# Children's Behavioral Health Mobile Response and Stabilization Services[1]

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Mobile Response and Stabilization Services (MRSS) is a specific kind of mobile crisis service and stabilization service for children and youth with behavioral health conditions. It is an upstream intervention for children and youth that are beginning to experience an acute behavioral health issue and are in crisis.[3] This evidence-based service can help prevent unnecessary emergency department utilization and hospitalization.

This fact sheet discusses the evidence-base for MRSS as well as children's right to access MRSS via Medicaid. It concludes with recommendations for concrete steps advocates can take to ensure that children can access MRSS when and where they need it.

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[2] Significant research for this Q&A was provided by Alexis Robles-Fradet, Health Policy Analyst, National Health Law Program.

[3] *Compare* SAMHSA, Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies (2014), https://store.samhsa.gov/shin/content//SMA14-4848/SMA14-4848.pdf (according to an environmental scan conducted by SAMHSA, all 50 states and the District of Columbia indicate that they provide some kind of crisis services, but the services vary widely in type and availability state) *with* Institute for Innovation & Implementation at the University of Maryland, *Mobile Response and Stabilization Services (MRSS) Best Practices for Youth & Families* (2019) https://wraparoundohio.org/wp-content/uploads/2020/09/MRSS-National-Best-Practice-Standards.pdf, (hereinafter "MRSS Best Practices").

## I. The Evidence for Mobile Response and Stabilization Services

MRSS are a kind of crisis service that allows children and families to receive immediate assistance and prevents unnecessary hospitalization. MRSS is different from traditional crisis screening, triage, and referral services. Instead, MRSS entails rapid deployment of a team of specialized child and adolescent trained staff that can provide interventions that build on natural support structures.[4] Unlike a hospital emergency department or crisis center-based stabilization services, mobile crisis services are provided in children's natural environment, wherever the crisis occurs, whether that is the home, school, or other setting.[5] The services should be available 24 hours a day, 7 days a week.[6] After responding to the immediate crisis, the team provides stabilization services, including connections to follow-up services and supports and any needed treatment services.[7]

MRSS should be differentiated from adult mobile crisis intervention, and MRSS systems should not rely on predominantly adult-oriented crisis response workers.[8] One important component of MRSS is that the crisis is defined by the caller, not the team.[9] Because families are often in the best place to identify changes in a child's behavior early, before it comes to the attention of schools or professionals, services should be readily available when the family determines they are needed.[10]

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[4] National Ass'n of State Mental Health Program Directors, *Making the Case for a Comprehensive Children's Crisis Continuum of Care* 5 (Aug. 2018), https://www.nasmhpd.org/sites/default/files/TACPaper8_ChildrensCrisisContinuumofCare_508C.pdf (hereinafter "NASMHPD Assessment #8").

[5] NASMHPD Assessment # 8 at 11; MRSS Best Practices.

[6] *Id.*

[7] *Id. See also* SAMHSA, *National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit* 18 (2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (mobile crisis services for both children and adults should (1) be provided by a licensed or credentialed clinician capable of assessing needs, (2) respond where the person is and not restrict services to select locations or particular days or times; and (3) connect individuals to facility-based care as needed through warm hand-offs and coordination transportation when and only if situations warrant transition to other locations.").

[8] NASMHPD Assessment # 8 at 11; MRSS Best Practices.

[9] Casey Family Found., *What is New Jersey's Mobile Response and Stabilization Intervention?* (2018), https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_New-Jersey-MRSS.pdf.

[10] NASMHPD Assessment # 8 at 12.

MRSS can improve children's functioning and reduce subsequent utilization of emergency departments, juvenile justice facilities and other out-of-home placements.[11]

## II. Medicaid-Enrolled Youth Entitlement to MRSS

MRSS must be covered under a state's Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit when medically necessary.

