Ohio | Department of Medicaid

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RE: ODM: BIA:ERF 190726 OhioRISE Rule Comments

Dear Teresa,

Thank you for taking time to review and comment on the OhioRISE Ohio Administrative Code (OAC) rules. The Ohio Department of Medicaid (ODM) reviewed your comments and responded to your concerns below.

5160-59-01 OhioRISE Definitions

1. In (B)(6) we recommend include additional language define how the child and family centered care plan will be used to meet the OhioRISE HCBS Waiver services "person centered plan" as defined in 5160-44-02. The OhioRISE HCBS rule 5160-59-05(B) makes this reference and then (C) speaks to services being authorized in the child and family centered care plan. So, clarifying these are one-in- the same for purposes of OhioRISE or describing how it differs under the Waiver would improve the rule.

   The definition of the child and family-centered care plan in 5160-59-01 is the definition to be used throughout the different rules for OhioRISE program. The OhioRISE 1915(c) waiver services described in OAC 5160-59-05 have additional requirements, as described in OAC 5160-44-02, for waiver services when included and approved on the child and family-centered care plan. These additional requirements do not apply to the non-1915(c) services. The definition in 5160-59-01 will be updated to reflect the requirements for waiver services when being included on the child and family-centered care plan.

2. In (B)(10), the added definition of "Individual Crisis and Safety Plan" is useful, but further description is needed as to what documentation and clinical oversight is required if this document is also intended to serve a "behavior support plan" that serves to authorize and/or manage the use of restraint, seclusion, or other restrictive interventions. Specifically, since the OhioMHAS seclusion and restraint rule is still under revision and does not currently require a specified "behavior support plan", DODD rules for behavior support plans are very prescriptive, and the definition does not indicate whether the "behavior support plan" component applies at all levels of care coordination, only OhioRISE waiver services, and/or PRFT level of care. It is unclear if this is a duplicate requirement, supplemental plan, incorporated by reference to other existing rules, or a new requirement for all OhioRISE members. Adding the behavior support plan language adds a significant clinical component to the crisis and safety plan that will also require additional costs and likely documentation requirements. We recommend clarifying the components of the Individual Crisis Safety Plan and under what conditions and circumstances the "behavior support plan" must be developed as the term is not used elsewhere in the rule package.

Thank you for your comments. In response to your feedback: - 5160-59-03.2 was updated to include the following language at (C)(1)(vi) and (C)(2)(ci): "For youth with behaviors that pose safety concerns for the youth or others, a licensed clinician working within or for the CME will consult on the individual crisis and safety plan, recommend de-escalation strategies that can be learned and used by the youth, parents, other caregivers to support the youth and prevent the use of restrictive interventions, and approve of the crisis and safety plan prior to its submission to the OhioRISE plan." - The definition of individual crisis and safety plan within 5160-29-01 was updated to reflect required de-escalation and prevention strategies. - Additional training and documentation requirements on de-escalation and restrictive interventions for providers of BH respite, out of home respite, and TSS that serve children and youth with behaviors that pose safety concerns for the youth or others.

5160-59-02 OhioRISE: Eligibility and Enrollment

3. We appreciate the added language describing the use of the CANS decision support model for eligibility and enrollment. It adds substantive clarity in rule. We also support the decision to remove the MRSS driven enrollment process and allow enrollment to occur under the standard process and "rolling enrollment" described in the rule. While maybe considered an operations and implementation issue, we would still like to see language that informs families prior to completing the CANS that the outcome/score on the CANS may change their health plan coverage as enrollment in OhioRISE is mandatory per (C). Transparency and informed consent about the use of the CANS remains imperative to support youth and family choice.

   As stated, the rule does indicate enrollment to OhioRISE is mandatory, and member rights will be explained in member materials. Educational materials are being developed for CANS assessors for completing a CANS assessment and for families receiving an assessment noting the outcome of the assessment may result in the mandatory enrollment. ODM is also considering updates to CANS assessor training with the COE.

