EXHIBIT B-1

Mobile Crisis Intervention Services (MCIS) Program Provisions

Overview

The Mobile Crisis Intervention Services (MCIS) contractor shall administer Kentucky's community-based mobile crisis intervention (MCI) System Model and deliver quality MCI services to adults, youth, and children who are experiencing behavioral health crisis who are eligible to receive medically necessary services regardless of insurance status, ability to pay, county of residence, immigration status, or level of income.

For all Mobile Crisis Intervention Services (MCIS) provider organizations, including but not limited to Community Mental Health Centers (CMHCs), Behavioral Health Service Organizations (BHSOs), and others designated by the Kentucky Department for Medicaid Services ("the Department"), Carelon Behavioral Health, Inc. as the Mobile Crisis Intervention Services Administrative Service Organization (MCIS-ASO), shall provide administrative oversight, enforcement, and billing services that result in MCIS provider compliance with all applicable state and federal law and regulation, State Plan Amendments (SPA), materials incorporated by reference, billing manuals, transmittal letters, policies and procedures, an Ancillary Settlement Adjustment Report (if applicable), and the budget bill or expenditure targets as provided by the Department.

Mobile Crisis Intervention Services

General

1. The MCI service providers shall ensure quality, best practice-based MCI service delivery that meets the requirements of the December 28, 2021, CMS SHO Letter #21-008.

2. Mobile crisis services shall be available to any individual within their geographic area who is experiencing a behavioral health crisis and is determined to need a face-to-face clinical screening in Kentucky at no cost, regardless of income, age, residency, or immigration status.
    a. Prior authorization is not required for mobile crisis intervention services level of care.
    b. Mobile crisis services are continued until the individual no longer meets medical necessity criteria or until the individual is transitioned to another source and/or level of care.

3. Prior authorization is not required for mobile crisis services level of care. However, providers will be subject to quality-of-care audits and review of services rendered based on published Carelon guidelines and applicable state policy.

4. MCI service providers must maintain Mobile Crisis Team (MCT) capacity necessary to serve people regardless of age, disability, level of income, race or ethnicity, gender, payer status, and/or those with population-specific needs.

5. MCI service delivery and MCT-related policies, protocols and procedures ensure that an individual in crisis has a voice of choice and may decline service or refuse treatment during or after the crisis encounter.

6. MCTs will not respond to locations where services and clinically trained behavioral health clinicians are already available and mobile crisis intervention services would be duplicative.

7. MCI services must be delivered to all individuals in the RSA (including, but not limited to adults, youth, children, and those with I/DD) across the Commonwealth, with programs appropriate for each group, regardless of insurance status, ability to pay, state of residence, level of income, or immigration status.

8. MCI services must be available 24/7/365 days per year.

9. MCI Services providers must provide community-based, face-to-face rapid response to individuals in active crisis, responding to the location within one (1) hour or less in urban areas and two (2) hours or less in rural communities. If the MCT cannot make it within the timeframe, they are to contact the person by telephone to advise of estimated arrival time and to coordinate safe response.

10. MCI Service providers must provide crisis interventions for individuals, wherever the crisis maybe occurring, and begin the process of screening and definitive treatment outside of a hospital or health care facility.

11. MCI Services providers must ensure a qualified behavioral health professional will conduct a crisis screening and provide intervention and referral services on-scene or via telehealth processes as allowed in the KY DMS SPA Definition. The screening shall collect information on the circumstances of the crisis event, safety and risk related to the individual and others involved, medication, substance use, strengths and resources of the individual, recent inpatient hospitalizations or mental health services, mental health conditions, medical history, and other pertinent information.

12. MCI contracted providers will hire people with lived experience as staff. These staff with lived experience will have meaningful input into the planning, implementation, and ongoing operations of the service.

13. MCI Service Providers must engage with KYNECT Connector or community health worker when an individual does not have any health coverage to determine Medicaid eligibility.

14. MCI providers must link the individual in crisis to ongoing services to address the identified needs within 72 hours of the crisis incident. Services may include, but are not limited to referrals for crisis stabilization, inpatient hospitalization, acute withdrawal management services, residential treatment services, recovery support services, medication services, home-based services, outpatient services, respite services, housing, and follow-up contacts. Though services must be linked within 72 hours, linkage for acute needs should be effective as soon as possible to support safety for the Individual in crisis.

15. MCI service provider must follow policies and protocols to determine when 23-hour Crisis Observation Stabilization Services (COSS) and Residential Crisis Stabilization Services (RCSS) are clinically appropriate for individuals experiencing a behavioral health crisis.

