

Office of Mental Health | Department of Health

New York State Crisis Intervention Benefit:

Crisis Residence Component

Medicaid Managed Care Benefit and Billing Guidance

February 2025

Introduction: Crisis Residence Services

The Crisis Intervention (CI) benefit, including Crisis Residence services (implemented in 2019), was authorized under the New York State (NYS or the State) 1115 waiver as a demonstration benefit for adults aged 21 and older in Medicaid managed care. Crisis Intervention services for youth up to age 21 were developed under the Children and Family Treatment and Support Services (CFTSS) benefit implemented through the Children's Medicaid Transformation in 2019. Medicaid Advantage Plus (MAP) Plans began covering the CI benefit in January 2023.[1] Crisis Residence programs are an important part of the statewide comprehensive crisis service continuum and are intended to help avert extended emergency room visits and inpatient hospitalizations.

On June 29, 2023, NYS received approval from the Centers for Medicare and Medicaid Services (CMS) for the CI *State Plan Amendment (SPA) #22-0026*. The CI SPA has an effective date of April 1, 2022. The CI SPA consolidated and aligned Medicaid authority, coverage, and reimbursement policies for children and adult Mobile Crisis services. Crisis Residence services for adults, which were previously authorized under the NYS 1115 waiver, are now State Plan services. Crisis Residence services for children authorized under the CFTSS benefit remain State Plan services under the CI SPA.

This document provides an overview of the types of services provided by Crisis Residence programs and guidance about the Medicaid managed care benefit and billing requirements for children, youth, and adults. Medicaid reimbursement for the Crisis Residence benefit is available through Medicaid fee-for-service (FFS) and Medicaid Managed Care Plans (collectively referred to as MMCPs), including Mainstream Medicaid Managed Care Organizations, Health and Recovery Plans (HARPs), HIV Special Needs Plans (HIV SNPs), and Medicaid Advantage Plus (MAPs) Plans. MMCPs must reimburse for services provided under the CI SPA and meet network requirements as outlined in this guidance.

Until such time as the *Transition of Behavioral Health Benefit into Medicaid Managed Care and Health and Recovery Program Implementation*, the *Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract* *(Medicaid Managed Care Model Contract)*, the *Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus*, the *Medicaid Advantage Plus (MAP) Model Contract*, and the *CFTSS Provider Manual* are updated to reflect requirements applicable to CI services, the provisions contained therein regarding CI services remain applicable, except where this guidance and any of the documents listed above conflict, this guidance will be applicable.

This document is organized into the following five sections:

I. Overview and Program Standards;
II. Crisis Residence Program Descriptions;
III. Crisis Residence Program Standards;
IV. Medicaid Managed Care Plan Requirements for Crisis Residence Programs; and
V. Rates and Billing Requirements.

[1] MAP Plans are required to cover the two Adult Crisis Residence Programs (Intensive Crisis Residences and Residential Crisis Support). MAP Plans are not required to cover Children's Crisis Residences. MAP Plan enrollees under 21 years old can access Children's Crisis Residence through Medicaid FFS.

I. Overview and Program Standards

Crisis Residence programs are licensed and regulated by the Office of Mental Health (OMH) pursuant to Part 589 of Title 14 of the New York Codes, Rules, and Regulations. These regulations establish standards for the operation of Crisis Residence programs to provide short-term residential support to individuals exhibiting symptoms of mental illness who are at risk of experiencing or are experiencing a psychiatric crisis.

Crisis Residence programs address the cause of an individual's psychiatric crisis and avert or delay the need for emergency department stabilization or acute psychiatric inpatient hospitalization. Programs provide services and supports to stabilize and transition individuals into the community. Crisis Residence programs are appropriate for individuals experiencing a period of acute stress significantly impairing their capacity to cope with life circumstances.

Crisis Residence programs are an integral part of the State's coordinated behavioral health (BH) crisis response continuum of care. They offer a safe place for the stabilization of psychiatric symptoms and provide services ranging from support to treatment.

Crisis Residence programs provide short-term stays and are not permanent or long-term housing.

