Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

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Medicaid Clearance Letter

TO: All Clearance Reviewers

FROM: Ryver Penix, OhioRISE Policy & Program Development, Ohio Department of Medicaid

SUBJECT: Ohio resilience through integrated systems and excellence (OhioRISE) Rules

As a part of Ohio Medicaid's effort to launch the next generation of its managed care program, ODM will implement OhioRISE (Resilience through Integrated Systems and Excellence), a specialized managed care program for youth with complex behavioral health and multi-system needs. The OhioRISE Program will facilitate Ohio's goals by:

- Creating a seamless delivery system for children, families, and system partners;
- Providing a "locus of accountability" by offering intensive care coordination (ICC) and moderate care coordination (MCC) through regional care management entities (CMEs); and
- Expanding access to critical services needed by this population and assisting families, state and local child-serving agencies, and other health providers to locate and use necessary services.

The OhioRISE program will use a managed care prepaid inpatient health program (PIHP). The rules to be proposed (listed below) have been developed through the stakeholder process and are the policies related to the administration of the OhioRISE program. The new rules describe the components of the OhioRISE program and state applicable policies and requirements unique to the rule topic.

The following rules will be proposed for adoption to implement the OhioRISE program:

Rule 5160-59-02.1 "OhioRISE: first day eligibility and enrollment."
Rule 5160-59-03.5 "OhioRISE: wraparound supports."
Rule 5160-59-03.9 "OhioRISE: Reimbursement for OhioRISE exclusive services."
Rule 5160-59-04"OhioRISE home and community-based services waiver: eligibility and enrollment."
Rule 5160-59-05 "OhioRISE home and community-based services waiver: covered services and providers."
Rule 5160-59-05.1 "OhioRISE home and community-based services waiver: out-of-home respite."
Rule 5160-59-05.2 "OhioRISE home and community-based services waiver: transitional services and supports"
Rule 5160-59-05.3 "OhioRISE home and community-based services waiver: therapeutic mentoring."

Rule 5160-59-05.4 “OhioRISE home and community-based services waiver: therapeutic mentoring.”

The OhioRISE rules are planned to be effective on July 1, 2022. This is the second package of rules for the OhioRISE program to be posted for clearance.

Additional Information

Information about the services and programs of the Ohio Department of Medicaid (ODM) may be accessed through the main ODM web page, https://medicaid.ohio.gov/ . Information about the OhioRISE program is also available from the ODM web page, https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise .

Questions pertaining to this letter should be directed to the Ohio Department of Medicaid:

P.O. Box 182709
Columbus, OH 43218-2709
(800) 686-1516

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

(A) Scope. This rule sets forth the provisions for enrollment into Ohio resilience through integrated systems and excellence (OhioRISE) on the first day the program is effective. Individuals who 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. Individuals who meet criteria in paragraphs (B)(1) to (B)(4) of this rule will be enrolled in OhioRISE on the first day the program is in effect:

(1) Be twenty years of age or younger on the first day the program is in effect;

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

(3) Not be 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) Have prior receipt of one or more of the following behavioral health services:

(a) 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 rule 5160-59-03.6 of the Administrative Code, 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) 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.

(iii) Youth for whom an intermediate care facility for individuals with intellectual disabilities (ICFIID) is receiving the intensive behavioral support rate add-on as described in rule 5123-7-28 of the Administrative Code.

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

(i) Received therapeutic behavioral group services - hourly or per diem as defined in rule 5160-27-06 of the Administrative Code; or

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

(iii) 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 residential parenting facility as described in rule 5101:2-5-03 of the Administrative Code.

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

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5160-59-03.5 OhioRISE: wraparound supports.

(A) Scope. This rule sets forth provisions governing coverage for wraparound supports furnished as part of the Ohio resilience through integrated systems and excellence (OhioRISE) program.

(B) "Wraparound supports" are the 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 as defined in rule 5160-59-01 of the Administrative Code. Wraparound supports 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.

(C) Eligible providers and conditions of participation.

(1) The provider of wraparound supports will be one of the following:

(a) The OhioRISE plan; or
(b) A provider under contract with the OhioRISE plan to complete the purchase and reimbursement of wraparound supports authorized by the OhioRISE plan.

(2) With the exception of paragraph (B)(2)(c) 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.

(3) Providers will comply with incident reporting standards as outlined in rule 5160-44-05 of the Administrative Code, unless otherwise stated in paragraphs (C)(3)(a) to (C)(3)(b) of this rule.

