OhioRISE Care Management Entity Manual

July 2026

OhioRISE Care Management Entity Manual Version History			
Version	**Description of Changes**	**Last Editor**	**Release Date**
Version 0.5	Initial Draft for CME Review	State OhioRISE Team and Aetna Better Health of Ohio	4/13/2022
Version 1.0	• Initial Release	State OhioRISE Team and Aetna Better Health of Ohio	5/24/2022
Version 1.1	• Updated Waiver LOC CANS language and provided description/list of Functional Limitations for Waiver Eligibility (top of page 25). • Added information about care coordinator / QMHS training requirements (page 29). • Deleted statement re: initial face-to-face visit requiring CME notification to Aetna via Family Connect (page 43). • Added Aetna's full CFCP Approval Process (page 50). • Updated language about CME letter when making outreach attempts (page 35). • Updated information about signatures of caregiver, care coordinator/supervisor (and/or) youth (page 59). • Added guidance regarding audio signatures (page 59). • Updated CME billing information (pages 77-84): o Added practitioner abbreviation and practitioner modifier charts. o Added CANS assessment billing information. o Clarified CANS IT system submission requirements. o Clarified practitioner modifier billing requirements.	State OhioRISE Team and Aetna Better Health of Ohio	6/14/2022
Version 1.2	• Updated practitioner modifier billing requirements. • Added POS clarifications.	State OhioRISE Team and Aetna Better Health of Ohio	6/21/22
Version 1.3	• Added G code for reporting research activities • Adjusted language and rates to reflect updates in the 5160-59-02 and 5160-59-03.2 rules o Updated the Initial Supplemental Assessment and ICC/MCC rates o Incorporated timelines removed from the 5160-59-03.2 rule o Adjusted the caseload ratio for MCC	State OhioRISE Team and Aetna Better Health of Ohio	

Version 1.4	• Reviewed by Workgroup consisting of representation from ODM, COE, Aetna and CMEs in 2024; incorporated changes as appropriate. • Added hyperlinks • Clarified best practice vs contractual expectation / OAC rule • Adjusted language to reflect updated OAC rules • Eliminated duplicative language throughout manual • Updated to reflect current expectations and processes	State OhioRISE Team and Aetna Better Health of Ohio	8/13/2026

Foreword

This manual reflects care coordination best practices focused on coordinating behavioral health care and natural supports for youth with complex mental health and addiction needs. It is grounded in key principles of the National Wraparound Initiative (NWI) high-fidelity wraparound (HFWA) model and system of care (SOC) approach. This manual cannot account for every specific situation that will arise during CME services. However, the CME Manual does outline and provide expectations and recommended best practices that support the underlying premise that care coordination practice upholds the best interest of the youth and family as planned for through the child and family team (CFT) which collectively can support any circumstance. These best practices will also assist CMEs in meeting the expectations of contracts, quality and performance monitoring.

Legal Disclaimer

This Manual is provided by Aetna Better Health of Ohio (Aetna), the OhioRISE Plan, after review by the Ohio Department of Medicaid (ODM).

This Manual serves as a guide to the policies and procedures governing the administration of the OhioRISE program by the OhioRISE Plan, Aetna Better Health of Ohio. It is an extension of and supplement to the agreement between Aetna Better Health of Ohio and OhioRISE Care Management Entities (CMEs) delivering service(s) to our members. We retain the right to add, delete and otherwise modify this manual. Revisions to this manual reflect changes made to our policies and procedures updated at least annually. Revisions will be binding and will comply with any statutory, regulatory, contractual and accreditation requirements. As policies and procedures change, we will let you know in advance via our CME Leadership Newsletter, email and CME Memos. All updates will be incorporated into subsequent versions of this Manual.

In the case of any conflict between the information contained in this Manual and Ohio Administrative Code or Ohio Revised Code, the Ohio Administrative Code or Ohio Revised Code, as applicable, prevails. This Manual is not intended to be a substitute for professional legal, financial, or business advice. This Manual does not create, nor is it intended to create an attorney-client relationship between you and the State of Ohio or Aetna. You are urged to consult with your attorney, accountant, or other qualified professional if you require advice or opinions tailored to your specific needs and circumstances.

We’re always looking to improve the usefulness of the tools and information we make available to our CMEs. We welcome your comments and feedback. Please email your comments, feedback and suggestions to Aetna through your Relationship Manager.

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Section 1: OhioRISE Purpose and Goals

OhioRISE has been jointly developed by the Ohio Department of Medicaid (ODM), the Governor's Office of Children's Initiatives, and other state youth serving agencies. This multi-agency partnership is responsible for the shared governance of OhioRISE. This approach reflects the OhioRISE target population that includes children and youth with serious or complex behavioral health needs who are at risk of involvement or are involved in multiple youth-serving systems. These youth serving systems include the Department of Developmental Disabilities (DODD), Ohio Department of Education and Workforce Development (ODEW), Ohio Department of Health (ODH), Ohio Department of Children and Youth (DCY), Ohio Department of Behavioral Health (DBH), Ohio Department of Rehabilitation and Correction (ODRC), Ohio Department of Youth Services (DYS), and Ohio Family and Children First (OFCF).

OhioRISE aims to shift the system of care and keep more youth and families together by creating new access to in-home and community-based services for youth with the most complex behavioral health challenges. The OhioRISE program's child and family-centric delivery system recognizes the need to specialize in services and support for this unique group of youth and families. Aetna Better Health of Ohio (the OhioRISE plan) is partnering with Ohio Department of Medicaid (ODM), partner state agencies, providers, families, and other stakeholders to develop and implement new and enhanced services.

The OhioRISE Program will use intensive care coordination (ICC) and moderate care coordination (MCC), provided through eighteen local Care Management Entities to improve the timeliness and appropriateness of service delivery to its youth. Using the high fidelity wrap around care coordination model offered by the CMEs, the OhioRISE Program seeks to:

- Reduce unnecessary hospitalizations and emergency room visits.
- Decrease involvement with the juvenile justice and corrections systems.
- Reduce out-of-home and out-of-state placements (residential care and foster care).
- Increase school attendance and performance.
- Reduce custody relinquishment for children, youth, and families.

The OhioRISE Program includes new and expanded Medicaid services for youth and families experiencing complex behavioral health needs. In addition to ICC and MCC, OhioRISE will work with local systems of care and CMEs to enhance and expand access to critical behavioral health services and supports, such as:

- Mobile Response and Stabilization Services (MRSS).
- Intensive Home-Based Treatment (IHBT), including evidence-based practices such as Multisystemic Therapy (MST) and Functional Family Therapy (FFT).
- In-state Psychiatric Residential Treatment Facilities (PRTF) to reduce the need for out-of-state treatment.
- Respite Services.
- OhioRISE Waiver.
- Flexible Funds.

In addition to these new services, OhioRISE offers Medicaid services for youth including:

- Outpatient mental health and substance use disorder (SUD) services.
- SUD Residential services.
- Inpatient mental health and SUD services.

ODM selected Aetna Better Health of Ohio (Aetna) to serve as the specialized managed care organization for the state's youth, ages 0-21, with the most complex behavioral health needs for the OhioRISE program. Aetna continues to work with ODM, state sister agencies, Care Management Entities, Child and Adolescent Behavioral Health Center of Excellence (CABHCOE), providers, families, youth, and stakeholders to implement, refine, and expand a youth and family-centric model featuring new targeted services and intensive care coordination delivered by community partners.

The foundation for OhioRISE, and its success in supporting youth with complex behavioral health needs, and their families, is the tenets of systems of care (SOC) and high-fidelity wraparound (HFWA) care coordination. A system of care is a spectrum of effective, community-based services and supports for children, youth and families/caregivers who are experiencing complex behavioral health needs. The system of care is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs to help them to function better at home, in school, in the community, and throughout life. As such, OhioRISE is designed to be:

- **Family Driven and Youth Guided** – Children, youth, families and caregivers are engaged as active participants at all levels of planning, organization, and service delivery.
- **Culturally and Linguistically Competent** – Supports will incorporate the youth and family's culture, values, preferences, and interests into the planning process, including the identified language of the family.
- **Community Based** – Locally based services that are the least restrictive, accessible, and sustainable to maintain and strengthen the family's existing community relationships.

To support the needs of multi-system youth with complex behavioral health needs, OhioRISE has chosen the National Wraparound Initiative Wraparound Model of care coordination, as referenced in OAC Rule 5160-59-03.2. OhioRISE implements this model of care coordination within the framework of a Medicaid managed care structure to ensure sustainable statewide funding and operational framework. This includes tiered care coordination levels which are necessary to support implementation at scale. Intensive Care Coordination (ICC) reflects true fidelity to high-fidelity wraparound, while Moderate Care Coordination (MCC) and Limited Care Coordination (LCC) are structured adaptations grounded in the same principles and designed to meet the diverse needs of youth and families statewide. These adaptations allow for payment methodologies, staffing structures, and service intensity standards that maintain fidelity to the wraparound philosophy while accommodating system-wide operational requirements.

High-fidelity wraparound (HFWA) differs from many service delivery strategies, in that it provides a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the youth and family at the center. With support from a team of professionals, the community, and natural supports, the family's ideas and perspectives about what they need and what will be helpful drive all the work in HFWA.

The youth and their family members or caregivers work with a CME care coordinator to build their child and family team (CFT), which can include the family's friends and people from the wider community, as well as providers of services and supports, Managed Care Plans and others.

With the help of the CFT, the family and youth take the lead in deciding team vision and goals, and in developing creative and individualized services and supports that will help them achieve their goals and vision. Team members work together to put the plan into action, monitor how well it is working, and change it as needed.

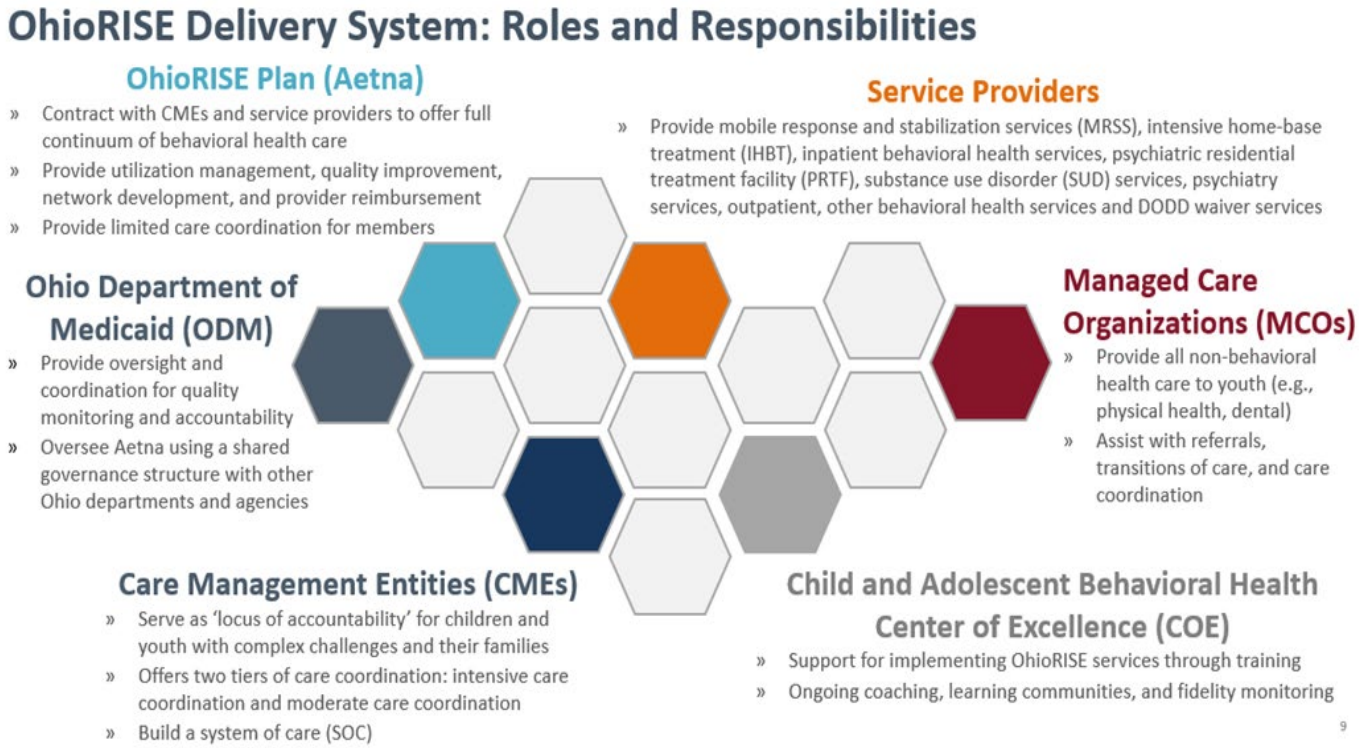
Click here for more information about HFWA care coordination.

ODM and Aetna are committed to operating OhioRISE in a manner consistent with the ten core principles that form the foundation of the Wraparound Model:

- **Family and Youth Voice and Choice:** Family and youth voice, choice and preferences are intentionally sought and prioritized during all phases of the process, including planning, delivery, transition, and evaluation of services. Services and interventions are family-focused and youth-centered from the first contact with or about the family or youth.
- **Team based:** Services and supports are planned and delivered through a collaborative teaming approach known as the Child and Family Team (CFT) In addition to the youth, their family / guardian(s) and Care Coordinators, additional team members are chosen by the family and the youth and are connected to them through natural, community, and formal support and service relationships. The Child and Family team serves to educate the youth and family, and together, to develop and implement a plan to address unmet needs and work toward the youth's and family's vision in a way that is appropriate to the identified needs of the youth.
- **Natural Supports:** The team actively seeks out and encourages the full participation of supports drawn from the youth's and family's networks of interpersonal and community relationships (e.g., friends, neighbors, community, and faith-based organizations). The care plan reflects activities and interventions that draw on sources of natural support to promote recovery and resiliency.
- **Collaboration:** The system responds effectively to the behavioral health needs of multi-system involved youth and their caregivers, including youth in the child welfare, juvenile justice, developmental disabilities, substance abuse, primary care, and education systems.
- **Home- and Community-Based:** Youth are first and foremost safely maintained in, or returned to, their own homes. Services and support strategies take place in the most inclusive, most responsive, most accessible, most normative, and least restrictive setting possible.
- **Culturally Relevant:** Services are culturally relevant and provided with respect for the values, preferences, beliefs, culture, and identity of the participant/youth and family and their community.
- **Individualized:** Services, strategies, and supports are individualized and tailored to the unique strengths and needs of each youth and family. They are altered when necessary to meet changing needs and goals or in response to poor outcomes.
- **Strengths-Based:** Services and supports are planned and delivered in a manner that identifies, builds on, and enhances the capabilities, knowledge, skills, and assets of the youth and family, their community, and other team members.
- **Outcome-Based:** Based on the youth and family's needs and vision, the team develops goals and strategies, ties them to observable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly. Services and supports are designed to be persistent and flexible, helping to overcome setbacks and achieve their intended goals and outcomes. Safety, stability and permanency are priorities.
- **Unconditional:** A youth and family team's commitment to achieving its goals persists regardless of the youth's behavior, placement setting, family's circumstances, or availability of services in the community. The team continues to work with the family toward their goals until the family indicates that a formal process is no longer required.

Section 2: OhioRISE Delivery System: Key Partners

Section Two briefly introduces the key partners in OhioRISE and their responsibilities. CME collaboration with each OhioRISE partner is discussed more fully in later sections of the manual. **Building this system of care is a shared responsibility between all key partners.**



OhioRISE Plan (Aetna)

Aetna serves as the specialized managed care organization for OhioRISE, the insurance plan that covers Ohio's children with the most complex behavioral health needs. Aetna serves as a point of access to OhioRISE and connects youth and their families with the care they need at the right intensity.

Aetna Better Health of Ohio is responsible for contracting with CMEs and supporting CME implementation of OhioRISE. There are numerous supportive roles within Aetna to support the CMEs, and Aetna understands that the success of OhioRISE starts with a strong partnership with the various agencies chosen to provide care coordination. In contracting with a range of behavioral health providers, Aetna collaborates with others and works toward improving the continuum of all OhioRISE behavioral health services.

The OhioRISE Plan facilitates and supports utilization management, quality improvement, and data analysis for OhioRISE. In this administrative support role, Aetna provides system partners with the information needed to manage the care planning process toward quality outcomes and cost-effective treatment.

Aetna maintains a toll-free statewide number (1-833-711-0773 (TTY: 711)) that families may call to access OhioRISE assistance. In addition to the youth/family self-referral option, Aetna is available to assist providers, system partners, managed care organizations, and stakeholders to refer youth to OhioRISE.

Aetna Limited Care Coordination/Tier 1

Aetna Tier 1 care coordination offers multiple options to meet the varied needs of members and their families. Limited Care Coordination is an active care coordination approach guided by Wraparound principles for youth who are eligible for OhioRISE but who either have lower-intensity behavioral health needs (CANS recommendation of Tier 1) or choose to receive lower-intensity care coordination rather than moderate or intensive care coordination. Youth enrolled in OhioRISE who receive wraparound care coordination through a Family and Children First Council (FCFC) also receive limited care coordination through Aetna. In this scenario, the FCFC care coordinator is the primary contact while the Aetna care coordinator takes a secondary role and assists the youth with accessing OhioRISE benefits. When youth are in Limited Care Coordination, they receive one call or visit per month and a quarterly Child and Family Team meeting.

Youth who are unable to be reached to consent to care coordination are assigned to Tier 1. These youth receive two phone calls and one letter per month in an attempt to engage the members and their families in care coordination.

Youth who decline all care coordination are also assigned to Tier 1 where they receive one outreach call every 90 days.

All Tier 1 members have the ability to access all necessary services and OhioRISE benefits through a Tier 1 care coordinator. In order to promote efficient access to these benefits, participation in Limited Care Coordination best facilitates ongoing and proactive needs assessment and care planning.

Transition of Care Support

Aetna's OhioRISE Transition of Care (TOC) team will partner with assigned care coordinators to collaboratively ensure seamless care transitions and follow-up, including coordinating services and transitions within the OhioRISE plan and across youth-serving systems and community providers. These OhioRISE Transition of Care Coordinators (TOCCs) are the primary points of contact with the Medicaid Managed Care Organizations (MCOs) and with state agency staff for planning, managing, and troubleshooting transition issues as youth transition from MCOs onto the OhioRISE Plan or back to the MCOs. The OhioRISE Plan, in collaboration with CMEs, will also support youth and caregivers to ensure continuity of care during the transition into and out of inpatient

hospitalizations or residential treatment facilities, as well as when a youth transitions onto or off a Waiver. TOC staff are regionally based and available to help coordinate information sharing and problem-solving on any issues related to the youth's engagement with Aetna.

System of Care (SoC) Development and Support

Aetna partners with the Ohio Department of Medicaid (ODM), each of the 18 Care Management Entities (CMEs), the Aetna provider network, the Centers of Excellence (COE), Aetna's Youth Advisory Council and Member and Family Advisory Council, and other state or local agencies. Together, this team works collaboratively to facilitate system change through the engagement of community leaders and partner agencies. Using data-driven methodology to identify specific community-level needs, they work to identify gaps and needs in the system of care, build capacity, enhance engagement, help providers expand and develop innovative services, design system training, and align stakeholders toward common goals that will lead to next-generation care for youth and families served by OhioRISE.

Aetna will:

- Utilize the voice of youth and families through the Aetna Youth Advisory Council and Member and Family Advisory Council to guide the system of care strategies.
- Utilize community level social determinants of health data, claims data with z codes and diagnoses, and analysis of access to care to determine gaps in services and levels of care within all 20 catchment areas, to determine an overall strategy to target specific system needs.
- Partner with the CMEs and the OhioRISE care coordination teams across the state to utilize the voice of youth and families and data analysis to facilitate an overall strategy to target specific system of care development in each catchment area.
- Support and collaborate with individual CMEs in building services across their catchment areas so care coordination can be delivered close to and within youths' homes and communities.
- Partner with the CMEs and COE to identify training and educational opportunities for youth and their circle of support, community partners, ODM, CME and health plan staff.
- Participate in internal and external stakeholder activities. Aetna will provide a statewide view and identify opportunities for community development and investments based on needs assessments completed by Aetna and other SoC partners.
- 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.
- Work with the CMEs and Population Health teams to provide resources and information which identify person-centered services and supports that meet the needs of our youth.

Aetna External Affairs Team

The Aetna External Affairs Administrators serve as the dedicated points of contact for local youth-serving stakeholders within the region of the state in which each Administrator serves: Central, Northeast, East, Northcentral, West, Northwest, Southeast, and Southwest. The External Affairs Administrators inform, support, and execute the OhioRISE Plan's outreach and engagement activities in priority communities and with priority stakeholders, promoting alignment between community needs and the OhioRISE Plan and encouraging collaboration among local leaders, organizations, stakeholders, CMEs, and the OhioRISE Plan. Administrators develop and offer resources such as presentations, workshops, forums, and trainings for county or local child-serving entities regarding the roles and responsibilities of the OhioRISE Plan; arrange regular meetings with local stakeholders and community-based organizations, using these meetings to bolster the presence of the OhioRISE

Plan as a trusted collaborative partner, share updates, discuss objectives, and strengthen collaboration; and act as priority system experts, providing specialized guidance and support to both internal and external partners. External Affairs Administrators also serve as subject matter experts and support system transformation at the state level. They also support CMEs by providing education and resources on effective strategies and resources to work with special populations. Each Administrator is a subject matter expert in a different area. These are:

- Juvenile Justice
- Child Welfare
- Intellectual & Developmental Disabilities
- ADAMH Boards/Behavioral Health System
- Education/Schools
- Hospitals
- Family and Children First Councils

Aetna Family and Youth Engagement Support

Drawing on their own lived experience, Aetna's Family and Youth Engagement Directors partner with youth and families across the state and collaborate with system stakeholders, including the CMEs, to ensure family and youth voice and choice are woven into the OhioRISE program and present in OhioRISE policies, processes, and procedures. The Engagement Directors provide leadership for the Family and Youth Advisory Councils. The Advisory Councils regularly provide meaningful input to ensure family and youth voice aligns OhioRISE with practices and continuous quality improvement activities and initiatives. The Engagement Directors will actively collaborate with the CMEs to identify youth and families interested in joining the Advisory Councils. The Advisory Councils meet monthly and focus on challenges seen by OhioRISE youth and families. Discussions include feedback on services and supports that may or may not be currently available and/or working as intended. In addition, the Advisory Council members brainstorm solutions and provide input and recommendations about the OhioRISE plan.

Aetna Population Health Support

The Aetna OhioRISE Population Health Management Strategy (PHMS) is designed to improve the health outcomes of the children and youth who have complex behavioral health needs enrolled in OhioRISE. The PHMS includes direction and collaboration with ODM for PHM and encompasses all Aetna, OhioRISE departments and staff, youths, Managed Care Entities (MCE) [which are comprised of Managed Care Organizations (MCOs) and the Single Pharmacy Benefit Manager (SPBM)], Care Management Entities (CME), providers, and community-based organizations. Aetna OhioRISE will work with ODM and the MCOs to develop cross-cutting population health and quality improvement initiatives for high-risk children and youth within its population stream. The PHM strategy implements monitoring and evaluation of population health and quality improvement activities under this population stream. Furthermore, as it relates to this population stream, Aetna OhioRISE will provide consultation, upon ODM request, to ODM, the MCOs, the SPBM, and other ODM-contracted managed care entities in the following areas:

- The development and implementation of population health strategies.
- The collection, analysis, and reporting of quality measures.
- Service system and clinical issues.
- Health and race equity issues.
- Strategic initiatives and other quality improvement activities.

Reducing Health Disparities

To assist youth in achieving health equity, it is important to identify the root causes of health outcomes. Aetna OhioRISE supports ODM, the MCOs, CMEs, and contracted providers in their efforts to reduce health disparities, address social risk factors, and achieve health equity for all youth. The Aetna OhioRISE Population Health Management Strategy strives to reduce the disparities and lack of resources and opportunities for marginalized and minority youths, and the barriers they encounter in accessing needed services.

Aetna OhioRISE ensures that health care disparities are addressed and ensures equitable access to the delivery of services to all youth. OhioRISE ensures culturally competent care and linguistically appropriate services by placing every member at the center of everything we do. We are committed to understanding and honoring every member's cultural and language preferences, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. Health equity is embedded in each PH project to ensure we are reducing disparities for our members, monitoring progress, and continuously improving to ensure that members' needs are met. Aetna, its subcontractors, and network providers provide physical access, reasonable accommodation, and accessible equipment for youths with physical or mental disabilities.

