

OhioRISE Frequently Asked Questions

OhioRISE (Resilience through Integrated Systems and Excellence) is a specialized managed care program for children and youth with complex behavioral health and multisystem needs. On April 1, 2021, ODM selected Aetna Better Health of Ohio (Aetna) to serve as the OhioRISE plan. OhioRISE services became available on July 1, 2022. Eligible children and youth receive their behavioral health benefits through Aetna Better Health of Ohio, the OhioRISE plan. OhioRISE aims to expand access to in-home and community-based services for its members through a Systems of Care approach, which provides a continuum of effective services and supports to children, youth, and their families with mental health or other challenges. OhioRISE will provide members and families resources they need to work with multiple community systems such as juvenile justice, child protection, developmental disabilities, schools, mental health and addiction, and more. Depending upon the needs of a member, either a care coordinator from Aetna or a care management entity (CME) will assist the member and their family.

The Ohio Department of Medicaid (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 through workgroups to develop and implement the program. Their work includes developing new and improved services, key components of the program, and implementing and operationalizing the program. OhioRISE will also feature a new 1915(c) Medicaid waiver. The purpose of the waiver is to prevent institutionalization for the most vulnerable families. Children and youth who may benefit from OhioRISE:

- Have multiple needs that result from behavioral health challenges.
- Have multisystem needs or are at risk for deeper system involvement.
- Are at risk of out-of-home placement or are returning to their families from out-of-home placement.

This FAQ will help to communicate responses to ongoing questions and will continue to be updated and shared on a frequent basis.

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General

Who is eligible to enroll into OhioRISE?

Children or youth who may be eligible for OhioRISE:

- Are eligible for Ohio Medicaid (either managed care or fee-for-service),
- Are age 0-20,
- Are not enrolled in a MyCare Ohio plan, and
- Require significant behavioral health treatment needs, measured using the Ohio Child and Adolescent Needs and Strengths (CANS) assessment.

Children and youth may also be eligible for OhioRISE due to certain urgent conditions. For example, if a child or youth is in a hospital for behavioral health reasons or is admitted into a Psychiatric Residential Treatment Facility (PRTF).

If a youth is enrolled in a MyCare Ohio plan and has qualifying needs for OhioRISE services, they can still get access to the care they need. The Medicaid Consumer Hotline can assist with discussing options.

What is “Day One” enrollment?

Some children and youth will be enrolled in OhioRISE effective July 1, 2022, (day one) based on:

- Behavioral health services they received in the past several months, or
- Because a Child and Adolescent Needs and Strengths (CANS) assessment showed they may benefit from the new and improved services available as part of OhioRISE.

These children and youth will receive an updated Medicaid ID card showing OhioRISE enrollment and information about the benefits and services of the program. Also, a care coordinator will be assigned to help these children, youth, and their families understand the program and coordinate services.

Children and youth who have not already received a CANS assessment will be contacted by OhioRISE to complete this assessment. This will allow the OhioRISE plan to understand how they can best serve the member.

When can a child or youth start receiving OhioRISE services?

Following a CANS assessment, children and youth found to be eligible are enrolled in OhioRISE effective the date their CANS assessment is submitted. In urgent cases, enrollment into OhioRISE will be:

- The date of admission for an inpatient hospital stay for mental illness or substance use disorder or
- The date of admission into a Psychiatric Residential Treatment Facility (PRTF).

This is different from other managed care enrollment policies where enrollment is dated back to the first of the month in which a person is eligible.

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What services are available for children and youth enrolled in OhioRISE?

OhioRISE covers all medically necessary Medicaid covered behavioral healthcare services for eligible children and youth, with a few exceptions. Children and youth enrolled in the program continue to receive their emergency department services through their managed care organization (MCO) or fee-for-service (FFS) Medicaid, while their behavioral health services are covered by Aetna, the OhioRISE plan. OhioRISE also covers medications a doctor gives to a member in the office to treat mental health and substance use disorders.