4. In (D) it appears that a youth will remain continuously enrolled in OhioRISE until regardless of any further CANS score or change in clinical need or functioning. Is that the intent or is language needed that would allow for a transition back to coverage by the traditional Medicaid MCOs based on changes in clinical need and functioning?

   Paragraph (D) describes the conditions that would trigger a disenrollment from OhioRISE, as well as the timing for when the disenrollment would be effective. The rule language in (D)(1)(b) has been modified to clarify the disenrollment criteria, as follows: Once enrolled in OhioRISE, the youth will remain enrolled for a minimum of 180 days unless they reach the maximum age for OhioRISE eligibility. Following the initial 180 days, when a youth no longer meets OhioRISE eligibility based on a current CANS or a recent inpatient psychiatric admission (within 180 days), the youth will be disenrolled. This could occur if (after the first 180 days) the youth has a subsequent CANS that no longer meets OhioRISE eligibility or if there is no CANS submitted within six months to support continued enrollment in OhioRISE. OhioRISE disenrollment does not impact the youth's enrollment in their MCO. When a youth is disenrolled from the OhioRISE plan, the OhioRISE and the MCO will work together on a transition plan for the youth's behavioral health services and needs.

5160-59-02.1 OhioRISE: First day eligibility and enrollment

5. We support and appreciate the revisions made to this rule.

Thank you.

5160-59-03 OhioRISE: Covered Services

6. In (B)(6), we recommend removing the reference to "methadone administration programs" since that is historical language that doesn't include the broader range of medication assisted treatment and the OhioMHAS rule language has been updated. We recommend simply rephrasing the language to reference OTPs licensed by OhioMHAS under OAC Chapter 5122-40.

   ODM will update the rule with recommended language to remove the "methadone administration program" terminology.

7. (B)(10) indicates OhioRISE will cover all behavioral health services covered by outpatient hospital provider in accordance with Chapter 5160-2; however, it's not clear whether outpatient hospital providers will be expected to follow the rules governing service delivery in Chapters 5160-27 and/or 5160-59. To support consistency across the industry, we recommend clarifying that rules governing service delivery also apply for outpatient hospital providers on par with community behavioral health provider

   Service coverage rules that have been developed for new or enhanced OhioRISE services (including IHBT and MRSS) specify provider requirements of those services - including certification by MHAS, where applicable. Where MHAS certification is required and specified within these specific service rules, that requirement will apply to hospital providers. We appreciate your recommendation regarding further clarification regarding the applicability of other provisions within Chapter 5160-27 and 5160-59 to hospital providers more broadly and will consider those recommendations for future revisions to rules in Chapter 5160-2.

5160-59-03.1 OhioRISE: utilization management

8. We appreciate the added clarification regarding consideration of the child and family centered care plan as well as the specific reference to the Mental Health Parity and Addiction Equity Act.

   Thank you.

5160-59-03.2: OhioRISE: Care Coordination

9. Similar to comments on the OhioRISE Enrollment and Eligibility rule, we support the added language defining the CANS decision support tool in rule. This will promote consistency with use of the CANS.

   Thank you.

10. In (B)(2)(e), we understand the design of OhioRISE is to have all child and family centered care plans submitted to Aetna, the OhioRISE plan for review and approval. However, we continue to have substantive concerns about how this review and approval process may delay care and/or result in changes in service delivery outside the approved utilization management process. While ODM continues to report this is intended to be a quality improvement process, adding the "approval" language in rule could equally be construed as the OhioRISE plan being able to deny care agreed upon by the youth, family, and child and family team members. As previously

requested, we recommend stronger language to clarify services may not be denied following a review by the OhioRISE plan outside of the utilization management process.

All child and family-centered plans must be approved by the OhioRISE plan. Per draft 5160-59-03.1 OhioRISE Utilization Management (A)(3)(d), the OhioRISE plan must review and consider the child and family-centered care plan as part of their utilization management processes.

