Common Sense Initiative

Mike DeWine, *Governor*
Jon Husted, *Lt. Governor*
Joseph Baker, *Director*

Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

Rule Contact Name and Contact Information: Tommi Potter, Rules Administrator, Rules@medicaid.ohio.gov, 614-752-3877

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

Ohio Resilience Through Integrated Systems and Excellence (OhioRISE) Rule

Rule Number(s): 5160-59-03.2

Date of Submission for CSI Review: 9/20/2023

Public Comment Period End Date: 9/27/2023

Rule Type/Number of Rules:

New/___ rules
No Change/____ rules (FYR? ___)
Amended/_1__ rules (FYR? ___)
Rescinded/____ rules (FYR?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.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   The rule listed below has been summarized to provide a brief description of the rule and the planned proposed amendments to the rule language. The amendments being proposed do not affect the adverse business impact; however, there is adverse impact in the rule content that is not being amended. The estimated effective date for the amended rule to be proposed is January 2024.

   OAC rule 5160-59-03.2, entitled "OhioRISE: care coordination (ICC/MCC)," defines OhioRISE care coordination, including the role of care management entities and their responsibilities over care coordination of an OhioRISE member. The service codes and reimbursement are in Appendix A of the rule.

   This rule is being proposed for amendment to remove some of the more restrictive timeframes related to care coordination activities to allow for greater responsiveness and flexibility in service delivery, clarify care coordination activities timeframes for those with retroactive eligibility, and make technical corrections. This rule is also being proposed to increase reimbursement rates.

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 5162.03, 5167.02 authorizes ODM to adopt the rule.
   - Revised Code Sections 5167.02, 5167.03, 5167.04, 5167.10, 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 rule is not related to changes to federal regulation.

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

   The rule is 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 public purpose for the planned amendment of this rule is to revise regulation of OhioRISE care coordination services and to revise the rates associated with OhioRISE care coordination services.

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.

   ODM has consistently involved 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 Advisory Council's creation in January 2021, ODM has held monthly meetings with stakeholders to discuss general program principles and system of

care philosophy, federal authorities, and service concepts. The new and enhanced state plan, 1915(b), 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.

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
Ohio Children's Alliance
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 also been working collaboratively with other state and local 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.

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

The changes to OAC 5160-59-03.2, the Care Coordination rule, were made at the request of OhioRISE stakeholders who asked for increased flexibility with meeting care coordination activities timeframes so they can be more responsive to children/youth and their families/caregivers.

Policy updates being made to OAC 5160-59-03.2 were shared with the OhioRISE Advisory Council in June 2023; based on additional stakeholder feedback, more updates to the rule were made, and these updates were shared with Care Management Entities on September 1, 2023.

In accordance with the budget provisions in Am. Sub. H.B. 33 of the 135th Ohio General Assembly, the Ohio Department of Medicaid is also amending this rule to increase payments made to providers for rendering the service starting in calendar year 2024.

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 support this rule. 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? ***Alternative regulations may include performance-based regulations, which define the required outcome, but do not dictate the process the regulated stakeholders must use to comply.***

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 rule is being implemented to allow for ODM to specifically regulate and enforce the OhioRISE program and the OhioRISE plan.

13. 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 this rule. ODM staff reviews rules with other ODM offices and works across the Medicaid OAC rules to use incorporations by reference to avoid duplicative regulations. Incorporations by reference are used in the rules within Chapter 5160-59 to prevent duplication of existing Ohio regulation.

All Medicaid regulations governing managed care programs are promulgated and implemented by ODM only. No other state agencies impose requirements that are specific to the Medicaid managed care program.

14. 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.

The OhioRISE plan and ODM staff will be trained to assist with inquiries and technical assistance related to the proposed revisions to this rule. ODM will continue to work with the stakeholder groups and also provide communications to advocacy and association organizations to be shared with the OhioRISE community.

ODM will notify the OhioRISE Advisory Council, the OhioRISE plan, and other MCOs when the OhioRISE OAC rule has been final filed along with their effective date via email notification. ODM will ensure the OhioRISE plan is made aware of any future OAC rule changes via established communication processes.

Adverse Impact to Business

15. Provide a summary of the estimated cost of compliance with the rule(s). Specifically, please do the following:

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

This OAC rule 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 this OAC rule and provided to Medicaid recipients 20 years of age and under.

