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ODM CSI MRSS Rule Comments
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Thank you for the opportunity to provide comments and feedback on the OAC Rules 5160-27-13 and 5160-27-03 to implement new coverage and reimbursement methods for Mobile Response and Stabilization Services. We appreciate the collaborative efforts to build this important, crisis service needed by youth with urgent behavioral health needs and challenges.

Below are our specific comments on the OAC 5160-27-13.

1. B(2) states that eligible rendering providers are employed by or under contract with an eligible and designated regional MRSS provider. The language used in the proposed rule can be interpreted to limit contractual relationships solely to individual employed or contracted employees rather than allow and encourage establishing contracts with other provider organizations to provide services as part of the regional MRSS teams. Furthermore, agreements to provide services may be developed by contracts but may also include memorandums of understanding, of which no clarification is given in the current draft.
    a. **Recommendation**: Clarification that regional MRSS teams may enter into contracts or memorandum of understanding with other provider organizations as well as the MRSS team employing or contracting with individual rendering providers.

2. E(4)(b), E(4)(d) and E(4)(e) limits individuals in inpatient and residential treatment settings from receiving mobile response and stabilization services except to support admission. Stabilization services allow services to be provided to patients for up to six weeks, whereas inpatient or residential stays may not last six weeks. Stabilization services can support discharge planning, specifically with preparing caregivers and the young person for transitioning from a structured inpatient or residential stay back to a home setting with more triggers and less predictability, where there is also less immediate support and treatment incorporated into daily living. For example, a mobile response for a youth experiencing homicidal ideation with a detailed plan requires inpatient hospitalization, the mobile responder can assist with preparing the caregivers for discharge from the inpatient stay by working with those in the home to develop a safe transition plan back to the home. Stabilization services can support the family with securing and removing weapons and sharps, increasing informal support to develop a supervision plan, empowering and building skills with caregivers to manage the young person's symptoms, and coordinating with the hospital to incorporate any medication changes to the home structure and routine, etc. There are several ways for stabilization services to support the youth and their family with placement disruption while a young person is receiving another Medicaid service outlined in E(4)(b), E(4)(d) and E(4)(e).
    a. **Recommendation**: Revise the language in the aforementioned sections outlining exceptions to services limitations to also include services specifically to support discharge planning from SUD residential, hospitalization, and PRTFs respectively.

3. Appendix A, while intended for illustration purposes, does not incorporate the staffing models permitted under 5122-29-14 (M)(2) as proposed by OhioMHAS but rather almost exclusively describes teams operating under (M)(2)(b)(iii) and may be further interpreted as delivery of mobile response and not stabilization services. As drafted, this Appendix has zero weekly hours for licensed professionals under "practitioner" in each model, whereas peers, QBHS have hours identified as the only "practitioners". There are identified total weekly hours for a licensed professional under "supervisor" and an independent licensed professional under "consultation". However, a dependently licensed practitioner does not have a scope of practice to supervise. Further, OhioMHAS specified in 5122-29-14 (H)(1), as drafted, a licensed clinician is required as part of the mobile response team and may or may not be the supervising (independently licensed) clinician the for the team. Although the licensed supervisor can also be a team member, the hours reflected under the supervisor category are insufficient to meet mobile responses as part of the team. We believe this is an oversight and is creating concern that ODM is only anticipating rate setting to specifically prioritize and prefer models that limit the use of licensed clinicians or only view licensed clinicians as supervising services not directly delivering care.
    a. **Recommendation**: Revise the illustrative models in Appendix A to include the variety of MRSS team compositions as defined in 5122-29-14.

Thank you for the opportunity to share these comments. We share the goal of successful implementation of statewide, regional Mobile Response and Stabilization Services within the continuum of care for children and youth. We appreciate the collaborative effort on these rules. These services are imperative for youth with significant behavioral health challenges to stabilize in their least restrictive environments. We look forward to continuing our collaboration to create a regulatory environment that will support statewide expansion of MRSS in Ohio. If you would like to discuss our comments further, please do not hesitate to contact me at lampl@theohiocouncil.org.