Question	Response
At what level of confidentiality is the CANS portal? We will need to include it in our Release of Information. Do you have any language you would suggest?	CANS System users are required to attest that they won't access any information that they should not have access to. The CANS System is HIPAA Compliant.
Who is going to operate/ staff the MRSS program? Is the FCFC going to be responsible to ensure we have one in Lawrence County?	Efforts are underway to develop MRSS system capacity across the state. FCFC is not responsible for ensuring an MRSS is present in any county.
Did you say the $1,500 is for respite?	The $1,500 is flexible funding separate from respite.
How often do we need to renew our CANS certification -is it yearly, etc??	Annually
Does the CANS have to be done if the family chooses to only utilize pooled funding?	An assessment tool is still required for every youth in service coordination.
Will county FCFCs enter CANS assessments into the IT system for youth who are only involved in Service Coordination (Not QRTP and Not OhioRise)?	We recommend that every Ohio Children's Initiative CANS assessment completed by a CANS Certified Assessor be entered into the portal. You can then download your results and eventually upload them into OFCF's new IT system.
What expectations are there for Aetna and CMEs to explain the option of continuing care coordination with FCFC or other entity?	OhioRISE Care Coordinators will explain that care coordination is a core feature of the OhioRISE program that members / families can choose to participate in. Members / families may decline OhioRISE Care Coordination at any time. OhioRISE Care Coordinators would seek to understand if other care coordination supports are already in place.
Do families have to opt out of OhioRise to stay with FCFC or other community partners who do wraparound?	They would not opt out of OhioRISE to still be served by the FCFC. They are declining OhioRISE Care Coordination delivered by Aetna or the CME only. However, if a youth is eligible through 1915(c)Waiver, then they must be receiving Care Coordination through OhioRISE.
Will the OhioRise family brochure be revised to communicate voice and choice and clarify that they can choose another Care Coordination provider and still get OhioRise services?	The OhioRISE family brochure does not include a section on care coordination. Like other OhioRISE covered services, a family may or may not choose to participate.
If the family chooses to keep care coordination with FCFC, what specific services would OhioRISE be able to offer to the family?	All OhioRISE services will remain available to the family, but they would not be able to participate in the 1915(c) waiver. An individual must participate in OhioRISE Care Coordination when enrolled in the waiver.
Could a family then end up with two different care coordination teams?	Families would not have two different care or service coordination teams. The family can choose

	OhioRISE Care Coordination or FCFC for service coordination.
Are CMEs permitted to subcontract with an FCFC for part time Care Coordination so that we can continue to provide services to non-OhioRise families?	Yes, CMEs are permitted to sub-contract with FCFCs given the CME is able to maintain appropriate OhioRISE caseload ratios.
What is a little disconcerting to me is that while ODM has paid very careful attention to ensuring coordination and continuity of care at the state level, it does not feel like there has been little to no operational guidance to CMEs and local Councils on how they should be working together? It seems that this has just been left to the local level to work out which can result in fragmentation of care rather than coordination of care in some cases. I understand that ODM should not have to work out the operational details for the local level, but it should have been made clear that all CMEs are expected to work with and coordinate with the Local Councils.	The operational maps and information we are discussing here today continue the operational guidance you are referencing in your comment above (several ODM forums and modules have also started that operational guidance). In addition, CMEs have been provided guidance on working with the FCFCs. We would also desire bidirectional sharing between CMEs and FCFCs.
Can you describe the initial assessment? This is not the same as the CANS assessment?	Correct, the initial comprehensive assessment will be completed by the Aetna or CME Care Coordinator and is separate from the CANS assessment tool. The initial comprehensive assessment includes psychosocial elements as well as information about the member / family Aetna is required to collect in their Provider Agreement.
Neither Aetna or CME are in our catchment area so they know very little about our SOCs. I don't know how they are going to do Tier one (info/referral) apart from handing out FCFCs phone numbers.	CMEs are expected to outreach to FCFCs. However, FCFCs are also encouraged to outreach to the CMEs, as well, to begin to build that relationship.
I would love to establish a relationship with my CME. I have tried reaching out through email and phone, but I'm coming at a dead end to start this relationship, unfortunately. Any ideas on what other techniques might be more effective?	Please reach out to your OFCF regional coordinator. We'll work, as needed, with ODM and Aetna to ensure you receive a response. OFCF is meeting regularly with Aetna regional coordinators, as well as continuing close contact with ODM.