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

- **OAC rule 5160-59-03.2 OhioRISE: care coordination (ICC/MCC)** requires Care Management Entities to conduct care coordination activities for OhioRISE enrollees, maintain records and service plans for members, and complete the care plan process within specified timeframes for OhioRISE 1915(c) waiver enrollees. Care Management Entities are to report to ODM and the OhioRISE Plan incidents that are not consistent with the routine care of, and/or service delivery to, an individual. 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. Costs to the Care Management Entities include staff time to maintain and submit/report information to the OhioRISE plan, and the cost to complete the required training.

16. Are there any proposed changes to the rules that will <u>reduce</u> a regulatory burden imposed on the business community? Please identify. *(Reductions in regulatory burden may include streamlining reporting processes, simplifying rules to improve readability, eliminating requirements, reducing compliance time or fees, or other related factors).*

Changes were made to OAC rule 5160-59-03.2, entitled "OhioRISE: care coordination (ICC/MCC)," to reduce regulatory burden. This rule is being updated to eliminate certain plan completion timeframe requirements and reduce the staffing burden related by the previous maximum staffing ratios.

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

The OhioRISE program supports the most vulnerable children in the state of Ohio who need specialized and targeted behavioral health support and services. It has also worked to move the behavioral health system from out-of-home placements towards a community care network, 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's 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 ensure 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 rule 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 rule 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/.

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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 six years of age and older when paragraph (A)(1)(a) and either paragraph (A)(1)(b) or (A)(1)(c) of this rule are met:

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

(i) Psychosis~~psychosis~~;

(ii) Impulsivity~~impulsivity~~/hyperactivity;

(iii) Depression~~depression~~;

(iv) Anxiety~~anxiety~~;

(v) Oppositional~~oppositional~~ behavior;

(vi) Conduct~~conduct~~;

(vii) Adjustment~~adjustment~~ to trauma;

(viii) Anger~~anger~~ control;

(ix) Substance~~substance~~ use;

(x) Eating~~eating~~ disturbance;

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

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

(i) Suicide~~suicide~~ risk;

(ii) Non-suicidal~~non-suicidal~~ self-injury behavior;

(iii) Other~~other~~ self-harm;

(iv) Danger~~danger~~ to others;

(v) Delinquent~~delinquent~~ behavior;

(vi) Runaway~~runaway~~;

(vii) Intentional~~intentional~~ misbehavior;

(viii) Fire~~fire~~ setting;

(ix) Victimization~~victimization~~/exploitation;

(x) Sexually~~sexually~~ problematic behavior;

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

(i) For the Ohio children's initiative brief CANS assessment:

~~(i)~~ (a) Family~~family~~ functioning;

~~(ii)~~ (b) Living~~living~~ situation;

~~(iii)~~ (c) Social~~social~~ functioning;

~~(iv)~~ (d) Developmental~~developmental~~/intellectual;

~~(v)~~ (e) Legal~~legal~~;

~~(vi)~~ (f) Medical~~medical~~/physical;

~~(vii)~~ (g) Sleep~~sleep~~;

~~(viii)~~ (h) Decision~~decision~~ making;

~~(ix)~~ (i) School~~school~~.

(ii) For the Ohio children's initiative comprehensive CANS assessment:

(a) Family functioning;

(b) Living situation;

(c) Social functioning;

(d) Developmental/intellectual;

(e) Legal;

(f) Medical/physical;

(g) Sleep;

(h) Decision making;

(i) School attendance or school behavior.

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

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

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

(i) Supervisionsupervision;

(ii) Knowledgeknowledge;

(iii) Residentialresidential stability;

(iv) Medicalmedical/ physical;

(v) Mentalmental health;

(vi) Substancesubstance use;

(vii) Familyfamily stress;

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

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

(i) Impulsivityimpulsivity/hyperactivity;

(ii) Depressiondepression;

(iii) Anxietyanxiety;

(iv) Oppositionaloppositional behavior;

(v) Adjustmentadjustment to trauma;

(vi) Regulatoryregulatory;

(b) For caregiver resources and needs domain items, at least one of the following items prevents the

provision of care and needs immediate ~~and/~~or intensive action or at least one of the following items is interfering with the provision of care and action is needed to ensure that the identified need is addressed:

(i) Supervision~~supervision~~;

(ii) Residential~~residential~~ stability;

(iii) Medical~~medical~~/physical;

(iv) Mental~~mental~~ health;

(v) Substance~~substance~~ use;

(vi) Developmental~~developmental~~;

(vii) Family~~family~~ stress;

(viii) Caregiver~~caregiver~~ post-traumatic stress reaction;

(ix) Marital~~marital~~/partner violence;

(x) Family~~family~~ relationship with the system;

(xi) Legal~~legal~~ involvement;

(xii) Early~~early~~ childhood domain item developmental/intellectual;

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

(i) Sleep~~sleep~~;

(ii) Family~~family~~ functioning;

(iii) Early~~early~~ education;

(iv) Social~~social~~ and emotional functioning;

(v) Medical~~medical~~/physical;

(vi) Failure~~failure~~ to thrive;

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

(i) Aggressive~~aggressive~~ behaviors;

(ii) Atypical~~atypical~~ behaviors;

(iii) Self-harm~~self-harm~~;

(iv) Exploited~~exploited~~;

(v) Problematic~~problematic sexual behavior~~.

