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5160-59-01 OhioRISE: definitions.

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

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

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

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

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

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

(3) "Child and adolescent needs and strengths (CANS) assessment" means either the "Ohio Brief CANS assessment" or the "Ohio Comprehensive CANS assessment" found at medicaid.ohio.gov (October 1, 2021) administered by an individual who has successfully completed training and is certified by the Ohio department of medicaid (ODM) designated entity to administer the CANS assessment.

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

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

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

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

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

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

(10) "OhioRISE plan" means a prepaid inpatient health plan (PIHP) as defined in C.F.R. 438.2 (October 1,

2021) and a health insuring corporation (HIC) as defined in Ohio Rev. Code 1751.01 which enters into an OhioRISE plan provider agreement with ODM.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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5160-59-02 OhioRISE: eligibility and enrollment.

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

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

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

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

(4) ~~As determined by the~~For youth age 6 through 20, have an Ohio ~~department of medicaid (ODM)~~Brief or ~~its designee, meet criteria for OhioRISE eligibility on the~~Comprehensive "child and adolescent needs and strengths" (CANS) assessment ~~that reflects sufficient behavioral health challenges and functional impairment~~, available on www.medicaid.ohio.gov (October 1, 2021), completed by a certified Ohio CANS assessor within 90 days of eligibility determination, indicating:

(a) Behavioral/emotional needs that require ~~coordinated intervention~~action to ensure that the identified ~~behavioral health needs, risk behaviors, and life~~need is addressed, and the need is interfering with functioning ~~are addressed~~; or the need is dangerous or disabling and requires immediate or intensive action; and either

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

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

(5) For youth age birth through 5, have an Ohio Brief or Comprehensive "child and adolescent needs and strengths" (CANS) assessment, available on www.medicaid.ohio.gov (October 1, 2021), completed by a certified Ohio CANS assessor within 90 days of eligibility determination, indicating:

(a) Early childhood challenges that require action to ensure that the identified need is addressed, and the need is interfering with functioning; or the need is dangerous or disabling and requires immediate or intensive action; and either

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

(c) Caregiver resources and needs indicate safety is an identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.

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

(1) Be an inpatient in a hospital with a primary diagnosis of mental illness or substance use disorder;

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

(3) Have an immediate need for OhioRISE services due to a behavioral health crisis, as indicated by a CANS assessment completed by a mobile response and stabilization services provider in accordance with rule 5160-27-13 of the Administrative Code, that demonstrates:

(a) The need for action or immediate intensive intervention to ensure that the identified behavioral health needs, risk behaviors, and life functioning are addressed; and

(b) The youth demonstrates at risk behaviors or other psychosocial factors which place the youth at high likelihood for out of home treatment or psychiatric hospitalization.

~~(C)~~ Enrollment in OhioRISE is mandatory for eligible youth who meet the requirements in paragraphs (A) or (B) of this rule and begins the earlier of:

(1) The first day of the month following the determination that the youth meets the requirements in paragraphs (A)(1) to (A)(4) of this rule; or

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

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

(4) The date mobile response and stabilization services are initiated for youth with an immediate need for OhioRISE services as described in paragraph (B)(3) of this rule; or

(5) The effective date of enrollment in the OhioRISE 1915(c) waiver.

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

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

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

(b) No longer meets the eligibility criteria described in paragraphs (A)(2) to (A)(4) of this rule.

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

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

(4) The date the provider agreement between ODM and the OhioRISE plan is terminated.

(5) The date the youth dies.