In addition to all the mental health and substance use disorder services currently covered by Ohio Medicaid, new and improved services under the OhioRISE plan include:

- **Moderate and Intensive Care Coordination:** Depending on a child's or youth's needs, they will receive one of three levels or "tiers" of care coordination. Tiers two and three of this service (moderate and intensive) will be delivered by a local care management entity (CME) provider, which are contracted by Aetna Better Health of Ohio. Aetna Better Health of Ohio will provide care coordination for children or youth in tier one.
- **Mobile Response and Stabilization Service (MRSS):** Provides children and youth in crisis and their families – for example, those who may be considering going to the emergency room or calling law enforcement – with immediate behavioral health services when they call to say they need help for that behavioral health situation. MRSS helps ensure children and youth are safe, served in their homes and communities, and receive necessary support and access to care they urgently need.
- **Intensive Home-Based Treatment (IHBT):** IHBT is an umbrella over multiple evidence-based practices and is an intensive treatment delivered in the home, school, and community settings to reduce the need for out-of-home placement. It aligns with the Family First Prevention Services Act (FFPSA) to cover multi-system therapy (MST) and functional family therapy (FFT).
- **Psychiatric Residential Treatment Facility (PRTF):** Ohio's PRTF service will keep children and youth with the most intensive behavioral health needs in state and closer to their families and support systems. It will be available in state beginning in January 2023, and today it's covered when children or youth need this level of care from facilities located outside Ohio.
- **Behavioral Health Respite:** Provides 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:** Provides funding to purchase services, equipment, or supplies not otherwise provided through Medicaid that address a need in a child's or youth's service plan. Funds must be used to purchase services/items that will reduce the need for other Medicaid services, keep kids and families safe in their homes, or help the child or youth be better integrated into the community.

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How will child/youth and family input be collected and honored in the OhioRISE System of Care?"

Consistent with System of Care core principles, OhioRISE intends to provide individualized services informed by the child's or youth's and family's voice and choice. The care coordinator will lead in creating the Child and Family Team (CFT). This team meets regularly to assist with care planning that focuses on the child's or youth's and family's strengths, beliefs, culture, community/natural supports, and their voice and choice. The CFT develops the Child- and Family-Centered Care Plan (CFCP) and regularly meets to address ongoing changes and needs of the youth and family.

How will the managed care organization (MCO) care coordinators collaborate with the OhioRISE plan?

OhioRISE members will have their physical health services covered by their MCO. A child or youth's care coordinator at their MCO will take an active role in the Child and Family Team (CFT) and the Child- and Family-Centered Care Plan (CFCP) and as needed.

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

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

An FCFC may be part of a Child and Family Team (CFT) and could be selected to lead care coordination. Each child/youth and caregiver determine who will be a member of their CFT to support them. For example, the member and family may select an FCFC to be part of the CFT and select the FCFC to lead care coordination. In this situation, the FCFC leads care coordination, and the OhioRISE care coordinator can assist with limited care coordination activities such as making referrals to Medicaid service providers, provide linkage to transportation through the members managed care organization (MCO), and ensures the member remains eligible for OhioRISE.

Multi-System Youth (MSY) funding initiatives will be available to youth in need. FCFCs will continue processing MSY applications for the individuals they serve as the lead care coordinator.

How will level of care coordination be determined?

Once the Child and Adolescent Strengths and Needs (CANS) assessment is submitted into the CANS IT system, eligibility is determined, and a level of care coordination tier is recommended. Aetna will review this information and assign initial level of care coordination based on available information at the time of assignment to a CME. Available information includes complexity of behavioral health need, information from the most recent CANS data, Mobile Response and Stabilization Services (MRSS), current and previous utilization of community-based and out-of-home behavioral health services, and available information about the child's or youth's social determinants of health and safety risk factors.

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How will initial member distribution occur when OhioRISE begins?

Care management entities (CMEs) will be regionally located in 20 catchment areas across the state to serve children and youth in tiers 2 and 3 (moderate and intensive care coordination). Each catchment area will serve approximately 1,300-3,000 children. Children and youth assigned to tier 1 care coordination will receive coordination from Aetna Better Health of Ohio.

Who will perform outreach to newly eligible members and their families?

