Ohio | Common Sense Initiative

Mike DeWine, Governor
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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid (ODM)

Rule Contact Name and Contact Information:

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Regulation/Package Title (a general description of the rules' substantive content):

Updated Ohio Resilience Through Integrated Systems and Excellence (OhioRISE) Rules

Rule Number(s): 5160-59-03, 5160-59-03.1, 5160-59-03.2, 5160-59-03.3, 5160-59-03.4, 5160-59-03.5, 5160-59-05.1, 5160-59-05.2, 5160-27-13; 5160-27-05R

Not subject to business impact analysis, included for informational purposes only:

5160-59-01, 5160-59-01.1, 5160-59-02, 5160-59-02.1, 5160-59-04, 5160-59-05, 5160-59-05.3, 5160-27-02

Date of Submission for CSI Review: March 1, 2022

Public Comment Period End Date: Extended to March 18, 2022

Rule Type/Number of Rules:

New/__9_ rules **No Change/____ rules (FYR? ___)**

Amended/____ rules (FYR? ___) **Rescinded/__1__ rules (FYR? ___)**

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies should promote transparency, responsiveness, predictability, and flexibility while developing

regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☒ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☐ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☒ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**

As part of its Next Generation of Managed Care, and in partnership with the Governor's Children's Initiative and other child-serving state agencies, the Department of Medicaid is designing a reimagined Medicaid system and structure to better serve children and youth who have complex behavioral health and multi-system needs through the . Ohio Resilience through Integrated Systems and Excellence (OhioRISE) program.

The OhioRISE program will leverage a single statewide managed care organization - a Prepaid Inpatient Health Program (PIHP) – that will be held accountable for improving individual and population health outcomes for enrolled children. The rules listed below have been developed through the stakeholder process and are the policies related to the administration of the OhioRISE program. Each rule has been summarized to help describe the program and the services being provided. The rules will be proposed for filing to support implementation of the OhioRISE program effective on July 1, 2022.

OAC rule 5160-59-03, entitled "OhioRISE: covered services," sets forth the services which must be covered by the OhioRISE plan and addresses any exclusions or limitations for those services. The new rule includes the different professional and facility types that will provide the services.

OAC rule 5160-59-03.1, entitled "OhioRISE: utilization management," sets forth the requirements of the utilization management program, including structures and processes, that the OhioRISE plan will implement to maximize the effectiveness of the care provided to the member. The new rule also includes the conditions around prior authorizations of services and references to the OAC rules for adverse benefit decisions.

OAC rule 5160-59-03.2, entitled "OhioRISE: care coordination (ICC/ MCC)," sets forth the two tiers of OhioRISE care coordination service and outlines coverage and limitations for both tiers. This new rule also defines the care management entities, their responsibilities over care coordination of an OhioRISE member, and the qualifications to be a care coordinator delivering ICC and MCC. The service codes and reimbursement are in Appendix A of the rule.

OAC rule 5160-59-03.3, entitled "OhioRISE: intensive home-based treatment (IHBT)," sets forth the definition of intensive home-based treatment as the service described in OhioMHAS rule 5122-29-28, sets Medicaid policy for coverage, payment and limitations, and includes the eligibility criteria for service providers. The service code and reimbursement are in Appendix A of the rule. The current IHBT rule, 5160-27-05, will be rescinded.

OAC rule 5160-59-03.4, entitled "OhioRISE: behavioral health respite services," sets forth the restructure of the current 1915(b)(3) respite service covered under OAC rule 5160-26-03 for the purposes of covering behavioral health respite under the OhioRISE program. The behavioral health respite service will remain available under the existing 1915(b)(3) authority but will only be available to those enrolled on the OhioRISE program. This new rule significantly expands eligible providers of service, eligible members, as well as service location to ensure respite services are accessible to children enrolled on OhioRISE.

OAC rule 5160-59-03.5, entitled "OhioRISE: primary flex funds," sets forth the definition of primary flex funds along with the governing coverage for using flex funds provided as part of the OhioRISE program. In addition, the new rule also sets the yearly budget available for the flex funds for each OhioRISE member, the limitations on purchases, and the service documentation that will be required for purchases.

OAC rule 5160-59-05.1, entitled "OhioRISE home and community-based services waiver: out-of-home respite," sets forth the structure of out-of-home respite service covered under the OhioRISE home and community-based service waiver for the purposes of providing short term relief of those persons who normally care for the member. This new rule includes the eligible facility types and providers of the service, limitations around the service and how the child and family-centered care plan needs to be updated and approved, as well as addresses emergency out-of-home respite services for emergency circumstances. References to the OAC rules for adverse benefit decisions is also listed.

OAC rule 5160-59-05.2, entitled "OhioRISE home and community-based services waiver: transitional services and supports (TSS)," sets forth the definition of transitional services and supports service covered under the OhioRISE home and community-based service waiver including the eligibility criteria for service providers. This new rule also includes the coverage limitations of the service along with how the child and family-centered care plan will need to be updated and approved for TSS and includes references to the OAC rules for adverse benefit decisions.

OAC rule 5160-27-13, entitled "Mobile response and stabilization service (MRSS)," sets forth the definition of mobile response and stabilization services as the services described in Ohio Mental Health and Addiction Services (MHAS) OAC rule 5122-29-14, and sets Medicaid policy for coverage, payment and limitations, sets eligibility criteria for service providers, and describes the interaction of MRSS with other Medicaid services.

OAC rule 5160-27-05, entitled "Intensive home-based treatment (IHBT)," sets forth the eligibility criteria for the service as well as provider requirements. This rule is being rescinded as the service will be defined in proposed rule 5160-59-03.3.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

    - Revised Code Section 5164.02, 5166.02, 5167.02 authorizes ODM to adopt the rules.
    - Revised Code Sections 5162.02, 5162.03, 5164.02, 5166.02, 5166.04, 5167.02, 5167.03, 5167.10, 5167.12, 5167.13 amplify that authority.

4. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?** ***If yes, please briefly explain the source and substance of the federal requirement.***

    No, however, 42 CFR Part 438 imposes comprehensive requirements on the state regarding Medicaid managed care programs. The proposed rules are not related to changes to federal regulation.

5. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

    Federal regulations do not impose requirements directly on MCOs or PIHPs; instead they require state Medicaid agencies to ensure MCO and PIHP compliance with federal standards. The rules are consistent with federal managed care requirements outlined in 42 CFR Part 438 that require the state to implement policies and regulations as the state deems necessary and appropriate.

6. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

    The rules in OAC Chapter 5160-59 are necessary for various reasons. Federal regulations require state Medicaid agencies to ensure PIHP, 1915(b), and 1915(c) waiver compliance with federal standards, therefore these rules ensure ODM compliance with federal regulations governing Medicaid managed care programs, compliance with 1915(c) home and community-based services waiver, and the OhioRISE program. The public purpose of this regulation is to:

    - Ensure the provision of medically necessary services, emergency services, and post stabilization services to promote the best outcomes for individuals enrolled in the Medicaid

managed care program by requiring the OhioRISE plan to follow established guidelines and to ensure providers are paid appropriately for services delivered;
- Ensure that information maintained by the OhioRISE plan is readily available to the State and, if requested, by the Centers for Medicare and Medicaid Services (CMS);
- Ensure oversight of the OhioRISE program and the OhioRISE plan; and
- OAC rule 5160-59-01.1 uses incorporation by reference to chapter 5160-26 of the OAC to ensure regulation on managed care organization are not duplicate to existing Ohio regulation. Ensure members' rights and protections.

7. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

ODM monitors compliance with the regulation through reporting requirements established within the managed care provider agreement and the OhioRISE plan provider agreement. Successful outcomes are measured through a finding of compliance with these standards as determined by monitoring and oversight.

8. Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?
If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

No.

Development of the Regulation

9. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.
If applicable, please include the date and medium by which the stakeholders were initially contacted.

The first draft versions of the Chapter 59 rules were included in the OhioRISE Request for Application (RFA) process (ODMR202010025), which allowed for the public review. The RFA was posted on October 28, 2020 and awarded on April 1, 2021 to Aetna Better Health of Ohio.

While developing the OhioRISE managed care program, ODM has consistently sought to involve interested parties in the development and operational activities pertaining to managed care and behavioral health. The OhioRISE Advisory Council and its workgroups were developed to obtain critical stakeholder feedback and expert clinical advice for OhioRISE's services and operations. Since the Council's creation in January 2021, ODM has held 40 separate meetings with stakeholders to discuss general program principles and system of care philosophy, federal authorities, and service concepts. The new and enhanced state plan and 1915(c) waiver behavioral health services, service specifications and regulatory concepts, draft rule language, and service rate setting were also discussed with these groups.

In addition to the Advisory Council, ODM used workgroups to develop the draft rules for new and enhanced services and for the discussion of specific issues related to the OhioRISE eligibility and the enrollment using CANS assessment, care coordination, IHBT, MRSS, respite services, flex funds, and other relevant regulatory topics.

Stakeholders include, but are not limited to:
The ARC of Ohio
Ohio Association of Health Plans
Ohio Association of County Boards Serving People with Developmental Disabilities
Ohio Family & Children First Councils
County Public Children Services Agencies
The Center for Community Solutions
The Ohio Council for Behavioral Health & Family Services Providers
Ohio Center for Autism and Low Incidence
The Buckeye Ranch
New Directions and Crossroads Health
Mercy Health Foundations Behavioral Health Services
Centers for Innovative Practices, Case Western Reserve University
Ohio Association of County Behavioral Health Authorities

ODM has continued our robust stakeholder engagement efforts. We are working collaboratively with other state agencies such as Ohio Department of Job and Family Services (ODJFS), County Departments of Job and Family Services (CDJFS), Mental Health Addiction Services (MHAS), Department of Developmental Disabilities (DODD), Department of Youth Services (DYS) and Ohio Department of Education (ODE), Ohio Department of Health (ODH) to keep the focus of the new program on the individual with the goal of providing a seamless experience for the members and providers.

The rules were separated into two packages and posted through the two different clearance processes. First set of rules were in clearance from June 9 to June 18, 2021 for stakeholders to provide comments. Second set of rules were in clearance from September 7 to September 21, 2021, for stakeholders to provide comments. All comments received from both clearance postings were compiled into one document and ODM has provided responses to each comment. This document will be posted to the OhioRISE web page so the all the responses will be available for review by all stakeholders. Document can be found here:
https://managedcare.medicaid.ohio.gov/managed-care/ohiorise/6-community+and+provider+resources

10. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

Multiple feedback opportunities were provided to develop the draft rules in collaboration with stakeholders prior to the clearance process. The agency received over 400 comments through an extensive internal review process. Based on the stakeholder comments, revisions to the draft rules were made to address clarity, correct references to OAC rules, and definitions were added. Additionally, a few of the rules were also updated as described below.

Based on feedback, ODM revised IHBT rule language, and will clarify in future OhioRISE rules, polices related to IHBT and OhioRISE eligibility. Additionally, ODM clarified language related to the provision of other services while receiving IHBT.

For out-of-home respite service, MHAS class one residential facilities were added as an eligible provider type based on comments received for consideration.

The rule/ service name of the flex fund services was changed due to comments received. Stakeholders indicated the original name was confusing and the two services needed to differentiate between them. Primary and Secondary were the terms agreed upon with the Advisory Council.

11. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

Ohio Medicaid claims data were the main source of information used to guide the policy and budget models that undergird these rules. This data was used to determine the fiscal impact on ODM.

12. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

ODM is required by ORC 121.93 to use OAC rules to state and implement policies and regulations so it may enforce and, when necessary, conduct program integrity activities regarding the provision of services to Medicaid recipients. If ODM attempted to use alternative regulations, this may allow for inconsistencies across the Medicaid program and not enforce the necessary regulations.

The proposed rules are being implemented to allow for ODM to specifically regulate and enforce the OhioRISE program and the OhioRISE plan.

13. Did the Agency specifically consider a performance-based regulation? Please explain. ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

A performance-based regulation would not be appropriate because ODM is required to comply with detailed federal requirements set forth in 42 CFR Part 438 (October 1, 2021). The performance requirements are outlined in the Ohio Resilience Through Integrated System and Excellence (OhioRISE) Plan Provider Agreement available on the ODM website: https://medicaid.ohio.gov/.

14. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

ODM, as the agency charged with administrating the Ohio Medicaid program, is the only entity authorized to enact the regulations in these rules. ODM staff reviews the rules with other ODM offices and works across the Medicaid OAC rules to use incorporation by references to minimize

duplicative regulations. In addition, OAC rule 5160-59-01.1 uses incorporation by reference to chapter 5160-26 of the OAC to ensure regulations on managed care organization are not duplicate to existing Ohio regulation. Incorporation by references are used in other rules within Chapter 5160-59 as well, to prevent duplication to of existing Ohio regulation. Also, as the services described in the rules are behavioral health in nature, OhioMHAS, Ohio's regulatory body for mental health and addiction treatment services, reviewed the rules.

Also, all Medicaid regulations governing managed care program are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid managed care program, and the rules included in Chapter 5160-59 are not duplicated elsewhere in Agency 5160.

15. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

OhioRISE implementation plans include a robust provider training platform, which will be offered online to assure statewide access beginning in February 2022. Provider training will cover broad OhioRISE system of care principles, covered services and their specifications, care coordination, and community engagement. The OhioRISE plan, ODM staff, including provider support staff, will be trained to assist with assisting individual provider queries. In addition to updating the OhioRISE web page, ODM will continue to work with the stakeholder groups and also provide communications to advocacy and association organizations to be shared with the provider community. The OhioRISE plan, as well as the state's contracted Child and Adolescent Behavioral Health Center of Excellence (CABHCOE), will also be conducting outreach for provider training and education.

ODM will notify the OhioRISE Advisory Council, the OhioRISE plan and other MCOs when the OhioRISE OAC rules have been final filed along with their effective date via email notification. Additionally, per the OhioRISE Plan Provider Agreement, the OhioRISE plan and other MCOs are required to subscribe to the relative distribution lists for notification of OAC RuleWatch Ohio. ODM will ensure the OhioRISE plan is made aware of any future OAC rule changes via established communication processes.