Exclusions

1. MCIS may not be provided at, and MCT shall not be dispatched to, the following location types:

    a. Jails
    b. Prisons
    c. General Hospitals (Medicaid PT 01)
    d. Mental Hospitals (Medicaid PT 02)
    e. Behavioral Health Services Organizations (Medicaid PT 03) Tier III, SUD Residential Facilities
    f. Nursing Facilities (Medicaid PT 12)

988 CCC Triage/Dispatch to MCT Transition

1. A MCT will be dispatched based on a Cabinet-developed and standardized triage process utilized by all CCCs. **See Appendix C for approved process.**

2. If a MCT is deployed, the 988 CCC will conduct a warm hand-off to the MCT, allowing the MCT to remain in communication during transit. If a warm hand-off to the MCT is not possible, the 988 CCC will remain on the phone until the MCT arrives on-scene.

3. 988 CCCs will utilize the approved ATC platform during the triage and dispatch process to share information, when possible. MCT providers are required to utilize the ATC platform to receive dispatch orders, utilize GPS tracking for safety, and make referrals and schedule appointments to appropriate levels of care during disposition.

    a. Providers are required to Sign a No-Fee User Agreement for utilization of ATC.
    b. Providers are required to Sign a Business Associate Agreement for utilization of ATC.

4. If EMS or LEO are required based on the triage level, the 988 CCC and MCT will coordinate during transit and service delivery.

MCI service provider must dispatch when requested with a two-person MCT, which always includes a minimum of one (1) provider type listed in the left column and one (1) additional provider type from either column. **See Appendix A for List of Eligible Provider Types.**

    a. The response shall include at least one behavioral health professional, as defined in the December 28, 2021, CMS SHO Letter #21-008, and described as a Practitioners Permitted to Render MCI Services within Appendix A.
    b. Mobile response shall be a paired response to include two (2) staff when dispatched to community locations, including but not limited to an individual's home and/or secluded areas out of cell range.
    c. The MCT must be equipped to respond to the individual in crisis where they are located in the community. A protocol will ensure safety and identify situations that necessitate coordination with law enforcement and/or other first responders, **as defined in the December 28, 2021, CMS SHO Letter #21-008.**
    d. .

5. MCI service providers will conduct screening for Medicaid eligibility per Carelon policies and protocols.

MCT Staffing

1. MCI service provider must consist of a minimum of a two-person or more multi-disciplinary team composed of provider types approved by the Commonwealth, including:
    a. At least one (1) licensed behavioral health clinician who is qualified to provide an assessment under state law.
    b. At least one (1) other professional or paraprofessional with expertise in behavioral or mental health OR a peer/family support provider who receives supervision and training in crisis response.
    c. One (1) or more person on the team must be in-person (face-to-face) and the second team member may be connected via telehealth. The second team member cannot just be "available" and must actively engage throughout the encounter. The team member connected via telehealth may be a behavioral health professional who can conduct an assessment under the state scope of practice.
    d. Access to a prescribing provider 24/7/365.

MCI Service Provider Training

1. MCI service provider to ensure each MCI staff satisfactorily completed the following training within the first ninety (90) days of employment when deemed necessary or required for their positions. Periodic refreshers of training,

as reviewed and approved by DMS, are also required based on their position. MCI staff must be knowledgeable of the following:

a. Cultural awareness, responsiveness, and linguistic competency to ensure the MCT delivers MCI services in a culturally and linguistically competent manner and are responsive to the diverse communities served, including individuals for whom English is a second language.
b. Trauma-informed care to ensure delivery of a recovery-oriented, person-centered approach and any trauma-specific interventions currently offered or to be implemented.
c. Evidence-based and promising practices.
d. Mental health screening and assessment.
e. Risk assessment and safety planning.
f. Personal safety in the field and staff safety standards for community response.
g. SUDs.
h. Co-occurring disorders.
i. Dementia.
j. Chemical dependency screening and intervention.
k. Psychiatric medications and side effects.
l. Traumatic brain injuries.
m. Developmentally appropriate interventions for children and adolescents.
n. Intellectual and developmental disorders.
o. Crisis intervention services and practices.
p. Risk assessment and suicide screening.
q. Harm reduction.
r. De-escalation techniques.
s. Motivational interviewing.
t. National standards for CLAS, including DMS standards policies; CLAS delivery.
u. Crisis medication training.

Transportation

1. MCI service provider must follow DMS policies and protocols for coordinating clinically appropriate transportation or BHCT for individuals between levels of care within the Kentucky MCI system, leveraging all payer sources, including Medicaid.

2. MCTs must arrange or coordinate BHCT from the in-person MCI service delivery location to the nearest appropriate facility capable of triaging, stabilizing, and determining medical necessity for ongoing care (e.g., a crisis stabilization facility) when it is determined that a higher level of care placement is needed.

Follow up

1. MCI service provider must have follow-up policies and protocols for coordinating post-crisis care for adults and youth/children, including but not limited to referrals.

2. The MCT shall be trained and/or work directly with two (2) care managers who provide post-crisis follow-up care. The following shall be completed by the MCT and/or care managers to assist in diverting individuals in crisis from short-term to more permanent community support services:
    a. Assess the individual for short-term needs, such as food and shelter.
    b. Connect individuals to providers and resources that are best suited to their immediate and long-term needs.
    c. Provide transportation assistance to ensure connection to long-term providers.
    d. Develop care plans in conjunction with support systems to minimize future 911 crisis needs, law enforcement involvement, and EMS and ED utilization.

e. Identify solutions to minimize future 911 crisis needs and assist in stabilization.

