OhioRISE Rule Packages 1 and 2 - Record of Clearance Comments and Responses to Authors

Commenter	Rule Number	Comment	Response to Author
		MRSS-RELATED RULES - OhioMHAS and ODM	
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	Although all activities included are to be offered "as applicable or needed" during the Mobile Response, are they also permitted during Stabilization even if not listed in that part of the rule?	Yes.
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	As the MRSS Practice Standards have not been available for review, we have concerns about their content and expectations and the lack of an opportunity to respond in conjunction with our current input.	The MRSS practice manual is available here: https://wraparoundohio.org/wp-content/uploads/2021/09/MRSS-Practice-Manual-Final-Draft-September-3-2021-1.pdf
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	By OHMHAS rules, "consultation" is not permitted with the client. It is only permitted with others. We request clarification of the word "consultation" in this paragraph.	This MRSS rule specifically allows consultation with the young person or family.
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	In this description of MRSS, it is stated that MRSS is a "structured face-to-face intervention." In paragraph E, it states that the provider must "be able to provide all allowable services by telehealth." For this reason, we recommend that it be clarified in paragraph A that services provided by telehealth are considered "face-to-face" services.	OhioMHAS is updating the telehealth rule to include MRSS and added additional details about delivering MRSS using a telehealth modality in paragraph (C).
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	This paragraph implies that referrals and information sharing may only be done in the presence of the youth or family. We recommend that this paragraph be modified to state that referrals may be made without the youth and/or family present, if needed.	The rule was updated to indicate that referrals and sharing of information should occur with the young person or family present when possible.
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	This section states that "If a young person or family is already involved with an intensive home-based service (i.e., IHBT, wraparound) the mobile response team is dispatched to de-escalate the presenting crisis. Once the family is stabilized, the family is re-connected with the existing service." However, the Medicaid rule indicates that stabilization services provided by a service other than IHBT won't be paid for. We request clarification of this section to clearly state which services the MRSS team can bill.	Mobile response services (up to 72 hours) are allowable for individuals receiving IHBT. Stabilization services are not allowable for individuals receiving IHBT.

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Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	We agree that any agency that offers MRSS should have a continuum of services available to the youth and families they serve. However, the requirement for peer certification may not be applicable if the peers are employed by other non-profit, non-mental health provider agencies. We ask that you clarify the goal of this section and the intent of the requirements, as well as the specific requirements for peer services to be billed.	The goal/intent is to for the certified agency to have staff and service competencies to support the MRSS service. Medicaid payment is allowable for MRSS services rendered by peer supporters affiliated with a MRSS provider. The MRSS provider will bill using the MRSS billing codes stated in OAC rule 5160-27-03 Appendix A.
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	We note that the responsibilities of a local crisis line that receives a request for assistance are not addressed in this section.	Correct. This rule applies to the service of MRSS, not a referral/dispatch source such as a local crisis line.
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	We recommend that a non-clinician be permitted to respond to the initial call if determined to be appropriate based on the initial triage assessment and the needs of the youth/family.	(N)(2) requires a practitioner identified in (G)(1)(a) only if they are responding alone (one person response). If more than one team member is responding, then a non-clinician may respond.
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	We recommend that the "discharge plan" be referred to as a "transition plan."	The rule was updated to make this change in terms.
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	We recommend that the age limit be consistent with the current model and with the draft Medicaid rule which allows services to young adults up to the age of 22 years.	The age requirement of up to 21 is consistent with the ODM rule.
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	We recommend that the rule clarify that the 24/7 response be made by a qualified individual who has been trained in MRSS. This will allow agencies to utilize professionals from other programs (i.e. Mobile Crisis Teams) to respond if needed. Workforce and resource issues at the local level necessitate this flexibility in the rule.	Qualified individuals from other programs can provide MRSS.

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Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	We recommend that the rule reflect the use of trauma responsive language such as "soothing plans" rather than crisis plans. We would also be satisfied with the term "Individualized MRSS Plan." The use of "crisis" also does not reflect the shift from mobile crisis to a more family-driven response that is the goal of MRSS. If "crisis plans" remains, we request clarification of the definition and/or rule to be used (i.e., Crisis Intervention Service Rule).	The rule was updated to use the term "individualized MRSS plan".
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	We recommend that the stated requirement to respond within 60 minutes of a request for services be modified to state that a caregiver or youth may request a response time that is greater than 60 minutes, based on their situation and/or needs of their family.	Paragraph (C) was amended to allow for initial mobile response longer than 60 minutes when requested by the child or family.
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	We recommend that the word "continued" be removed from this sentence, as it implies ongoing involvement of the MRSS team.	The rule was updated by removing the word "Continued".
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	We recommend that this be modified to state "Telephonic psychiatric consultation initiated when indicated."	The rule was updated based on this suggestion.
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	We request clarification of the "Care Coordination" service as included for MRSS. Are MRSS providers required to meet the requirements of 5160-59-03.2? If not, we recommend that the wording be changed from "Care Coordination" to "Care Management."	Rule language has been clarified and care coordination is no longer used.

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Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	We respectfully request that the concerns expressed in this memo be addressed before the rule is finalized. The boards and providers listed have been in the process of implementing, evolving and fine-tuning MRSS services for almost four years, and have gained much experience and learned many lessons during that time. We all believe in the viability of MRSS services and the positive impact on youth and families, and we want to assure that the statewide implementation of this service as part of OhioRISE is based on sound, effective and achievable rules, standards and rates. Overarching concerns: - Although the MRSS model is designed to serve any family requesting support for a situation they identify as needing immediate intervention, the rule continues to focus on "crisis." In fact, the word "crisis" is used 20 times in four pages. The lack of flexibility in team composition and staff response creates requirements that do not allow agencies to respond in alternate ways that are more efficient and maximize resources. It also does not reflect the current need to offer services in non-traditional ways in the midst of a significant workforce shortage and does not allow the needs and preferences of the community to drive the appropriate response.	OhioMHAS made a number of changes to the draft rule in response to public input and comments. As with any rule, we will continue to monitor the rule requirements and make adjustments or changes when needed.
Nationwide Children's Hospital	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	"All calls with a young person or family in crisis where 911 is not indicate, are responded to a with a mobile response"- currently we are called often by parents when the child is not home. Are we required to go to the home if the person in crisis is not in the home? Is the expectation that the team could wait until the child is home or perhaps go to where the child is i.e. school, or does the parent make the decision?	During the screening and triage process, the MRSS team will work with the caller to determine the appropriate initial mobile response location.
Nationwide Children's Hospital	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	Allowing the clinical team to triage down the initial call to telehealth if the family is amenable. For example if a family calls about truancy and we feel and family agreeable to a telehealth appointment since the matter is not imminent regarding safety. A concern is that we will send licensed staff to non-imminent/non-safety issues and not be able to meet with needs of additional callers as we anticipate several thousands of calls annually.	OhioMHAS is updating the telehealth rule to include MRSS and added additional details about delivering MRSS using a telehealth modality in paragraph (C).
Nationwide Children's Hospital	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	I have heard some organizations planning to use this as a step down from emergency departments i.e. child goes to emergency dep vs calling MRSS team and the ER refers them to ABC organization and ABC organization sends their MRSS team as the follow up care. If that is permissible, how do you bill that given you did not do the initial mobile response? can you bill for follow up de-escalation?	MRSS is not a step down from ED care but there may be instances where the family has a precipitating crisis close to the ER discharge where MRSS is requested.
Nationwide Children's Hospital	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	If police (911) are dispatched (situation too dangerous to send clinician), is the expectation stay engaged for follow up stabilization?	No. If no initial mobile response is provided MRSS hasn't occurred. If the family would contact the MRSS team subsequent to the 911 experience, then an initial mobile response would be expected. This would be considered triage follow-up.

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Nationwide Children's Hospital	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	If we are required to respond to adults 18-20 and the person calls from their university dorm room for example, is the MRSS team responsible to navigate university and college parking/entering of premises with unknown environmental factors/risks?	Yes. MRSS is founded in the child or family defining the crisis and being able to seek and receive the service in the setting of their choosing.
Nationwide Children's Hospital	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	Rule states that we cannot require a family to present a static location during the stabilization period. If the MRSS clinical team feels as though family has returned to pre-crisis functioning and therefore stable enough for transition in care, but the family still wants services in the home, is the MRSS team required to respond via mobile for the duration of the 6 weeks?	The stabilization period will vary based on the unique circumstances of the child and their family. The MRSS team is not required to provide six weeks of stabilization services for every child and their family. The MRSS team needs to provide services using the modality or modalities selected by the family (in-home, mobile, in-community) during the stabilization period.
Nationwide Children's Hospital	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	The current draft of MRSS code (5122-29-14) indicates MRSS is provided to all people who are under the age of 21. Except when a law enforcement response is indicated, this will include a wide array of clinical presentations, living arrangements, service locations, multi-system involvement, etc. As existing behavioral health systems and rules require separate care pathways for youth under 18, this will pose significant challenges to potential MRSS providers with expertise in and treatment for child and adolescent behavioral health. In addition to different regulations surrounding consent and confidentiality, there are different models of care for key community based services. MST only serves 12-17; FFT only serves 11-18; Ohio IHBT model serves under 18. As a result, potential MRSS providers with IHBT servicers will be unable to provide handoffs to their corresponding IHBT teams the 18-20 year old population. Education and criminal justice are likewise vastly different for many individuals over 17 years of age, furthering challenges to implementing the a successful MRSS program in Ohio. Limiting the MRSS eligible population to under 18, and 18-20 for those with an intellectual or developmental disability, will allow child and adolescent providers and systems to better focus their efforts and ensure smoother transitions of care for Ohio's children and adolescents.	While we understand there may be unique challenges for the 18-20 population, OhioMHAS has established the age criteria of under 21 for both MRSS and IHBT. This age group also aligns with the OhioRISE program eligibility criteria, which creates consistency across programs and services.
Nationwide Children's Hospital	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	The rules appear to indicate the initial call must be followed with a mobile response. Does this mean that subsequent de-escalation visits in the first 72 hours could be telehealth if the family is amenable? (we are not attempting to avoid the mobile aspect, but feel as though we could serve more youth if technology is allowable when clinically indicated given the efficacy that telehealth has shown in comparison to physical face to face).	The MRSS model is founded on traditional in-person face-to-face crisis response. The decision on alternative delivery modalities, such as telehealth, would ultimately be up to the youth and family.

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Nationwide Children's Hospital	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	What is the MRSS team to do if we no longer have staff to send to a new caller in the required 60 minutes (due to volume of deployment)?	Triage the call and respond as soon as possible. Additionally, please reference paragraph (C) for a telehealth option. OhioMHAS is updating the telehealth rule to include MRSS and added additional details about delivering MRSS using a telehealth modality in paragraph (C).
The Ohio Council of Behavioral Health & Family Services Providers	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	In (D), it is curious to see that MRSS does not require certification in crisis intervention services. Can you provide the rationale for this omission?	Crisis services provided by the MRSS team staff defined in paragraph (G) of this rule are covered under the OhioMHAS general services service, therapeutic behavioral services, and psychosocial rehabilitation services.
The Ohio Council of Behavioral Health & Family Services Providers	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	The most significant barrier community BH providers are identifying is the requirement for 24/7 MRSS provider availability in (I)(2) as a separate and distinct MRSS response. Most provider organizations offering MRSS also provide traditional crisis teams or adult mobile response teams. The ability to staff multiple teams using a firehouse model is concerning –and we anticipate few MRSS calls for youth between the hours of midnight – 6AM. Typical call patterns demonstrate youth MRSS calls cluster before school, after school, and around bedtime with very few occurring between mid-night and 6AM. We urge reconsideration to support blended or cross coverage between MRSS and traditional crisis teams during those hours. Absent this, we fear this will be a barrier that prevents statewide adoption of MRSS due to staff shortages.	The rule was updated to allow providers one year from the date of initial MRSS certification to attain the 24/7 availability requirement.
The Ohio Council of Behavioral Health & Family Services Providers	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	The MRSS Mobile response timeline of 60 minutes discussed in (C) and (I)(3) remains a concern. Practically, this timeframe may not be feasible for providers depending on geographic location, time of day, weather, traffic, staffing patterns, and volume of requests. In more rural areas, we anticipate on MRSS team may cover multiple counties. This simply will become a barrier for delivering care. Additionally, it remains unclear when the "clock starts", who defines when the clock starts, what happens if the provider arrives at 62 minutes, and how this will be validated or audited. If the provider arrives for the mobile response at minute 62, will that result in a payment denial for the entire 72 hour Mobile response episode? Further, the rule lacks any language about how telehealth may be efficiently used, how the decision to deploy telehealth is determined, or how the youth or family is engaged in this decision and by who – the triage screener or the mobile response provider. We strongly recommend more flexibility to adjust for these unknown variables and to offer more clarifications on the "counting" if this is to remain. If MHAS and ODM want to continue to support a 60 minute response, we recommend this become a monthly team average response time rather than a per client response time. Or, if the intent is to retain a per client response time, extend the time to 90 minutes.	OhioMHAS will be maintaining the 60 minute mobile response requirement, which is a key tenant of the MRSS model. In response to stakeholder feedback, OhioMHAS added MRSS to the telehealth rule to help accommodate meeting the 60 minute mobile response time requirement.

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The Ohio Council of Behavioral Health & Family Services Providers	**5122-29-14:** Mobile Response and Stabilization Service (OhioMHAS rule)	With regarding to the initiation of stabilization services described in (J)(3)(a), several practical application questions have been raised that need further clarification. First, can the youth and family opt-out of stabilization services and how will the provider document this family choice? Second, the language indicates stabilization services must "immediately follow the 72-hour mobile response" so how will that be defined operationally. Does it mean a stabilization service must be provided the next day? Within 3 days? As defined by the family in the crisis plan? And finally, what happens if a crisis re-emerges within the six-week window following a mobile response, but either the family opted out of stabilization or disenrolled from stabilization. Will the triage and mobile response be provided and compensated as a "new" episode of mobile response within that six-week window? Finally, how will services be coordinated, if at all, when a youth or family present at an emergency room, detention center, or other similar locations?	As with any service, the MRSS service may be declined at any time. When 'counting' the time, the mobile response starts the 'clock.' 72-hour mobile response starts when the team arrives and the stabilization services start after the 72-hour mobile response period. Stabilization services need to be provided in accordance with the individualized crisis plan. If a crisis re-emerges/re-occurs or a new one occurs, then the process starts over with the initial mobile response.
Cincinnati Children's Hospital Medical Center	**5160-27-13**: Mobile Response and Stabilization Service (ODM rule)	Concerns about this wording as it seems MRSS would not be covered if child is enrolled in IHBT, but in OhioMHAS MRSS (J)(1)(c) it states MRSS can be dispatched to de-escalate the presenting crisis and then re-connected with existing services.	This section of the rule refers to the 'stabilization services' portion of MRSS, not mobile response. Mobile response is allowable for child enrolled in IHBT; after the mobile response period (up to 72 hours), the youth will be transitioned back to the IHBT team from whom they are already receiving services, or other services, as determined appropriate for that youth and family.
Cincinnati Children's Hospital Medical Center	**5160-27-13**: Mobile Response and Stabilization Service (ODM rule)	If as a provider I notify ODM that stabilization services are started, what will the ODM designated entity do with that information? Will someone at the designated entity be looking at all of these to insure they are appropriate (approve/deny; or just track)?	The rule was updated to clarify notification requirements. Upon notification, MCOs or the OhioRISE plan will assist in coordination and transition to appropriate services.
Cincinnati Children's Hospital Medical Center	**5160-27-13**: Mobile Response and Stabilization Service (ODM rule)	Is it possible to close the case prior to six weeks for MRSS or is the MRSS provider absolutely required to keep the case open for the entire six weeks.	Transition from MRSS to other services should occur as soon as appropriate based on the youth's unique needs. OAC rule 5122-29-14 describes expectations related to service transition.
Cincinnati Children's Hospital Medical Center	**5160-27-13**: Mobile Response and Stabilization Service (ODM rule)	Similar to comment above about IHBT and MRSS - what will be the mechanism for identifying pts are enrolled in ACT, and will those patients have access to 24/7 emergency services through MRSS	MRSS mobile response will be available to youth up to age 21. If the youth is receiving services from an ACT team, the MRSS provider will, after the mobile response, transition services to the existing ACT provider as appropriate.
Cincinnati Children's Hospital Medical Center	**5160-27-13**: Mobile Response and Stabilization Service (ODM rule)	While it makes sense that you would not pay for MRSS if child is in inpatient, it might make sense to continue MRSS while child is beginning IHBT for transition. Perhaps there could be a seven day overlap that would be allowable? It is also possible that MRSS and ACT at the same time might also be beneficial.	The MRSS team is expected to work with the youth and family and coordinate with other providers to determine the appropriate time for transition to other services during the stabilization period. Once enrolled in IHBT (or ACT), which is a comprehensive service, MRSS stabilization services are no longer reimbursable.

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Ohio Association of County Behavioral Health Authorities	**5160-27-13**: Mobile Response and Stabilization Service (ODM rule)	The MRSS rule in development by the Department of Medicaid includes several references to the OhioMHAS service rule proposed as OAC 5122-29-14. There are a handful of unresolved questions and concerns about the proposed service rule that would impact the ODM proposed rule. For instance, it would be difficult for many organizations to meet the requirement to have MRSS available 24/7 due to the behavioral health workforce shortage. The lack of human resources, coupled with the current pay structure, would make it challenging for organizations to have someone on call 24/7 specifically to respond to MRSS needs. It would be beneficial to consider allowing cross-training of the on-call staff so that they may be equipped and able to serve as the 24/7 on-call staff for MRSS and other services, with a strategy for seamless connections to the teams delivering the care. This would allow community organizations the opportunity to have more flexibility in staffing multiple 24/7 requirements. We also have concerns about the mandate requiring that the initial mobile response include a licensed team member. This is challenging for communities who may only have one MRSS team and limited capacity. These communities may instead deploy peers or paraprofessionals to serve as the first responders, should the licensed clinician be unavailable. If a more formal response is needed, the team member may contact a clinical staff member.	These comments are related to MHAS rule 5122-29-14. Please see responses associated with that rule. ODM worked closely with MHAS to develop Medicaid coverage and reimbursement policy to align with the MRSS model described in rule 5122-29-14.