It seems that some CMEs are depending on the providers to provide some of the things required of the CME, which is putting those of us who are willing to be providers, into a different level of service provision. Is there guidance on HOW the CMEs are to provide those things?	CMEs may subcontract with community providers and organizations to deliver care coordination.

Can you expand a little more on the Waiver? Are there limits on waivers? Why/when would a waiver be requested?	For additional information on the 1915(c) waiver, please refer to the OhioRISE website. There is a specific module on the 1915(c) waiver.
If contract for a part-time, how would the caseload limits come into effect?	CMEs must maintain appropriate OhioRISE caseloads with any sub-contracted entity. OhioRISE CME manual is posted on the OhioRISE website and gives guidance around caseloads.
So if a youth is not known to the local SOC, OhioRise will do the MSY application and we don't need to sign off?	Correct, if an OhioRISE member is not already receiving MSY funding but needs to apply for it, the OhioRISE Care Coordinator will be fully responsible for submitting the application.
What if MSY turns down an application? Does the local have to cover room and board, etc?	The outcome would the be exact same as it is now if an MSY application is not authorized.
Is there funding thru OhioRise for youth that may need a high level of care (residential) but have been turned down for MSY?	OhioRISE does not have additional funding for room / board since they are not covered by Medicaid. PRTFs will be covered by OhioRISE and are anticipated to be available in Ohio in early 2023.
Can you say more about the additional care coordination resources-- calming comfort collection, career and life skills, GED; connections for life?	The 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.
Will the CME visit face to face with youth who are in residential? Some youth are placed 2-4 hours away.	Potentially. They will also be able to take advantage of virtual visits.
Are the CMEs attempting to reach out to the local ERs for connection in their assigned areas and informing them of their upcoming services - for example residential placement since they and the residential care facilities tell families FCFCs have money to cover the expenses for residential care with no concern for local processes.	CMEs will work with local and regional stakeholders (including hospitals / emergency rooms) to understand OhioRISE and further develop systems of care. Additionally, ODM is hosting a hospital specific provider training in June 2022.
Is there any possibility to make the Journey Map larger text to be able to print?	Unfortunately, due to Microsoft Visio limitations, there are only two options - to use larger paper when you print (and zoom) or print and paste together multiple sheets of paper.
If an MSY application is submitted by the CME how or will the FCFC be made aware of the youth?	CMEs will only submit MSY applications for youth receiving OhioRISE Care Coordination. Those youth would not also be receiving FCFC service coordination so FCFC would not need to sign off on the MSY application.
Does the original CANS assessor continue the future CANS for that youth, if the youth goes into OhioRISE?	Once the youth is enrolled in OhioRISE, the OhioRISE Care Coordinator at Aetna or the CME will continue with the assessments.

What is the timeframe for all this determination - most families when they hit our door are not in preventive mode as they want help and want it fast	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).
Is the initial comprehensive assessment the same as the CANS comprehensive assessment?	The initial comprehensive assessment will be completed by the Aetna or CME Care Coordinator and is separate from the CANS assessment tool. The initial comprehensive assessment includes psychosocial elements as well as information about the member / family Aetna is required to collect in their Provider Agreement.
So in a lone FCFC employee county, in determining eligibility for OhioRISE, doing the front end loading (information/referral, possibly CANS) is not medicaid billable? However, if we refer to a CANS assessor, they can bill?	You can bill for completing a CANS assessment if you are a certified CANS assessor and enrolled as a Medicaid provider.
So, FCFC SCs can complete the CANS as a qualified assessor and add into the system to qualify for OhioRISE? I just want to clarify so families are not having to repeat their entire stories when it's not necessary.	Correct, if the FCFC SC is a certified Ohio Children's Initiative CANS Assessor, they can complete the CANS assessment and submit it to the CANS IT System to determine OhioRISE eligibility.
So, our AA will not be involved in MSY funds when Ohio Rise are the ones filling out the applications? The money will be distributed to them. Correct?	Correct.
Quick suggestion…could you freeze column "A" so the swim lanes always appear while scrolling the document?	Unfortunately, the Microsoft Visio program does not allow for this capability.
