OhioRISE
Frequently Asked Questions

OhioRISE is a specialized managed care program for youth with complex behavioral health and multi-system needs. On April 1, 2021, ODM selected Aetna Better Health of Ohio to serve as the OhioRISE plan. Based on a System of Care approach, OhioRISE aims to expand access to in-home and community-based services. Aetna will contract with regional care management entities to connect OhioRISE members and families with the resources they need to navigate their interactions with multiple systems such as juvenile justice, child protection, developmental disabilities, mental health and addiction, education, and others.

ODM, state agencies, the Child and Adolescent Behavioral Health Center of Excellence (COE), providers, families, Aetna, and other stakeholders from local and state child-serving systems are engaging through an advisory council and workgroups to develop and implement the program, including new and enhanced services and other major components. OhioRISE will also feature a new 1915(c) Medicaid waiver that will drive toward improving cross-system outcomes for its enrollees that will help families prevent custody relinquishment. This FAQ will help to communicate responses to ongoing questions and will continue to be updated and shared on a frequent basis.

General

Who is eligible to enroll into OhioRISE?

- Enrolled in Ohio Medicaid – either managed care or fee for service
- Ages 0 – 20
- In need of significant behavioral health services
- Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) tool

Additionally, if a child or youth have an inpatient stay in a hospital for mental illness or substance use disorder (SUD); or an inpatient in a psychiatric residential treatment facility (PRTF)

What is OhioRISE's rolling enrollment policy?

OhioRISE will use a rolling enrollment policy for all youth, rather than enrollment beginning at the first day of the next month. This means that following a CANS assessment, youth who are determined eligible for OhioRISE will be enrolled as of the date their CANS assessment is submitted. This is different from other managed care "day one enrollment" policies where enrollment is dated back to the first of the month in which a person is eligible.

Updated April 12, 2022
*This FAQ will continue to be revised as the services and components of the program are being developed and all responses are subject to change.

What services are available for youth in OhioRISE?

New and enhanced services available through OhioRISE include:

- **Care Coordination:** Depending on the youth's needs, they will receive one of three levels of care coordination. Tiers two and three of this service (moderate and intensive) will be consistent with principles of High-Fidelity Wraparound and be delivered by a Care Management Entity. Aetna Better Health of Ohio will provide care coordination for youth in tier one.
- **Mobile Response and Stabilization Service (MRSS):** Provide youth in crisis and their families with immediate behavioral health services to ensure they are safe and receive necessary supports and access to care (this new service will also be available to children who are not enrolled in OhioRISE).
- **Intensive Home-Based Treatment (IHBT):** Provides intensive, time-limited behavioral health services for children, youth and families that helps stabilize and improve behavioral health functioning. IHBT is an umbrella over multiple evidence-based practices. It aligns with the Family First Prevention Services Act (FFPSA) to cover MST and FFT.
- **Psychiatric Residential Treatment Facility (PRTF):** This service is aimed at keeping youth with the most intensive behavioral health needs in-state and closer to their families and support systems.
- **Behavioral Health Respite:** provide short-term, temporary relief to the primary caregiver(s) of an OhioRISE plan enrolled youth, in order to support and preserve the primary caregiving relationship.
- **Primary Flex Funds:** Services, equipment, or supplies not otherwise provided through the Medicaid state plan that address an identified need in the service plan, including improving and maintaining the individual's opportunities for full participation in the community.

What is the path in which youth and family input will be provided and honored into the system of care?

Consistent with System of Care core principles, OhioRISE intends to provide individualized services informed by youth and family voice and choice. The care coordinator will develop the Child and Family Team (CFT) that consists of the youth and both formal and natural supports. The CFT, together, develops the child and family-centered care plan and continuously meet to address ongoing changes and needs of the youth and family.

How will the MCO Care Coordination for physical healthcare factor into collaboration with OhioRISE stakeholders?

The MCOs providing physical health care services will take an active role in the child and family-centered care plan and child and family team as needed.

What is the future role of Family and Children First Councils and Multi-System Youth funding initiatives?

Family and Children First Councils play an integral role in ongoing support linking children and families to services and community resources including needed multi-system youth funding.

Updated April 12, 2022
*This FAQ will continue to be revised as the services and components of the program are being developed and all responses are subject to change.

What are the specific linkages among early identification (ex. through MRSS) to assessment, to CANS, to diagnosis, to care coordination?