11. We appreciate and support ODM is requiring electronic, bi-directional data and information exchange between the ICC/MCC providers, OhioRISE plan, and the independent validation entity in (B)(2)(f). While this may be a starting point, we feel strongly that electronic, bi-directional data and information exchange is needed to support efficiency in business and clinical practice among all providers participating in the child and family team. It is costly and inefficient for providers to have to check various MCO and OhioRISE plan portals on an individual client basis to obtain electronic information. We again recommend including providers participating in the child and family team in (B)(2)(f).

    Thank you for your feedback. At this time, our focus is to operationalize sharing information bidirectionally between the CMEs and the OhioRISE Plan. ODM, the OhioRISE Plan, and the CMEs will work to share the child and family-centered care plan with members of the child and family team.

12. Language in (B)(2)(g) references reporting incident reports consistent with 5160-44-05, which applies to waiver programs. As drafted, it could be construed that this requirement applies to all OhioRISE services not just the OhioRISE waiver services. If the intent is to apply the incident reporting definitions of 5160-44-05 to all OhioRISE services, this will create new administrative reporting requirements that will be passed along to OhioRISE providers as the definition in this rule is more expansive and had different definitions than the OhioMHAS rules that community BH providers are required to report. CMEs will need to require the community BH providers and others participating in the child and family centered team to report these types of incidents. This will add substantive costs to revise processes, train community-based providers, and monitor reporting. We strongly recommend ODM clarify whether incident reporting under 5160-44-05 only applies to OhioRISE waiver service recipients and if not, update the BIA to incorporate the added costs to community providers.

    The requirement for the reporting incidents will apply to OhioRISE program, not just the 1915(c) waiver portion of the program. This rule pertains to the CMEs' responsibilities for reporting incidents in accordance with OAC 5160-44-05, which is being updated to include the OhioRISE program and is being filed to be effective 7/1/22. The OhioRISE plan has other responsibilities for reporting incidents in accordance with its Provider Agreement with ODM. Since the OhioRISE care coordination rule points to 5160-44-05 for compliance (where the requirements are outlined), the BIA for that rule includes the cost to providers for implementing the new requirement.

13. Language in (B)(2)(j) that allows CMEs one business day from the date of referral to contact the family to explain the services and obtain consent; however, language in (C)(1)(a)(i) requires ICC face- to-face contact within 2 calendar days of referral. This is likely to create a conflict in expectation as the ICC face-to-face referral could be required prior to one business day for contact to explain the service. At best, these are one in the same and the language in paragraph (C) would govern meaning services are initiated in 2 calendar days. At worst, contact could be

delayed by up to 4 or 5 days. As example, if a referral is made on Friday before a holiday weekend, under (B), the CME would not have to contact the family until Tuesday and then maybe the ICC Care Coordinator two days later on Thursday. However, if the referral was immediate for ICC, the family would be contacted from a Friday referral no later than Sunday, regardless of weekends or holidays. We recommend adding some clarifying language as to when contact is expected or defining the difference between (B)(2)(j) and (C)(1)(a)(i) to support youth and family access to care.

CMEs will operationalize these requirements as they see fit. ODM foresees outreach and engagement of the family for both of the activities noted by the commenter might take place within a single contact following the shortest timeframe required in the rule.

For example, the CME might have the assigned care coordinator reach out within one business day to explain the service and obtain consent. At the same time, the care coordinator could offer and schedule the initial face-to-face contact. In some cases, outreach to offer the initial face-to-face contact within two calendar days will be able to satisfy the requirement to outreach to the family within one business day if that same outreach includes an explanation of the service and obtaining consent.

14. With the revised staffing qualification in (D)(1) and (D)(3)(a), will this now allow individuals with peer recovery supporter certification to be care coordinators? Language in Appendix A of the rule notes in that peer recovery supporters are not eligible providers for payment for the required care coordination assessment services. However, the rule is now silent on this point. We recommend clarification as to whether peer recovery supporters are now fully eligible to be care coordinators for ICC/MCC and if lived experience meets the requirement of providing community-based services defined in (D)(3)(a)

To the extent a peer recovery supporter meets the requirements to be an ICC/MCC provider, they could provide ICC/MCC. Delivery of peer recovery services does count toward the years of experience required to deliver ICC/MCC. ODM, in consultation with the CABH COE, will provide additional guidance to CMEs regarding inclusion of lived experience in considering years of experience to qualify as a provider of ICC/MCC services. Rule language has been amended to clarify the experience requirement includes the provision of community-based services and supports.