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		IHBT-RELATED RULES - OhioMHAS and ODM	
The Ohio Council of Behavioral Health & Family Services Providers	**5122-29-28:** Intensive Home-Based Treatment (OhioMHAS rule)	Currently, the rule speaks to the immediate availability of 24/7 crisis response in (C)(5) and the implementation of a crisis safety plan in (C)(6). While the goal of the service is to prevent movement to higher levels of care there will be times where inpatient hospitalization or out-of-home crisis stabilization may be clinically indicated. Given the ODM rule prohibits payment for MRSS service or portions thereof, additional consideration may be necessary to address access to inpatient hospitalization or temporary placement in a crisis stabilization program outside the home. This level of crisis/risk assessment and placement may or may not be within the scope or designation of the IHBT team and should not delay access to needed care or create unnecessary barriers. Additional clarification is needed in either this rule and/or the ODM rule on crisis assessment access.	Medicaid reimbursement is allowable for IHBT activities that are consistent with MHAS rule 5122-29-28, including crisis risk assessment. If hospitalization is necessary, IHBT services will be paused while the youth is stabilized in the hospital setting, and Medicaid will cover the hospitalization service followed by a transition back to IHBT services upon discharge when clinically indicated.
The Ohio Council of Behavioral Health & Family Services Providers	**5122-29-28:** Intensive Home-Based Treatment (OhioMHAS rule)	Additionally, in (D)(1) it appears that the child/youth must meet all the elements defined in (a)-(d); however (d) is drafted as optional. This is confusing. Given the population being served, it seems that involvement in services with at least one other child-serving system would be required. Recommend removing the word “may” in (D)(1)(d) or moving this element for possible multi-system involvement under (D)(2).	The rule was updated to clarify IHBT eligibility criteria.
The Ohio Council of Behavioral Health & Family Services Providers	**5122-29-28:** Intensive Home-Based Treatment (OhioMHAS rule)	Based on previous discussions the intent was to generally maintain the current approach for IHBT eligibility with some changes. However, in (D)(1) it appears much of the specific descriptions related to functional impairments and risk/safety concerns that exist in the current ODM rule (and historically an earlier version of the MHAS rule) have been removed and replaced with general terms such as “marked or severe emotional/behavior” or “impairments that seriously disrupt family or interpersonal relationships”. While we appreciate the reliance on the CANS, we are concerned that without more specificity this may result in either inappropriate placements or conflicts about the applicability and efficacy of IHBT. We would recommend retaining some specific language as exists in the rule structures today.	The rule was updated to clarify IHBT eligibility criteria.
The Ohio Council of Behavioral Health & Family Services Providers	**5122-29-28:** Intensive Home-Based Treatment (OhioMHAS rule)	The proposed caseload sizes in (C)(4) are intended to support the availability of intensive services, but further study may be necessary to determine if this reduction is feasible given the workforce shortages and challenges in recruiting and retaining staff for home-based services. We would not want this change to create new barriers or exacerbate existing workforce challenges.	The staff to patient ratios required for this service intended to support intensive individualized care.

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The Ohio Council of Behavioral Health & Family Services Providers	**5122-29-28:** Intensive Home-Based Treatment (OhioMHAS rule)	We appreciate the descriptions of the various team composition models in (K). It would be useful to carry over the minimum team composition definition of 2 practitioners in (K)(1) for consistency and clarity with (E)(1).	No change made. (E)(1) describes the team while (K)(1) describes who can provide.
The Ohio Council of Behavioral Health & Family Services Providers	**5122-29-28:** Intensive Home-Based Treatment (OhioMHAS rule)	We specifically appreciate that documentation requirements are aligned with 5122-27-03 rather than 5160-8-05 in (C)(1). This is a welcome change that reduces regulatory burden and offers more flexibility to support intensive and frequent interventions.	Thank you for your feedback on the change.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-27-05:** Intensive Home Based Treatment (pre-OhioRISE ODM rule)	While we understand IHBT is a comprehensive and integrated service delivery model, we would like to point to some continuing concerns with the list of services in (D)(2) that may not be provided concurrently that create challenges for some youth and families. a. Given the regularity with which the CANS will likely be administered with this population, we encourage ODM to make some exceptions in (D)(2)(a) to permit coverage for completing the CANS tool. b. Mental health nursing services are currently covered under TBS and PSR, so as drafted youth will not be eligible to receive any MH specific nursing services even though psychiatric/medical services are not part of the defined comprehensive service in 5122-29-28 (B). We recognize that the current coding and payment structure for MH nursing falls under these broader service categories of TBS and PSR. We strongly recommend adding language to (D)(2)(c) and (d) that would make an exception for nursing care. c. Similarly, it is common for a school to have a dedicated partnership with a provider for integrated behavioral health/education programs where the mental health provider is billing the MCO/Fee-for-service program for TBS – Group Per Diem services (aka Day Treatment). For these youth, it is unwise to disrupt the integrated BH/school program because the family is also enrolling in IHBT. Schools with these established programs are unlikely to allow the IHBT provider to be in the school program and the BH provider should not be financially penalized because the youth's needs are significant, complex and interfering with functioning in multiple settings. From a workforce perspective, this type of duplication is unnecessary. OhioRISE is intended to support the level of care coordination to support collaboration and success in both school and home with the available providers delivering appropriate care in both locations. Again, because of the policy decision to cover "day treatment" under TBS, it can create an appearance of duplication, yet these are distinct and separate services intended to support the youth in being successful at school and at home. Families should not be placed in the position of having to choose one or the other. We strongly recommend allowing TBS Group & Per Diem to be allowed when offered in a school setting. d. As discussed in comment 3 above, additional clarification is needed regarding the (D)(2)(h) as it relates to crisis stabilization. Specifically, when a youth requires crisis/risk assessment for hospitalization or out-of-home crisis stabilization, will ODM cover mobile crisis services as defined in 5122-29-14 as well as crisis intervention services provided under 5122-29-10. Given the current variation in crisis service access and risk assessment, we strongly recommend allowing both mobile crisis and crisis intervention services to support access to higher levels of care when clinically indicated.	a. The rule was updated to clarify that a separate Medicaid payment is allowable for CANS assessments completed in accordance with 5160-59-03.2. b. The rule was updated to clarify that a separate Medicaid payment may be made for additional services, with prior authorization to determine medical necessity and ensure services are not duplicated with IHBT. c. The rule was updated to clarify that a separate Medicaid payment may be made when services such as group therapy, therapeutic behavioral group services, or SUD case management are prior authorized. d. ODM adopted the enhanced IHBT service prior to MRSS. Policy related to coverage of MRSS when an individual is enrolled in IHBT will be addressed in the MRSS rule. ODM intends to allow separate payment for mobile response, but not stabilization services, when a youth is receiving IHBT.

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The Ohio Council of Behavioral Health & Family Services Providers	**5160-27-05:** Intensive Home Based Treatment (pre-OhioRISE ODM rule)	ODM has indicated that MH IBHT will only be available to individuals under the OhioRISE program. However, the rule doesn't contain this limitation which will create confusion. Clarification is needed if the rule is to remain in Chapter 5160-27.	Medicaid-enrolled youth who meet the criteria to receive IHBT will also meet the criteria to be enrolled in OhioRISE when that program begins. Following the start of OhioRISE, IHBT will be provided through the OhioRISE plan. ODM is moving the IHBT rule to the new OhioRISE Chapter in OAC 5160-59 once that program begins; however, since the enhanced IHBT rule is being adopted prior to the start of OhioRISE, the rule will remain in 5160-27 until OhioRISE begins.
Cincinnati Children's Hospital Medical Center	**5160-59-03.3:** Intensive Home-Based Treatment (post-OhioRISE ODM rule)	A child who is in IHBT might also benefit from some of these other services especially group therapy. Saying IHBT is the only service that can be provided seems very limiting.	The rule was updated to clarify that a separate Medicaid payment may be made when services such as group therapy, therapeutic behavioral group or SUD case management are prior authorized.
Cincinnati Children's Hospital Medical Center	**5160-59-03.3:** Intensive Home-Based Treatment (post-OhioRISE ODM rule)	Clarify if animal based therapies are excluded/included	The rule was updated to clarify that animal therapies may be used if they are incorporated into the IHBT treatment modality in accordance with the appropriate evidence-based model.
Cincinnati Children's Hospital Medical Center	**5160-59-03.3:** Intensive Home-Based Treatment (post-OhioRISE ODM rule)	Clarify that if a kid is receiving IHBT, the therapist will not be reimbursed for any assessments except the CANS? Is this because those additional assessments would be covered by the payment for the time it takes to complete them in the home?	IHBT providers will be reimbursed for all components of IHBT (including assessments) using the new IHBT rates and CANS will also be billable separately. Rule language has been updated to clarify.
Cincinnati Children's Hospital Medical Center	**5160-59-03.3:** Intensive Home-Based Treatment (post-OhioRISE ODM rule)	Concerns about this wording - there may be children who benefit from IHBT to address significant BH concerns in the home, but would also benefit from a group treatment approach to practice application of skills with peers - are there opportunities to allow for multiple treatment modalities if not duplicative?	The rule was updated to clarify that a separate Medicaid payment may be made when services such as group therapy, therapeutic behavioral group or SUD case management are prior authorized.
Cincinnati Children's Hospital Medical Center	**5160-59-03.3:** Intensive Home-Based Treatment (post-OhioRISE ODM rule)	Is there a separate mechanism to pay for these academic related interventions for children needing additional tutoring/support that has an associated cost	Interventions that are consistent with IHBT activities as defined in rule 5122-29-28 may be billed as IHBT. Academic services, such as tutoring, are not coverable Medicaid services.

Commenter	Rule Number	Comment	Response to Author
Cincinnati Children's Hospital Medical Center	**5160-59-03.3:** Intensive Home-Based Treatment (post-OhioRISE ODM rule)	Payment for the CANS will not be made under IHBT because the CANS will already be completed by CME? Aetna will not pay to do it again at the IHBT provider?	The rule was updated to add clarifying language regarding separate CANS coverage. ODM intends for the enhanced IHBT rules to go into effect March 1, 2022, prior to OhioRISE go-live. IHBT providers will be reimbursed for all components of IHBT (including assessments) using the new IHBT rates. Once OhioRISE begins, the OhioRISE care coordinators will be responsible for ensuring a CANS is completed and updated in coordination with the IHBT team; and the IHBT team will continue to be reimbursed for all components of IHBT rendered, as well as the CANS when appropriate.
Cincinnati Children's Hospital Medical Center	**5160-59-03.3:** Intensive Home-Based Treatment (post-OhioRISE ODM rule)	Similar to above item, with specialized approaches to SUD, it is possible a patient would benefit from IHBT and SUD targeted case management	The rule was updated to clarify that a separate Medicaid payment may be made when services such as group therapy, therapeutic behavioral group or SUD case management are prior authorized.
Ohio Children's Alliance	**5160-59-03.3:** Intensive Home-Based Treatment (post-OhioRISE ODM rule)	Children enrolled on Medicaid who are referred to and enrolled in an IHBT program should be categorically eligible for OhioRISE.	Medicaid-enrolled youth who meet the criteria to receive IHBT will also meet the criteria to be enrolled in OhioRISE when that program begins. Once OhioRISE begins, IHBT for all children and youth in Medicaid will be provided through the OhioRISE plan.
Public Children Services Association of Ohio	**5160-59-03.3:** Intensive Home-Based Treatment (post-OhioRISE ODM rule)	We continue to have concerns with IHBT being available only through OhioRISE. We believe this could impact Family First prevention services and utilization of IHBT within treatment foster care. Once we are provided with more information, additional comments may be provided for this rule	IHBT may be provided to children living in the custody of a Title IV-E agency, including those living in treatment foster homes. Once OhioRISE begins, IHBT for all children and youth in Medicaid will be provided through the OhioRISE plan. Medicaid-enrolled children and youth who meet the criteria to receive IHBT will also meet the criteria to be enrolled in OhioRISE when OhioRISE begins. When a child or youth is not enrolled in Medicaid, IHBT may be available through other funding sources, including through FFPSA Prevention Services.

Commenter	Rule Number	Comment	Response to Author
		GENERAL BEHAVIORAL HEALTH POLICY RULES	
The Buckeye Ranch	**5160-27-02:** Coverage and limitations of behavioral health services	Is the CANS able to billed on the same day as a psychiatric diagnostic assessment is billed? This is not clear as the rule is written. We would advocate for this due to the complexity of services and the additional work associated with administration of the CANS tool. Additionally, we would like to advocate for the flexibility to bill for administration of the CANS tool without having to complete a full psychiatric diagnostic assessment to support identification of youth in need of services, assess levels of care and support needs, and maximize coordination of care for youth and families	Beginning 7/1/22 when this rule becomes effective, there will be a distinct billing code for completion of the CANS. Providers will be required to use this code when billing for the CANS. Other services done on the same date (such as a psychiatric diagnostic evaluation) can be billed in addition to the new CANS code. Other services billed would not include time spent administering the CANS, as the time spent conducting the CANS will only be billable using the CANS billing code.
Not Available	All BH rules (5160-27-02, 5160-27-03, 5160-27-06, & 5160-27-08)	While we do not have any current comments or recommendations related to these rule changes, we appreciate the opportunity to review and comment on any future changes to these or other rules impacting behavioral health services.	Thank you for reviewing the rules.

Commenter	Rule Number	Comment	Response to Author
		OHIORISE PROGRAM RULES	
Cincinnati Children's Hospital Medical Center	**5160-59-02:** OhioRISE Eligibility and Enrollment	Can a parent decline OhioRISE services? If not, does that mean that members who "qualify" for OhioRISE are no longer eligible for other BH MCE services?	Enrollment in OhioRISE is not optional, but youth and families have the right to choose whether or not to receive services offered. Youth who are enrolled in OhioRISE will have access to the same behavioral health services available through the managed care plan, plus additional OhioRISE services.
Cincinnati Children's Hospital Medical Center	**5160-59-02:** OhioRISE Eligibility and Enrollment	CANS decision support document was just shared yesterday. We need to deep dive into it and will probably have additional comment but we need to review. We think we will probably have concerns about CANS decision support in correlation to PRTF.	Thank you for your feedback.
Cincinnati Children's Hospital Medical Center	**5160-59-02:** OhioRISE Eligibility and Enrollment	When will the CANS version be shared?	The Ohio CANS decision support model was initially shared with stakeholders on June 17, 2021 during an OhioRISE CANS and Care Coordination stakeholder meeting. The material from that meeting and other CANS resources can be found on the OhioRISE web page: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise
Cincinnati Children's Hospital Medical Center	**5160-59-02:** OhioRISE Eligibility and Enrollment	While we understand one of the primary goals of OhioRISE is to keep kids in state for services, in rare instances, it may be possible that the best services to care for the child may be out of state. Is section F designed to accommodate those rare instances? The burden for disenrollment from OhioRISE according to these rules is complex. Will Aetna have the flexibility to disenroll for out of state care in the rare instance there are no other alternatives?	We do not anticipate any changes to existing out of state service coverage as a result of this rule. The OhioRISE plan is responsible for providing for medically necessary behavioral health services in the setting and location appropriate to meet the youth's needs.
Cincinnati Children's Hospital Medical Center	**5160-59-02:** OhioRISE Eligibility and Enrollment	While we understand the desire to make age eligibility match the federal Family First Prevention Services Act, we also believe the 18-21 year old population will be a challenge to serve in PRTF, and MRSS in particular because those services primarily exist in the adult system and not the pediatric system. Staffing and skill sets vary widely to serve the 18-21 year old population compared to under 18 years. There is also a different legal status for 18-21 year old.	While we understand the complexities involved with serving older youth, the ages for OhioRISE eligibility are not being adjusted.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02:** OhioRISE Eligibility and Enrollment	Additionally, the rule does not define roles or responsibility for discussing the benefit or coverage changes that occur with enrollment in OhioRISE. We strongly recommend that this rule clearly articulate the responsible party for attaining informed consent for OhioRISE this rule clearly articulate the responsible party for attaining informed consent for OhioRISE enrollment. Assigning this key duty to a designated party was a significant lesson learned in the MyCare Ohio implementation.	Enrollment in OhioRISE is mandatory if individuals meet the enrollment criteria. The individual has the choice whether to accept and participate in services that are available to the individual due to OhioRISE enrollment. Therefore, there is no need for separate informed consent to be obtained upon enrollment.

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The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02:** OhioRISE Eligibility and Enrollment	From a payment perspective and understanding enrollment in OhioRISE is a change in plan coverage, we appreciate the simplicity of all enrollments occurring the 1st of the month following the eligibility determination as described in (C)(1). However, this process could delay access to the OhioRISE benefit for 30-45 days, depending on when the referral and CANS assessment is completed. Further, we anticipate this means the ICC/MCC/Limited care coordination assessment and child-family plan development would not begin until after the official enrollment date, which will potentially leave a family waiting for several weeks before needed services could be considered, authorized, and initiated. This does not align with the youth and family centered approach, and it seems more details are needed to support both continuity of care and immediate access to the services within the OhioRISE benefits.	The rule language and policy were updated to allow OhioRISE enrollment to begin upon submission of the CANS assessment.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02:** OhioRISE Eligibility and Enrollment	In (A)(4), the language now indicates that ODM "or its designee" will be responsible for OhioRISE eligibility determination. In previous discussions, ODM retained sole responsibility for eligibility determination, please share the rationale for this substantive policy shift. We recommend ODM retain sole authority for eligibility determinations.	The rule was updated and the phrase "or its designee" was removed.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02:** OhioRISE Eligibility and Enrollment	In (B), we believe a technical change is necessary to reference (A)(1) – (A)(4) of the rule.	The rule was updated to clarify eligibility conditions.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02:** OhioRISE Eligibility and Enrollment	Similarly, with disenrollment, the language in (D) could be improved by including more specification or how much notice is provided to the family/youth, transition of care expectations (i.e. service authorization moving back to traditional MCO), and dispute options if the family doesn't agree with the CANS score.	If families do not agree with a disenrollment decision or tier assignment, appeals and hearing rights are available and referenced in the OhioRISE rules. Prior authorizations issued by the previous MCO will be accepted by OhioRISE plan. The OhioRISE plan will provide a notice six weeks prior to when members turn 21 years of age (that the member will not be eligible for OHR once they turn 21) .
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02:** OhioRISE Eligibility and Enrollment	The new language on "just cause disenrollments" in (F) is concerning. Please clarify "who" may request a just cause disenrollment – is this the youth/family or the MCO? With the exception of (a), this entire paragraph seems antithetical to the intent and purpose of EPSDT and OhioRISE which is to ensure that youth's needs and services are prioritized and the MCO is the single point of accountability for obtaining these services using a Systems of Care philosophy. This is wholly inconsistent with other conversations around "no reject, no eject" with providers – but appears to allow the MCO to disenroll a youth if service access becomes too difficult or challenging. We would like an opportunity to discuss and understand how (F) (b-e) is consistent with the goals of OhioRISE.	The rule was updated. Language in this section been revised to clarify that this pertains to member-initiated disenrollment requests.