Care Management Entity Support and CME Relationship Managers

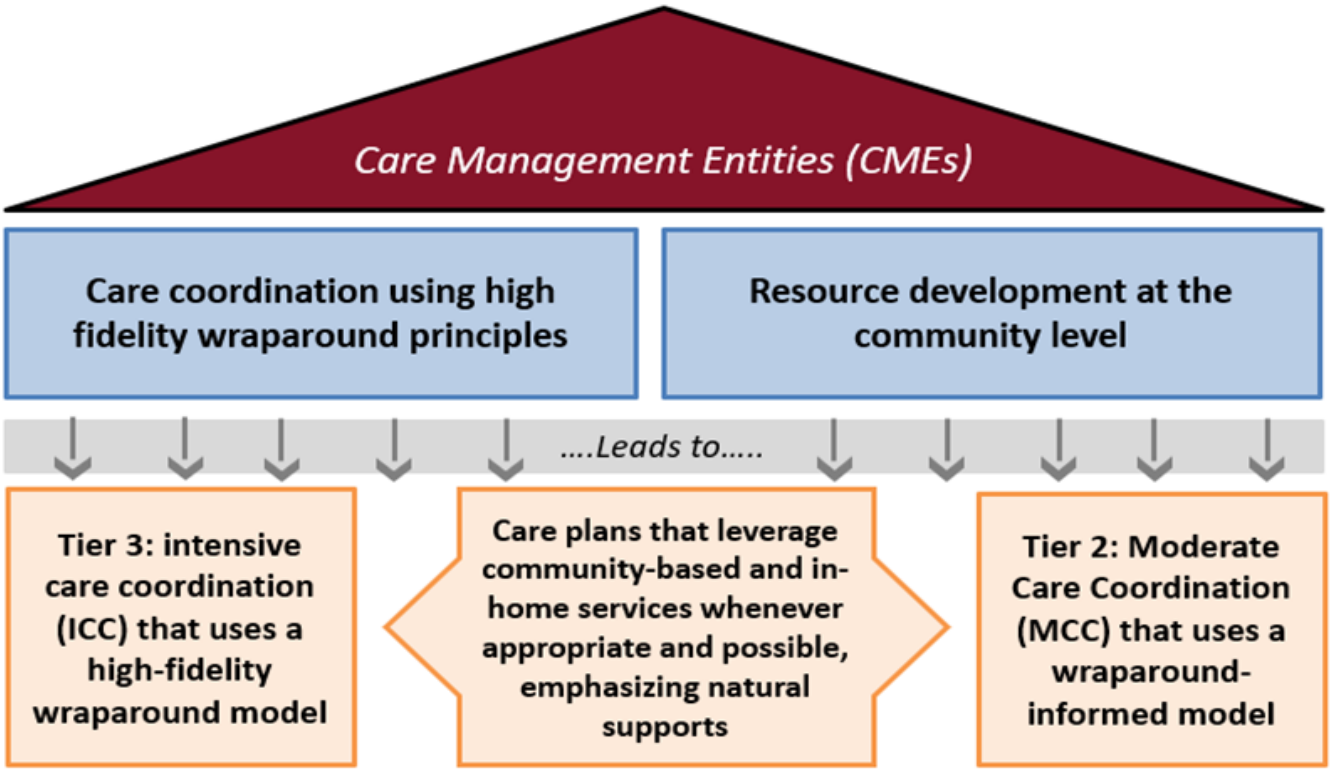
Each CME is assigned a Relationship Manager who is solely focused on supporting the CME in its operationalization of OhioRISE. The Relationship Manager is the primary point of contact for the CME when a problem or query arises. The Relationship Managers are adept at accessing Aetna's internal systems to check youth information, enrollment data, required documentation, and membership trends. They also ensure clear communication of OhioRISE processes and any associated changes. Finally, they collaborate with various Aetna teams, including the CME Alliance Hub and Quality teams, to monitor metrics and work with the CMEs to implement necessary programmatic changes.

Aetna CME Compliance and Performance Monitoring

Aetna is responsible for monitoring Care Management Entities (CMEs) to ensure compliance with contractual obligations as defined in Ohio Administrative Code Chapter 5160-59, the OhioRISE Plan Provider Agreement, the CME Manual, the PRTF Program Manual, and defined performance metrics. At its discretion, Aetna may conduct audits to verify that CMEs are meeting the requirements outlined in their contracts and are aligned with the expectations of the OhioRISE program. CMEs found to have deficiencies in performance or contractual obligations may be required to develop and implement a performance improvement plan or may be put under a formal corrective action plan. If satisfactory progress is not achieved, Aetna may initiate progressive disciplinary actions. These actions may include increased monitoring and reporting requirements, financial penalties, or termination of the CME's participation in the OhioRISE program.

CMEs may be held financially liable for all sanctions and fines imposed on Aetna as a result of a CME's failure to meet defined obligations within its contract, Aetna's most recent OhioRISE Plan Provider Agreement with ODM, the Ohio Administrative Code, the Ohio Revised Code, the CME Manual, the PRTF Program Manual, the OhioRISE 1915(c) Home and Community-Based Waiver, or other written directives from the Ohio Department of Medicaid or Aetna. In any instance where it is identified that a CME may have failed to meet contractual obligations resulting in a financial sanction on Aetna, Aetna will convene a meeting with CME leadership to thoroughly evaluate the circumstances leading to the CME's failure to meet contractual obligations. Aetna Executive Leadership will hold final authority on decisions to hold CMEs accountable for all financial sanctions.

Care Management Entities (CMEs)



Care management entities (CMEs) are regionally based organizations contracted with Aetna Better Health of Ohio to provide care coordination and System of Care (SoC) development across the state. As an extension of the OhioRISE plan, through this contractual relationship, CMEs work closely with local partners, the OhioRISE plan and ODM to increase services and supports where there are identified needs. CMEs are responsible for face-to-face care coordination and comprehensive service planning for youth and their families with intensive and moderate care coordination needs. CMEs coordinate Child and Family Team (CFT) meetings and implement Child and Family Centered Care Plans (CFCPs) for each youth and their family. They coordinate the delivery of services and supports needed to maintain stability and progress towards goals for each youth, utilizing a Wraparound approach to planning.

The CME's role is to help families succeed by developing a plan to address their needs and removing barriers that may impede progress. Their goal is to help youth and families develop a long-term, sustainable plan that will support them in improved functioning long after CME involvement. The CFT endeavors to identify youth needs, remove barriers to care, and facilitate creative, flexible planning to support the family and youth.

CME services include, but are not limited to:

- Engagement of the youth and family into care coordination services.
- Conducting face-to-face visits in the home or community to build rapport and develop relationships with youth and their families.
- Conducting all necessary assessments, including the Child and Adolescent Needs and Strengths Assessment and the Supplemental Assessment.
- Safety planning and discussion, which results in the development of a Crisis and Safety Plan.
- Configuration of a Child and Family Team through active collaboration with the family.

- Facilitation of the Child and Family Team meetings where the Child and Family Centered Care plan is developed, implemented, and updated.
- Identifying, linking, and supporting community providers to build and blend services and supports in the youth's community.
- Accessing Flex Funds, Value-Added Benefits, and additional resources to creatively address youth needs.
- Supporting system partners when appropriate services are not accessible in a timely manner.
- Monitoring service quality and outcomes for each youth and engaging in quality improvement activities.
- Gathering appropriate documentation to facilitate and secure services and supports decided upon by the CFT, which may include, but is not limited to, documentation to secure extracurricular activities, educational activities, treatment services, and MSY/PRTF applications.
- Planning for transitions, in and out of the program and ensuring warm hand-offs and smooth transitions when necessary.

CMEs and Local Systems of Care

Developing a strong local system of care requires intentional partnership and ongoing collaboration through all levels of OhioRISE. The role of the CME in building this system of care is:

- To ensure that youth and their families have access to needed services and supports.
- To identify gaps in services and supports within each community served by the CME.
- To engage community partners to address identified gaps. CMEs will identify and inform the OhioRISE plan of unmet needs and barriers to effective care, and Aetna and the CME will work together, along with other local partners, in developing community resources to meet youth and families' needs.

This CME work will be supported by the Aetna External Affairs Team, the Aetna Provider Network Team, and other state-level partners as appropriate.

Catchment Areas

Children and youth enrolled in OhioRISE will be served regionally through twenty catchment areas that have been created across the state. Counties were grouped in catchment areas to ensure multi/combined-county children's services agencies and mental health and addiction services boards are contained within a single catchment area. In many circumstances, counties with a higher volume of behavioral health provider resources were grouped with counties that have fewer resources. Ohio's three most populous counties, Cuyahoga, Franklin, and Hamilton are divided into multiple catchment areas to accommodate population maximum limitations of a catchment area and to provide an opportunity for more than one organization to become a CME within the most populous counties. The chart below includes the number of specific counties in the catchment area and the geographic area covered.


Lake
Ashtabula
Williams
Fulton
Lucas
Ottawa
Cuyahoga
Geauga
Trumbull
Defiance
Henry
Wood
Sandusky
Erie
Lorain
Summit
Portage
Paulding
Putnam
Hancock
Seneca
Huron
Medina
Mahoning
Van Wert
Wyandot
Crawford
Richland
Ashland
Wayne
Stark
Columbiana
Allen
Hardin
Marion
Holmes
Carroll
Mercer
Auglaize
Morrow
Knox
Tuscarawas
Jefferson
Logan
Union
Delaware
Coshocton
Harrison
Shelby
Darke
Champaign
Licking
Guernsey
Belmont
Miami
Franklin
Muskingum
Clark
Madison
Noble
Monroe
Preble
Montgomery
Greene
Fayette
Pickaway
Fairfield
Perry
Morgan
Washington
Hocking
Butler
Warren
Clinton
Ross
Athens
Vinton
Hamilton
Clermont
Highland
Meigs
Pike
Jackson
Brown
Adams
Scioto
Gallia
Lawrence

CME Provider	Counties	Area
Unison Health	Defiance, Fulton, Henry, Lucas, Mercer, Paulding, Putnam, Van Wert, Williams	**A**
Harbor	Crawford, Erie, Hancock, Huron, Marion, Ottawa, Sandusky, Seneca, Union, Wood, Wyandot	**B**
National Youth Advocate Program*	Allen, Auglaize, Champaign, Clark, Darke, Hardin, Green, Logan, Madison, Miami, Shelby	**C**
Choices Coordinated Care Solutions	Montgomery, Preble	**D**
CareStar	Butler, Clinton, Warren	**E**
Lighthouse Youth and Family Services*	Hamilton (West)	**F**
Cincinnati Children's HealthVine	Adams, Brown, Clermont, Hamilton (East), Lawrence, Scioto	**G**
Integrated Services for Behavioral Health	Athens, Fayette, Gallia, Jackson, Highland, Hocking, Meigs, Pickaway, Pike, Ross, Vinton	**H**
Integrated Services for Behavioral Health	Coshocton, Fairfield, Guernsey, Morgan, Muskingum, Noble, Perry, Washington	**I**
Jefferson Co. Educational Service Center	Belmont, Carroll, Columbiana, Harrison, Jefferson, Monroe, Stark, Tuscarawas,	**J**
The Village Network*	Franklin (West)	**K**
The Buckeye Ranch	Franklin (East)	**L**
I Am Boundless, Inc.	Delaware, Knox, Licking, Morrow	**M**
Wingspan Care Group	Lorain, Medina	**N**
Coleman Health Services	Ashland, Holmes, Richland, Wayne	**O**
OhioGuidestone	Cuyahoga (West)	**P**
Positive Education Program	Cuyahoga (Central)	**Q**
Ravenwood Health	Ashtabula, Cuyahoga (East), Geauga, Lake	**R**
Coleman Health Services	Portage, Summit	**S**
Cadence Care Network*	Mahoning, Trumbull	**T**

*In Partnership with the Child and Family Health Collaborative

OhioRISE Services and Service Providers

CMEs will collaborate with a range of behavioral health providers who are providing services to OhioRISE youth. It is expected that CME Care Coordinators will actively engage service providers in the youth and family teaming process to support the youth and family's goals, and to provide progress updates to ensure that the needs of the youth are fully addressed.

Aetna continually evaluates the availability of OhioRISE covered services across the state of Ohio to ensure all youth have access to needed services. When gaps in services are identified, Aetna's Provider Network works collaboratively with service providers, CMEs, ODM, CABHCOE and other key system of care partners to increase OhioRISE services and in-network service providers.

The OhioRISE Provider Directory lists all OhioRISE network providers. CMEs can visit https://www.aetnabetterhealth.com/ohiorise/find-provider to view up to date provider network information or request a printed Provider Directory by calling Member Services at **1-833-711-0773 (TTY: 711)** from 7 a.m. to 8 p.m. Monday through Friday.

Mobile Response and Stabilization Services (MRSS)

The Ohio Department of Behavioral Health (DBH) has implemented MRSS statewide. MRSS is a service that provides immediate help for children and young adults 20 and under who are experiencing overwhelming mental, emotional, or behavioral distress. With MRSS, when a crisis like this occurs, a team of trained professionals responds within 60 minutes directly to the young person's home, school, or any other location to de-escalate the crisis and provide ongoing support – all at no cost to the young person or their family.

Previously only available in certain areas of the state, the Ohio Department of Behavioral Health (DBH) and the Ohio Department of Medicaid (ODM) have teamed up with a network of regional partners that will allow MRSS to cover the whole state for the first time. Twelve different organizations have been selected to provide MRSS services across the state. These organizations will cover 18 regions, enabling response teams to get to any location in the state in less than 60 minutes after receiving a call though **Ohio's 988 Suicide and Crisis Lifeline**.

For a current list of MRSS Providers in Ohio, organized by county, please visit: MRSS Providers in Ohio by County - MRSS (mrssohio.org)

Each Regional MRSS Provider (RMP) is responsible for all aspects of MRSS support in their area, including initial dispatch, de-escalation, stabilization, data monitoring, and quality care assurance.

Ohio relies on a family's definition of a crisis as the standard for defining what constitutes a crisis and thus precipitates an offer for MRSS services.

The MRSS initial response offers face-to-face service delivery to families in the community at the site of the escalating behavior, whether this is the youth's home, school or another living arrangement, such as resource and foster family homes.

The initial phase of MRSS can extend for up to 72 hours after the dispatch request and includes de-escalation, assessment, and crisis planning services with a focus on youth and family engagement. The initial MRSS response will be available to every youth in Ohio. This includes an extended stabilization phase available for MRSS to remain involved with the youth and family for up to six weeks for stabilization management, during

which time MRSS staff will coordinate formal and informal services for the youth and family. MRSS staff will work with the youth and family during this time to ensure a proper transition plan is in place at the end of the youth and family's stabilization period.

Additional information can be found here:

MRSS Statewide Expansion | Department of Mental Health and Addiction Services

Psychiatric Residential Treatment Facility (PRTF)

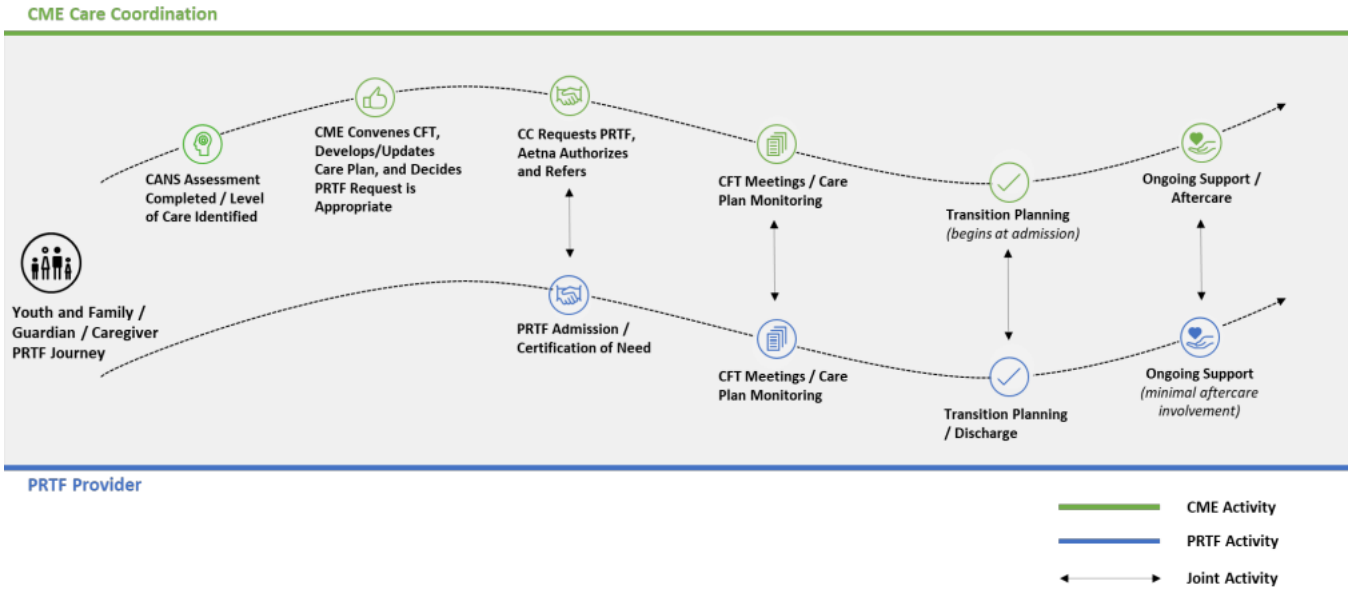
A PRTF is an inpatient level residential treatment provided in a nonhospital setting for youth with complex needs. A PRTF delivers trauma-informed, evidence-based, and individualized services to youth and their families/guardians/caregivers under direction of a physician, in order to stabilize behaviors to help youth and their families/guardians/caregivers develop the knowledge and skills needed to safely manage the youth's needs in the community. PRTF includes daily active treatment, achieved through a combination of family/guardian/caregiver, group, and individual therapy adapted to meet the individual needs and capabilities of the youth, consultation, and treatment planning with a comprehensive team of medical and behavioral health staff, in a highly structured living environment that accommodates the individual needs of the youth.

PRTFs aim to reduce long-term and repeated psychiatric hospitalization by delivering intensive care designed to help stabilize a youth, provide for immediate treatment needs, and quickly return youth to their prior care setting in less than six months to continue their course of treatment. As such, they are an integral part of the OhioRISE home and community-based continuum of care. Offering PRTF in Ohio ensures that youth in these settings remain close to their families/guardians/caregivers when receiving medically necessary services, and families/guardians/caregivers (and others on the CFT) can remain connected, participate in, and inform the treatment as needed. ODM and DBH have partnered with state system partners, Aetna, and other stakeholders to develop standards for PRTF.

The PRTF provider provides a consistent and predictable environment with intensive support and supervision in which there is a demonstrative understanding of the explicit and/or implicit trauma the youth may have experienced; delivers evidenced based and informed interventions to stabilize a youth and provide quality treatment to support a youth's return home, and interventions that are reflective of Ohio's commitment to reduce seclusion and restraint. The PRTF provider demonstrates the ability to successfully engage youth and families/guardians/caregivers in PRTF services, and responsiveness to youth and family/guardian/caregiver voice.

Care Management Entities and PRTFs

Youth entering PRTF will already have an OhioRISE care coordinator engaged via a CME, FCFC, or Aetna. These care coordinators will continue to provide care coordination, develop the CFCP, and convene the Child and Family Team, in which the PRTF will participate. PRTF staff are expected to participate in a youth's CFT for the duration of the youth's PRTF treatment and following a youth's transition to support successful transition back to the community, school and family/guardian/caregiver. As part of the PRTF treatment process, the PRTF provider, the youth's family, the Child and Family Team, and the CME will partner throughout the youth's treatment process focused on providing evidence based, trauma informed treatment while engaging the family in treatment activities focused transition and discharge planning back home and to the community.



Intensive Home-Based Therapy (IHBT) and other Intensive In-Home and Community-Based Services

IHBT is an intensive, time-limited behavioral health treatment for children and adolescents with significant behavioral health challenges and related functional impairments in key life domains. IHBT programs incorporate a comprehensive set of behavioral health services delivered in the home, school, and community. There are several specific clinical models that fall under the broad umbrella of Ohio's Intensive Home-Based Service Delivery model (IHBT): High Fidelity Intensive Home-Based Treatment (IHBT), Multi-Systemic Therapy (MST), and Functional Family Therapy (FFT). The hallmarks of an IHBT program are family involvement, small caseload size, intensity and frequency of service, 24/7 on-call services, and services delivered in the home and community. IHBT programs may not be available in all areas and are continuing to expand as OhioRISE matures. For a list of the current IHBT services please reference (https://medicaid.ohio.gov/news/press-release/odm-authorizing-funds-to-help-at-risk-youth).

IHBT models are delivered at an intensity greater than traditional outpatient counseling, and the caseloads are kept small to facilitate the needs of the youth and family. Treatment concludes within six months of the start date and will often focus on crisis stabilization, safety planning, skill building, trauma, and family interventions. The models are delivered by licensed staff and must meet the requirements of a rigorous credentialing process.

IHBT is meant to work within the HFWA model. IHBT providers, like other behavioral health providers, frequently become part of the CFT.

Behavioral Health Respite

Behavioral Health (BH) Respite is a service that is available to all youth who are enrolled in the OhioRISE plan. The goal of BH Respite is to provide relief to the primary caregiver of the OhioRISE-enrolled youth. This service may include the following activities: supporting the youth in a home or community setting, assisting the youth with their daily activities, or transporting the youth *while* providing respite activities to support the youth. The service must be provided by an OhioRISE provider. The service does not need prior authorization until after the 90th day of BH Respite is provided. If the youth needs BH Respite beyond 90 days, Prior Authorization is necessary.

Flex Funds

All youth in OhioRISE are eligible to access monies to purchase items or services which decrease the need for other Medicaid services, promote the youth's inclusion in the community, and/or increase the youth's safety in the home environment. The youth must be the direct recipient of any goods or services purchased using Flex Funds. The Flex Funds service is required to be participant-directed, included on the Child and Family Care Plan, and authorized by the Care Plan Reviewer prior to purchase. Flex Funds cannot be given directly to the youth or caregiver for purchase or reimbursement, and neither the youth nor caregiver can be a provider of goods and services purchased with Flex Funds. In addition, all other funding options must be exhausted prior to the Flex Funds request. OAC Rule 5160-59-03.5 clarifies these requirements. Flex Funds fall under a 365-day funding period and reset annually on the youth's enrollment date. The total amount allotted annually for Primary Flex Funds is $1,500. Youth on the OhioRISE Waiver are eligible to access additional monies, as well as emergency funds.

The following exclusions apply to the use of Flex Funds:

- Experimental treatments as outlined in rule 5160-1-61 of the Ohio Administrative Code
- Items used solely for entertainment or recreational purposes
- Pools, spas, and saunas
- Tobacco or alcoholic products
- Food
- Internet services
- Items of general utility
- More than one of the same items for the same youth unless there is a documented change in the item's condition that warrants replacement
- Home modifications that are of general utility or that add to the total square footage of the home
- Items or treatments that are illegal or otherwise excluded through federal or state regulations
- The costs of room and board as described in 42 CFR 441.310 (October 1, 2023)

Flex fund requests will be approved at an amount up to 20 percent above the originally submitted price. The actual amount paid for the item will be deducted from the individual's flex fund balance. Allowing for this 20 percent variance eliminates the need to reprocess requests if item prices increase after the original submission.

Multi-System Youth (MSY) Custody Relinquishment Prevention Program

The State of Ohio's program to prevent custody relinquishment for youth with multi-system needs was created with the goal of preventing transfer of custody to the child protection system solely for the purpose of obtaining funding to access treatment. The custody relinquishment prevention program is referred to as the Multi-System Youth (MSY) Program.

The MSY Program is sponsored by the Ohio Family and Children First (OFCF) Cabinet, including the Ohio Departments of Children and Youth, Developmental Disabilities, Education and Workforce, Behavioral Health, Medicaid and Youth Services.

The MSY Program is built on six core program principles:

1. Eligibility and Custody Prevention Requirements

Children and youth must be at risk for custody relinquishment or have been recently relinquished (no more than 30 days) solely to obtain access to care. Youth must meet multi-system eligibility criteria, defined as involvement with two or more child-serving systems. Funding will only be authorized for care provided on or after the date of application submission and for dates of service following custody return.

As MSY is designed to prevent custody relinquishment, funding cannot be requested for children already in the custody of a PCSA unless the request is directly tied to reunification efforts and supports a transition back to a family-based setting.

2. Multi-System Team Involvement and Care Coordination

Children and youth must have documented multi-system needs and be supported by an actively engaged local or regional multi-system team. Applications must clearly demonstrate ongoing care coordination and collaboration across systems involved in the youth's care.

The team must actively coordinate services, monitor progress, and implement creative, individualized solutions to meet the unique needs of the child or youth and their caregivers. Documentation of team involvement, care coordination activities, and creative strategies must be included in Section 3 of the application.

3. Clinical Necessity and Documentation Requirements

Care must be clinically appropriate and provided in the least restrictive setting necessary to meet the child's or youth's needs.

Applications must include robust clinical documentation demonstrating medical necessity, including:

- A mandatory clinical recommendation letter completed by an independently licensed clinician
- Documentation of at least six (6) months of prior treatment history, including dates, duration, level of care, and youth engagement
- Evidence of at least one ancillary support currently in place
- Identification and confirmation of the requested service provider prior to submission
- For out-of-home care requests, applications must include:
    - A recent (within 30 days) Child and Adolescent Needs and Strengths (CANS) assessment recommending out-of-home care, or comparable clinical documentation
- For substance use treatment, a recent (within 30 days) ASAM assessment recommending residential level of care

Applicants must demonstrate either:

- Utilization of intensive community-based services for a minimum of 12 weeks, OR
- Documented unavailability of services, defined as at least three (3) documented attempts to access appropriate services

Additional requirements for out-of-home care include adherence to expectations regarding family therapy frequency and appropriate provider service intensity levels.

4. Family Engagement and Reunification Expectations

Each child or youth must have one or more legal guardians who are willing and able to actively participate in care planning and treatment. Guardians must demonstrate ongoing engagement and a clear commitment to reunification when out-of-home care is utilized.

Guardians must affirm their participation and intent through the Requestor and Legal Guardian Attestation Form. For youth receiving out-of-home care, guardians must be willing to have the youth return home as soon as clinically appropriate and participate in required family therapy services.

5. Funder of Last Resort Requirements

The MSY Program is the payer of last resort and is only available after all other funding sources have been fully explored and exhausted. MSY funding cannot be used to supplant existing funding streams.
Applications must include clear documentation demonstrating:

- Exhaustion of local funds, Medicaid, OhioRISE, private insurance, post-adoption supports, and other funding sources
- Use of available benefits or a detailed justification for out-of-network or uncovered services

MSY funds may be used for a range of approved services and supports, including community-based services and residential treatment room and board, but cannot be used for educational services, transportation, or services typically covered by Medicaid or OhioRISE.

6. Program Scope, Duration, and Operational Requirements

The MSY Program is intended to address acute needs and prevent immediate custody relinquishment. It is not designed to provide long-term funding but rather to fill temporary gaps while sustainable funding and services are secured.

Out-of-home placements are subject to a maximum duration of 180 days, authorized in increments of up to 90 days per funding cycle. Continued funding requires demonstration of ongoing medical necessity and progress toward reunification.

MSY funding must be requested through the MATS portal by the CME or FCFC care coordinator responsible for care coordination. The coordinator is responsible for ensuring the completeness, accuracy, and timeliness of all applications and updates.

