Medicaid Services Manual
Transmittal Letter

January 30, 2024

To: Custodians of Medicaid Services Manual

From: Casey Angres
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 400 – Mental Health and Alcohol/Substance Use Services

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 400 – Mental Health and Alcohol/Substance Use Services are being proposed to update the time and distance standards for Mobile Crisis Response Delivered By Designated Mobile Crisis Team (DMCT). Clarification is provided for team members who are certified peer and recovery support services providers.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: This proposed change affects all Medicaid-enrolled providers delivering DMCT services. Those provider types (PT) include but are not limited to Behavioral Health Outpatient (PT 14), Certified Community Behavioral Health Center (PT 17) and Crisis Services (PT 87).

Financial Impact on Local Government: No financial impact is expected.

These changes are effective January 31, 2024.

Material Transmitted	Material Superseded
MTL OL Chapter 400 – Mental Health and Alcohol/Substance Use Services	MTL 12/23 Chapter 400 – Mental Health and Alcohol/Substance Use Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
Section 403.6I(1)	**Scope of Services**	Updated language to average response time for adults and children to one hour in Calrk and Washoe counties; updated to two hours in rural areas. Added language for telehealth response as soon as possible,

		within one hour; added face-to-face and in-person team members arriving within one hour in urban areas and within two hours in rural areas.
Section 403.6I(4)(d)(8)	**DMCT Provider Eligibility Requirements**	Clarified language to identify DMCT member as Certified Peer Supporter under the Nevada Certification Board who is Qualified-Behavioral Aide (QBA)-level.

2. Provider Qualifications: QMHPs may provide CI services. If a multidisciplinary team is used, the team must be led by a QMHP. The team leader assumes professional liability over the CI services rendered.

3. Service Limitations: Recipients may receive a maximum of four hours per day over a three-day period (one occurrence) without prior authorization. Recipients may receive a maximum of three occurrences over a 90-day period without prior authorization.

Service Limitations	Children: CASII	Adults: LOCUS
Levels I to VI	• Maximum of four hours per day over a three-day period (one occurrence) • Maximum of three occurrences over a 90-day period	• Maximum of four hours per day over a three-day period (one occurrence) • Maximum of three occurrences over a 90-day period

4. Admission Criteria: Clinical documentation must demonstrate that the recipient meets any combination of the following:

   a. Recipient's behavior requires immediate and intensive interventions to help stabilize the current situation and prevent hospitalization;

   b. Recipient presents a moderate risk of danger to themselves and others (or to deteriorate to this dysfunctional level);

   c. Recipient's immediate behavior is unmanageable by family and/or community members; and/or

   d. Recipient will benefit from the stabilization, continuity of care and the referrals for ongoing community mental and/or behavioral health services.

403.6I MOBILE CRISIS RESPONSE DELIVERED BY DESIGNATED MOBILE CRISIS TEAM

On September 17, 2021, per Section 9813 of the American Rescue Plan Act (ARPA), the Nevada DHHS was awarded a state planning grant by the US Centers for Medicare & Medicaid Services (CMS) to assist in the development and implementation of qualifying community-based mobile crisis intervention services under its Medicaid state plan. In addition, Section 9813 of the ARPA established Section 1947 of the US Social Security Act (SSA), which authorizes optional state plan coverage and reimbursement for qualifying mobile crisis intervention services with a temporarily enhanced 85 percent federal medical assistance percentage (FMAP) for 12 quarters during the timeframe of April 2022 to March 2027. Section 1947 also waives standard state plan requirements for state wideness, comparability, and provider choice, in addition to providing definition for

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qualifying community-based mobile crisis services.

The following policy is contingent upon State Plan Amendment (SPA) approval by CMS.

1. Scope of Services

Nevada shall ensure that Mobile Crisis Response teams respond in person at the location in the community where a crisis arises~~,~~ or a ~~location agreed upon by the family and Team~~ family's location of choice. For individuals 18 years of age and younger, responses in urban Clark and Washoe counties will be conducted face-to-face and in-person, ~~within a *proposed average response time* of 30 minutes in Clark and Washoe Counties~~ with an average response time within one hour; average response times for these individuals in rural areas are within two hours.~~and one hour in the rest of the state~~. For adults, responses in urban areas shall be within one hour and within two hours in rural areas. Telehealth responses in these locations shall be initiated as soon as possible, within one hour, with face-to-face and in-person team members arriving within one hour in urban areas and within two hours in rural areas. Nevada identifies these Mobile Crisis Response teams that comply with ARPA and the US SSA as DMCT.