(a) Providers will report all critical or reportable incidents, as defined in paragraphs (E) and (F) of rule 5160-44-05 of the Administrative Code, to the OhioRISE plan;

(b) Providers will take immediate action to ensure the health and welfare of the individual and complete any reporting as specified in paragraph (H)(2) of rule 5160-44-05 of the Administrative Code.

(D) Coverage.

(1) Authorization and coverage of wraparound supports 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) At least one of the following will be documented on the child and family-centered care plan as evidence of the necessity of wraparound supports to meet a youth's needs:

(a) The wraparound supports will decrease the need for other Ohio department of medicaid (ODM) services;

(b) The wraparound supports will promote the individual's inclusion in the community; or

(c) The wraparound supports will increase the individual's safety in the home environment.

(3) The care management entity (CME), as defined in rule 5160-59-01 of the Administrative Code, will assist the youth and their primary caregiver in determining how much of the participant-directed budget will

be used for the purchase of wraparound supports, while ensuring the least costly appropriate service, equipment, or supply is evaluated.

(4) The CME will document the recommendation for authorization of wraparound supports on the child and family-centered care plan.

(E) Limitations.

(1) The following items are excluded for wraparound support 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 type of 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 that are illegal or otherwise prohibited 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 wraparound supports is limited to one thousand five hundred dollars within three hundred sixty-five days.

(3) Authorization of wraparound supports by the OhioRISE plan will:

(a) Occur when the youth or their primary caregiver does not have the funds to purchase the services, equipment, or supplies;

(b) Occur when there is not another available funding source for the services, equipment, or supplies; and

(c) Follow the utilization management process established for the OhioRISE program in accordance with rule 5160-59-03.1 of the Administrative Code.

(4) Wraparound supports 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 wraparound supports provider is purchasing the item from an active ODM provider of like services.

(F) Service documentation for wraparound supports will include each of the following to validate payment for medicaid services.

(1) Documentation on the child and family-centered care plan indicating at least one of the concepts in paragraphs (D)(2)(a) through (D)(2)(c) will be addressed by authorizing wraparound supports;

(2) A written 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 wraparound supports.

(G) Payment.

(1) Reimbursement for wraparound supports is outlined in rule 5160-59-05.9 of the Administrative Code.

(2) If the provider of wraparound supports is contracted by the OhioRISE plan, the OhioRISE plan will reimburse the provider for the purchase of wraparound supports.

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5160-59-03.9 OhioRISE: Reimbursement for OhioRISE exclusive services.

(A) Medicaid rates for services described in rules 5160-59-03.2 and 5160-59-03.3 of the Administrative Code are listed in the appendix to this rule.

(B) Services that are reimbursable by a third-party payer are subject to the provisions of rule 5160-26-09.1 of the Administrative Code.

Appendix A

Fee Schedule for OhioRISE Care Coordination services provided on and after January 5, 2022

5160-59-03.2 OhioRISE: Care Coordination

Service	Provider Type	HCPCS Code	Payment Amount
Intensive Care Coordination (ICC) - Monthly	Care Management Entity	T2023	$1,036.56
Moderate Care Coordination (MCC) - Monthly	Care Management Entity	T2022	$414.44

Service	Practitioner Type	HCPCS Code	Payment Amount*
Initial Comprehensive Assessment - Per Encounter	Unlicensed Practitioner[1]	H2000	$166.08
	Licensed Practitioner[2]	H2000	$185.46
	Independent Practitioner[3]	H2000	$191.54
	PA, CNS, CNP[4]	H2000	$364.58
	Physician[5]	H2000	$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.

Appendix B
Fee schedule for IHBT provided on and after January 5, 2022

5160-59-03.3 OhioRISE: Intensive Home-Based Treatment (IHBT)

Service	Practitioner Type	HCPCS Code	Payment Amount*
Multisystemic Therapy For Juveniles (MST) - 15 minutes	Licensed Practitioner[1]	H2033	$41.10
	Independent Practitioner[2]	H2033	$42.24
Functional Family Therapy for Juveniles (FFT) - 15 minutes	Licensed Practitioner[1]	TBD	$34.05
	Independent Practitioner[2]	TBD	$34.98
IHBT (other than MST or FFT) - 15 minutes	Peer Recovery Supporter[3]	H2015	$27.51
	Unlicensed Practitioner[4]	H2015	$34.21
	Licensed Practitioner[1]	H2015	$37.57
	Independent Practitioner[2]	H2015	$38.60

1. Licensed practitioner has the same meaning as "supervised practitioner" as described in 5160-8-05
2. Includes licensed psychologists and independent practitioners as described in 5160-8-05
3. Peer recovery supporter as described in rule 5160-27-02
4. Includes unlicensed practitioners as described in 5160-27-01, except for peer recovery supporters

*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.