Adverse Impact to Business

16. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community; and

The new OAC rules will impact the OhioRISE plan (Aetna Better Health of Ohio), MCOs that contract with Ohio Medicaid, and those behavioral health providers that render the services addressed in these OAC rules and provided to Medicaid recipients 20 years of age and under.

b. Identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance,); and

- **OAC rule 5160-59-03 OhioRISE: covered services** requires the OhioRISE plan to submit a written request to ODM for approval to refer members to hospitals that decline to contract with OhioRISE plan. The request will document the OhioRISE plan's contracting efforts and why it is necessary to obtain services from this provider. Upon request, the OhioRISE plan must also provide the process and procedures for claim submission. The cost of both these items would be the staff time to establish the policy and then the staff time to submit the request.

- **OAC rule 5160-59-03.1 OhioRISE: utilization management** requires the OhioRISE plan to share specific information with ODM and certain providers, to maintain a log, and to implement written policies and procedures. The cost would be the staff time to maintain and implement written policies and procedures.

- **OAC rule 5160-59-03.2 OhioRISE: care coordination (ICC/ MCC)** requires care management entities to maintain records and service plans for members, complete the care plan within specified timeframes, and submit to the OhioRISE plan for approval. Care management entities to report incidents that are not consistent with the routine care of, and/or service delivery to an individual to ODM or the OhioRISE plan. This is a federal requirement and is necessary to ensure the health and safety of individuals enrolled in OhioRISE program. Care coordinators and supervisors will complete training for high-fidelity wraparound and complete skill and competency-based programs. The cost would be the staff time to maintain and submit/ report information to the OhioRISE plan and the cost to complete the required training.

- **OAC rule 5160-59-03.3 OhioRISE: Intensive Home Based Treatment (IHBT)** requires eligible providers of IHBT service to be OhioMHAS certified. The cost of certification through OhioMHAS is based upon the budget of the agency that is applying for certification. The fee schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08.
  Note: OAC 5160-27-05 is being rescinded and replaced with this new rule.

- **OAC rule 5160-59-03.4 OhioRISE: Behavioral Health Respite Services** requires behavioral health respite providers to be OhioMHAS certified and/or be DODD certified. Behavioral health respite providers must obtain first aid certification. The cost of certification through OhioMHAS is based upon the budget of the agency that is applying for certification. The fee schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08. First aid training costs will also vary by program and geographic region. An informal survey of American Red Cross, American Heart Association and other first aid courses around the state suggests that the average cost is about $70-75. Tuition can range anywhere from $50 to over $110, with lower rates in more rural counties.

- **OAC rule 5160-59-03.5 OhioRISE: Primary Flex Funds** requires care management entities to maintain records and service plans for primary flex funds/ goods and services and

submit to the OhioRISE plan for approval. CME costs include the staff time to maintain and submit/ report information to the OhioRISE plan. The OhioRISE plan's processes for approving and distributing flex funds carries an additional administrative cost.

- **OAC rule 5160-59-05.1 OhioRISE home and community-based services waiver: out-of-home respite** requires providers to be licensed by OhioMHAS, be DODD certified, and for agency providers to hold a certification for community respite services. Providers must also obtain first aid certification. The cost of certification through OhioMHAS is based upon the budget of the agency that is applying for certification. The fee schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08. First aid training costs will also vary by program and geographic region. An informal survey of American Red Cross, American Heart Association and other first aid courses around the state suggests that the average cost is about $70-75. Tuition can range anywhere from $50 to over $110, with lower rates in more rural counties.

- **OAC rule 5160-59-05.2 OhioRISE home and community-based services waiver: transitional services and supports** requires providers to be licensed by OhioMHAS, or for agency providers/ individual practitioners to hold a certification for homemaker/ personal care services and complete behavioral health support trainings. Providers must also obtain first aid certification. The cost of certification through OhioMHAS is based upon the budget of the agency that is applying for certification. The fee schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08. First aid training costs will also vary by program and geographic region. An informal survey of American Red Cross, American Heart Association and other first aid courses around the state suggests that the average cost is about $70-75. Tuition can range anywhere from $50 to over $110, with lower rates in more rural counties.

- **OAC rule 5160-27-13 Mobile response and stabilization service (MRSS)** requires eligible providers of MRSS services to be certified by OhioMHAS. Providers will also submit information regarding termination or transition of services within the timeframe outlined in the rule. The cost would be the staff time to maintain and submit/ report information to the OhioRISE plan along with the cost of certification through OhioMHAS. Their fee is based upon the budget of the agency that is applying for certification. The fee schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08. In a few instances, a provider will need to request prior authorization in order to render a service longer than six weeks.

- **OAC rule 5160-27-05 Intensive home-based treatment (IHBT)** is being rescinded as the service will be defined in proposed rule 5160-59-03.3. The impact to providers is described in the paragraph, 5160-59-03.3, above.

c. Quantify the expected adverse impact from the regulation.

The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

The OhioRISE plan will be paid a per member per month amount. ODM must pay the OhioRISE plan rates that are actuarially sound, as determined by an outside actuary in accordance with 42 CFR 438.4 (October 1, 2021), 42 CFR 438.5 (October 1, 2021), and CMS's Medicaid Managed Care Rate Development Guide. ODM's actuary will develop capitation rates for the OhioRISE plan that is "actuarially sound" for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. Costs include but are not limited to expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital and government mandated assessments, fees, and taxes.

Through the administrative component of the capitation rate paid to the OhioRISE plan by ODM, the OhioRISE plan will be compensated for the cost of the requirements found in these rules.

- For the OhioRISE plan, the rates and actuarial methods will be found in Appendix M ("Rate Methodology") of the Medicaid OhioRISE Plan Provider Agreement.

For OAC rule 5160-59-03 Covered services:

- The cost for the OhioRISE plan to submit documents on non-contracting hospitals along with claim submission process and procedures could vary but would be administrative in nature. The administrative component is being included in the capitation rate being paid to the OhioRISE plan above.

For OAC rule 5160-59-03.1 Utilization management:

- Quantifying the cost of maintain records, reporting incidents, and submitting information regarding termination or transition of services is difficult because of the significant variances for each entity, the number of service locations, agency workforce, and client caseload.

For OAC rule 5160-59-03.2 Care coordination:

- Quantifying the cost of maintain records, reporting incidents, and completing training is difficult because of the significant variances for each entity, the number of service locations, agency workforce, and client caseload.

For OAC rule 5160-59-03.3 Intensive Home-Based Treatment (IHBT):

- The cost of certification through OhioMHAS is based upon the budget of the agency that is applying for certification. The fee schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08. A provider already certified by OhioMHAS, requesting to add an additional service(s) pays a fee based only upon their budget for the new service(s), not their entire budget. When the agency has appropriate accreditation from The Joint Commission, CARF, or COA there is no certification fee owed to OhioMHAS.

For OAC rule 5160-59-03.4 Behavioral Health Respite Services:

- The cost of certification through OhioMHAS is based upon the budget of the agency that is applying for certification. The fee schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08. A provider already certified by OhioMHAS, requesting to add an additional service(s) pays a fee based only upon their budget for the new service(s), not their entire budget. When the agency has appropriate accreditation from The Joint Commission, CARF, or COA there is no certification fee owed to OhioMHAS.
- First aid training costs will also vary by program and geographic region. An informal survey of American Red Cross, American Heart Association and other first aid courses around the state suggests that the average cost is about $70-75. Tuition can range anywhere from $50 to over $110, with lower rates in more rural counties.

For OAC rule 5160-59-03.5 Primary Flex Funds:

- Quantifying the staff time and cost of maintaining records is difficult because of the significant variances for each entity, the number of service locations, agency workforce, and client caseload.

For OAC rule 5160-59-05.1 Out-of-home respite services:

- The cost of certification through OhioMHAS is based upon the budget of the agency that is applying for certification. The fee schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08. A provider already certified by OhioMHAS, requesting to add an additional service(s) pays a fee based only upon their budget for the new service(s), not their entire budget. When the agency has appropriate accreditation from The Joint Commission, CARF, or COA there is no certification fee owed to OhioMHAS.
- First aid training costs will also vary by program and geographic region. An informal survey of American Red Cross, American Heart Association and other first aid courses around the state suggests that the average cost is about $70-75. Tuition can range anywhere from $50 to over $110, with lower rates in more rural counties.

For OAC rule 5160-59-05.2 Transitional Services and Supports:

- The cost of certification through OhioMHAS is based upon the budget of the agency that is applying for certification. The fee schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08. A provider already certified by OhioMHAS, requesting to add an additional service(s) pays a fee based only upon their budget for the new service(s), not their entire budget. When the agency has appropriate accreditation from The Joint Commission, CARF, or COA there is no certification fee owed to OhioMHAS.
- First aid training costs will also vary by program and geographic region. An informal survey of American Red Cross, American Heart Association and other first aid courses around the state suggests that the average cost is about $70-75. Tuition can range anywhere from $50 to over $110, with lower rates in more rural counties.

For OAC rule 5160-27-13 Mobile response and stabilization service (MRSS):

- Providers of MRSS must hold an OhioMHAS certification. The cost of certification through OhioMHAS is based upon the budget of the agency that is applying for certification. The fee

schedule showing the correlation between the agency's budget and the certification cost is located in OhioMHAS OAC rule 5122-25-08. A provider already certified by OhioMHAS, requesting to add an additional service(s) pays a fee based only upon their budget for the new service(s), not their entire budget. When the agency has appropriate accreditation from The Joint Commission, CARF, or COA there is no certification fee owed to OhioMHAS. There is no financial cost to the provider to request prior authorization, just staff time to complete the request.

17. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The OhioRISE program will support the most vulnerable children in the state of Ohio who need specialized and targeted behavioral health support and services. It also moves the behavioral health system from out-of-home placements to a community care, providing support where youth and young adults live. The use of OAC is needed to implement and enforce program integrity along with safety of the Medicaid individuals. The use of OAC is also needed for the OhioRISE plan compliance with federal regulations.

Regulatory Flexibility

18. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

No, to ensue uniform and consistent treatment of Medicaid providers, ODM is not able to make exemptions or provide alternative means for compliance for small businesses.

19. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

This regulation does not apply to this rules package because it does not impose any fine or penalty for a paperwork violation.

20. What resources are available to assist small businesses with compliance of the regulation?

All Medicaid providers in need of technical assistance can contact the Medicaid Provider Assistance telephone line at 1-800-686-1516. Behavioral health providers impacted by the proposed rules have a unique email address available to them for assistance, OhioRISE@medicaid.ohio.gov. They can also contact the OhioRISE plan, Aetna, through their telephone line at 1-833-711-0773, or by e-mail at OHRise-Network@aetna.com. Providers also have access to detailed information by visiting the dedicated OhioRISE internet site:
https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/

DRAFT - NOT FOR FILING

5160-59-01 OhioRISE: definitions.

(A) The definitions set forth in rule 5160-26-01 of the Administrative Code, with the exceptions noted in paragraphs (A)(1) and (A)(2) of this rule, apply to the Ohio resilience through integrated systems and excellence (OhioRISE) rules set forth in Chapter 5160-59 of the Administrative Code. Definitions that reference managed care organizations (MCOs) in Chapter 5160-26 of the Administrative Code apply to the OhioRISE plan.

(1) Definitions that reference rule 5160-26-03 of the Administrative Code are replaced by reference to rule 5160-59-03 of the Administrative Code.

(2) Definitions that reference rule 5160-26-03.1 of the Administrative Code are replaced by reference to rule 5160-59-03.1 of the Administrative Code.

(B) In addition to the definitions set forth in rule 5160-26-01 of the Administrative Code, the following definitions apply to Chapter 5160-59 of the Administrative Code:

(1) "Back-up waiver service plan" means a plan that is in place for substitute coverage of 1915(c) waiver services for a youth when a provider is unable to or unresponsive in providing scheduled services. A back-up plan can include natural supports or other certified providers as the substitute of coverage. The child and family team identifies possible back-up options and includes them in the child and family-centered care plan.

(2) "Care coordination" means the model described in rule 5160-59-03.2 of the Administrative Code.

(3) "Care management entity (CME)" means the agency described in rule 5160-59-03.2 of the Administrative Code.

(4) "Child and adolescent needs and strengths (CANS) assessment" means either the "Ohio Children's Initiative Brief CANS assessment" or the "Ohio Children's Initiative Comprehensive CANS assessment" found at https://www.medicaid.ohio.gov administered by an individual who has successfully completed training and is certified by the Ohio department of medicaid (ODM) designated entity to administer the CANS assessment.

(5) "Child and family-centered care plan" means the individualized, child-centered, strength-based and family-focused plan of services and supports developed by the child and family team (CFT), the care management entity (CME), the OhioRISE plan, or a combination thereof.

(6) "Child and family team (CFT)" means a group of people composed of natural supports (relatives, friends, neighbors, etc.) and formal helpers (teachers, therapists, other professionals, etc.), who are involved with the child and family and who play an important role in the child's life.

(7) "Electronic health record (EHR)" means a record in digital format that is a systematic collection of electronic health information. EHRs may contain a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, and billing information.

(8) "Family" means any individual or caregiver related by blood or affinity whose close association with the person is the equivalent of a family relationship as identified by the person, including kinship and foster care.

(9) "Incident" has the same meaning as in rule 5160-44-05 of the Administrative Code.

(10) "Individual Crisis and Safety Plan" means a plan developed through care coordination and the Child and Family Team (CFT) to determine specific steps to ensure child and family safety and reduce the risk of harm in the home and community. The Individual Crisis and Safety Plan encompasses what is also referred to as a behavior support plan, which details when an individual's intensive behavior warrants the use of restraints, seclusion, or restrictive intervention to ensure the safety of the individual and those with whom they interact. Restraints, seclusion, and restrictive interventions should only be used as a last resort.

(11) "Natural supports" means a uniquely identified network of individuals or groups upon which a primary caregiver or the member rely for assistance in addressing the member's behavioral health diagnosis, community integration, and management of typical activities of daily living.

(12) "OhioRISE plan" means a prepaid inpatient health plan (PIHP) as defined in C.F.R. 438.2 (October 1, 2021) and a health insuring corporation (HIC) as defined in Ohio Rev. Code 1751.01 which enters into an OhioRISE plan provider agreement with ODM.

(13) "System of care" means a spectrum of effective, community-based services and supports for children and youth with, or at risk for, mental health or other challenges and their families. The system of care is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs in order to help them function better at home, in school, in the community, and throughout life.

(14) "Telehealth" has the same meaning as in rule 5160-1-18 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-59-01.1 OhioRISE: application of general managed care rules.