Additional MSY requirements and rules:

- No retroactive funding will be approved under any circumstances
- Incomplete applications will be automatically denied
- Initial applications must be submitted no later than the date of admission
- Continued funding requests must be submitted to Aetna through MATS no later than 21 days prior to funding expiration
- MSY funding cycles may not exceed 90 days per request
- A six (6) month waiting period is required before reapplying for MSY out-of-home funding following prior authorization
- Failure to submit timely and complete applications will result in funding denials, and any resulting service gaps will be the financial responsibility of the CME to rectify.
- While MSY applications may be submitted for continued funding, approval is not guaranteed.

MSY Logistics

- All MSY applications must be submitted through ODM's Multisystem Youth Application Tracking System (MATS).

    - Anyone wishing to create or submit an application in MATS must complete an ODM 7078 form (available on the OhioRISE Training and Resource E-Share) and submit it to Aetna at aetnamsyaccess@aetna.com. Aetna will review and submit all applications to ODM for final approval and provisioning. Please allow up to 10 days for processing and approval of the application.
    - MATS training is available on the OhioRISE Training and Resources E-Share for new users.
- CMEs must have an internal review system to allow for supervisors and CME Clinical Leadership review and approval to submit an MSY application.
- CMEs must have an internal tracking system to monitor funding expirations and reporting deadlines.

Additional Resources

In addition to services and supports available under the OhioRISE Plan and OhioRISE Waiver Program, CMEs will have the ability to access additional benefits for OhioRISE youth offered through Aetna. Additional benefits are resources designed to support health and wellness goals of youth. They are provided at no cost to youth and families and can alleviate the need to utilize Flex Funds. Additional Resources provided through the OhioRISE Plan are periodically changed and updated based on the needs of the youth.

OhioRISE Working Board

The OhioRISE Working Board fosters statewide, cross-system collaboration for youth enrolled in OhioRISE and served across systems. The OhioRISE Working Board represents a diverse range of expertise and experience. The board includes local system partners, associations and providers of services, and youth and family with lived experiences. It is a forum for sharing timely programmatic updates and gathering critical feedback and expert guidance for the program. Working Board Members play a vital role in advancing OhioRISE by offering constructive input and feedback driving system of care work in local communities. Official members of the Working Board represent the system of care at both the state and local levels.

Child and Adolescent Behavioral Health Center of Excellence

The OhioRISE initiative is supported in partnership with the Ohio Department of Behavioral Health, which has designed and implemented the Child and Adolescent Behavioral Health Center of Excellence (CABHCOE). The role of the CABHCOE will be to assist the state 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 CMEs will participate in training and coaching opportunities led by the CABHCOE to ensure consistency in delivering care coordination, fidelity monitoring, and quality improvement activities.

Medicaid Managed Care Entities

Managed Care Organizations (MCOs)

Most youth enrolled in OhioRISE also will be enrolled in managed care to receive their physical healthcare benefits. CMEs will coordinate with MCOs to support the medical needs of ICC and MCC enrolled youth. These are the MCOs serving OhioRISE enrolled youth:

- AmeriHealth Caritas Ohio, Inc.
- Anthem Blue Cross and Blue Shield
- Buckeye Community Health Plan (Centene)
- CareSource Ohio, Inc.

- Humana Health Plan of Ohio, Inc.
- Molina Healthcare of Ohio, Inc.
- UnitedHealthcare Community Plan of Ohio, Inc.

Youth who do not qualify for OhioRISE will continue to get behavioral health benefits through one of the above MCOs or through Medicaid's fee-for-service program.

Single Pharmacy Benefit Manager (SPBM)

A statewide Medicaid SPBM, managed by Gainwell Technologies, is responsible for providing and managing pharmacy benefits for all Ohio Medicaid members. Aetna will coordinate and collaborate with the SPBM to ensure that youth receive medically necessary pharmacy services.

All OhioRISE members can take advantage of Aetna pharmacists and subject matter experts to consult, coordinate, and provide training for medication issues relevant to youth. CMEs can access this consultation for a CME enrolled youth through their Aetna assigned Relationship Manager.

Section 3: OhioRISE Eligibility

The goal of OhioRISE is to serve children and youth with complex behavioral health needs that may lead to involvement with multiple youth-serving systems. Youth must meet the following requirements to qualify for OhioRISE:

- Be between the ages of 0-20 at the time of enrollment.
- Be determined eligible for Ohio Medicaid
- Require significant and intensive behavioral health treatment,
    - As assessed by the Child and Adolescent Needs and Strengths (CANS) assessment; or
    - An inpatient stay in a hospital for mental illness or substance use disorder (SUD).

Section 4: OhioRISE Enrollment

Anyone can refer a youth for enrollment in OhioRISE, including behavioral health and physical health providers, schools, state and local agency staff, the statewide crisis line, MRSS providers, and inpatient behavioral health units. A parent/caregiver or youth can also self-refer.

Initiating a Referral to OhioRISE

There are multiple avenues for referrals to be made:

- Contact OhioRISE Member Services at **833-711-0773 (TTY: 711)** from 7 a.m. to 8 p.m. Monday through Friday and Aetna Better Health of Ohio will work with the youth and their MCO to coordinate a referral for a CANS Assessment to determine eligibility for the OhioRISE program.
- Contact the youth's local Care Management Entity (CME) to initiate a referral for a CANS assessment to determine eligibility for the OhioRISE program.
- Contact the youth's MCO to initiate a referral for a CANS assessment within one business day to determine eligibility for the OhioRISE program. Below are the emails and phone numbers that youth and families/caregivers can use to reach out directly to their Managed Care Organization:

MCO	Care Coordination Phone	Email	Member Services Phone
AmeriHealth Caritas	1-833-464-7768	ACOHCareCoordination@ amerihealthcaritasoh.com	1-833-889-6446
Anthem Blue Cross and Blue Shield	1-844-912-0938	Lori.hughes@anthem.com	1-844-912-0938
Buckeye Community Health Plan	1-513-630-7189	brandi.m.hahn@centene.com	1-866-246-4358
CareSource Ohio, Inc.	1-800-488-0134	Care4uspecialpopulations@caresource.com	1-800-488-0134
Humana Healthy Horizons in Ohio	1-877-856-5707	OHMCDOhioRISE@humana.com	1-877-856-5702
Molina Healthcare of Ohio, Inc.	1-833-711-0773	OHBehavioralHealthReferrals@MolinaHealthCare.com	1-866- 403-8293
United Health	1-800-404-6789	alicia_vonville@uhc.com	1-800-421-6204

- If the youth has fee-for-service Medicaid, the Medicaid Consumer Hotline 1-800-324-8680 (TTY: 711) can assist with locating a certified CANS assessor.

Routine Eligibility Process

When a youth is referred for a CANS (Child and Adolescent Needs and Strengths) assessment, the process begins promptly. Within **10 business days**, a CANS assessor contacts the family, schedules a face-to-face meeting, and completes either a Brief or Comprehensive CANS assessment. The assessor incorporates the perspectives of

both the youth and family to ensure a comprehensive understanding of the youth's needs. The completed assessment must be entered into the **CANS IT System within 72 hours** of the assessment date.

Once submitted, the system determines whether the youth is eligible for OhioRISE and recommends a care coordination tier:

- **Tier 1 – Limited Care Coordination**
- **Tier 2 – Moderate Care Coordination**
- **Tier 3 – Intensive Care Coordination**

If the youth is eligible, enrollment in OhioRISE is effective as of the CANS submission date. The Ohio Department of Medicaid (ODM) notifies Aetna of the youth's enrollment. During this time, Aetna and the MCOs coordinate to share updates and support the youth's transition into the OhioRISE program.

If the youth is not eligible, ODM sends a notification to the family. In these cases, the youth's Managed Care Organization (MCO) is responsible for following up to ensure behavioral health needs are addressed. If an external provider completed the CANS, appropriate authorization is needed to inform that provider of the youth's eligibility and care coordination status.

Crisis Eligibility Process

In psychiatric crisis situations, the eligibility process is expedited. With guardian consent, Mobile Response and Stabilization Services (MRSS) can notify Aetna of a potential referral. MRSS providers may also complete a crisis CANS, which is entered into the CANS IT System.

Hospital Admission-Driven Enrollment

Youth under age 21 who are admitted for inpatient behavioral health treatment with a primary diagnosis of mental health or substance use disorder are automatically eligible for OhioRISE. Enrollment begins on the date of admission.

Aetna's Utilization Management Team or the hospital team notify the CANS IT System of the inpatient admission.

Care Coordination Tier Assignment

Initial tier assignments and CME referrals are based on available information at the time, including:

- Complexity of behavioral health needs;
- Recent psychiatric hospitalizations;
- Results from the most recent CANS or MRSS assessments;
- Use of community-based or out-of-home behavioral health services;
- Youth and family circumstances;
- Social determinants of health (SDOH); and
- Safety risk factors.

For youth assigned to Limited Care Coordination (Tier 1), Aetna provides care coordination services directly through the OhioRISE Plan.

When a youth is assigned to Moderate (Tier 2) or Intensive (Tier 3) Care Coordination, Aetna refers the youth to a Care Management Entity (CME) based on the youth's place of residence. Aetna sends daily Member Alignment Files (MAFs) to each CME listing their assigned members.

For all tiers, the referral timelines vary by enrollment pathway:

- **Routine Enrollment**: Aetna must refer the youth to a CME within **2 business days** of receiving eligibility confirmation from ODM.
- **Crisis Enrollment**: Aetna must refer the youth to a CME within **24 hours** of the CANS submission.
- **Inpatient Admission**: Aetna refers the youth to a CME **immediately upon becoming aware** of the admission and eligibility.

For youth in PCSA (Public Children Services Agency) custody, the CME assignment is based on the county of origin. To avoid disruptions in care, it is expected that youth remain with the CME representing their county of origin, even if they are temporarily placed elsewhere. Exceptions need to be approved by Aetna.

Once referred, the CME begins engaging with the youth and family. This early engagement, along with the development of a child- and family-centered care plan, helps confirm or adjust the tier level to ensure the youth receives the appropriate ongoing level of support.

Verifying Enrollment Status

If there is uncertainty about whether a youth is already enrolled in OhioRISE, Aetna, the youth's MCO, or a behavioral health provider can assist. They can check ODM's provider portal.

Disenrollment from OhioRISE (including age out and change of youth circumstance)

All transitions out of OhioRISE should be planned in advance of disenrollment to allow for successful planning for the transition.

General OhioRISE / CME Responsibilities at the time of OhioRISE Disenrollment

The OhioRISE plan performs outreach to MCOs and key behavioral health (BH) providers/CMEs for input on the care plan.

The transition plan is to be completed no less than 15 days prior to disenrollment and shared with the MCO's Care Coordination (CC) team prior to the planned effective disenrollment date. Following the transition, the MCO's CC team follows the youth for at least 90 days to assist with accessing any services and resources needed. A transition plan is also required to be completed for youth who are being disenrolled due to loss of Medicaid. The Care Coordination team should support the youth with the transition to ensure no interruption to services.

General MCO Responsibilities at time of OhioRISE Disenrollment:

In addition to participating in transition planning for each applicable youth, the MCOs will:

- Honor prior authorizations for behavioral health services approved prior to the youth's transition from OhioRISE through the expiration of the authorization, regardless of whether the authorized or treating provider is in or out-of-network with MCO.
- Conduct a medical necessity review for previously authorized services if the youth's needs change to warrant a change in service. MCOs must render an authorization decision pursuant to OAC rule 5160-26-03.1.

- Assists the youth to access services through a network provider when any of the following occur:
    - The youth's condition stabilizes and MCO can ensure no interruption to services.
    - The youth chooses to change to a network provider.
    - If there are quality concerns identified with the previously authorized provider.

Member Transitions

The OhioRISE program aims to seamlessly transition youth into and out of the OhioRISE program, as well as facilitate seamless transitions at any other time of change in health insurance coverage. MCOs, in coordination with the OhioRISE plan, and/or CMEs as assigned, must effectively and comprehensively manage youth transitions of care to prevent unplanned or unnecessary hospital readmissions, emergency department visits, and/or adverse outcomes.

Section 5: OhioRISE 1915(c) Waiver Eligibility and Enrollment

The OhioRISE 1915(c) Waiver provides additional services and supports to youth with serious emotional disturbances and functional limitations that indicate the need for services similar to those provided by an inpatient behavioral health treatment facility. Youth may be considered eligible for the OhioRISE Waiver if they:

- Meet requirements for Medicaid and OhioRISE program eligibility.
- Meet a level of care equivalent to an inpatient psychiatric (IP) level of care, as determined by:
    - A Waiver Child and Adolescent Needs and Strengths (CANS) assessment.
    - A documented serious emotional disturbance (SED) diagnosis; and
    - Documented functional limitations.
- Be determined to need, and agree to receive, at least one OhioRISE Waiver service.
- Have waiver needs that cost less than or equal to the OhioRISE Waiver service cost limit.
- Reside in a private residence in the community.

It should be noted that OhioRISE eligibility at the time of initial enrollment is limited to youth ages 20 and younger. However, once enrolled, the OhioRISE Waiver will allow continued enrollment through age 22 if a youth continues to meet eligibility requirements through the Waiver Level of Care Annual Redetermination assessment.

The OhioRISE Waiver is a program that helps individuals stay in their homes and communities, rather than being placed in a facility or institution. Youth enrolled in the OhioRISE Waiver have their behavioral healthcare services covered through OhioRISE. They are also eligible to receive additional services through the OhioRISE Waiver. These services include Out-of-Home Respite, Transitional Services and Supports (TSS), and Secondary Flex Funds. The purpose of these waiver services is to avoid institutionalization by preventing adverse health and life outcomes for youth with serious emotional disturbance and functional limitations.

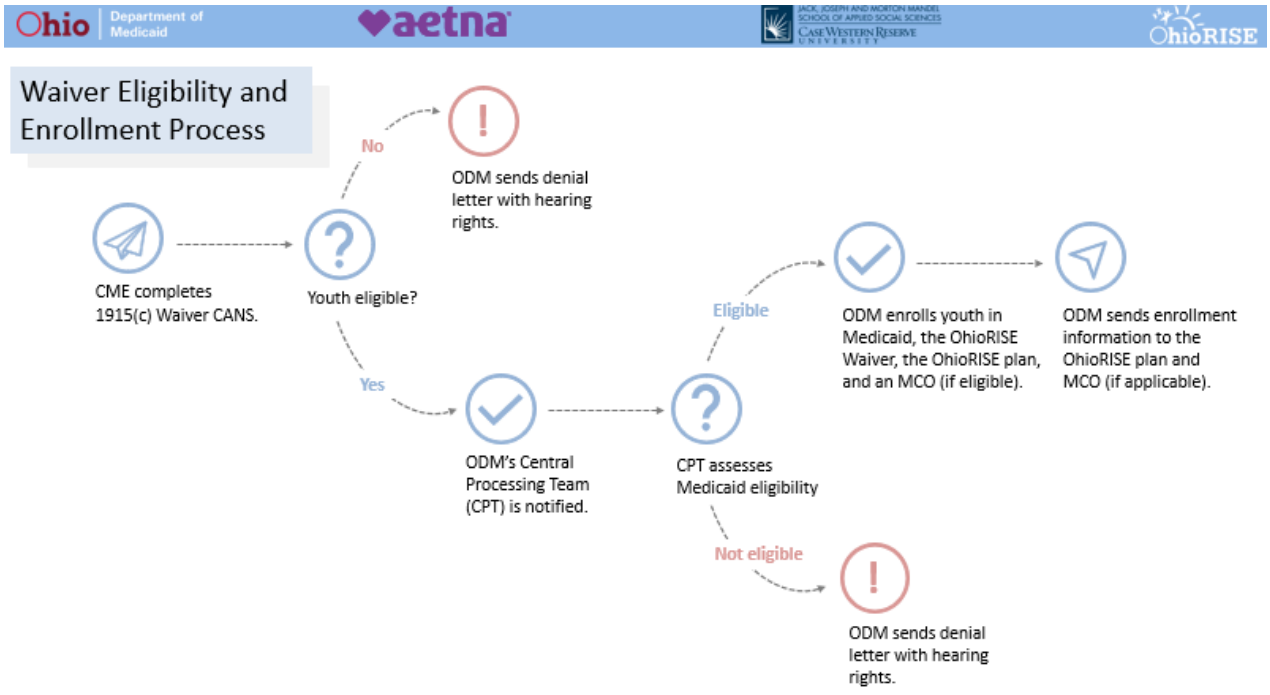
To complete Initial and Redetermination Waiver LOC Assessments, CMEs conduct a Waiver Level of Care (LOC) CANS assessment and work with the youth and/or their family/caregiver to determine and document additional level of care criteria outlined in OAC 5160-59-04. Documented Serious Emotional Disturbance (SED) diagnosis must be uploaded into the CANS IT system at time of the completion of the Waiver CANS. Acceptable documentation includes:

    - A diagnostic assessment dated no more than two years prior to the date of application for the OhioRISE waiver with an applicable SED diagnosis performed by a licensed practitioner operating within their scope of practice; or
    - A treatment plan showing an applicable SED diagnosis signed by the licensed clinician that is the treating provider dated no more than two years prior to the date of application for the OhioRISE waiver, accompanied by the diagnostic assessment that resulted in the applicable SED diagnosis performed by a licensed clinician.

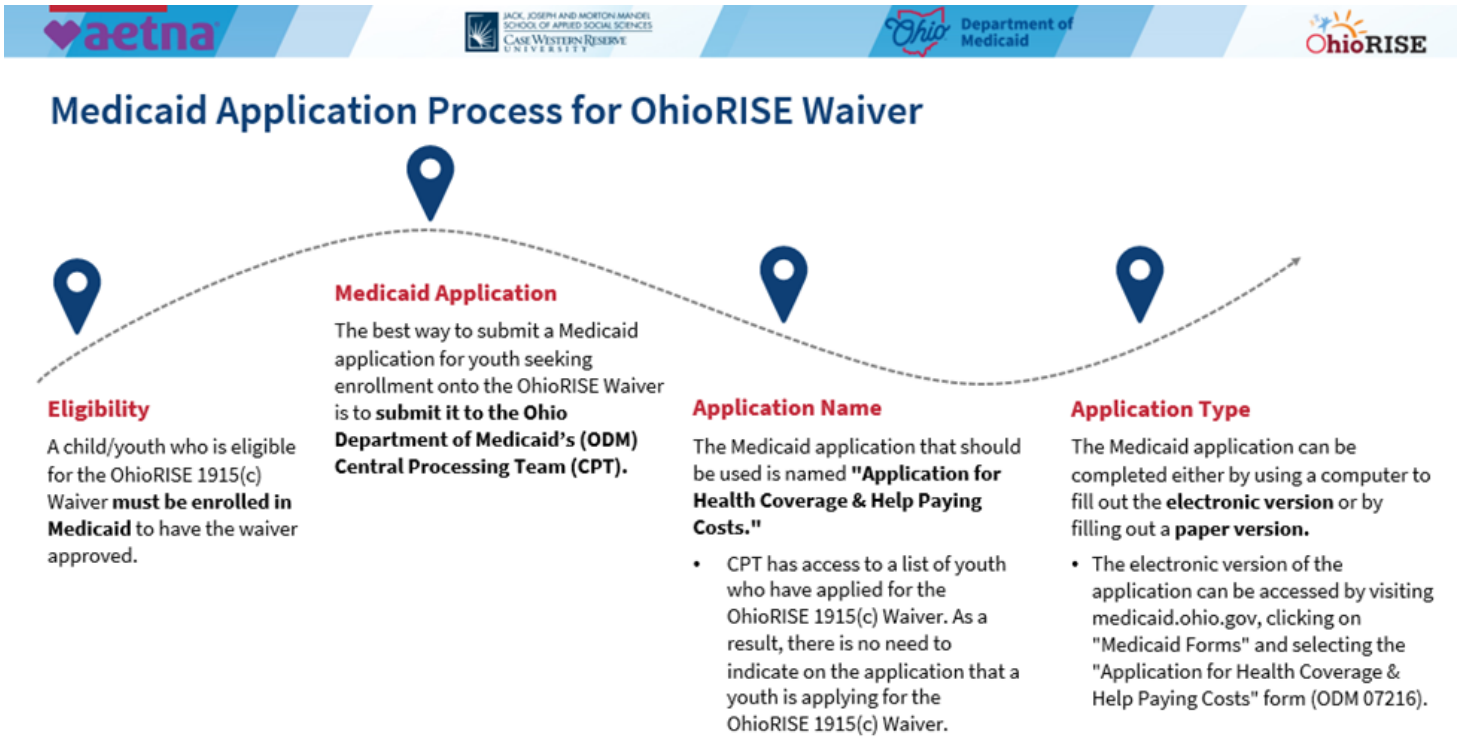
- Documented functional impairment and behaviors are indicated by the youth's CANS scores or by separate documentation provided by the youth or caregiver (which must be uploaded into the CANS IT System). The documentation of functional impairment and behaviors must show evidence of one or more of the following:

Functional Limitations	Documentation within the CANS
Persistent physical abuse or violence that results in physical injury or emotional distress to caregivers, family members, and others in the home and community or physical destruction of property that impacts their housing stability.	Anger Control (2 or 3), Oppositional Behavior (2 or 3), Conduct (2 or 3), Danger to Others (2 or 3), Delinquent Behavior (3), Fire Setting (2 or 3), Living Situation (3)
History of suicidal ideation with intent, or history of suicide attempts, within the past six months.	Suicide Risk (2 or 3)
Sexually problematic behavior that creates a safety risk for themselves or others without a high-level of direct supervision.	Sexually Problematic Behavior (2 or 3)
Suspension or expulsion from school or withdrawal from school, daycare, or preschool program as the result of their actions/intensive behaviors.	School Behavior (2 or 3), School Attendance (3)
Law enforcement or child welfare contact or involvement due to the child or youth's intensive behaviors.	Delinquent Behavior (2 or 3), Disruptions in Caregiving/Attachment (Yes), Legal (1 - 3)
History of victimization or exploitation, including human trafficking within the past twelve months, and re-victimization may be imminent. This may include physical or sexual abuse, sexual exploitation, or violent crime.	Vicimization/Exploitation (2 or 3)

The following shows the OhioRISE Waiver Eligibility Enrollment Process:



The following shows the Medicaid Application Process for OhioRISE Waiver eligible youth:



Medicaid Application Process for OhioRISE Waiver, cont.

Application Submission

After the application is completed and signed, it should be sent to ODM's CPT team via:

- Email at OhioRISECPT@medicaid.ohio.gov or
- Mail at Ohio Department of Medicaid, Attn: Central Processing, PO Box 182709, Columbus, OH 43272.

Note: Applications submitted online through the Ohio Benefits Self-Service Portal, in person at a local County Department of Job and Family Services, or via phone will also be accepted. However, **submitting the application directly to CPT is the preferred method.**

This preferred process is outlined in the new "Medicaid Application Handout for Young People Interested in the OhioRISE Waiver" flyer.

- The flyer can be used by CMEs and youth, families, and caregivers to understand the Medicaid application process for youth who are interested in/eligible for the OhioRISE Waiver.

Role of CMEs in Determining OhioRISE Waiver Eligibility

CMEs and their sub-delegates are the only CANS assessors and Waiver care coordination providers authorized by ODM and CMS to complete OhioRISE Waiver assessments.

The CMEs play a key role in the process of determining whether a youth is eligible for the OhioRISE Waiver. Generally, the CME will:

- Assist ODM with conducting waiver eligibility assessments and reassessments.
    - Collect and submit information for the waiver level of care (LOC) assessment into the CANS IT system, including:
        - Waiver CANS Assessment.
        - SED diagnosis documentation – the CME CANS assessor is required to collect and upload into the CANS IT System. This documentation must be either:
            - A diagnostic assessment with an applicable SED diagnosis performed by a licensed clinician within two years of the date of application for the waiver; or
            - A treatment plan showing an applicable SED diagnosis signed by the treating provider within two years of the date of application for the OhioRISE waiver, accompanied by the diagnostic assessment that resulted in the applicable SED diagnosis performed by a licensed clinician.
        - Functional limitation criteria documentation – the CME is required to upload to the CANS portal any additional documentation showing functional limitation criteria that are met.
    - Review OhioRISE Waiver Member Handbook with youth and their guardian to ensure the youth and/or guardian have an understanding of their rights and services available under the waiver.
        - Complete and upload the *Freedom of Choice* and *Home and Community-Based Services (HCBS) Settings Review* forms – The CME is required to upload the completed, dated and signed forms that support waiver eligibility into the CANS IT System.
            - The *Freedom of Choice* and *HCBS Settings Review* forms must be completed at enrollment in the OhioRISE Waiver and annually thereafter, for as long as the youth is enrolled in the OhioRISE Waiver.
            - The *HCBS Settings Review* must be completed within 90 calendar days of the start of the OhioRISE Waiver year span.
    - Determine if waiver applicants have a need for OhioRISE Waiver services costing less than the annual cost cap.
    - Assist with Medicaid eligibility referrals to the ODM Central Processing Team (CPT). When completing the initial Waiver LOC CANS Assessment, the following outcomes are possible:
        - *Enrolled* – youth meets OhioRISE Waiver LOC criteria and ODM will make final determination.
        - *Pending Medicaid Eligibility* – youth meets OhioRISE Waiver LOC but is not enrolled in Medicaid.
            - The CME CANS assessor will provide youth/ caregiver with the “Medicaid Application Handout for Young People Interested in the OhioRISE Waiver”
            - Youth/ caregiver need to submit the Ohio Medicaid application within 30 calendar days of the Waiver CANS.
        - *Denied/Waiver Denied*: youth does not meet waiver criteria. A review process will take place. CMEs will complete the following steps:
            - The CME CANS assessor will be responsible for informing youth/caregiver if it is determined the youth does not meet the OhioRISE Waiver LOC criteria and

therefore will not be enrolled in the OhioRISE Waiver. This should include linkage to other resources to support the youth and family.
    - CME supervisory staff will review the Waiver LOC CANS Assessment for accuracy to confirm the ratings.

Role of CME in Continuing OhioRISE Waiver Enrollment

Youth whose Waiver LOC CANS assessments recommend MCC or ICC would receive OhioRISE care coordination through a CME or its subdelegate. Youth whose Waiver LOC CANS assessments recommend LCC criteria or who choose to receive LCC will receive care coordination through Aetna. OhioRISE Waiver youth must be in contact with the CME or Aetna and must not be in Promoting Active Connections (PAC) status or receiving care coordination through an FCFC to maintain their OhioRISE Waiver enrollment.

