Mobile Crisis Response

Program integrity, utilization concerns, and agency responses

Behavioral Health Commission

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Mobile Crisis Growth

Monthly tracking created a clearer picture of publicly-funded capacity and increasingly ambitious statewide goals

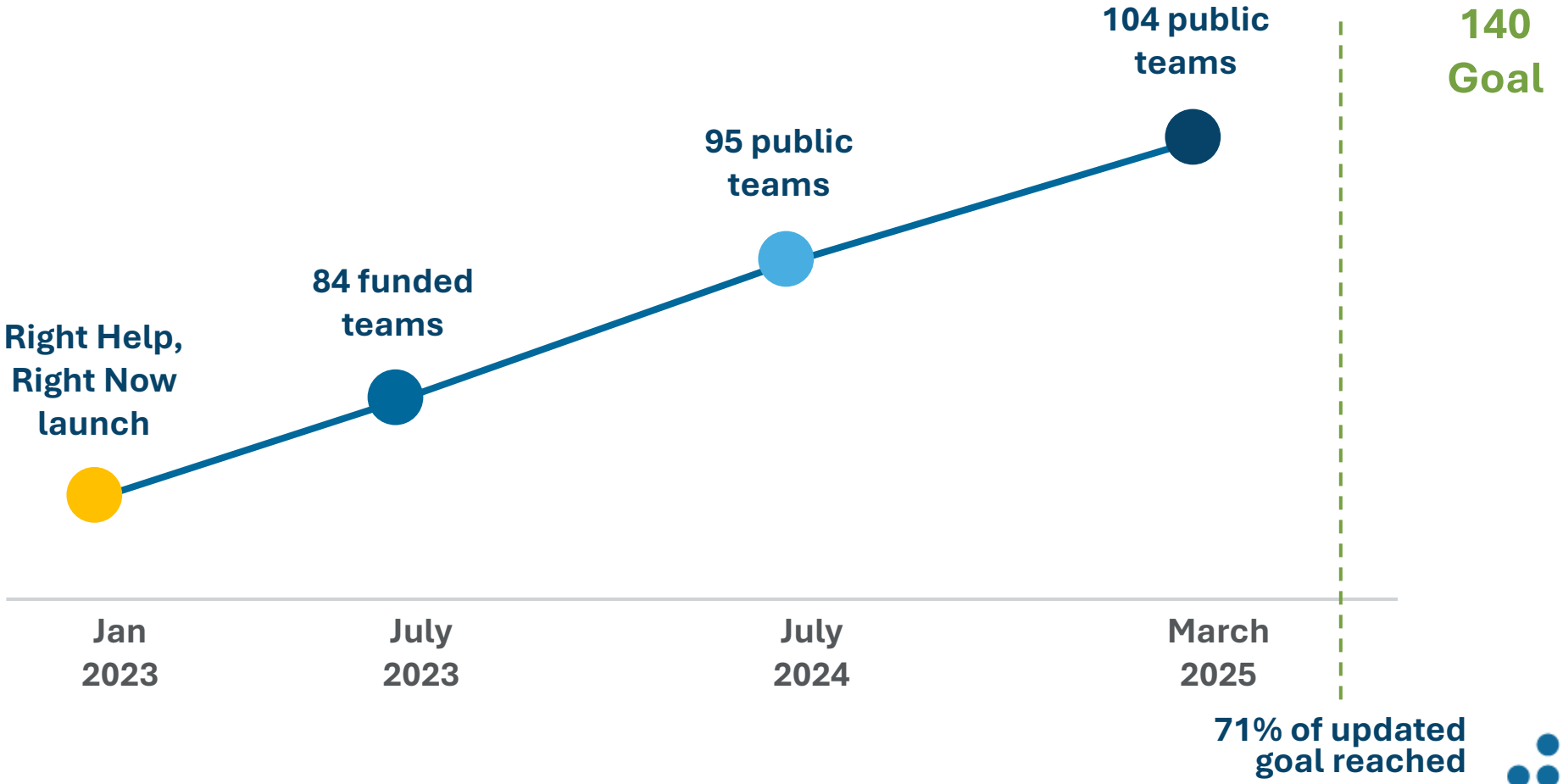
70

Initial goal
January 2023

140

Updated goal
July 2023

Monthly tracking continues



Private Footprint for Mobile Crisis Response (MCR)

