5160-59-03.2 **OhioRISE: care coordination.**

(A) The Ohio resilience through integrated systems and excellence (OhioRISE) plan will assign a care coordination tier for all youth eligible for enrollment in the OhioRISE plan. Tier assignment of limited, moderate, or intensive is based on assessed or indicated needs and may be modified to be based on individual circumstances or to best fit the youth or family capacity and choice.

(1) Moderate care coordination (MCC) is recommended for youth six years of age and older when paragraph (A)(1)(a) and either paragraph (A)(1)(b) or (A)(1)(c) of this rule are met:

(a) An Ohio children's initiative child and adolescent needs and strengths (CANS) assessment, the tool available on https://www.medicaid.ohio.gov (September 20, 2021), indicates for behavioral/emotional needs domain items, at least one of the following items is dangerous or disabling and needs immediate action or two or more of the following items are at least interfering with functioning and need action to ensure that the identified need is addressed:

(i) psychosis;

(ii) impulsivity/hyperactivity;

(iii) depression;

(iv) anxiety;

(v) oppositional behavior;

(vi) conduct;

(vii) adjustment to trauma;

(viii) anger control;

(ix) substance use;

(x) eating disturbance;

(xi) interpersonal problems (for youth age fourteen and older);

(b) For risk behavior domain items, at least one of the following items is dangerous or disabling and needs immediate action or two or more of the

following items are interfering with functioning and need action to ensure that the identified behavior is addressed:

(i) suicide risk;

(ii) non-suicidal self-injury behavior;

(iii) other self-harm;

(iv) danger to others;

(v) delinquent behavior;

(vi) runaway;

(vii) intentional misbehavior;

(viii) fire setting;

(ix) victimization/exploitation;

(x) sexually problematic behavior;

(c) For life functioning domain items, at least one of the following items is dangerous or disabling and needs immediate action or two or more of the following items are interfering with functioning and need action to ensure that the identified need is addressed:

(i) family functioning;

(ii) living situation;

(iii) social functioning;

(iv) developmental/intellectual;

(v) legal;

(vi) medical/physical;

(vii) sleep;

(viii) decision making;

(ix) school.

(2) Intensive care coordination (ICC) is recommended for youth six years of age and older when:

(a) Criteria for MCC are met as described in paragraph (A)(1) of this rule; and

(b) An Ohio children's initiative CANS assessment, the tool available on https://www.medicaid.ohio.gov (September 20, 2021), indicates for caregiver resources and needs domain items, at least one of the following items is dangerous or disabling and needs immediate action or two or more of the following items are at least interfering with functioning and need action to ensure that the identified need is addressed:

(i) supervision;

(ii) knowledge;

(iii) residential stability;

(iv) medical/ physical;

(v) mental health;

(vi) substance use;

(vii) family stress;

(3) MCC is recommended for youth under six years of age when paragraphs (A)(3)(a), (A)(3)(b), and either paragraph (A)(3)(c) or (A)(3)(d) of this rule are met.

(a) An Ohio children's initiative CANS assessment, the tool available on https://www.medicaid.ohio.gov (September 20, 2021), indicates for early childhood domain items, at least one of the following items is dangerous or disabling and needs immediate action or two or more of the following items are at least interfering with functioning and need action to ensure that the identified behavior is addressed:

(i) impulsivity/hyperactivity;

(ii) depression;

(iii) anxiety;

(iv) oppositional behavior;

(v) adjustment to trauma;

(vi) regulatory;

(b) For caregiver resources and needs domain items, at least one of the following items prevents the provision of care and needs immediate and/or intensive action or at least one of the following items is interfering with the provision of care and action is needed to ensure that the identified need is addressed:

(i) supervision;

(ii) residential stability;

(iii) medical/physical;

(iv) mental health;

(v) substance use;

(vi) developmental;

(vii) family stress;

(viii) caregiver post-traumatic stress reaction;

(ix) marital/partner violence;

(x) family relationship with the system;

(xi) legal involvement;

(xii) early childhood domain item developmental/intellectual;

(c) For early childhood domain items, at least one of the following items is dangerous or disabling and needs immediate action or at two or more of the following items are at least interfering with functioning and need action to ensure that the identified need is addressed:

(i) sleep;

(ii) family functioning;

(iii) early education;

(iv) social and emotional functioning;

(v) medical/physical;

(vi) failure to thrive;

(d) For early childhood domain items, at least one of the following items is dangerous or disabling and needs immediate action or at least one of the following items is interfering with functioning and needs action to ensure that the identified need is addressed:

(i) aggressive behaviors;

(ii) atypical behaviors;

(iii) self-harm;

(iv) exploited;

(v) problematic sexual behavior.