15. Under (H)(2), the language indicates that the CME may recommend a care transition based on the child and family centered plan, but doesn't mention use of the CANS or other assessment tools. Does this imply that care transitions may be more fluid and can be made without completion of the CANS? Is it also correct this change in the child and family centered plan would need to be reviewed and approved by the OhioRISE plan? We recommend adding more clarity about what documentation or circumstances may necessitate a transition from ICC/MCC or MCC/ICC or to limited care coordination.

The care coordinator must update the child and family-center care plan every 30 days (ICC) or 60 days (MCC) or whenever there is a significant change. The CANS assessment is used to inform the child and family centered care plan and information from the assessment will be incorporated into the plan. If the child and family-centered plan is updated to indicate a change in tier, the CME would then pursue the transition.

Language at (H)(2) has been updated to reflect that the CME or the OhioRISE plan may pursue a transition of a youth to another care coordination tier when a CANS assessment or the child and family-centered care plan indicated that the youth's needs are no longer appropriate for the current tier.

16. Appendix A indicates that care coordination will be permitted in all valid place of service (POS) codes as defined by CMS. However, ODM currently is not using the CMS codes for telehealth services (02 and 10) but is relying on the GT modifier for telehealth. There may be other circumstances where the CMS POS codes differ from what ODM is allowing. This should be reviewed.

    There are no place of service restrictions on the coverage of ICC and MCC specifically. Additional details about use of modifiers will be provided in CME billing training.

17. Additionally, we note that the current rule omits any reference to the documentation requirement for care coordination activities and the child and family centered care plan, which seems necessary to support quality of care and compliance with expectations. We recommend adding language that defines the documentation expectations.

    Documentation requirements will be outlined in the CME manual developed collaboratively between, Aetna, CABHCOE and ODM. Final CME manual approval will come from ODM and will be used as a training tool for all CMEs.

18. Finally, similar to comments in item 15, we would note that beyond the initial ICC/MCC engagement, the rule is silent on further use of the CANS or other assessment tools to support continued stay or coverage. Both ICC/MCC services require a review of the child and family centered care plan every 30/60-days, respectively, or when clinical indicated, but doesn't reference further use of the CANS. OhioRISE advisory committee meeting and workgroup meeting have discussed more regular use of the CANS and CANS scores are used to determine eligibility for OhioRISE. We recommend further clarification on expected use of the CANS and/or frequency of completion.

    (C)(1)(iv) and (C)(2)(iv) require Ohio Children's initiative CANS assessment updates at a minimum of every ninety calendar days or whenever there is a significant change in the youth's needs or circumstances for youth receiving ICC and MCC (respectively). Care coordinators may choose to update the CANS when a significant change is noted as part of the child and family-centered care planning process. There are no limitations on the number of times the CANS can be used and billed when performing a CANS assessment is medically necessary.

<u>5160-59-03.3 OhioRISE: Intensive Home-Based Treatment</u>

19. Similar to our comment #6 above, as stated in (C) it does not appear that outpatient hospital providers would be considered eligible providers of IHBT. Is that correct? If not, please clarify that hospital outpatient providers are expected to provide services consistent with (C) and include them in the rule.

    Hospitals can be providers of IHBT through OPHBH and need meet the criteria in paragraph (C) to be able to provide the service.

20. We appreciate the enhanced rates for IHBT, MST, and FFT and the early adoption of these rates as of March 1, 2022. However, as community BH providers are facing significant new challenges in attracting clinical and supervisory staff to provide home and community-based services that require non-traditional hours, evenings and weekends, it may be necessary to review the actuarial soundness of these rates developed in August as the current recruitment and retention has changed in the marketplace. While the shortage of BH workforce is not new, new competition from the service, retail, distribution and insurance sectors are impacting staffing. Provider organizations want to expand IHBT services to support OhioRISE but may not be successful under the current rate structure. We recommend a plan and process to review the rate structure more regularly.

