

Application for

Section 1915(b) (4) Waiver

Fee-for-Service

Selective Contracting Program

February 2025

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Face sheet

The **State** of Ohio requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The **name of the waiver program** is Regional Mobile Response and Stabilization Services.

(List each program name if the waiver authorizes more than one program.)

Type of Request. This is:

an initial request for new waiver. All sections are filled.

a request to amend an existing waiver, which modifies Section/Part ____

a renewal request

Section A is:

replaced in full

carried over with no changes

changed noted in **BOLD.**

Section B is:

replaced in full

changed noted in **BOLD.**

Effective Dates: This waiver/renewal/amendment is requested for a period of 2 years beginning 4/1/2025 and ending 3/31/2027.

State Contact: The state contact person for this waiver is Rebecca Jackson and can be reached by telephone at (____) _____, or fax at (____) _____, or email at Rebecca.Jackson@medicaid.ohio.gov (List for each program)

Section A – Waiver Program Description

Part I: Program Overview

Tribal Consultation:

Describe the efforts the State has made to ensure that federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal (if additional space is needed, please supplement your answer with a Word attachment).

N/A – There are no Federally recognized tribes in Ohio.

Program Description

Provide a brief description of the proposed selective contracting program or, if this is a request to amend an existing selective contracting waiver, the history of and changes requested to the existing program. Please include the estimated number of enrollees served throughout the waiver (if additional space is needed, please supplement your answer with a Word attachment).

This fee-for-service selective contracting 1915(b)(4) waiver includes services as described in Ohio's State Plan Mobile Response and Stabilization Service (MRSS, Attachment 3.1-A, Item 4-b.)

Mobile response and stabilization services (MRSS) is a structured intervention and support service provided by a mobile response and stabilization service team that is designed to promptly address a crisis with young people who are experiencing emotional symptoms, behaviors, or traumatic circumstances that have compromised or impacted their ability to function within their family, living situation, school, or community. MRSS is provided to people who are under the age of twenty-one. MRSS is intended to be delivered in-person where the young person or family is located, such as their home or a community setting.

MRSS provides immediate de-escalation, delivers rapid community-based assessment, and implements stabilization services to help the young person remain in their home and community. MRSS consists of two activities: mobile response and follow-up and stabilization.

This waiver seeks to selectively contract with one Regional MRSS Provider (RMP) per multi-county region. RMPs will be certified by Ohio's community mental health services authority, Ohio Mental Health and Addiction Services (OhioMHAS), to provide MRSS and may contract with other certified MRSS teams to ensure regional capacity. The RMP will provide regional mobile response and stabilization services, including administrative support, data collection and reporting responsibilities. RMP services shall support the overall MRSS program through initial dispatch for mobile crisis response, follow-up, de-escalation, stabilization, and monitoring for Ohio youth requiring crisis services.

The RMP model leverages resources and efficiencies to accelerate the expansion of MRSS, with the goal of achieving statewide capacity. Upon implementation, this model will improve the broader behavioral health continuum of care to better support youth, families, and caregivers in their homes and

communities. The intent of this approach is to create increased service coverage predictability, coordination, and accountability.

This program is projected to serve approximately 85,000 recipients over the 2-year waiver period.

Waiver Services:

Please list all existing State Plan services the State will provide through this selective contracting waiver (if additional space is needed, please supplement your answer with a Word attachment).

The state plan service provided under this selective contracting waiver is the Mobile Response Stabilization Service as described in the Ohio Medicaid State Plan Attachment 3.1-A, Item 4-b.

The waiver program will be implemented statewide.

A. Statutory Authority

1. **Waiver Authority.** The State is seeking authority under the following subsection of 1915(b):
 1915 (b)(4) – FFS Selective Contracting program
2. **Sections Waived.** The State requests a waiver of these sections of the 1902 of the Social Security Act:
 - a. Section 1902(a) (1) – Statewideness
 - b. Section 1902 (a) (10) (B) – Comparability of Services
 - c. Section 1902 (a) (23) – Freedom of Choice
 - d. Other Sections of 1902 – (please specify)

B. Delivery Systems

1. **Reimbursement.** Payment for the selective contracting program is:
 the same as stipulated in the State Plan
 is different than stipulated in the State Plan (please describe)
2. **Procurement.** The state will select the contractor in the following manner:
 Competitive procurement
 Open cooperative procurement
 Sole source procurement
 Other (please describe)

C. Restriction of Freedom of Choice

1. Provider Limitations

Beneficiaries will be limited to a single provider in their service area. The state will require MCO enrollees to obtain services only from one Regional MRSS Provider (RMP) per region.