Once the youth is enrolled on the OhioRISE Waiver, Routine CANS reassessments must be completed every 90 days (or sooner if a change in circumstance or level of functioning requires the CANS to be updated).

- Initial OhioRISE Waiver CANS (Day 1)
    - Routine Reassessment CANS (Day 90)
    - Routine Reassessment CANS (Day 180)
    - Routine Reassessment CANS (Day 275)
- Annual Redetermination Waiver CANS (Due before Day 365)
    - Routine Reassessment CANS (Day 90)
    - Routine Reassessment CANS (Day 180)
    - Routine Reassessment CANS (Day 275)

Other CME OhioRISE Waiver Roles and Responsibilities

- Assist with OhioRISE Waiver provider recruitment functions.
- Participate in OhioRISE Waiver quality and performance improvement activities.

Aetna OhioRISE Waiver Roles and Responsibilities

Aetna will undertake quality monitoring and oversight of the CMEs' role in this process by:

- Overseeing CME OhioRISE Waiver enrollment activities to ensure consistent application of LOC eligibility criteria.
- Ensuring CMEs complete and submit Initial Waiver LOC Assessments for the purposes of all initial waiver eligibility determinations in a timely manner.
- Ensuring CMEs perform Annual Redetermination Waiver LOC Assessments in a timely manner for individuals enrolled on the OhioRISE Waiver
- Monitoring the cost of services for each individual enrolled on the OhioRISE Waiver to ensure they do not exceed the OhioRISE Waiver service limit of $15,000 per year.

OhioRISE Waiver Services

OhioRISE Waiver services include Out-of-Home Respite, Transitional Services and Supports (TSS) and Secondary Flex Funds.

Service	Coverage/ Limitations*	Prior Approval
Out-of-Home Respite	90 days in 365-day waiver span	Need prior approval on Child and Family-Centered Care Plan
Transitional Services and Supports	Covered	Need prior approval on Child and Family-Centered Care Plan, initial approvals are for 72 hours; additional hours may be approved as needed.
Secondary Flex Funds	$3,000 limit in 365-day waiver span	Need prior approval on Child and Family-Centered Care Plan
Emergency Flex Funds	$2,000 limit in 365-day waiver span	Need prior approval on Child and Family-Centered Care Plan

Role of CME to Conduct Annual OhioRISE Waiver Redetermination Assessment

CMEs and their subdelegate organizations are responsible for completing Waiver LOC Annual Redetermination CANS assessments. The following steps are used to complete Waiver LOC Annual Redeterminations:

- Complete annual Waiver LOC redetermination assessments in a timely manner for individuals enrolled in the OhioRISE Waiver. The Annual Redetermination Waiver LOC CANS assessment must be completed and submitted in the CANS IT System 45 calendar days prior to the youth's 365th day of enrollment on the OhioRISE Waiver. Failure to submit the Waiver LOC CANS assessment by this deadline puts the youth at risk of disenrollment.
- The Waiver Annual Redetermination CANS is available 90 days prior to day 365 of the Waiver year. Select the date of day 365 of the youth's waiver enrollment as the "Waiver Request Date".

When completing the initial Waiver LOC CANS Assessment, the following outcomes are possible:

- *Enrolled* – youth meets OhioRISE Waiver criteria and continues enrollment in the OhioRISE Waiver.
- *Under Review for Enrollment* – youth does not meet waiver criteria.

If a youth does not meet waiver criteria, a review process will take place. The CMEs will complete the following:

- The CME CANS assessor will inform the youth/caregiver what may happen if it is determined the youth does not meet the OhioRISE Waiver LOC criteria. The CME CANS assessor should discuss with the youth/caregiver that a review of the OhioRISE Waiver LOC assessment will be completed before a final determination regarding disenrollment is made.
- If the youth qualifies for Ohio Medicaid under Special Income Level (SIL), ODM Central Processing Team (CPT), will review if the youth would qualify for Ohio Medicaid under another Medicaid category if the youth is disenrolled from the OhioRISE Waiver.
- CME supervisory staff will review the Redetermination Waiver LOC CANS Assessment for accuracy and to validate the ratings.

- If the CANS Assessor Supervisor doesn't agree with the CANS Assessor's Waiver LOC CANS ratings for the youth, the CANS Assessor Supervisor is permitted to collaborate with the Assessor to reevaluate and resubmit a revised version of the Annual Redetermination Waiver LOC CANS Assessment. By doing this, they can re-rate the youth based on the information they've gathered about them. They can then submit the revised Annual Redetermination Waiver LOC Assessment in the CANS IT System to determine if the revised ratings meet the Waiver LOC criteria.

If, after supervisory review, the youth does not meet Redetermination Waiver LOC criteria:

- CME supervisor will notify Aetna at OhioRISEWaiver@aetna.com and OhioRISEoperations@medicaid.ohio.gov about the Waiver LOC Redetermination CANS findings. At minimum, the email will include the following elements:
    - Youth name
    - Date of birth
    - Medicaid number
    - Date of annual Redetermination Waiver LOC CANS Assessment
    - Confirmation that CME supervisory staff reviewed and validated the ratings
    - The email sent to OhioRISEWaiver@aetna.com and OhioRISEoperations@medicaid.ohio.gov must be encrypted or sent securely to protect the youth's confidentiality and privacy.
- If, after review, ODM or its designee agrees with the outcome of the Redetermination Waiver LOC CANS assessment, the CME Care Coordinator will complete a transition of care plan and send the OhioRISE disenrollment form to OhioRISEwaiver@aetna.com.
- If, after review, ODM (or designee) does not agree with the outcome of the Redetermination Waiver LOC CANS assessment, ODM (or designee) will provide guidance to the CME on areas where the CANS indicate the youth still meets the OhioRISE Waiver LOC criteria. Based on this guidance, if the CANS revisions show that the youth continues to meet the Waiver LOC, the youth would not be disenrolled from the waiver.

The CME will provide OhioRISE Waiver service coordination for intensive and moderate care coordination (ICC and MCC).

- Review OhioRISE Waiver Member Handbook with youth (and guardian, if applicable) to ensure the youth and/or guardian have an understanding of their rights and services available under the waiver and have them sign the Freedom of Choice form if they agree with being voluntarily enrolled in the OhioRISE waiver at the time of completion of the Waiver LOC Assessment.
- Conduct a Home and Community-Based Services (HCBS) Settings Review for each OhioRISE Waiver enrollee assigned to ICC and MCC.
- Develop, implement, and monitor Child and Family-Centered Care Plan in collaboration with the Child and Family Team.
    - Requesting prior approval for needed OhioRISE Waiver services.
    - Including method of monitoring youth's OhioRISE Waiver needs on at least a monthly basis.
    - Must ensure the CFCP has an established back-up plan for each OhioRISE Waiver service received by the youth.

The OhioRISE Plan must provide instruction to individuals, caregivers, and authorized representatives about how to notify the authorities if health and welfare may be in jeopardy. Aetna will train care coordinators on processes to report critical incidents and assist individuals and/or their informal caregivers with any formal notification needed.

CME Role in OhioRISE Waiver Disenrollments

The reasons that a youth may be disenrolled from the OhioRISE Waiver include:

- Youth no longer meets OhioRISE Waiver eligibility criteria per OAC 5160-59-04.
- Youth has resided in an intermediate care facility for individuals with intellectual disabilities for 90 consecutive days, or an institutional setting for 180 consecutive days
- Youth has turned 23 years old
- Youth/Caregiver has requested voluntary disenrollment from the OhioRISE waiver
- In any situation where a CME care coordinator believes a youth should be disenrolled from the OhioRISE Waiver.

In any situation where the CME care coordinator believes a youth should be disenrolled from the OhioRISE Waiver, the CME care coordinator will review the case with their supervisor or Waiver SME. If following CME supervisory review and oversight, it is believed the OhioRISE youth should be disenrolled from the waiver, the CME care coordinator should discuss with the youth and caregiver. Upon the determination of disenrollment from the OhioRISE Waiver, the CFT will convene to update the CFCP to include transition services to cover the youth's needs for the 90 calendar days following disenrollment from the OhioRISE Waiver. The CME care coordination team will email the disenrollment recommendation to Aetna at OhioRISEwaiver@aetna.com.

If a youth is expected to be in an Intermediate Care Facility (ICF) longer than 90 days, the CME should submit a request for disenrollment to Aetna 45 days after admission. If a youth is expected to be in any other type of residential facility for longer than 180 days, the CME should submit the request for disenrollment to Aetna 130 days after admission.

Disenrollment Recommendation Regarding Waiver services

Youth enrolled in the OhioRISE Waiver will receive their care coordination from the CME (ICC and MCC) or Aetna (LCC). The youth/caregiver must also consent to receive at least one OhioRISE Waiver service, as documented in the Child and Family-Centered Care Plan. In the event a youth or caregiver declines the continued need for receipt of OhioRISE Waiver services or OhioRISE care coordination, on at least a monthly basis the CME care coordinator must document in the Child and Family-Centered Care Plan that they verified the youth's current health and safety status, and discussed the risks associated with declining or refusing OhioRISE care coordination with the youth/caregiver. If, after the review of risks associated with declining OhioRISE care coordination or waiver services, the youth/caregiver continues to report they want to proceed to voluntarily disenroll from the OhioRISE waiver, the CME care coordinator will document that in the CFCP, review with their supervisor, and submit a completed Waiver Disenrollment Form to OhioRISEwaiver@aetna.com.

Aetna will review with ODM, and a final determination will be made following the review.

Disenrollment Recommendation Due to Not Meeting Redetermination Waiver CANS LOC Criteria

If the youth does not meet the OhioRISE Waiver criteria, a review process will occur. Those steps include:

- CME supervisor will review the Redetermination Waiver LOC CANS to ensure accuracy and to confirm the ratings.
- The CME will inform the youth/caregiver what may happen if it is determined the youth no longer meets the Waiver LOC criteria and, therefore, may be disenrolled from the OhioRISE Waiver.

- If a youth is under the Medicaid category of "Waiver Special Income Level" (SIL), the youth may also lose access to Medicaid services (including OhioRISE).
- If, after supervisory review, the youth does not meet OhioRISE Waiver LOC criteria:
    - Supervisor will notify Aetna at OhioRISEWaiver@aetna.com.
- If ODM (or designee) agrees with the disenrollment recommendation, the youth will be scheduled to be disenrolled.
    - The youth will be scheduled to be disenrolled from the OhioRISE Waiver with an effective disenrollment date no later than the day after Day 365 of the current OhioRISE Waiver year.
    - A notice of hearing rights will be sent to the youth and/or caregiver.
    - The CME care coordinator must create a transition plan within the Child and Family Centered Care Plan ***prior*** to disenrollment that addresses the services needed to support the youth's needs for a minimum of 90 days post-disenrollment.
    - For youth on SIL, ODM Central Processing Team (CPT) will also be notified for them to conduct a Pre-Termination Review (PTR) to determine if the youth meets other Medicaid categories.

Disenrollment Recommendation Due to Member Declining Waiver or OhioRISE Care Coordination

The youth/caregiver must agree to receive at least one OhioRISE Waiver service, as documented in the Child and Family-Centered Care Plan. In the event a youth or caregiver declines either OhioRISE Waiver services or OhioRISE care coordination, the CME care coordinator must document that they discussed the risks associated with declining or refusing OhioRISE care coordination with the youth/caregiver. If, after the review of risks associated with declining OhioRISE care coordination or waiver services, the youth/caregiver continues to report they want to proceed, the CME care coordinator will document that in the CFCP, review with their supervisor, and submit a completed Waiver Disenrollment Form to OhioRISEWaiver@aetna.com.

Section 6: Care Coordination Tiers in OhioRISE

All children and youth enrolled in OhioRISE have access to care coordination and a range of behavioral health services and supports designed to address the needs of multi-system youth with complex behavioral health needs to remain close to their homes and natural supports whenever possible. The intensity of care coordination provided and services and supports mobilized will be based on an assessment of the youth and family's needs in the Initial Comprehensive CANS and the Initial Supplemental Assessment. Once the youth's needs have been identified, the care coordinator will work collaboratively with the family to identify and configure a group of individuals with direct experience and relationships with the child and parent or other family members. This group will function as the Child and Family Team. The Care Coordinator will set the stage to blend perspectives starting with the child and parent's opinions and work to reach agreement about underlying needs, desired goals and strategies, interventions and supports that will make up the comprehensive Plan. The Care Coordinator will facilitate ongoing communication among team members through a variety of strategies including hosting team meetings, establishing communication protocols among team members and encouraging cross member communication. Through the construct of the facilitated child and family team, a child and family centered care plan will be collaboratively developed that addresses identified needs by utilizing and building upon the youth/family's strengths and assets. The child and family centered care plan will be used to link youth to formal and informal services and supports. A Crisis Safety Plan will also be developed through the construct of the child and family team.

There are three tiers of OhioRISE care coordination: Limited Care Coordination (LCC or Tier 1), Moderate Care Coordination (MCC or Tier 2), and Intensive Care Coordination (ICC or Tier 3). All three tiers of OhioRISE care coordination are based on a System of Care approach and a Wraparound philosophy. The CMEs provide two tiers, or levels, of care coordination: Intensive Care Coordination (Tier 3) and Moderate Care Coordination (Tier 2). Both tiers of care coordination provided by the CME are:

- Grounded in a System of Care approach and a Wraparound philosophy.
- Use a child and family team process.
- Develop an individualized child and family-centered care plan.

Aetna Better Health of Ohio provides limited (Tier 1) care coordination to OhioRISE youth.

The frequency and intensity of OhioRISE care coordination will vary, depending on the tier level and identified needs of the youth throughout the course of care or throughout the enrollment period. To support the intensity of need of youth enrolled in tiers 1, 2 and 3, the maximum caseload size for each tier differs. The care coordinator to youth ratio of ICC (tier 3) is 1:10 and the care coordinator to youth ratio for MCC is 1:20. The staff to youth ratio for LCC is 1:62.

Summary of Key Activities and Timelines

The table below summarizes key activities and timeframes discussed above for completion of care coordination activities for ICC and MCC.

	Timeline Requirements for ICC and MCC	
Activity	**ICC (Tier 3)**	**MCC (Tier 2)**
Referral, engagement, and initial face-to-face meeting (obtain consent).	Contact within two business days from receipt of the member on the CME MAF for a routine referral and one business day from receipt of the member on the CME MAF for a crisis referral. The purpose of this contact is to: • Introduce OhioRISE and welcome the youth and family • Explain care coordination benefits and expectations, including the tier level to which the youth has been initially assigned • Obtain consent to receive care coordination services from the CME at the assigned tier level • Offer time for an initial face-to-face meeting with the youth and family within two business days (for routine referral) or as soon as possible and within one business day for a crisis referral	Contact within two business days from receipt of the member on the CME MAF for a routine referral and one business day from receipt of the member on the CME MAF for a crisis referral. The purpose of this contact is to: • Introduce OhioRISE and welcome the youth and family • Explain care coordination benefits and expectations, including the tier level to which the youth has been initially assigned • Obtain consent to receive care coordination services from the CME at the assigned tier level • Offer time for an initial face-to-face meeting with the youth and family within seven business days (for routine referral) or as soon as possible and within one business day for a crisis referral
Development of Crisis and Safety Plan	Use of existing safety plan that includes required elements or development of a safety plan as soon as possible and no longer than 14 calendar days from the date of consent.	Same as ICC
Initial Home-based, Supplemental Assessment	Within 14 calendar days of consent	Same as ICC

	Timeline Requirements for ICC and MCC	
Activity	**ICC (Tier 3)**	**MCC (Tier 2)**
Comprehensive CANS Assessment	A Comprehensive CANS must be completed within 30 days of consent and then no more than every 90 calendar days thereafter. A Comprehensive CANS completed up to 90 days before OhioRISE enrollment fulfills the requirement for a Comprehensive CANS to be completed within 30 days of OhioRISE enrollment.	Same as ICC
Change of Circumstance CANS	A Change of Circumstance CANS should be completed whenever there is a significant change in youth's BH needs or circumstances (examples: crisis, inpatient hospitalization, change in placement, change in custody, significant family changes such as divorce or loss of a loved one, changes to school, a move to a new home, etc.).	Same as ICC
Initial CFT and Development of CFCP	Within 30 calendar days of consent	Same as ICC
Review of Crisis and Safety Plan	At a minimum every 30 calendar days, or whenever a youth shows an escalation in behaviors that create a risk to the youth or family.	At a minimum every 60 calendar days, or whenever a youth shows an escalation in behaviors that create a risk to the youth or family.
Ongoing CFT Meetings and Care Plan Updates	Minimum every 30 calendar days and upon discharge from out-of-home placement	Minimum every 60 calendar days and upon discharge from out-of-home placement
Face-to-Face Contact*	Minimum of 4 per month	Minimum of 2 per month
Additional contacts via phone calls, text or email (Please note: this is in addition to face-to-face required contacts)	1 per week	2 per month

The youth is central to the Child and Family Team (CFT) process and should participate in all CFT meetings whenever appropriate. If there is a valid reason for the youth to be excluded from part or all of a meeting, the Care Coordinator must ensure direct contact with the youth in another setting so the youth's perspective is heard and considered, the youth is informed of decisions and plans developed by the CFT, and the youth's safety and well-being are assessed.

The time between each visit should be determined between the Care Coordinator and family based on the family and youth's current need but MUST meet the minimum requirements listed above. For example, a youth enrolled at ICC level MUST have four (4) face-to-face visits per month plus a weekly touch base via phone, email or text. If two face-to-face meetings happen in week one, one in week 2 and one in week 3, an additional meeting DOES NOT need to be scheduled for week 4 UNLESS THE NEEDS OF THE YOUTH AND FAMILY INDICATE ADDITIONAL MEETINGS ARE NEEDED. Please keep in mind these are minimum standards and additional meetings may be needed at times based on the needs and circumstances of the family.

*Direct, in-person interaction with the youth and their family is essential for creating a team-based, strengths-focused plan that reflects the family's priorities and voice. Meeting in the family's home environment or community provides valuable insight into their daily routines, resources, and cultural context, which supports truly individualized planning. In person face-to-face contact builds trust, strengthens relationships, and allows for richer communication and collaboration. These elements are critical for developing plans that lead to sustainable outcomes. While virtual visits can help maintain continuity when unavoidable - such as during severe weather or unexpected scheduling issues - they should never replace the personal connection and relationship-building that drive successful care coordination. Virtual visits are not permitted to be initiated based on the convenience of the CME or Care Coordinator. Virtual visits may only be accommodated from time to time at the request of the family / guardian.

Section 7: Care Management Entity Role and Functions

Introduction of the Two Primary Roles of CMEs

CMEs are responsible for all aspects of OhioRISE Care Coordination for their assigned youth. They are responsible for helping families identify and develop a network of support consisting of both informal and formal service supports. This task requires both identifying existing supports and integrating them into the youth's individual system of care. CMEs also support the development of new supports based on the needs, culture, and values of the youth and families served. This work ultimately informs the need for local stakeholders to identify and address gaps in the available continuum of care when there is a discrepancy between what is needed and what is available.

As such, CMEs have two primary functions in their role:

- **Coordinate the delivery of services and supports to youth enrolled in OhioRISE by providing intensive and moderate care coordination services.**
- **Community resource collaboration and development.**

Care Coordination (Intensive and Moderate)

CMEs, through the use of well-trained Care Coordinators, provide Care Coordination services at the intensity level determined by the CANS and Child and Family Team. These services are provided in a multitude of ways, from in-person visits to phone calls and text messages and aim to meet the expectations of the model, which should be informed by the needs of the youth. CME services include, but are not limited to:

- Engagement of the youth and family into care coordination process.
- Needed assessments, including the CANS.
- Safety planning and discussion which results in the development of a Crisis and Safety Plan.
- Configuration of a Child and Family Team through active collaboration with the family.
- Facilitation of the Child and Family Team meetings where the Child and Family Centered Care plan is developed, implemented, and updated.
- Assistance with identifying, linking, and supporting providers to build and blend services and supports in the youth's community.
- Access Flex Funds, Value-Added Benefits, and additional resources to creatively address youth needs.
- Support youth and families when appropriate services are not accessible in a timely manner by collaborating with system partners and Aetna's Network Development and Provider Relations team to identify and make referrals to alternative services to support the needs of the youth.
- Monitor service quality and outcomes for each youth and engage in quality improvement activities.
- Upon recommendation of the CFT, gather appropriate documentation and submit MSY applications and PRTF Request Forms.
- Plan for transitions, in and out of the program, as described in the previous section.

The ultimate goal of OhioRISE care coordination is to help youth and families develop a long-term, sustainable plan that will improve the youth's health, well-being, and level of functioning long after CME involvement. Activities within care coordination often focus on improving access to behavioral health services and supports, increasing the youth's and family member's access to supportive community connections, and building an improved and sustained level of functioning in the home and community. This is accomplished by developing a plan to address their complex behavioral health needs and removing barriers that may impede progress.

The Child and Family Team (CFT) is pivotal in supporting the youth and family to achieve their goals. The CFT, which is facilitated by the care coordinator, keeps all members of the team focused on the stated goals of the

youth and/or guardian, is responsible for removing barriers to care, driving care utilizing a System of Care approach, and facilitating creative, flexible planning to support the family and youth.

Care Coordinator and Care Coordinator Supervisor Qualifications

CME care coordinators and supervisors must meet the requirements outlined in OAC 5160-59-03.2. CME care coordinator qualifications state care coordinators "will be a licensed or an unlicensed practitioner in accordance with rule 5160-27-01 of the Administrative Code, except that an ICC or MCC care coordinator will be employed by or under contract with a CME as described in this rule." This means that ICC and MCC care coordinators must also meet qualifications to be and enroll as one of the provider types listed in the rule. Care coordinators who are unlicensed may meet this requirement by enrolling as a qualified behavioral health specialist (QMHS) or a SUD care management specialist (CMS).

CMEs will ensure all contracted and employed ICC and MCC care coordinators meet QBHS requirements, either by requiring unlicensed care coordinators to attend the organization's existing QBHS trainings or by amending existing trainings to supplement what is offered by the CABHCOE as part of the required OhioRISE curriculum for ICC and MCC care coordinators.

CMEs may consider hiring a care coordinator who partially meets the years of experience requirements found in 516-59-03.2(D)(3). All such potential care coordinators must be evaluated and approved by Aetna prior to allowing the candidate to provide and bill for ICC or MCC care coordination services. To obtain approval for a partially qualified care coordinator candidate, the CME will complete an application for an OhioRISE ICC or MCC Care Coordinator who partially meets years of experience requirements. This application can be found in the CME E-Share Training Folder. This application, along with the potential care coordinator's resume, must be sent to OhioRISEtraining@aetna.com.

Per OAC 5160-59-03.2(E), care coordination supervisors will meet CME care coordinator qualifications described in paragraph (D)(3)(a)(iv). Supervisors are also required to complete

- All high-fidelity wraparound training provided by CABHCOE.
- Successfully complete skill and competency-based training to supervise the delivery of ICC and MCC.

CME care coordination supervisors who are unlicensed practitioners will have regular supervision with a licensed practitioner and real-time access to a psychiatrist for case consultation 24 hours a day, 7 days a week. A supervisor that is an unlicensed practitioner must have a licensed clinical supervisor who provides them with regular clinical supervision, which should occur at a minimum of one hour per month. Their licensed clinical supervisor is not required to also be their administrative supervisor; however, the licensed clinical supervisor may not be a direct or indirect report of the unlicensed supervisor.

CME care coordinators and supervisors will participate in initial and ongoing training, coaching, and supports provided by CABHCOE, Aetna or ODM to ensure consistency in care coordination. CMEs will also ensure care coordination staff and supervisors have the experience necessary to manage complex cases and the ability to navigate state and local youth serving systems.

CMEs must have the ability to respond to youth crisis needs twenty-four (24) hours a day, seven (7) days a week. This response should take into consideration resources available in the community where the youth resides, and clear processes to address member crises after hours and on weekends. The CME Care Coordinator should work with each family to develop a Crisis / Safety Plan. The CME should have staff on call 24/7 who can help support the family in implementing this plan when the family faces a crisis. As the CME walks alongside the family in crisis, the plan may call for deployment of MRSS or other community-based crisis response services. The availability of these services in a community does not release the CME from the responsibility to have 24/7 response for families and youth in crisis.

CMEs must also have the capacity to provide real-time or on-demand clinical and psychiatric consultation for youth engaged in ICC and MCC.

CMEs will employ sufficient numbers of administrative and program staff to meet all CME requirements to achieve quality, performance, and outcome measures set by ODM and Aetna. This includes hiring sufficient ICC and MCC care coordinators and supervisors to both serve OhioRISE eligible youths in the CME's assigned catchment areas(s) and to meet the coordinator-to-youth and supervisor-to-coordinator requirements.

To monitor care coordinator and supervisor capacity, CMEs will provide a Monthly CME Oversight Report that will include the following information:

- Number of active care coordinators, number of care coordinators hired and starting in the next two weeks, and number of care coordinators in training.
- Care coordination attrition.
- Number of active supervisors.
- Number of open Care Coordinator and Supervisor positions.

CME Care Coordination Capacity Expectations

CMEs are expected to maintain sufficient staff to accept all OhioRISE referrals within the required timeframes. If a CME has any limitations or expects limitations on its ability to immediately accept all OhioRISE referrals, written notice must be issued to the Relationship Manager. If a CME has capacity challenges, it will be required to submit a written corrective action plan, including a timeline and plan to address capacity challenges. A weekly monitoring meeting with the CME Relationship Manager will be required, which must be attended by CME leadership to review the plan.

CMEs must make sure members who have consented to receiving care coordination, but have not yet been assigned a care coordinator, have access to their OhioRISE service benefits, including all applicable requirements in Ohio Administrative Code Rule 5160-59-03.2 and the OhioRISE Care Management Entity (CME) Manual.

Any youth pending care coordination with a CME MUST be reported to their Aetna Relationship Manager weekly (Friday by 5pm). Youth pending care coordination MUST receive weekly outreach from the CME to determine if there are critical needs, escalations or needed referrals.