Crisis residences are:

- *Recovery/Resiliency oriented*: Services are provided based on the principle that all individuals have the capacity to recover from mental illness or addiction disorders. Services are strength-based and determined by the individual's own path to recovery and resiliency;
- *Person-centered/Family Driven and Youth Guided*: The strengths, needs, preferences, experiences, and cultural backgrounds of individuals are reflected in the services and supports identified in an individual's service plan;
- *Trauma-informed*: Services are provided within the context of understanding trauma, and recognize and are responsive to the effects of trauma; and
- *Culturally and linguistically responsive*: Cultural and linguistic responsiveness describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including the tailoring of health care delivery to meet patient's social, cultural and linguistic needs.

II. Crisis Residence Program Descriptions

Crisis Residence programs include the following modalities: Residential Crisis Support, Intensive Crisis Residence and Children's Crisis Residence. Previously, Residential Crisis Support and Intensive Crisis Residence programs followed CFTSS requirements for individuals aged 18-20. Effective April 1, 2022, there are no longer different requirements for individuals aged 18-20 in a Residential Crisis Support or Intensive Crisis Residence.

1. <u>Residential Crisis Support</u>

A. Residential Crisis Support Definition

Residential Crisis Support is a short-term, voluntary, residential program for individuals aged 18 and older experiencing symptoms of mental illness or challenges in daily life that create risk for an escalation of symptoms that cannot be managed in the individual's home and community environment

without on-site supports. Individuals may receive Residential Crisis Support Program services for up to 28 consecutive days.

Expected outcomes of this program are crisis symptom(s) stabilization by addressing the cause of the crisis and averting or delaying the need for acute psychiatric inpatient hospitalization or emergency services through connections to community services and supports identified in the service plan.

B. Residential Crisis Support Service Components

Residential Crisis Support programs must develop an admission process to: determine if the individual is appropriate for admission; screen for risk of harm to self and others; identify substance use issues, strengths and protective factors, housing needs, employment status, and identification of goal(s) to stabilize psychiatric crisis symptoms, treatment or other community providers, cultural / linguistic / religious considerations, and recovery goals.

Residential Crisis Support programs must offer the following service components:

- Individual Service Planning;
- Psychiatric Crisis Rehabilitation and Skills Training;
- Peer Support;
- Crisis/Safety Planning;
- Care Coordination;
- Medication Management and Training; and
- Medication Monitoring.

2. Intensive Crisis Residence

A. Intensive Crisis Residence Definition

Intensive Crisis Residence is a short-term, voluntary, residential treatment program for individuals aged 18 and over experiencing an acute escalation of mental health symptoms. Individuals may receive Intensive Crisis Residence services for up to 28 consecutive days. Individuals in need of Intensive Crisis Residence services are at imminent risk for loss of functional abilities and may raise safety concerns for themselves and others without this level of care. The immediate goal of Intensive Crisis Residence programs is to provide treatment and supports to help the individual stabilize crisis symptoms. Intensive Crisis Residence programs can also be used as a subacute, step-down level of care after discharge from an inpatient hospitalization or after presenting at other emergency services, such as a Comprehensive Psychiatric Emergency Program (CPEP) or an Emergency Department if the individual requires additional treatment.

B. Intensive Crisis Residence Services Components

Intensive Crisis Residence programs must develop an admission process to: determine if the individual is appropriate for admission; screen for risk of harm to self and others; identify substance use issues, strengths and protective factors that can and should be used in goal planning, housing needs, employment status, and identification of goal(s) to stabilize psychiatric crisis symptoms, treatment or other community providers, prior treatment history, including what has worked and not worked in the past to stabilize the individual during and after a crisis, barriers and limitations, cultural / linguistic / religious considerations, and recovery goals.

A primary mental health diagnosis is required to receive treatment services in an Intensive Crisis Residence Program. This diagnosis may be obtained after admission.

Treatment services must be provided by licensed mental health professionals operating within their scope of practice. In addition to treatment services, Intensive Crisis Residence programs must provide all the required services provided by Residential Crisis Support programs in addition to the following additional service components:

- Mental Health and Substance Use Assessments;
- Service Planning;
- Crisis/Safety Planning
- Individual, Family, and Group Counseling;
- Care Coordination;
- Peer Support;
- Medication therapy;
- Medication Monitoring;
- Medication Management and Training; and
- Psychiatric Crisis Rehabilitation and Skills Training.