(4) ICC is recommended for youth under six years of age when paragraphs (A)(4)(a), (A)(4)(b) and either paragraph (A)(4)(c) or (A)(4)(d) of this rule are met.

(a) An Ohio children's initiative CANS assessment, the tool available on https://www.medicaid.ohio.gov (September 20, 2021) indicates for early childhood domain items, at least one of the following items is dangerous or disabling and needs immediate action or two or more of the following items are at least interfering with functioning and need action to ensure that the identified behavior is addressed:

(i) impulsivity/hyperactivity;

(ii) depression;

(iii) anxiety;

(iv) oppositional behavior;

(v) adjustment to trauma;

(vi) regulatory;

(b) For caregiver resources and needs domain items, two or more of the following items prevents the provision of care and needs immediate and needs immediate and/or intensive action or three or more of the following

items are at least interfering with the provision of care and action is needed to ensure that the identified need is addressed:

(i) supervision;

(ii) residential stability;

(iii) medical/physical;

(iv) mental health;

(v) substance use;

(vi) developmental;

(vii) family stress;

(viii) caregiver post-traumatic stress reaction;

(ix) marital/partner violence;

(x) family relationship with the system;

(xi) legal involvement;

(xii) early childhood domain item developmental/intellectual;

(c) For early childhood domain items, at least one of the following items is dangerous or disabling and needs immediate action or two or more of the following items are at least interfering with functioning and need action to ensure that the identified behavior is addressed:

(i) sleep;

(ii) family functioning;

(iii) early education;

(iv) social and emotional functioning;

(v) medical/physical;

(vi) failure to thrive;

(d) For early childhood domain items, at least one of the following items is dangerous or disabling and needs immediate action or at least one of the following items is interfering with functioning and needs action to ensure that the identified need is addressed:

(i) aggressive behaviors;

(ii) atypical behaviors;

(iii) self-harm;

(iv) exploited;

(v) problematic sexual behavior.

(5) MCC or ICC may also be recommended when the CANS assessment alone does not indicate MCC or ICC as described in paragraphs (A)(1) through (A)(4) of this rule, but other documentation supports the need for the frequency and intensity of MCC or ICC activities. Other supporting documentation that provides clinical justification may include a comprehensive assessment, psychological evaluation, biopsychosocial assessment, or documentation illustrating a history of unsuccessful past services.

(6) Limited care coordination delivered by the OhioRISE plan is recommended when the youth's needs do not meet the ICC or MCC recommendations, or for youth that meet criteria for ICC or MCC but decline to participate in ICC or MCC.

(7) Denials of assignment to ICC or MCC are subject to the appeal process described in rule 5160-26-08.4 of the Administrative Code.

(B) Care management entities (CMEs).

(1) ICC and MCC are delivered by care management entities (CMEs) designated by the OhioRISE plan.

(2) CMEs will:

(a) Maintain an active, valid medicaid provider agreement as defined and set forth in rule 5160-1-17.2 of the Administrative Code;

(b) Comply with all applicable provider requirements set forth in this rule;

(c) Participate in initial and ongoing training, coaching, and supports from an independent validation entity recognized by the Ohio department of medicaid (ODM) to ensure consistency in delivering care coordination;

(d) Have documentation of completion of an initial readiness review by an independent validation entity recognized by ODM within sixty calendar days of billing for ICC or MCC;

(e) Ensure that all child and family-centered care plans (including initial plans, changes to plans, and transition plans) are submitted to the OhioRISE plan for review and approval;

(f) Exchange electronic, bidirectional data and other information regarding the youth and family receiving ICC and MCC with the OhioRISE plan and the independent validation entity recognized by ODM;

(g) Report incidents in accordance with rule 5160-44-05 of the Administrative Code;

(h) Implement quality improvement activities related to the CME's performance consistent with ODM's population health management strategy;