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The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02:** OhioRISE Eligibility and Enrollment	The rule does not define roles or responsibility for discussing the benefit or coverage changes that occur with enrollment in OhioRISE. We strongly recommend that this rule clearly articulate the responsible party for attaining informed consent for OhioRISE enrollment. Assigning this key duty to a designated party was a significant lesson learned in the MyCare Ohio implementation.	Enrollment in OhioRISE is mandatory if youth meet the enrollment criteria. The youth and family have the choice whether to accept and participate in services that are available to the youth due to OhioRISE enrollment. Therefore, there is no need for separate informed consent to be obtained upon enrollment.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02:** OhioRISE Eligibility and Enrollment	We reiterate the struggle to understand who the intended eligible population will be in the OhioRISE program in (A) and (B). We appreciate the intent is to rely on the CANS and the soon-to-be-shared CANS decision support module, however, that does not lend itself to clarity for families, providers, or any of the MCOs. With Ohio developing a modified CANS tool, we understand the desire for flexibility to adjust as the CANS tool is tested and modified; however, eligibility criteria should be transparent and clear for all. We had anticipated seeing more defined criteria such as reference to functional impairments, co-occurring health conditions, behavioral health diagnosis or DSM-5/ICD-10 Dx, or involvement in multiple systems in this rule as those would be consistent with the language used to describe the population of youth in the Medicaid MCO RFA and OhioRISE RFA. At a minimum, further description as to how or what the eligible CANS score would be and how it will be derived would be helpful. As a Medicaid program, providers are expecting to see defined criteria in rule that will support medical necessity for accessing these new, intensive services.	The rule was updated to clarify the eligible population. Additionally, the OhioRISE CANS decision support model is available on the OhioRISE web page: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02:** OhioRISE Eligibility and Enrollment	We want to draw attention (B)(3) and our continuing concerns that MRSS is the only pathway for immediate access to OhioRISE eligibility outside of admission to an inpatient level of care. Certainly, this is appropriate when there are immediate crisis situations and MRSS is dispatched to assess and intervene. However, we are concerned MRSS will become a de facto access point when a youth needs an urgent (but not crisis) change in placement, addition of intensive services (IHBT) in a family/kin/foster care setting, or a court wants immediate admission rather than waiting for 30-45 days to access admission through the traditional first of the month enrollment defined in (C)(1). Mid-month changes in plan enrollment are challenging and difficult, however, MRSS cannot become the go-to source simply to access needed services mid-month as it will raise medical necessity concerns and put undue strain on a developing service. Secondarily, if a community doesn't yet have an MRSS team, does that mean there is no opportunity for immediate access to OhioRISE? Finally, if a youth seeks crisis services through the traditional emergency department or crisis stabilization unit (if available), will that youth only be able to enter OhioRISE through the traditional pathway? What is the pathway to access immediate intensive interventions to prevent hospitalization or out of home placement?	The rule language and policy were updated to allow OhioRISE enrollment to begin upon submission of the CANS assessment. Additionally, all youth will continue to have access to the full array of behavioral health services through their Managed Care Plan until they are enrolled in OhioRISE, so if there is need for immediate behavioral health services they will be accessible.

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The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02:** OhioRISE Eligibility and Enrollment	While it may not belong in this rule, there is currently no language that describes the CANS tool(s), expected processes, interviews or timelines, documentation requirements, or the eligible providers. The rule package should address this either here or elsewhere.	Rule language has been revised to provide additional information about the CANS requirements, including the timelines for CANS completion for eligibility purposes. Rule 5160-59-03.2 has additional details related to CANS completion as part of care coordination.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02:** OhioRISE Eligibility and Enrollment	With disenrollment, please explain why (E)(3) does not require completion of a consumer contact record. Does this mean the OhioRISE plan is not responsible for notifying the youth and family of disenrollment? Further, while ODM may believe these are operational issues, we strongly encourage more specification on how much notice is provided to the family/youth and providers, transition of care expectations (i.e. service authorization moving back to traditional MCO), and specific requirements for dispute options if the family doesn't agree with the CANS score. This was a major lessoned learned through the MyCare Ohio program and something that we hope will be addressed in rule not policy documents.	The language in paragraph (E) has been removed, as this information is covered in the OhioRISE plan provider agreement. If families do not agree with a disenrollment decision or tier assignment, appeals and hearing rights are available as referenced in the OhioRISE rules.
Groundwork Ohio	**5160-59-02.1:** First Day Eligibility and Enrollment	The current language in proposed rule 5160-59-02.1 outlines the behavioral health services that a child would have to have utilized to qualify for OhioRISE; however, these are not settings that are equipped to care for very young children. We recommend that the state add additional eligibility criteria specific to children under age five, such as removal from the home, to ensure that these children can benefit from the services under OhioRISE. It is the shift of thinking from emergent triage to strong prevention that will ultimately drive improved outcomes.	OhioRISE does not specifically indicate a minimum age for enrollment into the program, but as pointed out, youth do need to meet specific requirements for OhioRISE program eligibility. While proposed rule 5160-59-02.1 outlines eligibility on day one of the OhioRISE program, ongoing eligibility requirements are outlined in 5160-59-02. OAC 5160-59-02 includes specific OhioRISE eligibility criteria for youth ages 5 and under.
Legal Aid Society of Greater Cincinnati	**5160-59-02.1:** First Day Eligibility and Enrollment	(B)(1): The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) provision of Medicaid covers youth until they are twenty-one (21) years old. The proposed regulations state that an individual must be twenty (20) years of age or younger on the first day the OhioRISE program is in effect. To align with EPSDT and maintain consistency with the language used in OAC 5160-1-14(A)(1) to define EPSDT eligibility in Ohio, this language should be revised to say that individuals who are "younger than twenty-one years of age" are eligible for OhioRISE.	ODM carefully reviewed this recommendation on aligning the language around the age limitations with EPSDT, and although it might be stated slightly different, both represent individuals 20 years of age or younger.
Legal Aid Society of Greater Cincinnati	**5160-59-02.1:** First Day Eligibility and Enrollment	(B)(3): This section should be amended. As stated in our previous comments, MyCare and OhioRISE services are not duplicative. A consumer may need OhioRISE services even if they are enrolled in MyCare. This language should be revised to allow an individualized assessment of whether an individual enrolled in MyCare should be enrolled in, or transferred to OhioRISE.	Individuals in MyCare Ohio who meet the eligibility criteria for the OhioRISE program will still have access to the state plan services offered by the OhioRISE program. These individuals cannot be enrolled within the MyCare program and the OhioRISE managed care programs at the same time, so they will need to access their state plan services through their MyCare plans.
Legal Aid Society of Greater Cincinnati	**5160-59-02.1:** First Day Eligibility and Enrollment	(B)(4)(a): As drafted, this section automatically enrolls individuals in OhioRISE if they have been admitted to an out of state PRTF in the last six (6) months, but not a PRTF in Ohio. The language "out of state" should be removed or amended to read "both in and out of state" so individuals admitted to any PRTF in the last six (6) months should be enrolled in OhioRISE.	Currently, there are no in-state PRTFs recognized by the state of Ohio. ODM expects to implement policy to reimburse OMHAS licensed in-state PRTF providers in January 2023.

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Legal Aid Society of Greater Cincinnati	**5160-59-02.1:** First Day Eligibility and Enrollment	(B)(4)(c)(iii) This section should be reviewed to ensure the citations are correct. This section states youth in foster care who are in residential treatment or a residential parenting facility as described by OAC 5101:2-5-03 will be enrolled in OhioRISE. However, the cited provision describes child welfare licensing responsibility, but not the facilities or their requirements, which are discussed in more detail at OAC 5101:2-9.	The rule was updated to rule reference to OAC 5101:2-9.
Legal Aid Society of Greater Cincinnati	**5160-59-02.1:** First Day Eligibility and Enrollment	Additionally, if youth in children's services custody are automatically enrolled in OhioRISE on the first day the program is in effect, OhioRISE should develop clear policies as to who has authority to consent to a youth's enrollment in OhioRISE, as well as who will be included in the development of the youth's child and family centered care plan for OhioRISE services.	OhioRISE enrollment is mandatory for youth who meet eligibility criteria outlined in 5160-59-02 and 5160-59-02.1. Youth and their families will be notified of their enrollment in the OhioRISE program. 516-59-02 outlines conditions for disenrollment from the OhioRISE program. Once notified of pending enrollment for day-one eligibility, the OhioRISE Plan will start the process to assess the individual to determine and assign a tier of care coordination and begin the care coordination process. 5160-59-03.2 outlines OhioRISE care coordination requirements, including requirements for development of the child and family centered care plan.
Public Children Services Association of Ohio (PCSAO)	**5160-59-02.1:** First Day Eligibility and Enrollment	Section (B) (4) (c) (iii). Please clarify if this also includes children placed in a group home. If it does not, we recommend including group homes.	The 'first day' eligibility rule was developed to help ODM identify youth who would most likely be found eligible for the OhioRISE program if they were assessed using the CANS. Although the group home is not included, youth placed in a group home might be enrolled for 'first day' eligibility if they meet other eligibility criteria in 5160-59-02.1 (e.g., have had a CANS showing they meet the program eligibility or receive IHBT services within three months of the program's effective date)
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02.1:** First Day Eligibility and Enrollment	In (B)(4)(a), does eligibility require the actual admission date to be within the previous six months or is the intent that the youth will have received an out-of-state PRTF or IP psychiatric service within that timeframe. We anticipate the intent is that the youth would have received one of these services within the previous six months. Clarification is recommended.	For purpose of day one eligibility, the youth would need to have an identifiable admission to the out-of-state PRTF, or an identifiable 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 within six months prior to the effective date of the OhioRISE program based on the admission date.

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The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02.1:** First Day Eligibility and Enrollment	In (B)(4)(c)(i), since the remaining subpoints of this (c) reference residential placement, we want to understand if ODM truly intends to capture all youth that are receiving TBS Group services – hourly or per diem. While TBS Group services – hourly or per diem is commonly provided for youth in licensed MH residential treatment, it is also routinely provided in other settings such as schools, after-school programs, or general outpatient programming. Given the limited experience with the CANS for eligibility determination, it is a reasonable assumption youth in a MH residential placement would meet the OhioRISE Eligibility under the CANS. However, it is less certain that all youth receiving school based, after school, or outpatient TBS Group Services – hourly or per diem will meet the requirement depending on the level of intensity and frequency of the program. Please clarify that ODM intends for (c)(i) to capture a wider group of youth than the remaining references in (c)(ii) and (iii) that are receiving residential services.	The rule was updated. Recent therapeutic behavioral group service (hourly and per-diem) will no longer serve as criteria for OhioRISE day one eligibility.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-02.1:** First Day Eligibility and Enrollment	Once determined eligible under (B), the rule is silent on the intended enrollment process, initiation of the CANS, assignment to a care coordination tier, or whether these factors that would confirm eligibility and enrollment were appropriate. Will the CANS be administered, by whom, and by when? What transition of care requirements will be expected and by when?	For those youth eligible and enrolled as of the first day the OhioRISE program is effective in accordance with this rule, the OhioRISE plan will follow the process described in the Care Coordination rule (5160-59-03.2) to assign a care coordination tier. If the youth has a had a CANS assessment completed within the last 90 days, the OhioRISE plan will use that CANS and other clinical information available to assign an initial care coordination tier. If the youth has not had a CANS assessment completed, the OhioRISE plan will assign an initial care coordination tier based on information available and will arrange for a CANS to be completed. Once the CANS is completed, the care coordination tier will be updated as needed.
Cincinnati Children's Hospital Medical Center	**5160-59-03:** OhioRISE Covered Services	Is it possible given the new criteria and rules for PRTF that our current 30 bed inpatient residential treatment unit might be categorized as out of network non contract care but would still be covered under this section of rules?	The OhioRISE plan will be responsible for ensuring access and coverage of medically necessary behavioral health services, as outlined in this rule. PRTF rules are still under development.
Cincinnati Children's Hospital Medical Center	**5160-59-03:** OhioRISE Covered Services	We assume Cincinnati Children's inpatient and hospital will be a contracted provider. However, the current 30 bed residential unit may not meet the PRTF rules/requirements (see final comments below	The OhioRISE plan will be responsible for ensuring access and coverage of medically necessary behavioral health services, as outlined in this rule. PRTF rules are still under development.

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Cincinnati Children's Hospital Medical Center	**5160-59-03:** OhioRISE Covered Services	While we understand one of the primary goals of OhioRISE is to keep kids in state for services, in rare instances, it may be possible that the best services to care for the child may be out of state. Is section F designed to accommodate those rare instances? The burden for disenrollment from OhioRISE according to these rules is complex. Will Aetna have the flexibility to disenroll for out of state care in the rare instance there are no other alternatives? Is it possible given the new criteria and rules for PRTF that our current 30 bed inpatient residential treatment unit might be categorized as out of network care but would still be covered under this section of rules?	ODM does not anticipate any changes to existing coverage of out of state services as a result of this rule. Aetna will be responsible for ensuring access and coverage of medically necessary behavioral health services, as outlined in this rule.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03:** OhioRISE Covered Services	(A)(3) permits the OhioRISE plan to establish prior authorization practices allowing services to exceed preidentified limits on some services when medically necessary. Does ODM approve the OhioRISE predetermined service limits or prior authorization as it does for the traditional MCOs? If so, ODM's approval should be clearly added to the rule.	The OhioRISE provider agreement outlines the service and prior authorization requirements the OhioRISE plan may establish. The OhioRISE provider agreement can be found on the OhioRISE web page: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise

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The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03:** OhioRISE Covered Services	In (B)(10), we have substantive concerns with narrowly defining behavioral health coverage for medical services under Chapter 5160-4 to psychiatrists or physician assistants supervised by psychiatrists. Given the well documented shortage of psychiatrists, it is implausible that OhioRISE would set this limit that does not exist in the community behavioral health benefit. Some pediatric behavioral health medical services are provided by family practitioners or pediatricians employed by community behavioral health organization. We strongly urge ODM to remove the reference to psychiatrist and recognize the existing and available physician workforce.	Paragraph (B)(10) applies to behavioral health services rendered by psychiatrists, physician assistants (PAs) working under psychiatrists, and psychiatric APRN services that are operating outside of community behavioral health centers (CHBCs - also known as ODM provider types 84 and 95) or other entities covered in paragraph (B) such as outpatient hospitals, FQHCs, and RHCs. The OhioRISE plan is responsible for these services, but will not be responsible for BH services rendered by other physicians (non-psychiatrists), PAs, (not working under a psychiatrist) or non-psychiatric APRNs. When a youth enrolled in OhioRISE has a need for BH services from a non-psychiatric physician/PA/APRN, the MCO or FFS will be responsible for paying those services. The OhioRISE care coordinator is responsible for coordinating all BH services, even those limited services (such as separate family practitioner BH services) that remain covered by the MCOs or FFS. Paragraph (B)(8) states that all services provided by OhioMHAS certified community behavioral health center (CHBCs - also known as ODM provider types 84 and 95) are covered by the OhioRISE plan. This includes the medical services in the CBHC benefit package, and covers all of the qualified staff employed by or under contract with the CBHCs rendering covered services (such as family practitioners or pediatricians).
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03:** OhioRISE Covered Services	In (F), it is unclear how “post-stabilization care services” are defined and if these are intended to be associated with inpatient services. Clarification for this entire paragraph is needed since the coverage rule appears to be inclusive of the full continuum of services, including inpatient care.	Post-stabilization care services are defined in Ohio Administrative Code rule 5160-26-01, Managed health care programs: definitions, as follows: "Post-stabilization care services" means covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized in order to maintain the stabilized condition, or under the circumstances described in 42 C.F.R. 422.113 (October 1, 2019) to improve or resolve the member's condition.

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The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03:** OhioRISE Covered Services	In (G)(3), we understand the OhioRISE MCO is not responsible to pay for services provided through the MSP program; however, we want to assure that community behavioral health services provided in a school location or setting (i.e. school-based services) remain covered by the OhioRISE plan.	Medicaid School Program (MSP) will continue to cover and reimburse for services as defined in chapter 5160-35 of Ohio Administrative Code. The OhioRISE plan will reimburse for the services outlined within the covered service rule, 5160-59-03.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03:** OhioRISE Covered Services	Similar to comments on (A)(3), we encourage ODM to clarify in (C) that ODM will review and approve any limits placed on a service prior to the OhioRISE plan implementing utilization control practices.	The OhioRISE provider agreement outlines the service and prior authorization requirements the OhioRISE plan may establish. The OhioRISE provider agreement can be found on the OhioRISE web page: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise
University Hospitals	**5160-59-03:** OhioRISE Covered Services	We suggest changing Physician to LIP. NP's will be increasingly filling these positions and shortage of MD's could be a barrier for agencies	The service descriptions and provider types described in this rule are aligned with the Medicaid benefit described in OAC Chapter 5160. Both physicians and nurse practitioners are addressed.
Cincinnati Children's Hospital Medical Center	**5160-59-03.1**: OhioRISE Utilization Management	We believe most OhioRISE services will be more urgent, we have concerns 10 days would be too long for UM review. If a patient needs something high level will it be approved more quickly? Not sure we found a mechanism for that in the rules per say or maybe we missed it.	The 10-day timeframe is used for standard authorization decisions. The OhioRISE plan must provide notice to the provider and member as expeditiously as the member's health condition requires, but no later than ten calendar days following receipt of the request for service. If a provider indicates or the OhioRISE plan determines the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the OhioRISE plan must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires, but no later than forty-eight hours after receipt of the request for service.
Public Children Services Association of Ohio	**5160-59-03.1**: OhioRISE Utilization Management	As mentioned in our comments on 5101-59-03 Section (A), a consistent definition of medical necessity should be included throughout the OhioRISE rules, including in Sections (A)(1) and (2) in this rule. In addition, consider adding language referencing parity requirements in (A)(3).	ODM defines medically necessity in Ohio Administrative Code rule 5160-1-01, Medicaid medical necessity: definitions and principles. This definition is used throughout Medicaid and it's various programs. The rule was updated to add Mental Health Parity and Addiction Equity Act (MHPAEA) requirements to (A)(3).

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Public Children Services Association of Ohio	**5160-59-03.1**: OhioRISE Utilization Management	In addition to the member, this notice should go to the primary caregiver of the member, whether that is family of origin, kinship caregiver, or in the case of a youth in custody, the custodial agency. Communication and decision making for youth in custody of a PCSA directly contributes to improved outcomes for youth. For these youth, OhioRISE should notify custodial agencies, resource families, as well as the family of origin.	Notices are sent to members or their authorized representative, as designated. Authorized representative is defined in Ohio Administrative Code Rule 5160:1-1-01 as a person, who is at least eighteen years old, or a legal entity who stands in place of the individual. Actions or failures of an authorized representative will be accepted as the action or failure of the individual. If an individual has designated an authorized representative, all references to "individual" in regard to an individual's responsibilities include the individual's authorized representative.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.1**: OhioRISE Utilization Management	In (A)(1), we strongly urge ODM to add a reference to the state's definition of medical necessity to ensure consistency in medical necessity determinations between and across the MCOs, including the OhioRISE plan.	ODM defines medically necessity in Ohio Administrative Code rule 5160-1-01, Medicaid medical necessity: definitions and principles. This definition is used throughout the Medicaid and it's various programs.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.1**: OhioRISE Utilization Management	In (A)(2), we would also recommend adding a reference to the OAC definition of medical necessity and clarify in (a) and/or (b) that the criteria used to make UM decisions is specific to the developmental needs of a pediatric or adolescent population. Too often, we know that UM criteria is largely based on adult populations rather than considering the unique needs of children and youth. Additionally, in (A)(2) we would encourage a reference to following ASAM guidelines for youth experiencing substance use disorders as is done in other behavioral health rules for consistency.	ODM defines medically necessity in Ohio Administrative Code rule 5160-1-01, Medicaid medical necessity: definitions and principles. This definition is used throughout Medicaid and it's various programs. The OhioRISE plan will be required to cover SUD services in accordance with ASAM as described in rule 5160-27-09.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.1**: OhioRISE Utilization Management	Language in (B) and particularly (B)(2) speaks to processes and procedures for initial and continuing "authorization of services". Similar to comments made on 5160-59-03.2 OhioRISE Care Coordination, we need to fully understand the definition of "authorization of services" and "prior authorization of services". From a clinical and patient care perspective, does OhioRISE have to approve or "authorize" all services BEFORE any service can be delivered or reimbursed? As drafted, we have significant concerns OhioRISE is adding costly administrative processes that will delay care and reimbursement. Please fully define the expectation for "authorization of services"	The OhioRISE provider agreement outlines the service and prior authorization requirements the OhioRISE plan may establish, including publishing a list of services requiring authorization. Not all services will require prior authorization. The OhioRISE provider agreement can be found on the OhioRISE web page: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.1**: OhioRISE Utilization Management	Please describe how ODM will consider or apply federal parity requirements as part of the OhioRISE UM program described in (A)(3). We recommend adding language consistent with parity to this section.	The rule was updated and language was added to the rule for clarification: Must comply with Mental Health Parity and Addiction Equity Act (MHPAEA) requirements outlined in 42 CFR Part 438 Subpart K (October 1, 2021).
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	Clarification - does "have the capability" mean it can occur, or is required that outreach occur within one business day?	It is required. The rule was updated to add clarification.