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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), an individual will be determined by the Ohio department of medicaid (ODM), or its designee, to meet all of the following requirements:

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

(2) Be determined to meet the following criteria for inpatient psychiatric (IP) services for individuals age twenty-one and under level of care (LOC):

(a) Have a child and adolescent needs and strengths (CANS) assessment, available on www.medicaid.ohio.gov (October 1, 2021), completed by a certified Ohio CANS assessor, indicating:

(*i*) Behavioral/emotional needs that require action to ensure that the identified need is addressed, and the need is interfering with functioning; or the need is dangerous or disabling and requires immediate or intensive action;

(*ii*) Risk behaviors require action to ensure that the identified need is addressed, and the need is interfering with functioning; or the need is dangerous or disabling and requires immediate or intensive action; and

(iii) Caregiver needs that require action to ensure that the identified need is addressed, and the need is interfering with functioning; or the need is dangerous or disabling and requires immediate or intensive action; or

(iv) There is no currently viable caregiver.

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

(c) Have documentation indicating a known risk factor regarding the following:

(*i*) Risk of custody relinquishment; and either

(*ii*) Risk of institutional placement in any of the following settings:

(*a*) A psychiatric residential treatment facility (PRTF) as defined in rule 5160-59-03 of the Administrative Code;

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

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

(*d*) Another acute care institution; or

(*iii*) Within the past six months prior to a LOC determination as described in paragraph (A)(2) of this rule had an admission to any of the settings described in paragraphs (A)(2)(c)(*ii*)(*a*) through (A)(2)(c)(*ii*)(*d*) of this rule.

(3) Have a completed IP LOC assessment according to the following:

(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 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) 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, and consent to the plan by signing and dating it.

(6) 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 5160-59-05.4 of the Administrative Code.

(7) Indicate in writing during the course of assessment, or in an alternative manner at the discretion of ODM, that the youth has been informed of all 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.

(8) While enrolled in the waiver, the individual will reside in a setting that possesses the home and community-based setting characteristics set forth in rule 5160-44-01 of the Administrative Code.

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

(10) Meet the following age criteria:

(a) Be between the ages of birth and twenty years 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 eligibility criteria set forth in paragraphs (A)(1) through (A)(9) of this rule.

(11) The individual 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) The youth will reside in an approved setting, as described in paragraph (A)(8) of this rule, prior to the first date of enrollment on the waiver.

(C) If, at any time, an individual does not meet any of the eligibility criteria set forth in paragraph (A) of this rule, the individual will be denied enrollment to, or disenrolled from, the waiver.

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

(1) Dependent on the 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 ninety calendar days following disenrollment from the OhioRISE program.

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

(F) 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 furnish those services to youth enrolled on the waiver.

(B) Providers seeking to furnish services in the waiver program will meet the criteria in Chapters 5160-59, 5160-44, and 5160-45 of the Administrative Code, as appropriate.

(C) Prior to a qualified waiver provider furnishing 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. 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;

(3) Therapeutic mentoring as set forth in rule 5160-59-05.3 of the Administrative Code; and

(4) Supplemental wraparound supports as set forth in rule 5160-59-05.4 of the Administrative Code.

(E) Supplemental wraparound supports service is subject to participant-direction through budget authority. To exercise this authority, a youth or their family will demonstrate the ability to participant-direct the supplemental wraparound supports service in accordance with rule 5160-59-05.4 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 furnished 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 furnished 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 that 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 defined in rule 5160-59-03.6 of the Administrative Code that is licensed by the Ohio department of mental health and addiction services (OMHAS) and holds the appropriate waiver certification with the Ohio department of medicaid (ODM).

(2) With the exception of paragraph (B)(2)(c) 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 comply with incident reporting standards as outlined in rule 5160-44-05 of the Administrative Code, unless otherwise stated in paragraphs (C)(3)(a) to (C)(3)(b) of this rule.

(a) Providers will report all critical or reportable incidents, as defined in paragraphs (E) and (F) of rule 5160-44-05 of the Administrative Code, to the OhioRISE plan;

(b) Providers will take immediate action to ensure the health and welfare of the individual and complete any reporting as specified in paragraph (H)(2) of rule 5160-44-05 of the Administrative Code.

(4) 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.

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

(6) 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) Payment may be made for the out-of-home respite service when rendered by a provider in accordance with paragraph (C) of this rule to a youth enrolled in the waiver program in accordance with rule 5160-59-04 of the Administrative Code.

(2) 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.

(3) Service delivery will occur outside of the youth's primary residence.

(4) 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.