Beneficiaries will be given a choice of providers in their service area.

(NOTE: Please indicate the area(s) of the State where the waiver program will be implemented)

2. State Standards:

Detail any difference between the state standards that will be applied under this waiver and those detailed in the State Plan coverage or reimbursement documents (if additional space is needed, please supplement your answer with a Word attachment).

There are no differences in state standards under this waiver compared to those detailed in the State Plan coverage or reimbursement documents. The proposed waiver does not change the provider/service standards and expectations outlined in Attachment 3.1-A, Item 4-b

D. Populations Affected by Waiver

(May be modified as needed to fit the State’s specific circumstances)

1. **Included Populations.** The following populations are included in the waiver:

Section 1931 Children and Related Populations:

A sub-population of Medicaid Expansion (MAGI Adult Category) is eligible. Individuals in this affected population group would be eligible for the service beginning at age 19 until age 21.

Section 1931 Adults and Related Populations

Blind/Disabled Adults and Related Populations

Blind/Disabled Children and Related Populations

Aged and Related Populations

Foster Care Children

Title XXI CHIP Children

2. **Excluded Populations.** Indicate if any of the following populations are excluded from participating in the waiver:

Dual Eligibles

Poverty Level Pregnant Women

Individuals with other insurance

Individuals residing in a nursing facility or ICF/MR

Individuals enrolled in a managed care program

individuals participating in a HCBS Waiver program

American Indians/ Alaskan Natives

Special Needs Children (State Defined). Please provide this definition

Individuals receiving retroactive eligibility

Other (Please define): Within the included population groups identified above, there may be certain groups of individuals who are excluded from the program. For example, the “Foster Care Children” population may be eligible for the service but would also need to be under the age of 21 within that population, including “former foster care children” who are not otherwise in an included population.

Part II: Access, Provider Capacity, and Utilization Standards

A. Timely Access Standards

Describe the standard that the State will adopt (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has adopted) defining timely Medicaid beneficiary access to the contracted services, *i.e.*, what constitutes timely access to the service?

1. How does the State measure (or propose to measure) the timeliness of Medicaid beneficiary access to the services covered under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment)?

Timeliness of access will be monitored and evaluated using utilization data and through required reporting elements captured in the state's MRSS data system (DMS).

Service timelines will be delivered in accordance with the following:

- The initial mobile response must occur within sixty minutes from the end of the initial call.
- When applicable, the de-escalation period occurs during the seventy-two hours following initial response, and a stabilization period may occur for up to six weeks.
- Within three years from the model implementation effective date MRSS will be available state-wide twenty-four hours a day, seven days a week.

RMP and MRSS team fidelity reviews (see appendix A for Fidelity tool) will be conducted by Ohio's Child and Adolescent Behavioral Health Center of Excellence (CABH COE).

Fidelity benchmarks that measure timeliness to service include:

- Response Time: 60 Minutes
- Service Outcome: Stabilization Services Received
- MRSS Service Availability

Additionally, providers will participate in MRSS quality improvement activities, informed by monitoring and fidelity activities.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiaries are unable to access the contracted service in a timely fashion (if additional space is needed, please supplement your answer with a Word attachment).

Provider status/certification is contingent upon adherence to relevant Ohio Administrative Code and OhioMHAS certification standards, including adherence to fidelity. The fidelity process provides guidance and quality improvement support to RMP's and MRSS teams and ensures high standards of service. If an agency fails to comply with these standards, as a last resort, the state maintains the authority to remove their designation as an RMP and select a new contractor. This will be outlined in the provider contract.

B. Provider Capacity Standards

Describe how the State will ensure (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State has ensured) that its selective contracting program provides a sufficient supply of contracted providers to meet Medicaid beneficiaries' needs.