(i) Provide all staff with training regarding cultural and trauma-informed care competency within three months of the date of hire and annually thereafter;

(j) Conduct virtual, in-person, or telephonic outreach to the youth's family within two business days of referral to ICC or MCC to explain the service and obtain consent;

(k) Have administrative and program staff, in sufficient quantity to meet all the CME requirements to achieve the quality, performance, and outcome measures set by ODM;

(l) Ensure care coordination staff and supervisors have the experience necessary to manage complex cases and the ability to navigate state and local child serving systems:

(m) Have sufficient care coordination staff to meet care coordinator-to-youth ratio requirements described in this rule;

(n) Have supervisory personnel to provide coaching and support for ICC and MCC care coordinators, not to exceed the supervisor ratio described in this rule;

(o) Provide real-time or on demand clinical and psychiatric consultation for youth engaged in ICC or MCC;

(p) Respond to the youth and family twenty-four hours a day;

(q) Ensure youth and family choice is incorporated regarding the services and supports they receive and from whom;

(r) Ensure that all care coordination services are provided in a conflict-free manner, with particular attention to ensuring care coordination services, functions, and staff are separated from the organization's function and staff related to other services. If the CME has multiple lines of business, the CME must establish firewalls between its care coordination services and staff and the functions and staff of its other services;

(s) Identify and inform the OhioRISE plan of unmet needs and barriers to effective care and assist in developing community resources to meet youth and families' needs; and

(t) Assist with required activities related to the OhioRISE 1915(b)/(c) waivers, including:

(i) Gather and submit information to assist ODM in determining OhioRISE 1915(c) waiver eligibility;

(ii) Assess the initial and ongoing settings where youth will receive 1915(c) home and community-based services for settings requirements using the review tool designated by ODM; and

(iii) Help youth and caregivers in determining the need for OhioRISE 1915(b)/(c) waiver services.

(C) Care coordination activities.

(1) CMEs delivering ICC will:

(a) Provide structured service planning and care coordination through high-fidelity wraparound as established by the national wraparound initiative, found at https://nwi.pdx.edu (October 1, 2021), including:

(i) Offering initial face-to-face contact within two calendar days of conducting initial outreach contact for ICC; and

(ii) Completing an initial comprehensive assessment within fourteen calendar days of the youth's referral to ICC that includes:

(a) Information from a new Ohio children's initiative CANS assessment or existing Ohio children's initiative CANS assessment that was completed within the ninety calendar days prior to the comprehensive assessment; and

(b) Other tools as determined necessary that inform and result in the development of the child and family-centered care plan;

(iii) Completing an Ohio children's initiative comprehensive CANS assessment within thirty calendar days of referral to ICC;

(iv) Updating the Ohio children's initiative CANS assessment at a minimum of every ninety calendar days or whenever there is a significant change in the youth's needs or circumstances;

(v) Convening and facilitating the child and family team within thirty calendar days of referral for ICC that will:

(a) Develop and implement the initial child and family-centered care plan within the thirty-calendar day period; and

(b) Review the child and family-centered care plan every thirty calendar days, and whenever there is a significant change in the youth's needs or circumstances.

(c) For individuals enrolled in the OhioRISE 1915(c) waiver, develop the back-up waiver service plan, as described in rule 5160-59-01 of the Administrative Code, to be included in the child and family-centered care plan. The back-up waiver service plan should be updated when the child and family-centered care plan is updated

(vi) Developing an individual crisis and safety plan within fourteen calendar days of referral for ICC, for incorporation into the child and family-centered care plan. For youth with behaviors that pose safety concerns for the youth or others, a licensed clinician working within or for the CME will consult on the individual crisis and safety plan, recommend de-escalation strategies that can be learned and used by the youth, parents, other caregivers to support the youth and prevent the use of restrictive interventions, and approve of the crisis and safety plan prior to its submission to the OhioRISE plan;

(vii) Monitoring the child and family-centered care plan to ensure that services are delivered in accordance with the plan;

(viii) Performing referrals and linkages to appropriate services and supports, including natural supports, along the continuum of care;

(ix) Facilitating discharge planning activities for youth admitted to a psychiatric residential treatment facility or an inpatient behavioral health facility; and

(x) Facilitating transition planning and activities for youth exiting the OhioRISE program or the OhioRISE 1915(c) waiver. For youth receiving ICC who are enrolled in the OhioRISE 1915(c) waiver, transition planning must identify supports the youth will need for the ninety calendar days following disenrollment from the OhioRISE 1915(c) waiver.