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

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

(i) Impulsivity~~impulsivity~~/hyperactivity;

(ii) Depression~~depression~~;

(iii) Anxiety~~anxiety~~;

(iv) Oppositional~~oppositional~~ behavior;

(v) Adjustment~~adjustment~~ to trauma;

(vi) Regulatory~~regulatory~~;

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

(i) Supervision~~supervision~~;

(ii) Residential~~residential~~ stability;

(iii) Medical~~medical~~/physical;

(iv) Mental~~mental~~ health;

(v) Substance~~substance~~ use;

(vi) Developmental~~developmental~~;

(vii) Family~~family~~ stress;

(viii) Caregiver~~caregiver~~ post-traumatic stress reaction;

(ix) Marital~~marital~~/partner violence;

(x) Familyfamily relationship with the system;

(xi) Legallegal involvement;

(xii) Earlyearly childhood domain item developmental/intellectual;

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

(i) Sleepsleep;

(ii) Familyfamily functioning;

(iii) Earlyearly education;

(iv) Socialsocial and emotional functioning;

(v) Medicalmedical/physical;

(vi) Failurefailure to thrive;

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

(i) Aggressiveaggressive behaviors;

(ii) Atypicalatypical behaviors;

(iii) Self-harmself-harm;

(iv) Exploitedexploited;

(v) Problematicproblematic sexual behavior.

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

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

(a) The youth's needs do not meet the ICC or MCC recommendations; or

(b) The youth meets criteria for ICC or MCC but declines or does not consent 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 prior to providing~~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 engagement~~outreach~~ to the youth's family within two business days of receipt 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 will~~must~~ establish firewalls between its care coordination services and staff and the functions and staff of its other services;

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

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

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

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

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

(C) Care coordination activities.

(1) CMEs delivering ICC will:

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

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

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

~~(A)~~ (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 supplemental~~comprehensive~~ assessment; and

~~(B)~~ (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 with the youth if not already completed~~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)~~ (a) Develop and implement the initial child and family-centered care plan ~~within the thirty-calendar day period~~; and

~~(B)~~ (b) Review, and when appropriate, update, 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. When a youth and their caregiver is unable to participate in the review of the child and family-centered care plan within thirty calendar days, the child and family-centered care plan will be reviewed, and when appropriate, updated, within sixty calendar days.

~~(C)~~ (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~~

(i) Develop and implement the initial child and family-centered care plan within thirty calendar days of enrollment on the OhioRISE 1915(c) waiver; and

(ii) Review, and when appropriate, update, the child and family-centered care plan at least every thirty calendar days. If there is a significant change in the youth's needs or circumstances, the child and family-centered care plan will be reviewed and updated within fourteen calendar days of identifying a change in the youth's needs and circumstances; and

(iii) 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; and

(iv) Submit the child and family-centered care plan to the OhioRISE plan within one business day of completion and signature from the youth, caregiver, and OhioRISE waiver providers.

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

(a) For youth following an established individual crisis and safety plan previously created through another mechanism, the crisis and safety plan created by another mechanism will be reviewed to ensure it contains the required plan elements. If the plan includes required elements, it can be used as a preliminary OhioRISE crisis and safety plan and be updated during a child and family team meeting. If it does not meet the required plan elements, a new individual crisis and safety plan will be developed as soon as possible.

(b) For youth who are enrolled in the OhioRISE 1915(c) waiver, the individual crisis and safety plan will need to be completed within fourteen calendar days following enrollment in the OhioRISE 1915(c) waiver. The individual crisis and safety plan will be reviewed, and when appropriate, updated, at least every ninety calendar days.

(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 facility for behavioral health treatment or inpatient behavioral health treatment~~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 will~~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 upon completion~~within one business day of completion of the child and family-centered care plan~~.