(A) The Ohio resilience through integrated systems and excellence (OhioRISE) plan has to adhere to all of the requirements applicable to managed care organizations (MCOs) or managed care entities (MCEs) in the following rules:

(1) Rule 5160-26-05 of the Administrative Code with the exception of paragraphs (B)(4), (B)(5), (D)(21), (D)(25), and (D)(26);

(2) Rule 5160-26-05.1 of the Administrative Code with the exception of paragraph (B)(1);

(3) Rule 5160-26-06 of the Administrative Code;

(4) Rule 5160-26-08.3 of the Administrative Code with the exception of paragraphs (A)(19) and (A)(25);

(5) Rule 5160-26-08.4 of the Administrative Code;

(6) Rule 5160-26-09.1 of the Administrative Code;

(7) Rule 5160-26-10 of the Administrative Code with the exceptions of paragraphs (B)(2)(c), (B)(2)(d), and (B)(2)(e); and

(8) Rule 5160-26-11 of the Administrative Code.

(B) For all rules listed in paragraph (A) of this rule, the following provisions apply to the OhioRISE program described in Chapter 5160-59 of the Administrative Code:

(1) All references to rule 5160-26-01 of the Administrative Code are replaced by references to rule 5160-59-01 of the Administrative Code.

(2) All references to rule 5160-26-02 and 5160-26-02.1 of the Administrative Code are replaced by references to rule 5160-59-02 of the Administrative Code.

(3) All references to rule 5160-26-03 of the Administrative Code are replaced by references to rule 5160-59-03 of the Administrative Code.

(4) All references to rule 5160-26-03.1 of the Administrative Code are replaced by references to rule 5160-59-03.1 of the Administrative Code.

(C) The following rules in Chapter 5160-26 of the Administrative Code do not apply to OhioRISE:

(1) Rule 5160-26-02 of the Administrative Code;

(2) Rule 5160-26-02.1 of the Administrative Code;

(3) Rule 5160-26-03 of the Administrative Code;

(4) Rule 5160-26-03.1 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-59-02 OhioRISE: eligibility and enrollment.

(A) To be eligible for enrollment in the Ohio resilience through integrated systems and excellence (OhioRISE) program, an individual has to meet the criteria for first day eligibility and enrollment in rule 5160-59-02.1 of the Administrative Code or the criteria in paragraphs (A)(1) to (A)(3) and either paragraph (A)(4), (A)(5), or (B) of this rule.

(1) Be twenty years of age or younger at the time of enrollment;

(2) Be determined eligible for Ohio medicaid in accordance with Chapters 5160:1-1 to 5160:1-6 of the Administrative Code;

(3) Not be enrolled in a MyCare Ohio plan as described in Chapter 5160-58 of the Administrative Code;

(4) For youth age six through twenty, have an Ohio children's initiative brief or comprehensive "child and adolescent needs and strengths" (CANS) assessment, using the tool available on https://www.medicaid.ohio.gov (September 20, 2021), and completed by a certified Ohio CANS assessor within ninety days prior to eligibility determination that indicates paragraph (A)(4)(a) and either paragraph (A)(4)(b) or (A)(4)(c) of this rule have been met:

(a) For behavioral/emotional needs domain items, at least one of the following items is dangerous or disabling and requires immediate action or at least one of the following items is interfering with functioning and requires 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) attachment difficulties;

(xii) for youth age fourteen or older, interpersonal problems

(b) For risk behavior domain items, at least one of the following items is dangerous or disabling and requires immediate action or at least one of the following items is interfering with functioning and requires action to ensure that the identified need 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 requires immediate action or at least one of the following items is interfering with functioning and requires action to ensure that the identified need is addressed:

(i) family functioning;

(ii) living situation;

(iii) social functioning;

(iv) sleep;

(v) school.

(5) For youth age birth through five, have an Ohio children's initiative brief or comprehensive CANS assessment, using the tool available on https://www.medicaid.ohio.gov (September 20, 2021), and completed by a certified Ohio children's initiative CANS assessor within ninety days prior to eligibility determination that indicates paragraph (A)(5)(a) and either paragraph (A)(5)(b), (A)(5)(c), or (A)(5)(d) of this rule have been met:

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

(i) impulsivity/hyperactivity;

(ii) depression;

(iii) anxiety;

(iv) oppositional behavior;

(v) attachment difficulties;

(vi) adjustment to trauma;

(vii) regulatory.

(b) For caregiver resources and needs domain items, at least one of the following items is dangerous or disabling and requires immediate action or at least one of the following items is interfering with functioning and require action 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) The caregiver resources and needs domain item "safety" is identified as a need that at least requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.

(d) For early childhood domain items, at least one of the following items is dangerous or disabling and requires immediate action or at least one of the following items is interfering with functioning and require 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.

(B) Youth who meet the criteria in paragraphs (A)(1) to (A)(3) of this rule are eligible for OhioRISE enrollment under any of the following conditions and will remain in OhioRISE until the youth meets the criteria for disenrollment in paragraph (D) of this rule.

(1) Be an inpatient in a hospital, as defined in in Chapter 5160-2 of the Administrative Code, with a primary

diagnosis of mental illness or substance use disorder.

(2) Be an inpatient in a psychiatric residential treatment facility (PRTF), as described in 42 CFR 441.150 through 42 CFR 441.184 (October 1, 2021).

(C) Enrollment in OhioRISE is mandatory for eligible youth who meet the requirements in paragraph (A) or (B) of this rule. Except for youth eligible for first day eligibility and enrollment in rule 5160-59-02.1 of the Administrative Code, enrollment begins the earlier of:

(1) The submission date of the CANS assessment that determines the youth meets the requirements in paragraph (A)(4) or (A)(5) of this rule; or

(2) The date of admission to an inpatient hospital with a primary diagnosis of mental illness or substance use disorder; or

(3) The date of admission to a PRTF as described in paragraph (B)(2) of this rule; or

(4) The effective date of enrollment in the OhioRISE 1915(c) waiver as described in rule 5160-59-04 of the Administrative Code.

(D) Disenrollment from OhioRISE occurs upon any of the following:

(1) The last day of the following month of when the youth:

(a) Turns twenty-one years of age, except for as described in paragraph (D)(2) of this rule: or

(b) Has been enrolled in OhioRISE for at least one hundred-eighty days and has not had a CANS assessment meeting the eligibility criteria in paragraph (A)(4) or (A)(5) of this rule completed within the last one hundred-eight days and has not experienced either of the conditions described in paragraph (B)(1) or (B)(2) of this rule in the last one hundred-eighty days.

(2) Youth who are receiving inpatient psychiatric services in a hospital or PRTF upon turning twenty-one years of age, will remain enrolled in OhioRISE until the youth is discharged or upon turning twenty-two years of age, whichever occurs first.

(3) The date the youth begins enrollment in a MyCare Ohio plan, as described in Chapter 5160-58 of the Administrative Code.

(4) The date of the youth's death.

(5) The date the youth is no longer eligible for medicaid.

(E) Member initiated disenrollment.

(1) In accordance with 42 C.F.R. 438.56(d)(2) (October 1, 2021), a change or termination of OhioRISE plan enrollment may be permitted for any of the following just cause reasons:

(a) The youth moves out of the OhioRISE plan's service area;

(b) The OhioRISE plan does not, for moral or religious objections, cover the service the youth seeks;

(c) The youth needs related services to be performed at the same time, not all related services are available within the OhioRISE plan's network, and the youth's primary care provider or another

provider determines that receiving services separately would subject the youth to unnecessary risk;

(d) The youth has experienced poor quality of care and the services are not available from another provider within the OhioRISE plan's network; or

(e) The youth cannot access medically necessary medicaid-covered services or cannot access the type of providers experienced in dealing with the youth's care needs.

(2) The following provisions apply when a youth seeks a termination in OhioRISE enrollment for just cause:

(a) The youth will contact the OhioRISE plan to identify providers of services before seeking a determination of just cause from ODM.

(b) The youth may make the request for just cause directly to ODM or an ODM-approved entity, either orally or in writing.

(c) ODM will review all requests for just cause within seven working days of receipt. ODM may request documentation as necessary from both the youth and the OhioRISE plan. ODM will make a decision within forty-five days from the date ODM receives the just cause request. If ODM fails to make the determination within this timeframe, the just cause request is considered approved.

(d) ODM may establish retroactive termination dates and recover capitation payments as determined necessary and appropriate.

(e) The effective date of an approved just cause request will be no later than the first day of the second month following the month in which the member requests change or termination.

(f) Requests for just cause may be processed at the individual level or case level as ODM determines necessary and appropriate.

(F) If a youth is denied enrollment in the program pursuant to paragraph (A) or (B) of this rule, is disenrolled from the program pursuant to paragraph (D) of this rule, or if the youth-initiated disenrollment is denied pursuant to paragraph (E) of this rule, the youth will be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-59-02.1 OhioRISE: first day eligibility and enrollment.

(A) Scope. This rule sets forth the provisions for eligibility and enrollment into Ohio resilience through integrated systems and excellence (OhioRISE) on the first day the program is effective. Individuals that do not meet the OhioRISE first day eligibility criteria described in paragraph (B) of this rule will have the opportunity to be enrolled in OhioRISE as set forth in rule 5160-59-02 of the Administrative Code.

(B) Eligibility. For individuals who meet criteria in paragraphs (B)(1) to (B)(4) of this rule, enrollment will be mandatory in the OhioRISE program on the first day the program is in effect:

(1) Be twenty years of age or younger;

(2) Be determined eligible for Ohio medicaid in accordance with Chapters 5160:1-1 to 5160:1-6 of the Administrative Code;

(3) Not enrolled in a MyCare Ohio plan as described in Chapter 5160-58 of the Administrative Code on the first day the program is in effect; and

(4) Meet one or more of the following criteria:

(a) Within six months prior to the effective date of the OhioRISE program had an admission into an out of state psychiatric residential treatment facility (PRTF) as defined in 42 C.F.R. 441.150 (October 1, 2021) through 42 C.F.R. 441.184 (October 1, 2021), or had an inpatient admission to a hospital, as defined in Chapter 5160-2 of the Administrative Code, with a primary diagnosis of mental illness or substance use disorder; or

(b) Within three months prior to the effective date of the OhioRISE program:

(i) Received intensive home-based treatment (IHBT) as described in rule 5160-27-05 of the Administrative Code; or

(ii) Met the criteria described in either paragraph (A)(4) or (A)(5) in rule 5160-59-02 of the Administrative Code; or

(iii) Received the intensive behavioral support rate add-on at an intermediate care facility for individuals with intellectual disabilities as described in rule 5123-7-28 of the Administrative Code; or

(c) Within two months prior to the effective date of the OhioRISE program:

(i) Received substance use disorder residential treatment services as described in rule 5122-29-09 of the Administrative Code; or

(ii) While in the custody of a Title IV-E agency as defined in rule 5101:2-1-01 of the Administrative Code, was placed in a children's residential center or was a parent in a residential parenting facility as described in rule 5101:2-9 of the Administrative Code.

(C) For individuals enrolled by meeting the criteria in paragraph (B) of this rule, the conditions for disenrollment from OhioRISE set forth in rule 5160-59-02 of the Administrative Code apply.

DRAFT - NOT FOR FILING

5160-59-03 OhioRISE: covered services.

(A) The Ohio resilience through integrated systems and excellence (OhioRISE) plan has to ensure:

(1) Services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are provided;

(2) The amount, duration, and scope of a medically necessary service is not arbitrarily denied or reduced solely because of the diagnosis, type of illness, or condition;

(3) Prior authorization is available for services on which the OhioRISE plan has placed a preidentified limitation to ensure the limitation may be exceeded when medically necessary;

(4) Coverage decisions are based on the coverage and medical necessity criteria published in agency 5160 of the Administrative Code and practice guidelines specified in rule 5160-26-05.1 of the Administrative Code; and

(5) If a member is unable to obtain medically necessary services described in this rule through an OhioRISE plan network provider, the OhioRISE plan has to adequately and timely cover the services out of network, until the OhioRISE plan is able to provide the services from a network provider.

(B) The OhioRISE plan has to ensure members have access to the following services when medically necessary:

(1) Care coordination as described in rule 5160-59-03.2 of the Administrative Code.

(2) Intensive home-based treatment (IHBT) as described in rule 5160-59-03.3 of the Administrative Code.

(3) Respite services for members twenty years of age or younger with behavioral health needs in accordance with rule 5160-59-03.4 of the Administrative Code.

(4) Inpatient hospital services provided in accordance with Chapter 5160-2 of the Administrative Code in a free-standing psychiatric hospital or a general acute care hospital that are:

(a) Inpatient psychiatric services; or

(b) Inpatient substance use disorder (SUD) services (including withdrawal management) provided in accordance with American society of addiction medicine (ASAM) level of care four.

(5) Psychiatric residential treatment facility (PRTF) services as described in 42 C.F.R. 441.150 (October 1, 2021) through 42 C.F.R 441.184 (October 1, 2021).

(6) Opioid treatment program (OTP) services delivered by community SUD programs licensed by Ohio department of mental health and addiction services as a methadone administration program and/or certified by the substance abuse and mental health services administration (SAMHSA) as an OTP.

(7) Behavioral health services provided in accordance with Chapter 5160-27 of the Administrative Code.

(8) Behavioral health services provided in accordance with rule 5160-8-05 of the Administrative Code.

(9) Behavioral health services rendered by psychiatrists and physician assistants under the supervision of psychiatrists in accordance with Chapter 5160-4 of the Administrative Code and psychiatric advanced practice registered nurses in accordance with rule 5160-4-04 of the Administrative Code.

(10) Behavioral health services rendered by outpatient hospital providers in accordance with Chapter 5160-2 of the Administrative Code except for emergency department services.

(11) Behavioral health services rendered in federally qualified health centers (FQHCs) and rural health clinics (RHCs) in accordance with Chapter 5160-28 of the Administrative Code.

(12) Physician administered drugs in accordance with rule 5160-4-12 of the Administrative Code for the treatment of mental health and SUD conditions.

(13) Primary flex funds as described in rule 5160-59-03.5 of the Administrative Code.

(14) Services and supports included in the OhioRISE 1915(c) home and community-based services waiver in accordance with rule 5160-59-05 of the Administrative Code.

(C) The OhioRISE plan may place appropriate limits on a service:

(1) On the basis of medical necessity for the member's condition or diagnosis; or

(2) For the purposes of utilization control, provided the services can be reasonably expected to achieve their purpose as specified in paragraph (A)(1) of this rule.