(b) Have documentation of annual fidelity review, monitoring, and adherence to high-fidelity wraparound by an independent validation entity recognized by ODM. The fidelity review will assess for consistent use of high-fidelity wraparound standards established by the national wraparound initiative.

(c) Submit the child and family-centered care plan to the OhioRISE plan within one business day of completion of the child and family-centered care plan.

(2) CMEs delivering MCC will:

(a) Provide structured service planning and care coordination based on wraparound principles, as established by the national wraparound initiative, found at https://nwi.pdx.edu (October 1, 2021), including;

(i) Offering an initial face-to-face contact within seven calendar days of conducting initial outreach contact for MCC; and

(ii) Completing an initial comprehensive assessment within fourteen calendar days of the youth's referral to MCC that includes:

(a) Information from a new Ohio children's initiative CANS assessment or existing Ohio children's initiative CANS assessment completed within the ninety calendar days prior to the comprehensive assessment; and

(b) Other tools as determined necessary that inform and result in the development of the child and family-centered care plan.

(iii) Completing an Ohio children's initiative comprehensive CANS assessment within thirty calendar days of referral to MCC;

(iv) Updating the Ohio children's initiative CANS assessment at a minimum of every ninety calendar days or whenever there is a significant change in the youth's behavioral health needs or circumstances;

(v) Convening and facilitating the child and family team within thirty calendar days of referral for MCC that will:

(a) Develop and implement the initial child and family-centered care plan within the thirty-calendar day period; and

(b) Review the child and family-centered care plan every sixty calendar days, and whenever there is a significant change in the youth's needs or circumstances.

(c) For individuals enrolled in the OhioRISE 1915(c) waiver, develop the back-up waiver service plan, as described in rule 5160-59-01 of the Administrative Code, to be included in the child and family-centered care plan. The back-up waiver service plan should be updated when the child and family-centered care plan is updated

(vi) Developing an individual crisis and safety plan within fourteen calendar days of referral for MCC, for incorporation into the child and family-centered plan. For youth with behaviors that pose safety concerns for the youth or others, a licensed clinician working within or for the CME will consult on the individual crisis and safety plan, recommend de-escalation strategies that can be learned and used by the youth, parents, other caregivers to support the youth and prevent the use of restrictive interventions, and approve of the crisis and safety plan prior to its submission to the OhioRISE plan;

(vii) Monitoring the child and family-centered care plan to ensure that services are delivered in accordance with the plan;

(viii) Performing referrals and linkages to appropriate services and supports, including natural supports, along the continuum of care;

(ix) Facilitating discharge planning activities for youth admitted to a PRTF or an inpatient behavioral health facility; and

(x) Facilitating transition planning and activities for youth exiting the OhioRISE program or the OhioRISE 1915(c) waiver. For youth receiving MCC who are enrolled in the OhioRISE 1915(c) waiver, transition planning must identify supports the youth will need for the ninety calendar days following disenrollment from the OhioRISE 1915(c) waiver.

(b) Have documentation of annual fidelity review, monitoring, and adherence to MCC by an independent validation entity recognized by ODM. The fidelity review will assess for consistent application of system of care principles adherence to the MCC planning process and service components.

(c) Submit the child and family-centered care plan to the OhioRISE plan within one business day of completion of the child and family-centered care plan.

(D) CME care coordinator qualifications.

(1) An ICC or MCC care coordinator will be a licensed or an unlicensed practitioner in accordance with rule 5160-27-01 of the Administrative Code, except that an ICC or MCC care coordinator will be employed by or under contract with a CME as described in this rule.

(2) ICC and MCC care coordinators will complete the high-fidelity wraparound training program provided by an independent validation entity recognized by ODM. Care coordinators will successfully complete skill and competency-based training to provide ICC and MCC.