The primary objective of this Mobile Crisis Response service is to offer "someone to come" in the crisis continuum, established through Senate Bill 390 (during the 81st Nevada Legislative Session) and subsequent legislation that formulates a comprehensive safety net of crisis services for all Nevadans. DMCTs will respond to an individual in crisis at the individual's location, 24/7/365.

While a crisis episode is not defined outside of the individual experiencing the crisis, the dispatch of a DMCT indicates a higher level of care is needed through an in-person response for the individual's acute/emergent episode of crisis. An assessment, including the evaluation of suicidality, is required to be delivered by a qualified and/or licensed behavioral health professional. The resulting intervention and stabilization of the crisis by the DMCT includes care coordination (through active engagement and "warm hand-off") and follow-up by providers. Care coordination is inclusive of coordinated transportation to other locations when recipients are determined to need facility-based care.

2. DMCT Access and Accessibility

   a. DMCT services shall be available 24/7/365 for in-person response and ensure 24 hour/7 days per week on-call coverage and back-up availability.

   b. DMCT services shall not be restricted to certain locations or days/times within the covered area. DMCTs shall:

DRAFT

1. Respond to wherever the recipient is in the community outside of a hospital or other facility settings.

2. Never require the individual in crisis to travel to the DMCT.

3. Respond to the preferred location based on individual in crisis and/or caregiver preference.

4. Respond with the least restrictive means possible, only involving public safety personnel when necessary.

5. DMCTs are expected to respond to dispatch through a designated call center and shall advise the designated call center of any changes to the DMCT's availability (i.e., in the event of self-dispatch to a crisis on-site).

c. DMCTs shall attempt to meet the needs of all Nevadans, with consideration given to the providers' identified catchment area and including specific populations (i.e., Tribal communities and multicultural communities, LGBTQ+, children and adolescents, aging populations, individuals with disabilities, individuals experiencing substance use, etc.).

d. For all DMCT providers, the individual served does not have to be a previous or existing client.

e. Continuity of operations and disaster plans shall comply with state standards, DHHS requirements for endorsement or credentialing, and DHCFP requirements for enrollment.

f. DMCTs shall have GPS devices linked to the designated call center(s) and a means of direct communication available at all times with all partners (including the crisis call center, Emergency Medical Services, Law Enforcement, Intensive Crisis Stabilization Service providers, and other community partners), such as a cellular phone or radio for dispatch.

g. DMCTs shall not refuse a request for dispatch unless safety considerations warrant involvement of public safety.

1. In such cases, DMCTs shall have established standardized safety protocols for community response and when public safety involvement is needed (e.g., in instances of serious injury, overdose, medical emergency, and imminent risk of harm).

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2. Policies shall appropriately balance a willingness to help those in crisis with the team's personal safety and not involve broad rules that would exclude whole populations (i.e., individuals actively using substances or those with a criminal history).

3. Ensure all interventions are offered in a clinically appropriate manner that respects the preferences of the individual in crisis and their supportive family systems while recognizing the need to maintain safety.

h. DMCTs shall accept all referrals from a designated call center and shall respond without reassessing the individual on-site only if the designated call center has completed an initial safety screen and provided the screening information to the DMCT.

i. DMCTs shall use available technology to support care coordination activities and to determine access to available post-crisis care options (e.g., through- health information technology, prior treatment information through crisis including safety plans, and psychiatric advance directive (PAD), hospital/provider bed availability, and appointment availability/scheduling).

j. DMCTs shall provide culturally and linguistically appropriate care.

k. Individuals with limited English proficiency or communication/language-based disabilities shall have timely access to interpretation/translation service(s), auxiliary aids, and ADA-compliant services (e.g., sign language interpreters, TTY lines).

l. Services to children and youth up to 18 years old shall adhere to DHHS DCFS System of Care core values and guiding principles.

m. DMCTs shall provide timely services to individuals in crisis as defined by state and federal regulations, policy, and/or guidance, including the DMCT Certification Criteria.

3. DMCT OPERATIONAL REQUIREMENTS

a. Inclusive Services

1. Screening

a. DMCTs must establish policies and protocols to ensure:

1. Consistent screening of all individuals, and

DRAFT

2. Documentation of all screenings and screening findings, and

3. Screenings are conducted only by QMHPs and QMHAs who have continuous access to a QMHP for consultation.

b. Selected screening tools must include use of adopted tools for evaluation of risk, violence, and suicidality.