3. The MCT member delivering MCI services conducts follow-up activities, including:
    a. Provide resources and referrals to individual in crisis. Resources provided shall always include the statewide hotline phone number and text information.
    b. Document all referrals provided in the individual's EHR and include, at a minimum, the provider's name, date, and time of the appointment.
    c. Make referrals to available outpatient behavioral health appointments, including same-day appointments as needed
    d. Use FindHelpNowKY.org to identify referrals to higher levels of care such as crisis stabilization centers, residential American Society of Addiction Medicine levels of care, etc.
    e. Follow-up telephone calls that are attempted within three (3) calendar days of the initial crisis contact for those individuals that did not require a referral to a higher level of care.
    f. Reassessing risk, reviewing/updating immediate and short-term safety plans, collaborating with immediate/available supports, and providing ongoing support and outreach.
    g. If the individual does not have short-term plans to engage in behavioral health care, a second follow-up call shall be attempted within ten (10) calendar days of the initial crisis contact.
    h. If mobile crisis services were initiated by 988, then the MCT shall update the crisis line with the outcome of their visit within twenty-four (24) hours.

Reporting Requirements

The MCI service provider shall provide regular reports to Carelon related to MCI operations. Carelon may request additional ad-hoc reports and will work with the MCI service provider to define what the requirements are for the ad hoc reports and the timeframe for their submission.

The MCIS-ASO shall require subcontracted MCI service providers to track and report on the specific datasets enumerated by DMS. **Refer to Appendix B, Reporting Requirements, for details.**

The MCIS-ASO shall complete the following data reporting:

1. For privately insured persons receiving services, information necessary to process claims with insurance provider.
2. Quarterly data quality reports, including work plan and narrative regarding how the MCIS-ASO ameliorates data issues.
3. Monthly data trend analysis report with accompanying narrative regarding any staffing or organization matters that contribute to data trends or performance.
4. Monthly data reports, including administrative data points prescribed by DMS.
5. Monthly report on collected basic demographic information to enable Medicaid billing and leveraging of potential federal matching.

EXHIBIT B-2

23-Hour Crisis Observation Stabilization Services (COSS) Program Provisions

Overview

The Mobile Crisis Intervention Services (MCIS) contractor shall administer Kentucky's community-based mobile crisis intervention (MCI) System Model and deliver quality MCI services to adults, youth, and children who are experiencing behavioral health crisis who are eligible to receive medically necessary services regardless of insurance status, ability to pay, county of residence, immigration status, or level of income.

For all Mobile Crisis Intervention Services (MCIS) provider organizations, including but not limited to Community Mental Health Centers (CMHCs), Behavioral Health Service Organizations (BHSOs), and others designated by the Kentucky Department for Medicaid Services ("the Department"), Carelon Behavioral Health, Inc. as the Mobile Crisis Intervention Services Administrative Service Organization (MCIS-ASO), shall provide administrative oversight, enforcement, and billing services that result in MCIS provider compliance with all applicable state and federal law and regulation, State Plan Amendments (SPA), materials incorporated by reference, billing manuals, transmittal letters, policies and procedures, an Ancillary Settlement Adjustment Report (if applicable), and the budget bill or expenditure targets as provided by the Department.

23-Hour Crisis Observation Stabilization Services

General

1. 23-Hour Crisis Observation Stabilization Services (COSS) is a voluntary, 23-hour direct service, designed to stabilize and restore the individual to a level of functioning in the least restrictive environment.
2. All COSS clinicians and staff adhere to strict confidentiality and privacy protocols to protect the rights and dignity of individuals seeking crisis stabilization services.
3. COSS provides behavioral health and medical screenings, evidence-based crisis interventions, and de-escalation to individuals experiencing a behavioral health crisis for a period of up to 23 hours in a Crisis Observation Stabilization Services Unit (COSSU).
4. COSS is indicated for those situations wherein an individual is in an acute behavioral health crisis that cannot be safely accommodated within the community but may be safely served in a COSSU environment as an alternative to inpatient psychiatric hospitalization.
5. COSS shall be:
    a. Person-centered
    b. Medically necessary
    c. Reflective of the cultural and linguistic needs of the recipient
    d. Evidence-based
    e. Trauma-informed
2. The purpose of COSS services are to:
    a. Stabilize a crisis and divert an individual from a higher level of care;
    b. Stabilize an individual and provide medication management, if applicable;
    c. Reintegrate an individual into the individual's community or other appropriate setting as soon as the person is no longer in crisis and does not meet the criteria for a higher level of care.