(3) ICC and MCC care coordinators will:

(a) Have experience providing community-based services and supports to children and youth and their families or caregivers in areas of children's behavioral health, child welfare, intellectual and developmental disabilities, juvenile justice, or a related public sector human services or behavioral health care field for:

(i) three years with a high school diploma or equivalent; or

(ii) two years with an associate's degree or bachelor's degree; or

(iii) one year with a master's degree or higher; or

(iv) With ODM or its designee approval, partially meets years of experience in paragraph (D)(3)(a)(i), (D)(3)(a)(ii), or (D)(3)(a)(iii)

of this rule and meets the following until experience requirements are met:

(a) Demonstrates specific skills and competencies needed for the care coordination activities described in paragraph (C) of this rule; and

(b) Receives additional supervision to monitor skills and competencies to ensure effective care coordination; and

(c) Receives additional quarterly training to improve skills and competencies to ensure effective care coordination.

(b) Have a background and experience in one or more of the following areas of expertise:

(i) Family systems;

(ii) Community systems and resources;

(iii) Case management;

(iv) Child and family counseling or therapy;

(v) Child protection; or

(vi) Child development.

(c) Be culturally competent or responsive with training and experience necessary to manage complex cases; and

(d) Have the qualifications and experience needed to work with children and families who are experiencing serious emotional disturbance (SED), trauma, co-occurring behavioral health disorders and who are engaged with one or more child-serving systems (e.g., child welfare, intellectual and developmental disabilities, juvenile justice, education).

(E) CME care coordinator supervisory qualifications.

(1) A supervisor of ICC or MCC will meet CME care coordinator qualifications described in paragraph (D), with exception of (D)(3)(a)(iv), of this rule.

(2) A supervisor that is an unlicensed practitioner will have regular supervision with a licensed practitioner and real-time access to a psychiatrist for case consultation.

(3) Supervisors of ICC or MCC will complete the high-fidelity wraparound training program provided by an independent validation entity recognized by ODM. Supervisors will successfully complete skill and competency-based training to supervise delivery of ICC and MCC.

(F) ICC and MCC staffing requirements.

(1) ICC will be facilitated by a care coordinator with a ratio of one full-time care coordinator to no more than ten OhioRISE youth receiving ICC.

(2) MCC will be facilitated by a care coordinator with a ratio of one full-time care coordinator to no more than twenty-five OhioRISE youth receiving MCC.

(3) Supervisory staffing ratios will not exceed one supervisor to eight care coordinators.

(G) Care coordination documentation will include:

(1) Care coordination activities set forth in paragraphs (C)(1) and (C)(2) of this rule will be identified on claims submitted in accordance with rule 5160-26-05.1 of the Administrative Code;

(2) Progress notes to document the care coordination activities described in this rule, including face-to-face and telehealth meetings with the youth and the youth's family and/or collateral contacts;

(3) An individual crisis and safety plan for each youth receiving ICC or MCC;

(4) A back-up plan for each youth receiving ICC or MCC who is enrolled in the OhioRISE 1915(c) waiver;

(5) Assessments and child and family-centered care plans, including specifications for standard assessment and plan elements in CME's electronic health records; and

(6) Upon transition of a youth from ICC or MCC to a different care coordination tier, the CME will document the circumstances regarding transition.

(H) Transition from ICC or MCC.

(1) A youth or the youth's guardian may request to transition out of ICC or MCC at their discretion. The CME will notify the OhioRISE plan of the transition request.

(2) The CME or OhioRISE plan may pursue transition of a youth to other care coordination tiers when a CANS assessment or the child and family-centered care plan indicates that the youth's needs are no longer appropriate for the current tier.

(I) Limitations.

(1) The following activities are not reimbursable as ICC or MCC:

(a) Transportation for the youth or family; and

(b) Direct services to which the youth has been referred such as medical, behavioral, educational, or social services.

(2) Reimbursement for substance use disorder targeted case management is not allowable when a youth is enrolled in ICC or MCC.

(J) Reimbursement for MCC and ICC services as described in the rule is listed in Appendix A of this rule.

(K) Reimbursement for a CANS assessment is listed in the Appendix to rule 5160-27-03 of the Administrative Code.

(L) Care coordination activities described in paragraph (C) of this rule may be provided via telehealth in accordance with rule 5160-1-18 of the Administrative Code.

(M) For the first ninety days from the effective date of this rule, the established timeframes for CME activities in paragraph (B) of this rule and care coordination activities in paragraph (C) of this rule will not be enforced.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
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