~~(E) All of the following apply when enrollment in the OhioRISE plan is terminated for any of the reasons set forth in paragraph (D) of this rule:~~

(1) ~~Such terminations may occur either in a mandatory or voluntary service area.~~

~~(2) All such terminations occur at the individual level.~~

~~(3) Such terminations do not require completion of a consumer contact record.~~

~~(4) If ODM fails to notify the OhioRISE plan of a youth's termination from the OhioRISE plan, ODM shall continue to pay the OhioRISE plan the applicable monthly capitation rate for the youth. The OhioRISE plan shall remain liable for the provision of covered services as set forth in rule 5160-59-03 of the Administrative Code, until such time as ODM provides the OhioRISE plan with documentation of the youth's termination.~~

~~(5) ODM shall recover from the OhioRISE plan any capitation paid for retroactive enrollment termination occurring as a result of paragraph (D) of this rule.~~

~~(F) Just cause~~(E) Member initiated disenrollments.

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

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

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

(c) The youth needs related services to be performed at the same time, not all related services are available within the OhioRISE plan's network, and the youth's primary care provider or another provider determines that receiving services separately would subject the youth to unnecessary risk;

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

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

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

(a) The youth or an authorized representative must contact the OhioRISE plan to identify providers of services before seeking a determination of just cause from ODM.

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

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

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

(e) The effective date of an approved just cause request must be no later than the first day of the second

month following the month in which the member requests change or termination.

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

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

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5160-59-03 OhioRISE: covered services.

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

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

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

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

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

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

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

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

(2) Mobile response and stabilization services (MRSS) as described in rule 5160-27-13 of the Administrative Code.

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

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

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

(a) Inpatient psychiatric services; or

(b) Inpatient substance use disorder (SUD) services (including withdrawal management) provided in accordance with American Society of Addiction Medicine (ASAM) level of care four.

(6) Psychiatric residential treatment facility (PRTF) services as described in 42 C.F.R. 441.151(October 1, 2021) through 42 C.F.R 441.184 (October 1, 2021).

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

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

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

(10) Behavioral health services rendered by psychiatrists and physician assistants under the supervision of

psychiatrists in accordance with Chapter 5160-4 of the Administrative Code and psychiatric advanced practice registered nurses in accordance with rule 5160-4-04 of the Administrative Code.

(11) Behavioral health services rendered by outpatient hospital providers in accordance with Chapter 5160-02 of the Administrative Code except for emergency department services.

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

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

(14) Limited customized goods and services described in rule 5160-59-03.5 of the Administrative Code included in a wraparound plan using flexible funding.

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

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

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

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

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

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

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

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

(4) The OhioRISE plan has to cover services as described in paragraph (B) in this rule related to the member's emergency medical condition when the member is instructed to go to an emergency facility by a representative of the OhioRISE plan or the member’s managed care organization (MCO), including but not limited to, the member's primary care provider (PCP) or the OhioRISE plan or MCO’s twenty-four-hour toll-free call-in-system.

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

(6) The OhioRISE plan has to cover the services described in paragraph (B) of this rule that are emergency services when the services are delivered by a non-contracting provider of emergency services. Such services will be reimbursed by the OhioRISE plan at the lesser of billed charges or one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate (less any payments for indirect costs of medical education and direct costs of graduate medical education that is included in the Ohio

medicaid program fee-for-service reimbursement rate) in effect for the date of service. If an inpatient admission results, the OhioRISE plan has to reimburse at this rate only until the member can be transferred to a provider designated by the OhioRISE plan.

(7) The OhioRISE plan has to cover the services as described in paragraph (B) of this rule that are emergency services until the member is stabilized and can be safely discharged or transferred.

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

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

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

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

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

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

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

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

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

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

(ii) The OhioRISE plan cannot be contacted; or

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

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

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

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

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

(d) The member is discharged.

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

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

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

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

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

(3) The OhioRISE plan is not responsible for payment of services provided through the medicaid school program (MSP) pursuant to Chapter 5160-35 of the Administrative Code. The OhioRISE plan will

ensure access to services described in paragraph (B) of this rule for members who are unable to timely access services or are unwilling to access services through MSP providers.

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

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

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5160-59-03.1 OhioRISE: utilization management.