(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 case manager or the OhioRISE plan is responsible for tracking and maintaining records for purposes of tracking out-of-home respite utilization within each three hundred sixty-five-day period.

(a) 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 case manager or the OhioRISE plan will coordinate with the youth's child and family care team to determine the need and recommendation for planned out-of-home respite service.

(b) Either the CME or the OhioRISE plan will document any recommended planned out-of-home respite services on the youth's child and family-centered care plan prior to receipt and payment of the service. Planned out-of-home respite will be authorized in accordance with the utilization management process set forth in rule 5160-59-03.1 of the Administrative Code.

(c) Either the CME or the OhioRISE plan will ensure emergency out-of-home respite services is documented on the youth's child and family-centered care plan prior to payment of the service.

(4) Payment 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.

(F) Service documentation for out-of-home respite will include each of the following to validate payment 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.

(G) Payment.

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

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

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

(4) The reimbursement rate for out-of-home respite is outlined in rule 5160-59-05.9 of the Administrative Code.

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 furnished 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 support youth and their families experiencing changes in circumstances or qualifying conditions. The service is intended to assist families with understanding, mitigating, and establishing connections to longer term solutions to address behavioral health challenges. TSS is used to support a youth and their family 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 agency provider holding certification with the Ohio department of mental health and addiction services (OMHAS) for the provision of behavioral health services in accordance with rule 5160-27-01 of the Administrative Code.

b. An agency provider holding certification for homemaker/personal care services.

c. An individual practitioner who meets criteria for payment of behavioral health services provided in non-institutional settings, as described in rule 5160-8-05 of the Administrative Code.

d. An individual practitioner holding certification for homemaker/personal care services.

(2) Providers who hold certification for homemaker/personal care services 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)(2)(c) 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 comply with incident reporting provisions as outlined in rule 5160-44-05 of the Administrative Code, unless otherwise stated in paragraphs (C)(4)(a) to (C)(4)(b) of this rule.

(a) Providers will report all critical or reportable incidents, as defined in paragraphs (E) and (F) of rule 5160-44-05 of the Administrative Code, to the OhioRISE plan;

(b) Providers will take immediate action to ensure the health and welfare of the individual and complete

any reporting as specified in paragraph (H)(2) of rule 5160-44-05 of the Administrative Code.

(5) 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.

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

(7) 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. Training the youth and family in behavior de-escalation techniques related to the youth's serious emotional disturbance diagnosis;

b. Implementing supports as identified by the care coordination and high-fidelity wraparound teams;

c. Working with the youth to identify triggers and developing person-centered approaches for preventing behavioral crisis prior to occurrence;

d. 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 for families regarding mitigation and support techniques for when crises occur;

b. Training for families to understand and implement positive coping strategies to directly address crisis or escalation of risk behaviors;

c. Acting as a conduit between the family and waiver enrolled youth and the high-fidelity wraparound team or the OhioRISE Plan and the care management entity (CME) to assist in system navigation;

d. Assistance to the waiver enrolled individual with engagement in the broader community; and

e. Assistance with coping skills both in home and community settings for the waiver enrolled youth and the family.

(3) Other activities which may be considered as permissible tangential activities allowable under the TSS service may only be provided if approved by the OhioRISE plan prior to a provider rendering and receiving payment 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 two to one staffing is authorized by the OhioRISE plan and documented by the CME on the child and family-centered care plan.

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

E. Limitations.

(1) TSS is only authorized 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 rule 5160-59-03.6 of the Administrative Code;

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 in effect as of August 16, 2010;

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. When the youth is transitioning between foster care settings; 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)(1)(a)(i) through (E)(1)(a)(iv) of this rule.

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

(3) 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.

(4) TSS is authorized for an initial seventy-two hours, or until other appropriate behavioral health services provided under the OhioRISE plan are scheduled to begin, whichever occurs first. When transitional services and supports is needed beyond a seventy-two-hour period a request for prior authorization will need to be submitted.

(5) Payment for TSS will not duplicate payment for other OhioRISE covered services.

F. Service documentation for TSS will include each of the following to validate payment 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.

G. The reimbursement rate for TSS is outlined in rule 5160-59-05.9 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-59-05.3 OhioRISE home and community-based services waiver: therapeutic mentoring.

(A) Scope. This rule sets forth provisions governing coverage for therapeutic mentoring furnished 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) "Family" includes biological and/or foster parents, adoptive parents, and a "unit" of individuals uniquely identified by the youth.

(2) "Lived experience" is defined as the personal knowledge about youth with multi-system needs gained through direct, first-hand involvement in everyday events.