(2) CMEs delivering MCC will:

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

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

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

~~(A)~~ (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 supplemental~~comprehensive~~ assessment; and

~~(B)~~ (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 with the youth if not already completed~~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)~~ (a) Develop and implement the initial child and family-centered care plan ~~within the thirty-calendar day period~~; and

~~(B)~~ (b) Review, and when appropriate, update, 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)~~ (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~~

(i) Develop and implement the initial child and family-centered care plan within thirty days of enrollment on the OhioRISE 1915(c) waiver; and

(ii) Review, and when appropriate, update, the child and family-centered care plan at least every thirty days. If there is a significant change in the youth's needs or circumstances, the child and family-centered care plan will be reviewed and updated within fourteen calendar days of identifying a change in the youth's needs and circumstances; and

(iii) 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; and

(iv) Submit the child and family-centered care plan to the OhioRISE plan within one business day of completion and signature from the youth, caregiver, and OhioRISE waiver providers.

(vi) Developing an individual crisis and safety plan as soon as possible ~~within fourteen calendar days of referral for MCC, for incorporation into the child and family-centered plan~~. For youth with behaviors that pose safety concerns for the youth or others, a licensed clinician working within

or for the CME will consult on the individual crisis and safety plan, recommend de-escalation strategies that can be learned and used by the youth, parents, other caregivers to support the youth and prevent the use of restrictive interventions, and approve of the crisis and safety plan prior to its submission to the OhioRISE plan;

(a) For youth following an established individual crisis and safety plan previously created through another mechanism, the crisis and safety plan created by another mechanism will be reviewed to ensure it contains the required plan elements. If the plan includes required elements, it will be used as a preliminary OhioRISE crisis and safety plan and be updated during a child and family team meeting. If it does not meet the required plan elements, a new individual crisis and safety plan will be developed as soon as possible.

(b) For youth who are enrolled in the OhioRISE 1915(c) waiver, the individual crisis and safety plan needs to be completed within fourteen calendar days following enrollment in the OhioRISE 1915(c) waiver. The individual crisis and safety plan will be reviewed, and when appropriate, updated, at least every ninety calendar days.

(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 facility for behavioral health treatment or inpatient behavioral health treatment~~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 will~~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 upon completion~~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 initial skill and competency-based training to provide ICC and MCC.

(3) ICC and MCC care coordinators will:

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

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

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

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

(iv) With ODM or its designee approval, partially meets years of experience in paragraph (D)(3)(a)(i), (D)(3)(a)(ii), or (D)(3)(a)(iii) of this rule and meets the following until experience requirements are met:

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

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

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

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

(i) Family systems;

(ii) Community systems and resources;

(iii) Case management;

(iv) Child and family counseling or therapy;

(v) Child protection; or

(vi) Child development.

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

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

(E) CME care coordinator supervisory qualifications.

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

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

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

(F) ICC and MCC staffing requirements.

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

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

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

(G) Care coordination documentation will include:

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

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

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

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

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

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

(H) Transition from ICC or MCC.

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

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

(I) Limitations.

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

(a) Transportation for the youth or family; and

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

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

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

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

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

(M) When a youth's OhioRISE eligibility is added for a month that has already passed, the established timeframes for CME activities in paragraph (B) of this rule and care coordination activities in paragraph (C) of this rule will be based on the date the CME receives the referral for care coordination of the youth from the OhioRISE plan.~~For the first ninety days from the effective date of this rule, the established timeframes for CME activities in paragraph (B) of this rule and care coordination activities in paragraph (C) of this rule will not be enforced.~~

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~~ 1/1/2024	~~1036.56~~ $1168.72
T2022	N/A	Moderate Care Coordination (MCC) - Monthly	Care Management Entity	~~7/1/2022~~ 1/1/2024	~~$414.44~~ $577.30

HCPCS CODE	MODIFIERS	DESCRIPTION	PRACTITIONER TYPE	EFFECTIVE DATE	CURRENT MAXIMUM
H2000	TG	Initial Supplemental ~~Comprehensive~~ Assessment - Per Encounter	Unlicensed Practitioner[1]	~~7/1/2022~~ 1/1/2024	~~$166.08~~ $187.26
H2000	TG		Licensed Practitioner[2]	~~7/1/2022~~ 1/1/2024	~~$185.46~~ $209.11
H2000	TG		Independent Practitioner[3]	~~7/1/2022~~ 1/1/2024	~~$191.54~~ $215.96
H2000	TG		PA, CNS, CNP[4]	~~7/1/2022~~ 1/1/2024	~~$364.58~~ $411.06
H2000	TG		Physician[5]	~~7/1/2022~~ 1/1/2024	~~$591.83~~ $667.29

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