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Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	Clarifying that p and q would not necessarily be provided by care management team, but could be met using other providers who are part of the CME.	These items are required CME capabilities.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	Confirming this means the plan templates are submitted, not every individual child's plan?	Each child's care plan will be reviewed by the OhioRISE plan.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	Consider 1:15 if 5 in caseload are monitoring status	The ratio for ICC aligns with National Wraparound standards.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	Consider 15 instead of 25	Ratios were set in accordance with national standards and are not being adjusted at this time.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	Consider changing this to two business days versus calendar days. Can telehealth be used for this service?	Initial face-to-face contact must be offered within two calendar days of referral for ICC. Per (B)(2), CMEs are required to respond to youth and families 24 hours/day. Services may be provided via telehealth when this service delivery method is chosen by the family.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	Consider having the supervisor of ICC/MCC to be licensed or have weekly required supervision (not just access to a licensed person)	The rule was updated to reflect requirements for unlicensed practitioners who are in a supervisory role to have regular supervision with a licensed practitioner.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	Do all member needs need responded to 24 hours a day, or only those deemed crisis level (e.g., evenings/weekends/holidays - would expectation that any member request be responded to?)	CMEs are required to respond to the family 24 hours/day. Crisis needs must be responded to within 24 hours or one business day. Non-crisis needs must be responded to within 48 hours or two business days.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	Given the staffing requirements and high number of potential OhioRISE enrollees, will there be phases to the opening up eligibility to allow staffing to grow over time?	Per 5160-59-02.1, some youth will be enrolled in OhioRISE upon go-live. Additional youth will be enrolled as they are identified and determined eligible according to the criteria in 5160-59-02.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	How will the CANS assessment or other processes/criteria assist in defining "significant" and "moderate" behavioral health challenges and ensure consistency in definition, (given the different staffing ratio requirements this will be important)?	The rule was updated to help differentiate between these levels.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	It is not clear whether all services at all times need to be preformed by the CME or if it is allowable for the CME to contract with sub providers to do some of the services. Do ALL member needs have to be addressed in timeframes given or only those members identified in crisis?	CME may contract with providers to do some services, particularly real-time or on demand clinical and psychiatric consultation. ICC/MCC activities need to be provided according to all of the timeframes identified in the rule, not just if the member is in crisis.

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Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	One day includes weekends so it would be necessary to staff seven days? Can any be done telemedicine or telephonic?	The rule was updated by adding clarifying language to this section of the rule. Per (B)(2), CMEs are required to respond to youth and families 24 hours/day. Services may be provided via telehealth when this service delivery method is chosen by the family.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	Propose telehealth option for initial face to face when in person not possible.	Services may be provided via telehealth when this service delivery method is chosen by the family.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	This person should be licensed only or have licensed supervision	The rule was updated to reflect requirements for unlicensed practitioners who are in a supervisory role to have regular supervision with a licensed practitioner.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	This should only include members who qualify but refuse. No staffing numbers are provided in this document for members who decline or who do not require ICC or MCC.	The staffing ratio for limited care coordination (LCC) is outlined in the OhioRISE provider agreement. Please also note that LCC is also available for youth who meet the OhioRISE enrollment criteria who do not require care coordination at the intensity of that provided through ICC and MCC.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	This would require 7 day per week CM coverage. Consider changing working to within 2 business days. Propose using telehealth as an option for face to face.	The initial face-to-face contact must be offered within two calendar days of referral for ICC. CMEs are required to respond to youth and families 24 hours/day. Services may be provided via telehealth when this service delivery method is chosen by the family.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	We assume this means the template and not every single individual child's plan?	Each youth's child and family-centered care plan must be submitted/shared with the OhioRISE plan for review.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	We need to delve deeper into the CANS decision support documentation	The rule was updated to add language clarifying and detailed language about the CANS decision support model and care coordination tier assignments.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	What does this mean? What is the definition of firewall? Is this an IS firewall? Can we not coordinate with the provider side of Cincinnati Children's Hospital Medical Center if HealthVine is the CME? Is this really about referral patterns and that there should be separations around referral patterns so not all kids are getting referred to Cincinnati Children's Hospital Medical Center? What does compliance look like for this?	The rule was updated to further clarify this provision. This provision is related to referral patterns and ensuring that the CME is directing youth to the most appropriate services to meet their needs. Compliance may be monitored via OhioRISE plan UM and COE QI efforts.
Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	Will this open all at once or will there be a phase in over time?	Ratios will be applied when this rule goes into effect.

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Cincinnati Children's Hospital Medical Center	**5160-59-03.2:** OhioRISE Care Coordination	Would these be covered by the MCO?	Most behavioral health services will be covered by the OhioRISE plan and others will be covered by the MCO or FFS.
Hamilton County Jobs and Family Services	**5160-59-03.2:** OhioRISE Care Coordination	According to 5160-59-03.2, Section D (8), The OhioRISE plan has to adhere to the judgment of the attending provider when the attending provider requests a member's transfer to another facility or discharge. As written, the current language appears to leave aside the judgment of the Child and Family Team (CFT) in the decision to request discharge from emergency services and to plan the transfer to another facility. Most important, youth involvement in emergency services should not preclude the judgment of the Child and Family Team (CFT) when the attending provider requests a member's transfer to another facility or discharge. Given the prominence of the "child and family centered care plan" as the key driver for achieving quality outcomes, the OhioRISE plan has to ensure the continuity of each member's "child-centered individualized, child-centered, strength-based and family-focused" goals irrespective of the service delivery setting. Above all, adhering to the judgment of the Child and Family Team (CFT) across the system of care will reinforce the OhioRISE program's intent to prioritize need-driven planning as defined in the "child and family centered care plan" while implementing seamless service delivery (including emergency services) for youth with needs that require interventions across multiple community and institutional-based settings throughout their episode of OhioRISE enrollment.	This provision is related to federal requirements. 42 CFR 438.114(B)(3) and is intended to protect the member. While the child and family team may be working with the provider, the final decision to discharge the responsibility of the physician.
Ohio Children's Alliance	**5160-59-03.2:** OhioRISE Care Coordination	As youth move to higher levels of care coordination, how do we ensure that client rights are being upheld? (I.e. – can parents insist that current therapeutic relationships be preserved?)	The child and family team will work collaboratively to identify the treatment needs and providers of therapeutic services. CMEs are required to ensure youth and family choice is incorporated regarding the services and supports they receive and the providers of those services.
Ohio Children's Alliance	**5160-59-03.2:** OhioRISE Care Coordination	Consider changing ICC ratio to 1:15 to address Ohio's workforce shortage.	The ratio for ICC aligns with National Wraparound standards.
Ohio Children's Alliance	**5160-59-03.2:** OhioRISE Care Coordination	Does this mean youth with very serious and complex behavioral health conditions who are placed in QRTPs are categorically ineligible for ICC? If so, will the MCC team be able to adequately support them and prevent escalation in their level of care need?	The rule was updated to reflect that ICC is not intended to be provided only in the home.

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Ohio Children's Alliance	**5160-59-03.2:** OhioRISE Care Coordination	Given it will take 30 days to develop a service plan, this could result in significant service and reimbursement delays.	The Child and Family Centered Care Plan review process is intended to improve the quality of care plans and ensure resources are in place to meet the youth and family's needs. The OhioRISE provider agreement provides more detail on the purpose and process for the review. Approving the child and family-centered care plan does not require prior authorization. It is a quality improvement measure to ensure care coordination and resources are in place to meet the youth and family's needs. The OhioRISE plan must use the child and family care plan when making prior authorization decisions.
Ohio Children's Alliance	**5160-59-03.2:** OhioRISE Care Coordination	It is generally unclear where the 2,000 or so youth in Ohio, who are enrolled on Medicaid, and are placed in QRTPs, would fall in the OhioRISE care coordination tiers.	Each youth's care coordination tier will be assigned by the OhioRISE plan with consideration of the CANS assessment and the best fit for the youth and family based on family capacity and choice.
Ohio Children's Alliance	**5160-59-03.2:** OhioRISE Care Coordination	Not every youth in an inpatient episode of care will require ICC. Requiring ICC for youth who are inpatient allows for no flexibility for ensuring the right level of care is obtained.	The rule was updated based on stakeholder feedback. The OhioRISE plan will assign the care coordination tier using information recommended by their CANS assessment, and assigned care coordination tier may be modified based on individual circumstances to best fit the youth or family capacity and choice. If the youth or family assigned it ICC or MCC declines the service, the youth will be assigned to the limited care coordination tier.
Ohio Children's Alliance	**5160-59-03.2:** OhioRISE Care Coordination	Regarding: "Facilitating discharge planning and transition activities for youth admitted to a psychiatric residential treatment facility or an inpatient behavioral health facility." Clarify if the ICC must do this even for members who are not enrolled in ICC.	ICC requirements are specific to those youth assigned to the ICC tier of care coordination provided by the CME.
Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	For children in custody of PCSAs, this information should be electronically provided to PCSAs through SACWIS. The progress notes, crisis safety plan, assessments, and child and family care plans will be needed for PCSAs.	PCSAs will have access to this information through the OhioRISE plan's member and care coordination systems.
Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	Given that this section is describing the supervisor of care coordinators, we recommend the qualifications for such a position be at least similar to Section (D)(3)(a-d), ensuring independent licensure of at least the supervisor.	The rule was updated to reflect this change.

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Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	It is difficult to comment on this rule without knowing the organizational and operational infrastructures and relationships among the OhioRISE vendor, CMEs, providers, and the Center of Excellence (COE). This information is needed to better understand how the rule impacts children and families involved with and at risk of being involved with PCSAs, including how CMEs will be structured, how accessible by counties, the regions, who is responsible for ensuring CMEs, how FCFC connects, etc. • OhioRISE care coordination provides a critical opportunity to improve the care and outcomes for children and youth in foster care or on a Family First prevention plan. Clarity regarding how timely, efficient, and comprehensive communication and documentation will be shared between the OhioRISE entities and PCSAs must be established. For example, how do the crisis safety plan in (1) (a)(v1) and a PCSA safety plan align and support each other? How will PCSAs access OhioRISE information to establish, review, and update case plans and prevention plans? This should be done through an interface with SACWIS so that PCSAs do not have an added administrative burden. In addition, OhioRISE and PCSAs will both utilize family engagement and planning efforts. Effective communication is vital to prevent duplicative and/or conflicting family planning processes. • Regarding care coordination overall, transitions and hand-offs between providers and care coordination levels are critical junctures and can create severe challenges if not handled appropriately. Specifically: o What are the processes that accompany a youth moving among the tiers? o How will OhioRISE ensure that a youth who makes progress in one tier, then is assigned to a lower tier, maintains that progress? o What is the estimated breakdown of expected youth per each tier of care coordination, including limited?	We believe that many of these points will be addressed throughout implementation. Some of these details are outlined in the OhioRISE provider agreement, COE implementation, and OhioRISE and COE Quality Improvement plans.
Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	Please clarify if staff should have this training within “twelve months of program enrollment” or “date of employment.”	The rule was updated to clarify that training should occur within three months of hire and annually thereafter.
Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	Please confirm that provisions also apply to youth admitted to a Qualified Residential Treatment Program (QRTP) and if OhioRISE will assist in transition activities if a youth is in another out-of-home placement such as a foster home.	The OhioRISE program will assist with transition activities when children move and transition between settings. The rule was updated to clarify this expectation.
Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	Please ensure that “family” includes the PCSA for youth in custody, as these data and other information should inform PCSA case plans.	The definition of family used in this chapter (defined in OAC 5160-59-01, and is the same definition used by Ohio Department of Mental Health and Addiction Services) is meant to include PCSAs for youth in custody.

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Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	Please ensure that "family" includes the PCSA for youth in custody.	The definition of family used in this chapter (defined in OAC 5160-59-01, and is the same definition used by Ohio Department of Mental Health and Addiction Services) is meant to include PCSAs for youth in custody.
Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	The rule should include details on how a decision will be made to transition a youth to another care coordination tier. Details should include the role of CANS, recommendation of the care team, service completion, and so forth.	Care coordination levels will be assigned by the OhioRISE plan for all youth in OhioRISE. The CANS assessment will provide a recommendation that will be used, along with consideration of individual circumstances and family capacity and choice to determine the care coordination tier.
Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	These sections require a CANS assessment "and other clinical documentation." Please provide more information on what other clinical documentation entails, what entity is responsible for providing the other clinical documentation, and the process to ensure reliability and validity of the other clinical documentation.	The rule was updated to provide more information regarding other clinical documentation.
Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	This rule does not include any details on the "limited care coordination" (LCC) tier. We strongly recommend adding section (C)(3) to fully define the care coordination activities and expectations for Limited Care Coordination delivered by the OhioRISE plan so that there is clarity and consistency in expectations. Given how tiers are typically stratified, we assume a majority of OhioRISE youth will be assigned to this category. o What are the OhioRISE care coordination responsibilities for limited care coordination? If there is no wrap-around process for these youth, how will they access services? Will there be a child-family approved plan? o How is this level of care coordination different from what a member would receive from a traditional MCO? o How will the LCC tier be used to help ensure kids do not progress to needing the higher care management tiers?	Limited care coordination requirements are defined in the OhioRISE plan provider agreement. The OhioRISE provider agreement can be found on the OhioRISE web page: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise
Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	This section should include a provision requiring reporting metrics regarding race and equity data. This is especially needed given the disenrollment provisions.	Health equity is a central part of ODM's population health strategy. CMEs will be working with the OhioRISE plan and the MCOs to improve health equity.

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Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	We are concerned that this provision could result in service delays for youth. Timelines for the CME to submit the child- and family-centered care plan to OhioRISE and for OhioRISE to review and approve should be included here. What does it mean that the OhioRISE plan must review and approve each child-family plan? Does that mean all OhioRISE services must be pre-approved by the OhioRISE plan before any service is delivered or reimbursed? We are concerned that this might impact continuity of care for youth and their families.	The Child and Family Centered Care Plan review process is intended to improve the quality of care plans and ensure resources are in place to meet the youth and family's needs. The OhioRISE provider agreement provides more detail on the purpose and process for the review. Approving the child and family-centered care plan does not require prior authorization. It is a quality improvement measure to ensure care coordination and resources are in place to meet the youth and family's needs. The OhioRISE plan must use the child and family care plan when making prior authorization decisions.
Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	We recommend adding here that the youth and his or her guardian/ custodian/family should be notified of services that will no longer be available if they choose to transition out of ICC or MCC such as behavioral health respite service.	OhioRISE services are available based on medical necessary and are not dependent on receiving a particular tier of care coordination. If warranted by their needs, youth receiving limited care coordination will have access to the same OhioRISE services as those receiving ICC and MCC.
Public Children Services Association of Ohio	**5160-59-03.2:** OhioRISE Care Coordination	We would suggest breaking apart this section if fidelity for high-fidelity wraparound is different from that of moderate care coordination. This is also assuming that CMEs will be expected to provide both ICC and MCC.	The rule was updated and requirements were moved to their respective sections of the rule (ICC and MCC).
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	As repeatedly shared, the definitions in (A)(1) of ICC and (A)(2) of MCC continue to stymie our membership with their generalities and vagueness. It's not clear what "other clinical" documentation will be considered or how "significant" behavioral health challenges will be differentiated from "moderate" behavioral health challenges. And the language related to assessment "at risk behaviors or other psychosocial behaviors placing the youth at risk of out of home placement or hospitalization" is identical for both ICC and MCC. It's unclear how medical necessity will be determined between these two levels of care coordination or how these differences will be described to families through an informed consent process. We strongly urge ODM to add more clarifying terminology and details to differentiate ICC and MCC clinical and practically.	The rule was updated. ICC/MCC language has been revised to be more specific about determination of recommended tiers of care coordination.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	In (C) we strongly recommend adding section (3) to fully define the care coordination activities and expectations for Limited Care Coordination delivered by the OhioRISE plan so there is transparency, clarity and consistency in expectations for each care coordination level.	Limited care coordination requirements are defined in the OhioRISE plan provider agreement. The OhioRISE provider agreement can be found on the OhioRISE web page: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise

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The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	In (F), we recommend including staff: youth ratios for Limited Care Coordination as well to support transparency and consistency across all levels of care coordination.	The staffing ratio for limited care coordination (LCC) is outlined in the OhioRISE provider agreement. The OhioRISE provider agreement is available at https://managedcare.medicaid.ohio.gov/managed-care/ohiorise.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	In (G) we were surprised the Child and Family Centered Care Plan is not listed as required documentation. We suspect this was simply an oversight and recommend adding it to this paragraph.	The Child and Family Centered Care Plan is listed in (G)(4).
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	It would be helpful in (C)(2)(a) to define what HFW principles or subset of fidelity measures are expected for MCC.	Philosophy and principles of ICC and MCC are the same. The two services differ in size of child and family-centered care team, care coordinator to family ratios, and frequency and intensity of required contact. High-fidelity wraparound measures (e.g., WFI, TOM) will be used for ICC, and these measure will not be used with MCC. Other measures of fidelity for MCC will be developed/used. The COE will further delineate specifics related to MCC fidelity.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	Language in (A) now indicates a care coordination tier will be assigned to all youth enrolled in OhioRISE; however, the rule does not identify who is responsible for making that determination. We recommend clarifying who is responsible for that decision and what rights a youth/family has to appeal the determination.	Care coordination levels will be assigned by the OhioRISE plan for all youth in OhioRISE. The CANS assessment will provide a recommendation that will be used, along with consideration of individual circumstances and family capacity and choice to determine the care coordination tier. The rule was updated to add appeal rights language.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	Our membership has had multiple discussions regarding the CME care coordinator and supervisor qualifications discussed in (D) and (E). The workforce challenges are daunting and growing daily, particularly with finding qualified and available practitioners willing to do home-based work that will involve non-traditional hours and on-call availability. Striking a balance is necessary. However, when considering the clinical intensity and complexity of youth currently placed out-of-state and those likely to need ICC and MCC, we believe that at a minimum, the CME care coordination supervisor should be a licensed practitioner, and ideally the CME should have a program manager or clinical supervisor that is independently licensed if the care coordination supervisor is not. The language in (D)(3)(d) requiring experience necessary to manage complex cases is useful but is open to wide interpretation. Further, the severe shortage of psychiatrists, let alone child psychiatrists to consult in the absence of a licensed supervisor described in (E)(2) will be challenging to meet and likely unachievable. Our recommendation, at a minimum, is to add descriptive clarifying language defining “management of complex cases” in (D)(3)(d) and requiring a CME care coordination supervisor to be licensed in (E)(2).	The rule was updated and language was added to (E)(2) to ensure supervisor has, at minimum, regular supervision with a licensed practitioner and real-time access to a psychiatrist.