Medicaid's EPSDT benefit is a broad entitlement for beneficiaries under age 21 which provides medically necessary behavioral health services that are targeted to effectively ameliorate identified conditions.[12] This means that if a service is listed under 42 U.S.C. § 1396d(a) (the section of Medicaid statute that defines "Medical Assistance"), and the service is medically necessary, then the state must provide the service.[13] This mandate applies to all categories of

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[11] *See* Jeffery Vanderploeg et al., *Mobile Crisis Services for Children and Families: Advancing a Community-based Model in Connecticut, 71* Child. & Youth Servs. Rev. 103 (2016) (Rapid mobile response with face-to-face crisis stabilization in the home, school, and community can improve functioning and reduce utilization of emergency departments and juvenile justice facilities); Ryan Shannahan & Suzanne Fields, Nat'l Technical Assistance Network for Children's Mental Health, *Services in Support of Community Living for Youth with Serious Behavioral Health Challenges: Mobile Crisis Response and Stabilization Services* 3 (2016) ("MRSS are considered a viable alternative to EDs and inpatient treatment because they consistently demonstrate potential for cost-savings while helping to improve or maintain the level of functioning for children and youth. When compared to ED and inpatient admissions, MRSS tend to achieve better outcomes at lower cost, and with higher family satisfaction."); Priyanka Vakkalanka, et al., *Mobile Crisis Outreach and Emergency Department Utilization: A Propensity Score-matched Analysis*, 22 West J. Emerg. Med. 5 (Sept. 2, 2021) (mobile crisis outreach patients were less likely to have family and social support and yet were less likely to require hospitalization for each visit); Michael Fendrich et al., *Impact of Mobile Crisis on Emergency Department Use Among Youths with Behavioral Health Service Needs*, 70 Psych. Servs. 881 (Oct. 1, 2019) (youth who received mobile crisis services had a significant reduction in odds of a subsequent behavioral health ED visit compared with youth who did not receive community-based mobile crisis services).

[12] 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r); see also S.*D. ex rel. Dickson v. Hood*, 391 F.3d 581, 590 (5th Cir. 2004) (services that are appropriately defined as "medical assistance" under the Medicaid regulations and are medically necessary to correct or ameliorate a condition" must be provided to children under 21).

[13] CMS, *Medicaid Guidance on the Scope and Payments for Qualifying Community-Based Mobile Crisis Intervention Services,* (Dec. 28, 2021), https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf ("The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT benefit for eligible children under 21 also provides for all 1905(a) benefits to treat or ameliorate health conditions, including mental health and SUD conditions. This means that states must provide

Medical Assistance, even if the service is generally classified as an "optional" service or is not included as a covered service under the state's Medicaid plan.[14]

While the Medicaid Act includes broad categories of services that must be covered, it does not list every specific medical or mental health service that falls under each broad category. MRSS is not specifically listed as its own category under 1396d(a), but it is included in the definition of a number of different categories.[15]

A series of administrative guidance, cases, and ensuing settlements have fleshed out the contours of the right to MRSS, when medically necessary, pursuant to the broad EPSDT mandate. For example, in *Rosie D.* the court recognized that mobile crisis is "widely recognized as clinically appropriate and, indeed, essential for children with serious emotional disturbances," and thus required the state to provide such services.[16] Similarly, the Centers for Medicare and Medicaid Services (CMS) has recognized that "mobile crisis response and stabilization services are instrumental in defusing and de-escalating difficult mental health situations and preventing unnecessary out-of-home placements" and that such services are coverable under Medicaid.[17]

The Department of Justice has also recognized crisis services to be essential for children under 21 with mental illness to receive supports and services in the most integrated setting

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coverage of all medically necessary services for children under 21 that are included within the categories of mandatory and optional services listed in section 1905(a) of the Act, regardless of whether such services are covered under the State plan for adults.")(emphasis in the original).

[14] Id.; *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581, 590 (5th Cir. 2004) (states must offer children "such other necessary health care, diagnostic services, treatment, and other measures described in § 1396d(a)," whether or not such services are covered in the state's Medicaid plan).

[15] *Supra note 12* at 4. These authorities include: physician services, as covered via 42 U.S.C.A. § 1396(a)(5) and 42 C.F.R. § 440.50; the rehabilitative services benefit as covered by 42 U.S.C.A. § 1396d(a)(13); 42 C.F.R. § 440.130; and "Medical or Remedial Care Provided by Licensed Practitioners" benefit, 42 U.S.C.A. § 1396d(6), 42 C.F.R. § 440.60. MRSS can also be covered as part of targeted case management. 42 U.S.C.A. § 1396d(a)(19); 42 C.F.R. §§ 441.18, 441.169(b). States may also cover these services via various waivers.