    Thank you for your feedback. We will continue to monitor workforce develop and the impact rates have on expansion of IHBT services across the state.

5160-59-03.4 OhioRISE: Behavioral Health Respite Services

21. We appreciate and support the changes that expand respite services settings and definitions.

    Thank you.

5160-59-03.05 OhioRISE: Primary Flex Funds

22. We support the name change for the rule and the additional clarifying language added to the rule, particularly describing the participant direction and participant directed budget as well as appeal rights under the adverse determination language.

    Thank you.

5160-59-04 OhioRISE HCBS Waiver: Eligibility and Enrollment

23. The proposed rule offers enhanced clarity and readability regarding the requirements for eligibility for the OhioRISE HCBS Waiver. We appreciate the additional clarification on the CANS criteria, functional impairment and behaviors that may result in custody relinquishment, inability to be enrolled in other HCBS waivers simultaneously, and that the youth will also be enrolled in Medicaid managed care.

    Thank you.

24. Once eligible for the OhioRISE HCBS Waiver, in (B)(1) we appreciate that the child and family care plan must be developed consistent with 5160-44-02, but the rule isn't clear whether this process will be led by the OhioRISE plan or the CME. Some additional clarification would be beneficial.

    The child and family care plan is developed by the OhioRISE plan or the CME, depending on the tier of care coordination to which the youth is assigned. As stated previously, ODM will be working with the OhioRISE plan to develop a manual on how the child and family-centered plans will operationalize the approval process for waiver services.

5160-59-05 OhioRISE HCBS Waiver: Covered Services and Providers

25. We appreciate the clarification made in the rule. In (B), the reference to 5160-44-31 could be confusing as that rule references several other HCBS related waiver rules, making provider eligibility complicated in terms of what is actually required. Further, it's not clear why the provider organization cannot be the CME developing the child and family centered care plan, which is assumed to be the person-centered plan referenced in 5160-44-02, and also the service provider if the appropriate firewalls are in place. Given the complexity and small enrollment projected, this may result in few providers willing to offer these specialized services.

    As part of the 2014 Home and Community-Based Services (HCBS) rule, the Centers for Medicare and Medicaid Services (CMS) established requirements for conflict-free case management for Medicaid beneficiaries obtaining HCBS, requiring that waiver case management activities be independent from the delivery of HCBS services. Firewall provisions that had previously been in place for states with 1915(c) waivers whose case management agencies were also providers of 1915(c) waiver services were eliminated, and those case management agencies were required to divest themselves from being waiver service providers if they wanted to continue to provide case management for 1915(c) waiver enrollees.

    The intent of these CMS requirements is to promote choice and independence by limiting any conscious or unconscious bias by a case manager when assisting an individual in identifying HCBS needs and developing plans to access services (i.e., preventing a care manager from steering individuals to the same agency where they are employed). Please note, CMEs are only expressly prohibited from providing the waiver services delivered under the 1915(c) OhioRISE waiver.

5160-59-05.1 OhioRISE HCBS Waiver: Out-of-Home Respite

26. We appreciate the addition of OhioMHAS Type 1 Residential programs as an eligible location for out- of-home respite services. We understand that the HCBS Waiver must include distinct services that are not part of the typical/available covered Medicaid benefit offered under OhioRISE. However, we continue to be concerned that youth and families do not have access to an out-of-home respite option unless they qualify for services under the waiver. In listening to families, we know this service is one of the most frequently requested service to support family stability, healthy coping, and management of acute symptoms.

    Respite is not coverable as a state plan service. Ohio Medicaid is creating significant additional flexibility to make the new BH respite service to all OhioRISE enrollees when medically necessary. The 1915(c) out of home respite service is being authorized under 1915(c) waiver authority and will only be available to children and youth enrolled on the OhioRISE 1915(c) waiver.