Commenter	Rule Number	Comment	Response to Author
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	Similar to comments made on 5160-59-03.1 OhioRISE Unitization Review, in (B)(2)(e), it states the CME will be responsible for ensuring the child and family-centered care plan is submitted to the OhioRISE plan for "review and approval". We would like to understand what this means specifically. As presented, it can be interpreted that all OhioRISE services must be pre-approved by the OhioRISE plan before any service is delivered or reimbursed. Is that an accurate statement – and does that mean the CME care coordinator or OhioRISE plan can deny a treatment plan recommendation from a licensed independent practitioner or otherwise intervene in the clinical treatment planning for needed services? How will continuity of care be maintained as youth transition from an MCO to OhioRISE? What safeguards exist to ensure services and reimbursements are not disrupted as other services and natural supports may be augmented or engaged to support the youth and family?	Approving the child and family-centered care plan does not require prior authorization. Review of the child and family-centered care plan is intended to improve the quality of care plans and ensure resources are in place to meet the youth and family's needs. It is meant to be a process for Aetna to provide feedback on the Child and Family Centered Care plan. The OhioRISE plan may still require prior authorization on certain services after approving on the child and family-centered care plan.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	Similarly, in (A)(1)(b) we would like to understand what data and information was used to determine ICC would require the majority of care coordination activities occur in the home and what that actually means for families. While high fidelity wraparound (HFW) is focused on supporting the youth and family in sustaining home and community living and coordinating all the available supports and services, by nature, care coordination is largely focused on coordinating services. How will this "in home" service need be defined, calculated, measured, and evaluated? Is this consistent with the fidelity requirements for the National Wraparound Initiative or youth and family centered care?	The rule was updated to change language to in the "community."
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	We appreciate the added clarification in (B)(2)(s) that a provider could deliver services and care coordination with appropriate safeguards and firewalls.	Thank you for your feedback.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	We appreciate the language in (B)(2)(g) that requires bidirectional electronic data exchange between the CME, OhioRISE plan, and CABH COE. Will this expectation equally apply with BH providers? Or will the CME continue to be able to require BH providers to both push and pull data to/from the CME and/or OhioRISE plan portal? We strongly recommend this bidirectional approach also extend to the MCOs, OhioRISE plan, CME, and COE and providers.	The OhioRISE plan will work with MCOs and CMEs to build data exchange capabilities.

Commenter	Rule Number	Comment	Response to Author
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	We do not agree with (A)(1)(b)(ii) or (C)(1)(a)(ix) that would place every youth discharged from IP hospitalization at the ICC level of care coordination. Under the OhioRISE model, any youth that experiences inpatient hospitalization will be automatically enrolled in OhioRISE – even if this is their first experience with the behavioral health system. Since COVID, we have seen a significant increase in youth accessing crisis services with suicidal behaviors and actions with more than half never having accessed behavioral health care. For those experiencing an initial major depressive episode, impulsive behavioral response, or anxiety related hospitalization admission, they will require good discharge planning and a warm hand-off to outpatient treatment services – but few will require a HFW assessment and intervention at the level of ICC. Certainly, ICC is likely appropriate for youth experiencing multiple hospitalizations. However, we urge more flexibility and clinical decision making on placement of youth discharging from IP hospitalization into an appropriate level of care coordination based on medical necessity. It should not be a one-size fits all approach at the highest level of intensity.	The CANS assessment recommends a tier of care coordination, and the assigned tier may be modified to best fit the youth or family capacity and choice. If ICC is recommended at OhioRISE enrollment, the youth/family can decline ICC or MCC and will default to limited care coordination. For the youth described in your question, they may be assessed after enrollment and determined to not meet the enrollment criteria for OhioRISE.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.2:** OhioRISE Care Coordination	What types of assurances and experience will be used to validate the care coordination staff have the experience to manage clinical intense, complex cases described in (B)(2)(m)?	The OhioRISE plan is responsible for ensuring their CME providers have the required qualified and credentialed staffing and expertise to address the needs of the populations they serve. Assurance of expertise in high-fidelity wraparound will occur through COE training/certification.
University Hospitals	**5160-59-03.2:** OhioRISE Care Coordination	For both ICC and MCC, we would recommended adding care coordination responsibility: if the youth requires a higher level of care such as crisis stabilization, inpatient psychiatric admission, or residential care, the Care Coordinator will contact the treating team within 24 hours of placement and work collaboratively to ensure treatment plan maintained and development of safe discharge plan.	This concept is currently covered at a high level in the activity requirements: (viii) Performing referrals and linkages to appropriate services and supports, including natural supports, along the continuum of care; and (ix) Facilitating discharge planning and transition activities for youth admitted to a psychiatric residential treatment facility or an inpatient behavioral health facility Additional CC best practices for transitions will be incorporated during implementation via training and guidance.
University Hospitals	**5160-59-03.2:** OhioRISE Care Coordination	There are care plans approved by OhioRISE....Question: are those accessible to others providing healthcare to the youth? If not, we would raise that for consideration and if so, there should be language to that effect.	The Child and Family Centered Care Plan is available to the child and family team via the OhioRISE plan's member and care coordination portals.

Commenter	Rule Number	Comment	Response to Author
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	All foster parents will not be adequately prepared to manage this population. How will they ensure families are prepared to manage these children?	The rule was updated to add new language in paragraph (C) to specify instances in which a foster care setting will be eligible to provider behavioral health respite. Further details will be addressed in guidance issued to providers regarding training requirements and supports for service delivery.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	Any foster home? Therapeutic? Not all foster homes will be adequately prepared to provide the care needed for these youth.	The rule was updated to include a definition of "treatment foster home" and provisions to improve the clarity on settings in which behavioral health respite may be provided.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	Are kinship homes included?	The rule was updated to include a definition of "kin" and provisions to improve the clarity on settings in which behavioral health respite may be provided.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	Can the need for emergency BH respite be the trigger for enrollment in OhioRISE?	At this point in time, only children first enrolled in the OhioRISE program may be eligible to receive behavioral health respite. ODM will continue to monitor usage of behavioral health respite once the service is effective.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	Does this include kinship homes?	The rule was updated to include a definition of "kin" and provisions to improve the clarity on settings in which behavioral health respite may be provided.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	Does this include therapeutic foster homes? Where do they fall? Are they getting respite through other mechanisms and not OhioRISE?	The rule was updated to include a definition of "treatment foster home" and provisions to improve the clarity on settings in which behavioral health respite may be provided.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	Does this include therapeutic/treatment foster homes?	The rule was updated to include a definition of "treatment foster home" and provisions to improve the clarity on settings in which behavioral health respite may be provided.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	How does this get approved for emergency respite? What documentation is needed for emergency respite versus on going respite access?	Emergency behavioral health respite by nature is not considered an ongoing need. If behavioral health respite is needed for a longer term period, rather than a short term-basis, to help address the needs of a youth and/or a primary caregiver, ongoing behavioral health respite may be provided so long as ongoing coverage is supported by a CANS assessment and additional medical necessity criteria in accordance with care coordination timeframes. Behavioral health respite always will be documented on the Child and Family-Centered Care Plan

Commenter	Rule Number	Comment	Response to Author
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	How does this get documented? How do you track this?	The expectations for coverage of behavioral health respite will be documented on the Child and Family-Centered Care Plan. Documentation will be in accordance with high fidelity wraparound practices and with consideration of person-centered planning standards. Further details will be addressed in guidance issued to providers and care management entities.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	How would this work for emergency behavioral health respite?	Emergency behavioral health respite by nature is not considered an ongoing need. If behavioral health respite is needed for a longer term period, rather than a short term-basis, to help address the needs of a youth and/or a primary caregiver, ongoing behavioral health respite may be provided so long as ongoing coverage is supported by a CANS assessment and other medical necessity criteria in accordance with care coordination timeframes.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	Is there a plan to regulate or enforce this, such as documentation provided of sleep/waking times each night? Assuming the point of this is to ensure that caregivers provide adequate supervision regardless of time of day/night, then consider stating that	Additional guidance will be forthcoming regarding appropriate documentation of awake and sleep hours on the child and family-centered care plan. At minimum it is the expectation that all behavioral health respite hours will be documented on the child and family-centered care plan and planned in accordance with high fidelity wraparound processes and with the involvement of the youth and their primary caregiver.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	Not all foster homes will be able to handle this. How does one foster home qualify while another does not? What is the criteria?	The rule was updated to add language to paragraph (C) to specify instances in which a foster care setting will be eligible to provider behavioral health respite. Further details will be addressed in guidance issued to providers regarding training requirements and supports for service delivery.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	This is unclear. Right now JFS pays for behavioral health respite. In what scenarios would OhioRISE pay for this service for a child in JFS custody?	The rule was updated to specify that Title IV-E funding cannot be used for coverage of the OhioRISE behavioral health respite. The OhioRISE Plan is responsible for reimbursement of the behavioral health respite service, regardless of service delivery location.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	This might set up finger pointing of who pays? OhioRISE or JFS? This is a big concern that both will deny while they point to each other to pay.	The rule was updated to add new language in paragraph (C) to specify instances in which a foster care setting will be eligible to provider behavioral health respite. Further details will be addressed in guidance issued to providers regarding training requirements and supports for service delivery.

Commenter	Rule Number	Comment	Response to Author
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	what is the training for the respite providers? Not all foster care parents can handle. Are kinship homes included?	Provider eligibility criteria, including training, is detailed in paragraph (C) of the rule. The rule was updated to add kinship homes as a permissible setting in which behavioral health respite may be provided.
Cincinnati Children's Hospital Medical Center	**5160-59-03.4:** OhioRISE Behavioral Health Respite	Will this include therapeutic/treatment foster homes?	The rule was updated to include a definition of "treatment foster home" and provisions to improve the clarity on settings in which behavioral health respite may be provided.
Ohio Children's Alliance	**5160-59-03.4:** OhioRISE Behavioral Health Respite	Children enrolled on Medicaid who are referred to and enrolled in a BH Respite program should be categorically eligible for OhioRISE. Often times, this type of program serves children in crisis situations. If children must already be enrolled into OhioRISE, then very few deserving children will have access to BH Respite as a preventative service.	At this point in time, only children first enrolled in the OhioRISE program may be eligible to receive behavioral health respite. ODM will continue to monitor usage of behavioral health respite once the service is effective, and will reexamine any necessary programmatic changes in the future.
Public Children Services Association of Ohio	**5160-59-03.4:** OhioRISE Behavioral Health Respite	“Primary caregiver” is used in this section and in Section (D)(5)(a). “Guardian” is used in Rule 5101 59-03.2, and family is defined in this section and in Rule 5160-59-01. We recommend being consistent throughout with using the same terminology with associated definition(s).	Thank you for your recommendation.
Public Children Services Association of Ohio	**5160-59-03.4:** OhioRISE Behavioral Health Respite	How is “care coordination arrangement” being defined? Would this include limited care coordination?	Care coordination is defined in OAC rule 5160-59-01 and 5160-59-03.2. Limited care coordination is included.
Public Children Services Association of Ohio	**5160-59-03.4:** OhioRISE Behavioral Health Respite	If this provision only applies to children in custody of a PCSA, then this section should also include kinship caregivers caring for youth in PCSA custody. We suggest the following language: “Payment is allowed for behavioral health respite for children in PCSA custody delivered in resource family home when: …”.	The rule has been updated to include the recommendation.
Public Children Services Association of Ohio	**5160-59-03.4:** OhioRISE Behavioral Health Respite	Thank you for including foster homes as a population that can access behavioral health respite services.	Thank you for your feedback.
Public Children Services Association of Ohio	**5160-59-03.4:** OhioRISE Behavioral Health Respite	What assessments will be used to determine if ongoing behavioral health respite is needed by the youth and family? Respite is a service typically utilized when a family requests it – we are concerned about the need to assess whether a family “needs” respite or not if it is something they are requesting for a child with significant behavioral health needs in their care.	Establishment of medical necessity criteria and ongoing determination of medical necessity for behavioral health respite services will be conducted by the OhioRISE plan. The OhioRISE provider agreement outlines the service and prior authorization requirements the OhioRISE plan may establish. The OhioRISE provider agreement can be found on the OhioRISE web page: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise

Commenter	Rule Number	Comment	Response to Author
Legal Aid Society of Greater Cincinnati	**5160-59-03.5:** OhioRISE Wraparound Support (renamed Primary Flex Funds)	(B): As drafted, it is unclear what this section means by "wraparound supports" and it should be revised for clarity. It is unclear from the language of this definition what relationship, if any, there is between the wraparound supports provide by OhioRISE and wraparound as an existing high-fidelity model of care coordination. See https://wraparoundohio.org/. This can also be confusing as this rule package provides a separate definition for "supplemental wraparound supports" at proposed rule OAC 5160-59-05.4(B)(4).	As a result of public feedback, the Ohio Department of Medicaid (ODM) is changing the name of the service defined in 5160-59-03.5 to "Primary flex funds."
Legal Aid Society of Greater Cincinnati	**5160-59-03.5:** OhioRISE Wraparound Support (renamed Primary Flex Funds)	(E)(1)(b): This section should be revised to eliminate its exclusion of "items solely for entertainment or recreational purposes." One benefit of wraparound funds is that funds can be used for creative therapies or items that will prevent a youth from needing hospitalization (such as an inexpensive mobile phone to text a clinical provider, or enrollment in art therapy). We are concerned that this limitation will result in unnecessary limitations of wraparound supports that may, at first glance, appear to be for entertainment purposes but are actually therapeutic.	This exclusion aligns with similar services available under other 1915(c) waivers and is consistent with the application of such funds. Primary flex funds must support and address an identified need in the child and family-service plan within the confines of what is allowable the claiming of Federal Financial Participation (FFP).
Legal Aid Society of Greater Cincinnati	**5160-59-03.5:** OhioRISE Wraparound Support (renamed Primary Flex Funds)	(E)(2): As drafted, this section sets a budget ceiling of fifteen hundred (1,500) dollars a year for wraparound supports. This does not seem realistic. Depending on what additional services a youth may need, this will not be able to cover those services. For example, the fifteen hundred (1,500) dollars would not cover the cost of an ongoing service such as equine therapy, or be able to fund a therapeutic camp as well as another service. Rather than setting a specific cost cap, we recommend this section be revised to allow additional funds to be released as needed.	The available primary and secondary flex funds are in addition to the funds already available to the individual through existing community resources. They are not intended to replace other funds already available, and instead should be added in and used when local resources are not available or adequate to address needs.
Legal Aid Society of Greater Cincinnati	**5160-59-03.5:** OhioRISE Wraparound Support (renamed Primary Flex Funds)	(E)(3)(a)-(b): These sections should be amended to explain how a youth's resources will be assessed before wraparound funds are utilized. Youth may not receive needed services when assumptions are made about what resources are available to them (e.g., reliance on a caregiver who cannot actually provide the support an agency believes they can, or access to a fund that is limited or by application only). This section should be revised to clarify who will assess what resources are available, how this will be communicated, and what a youth or family should do if they disagree with this assessment.	The requirement that a youth or their primary caregiver does not have funds to purchase services, equipment, or supplies to authorize wraparound supports is a Federal requirement for the use of this type of funding. The OhioRISE Plan will be reviewing the request of budget authority for flex funds. The Ohio Department of Medicaid (ODM) will work with the OhioRISE Plan to address these concerns in future guidance to best meet the needs of youth served by the OhioRISE program.
Legal Aid Society of Greater Cincinnati	**5160-59-03.5:** OhioRISE Wraparound Support (renamed Primary Flex Funds)	As drafted, this section also poses implementation challenges for youth in foster care. Without explicit policies, a child in foster care may not get wraparound services because OhioRISE determines Job and Family Services will fund a service, and JFS relies on OhioRISE to fund the service. This section should be amended to include specific language for youth in foster care, or to reference clear policies as to how resource availability will be assessed for youth in foster care.	The requirement that a youth or their primary caregiver does not have funds to purchase services, equipment, or supplies to authorize wraparound supports is a Federal requirement for the use of this type of funding. The Ohio Department of Medicaid (ODM) will work with the Ohio Department of Job and Family services to address these concerns in future guidance to best meet the needs of youth in foster care who are served by the OhioRISE program.

Commenter	Rule Number	Comment	Response to Author
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.5:** OhioRISE Wraparound Support (renamed Primary Flex Funds)	In (C)(2), we are confused by the included cross-reference to 5160-44-31 since this rule is not an HCBS waiver service. Further requirements in 5160-44-31 are inconsistent, duplicative, or conflict with other requirements of OhioRISE contained in this chapter (5160-59). As example, 5160-44-31 (B)(8) references “case managers”, but OhioRISE references CMEs and care coordinators; (B)(10) and (11) reference training requirements for other HCBS waivers not covered by OhioRISE; and (B)(14) describes documentation requirements that are inconsistent with paragraph (F) contained in this rule. While this cross reference is convenient, it creates confusion as to which program standards apply, training requirements are needed, and documentation expectations that varies for OhioRISE from other programs. More clarity is needed to understand why Waiver requirements are being applied to a non-Waiver service and to support provider compliance activities.	The primary flex funds described in this rule are a 1915(b) service and providers will be required to comply with the conditions of participations as referenced to in OAC 5160-44-31. When revising OAC 5160-44-31, the Department will consider adding clarification to the OhioRISE CMEs and care coordinators when case managers are being referenced.
Not Available	**5160-59-03.9**: Reimbursement (rule was deleted and content was incorporated into service-specific rules)	Fee Schedule for Care Coordination. The care management entity will receive a monthly payment of $1,036.56 for individuals who need intensive care coordination and $414.44 for those with moderate care coordination. There still has not been any discussion as to how the funds will flow to the managed care entity….is it based on the “predicted number to be served” or on the actual number to be served. During the behavioral health transformation to managed care, the managed care entities received the money up front and then the agencies had to bill to get it; there was no incentive to move the money to the providers. How will this issue be prevented under OhioRISE?	The OhioRISE Plan Provider Agreement details how payments will be made to the OhioRISE Plan. The OhioRISE Plan Provider Agreement can be found on the OhioRISE webpage https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise (link to PA). The provider agreement also includes requirements for payment to providers for services rendered, including prompt payment.