Is there a conflict-of-interest concern about FCFCs who are certified CANS assessors and will be OhioRISE Care Coordinators completing the initial assessment? If FCFC has the child initially, then completes the CANS, enters into the system, then ultimately ends up with the Care coordination. Is that a conflict?	Any certified Ohio Children's Initiative CANS assessor can conduct and submit the CANS assessment results to the CANS IT System to determine OhioRISE eligibility.
Sometimes a family has been involved in MH services for their child, but not involved with FCFC. When interventions are not sufficient and the child is in crisis, their provider may recommend residential treatment and tell the family to call up FCFC. If FCFC receives an initial	In this scenario, if the youth is not already enrolled in OhioRISE but there is a suggestion that a higher level of care is needed due to a behavioral health concern, referral for a CANS assessment to determine OhioRISE eligibility is appropriate.

call from a parent seeking residential treatment and they have Medicaid insurance, should we refer them directly to the CME or should we still start the FCFC process and start an IFSCP (which may cause a delay in residential treatment)?	
Does the CC do the initial comprehensive assessment?	Yes.
Just to clarify..., the "Initial Brief CANS" different than the initial assessment with OhioRise?	Yes. The initial comprehensive assessment will be completed by the Aetna or CME Care Coordinator and is separate from the CANS assessment tool. The initial comprehensive assessment includes psychosocial elements as well as information about the member / family Aetna is required to collect in their Provider Agreement.
I'm still confused. I thought the BRIEF was used for eligibility to OhioRISE (per previous slides). And what does the "initial CANS assessment" mean?	The initial CANS assessment is the first time the youth have a CANS assessment to determine OhioRISE eligibility. That CANS can be the Brief or Comprehensive version, both will determine OhioRISE eligibility. When The Brief CANS is used to determine OhioRISE eligibility, the Comprehensive CANS must be completed within 30 calendar days of referral to OhioRISE Care Coordination. The "initial comprehensive assessment" is separate from the CANS tool and will be completed by the Aetna or CME Care Coordinator. The initial comprehensive assessment includes psychosocial elements as well as information about the member / family Aetna is required to collect in their Provider Agreement.
If the CME does the initial assessment for a youth that isn't found to be T2 or 3, do they get paid?	CMEs can bill for CANS assessments.
What tool is used for the initial comprehensive assessment?	The initial comprehensive assessment is an Aetna specific tool.
Is this map only for Tier 1 as it states at the top?	Correct. There are 7 different Visio Operational Maps, each with a different purpose.
I complete CANS assessments for children in custody of CPS to determine QRTP eligibility. However, I am not contracted with the CME to conduct CANS for OhioRISE purposes. If I have an FCFC child who I believe would qualify for OhioRISE, would I refer them for a CANS or would I complete the CANS on their behalf?	If you are a certified CANS assessor, you can certainly complete the CANS, or refer to a Certified CANS assessor.
If families choose to return to FCFC, through the process, has considerations been made	Yes, this transition back to FCFCs has been discussed. It would be the hope that most families leaving OHR, will not still need SC. However, if it is

regarding waitlists, caseload size requirements etc.	needed, that would be a case-by-case discussion for that child/family/team.
Care Coordination" is a new term. Families may say they aren't receiving it because they are using "Service Coordination" or "Wraparound".	Care coordination may be a new term for some families. However, there are systems, like the medical community, for example, that have utilized the term care coordination for many years.
What does support in the background mean?	When a youth / family has declined OhioRISE Care Coordination, an Aetna Care Coordinator remains available for support on request and is still required to complete interval assessments (i.e., Health Risk Assessment, etc.) identified within their provider agreement.
How does this impact the scope of our work per ORC 121.37? Obviously, it will reflect a greatly diminished capacity in regards to service coordination. What are the implications of such?	While OhioRISE may change some of the scope of work, it does not do away with our work. There are over 2.5 million children in Ohio. OhioRISE will serve 50-60,000 of those children. However, there are numerous families we can net further upstream, hopefully keeping them safely in their home and community, preventing them from ever needing higher levels of care.