(A) The Ohio Resilience through Integrated Systems and Excellence (OhioRISE) plan will have a utilization management (UM) program with clearly defined structures and processes designed to maximize the effectiveness of the care provided to the member.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

of medicaid (ODM).

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

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

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

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

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

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

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

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

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

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5160-59-03.2 OhioRISE: care coordination.

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

~~.~~(1) Intensive care coordination (ICC) using high-fidelity wraparound ~~(ICC)~~ is utilized when a "child and adolescent needs and strengths" (CANS) assessment and other clinical documentation indicates:

~~.~~(a) Significant behavioral health challenges that require an action or immediate intensive action to ensure that the identified behavioral health needs, risk behaviors, life functioning and caregivers needs are addressed; and

~~.~~(b) The youth requires the majority of care coordination activities be delivered in the ~~home setting~~community; and one of the following:

~~.~~(i) The youth demonstrates at risk behaviors or other psychosocial factors which place the youth at high likelihood for out of home treatment or psychiatric hospitalization~~.~~;

~~(ii~~ (ii) The youth is awaiting out of home behavioral health treatment;

~~.~~(iii) The youth is being discharged or has recently been discharged from a psychiatric residential treatment facility (PRTF), as described in ~~42 CFR 441.50 (October 1, 2021) through 42 CFR 441.184 (October 1,2021), or other~~ 5160-59-03.6, inpatient psychiatric hospitalization~~.~~ or other residential treatment facility and is returning to a community setting; or

~~.~~(iv) The youth has had multiple episodes of inpatient psychiatric hospitalization, or other institutional or residential community based treatment facility stays within the past 12 months.

~~.~~(2) Moderate care coordination (MCC) using a wraparound ~~(MCC)~~ informed model is utilized when a CANS assessment and other clinical documentation indicates:

~~.~~(a) Moderate behavioral health challenges that require an action or immediate intensive action to ensure that the identified behavioral health needs, risk behaviors, and life functioning are addressed; and one of the following:

~~(b~~ (i) The youth demonstrates at risk behaviors or other psychosocial factors which place ~~him or her~~the youth at ~~high likelihood~~moderate risk for out of home treatment or psychiatric hospitalization~~.~~;

~~(3~~ (ii) The youth has had an episode of inpatient psychiatric hospitalization, or other institutional or community based behavioral health treatment facility stay within the past 12 months; or

~~.~~(iii) The youth is currently involved with two or more child serving systems, which includes either child welfare, detention, or juvenile justice.

~~.~~(3) Denials of enrollment in ICC or MCC are subject to the appeal process described in rule 5160-26-08.4.

~~.~~(4) Limited care coordination delivered by the OhioRISE plan is utilized when a CANS assessment and other clinical documentation indicate that the youth's needs do not meet the ICC or MCC criteria, or for

youth that meet criteria for ICC or MCC but decline to participate in ICC or MCC.

(B) Care management entities (CMEs).

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

(2) CMEs will:

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

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

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

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

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

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

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

~~(h~~ (g) Report the incidents consistent with ODM policies in accordance with rule 5160-59-06 of the Administrative Code;

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

~~(j~~ (i) Provide all staff with training regarding cultural and trauma-informed care competency ~~as deemed acceptable by ODM~~, within ~~twelve~~three months of ~~program enrollment~~the date of hire and annually thereafter;

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

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

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

~~(n~~ (m) Have sufficient care coordination staff to meet care coordinator-to-youth ratio requirements

described in this rule;

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

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

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

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

~~(s~~ (r) Ensure that all care coordination services are provided conflict-free, meaning that care coordination functions are separated from service delivery functions. If the CME has both lines of business, the CME must establish firewalls between its care coordination function and its service delivery function.; and

(s) ~~I~~dentify and inform the OhioRISE Plan of unmet needs and barriers to effective care and assist in developing community resources to meet youth and families' needs.

(t) ~~E~~nsure care coordination activities provided are provided via telehealth only when it is the youth or family's choice for service delivery via telehealth.