(3) "Natural supports" has the same meaning as set forth in rule 5160-59-01 of the Administrative Code.

(4) "Therapeutic mentoring" is a service intended to assist youth enrolled in the waiver program and their families by providing supports to enable them to function to the highest degree within their family unit and their community.

(C) Eligible providers and conditions of participation.

(1) The following providers are eligible to provision therapeutic mentoring under the waiver program:

(a) An agency provider holding certification with the Ohio department of mental health and addiction services (OMHAS) for the provision of behavioral health services in accordance with rule 5160-27-01 of the Administrative Code.

(b) An individual practitioner holding licensure for the provision of behavioral health services in accordance with rule 5160-8-05 of the Administrative Code.

(c) Natural supports with lived experience.

(2) With the exception of paragraph (B)(2)(c) 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 comply with incident reporting provisions as outlined in rule 5160-44-05 of the Administrative Code, unless otherwise stated in paragraphs (C)(3)(a) to C(3)(b) of this rule, as follows:

(a) Providers will report all critical or reportable incidents, as defined in paragraphs (E) and (F) of rule 5160-44-05 of the Administrative Code, to the OhioRISE plan;

(b) Providers will take immediate action to ensure the health and welfare of the individual and complete any reporting as specified in paragraph (H)(2) of rule 5160-44-05 of the Administrative Code.

(4) Providers will obtain and maintain first aid certification from instruction which includes hands-on training by a certified first aid instructor. At its discretion, the Ohio department of medicaid (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 the conditions of their licensure or certification in

addition to ongoing monitoring conducted by the OhioRISE plan.

(D) Coverage.

(1) Therapeutic mentoring is developed in accordance with high-fidelity wraparound processes for service plan development and with consideration of trauma-informed practices.

(2) Therapeutic mentoring may include, but is not limited to, the following:

(a) Assisting families and the enrolled youth with identifying community-supports, including families and other youth with similar lived experiences, to build connections and build a network of peer support services;

(b) Providing resources to families and the enrolled youth to educate, train, and inform on available services through community resources to address needs and issues in the home environment; and

(c) Providing advocacy building techniques for families and enrolled individuals.

(3) Other activities which may be considered as permissible tangential activities allowable under the therapeutic mentoring service may only be provided if approved by the OhioRISE plan and documented on the child and family-centered care plan by the care management entity (CME), as defined in rule 5160-59-01 of the Administrative Code, prior to a provider rendering and receiving payment for the service.

(E) Limitations.

(1) Payment will be made for therapeutic mentoring when rendered by an eligible provider in accordance with paragraph (C) of this rule to a youth enrolled in the waiver program in accordance with rule 5160-59-04 of the Administrative Code.

(2) Therapeutic mentoring 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) Therapeutic mentoring will be authorized in accordance with the utilization management process as set forth in rule 5160-59-03.1 of the Administrative Code and provided only to a youth enrolled on the waiver at the time-of-service delivery.

(F) Service documentation for therapeutic mentoring will include each of the following to validate payment 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 identification;

(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) The reimbursement rate for therapeutic mentoring is outlined in rule 5160-59-05.9 of the Administrative Code.

DRAFT - NOT FOR FILING

5160-59-05.4 OhioRISE home and community-based services waiver: supplemental wraparound supports.

(A) Scope. This rule sets forth provisions governing coverage for supplemental wraparound supports furnished 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) "Budget authority" has the same meaning as in rule 5160-59-03.5 of the Administrative Code.

(2) "Emergency funds" are an additional allotment of waiver funding used for the purchase of authorized supplemental wraparound supports based on a youth's unmet needs as determined by the OhioRISE plan as defined in rule 5160-59-01 of the Administrative Code.

(3) "Participant-directed budget" is the maximum, non-emergency funding, allowable for the purchase of supplemental wraparound supports under the OhioRISE 1915(c) waiver.

(4) "Supplemental wraparound supports" 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 as defined in rule 5160-59-01 of the Administrative Code. Wraparound supports are intended to enhance and supplement the array of services available to a youth enrolled on the OhioRISE program and are discussed, authorized, and implemented through the care coordination process as described in rule 5160-59-03.2 of the Administrative Code. Supplemental wraparound supports 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 supplemental wraparound supports provided under the waiver.

(D) The following additional criteria apply to supplemental wraparound supports provided under the waiver:

(1) The total participant-directed budget for supplemental wraparound supports 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 supplemental wraparound supports when all wraparound supports 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 wraparound supports as described in 5160-59-03.5 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

supplemental wraparound supports.

(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) Supplemental wraparound supports service is additive to the wraparound supports described in rule 5160-59-03.5 of the Administrative Code.