If a child or youth is eligible for OhioRISE, a care coordinator from Aetna or a care management entity (CME) will contact the children, youth, and their family to coordinate services. They will also explain the program and get input on new services that might be appropriate. If a child or youth is not eligible for OhioRISE, the Ohio Department of Medicaid (ODM) will issue a denial notice to them, which provides information on the reason for the denial and appeal rights.

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

Current providers can talk with children, youth, and families about OhioRISE and either perform the Child and Adolescent Strengths and Needs (CANS) assessment or refer them for a CANS assessment. The Ohio Department of Medicaid developed materials for OhioRISE to assist with educating community partners and children, youth, and families about the program. These include a [brochure](#) for members and families and a [flyer](#) to help community partners explain OhioRISE.

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 complements these funding streams and provides additional resources and supports including new and improved services.

CANS

What is a CANS assessment?

The Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS) tool, developed with leadership from Governor DeWine's Children's Initiatives and Ohio's child-serving state agencies, is being used by a wide variety of providers to inform care planning and decision-making for children and adolescents with behavioral health needs. The Ohio Children's Initiative CANS will also be used to establish eligibility for the new OhioRISE program. Certified Ohio Children's Initiative CANS assessors are expected to use the CANS to gather all information about the child or youth and their family's story to describe their strengths and needs.

Is there 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 Children's Initiative brief and comprehensive CANS assessment tool is being used across all child-serving systems in the state. There will be a CANS IT system to help state agencies and local entities monitor outcomes and share information on children and youth with multisystem needs.

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

All community partners and state and local systems that have certified CANS assessors will be trained by the Child and Adolescent Center of Excellence (COE) 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 do not have to have a clinical background and can obtain certification after training with the Center of Excellence (COE) and passing the exam with the Praed Foundation. They must recertify annually. To learn more, please visit the [OhioRISE webpage](#).

How do referrals to receive a CANS work?

Referrals for a CANS assessment to determine OhioRISE eligibility may be to the child's or youth's managed care organization (MCO), the OhioRISE plan, a care management entity (CME) a behavioral health provider, a Mobile Response and Stabilization Services (MRSS) provider, a Family and Children First Council (FCFC), the Medicaid Consumer Hotline, etc. There is no wrong door.

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How will organizations access the CANS results or submit CANS results for use by OhioRISE and others in a centralized place?

ODM has launched the [CANS IT system](#), which is accessible to CANS assessors, Aetna, the COE, care management entities, and State of Ohio administration staff.

Where can I find more information about being a CANS assessor?

Please refer to the [OhioRISE CANS Resources webpage](#) and the [CANS Assessor User Guide](#).

Care Coordination

What is the estimate of the percentage of children and youth who will be in limited, moderate, and intensive care coordination?

Most children and youth in OhioRISE will be served by care management entities (CMEs). With CME-provided care coordination, it is projected most children youth will need moderate care coordination and 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 the Child and Family Team meetings?

The Aetna or 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 to Child and Family Team meetings?

The care coordinator will schedule and invite the Child and Family Team members to participate in meetings.

What are the requirements in the Ohio Administrative Code to be a care coordination provider?

The requirements are outlined in Ohio Administrative Code (OAC) rule 5160-59-03.2. Although the OhioRISE OAC rules won't be effective until July 1, 2022, the current version is available for review on the Register of Ohio website:

[All final files OhioRISE rules will be available on the Ohio Administrative Code rule webpage at https://codes.ohio.gov/ohio-administrative-code/chapter-5160-59 and are effective July 1.](https://codes.ohio.gov/ohio-administrative-code/chapter-5160-59)

For children and youth enrolled in OhioRISE receiving moderate or intensive care coordination services, there will likely be scenarios in which those children or youth would also see a case manager from another agency, such as for treatment foster care or in-home therapeutic behavioral support (TBS) and psychosocial rehabilitation services (PSR). 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 and youth enrolled in OhioRISE?