1. Provide a detailed capacity analysis of the number of providers (e.g., by type, or number of beds for facility-based programs), or vehicles (by type, per contractor for non-emergency transportation programs), needed per location or region to assure sufficient capacity under the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

The selective contracting approach will serve to limit the number of providers to only those that are needed based on the needs of the youth being served, while also ensuring access to providers in areas it does not exist today. As part of the implementation of this service model and selective contracting, Ohio will complete detailed tracking to ensure the needs of our members are met. The 18 RMP regions were created based on a geographic analysis of behavioral health crisis utilization (988 call encounters, other episodes of crisis), regional suicide rates, BH diagnosis prevalence, etc. and the existing provider network to ensure statewide capacity after an initial ramp-up period of 3 years. To estimate potential need statewide, Ohio leveraged existing volumes from regions with robust provider networks and extrapolated the needs per youth from that region to the rest of the state. Additionally, RMP's are encouraged to subcontract with existing providers to ensure they meet regional needs and preserve existing capacity. This may include leveraging existing arrangements with community behavioral health providers, including those certified for MRSS. Because crisis needs tend to fluctuate, direct RMP technical assistance, readiness activities, and adjustments over time will occur to ensure capacity standards are met.

2. Describe how the State will evaluate and ensure on an ongoing basis that providers are appropriately distributed throughout the geographic regions covered by the selective contracting program so that Medicaid beneficiaries have sufficient and timely access throughout the regions affected by the program (if additional space is needed, please supplement your answer with a Word attachment).

The state will use a two-pronged process to ensure Medicaid beneficiaries have sufficient and timely access in each region:

- The state will use geographical information system (GIS) mapping analysis to review dispatch locations in each region and the corresponding drive time to reach the population in each region within 60 minutes. ODM will work with selected providers to ensure they can meet timeliness standards within their region with the established dispatch locations.
- The state will review instances where the initial mobile response occurs greater than sixty minutes from the time of dispatch to ensure the extended response time was due to beneficiary needs and not lack of access to MRSS staff.

C. Utilization Standards

Describe the State's utilization standards specific to the selective contracting program.

The State of Ohio expects each eligible recipient in crisis, to receive MRSS in the amount and service-type required to de-escalate the crisis, assess and stabilize an individual and provide appropriate referrals and linkages that support ongoing stabilization. The state expects these services will be provided within the timelines required to meet fidelity standards. The utilization standard will be

monitored through ongoing review of the RMP's performance and on-going monitoring and compliance activities.

1. How will the State (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State) regularly monitor(s) the selective contracting program to determine appropriate Medicaid beneficiary utilization, as defined by the utilization standard described above (if additional space is needed, please supplement your answer with a Word attachment)?

The state requires claims submission of both Medicaid and non-Medicaid encounters that will be used for utilization monitoring. Additionally, all MRSS referral, intake and discharge data must be entered into the MRSS Data Management System (DMS) within the established timeframes. Such data will be utilized to monitor overall service delivery, identify areas for improvement, track progress towards achieving benchmarks, monitor many of the MRSS fidelity measures and monitor utilization. Standard utilization management requirements for managed care plans will apply and will support determination of appropriate Medicaid beneficiary utilization.

2. Describe the remedies the State has or will put in place in the event that Medicaid beneficiary utilization falls below the utilization standards described above (if additional space is needed, please supplement your answer with a Word attachment).

The CABH COE will work with providers through the fidelity process to ensure all utilization standards are met and provide process improvement support as needed. Periodic cost-reports and staff-reports will be required and will reflect expected vs actual utilization and will guide process improvement outcomes such as the need for rate changes or staffing changes. If an agency fails to comply with these standards, as a last resort, the state maintains the authority to remove their designation as an RMP and select a new contractor. This will be outlined in the provider contract.

Part III: Quality

A. Quality Standards and Contract Monitoring

1. Describe the State's quality measurement standards specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the State's Quality standards of the selective contracting program.