Assuming these scenarios apply to partner agencies who are funded locally too. Right?	Correct. When OhioRISE enrollees and their families/caregivers first engage their care coordinators, they'll have the chance select informal supports and formal providers who they want to have as part of their "child and family team" that will develop a unified plan to guide the delivery of services and supports. Some local child serving systems may be kept apprised of the care planning process and care plan, and others may be asked to participate in the child and family team.
Our FCFC plans to contract with CME to do CC and CANS. Can you help me understand why FCFC staff would need to apply for a Medicaid IPN, if billing is required to be submitted under the CME's Medicaid #? (The world of billing Medicaid is new to me, sorry if dumb question). Also, if our FCFC Administrative Agent already bills Medicaid could we use their # instead of individual FCFC staff applying for an IPN?	The individual who renders the care coordination service are required to be submitted on the claim. Therefore, while the CME agency submits the claim for the service, they need to list the actual person providing the CC and/or rendering the CANS assessment. To do so, each individual needs to obtain an NPI, enroll as an Ohio Medicaid provider and affiliate with the CME.
Has anyone found a way to make the Vizio flows larger? I have printed on legal paper, but still way too small to read. Enlarging on copier makes it blurry/unreadable. Admin Asst & our IT have tried but say they cannot print it larger.	Unfortunately, Microsoft Visio does not have functionality to make the maps larger (especially when in PDF format, since we understand that not everyone has the Visio software). We are looking into other possible solutions.

If a family chooses not to switch to the OhioRise CME and stay with FCFC for SC/WA will the CANS portal be able to distinguish this? It is my understanding that Aetna or CME will be contacting families automatically if they qualify for OhioRise.	The CANS portal will not be able to distinguish this and does not talk in a bi-directional way at this point and there is no way to input into it from another system. However, if the family knows they want to stay with the FCFC, the FCFC can proactively contact Aetna to let them know they have a longstanding relationship, believe the family will be OhioRISE eligible, and the family wants to stay with them. Not a perfect solution but may assist with communication.
What type of education is happening with local ERs or the Children's Hospitals regarding OhioRISE and connection with CMEs - is it up to local community systems to educate our hospitals or are the CMEs expected to introduce this new system to them? I'm concerned about the youth that present with homicidal/suicidal ideation and in the past, parents have been told FCFC have funding for residential care and to call them - which obviously is all wrong as well. But just trying to figure out how to support families that are more in crisis mode rather than prevention mode.	There will not be an immediate switch on Day 1 and this scenario will likely still occur until there is statewide awareness and engagement in the OhioRISE program. Hospital specific training for OhioRISE will be provided by ODM in June 2022. However, system change is an incremental process and team effort. FCFCs and other community providers can also try to educate hospitals through existing relationships. We realize that it is important that hospitals are not making autonomous decisions about a youth's path without including family team. OhioRISE recognizes there is still a lot of work to be done to educate community providers and is committed to that work in the months and years to come.
I'm very concerned about this (above) as our CME is our children's hospital & QRTP/RT is typically the recommendation. With the CME overseeing the MSY funds for OhioRISE youth, will they just be applying for MSY funds to place in RT instead of implementing creative community services/supports.	There will still be a MSY Team that will be reviewing and making these determinations. The CME will not have final say.
It was stated that if a family stays with the FCFC, Aetna will have oversight to assure the 90 days CANS is completed. Thus, is there any other 'oversight' Aetna will have re FCFs? And what does this 'oversight' mean?	Aetna will not have any oversight of FCFCs. Aetna is responsible for making sure the CANS reassessments are completed in a timely manner which they are required to do through their provider agreement with ODM. They will collaborate with the FCFC to ensure it is done.
CME has said they will not be subcontracting out care coordination, is this allowable?	There are minimum contractual requirements with community providers, including FCFCs, but there is no requirement that they must subcontract.
Where in the process is a family determined/identified Medicaid eligible? And who is responsible for that if, for example, the referral comes to FCF first.	When a CANS is entered into the CANS IT system, it will know whether a youth is already Medicaid eligible. If they are not, it will notify the Central Processing Team (CPT) and CPT will work with family to determine Medicaid eligibility.

If a youth is enrolled on Day 1 due to a previously completed CANS, is the 90-day CANS triggered by the initial CANS date or from OHR enrollment (July1)	Aetna / CME will be working to complete a Comprehensive CANS assessment for everyone enrolled in the Day 1 group within 30 days of 7/1/22.