Crisis Observation Stabilization Services Offered and Facility Requirements

1. COSS within a COSSU shall be outpatient, community-based programs that offer an array of evidence-based services and interventions including the following in order to stabilize a crisis:
    a. Crisis and Risk-Screening

    b. Crisis intervention and de-escalation techniques
    c. Medical screening and evaluation
    d. Ambulatory withdrawal management with on-site monitoring
    e. Development of a crisis care plan to determine appropriate level of care
    f. Care coordination
2. COSS clinicians shall conduct a behavioral health screening to understand the individual's behavioral health status and needs and to assess current risk.
3. COSS medical staff (minimum of an RN) conducts a comprehensive medical screening to understand the individual's health status and needs, including the risk of drug and alcohol related overdose, and provides support following a non-fatal overdose after the individual is medically stable. Overdose prevention activities include ensuring access to naloxone for overdose reversal.
4. COSSU facilities offer medication management and administration as needed to address acute symptoms.
5. COSS clinicians and staff collaborate with individual to develop safety plans and coping strategies for managing future crises.
6. COSSU must have referral relationships to both outpatient and inpatient levels of care as next level of care options and must facilitate transfers as indicated by an individual's needs.

Multidisciplinary Team Requirements

1. COSS providers must be in a licensed organization and meet the following:
    a. Within one (1) year of ASO oversight of crisis continuum going live, COSS Provider must have 24-hour on-site Nursing services with a minimum of an RN. In this intervening year, Provider must be able to virtually contact an RN within one (1) hour of an Individual's presentation for services at the COSSU. Note that specific requirements for CCBHCs differ, as described in items 3 and 4 below.
    b. 24-hour on-site Nursing services with at minimum an RN (except as noted in *a* preceding)
    c. 24-hour on-site behavioral health practitioner or associate
    d. Capacity to provide the full range of services included in the COSS definition
    e. Access to a prescriber for Medication for Opioid Use Disorder (MOUD) 24/7/365
    f. Access to a board-certified or board-eligible psychiatrist 24/7/365
2. COSSUs are required to adhere to a 5:1 staffing ratio, with a minimum of 1 of each required staff. COSSUs may supplement with a paraprofessional or any qualified staff.
3. CCBHCs must either:
    a. Provide COSS by June 2024 or
    b. Receive approval from DMS by June 2024 for a plan to provide COSS by 12/31/2024.
4. CCBHCs must adhere to COSS on-site RN staffing requirements by 12/31/2024 to satisfy this requirement for their 2025 demonstration year.

Medicaid Eligible Provider Types: Multi-Disciplinary Team

See **Appendix A** for Eligible Provider Types.

COSS Therapeutic Environment

1. COSSU shall be a safe and calming environment conducive to crisis resolution and stabilization and shall offer comfortable and non-restrictive facilities to enhance the overall well-being of individuals in crisis.

Intake and Discharge Processes

1. Admission criteria for withdrawal management level of care provided within the COSSU must be in accordance with the most current version of the ASAM Criteria for withdrawal management levels in an outpatient setting.
2. An individual receiving withdrawal management services shall meet:
    a. Most current edition of diagnostic criteria for substance withdrawal management found in the Diagnostic and Statistical Manual of Mental Disorders; and
    b. Current dimensional admissions criteria for withdrawal management level of care as found in the ASAM criteria
3. COSSU shall implement the following crisis stabilization best practices for intake and discharge:
    a. Intake
        i. Crisis Risk Screening to information Level-of-Care needs: Conduct an initial screening for risk of suicide or harm to others, current and previous level of functioning, history of psychiatric placements
        ii. Nursing Screening: Conduct an initial screening for medical conditions and/or physical health needs
        iii. Consult existing crisis or safety plan (if available)
        iv. Determination of need for facility-based crisis intervention services, whether observation and/or detoxification is clinically necessary
    b. Discharge
        i. Admission criteria are no longer met, or criteria are met for a less or more intensive level of care
        ii. Availability of natural supports or services to which the individual can be discharged
        iii. Discharge planning to include transition to other services is a required service component

Care Coordination

1. Care coordination in mental health and substance use disorder is essential in meeting recipients' needs and treatment goals to improve overall health outcomes, and requires continued follow up, progress monitoring and tracking of patient outcomes to ensure these goals are met.
2. Care coordination shall include at minimum;
    a. Referring the recipient to appropriate community services through a warm handoff
    b. Transferring of medical records
    c. Facilitating medical and behavioral health follow-ups
    d. Linking to appropriate levels of substance use treatment within the continuum in order to provide on-going support
    e. Providing a discharge summary
    f. Facilitating medication-assisted treatment as necessary, per patient choice, if the medication is not offered on-site
    g. Completing post crisis follow-up with the individual within 72 hours of the discharge from the COSSU
    h. Referring the individual to appropriate community services
    i. Facilitating medical and behavioral health follow-ups or linkage to current providers
    j. Linking to appropriate levels of behavioral health treatment in order to provide ongoing support