OhioMHAS regulates the state's certification process for RMPs and MRSS teams. To achieve state certification, RMPs and contracted MRSS teams will have an initial fidelity review no more than twelve months from the initial date of interim certification and can achieve full certification once the agency has passed a fidelity review within three years from the date of interim certification. For continuing full

certification, each MRSS provider will achieve and maintain a passing benchmark score as a component of overall fidelity. Once a provider has achieved full certification, subsequent fidelity reviews will take place annually and be based on performance from the previous 12 months. An onsite survey is scheduled based on when the provider has enough clinical charts to review for MRSS and the five required services. Each RMP is responsible for designing an organizational plan for Regional MRSS quality assurance monitoring and oversight. As part of the RMPs commitment to quality, the RMP will have personnel dedicated to quality assurance activities. Quality assurance activities will include but are not limited to; ensuring the region is compliant with data collection parameters, compliance status with training, supervision, minimum credentialing, and certification parameters, compliance with the established OhioMHAS and ODM rules, monitoring the overall MRSS service implementation through program benchmarks, identifying areas for improvement, identifying system trends, gaps and needs and to track overall progress towards achieving benchmarks and fidelity metrics. The regional quality personnel will work in concert with the Regional Clinical Director, MRSS supervisors, State personnel, COE and community stakeholders to track progress towards achieving the regional milestones that will result in operationalization of a high fidelity MRSS program.

All MRSS referral, intake and discharge data must be entered into the MRSS DMS within the established timeframes. Such data will be utilized to monitor overall service delivery, identify areas for improvement, track progress towards achieving benchmarks and monitor many of the MRSS fidelity measures. Additionally, data can be used: 1) by providers to inform and strengthen program operations and to generate site or county specific reports; 2) by OhioMHAS and other state partners to identify system trends, gaps and needs; and 3) by the CABH COE to identify and oversee training needs and other quality improvement activities.

ii. Take(s) corrective action if there is a failure to comply.

Provider certification and contract is contingent upon adherence to relevant state regulations and standards. The fidelity process provides guidance and quality improvement support to RMP's and MRSS providers through the CABH COE to ensure they meet fidelity standards of service. If an agency fails to comply with these standards, as a last resort the state maintains the authority to remove their designation as an RMP and select a new contractor. This will be outlined in the provider contract.

2. Describe the State's contract monitoring process specific to the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

a. Describe how the State will (or if this is a renewal or amendment of an existing selective contracting waiver, provide evidence that the State):

i. Regularly monitor(s) the contracted providers to determine compliance with the contractual requirements of the selective contracting program.

The selected RMP's agree to maintain compliance with contractual requirements through the RFP application process, the provider agreement, as well as the state certification process. The state maintains the authority to monitor RMP activities through annual fidelity reviews, quality improvement

evaluations, on site audits, review of written, electronic, and recorded records, as well as RMP data submission through the DMS.

ii. Take(s) corrective action if there is a failure to comply.

Provider certification and contract is contingent upon adherence to relevant state regulations and standards. The fidelity process provides guidance and quality improvement support to RMP's and MRSS providers through the CABH COE to ensure they meet fidelity standards of service. If an agency fails to comply with these standards, as a last resort the state maintains the authority to remove their designation as an RMP and select a new contractor. This will be outlined in the provider contract.

B. Coordination and Continuity of Care Standards

Describe how the State assures that coordination and continuity of care is not negatively impacted by the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

The Regional framework of MRSS is designed to enhance the overarching goal of Systems of Care (SOCs) for youth and families, which is to receive the necessary array of services and supports to increase the likelihood of youth with complex behavioral challenges remaining at home and in their local communities. To achieve these aims, local SOC, including care management and coordination entities, child-serving systems and programs, and formal and informal support networks share responsibility for prevention and intervention with youth and families experiencing high levels of distress. MRSS is embedded in the SOC and is an essential part of the crisis continuum of care. As part of a local SOC, MRSS develops collaborative partnerships to assure that services, supports, planning, and linkages are coordinated.

MRSS providers are required to establish formal Memorandums of Understanding (MOUs) throughout the SOC. Agreements may include partnerships with child-serving agencies and organizations (OhioRISE Care Management Entities (CME), schools, law enforcement, juvenile courts), and other health care providers (Eds, residential treatment providers, community behavioral health providers, primary care physicians, managed care entities) in their regions to ensure continuity across the system of care.

The ongoing stabilization activities of MRSS include monitoring a client for up to 42 days after the initial call and response. During this time, it is the responsibility of the MRSS team/RMP to provide and monitor referrals, linkages, and coordination of any clinically or socially indicated services to support the goal of long-term stabilization.