1. Tools chosen must be nationally accepted or evidenced-based, peer-reviewed tools, and

2. Screening tools include the Columbia Suicide Screening Tool (Columbia) and other tools that meet state requirements.

2. Assessment

a. Mobile crisis teams must ensure a qualified team member (as outline in MSM 403.6I Provider Qualifications) completed a behavioral health assessment and documents the findings, when indicated.

b. Selected assessments tools must be:

1. Nationally accepted or evidenced-based, peer reviewed tools, and

2. Support evaluations necessary for an involuntary hold, when a hold is initiated.

c. Selected assessment tools may include the Collaborative Assessment & Management of Suicidality (CAMS) and other tools that meet state requirements.

d. Mobile crisis teams shall establish policies and protocols to ensure:

1. Consistent application of assessment tools as appropriate to the age of the individual receiving mobile crisis services and the circumstances, and

2. Documentation of assessment results.

e. Crisis and Safety Plans

DRAFT

1. Crisis and safety plans shall be shared with the individual, their supportive family system, and documented in their clinical record, and

2. As part of the crisis and safety planning, DMCTs must either complete an assessment indicating individual is able stay in current placement/location or coordinate the transfer of the individual to an appropriate higher level of care.

3. Medical Records

   a. Medical records shall be kept in accordance with documentation standards set forth in MSM Chapter 100 and MSM Chapter 400, and

   b. Shared with whomever is providing the services (the follow up provider where the individual is being discharged) to support coordination of care (i.e., triggering words, specific circumstances of individual, etc.)

4. Advance Directives

   1. DMCTs shall establish protocols regarding when to consider and assist with the completion of a Psychiatric Advance Directive (PAD), in accordance with state laws and regulations, and

   2. DMCTs must follow Nevada Medicaid guidance on advance directives, as set forth in MSM 100.

5. Harm Reduction

   1. When applicable, DMCTs shall educate individuals on harm reduction practices,

   2. DMCTs shall carry harm reduction supplies, including Fentanyl test strips, and

   3. Mobile crisis teams shall carry Naloxone and have team members trained on its administration (as specified in MSM 403.6I Provider Training).

6. Family Engagement

   1. Mobile crisis teams shall establish protocols to allow family members and other collateral contacts to represent an individual in

DRAFT

crisis, and

2. DMCTs shall follow Nevada Medicaid guidance on supported decision-making, as set forth in MSM 100.

7. Coordination of Care

a. DMCT providers shall coordinate timely follow-up services and/or referrals with providers, social supports, and other services as needed, including but not limited to:

1. Assigned case managers

2. Primary Care Providers (PCP)

3. Existing (or referral) behavioral health providers/care teams, including mental health and substance use disorder (SUD) support, where available

4. Harm-reduction resources, where available

5. Appropriately shared information with whomever is providing the services, the follow up provider, to where the individual is being discharged – to support coordination of care (i.e., triggering words, specific circumstances to individual, etc.)

b. Discharge from episode of care

1. DMCTs shall document discharge of the individual from the crisis episode in situations where

a. Acute/emergent presentation of the crisis is resolved

b. Appropriate referral(s) and service engagement(s) to stabilize the crisis are completed, including transfer to a Crisis Stabilization Center (CSC) or other level of care

c. Ongoing or existing services, supports, and linkages have been recommended and documented

d. Services provided (in-person or via telehealth) up to

DRAFT

72 hours following the initial engagement with the DMCT are considered part of the crisis episode (i.e., pre-discharge)

e. DMCTs may continue to provide bridge services and supports to the individual for up to 45 days for continued stabilization in an outpatient setting; these covered services rendered after 72 hours shall be billed to Medicaid by appropriately enrolled providers. with the appropriate outpatient billing codes

8. Telehealth

a. Reference Chapter 3400 related to telehealth modality. The use of telehealth shall be

1. Dictated by client preference

2. Utilized to include additional member(s) of the team not on-site

3. Utilized to provide follow-up services to the individual following an initial encounter with the DMCT

4. Utilized to include highly trained members of the team, such as psychiatrists, psychiatric nurse practitioners, or others who can prescribe and/or administer medications

b. Best Practices

1. An individual in crisis is to be represented in screening/assessment, crisis planning, and follow-up by a family member or other collateral contact that has knowledge of the individual's capabilities and functioning, especially when working with children and youth.