[16] *Rosie D. v. Romney,* 410 F. Supp. 2d 18, 31 (D. Mass. 2006).

[17] Joint CMS and SAMHSA Informational Bulletin, *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions* 5 (May 7, 2013), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf. *See also* CMS, *Medicaid Guidance on the Scope and Payments for Qualifying Community-Based Mobile Crisis Intervention Services* (Dec. 28, 2021), https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf.

appropriate to their needs in order to comply with the Americans with Disabilities Act. In a findings letter regarding West Virginia's children's mental health system, the DOJ stated:

> A sufficient array of in-home and community-based services incorporates several discrete clinical interventions, including, at a minimum . . . [r]esponsive and individualized crisis response and stabilization services available 24 hours a day, 7 days a week, including immediate access to back-up crisis stabilization when actually needed so a youth can spend the majority of his/her time living in a more integrated community setting."[18]

## III. Conclusion and Recommendations

Since the start of the Covid-19 pandemic, the proportion of pediatric emergency department visits for mental health conditions compared to visits for all other reasons has grown.[19] The U.S. Surgeon General just issued an Advisory on the youth mental health crisis and the pandemic's unprecedented impacts on the mental health of America's youth and families.[20] The American Academy of Pediatrics, along with others, have declared a "national emergency in child and adolescent mental health," noting this increase in emergency department visits and increasing "rates of depression, anxiety, trauma, loneliness, and suicidality."[21] Against this backdrop, recent legislation gave states new opportunities to access additional funding for

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[18] Dep't of Justice, *Findings Letter, Investigation of West Virginia Children's Mental Health System Pursuant to the Americans with Disabilities Act* 22 (June 1, 2015)(finding that the State did not comply with Title II of the Americans with Disabilities Act of 1990 ("ADA"), 42 U.S.C. §§12131-12134 (2006), as interpreted in *Olmstead v. L.C.*, 527 U.S. 581 (1999), requiring that individuals with disabilities with disabilities, including children with mental illness, receive supports and services in the most integrated setting appropriate to their needs), https://www.ada.gov/olmstead/documents/west_va_findings_ltr.pdf

[19] CDC, Morbidity and Mortality Weekly Report, Mental Health-Related Emergency Department Visits Among Children Aged <18 Years During the Covid-19 Pandemic—United States, January 1-October 17, 2020 (Nov. 13, 2020) ("whereas the overall number of children's mental health–related ED visits decreased, the proportion of all ED visits for children's mental health–related concerns increased, reaching levels substantially higher beginning in late-March to October 2020 than those during the same period during 2019."), https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm?s_cid=mm6945a3_w.

[20] Protecting Youth Mental Health: The U.S. Surgeon General's Advisory (December 7, 2021), https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf.

[21] American Academy of Pediatrics, *A declaration from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association* (Oct. 19, 2021), https://www.aap.org/en/advocacy/child-and-adolescent-healthy-mental-development/aap-aacap-cha-declaration-of-a-national-emergency-in-child-and-adolescent-mental-health/.

adult and child mobile crisis services in general, including MRSS.[22] Between the increased need and the increased funding, many states are paying renewed attention to ways to improve their responses to children's mental health crises in the community. As states consider their response, advocates should consider the following actions to inform state policies:

- Review your state's current coverage and availability of MRSS for Medicaid eligible children and youth, in particular under the EPSDT mandate. Crisis services should not be limited to, or only be available through, specific settings such as crisis stabilization units, crisis residential care or hospitalization.