Part IV: Program Operations

A. Beneficiary Information

Describe how beneficiaries will get information about the selective contracting program (if additional space is needed, please supplement your answer with a Word attachment).

Upon implementation, Ohio will inform the public about the expanded availability of MRSS and identify the RMPs. Recipients will receive information on their rights at any time a service is denied, terminated, or reduced. If recipients are concerned with their services, they may request a fair hearing (to dispute a denial or limitation) or file a formal grievance with ODM.

MRSS fills a gap in the continuum of crisis services for young people and their families. Informing the public of this service requires intentional marketing and communication planning to disseminate materials across community systems and groups, through mass communication channels and one-on-one or group meetings. The state and selected RMPs will perform marketing and outreach efforts to ensure beneficiaries understand how to access the services.

B. Individuals with Special Needs.

X The State has special processes in place for persons with special needs (Please provide detail).

MCOs and the OhioRISE plan are required to provide additional assistance to hearing-impaired, vision-impaired, limited-reading proficient and limited English proficient members.

Section B

Waiver Cost Effectiveness & Efficiency

1. Provide a description of the State's efficient and economic provision of covered care and services (if additional space is needed, please supplement your answer with a Word attachment).

The state recognizes the need for supportive funding to expand and sustain a system of MRSS delivery. To support more sustainable funding consistent with national best practices, a "firehouse" model funding approach is proposed within each region. This approach, subject to approval by CMS, varies significantly from historical payment methodologies and is described below.

- Payment for RMPs will be developed to support staffing, billing, contracting, and subcontracting, monitoring, quality improvement and capacity building functions. RMPs are required to complete an initial Staffing and Rate Template and will be required to complete additional cost reporting to reflect the cost of required functions, as well as costs needed to support dispatch locations. Additionally, RMPs will be required to complete quarterly staffing reports such that the provision of services is aligned with the staffing in place within the region, as well as their associated costs. This change in payment methodology and increase in access and availability of services statewide is the primary driver of the large trend from historical experience.

The state has determined that a regionalized approach is the most efficient, effective, and expeditious strategy to scale MRSS statewide. The intent behind designating RMPs for the 18 regions is to increase efficiency, enhance coordination, accountability, and coverage for MRSS and ultimately expand access within a region. Utilization of the MRSS regional approach allows the state to ensure capacity is met but not exceeded by establishing regions based on a geographical needs analysis. This ensures the provider network is established based on actual needs of the populations served and resources are efficiently

expended. Holding RMPs responsible for the administrative support, data collection, and reporting aspects in its respective region allows for better quality management and standardization of processes as well as better data analysis, and regulatory compliance. Each RMP will work closely with the state and local agencies listed in this RFP, providers, and other entities as needed to monitor adherence to the MRSS model and practice guidelines, improve access and outcomes, and carefully monitor and address costs of care.

2. Project the waiver expenditures for the upcoming waiver period.

Year 1 from:	4/1/2025 to 12/31/2025
Trend rate from current expenditures:	266.4%
Projected pre-waiver cost:	\$ 353,470
Projected Waiver cost:	\$ 353,470
Difference:	\$ 0.00
Year 2 from:	1/1/2026 to 12/31/2026
Trend rate from current expenditures:	140.8%
Projected pre-waiver cost:	\$ 490,146
Projected Waiver cost:	\$ 490,146
Difference:	\$ 0.00
Year 3 from:	1/1/2027 to 3/31/2027
Projected pre-waiver cost:	\$ 127,438
Projected Waiver cost:	\$ 127,438
Difference:	\$ 0.00

Appendix A.

MRSS Fidelity Tool Version 11/2023
Child and Adolescent Behavioral Health Center of Excellence/Center for Innovative Practices