(D) The OhioRISE plan has to ensure that the services described in paragraph (B) of this rule that are emergency services, as described in rule 5160-26-01 of the Administrative Code, are provided and covered twenty-four hours a day, seven days a week. At a minimum, covered services described in paragraph (B) of this rule that are emergency services have to be provided and reimbursed in accordance with the following:

(1) The OhioRISE plan will not deny reimbursement for treatment obtained when a member had an emergency medical condition.

(2) The OhioRISE plan cannot limit what constitutes an emergency medical condition on the basis of diagnoses or symptoms.

(3) The OhioRISE plan has to cover emergency services without requiring prior authorization.

(4) The OhioRISE plan has to cover services as described in paragraph (B) in this rule related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the OhioRISE plan, the member's managed care organization (MCO), or the member's primary care provider (PCP).

(5) The OhioRISE plan cannot deny reimbursement of emergency services based on the treating provider, hospital, or fiscal representative not notifying the member's PCP of the visit.

(6) The OhioRISE plan has to cover the services described in paragraph (B) of this rule that are emergency services when the services are delivered by a non-contracting provider of emergency services. Such services will be reimbursed by the OhioRISE plan at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any reimbursements for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio medicaid program fee-for-service reimbursement rate) in effect for the date of service. If an inpatient admission results, the OhioRISE plan has to reimburse at this rate only until the member can be transferred to a provider designated by the OhioRISE plan.

(7) The OhioRISE plan has to cover the services as described in paragraph (B) of this rule that are emergency

services until the member is stabilized and can be safely discharged or transferred.

(8) The OhioRISE plan has to adhere to the judgment of the attending provider when the attending provider requests a member's transfer to another facility or discharge. The OhioRISE plan may establish arrangements with hospitals whereby the OhioRISE plan may designate one of its contracting providers to assume the attending provider's responsibilities to stabilize, treat and transfer the member.

(9) A member who has had an emergency medical condition will not be held liable for reimbursement of any subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

(E) The OhioRISE plan has to establish, in writing, the process and procedures for the submission of claims for services delivered by non-contracting providers, including non-contracting providers of emergency services. Such information will be made available upon request to non-contracting providers, including non-contracting providers of emergency services. The OhioRISE plan will not establish claims filing and processing procedures for non-contracting providers, including non-contracting providers of emergency services, that are more stringent than those established for their contracting providers.

(F) The OhioRISE plan has to ensure any services described in paragraph (B) of this rule that are post-stabilization care services, as described in rule 5160-26-01 of the Administrative Code, are provided and covered twenty-four hours a day, seven days a week.

(1) The OhioRISE plan has to designate a telephone line that is available twenty-four hours a day to receive provider requests for coverage of post-stabilization care services. The OhioRISE plan has to document that the telephone number and process for obtaining authorization has been provided to each emergency facility in the service area. The OhioRISE plan has to maintain a record of any request for coverage of post-stabilization care services that is denied including, at a minimum, the time of the provider's request and the time the OhioRISE plan communicated the decision in writing to the provider.

(2) At a minimum, the services described in paragraph (B) of this rule that are post-stabilization care services have to be provided and reimbursed in accordance with the following:

(a) The OhioRISE plan has to cover services obtained within or outside the OhioRISE plan's network that are pre-approved in writing to the requesting provider by a plan provider or other OhioRISE plan representative.

(b) The OhioRISE plan has to cover services obtained within or outside the OhioRISE plan's network that are not pre-approved by a plan provider or other OhioRISE plan representative but are administered to maintain the member's stabilized condition within one hour of a request to the OhioRISE plan for pre-approval of further post-stabilization care services.

(c) The OhioRISE plan has to cover services obtained within or outside the OhioRISE plan's network that are not pre-approved by a plan provider or other OhioRISE plan representative but are administered to maintain, improve or resolve the member's stabilized condition if:

(i) The OhioRISE plan fails to respond within one hour to a provider request for authorization to provide such services;

(ii) The provider has documented an attempt to contact the OhioRISE plan to request authorization, but the OhioRISE plan cannot be contacted; or

(iii) The OhioRISE plan's representative and treating provider cannot reach an agreement concerning

the member's care and a plan provider is not available for consultation. In this situation, the OhioRISE plan will give the treating provider the opportunity to consult with an OhioRISE plan provider and the treating provider may continue with care until a plan provider is reached or one of the criteria specified in paragraph (F)(3) of this rule is met.

(3) The OhioRISE plan's financial responsibility for services described in paragraph (B) of this rule that are post-stabilization care services not pre-approved ends when:

(a) An OhioRISE plan provider with privileges at the treating hospital assumes responsibility for the member's care;

(b) An OhioRISE plan provider assumes responsibility for the member's care through transfer;

(c) An OhioRISE plan representative and the treating provider reach an agreement concerning the member's care; or

(d) The member is discharged.

(G) OhioRISE plan responsibilities for reimbursement of other services.

(1) ODM may approve referral of the OhioRISE plan's members to certain OhioRISE plan non-contracting hospitals, as specified in rule 5160-26-11 of the Administrative Code, for non-emergency hospital services that are OhioRISE covered services as described in paragraph (B) of this rule. When ODM permits such authorization, ODM will notify the OhioRISE plan and the OhioRISE plan's non-contracting hospital of the terms and conditions of the approval, including the duration, and the OhioRISE plan will reimburse the OhioRISE plan's non-contracting hospital at one hundred per cent of the current Ohio medicaid program fee-for-service reimbursement rate in effect for the date of service for all medicaid-covered non-emergency hospital services delivered by the OhioRISE plan's non-contracting hospital. ODM will base its determination of when an OhioRISE plan's members can be referred to an OhioRISE plan non-contracting hospital pursuant to the following:

(a) The OhioRISE plan's submission of a written request to ODM for the approval to refer members to a hospital that has declined to contract with the OhioRISE plan. The request will document the OhioRISE plan's contracting efforts and why the OhioRISE plan believes it will be necessary for members to be referred to this hospital; and

(b) ODM consultation with the OhioRISE plan non-contracting hospital to determine the basis for the hospital's decision to decline to contract with the OhioRISE plan, including but not limited to whether the OhioRISE plan's contracting efforts were unreasonable and/or that contracting with the OhioRISE plan would have adversely impacted the hospital's business.

(2) Paragraph (G)(1) of this rule is not applicable when the OhioRISE plan and an OhioRISE plan non-contracting hospital have mutually agreed that the non-contracting hospital will provide non-emergency OhioRISE covered hospital services to the OhioRISE plan's members. The OhioRISE plan will ensure that such arrangements comply with rule 5160-26-05 of the Administrative Code.

(3) The OhioRISE plan is not responsible for reimbursement of services provided through the medicaid school program (MSP) pursuant to Chapter 5160-35 of the Administrative Code. The OhioRISE plan will ensure access to services described in paragraph (B) of this rule for members who are unable to timely access services or are unwilling to access services through MSP providers.

(4) The OhioRISE plan is not required to cover services provided to members outside the United States.

(5) The OhioRISE plan will ensure that eligible members receive all behavioral health early and periodic screening, diagnosis and treatment (EPSDT) services in accordance with rule 5160-1-14 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-59-03.1 OhioRISE: utilization management.

(A) The Ohio resilience through integrated systems and excellence (OhioRISE) plan will have a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member.

(1) The OhioRISE plan has to ensure decisions rendered through the UM program are based on medical necessity.

(2) The UM program has to be based on written policies and procedures that include, at a minimum:

(a) The information sources used to make determinations of medical necessity;

(b) The criteria, based on sound clinical evidence, to make UM decisions and the specific procedures for appropriately applying the criteria;

(c) A specification that written UM criteria will be made available to both contracting and non-contracting providers; and

(d) A description of how the OhioRISE plan will monitor the impact of the UM program to detect and correct potential under-and over-utilization.

(3) The OhioRISE plan's UM program has to ensure and document the following:

(a) An annual review and update of the UM program;

(b) The involvement of a designated senior physician in the UM program;

(c) The use of appropriate qualified licensed health professionals to assess the clinical information used to support UM decisions;

(d) Review and consideration of the child and family centered care plan;

(e) The use of board-certified consultants to assist in making medical necessity determinations, as necessary;

(f) That UM decisions are consistent with clinical practice guidelines as specified in rule 5160-26-05.1 of the Administrative Code. The OhioRISE plan may not impose conditions around the coverage of a medically necessary-covered service unless they are supported by such clinical practice guidelines;

(g) The reason for each denial of a service, based on sound clinical evidence;

(h) That compensation by the OhioRISE plan to individuals or entities that conduct UM activities does not offer incentives to deny, limit, or discontinue medically necessary services to any member; and

(i) Adherence to the Mental Health Parity and Addiction Equity Act (MHPAEA) requirements outlined in 42 CFR Part 438 Subpart K (October 1, 2021).

(B) The OhioRISE plan has to process requests for initial and continuing authorizations of services from their providers and members.

(1) The OhioRISE plan has to have written policies and procedures to process requests. Upon request, the OhioRISE plan's policies and procedures have to be made available for review by the Ohio department

of medicaid (ODM).

(2) The OhioRISE plan's written policies and procedures for initial and continuing authorization of services have to also be made available to contracting and non-contracting providers upon request.

(C) The OhioRISE plan has to ensure and document the following occurs when processing requests for initial and continuing authorizations of services:

(1) Consistent application of review criteria for authorization decisions.

(2) Consultation with the requesting provider, when necessary.

(3) Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested has to be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease.

(4) That a written notice will be sent to the member and the requesting provider of any decision to reduce, suspend, terminate, or deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the member has to meet the requirements of division 5101:6 and rule 5160-26-08.4 of the Administrative Code.

(5) For standard authorization decisions, the OhioRISE plan has to provide notice to the provider and member as expeditiously as the member's health condition requires but no later than ten calendar days following receipt of the request for service. If requested by the member, provider, or the OhioRISE plan, standard authorization decisions may be extended up to fourteen additional calendar days. If requested by the OhioRISE plan, the OhioRISE plan has to submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the OhioRISE plan's extension request, the OhioRISE plan has to give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if the member disagrees with that decision. The OhioRISE plan has to carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(6) If a provider indicates or the OhioRISE plan determines that following the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the OhioRISE plan has to make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than forty-eight hours after receipt of the request for service. If requested by the member or OhioRISE plan, expedited authorization decisions may be extended up to fourteen additional calendar days. If requested by the OhioRISE plan, the OhioRISE plan has to submit to ODM for prior-approval, documentation as to how the extension is in the member's interest. If ODM approves the OhioRISE plan's extension request, the OhioRISE plan has to give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. The OhioRISE plan has to carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

(D) The OhioRISE plan has to maintain and submit as directed by ODM a record of all authorization requests, including standard and expedited authorization requests and any extensions granted. The OhioRISE plan's records have to include member identifying information, service requested, date initial request received, any extension requests, decision made, date of decision, date of member notice, and basis for denial, if applicable.

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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 age six 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 requires immediate action or two or more of the following items are at least interfering with functioning and require 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 requires immediate action or two or more of the following items are interfering with functioning and require 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 requires immediate action or two or more of the following items are interfering with functioning and require 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 age six 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 requires immediate action or two or more of the following items are at least interfering with functioning and require 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 age six 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 requires immediate action or two or more of the following items are at least interfering with functioning and require 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 requires immediate and/or intensive action or at least one of the following items is interfering with the provision of care and action is required 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 requires immediate action or at two or more of the following items are at least interfering with functioning and require 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 requires immediate action or at least one of the following items is interfering with functioning and requires 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 age six 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 requires immediate action or two or more of the following items are at least interfering with functioning and require 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 requires immediate and requires 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 required 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 requires immediate action or two or more of the following items are at least interfering with functioning and require 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 requires immediate action or at least one of the following items is interfering with functioning and requires 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 need 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 one business day 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 referral 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;

(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 referral 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;

(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 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.

(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) 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) Required care coordination documentation includes:

(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 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 may pursue transition of a youth to other care coordination tiers when 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.

Appendix A
Fee Schedule for OhioRISE Care Coordination services

5160-59-03.2 OhioRISE: Care Coordination

HCPCS CODE	MODIFIERS	DESCRIPTION	PROVIDER TYPE	EFFECTIVE DATE	CURRENT MAXIMUM
T2023	N/A	Intensive Care Coordination (ICC) - Monthly	Care Management Entity	7/1/2022	$1,036.56
T2022	N/A	Moderate Care Coordination (MCC) - Monthly	Care Management Entity	7/1/2022	$414.44

HCPCS CODE	MODIFIERS	DESCRIPTION	PRACTITIONER TYPE	EFFECTIVE DATE	CURRENT MAXIMUM
H2000	TG	Initial Comprehensive Assessment - Per Encounter	Unlicensed Practitioner[1]	7/1/2022	$166.08
H2000	TG		Licensed Practitioner[2]	7/1/2022	$185.46
H2000	TG		Independent Practitioner[3]	7/1/2022	$191.54
H2000	TG		PA, CNS, CNP[4]	7/1/2022	$364.58
H2000	TG		Physician[5]	7/1/2022	$591.83

1. Includes unlicensed practitioners as described in OAC rule 5160-27-01, except for peer recovery supporters
2. Licensed practitioner has the same meaning as "supervised practitioner" as described in OAC rule 5160-8-05
3. Includes licensed psychologists and independent practitioners as described in OAC rule 5160-8-05
4. Includes physician assistant, clinical nurse specialist, or certified nurse practitioner as described in OAC rule 5101-27-01
5. Physican as described in OAC rule 5160-27-01

*For a service rendered by a supervised trainee under direct supervision as described in 5160-8-05, the payment amount is the supervising practitioner rate. For a service rendered by a supervised trainee under general supervision as described in 5160-8-05, the payment amount is eighty-five per cent of the rate of their supervising practitioner.

All valid place of service codes are allowed. Place of Service codes, defined by the CMS, are found at https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

DRAFT - NOT FOR FILING

5160-59-03.3 OhioRISE: intensive home-based treatment service.

(A) Scope. This rule sets forth provisions governing medicaid coverage of intensive home-based treatment (IHBT) services.

(B) Definition. IHBT is the service and activities as set forth by the Ohio department of mental health and addiction services (OhioMHAS) in rule 5122-29-28 of the Administrative Code.

(C) Eligible providers of IHBT services.