CMEs must prioritize youth with high-acuity needs, including those referred from an inpatient hospitalization or MRSS, for immediate care coordination assignment.

CMEs must work with urgency to eliminate members from pending care coordination to actively participating in care coordination, meeting Tier requirements. Failure to maintain adequate staffing capacity for an extended period may result in disciplinary action from Aetna, including corrective action plans, financial penalties or non-renewal of contract.

Mixed Caseload Guidance

CMEs have the option to carry mixed caseloads. CMEs can use the following formula to determine the maximum allowable size and ICC-MCC ratio for a mixed caseload:

One ICC case is equivalent to two MCC cases. Examples of how to use the calculation to determine the maximum allowable mixed ICC-MCC caseload are as follows:

Mixed Caseload	Intensive CC Maximum Ratio	Moderate CC Maximum Ratio
Example 1: 5 ICC and 10 MCC = mixed caseload of 15 cases	1:10	1:20
Example 2: 6 ICC and 8 MCC = mixed caseload of 14 cases	1:10	1:20
Example 3: 3 ICC and 14 MCC = mixed caseload of 17 cases	1:10	1:20

Community Resource Collaboration and Development

In addition to providing intensive and moderate care coordination, CMEs are responsible for facilitating the connections to, enhancing, and further developing local systems of care. This includes developing relationships with key service providers and stakeholders in their catchment areas to support the implementation of integrated, holistic, family centered, strength-based care plans that fully address the needs of multi-system youth with complex behavioral health needs. The purpose of this role is to ensure that youth and parents/caregivers engaged with the CME have access to needed services and supports, and that a process exists to identify gaps in services and supports and engage community partners to address those gaps. The CMEs will work within their local communities to invite diverse representations and establish appropriate communication channels for engaging family, youth, and local community representatives to inform local policymaking and program planning.

Required Local Cross-System Collaboration

Developing and deepening relationships with local partners in the system of care is critical to ensure successful care coordination for children and youth enrolled in OhioRISE. All CMEs are tasked with developing and using these relationships to implement and operate the OhioRISE program. The CME will receive support and technical assistance from the OhioRISE Plan's External Affairs Administrators.

Collaboration with Children's Services

Collaboration with service and custodial agencies such as the Ohio Department of Children and Youth (DCY), Public Children's Services Agencies (PCSAs), and Title IV-E courts are essential to achieve the goals of OhioRISE. CMEs must work closely with local PCSAs, and Title IV-E court offices both in the course of work on behalf of individual youth and their families/caregivers and through ongoing communication between the CME and local agencies' leaders. For children in the custody of Title IV-E agencies, the CME, in collaboration with youth and parents/caregivers/guardians, will make every effort to:

- Work with PCSA staff to determine if ICC and MCC are appropriate levels of care coordination for each youth. In some cases, local PCSA staff may have additional information about the youth or the capacity for the youth and their caregivers to participate in ICC or MCC.
- Include appropriate local PCSA staff in CFTs.
- Assist with locating and accessing treatment services and supports for youth with open PCSA cases and/or who are in the custody of children's services agencies that address the identified behavioral health needs of the youth and are based on the recommendations of the CFT.
- Work with children's services staff to determine if/when placement providers, family, and other caregivers should be included in the CFT, noting that the list of appropriate parties will likely change over the course of involvement in ICC/MCC.
- Schedule CFT meetings collaboratively with children's services staff, and, whenever possible, attempt to combine meetings across systems to create efficiencies for case workers, children/youth and their caregivers.
- Leverage the CFT to assist children's services staff with developing and implementing permanency planning.
- Assist children's services with identification and referral to potential treatment providers.

Collaboration with Other Providers of Behavioral Health Services.

CMEs must work closely with Providers of Behavioral Health in the course of work on behalf of individual youth and their families/caregivers, and through ongoing communication between the CME and local agencies' leaders.

CMEs are responsible for assisting the OhioRISE youth or child in accessing medically necessary covered services. As part of this role, behavioral health service providers are key partners in developing the local system of care. Additionally, behavioral health practitioners shall be considered CFT members and regularly invited to attend CFT meetings.

Collaboration with County Departments of Developmental Disabilities.

CMEs must establish relationships with all Boards of Developmental Disabilities in their catchment area to ensure both parties are informed of programming and services available, eligibility standards and processes for enrollment.

CMEs must work closely with County Boards of Developmental Disabilities in the course of work on behalf of individual youth and their families/caregivers, and through ongoing communication between the CME and local agencies' leaders.

For OhioRISE Program youth with intellectual disabilities and developmental disabilities and receiving care coordination/service and support administration through the county board of DD/DODD, including participating in home and community-based services waivers, CME care coordinators will collaborate closely with the local Boards of Developmental Disabilities through inclusion of Board staff in CFT meetings and sharing of the Child and Family Centered Care Plan.

Collaboration with Local Justice/Court Systems.

CMEs must work closely with local criminal justice agencies and courts in the course of work on behalf of individual youth and their families/caregivers, and through ongoing communication between the CME and local agencies' leaders.

The CME will outreach and engage local courts and criminal justice agencies to ensure such entities are informed about OhioRISE, the benefits and services available, eligibility criteria and processes for enrollment.

The care coordination planning process shall include an assessment of and planning regarding a youth's involvement in the juvenile or adult justice systems, if any. Involvement of court, probation, or juvenile justice staff in the youth's CFT will depend on the status of the legal proceedings and needs and preferences of the youth or parent/guardian, and the advice of the youth or parent/guardian's legal counsel.

The CME will work with the youth and family/caregiver and CFT to identify natural supports in effort to prevent reentry into the juvenile justice system or entry into the adult criminal justice system.

Collaboration with Schools.

CMEs must work closely with local schools in the course of work on behalf of individual youth and their families/caregivers, and through ongoing communication between the CME and local agencies' leaders.

CMEs will engage and work with local schools within their catchment areas. At a minimum, they should make sure schools in their areas know how to make a referral to the CME for a CANS assessment to determine OhioRISE eligibility.

Additionally, to ensure a youth's needs are met in the educational setting, the CMEs will develop partnerships to engage school systems in the Child and Family Centered Care Planning process.

Collaboration with Family and Children First Councils.

CMEs must establish relationships with each Family and Children First Council (FCFC) in their catchment area(s). CMEs will collaborate with local FCFCs in each county. At a minimum, CMEs will consult with local FCFCs to understand local resources and collaboratively develop capacity for community and natural supports. CMEs will also consider engaging local FCFCs in additional methods of collaboration.

Collaboration with Service Providers.

CMEs will develop relationships with local primary care organizations, some of which may be interested in using or developing expertise in serving children with complex behavioral health needs. Additionally, CMEs will actively engage youth service providers as part of CFTs.

Local Governance Process

This CME supported work at the regional level will be further supported by the statewide governance structure. Local system of care work includes, but is not limited to:

- Identifying formal and informal resources in their catchment area, initially and on an ongoing basis, paying particular attention to the availability of culturally responsive resources for youth and family/caregivers of the various racial and ethnic communities in the area. These shall include, but are not limited to, affiliations with informal or natural helping networks such as neighborhood and civic associations, faith-based organizations, and recreational programs.
- Referring identified service providers of potentially Medicaid-billable services who are not currently contracted with the OhioRISE Plan to the Plan either for contracting or to develop a Single Case Agreement (SCA).
- Capturing information on resources in a useable format, such as a database, and making it accessible to Care Coordinators, Child and Family teams, and family/caregivers to use when coordinating care for enrolled youth.
- Collecting and using feedback on resources from youth, family/caregivers and child and family team.

- Developing the capacity to support and use peer and/or parent supports in CME care coordination activities. Identifying current peer and/or parent supports available to assist in this work, as well as work to develop new peer and parent support options to assist with CME care coordination activities.
- Assisting ODM and the OhioRISE Plan with identifying the need for additional service capacity and/or new resources.
- When making referrals for Medicaid-covered services, ensuring the youth and caregivers are given a choice between at least two providers of a needed Medicaid-covered service. If the CME is not aware of at least two providers of a needed Medicaid service, the CME may refer youth and caregivers to a single provider.
- Working with the OhioRISE Plan, providers of services and supports, and community leaders to identify any gaps in services, including when the CME is aware that fewer than two Medicaid service providers exist for a particular service to which youth and caregivers can be referred. The CME must collaborate with the OhioRISE Plan, ODM, and other state and local agencies to strategize methods for closing service gaps.
- Preparing an annual resource development plan to be shared with the OhioRISE Plan and ODM. The resource development plan should:
    - Identify gaps in services and providers of Medicaid services and make recommendations about how those gaps could be filled.
    - Identify how the CME will work with community members and organizations to enhance the availability of informal services to support youth and their caregivers.
    - Explain which system of care partners the CME has the strongest and weakest relationships with and describe why.
    - Discuss plans for relationship building and partnerships.
    - List formal partnerships with any system of care partners across the catchment area.
        - Describe which local committee structures support the CME's system of care development. Some CMEs may propose using existing local committee structures to carry out their local governance work to connect and support system of care development. Others may choose to create new local committee processes. If a CME proposes using an existing local committee process, the CME will need to demonstrate that the scope and charter of the meeting, attendees, and frequency of meetings are consistent with this CME function. While recognizing that some regions may have collaborative cross-system meetings dedicated to this same purpose, adding this function as an agenda item into an existing meeting not solely dedicated to this purpose would not be sufficient. The overall purpose of the meeting needs to be directed to a shared population of youth with multi-system needs, with a specific focus on using data and ongoing dialogue with youth and families to build upon strengths, identify gaps, and enhance local resources to better meet the needs of youth and families.

CMEs will collaborate with the Aetna External Affairs Administrators to engage with system of care partners and develop strategic plans for activities.

Delivering Intensive and Moderate Care Coordination

The information in this section applies to both tiers of care coordination, intensive care coordination and moderate care coordination, unless otherwise noted.

High Fidelity Wraparound (HFWA) is an intensive, individualized care planning and care coordination process that brings together the youth, parents/caregivers/guardians, professionals working with the youth and family/caregiver, other systems serving the youth, and informal and community supports to develop and

implement a plan to meet the family's needs. OhioRISE care coordination utilizing the High-Fidelity Wraparound Model aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process, when compared with traditional treatment planning, is demonstrated to result in care planning that is more effective and more relevant to the youth and family, allowing the youth to achieve and maintain improved behavioral health functioning in a home/community setting. Wraparound plans are holistic and designed to meet the identified needs of the youth, caregiver(s), and siblings in a range of life domains. Plans focus on skill building, integrating the youth and family into the community, and building the family's social network of supports.

The HFWA care coordination approach begins from the principle of "family voice and choice," which means that the perspectives, preferences, and choices of the family members, including the youth, are listened to, discussed during CFT meetings, and used to develop treatment interventions and assist the youth and family in achieving their stated behavioral health goals. Family voice and choice is an ongoing process and is used as a central HFWA principle during all phases and activities of the wraparound process to empower youth and families to lead their behavioral health care.

These principles, including methods of implementation, will be addressed through the CABHCOE's training and coaching with each CME and are expected to be reinforced and supported through the CME's own internal supervision and oversight processes (see Section 9: *Training and Coaching*).

OhioRISE care coordination places emphasis on how communication affects interactions, youth and family engagement, and ultimately, youth and family outcomes. Communication that is familiar to and respectful of the youth and family, including terms and language that are natural for the youth and family, is reflective of the HFWA approach and not the "medical model," in which treatment professionals are the "experts" in treatment and often use technical terms, language, and jargon that are unfamiliar and confusing to some youth and families. Using a common language to discuss youth and family needs respects both the expertise of the youth and other family members, as well as the expertise of providers, both of whom are imperative to the process.

Conflict-Free Care Coordination

The OhioRISE Plan ensures all care coordination services are provided conflict-free, meaning that care coordination functions are separated from any other service delivery functions of the organizations providing moderate or intensive care coordination.

If the CME (or subdelegate organization) provides both OhioRISE care coordination and other behavioral health or other community services and resources as part of their lines of business, they must establish firewalls (structural, processes, procedures) between its care coordination function and its service delivery function, which will be monitored by the OhioRISE Plan.

When making referrals for Medicaid-covered services, the CME must ensure the youth and caregivers are given a choice between at least two providers of a needed Medicaid covered service when the CME is aware of at least two such providers.

If CME is not aware of at least two providers of a needed Medicaid service:

They should review the Aetna OhioRISE "Find a Provider" directory to ensure there are not additional service providers they are unaware of in their catchment area. Care coordinators can access and search the Aetna OhioRISE "Find a Provider" directory at **aetnabetterhealth.com/ohiorise/find-provider**.

They may refer youth and caregivers to a single provider if no additional service providers are available.

CMEs will use information about gaps in service (i.e., choice of providers is not available) to coordinate with Aetna to implement system of care development work.

CME Care Coordination Assignment, Engagement, and Initial Face-to-Face Meeting

Introduction and engagement between the ICC/MCC Care Coordinator, youth, and family begins at the time a referral is received by the CME and communication efforts begin. This introduction to OhioRISE during the Hello Phase of Wraparound Care Coordination is crucial in establishing relationships, understanding and expectations among the Child and Family Team. This phase is also important for obtaining needed consent, completing required assessments and creating an initial Child and Family Centered Care Plan to guide the work of the CFT.

It is extremely important that the youth, to the extent that they are able, is present and involved in all care coordination efforts, including attending all CFT meetings. In cases where a youth is excluded from a CFT meeting, the Care Coordinator should ensure direct contact with the youth in another setting to ensure the youth's voice is being heard and considered, that the youth is informed of the plans being made by the CFT.

OhioRISE youth, to the extent that they are able, will be the ones to define who constitutes family to them. For legal reasons (including but not limited to consents to treat and releases of information) the youth's legal guardian (whether that be birth/adoptive parents, custodial agent or other) will be both verified and become a required and integral member of the CFT as they will help identify persons, systems of care and service providers that need to be included on the CFT. Potential CFT members may include, but are not limited to, birth parents, relatives or kin, foster parents, adoptive parents, or other important persons who the youth and guardian feel they would like included. Attention must be paid to the cultural and linguistic needs of the family. During this phase, the groundwork for trust and shared vision among the youth, family, and care coordinators is being developed, so people are prepared to come to meetings and collaborate.

The tone is set for teamwork and team interactions that are consistent with the OhioRISE principles, particularly through the initial conversations about strengths, needs, and culture. In addition, this phase begins to shift the youth and family's orientation to one in which they understand they are an integral part of the process, and their preferences are prioritized.

Engagement goes beyond inviting a youth and family to a meeting or to be a part of the process. An engaged family and youth feel the person with whom they are communicating is listening to and understands each of their circumstances and feelings from their perspectives in a non-judgmental, accepting, or empathic way. Meeting the youth and family where they are is an important first step as it will build trust and allow the Care Coordinator, CFT, youth, and family to discuss challenges openly knowing there is mutual respect.

- Care coordination activities described in OAC rule 5160-59-03.2 will prioritize delivery of face-to-face and in-person care coordination activities but care coordination may be provided via telehealth in accordance with rule 5160-1-18 of the Administrative Code. Care coordination should be delivered face-to-face in-person unless there is a substantive reason supporting the need for telehealth delivery that results in greater benefit to the youth / family. This decision should always be driven by the youth and family, not the convenience of the care coordinator. This includes visiting youth who are receiving care outside of the CME's catchment area. Care coordinators must work diligently to build relationships and engagement with youths / families to increase their motivation to participate in face-to-face care coordination activities.

Aetna Referrals and Assignment for ICC/MCC Care Coordination

Upon a youth's referral from Aetna to the CME, the CME will conduct an initial outreach. The initial outreach contact must be made within the following timelines which apply to ICC and MCC.

- **Referral marked routine**: Within two business days of receiving the referral from Aetna.
- **Referral marked crisis**: As soon as possible, but not later than one business day after receiving the referral from Aetna.

During the initial outreach contact, the Care Coordinator must offer an initial face-to-face meeting with the youth and or family at their home or a community location of the family's choice and at a time convenient for the family, including outside of 9 a.m.- 5 p.m. business hours. The Care Coordinator must offer to meet the youth/family face-to-face within the following timelines.

- **For ICC referrals marked routine**: Within two calendar days of conducting the initial outreach contact.
- **For MCC referrals marked routine**: Within seven calendar days of conducting the initial outreach contact.
- **For ICC and MCC referrals marked crisis:** Within one calendar day of conducting the initial outreach contact.

There will be circumstances in which reaching referred families requires persistence, including phone calls, texting, and direct contact at the family home (unless there are valid safety concerns). It is expected that the CME will utilize various methods **within the required timeframes** to reach the family. At a minimum, CMEs must work to engage children/youth and their families/caregivers by attempting the following engagement efforts within each 30-day period:

- Three phone calls at different times of day.
- One mailed letter that includes information about the CME.
- One in-person visit to the home (unless there are valid safety concerns).

The CME should attempt work on engagement until the earlier of the following:

- After hearing an explanation of ICC or MCC and the wraparound model, the family declines further involvement in ICC or MCC.
- 90 calendar days after receiving the referral from Aetna.

The CME is asked to track and report the number of attempts made to reach the family, including methods used. CMEs will be able to bill for engagement activities outlined in the billing section of this manual.

Initial Face-to-Face Meeting

The initial face-to-face meeting serves several purposes, including, but not limited to:

- Introducing OhioRISE and care coordination.
- Addressing any immediate needs including safety.
- Identification of CFT members.
- Initiating an Initial Supplemental Assessment and CANS.
- Obtaining any releases of information.
- Orienting themselves to the family's story and experience.

Introducing Care Coordination

The Care Coordinator, youth, and family are introduced to one another, and the Care Coordinator continues youth and family engagement by beginning to hear the youth and family's story. Care Coordinators are expected to support all family members, including the youth, in sharing relevant information from their perspective.

The Care Coordinator is responsible for introducing OhioRISE services and describing the System of Care and Wraparound approach to the youth, parent/guardian, and other family members. The care coordinator also explains the Child and Family Team process, including roles and responsibilities of all involved. The Care

Coordinator will ensure the youth and family provide informed consent for care coordination, which includes reviewing with youth and families:

- The benefits and goals of care coordination include how care coordination can help the youth and family address any behavioral health challenges they are experiencing.
- An overview of the OhioRISE services and benefits.
- An overview of ICC and/or MCC, including what families should expect and frequency of care coordination.
- The roles and responsibilities of the CME, care coordinator, youth, parent/guardian/caregiver and CFT.
- Notification that ICC or MCC services are voluntary.

The Care Coordinator uses family-friendly language and explains how HFWA values and principles drive moderate and intensive care coordination. The family's and youth's understanding of their role and of their participation in the process is imperative for positive outcomes.

Informed consent is important in framing the steps of the CFT process, care planning, and identifying family, friends, and formal services to include in the CFT. Although youth under age 18 are not required to consent for treatment, the CME care coordinator should engage the youth and help them understand that their voice is important to the process.

Releases of Information for collateral contact information, record access and other documents must be completed and signed by the legal guardian (and youth if over age 14). As part of the release of information process, care coordinators will understand the purpose of the release of information request, types of information that can be shared, and steps guardians and youth may take to revoke a signed release of information. Per 42 CFR Part 2, youth will also need to sign the release of information to disclose certain substance use treatment information. CMEs should consult with an attorney about any questions pertaining to the release of information.

Family Safety and Crisis Planning

The initial visit includes the care coordinator helping families develop an individual plan to manage safety or crisis situations related to identified needs that might arise. This is the Individual Crisis and Safety Plan. In some instances, families may have been referred to Care Coordination from MRSS, and a current safety plan is in place from MRSS for the Care Coordinator to discuss with the family. There may be other instances where a therapist has worked with a family to develop a crisis or safety plan. In those instances, the existing plans can be used to inform and create the OhioRISE Individual Crisis and Safety Plan. In the absence of an existing plan, the care coordinator will begin to identify any potential circumstances that may precipitate a crisis for the youth and/or family. The family's definition of a crisis, as well as risks and triggers that could lead to a crisis are discussed.

The care coordinator and family will together define elements of a supportive individual crisis and safety plan, which includes, at a minimum:

- What a crisis would be for the youth and family, including the acknowledgement that members of the family may view and experience "crisis" in a different way.
- Risk factors and triggers that precipitate safety risks and crises.
- Signs of distress that a crisis may be likely to occur to assist the youth and family in identifying potential crisis early
- Concrete, functional strategies that reduce the likelihood of or the severity of a crisis.
- Resources that may help youth or families in a crisis.
- Functional strengths of the youth and family and how they can assist in a crisis situation.
- Recommended de-escalation strategies that can be learned and used by the youth, parents, and other caregivers to support the youth and prevent the use of restrictive interventions.

Care coordinators should help families identify multiple strategies to use in a crisis situation. The strategies should be specific to the crisis situations identified by the youth and family and include responses to triggers for both youth and the family. The goal of crisis planning is to assist the youth and families with strategies and supports that can be used to respond at the earliest sign of escalation, and to foster and practice skill building that enables the family to move toward managing crises on their own.

Care coordinators will emphasize that the youth and family can reach out to the CME 24 hours a day, seven days a week, for guidance and help to follow the plan when necessary. When a family calls after hours, the CME is responsible for helping them implement their crisis plan and resolve their crisis.

MRSS services are available statewide. CMEs and MRSS providers may want to develop specific MOUs, and clear policies for coordination. These activities will be supported by Aetna, ODM and DBH to ensure statewide consistency in practice.

For regions where MRSS providers exist, it is expected that MRSS and CME will ensure seamless coordination and communication for CME enrolled youth and families that may access MRSS. The availability of MRSS in a region does not alter the 24-hour availability of the CME to youth and families enrolled in ICC or MCC. MRSS should not serve as the on-call system for the CME.

An individual crisis and safety plan must be completed within 14 calendar days of consent to ICC or MCC. If an already existing safety plan exists, it may be used until one can be developed in collaboration with the youth and family team.

For youth with behaviors that pose safety concerns for the youth or others, a licensed clinician working within or for the CME should consult on the individual crisis and safety plan, recommend de-escalation strategies that can be learned and used by the youth, parents, and other caregivers to support the youth and prevent the use of restrictive interventions. Additionally, they should support and approve the crisis and safety plan prior to its submission to the OhioRISE Plan.

A wraparound-driven care plan process involving an OhioRISE youth's care coordinator, a licensed clinician (physician, licensed psychologist, or another licensed behavioral health professional) working within or for the CME, and the CFT should be used to determine if an OhioRISE youth may need to use restraint, seclusion, or restrictive intervention. The OhioRISE plan is available to consult on crisis and safety plans for these youths. To the extent possible, restraints are last resort measures that are authorized when less restrictive measures, such as verbal redirection/prompting and behavior management strategies are ineffective in ensuring health and welfare. The care coordinator must document the possible use of a restrictive intervention identified by a licensed clinician (physician, licensed psychologist, or another licensed behavioral health professional) within the crisis and safety plan if using one of these methods may be needed.

Initial Supplemental Assessment incorporating the CANS

While listening to the youth and family's story, the Care Coordinator will gather information about the youth and caregiver/family that will be used to complete an initial supplemental assessment within 14 calendar days. This assessment is not a diagnostic assessment. Components of this assessment include:

- Affirming the youth and family's willingness to participate in the program.
- Identifying the strengths of the youth and family that will be built upon.
- Identifying the youth and family's goals and their priorities.
- Engaging in the Ohio Children's Initiative CANS or reviewing a current Ohio Children's Initiative CANS assessment that was completed within the previous 90 days.
- Identifying current services or supports, including natural supports.
- Identifying what services have worked in the past and what have been a challenge for the family.

- Other tools as determined necessary that inform and result in the development of the child and family-centered care plan.

It may take more than one discussion with the youth and family to complete an initial assessment. Because it may take more than one session to complete the assessment process, care coordinators should prioritize engaging the youth and family, addressing immediate needs, and safety/crisis planning.

As the care coordinator engages the youth and family, it will be important to be sensitive to expecting youth and families to retell their story. In some instances, a family has told their story multiple times to different providers in their effort to obtain help for their child. It will be important for the care coordinator to review the CANS assessment details before meeting the family for the first time. During the first meeting, the care coordinator will review the CANS assessment, confirm accuracy from the youth and family's perspective, and gather new and updated information.

Child and Adolescent Needs and Strengths (CANS)

The Child and Adolescent Needs and Strengths Assessment (CANS) is a multi-purpose tool developed to support decision making, including level of care and care planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The CANS is designed to be used as part of a comprehensive assessment process for children, youth and families. The tool is based on communimetrics theory and helps identify strengths and needs in multiple domains, including behavioral/emotional needs, traumatic/adverse childhood experiences, life functioning, and risk behaviors. The CANS is used to inform an individualized care plan covering multiple domains, eliminating the need for duplicative assessments. The CANS supports integration of information and communication across the multiple systems in which a youth and family may be involved.

The Ohio Children's Initiative CANS consists of two versions: Brief CANS and Comprehensive CANS, which can both be used for children and youth ages 0 through 5 and ages 6 through 22.

The Brief CANS and Comprehensive CANS will be used as follows:

- Brief CANS:
    - Used for OhioRISE eligibility determinations and as a decision support tool for care coordination and treatment/service planning.
    - Used by Mobile Response and Stabilization Services (MRSS) providers as part of an initial mobile response intervention (completed within 48 hours).
- Comprehensive CANS:
    - Used for OhioRISE Waiver level of care assessments.
    - Used for ongoing assessment and care planning for children ages 0 through 20 and must be updated at a minimum of every ninety (90) calendar days or whenever there is a significant change in the youth's needs or circumstances.
    - Each Comprehensive CANS submitted to the CANS IT System sets the due date for the next Comprehensive Reassessment to 90 days from the date of submission.
        - CANS Assessors should check CANS IT System data to confirm a 90-day Comprehensive CANS is due prior to administering the CANS.

As part of initial engagement with OhioRISE, the Care Coordinator will introduce the child/youth, family, and team members to the CANS, its purpose, and the process by which it is used to document needs and strengths. Care Coordinators will facilitate the discussion within the CFT to determine which items require action. Action level items will be prioritized by the family and addressed with strategies and supports in the planning process.