MRSS Benchmark Components							
Rating	0	1	2	3	4	5	6
Benchmark 1 Initial Visit: Face-to-face in the home or community 90% Benchmark	Benchmark data: 0-64% of the cases had a face-to-face visit in the community.	Benchmark Data: 65-69% of the cases had a face-to-face visit in the community.	Benchmark data: 70-74% of the cases had a face-to-face visit in the community	Benchmark Data: 75-79% of episodes had a face-to-face visit in the community.	Benchmark data: 80-84% of the episodes had a face-to-face visit in the community.	Benchmark data: 85-89% of the episodes had a face-to-face visit in the community.	Benchmark data: 90-100% of the episodes had a face-to-face visit in the community.
Benchmark 2 MRSS Services: Safety planning 90% Benchmark	Benchmark Data: 0-64% of the time a safety plan was done at first contact with the youth.	Benchmark Data: 65-69% of the time a safety plan was done at first contact with the youth.	Benchmark Data: 70-74% of the time a safety plan was done at first contact with the youth	Benchmark Data: 75-79% of the time a safety plan was done at first contact with the youth.	Benchmark Data: 80-84% of the time a safety plan was done at first contact with the youth.	Benchmark Data: 85-89% of the time a safety plan was done at first contact with the youth.	Benchmark Data: 90-100% of the time a safety plan was done at first contact with the youth.
Rating	0	1	2	3	4	5	6
Benchmark 3 Response Time: Immediate: 60 Minutes 80% for Triage Decision Only	Benchmark data: 0-59% or below of the immediate episodes of care receive face-to-face services in the community within 60 minutes.	Benchmark Data: 60-64% of the Immediate episodes of care receive face-to-face services in the community within 60 minutes.	Benchmark data: 65-69% of the Immediate episodes of care receive face-to-face services in the community within 60 minutes.	Benchmark data: 70-74% of the Immediate episodes of care receive face-to-face services in the community within 60 minutes.	Benchmark data: 75-79% of the Immediate episodes of care receive face-to-face services in the community within 60 minutes.	Benchmark data: 80-100% of the immediate episodes of care receive face-to-face services in the community within 60 minutes.	

Benchmark 4 Service Outcome: Stabilization Services Received 70% Benchmark	Benchmark data: 0-49% or less of youth received stabilization services (4 days or more)	Benchmark Data 50-54% of youth received stabilization services (4 days or more)	Benchmark data: 55-59% of youth received stabilization services (4 days or more)	Benchmark data: 60-64% of youth received stabilization services (4 days or more)	Benchmark data: 65-69% of youth received stabilization services (4 days or more)	Benchmark data: 70-100% of youth received stabilization services (4 days or more)	
Benchmark 5 MRSS Services: Family Defined Problem 90% Benchmark	Benchmark Data: 0-69% of time the family defined the problem.	Benchmark Data: 70-74% of time the family defined the problem.	Benchmark Data: 75-79% of time the family defined the problem.	Benchmark Data: 80-84% of time the family defined the problem.	Benchmark Data: 85-89% of time the family defined the problem.	Benchmark Data: 90-100% of time the family defined the problem.	
Benchmark 6 Referrals and linkages 80% Benchmark	Benchmark data: 0-59% of the clients were referred to services or supports that were indicated prior to MRSS discharge.	Benchmark data: 60-64% of the clients were referred to services or supports that were indicated prior to MRSS discharge.	Benchmark data: 65-69% of the clients were referred to services or supports that were indicated prior to MRSS discharge.	Benchmark data: 70-74% of the clients were referred to services or supports that were indicated prior to MRSS discharge.	Benchmark data: 75-79% of the clients were referred to services or supports that were indicated prior to MRSS discharge.	Benchmark Data: 80-100% of the youth/families were referred to services or supports that were indicated prior to MRSS discharge.	

Rating	0	1	2	3	4	5	6
Benchmark 7 MRSS Service Availability		Benchmark data: MRSS is only available for immediate Mobile Response during weekday business hours evidenced by weekly staffing schedule.	Benchmark data: MRSS Services available for immediate Mobile Response during extended business hours (at least 8 pm weekdays) AND/OR on weekends evidenced by weekly staffing schedule.	Benchmark data: MRSS Services available for immediate Mobile Response during extended business hours (at least 10 pm weekdays) AND on weekends evidenced by weekly staffing schedule.	Benchmark data: MRSS services available 24/7 for an immediate Mobile Response evidenced by weekly staffing schedule.		
Incentive/Bonus Points							
Rating	1			2			
MRSS Services: Youth and/or Family Peer Support Services 2 Potential Incentive Points	25 – 49% Youth and/or caregiver received youth and/or family peer support services.			50 – 100% Youth and/or caregiver received youth and/or family peer support services.			