(1) Providers eligible for medicaid payment for IHBT will:

(a) Meet the requirements in paragraph (A)(1) or (A)(2) of rule 5160-27-01 of the Administrative Code; and

(b) Provide the service in accordance with rule 5122-29-28 of the Administrative Code.

(D) Coverage.

(1) Payment may be made for IHBT services rendered face-to-face in person or via telehealth in accordance with rule 5122-29-31.

(2) Payment may be made for services rendered by IHBT staff described in rule 5122-29-28 of the Administrative Code that are eligible as a provider of behavioral health services in accordance with rule 5160-27-01 of the Administrative Code.

(3) Medicaid rates for services described in this rule are listed in the appendix A of this rule.

(E) Limitations.

(1) The following activities are not reimbursable as part of IHBT:

(a) Time spent doing, attending, or participating in recreational activities.

(b) Child care services or services provided as a substitute for the parent or other individual responsible for providing care or supervision.

(c) Respite care.

(d) Transportation for the beneficiary or family.

(e) Any art, movement, dance, drama, or animal therapies, unless incorporated into the IHBT treatment modality.

(f) Services provided to teach academic subjects or as a substitute for educational personnel including, but not limited to a teacher, teacher's aide, or an academic tutor.

(2) A separate medicaid payment will not be made for any of the following services or treatments while the youth is enrolled in IHBT services, unless the service is prior authorized by the OhioRISE plan:

(a) Behavioral health assessments, screenings, and diagnostic evaluations, except of an Ohio children's initiative "child and adolescent needs and strengths" (CANS) assessment completed in accordance with rule 5160-59-03.2 of the Administrative Code that is separately reimbursable.

(b) Individual, group, or family psychotherapy and counseling.

(c) Therapeutic behavioral services, except for therapeutic behavioral group service - hourly and per diem as defined in rule 5160-27-06 of the Administrative Code.

(d) Community psychiatric supportive treatment as described in rule 5122-29-17 of the Administrative Code.

(e) Psychosocial rehabilitation as described in rule 5160-27-08 of the Administrative Code.

(f) Substance use disorder (SUD) residential treatment services as described in rule 5160-27-09 of the Administrative Code.

(g) Assertive community treatment as described in rule 5160-27-04 of the Administrative Code.

(h) Stabilization services as defined in rule 5160-27-13 of the Administrative Code and rendered by a mobile response and stabilization service (MRSS) provider in accordance with rule 5160-27-13 of the Administrative Code.

(i) SUD targeted case management as described in rule 5160-27-10 of the Administrative Code.

(3) When the OhioRISE plan denies, reduces, terminates or suspends IHBT, this constitutes an adverse benefit determination, and can be appealed in accordance with rule 5160-26-08.4 of the Administrative Code.

5160-59-03.3
APPENDIX A

Fee schedule for OhioRISE Intensive Home Based Treatment (IHBT)

HCPCS CODE	Modifier	DESCRIPTION	EFFECTIVE DATE	CURRENT MAXIMUM PAYMENT AMOUNT *	ALLOWABLE PLACES OF SERVICE **
H2033		Multisystemic Therapy for Juveniles (MST) (Licensed Practitioner[1]), per 15 minutes	7/1/2022	41.10	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2033		Multisystemic Therapy for Juveniles (MST) (Independent Practitioner[2]), per 15 minutes	7/1/2022	42.24	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2015	TF	Functional Family Therapy for Juveniles (FFT) (Licensed Practitioner[1]), per 15 minutes	7/1/2022	34.05	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2015	TF	Functional Family Therapy for Juveniles (FFT) (Independent Practitioner[2]), per 15 minutes	7/1/2022	34.98	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2015		IHBT (other than MST or FFT) (Peer Recover Supporter[3]), per 15 minutes	7/1/2022	27.51	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2015		IHBT (other than MST or FFT) (Unlicensed Practitioner[4]), per 15 minutes	7/1/2022	34.21	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2015		IHBT (other than MST or FFT) (Licensed Practitioner[1]), per 15 minutes	7/1/2022	37.57	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2015		IHBT (other than MST or FFT) (Independent Practitioner[2]), per 15 minutes	7/1/2022	38.60	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99

* For a service rendered by a supervised trainee under direct supervision as described in rule 5160-8-05 of the Administrative Code, the payment amount is the supervising practitioner rate.

**Refers to CMS places of service codes found https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

1. Licensed practitioner has the same meaning as "supervised practitioner" as described in rule 5160-8-05 of the Administrative Code.

2. Includes licensed psychologists and independent practitioners as described in OAC rule 5160-8-05.

3. Peer recovery supporter as described in rule 5122-29-15.1 of the Administrative Code.

4. Includes unlicensed practitioners of mental health services as described in rule 5160-27-01 of the Administrative Code; and "supervised trainees" as described in rule 5160-8-05 of the Administrative Code under general supervision.

DRAFT - NOT FOR FILING

5160-59-03.4 OhioRISE: behavioral health respite services.

(A) This rule sets forth provisions governing coverage for behavioral health respite services delivered as part of the Ohio resilience through integrated systems and excellence (OhioRISE) program.

(B) Definitions. For this rule, the following definitions apply:

(1) "Behavioral health respite services" are services that provide short-term, temporary relief to the primary caregiver of an OhioRISE plan enrolled youth, in order to support and preserve the primary caregiving relationship.

(2) "Foster home" has the same meaning as "certified foster home" in rule 5101:2-1-01 of the Administrative Code.

(3) "Kin" has the same meaning as in rule 5101:2-1-01 of the Administrative Code.

(4) "Public children services agency" (PCSA) has the same meaning as in rule 5101:2-1-01 of the Administrative Code.

(5) "Treatment foster home" has the same meaning as in rule 5101:2-1-01 of the Administrative Code.

(C) Eligible providers of OhioRISE respite services.

(1) Behavioral health respite services can be provided by the following individuals or organizations:

(a) Behavioral health entities operating in accordance with paragraph (A)(1) or (A)(2) of rule 5160-27-01 of the Administrative Code. Rendering practitioners will meet requirements to be an eligible provider of behavioral health services in accordance with rule 5160-27-01 of the Administrative Code.

(b) Department of developmental disabilities (DODD)-certified providers of community respite as set forth in rule 5123-9-22 of the Administrative Code;

(c) DODD-certified providers of informal respite as set forth in rule 5123-9-21 of the Administrative Code;

(d) Family, who do not also meet the definition of "legally responsible family member" as defined in rule 5160-45-01 of the Administrative Code, and who do not reside in the home with the youth;

(e) Natural supports; or

(f) Foster care settings as described in rule 5101:2-47-16 of the Administrative Code are excluded from being eligible providers of behavioral health respite services when these settings are currently fostering youth, unless the foster home:

(i) Has an established relationship with the youth who will receive respite services in the foster home;

(ii) Is fostering siblings or kin of the youth who will receive respite services in the foster home; or

(iii) Is fostering the child of a parenting youth who will receive respite services in the foster home.

(2) Behavioral health respite providers will adhere to the criminal records check requirements set forth in rule 5160-43-09 of the Administrative Code.

(3) All eligible providers of behavioral health respite will obtain and maintain first aid certification from instruction which includes hands-on training by a certified first aid instructor. At its discretion, ODM may accept training conducted by a solely internet-based class as sufficient for the purposes of first aid certification.

(4) All eligible providers of behavioral health respite will complete training in trauma-informed care practices as set forth in rule 5101:2-9-42 of the Administrative Code.

(D) Coverage.

(1) Components of the behavioral health respite service may include:

(a) Assistance with activities of daily living;

(b) Transportation; and

(c) Supports in home and community-based settings.

(2) Reimbursement may be made for behavioral health respite when rendered to youth enrolled in the OhioRISE plan in accordance with rules 5160-59-02, 5160-59-02.1, and 5160-59-04 of the Administrative Code who:

(a) Resides:

(i) With the youth's primary caregiver in a home that is not owned, leased, or controlled by a provider of any health-related treatment or support services; and

(ii) In a foster home licensed by the Ohio department of job and family services (ODJFS);

(iii) In the home of kin; or

(iv) In a medically fragile or treatment foster home; and

(b) Have behavioral health needs for the behavioral health respite as determined by the OhioRISE plan.

(3) Respite services may be provided either during normal awake hours or overnight. The provider of the behavioral health services will be awake when the youth is awake during the provision of behavioral health respite services. The child and family-centered care plan will document when a provider will be required to be awake during overnight hours dependent on a youth's assessed needs.

(4) The behavioral health respite service may be provided on a planned or emergency basis. An emergency behavioral health respite service may be provided to address either a primary caregiver's unexpected need for behavioral health respite or to address an urgent need related to the youth's behavioral health diagnosis.

(5) Respite services delivery may occur in the following locations:

(a) The primary caregiver's home that is not owned, leased, or controlled by a provider of any health-related treatment or support services;

(b) A qualifying provider's place of residence when approved by the youth's legal guardian;

(c) A foster home licensed by ODJFS;

(d) In the home of kin;

(e) In a treatment foster home certified by ODJFS; or

(f) A community setting in which the general public has access.

(6) Coverage of behavioral health respite is subject to authorization by the OhioRISE plan in accordance with rule 5160-59-03.1 of the Administrative Code.

(a) Behavioral health respite services may be authorized in an amount and duration consistent with the youth's needs and behavioral health history.

(b) Coverage of the behavioral health respite services is based on a determination that the youth's primary caregiver has a demonstrated need for temporary relief from the care of the youth as a result of the youth's behavioral health needs.

(c) Behavioral health respite is identified on a youth's child and family-centered care plan developed by the care management entity or the OhioRISE plan.

(E) Limitations.

(1) Reimbursement is allowed for behavioral health respite delivered in a foster home or treatment foster home when:

(a) The behavioral health respite need is determined to meet the provisions set forth in this rule for behavioral health respite;

(b) The behavioral health respite does not duplicate reimbursement for otherwise available respite services in a foster home or treatment foster home;

(c) The medicaid reimbursement does not cover room and board costs; and.

(d) Title IV-E funding is not used for coverage of the OhioRISE behavioral health respite service.

(2) Reimbursement for behavioral health respite is not allowable when the youth is receiving otherwise available respite services as defined in rules 5160-26-03.2, 5160-44-17, and 5160-59-05.1 of the Administrative Code, or in Chapter 5123-9 of the Administrative Code.

(3) Reimbursement for the behavioral health respite services is not allowable when delivered by the youth's "legally responsible family member" as defined in rule 5160-45-01 of the Administrative Code.

(4) Transportation activities that do not include the provision of behavioral health respite are not reimbursable as behavioral health respite.

(5) When the OhioRISE plan denies, reduces, terminates or suspends behavioral health respite services, this constitutes an adverse benefit determination, and can be appealed in accordance with rule 5160-26-08.4 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-59-03.5 OhioRISE: primary flex funds.

(A) Scope. This rule sets forth provisions governing coverage for primary flex funds provided as part of the Ohio resilience through integrated systems and excellence (OhioRISE) program.

(B) Definitions.

(1) "Primary flex funds" are services, equipment, or supplies not otherwise provided through the medicaid state plan benefit or the OhioRISE program that address a youth's identified need as documented in the child and family-centered care plan. Primary flex funds are intended to enhance and supplement the array of services available to a youth enrolled in the OhioRISE program and are discussed, recommended, and implemented through the care coordination process as described in rule 5160-59-03.2 of the Administrative Code.

(2) "Financial management services" (FMS) means an entity contracted with the OhioRISE plan to perform necessary financial transactions on behalf of individuals enrolled in the OhioRISE program

(3) "Participant direction" means the opportunity for a youth enrolled in OhioRISE to exercise choice and control in managing a budget for the applicable service in accordance with their needs.

(4) "Participant-directed budget for primary flex funds" is the OhioRISE enrollee's maximum approved funding for the purchase of primary flex funds under the OhioRISE program.

(C) Eligible providers and conditions of participation.

(1) The provider of primary flex funds will be the FMS entity under contract with the OhioRISE plan to complete the purchase and reimbursement of primary flex funds approved by the OhioRISE plan.

(2) With the exception of paragraph (B)(14) of rule 5160-44-31 of the Administrative Code, the provider will comply with conditions of participation as set forth in rule 5160-44-31 of the Administrative Code.

(D) Coverage.

(1) Coverage of primary flex funds will occur through participant-direction and will incorporate discussion and education with the youth and their primary caregiver of their ability to exercise budget authority during the participant-directed process.

(2) The youth's care coordinator working within a care management entity (CME), or the OhioRISE plan, will assist the youth and their primary caregiver in determining the need for the use of primary flex funds while ensuring the least costly appropriate service, equipment, or supply is evaluated.

(3) The youth's care coordinator working within the CME, or the OhioRISE plan, will document the recommendation for approval of the participant-directed budget for primary flex funds on the child and family-centered care plan as evidence of the necessity of primary flex funds to meet a youth's needs:

(a) The primary flex funds will decrease the need for other Ohio department of medicaid (ODM) services;

(b) The primary flex funds will promote the youth's inclusion in the community; or

(c) The primary flex funds will increase the youth's safety in the home environment.

(4) The OhioRISE plan will need to approve the youth's participant-directed budget for primary flex funds as part of the child and family-centered care plan prior to use of the service.

(E) Limitations.

(1) The following items are excluded for primary flex funds purchase:

(a) Experimental treatments as outlined in rule 5160-1-61 of the Administrative Code;

(b) Items used solely for entertainment or recreational purposes;

(c) Tobacco or alcoholic products;

(d) More than one of the same item for the same youth unless there is a documented change in the item's condition that warrants replacement;

(e) Home modifications that are of general utility or that add to the total square footage of the home;

(f) Items or treatments that are illegal or otherwise excluded through federal or state regulations; and

(g) The costs of room and board as described in 42 CFR 441.310 (October 1, 2021).

(2) The total available budget for primary flex funds is limited to one thousand five hundred dollars within three hundred sixty-five days.

(3) Approval for primary flex funds by the OhioRISE plan will not occur when:

(a) The youth or their primary caregiver has the funds to purchase the services, equipment, or supplies; or

(b) There is another available funding source for the services, equipment, or supplies.

(4) Primary flex funds will first be submitted for consideration under the medicaid state plan or other available OhioRISE plan services including, but not limited to, value-add services, when the primary flex funds provider is purchasing the item from an active ODM provider of like services.

(5) When the OhioRISE plan denies, reduces, terminates or suspends primary flex funds, this constitutes an adverse benefit determination, and can be appealed in accordance with rule 5160-26-08.4 of the Administrative Code.