Crisis Education

1. COSS clinicians provide psychoeducation to individuals and their families on crisis prevention, coping skills, and available mental health resources. COSS clinicians develop a comprehensive follow-up care plan to address the individual's ongoing mental health needs.
2. Required Psychoeducation components include:

a. For those under withdrawal management protocols, education about how the medication works, including associated risks and benefits and overdose prevention.
b. Development of a Crisis Intervention and Prevention Plan (CIPP)
    i. CIPP shall support the restoration of recipient's functional level to the recipient's best possible functional level, and:
        1. Performed using a person-centered planning process
        2. Be directed by the recipient
        3. Include practitioners of the recipient's choosing, and
    ii. May include:
        1. A mental health advanced directed filed with a local hospital
        2. A safety plan (required for all individuals with elevated risk)
        3. A relapse prevention strategy or plan
c. Relapse prevention strategies or plan
d. Crisis interventions required to promote health and well-being of the individual
e. Awareness of appropriate treatment services and how to access them

Exclusions

1. COSS does not include, and federal financial participation (FFP) is not available for:
    a. Room and board services
    b. Educational, vocational and job training services
    c. Habilitation services
    d. Services to inmates in public institutions as defined in 42 CFR §435.1010
    e. Services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010
    f. Recreational and social activities
    g. Services that must be covered elsewhere in the state Medicaid plan.

Facility Requirements

1. COSSU must be licensed by the Office of Inspector General (OIG) and enrolled with the Department as a COSSU.
2. COSSU must be licensed as a residential crisis stabilization unit (PT 25) or community mental health center (PT 30).
3. COSSU must be contracted with the administrative services organization (ASO).
4. COSSU shall not:
    a. Be part of a hospital
    b. Contain less than three (3) or more than twenty (20) chairs, unless a waiver or other approval is received from the federal government

Documentation and Reporting

1. All COSS providers shall maintain thorough and accurate documentation of screenings, interventions, and care provided during the crisis stabilization period.
2. COSSUs are required to contract with the administrative services organization and comply with documentation and reporting requirements outlined in the provider contract.

Provider Training

1. COSS shall ensure each staff satisfactorily complete the following training within the first ninety (90) days of employment when deemed necessary or required for their positions. Periodic refreshers of training, as reviewed and approved by DMS, are also required based on their position. Staff must be knowledgeable of the following:
    a. Cultural awareness, responsiveness, and linguistic competency to ensure services are delivered in a culturally and linguistically competent manner and are responsive to the diverse communities served, including individuals for whom English is a second language.
    b. Trauma-informed care to ensure delivery of a recovery-oriented, person-centered approach and any trauma-specific interventions currently offered or to be implemented.
    c. Evidence-based and promising practices.
    d. Mental health screening and assessment.
    e. Risk assessment and safety planning.
    f. SUDs.
    g. Co-occurring disorders.
    h. Dementia.
    i. Chemical dependency screening and intervention.
    j. Psychiatric medications and side effects.
    k. Traumatic brain injuries.
    l. Developmentally appropriate interventions for children and adolescents.
    m. Intellectual and developmental disorders.
    n. Crisis intervention services and practices.
    o. Risk assessment and suicide screening.
    p. Harm reduction.
    q. De-escalation techniques.
    r. Motivational interviewing.
    s. National standards for CLAS, including DMS standards policies; CLAS delivery.
    t. Crisis medication training.

EXHIBIT B-3
Residential Crisis Stabilization Services (RCSS) Program Provisions

Overview

The Mobile Crisis Intervention Services (MCIS) contractor shall administer Kentucky's community-based mobile crisis intervention (MCI) System Model and deliver quality MCI services to adults, youth, and children who are experiencing behavioral health crisis who are eligible to receive medically necessary services regardless of insurance status, ability to pay, county of residence, immigration status, or level of income.
For all Mobile Crisis Intervention Services (MCIS) provider organizations, including but not limited to Community Mental Health Centers (CMHCs), Behavioral Health Service Organizations (BHSOs), and others designated by the Kentucky Department for Medicaid Services ("the Department"), Carelon Behavioral Health, Inc. as the Mobile Crisis Intervention Services Administrative Service Organization (MCIS-ASO), shall provide administrative oversight, enforcement, and billing services that result in MCIS provider compliance with all applicable state and federal law and regulation, State Plan Amendments (SPA), materials incorporated by reference, billing manuals, transmittal letters, policies and procedures, an Ancillary Settlement Adjustment Report (if applicable), and the budget bill or expenditure targets as provided by the Department.