The care coordination rule pointed to above currently only excludes substance use disorder-targeted case management from being billed while a child or youth is receiving intensive or moderate care coordination. Wraparound requires other parties in a child's or youth's life to remain involved and engaged. There is an expectation that other providers and community partners will participate in the Child and Family Team (CFT) to develop the Child- and Family-Centered Care Plan (CFCP) for that youth and family. This process is critical for ensuring services and interventions support the goal of one plan across systems while avoiding duplication and fragmentation.

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

Therapeutic behavioral support (TBS) and psychosocial rehabilitation services (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. The caseload sizes are,

- Intensive care coordination staffing ratio 1:10
- Moderate care coordination staffing ratio 1:25
- Limited care coordination staffing ratio 1:62

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

Managed care organizations (MCOs) and OhioRISE plan will coordinate and collaborate through the care coordination process. In intensive and moderate care coordination, they will help develop the Child- and Family-Centered Care Plan (CFCP) with the child or youth and their family.

What is meant by approval verses prior authorization for the Child- and Family-Centered Care Plan? When can services begin, change, or terminate and who ultimately makes this decision?

Approving the Child- and Family-Centered Care Plan (CFCP) is a quality improvement measure to ensure care coordination and resources are in place to meet the child's or youth's and their family's needs. Prior authorizing a service is to determine medical necessity and appropriate setting is met. Although a CFCP has been approved, the OhioRISE services included on the CFCP may still require prior authorization.

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For those limited OhioRISE services that do require prior authorization, the services still need to be documented in detail on the CFCP, and the CFCP must be approved by the OhioRISE plan. After the CFCP has been approved, providers will then need to request the authorization before services can begin. Care coordinators will understand services requiring prior authorization, work to ensure these services are considered by the Child and Family Team (CFT), and when appropriate work to include providers of these services in the CFT. The OhioRISE plan, working with the care coordinator, would make the final decisions on changes to services.

Where can I find more information about care coordination?

Additional information on care coordination can be found in the [Care Management Entity Manual](#). Also, the Child and Adolescent Behavioral Health Center of Excellence (COE) is providing training opportunities, which can be found on the [OhioRISE website](#).

Psychiatric Residential Treatment Facilities (PRTF)

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

The Ohio Department of Medicaid (ODM) is in the process of reviewing information regarding the number and location of PRTF beds and will make assumptions and projections later as we will not roll out this benefit until 2023.

Aetna Better Health of Ohio

How will Aetna build a provider network? What responsibility do they have to ensure services are available in each area (e.g., recruitment of providers, including CMEs and for underserved populations – geographically and demographically)?

Aetna is developing a network of participating providers to ensure adequacy and accessibility requirements stipulated by the Ohio Department of Medicaid (ODM) in sufficient number, mix, geographic distribution. This is being completed 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, federally qualified health centers, mental health clinics, and inpatient and 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. 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 community mental health center (CMHC) to contract with OhioRISE?

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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, accessibility requirements, and credentialing requirements noted in the provider manual, as specified in the provider agreement.

Will contracting with Aetna differ from the typical managed care organization (MCO) contract?

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

What was the application process for the care management entities (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 Mobile Response and Stabilization Services (MRSS)?

The OhioRISE plan will contract with all providers identified by ODM as eligible to provide MRSS, except where there are documented instances of quality concerns.

How will care coordination provided by Aetna relate to care coordination in the community between various agencies providing services to same child, youth, and/or family?

Aetna Better Health of Ohio will facilitate care coordination by working with care management entities to deliver care coordination activities with other child-serving system of care partners in their geographic regions across the state.

OhioRISE care coordinators will partner with managed care organizations, members, providers, families, caregivers, and support systems. These partners will be part of the Child and Family Team (CFT) that develops the Child- and Family-Centered Care Plan (CFCP). This care coordination and care planning will ensure there is one plan for the child or youth and their family across multiple systems.

Will there be a care coordinator assigned from Aetna as the point of contact for members?