New licensing, memorandum of understanding (MOU) and staffing data show the scale of the provider network

ACTIVE LICENSED CRISIS SERVICES (007-006)

425

Includes MCR and community stabilization

MCR MOUs

188

148 private / 40 CSB

PRIVATE MCR STAFF

1,276

Staff listed for private MCR

≈ 510 theoretical private teams if the same 2.5-staff-per-team method applied

COMPARISON

104 DBHDS-funded MCR teams as of March 2025

IMPORTANT CAVEAT

Staff-role data do not establish fully staffed teams, hours worked, or actual operational capacity

Overutilization of Mobile Crisis Response

DBHDS saw overutilization concerns and began testing if service delivery aligned with an appropriate crisis response

Region 4 became an early focus for intervention

1 **VERIFY**

Partnership with DMAS to verify eligibility to deliver the service

2 **BUILD**

Partnership with HopeLink, Inc. to build out team capacity

3 **REVIEW**

Quality reviews of providers

Launching the Centralized Dispatch

Agency guidance became progressively more specific as operational conflicts and program-integrity concerns surfaced.

NOV 2023
Transition memo
Centralized MCR dispatch announced for Dec. 15

DEC 2023
Dispatch begins
Conflicts emerge between service providers and 988 staff

MAY 2024
Purpose clarified
Memo to licensed providers outlines the purpose of MCR

JUNE 2024
MOU expectation
Providers must respond to all dispatches regardless of insurance or ability to bill

OCT 2024
Exploitation concern
DBHDS/OHR memo addresses coaching of individuals to request dispatch for provider financial gain

WINTER 2024 In-state answer rate initially dipped to 80%; staffing shifted to a fully staffed model and additional funds went to Regional Hubs, producing a slight increase.

Provider behavior was affecting the broader crisis system

Solicitation concerns, rising call volume and workforce strain converged during 2024

SPRING–SUMMER 2024

Solicitation + volume

- Anecdotal reports of providers soliciting MCR dispatch in Richmond persisted.
- Call volume exceeded modeling and funding; answer rate slowly declined.

SUMMER–FALL 2024

Workforce strain

- Call centers reported significant turnover amid high workload and unpredictable calls.
- Reports included aggressive and abusive behavior by callers/ providers demanding dispatch.

FALL 2024

Additional demand

- T-Mobile and Verizon geo-routing contributed to a 25% rise in call volume.
- The increase was not fully identified for more than two months; the in-state answer rate began a precipitous decline in October.

Program integrity concerns can become access and system-performance concerns when they consume crisis-system capacity

DBHDS moved from broad guidance to provider-specific intervention

Quality review, technical assistance, and structural changes in Region 4 were layered onto earlier controls

1 Nov 2024–Feb 2025

1:1 quality reviews + technical assistance

2 Dec 2024–Feb 2025

Specialized Region 4 team

HopeLink staff team designed collaboratively; training underway; calls planned for 2/24