Commenter	Rule Number	Comment	Response to Author
The Buckeye Ranch	**5160-59-03.9**: Reimbursement (rule was deleted and content was incorporated into service-specific rules)	The The Buckeye Ranch is commenting on the rates for FFT Services through the new OhioRISE exclusive services. The The Buckeye Ranch has been operating a Family Functional Therapy team for over 8 years and has a lot of experience with this model and ability to successfully sustain a break-even model. With the current Medicaid rates, The The Buckeye Ranch will still lose significant funding to operate a team and adhere to the fidelity of the model. The The Buckeye Ranch currently must supplement funding above and beyond the Medicaid rates for the FFT program and will need to continue to supplement with the new rates proposed. Our revenue will decrease further from going to an encounter-based model to time-based model. Furthermore, the IHBT rates were increased related to travel time, administrative program support and overheard however these aspects were not change with the FFT rate. The only assumption that was changed specific to FFT rate was the time in the community. The assumption related to the direct hours per week for FFT was not updated either. IHBT and MST rates were increased by about 21% while FFT rate was only increased by about 13%. The The Buckeye Ranch has been providing both FFT and MST services for the last 8 years and we do not understand the difference in assumptions for aspects between MST and FFT regarding administrative support and overhead. We are asking to reconsider looking at the FFT rates.	IHBT will be a time-based reimbursement methodology (one unit = 15 minutes). While revising the IHBT rates that are incorporated into this rule, a number of changes in assumptions were applied to all of the types of IHBT (FFT, MST, and "base" IHBT). For example, changes in travel time, practitioner wages, and administrative program support were incorporated into updated rates for all types of IHBT. In other areas, differing factors of delivering the different types of IHBT lead to different assumptions factored into the rates. For example, differences in average caseload size across the types of IHBT drive differences in direct and indirect time assumptions for each type of service. FFT has the largest caseload out of all types of IHBT, and therefore caseload-related assumptions about direct and indirect time for FFT differ from the other types of IHBT, which have similarly smaller caseloads. In total, the FFT rate is being increased from the IHBT "umbrella" rate that is in place today by 2% for licensed practitioners and by 5% for independently licensed practitioners. Following implementation of the enhanced IHBT services and rates, ODM will continue to monitor and make adjustments to the services and rates as needed.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.9**: Reimbursement (rule was deleted and content was incorporated into service-specific rules)	In Appendix A and B, we recommend following the same table format for rates that includes any applicable modifiers and eligible place of service as is found in 5160-27-03, Appendix A. This will provide both clarity and consistency as well as support for implementation of the fiscal intermediary.	The content of this rule was moved to appendices for appropriate service-specific rules. The appendix of the appropriate rules were updated to match the format in 5160-27-03 upon original filing. Specifically, the places of services were added as currently in 5160-27-03.

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The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.9**: Reimbursement (rule was deleted and content was incorporated into service-specific rules)	In Appendix A, the service name "initial comprehensive assessment" sounds very clinical and likely will be confused with the comprehensive diagnostic assessment. Previous documentation and rate setting referred to this service as the "initial in-home assessment", which is preferred language and more consistent with the HCPCS naming terminology for this code, which is "Family Assessment by licensed BH professional for state defined services". We realize ODM chooses HCPCS codes that are close to the service being provided, and as a state defined code, ODM can make it available for unlicensed practitioners. However, we strongly urge renaming this service as either "initial in-home assessment" or "initial family/caregiver assessment".	The content of this rule was moved to appendices for appropriate service-specific rules. The code description will be as stated in the Appendix to rule 5160-59-03.2.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.9**: Reimbursement (rule was deleted and content was incorporated into service-specific rules)	In Appendix B, we appreciate ODM is using H2033 for MST and look forward to seeing which code ODM selects for FFT.	The content of this rule was moved to appendices for appropriate service-specific rules. H2015 with the TF modifier will be used for FFT. The code and modifier have been added to the appendix to rule 5160-27-05 (from 3/1/22-6/30/22) and rule 5160-59-03.3 beginning 7/1/22.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-03.9**: Reimbursement (rule was deleted and content was incorporated into service-specific rules)	We noticed that neither MRSS nor BH Respite Services are included as covered OhioRISE services in this rule. While MRSS will be covered under both Medicaid MCOs and OhioRISE, the most recently available OhioRISE Covered Services rule (5160-59-03) doesn't include reference to payment for MRSS– only MHAS certification requirements. Please provide information as to why neither service is included in the reimbursement rule and how reimbursement will be set.	The content of this rule was moved to appendices for appropriate service-specific rules. The behavioral health respite service is described in OAC 5160-59-03.4. The OhioRISE plan will be responsible for determining reimbursement for behavioral health respite. The OAC rule for MRSS will be included in the behavioral health chapter as 5160-27-03, and the reimbursement for MRSS will be included in the behavioral health fee schedule in rule 5160-27-03.

Commenter	Rule Number	Comment	Response to Author
		OHIORISE 1915(c) WAIVER RULES	
Legal Aid Society of Columbus	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	(A)(2)(b) specifies that an individual must "[h]ave a diagnosis of serious emotional disturbance (SED) as defined in rule 5122-24-01 of the Administrative Code" to qualify for waiver services. Per O.A.C. § 5122-24-01(35)(a)(1), an individual can only qualify as an individual with an SED if they are under the age of eighteen. If read literally, only children under the age of eighteen are eligible for the OhioRISE waiver, which is contrary to ODM's intent.	The Ohio Department of Mental Health and Addiction Services is updating rule 5122-24-01 to increase the age limitation in the definition of "Serious Emotional Disturbance. (SED)" As amended, the definition for SED will apply to individuals under the age of 21.
Legal Aid Society of Columbus	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	(A)(2)(c)(i) waiver eligibility requires "documentation of a risk of custody relinquishment." We would recommend clarifying this to include examples of acceptable documentation, to ensure objective and equitable application of this requirement when establishing waiver eligibility.	The Ohio Department of Medicaid (ODM) and the OhioRISE Plan will provide training and guidance to care management entities to clarify enrollment processes and expectations for the OhioRISE 1915(c) waiver.
Legal Aid Society of Columbus	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	(A)(5) an individual must consent to the child and family-centered care plan by signing and dating it to be eligible for the OhioRISE waiver. Similarly, per O.A.C. § 5160-59-04(C) an individual will be denied enrollment to, or disenrolled from the waiver if they do not meet any of the eligibility criteria in paragraph (A) at any time. We would recommend the proposed rules clarify that individuals have the right to due process regarding elements of the child and family-centered care plan. When families know that their eligibility for waiver services is contingent on signing a care plan, they are reluctant to disagree with the level, frequency, and duration of services listed. Once the care plan has been signed, LASC clients enrolled in similar 1915(c) waivers have shared that their case managers are unwilling to request additional services, especially if a new service is requested shortly after the signing of the care plan. Additionally, Bureau of State Hearings (BSH) hearing officers look to the signed care plan as proof that the individual agrees with the services listed and therefore do not need additional services. We suggest that OhioRISE offer a specific mechanism (a notice with appeal rights) that allows the family to object to the services in the care plan and pursue appeal options, while the child continues to receive the OhioRISE services that the parties can agree upon. Other sections in the O.A.C. allow for appeal rights similar to those mentioned above. For example, O.A.C. § 5123-9-06(K)(2) (rule related to the Department of Developmental Disabilities' Individual Options and Level One waivers) notes that an individual has the right to due process for disagreements with the type, amount, level, scope, or duration of services included in or excluded from an individual service plan. Similarly, O.A.C. §§ 5123-4-02(F)(2)(l)(i)-(v), 5123-4-02(F)(2)(m) require both written notice and an explanation from the service and support administrator regarding coverage decisions, regardless of whether the service is funded by the waiver or state plan.	The rule was updated to allow for the child and family-centered care plan to be signed by the 30th day of enrollment into the OhioRISE 1915(c) waiver. If the child and family-centered care plan is not agreed upon, hearing right will be available through the disenrollment process.

Commenter	Rule Number	Comment	Response to Author
Legal Aid Society of Columbus	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	(E) a youth will be provided notice and hearing rights regarding denial or termination of enrollment. o We would recommend adding that an individual's authorized representative is also entitled to receive this notice. o We would also recommend that the proposed rule clarify that individuals terminated from the waiver have the right to a pre-termination review of eligibility for other categories of Medicaid.	When the OhioRISE rules references a youth receiving hearing rights, those would be sent to their authorized representative or guardian, specifically for those under 18. For those being disenrolled, notification will be sent 30 days prior to the disenrollment with hearing rights. The OhioRISE plan and CME will work with child and family team to assist with developing a transition plan for those being disenrolled from the waiver.
Legal Aid Society of Columbus	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	We have limited ability to comment on this section, as the Ohio CANS assessment will not be available for public review until October 1, 2021. We would ask that the proposed rules be republished for comment after the CANS assessment is available for review. For example, per O.A.C. § 5160-59-04(A)(2)(a)(iii), one of the assessment criteria requires an individual to have "caregiver needs that require action to ensure 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." The proposed rule does not specify whether the "identified need" is interfering with the functioning of the caregiver or the individual. We would recommend that eligibility explicitly take into account, but not be contingent on, the health needs of available caregivers as it relates to their ability to continue to safely and independently care for the individual without waiver supports.	ODM is submitting all of the OhioRISE rules to the Common Sense Initiative Office (CSIO) for review. As part of the CSIO process, there will be additional opportunities for stakeholders and the general public to provide input on rules governing the OhioRISE program. The CANS assessment tool, decision support models, and assessor training information may be found on the OhioRISE website: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise.
Legal Aid Society of Columbus	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	We would ask that the proposed rules include an alternative method to the CANS assessment to establish eligibility where appropriate.	The Ohio CANS assessment tool was developed for broad application across multiple systems, including youth involved in child protection, developmental disability, department of youth services, and mental health and addiction. This ensures youth only need to go through one assessment across multiple providers. The tool gathers all dimensions of the youth and family story to determine needs and strengths and integrates multiple storytellers capturing the voice of the youth and family to produce a full consensus-based assessment. The CANS is updated routinely over the course of treatment to continue ongoing care planning. The CANS assessment will be used as a component in determining the inpatient psychiatric level of care needed for enrollment to the OhioRISE. Establishing level of care is a Federal assurance which the State must adhere to in order to operationalized a 1915(c) waiver.

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Legal Aid Society of Greater Cincinnati	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	(2)(b): As currently defined by the OAC, a diagnosis of serious emotional disturbance diagnosis (SED) is only available for people under eighteen (18). We recommend expanding this eligibility category to allow anyone age-eligible for OhioRISE who meets the other criteria for an SED diagnosis to qualify.	The Ohio Department of Mental Health and Addiction Services is updating rule 5122-24-01 to increase the age limitation in the definition of "Serious Emotional Disturbance. (SED)" As amended, the definition for SED will apply to individuals under the age of 21.
Legal Aid Society of Greater Cincinnati	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	(3)(c): As drafted, this section is written in such a way that a youth in transition could be assessed very frequently. This would be repetitive and resource intensive. We recommend being more specific about what constitutes a "significant change" and limiting LOC assessments to no more than once every sixty (60) days.	A youth's change in condition or situation may warrant an update to their child and family-centered care plan. Significant changes may include, but are not limited to, a change in health status, referral to or active involvement on the part of a protective child service agency, and/or institutionalization.
Legal Aid Society of Greater Cincinnati	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	(A)(10)(a): Given that youth are eligible for OhioRISE if under twenty one (21) pursuant to EPSDT, the same age group should be eligible for the waiver. To align with EPSDT and maintain consistency with the language used in OAC 5160-1-14(A)(1) to define EPSDT eligibility in Ohio, this language should be revised to say that individuals who are "younger than twenty-one years of age" are eligible for OhioRISE.	Although it might be stated differently, both represent individuals 20 years of age or younger.
Legal Aid Society of Greater Cincinnati	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	(A)(2)(a): This section should be revised for clarity. It is difficult to assess the CANS criteria discussed in this proposed rule section without being able to see the CANS and understand what is required to meet the four (4) criteria listed. In addition, it is confusing which criteria must be met to be found eligible for a waiver under the CANS. It appears that, perhaps, one must meet both subsections (i) and (ii) as well as either (iii) or (iv). If this is correct, it should be made clearer in the rule.	The rule was updated to provide clarification regarding how eligibility is operationalized using the CANS, rating tool, and decision support model. Additionally, CANS training provides additional clarity on rating caregiver needs and strengths when no caregiver is identified.

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Legal Aid Society of Greater Cincinnati	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	(A)(6): This section should be revised to be consistent with enrollment and eligibility requirements language for DODD waivers. See OAC 5123-9-01(D)(6). Additionally, the cost cap should be eliminated. Youth with significant mental health needs might be eligible for the OhioRISE waiver, but have needs that are estimated at over fifteen thousand (15,000) dollars. Not only will the waiver provide specific services, but also gives a Medicaid ineligible youth access to medically necessary services under Medicaid which could exceed this cost cap. These individuals with extreme needs should not be denied a waiver because their needs may exceed this cost cap. Thus, this section should be revised to indicate that individuals should be able to have "needs met through waiver services at or below the cost limitation, and through a combination of informal and formal supports including, but not limited to, waiver services, Medicaid state plan services, private health insurance plan benefits, non-waiver services, and/or natural supports." Additionally, we recommend revising the cost cap. Instead of having a universal waiver cost cap, each youth should be assigned an individual funding level based on their assessed needs, similar to the funding scheme for the Individual Options (IO) waiver.	ODM worked with its actuary to determine the cost limit threshold for the OhioRISE 1915(c) waiver and each of the OhioRISE waiver services based on the amount and duration of waiver services the enrollees might need. Cost limit thresholds were developing with an understanding that youth enrolled in the waiver are likely to access to the new, enhanced, and existing services that offered through the full OhioRISE program. Ohio Medicaid will monitor the use of the OhioRISE 1915(c) services and the needs of waiver enrollees as the OhioRISE program matures.
Legal Aid Society of Greater Cincinnati	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	(E): This section should be amended. Consumers should be issued notice and hearing rights for enrollment in the OhioRISE waiver, disenrollment or termination, and denial of specific waiver services.	The rule includes provisions related to hearing rights when a youth is denied enrollment to the waiver and disenrolled from the waiver. Ohio Administrative Code rule 5160-59-03.1 describes the process the OhioRISE plan must follow when issuing written notice on authorization changes or denials of authorized services. Each of the 1915(c) waiver rules was updated to include language regarding OhioRISE plan denial, reduction, termination, or suspension of OhioRISE 1915(c) waiver services constituting an adverse benefit determination that can be appealed in accordance with 51160-26-08.4.

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Ohio Council for Home Care & Hospice	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	Additionally, there is a technically change to be made in rule 5160-59-04- OhioRISE Home and community based services waiver (HCBS): eligibility and enrollment. The age is defined "individuals age 21 and under level of care" we believe it is supposed to say "under the age 21". Currently, there are a lack of mental health/ behavioral health HCBS providers in the community and we believe that the inclusion of home skilled nursing, therapy, and social work throughout these rules would help achieve the vision / mission that ODM is trying to enact with the OhioRISE program.	The rule was updated to include clarifying language. Also, the types of services being described in your comments (e.g., skilled nursing, therapy, and social work services) will remain available and accessible to youth enrolled on the OhioRISE 1915(c) waiver. These types of state plan services will be available through either a traditional Managed Care Organization (MCO) or through Fee-for-Service. The rules governing the provisioning of home health nursing, therapy, and social work services are available within other Ohio Department of Medicaid rules located in 5160 of the Ohio Administrative Code.
Public Children Services Association of Ohio (PCSAO)	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	Section (A) (2) (iv). We are confused by this section. Please clarify the intent of this provision.	This language is reflective of the CANS decision support model used to determine appropriate level of care for OhioRISE waiver eligibility. CANS decision support model information may be found on the OhioRISE website: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	How will the waiver costs be calculated in (A)(6)? Does this include only the costs associated with Waiver services covered under these HCBS rules? How will those costs be estimated at the time of enrollment? Is it accurate that a youth/family would be ineligible if cost estimates exceed $15,000?	The waiver cost cap of $15,000 is inclusive of all OhioRISE 1915(c) waiver services, excluding the emergency funding for secondary flex funds. Youth enrolling on the waiver must be expected to use less than or equal to the waiver cost cap during a year of waiver enrollment. The waiver cost cap is set to accommodate youth with intensive needs and expected costs for these specific waiver services. State plan and other services included in the OhioRISE benefit package can be utilized to serve all youth enrolled on the OhioRISE 1915(c) waiver, and the 1915(c) waiver cap costs do not include the costs associated with non-waiver services.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	In (A)(2), we remain concerned that OhioRISE Waiver eligibility is limited solely to individuals that meet an inpatient (IP) LOC even though the criteria has been clarified. When referencing IP LOC does ODM intend to mean the individual actually meets the requirement for placement in setting defined in (A)(2)(c)(ii) and is not just "at risk of institutional placements"? This continues to be a very high bar to access waiver services and further clarification is needed.	For an individual to be enrolled in any 1915(c) waiver, a State must ensure an individual meets a qualifying institutional level of care (LOC), as indicated in the Federally approved waiver application. As specified in the OhioRISE 1915(c) waiver application, a youth must meet the " hospital inpatient psychiatric facility for individuals age 21 and under" level of care.

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The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	Language in (A)(2)(a) relies on the CANS assessment as part of the IP LOC determination. However, the CANS decision support model, at currently available includes criteria for PRTF, but does not otherwise address psychiatric IP services, ICF/IID, or other acute care institutional setting. Further, clinical decision making to determine appropriateness of placement at an inpatient level of care currently requires an independently licensed practitioner or health officer today. Utilization of the CANS and the assigned assessor credentials requires further consideration if this is the entry point for Waiver eligibility.	The Ohio Department of Medicaid (ODM) worked with the Praed Foundation to develop a specific decision support model for the purposes of determining the qualifying level of care needed for enrollment in the OhioRISE 1915(c) waiver. As specified in the OhioRISE 1915(c) waiver application, a youth must meet the " hospital inpatient psychiatric facility for individuals age 21 and under" level of care to be eligible for the waiver. Other Ohio Medicaid 1915(c) waivers cover alternative institutional levels of care (e.g., hospital, nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID.) This OhioRISE 1915(c) waiver decision support model can be found in the CANS section of the OhioRISE website: https://managedcare.medicaid.ohio.gov/wps/portal/gov/manc/managed-care/ohiorise/ohiorise.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	What is the IP LOC assessment now referenced in (A)(3)? How is this similar or different from the CANS? What individuals or licensed clinicians are eligible to conduct the IP LOC assessment? How is this similar or different to the criteria outlined in (A)(2)?	The IP LOC assessment is a reference to all three components comprising the assessment mentioned in (A)(2)(a)-(A)(2)(c). The rule was updated to add language to paragraph (A)(2) of proposed rule 5160-59-04 for clarification.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-04:** OhioRISE 1915(c) Eligibility and Enrollment	Who makes and what criteria will be used in (A)(9) to determine a youth's needs can safely be met in a HCBS setting? More definition of the criteria and eligible practitioner making this safety determination is strongly suggested.	During the course of an assessment for initial and ongoing 1915(c) waiver program eligibility, the Case Management Entity will make the determination that the approval of waiver services, in conjunction with other informal or formal supports, will ensure needed supports to enable an individual to live safely in a HCBS setting.