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 tiers 2 and 3, a care coordinator from a care management entity (CME) 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 prior approval or prior authorization is medically necessary and follows evidence-based criteria. However, utilization management does not dictate treatment decisions; those are determined by the provider. A limited number of services require prior authorization by the OhioRISE plan. In fact, a new process in addition to prior authorization called prior approval will be used to support needed services identified by the Child and Family Team (CFT) and listed on the Child- and Family-Centered Care Plan (CFCP). Services that will require prior authorization (PA) using the traditional provider-initiated PA process will include:

- Inpatient psychiatric services (including hospital and PRTF services)
- Electroconvulsive Therapy (ECT)
- SUD Partial Hospitalization

Services requiring prior approval through the CFCP that need to be approved before they can be provided and reimbursed:

- Primary Flex Funds
- OhioRISE 1915(c) Waiver Services:
 - Secondary Flex Funds
 - Transitional Services and Supports
 - Out-of-Home Respite

If there is disagreement on approvals or authorizations, how are those solved?

Child- and Family-Centered Care Plans (CFCP) will be reviewed by Aetna care plan reviewers. At times, they may have additional questions related to recommendations. In those instances, the care plan reviewer may make suggestions to the care coordinator to review with the child and family team for possible adjustments. If the child and family team and the care plan reviewer cannot come to a consensus, the appeals process will be initiated in accordance with Ohio Administrative Code rule 5160-26-08.4 managed healthcare programs: managed care plan appeal and grievance system.

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

How long will contracts last?

The OhioRISE initial term of the contract with Aetna Better Health of Ohio is three years.

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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 Better Health of Ohio, including Health Information Exchange (HIE) requirements—both as a care management entity (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 (i.e., Electronic Health Record) in the OhioRISE care coordination portal. The OhioRISE plan will provide the necessary technical assistance to participate in Ohio's two HIEs. 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.

How will the credentialing process look differently for behavioral health providers already contracted with Aetna with 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 care management entities (CMEs)?

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?

More information on claims processing, timelines, and process flow to Aetna Better Health of Ohio can be found in the [training presentation by Aetna for providers and CMEs](#) and in the [OhioRISE](#)

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Module 3 Training. The fiscal intermediary is part of the Next Generation of managed Ccare's staggered implementation approach and is set to begin late 2022.

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

Aetna Better Health of Ohio provides a unique provider ID and submitter ID for each of its services.

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 cutoff for OhioRISE services or gradual implementation if a child or youth'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 is to provide continuity of care to the child or youth and family.

Will the members and other community partners get to complete satisfactory surveys regarding services?

Aetna and the Ohio Department of Medicaid (ODM) will provide families, children, youth, and providers the opportunity to complete satisfaction surveys.

How will contracting work for specific services vs. the care management entity (CME)?

Aetna will contract with a network of providers and with CMEs to provide specific services. CMEs deliver care coordination and are able to provide other services, work with existing providers, or refer for services identified by the Child- and Family-Centered Care Plan (CFCP). CMEs can also subcontract with other providers to deliver care coordination activities.

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

Yes, Aetna's network contracting includes ample opportunity for providers to participate in its value-based incentive-based payment programs. Aetna's network contract managers work directly with interested providers to present and address contracting opportunities, including compensation and value-based payment arrangements.

How will the contract with OhioRISE interact with the managed care organizations (MCOs) and the Single Pharmacy Benefit Manager (SPBM) contracts?

The OhioRISE plan must execute and comply with an agreement with each MCO and with the SPBM.

How is Aetna required to interface with local communities?

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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?

Care management entities (CMEs) will have to develop, track, and share metrics that can identify gaps in service networks and provide insight into utilization and out-of-state placements for Residential Treatment (RTC) and Psychiatric Residential Treatment (PRTF) facilities.

How will local systems have opportunities to provide services for OhioRISE children and youth in partnership with Aetna, such as Family and Children First Councils (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, courts, and providers certified by the Ohio Department of Mental Health and Addiction Services.

Care management entities (CMEs) are required to build partnerships with local community partners including FCFCs and may subcontract with them to provide care coordination activities and community supports. How will OhioRISE ensure that there is a strategy for communication and awareness across the system for service providers and families?

In collaboration with the Ohio Department of Medicaid (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 and Member and Family Advisory Council that reports to a governance council. This allows facilitation of solutions based on community strengths and gaps and integration with OhioRISE guiding principles and best practices. Aetna's 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, children, youth, and biological, foster, kinship and adoptive parents. 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 or youth in OhioRISE—without duplication of services and clarity of roles?