3. Children's Crisis Residence

A. Children's Crisis Residence Definition

Children's Crisis Residence is a voluntary sub-acute treatment program for youth ages 5-20 intended to stabilize a child who is at risk of experiencing or experiencing a psychiatric crisis and assists with restoring the youth to a level of functioning that supports their transition back to a lower level of care. Youth in need of a Crisis Residence may require such a level of care after having been diverted from inpatient hospitalization or after presenting at other emergency services, such as a Comprehensive Psychiatric Emergency Program (CPEP) or an Emergency Department. In addition, children in the community who may have required mobile CI services or other community-based BH services, may be determined appropriate for additional services through a crisis residence program, until such time as they can return home or to the community safely and with adequate supports. Children's Crisis Residence are intended to be short-term with an anticipated stay of up to 21 days. Stays may be extended up to 28 days when the need presents.

B. Children's Crisis Residence Services Components

For youth aged 18-20, determination of whether a Children's Crisis Residence, Residential Crisis Support, or Intensive Crisis Residence program is most appropriate must be made by the individual, their parent/guardian (as appropriate) and the provider(s). Youth cannot be admitted to a Children's Crisis Residence program for the sole purpose of receiving any one of the below program components as a standalone service.

The Children's Crisis Residence must work to support the child's transition to a lower level of care and ensure the receipt of adequate community-based services and supports post discharge to prevent or reduce future psychiatric crises. The crisis residence provides 24/7 monitoring and supervision, as well as intensive crisis treatment and support for the child, family, and caregivers to facilitate the child's successful return to home or the community.

The program and environment are designed to:

- Stabilize the child's psychiatric crisis symptoms and prevent unnecessary inpatient or residential admission or stabilize the child to prevent psychiatric crisis;
- Restore the child to a level of functioning and stability that supports the child's transition to community-based services and supports;
- Mobilize the resources of the family and community to support the child's on-going treatment and recovery needs in order to prevent future crises, or to reduce the intensity and duration of crises that may arise; and
- Provide a safe and therapeutic living environment where services are delivered through a trauma-informed approach and are consistent with the child's conditions and needs.

Programs must clearly define their admission criteria in accordance with the following:

- Child or youth is under the age of 21;
- Youth must meet medical necessity for the Crisis Residence program;
- Youth must be experiencing, or be at risk of, a psychiatric crisis;
- Youth is not at imminent risk of harm to self or others; and
- Parent or guardian provides consent for any child or youth, unless the youth is legally authorized to consent to their own treatment.

Children's Crisis Residence programs are expected to deliver the following components of the Medicaid Service Crisis Stabilization/Residential Supports:

- Mental Health and Substance Use Assessment;
- Service Planning;
- Crisis/Safety Planning;
- Care Coordination, including consultation with Psychiatric prescribers;
- Individual, Family, and Group counseling;
- Health Screening;
- Medication Monitoring;
- Medication Management and Training;
- Psychiatric Crisis Rehabilitation and Skills Training; and
- Family/Caregiver Psychoeducation and Support.

III. Crisis Residence Program Standards

1. Provider Licensure, Oversight, and Setting Standards

In order to provide Medicaid billable Crisis Residential services, Crisis Residence providers must be licensed by OMH.

OMH licensed Crisis Residence provider agencies must:

- Enroll in the NYS Provider Medicaid program, as directed by NYS Department of Health (DOH); and
- Comply with the settings standards outlined in *Part 589 of Title 14 of the New York Codes, Rules, and Regulations.*

IV. Medicaid Managed Care Plan Requirements for Crisis Residence Programs

1. Medicaid Managed Care Plan Credentialing

MMCPs must accept the Crisis Residence program's OMH license to fulfill the MMCP's credentialing requirements. Licensure can be verified by a current Operating Certificate authorized by OMH. The MMCP may not individually credential any Crisis Residence staff. The State's approval of a Crisis Residence provider meets the MMCP's credentialing requirement to ensure Crisis Residence providers possess the qualifications to provide Crisis Residence services.