Using MRSS as an example, the MRSS team will use the CANS tool to assess youth. If a youth meets certain criteria, they will enroll into OhioRISE to access the new and enhanced services including care coordination.

How will level of care be determined?

The CANS assessment along with other documentation will determine level of care coordination.

How will initial client attribution occur when OhioRISE begins?

Care management entities will be regionally located in 20 catchment areas across the state to serve children in tier two and three. Each catchment area will serve approximately 1,300 – 3,000 children.

Who will perform outreach to clients and families?

If the youth is eligible for OhioRISE, the OhioRISE plan, Aetna Better Health of Ohio notifies the family or guardian and assigns a level of care coordination. If the youth is not eligible for OhioRISE, ODM notifies the family or guardian of the determination and provides information on appeal rights.

How can current providers of these youth assist with messaging and initial onboarding to OhioRISE?

Current providers can talk with youth and families about OhioRISE and either perform the CANS or refer them for a CANS assessment by reaching out their MCP or a regional care management entity. The Ohio Department of Medicaid is developing member materials to assist with educating community partners and youth and families about the program.

How does OhioRISE work with already established local funding sources such as shared funding at Family and Children First Councils, Developmental Disability waiver funding and Multi-System Youth funds?

OhioRISE compliments these funding streams and provides additional resources and supports including new and enhanced services.

CANS

Will there be a universal CANS or other statewide provided assessment tools that county partners use so we are all utilizing the same assessment tool(s)?

Yes, the Ohio brief and comprehensive CANS assessment tool is being used across all child-serving systems in the state. There will be a CANS data system to help state agencies and local entities monitor outcomes and share information on multi-system youth.

How will we ensure consistent training and utilization of the CANS for OhioRISE, child welfare, and courts?

All systems and assessors will be trained by the Child and Adolescent Center of Excellence and use the same certification process from the Praed Foundation.

Who is performing the CANS, and how do they become contracted/approved to do them?

CANS assessors must maintain certification with the Praed Foundation and re-certify annually.

How do referrals to receive a CANS work?

Referrals for a CANS assessment to determine OhioRISE eligibility may be to the youth's MCO, the OhioRISE plan, a CME, a behavioral health provider, an MRSS provider, etc. There is no wrong door.

How will organizations access the CANS results or submit CANS results for use by OhioRISE and others? Providers are wondering how the communication will be handled, for example will there be a portal or centralized place that the CANS can be accessed and updated across different systems of care? Will Aetna, ODM, and/or the COE be building the CANS database for this information to reside in?

ODM is building the CANS database that will be accessible to CANS assessors, Aetna, the COE, Care Management Entities, and state administration staff.

Care Coordination

What is the assumption on the percent of youth that will be in intensive care coordination, moderate care coordination, and plan care coordination?

Most youth in OhioRISE will be served by care management entities. Within care management entity-provided care coordination, it is projected most youth will need moderate care coordination, fewer will need intensive care coordination. CMEs will serve approximately 1,300 – 3,000 children and youth per catchment area.

Who is the primary lead for child and family team meetings?

The CME's care coordinator is the primary lead for the child and family team meetings.

Will the CME be responsible for scheduling and inviting members?

The care coordinator will schedule and invite the child and family team members to participate in care planning meetings.

What are the requirements to be a care coordination provider?

The requirements are outlined in Ohio Administrative Code rule 5160-59-03.2.

For children enrolled on OhioRISE receiving moderate or intensive care coordination services, there will likely be scenarios in which those children would also see a case manager from another agency, such as for treatment foster care, or in-home TBS and PSR services. Can you confirm that there are no plans to limit the ability of non-CME case managers to provide Medicaid-funded case management services to children enrolled on OhioRISE.

The rule currently only excludes SUD TCM from being billed while a child is receiving ICC or MCC. Wraparound requires other parties in a child's life to remain involved and engaged. There is an expectation to participate in the Child and Family Team to understand roles of staff members providing services (including care coordination) and to incorporate services and roles into the child and family-centered plan will be critical for ensuring service and interventions support the goal of the plan and ensure there are services to meet those goals while avoiding duplication and fragmentation.

Will non-CME providers be at a heightened audit risk if they provide case management services to children enrolled on a moderate or intensive OhioRISE care coordination program?

TBS and PSR are therapeutic interventions, not case management services.

Are the moderate and intensive caseload sizes recommended ceilings or actual ceilings?

The caseload sizes are actual ceilings.

