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 new OhioRISE specialized managed care organization. OhioRISE aims to expand access to in-home and community-based services. Aetna will contract with regional care management entities to ensure OhioRISE members and families have 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, 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 major components of OhioRISE and the new and enhanced services. 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 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
- Under the age of 21
- Meet a functional needs threshold for behavioral health care, as identified by the Child and Adolescent Needs and Strengths (CANS) tool

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 three and two of this service (intensive and moderate) 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 services (this new service will also be available to children who are not enrolled in OhioRISE).

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- **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.
- **Flexible Funds/Customized Goods and Services:** 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?

The youth and family voice and choice is at the heart of OhioRISE. 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 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.

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 geographically located across the state to serve children in tier two and three care coordination.

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.

CANS

What is a CANS Assessment?

The Child and Adolescent Needs and Strengths (CANS) is a functional assessment tool that assesses both the child and family's needs and strengths. It provides decision support to identify appropriate approaches to care and services. It will be used across all systems. In OhioRISE, it is used to make eligibility determinations and support care planning.

Brief CANS is used as the initial assessment and includes core items to determine eligibility, tier of care coordination, QRTP LOC, and recommendations for care planning.

Comprehensive CANS is used for ongoing assessments and expands items in the Brief CANS to improve care planning and coordination. It can be used at the time of initial assessment if preferred by the assessor.

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 developed to use across all systems in the state.

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

All systems' assessors will be trained using 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 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 OhioRISE 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.

Who is the primary lead for the Child and Family Team (CFT) meetings?

The 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?

CMEs will be selected by the OhioRISE plan. 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.

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 ICC/MCC, they will help develop the care plan with the youth and family.

What is meant by authorization versus prior authorization for the child and family-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.

MRSS

What is Mobile Response and Stabilization Service?

Provides youth in crisis and their families with immediate behavioral health services to ensure they are safe and receive necessary supports and services (this new service will also be available to children who are not enrolled in OhioRISE). The initial mobile response occurs within sixty minutes, with a de-escalation period up to seventy-two hours and a stabilization period for up to six weeks. The six weeks of stabilization services immediately follows the 72 hours of mobile response.

Mobile response: Initial CANS assessment and planning at request of child/family
Stabilization service: Coordination and delivery of services, link to longer-term supports

Behavioral Health Respite

What is Behavioral Health Respite?

Behavioral health respite services are services that 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.

IHBT

What is IHBT?

Intensive home-based treatment (IHBT) service is a comprehensive behavioral health service provided to a child/adolescent with serious emotional disturbance (SED) and their family for the purpose of preventing out of home placement or facilitating a successful transition back home. These intensive, time-limited behavioral health services are provided in the child/adolescent's natural environment with the purpose of stabilizing and improving their behavioral health functioning.

PRTF

What is a PRTF?

A Psychiatric Residential Treatment Facility (PRTF) is an inpatient level, intensive multi-disciplinary residential treatment provided in a non-acute setting for youth with complex needs. PRTFs treat youth with complex mental illness or co-occurring diagnoses and significant behavioral challenges.

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 this year 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 is 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.

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 data collection requirements will be for all of the data elements related to care coordination (eg. Timely initial outreach, assessments, timely care plan completion, etc.).

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.' We 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 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 90-day transition of care period. The goal of that transition of care period, in additional to providing continuity to the child and family, is to allow for providers to proceed with contracting requirements.

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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.

Will there be metrics agencies will need to agree to (performance metrics, quality, etc...) and if so, is Aetna including these 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 Family and Children First Councils?

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 will Aetna 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. 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 Care Coordination Tier 1 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 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.

Care Management Entities

What are Care Management Entities?

Care Management Entities (CMEs) are local community agencies that will contract with the OhioRISE plan to provide intensive and moderate care coordination to enrolled youth.

How many CME's will be selected per region?

CMEs will be geographically located across the state using a regional approach.

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.

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

Selected CMEs should be rooted in the community and have strong ties to community resources and other local entities to support care coordination. CMEs should continue to grow connections and build relationships with child and family serving organizations.

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

Yes, care coordination is at the center of supporting youth in OhioRISE and does not replace therapeutic services provided by IHBT.

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?

No, as TBS and PSR are therapeutic interventions, not case management services.

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. **Individualized Behavioral Supports and Training (IBST):** 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. **Therapeutic Mentoring**: Intended to assist individuals enrolled in the OhioRISE 1915(c) Waiver program and their families by providing supports to enable them to function to the highest degree within their family unit and their community.
4. **Flex Funds/Customized Goods and Services:** 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 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.

Family First Prevention Service Act

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

Passed in 2018, the federal Family First Prevention Services Act (FFPSA) is the most significant change in child protection in Title IV-E funding in decades. It's required to be implemented by October 2021. OhioRISE ensures compliance with the federally mandated changes in FFPSA by focusing on prevention from entering the child protection system.

OhioRISE serves many of the same children and aims to align with FFPSA to prevent youth from entering the child protection system, preventing custody relinquishment due to needing access to services, reducing the need for residential treatment, and reducing out-of-state 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.