MMCPs must ensure Crisis Residence provider agencies are licensed by OMH, and their staff have not been disqualified or de-barred from participation in any other federal or State program, per Section 21.4(a)(ii) of the *Medicaid Managed Care Model Contract*.

MMCPs maintain responsibility to ensure program integrity pursuant to federal law. The MMCP's credentialing committee shall develop and adhere to procedures consistent with 42 CFR 455.436, Sections 18.9 and 21.4(a)(ii) of the *Medicaid Managed Care Model Contract,* and Section 18.9 of the *MAP Model Contract*. If an MMCP determines a Crisis Residence provider or a practitioner providing Crisis Residence services to a Medicaid beneficiary is excluded, any claims submitted for services provided by such provider or practitioner must be denied.

2. Network Adequacy Requirements and Reporting

MMCPs must ensure access to Crisis Residence services for their enrollees, as outlined in this guidance. NYS will continue to monitor network adequacy for Crisis Residence services using the Children's Network Contracting Status Report (Exhibit 4) and Crisis Services Contracting Status Report Workbook (Exhibit C) network reporting templates.

Section 21.19(d) of the *Medicaid Managed Care Model Contract* mandates MMCPs contract with an adequate number of Crisis Intervention services providers. Section 1.0(A)(21)(ii) of the *Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus* requires MMCPs to contract with all OMH licensed Crisis Residence providers operating in their service area.

MMCPs are required to reimburse OMH licensed Crisis Residence providers for services delivered to their enrollees regardless of the provider's contracting status, pursuant to Section 10.13(d)(ii)(D) of the *Medicaid Managed Care Model Contract* and Section 1.0(A)(2)(ii) of the *Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus*.

3. Culturally and Linguistically Responsive Provider Networks

Pursuant to Sections 15.10 and 15.11 of the *Medicaid Managed Care Model Contract* and Section 15.3 of the *MAP Model Contract*, MMCPs must maintain a culturally responsive provider network capable of delivering services to all enrollees including those with limited English proficiency. Information on the NYS approved cultural competence training offered by the United States Department of Health and Human Services (HHS) can be found in *Cultural Competency Training for Participating Providers*. MMCPs must arrange for language assistance services and adequately reimburse Crisis Residence providers for language assistance services when network providers cannot meet an enrollee's language needs. MMCPs are also responsible for informing Crisis Residence providers how to access

and be adequately reimbursed for language assistance services for enrollees with limited English proficiency.

4. Utilization Management (UM)

Pursuant to Section 10.21(a) of the *Medicaid Managed Care Model Contract* and Section 10.7(c) of the *MAP Model Contract*, MMCPs must adhere to State-issued UM and level of care guidelines for making initial and ongoing mental health level of care decisions. In addition, MMCPs must utilize evidence-based, peer-reviewed, and age-appropriate medical necessity criteria that has been reviewed and approved by OMH, in consultation with DOH, as required by NYS Public Health Law §4902. To aid MMCPs in developing compliant medical necessity criteria, OMH issued *OMH Guiding Principles for the Review and Approval of Clinical Review Criteria for Mental Health Services* (*OMH Guiding Principles*). MAP Plan utilization management and eligibility requirements for Residential Crisis Support Programs and Intensive Crisis Residences are the same as the requirements in HARPs and the Mainstream Managed Care Plans. Please refer to the *New York State Medicaid Advantage Plus (MAP) Plans Behavioral Health Billing and Coding Manual* for additional information.

Prior authorization for Medicaid managed care enrollees to access Crisis Residence services is prohibited.[2] Crisis Residence providers determine whether an individual is appropriate for admission based on OMH-approved admission criteria.

Crisis Residence providers must notify MMCPs within two business days of an enrollee's admission. OMH developed suggested Crisis Residence Admission Notification Forms. These forms are not required; however, they contain the necessary information providers must submit to a MMCP within two business days of an individual's admission. MMCPs may use the OMH developed forms or create their own but can only require providers to submit the information contained within the Crisis Residence Admission Notification Forms.

Crisis Residence services must be recommended by a Licensed Practitioner of the Healing Arts (LPHA) operating within their scope of practice, who may or may not be employed or contracted by the Crisis Residence program. The LPHA recommendation is not required prior to admission and the absence of it at referral should not be used as exclusionary criteria. The recommendation should be obtained prior to discharge, signed by the LPHA, and documented in the individual case record to reflect medical necessity from the date of admission. LPHA recommendations are valid through a recipient's episode of care.

