**No Change:** Thank you for your comment.

Number	Date Received	Section Reference	Comment	Bureau for Medical Services (BMS) Response:
041	12/1/2023	503H.10, page 6	503H.10 Staff Qualifications – Need to utilize a trained Bachelor's level with 2 years of experience instead of a Master's level person to present for a face-to-face situation while maintaining Master's level staff available for immediate consultation. Recommendation is made as a result of continuing workforce issues.	**No Change:** The federally approved State Plan Amendment requires the Master's level clinician.
042	12/1/2023	503H.13, page 7	503H.13 Direct Care Staff – Can the Crisis Specialists also serve in the role as the Case Manager?	**No Change:** In theory, if both Crisis Specialist and Case Manager requirements are met, however we would strongly urge caution and internal legal review regarding self-referral prohibition as we are unable to provide legal advice.
043		503H.14, page 8	503H.14 Documentation – The list provided for mobile crisis response services may not include the entire list provided in this draft; these are crisis situations and the level of information requested may not be possible to obtain at that moment. Consider the information that is minimally necessary and then make an additional list of other items that the staff can try to obtain.	**No Change:** Thank you for your comment.
044		503H1, page 4B Application	Appendix 503H1 – Mobile Crisis Team Services Application – Page 4 B – this document only provides for adolescents and adults; what about children/youth?	**No Change:** Thank you for your comment.