It should be noted that assessment is an ongoing process, and all needs may not be readily apparent at the beginning of the CFT process but may emerge as relationships grow.

In some situations, a youth may need an additional assessment done by someone with extra experience or qualifications, such as in substance use or developmental disabilities. The CFT will discuss accessing already existing evaluations (e.g., youth study team) or pursuing further or specialty evaluations as needs present.

In the instance of enrollment being based on an inpatient psychiatric hospital stay, a Brief or Comprehensive CANS assessment may not be completed. If this is the case, Aetna or the CME will need to complete the CANS assessment for appropriate Tier recommendation and assignment.

During the initial home-based meeting, the care coordinator may have received a recent CANS that was used to determine eligibility for OhioRISE. If the initial CANS assessment was the Brief CANS, the care coordinator needs to complete the Comprehensive CANS assessment with the CFT within the first 30 days of consent to ICC or MCC. Additionally, the care coordinator will help the youth and family to understand the ongoing use of the CANS as part of Child and Family Team meetings and Care Plan updates. The care coordinator is expected to review any recent CANS information with the youth, family and multiple perspectives and gather updated or new information. Reviewing and updating previous CANS information prevents the need for the youth and family to retell their story.

Interim Planning

While listening to the youth and family's story, the care coordinator can help the youth and family identify immediate needs. The care coordinator, youth and family will make an interim plan for addressing urgent needs prior to the initial CFT with the resources currently available to the youth, family, and CME. The CME will follow through with service requests and coordination of supports and services as discussed during the initial visit.

Wrapping Up the Initial Visit

At the conclusion of the initial visit, the care coordinator will review the next steps with the youth and family. This includes engaging CFT members, convening a CFT, and gathering contact information from youth and family supports and service providers, such as the youth's school, primary physician, state or county agency worker, psychiatrist or other mental health professional, clergy or other spiritual advisor, afterschool activity provider, friends of the youth and caregiver(s), and extended family members.

There is an expectation that formal support contacts will include schools, other child-serving systems such as youth welfare, juvenile justice, behavioral health, service providers, informal supports, Department of Developmental Disabilities, and medical providers, at a minimum, as applicable.

Care coordinators will engage with the family to obtain necessary consent to access relevant input from collaterals. If valid Release of Information forms are on file, care coordinators are expected to maintain contact with collateral supports and providers throughout the youth and family's involvement to ensure that care is coordinated across systems and all parties are aware of progress and emerging needs of the youth.

The outcome of the initial visit is documented in the youth's electronic health record (EHR). This document includes fields that can be used to document needs, strategies, and service requests related to interim planning, in addition to the youth and family crisis planning elements.

The Child and Family Team Process

The CFT is a group of people, determined by the youth and family, who are relevant to the life of the child/youth (e.g., family members, members of the family's social support network or natural supports, service providers, and state or local agency representatives). A primary function of the CFT is to participate in building and

monitoring a strengths-based Child and Family-Centered Care Plan (CFCP), with facilitation by the assigned care coordinator.

The CFT participates in the development and implementation of a written, Child and Family-Centered Care Plan (CFCP) to assist each youth to access to covered and non-covered services and supports needed to address identified behavioral health needs and to document and monitor progress toward the youth / family's goals. The CFT serves as a forum to address the youth's specific needs and may include the discussion of any health, social determinants of health (SDOH) and socio-cultural factors that may be having an impact on the youth's overall health or place the youth at risk for an adverse outcome. Input is provided by the CFT based on their expertise in physical and behavioral health, or social and community services.

Initiating the CFT

Care coordinators will reach out to identified collateral contacts and obtain relevant information as discussed in the initial meeting with the youth and family. Collateral information, such as input from those involved in caring for or educating the youth, as well as documentation from assessments and provider notes, is important in accessing necessary information that will inform the assessment of needs, completion of the CANS, and planning process with the family and CFT. The youth and family may identify sources of collateral information as important members of the CFT, as their perspective may add to the breadth of the process. The care coordinator, youth and family begin to engage potential team members and schedule a CFT. The CFT is the mechanism by which all assessment and planning for a youth and their family are accomplished. It drives all care coordination activities. The general goal of the CFT is to support youth and families in addressing their behavioral health needs while assisting them in building strengths and a natural support system, which will allow the youth and family to coordinate supports for themselves. The CFT works toward developing a long-term sustainable plan for the youth and family that can support them without reliance on a formal system to meet their needs. Through the CFT process, the team assesses youth and family needs and designs, implements, and manages youth guided and family driven supports and services for youth.

The initial CFT should be convened within 30 calendar days of consent to ICC or MCC. It is important for the Child and Family Team to be held in a timely manner so that an initial plan can be developed and approved by Aetna within 30 days from consent to ICC or MCC.

The youth and/or guardian, parents/caregivers, and other CFT participants should be invited to attend the CFT meeting in person and have a voice in the development of the youth and family's CFCP. CFTs are intended to be held and are strongest when youths attend in person. If there are circumstances when that is not possible, care coordinators may explore having youths participate by other means, such as technology or through information gathered ahead of time. A family may elect to convene the CFT outside of the timeframe due to their availability or availability of key CFT members identified. In this instance, the Care Coordinator will document this information in the youth's electronic health record.

While arranging the CFT, care coordinators will follow up with identified action steps from the initial visit. Care coordinators continue to focus on relationship building with the youth and family during this time and ensure ongoing communication about ongoing activities and next steps. Engagement is the ongoing process that occurs throughout the entire relationship. CMEs should be continuously monitoring the degree of engagement throughout the process while assuring Care Coordinators have a range of tools available to assure authentic engagement.

CFT meeting frequency is driven by the behavioral health needs of the youth and family, including any new, emergency, or crisis needs, but must adhere to minimum requirements as prescribed in the Ohio Administrative Code. CFT meetings are used to assess progress, review team members' rating of met need, review goals and the effectiveness of identified interventions on the Child and Family-Centered Care Plan, and revise it as needed to ensure the youth's behavioral health needs are being met and the youth is making progress toward identified

goals. For youth enrolled in ICC, CFTs must meet and review the CFCP every 30 calendar days, or sooner if there is a significant change in the youth's needs or circumstances. For youth enrolled in MCC, CFTs must meet and review the CFCP every 60 calendar days, or sooner if there is a significant change in the youth's needs or circumstances.

The CFT can and should meet more frequently if there is a change in youth or family circumstances, an emerging or emergent need, or any situation that warrants planning revisions, including but not limited to when a youth is placed in an out of home setting including foster care, detention, hospital, or when arrested. Any team member can request a CFT meeting at any time. The OhioRISE care coordinator is the point person for setting up CFT meetings, and they are primarily responsible for facilitating the meeting. The care coordinator will contact team members to schedule the meetings, which take place at a time and location convenient for the youth and family. This allows for the most flexible and relevant planning.

All outcomes of the CFT will be documented in the Child and Family-Centered Care Plan (CFCP).

Composition of the CFT

A CFT has structured membership and consists of, at a minimum:

- The youth, legal guardian, and caregiver(s).
- The care coordinator.
- Natural supports identified by the family, such as family, friends, or any other informal supports.
- Any clinical provider involved with the youth's treatment, if desired by the family.
- Representatives from other entities involved with the youth, such as current service providers, probation/parole officers, teachers, or other school personnel, if desired by the family.
- Child welfare caseworker assigned to the youth if the youth is receiving protection or permanency services from child welfare/PCSA.
- Physical Health provider-pediatrician and/or specialist, if desired by the family.
- Representatives from out of home treatment programs, if relevant and as permitted by the family.

The goal for CFT membership is to have a CFT primarily composed of informal, and community supports, so that the youth and family continue to have a network of support long after transitioning out of ICC/MCC services.

While the youth's initial CFT is likely to contain more formal than informal supports, the team should at all times be looking to expand the team to include informal supports as they are identified or developed. Over time, the team should expand as informal supports are identified and integrated and should remain the same even as formal supports are phased out and informal supports continue to expand. The CFT may expand or change in membership/composition based on family request, changing circumstances, or revised treatment goals.

The OhioRISE care coordinator will make every effort to assure participation of all persons requested by the youth and family to be on the CFT. If the Care coordinator is unable to secure participation of a youth or family-requested member despite diligent efforts, this should be documented in the progress notes and CFT meeting documentation.

CFT Member Roles and Responsibilities

The OhioRISE care coordinator is responsible for convening and facilitating the CFT and process. The care coordinator's primary role is to facilitate, implement, and monitor the informed decisions of the Child and Family Team. They are responsible for framing the CFT process, setting the tone of meetings to encourage open and collaborative discussion about how to best meet the youth's needs, and managing the pace of each CFT meeting to ensure the team is developing action items and fully implementing the Child and Family-Centered Care Plan. At the initial Child and Family Team meeting and, as needed, throughout the process, the care coordinator ensures team members are introduced to one another and that the goals, values, and principles of

OhioRISE and the CFT process are fully described to each team member. The care coordinator will review with the team:

- Goal of the CFT.
- Structure of the CFT.
- Roles and responsibilities of each CFT member.
- Activities of the CFT, including assessment and planning processes, in an effort to frame the CFT work going forward.

As the youth and family builds skills through the CFT process, they will be encouraged and supported by the OhioRISE care coordinator to coordinate and facilitate their own CFT, with the ultimate goal of empowering the youth and family to coordinate their own supports and services after they transition from OhioRISE and move into adulthood.

Activities of the CFT

Family Vision

The CFT begins by understanding the youth and family's vision and proceeds with identifying strengths, current needs, strategies to meet those needs, and desired outcomes. Assessment begins with the team offering the family to share their story or journey with the team.

The Family Vision reflects how family members see their sense of hope and future and where they see their lives going. It is not a list of needs or services, but rather an expression of what the family envisions their life would be like if the current needs were met, and/or what life was like for them before their current challenges. It includes not just the vision of the caregiver(s) or the vision of the youth, but the vision of the family as a whole. It provides the CFT with a focal point towards which all activities will guide the family and provides a central theme by which all strategies are considered and measured.

The care coordinator facilitates the discussion of the Family Vision within the CFT. The care coordinator will search for common themes and provide feedback, reframe as necessary, and negotiate differing views of team members. The goal is to create a Team Mission with which everyone on the team can agree, and to which everyone can commit.

Identification of Strengths

Strengths are personal attributes, skills and resources as well as things that people do well, are interested in, and come naturally to them. Strengths are identified so that they can be used to build strategies. Strengths are different than attributes. Attributes are characteristics of a person, whereas strengths refer to skills or abilities that someone has and may include skills or abilities they had in the past and ways they managed challenges in the past. Strength identification is an intentional process during which strengths inherent to the youth, family, and other team members are explored and identified. Strengths identified should be functional, meaning that they can be used as a basis for strategies designed to meet the family's needs.

The family strengths discovery results are part of the initial CFT Team meeting. The Care Coordinator introduces these strengths and facilitates a discussion of the strengths of each team member in terms of what they can add to the process. Over time, the Team will develop a practical understanding of the functional strengths of family members.

Identification of Needs

Once the team has been briefed on the Family's Vision and generated a common Team Mission, underlying needs are reviewed. As the Care Coordinator facilitates the discussion of unmet needs, the team members work together to identify all unmet needs of the youth and family members. Needs are not equivalent to services;

they point toward strategies that may include a service, but may also be addressed through other methods, such as informal or community supports.

OhioRISE has identified key areas that should be considered and referenced when assessing family needs. The planning process shall, at minimum, address areas of unmet need requiring action in all areas of the following life domains:

- Youth safety.
- Youth risk.
- Crisis management.
- Emotional and/or clinical needs.
- Non-clinical needs, if deemed therapeutic and approved by the CFT, such as housing, recreational, financial, medical, legal, cultural, and spiritual needs.
- Educational needs.
- Permanency planning.
- Community safety needs.
- Family/Caregiver needs.
- Transition needs.
- Talents/Interests of the youth and caregiver(s).

Care Coordinators will identify unmet needs with the youth, caregiver and family by reviewing a variety of sources which will include completing an interview with the parent and child, reviewing behavioral events along with the family's history to generate unmet needs. The youth and family will prioritize needs including basic needs (food, shelter, safety, etc.)

When applicable, youth safety, youth risk, permanency planning, and community safety needs shall be coordinated with PCSAs, the court system, and DYS as needed. CMEs will assure that Care Coordinators who are interfacing with court-based agencies have access to appropriate supervision and resources for facilitating collaborative planning with these system partners and for guidance on approach and concrete strategies.

CMEs will utilize their own electronic health record to document OhioRISE care coordination activities and store the youth's record. All documentation including assessments, other assessment documentation and other relevant information will be entered into these systems. Standardized forms and documents are developed and implemented through collaborative leadership of ODM, Aetna, the CMEs and CABHCOE. Required data set specifications have been developed and may be updated as needed to meet the needs of the program and reporting needs. Aetna has developed and implemented a workflow to allow data sharing from CMEs to Aetna through automations built by i2i. CMEs will also have access to the CME User Interface (UI) which will share data from Aetna back to the CMEs. The UI will share information such as notifications available on Family Care Central (FCC), Member Alignment File, Care Plan/Crisis Safety Plan Response, Care Transition Notifications, Critical Incident Event Alerts, Gap in Service Notifications, Portal Message Notifications, Sentinel Placement Notifications, IP Alerts, MRSS Provider Contact Alerts, Restriction/Lock-In Notifications, and Appointments Notifications. FCC notifications presented in the UI should be viewed in the Family Care Central portal. This can be viewed by families, CMEs, PCSAs, MCOs, and other members of a youth's CFT, based on consent of the youth and/or guardian.

Planning/Strategies

Based on assessment information, the next step of the CFT is planning to address identified needs. Comprehensive care planning incorporates areas of planning for crisis situations, ongoing treatment, and transition needs. All areas should be reviewed by the CFT at each meeting, including funding and youth benefits

such as MSY, Flex funds, Additional Resources, etc. It is imperative that CFTs can articulate why a particular plan is appropriate for the youth.

Strategies should be strengths-based and reflect the steps the CFT will take to address the identified and prioritized needs. These strategies should have measurable goals and time frames, identify specific individuals responsible for each strategy, and identify the roles and responsibilities of all CFT members. Strategies should be geared toward developing skills and building strengths to support long term sustainability of the plan.

Safety and Crisis Planning

The care coordinator will facilitate the CFT review of the individual safety and crisis plan initially developed with the youth and family at each CFT meeting. As needs and resources change, the crisis plan should be updated to account for new information relevant to the youth and family's definition of a crisis and reflect newly developed strategies and helpful concrete strategies and community resources that can assist in a crisis. The crisis plan should also:

- Describe a hierarchy of crisis response, based on the severity of the crisis, and who should be involved in each strategy.
- Direct families when to contact the CME for their assistance in coordination of crisis strategies, and how the CME will be available in a crisis situation.
- Be built on consensus with the family as they need to feel comfortable in employing the identified strategies in a crisis situation. Youth and families have a spectrum of lived experience and perception around crisis services. It is critical for care coordinators to identify, understand, and resolve any barriers families may have to employing crisis strategies including the use of crisis services.

For youth with behaviors that pose safety concerns for the youth or others, a licensed clinician working with or for the CME will consult on the individual crisis and safety plan, recommend de-escalation strategies that can be learned and used by the youth, parents, and other caregivers to support the youth and prevent the use of restrictive interventions.

Ongoing Individualized Planning

Ongoing planning by the CFT begins at the initial CFT meeting. The supplemental assessment along with the Comprehensive CANS Assessment information gathered through the CFT process is used to help inform the care planning process to address the youth and families identified needs. The planning process is individualized for each family and grounded in their strengths, and shall consist of the CFT developing outcome based, short term, interim, and long-term strategies to address each area of need and life domain, according to the assessment. It is holistic in nature and addresses areas of everyday living beyond the treatment of behavioral health symptoms. The planning process shall identify all supports and services used by the youth and family to implement the strategies. All supports and services should be provided in the least restrictive manner possible. The Care Coordinator is responsible for being familiar with a wide breadth of local and state level resources both formal and informal and be able to describe them to the CFT to assist them in determining the most appropriate, least restrictive, and most sustainable resource to meet a need.

The CFT care planning is a fluid, ongoing process. The care plan strategies are reviewed regularly through contact with youth and family and other CFT members, both during scheduled CFT meetings and between meetings, to ensure that the plan and identified strategies are being implemented and to assess progress. The development and monitoring of the plan are collaborative efforts shared by all team members.

At each CFT meeting, the care coordinator facilitates the discussion and identification of care planning elements, which include team vision, strengths, needs, strategies, desired outcomes, and the individual crisis and safety plan. These plan elements are reviewed at each meeting to determine if the strategies are effective in utilizing family members' strengths to meet their needs, thereby moving the family closer to their Family Vision. If the

CFT determines that the current care plan is not effective in helping the youth and family meet their goals, additional strategies, supports, and services will be explored.

Care coordinators are required to maintain contact with the youth and family minimally weekly and to maintain face-to-face visits with the youth and family optimally once a week or twice per month depending on level of care coordination.

- The number of visits will vary depending on family needs and circumstances, as discussed in the CFT and supervision.
- The location of face-to-face visits should be flexible based on the youth and family's needs and preferences.
- While face-to-face visits reflect best practice, care coordinators are encouraged to explore technical means of support for face-to-face visits, such as video conferencing, when circumstances arise.
    - Technical supports do not supplant face-to-face visits and may serve as an interim strategy to facilitate communication among CFT members and to facilitate youth and family /caregiver involvement in treatment team meetings.
    - Use of technological means must be driven by need of the youth / family, discussed with the CFT, and described thoroughly in documentation.
    - Additionally, in some cases a hybrid approach may be considered if key participants are in another part of the state or have barriers to attending face-to-face.
    - If exceptions to the face-to-face visit requirement occur, care coordinators will seek supervision and ensure that engagement attempts, and justification are clearly documented in the youth's EHR.

These contacts and visits ensure that the care manager gathers new information, monitors implementation of the plan by reviewing strategies and their effectiveness, and coordinates with team members. When care coordinators have persistent challenges connecting with a family/caregiver, they will seek supervision to explore further options. Additionally, after 30 days with no contact in either ICC or MCC, the member will be reassigned to Limited Care Coordination and the OhioRISE plan care coordinator will continue to make attempts to engage the family in services. After two years have passed since the youth's enrollment in OhioRISE, with no contact and no updated CANS assessment, the member may be disenrolled from the OhioRISE program.

Coordinated Services Program

Some youth and young adults enrolled in OhioRISE who have a pattern of taking medications incorrectly may be required to use only one pharmacy to fill their medications. This is called the Coordinated Services Program (CSP). The Coordinated Services Program is administered in accordance with Ohio Administrative Code 5160-20-01 and 5160-20-04.

Youth enrolled in the CSP can choose one pharmacy to provide their prescriptions; if they do not choose a pharmacy, one will be selected for them. Using a single pharmacy can help reduce incorrect prescription drug use. The Aetna Pharmacy and Medical Directors will regularly review medication reports and may recommend that a youth be signed up for the CSP.

If recommended by Aetna's Pharmacy and Medical Director, the care coordinator will work with Aetna to hold a CFT meeting, including the youth's managed care plan (if applicable), to discuss and decide if the youth will be recommended for and enrolled in the CSP. Youth will get a letter to inform them of their enrollment in the CSP, and the youth and/or guardian has the right to a state hearing if they do not agree with the decision to enroll in the CSP.

For youth enrolled in the CSP, care coordinators will need to provide information about the program, including information about the youth's ability to select a single pharmacy and the option to switch to a different pharmacy at a later date.

Summary of Roles and Responsibilities within the CFT

Care coordinator responsibilities include, but are not limited to:

- Engaging the youth and their family in forming their unique CFT, preparing them to be full partners in the assessment, planning, and implementation of their ISP.
- Convening CFT meetings, ensuring that CFT meetings are convenient for the youth and family.
- Serving as the facilitator of the CFT, ensuring that the CFCP development is a collaborative effort of all the team members.
- Serving as the point person for the CFT, remaining in contact with all members to ensure implementation and effectiveness of the CFCP, monitoring the commitments of the team members and assisting with implementation issues.
- Developing and implementing an individual Crisis and Safety Plan in conjunction with the youth and family.
- Coordinating care with all providers and agencies with whom the youth and family is involved, including youth's behavioral health providers, physical health providers, other systems involved in the youth's life (e.g., school personnel, developmental disabilities worker, probation officer, etc.), natural supports, other service providers providing resources and supports to the youth, and the MCO providing physical health benefits to the youth (e.g., CareSource, Molina, UnitedHealth, Buckeye Health Plan, etc.).
- Ensuring timely and effective referrals and linkages with appropriate assessments, supports, resources and services.
- Ensuring that all services, supports, and care coordination processes respect the youth and family's rights to define their specific goals and choose their providers and resources, and monitoring to ensure that all supports and services are youth and family friendly and culturally competent.
- Communicating ongoing CFCP implementation progress and updated strategies to all team members, obtaining their cooperation and approval.
- Working with others to develop community resources to meet youth and families' needs, as identified.
- Ensuring useful information management and documentation, including attendance of team members and their approval of the CFCP are documented in the youth's EHR.
- Ensuring that the written CFCP is signed by the youth (as age appropriate), family/caregiver(s), and the care coordinator and placed in the youth's record within 2 weeks of the CFT meeting.
- Ensuring that the CFCP is provided to Aetna for quality review and initiating the authorization process for services, as needed, within the timeframe indicated by ODM and Aetna.
- Ensuring the OhioRISE Waiver services included on the CFCP are reviewed and approved by Aetna prior to those services starting.
- Ensuring the OhioRISE Waiver providers have signed the CFCP for the waiver services they are providing.
- Forwarding the final approved CFCP to the family within one week of the CFT, and to each team member upon request.
- Ensuring that the OhioRISE share plan is left with the family and all community partners at the conclusion of the CFT or planning meeting, which clearly documents next steps, assigns responsibility, and develops timelines for completion of all tasks.

Supported by the Care Coordinator, youth and family roles and responsibilities include:

- Presenting strengths and needs to the team as they arise.
- Identifying and engaging potential CFT members.
- Maintaining communication with Care Coordinator, service providers, and other system partners.

- Employing agreed upon planning strategies and providing feedback to the team on their feasibility and effectiveness.
- Being available for and participating in CFT meetings.
- Being available for and participating in agreed upon supports and services.

Supported by the Care Coordinator, other team members' roles and responsibilities include:

- Maintaining communication with the family, the Care Coordinator, and other CFT members.
- Employing agreed upon planning strategies and providing feedback to the team on their feasibility and effectiveness.
- Being available for and participating in CFT meetings.
- Coordinating referrals for agreed upon supports and services as indicated.

Expectations for Virtual CFTs and Other Meetings

- It is the expectation that in person, face-to-face involvement with the youth and family occurs every month. It is best practice for the majority, if not all, meetings to be in person.
- Virtual CFTs may only be held at the request of the youth or family. Every effort should be made to have CFT meetings in person.
- In the event the youth or family requests a virtual CFT meeting, the CME Care Coordinator must adhere to the following requirement:
    - The Care Coordinator must be in a working environment that ensures appropriate protection of youth/family privacy and minimizes distractions, such as driving, during CFT meetings.
    - The Care Coordinator and any other CME staff must be on camera during the entirety of the meeting. All other participants should be strongly encouraged to be on camera.
    - Virtual CFTs involving a Care Coordinator not being in-person with the family should be very limited and should be an exception and not the ongoing process.

Role of Care Coordinator Supervisors

CMEs will have supervisory personnel to provide coaching and support for ICC and MCC care coordinators, not to exceed the supervisor ratio described in OAC rule 5160-59-03.2(F) which states supervisory staffing ratios will not exceed one supervisor to eight care coordinators (1:8).

Supervisors are on call 24/7 for their care coordination staff and are available for field-based coaching as needed. Supervisors are fully versed in both ICC and MCC care coordination models and assist care coordination staff in adherence to the respective model.

The care coordination supervisor will be responsible for supporting care coordinators in the following areas:

- Review of care coordination pathways including family-centered strength-based documentation.
- Ensure care coordinators complete required OhioRISE training and other skill and competency-based trainings within first 90 days of hire and annually, thereafter.
- For complex cases involving other leadership-level system partners, supervisors and other CME leadership should co-facilitate CFT meetings. It is important for CME leaders to model the problem-solving skills needed across systems regarding complex cases and to interface directly with their leadership counterparts from community agencies and organizations. Additionally, either the CME Director or a CME clinical leader should be present when state partners are involved in CFTs. The CME should have a defined process to elevate barriers in complex cases to the CME Director when intervention with community partners is needed to ensure the care of the youth.

- Ensuring high-quality and consistent use of the Child and Adolescent Needs and Strengths (CANS) tool across their assigned care coordination staff. Supervisors must:
    - Provide ongoing oversight of care coordinators' application of the CANS tool, including accuracy, completeness, and alignment with OhioRISE practice standards.
    - Support and develop care coordinators' competency in using the CANS by offering feedback, coaching, and skill-building opportunities during routine supervision.
    - Apply the CANS Quality Review Tool (CQRT), at minimum, on a quarterly basis for each Care Coordinator they supervise, as part of routine, collaborative supervision, to monitor quality, guide coaching, and promote continuous improvement in care coordinators' use of the CANS.
    - Ensure that insights from the CANS are consistently incorporated into care planning, ongoing assessment, and communication with the Child and Family Team.
- Develop care coordinators in the areas of:
    - Family systems.
    - Systems of Care philosophy.
    - Care coordination activities that support the child and family team.
    - Quality Implementation of the Wraparound Planning Process.
    - Other CME specific activities.

Collaboration with Child-Serving State Agencies, Schools, and Primary Care

When youth are involved with youth protection, education, developmental disabilities, court, or justice systems, planning is done collaboratively between the CME care coordinators and direct service staff from the other youth-serving system partners and service providers. While the CFT and the other agencies review and oversight processes differ, it is expected that the care coordinator and case workers or leads from the other youth-serving systems are working collaboratively.