How will the MCO and OhioRISE plan coordinate and collaborate with families, youth, and providers?

The MCO and OhioRISE plan will coordinate and collaborate through the care coordination process. In intensive and moderate care coordination, they will help develop the care plan with the youth and family.

What is meant by authorization verses prior authorization for the child centered care plan and when services can begin, change, or terminate and who ultimately makes this decision?

Authorizing the Child and Family-Centered Care Plan does not require prior authorization. It is a quality improvement measure to ensure care coordination and resources are in place to meet the youth and family's needs.

PRTF

Are there any assumptions established regarding maximum annual budget, total permitted beds, total approved facilities, etc?

ODM is in the process of reviewing information regarding the number and location of PRTF beds and will make assumptions and projections later since we will not roll out this benefit until FY2023.

Aetna Better Health of Ohio

How will Aetna build a provider network?

Aetna is developing a network of participating providers to ensure adequacy and accessibility requirements stipulated by ODM in sufficient number, mix, geographic distribution in accordance with stipulated time and distance standard access to providers that will serve the intended membership. Network contracting teams are presently engaged with behavioral health, substance use disorder, FQHCs, mental health clinics, and inpatient & residential treatment facilities across the state.

Is the contracting approach regional, all willing providers, preferred providers, etc?

Aetna is developing its network of participating providers on a statewide basis and providers who meet federal, state and Aetna requirements to participate as a network provider and are invited to join their network.

What will be the requirements for a CMHC to contract with OhioRISE?

A CMHC will be required to complete a participating provider agreement and agree to terms and conditions as set forth by policies and procedures, such as claims submission, enrollee rights, timeliness of appointment and accessibility requirements and credentialing requirements noted in the provider manual as incorporated in the provider agreement.

Will contracting with Aetna differ from the typical MCO contract?

Generally, Aetna contracting requirements are similar but limited variations may be evident given the nature and specificity of the OhioRISE program.

What will be the application process for CMEs?

The RFA is posted here. CMEs were announced in February. You can find more information about CMEs on the OhioRISE webpage.

What is the procurement process for MRSS?

The OhioRISE plan will contract with all providers identified by ODM as eligible to provide Mobile Response and Stabilization Services (MRSS), except where there are documented instances of quality concerns.

What responsibility will Aetna have to assure services are available in each area (e.g., recruitment of providers, including CMEs)?

Aetna is obligated to develop a network of participating providers to ensure adequacy and accessibility requirements stipulated by ODM in sufficient number, mix, geographic distribution in accordance with stipulated time and distance standard access to providers that will serve the intended membership, which include necessary and required provider specialty types such as, MRSS, CME's, Opioid treatment, behavioral health, substance use disorder, FQHCs, mental health clinics, and inpatient & residential treatment facilities, across the state.

How will care coordination provided by managed care relate to care coordination in the community between various agencies providing services to same child/family?

Aetna Better Health of Ohio will facilitate Ohio Department of Medicaid (ODM) and other state child serving agency goals by creating a seamless delivery system for children, families, and system partners; providing a "locus of accountability" by offering intensive care coordination; and expanding access to critical services needed for this population and assisting families, state and local child serving agencies, and other health providers to locate and use necessary services. Aetna's care coordinators will partner with members, providers, caregivers and support systems already in place to develop the Child and Family Team.

Will there be a case manager assigned from Aetna as the point of contact for clients?

For members assigned to Tier 1, there will be an Aetna assigned Care Coordinator serving as their single point of contact; for members assigned to Tier 2/Tier 3, the CME Care Coordinator will serve as their single point of contact with Aetna providing support to the CME care coordinator as needed.

How much input will Aetna have regarding treatment decisions?

The Aetna utilization management clinician reviews whether a request for authorization is medically necessary and follows evidenced based criteria. However, utilization management does not dictate treatment decisions; those are determined by the provider.

If there is disagreement, how are those solved?

For treatment concerns specific to whether a service is meeting medical necessity or is evidenced based, those items are typically discussed during the review process. During this time, recommendations regarding potential interventions and changes in the Child and Family-Centered Care plan may be suggested.

How long will contracts last?

The OhioRISE initial contract term is 3 years.

What information will be provided on opportunities to negotiate rates and value-based agreements with Aetna?

Aetna's Network contract managers work directly with interested providers to present and address contracting opportunities, including compensation and value-based payment arrangements.

What are the data collection requirements with Aetna, including HIE requirements - both as a CME and as a provider?