Residential Crisis Stabilization Services

General

1. Residential Crisis Stabilization Services (RCSS) are provided in residential crisis stabilization units (RSCU) that are community-based residential programs.
2. These services are used when individuals in a behavioral health crisis cannot be safely accommodated within the community, are not in need of hospitalization or inpatient treatment, and need stabilization that cannot safely be achieved at a lower level of care.
3. The purpose is to stabilize the individual and reintegrate back into the community when the individual no longer meets criteria for this level of care.
4. RCSS provides assessment and stabilization interventions to individuals experiencing a behavioral health crisis.
5. Services should be:
    a. Strengths-based
    b. Person-centered
    c. Trauma-informed
    d. Medically-necessary
    e. Culturally-competent
    f. Evidence-based
    g. Coordinated
    h. Focused on outcomes
        i. Service engagement
        ii. Decrease in arrests
        iii. Decrease in emergency department boarding
6. All RCSU clinicians and staff adhere to strict confidentiality and privacy protocols to protect the rights and dignity of individuals seeking crisis stabilization services, as required under state and federal law.

Service Requirements

1. Services must include the following in order to stabilize a crisis:
    a. Behavioral Health Screening and Assessment.
    b. Crisis Education, Intervention, and Prevention Plan (CIPP). RCSS providers develop the CIPP based on the initial crisis screening and assessment to determine appropriate level of care.
    c. Evidence-based Stabilization Interventions. Based on the CIPP, RCSUs provide access to appropriate care, to further stabilize the crisis, including but not limited to:
        i. Individual, group, and family therapy
        ii. Psychoeducation
        iii. Management of withdrawal symptoms
        iv. Extended on-site monitoring relating to medication management
        v. Peer support services.
    d. Care Coordination. RCSUs ensure access to care coordination to meet the recipients' needs and treatment goals to improve overall health outcomes, facilitate follow-ups, and monitor patient outcomes.
2. RCSU must:
    a. Provide a safe and calming environment conducive to crisis resolution and stabilization.
    b. Offer comfortable and non-restrictive facilities to enhance the overall well-being of individuals in crisis.

Intake and Discharge Process

RCSU shall implement the following crisis stabilization best practices for intake and discharge:

1. Intake
    a. Risk Assessment & Crisis Evaluation to Inform Level-of-Care Needs: Conduct an initial screening upon admission for:
        i. Risk of suicide or harm to others
        ii. Current and previous level of functioning
        iii. History of psychiatric placements (see CIPP referenced in the above Services section)
    b. Nursing Assessment: Conduct:
        i. Initial screening upon admission for: urgent medical conditions and/or physical health needs
        ii. Full nursing assessment within 8 hours of admission.
    c. Consult existing Crisis or Safety Plan (if available)
    d. Provide access to need treatments as identified in the intake assessment.
    e. Identification of existing treatment providers and natural supports to support care coordination and discharge planning
2. Discharge
    a. Admission criteria are no longer met, or criteria are met for a less or more intensive level of care.
    b. Availability of natural supports or services to which the individual can be discharged.
    c. Discharge planning to include transition to other services is a required service component.
    d. Discharge summary provided by Care Coordination staff.

Care Coordination

1. Care coordination in mental health and substance use disorder is essential in meeting recipients' needs and treatment goals to improve overall health outcomes, and requires continued follow up, progress monitoring and tracking of patient outcomes to ensure these goals are met.
2. RCSU must have referral relationships with outpatient and inpatient levels of care to effect linkage of individuals.
3. Care coordination shall include at minimum;

a. Referring the recipient to appropriate community services through a warm handoff
b. Transferring of medical records
c. Facilitating medical and behavioral health follow-ups
d. Linking to appropriate levels of substance use treatment within the continuum in order to provide on-going support
e. Providing a discharge summary
f. Facilitating medication assisted treatment as necessary, per patient choice, if the medication is not offered on-site
g. Completing post crisis follow-up with the individual within 72 hours of discharge from the RCSU

Substance Use Disorder Treatment Requirements

1. RCSUs providing SUD treatment must meet service criteria for medically monitored intensive inpatient services, including medically monitored inpatient withdrawal management services using the current edition of *The American Society of Addiction Medicine's (ASAM) Criteria, Treatment Criteria for Addictive, Substance-Related, and co-Occurring Conditions.*
2. RCSUs shall meet patient education as required in the current ASAM criteria for Treatment of Addictive, Substance-Related, and Co-Occurring Conditions. RCSUs shall "educate the patient about how the medication works, including associated risks and benefits, overdose prevention."

RCSS Crisis Education, Intervention, and Prevention Plan (CIPP)

1. RCSUs shall meet patient education as required in the current ASAM criteria for Treatment of Addictive, Substance-Related, and Co-Occurring Conditions.
2. RCSUs shall:
    a. Develop a Crisis Intervention and Prevention Plan (CIPP) in active cooperation with the individual that is individualized and that:
        i. Supports restoration of a recipient's functional level to the best possible functional level
        ii. Is created through a person-centered process
        iii. Is self-directed by the recipient
        iv. Includes practitioners of the recipient's choosing
        v. May include:
            1. A mental health advanced directive being filed with a local hospital
            2. A safety plan (required for anyone who exhibited an elevated risk level during the treatment episode)
            3. A relapse prevention strategy or plan
    b. Implement relapse prevention strategies and develop a relapse prevention plan with individuals with SUD needs
    c. Provide therapy required to promote health and well-being of the individual
    d. Offer group therapy services centered on goals, including:
        i. Building and maintaining health relationships,
        ii. Personal goal-setting
        iii. The exercise of personal judgment
    e. Offer family therapy services consisting of a crisis intervention plan to address issues interfering with the relational functioning of the family and to improve interpersonal relationships within the recipient's home environment
    f. Engage the individual in developing an appropriate treatment relationship

