DRAFT - NOT FOR FILING

5160-59-03.2 OhioRISE: care coordination.

(A) 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 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 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) 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 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 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:

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

(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) 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;

(g) Report the incidents consistent with ODM policies in accordance with rule 5160-44-05 of the Administrative Code;

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

(i) Provide all staff with training regarding cultural and trauma-informed care competency, within three months of the date of hire and annually thereafter;

(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;

(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;

(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:

(m) Have sufficient care coordination staff to meet care coordinator-to-youth ratio requirements described in this rule;

(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;

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

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

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

(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) Identify 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) Ensure 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 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 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 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;

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

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

(b) 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.

(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.

(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 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 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;

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

(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 and MCC care coordinators will:

(a) 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;

(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 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).

(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 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, 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 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) Direct 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.