The CME care coordinator is responsible for maintaining regular and ongoing communication with case workers and other providers to discuss (in the context of the CFT) the needs of the youth and resources each team member is providing, in order to coordinate care and determine which team members will be responsible for each strategy/resource. The OhioRISE care coordinator will act as the organizer to make sure the team is able to provide the needed resources and support based on the assigned and agreed upon roles and responsibilities. This is an opportunity to ensure that goals and resources are coordinated and youth-focused, in support of the youth and family.

Prior to inviting case workers and other provider/support staff to join a youth's CFT, the OhioRISE care coordinator will ask the youth or legal guardian, as appropriate, to sign a release to allow the care coordinator to contact relevant partners, explain their role in the CFT, briefly outline the ICC or MCC process, ask for a copy of the most recent case plan, service plan, treatment plan, or Individualized Education Plan (IEP), and invite them to join the CFT. Following participation in the CFT, care coordinators should ensure these members of the CFT have access to an up-to-date Child and Family-Centered Care Plan (CFCP). Partnering with CFT members from other systems may require the CME and care coordinator to be creative and understanding of their time constraints. For example, engagement in the CFT may need to occur through email, phone calls, or other communication methods, including the use of telehealth or teleconferencing. When the family hesitates to incorporate a representative from another system with which they are involved, the care coordinator will engage the youth and parent/caregiver around their concerns. The care coordinator will listen to, validate, and fully respect the concerns the youth and/or family have regarding the representative participating in CFT discussions. Once the care coordinator understands the youth and parent/caregiver's concerns, they will work with the youth and family to problem-solve and develop possible solutions to address the voiced concerns, including support the youth and family may need from the entire team to help guide the youth and family toward the best possible outcomes.

As indicated in the CFT membership, care coordinators are required to collaborate with and include other child-serving system partners such as child welfare, juvenile justice, education, developmental disabilities supports, the primary care physician (PCP), and any other practitioners/providers, including the youth's assigned MCO and other existing care coordination/care management agencies.

For youth enrolled in OhioRISE, there are some circumstances in which OhioRISE enrollment or services are impacted by the youth's status with other child serving systems. For example:

- If a youth is taken into protective custody, OhioRISE enrollment does not change, and care coordination services can continue. As indicated, the Care Coordinator is expected to work with the child welfare caseworker to coordinate services and supports.
- If the County PCSA or IV-E court places a youth who is receiving ICC in a foster care setting, the CME will work with the caregiver and PCSA to schedule a team meeting for care coordination and planning.
- In instances when a youth is placed in a juvenile justice detention or correctional institution, the youth's Medicaid coverage will pause, and they will be disenrolled from OhioRISE. Upon planned exit from the juvenile justice correctional institution, the OhioRISE plan will collaborate with the Department of Youth Services to re-engage the youth and family in OhioRISE services, conduct updated assessments, and initiate up to 30 days of care coordination pre-release. Members will be transitioned to the appropriate CME through a warm hand-off within 30 days of release.

The Child and Family-Centered Care Plan (CFCP)

The CFCP is the documentation of the work of the CFT. The planning process and CFCP document is more than a collection of services. It integrates services with family strengths and natural support systems to achieve common goals. Each CFCP document should include information in the following areas:

- The participation of providers and local community partners, and the integration of available and appropriate services and resources.
- Documentation of the responsibilities, objectives, and requirements of child welfare, mental health, juvenile justice, the courts, and other service systems, as applicable.
- The specific supports and/or strategies identified and/or implemented to support the youth, including planning for the purchase of items or services necessary to support the youth/family's needs as determined by the CFT. These strategies should always be linked to the youth, parent or other family member's strengths.
- Measurable goals and the criteria to be met to obtain those goals.
- A plan for transitioning the youth from CME services to a community-based, natural support network of services and supports.
- A back-up plan in the event the youth is unable to receive service in the amount, frequency, and scope identified in the CFCP by the CFT based on the youth's needs.
- The signatures of the CME Care Coordinator/Care Coordinator Supervisor, the caregiver(s), and the youth receiving services. For OhioRISE waiver members, waiver providers' signatures must be included.
- Documentation of the coordination of applicable services with the MCO for physical health services.
- An individual crisis and safety plan.
- The team can expect that the CFCP document will be written, provided to the family within one week of the CFT, and provided to each team member. It will also be available in Family Care Central.
- All changes to the CFCP are agreed upon by the CFT and, at a minimum, signed by youth, caregiver(s), and Care Coordinator. For OhioRISE waiver members, waiver providers' signatures must be included.
- All flex fund requests and rationale should be included on the care plan

Additionally, meeting attendance must be documented, and best practice calls for a signed meeting attendance sheet for in-person meetings. The care coordinator must submit the CFCP to Aetna within one business day of completion.

The initial CFCP must be completed, approved by the supervisor, and submitted to Aetna within 30 calendar days of the youth's referral to ICC and MCC.

For subsequent CFCPs, for youth enrolled in ICC, the CFT meets monthly, and updates the CFCP in conjunction with the CFT. For youth enrolled in MCC, the CFT meets every 60 days, and updates the CFCP in conjunction with the CFT.

Coordinating Care for OhioRISE Waiver Enrollees

In addition to the care coordination activities requirements above, for those individuals on the OhioRISE Waiver the following must also be implemented:

- Complete the inpatient psychiatric Level of Care (LOC) Assessment annually within the required timeframe.
- A back-up waiver service plan must be completed at the same time as the CFCP. The back-up plan can include natural supports or other enrolled providers as the substitute of coverage. The Child and Family Team identifies possible back-up options and includes them in the Child and Family-Centered Care Plan.
- All OhioRISE waiver services must be reviewed and approved by Aetna prior to any services being started, for both planned and emergency waiver services.
- Educate youth and family on participant-directed budget of Secondary and Emergency Flex Funds.
- Monitor to ensure youth does not exceed the waiver cost cap and track utilization of waiver services.
- Waiver-enrolled youth and waiver service providers must sign off on the CFCP and be provided with a copy of the CFCP.
- At least 30 days prior to disenrollment, the CFCP must be updated to include a transition plan to identify needed supports for the 90 calendar days following disenrollment from the waiver to replace waiver services with other behavioral health services.
- Assist with required activities related to the OhioRISE Waiver, including:
    - Gather and submit information to assist ODM in determining OhioRISE Waiver eligibility.
    - Assess the initial and ongoing settings where youth will receive 1915(c) home and community-based services for settings requirements using the review tool designated by ODM.
    - Help youth and caregivers in determining the need for OhioRISE Waiver services.
- Aetna will serve as a resource to the CFT and serve as the conduit for Aetna sponsored services and supports and to support the youth's application for the OhioRISE waiver.

Care Plan Review Process

Care Coordinators will ensure that Child and Family-Centered Care Plans (CFCP) for youth enrolled in ICC or MCC (including initial plans, changes to plans, and transition plans) are completed and submitted to Aetna for quality review and approval.

For youth receiving ICC or MCC who are enrolled in the OhioRISE waiver, transition planning must identify the supports the youth will need for the 90 calendar days following disenrollment from the OhioRISE waiver. At a minimum, CMEs must submit the CFCP through their EHR systems every 30 days for ICC and every 60 days for MCC. These submissions will be processed through Aetna, with the data displayed in the i2i User Interface and ultimately made available in the FamilyCare Central portal. CMEs must also submit the CFCP between those regular intervals anytime it is changed by the CFT.

- The purpose of Aetna's quality review is to ensure that all necessary CME and other provider services and supports are incorporated into the Child and Family-Centered Plan of care at the needed intensity of service; and ensure the plans adhere and support a child and family-centered care planning process consistent with System of Care Principles, and High-Fidelity Wraparound practice.

Name of Process: OHR 101: Child and Family-Centered Care Plan Review Process (CFCP) **Date Created: 4/2022; Revised 10/2025**	
Purpose of the Process	• To ensure quality oversight and development of the CFCP for youth. • To ensure timely submission and approval of the CFCP. • To ensure appropriate services are designed for youths based on quality review, coaching, child and family team involvement, and consideration of family voice and choice throughout the process. •
Responsible Entities	• Child and Family Team • CME Care Coordinator /CME Supervisors/Leadership • Aetna Care Coordinators/Aetna OhioRISE Supervisors/Leadership • Care Plan Review/OhioRISE Program
Timeframe	• 5 Business Days for typical CFCPs • 2 Business Days for expedited CFCPs
Best Practice/Description of Process	**Initial Care Plan Development with Child and Family Team** • Care Coordinator and Child and Family Team convene to develop the initial CFCP. The Care Coordinator will solicit feedback from all members of the child and family team regarding appropriate services and approach to coordination of services. • Care Coordinator will develop the Child and Family-Centered Care plan and review with the Child and Family team. • The Child and Family Team will sign to include the youth and guardian, care coordinator, and all OhioRISE waiver service providers, if applicable. The Care Coordinator will submit the CFCP to the Care Plan Reviewer at the OhioRISE Plan. • The Care Coordinator will immediately begin implementing the CFCP following the submission to the OhioRISE plan. **Care Plan Quality Review and Approval Process** *The care plan review process should take no more than 5 business days.* The OhioRISE Plan's review of CFCPs **that do not include services requiring prior approval** will be focused on: • Ensuring completion of the CFCP. A CFCP is complete when each section of the CFCP has been answered;

- Providing feedback to improve the quality of CFCPs; and
- Looking for items of serious concern. If an item of serious concern is identified, the care plan reviewer will quickly reach out to the care coordinator's supervisor to develop a plan to immediately address the identified concerns within the CFCP.
- Within 5 business days, the OhioRISE plan will either auto-accept eligible CFCPs, or after a live review with a care plan reviewer, provide written feedback and a notice of CFCP acceptance.

For CFCPs that include services requiring prior approval:

- Care Plan Reviewer reviews the CFCP within 5 business days of submission.

If approval of services requires no additional information, the care plan reviewer will provide written feedback and a notice of CFCP approval, including approval of services requiring prior approval.

If additional information is needed for approval:

- The care plan reviewer will send a request for additional information notification to the Care Coordinator requesting additional information for the requested service.
- The Care Coordinator has 2 business days to respond to request for additional information.
- During this process the Care Plan Reviewer will do the following to support the care planning process as needed:
    - Reach out to the Care Coordinator by phone or email and provide coaching and collaboration related to the specific feedback for the CFCP
    - Provide feedback on best practices and support implementation of High Fidelity Wraparound principles with the CFT.
    - Provide ongoing support to the care coordinator/CME and CFT via coaching calls or email.
- Care Plan Reviewer will review additional information and render determination for services requiring prior approval.
- NOTE: As of 11/1/2025, the care plan review team will no longer be requesting additional information for flex fund item approvals. Decisions for Flex Funds will be rendered upon initial submission of information.

If services requiring prior approval are approved, the care plan reviewer will provide written feedback and a notice of CFCP approval, including approval of services requiring prior approval.

If services requiring prior approval do not meet the criteria for approval:

- Care Plan Reviewer will provide Care Coordinator with information regarding a Peer-to-Peer option post denial, which will be facilitated by either the care plan review team clinicians or the Aetna Medical Director Team.
- A letter called a Notice of Adverse Benefit (NOA) Determination will be mailed to the youth and the Care Coordinator. This notice will include Peer-to-Peer scheduling information and appeal rights.

	• Care Plan Reviewer will accept the CFCP, provide written feedback on the CFCP, and indicate the determination for each requested service • Care Plan Reviewer will reinforce appeal rights and provide alternative resources for the CFT to consider in meeting the identified need of the youth as outlined in the service prior approval request. OhioRISECarePlanReview@aetna.com **CFCP Quality Assurance:** Aetna's Care Plan Review Team utilizes the ODM approved care plan review tool for each review of the care plan. • Aetna's Care Plan Review Team participates in inter-rater reliability to evaluate the objectivity and consistency with which care plan reviews are conducted. • Care plan reviewers will participate in regular one-on-one and group supervision. • Care plan review team managers will complete regular audits of care plan reviews. • Care plan review team managers will monitor issued Requests for More Information and identify opportunities for ongoing coaching with care plan reviewers. • Results from the Care Plan Review are reviewed for trends and patterns in the QM/UM committee in aggregate and used in the evaluation and updating of the Quality Strategy. **Ongoing CFCP Approvals:** • Tier 3: Every 30 days the Youth and Family Team will submit an updated CFCP for youth in Intensive Care Coordination. • Tier 2: Every 60 days the Youth and Family Team will submit an updated CFCP for youth in Moderate Care Coordination. • Tier 1: Every 90 days the Youth and Family Team will submit an updated CFCP for youth in Limited Care Coordination. Repeat Care Plan Review and Approval Process for ongoing approval (see above)

Expedited / Urgent CFCP Creation and Review for OhioRISE Waiver Enrollees	***Process to Expedite Urgent Requests for Waiver Services***
	
	Aetna is committed to ensuring that needed OhioRISE waiver services and supports are not delayed because of the care plan review process.
	
	• Urgent Waiver Request Definition: A request for waiver services where application of the time frame for making a routine or non-life-threatening care determination:
	  ○ Could seriously jeopardize the life, health, or safety of the youth or others, due to the youth's psychological state, or
	  ○ In the opinion of the practitioner with knowledge of the youth's medical or behavioral condition, would subject the youth to adverse health consequences without the care or treatment that is the subject of the request.

	• The Care Coordinator will submit a Care Plan for expedited review of urgent waiver service requests by completing the following section of the Care Plan:
	  ○ Transitional Services and Supports (TSS), Out of Home Respite
	  ▪ Service Code with associated modifiers
	  ▪ Number of units requested/frequency
	  ▪ Name of provider/NPI number who will be providing the service
	  ▪ Service dates – anticipated start and end dates
	  ▪ Rationale for waiver service request
	  ○ Secondary/Emergency Flex Funds
	  ▪ Service code with any associated modifiers
	  ▪ Description of good or service
	  ▪ Cost of service or good, including any shipping and tax
	  ▪ Identify a specific vendor of the good/service, when identified
	  ▪ Medical necessity rationale
	  ▪ Unmet need and desired outcome from use of funds
	• Upon receipt of a Care Plan indicating an urgent request for waiver services, the Care Plan Reviewer will immediately reach out to the Care Coordinator to determine accuracy of the request meeting the definition of Urgent.
	• If the request does not meet the definition of Urgent, it will be processed within the standard time frame of 5 business days.
	• Upon confirmation that the request meets the definition of urgent, the Care Plan Reviewer will complete the review within one business day.
	• The Care Coordinator will flag urgent requests for waiver services by checking the appropriate box on the Care Plan.
	• All care plans that include a check in the urgent request for waiver services box will display in Aetna's Care Plan Review submission queue as requiring expedited review.
	• When all the necessary information is present and meeting service threshold requirements on the Care Plan, the Care Plan is approved, and the Care Plan Reviewer completes the internal Aetna system processing for waiver service approvals.
	• When further information is needed in order to complete the Care Plan Review, the Care Plan Reviewer will immediately outreach the Care Coordinator in order to discuss the request for urgent waiver services and obtain any remaining information to complete the Care Plan approval within the designated timeframe of one business day**.**
	• If the care plan reviewer is unable to reach the Care Coordinator (or CC Supervisor) via this immediate outreach, the Care Plan Reviewer will await the maximum 5 business days prior to rendering a denial.
	• If requested additional information is not received within the requested time frame, or if the information provided with the care plan does not support the service requested, the Reviewer will deny the request. These actions will result in a Notice of Adverse Benefit Determination (NOA).
	•

Monitoring and notification for certain services not on CFCP	Certain services should be documented and approved on the CFCP as a best practice. At a minimum, these should include
	• Intensive in-home / community services
	  ○ IHBT, MST, FFT, ACT
	  ○ Behavioral Health Respite
	  ○ TBS Day Treatment
	• Aetna will monitor services that are reimbursed but are not on the care plan prior to provision/payment.
	• Aetna will notify Care Coordinators if these services are provided and are not documented on the CFCP to encourage CFCP updates.
	Care coordinators should also receive notification if certain additional services are provided and are not on an approved care plan, such as Inpatient Behavioral Health Hospitalization, as this may be required on an emergency basis and therefore not able to be discussed in the CFT and captured on the CFCP.
	The services listed below, should be listed on the CFCP, but the rendering provider will have to submit a formal prior authorization request for them through the provider portal:
	• SUD Residential
	• SUD Partial Hospitalization
	• Electroconvulsive Therapy (ECT)
	• PRTF

Name of Tracking Tool/Checklist	• OhioRISE Care Plan Review Audit Tool V2 • OhioRISE Request for Additional Documentation • OhioRISE Notice of Care Plan Acceptance or Approval
Method to ensure implementation, consistency, and effectiveness of process.	Aetna will monitor and provide oversight including but not limited to: • Timely provision of all care plans • Timely submission of care plans to Aetna • Timely review and response from the Care Plan Review Team • Use inter-rater reliability results to identify opportunities to improve inter-rater reliability score • Regular one on one and group supervision with care plan reviewers • Case rounds with Medical Director and care plan reviewers • Monitor trends of requests for more information, conflict resolution requests, and notices of non-concurrence to identify opportunities for training, further coaching, and quality improvement initiatives with CMEs and care plan reviewers. • Elicit and review input received from the Youth and the Family Advisory Councils on the care plan review process

	• Feedback from Youth and Family Advisory Councils is brought to the QI System of Care Committee for review of patterns and trends and used in the evaluation and updating of Quality Strategy

Transition Planning

All youth will experience transitions during their participation in the OhioRISE Program. Transition points will occur among providers of formal and informal services and supports identified in the Child and Family-Centered Care Plan. Youth will be transitioned from the OhioRISE Program to MCO care management for various reasons. Some youth will be transitioned from higher levels of care (e.g., inpatient behavioral health hospitals or PRTFs) or across care coordinators (within a CME and across CMEs). Therefore, it is important to anticipate possible transitions as best as possible and develop a plan to ensure that such transitions are seamless, and that care coordination and other services are not interrupted.

Transition from CME

Transition planning for youth receiving CME services is intentionally considered within the context of the ongoing CFT process and guides the team from the time of the family's referral. The ultimate goal of the CFT process is to empower the family to manage their own plan within the community. It is understandable that families may have needs in the future, but the goal is for them to develop skills and resources to negotiate them independent of CME care coordination. It will be important for the youth and family to understand this at the beginning of services. The care coordinator will make this a part of their ongoing work together, so they are regularly communicating plans for transitions to informal and natural supports.

Transition planning requires the CME Care Coordinator to balance the family's current need for support with preparing them to transition out of OhioRISE by teaching the family the process of the CFT. From the initial meeting forward, the CME Care Coordinator will encourage the family to drive the CFT process by reinforcing their strengths, highlighting their successes, and empowering them to apply the skills learned to problem solve on their own. A transition plan is formally developed if one or more of the following criteria are met:

- The goals of the CFCP have been substantially achieved.
- The CFT determines that the youth no longer requires the intensive level of care coordination provided by the CME, as evidenced by results of an updated CANS assessment.
- The CFT determines that the youth is ready to be transitioned to adult services.
- The family requests transition or is unreachable for an extended period of time despite documented best efforts to contact family.
- The family or youth moves out of Ohio.
- The youth is sentenced to a term of incarceration.

Transitioning to Adulthood

Before a youth reaches 21, the CFT should consider what supports and services they may need as they approach adulthood. If a young adult needs further supports after the age of 21, the team should be coordinating linkages to adult systems and planning with the young adult for his/her transition to those services. This may include, but is not limited to, planning for and developing supports to address mental health needs, medical needs, developmental needs, housing needs, career and/or employment needs, and educational needs.

Those enrolled on the OhioRISE Waiver may stay enrolled through their twenty-second birthday, if they continue to meet eligibility requirements through the Waiver Level of Care Annual Redetermination Assessment.

Transition of Care Coordination Tiers

If youth and family/caregiver changes care coordination tiers due to changing needs or a preference for a lower care coordination tier, CMEs shall make the request to the OhioRISE Plan, which shall include a CANS assessment updated within 90 days. The CME or OhioRISE plan may pursue transition of a youth to other care coordination tiers when a CANS assessment of the child and family-centered care plan indicates that the youth's needs are no longer appropriate for the current tier.

For youth transitioning between care coordination offered by the CME (tiers 2 and 3), to maintain Intensive Care Coordination fidelity to National Wraparound Initiative standards, it is anticipated that the care coordinator working with the family may change, and that the CME will facilitate continuity during the transition for the youth and family. At a minimum, this will include joint (former and new care coordinator) participating in CFT meeting(s) until the transition is complete.

For youth transitioning to or from CME care coordination (tier 2 or 3) to/from Aetna care coordination (tier 1), CME, Aetna, youth, and family will facilitate continuity during the transition for the youth and family. At a minimum, this "warm handoff" will include sharing of all relevant information, joint (old and new care coordinator) participation in CFT meeting(s) until the transition is complete.

Transitions To/From Psychiatric Hospitalization

When a youth currently receiving care coordination from a CME is transitioning from a behavioral health facility, PRTF or other facility (e.g., QRTP), the CMEs Care Coordinators will support the planful, respectful, family-centered and community informed transition. The CME should work with the youth, family and CFT to contact the facility to participate in the transition planning process. If this contact does not result in some engagement between the CME and the facility, the CME shall contact their Aetna liaison to assist with facilitating engagement. Once engaged, the CME Care Coordinator should undertake the following:

- Participate in discharge planning activity with the facility, including arrangements for safe discharge placement and facilitating clinical hand-offs between the discharging facility and the CME.
- Obtain a copy of the transition plan and share the plan with the youth's CFT.
- Arrange and confirm services and supports as well as rendering organization are available in accordance with the transition plan.
- Obtain copies of the youth's medical records as appropriate and consistent with federal and state law.
- Conduct timely follow up with the youth and the youth's behavioral health providers to ensure post discharge services have been provided, consistent with the CME Care Coordination role.

PRTF Referral, Transition and Return to Community Plan

At times, Care Coordinators, families and teams may find that a more intensive treatment option like PRTF is necessary in order to achieve goals. When this happens, the Care Coordinator works with the family and Child and Family Team members along with Aetna to assure that this resource is engaged with a purpose, is actively monitored to assure strategies used are compatible with community-based strategies, and the culture and preferences of the child and parent are recognized. Even one night away from home due to a behavioral healthcare condition can be traumatic and Care Coordinators are expected to keep the team and family engaged with the PRTF to assure that no child has to sacrifice attachment and connection while seeking an intensive level of treatment. It is critical that transition planning begins upon admission and continues throughout the entire treatment and that the family is supported in being actively involved in the development of the plan for return to the community (or a transition plan for the youth if placement/ permanency goals and/or court directives otherwise define transition goals). Additionally, it is essential for care coordinators to maintain in-person contact with youth during their stay at PRTFs, regardless of whether the facility is located in-state or out-of-state.

Initiating a Referral to PRTF

To initiate a referral to PRTF, the OhioRISE care coordinator will provide information to Aetna using the PRTF Request Form. Information requested will include:

- Date of request.
- Demographic information.
- Current diagnoses.
- Need statement or reason for potential admission.
- PRTF treatment **must** be recommended by a qualified prescribing provider or by an independently licensed clinician, each with behavioral health expertise and direct observation of the youth's condition.
- The youth must be in Intensive (Tier 3) Care Coordination and the Child and Family Team's documentation of the youth's presenting treatment needs in the past 30 days must be consistent with the PRTF intensity of services. A youth not currently enrolled in Tier 3 will be expedited for enrollment at the Intensive (Tier 3) level.
- Previous treatment information should be limited to relevant treatment information and MUST include the last 30-60 days of clinical information. Information about current functioning.
- Other information and supporting documentation.
- Aetna's PRTF Release of Information (ROI) so that submitted documentation can be shared with the PRTFs to whom the youth is referred.

If sufficient information is not received to determine if the youth meets PRTF medical necessity criteria, Aetna may reach out to the care coordinator to request additional information to support the request for a PRTF admission. Aetna must issue an approval or denial related to the medical necessity of the PRTF request, with appeal rights, within seven business days of receiving a complete request.

The goal of PRTF treatment is to prepare the youth for the return to the community in the most family-centered or natural setting possible. It is critical that the process of transition planning take place before, during and after PRTF treatment. This should be discussed even before a PRTF referral is submitted to Aetna. Transition planning should continue throughout the entire course of the youth's stay in PRTF. The family is supported in being actively involved in the development of the plan for return to the community (or a transition plan for the youth if placement/ permanency goals and/or court directives otherwise define transition goals).

The Transition/Return to the Community Plan identifies the family's strengths, needs and cultural values previously identified in the individual plan of care, supports needed by the youth and family after transition from the PRTF, and living arrangements of the youth after PRTF treatment is complete. Care coordinators will continue to provide care coordination, development of the Child and Family Centered Care Plan (CFCP), and ongoing convening of the Child and Family Team, in which the PRTF will participate. CMEs are expected to work collaboratively with the PRTF to:

- Prioritize family/guardian/caregiver involvement in transition planning using a spectrum of practices including family therapy, parent skills training and family support groups. The family/guardian/caregiver is an equal and expert partner in the treatment and transition planning processes.
- Educate and communicate with families and other supports about the shared responsibilities involved in transition planning. Through the youth's CFT, other involved supports, including youth-serving systems, are invited to remain actively involved with the youth and family while receiving PRTF treatment.
- Identify and address barriers to transition at the onset of treatment.
- Develop realistic goals for completion prior to transition, in collaboration with the interagency team, and include the transition criteria on the individual plan of care. PRTF is an intervention intended to stabilize the youth and promote successful community reintegration.
- Define interventions that work for the youth and ensure that this information is integrated into the transition plan. Educate families/guardians/ caregivers about what interventions have proven to be most helpful to a youth.
- Ensure that family contact is maintained and that therapeutic leaves/home passes occur early in and throughout the treatment process. They are not to be approved or cancelled based upon behavior but viewed as opportunities to further treatment and transfer skills from the PRTF to the youth's home, school and or community.
- Help families/guardians/caregivers anticipate and respond to behaviors likely to occur during transitions (i.e., honeymooning, anxiety, ambivalence, limit testing).
- Encourage face-to-face CFT meetings and visits when it is clinically appropriate and at the recommendation of the PRTF

Transition planning, in coordination with the youth's CFT, should be discussed as soon as the team decides to submit a PRTF PA. Transition planning will be discussed at every CFT if the PRTF PA is approved. Care coordinators will meet with CFT members and PRTF staff a minimum every 30 days, and more often if it is determined to be needed by either the PRTF staff or members of the CFT. When youth is within 60 days of transition, care coordinators will meet with CFT members and PRTF staff at least three times within each 30-day period up until transition, or more if needed, to transfer skills and strategies, plan and connect with providers, schools, and/or employers for post-transition resources to support successful transition into the home, community, school, and workplace.