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Legal Aid Society of Columbus	**5160-59-05:** OhioRISE 1915(c) Covered Services and Providers	The proposed rule does not specify whether any part of the child and family-centered care plan is subject to prior authorization. To ensure continuity of care, we would ask that the rules specify that the services in child and family-centered care plans are not subject to prior authorization unless they request an overall amount above the funding limit, similar to O.A.C. § 5123-9-06(B)(16) and O.A.C. § 5123-09-07.	The OhioRISE plan will review and need to approve all members' child and family centered care plans, as indicated in the Ohio Administrative Code (OAC) rule 5160-59-03.2, OhioRISE Care Coordination. OhioRISE 1915(c) waiver services, including the participant directed budget for secondary flex funds, will need to be approved by the OhioRISE plan using the care plan review process. Some OhioRISE non-waiver services may require prior authorization. The OhioRISE plan will publish the service limitations that will require prior authorization along with the process how to request prior authorization when needed in accordance with the OAC rule 5160-59-03.1, OhioRISE Utilization Management. Please also note, the Department of Developmental Disability (DODD) rules cited in your comment are specific to funding ranges existing in the Individual Options waiver program. The OhioRISE 1915(c) waiver is not structured to include funding ranges, similar to those in existence for the IO program. Rather, individuals may use up to the $15,000 waiver cost cap proposed for the OhioRISE waiver for waiver services. Therefore, no changes will be made to rule 5160-59-05.
Legal Aid Society of Columbus	**5160-59-05**: 1915(c) Covered Services and Providers	§ 5160-44-02 is not mentioned in any other part of the proposed rules, most notably O.A.C. § 5160-59-01 or O.A.C. § 5160-59-03.2. As noted in the 1915(b) waiver application, all OhioRISE members are children with special health care needs. Therefore, we would recommend that any reference to the development and implementation of a child and family-centered care plan— especially the definition of this tool—include a reference to O.A.C. § 5160-44-02 to ensure clarity and consistency in the use of these plans in accordance with 42 C.F.R. § 438.208 and 42 C.F.R. § 438.210.	A child and family-centered care plan including any of the OhioRISE 1915(c) waiver services described in 5160-59-05 must be developed in accordance with 5160-44-02 due to federal HCBS waiver requirements implemented across all ODM 1915(c) waivers. Other services being provided through OhioRISE are not subject to these same requirements when updating the child and family-centered plan.
Legal Aid Society of Columbus	**5160-59-05:** OhioRISE 1915(c) Covered Services and Providers	5160-59-05(C) and O.A.C. § 5160-59-04(A)(5) the child and family-centered care plan is developed and implemented in accordance with the process and criteria set forth in O.A.C. § 5160-44-02.	A child and family-centered care plan including any of the OhioRISE 1915(c) waiver services described in 5160-59-05 must be developed in accordance with 5160-44-02 due to federal HCBS waiver requirements implemented across all ODM 1915(c) waivers. Other services being provided through OhioRISE are not subject to these same requirements when updating the child and family-centered plan.

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Legal Aid Society of Columbus	**5160-59-05:** OhioRISE 1915(c) Covered Services and Providers	The proposed rule does not specify a length of authorization periods for child and family centered care plan services. However, O.A.C. § 5160-59-03.2 requires 30- or 60-day reviews of these plans depending on the assigned tier of care coordination. To ensure continuity of care, we would ask that the proposed rule clarify that regardless of the frequency of plan reviews, service authorization periods can be up to 12 months, consistent with O.A.C. § 5160-44-02, 42 C.F.R. § 438.208 and 42 C.F.R. § 438.210 ("authorization periods [that] reflect the ongoing need for these services to avoid disruptions in care." 81 Fed. Reg. 27498, 27631 (May 6, 2016)).	The child and family centered plan will be reviewed and approved by the OhioRISE plan. When approving, the child and family centered plan will include the units of service and the length of time of the services are needed. It will then be monitored and updated as specified tier care coordination they are assigned. A level of care redetermination for OhioRISE 1915(c) waiver eligibility will be completed at least annually; a review of the child and family care plan may also be included as part of the redetermination process.
Legal Aid Society of Greater Cincinnati	**5160-59-05:** OhioRISE 1915(c) Covered Services and Providers	(D)(1)-(4): As drafted, this regulation limits waiver-covered services to out-of-home respite, transitional services and supports, therapeutic mentoring and supplemental wraparound supports. This is an extremely limited set of waiver services, compared to other waivers, which provide, for example, remote supports, transportation, and homemaker personal care services. We are concerned that the needs of youth in crisis will not be met by this limited range of services, and recommend OhioRISE waiver services be expanded to cover at a minimum the services a youth could receive on another waiver.	Youth enrolled on the OhioRISE 1915(c) waiver will have access to all state plan and other services offered through the OhioRISE program, including transportation. Ohio Medicaid will monitor the use of the OhioRISE 1915(c) services and the needs of waiver enrollees as the OhioRISE program matures.
Legal Aid Society of Greater Cincinnati	**5160-59-05:** OhioRISE 1915(c) Covered Services and Providers	(E): This section should be revised. The language, that youth or family "must demonstrate their ability to participant-direct the supplemental wraparound supports service," is confusing and we do not understand what concern it addresses. As written, language like this could result in youth or family being denied wraparound services. If the concern is that a youth might not utilize wraparound services when wraparound services are in place, agreements regarding youth compliance with wraparound services can be documented in the child and family-centered care plan.	OAC rule 5160-59-05.3 (renumbered from 5160-59-05.4) was updated to remove the language indicating self direction specific to the self waiver.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-05:** OhioRISE 1915(c) Covered Services and Providers	In (B), references to Chapters 5160-44 and 5160-45 were added as criteria for provider eligibility, "as appropriate". In reviewing these chapters this is clear overlap, duplication and some conflict with other rules in 5160-59. Is the intent of this section to include service providers authorized under these three chapters separately or to require compliance with the totality of the rules in these three chapters of OAC 5160? From a compliance perspective this will be difficult to manage and creates undue risk of overpayment as provider eligibility requirements are highly unclear. Please clarify specifically which reference in Chapters 5160-44 and 5160-45 are considered applicable and update this section.	The rule was updated to include only those rules from Chapter 5160-44 of the Administrative Code that apply to the OhioRISE 1915(c) waiver providers, which includes 5160-44-02 and 5160-44-31. References to Chapter 5160-45 were removed.

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The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-05:** OhioRISE 1915(c) Covered Services and Providers	We appreciate this rule references the care planning process set forth in 5160-44-02 that is compliant with federal HCBS regulations. However, given the anticipated urgency of service need for youth and families applying for Waivers, would encourage some added flexibility and clarity that the care plan may address urgent needs to create a short term, immediate child and family-centered care plan to allow for immediate initiation of services when a waiver is approved. It would be useful to add language to support initial care plans to authorize urgently needed services. Otherwise, the outlined process is expected to delay care unnecessarily.	Federal Financial Participation may be claimed only for those waiver services that are included in the service plan and may not be claimed for services furnished prior to the development of the service plan or for services not included in the service plan. The Ohio Department of Medicaid will work with the Care Management Entities and the OhioRISE plan to ensure immediate needs are addressed as quickly as possible for youth newly enrolled on the OhioRISE 1915(c) waiver. Newly enrolled waiver members will have access to general Medicaid and OhioRISE services while the waiver care planning process takes place.
Legal Aid Society of Columbus	**5160-59-05.1**: OhioRISE 1915(c) Out-of-Home-Respite	(E)(3)(b) indicates that planned out-of-home respite is authorized in accordance with the utilization management process in 59-03.1. We would recommend adding a reference to the child and family-centered care plan here for clarity as well.	The rule was updated to provide additional clarity about the child and family-centered care planning process and the approval of the child and family-centered care plan. As stated in (E)(3)(b) of proposed rule 5160-59-05.1, the Care Management Entity (CME) will document out-of-home respite on the child and family-centered care plan. The OhioRISE plan will review and approve the child and family-centered care plan. Once approved, the out of home respite service can be provided.
Legal Aid Society of Greater Cincinnati	**5160-59-05.1**: OhioRISE 1915(c) Out-of-Home-Respite	We recommend clear policies be developed to outline when out-of-home respite will and will not be used for youth in foster care, including whether out-of-home respite will be used for foster care placement disruptions, and who can access out-of-home respite for a youth if they are in a foster care placement (e.g., if the foster parent can request respite, or if the request must originate with Job and Family Services). We would also recommend policies be developed to prevent a youth in foster care from transferring between respite placements (e.g., if a child hits the waiver respite cap) to minimize disruption.	ODM will work with the Ohio Department of Job and Family services to address these operational considerations through future guidance to best meet the needs of youth in foster care who are served by the OhioRISE program.
Not Available	**5160-59-05.1**: OhioRISE 1915(c) Out-of-Home-Respite	E-3 indicates a total of 90 days per calendar year, however the total available is $15,000 per child per year. If it is an out of home placement, the costs for 90 days will likely exceed the allocated amount. Do we need to reference "a total of up to 90 days, as long as the cost does not exceed the available funding under the waiver"?	All waiver services must be provided up to the waiver cost limit. ODM worked with its actuary to determine the cost limit threshold for the OhioRISE 1915(c) waiver and each of the OhioRISE waiver services based on the amount and duration of waiver services enrollees might need. Cost limit thresholds were developing with an understanding that youth enrolled in the waiver are likely to access to the new, enhanced, and existing services that offered through the full OhioRISE program. Ohio Medicaid will monitor the use of the OhioRISE 1915(c) services and the needs of waiver enrollees as the OhioRISE program matures.

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Not Available	**5160-59-05.1**: OhioRISE 1915(c) Out-of-Home-Respite	Item G (2) Payment for the out-of-home respite service does not include room and Board. Who will be responsible for this cost? Youth are eligible for up to 90 days per year. Youth eligible under OhioRISE under Medicaid eligibility are not eligible for this service.	Reimbursement for out-of-home respite will not include room and board.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-05.1**: OhioRISE 1915(c) Out-of-Home-Respite	In (C), we remain concerned that the settings are limited to PRTFs and ICF/IDD programs that would also be considered IP LOC, which is the higher level of care placement this program is intended to prevent. Since organizations holding certification as (DD) community respite services are also considered eligible, we recommend also allowing MHAS licensed Class 1 MH Residential Treatment programs as options for out-of-home respite. Further, there may be licensed treatment foster care families that could also serve as options and similar to the DD community respite service designation. Relying on institutional setting such as PRTFs and ICF/IDDs assumes unused capacity exists to respond to urgent needs. Providers will not routinely hold beds for respite and therefore would be challenged to meet urgent needs. This can be expected to be yet another respite service that is rarely if ever used, yet it vitally needed and requested by families.	The rule was updated to include MHAS Class One Residential Facilities as eligible providers of out of home respite providers.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-05.1**: OhioRISE 1915(c) Out-of-Home-Respite	Please clarify in (C) (6) what is meant by additional compliance reviews specific to the providers licensure or certification criteria. Does this mean the provider must also remain compliant with other Medicaid or state agency licensure or certification? Or that ODM retains the right to conduct compliance reviews outside of OhioRISE compliance monitoring.	Yes, providers of out-of-home respite will need to ensure compliance with licensure or certification requirements, in addition to ongoing compliance monitoring conducted by the OhioRISE plan for the purposes of Federal 1915(c) assurances. As an example, an Intermediate Care Facility for Individuals with Intellectual Disabilities acting as an out-of-home respite provider must be compliant with Ohio Department of Health certification requirements, Department of Developmental Disabilities licensure requirements, and specific OhioRISE provider criteria to be considered “compliant” with OhioRISE provider requirements.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-05.1**: OhioRISE 1915(c) Out-of-Home-Respite	The reference to full compliance with 5160-44-31 in (C)(2) creates compliance concerns with significant overlap, duplication, and some conflicts with provider requirements under 5160-59. Like concerns outlined in comment #4 above, examples of concerns with 5160-44-31 include references in (B) (8), (10), (11), and (14), which specifically conflicts with (F) in this rule. While this cross reference is convenient, it creates confusion as to which program standards apply, training requirements are needed, and documentation required that varies for OhioRISE from other programs. More clarity is needed to support provider compliance activities.	The rule was updated to exempt paragraph (B)(14) of rule 5160-44-31 of the Administrative Code since the requirements from that rule are also included in paragraph (F) of 5160-59-05.1. Other provisions in 5160-44-31 apply, as they describe other ODM 1915(c) waiver provider requirements.

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The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-05.1**: OhioRISE 1915(c) Out-of-Home-Respite	We appreciate (E)(2) and that the HCBS waiver needs to include new services that are not otherwise offered to the "regular" Medicaid enrollees. However, it remains concerning that only families qualifying for the Waiver with higher incomes or insurance that does not meet their child's needs will have access to out-of-home respite. Respite is the one services that families request more than any other service. In-home respite is critically important, but it also means that the family's choice would be limited to leaving their child at home as the sole means of respite care unless they are under this Waiver. So, few families will benefit from this high in-demand service.	Federal provisions prohibit a State from including respite as a benefit under its Medicaid state plan. ODM is addressing youths' and families' needs by offering and expanding the availability of in-home/community-based behavioral health respite within the OhioRISE program.
Legal Aid Society of Columbus	**5160-59-05.2:** OhioRISE 1915(c) Transitional Services and Supports	§ 5160-59-05.2 limits transitional services and supports to the following qualifying conditions: (a) within twenty-four hours of the youth enrolling on the waiver following an institutional placement, (b) transitioning between foster care settings, and (c) if the youth does not yet have available other appropriate behavioral health services provided under OhioRISE. Transitional services and supports are a valuable tool that would be beneficial in a variety of contexts, including, but not limited to: graduation from high school, death of a caretaker, or any other circumstance that the case management entity deems appropriate.	TSS is intended to support youth and their families as they experience changes in circumstances or qualifying conditions. The rule was updated at (E)(3) to clarify additional types of changes in circumstances and qualifying conditions that could result in the approved use of TSS.
Legal Aid Society of Greater Cincinnati	**5160-59-05.2:** OhioRISE 1915(c) Transitional Services and Supports	(D)(1): This section should be revised to state, "Primary components of the TSS service shall include," given the importance of the elements that follow. We recommend an additional component be added to address the youth's educational needs, such as "Identifying any needs related to a youth's progress in school, and identifying whether additional school-based supports are needed."	TSS is intended to be a short-term transitional service. Children and youth enrolled in the OhioRISE waiver will engage in care coordination informed by or consistent with high-fidelity wraparound, which addresses assessment and care planning across multiple systems, including the educational system. When appropriate and supported by the family/caregiver, individuals from the educational system will be included in the Child and Family Team and care planning related to supports in the educational system can be included in the Child and Family-Centered Care Plan.
Legal Aid Society of Greater Cincinnati	**5160-59-05.2:** OhioRISE 1915(c) Transitional Services and Supports	(E)(1)(a): As drafted, this section is confusing. It states that a youth will receive TSS if they are enrolled in the OhioRISE waiver and placed in an institutional setting – regardless of projected discharge date. If the intention is to provide TSS services as a youth is transitioning in or out of an institution, this section should be revised to state: "a waiver-enrolled or eligible youth will be authorized for TSS within twenty-four (24) hours of their placement in one of the following settings, thirty (30) days before projected discharge from the following settings, or within twenty-four (24) hours of their transition between two of the following settings."	Waiver enrollment and waiver services are intended to support a child in a home or community-based environment. TSS will not be available while the youth is in an institutional setting, but instead is intended to assist with a child or youth's transition immediately after they leave an institutional setting or experience a significant change in environmental circumstances. In many circumstances, TSS will be helpful to the child or youth during their first hours or days of waiver enrollment following an institutional placement, prior to the establishment of other longer term services and supports offered through the OhioRISE program.

Commenter	Rule Number	Comment	Response to Author
Legal Aid Society of Greater Cincinnati	**5160-59-05.2:** OhioRISE 1915(c) Transitional Services and Supports	(E)(1)(a): This section should be revised to align with the list of facilities and services at Proposed Rule 5160-59.02.1(B)(4). Receipt of care in a qualified residential treatment program (QRTP) is not currently listed at Proposed Rule 5160-59.02.1(B)(4), and that section should be amended to include it.	The purpose of 5160-59-02.1, OhioRISE first day eligibility, is to identify children and youth who have intensive behavioral health needs and who can be identified for day-one enrollment into the OhioRISE program. The purpose of the types of services and facilities listed in 5160-59-02.1 differs from the use of types of settings listed in 5160-59-05.2.
Not Available	**5160-59-05.2:** 1915(c) Transitional Services and Supports	This service is described under item E as being limited to transitions “to” a placement and does not include transition “from” a placement. In looking at transitions “to” a placement; will that placement even allow a provider to deliver services there (i.e. hospital; residential treatment facility; ICF; QRTP, etc.) Seems like it would be more beneficial to assist the youth in a transition back home from a placement?	Transitional Services and Supports (TSS) are always intended to be provided when a youth is transferring from a facility, as described in paragraph (E)(1)(a), to the home and community-based waiver program. The rule was also updated to include "following a transition into a kinship caregiver's home."
Public Children Services Association of Ohio (PCSAO)	**5160-59-05.2:** OhioRISE 1915(c) Transitional Services and Supports	Section (E) (1) (b) Does this mean that a youth can be in foster care AND on an OhioRISE waiver? If so, what would be some examples of a child in this scenario?	The rule was updated within section (E) to reflect transitions between the more general "home" term rather than foster homes. As recognized, the OhioRISE 1915c waiver is intended to prevent children from entering the custody of children's services. There may be some limited circumstances in which a child in custody could be enrolled in the OhioRISE 1915c waiver.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-05.2:** OhioRISE 1915(c) Transitional Services and Supports	As previously mentioned in #4 and #13, the continued cross-reference to 5160-44-05 in (C)(3) is convenient but creates duplication, confusion and even conflict in requirements for this OhioRISE waiver with requirements under other waivers. Additional clarification of compliance expectations is warranted.	Rule 5160-44-05 is being updated to incorporate OhioRISE programming and critical incident management processes.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-05.2:** OhioRISE 1915(c) Transitional Services and Supports	In (E)(1)(b) is there a timeframe associated with transitions between foster care settings?	The rule was updated at (E)(1)(b) to provide additional clarification regarding changes in circumstances or qualifying conditions, including an example covering transition into a kinship caregiver's home.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-05.2:** OhioRISE 1915(c) Transitional Services and Supports	Please clarify in (C) (7) what is meant by additional compliance reviews specific to the providers licensure or certification criteria. Does this mean the provider must also remain compliant with other Medicaid or state agency licensure or certification? Or that ODM retains the right to conduct compliance reviews outside of OhioRISE compliance monitoring.	Yes, providers of out-of-home respite will need to ensure compliance with licensure or certification requirements, in addition to ongoing compliance monitoring conducted by the OhioRISE plan for the purposes of Federal 1915(c) assurances. As an example, an Intermediate Care Facility for Individuals with Intellectual Disabilities acting as an out-of-home respite provider must be compliant with Ohio Department of Health certification requirements, Department of Developmental Disabilities licensure requirements, and specific OhioRISE provider criteria to be considered “compliant” with OhioRISE provider requirements.