(F) Service documentation for primary flex funds will include each of the following to validate reimbursement for medicaid services:

(1) Documentation on the child and family-centered care plan indicating at least one of the concepts in paragraphs (D)(3)(a) to (D)(3)(c) will be addressed by approving primary flex funds;

(2) An invoice containing the youth's name and medicaid identification number;

(3) A description of the item or service provided;

(4) Identification of the purchaser of service;

(5) The date the item or service was purchased and provided;

(6) The amount paid by the provider for primary flex funds.

DRAFT - NOT FOR FILING

5160-59-04 OhioRISE home and community-based services waiver: eligibility and enrollment.

(A) To be eligible for the Ohio resilience through integrated systems and excellence (OhioRISE) home and community-based services (HCBS) 1915(c) waiver (waiver), a youth will be determined by the Ohio department of medicaid (ODM) to meet all of the following:

(1) Meet eligibility criteria set forth in paragraphs (A)(1) to (A)(3) of rule 5160-59-02 of the Administrative Code;

(2) Be determined to meet the following level of care (LOC) criteria for an inpatient psychiatric (IP) services through an IP LOC assessment:

(a) For youth age six through twenty years old have a comprehensive Ohio children's initiative child and adolescent needs and strengths (CANS) assessment, using the tool available on https://www.medicaid.ohio.gov (September 20, 2021), completed by a certified Ohio children's initiative CANS assessor employed by or under contract with the care management entity (CME) described in rule 5160-59-03.2 of the Administrative Code, indicating paragraphs (A)(2)(a)(i), (A)(2)(a)(ii), and either paragraph(A)(2)(a)(iii) or (A)(2)(a)(iv) of this rule are met:

(i) For behavioral/emotional needs domain items, at least two of the following items are dangerous or disabling and require immediate action or three or more of the following items are at least interfering with functioning and require action to ensure that the identified need is addressed:

(a) psychosis;

(b) impulsivity/hyperactivity;

(c) depression;

(d) anxiety;

(e) oppositional behavior;

(f) conduct;

(g) adjustment to trauma;

(h) anger control;

(i) substance use;

(j) eating disturbance;

(k) attachment difficulties;

(l) or interpersonal problems (for youth age fourteen and older).

(ii) For risk behaviors domain items, at least two of the following items are dangerous or disabling and require immediate action or three or more of the following items are at least interfering with functioning and require action to ensure that the identified need is addressed:

(a) suicide risk;

(b) non-suicidal self-injury behavior;

(c) other self-harm;

(d) danger to others;

(e) delinquent behavior;

(f) runaway;

(g) intentional misbehavior;

(h) fire setting;

(i) victimization/exploitation;

(j) sexually problematic behavior.

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

(a) supervision;

(b) residential stability;

(c) medical/physical;

(d) mental health

(e) substance use;

(f) family stress;

(iv) the youth has no current viable caregiver.

(b) For youth age birth through five, have a comprehensive Ohio children's initiative CANS assessment, using the tool available on https://www.medicaid.ohio.gov (September 20, 2021), completed by a certified Ohio children's initiative CANS assessor employed by or under contract with the CME described in rule 5160-59-03.2 of the Administrative Code, indicating paragraphs (A)(2)(b)(i), (A)(2)(b)(ii), and either paragraph (A)(2)(b)(iii) or (A)(2)(b)(iv) of this rule are met:

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

(a) impulsivity/hyperactivity;

(b) depression;

(c) anxiety;

(d) oppositional behavior;

(e) adjustment to trauma;

(f) regulatory;

(g) sleep.

(ii) For risk behavior and functioning domain items, at least two of the following items are dangerous or disabling and require immediate action or three or more the following items are at least interfering with functioning and require action to ensure that the identified need is addressed:

(a) self-harm;

(b) exploited;

(c) problematic sexual behavior;

(d) aggressive behavior;

(e) family functioning;

(f) social and emotional functioning.

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

(a) supervision;

(b) residential stability;

(c) medical/physical;

(d) mental health;

(e) substance use;

(f) family stress;

(iv) the youth has no current viable caregiver.

(c) Have a diagnosis of serious emotional disturbance (SED) as defined in rule 5122-24-01 of the Administrative Code; and

(d) Have documented functional impairment and behaviors that substantially interfere with or limit the youth's role or functioning in family, school, or community activities which result in recommended institutionalization and potential relinquishment of custody to the child welfare system. Documented functional impairment and behaviors include one or more of the following:

(i) Youth's persistent physical abuse or violence that results in harm to caregivers, family members, or others in the home.

(ii) Youth's history of suicidal ideation with intent, or history of suicide attempts, within the past six months.

(iii) Youth's sexually problematic behavior.

(iv) Youth's suspension or expulsion from school; or withdrawal from school, daycare, or preschool program as the result of the youth's actions/intensive behaviors.

(v) Law enforcement or child welfare contact or involvement due to the youth's intensive behaviors.

(vi) Youth has a history of victimization or exploitation, including human trafficking within the past twelve months, and re-victimization may be imminent. This may include physical or sexual abuse, sexual exploitation, or violent crime.

(3) Have a completed IP LOC assessment as follows:

(a) A LOC assessment determining a youth meets an IP LOC will be completed prior to initial enrollment on the waiver;

(b) A LOC assessment determining a youth meets an IP LOC will be completed within three hundred sixty-five calendar days of the previous LOC assessment for continued enrollment on the waiver; and

(c) Once enrolled in the waiver, all youth who experience a significant change in situation impacting health and welfare will receive an IP LOC assessment following the event to determine continued enrollment on the waiver.

(4) Be determined to have a need for, and agree to receipt of, at least one service available under the waiver that is otherwise unavailable through another source (including, but not limited to private pay, community resources, or the medicaid state plan) on at least a monthly basis.

(5) Have waiver needs which are less than or equal to the waiver services cost cap of fifteen thousand dollars in a twelve-month period. Once enrolled in the waiver, youth may have access to additional emergency funding as described in rule 5160-59-05.3 of the Administrative Code.

(6) Have been informed of, as recorded during the course of an assessment or in an alternative manner at the discretion of ODM, all of the following:

(a) Service alternatives including the choice and election to receive services on an HCBS program in lieu of institutional services; and

(b) Choice of providers who meet provider qualifications as described in Chapter 5160-59 of the Administrative Code to provide services under the waiver.

(7) Have needs that can be safely met in an HCBS setting through the waiver as determined by ODM or its designee.

(8) Meet the following age criteria:

(a) Be between the ages of birth and twenty years old at the time of initial enrollment; and

(b) Once enrolled, youth may continue enrollment on the waiver through their twenty-second birthday, so long as the youth meets the other eligibility criteria set forth in paragraphs (A) and (B) of this rule.

(9) Agrees to participate in the waiver, and while enrolled in the waiver, will not be simultaneously enrolled

in another HCBS 1915(c) waiver or the specialized recovery services program as defined in rule 5160-43-01 of the Administrative Code.

(B) Once eligibility to the OhioRISE 1915(c) waiver has been determined and before the OhioRISE 1915(c) waiver services described in rule 5160-59-05 of the Administrative Code can be provided, the youth will:

(1) Participate in the development and implementation of the child and family-centered care plan in accordance with the process and criteria set forth in rule 5160-44-02 of the Administrative Code. The youth or their authorized representative will consent to the child and family-centered plan by signing and dating it by the thirtieth calendar day of eligibility; and

(2) Reside, and will continue to reside, in a setting that possesses the home and community-based setting characteristics set forth in rule 5160-44-01 of the Administrative Code.

(C) All youth enrolled into the OhioRISE 1915(c) waiver will be automatically enrolled with a managed care organization as defined in rule 5160-26-01 of the Administrative Code.

(D) If, at any time, a youth does not meet any of the eligibility criteria set forth in paragraphs (A) and (B) of this rule, with the exception of paragraph (A)(8)(b) of this rule, the youth will be denied enrollment to, or be disenrolled from, the waiver.

(E) If a youth resides in an institution, as described in rule 5160-44-01 of the Administrative Code, for more than ninety consecutive days, the OhioRISE plan will initiate disenrollment from the OhioRISE 1915(c) waiver.

(F) When a youth is disenrolled from the waiver for any reason, the following will occur:

(1) Dependent in which care coordination tier a youth is enrolled, in accordance with rule 5160-59-03.2 of the Administrative Code, either the care management entity (CME) manager or the OhioRISE plan will work to develop a transition of care plan at least thirty calendar days prior to disenrollment.

(2) Either the CME or the OhioRISE plan will work to identify needed supports for the ninety calendar days following disenrollment from the OhioRISE program.

(G) When a youth is denied enrollment to, or disenrolled from, the waiver for failure to meet eligibility criteria as set forth in paragraph (A) or (B) of this rule, the youth or their authorized representative will be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

(H) The number of individuals enrolled in the waiver program will not exceed the centers for medicare and medicaid authorized limit for the waiver program year.

DRAFT - NOT FOR FILING

5160-59-05 OhioRISE home and community-based services waiver: covered services and providers.

(A) This rule establishes the services available under the Ohio resilience through integrated systems and excellence (OhioRISE) home and community-based services (HCBS) 1915(c) waiver program (waiver) established in accordance with 1915(c) of the Social Security Act 42 U.S.C. 1396n (January 1, 2022), and the providers eligible to deliver those services to youth enrolled on the waiver.

(B) Providers seeking to deliver services in the waiver program will meet the criteria in Chapter 5160-59 and set forth in rules 5160-44-02 and 5160-44-31 of the Administrative Code, as appropriate. Providers that have responsibility for developing the child and family-centered care plan cannot provide other direct 1915(c) waiver services to the youth.

(C) Prior to a qualified waiver provider delivering services to waiver recipients, the services will be documented on the youth's child and family-centered care plan as described in Chapter 5160-59 of the Administrative Code and approved by the OhioRISE plan. The child and family-centered care plan will be developed in accordance with person-centered practices as set forth in rule 5160-44-02 of the Administrative Code.

(D) Waiver covered services are limited to the following and are subject to any reimbursement provisions in the Ohio Administrative Code rules cited therein:

(1) Out-of-home respite as set forth in rule 5160-59-05.1 of the Administrative Code;

(2) Transitional services and supports as set forth in rule 5160-59-05.2 of the Administrative Code; and

(3) Secondary Flex Funds as set forth in rule 5160-59-05.3 of the Administrative Code. Secondary Flex Funds service is subject to participant-direction through budget authority.

(E) When the OhioRISE plan denies, reduces, terminates or suspends an OhioRISE waiver service, this constitutes an adverse benefit determination, and can be appealed in accordance with rule 5160-26-08.4 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-59-05.1 OhioRISE home and community-based services waiver: out-of-home respite.

(A) Scope. This rule sets forth provisions governing coverage for out-of-home respite services delivered as part of the Ohio resilience through integrated systems and excellence (OhioRISE) 1915(c) waiver program (waiver) established in accordance with 1915(c) of the Social Security Act, 42 U.S.C. 1396n (January 1, 2022).

(B) Definitions. For this rule, the following definitions apply:

(1) "Community respite" has the same meaning as set forth in rule 5123-9-22 of the Administrative Code.

(2) "Intermediate care facility for individuals with intellectual disabilities" (ICF/IID) has the same meaning as set forth in section 5124.01 of the Revised Code.

(3) "Out-of-home respite" is a service provided to youth unable to care for themselves who are enrolled on the waiver. The service is provided on a short-term basis because of the absence or need for relief of those persons who normally provide care for the youth.

(4) "Residential respite" has the same meaning as set forth in rule 5123-9-34 of the Administrative Code.

(C) Eligible providers and conditions of participation.

(1) The following providers are eligible to provide the out-of-home respite service available under the waiver program:

(a) An ICF/IID who is certified by the Ohio department of health (ODH), holds certification as a residential respite provider, and has an active license with the Ohio department of developmental disabilities (DODD).

(b) An agency provider holding certification for community respite services.

(c) A psychiatric residential treatment facility (PRTF) as described in 42 C.F.R. 441.150 (October 1, 2021) through 42 C.F.R 441.184 (October 1, 2021) that is licensed by the Ohio department of mental health and addiction services (MHAS) and holds the appropriate waiver certification with the Ohio department of medicaid (ODM);

(d) A class one residential facility licensed by Ohio MHAS in accordance with Chapter 5122-30 of the Administrative Code.

(2) With the exception of paragraph (B)(14) of rule 5160-44-31 of the Administrative Code, providers will comply with conditions of participation as set forth in rule 5160-44-31 of the Administrative Code.

(3) Providers will obtain and maintain first aid certification from instruction which includes hands-on training by a certified first aid instructor. At its discretion, ODM may accept training conducted by a solely internet-based class as sufficient for the purposes of first aid certification.

(4) Providers will maintain all initial and subsequent child and family-centered care plans.

(5) Providers are subject to compliance reviews specific to their licensure or certification criteria in addition to ongoing monitoring conducted by the OhioRISE plan.

(D) Coverage.

(1) Out-of-home respite may be provided on a planned or emergency basis. An emergency out-of-home respite service may be provided to address either a primary caregiver's unexpected need for out-of-home respite or to address an urgent need related to the youth.

(2) Service delivery must occur outside of the youth's primary residence.

(3) The out-of-home respite service available under the waiver program is additive to the behavioral health respite as set forth in rule 5160-59-03.4 of the Administrative Code.

(4) The youth's care coordinator working within the care management entity (CME), as defined in rule 5160-59-01 of the Administrative Code, or OhioRISE Plan, will assist the youth and their primary caregiver in determining the need for the use of planed and emergency out-of-home respite.

(5) The youth's care coordinator working within the CME, as defined in rule 5160-59-01 of the Administrative Code, or OhioRISE plan may recommend planned and emergency out-of-home respite, as well as the providers of out-of-home respite services, as part of the child and family-centered care plan.

(6) The OhioRISE plan will need to approve out-of-home respite service as part of the child and family-centered care plan prior to receipt and reimbursement of out-of-home respite service.

(E) Limitations.

(1) Out-of-home respite will not be provided to a youth prior to establishment of initial or ongoing enrollment and eligibility criteria for the waiver as set forth in rule 5160-59-04 of the Administrative Code.

(2) Out-of-home respite will be provided only to a youth enrolled on the waiver at the time of service delivery.