3 Feb–May 2025

Competitive RFP

Region 4 process to award a limited number of FY26 MOUs

More targeted

Education

↓

Provider review

↓

Structural change

By 2026, the response was more systematic

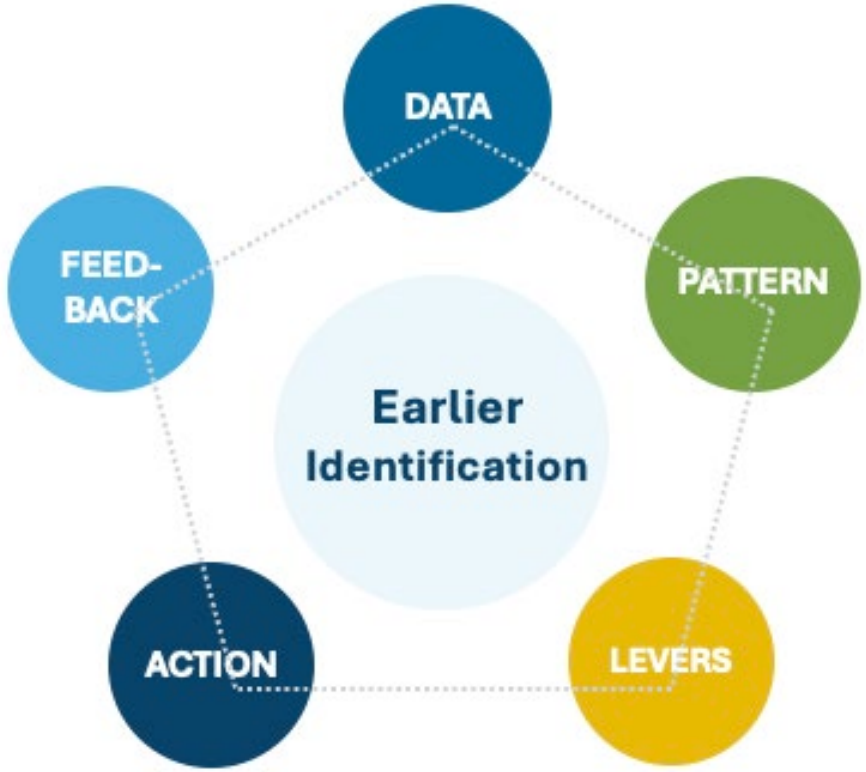
DBHDS identified agency levers and began building reports to flag provider behavior inconsistent with good service delivery

RECENT MILESTONES

DEC 2025 — Region 4 implements RFP

JAN–MAR 2026 — DBHDS identifies agency levers related to corrective action

JUN–AUG 2026 — DBHDS creates reports for Regional Hubs to identify provider behaviors typically inconsistent with good service delivery



A repeatable oversight cycle, not a one-time intervention

Key Medicaid Policy Changes

Community Stabilization (9/1/2022 changes)

- Transitioned to requiring Service Authorization
- Clarification of evidence of team treatment, requirement that both team member sign the note
- Clarification: hotel room or temporary housing and that housing it not a reimbursable service component

Community Stabilization (2/14/2023 changes)

- Removed allowance for telemedicine assessment; required in-person assessments

Mobile Crisis Response (9/1/2022 changes)

- Clarified that MCR cannot be provided in a group
- Added requirement that providers must use the GT modifier to identify the time spent in a telemedicine-assisted assessment

Mobile Crisis Response (12/15/2023 change)

- Mobile crisis transition from “self-referral” to hub dispatch, which resulted in a dramatic decrease which then returned to prior spending over 12 mo. period

Key Medicaid Operational Changes

- Provider Enrollment targeted clean up (2024)
  - Bulletins published August and October 2024 clarifying enrollment requirements
  - Service locations and providers removed from system who did not meet participation criteria, including having an MOU.
  - All MOUs are validated by DBHDS Central office based on Regional MOU lists to confirm MOU status prior to any new or returning provider enrollment action
  - MOUs required to be uploaded to provider enrollment system
  - *Timely clean-up following Region 4 RFP led to 40.8% reduction in claims for region 4 (6 months before vs. after implementation) and a 34.6% reduction statewide*
- Operational changes and improved coordination
  - Prepayment review by MCOs for providers with concerning patterns
  - DMAS network data and member data are now being validated in the VCC system with both agencies enforcing stricter data and network controls
  - Crisis-specific IAG appendix with DBHDS

Key Medicaid Program Integrity Actions

- Audits across Mobile Crisis and Community Stabilization
  - A total of 325 investigations (152 unique provider NPI)
  - 153 cases are currently open
- 172 cases are closed with a total overpayment identified of $38,052,930.55
- 92 referrals to Medicaid Fraud Control Unit (MFCU)
- Civil and criminal actions

Key Medicaid Program Integrity Actions

- Additional policy changes
  - Require clinical director for crisis agencies to participate in Medicaid
- Rate review/update and cross-state comparison
- Currently, HHR-led workgroup in progress to:
  - Improve cross-agency operations for information sharing and action
  - Standardize protocols for data analysis, payment suspension, provider network actions, and investigation of outliers specific to high-risk services