MMCPs may request documentary evidence of an LPHA recommendation for provider quality management purposes. It is the Crisis Residence provider's responsibility to retain LPHA recommendation information in the recipient's case record. Additional information on the LPHA recommendation can be found in the *Crisis Residence Program Guidance*.

MMCPs may conduct UM, other than prior authorization, only when State-approved predefined, clinical, or quality improvement-based triggers outlined in this guidance are met and only in a manner that complies with state and federal mental health and substance use disorder parity laws.

If UM is conducted for Crisis Residence services, coverage determinations must be based on the MMCP's evaluation of all of the following domains, which should be clearly described in the MMCP's approved clinical review criteria:

[2] *Medicaid Managed Care Model Contract,* Emergency Services- Section 10.13(e), and Mental Health Services- Section 10.21(i).

- Risk of harm;
- Functional status;
- Co-morbidity;
- Level of stress and support in the recovery environment;
- Treatment and recovery history; and
- Engagement and recovery status.

Residential Crisis Support is consistent with Basic Services – Prevention and Health Maintenance in the Level of Care Utilization System (LOCUS) published by the American Association for Community Psychiatry (AACP). Intensive Crisis Residential programs are consistent with Medically Monitored Residential Services in the LOCUS. Children's Crisis Residence programs are consistent with Basic Services – Prevention and Health Maintenance in the Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) published by AACP and the American Academy of Child and Adolescent Psychiatry (AACAP). Crisis Residences are appropriate for any individual with a mental health diagnosis who is experiencing psychosocial stressors that exceed their capacity to cope. Environmental stressors, rather than clinical acuity, are the deciding factor for admission to this level of care. The main purpose of this program is to connect the individual to more permanent community services and prevent a deterioration in clinical status.

In line with the *OMH Guiding Principles*, clinical review criteria that only takes into consideration current symptoms and current level of risk in determining continued stay is not appropriate and will not be approved for use. For example, the MMCP may not deny continued stay if an individual's crisis symptoms have stabilized but their living situation or medical comorbidity poses an imminent threat of decompensation, and a plan for the resolution of that situation is included in the Crisis Residence's service plan for that individual. Utilization review should be an interactive process between the MMCP and the provider to review the patient's progress and if necessary, problem solve challenges to discharge.

MMCPs are required to work collaboratively with Crisis Residence providers to share relevant information supporting the recipient's treatment, care coordination, and discharge planning. If there are barriers to discharge, a discussion between the MMCP and Crisis Residence provider can identify strategies to resolve them. The frequency of communication should reasonably reflect the complexity of the recipient's treatment and care coordination needs.

Once determined, Crisis Residence providers must notify the MMCP of the individual's discharge date. Lengths of stay for Medicaid managed care enrollees cannot exceed 28 days per admission in an OMH licensed Crisis Residence without State approval. An individual may have multiple admissions providing there is appropriate documentation demonstrating need. The expected length of a child's stay in a Children's Crisis Residence is less than 21 days.

Individuals admitted to Crisis Residence programs may continue to receive previously authorized community-based outpatient services or new outpatient services identified as part of the individual's Crisis Residence service plan. MMCP authorization of these services cannot be restricted because of an individual's Crisis Residence admission.

A. Concurrent Review for Supportive and Children's Crisis Residences

Even though the expected maximum length of stay for Supportive Crisis Residences is 28 days,

concurrent review cannot begin until day 30 unless the provider fails to notify the MMCP of the admission or provide an initial treatment plan within two business days. Concurrent review for Children's Crisis Residences cannot begin until day 15.

Periodic consultation between the MMCP and Crisis Residence provider is required during the time in which the MMCP is not conducting concurrent review. Consultation should occur as frequently as necessary, beginning early in the stay for individuals with multiple or complex needs (e.g., individuals who need referrals to multiple different agencies for wrap around services; are disengaged from previously effective outpatient and/or residential programs; develop new conditions their prior community supports may not be able to adequately address, etc.) and for all residents by no later than day 28 for Residential Crisis Support and by no later than day 21 for Children's Crisis Residences. The frequency of consultation should be individualized based on the recipient's needs and should not be tied to concurrent review.