The OhioRISE plan will work with the selected CMEs to assess their current and future ability to provide data in an electronic format (e.g. EHR) to the OhioRISE care coordination portal and the OhioRISE plan will provide the necessary technical assistance to participate in Ohio's two Health Information Exchange (HIE). Focus will include key elements such as existing/planned EHR capabilities, existing/planned data exchange capacity, ability to track contract requirements such as timeliness of activities, frequency of contacts and caseload, and ability to use data to track and inform community resource development.

Will providers need to credential with Aetna and ODM or just ODM?

Centralized Credentialing - At go-live (7/1/22), providers are to be credentialed only through the ODM Centralized Credentialing department for Medicaid, OhioRISE, and MyCare. Plans are not to credential at the plan level for these lines of business once our program has gone live. If a

provider who requires credentialing is not currently credentialed with ODM, a provider will be directed to the PNM so they are able to complete this process.

How will this process look differently for behavioral health providers already contracted with Aetna for MyCare Ohio?

Generally, Aetna contracting and credentialing requirements are similar but plan specific requirements between the MyCare Ohio program and OhioRISE may solicit minor variations in contracting.

How can providers best prepare to accept incoming new OhioRISE referrals for treatment services?

Aetna is preparing to host informational webinars to provide more detail on how providers can prepare to support OhioRISE plan members.

How is Aetna approaching care coordination delegation with the CME?

Aetna will support coordination of care across multiple system partners in recognition of CMEs as the 'locus of accountability.' They will prioritize members' preferences for where, when, and from whom they receive services by engaging CMEs and system stakeholders in collaborative training, providing technical assistance, and developing robust monitoring and oversight protocols.

Where is more information on claims processing, timelines, and process flow to Aetna and the fiscal intermediary?

For services that require a prior authorization, requests will be submitted through the Fiscal Intermediary Portal. The fiscal intermediary will streamline the prior authorization process and reduce provider burden by systemically standardizing prior authorization forms and the necessary clinical documentation to support the request.

How will Aetna and ODM assure the OhioRISE claims get appropriately directed to OhioRISE and not MyCare Ohio for dual enrolled provider organizations?

Aetna Better Health of Ohio, the OhioRISE plan and Aetna Better Health of Ohio each have a unique Provider ID and Submitter ID.

Will Aetna provide a primary list of contacts at Aetna for all essential business functions?

Yes, resources will be available on both the Aetna member and provider public and secure websites.

Will there be a hard cut off for OhioRISE services or gradual implementation if a child's current provider team would have to change?

There is a 180-day transition of care period. The goal of that transition of care period, in addition to providing continuity to the child and family, is to allow for providers to proceed with contracting requirements.

What are the technical requirements for submitting claims to OhioRISE?

Claims will be submitted directly to the ODM Fiscal Intermediary. ODM will provide additional information on submitting claims to the FI.

Will the consumer (courts and etc.) get to complete satisfactory surveys regarding services?

Aetna and ODM will provide families, youth and providers the opportunity to complete satisfaction surveys.

How will contracting work for specific services vs CME?

Aetna is developing a network of participating providers to ensure adequacy and accessibility requirements stipulated by ODM in sufficient number, mix, geographic distribution in accordance with stipulated time and distance standard access to providers that will serve the intended membership. Network contracting teams are presently engaged with behavioral health, substance use disorder, FQHCs, mental health clinics, and inpatient & residential treatment facilities, across the state.

Will outcome/performance-based incentives be a part of contracts?

Yes, Aetna network contracting includes ample opportunity for providers to participate in its value-based incentive-based payment programs.

How will the contract with OhioRISE interact with the individual MCO contracts?

The OhioRISE plan must execute an agreement with each MCO and with the Specialized Pharmacy Benefit Manager and comply with its written agreements with each MCO and the SPBM.

How is Aetna required to interface with local communities?

Aetna Regional SHINE (Systems of Care, Health, Integration, Network, and Education) teams will help facilitate a seamless delivery system with staff working on the ground to outreach and engage members in their communities. Regional coordinators are currently meeting with key stakeholders in the West, Northeast, and Central and Southeast regions of the state.

Will there be metrics agencies will need to agree to (performance metrics, quality, etc...) and if so, are these included in the contract?

Required metrics will be defined in the CME selection process and will be included in contracts or agreements with other entities as applicable.