Aetna will facilitate Ohio Department of Medicaid (ODM) and other state child-serving agency goals by creating a seamless delivery system for children, youth, families, and system partners. Aetna and its contracted care management entities (CMEs) will provide a "locus of accountability" by offering intensive and moderate care coordination, expanding access to critical services needed for members; and assisting families, state and local child-serving agencies, and other health providers to locate and use necessary services. OhioRISE care

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coordinators will partner with members, providers, families, caregivers, and support systems. These partners will be part of the Child and Family Team (CFT) that develops the Child- and Family-Centered Care Plan (CFCP). This care coordination and care planning will ensure there is one plan for the child or youth and their family across multiple systems while honoring the mandates and plans of other systems.

Care Management Entities (CMEs)

How many care management entities (CMEs) will serve children, 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 members be distributed to 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. In counties with multiple CMEs, the region each CME serves is broken out by zip code.

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 bring together formal and informal supports using high-fidelity wraparound approaches that put the child's or youth's and families' voice and choice at the center to develop a Child and Family Team (CFT) and Child- and Family-Centered Care Plan (CFCP). CMEs must work to address all the child's or youth's and families' needs by working with multiple local partners and having deep relationships in communities.

How will the juvenile courts, child protection agencies, 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 children, 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 child or youth is involved in other care coordination relationships at the same time as moderate and intensive care coordination services, the OhioRISE care coordinator and other care coordination supports will work together while maintaining their discrete functions.

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When a child or youth is in Intensive Home-Based Treatment or Multisystemic Therapy (MST), will they also be receiving care coordination from a CME?

Yes, a child or youth in OhioRISE receiving IHBT or MST will be able to access those services while receiving care coordination.

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

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

Where can I find more information about care management entities (CMEs)?

The [OhioRISE CME webpage](#) provides a list of all the CMEs along with their geographical regions and contact information.

OhioRISE 1915(c) Waiver

What are the services children and youth will have access to through the OhioRISE 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 Medicaid 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 OhioRISE 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 OhioRISE 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

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How can children and youth access the OhioRISE Waiver?

A child or youth can be referred for the waiver through their local care management entity (CME). Youth and families interested in receiving a waiver referral for the OhioRISE Waiver can do so through a number of different “access points.” It is anticipated that behavioral health providers a youth is connected with can help make the appropriate referral for a CANS assessment to determine waiver eligibility to a CME in the child’s or youth’s local area.

It is important to remember that a waiver referral is the first step in accessing the OhioRISE Waiver. In addition to meeting Medicaid and OhioRISE program eligibility, a child or youth must also meet the following requirements to be eligible for the waiver:

- Have an Inpatient Psychiatric Level of Care.
- Have a diagnosis of a Serious Emotional Disturbance (also known as SED).
- Have documented functional limitations.
- Need at least one of the OhioRISE Waiver services.
- Have waiver needs that are less than or equal to the waiver service cost limit of \$15,000.

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

The Ohio Department of Medicaid (ODM) anticipates most children and youth enrolled on the OhioRISE Waiver will be enrolled in moderate (tier 2) or intensive care coordination (tier 3), though a child or youth who is enrolled in limited care coordination (tier 1) is not prohibited from enrollment on the OhioRISE 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 (CFCP) development.

Implementation & Operations

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

In nearly all circumstances, the lead is the care coordinator. In some cases, there may be a need for multiple lead care coordinators to support significant physical healthcare needs. The expectation is for all entities involved in the child or youth and family’s life to be a part of the Child and Family Team (CFT) and Child- and Family-Centered Care Plan (CFCP). The CFCP is created by multiple child-serving entities to provide the child or youth and family with one plan.

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 child or youth is enrolled in OhioRISE. Providers should reference the [Mixed Services Protocol](#) to then clarify financial responsibility for OhioRISE services.

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

Both the Ohio Department of Medicaid (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 a child, youth, and family are involved with OhioRISE? What's the mechanism to initiate that contact/coordination?