B. Concurrent Review for Intensive Crisis Residences

Even though the expected maximum length of stay for Intensive Crisis Residences is 28 days without state approval, concurrent review for Intensive Residences cannot begin until day 30 unless the provider fails to notify the MMCP of the admission or provide an initial treatment plan within two business days, or if an enrollee meets a clinical criteria designated by OMH, which is outlined below and will be codified in OMH regulations. If the below clinical criteria are met, MMCPs should notify the provider to inform them of such. When conducting concurrent review for individuals meeting clinical criteria, MMCPs should also refer eligible individuals who consent to referral to Health Home Plus (HH+) or a Specialty Mental Health Care Management Agency.

Periodic consultation between the MMCP and Crisis Residence provider is required during the time in which the MMCP is not conducting concurrent review. Consultation for Intensive Crisis Residences should occur as frequently as necessary, beginning early in the stay for individuals with multiple or complex needs (e.g., individuals who need referrals to multiple different agencies for wrap around services; who are disengaged from previously effective outpatient and/or residential programs; who develop new conditions their prior community supports may not be able to adequately address, etc.) and for all residents by no later than day 28. The frequency of case consultation should be individualized based on the enrollee's needs and is not tied to concurrent review.

The clinical criteria for Utilization Review of Intensive Crisis Residences prior to day 30 are as follows:

- Individuals subject to a current Assisted Outpatient Treatment (AOT) court order;
- Individuals who were previously subject to an AOT court order and such order expired within the past five years;
- Individuals who have multiple readmissions to a hospital, or emergency department, or crisis residence facility within the prior 12 months, including:
    - Three or more admissions to hospital for inpatient psychiatric services. Such admissions may be voluntary or involuntary;
    - Four or more psychiatric admissions to a hospital emergency department, including a Comprehensive Psychiatric Emergency Program within an emergency department;

    - Three or more admissions to a hospital for any other inpatient hospital services for individuals with a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder; or
    - Three or more admissions to a crisis residence facility;
- Individuals discharged from a hospital within the past thirty days who have not received ambulatory mental health aftercare services; or
- Individuals discharged from a hospital within the past thirty days who have not received ambulatory primary care aftercare services.

For the purposes of this guidance, hospital shall have the same meaning assigned to such term in section 1.03 of the mental hygiene law which includes the inpatient services of state psychiatric centers, county inpatient psychiatric facilities, and a ward, wing, unit, or other part of article 28 hospitals providing services for the mentally ill pursuant to an operating certificate issued by OMH.

1. Member Services

MMCPs must ensure Member Services staff responsible for providing intake, referral, or crisis response referrals to enrollees receive adequate training regarding the Crisis Residence benefit and are provided access to updated training materials, whether these staff are employed by the MMCP directly or through subcontract.

2. Quality Management

As outlined in the *Medicaid Managed Care Model Contract* sections 16.1(c)(iii) and 16.2(d), MMCP BH UM Committees are charged with implementing a process to collect, monitor, analyze, evaluate, and report utilization and cost data, identify any findings of under and overutilization of BH services, interpret any variances, review outcomes, develop interventions, and approve interventions based on utilization and cost data.

MMCPs shall also develop and implement protocols for identifying participating providers that do not adhere to practice guidelines and for making reasonable efforts to improve the performance of these providers.

MMCPs should implement processes to ensure participating Crisis Residence providers are delivering services to enrollees according to State-issued guidelines. For State-issued guidelines for Crisis Residence Services, please refer to the *Crisis Residence Program Guidance*. MMCPs may conduct outlier management for purposes of enrollee care management and provider education. MMCPs shall have effective mechanisms to obtain information from Crisis Residence providers and report such information and related analytical data in a manner and format to be determined by the State and to evaluate the enrollee's level of care, service plan adequacy, provider qualifications, enrollee health and safety, financial accountability, and compliance with the terms of this guidance and the *Medicaid Managed Care Model Contract*.