How will contracting build capacity of providers to provide OhioRISE interventions and to effectively reach underserved populations - geographically and demographically?

Aetna, as part of its Network Development and Management Plan is developing and ensuring a network of participating providers that is sufficient and broad in the number of, mix that meets required adequacy and accessibility expectations that meet the needs of 'anticipated' and 'existing' members within and throughout the service area.

How will local systems have opportunities to provide services for OhioRISE youth in partnership with Aetna such as FCFCs?

The OhioRISE plan will be responsible for ensuring the care coordination efforts to support rather than supplant other child-serving systems case managers and providers, including County Boards of Developmental Disability, Regional Department of Youth Services, Public Child Serving Agencies, Family and Children First Councils, and providers certified by the Ohio Department of Mental Health and Addiction Services.

How to ensure there is a strategy for communication and awareness across the system for service providers and families?

In collaboration with ODM, Aetna will establish a cross-system governance structure that will utilize an upside-down triangle approach that draws feedback and solutions from local communities into policy and systemic interventions. Aetna will organize and coordinate a provider advisory council, member and family advisory council that report to a governance council. This allows facilitation of solutions based on community strengths and gaps and integration with OhioRISE guiding principles and best practices. Our governance structure is a working group and communication is bidirectional. It includes voices from legal, child protection, developmental disability, education systems, provider community, advocacy groups, biological, foster, kinship and adoptive parents, and youth. We will share feedback such as gaps and possible solutions outward to the same groups.

How will Aetna's tier 1 care coordination and provider agencies, courts, child welfare, etc. collaborate to serve a child in OhioRISE - without duplication of services and clarity of roles?

Aetna Better Health of Ohio will facilitate Ohio Department of Medicaid (ODM) and other state child serving agency goals by creating a seamless delivery system for children, families, and system partners; providing a "locus of accountability" by offering intensive and moderate care coordination; and expanding access to critical services needed for this population and assisting families, state and local child serving agencies, and other health providers to locate and use necessary services. Our care coordinators will partner with members, providers, caregiver and support systems already in place. These partners will be part of the Child and Family Team that develops the Child-Centered Care plan. This care coordination and care planning will ensure there is one plan for the youth and family across mulitple-systems.

Care Management Entities

How many Care Management Entities (CMEs) will serve youth and families across the state?

CMEs are geographically located across the state in what's known as catchment areas based on the projected population of OhioRISE enrollment. There are currently 20 CMEs contracted with 18 entities. Each catchment area or region will have one CME.

How will client attribution occur with CMEs if there are multiple CMEs per region?

In many instances, a child will receive care coordination by the CME nearest unless otherwise determined. There will only be one CME per region.

Will a provider organization also be able to be a CME if there are appropriate firewalls?

Yes, the vision is for providers and other child-serving entities who are interested to become a CME with appropriate firewalls in place.

How will the CME be selected?

An OhioRISE CME RFA was released by Aetna on October 18th and a bidders' conference was held to describe the RFA and process.

The selection process assessed prospective applicants' capacity to (1) perform High Fidelity Wraparound care coordination functions, and (2) develop and use community resources within their catchment area. Applicant's proposals were expected to specifically address how they will meet the behavioral health and social needs of the OhioRISE population within the geography of the catchment area the CME wanted to serve. Aetna will notify selected CMEs in early January 2022.

How will the CME complement rather than duplicate existing services and staff?

The CME will have a specific role to play in the region. Care coordinators will develop a Child and Family Team and Child-Centered Care Plan. CMEs must work to address all of the youth and families' needs by working with multiple local partners and have deep relationships in communities.

How will the juvenile courts, child protection, schools, pediatricians, and hospitals become aware of CMEs and how will these relationships develop?

The CMEs must demonstrate commitment and capacity to organize effective resource development at the community level that builds on strengths and effectively addresses needs. CMEs are responsible for helping families to identify and develop a network of support for each family consisting of natural supports, informal community supports, and formal service supports. This requires both the identifying of existing supports and integrating them into the family/local system of care, as well as developing new supports based on the needs, culture, and values of the youth and families served.

How will CMEs interface with local systems (wraparound, service coordination, FCFCs, etc.) who are already providing coordination of services successfully?

When a youth is involved in other care coordination relationships at the same time as ICC/MCC service, the OhioRISE care coordinator and other care coordination supports will work in concert with one another while maintaining their discrete functions.

When a youth is in IHBT or MST, will they also be receiving care coordination from a CME?