(3) The out-of-home respite service is available for a total of ninety calendar days within a three hundred-sixty-five day period while a youth is enrolled on the waiver. Dependent on the care coordination tier a youth is enrolled, in accordance with rule 5160-59-03.2 of the Administrative Code, either the CME care coordinator or the OhioRISE care coordinator is responsible for tracking and maintaining records for the purposes of tracking out-of-home respite utilization within each three hundred sixty-five -day period.

(4) Reimbursement for out-of-home respite is not allowable on the same day when the youth is receiving behavioral health respite as set forth in rule 5160-59-03.4 of the Administrative Code.

(5) When the OhioRISE plan denies, reduces or terminates or suspends out-of-home respite services, this constitutes and adverse benefit determination and can be appealed in accordance with rule 5160-26-08.4 of the Administrative Code.

(F) Service documentation for out-of-home respite will include each of the following to validate reimbursement for medicaid services:

(1) Date of service;

(2) Place of service;

(3) Name of youth receiving services;

(4) Medicaid identification number of youth receiving services;

(5) Name of provider;

(6) Provider identifier;

(7) Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider; and

(8) A summary of the amount, scope, duration, and frequency of services delivered that directly relate to the services specified in the approved child and family-centered care plan to be provided.

(G) Reimbursement..

(1) Only one provider may bill out-of-home respite for the same youth on any given day.

(2) Reimbursement for the out-of-home respite service does not include room and board.

(3) Reimbursement for the out-of-home respite service does not include transportation costs.

DRAFT - NOT FOR FILING

5160-59-05.2 OhioRISE home and community-based services waiver: transitional services and supports.

(A) Scope. This rule sets forth provisions governing coverage for transitional services and supports provided as part of the Ohio resilience through integrated systems and excellence (OhioRISE) 1915(c) waiver program (waiver) established in accordance with 1915(c) of the Social Security Act 42, U.S.C. 1396n (January 1, 2022).

(B) Definitions. For this rule, the following definitions apply:

(1) "Homemaker/personal care" has the same meaning as set forth in rule 5123-9-30 of the Administrative Code.

(2) "Transitional services and supports" (TSS) is a service designed to provide intensive in-home respite and skill-building for the youth, primary caregiver and family as a pathway to creating a stable environment for the youth and the family that lives in the home. It is meant to assist the youth, in conjunction with their family/primary caregiver, as a means to overcome the functional limitations as identified due to the result of the youth's intensive behaviors. TSS is used to support youths and their families in understanding, mitigating, and transitioning to long term solutions for behavior challenges. TSS is used to support a youth and their family to stabilize during a transition of care and is not intended to de-escalate crises.

(C) Eligible providers and conditions of participation.

(1) The following providers are eligible to provide TSS under the waiver program:

(a) An entity operating in accordance with paragraph (A)(1) or (A)(2) of rule 5160-27-01 of the Administrative Code. Eligible rendering practitioners employed by or under contract with the entity include those described in paragraphs (3), (4), (5), or (6)(a) of rule 5160-27-01 of the Administrative Code.

(b) An agency provider holding certification for homemaker/personal care services in accordance with rule 5123-9-30 of the Administrative Code.

(c) An individual provider who meets the criteria of an independent practitioner or licensed psychologist as described in rule 5160-8-05 of the Administrative Code.

(d) An individual provider holding certification for homemaker/personal care services in accordance with rule 5123-9-30 of the Administrative Code.

(2) Providers who hold certification for homemaker/personal care services, as designated in paragraphs (C)(1)(b) and (C)(1)(d) of this rule, will also complete behavioral health support trainings sponsored by the Ohio department of developmental disabilities (DODD) or an Ohio department of medicaid (ODM) approved behavioral health training prior to rendering the TSS service.

(3) With the exception of paragraph (B)(14) of rule 5160-44-31 of the Administrative Code, providers will comply with conditions of participation as set forth in rule 5160-44-31 of the Administrative Code.

(4) Providers will obtain and maintain first aid certification from an instruction which includes hands-on training by a certified first aid instructor. At its discretion, ODM may accept training conducted by a solely internet-based class as sufficient for the purposes of first aid certification.

(5) Providers will maintain all initial and subsequent child and family-centered care plans.

(6) Providers are subject to compliance reviews specific to conditions of their licensure or certification in addition to ongoing monitoring conducted by the OhioRISE plan.

(D) Coverage.

(1) Primary components of the TSS service may include:

(a) Supervision and direct care of the youth to alleviate the risk for an escalation of the youth's symptoms and/or disruption in the living environment when the youth and their family or caregivers are unable to manage without intensive assistance and support;

(b) Training the youth and family or caregivers in behavior stabilization techniques related to the youth's serious emotional disturbance diagnosis;

(c) Implementing supports as identified by the care coordinators and child and family care team;

(d) Working with the youth and family or caregivers to identify triggers and developing person-centered approaches for preventing behavioral crisis prior to occurrence;

(e) Assistance to the youth in acquiring, retaining, and improving areas of self-help and socialization.

(2) Permissible tangential activities allowable under the TSS service include but are not limited to:

(a) Training and skill-building for families and caregivers regarding mitigation and support techniques for when crises occur;

(b) Training and skill-building for families and caregivers to understand and implement positive coping strategies to directly address crisis or escalation of risk behaviors;

(c) Acting as a conduit between the family or caregivers, the youth and the youth's care coordinator to assist in system navigation;

(d) Assistance to the youth with engagement in the broader community; and

(e) Assistance to the youth and family or caregivers with coping skills both in home and community settings.

(3) Other intensive respite and skill building activities related to youth and family or caregivers stabilization and transition beyond those listed in paragraphs (D)(1) and (D)(2) of this rule may be considered as permissible tangential activities allowable under the TSS service only when approved by the OhioRISE plan as part of the child and family-centered care plan prior to a provider rendering and receiving reimbursement for the service.

(4) Staffing may be provided to a youth at a ratio of up to two to one when there is a demonstrated need for the staffing level and when approved by the OhioRISE plan and documented on the child and family-centered care plan by the youth's care coordinator working within the CME as defined in rule 5160-59-01 of the Administrative Code, or the OhioRISE plan.

(5) TSS may be made available within twenty-four hours upon a change in circumstance or qualifying condition as described in paragraph (E) of this rule.

(6) The youth's care coordinator working within the CME or OhioRISE plan will assist the youth and their primary caregiver in determining the need for the TSS.

(7) The youth's care coordinator working within the CME or OhioRISE plan may recommend TSS, as well as the providers of TSS, as part of the child and family-centered care plan.

(8) The OhioRISE plan will need to approve TSS as part of the child and family-centered care plan prior to receipt and reimbursement of TSS service

(E) Limitations.

(1) TSS will only be provided to youth meeting eligibility criteria for the waiver as set forth in rule 5160-59-04 of the Administrative Code and who are enrolled on the waiver at the time of service delivery.

(2) TSS will not be provided to a youth prior to establishment of initial or ongoing enrollment and eligibility criteria for the waiver as set forth in rule 5160-59-04 of the Administrative Code.

(3) TSS is only approved when a youth experiences one of the following changes in circumstances or qualifying conditions:

(a) Within twenty-four hours of the youth enrolling on the waiver following an institutional placement in one of the following settings:

(i) A psychiatric residential treatment facility (PRTF) as described in 42 C.F.R. 441.150 (October 1, 2021) through 42 C.F.R 441.184 (October 1, 2021);

(ii) An intermediate care facility for individuals with an intellectual disability (ICF/IID) as defined in section 5124.01 of the Revised Code;

(iii) An inpatient psychiatric hospital as defined in 42 CFR 440.160 (October 1, 2021);

(iv) A residential facility as defined in rule 5122-30-03 of the Administrative Code; or

(v) A qualified residential treatment program (QRTP) as described in rule 5101:2-9-42 of the Administrative Code.

(b) Within twenty-four hours of when the youth is transitioning between custodians and/or caregivers, for example, following a transition into a kinship caregiver's home; or

(c) If a youth does not yet have available other appropriate behavioral health services provided under the OhioRISE plan, within twenty-four hours following an institutional placement in one of the settings as described in paragraphs (E)(3)(a)(i) to (E)(3)(a)(v) of this rule.

(4) Reimbursement may be made for TSS when rendered by a provider in accordance with paragraph (C) of this rule to a youth enrolled in the OhioRISE 1915(c) waiver program in accordance with rule 5160-59-04 of the Administrative Code.

(5) When determined eligible for the OhioRISE 1915(c) waiver, the initial seventy-two hours will be approved with the child and family-centered care plan, or until other appropriate behavioral health service provided under the OhioRISE plan are scheduled to begin, or whichever occurs first. When TSS is required beyond a seventy-two hour period, the child and family-centered care plan will need to be updated, reviewed, and approved by the OhioRISE plan prior to additional TSS services being provided.

(6) When the OhioRISE plan denies, reduces, terminates or suspends TSS services, this constitutes an adverse benefit determination and can be appealed in accordance with rule 5160-26-08.4 of the Administrative Code.

(F) Service documentation for TSS will include each of the following to validate reimbursement for medicaid services:

(1) Date of service;

(2) Place of service;

(3) Name of youth receiving service;

(4) Medicaid identification number of youth receiving service;

(5) Name of provider;

(6) Provider identifier;

(7) Written or electronic signature of the person delivering the service, or initials of the person delivering the service if a signature and corresponding initials are on file with the provider; and

(8) A summary of the amount, scope, duration, and frequency of services delivered that directly relate to the services specified in the approved child and family-centered care plan to be provided.

DRAFT - NOT FOR FILING

5160-59-05.3 OhioRISE home and community-based services waiver: secondary flex funds.

(A) Scope. This rule sets forth provisions governing coverage for secondary flex funds delivered as part of the Ohio resilience through integrated systems and excellence (OhioRISE) 1915(c) waiver program (waiver) established in accordance with 1915(c) of the Social Security Act, 42 U.S.C. 1396n (January 1, 2022).

(B) Definitions. For this rule, the following definitions apply:

(1) "Emergency funds" are an additional allotment of waiver funding used for the purchase of approved secondary flex funds based on a youth's unmet needs as determined by the OhioRISE plan.

(2) "Participant direction" means the opportunity for an OhioRISE waiver youth to exercise choice and control in managing a budget for the applicable waiver service in accordance with their needs.

(3) "Participant-directed budget for secondary flex funds" is the waiver-enrolled youth's maximum approved, non-emergency funding allowable for the purchase of secondary flex funds under the OhioRISE 1915(c) waiver.

(4) "Secondary flex funds" is defined as the additional services, equipment, or supplies available through the waiver that are not otherwise provided through the medicaid state plan benefit or the OhioRISE program that address a youth's identified need as documented in the child and family-centered care plan. Secondary flex funds are intended to enhance and supplement the array of services available to a youth enrolled on the OhioRISE program and are discussed, recommended, and implemented through the care coordination process as described in rule 5160-59-03.2 of the Administrative Code. Secondary flex funds is inclusive of emergency funds and the participant-directed budget as described in this rule.

(5) "Waiver cost limit" is the maximum amount of funding, excluding emergency funds, available to a youth enrolled in the waiver. The waiver cost limit for the waiver is fifteen thousand dollars per twelve month period.

(C) With the exception of additional criteria defined in paragraph (D) of this rule, all provisions of rule 5160-59-03.5 of the Administrative Code apply to secondary flex funds provided under the waiver.

(D) The following additional criteria apply to secondary flex funds provided under the waiver:

(1) The total participant-directed budget for secondary flex funds is limited to three thousand dollars within three hundred sixty-five calendar days. The participant-directed budget is included in the waiver cost limit.

(2) The waiver enrolled youth may access up to the total participant-directed budget for secondary flex funds when all primary flex funds, described in rule 5160-59-03.5 of the Administrative Code, provided under the OhioRISE plan are exhausted.

(3) The total emergency funds available to a youth is limited to two thousand dollars within three hundred sixty-five days calendar days. Emergency funds are not included in the waiver cost cap.

(a) Emergency funds are only available to a youth when the youth has exhausted all primary flex funds, as described in rule 5160-59-03.5 of the Administrative Code, and all available funds in their participant-directed budget, and still have a demonstrated need which may be met through the emergency funds available under secondary flex funds.

(b) The youth's unmet need and desired outcome, resulting from the use of emergency funds, will be detailed in the child and family-centered care plan.

(4) Secondary flex fund services are additive to the primary flex funds described in rule 5160-59-03.5 of the Administrative Code.

(5) The OhioRISE plan will need to approve the waiver enrolled youth's participant-directed budget for secondary flex funds as part of the child and family care plan prior to use of the service.

(6) When the OhioRISE plan denies, reduces, terminates or suspends secondary flex funds services, this constitutes an adverse benefit determination, and can be appealed in accordance with rule 5160-26-08.4 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-27-02 Coverage and limitations of behavioral health services.

(A) This rule sets forth coverage and limitations for behavioral health services rendered to medicaid recipients by behavioral health provider agencies who meet all requirements found in agency 5160 of the Administrative Code unless otherwise specified.

(1) All claims for behavioral health services submitted to the Ohio department of medicaid (ODM) must include an ICD-10 diagnosis of mental illness or substance use disorder. The list of recognized diagnoses can be accessed at www.medicaid.ohio.gov.

(2) Medicaid reimbursable behavioral health services are limited to medically necessary services defined in rule 5160-8-05 of the Administrative Code and Chapter 5160-27 of the Administrative Code. Providers shall follow the requirements in rule 5160-8-05 of the Administrative Code and Chapter 5160-27 of the Administrative Code regarding services that cannot be billed in combination with other services.

(B) The following services have limitations on the amount, scope or duration of service that can be rendered to a recipient within a certain timeframe. These limits can be exceeded with prior authorization from ODM or its designee.

(1) Screening, brief intervention and referral to treatment (SBIRT) as defined by the American medical association's current procedural terminology book. Limitation for this service is one per code, per recipient, per billing provider, per calendar year.

(2) Assertive community treatment (ACT) as defined in rule 5160-27-04 of the Administrative Code is available on or after the date as determined by prior authorization approval.

~~(3)~~ (3) ~~Intensive home based treatment (IHBT) as defined in rule 5160-27-05 of the Administrative Code is available on or after the date as determined by prior authorization approval.~~

~~(4)~~ (3) Community psychiatric supportive treatment (CPST) services as defined in rule 5122-29-17 of the Administrative Code and meet the following requirements:

(a) All CPST services provided in social, recreational, vocational, or educational settings are allowable only if they are documented mental health service interventions addressing the specific individualized mental health treatment needs as identified in the recipient's individualized service plan.