Exclusions

1. Residential crisis stabilization does not include, and federal financial participation (FFP) is not available for:
    a. Room and board services
    b. Educational, vocational and job training services
    c. Habilitation services
    d. Services to inmates in public institutions as defined in 42 CFR §435.1010
    e. Services to individuals residing in institutions for mental diseases as described in 42 CFR§435.1010
    f. Recreational and social activities
    g. Services that must be covered elsewhere in the state Medicaid plan.
2. KY Medicaid will not pay for this service in a unit of more than 16 beds or multiple units operating as one unified facility with more than 16 aggregated beds except for services furnished pursuant to the state plan benefit "inpatient psychiatric services for individuals under 21" (section 1905(a)(16) of the Act; 42 CFR 440.160) or pursuant to an exclusion for individuals aged 65 or older who reside in institutions that are IMDs (section 1905(a) of the Act; 42 CFR 440.140.)

Provider Requirements

1. Residential Crisis Stabilization providers must be employed by a licensed organization and the following additional criteria:
    a. Capacity to employ practitioners and coordinate service provision among rendering providers
    b. Capacity to provide the full range of services included in the Residential Crisis Stabilization service definition
    c. Ability to provide Residential Crisis Stabilization services on a 24/7/365 basis
    d. Access to a board-certified or board-eligible psychiatrist on a 24/7/365 basis
    e. Within one (1) year of ASO oversight of crisis continuum going live, CRSS Provider must have 24-hour on-site Nursing services with a minimum of an RN. In this intervening year, Provider must be able to virtually contact an RN within one (1) hour of an Individual's presentation for services at the CRSSU.
    f. 24-hour on-site Nursing services with at minimum an RN (except as noted in *e* preceding).
    g. Access to a prescriber for Medication for Opioid Disorder (MOUD) when providing RCSS.

Facility Requirements

1. RCSU must be:
    a. Licensed by the Office of Inspector General (OIG).
    b. Enrolled as a Residential Crisis Stabilization Unit or Community Mental Health Center
    c. Contracted with the administrative services organization (ASO)

Multidisciplinary Team Requirements

1. RCSS Providers must be a licensed organization and must meet the following additional criteria:
    a. Capacity to employ practitioners and coordinate service provisions among rendering providers;
    b. Capacity to provide the full range of services included in the RCSS services definition;
    c. Ability to provide RCSS on a 24/7/365 basis;
    d. Access to a board-certified or board-eligible psychiatrist on a 24/7/365 basis;
    e. 24 hour On site Nursing services with a minimum of an RN;

f. Access to prescriber for Medication for Opioid Use Disorder (MOUD) when providing RCSS;

Medicaid Eligible Provider Types: Multi-Disciplinary Team

See **Appendix A** for Eligible Provider Types

Documentation and Reporting

All RCSU providers maintain thorough and accurate documentation of assessments, interventions, and care provided during the crisis stabilization period and comply with reporting requirements and regulations governing mental health crisis services.

Provider Training

1. RCSS shall ensure each staff satisfactorily complete the following training within the first ninety (90) days of employment when deemed necessary or required for their positions. Periodic refreshers of training, as reviewed and approved by DMS, are also required based on their position. Staff must be knowledgeable of the following:
    a. Cultural awareness, responsiveness, and linguistic competency to ensure services are delivered in a culturally and linguistically competent manner and are responsive to the diverse communities served, including individuals for whom English is a second language.
    b. Trauma-informed care to ensure delivery of a recovery-oriented, person-centered approach and any trauma-specific interventions currently offered or to be implemented.
    c. Evidence-based and promising practices.
    d. Mental health screening and assessment.
    e. Risk assessment and safety planning.
    f. SUDs.
    g. Co-occurring disorders.
    h. Dementia.
    i. Chemical dependency screening and intervention.
    j. Psychiatric medications and side effects.
    k. Traumatic brain injuries.
    l. Developmentally appropriate interventions for children and adolescents.
    m. Intellectual and developmental disorders.
    n. Crisis intervention services and practices.
    o. Risk assessment and suicide screening.
    p. Harm reduction.
    q. De-escalation techniques.
    r. Motivational interviewing.
    s. National standards for CLAS, including DMS standards policies; CLAS delivery.
    t. Crisis medication training.

EXHIBIT B-4

Behavioral Health Crisis Transportation (BHCT) Services

Overview

The Mobile Crisis Intervention Services (MCIS) contractor shall administer Kentucky's community-based mobile crisis intervention (MCI) System Model and deliver quality MCI services to adults, youth, and children who are experiencing behavioral health crisis who are eligible to receive medically necessary services regardless of insurance status, ability to pay, county of residence, immigration status, or level of income.