V. Rates and Billing Requirements

Under the CI SPA authority, Medicaid billing rates and rate code structures for children and adult Crisis Residence services were consolidated and made uniform.

1. Rate Requirements

Pursuant to Section 10.13(d)(ii)(D) of the *Medicaid Managed Care Model Contract* and Section 1.0(A)(2)(ii) of *the Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus*, MMCPs must reimburse both participating and non-participating Crisis Residence providers for services delivered to their enrollees, and rates for non-participating providers must be the same rate as participating providers. MMCPs may not deny claims submitted by non-participating network providers for being out of network.

CMS-approved Medicaid fee-for-service rates for Crisis Residence services are effective April 1, 2022, and are posted on the *OMH Medicaid Reimbursement Page*. Pursuant to Chapter 57 of the Laws of 2022 and as a result of the approval of SPA #22-0026, MMCPs are required to pay State-mandated rates for adult and children Crisis Residence services effective April 1, 2022.

However, as MAP Plans began covering additional ambulatory BH services on January 1, 2023, any updates related to the CI SPA are only retroactive back to the MAP Plan BH carve-in date of January 1, 2023.

2. Billing

Only Crisis Residence providers licensed by NYS OMH and enrolled in the Medicaid program are eligible to bill for Crisis Residence services provided to a Medicaid beneficiary. Provider agencies must be enrolled as a Medicaid provider. Information on how to become a Medicaid provider is available on the eMedNY website: Provider Enrollment (emedny.org).

Providers are responsible for verifying an individual's enrollment in Medicaid and whether they are enrolled in a MMCP or in Medicaid FFS. Providers can verify enrollment in Medicaid using *ePACES*. Claims for services delivered to an individual in receipt of Medicaid FFS are submitted by providers to eMedNY. Claim submissions need to adhere to the 90-day timely filing rules for Medicaid FFS or the timely filing rules as required by the enrollee's MMCP, which may not be less than 90 days. Claims will not be paid if the individual is not enrolled in Medicaid, or the claims are billed to the incorrect Plan.

Per Section 21.22 of the *Medicaid Managed Care Model Contract* and Section 1.0(B)(i)(a) of the *Behavioral Health Guidance for Managed Care Organizations Carving Behavioral Health into Medicaid Advantage Plus*, MMCPs are expected to provide education and technical assistance related to claims submission and payment to Crisis Residence providers. MMCPs may also initiate claims testing with providers to ensure claims processing and payment procedures are accurately configured.

Each Crisis Residence program type has its own rate code, procedure code, and modifier combination that must be used. All claims must be submitted with the appropriate combination of rate codes, procedure codes, and modifiers for the service provided (see below). Please see the *New York State Health and Recovery Plan (HARP) / Mainstream Behavioral Health Billing and Coding Manual* for details on MMCP claiming and encounter reporting processes.

For crisis/emergency services, providers can use diagnosis code R69 or F99 if there is not an available diagnosis, outlined below. For Medicaid managed care claims, the primary diagnosis code field cannot be blank, otherwise the claim will be denied or rejected.

- R69: Illness, unspecified, a billable/specific ICD-10-CM code can be used to indicate a diagnosis

for reimbursement purposes; or

- F99: Mental disorder, not otherwise specified, a billable/specific ICD-10-CM code that can be used to indicate a diagnosis for reimbursement purposes.

Crisis Residence providers may bill one per diem visit in a twenty-four-hour period. Providers cannot bill on the date of discharge. To bill the per diem rate for Crisis Residence services, the individual must be at the residence overnight and utilize the single occupancy bedroom provided. Costs for room and board are not included in the rate for Crisis Residential services, as these costs are not reimbursable by Medicaid.

Program Type	Rate Code	Procedure Code	Modifier	Unit Measure	Length of Stay Limit
Residential Crisis Support (18+)	4625	T2034	HE	Per Diem	28 days per admission
Intensive Crisis Residence (18+)	4626	T2034	ET	Per Diem	28 days per admission
Children's Crisis Residence (up to age 21)	4627	T2034	HK	Per Diem	28 days per admission

For additional Medicaid managed care claiming and billing resources, please refer to the information available on the *Managed Care Technical Assistance Center (MCTAC) website and the MCTAC Interactive Billing Tool*.