Aetna and the CME will have a specific role to play to initiate contact and care coordination. These entities will reach out to the child or youth and family to identify which other systems they are involved with to begin coordinating care. Care coordinators will be responsible to initiate coordination using high-fidelity wrap around approaches to develop the Child and Family Team (CFT).

What communications regarding the program will be sent directly to children, youth, and families? Who engages families in enrollment—managed care entities, providers, and/or social services agencies?

Children and youth who are eligible will receive communication through Aetna Better Health of Ohio once they are enrolled. The OhioRISE plan assigns a care coordination tier. The OhioRISE plan notifies the child or youth and their family and refers the child or youth to a care management entity for moderate or intensive care coordination. Aetna will facilitate care coordination for a child or youth who has a limited care coordination assignment. Then, the CME or Aetna care coordinator outreaches and engages with the family and child or youth.

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 (MRSS)
- Intensive Home-Based Treatment (IHBT)
- Moderate and Intensive care coordination (MCC/ICC), utilizing High Fidelity Wraparound
- Multisystemic Therapy
- Functional Family Therapy

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

Monthly training is underway by the Center of Excellence (COE). Announcements are sent and training information is on the OhioRISE website. The cost is covered by the state.

What is the plan to build capacity of High-Fidelity Wraparound care coordinators?

The Center of Excellence (COE) provides training to care management entity (CME) staff on moderate and intensive care coordination that uses High-Fidelity Wraparound and the model's approaches in coordinating care in tiers 2 and 3. 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's SHINE (Systems of Care, Health, Integration, Network, and Education) 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 the Ohio Department of Medicaid (ODM) within three (3) months of hire and annually thereafter.

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

Utilizing High-Fidelity Wraparound and the CANS assessment tool in care planning will ensure the workforce prioritizes the child's or youth's and family's 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 care management entities (CMEs), and OhioRISE?

Data sharing is an important component of the child and family team (CFT) process. All data sharing follows state and federal privacy laws and most of which are subject to the member and family's preference on if they would like the information to be shared or not. Data is shared via a variety of means including Aetna's FamilyConnect portal and through secure email. As information is shared during the CFT meetings, all CFT members are vetted by the youth and family and releases of information are signed.

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 care management entities (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 those enrolled in OhioRISE.
- The state is sponsoring training for staff to deliver our evidence-based practices, including the CANS assessment, moderate and intensive care coordination (MCC/ICC), 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 improved 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 children and youth enrolled in OhioRISE.

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FFPSA

How does OhioRISE align with Family First Prevention Services Act (FFPSA) implementation efforts?

Passed in 2018 and implemented on October 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 children/youth 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.

Ohio Administrative Code Rules (OAC)

Where can I find the OAC rules that govern OhioRISE services?

You can visit the Register of Ohio website at <https://www.registerofohio.state.oh.us/rules/search> or click on the below links to view the final filed OhioRISE rules:

- [5160-59-01 OhioRISE: definitions](#)
- [5160-59-01.1 OhioRISE: application of general managed care rules](#)
- [5160-59-02 OhioRISE: eligibility and enrollment](#)
- [5160-59-02.1 OhioRISE: first day eligibility and enrollment](#)
- [5160-59-03 OhioRISE: covered services](#)
- [5160-59-03.1 OhioRISE: utilization management](#)
- [5160-59-03.2 OhioRISE: care coordination](#)
- [5160-59-03.3 OhioRISE: intensive home-based treatment service \(IHBT\)](#)
- [5160-59-03.4 OhioRISE: behavioral health respite service](#)
- [5160-59-03.5 OhioRISE: primary flex funds](#)
- [5160-59-04 OhioRISE HCBS waiver: eligibility and enrollment](#)
- [5160-59-05 OhioRISE HCBS waiver: covered services and providers](#)
- [5160-59-05.1 OhioRISE HCBS waiver: out-of-home respite](#)
- [5160-59-05.2 OhioRISE HCBS waiver: transitional services and supports](#)
- [5160-59-05.3 OhioRISE HCBS waiver: secondary flex funds](#)

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