- Examine your state's behavioral health delivery system and advocate that the system meet the specific needs of children (and is not solely designed or available for adults), including the availability of home and community based mental health services.[23] This includes incorporating current evidence regarding best practices for children's MRSS

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[22] Starting April 1, 2022, all states will be eligible to receive an 85% match for from the federal government on "Qualifying Community-based Mobile Crisis Intervention Services" for up to 12 quarters (3 years). 42 U.S.C. §.1396w-6. In order to obtain this increased match, states' services must meet a number of requirements. The intervention must be delivered outside of a hospital or facility setting to someone experiences a mental health or substance use disorder crisis. It must be furnished by a multidisciplinary team that includes at least one behavioral health care professional who can provide assessments, that is trained in trauma-informed care, de-escalation and harm-reduction, that can respond in a timely manner, that maintains relationships with relevant community partners, and can maintain privacy and confidentiality. Last, the services must be available 24 hours per day, every day of the year. For more information, see CMS, *Medicaid Guidance on the Scope and Payments for Qualifying Community-Based Mobile Crisis Intervention Services* (Dec. 28, 2021), https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf. As a result of this new funding, many states will be reforming their services to ensure eligibility for the increased match. However, it is essential to note that nothing in this provision supersedes the statutory requirements described above regarding the EPSDT mandate to provide medically necessary services to all Medicaid-enrolled children. For example, the ARPA provision allows states to target specific areas of their state for "qualifying community-based mobile crisis intervention services." Thus, for adults, a state could decide to provide some mobile crisis services only in an urban area, where it is easier to reach individuals quickly. However, pursuant to the EPSDT mandate, children are still entitled to MRSS when medically necessary, no matter where in the state they live.

[23] MACPAC, REPORT TO CONGRESS ON MEDICAID AND CHIP, *Chapter 3: Access to Behavioral Health Services for Children and Adolescents Covered by Medicaid and CHIP 104* (Home- and community-based services can prevent the use of emergency departments and other restrictive settings, such as inpatient and residential treatment facilities, that remove children and adolescents from their homes, schools, and communities, Citing Jennifer Lav and Kim Lewis, National Health Law Program, *Children's Mental Health Services: The Right to Community-based Care* (2018), https://healthlaw.org/resource/childrens-mental-healthservices-the-right-to-community-based-care/.

into service delivery models. A children's system should look clinically different from adult-serving system and should include best practices, notably:

  - Not rely on predominantly adult-oriented crisis response workers.[24]
  - Require services to be available 24 hours a day, 7 days a week.[25]
  - Permit the family to define what constitutes a "crisis" and when they need assistance; [26]
  - Require services be provided in children's natural environment, at home and in the community wherever the crisis occurs.[27]

- Review state Medicaid utilization data of behavioral health services for beneficiaries under age 21 to determine which children and youth are receiving crisis services (demographic data, such as age, race, geographic location), as well as type and location of these services (crisis intervention in the community, crisis stabilization in facility or hospital settings, or crisis residential units). Also review utilization data of other home-and-community-based services that are available to children and youth under EPSDT. Finally, review data regarding the use or rates of psychiatric hospitalization (by region) that may indicate overreliance on hospital care due to a lack of availability of needed crisis service in the home and community.

- Ensure that any new or current initiative involving mobile crisis (including those undertaken to obtain enhanced federal funding available from the American Rescue Plan Act) recognizes children's entitlement to crisis services under Medicaid EPSDT precludes states from limiting services to a geographic area or to a specific diagnosis. Advocates may want to examine state policies to ensure that states are not limiting access to services in manner that violates the EPSDT mandate.

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[24] NASMHPD Assessment # 8.

[25] *Id.*

[26] *Id.*

[27] Joint CMS and SAMHSA Informational Bulletin, *Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions* 5 (May 7, 2013) (Mobile crisis services are available 24/7 and can be provided in the home or any setting where a crisis may be occurring), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf.

- Look for new opportunities to engage in state-level design of these systems, as states seek to address the growing need for behavioral health services and utilize new or existing funding to provide crisis services.[28]

[28] As part of the American Rescue Plan Act, $15 million in planning grants was appropriated to twenty states for purposes of developing a state plan amendment, a section 1115 demonstration application, or a section 1915(b) or 1915(c) waiver request to provide qualifying community-based mobile crisis intervention services. 42 U.S.C. §.1396w-6(e). These states are: Alabama, California, Colorado, Delaware, Kentucky, Massachusetts, Maryland, Maine, Missouri, Montana, North Carolina, New Mexico, Nevada, Oklahoma, Oregon, Pennsylvania, Utah, Vermont, Wisconsin and West Virginia. https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-community-based-mobile-crisis-intervention-services/index.html