MRSS Program Components					
Rating	0	1	2	3	4
8. Duration of Services: 42 Days	MRSS episode of care exceeds 42 days more than 40% of MRSS cases.	MRSS episode of care exceeds 42 days in 31 to 40% of the cases served.	MRSS episode of care exceeds 42 days in 21 to 30% of the cases served.	MRSS episode of care exceeds 42 days in 11 - 20% of the cases served.	MRSS episode of care exceeds 42 days in less than 10% of the cases served.
9. Safety plan content	Comprehensive safety planning includes one or less of five criteria (a)	Comprehensive safety planning includes two out of five criteria (a-b).	Comprehensive safety planning includes three out of five criteria (a-c).	Comprehensive safety planning is present in 100% of stabilization charts reviewed and includes four out of five criteria (a-d).	Comprehensive safety plans are present in 100% of charts reviewed and include the following: a) Assessment of safety concerns, risk behaviors, escalation patterns, and crisis triggers. b) Safety plans have actionable crisis stabilization steps created in collaboration with youth and family with strategies that are easily understood. c) Risk mitigation and safety promotion steps were identified, implemented, monitored, and updated as needed. d) Safety plans incorporate natural supports & do not rely exclusively on professional resources. e) Individualized safety plans, signed by youth and caretaker. Documentation of plan being provided to the family.
10. Stabilization Services	MRSS program routinely provide 3 or less out of 7 services listed (a-g)	MRSS program routinely provide 4 of 7 services listed (a-g)	MRSS program routinely provide 5 of 7 services listed (a-g)	MRSS program routinely provides 6 of 7 services listed (a-f)	Trauma-informed stabilization services and supports are provided as evidenced by: a) MRSS Comprehensive Crisis Assessment b) MRSS Plan c) Ongoing crisis stabilization d) System navigation, advocacy, continuity of care, and collaborative treatment and discharge planning e) Skill building with youth (communication, problem solving, regulation and coping skills) f) Skill building with parents/caretakers: Behavior management skills g) Individual and family support network development

11. System of Care Perspective	MRSS is implemented utilizing system of care principles as evidenced by meeting 2 or less of the 6 criteria (a-f).	MRSS is implemented utilizing system of care principles as evidenced by meeting 3 out of the 6 criteria (a-f).	MRSS is implemented utilizing system of care principles as evidenced by meeting 4 out of the 6 criteria (a-f).	MRSS is implemented utilizing system of care principles as evidenced by meeting 5 out of the 6 criteria (a-f).	<p>MRSS is implemented utilizing System of Care principles including:</p> <ul style="list-style-type: none"> a) Culturally and linguistically appropriate b) Trauma-informed c) Resiliency-focused and developmentally appropriate d) Strength-based e) Youth guided, family-driven f) Individualized to the unique needs and strengths of the youth and family
12. Clinical Supervisory Management, Support, and Availability	Supervisory support as evidenced by one or fewer criteria met (a-c).	Supervisory support as evidenced by 2 out of 5 criteria (a-c).	Supervisory support as evidenced by 3 out of 5 criteria (a-c).	Supervisory support as evidenced by 4 out of 5 criteria (a-d).	<p>Best practice criteria:</p> <ul style="list-style-type: none"> a) Staff receive individual supervision, that is appropriate for the staff person's role, scope, and expertise. b) Weekly group supervision conducted by a clinical supervisor or alternate clinical supervisor. c) Supervisory support is available 24/7 to MRSS staff for emergency consultation and supervision. d) Clinical Supervisor or alternate clinical supervisor is available for on-call back up for MRSS families. e) Triage and monitoring of level of acuity for every youth and family served is conducted by the clinical supervisor or clinical alternate supervisor who also assists staff in tailoring the service intensity to the stabilization needs of each youth and family.
13. Professional training and development	Professional training and development as evidenced by one of the five criteria (a-c).	Professional training and development as evidenced by 2 out of 5 criteria (a-c).	Professional training and development as evidenced by 3 out of 5 criteria (a-c).	Professional training and development as evidenced by 4 out of 5 criteria (a-d).	<p>Best practice criteria:</p> <ul style="list-style-type: none"> a) Every MRSS staff member, including the supervisor and peer supervisor complete the MRSS Core Training within 60 days of employment start date. b) Each MRSS staff including supervisor, peer supervisor and after-hours coverage staff have an individualized training plan based on an assessment of his or her specific training needs. c) Each MRSS supervisor receives training specific to the clinical & administrative supervision of MRSS.