~~-~~(C) Care coordination activities.

~~-~~(1) CMEs delivering ICC will:

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

~~-~~(i) An initial face-to-face contact will be offered within two calendar days of referral for ICC; and

~~-~~(ii) An initial ~~home- or community-based,~~ comprehensive assessment within fourteen calendar days of the youth's referral to ICC that includes:

~~-~~(a) Information from a new CANS assessment or existing CANS assessment that was completed within the ninety calendar days prior to the ~~home- or community-based~~comprehensive assessment; and

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

~~-~~(iii) A completed Ohio comprehensive CANS assessment within thirty calendar days of referral to ICC;

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

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

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

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

(vi) Developing a crisis safety plan, within fourteen calendar days of referral for ICC, for incorporation into the child and family-centered care plan;

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

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

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

~~(b~~ (x) Facilitating transition activities for youth transitioning amongst and between all facility and community-based settings.

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

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

(2) CMEs delivering MCC will:

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

(i) An initial face-to-face contact will be offered within seven calendar days of referral for MCC; and

(ii) An initial ~~home- or community-based,~~ comprehensive assessment within fourteen calendar days of the youth's referral to MCC that includes:

(a) Information from a new CANS assessment or existing CANS assessment completed within the ninety days prior to the ~~home- or community-based~~comprehensive assessment; and

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

(iii) A completed Ohio comprehensive CANS assessment within thirty calendar days of referral to MCC;

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

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

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

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

(vi) Developing a crisis safety plan, within fourteen calendar days of referral for MCC, for incorporation into the child and family-centered plan;

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

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

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

(b (x) Facilitating transition activities for youth transitioning between facility and community-based settings.

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

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

(D) CME care coordinator qualifications.

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

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

(3) ICC orand MCC care coordinators will:

(a) Have a minimum of three yearsyears' experience in children's mentalbehavioral health, child welfare, developmental disabilities, juvenile justice, or a related public sector human services or behavioral health care field, providing community-based services to children and youth, and their family or caregivers;

(b) Have a background and experience in one or more of the following areas of expertise: family systems, community systems and resources, case management, child and family counseling or therapy, child protection, or child development;

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

(d) Have the qualifications and experience ~~necessary~~needed to ~~manage complex cases and the ability to navigate state~~work with children and ~~local~~families who are experiencing SED, trauma, co-occurring behavioral health disorders and who are engaged with one or more child-serving systems. (e.g., child welfare, juvenile justice, education).

(E) CME care coordinator supervisory qualifications.

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

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

(3) Supervisors of ICC or MCC will complete the high-fidelity wraparound training program provided by an independent validation entity recognized by ODM.

(4) Supervisors will successfully complete skill and competency-based training to supervise delivery of ICC and MCC.

(5) Have a minimum of three years' experience in children's behavioral health, child welfare, developmental disabilities, juvenile justice, or a related public sector human services or behavioral health care field, providing community-based services to children and youth, and their family or caregivers;

(6) Have a background and experience in one or more of the following areas of expertise: family systems, community systems and resources, case management, child and family counseling or therapy, child protection, or child development;

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

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

(F) ICC and MCC staffing requirements.

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

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

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

(G) Required care coordination documentation includes:

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

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

(3) A crisis safety plan for each youth receiving ICC or MCC;

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

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

(H) Transition from ICC or MCC.

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

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

(I) Limitations.

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

(a) Transportation for the youth or family; and

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

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

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

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

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

(C) Eligible providers of IHBT services.

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

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

(b) Be certified by OhioMHAS in accordance with rule 5122-29-28 of the Administrative Code.

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

(D) Coverage.

(1) Medicaid payment may be made for IHBT rendered to individuals under age twenty-one years that meet the criteria for enrollment in the Ohio resilience through integrated systems and excellence (OhioRISE) plan as described in rule 5160-59-02 of the Administrative Code and the criteria to receive IHBT as described in rule 5122-29-28 of the Administrative Code.