For all Mobile Crisis Intervention Services (MCIS) provider organizations, including but not limited to Community Mental Health Centers (CMHCs), Behavioral Health Service Organizations (BHSOs), and others designated by the Kentucky Department for Medicaid Services ("the Department"), Carelon Behavioral Health, Inc. as the Mobile Crisis Intervention Services Administrative Service Organization (MCIS-ASO), shall provide administrative oversight, enforcement, and billing services that result in MCIS provider compliance with all applicable state and federal law and regulation, State Plan Amendments (SPA), materials incorporated by reference, billing manuals, transmittal letters, policies and procedures, an Ancillary Settlement Adjustment Report (if applicable), and the budget bill or expenditure targets as provided by the Department.

Behavioral Health Crisis Transportation Services

General

1. Behavioral Health Crisis Transportation (BHCT) Service means the use of a motor vehicle, other than an ambulance or other emergency response vehicle, that is specifically designed, equipped, and staffed by a licensed enrolled crisis transportation provider to transport a Medicaid recipient alleged to be in a behavioral health crisis and needing transportation to a higher level of care.
2. BHCT may be used for:
    a. The transport of a recipient after a mobile crisis team assesses that the recipient requires a higher level of care. Transport would be to 23-Hour Crisis Observation Stabilization, Residential Crisis Stabilization, residential or inpatient hospital. OR
    b. Facility-to-facility transport between facilities including but not limited to transportation from emergency departments to behavioral health crisis treatment, including 23-hour crisis observation stabilization, residential crisis stabilization units, or inpatient psychiatric hospitals.
3. Recipients must be transported to the most appropriate nearest Medicaid health care provider, behavioral health, or medical facility.
4. Family members or other unaccredited agents are not allowed to ride in the BHCT vehicle with the recipient, except for a recipient that requires a caregiver or legal guardian due to cognitive and/or intellectual disabilities, a parent of legal guardian for an individual under the age of 18.

Provider Service Requirements

1. Provider must deliver the level of assistance the recipient needs at the time of transport. This includes, but is not limited to:
    a. Getting from inside the recipient's residence or pick-up location to the vehicle,
    b. Getting into and out of the vehicle,
    c. Fastening seat belts,
    d. Getting into and out of the recipient's facility.
2. These services do not require prior authorization.

Provider Qualifications

1. Provider must meet the state transportation benefit requirements to obtain a Motor Carriers Certification, Passenger Vehicle – DRIVE (ky.gov) (**Application:** Microsoft Word - TC 95-627.docx (ky.gov)), and the following:
    a. Meet requirements to enroll as Provider Type 59,
    b. Provide a vehicle staffed by 2 employees that include a driver and a support staff person,
    c. 24/7/365 availability
    d. Annual staff trainings:
        i. Four (4) hours of evidence-based training on the de-escalation of conflicts
        ii. Eight (8) hours of evidence-based training concerning behavioral health which includes but is not limited to:
            1. Awareness of issues relating to mental health and substance use disorders
            2. Suicide risk assessment and intervention
            3. Response protocols for opioid overdose
            4. Naloxone use protocols
        iii. Cardiopulmonary resuscitation (CPR) certification

Specification for the BHCT Vehicle

1. Vehicles used for BHCT must include a driver's compartment that is separated from the passenger compartment in a manner that allows the driver and passenger to communicate and visualize one another, but also prohibits the passenger from easily accessing the driver or any control for operating the vehicle. For example, a transparent thermoplastic partition between the passenger and the vehicle driver.
2. The passenger compartment must have two (2) or more traditional vehicle seats with appropriate seat belts, is free from exposed sharp edges, equipped with doors that automatically lock and are not capable of opening while the vehicle is in motion (child-lock feature).
3. The BHCT provider may choose to have a video recorder located within the vehicle.

Documentation Requirements

Providers must maintain written or electronic records of all services and provide these records for review upon request by DMS or the ASO. Documentation must include the following data elements:

1. Name of the Individual transported
2. Name of any caregiver, guardian, or other support person who accompanied Individual
3. Individual's Date of Birth
4. Individual's Social Security Number (if known)
5. Individual's Address of Residence
    a. Street Name and Number
    b. Apt/Unit Number (if applicable)
    c. City
    d. State
    e. Zip Code
    f. County
6. Name of Driver
7. Name of Second Transportation Staff Member
8. Vehicle Number (assigned by BHCT Provider)
9. Request Details:

    a. Date
    b. Time
    c. Name of requesting agency
    d. Requestor provider type (if known)
    e. Name of receiving agency
    f. Receiver provider type (if known)
10. Pickup Details:
    a. Date
    b. Time
    c. Address
    d. Mileage
11. Delivery Details:
    a. Date
    b. Time
    c. Address
    d. Mileage