					<ul style="list-style-type: none"> d) Each agency has a written description of the skills and competencies required to provide MRSS service. e) The agency's training plan includes provisions for quarterly trainings specific to the identified training needs of the staff.
14. Quality Management and Practice improvement	Quality and practice improvement strategies utilized as evidenced by 1 or less of 5 (a).	Quality and practice improvement strategies utilized as evidenced by 2 out of 5 (a & c).	Quality management and practice improvement as evidenced by 3 of the 5 criteria (a-c).	Quality management and practice improvement as evidenced by 4 (a-d) of the 5 criteria.	<p>Best practice criteria:</p> <ul style="list-style-type: none"> a) Family Satisfaction with services data (report from BG or paper copies) is collected and utilized for quality improvement. b) External expert clinical consultant utilized. c) Benchmarks are regularly tracked and reviewed (i.e., response time for initial call etc.) and utilized in program quality improvement. d) Utilizes daily service-load tracking to implement real-time staffing adjustments. e) Additional agency specific outcomes utilized.
15. Worker Safety	Worker safety protocols are evidenced by 2 out of 6 criteria (a-f).	Worker safety protocols are evidenced by 3 out of 6 criteria (a-f).	Worker safety protocols are evidenced by 4 out of 6 criteria (a-f).	Worker safety protocols are evidenced by 5 out of 6 criteria (a-f).	<p>Worker Safety includes the following criteria:</p> <ul style="list-style-type: none"> a) Program has written protocols and policies for worker safety. b) Supervisor and/or team leader as well as administrative supervisor have access to staff schedules. c) Program has a protocol for staff check-ins when appointments are finished. d) Program establishes and maintains positive working relationships with local CIT officers. e) Safety screening protocol for first visit is utilized f) Staff are issued agency cell phones and hot spot technology (or are reimbursed for these).

<p>16. MRSS Staffing and Capacity</p>	<p>Team Composition and Program Capacity: a) Clinical Supervisor Less than 24% dedicated. b) BA level or higher MH licensed staff; and c) QBHS; OR a certified family or young adult peer support. d) No access to psychiatrist or certified nurse practitioner or clinical nurse specialist. e) MRSS provider operates in isolation – No QMHS or youth/family peer supporter.</p>	<p>Team Composition and Program Capacity: a) Clinical Supervisor 25 - 49% dedicated. b) BA level or higher MH licensed staff; and c) QBHS; OR a certified family or young adult peer support. d) Limited or no access to psychiatrist or certified nurse practitioner or clinical nurse specialist. e) MRSS Services are available for an immediate mobile response only during weekday business hours.</p>	<p>Team Composition and Program Capacity: a) Clinical Supervisor (50-74% dedicated); and b) BA level or higher MH licensed staff; and c) QBHS; OR a certified family or young adult peer support. d) Limited access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes. e) MRSS services available for an immediate response during extended business hours until 8 pm weekdays and/or on weekends evidenced by weekly staffing schedule. f) During periods of high-call volume, staff have to reschedule stabilization phase appointments.</p>	<p>Team Composition and Program Capacity: a) Clinical Supervisor (75-99% dedicated); and b) BA level or higher MH licensed staff; and c) QBHS; OR a certified family or young adult peer support. d) Access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes. e) MRSS services available during extended business hours at least to 10 pm weekdays AND on weekends evidenced by weekly staffing schedule. f) Sufficient staff are available during periods of high-call volume - staff do not need to reschedule stabilization.</p>	<p>Team Composition and Program Capacity: a) Clinical Supervisor(s) (100% dedicated); and b) BA level or higher MH licensed staff; and c) QBHS; OR a certified family or youth peer supporter. d) Access to a psychiatrist or certified nurse practitioner or clinical nurse specialist for consultation purposes. e) Mobile services are available for an immediate full 24/7 response evidenced by weekly staffing schedule. f) Sufficient staff are available during periods of high-call volume - staff do not need to reschedule stabilization.</p>