5160-59-05.2 OhioRISE HCBS Waiver: Transitional Support Services

27. We greatly appreciate the added clarification and definitions within the rule. It better defines the services and expectations for how this service will be offered and support individuals through these narrowly defined transitional events.5160-59-95.3 OhioRISE HCBS Waiver: Secondary Flex Funds

    Thank you.

28. We support the renaming of the rule and added clarification on participant direction and participant directed budget.

    Thank you.

5160-27-02 Coverage and Limitations of Behavioral Health Services

29. With this rule being open for revision, we recommend adding clarifying language in (B)(3)(c) to expressly permit coverage of CPST services for facilitating discharge planning while the individual is in a hospital setting. There have been several incidents where Medicaid MCOs are denying payment when CPST is billed on or before the date of hospital discharge, yet this service is expressly permitted to facilitate care coordination and discharge.

    The rule was revised to make ODM's policy clearer. ODM will also provide education to the MCOs regarding appropriate coverage of CPST in a hospital setting.

30. We understand the rational for removing the prior authorization language for SUD Partial Hospitalization and SUD Residential Treatment services in (C)(3) and (4) respectively as that language duplicates language in 5160-27-09. However, since this rule is included in the OhioRISE Clearance rule package that largely applies to individuals under age 21, it is not transparent to the SUD provider community that mostly serves adults. We urge ODM to make this rule language change more apparent and share widely with the SUD provider community.

    ODM will broadly disseminate information to behavioral health providers about the rule revision.

31. In (M), we understand and agree that the CANS payment is not included under CPST, TBS, or psychiatric diagnostic assessment. However, additional clarification is needed to permit same day service coverage and payment of the CANS and any of these three services. We want to assure that (M) is not read as denying payment when the CANS is rendered on the same day provided that time to complete the CANS is not included in the three other services.

    The rule was revised at (M) to state: The "Ohio children's initiative brief CANS assessment" and the "Ohio children's initiative comprehensive CANS assessment" are covered as defined in rule 5160-59-01 of the Administrative Code and may be billed separately for reimbursement.

5160-27-13 Mobile Response and Stabilization Services

32. With regard to reimbursable activities identified in (C)(1) and consistent with comments submitted to OhioMHAS regarding interpretation of 5122-29-14, providers need significantly more clarification as to how to count time in order to comply with definitions of the initial mobile response and the subsequent 72-hour mobile response timeframe. While this may be considered an operational issue, it's essential to have clarity in the rules to support coverage and reimbursement. We strongly recommend significant clarification be provided to support provider service development.

    The MHAS MRSS Practice Standards address when to begin counting time. Please see page 15 https://mha.ohio.gov/static/CommunityPartners/ECCY/MRSS-Practice-Standards-Final-Draft-March-2022%20.pdf. ODM will provide more detail regarding billing in the BH Provider Manual.

33. The language in (D)(2)(a) conflicts with (C)(1) that references OhioMHAS proposed rule 5122-29-14. In 5122-29-14 (M)(1)(c), it indicates mobile response may be provided to individuals enrolled in IHBT until the family is stabilized and then reconnected to the IHBT provider. This conflict is untenable and creates an inconsistency. Please review and update the appropriate rule(s) to resolve the conflict and assure coverage and reimbursement is clear.

    The MHAS MRSS Practice Standards clarify that if a young person is already involved with an intensive home-based service (IHBT, MST), the MRSS team is dispatched to de-escalate the presenting crisis. After the first mobile response visit occurs, the family is re-connected with the existing service within 24 hours and does not continue with the stabilization phase of the MRSS service. This is consistent with the ODM policy that allows coverage for the initial mobile respond and follow for a youth in IHBT, but does not allow coverage for stabilization services when a youth is in IHBT.

Again, thank you for taking the time to review and comment on the proposed rules. If you have any additional questions or concerns, please feel free to contact the OhioRISE Policy box at ohiorisepolicy@medicaid.ohio.gov.