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

(E) Limitations.

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

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

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

(c) Respite care.

(d) Transportation for the beneficiary or family.

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

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

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

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(a) Behavioral health assessments, screenings, and diagnostic evaluations, except for a "child and adolescent needs and strengths" (CANS) assessment completed in accordance with rule 5160-59-03.2 of the Administrative Code.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Eligible providers of OhioRISE respite services.

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

(a) Individuals employed by, or acting as an independent contractor of, an Ohio department of mental health and addiction services (MHAS)-certified and Ohio department of medicaid (ODM)-enrolled behavioral health provider as described in rule 5160-27-01 of the Administrative Code. Behavioral health providers are required to:

(i) Be credentialed or have received training for, or education in, behavioral health competencies and have demonstrated competencies in basic mental health skills, in accordance with rule 5160-27-01 and Chapters 5122-24 to 5122-29 of the Administrative Code; and

(ii) Receive supervision in accordance with rule ~~5165~~5160-27-01 of the Administrative Code~~:~~.;

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

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

(d) "Family" as defined in rule 5160-59-01 of the Administrative Code, who do not also meet the definition of "legally responsible family member" as defined in rule 5160-45-01 of the Administrative Code, and who do not reside in the home with the youth; or

(e) "Natural supports" as defined in rule 5160-59-01 of the Administrative Code.

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

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

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

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

(D) Coverage.

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

(a) Assistance with activities of daily living;

(b) Transportation; and

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

(2) Payment may be made for behavioral health respite when rendered to youth enrolled in the OhioRISE plan in accordance with rule 5160-59-02 of the Administrative Code who resides:

(a) ~~Reside with~~With his or her primary caregiver in a home that is not owned, leased, or controlled by a provider of any health-related treatment or support services; ~~and~~

(b) ~~Have~~In a foster home;

(c) In the home of kin; or

(d) In a treatment foster home; and

(e) Has behavioral health needs for the behavioral health respite as determined by the OhioRISE plan.

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

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

(5) Service delivery may occur in the following locations:

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

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

(c) A foster home licensed by the Ohio department of job and family services~~; or~~ (ODJFS);

(d) In the home of kin;

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

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

(6) Ongoing behavioral health respite services may continue to be covered if the youth participates in a care coordination arrangement, through the OhioRISE program, as described in rule 5160-59-03.2 of the Administrative Code.

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

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

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

(c) Behavioral health respite is identified on a youth's child and family-centered care plan developed by the care management entity or the OhioRISE plan as defined in rule 5160-59-01 of the Administrative Code.

(E) Limitations.

(1) Ongoing coverage of behavioral health respite is supported by assessments conducted in accordance with care coordination activity timeframes as set forth in rule 5160-59-03.2 of the Administrative Code when the provisions of paragraphs (D)(6) and (E)(1) of this rule are met.

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

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

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

(c) The medicaid payment does not ~~include~~cover room and board costs~~.~~; and

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

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

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

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

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5160-27-13 Mobile response and stabilization service.

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

(B) Eligible providers.

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

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

(C) Coverage.

(1) Payment may be made for the following MRSS activities:

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

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

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

(3) Prior authorization is not required for stabilization services when the following conditions apply:

(a) The provider has notified the Ohio department of medicaid (ODM) designated entity of the initiation of stabilization services; and

(b) Services are rendered within six weeks of completion of mobile response activities.

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

(5) The provider has to notify the ODM designated entity of termination or transition of services within three business days of the discharge date from stabilization services.

(D) Limitations.

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

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

(b) Respite care.

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

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

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

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

(a) Enrolled in intensive home based treatment as described in rule 5160-59-03.3 of the Administrative Code.

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

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

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

(e) Receiving psychiatric residential treatment facility services as described in rule 5160-59-03.6 of the Administrative Code, except for MRSS necessary to support admission to the facility.

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