(b) A billable unit of service for CPST may include ~~either face-to-face or telephone~~ contact between the mental health professional and the recipient or an individual essential to the mental health treatment of the recipient.

(c) CPST services are not covered under this rule when provided in a hospital setting, except for the purpose of coordinating admission to the inpatient hospital or facilitating discharge to the community following inpatient treatment for an acute episode of care.

(d) Medicaid reimbursement of CPST services is described in rule 5160-27-03 of the Administrative Code.

~~(5)~~ (4) Psychiatric diagnostic evaluation and psychiatric diagnostic evaluation with medical services are each limited to one encounter per recipient, per billing provider, per calendar year.

(C) The following services delivered to recipients with substance use disorders have limitations on the amount, scope or duration of service that can be rendered to a recipient within a certain timeframe. These limits can be exceeded with prior authorization from the ODM designated entity.

(1) Substance use disorder assessment as referenced in rule 5160-27-09 of the Administrative Code is limited to two assessments per recipient, per billing agency, per calendar year.

(2) Substance use disorder urine drug screening as referenced in rule 5160-27-09 of the Administrative Code, is limited to one per day, per recipient.

(3) ~~Substance use disorder peer~~ Peer recovery support as referenced in rules 5160-27-09 and 5160-43-04 of the Administrative Code is limited to four hours per day per recipient.

(4) Substance use disorder partial hospitalization as described in rule 5160-27-09 of the Administrative Code. ~~is available on or after the date as determined by prior authorization approval. The prior authorization request must substantiate that the recipient meets the partial hospitalization level of care of twenty or more hours of service per week. In accordance with rule 5160-1-27 of the Administrative Code ODM may retrospectively review the case that the number of hours of service delivered matches the approved level of care.~~

(5) Substance use disorder residential level of care as described in rule 5160-27-09 of the Administrative Code. ~~is available for up to thirty consecutive days without prior authorization per medicaid recipient for the first and second admission, during the same calendar year. If the stay continues beyond thirty days of the first or second stay, prior authorization is required to support the medical necessity of continued stay. If medical necessity is not substantiated and not approved by the ODM designated entity, only the initial thirty consecutive days will be reimbursed. Third and subsequent admissions during the same calendar year must be prior authorized by the ODM designated entity from the date of admission.~~

(D) The medications listed in the appendix to rule 5160-27-03 or appendix DD to rule 5160-1-60 of the Administrative Code are covered by ODM when rendered and billed by an eligible provider as described in rule 5160-27-01 of the Administrative Code. The medication must be administered by a qualified practitioner acting within their professional scope of practice.

(E) Laboratory services, vaccines, and medications administered in a prescriber office may be administered in accordance with rule 5160-1-60 of the Administrative Code.

(F) Medical and evaluation and management services stated in the appendix to rule 5160-27-03 of the Administrative Code or appendix DD to rule 5160-1-60 of the Administrative Code are covered by ODM when rendered by:

(1) A practitioner as described in paragraphs (A)(3) and (A)(4) of rule 5160-27-01 of the Administrative Code and operating within their scope of practice; or

(2) A pharmacist, rendering services in accordance with rule 5160-8-52 of the Administrative Code.

(G) CMS place of service code set descriptions may be found at www.cms.gov. The department further defines place of service 99 as "community," and this place of service may only be used when a more specific place of service is not available. Place of service 99 shall not be used to provide services to a recipient of any age

if the recipient is being held in a public institution as defined in 42 C.F.R. 435.1010 (October 1, 2016).

(H) The activities that comprise or are included in the aforementioned medicaid reimbursable behavioral health services must be intended to achieve identified treatment plan goals or objectives. Providers shall maintain treatment records and progress notes as specified in rules 5160-01-27 and 5160-8-05 of the Administrative Code. A treatment plan for mental health services may only be developed by a practitioner who, at a minimum, meets the practitioner requirements found in paragraph (A)(6)(a) of rule 5160-27-01 of the Administrative Code. A treatment plan for substance use disorder services may only be developed by a practitioner who, at a minimum meets the practitioner requirements found in paragraph (A)(6)(b)(i) or (A)(6)(b)(iii) of rule 5160-27-01 of the Administrative Code.

(I) The medications and services listed in the appendix to rule 5160-27-03 of the Administrative Code or the opiate treatment service section of appendix DD to rule 5160-1-60 of the Administrative Code are reimbursed by the department when rendered and billed by an opiate treatment program as described in Chapter 5122-40 of the Administrative Code and licensed as such by the Ohio department of mental health and addiction services and/or federally certified as such as stated in 42 CFR 8.11 (October 1, 2016). Reimbursement rates are determined by the methodology described in paragraph (E) of rule 5160-4-12 of the Administrative Code or as listed in the appendix to rule 5160-27-03 of the Administrative Code or as listed in appendix DD to rule 5160-1-60 of the Administrative Code.

(J) When permitted, provision of any service addressed in Chapter 5160-27 of the Administrative Code by telehealth as defined in rule 5122-29-31 of the Administrative Code, must comply with the appropriate telehealth requirement(s) found in rule 5160-1-18 of the Administrative Code.

(K) The services described in this chapter shall not substitute or supplant natural supports and do not include any of the following:

(1) Educational, vocational, or job training services.

(2) Room and board.

(3) Habilitation services including but not limited to financial management, supportive housing, supportive employment services, and basic skill acquisition services that are habilitative in nature.

(4) Services to recipients who are being held in a public institution as defined in 42 C.F.R. 435.1010 (October 1, 2016);

(5) Services to individuals residing in institutions for mental diseases as described in 42 C.F.R. 435.1010 (October 1, 2016);

(6) Recreational and social activities, including but not limited to art, music, and equine therapies;

(7) Services that are covered elsewhere in agency 5160 of the Administrative Code; and

(8) Transportation for the recipient or family.

(L) Peer recovery services ~~as~~ defined as peer support services in rule 5122-29-15 of the Administrative Code are covered when delivered:

(1) Through the specialized recovery services program in accordance with rule 5160-43-04 of the Administrative Code; or

(2) As a component of assertive community treatment as defined in rule 5160-27-04 of the Administrative Code: or

(3) As a component of substance use disorder residential treatment as defined in rule 5160-27-09 of the Administrative Code; or

(4) As a substance use disorder outpatient treatment service in accordance with rule 5160-27-09 of the Administrative Code~~.~~; or

(5) As a component of intensive home-based treatment service as defined in rule 5122-29-28 of the Administrative Code; or

(6) As a component of mobile response and stabilization service in accordance with rule 5122-29-14 of the Administrative Code.

(M) The "Ohio children's initiative brief CANS assessment" and the "Ohio children's initiative comprehensive CANS assessment" are covered as defined in rule 5160-59-01 of the Administrative Code. Payment for CPST, therapeutic behavioral services, or psychiatric diagnostic evaluation is not allowable for provision of the Ohio brief or Ohio comprehensive CANS assessment.

DRAFT - NOT FOR FILING

5160-27-13 Mobile response and stabilization service.

(A) For the purposes of this rule, mobile response and stabilization service (MRSS), is the service as set forth by the Ohio department of mental health and addiction services (OhioMHAS) in rule 5122-29-14 of the Administrative Code.

(B) Eligible providers.

(1) Providers certified by OhioMHAS in accordance with rule 5122-29-14 of the Administrative Code are eligible for MRSS reimbursement.

(2) Services rendered by MRSS team staff described in rule 5122-29-14 of the Administrative Code that are eligible providers of behavioral health services in accordance with rule 5160-27-01 of the Administrative Code are reimbursable.

(C) Coverage.

(1) The following MRSS activities are reimbursable:

(a) Mobile response activities as described in rule 5122-29-14 of the Administrative Code.

(b) Stabilization services as described in rule 5122-29-14 of the Administrative Code.

(2) Prior authorization is not required for mobile response activities.

(3) Prior authorization is required for stabilization services rendered more than six weeks from the completion of mobile response.

(4) For individuals enrolled in either a medicaid managed care organization (MCO) or the OhioRISE plan, it is the responsibility of the provider to notify the individual's MCO or the OhioRISE plan within three business days of initiation, termination, and transition from stabilization services. For individuals enrolled in both a medicaid managed care organization (MCO) and the OhioRISE plan, it is the responsibility of the provider to notify the OhioRISE plan within three business days of initiation, termination, and transition from stabilization services.

(D) Limitations.

(1) The following activities are not billable as MRSS:

(a) Childcare services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.

(b) Respite care.

(c) Transportation activities that do not include the provision of a mobile response activity or stabilization service.

(d) MRSS screening and triage activities described in rule 5122-29-14 of the Administrative Code.

(e) Activities not described in paragraph (C) of this rule.

(2) Reimbursement will not be made for stabilization services described in paragraph (C)(1) of this rule when an individual is:

(a) Enrolled in intensive home-based treatment as described in rule 5122-29-28 of the Administrative Code.

(b) Receiving substance use disorder residential treatment services as described in rule 5160-27-09 of the Administrative Code, except for MRSS necessary to support admission to the facility.

(c) Enrolled in assertive community treatment as described in rule 5160-27-04 of the Administrative Code.

(d) Receiving inpatient hospital psychiatric services as described in Chapter 5160-2 of the Administrative Code, except for MRSS necessary to support admission to the hospital.

(e) Receiving psychiatric residential treatment facility services as described in 42 C.F.R. 441.150 (October 1, 2021) through 42 C.F.R. 441.184 (October 1, 2021) except for MRSS necessary to support admission to the facility.

(E) Reimbursement. The medicaid reimbursement rate for MRSS is stated in the appendix to rule 5160-27-03 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-27-05 Intensive home based treatment service. RESCIND

(A) Scope. This rule sets forth provisions governing medicaid coverage of intensive home based treatment (IHBT) services.

(B) Definition. IHBT is the service and activities as set forth by the Ohio department of mental health and addiction services (OhioMHAS) in rule 5122-29-28 of the Administrative Code.

(C) Eligible providers of IHBT services.

(1) Providers eligible for medicaid payment for IHBT will:

(a) Meet the requirements in paragraphs (A)(1) or (A)(2) of rule 5160-27-01 of the Administrative Code; and

(b) Provide the service in accordance with rule 5122-29-28 of the Administrative Code.

(2) Payment may be made for services rendered by IHBT staff described in rule 5122-29-28 of the Administrative Code that are eligible as a provider of behavioral health services in accordance with rule 5160-27-01 of the Administrative Code.

(D) Coverage.

(1) Medicaid payment may be made for IHBT rendered to individuals under age twenty-one years that meet the criteria for IHBT as described in rule 5122-29-28 of the Administrative Code.

(2) Payment may be made for IHBT services rendered face-to-face in person or via telehealth in accordance with rule 5122-29-31 of the Administrative Code.

(3) The reimbursement rates for IHBT may be found in the appendix to this rule.

(E) Limitations.

(1) The following activities are not reimbursable as part of IHBT:

(a) Time spent doing, attending, or participating in recreational activities.

(b) Child care services or services provided as a substitute for the parent or other individuals responsible for providing care and supervision.

(c) Respite care.

(d) Transportation for the beneficiary or family.

(e) Any art, movement, dance, drama, or animal therapies, unless incorporated into the IHBT treatment modality.

(f) Services provided to teach academic subjects or as a substitute for educational personnel including, but not limited to, a teacher, teacher's aide, or an academic tutor.

(2) A separate medicaid payment will not be made for any of the following services or treatments while the recipient is enrolled in IHBT services, unless the service is prior authorized:

(a) Behavioral health assessments, screenings, and diagnostic evaluations.

(b) Individual, group, or family psychotherapy and counseling.

(c) Therapeutic behavioral services, except for therapeutic behavioral group service - hourly and per diem as defined in rule 5160-27-06 of the Administrative Code.

(d) Community psychiatric supportive treatment as described in rule 5122-29-17 of the Administrative Code.

(e) Psychosocial rehabilitation as described in rule 5160-27-08 of the Administrative Code.

(f) Substance use disorder (SUD) residential treatment services as described in rule 5160-27-09 of the Administrative Code.

(g) Assertive community treatment as described in rule 5160-27-04 of the Administrative Code.

(h) SUD targeted case management as described in rule 5160-27-10 of the Administrative Code.

5160-27-05 RESCIND
APPENDIX A

Fee schedule for Intensive Home Based Treatment (IHBT)

HCPCS CODE	Modifier	DESCRIPTION	EFFECTIVE DATE	CURRENT MAXIMUM PAYMENT AMOUNT *	ALLOWABLE PLACES OF SERVICE **
H2033		Multisystemic Therapy for Juveniles (MST) (Licensed Practitioner[1]), per 15 minutes	3/1/2022	41.10	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2033		Multisystemic Therapy for Juveniles (MST) (Independent Practitioner[2]), per 15 minutes	3/1/2022	42.24	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2015	TF	Functional Family Therapy for Juveniles (FFT) (Licensed Practitioner[1]), per 15 minutes	3/1/2022	34.05	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2015	TF	Functional Family Therapy for Juveniles (FFT) (Independent Practitioner[2]), per 15 minutes	3/1/2022	34.98	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2015		IHBT (other than MST or FFT) (Peer Recover Supporter[3]), per 15 minutes	3/1/2022	27.51	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2015		IHBT (other than MST or FFT) (Unlicensed Practitioner[4]), per 15 minutes	3/1/2022	34.21	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2015		IHBT (other than MST or FFT) (Licensed Practitioner[1]), per 15 minutes	3/1/2022	37.57	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99
H2015		IHBT (other than MST or FFT) (Independent Practitioner[2]), per 15 minutes	3/1/2022	38.60	03, 04, 11, 12, 14, 16, 18, 23, 53, 57, 99

* For a service rendered by a supervised trainee under direct supervision as described in rule 5160-8-05 of the Administrative Code, the payment amount is the supervising practitioner rate.

**Refers to CMS places of service codes found https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

1. Licensed practitioner has the same meaning as "supervised practitioner" as described in rule 5160-8-05 of the Administrative Code.
2. Includes licensed psychologists and independent practitioners as described in OAC rule 5160-8-05.
3. Peer recovery supporter as described in rule 5122-29-15.1 of the Administrative Code.
4. Includes unlicensed practitioners of mental health services as described in rule 5160-27-01 of the Administrative Code; and "supervised trainees" as described in rule 5160-8-05 of the Administrative Code under general supervision.