Yes, a youth in OhioRISE will be able to access both services.

If a CME is contracting out for ICC / MCC, how do they decide who to make a referral to for ICC or MCC if there are multiple contracted providers in an area?

Referrals for ICC and MCC should account for child and family choice, child and family location and should consider linkages to appropriate services and supports, including natural supports, along the continuum of care.

1915(c) Waiver Proposal

What are the proposed services children and youth will have access to through the waiver?

1. **Out-of-Home Respite:** A service provided to individuals unable to care for themselves that is furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the individual.
2. **Transitional Services and Supports (TSS):** Shorter term supports for individuals and their families to help them understand, mitigate, and provide connections to long-term solutions that address behavior challenges.
3. **Secondary Flex Funds:** Services, equipment, or supplies not otherwise provided through the waiver or through the Medicaid state plan that address an identified need in the service plan, including improving and maintaining the individual's opportunities for full participation in the community.

How many children and youth will be served on the waiver?

States must submit proposed waiver capacity, or "slots," to CMS for approval. This represents the maximum number of individuals who can enroll in the 1915(c) waiver during a waiver year.

Waiver Year 1: 1,000
Waiver Year 2: 1,235
Waiver Year 3: 1,446
Waiver Year 4: 1,648
Waiver Year 5: 1,844

How can families access the waiver?

Families interested in receiving a waiver referral for the OhioRISE 1915(c) program can do so through a number of different "access points." It is anticipated that behavioral health providers your child is connected with can help make the appropriate referral for a waiver assessment either to a care management entity (CME) in your area, or to the OhioRISE plan directly.

It is important to remember that a waiver referral is the first step in accessing the OhioRISE 1915(c) waiver. A child must meet program eligibility, including but not limited to having a Serious Emotional Disturbance (SED) diagnosis and the appropriate level of care, for waiver enrollment. The CMEs will conduct all initial assessments for program eligibility for a child seeking enrollment on the OhioRISE 1915(c) waiver program.

How will youth enrolled in the waiver interact with the OhioRISE plan for tier one care coordination?

The Ohio Department of Medicaid anticipates most children enrolled on the OhioRISE 1915(c) waiver will be enrolled in Tier Two or Tier Three Care Coordination, though a child who is enrolled in Tier One Care Coordination are not prohibited from enrollment on the waiver. The OhioRISE plan will hold responsibility for conducting annual level of care assessments for an individual enrolled in Tier One Care Coordination, as well as holding responsibility for child and family-centered care plan development.

Implementation & Operations

How will natural supports and community supports be defined and developed?

See section 2.4.7 of the CME RFA for details on the responsibilities of CMEs to develop natural and community supports.

What is the process for discussing course of treatment if multiple entities have different opinions?

In nearly all circumstances, the lead care coordinator is the CME. In some cases, there may be a need for multiple lead care coordinators to support significant physical health care needs. The expectation is for all entities involved in the child and family's life to be a part of the Child and Family Team.

How will enrollment in OhioRISE be communicated to all providers (i.e., so all providers know what other services can and cannot be billed)?

Providers should continue to check the MITS system to determine if a youth is enrolled in OhioRISE.

Who will handle releases of information that all partners will accept?

Both ODM and Aetna will facilitate obtaining releases of information depending on the partner and the corresponding relationship with ODM and Aetna.

How will these other systems know youth/family are involved with OhioRISE? What's the mechanism to initiate that contact/coordination?

The CME will have a specific role to play in their region and with local entities. CMEs must work to address all of the youth and families' needs by working with multiple local partners and have deep relationships in communities. Care coordinators will be responsible to initiate coordination using high-fidelity wrap around approaches to develop the Child and Family Team.

What communications regarding the program will be sent directly to families; who engages families in enrollment (managed care entity? providers? social service agencies?)

Families who are eligible will receive communication through Aetna Better Health of Ohio once they are enrolled. The OhioRISE plan assigns care coordination tier. The OhioRISE plan notifies the family and refers the child to the Care Management Entity for Intensive / Moderate care coordination or keeps for Limited care coordination. Then, the Care Management Entity or Limited care coordinator outreaches and engages with the family.

Training

What is the Child and Adolescent Behavioral Health Center of Excellence's (COE) role in the OhioRISE system, including clarity around their scope of work and what training/technical assistance they are offering?