Can you please offer who we should add to our local Release of Information forms to cover our discussions/dialogue and referrals	We recommend adding the CME and Aetna to your ROI.
Will day-1 families receive a phone number/contact information to get more information on Ohio Rise? We can let them know they have this option (FCFC or CME) and will be contacted, but shouldn't they contact Aetna or the CME for the details?	Families will get a welcome letter from Aetna educating the family that the youth is eligible and providing additional information. For families that are not auto enrolled on Day 1, completing the CANS in the CANS portal determines eligibility and then would notify Aetna if they are eligible.
For youth that are auto enrolled due to being placed in a CRC or an out-of-state PRTF, will those youth be covered by the CME in the same region as the Title IV-E custodial agency? (not the CME where the placement is located)	The youth will be served based on the CME that serves the custodial agency's county, not the location of the residential site. If there needs to be a transfer to another catchment area, that would be a discussion between the CMEs and Family Team.
How can FCFC's be aware of youth eligible for Ohio Rise that are currently receiving MSY funds?	It is recommended to reach out to your CME and discuss a plan of action to keep the communication open, especially regarding release of information. For example - one county reports that their CME has discussed setting up a business associate agreement and MOU to help facilitate the sharing of information.
Do you know when PCSA's will be getting the list of kids in custody that are going to OHR?	They are hoping the lists will go out later today or by the end of the week.
When you say "tagged" I have had no one reach out to me or talk to me regarding youth enrolled in FCFC.	We would recommend FCFCs reach out to CMEs to connect with their assigned CME; however, if they have not received a response, OhioRISE staff are happy to assist with connections.
We are working with two different CME's. We are intending to be a provider for the CMEs, and we have some questions regarding contracting with CME's. I have heard that some counties have MOUs to provide a certain amount of MCC/ICC. Our CME s have sent contracts to enter as a provider with a Medicaid provider number, even though we will not be actually billing the service and receiving payment. We are trying to figure out as an FCFC how to treat these dollars. How is it treated from an audit standpoint? What is the liability for our fiscal admin? Is this an agreement or a contract? What makes the best	ODM does not get in the middle of subcontract agreements. ODM provides the rate for the service. CME is responsible administratively for what they are held accountable for is in the agreement with Aetna, CME will be held accountable for making sure subcontractor is complying with all requirements (education, service requirements, reporting, etc.)

sense for FCFCs given our fiscal structure? Also, what is the fiscal liability	
I might have missed this before, but are there specific time limits due to Medicaid billing for care coordination in OhioRise?	There will be an updated CANS completed every 90 days to redetermine eligibility for their Tier level, so that is one way need for continued care coordination is addressed. The need could increase, decrease or stay the same based on CANS results. This will also be monitored during Family Team Meetings based on services and supports the family is receiving.
What happens to FCFCs if all our kiddos/family's go to OhioRISE? Where does FCFC fall if OhioRISE essentially provides the same thing FCFC's already provides. How does FCFC partner with OhioRISE I guess?	FCFCs will go in two directions; for FCFCs that are able and want to assist with OhioRISE youth, we will help support your continued involvement, including training and resources. If you want to do Service Coordination and not HFWA, we will support you in that work as well. There are ~2.5 million youth in Ohio and it is estimated that 50-60,000 will be served initially through OhioRISE. There will be families and youth who need support and will not qualify for OhioRISE. There is still a place for FCFCs in Ohio's landscape.
Is it fair to say that the CMEs have their list of day 1 enrollees and have contacted the families on their list?	Every CME looks a little different and their level of readiness looks a little different. We have some CMEs that are ready to address CANS and others are leaning on Aetna. Outreach to families is happening but there is not a deadline to contact the families.
Is there expectation that FCFCs will need to provide on call? One of our CMEs said, yes, the other said, no. This seems like a Behavioral Health expectation, and not traditionally a Wraparound Fidelity practice. We have a safety/crisis plan but have never been the one 'qualified' to provide on call services.	If you are contracting to provide care coordination on behalf of a CME, there are on call requirements. It may mean that there is a mobile crisis response need. The care coordinator is who the family is most connected to they want to make sure the CC is accessible if the family needs assistance. During the FTM, there should be discussion on what each professional/role would be responsible if an on-call crisis response is needed.