2. Reduce duplicative screening and assessments.

3. Access and review existing medical records/treatment information when available to support crisis intervention activities (e.g., seeking and leveraging clinical information from an existing crisis or safety plan, if available).

4. Providers are expected to develop and maintain a strengths-based, person-

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centered, trauma-informed, and culturally sensitive/respectful relationship with the individual.

5. Co-creation of a safety/crisis plan, when applicable.

6. Education for the individual on harm reduction practices, when applicable.

7. Regarding Peer-to-Peer Support Services, it is the intent of policy that the DMCT include one team member who is a certified peer and recovery support services provider (per Nevada Certification Board), to the greatest extent possible, as Peer Supporters will become mandatory team service providers, certified by DHHS and enrolled with Nevada Medicaid (per SB 390), by July 1, 2026.

c. Privacy and Confidentiality Protocols

1. Policies

a. Providers shall have established/written policies in compliance with State and Federal privacy and confidentiality laws (e.g., Health Insurance Portability and Accountability Act (HIPAA)), as well as established protocols set forth in accordance with MSM Chapter 100, Chapter 400, and Chapter 3300.

2. Training

a. DMCT Clinical Supervision is responsible for the initial and ongoing training of staff on privacy and confidentiality practices and protocols.

3. Collaboration and Data Sharing

a. DMCTs shall establish and maintain privacy and confidentiality policies and procedures to protect beneficiary information in accordance with State and Federal requirements, as well as DHHS oversight requirements.

b. Address what can and cannot be shared, especially in emergency situations.

c. Share screening and assessment information with the receiving clinical/medical provider, including crisis plans and PADs.

DRAFT

d. Develop and implement appropriate data-sharing agreements with partners, ensuring partners are also securing any data covered by state and federal privacy regulations.

e. Develop data sharing protocols and member information release authorizations to support collaboration practices in accordance with state and federal requirements.

f. Have formal, written, collaborative protocols, memorandums of understanding (MOU), and other agreements with community partners, as necessary:

1 Local Law Enforcement agencies

2 Emergency Medical Services (EMS) providers

3 988 crisis lines, designated crisis call centers, and dispatch centers providing service coordination among respondents

4 Medicaid Managed Care Organizations (MCO), as applicable in their catchment area.

d. Excluded Services

1. Services not eligible for reimbursement when rendered by a DMCT under Nevada Medicaid include:

a. Crisis services delivered without a screening or assessment, and/or

b. Crisis services delivered solely via telehealth without the availability of an in-person response to the individual in crisis, and/or

c. Crisis services delivered by one-member teams or one individual provider only, and/or

d. Crisis services delivered by a DMCT that is not enrolled under Provider Type and Specialty in Nevada Medicaid at the time service is rendered, and/or

e. Crisis services delivered by a Law Enforcement officer, and/or

f. Crisis services delivered within a hospital or nursing facility setting.

4. DMCT PROVIDER ELIGIBILITY REQUIREMENTS

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a. DMCTs must be endorsed or certified by DHHS

b. DMCTs must be enrolled as a Nevada Medicaid provider

c. DMCTs must include at least two team members, one of which shall be able to deliver the service at the location of the individual in crisis. DMCTs must be led by a:

1. QMHP-level Independent Professional, or

2. QMHP-level Intern under Direct Supervision of a QMHP-level Independent Professional, or

3. QMHA-level paraprofessional under the Direct Supervision of a QMHP-level Independent Professional.

d. DMCT members shall fall into one of the following categories:

1. Physician

2. Physician Assistant

3. Advance Practice Registered Nurse (APRN) and Independent Nurse Practitioner (NP) with a focus in psychiatric mental health

4. Psychologist

5. LMFT, LCSW, LCPC, and qualified Post-Graduate Interns (under clinical supervision)

6. Registered Nurse and QMHA-level

7. Substance use disorder (SUD) specialists: Licensed clinical alcohol and drug counselors (LCADCs), licensed alcohol and drug counselors (LADCs), certified alcohol and drug counselor (CADCs), and/or associated interns of these specialties (under supervision)

8. Certified Peer Supporter (per Nevada Certification Board) and Qualified Behavioral Aide (QBA)-level

e. Provider Supervision