Commenter	Rule Number	Comment	Response to Author
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-05.2:** OhioRISE 1915(c) Transitional Services and Supports	The definition of covered activities in (D) has been improved. However, if TSS is intended to be a stabilization service rather than a crisis de-escalation service as defined in (B)(2), the service components described in (D)(2)(a) and (b) remain in conflict as they specifically include de-escalating crisis or preventing crisis. It remains difficult to clearly differentiated these specific activities from MRSS or when it would be appropriate in place of MRSS. Please clarify or further revise to focus on stabilization support rather than crisis de-escalation.	The rule was updated in paragraph (D) to replace the word "de-escalation" with "stabilization."
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-05.2:** OhioRISE 1915(c) Transitional Services and Supports	The name change for this service offers more clarity – thank you.	Thank you for your support with the Ohio Department of Medicaid's proposed name change for this service.
Legal Aid Society of Columbus	**5160-59-05.3**: OhioRISE 1915(c) Therapeutic Mentoring	(B)(3) states that "natural supports" has the same meaning as set forth in O.A.C. § 5160-59-01. As recommended by other commenters, we would suggest using a definition of natural supports consistent with other sections of the Administrative Code. For example, O.A.C. § 5123-9-06 (B)(10) specifically notes that natural supports must be voluntary, consistent with requirements in 42 C.F.R. §§ 441.301(c)(1)-(3), 441.725(a)-(c).	Therapeutic Mentoring is being removed as an OhioRISE waiver service at this time. The definition of natural supports throughout the Chapter 59 rules was developed very specifically with stakeholders for OhioRISE programming. No changes to the natural support definition in either rule will be made at this time.
Legal Aid Society of Columbus	**5160-59-05.3**: OhioRISE 1915(c) Therapeutic Mentoring	(E)(3) indicates that therapeutic mentoring is authorized in accordance with utilization management process in O.A.C. § 5160-59-03.1. We would recommend adding a reference to the child and family-centered care plan here for clarity as well	Therapeutic Mentoring is being removed as an OhioRISE waiver service. 5160-59-03.1 was updated to add language specific to the child and family-centered care plan.
Legal Aid Society of Greater Cincinnati	**5160-59-05.3**: OhioRISE 1915(c) Therapeutic Mentoring	(B)(3): This section provides an alternate definition of "natural supports" although a definition already exists in the OAC. The definition of "natural supports" in this rule and 5160-59-01 should be consistent with the definition of "natural supports" used when defining other Medicaid waiver services.	Therapeutic Mentoring is being removed as an OhioRISE waiver service at this time. The definition of natural supports throughout the Chapter 59 rules was developed very specifically with stakeholders for OhioRISE programming. No changes to the natural support definition in either rule will be made at this time.
Legal Aid Society of Greater Cincinnati	**5160-59-05.3**: OhioRISE 1915(c) Therapeutic Mentoring	(B)(4): This section should be amended for clarity. The definition of "therapeutic mentoring" is vague and does not meaningfully distinguish these services from others that provide support to youth under OhioRISE. We recommend adding additional detail about the types of services provided under "therapeutic mentoring" in order to explain what makes this service different from others provided under OhioRISE	Therapeutic Mentoring is being removed as an OhioRISE waiver service.

Commenter	Rule Number	Comment	Response to Author
Not Available	**5160-59-05.3**: OhioRISE 1915(c) Therapeutic Mentoring	Eligible providers include natural supports with lived experience. There is no requirement that they are certified or linked to a certified provider. How will they be paid? The coverage includes "assisting families and the enrolled youth with identifying community supports". This is already listed as a required service of the CME's? They also list "providing advocacy building techniques for families and enrolled individuals...this is the same mission of NAMI's Parent Advocate Program and Youth Move Program. There is no identified limit for the service "it is as specified in the approved plan".	Therapeutic Mentoring is being removed as an OhioRISE waiver service.
Public Children Services Association of Ohio (PCSAO)	**5160-59-05.3**: OhioRISE 1915(c) Therapeutic Mentoring	Section (B) (1). We are unfamiliar with the term "unit" of individuals and suggest changing this to "network" of individuals as this is a more widely used term.	Therapeutic Mentoring is being removed as an OhioRISE waiver service.
Public Children Services Association of Ohio (PCSAO)	**5160-59-05.3**: OhioRISE 1915(c) Therapeutic Mentoring	Sections (C) and (F). We are concerned that many who would be appropriate therapeutic mentors will not be able to meet the requirements outlined in these sections. For example, folks identified by the youth as natural supports and/or who have lived experience but not a professional degree may be excluded from providing this critical service.	Therapeutic Mentoring is being removed as an OhioRISE waiver service.
The Ohio Council of Behavioral Health & Family Services Providers	**5160-59-05.3**: OhioRISE 1915(c) Therapeutic Mentoring	We continue to contend this service as defined and described essentially mirrors and duplicates activities and services covered under MH TBS and CPST services covered in OAC 5160-27. The eligible service providers in (C) and the covered activities in (D) are the same or similar to TBS and CPST activities. It's duplicative and could be billed as either of those certified and covered MH services. Unless ODM can demonstrate clear and convincing differences or gaps this service fills outside of MH TBS and CPST, our recommendation is to eliminate this service from the Waiver package.	Therapeutic Mentoring is being removed as an OhioRISE waiver service.
Legal Aid Society of Columbus	**5160-59-05.4:** 1915(c) Wraparound Support (Renumbered to 5160-59-05.3, renamed Secondary Flex Funds)	(C) notes that, with stated exceptions, all provisions of O.A.C. § 5160-59-03.5 apply to supplemental wraparound supports provided under the waiver. O.A.C. § 5160-59-03.5(E)(3)(c) states that wraparound supports are authorized in accordance with O.A.C. § 5160-59-03.1. We would recommend adding a reference to the child and family-centered care plan here for clarity as well.	The rules for primary and secondary flex funds (renamed from primary and supplemental wraparound) were updated. The rules are now clear that the youth's care coordinator will work with the youth and their authorized representatives to develop a care plan including flex funds. The care coordinator will submit a recommendation for a participant directed budget to the OhioRISE plan as part of their submission of the child and family care plan. The participant directed budget will be reviewed and approved by the OhioRISE plan as part of their review and approval of the child and family care plan.

Commenter	Rule Number	Comment	Response to Author
Legal Aid Society of Greater Cincinnati	**5160-59-05.4:** 1915(c) Wraparound Support (Renumbered to 5160-59-05.3, renamed Secondary Flex Funds)	(B)(1): As drafted, this section is confusing. The referenced proposed rule does not clearly define “budget authority.” The definitions section for the entire OhioRISE rules package should be revised to include all relevant definitions, including “budget authority.”	The rule was updated remove this term from the definitions.
Legal Aid Society of Greater Cincinnati	**5160-59-05.4:** 1915(c) Wraparound Support (Renumbered to 5160-59-05.3, renamed Secondary Flex Funds)	(B)(4): This section and the other proposed rules that deal with “wraparound supports” and “supplemental wraparound supports” should be revised for clarity. As written, it appears “supplemental wraparound supports” includes emergency funds and participant-directed services, however, it is not clear from other proposed rules that these services are not included in “wraparound supports” generally. Further, the use of the term “wraparound” is confusing without context. If the OhioRISE program incorporates the wraparound or high fidelity intensive care coordination model, and this is how services pulled into that model will be funded, the proposed rules should clearly state that. However, if “wraparound” is meant to refer to “integrated” or “holistic” services, we recommend a different term and definition be used.	The rule was updated to clarify that emergency funds are not included in the limits on primary and secondary flex funds.
Legal Aid Society of Greater Cincinnati	**5160-59-05.4:** 1915(c) Wraparound Support (Renumbered to 5160-59-05.3, renamed Secondary Flex Funds)	(B)(5): As drafted, this section is confusing. All definitions should be moved to one section of the proposed rules for OhioRISE. The “waiver cost limit” of fifteen thousand (15, 000) dollars a year for OhioRISE is too low. This is much lower than the cost cap for the Self-Empowered Life Funding (“SELF”) waiver, which also aims to provide participant directed services, and is capped at thirty-thousand (30,000) dollars a year for children. Fifteen thousand dollars a year is also not realistic, given that at a minimum the OhioRISE waiver can provide up to ninety (90) days of respite care, transitional services and supports, therapeutic mentoring and supplemental supports to maintain a youth in the community. We recommend instead of having a waiver cost limit that each youth be assigned an individual funding level based on their assessed needs, similar to the funding scheme for the IO waiver.	ODM worked with its actuary to determine the cost limit threshold for the OhioRISE 1915(c) waiver and each of the OhioRISE waiver services based on the amount and duration of waiver services the enrollees might need. Cost limit thresholds were developed with an understanding that youth enrolled in the waiver are likely to access the new, enhanced, and existing services offered through the full OhioRISE program. Ohio Medicaid will monitor the use of the OhioRISE 1915(c) services and the needs of waiver enrollees as the OhioRISE program matures.

Commenter	Rule Number	Comment	Response to Author
Legal Aid Society of Greater Cincinnati	**5160-59-05.4:** 1915(c) Wraparound Support (Renumbered to 5160-59-05.3, renamed Secondary Flex Funds)	(D)(1): This section should be revised. A cost cap of three thousand (3,000) dollars a year is too low for youth with intensive mental health needs. We recommend this and all other language regarding cost caps be revised to assign cost based on an individualized assessment.	ODM worked with its actuary to determine the cost limit threshold for the OhioRISE 1915(c) waiver and each of the OhioRISE waiver services based on the amount and duration of waiver services the enrollees might need. Cost limit thresholds were developed with an understanding that youth enrolled in the waiver are likely to access the new, enhanced, and existing services offered through the full OhioRISE program. Ohio Medicaid will monitor the use of the OhioRISE 1915(c) services and the needs of waiver enrollees as the OhioRISE program matures.
Legal Aid Society of Greater Cincinnati	**5160-59-05.4:** 1915(c) Wraparound Support (Renumbered to 5160-59-05.3, renamed Secondary Flex Funds)	(D)(3): As drafted, this section caps emergency funds at two thousand (2,000) dollars a year. This is too low. We recommend this and all other language regarding cost caps be revised to assign cost based on an individualized assessment.	ODM worked with its actuary to determine the cost limit threshold for the OhioRISE 1915(c) waiver and each of the OhioRISE waiver services based on the amount and duration of waiver services the enrollees might need. Cost limit thresholds were developed with an understanding that youth enrolled in the waiver are likely to access the new, enhanced, and existing services offered through the full OhioRISE program. Ohio Medicaid will monitor the use of the OhioRISE 1915(c) services and the needs of waiver enrollees as the OhioRISE program matures.

Commenter	Rule Number	Comment	Response to Author
Hancock County Board of Alcohol, Drug Addiction and Mental Health Services	**All 1915(c) rules**	While I realize the issue was raised prior, and discussed, we continue to be concerned about the Waiver rules in relationship to health disparities. If a youth becomes eligible for the Waiver services (as proposed) then they will receive these services as well as all other Medicaid services that are available to youth enrolled into OhioRISE. We understand the goal is to reduce the need for custody relinquishment, and so the Waiver is being used to get those youth who are clinically in need eligible for services. The concern is that income eligibility has no bearing on enrollment/participation in the with Waiver program. In essence, this program contributes to the already existing health disparities that exist in our state. If you are income eligible for OhioRISE, you are only eligible for Medicaid reimbursable services but if you are Waiver eligible for OhioRISE, you get all the Medicaid reimbursable services AND access to all of the proposed services in the Waiver; irrespective of income. So, those with more resources, get more resources. The health disparity gap widens. We continue to advocate that there needs to be a way to take income into account? We are all for providing assistance to families in need, however, the way the rules are written, one could have a six figure income and still be eligible under the Waiver and have to make no financial contribution to the cost of care Our understanding is that those enrolled in the waiver will receive benefits beyond what those who become eligible for OhioRISE under Medicaid eligibility. It is our understanding that the overall “waiver cost limit” per child (the maximum amount of funding, excluding emergency funds) is $15,000 per 12 month period.) We continue to be very concerned about this issue. Youth enrolled through the waiver, as we understand it, will receive the following services that won’t be available to those who are enrolled in OhioRISE via Medicaid: a. Wrap Around Supports: $1500 within 365 days. b. Out of Home Respite: 90 calendar days within a 365 day period. c. Transitional Services and Supports: Authorized for an initial 72 hours, or until other appropriate behavioral health services provided under the OhioRISE plan are scheduled to begin, whichever occurs first. Prior authorization needed beyond 72 hours No limited indicated on the number of “transitions” allowed be child for this service. d. Therapeutic Mentoring: No limit identified. (services provided as identified on the family-centered care plan) e. Supplemental Wrap-Around Supports: $3,000 withing 365 day period (participant directed); $2,000 emergency funds.	For all 1915(c) waiver programs in the State of Ohio, Medicaid eligibility may be determined using the Federally allowable financial eligibility determination called a special income level (SIL). Financial eligibility using the SIL is detailed in rule 5160:1-6-03.1. Long-term services and supports offered in each of Ohio’s 1915(c) waiver programs are often cost prohibitive to families in need; in this way, Ohio is providing opportunities for care to individuals who otherwise would not have access to long-term services and supports. Federal regulations require states operating 1915(c) waivers to offer unique waiver services to enrollees - these are services that cannot be covered by the state plan. The Ohio Department of Medicaid is sensitive to needing to expand services to youth enrolled in OhioRISE, and has intentionally proposed a small initial array of additional services under the OhioRISE waiver; it is our intention that our collective system resources are used to develop a robust service array for the entire OhioRISE program and its enrolled population.

Commenter	Rule Number	Comment	Response to Author
		GENERAL COMMENTS	
Legal Aid Society of Columbus	**General Comments**	Given the critical role we hope the OhioRISE Waiver will play for our clients, we would also ask the Agency to consider revising and republishing the regulations to allow stakeholders a longer period of time to provide meaningful recommendations for this new program.	ODM is submitting all of the OhioRISE rules to the Common Sense Initiative Office (CSIO) for review. As part of the CSIO process, there will be additional opportunities for stakeholders and the general public to provide input on rules governing the OhioRISE program.
Legal Aid Society of Columbus	**General Comments**	Given the critical role we hope the OhioRISE Waiver will play for our clients, we would also ask the Agency to consider revising and republishing the regulations to allow stakeholders a longer period of time to provide meaningful recommendations for this new program.	ODM is submitting all of the OhioRISE rules to the Common Sense Initiative Office (CSIO) for review. As part of the CSIO process, there will be additional opportunities for stakeholders and the general public to provide input on rules governing the OhioRISE program.
The MetroHealth System	**General Comments**	Will these services be added to the list of OPHBH services (OAC 5160-2-76)?	CANS and MRSS service codes and rates will be added to the OPHBH fee schedule.
Ohio Council for Home Care & Hospice	**General Comments**	As the rules are currently written, we do not believe that the language addresses how HCBS can help provide an appropriate level of care in home based settings for behavioral and mental health services. These rules are intended to be for providers of HCBS, but we do not believe they encompass all of the necessary services to ensure that children can thrive in the home environment. The rules do include a definition for HCBS personal care services but do not include skilled nursing, therapy, and social work services, which we believe are all vital to help these children remain in their communities. OCHCH recommends including home health nursing, therapy, and social work services to ensure that children are able to receive the appropriate levels of care to remain in their home environment, as necessary. We also want to ensure that providers are reimbursed accordingly for the services rendered.	The types of services being described in your comments (e.g. skilled nursing, therapy, and social work services) will remain available and accessible to youth enrolled on the OhioRISE 1915(c) waiver. The rules governing the provisioning of home health nursing, therapy, and social work services are available within other Ohio Department of Medicaid rules located in 5160 of the Ohio Administrative Code.
Ohio Council for Home Care & Hospice	**General Comments**	As the rules are currently written, we do not believe that the language addresses how HCBS can help provide an appropriate level of care in home based settings for behavioral and mental health services. These rules are intended to be for providers of HCBS, but we do not believe they encompass all of the necessary services to ensure that children can thrive in the home environment. The rules do include a definition for HCBS personal care services but do not include skilled nursing, therapy, and social work services, which we believe are all vital to help these children remain in their communities. OCHCH recommends including home health nursing, therapy, and social work services to ensure that children are able to receive the appropriate levels of care to remain in their home environment, as necessary. We also want to ensure that providers are reimbursed accordingly for the services rendered.	The types of services being described in your comments (e.g. skilled nursing, therapy, and social work services) will remain available and accessible to youth enrolled on the OhioRISE 1915(c) waiver. These types of state plan services will be available through either a traditional Managed Care Organization (MCO) or through Fee-for-Service. The rules governing the provisioning of home health nursing, therapy, and social work services are available within other Ohio Department of Medicaid rules located in 5160 of the Ohio Administrative Code.

Commenter	Rule Number	Comment	Response to Author
Ohio Council for Home Care & Hospice	**General Comments**	Our members want to be able to take care of behavioral health pediatric patients, post an inpatient and/or residential behavioral health stay. They currently provide skilled nursing home visits until they are able to connect with a behavioral/ mental health provider in the community. The goal is to assess medication adherence, ensure the family understands the behavior plan, and mitigate concerns before an inpatient admission is warranted. They can also assist by administering injectable medications at home for patients who are non-adherent to their medication regimen and are only able to function safely at home when injections are administered timely.	The types of services being described in this comment (e.g., skilled nursing, therapy, and social work services) will remain available and accessible to youth enrolled on the OhioRISE 1915(c) waiver. The rules governing the provisioning of home health nursing, therapy, and social work services are available within other Ohio Department of Medicaid rules located in 5160 of the Ohio Administrative Code.
Ohio Council for Home Care & Hospice	**General Comments**	Our members want to be able to take care of behavioral health pediatric patients, post an inpatient and/or residential behavioral health stay. They currently provide skilled nursing home visits until they are able to connect with a behavioral/ mental health provider in the community. The goal is to assess medication adherence, ensure the family understands the behavior plan, and mitigate concerns before an inpatient admission is warranted. They can also assist by administering injectable medications at home for patients who are non-adherent to their medication regimen and are only able to function safely at home when injections are administered timely.	The types of services being described in your comments (e.g. skilled nursing, therapy, and social work services) will remain available and accessible to youth enrolled on the OhioRISE 1915(c) waiver. These types of state plan services will be available through either a traditional Managed Care Organization (MCO) or through Fee-for-Service. The rules governing the provisioning of home health nursing, therapy, and social work services are available within other Ohio Department of Medicaid rules located in 5160 of the Ohio Administrative Code.
The MetroHealth System	**General Comments**	Will hospitals who provide OPHBH services be able to provide any OhioRISE services? MetroHealth has 3 providers (1 Counselor, 2 Psychologists) that want to do the CANS assessment but have been told they don't belong to an "agency" and therefore cannot conduct the training. Please let us know soon if this is a service that will be added to the OPHBH fee schedule and how our providers are to be trained in CANS. If there is more appropriate contact for these questions, please send along their info.	The CANS assessment will be added to OPHBH fee schedule. Please contact Support@tcomtraining.com for assistance with training registration, if needed.
The MetroHealth System	**General Comments**	Will hospitals who provide OPHBH services be able to provide any OhioRISE services? MetroHealth has 3 providers (1 Counselor, 2 Psychologists) that want to do the CANS assessment but have been told they don't belong to an "agency" and therefore cannot conduct the training. Please let us know soon if this is a service that will be added to the OPHBH fee schedule and how our providers are to be trained in CANS. If there is more appropriate contact for these questions, please send along their info.	Some of the new OhioRISE services, including the CANS assessment, will be added to OPHBH fee schedule. Staff registering for the CANS training should try to type the first few letters of their hospital name to populate the field. If this does not work, staff or your organization will need to contact Support@tcomtraining.com and request their hospital be added.
The Ohio Council of Behavioral Health & Family Services Providers	**General Comments**	While we do not have any current comments or recommendations related to these rule changes, we appreciate the opportunity to review and comment on any future changes to these or other rules impacting behavioral health services.	Thank you for reviewing the rule package.