The role of the COE will be to assist the State of Ohio in system transformation efforts by providing technical assistance, training, professional development, coaching, consultation, evaluation, fidelity monitoring, and continuous quality improvement to build and sustain capacity in delivering evidence-based practices to fidelity within a system of care framework.

The COE and OhioRISE plan will collaborate to ensure training, professional development and quality improvement needs of OhioRISE CMEs are both coordinated and met.

The COE will provide training in the areas of

- Child and Adolescent Strengths and Needs (CANS)
- Mobile Response Stabilization Services
- Intensive Home-Based Treatment
- ICC and MCC utilizing High Fidelity Wraparound
- Multisystemic Therapy
- Functional Family Therapy (conducted by FFT, LLC)

What is the plan to build the capacity of qualified CANS assessors?

Monthly training is underway by the COE. Announcements are sent and training information is on the OhioRISE website. The cost is covered by the state. Starting in 2022, the COE will provide CANS training. However, the certification exam will be provided through the Praed Foundation.

What is the plan to build capacity of HFWA care coordinators?

The OhioRISE plan will partner with the COE to provide staff training to CME staff on High Fidelity Wraparound and the Ohio Children's Initiative CANS tool. The OhioRISE plan, the CMEs, and COE will collaboratively identify other training and coaching needs on an ongoing schedule. Other training opportunities will be available through both Aetna Better Health of Ohio's SHINE University. This training collaborative will engage multiple stakeholders, community-based organizations, providers, members and their families/caregivers to identify training needs, develop curriculum and offer training opportunities. CMEs will participate in initial and ongoing training, coaching, and supports from COE on High-Fidelity Wraparound and the Ohio Children's Initiative CANS Assessment tools. CMEs will ensure all staff complete training regarding health equity/health disparities and trauma-informed care according to standards set by ODM, within three (3) months of hire and annually thereafter.

How do we train the workforce to elevate and respect family voice and community driven service systems?

Utilizing High Fidelity Wrap Around and the CANS assessment tool in care planning will ensure the workforce prioritizes the family voice and community driven service systems. These models were chosen for those purposes.

Data Sharing and Collection

What expectations are there for data sharing between providers, the CME, and OhioRISE?

The CME will be required to exchange electronic, bidirectional data and other information regarding the youth and family receiving ICC and MCC with the OhioRISE plan.

Workforce

How will OhioRISE address the behavioral health provider and child welfare workforce crisis and not contribute to it?

Ohio Medicaid, our sister state agencies, and our partners at Aetna recognize that workforce challenges will impact OhioRISE. We are offering provider supports and continuing to reexamine OhioRISE program requirements and staffing models for potential flexibilities while ensuring any changes made do not dilute the evidence-based care children and youth deserve to receive. We will monitor the program as it scales and provide support for provider expansion, as well as make any necessary changes, over time. Some examples of the steps our actions and considerations include:

• Ohio Medicaid is investing $19.5 million in transition grants allowing CMEs to launch before the OhioRISE go-live on July 1, 2022. The grants will assist with hiring and onboarding new CME staff and getting them ready to serve kids enrolled in OhioRISE.

• The state is sponsoring training for staff to deliver our evidence-based practices, including the CANS assessment, ICC and MCC, Intensive Home-Based Treatment (IHBT), Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), Mobile Response and Stabilization Services (MRSS). The new Child and Adolescent Behavioral Health Center of Excellence is providing trainings.

• Many of the new and enhanced OhioRISE services offer new options to allow an expanded set of practitioners, including people without licenses or certification who have appropriate experience, as well as non-agency providers and qualified community partners. Leveraging the expertise of all qualified providers who are willing to serve will be critical to meet the needs of

FFPSA

How does OhioRISE align with FFPSA implementation efforts?

Passed in 2018 and implemented on Oct. 1, 2021, the federal Family First Prevention Services Act (FFPSA) is the most significant change in child protection in Title IV-E funding in decades. OhioRISE ensures compliance with the federally mandated changes in FFPSA by focusing on prevention from entering the child protection system and out-of-home placement.

OhioRISE expands current community behavioral health services that greatly reduce the need for out-of-home placements (residential treatment, moves between foster homes, etc.) The state agencies are working closely together to align services such as intensive home-based treatment, intensive and moderate care coordination, and when necessary, residential treatment settings for kids served across systems. OhioRISE supports FFPSA goals, serves the same population, and reduces the need for costlier services. Without OhioRISE, implementing FFPSA would be much more difficult and would be much costlier.