While preparing for, during, and after the transition from PRTF services, the CFCP developed by the CFT will delineate roles, services, and supports to be delivered by the PRTF and other providers. To ensure comprehensive care and prevent the youth from feeling abandoned, PRTFs should actively participate in Team Meetings and formally commit to the Team Mission statement. They should agree on which identified needs they will primarily address and outline the strategies they will use to meet those needs. Additionally, a detailed communication plan should be established, including the frequency of updates, for the duration of the youth's stay, along with projected lengths of stay. When planning for the transition from PRTF services, the PRTF is expected to accommodate opportunities for external in-home and community-based providers to meet with the youth and family to facilitate the transition. As driven by the CFT process, it may be appropriate for external

providers to hold individual and/or family therapy sessions with the young person and/or their family while they are still receiving PRTF services.

CFT/Care Coordination and PRTF Transition Minimum Planning Guidelines	
Before 60 Days of Transition	CFT/CC + PRTF meeting minimum 1 x per month
60 Days before Transition	CFT/CC + PRTF meeting minimum = *3x per month
30 Days before Transition	CFT/CC + PRTF meeting minimum = *3x per month

**CFT/CC will have discretion regarding how these meetings are used. For example, if they need to be used for coordinating services locally and then informing PRTF of progress via email/phone/or CFT that may be documented as appropriate transition planning care coordination activities in collaboration with the PRTF.*

PRTF staff will remain available for consultation to the youth, family/guardian/caregiver, and CFT for at least six months-post transition from PRTF services to participate in CFT meetings and be available to the youth and family/guardian/caregiver to reinforce skills and strategies learned during PRTF, as well as collaborate on transition needs as the youth returns home

PRTF is a growing program in Ohio and may not be readily available to all youth who qualify for this service. Aetna continues to work with partners around the state to expand PRTF offerings and works with out-of-state PRTFs for treatment of youth with immediate needs when care within Ohio is not readily available.

Documentation and Recordkeeping

CMEs shall maintain all information required by Aetna for youth and families participating in OhioRISE and receiving care coordination from their organization. The required documentation is designed to thoroughly and accurately reflect the process and content of the CFT assessment and planning details. All critical information discussed within the CFT process should be reflected in fact-based statements and in a timely fashion. Child and Family Centered Plans, CANS and other assessments and progress note types should be available within the youth's EHR or other documentation protocol. Eventually, all assessment and planning processes will be documented in the CME's EHR or Dynamo.

The CME must ensure that all records, documents, data, or other information produced or used by the CME or any subcontractor under this Agreement are treated in accordance with OAC rule 5160-26-06 and must be provided to ODM or its designee at no cost if requested. CMEs must exchange electronic, bidirectional data and other information regarding the youth and family receiving ICC and MCC with the OhioRISE plan and the independent validation entity recognized by ODM.

The CME must retain all records relating to performance under or pertaining to this Agreement in accordance with the appropriate records retention schedule. Pursuant to 42 CFR 438.3(u) and 42 CFR 438.3(h), the appropriate records retention schedule for this Agreement is for a total period of ten years as are the audit and inspection rights for those records. For the initial three years of the retention period, the CME must store records in a manner and place that provides readily available access. If any records are destroyed prior to the date as determined by the appropriate records retention schedule, the CME must pay to ODM, all damages, costs, and expenses incurred by ODM associated with any cause, and Care Coordination documentation must meet the requirements set forth in OAC rule 5160-59-03 including:

- Care coordination activities set forth in paragraphs (C)(1) and (C)(2) of OAC 5160-59-03.2 will be identified on claims submitted in accordance with rule 5160-26-05.1 of the Administrative Code.

CME Care Coordination Record Keeping Requirements

Also see Care Coordination Activities Reporting within section 11: Claims Submission

Progress notes must document the care coordination activities described OAC 5160-59-03.2, including:

- All contacts with and on behalf of recipients
- Face-to-face and telehealth meetings with the youth and the youth's family
- Collateral contacts
  - Name of recipients
  - Name of provider agency and person providing the service
  - Nature, extent, duration, or units of service
  - Place of service delivery
- All consents obtained from the youth / family
- All restraints and seclusions
- Living Arrangements
- MAF Responses
- Disenrollments
- Staff / Client Files

The following items must be included as progress note documentation and shall be completed at a minimum on a per provision basis, or on a daily or weekly basis:

- The type, description, date, time of day, duration, location and, if documenting weekly services, the frequency of treatment, with dates of service.
- A description of the patient's current symptoms and changes in functional impairment.
- Changes in medications taken by or prescribed for the patient when applicable and known.
- The amount of time spent by the provider with the patient.
- Progress notes shall include assessment of the patient's progress or lack of progress and a brief description of the progress made, if any, significant changes in symptoms, functioning, or events in the life of the patient and recommendation for modifications to the treatment plan, if applicable.
- Evidence of clinical supervision, as required.

Additionally, care coordination documentation for each youth receiving ICC/MCC includes:

- The CFCP.
- An individual crisis and safety plan.
- A back-up plan for each youth on the OhioRISE Waiver
- Assessments, including standard assessment and plan elements in CME's electronic health records.
- Prior to and upon transition of a youth from ICC or MCC to a different care coordination tier and/or transition into and out of OhioRISE, documentation of the circumstances of the transition and the transition plan.

Child and Family-Centered Care Plan Documentation

The CFCP is the documentation of the work of the CFT.

Timeframes

- The initial plan must be completed, approved by the CME Care Coordinator supervisor, and submitted to Aetna within 30 days of the youth’s initial consent for ICC or MCC.

- On an ongoing basis CFCPs must be submitted to the OhioRISE Plan within 30 calendar days of the subsequent plan for ICC and within 60 calendar days of the subsequent plan for MCC CFCP must be submitted to the OhioRISE Plan anytime there is a change to the CFCP.
- The CFCP should ideally be submitted to the OhioRISE Plan within one business day of the CFT meeting in which the CFCP is developed, but no later than five (5) days from CFT.
- Families will be provided access to the CFCP after it is approved by the OhioRISE Plan.

Documentation

The CME Care Coordinator should follow the process outlined in this section to submit the CFCP to Aetna. At a minimum, the CFCP document should include information in the following areas:

- Measurable care coordination goals and the criteria to be met to obtain those goals as established by the child and family team.
- The specific supports and/or strategies identified and/or implemented to support the youth, including planning for the purchase of items or services necessary to support the youth/family's needs as determined by the CFT.
- The participation of providers and local community partners, and the integration of available and appropriate services and resources.
- Documentation of the responsibilities, objectives, and requirements of child welfare, mental health, juvenile justice, the courts, and other service systems, as applicable.
- The documentation of services, both formal and non-formal/natural supports identified to meet the youth's need, documenting when needed services are not accessible or available, documenting gaps and barriers, and identification of a backup plan to meet needs when services are not available.
- The signatures of the CME Care Coordinator and/or supervisor, the caregiver(s), and the youth receiving services.
- Verbal consent through virtual or telephonic communication is allowable and must be documented as such.
- Meeting attendance for all CFTs should be tracked in the CFT notes and/or care plan.
- An individual crisis and safety plan, which includes emergency response capability to respond in person to deliver in-home or off-site crisis support as warranted, and coordination of crisis response services, if intervention is needed beyond CME response to crisis situations. For youth with behaviors that pose safety concerns for self or others, a licensed clinician working within or for the CME will consult on the individual crisis and safety plan, recommend de-escalation strategies that can be learned and used by the youth, parents, and other caregivers to support the youth and prevent the use of restrictive interventions.
- A back-up waiver service plan for youth on the OhioRISE waiver.

Release of Information

When seeking collateral information and/or documentation, the CME Care Coordinator will obtain a signed Release of Information from the family, legal guardian, or custodial agent prior to contacting any collaterals. As part of this process, the CME Care Coordinator will review the purpose and the scope of the information being obtained. Certain information, such as substance use treatment, have different requirements for releasing information, as outlined under HIPAA laws and 42 CFR Part 2. The CME Care Coordinator should consult with their supervisors to ensure the parameters for appropriate release of information are met.

Aetna's Care Coordination Portal – Family Care Central

Aetna Better Health provides a Care Coordination Portal, specific to the OhioRISE Program that collects, stores, shares, and pushes out pertinent youth information to the entities involved in coordinating the youth's care, including ODM, MCEs, CCEs (Care Coordination Entities), CMEs, and ODM's SPBM as applicable. The Aetna

OhioRISE Care Coordination Portal also has the capability of sending electronic notifications of sentinel events to entities involved in the youth's care coordination. Each CME will have access to Aetna's OhioRISE Care Coordination Portal. The Aetna Care Coordination portal serves as a single point of reference for the case manager/care coordinator, youth, and the treating practitioners and providers to access and communicate about the youth's care plan and collaborate by sharing information about the results of assessments and ongoing management of the youth's physical health, behavioral health, and psychosocial services.

Section 8: Coordinating OhioRISE Covered Services

OhioRISE Covered Services

The OhioRISE program includes a broad array of services to support the needs of youth with behavioral health challenges. All supports and services offered through the OhioRISE Plan are grounded in System of Care approach and are driven by the values and principles of Wraparound.

Care Management Entity care coordinators should be versed in these services and local community resources, including resources and supports provided through the System of Care. These services include, but are not limited to, those delivered by local boards of developmental disabilities, local school districts, Children and Youth Services offices, and other local providers. The CME is expected to both be knowledgeable about these resources and support OhioRISE system transformation by collaborating with Aetna and ODM to develop working relationships with local service providers and other resources in their assigned catchment areas to both engage them as active participants in the CFT and build the local System of Care by collaborating with community service providers to identify gaps in care and build resources to ensure OhioRISE covered services are available to all youth, regardless of where they live in the state of Ohio. Youth enrolled in OhioRISE are eligible to receive a wide variety of behavioral health services, including but not limited to:

- Diagnostic assessments.
- Psychotherapy and counseling (individual and group).
- Substance use disorder services across ASAM levels of care (including outpatient, IOP, Partial Hospitalization and residential treatment).
- Therapeutic behavior services and psychosocial rehabilitation (TBS).
- Community psychiatric supportive treatment (CPST).
- Psychiatric evaluation and neurodevelopmental testing.
- Pharmacological and medication management.
- Partial hospitalization.
- Mental health day treatment.

In addition to the care coordination provided by the CME, the OhioRISE program includes the following formal services and supports for youth participating in the program:

- CANS assessments.
- Mobile Response and Stabilization Services (also offered outside of OhioRISE).
- Intensive home-based treatment (IHBT) to include Multi-systemic Therapy (MST) and Functional Family Therapy (FFT).
- Assertive Community Treatment (ACT).
- Behavioral health respite services.
- Inpatient behavioral health services.
- Psychiatric Residential Treatment Facilities (PRTF).
- Flex Funds.
- Additional Resources offered through the Aetna OhioRISE Plan.
- Other services and supports available to eligible youth through the OhioRISE Waiver program:
    - Transitional Services and Supports (TSS).
    - Secondary Flex Funds.
    - Out-of-Home Respite.

While the following activities may be needed or beneficial to youth and their families, they are not allowable or reimbursable under either moderate or intensive care coordination codes. These services may be billed, as allowable, to the appropriate managed care organization (MCO) or Medicaid:

- Providing transportation services or directly transporting youth or family, and
- Providing TBS or CPST services.
- Provider psychotherapy or counseling.
- Providing direct services to which the youth has been referred such as medical, behavioral, educational, or social services.
- Providing targeted substance use disorder case management services.

A full list of behavioral health services available to OhioRISE enrolled youth and their families is located in Ohio Administrative Code Chapter 5160-59-03: OhioRISE.

To view behavioral health providers who are contracted and in-network, refer to the Aetna Better Health of Ohio website online Provider Directory to search by specialty, zip code, county, or provider name. The Aetna OhioRISE Provider Directory is accessible at https://www.aetnabetterhealth.com/ohiorise/find-provider.

All services provided through the OhioRISE Plan are voluntary and require parent/guardian consent as required under state regulation. The exception is care coordination for youth and families enrolled in the OhioRISE Waiver. Youth enrolled in the OhioRISE Waiver may not decline care coordination, which must be provided through either a CME (MCC or ICC) or Aetna (LCC). While youth under 18 years of age are not required to provide written consent, they are encouraged to provide written assent and actively engage in the CFT and decision-making since their active participation is OhioRISE services and treatment interventions is necessary for a successful intervention.

Communicating Services and Supports

While the CME should be aware of services and supports (formal and informal) that are available to youth enrolled in OhioRISE, this information will need to be made available to each Child and Family Team. The CME care coordinator and supervisor need to be well versed in all OhioRISE services to fully facility the CFT and identify possible OhioRISE services or other available services and supports that may best meet the youth's needs.

For youth and families participating in the OhioRISE Waiver, CMEs are required to provide and review the OhioRISE Waiver Member Handbook, which provides an overview of OhioRISE Waiver eligibility criteria, services and supports available. Aetna Better Health of Ohio is responsible for publishing and making the OhioRISE Waiver Member Handbook available to CMEs. The CME will need to verbally review the content of the OhioRISE Waiver Member Handbook with the youth and family. The CME also will request and ensure that the individual or authorized representative sign the Freedom of Choice form that documents receipt of this handbook and upload this form in the CANS IT System (see Section 5: *OhioRISE Waiver Eligibility and Enrollment*).

Initial and Ongoing Authorizations for OhioRISE Services

OhioRISE care coordinators will work with youth and their Child and Family Teams (CFTs) to understand the individual needs of each youth and to develop a Care Plan that supports the youth and caregiver's goals and preferences, builds upon their natural supports and existing strengths and assets and best meets their behavioral health needs.

Most behavioral health benefits covered under the OhioRISE Plan do not require prior authorization or prior approval of services before they can be provided to children and youth enrolled in the program. For a limited set of OhioRISE services, prior approval or prior authorization of care from the OhioRISE Plan is required. The

OhioRISE Plan's utilization management policies outline medical necessity requirements for each of the services that require prior approval or prior authorization. Services that require prior authorization are outlined in the OhioRISE Member Handbook, which should be made available and verbally reviewed with all youth and caregivers. Care coordinators and supervisors will be familiar with OhioRISE services, the OhioRISE Member Handbook and those OhioRISE services and supports that require prior approval or prior authorization.

- **A service that requires prior approva**l will be authorized through a Child and Family-Centered Care Plan (CFCP) process. Care coordinators submit all CFCPs to the OhioRISE Plan for review, acceptance and approval if a prior authorization is required.
    - Services requiring prior approval must be fully documented, including identifying the behavioral health need that will be supported by the service, and the CFCP must be approved by the OhioRISE plan **prior** to the youth receiving the service and the provider billing for the service.
    - Care Coordinators are required to know the services and supports provided through the OhioRISE Plan and be fully knowledgeable of services requiring prior approval. The care coordinator will educate the youth and caregivers about OhioRISE services available, work with the CFT to identify OhioRISE services and supports that may help address the youth's behavioral health needs, and, when appropriate, outreach and engage providers of these services to support the youth need and join the CFT as a treatment or service provider.
    - After developing the CFCP with the CFT, the care coordinator submits the CFCP to the OhioRISE Plan.
    - For services that require prior approval before they can be provided/reimbursed, the OhioRISE Plan must approve the CFCP – this serves as approval to provide and bill for the services that must be approved using the CFCP process.
    - Upon submission, the OhioRISE Plan may approve the CFCP, or they may request more information and/or follow-up discussion(s) with the care coordinator.
    - Once a CFCP including these services is reviewed and approval is issued by the OhioRISE Plan, the services may be used by the youth and billed by the provider.
- **A service that requires prior authorization uses the provider-initiated prior authorization request process.**
    - Providers of these services must request and receive authorization from the OhioRISE Plan prior to billing for the service.
    - Process follows the traditional provider-initiated prior authorization request pathway.
    - Care coordinators will be knowledgeable of services requiring prior authorization. The care coordinator will educate the youth and caregivers about OhioRISE services available work with the CFT to identify OhioRISE services and supports may assist to address the youth's behavioral health needs, and, when appropriate, outreach and engage providers of these services to support the youth's need and join the CFT as a treatment or service provider. For services subject to the prior approval or prior authorization, if the OhioRISE Plan denies, reduces, terminates, or suspends an approval or authorization for the service, this constitutes an adverse benefit determination that can be appealed in accordance with rule 5160-26-08.4 of the Ohio Administrative Code.

More information about the specific services that require prior approval and prior authorization can be found in the OhioRISE Provider Enrollment and Billing Guidance document.

All behavioral health treatment and support services will always be listed on the CFCP, even if those services do not require prior approval or authorization. Aetna Better Health of Ohio is responsible for monitoring the utilization of OhioRISE services and supports, including over and underutilization.

Accessing OhioRISE Primary and Secondary Flex Funds

CMEs will be knowledgeable of processes and other parameters specific to these flex funds. Flex Funds may be utilized for services, equipment, or supplies including improving and maintaining the youth's opportunities for full membership in the community. Flex Funds include and must meet the following requirements:

- Not available through Medicaid.
- The purchased item/service decreases the need for other Medicaid services, and/or
- Promotes the youth's inclusion in the community, and/or
- Increases the youth's safety in the home environment.

To access Flex Funds, the youth and family must not have the ability to purchase the service or item through other available funds or via another source.

The CME should ensure the CFT understands the purpose, process, and parameters for using Flex Funds. If the CFT recommends the use of Flex Funds, the CME should ensure these are documented in the child and family-centered care plan.

During the Child and Family-Centered Care Plan development process, the CME care coordinator will discuss the ability to exercise "budget authority" for the Flex Funds. Flex Funds are accessed through a process where the youth and family develop a budget for these items. The budget and process for managing the budget will include:

- The maximum budget limitations. These budget limitations are as follows:
    - Primary Flex Funds are available to all youth enrolled on the OhioRISE Program — **$1,500 per 365-day period for services (Flex Funds balances reset based on a 12-month period from enrollment date)**, equipment, or supplies. Primary Flex Funds are not an OhioRISE Waiver service and must be used before Secondary Flex Funds are available.
    - Secondary Flex Funds are available only to youth enrolled on the OhioRISE Waiver Program — **$3,000 per 365-day period, and an additional $2,000 per 365-day** period for emergency funding limitations.
- A description of how those funds may be spent to help support the individual meet their stated goals and outcomes identified in the Child and Family-Centered Care Plan, and
- A description of how a youth and family can self-direct these services.

Aetna will review requests for budget authority for Primary and Secondary Flex Funds while reviewing the entire CFCP.

Accessing Psychiatric Residential Treatment Facilities

A core value of the Wraparound approach is that youth have more sustainable success when they remain in their homes and their communities, with supports and service that meet their needs in their natural environments, where family and community connections can be maintained and strengthened. The goal of the CME is to provide necessary supports and services in the community whenever possible. Some youth experience needs during their treatment that may prompt the CFT to consider a higher intensity level of service than can be provided in the youth's community, such as PRTFs. Removing a youth from his/her home for treatment has a significant impact on a youth and his/her family and must be done thoughtfully to maximize the treatment

benefit potential, reduce the youth's length of stay, maintain family relationships, and increase the sustainability of the youth's progress.

Interventions offered by PRTFs are aimed at stabilizing a youth's identified behaviors and needs and addressing the underlying etiology of these behaviors and needs so that he/she may safely return home with as little disruption to his/her life as possible. The goal of PRTFs is to facilitate the youth's reintegration into his/her family and community or into an alternative permanency plan preparing for independent living.

PRTF is one of OhioRISE Program's highest levels of intervention and thus should only be accessed when all other therapeutic interventions have been considered and treatment in a PRTF is determined by the CFT, based on the youth's assessed clinical treatment needs, to be the most appropriate level of intensity of service.

The CME strives to reduce PRTF lengths of stay and successfully provide this treatment in one episode per youth. PRTFs are distinct from other placement settings (e.g., QRTPs) which are designated for youth who are unable to remain in their own homes due to issues of abuse, neglect, and/or permanency. These placements offer different levels of supervision and structure and focus on supporting youth in achieving permanency.

More information related to PRTF services is outlined in the OhioRISE PRTF Program Manual.

Non-Emergency Medical Transportation (NEMT)

The OhioRISE Plan must collaborate with ODM, the MCOs, and the counties within the regions served to improve youth experience and access to transportation services.

Medicaid Managed Care Organization Transportation Benefit for youth enrolled with an MCO:

The MCO must arrange and provide transportation for youth who are enrolled with the OhioRISE Plan in a manner that ensures that children, youth, and their families served by the OhioRISE Plan do not face transportation barriers. Below is a list of resources:

- MCO covers transportation benefits when over 30 miles or more from their home.
- Transportation benefits are applicable to behavioral health appointments.
- Cover transportation required in the youth's Child and Family-Centered Care Plan.
- Meals and lodging are also included in transportation benefit when traveling 30 miles or more.
- Arranging transportation in cases where transportation of families, caregivers, and siblings (other minor residents of the home) when needed to facilitate the treatment needs of the youth and their family.
- Additional transportation benefits for youth under the age of 21 are also available through the MCO.
- Also ensures specialized transportation for youth who have cognitive or behavioral challenges that require different transportation providers or supports than available from counties or traditional Medicaid provider network.
- Check the youth's MCO's website for additional transportation benefits, such as free rides to food pantries.
- The general contact listing for each MCO can be found here: https://oahp.org/wp-content/uploads/2023/04/2023-All-MCP-Member-NEMT-Resource-Guide.pdf..
- Accessing Transportation Benefit for members enrolled with fee-for-service Medicaid, and for all Medicaid enrollees when traveling less than 30 miles.
- The County Department of Job and Family Services (CDJFS) will provide transportation through the Non-Emergency Transportation (NET) program. Call your CDJFS for more information and to schedule a ride. See: https://jfs.ohio.gov/County/County_Directory.stm
- Additional information is also available on the ODM web page: https://medicaid.ohio.gov/families-and-individuals/srvcs/transportation.

- For transportation by wheelchair van, providers will be contacted directly. A searchable directory of Medicaid providers is available at https://medicaid.ohio.gov.

Aetna staff can also assist with accessing MCO transportation benefits. CMEs should reach out to their assigned Relationship Manager for assistance.

Aetna Additional Resources

In addition to services and supports available under the OhioRISE Plan and OhioRISE Waiver Program, CMEs will have the ability to access additional benefits for OhioRISE members offered through Aetna. Additional benefits are resources designed to support health and wellness goals of the youth. They are provided at no cost to youth and families and can alleviate the need to utilize Flex Funds. Additional Resources provided through the OhioRISE Plan are periodically changed and updated based on the needs of youth and can be located in the OhioRISE Member Services Handbook. For a full description of these extra benefits, CME care coordinators, youth and/guardians can visit https://www.aetnabetterhealth.com/ohiorise/behavioral-mental-health.html or call Member Services at **1-833-711-0773**. To learn more about or request Additional Resources, CME care coordinators may also email OhioRISECCVAB@aetna.com.

Section 9: Training and Coaching

The CME must maintain an ongoing personnel management program that includes, but is not limited to, the hiring, onboarding, training, credentialing (including compliance with the ODM centralized credentialing / recredentialing process), supervision, monitoring and oversight of its employees and contractors providing services to OhioRISE members.

Care Coordinators, supervisors, and other CME personnel will be required to participate in ongoing training and coaching, in fidelity monitoring, and quality improvement activities. In addition to being required to ensure OhioRISE care coordinators and supervisors attend all required initial training and coaching, CMEs will develop and implement training oversight mechanisms to monitor staff attendance in and completion of required trainings and coaching.

CME care coordinator and supervisor training information may be reviewed as part of fidelity reviews and other quality initiatives.

Role Difference Related to Care Coordination Training

- CABHCOE will lead training and coaching on evidence-based and best practices.
- Aetna will lead training around operational aspects of care coordination, such as how to document services and submission processes.

CMEs ensure their staff attend and implement learnings from CABHCOE and Aetna trainings, as well as other training which may be required by the CME. The OhioRISE Plan is responsible for developing a Training Plan and monitoring oversight of its implementation.

CABCOE OhioRISE On-Boarding Care Coordination Training

All newly hired OhioRISE CME care coordinators and supervisors must complete a requisite series of training courses provided by the CABCOE to be able to provide moderate and/or intensive care coordination. To access and register for CABHCOE trainings, go to **https://wraparound ohio.org/ohiorise-trainings-care-coordination/.**

Each CME is expected to ensure all care coordinators and supervisors successfully complete all requisite training in the required timeframes. Evidence of skill competency and completed training will be documented and maintained by the CME. Evidence of training may be requested by ODM, Aetna or CABHCOE.

The CMEs will have access to attend COE, Aetna and ODM-led trainings. CME Leadership may provide input into gaps and needs to Aetna to develop further training content as needed.

CMEs will make sure their ICC/MCC care coordinators meet qualified behavioral health specialist (QBHS) requirements either by using existing QBHS trainings or by amending existing trainings to supplement what is offered by the COE as part of the ICC/MCC training. The following table provides a crosswalk of the required QBHS competencies and ICC/MCC competencies covered in the CABH COE training.

QBHS Required Competency described in
(D) Qualified behavioral health specialist. (1) Qualified behavioral health specialist (QBHS) means an individual who has received training for or education in either mental health or substance use disorder competencies; and who has demonstrated, prior to or within ninety days of hire the minimum competencies in basic mental health or substance use

disorder and recovery skills listed in this rule. The individual shall not otherwise be required to perform duties covered under the scope of practice according to Ohio professional licensure. (2) Basic competencies for each QBHS shall include, at a minimum, an understanding of:	
(a) Either mental illness or substance use disorder treatment and recovery;	No
(b) The community behavioral health system, social service systems, the criminal justice system, and other healthcare systems;	Yes
(c) Psychiatric and substance use disorder symptoms and their impact on functioning and behavior,	No
(d) How to therapeutically engage either with a person with mental illness or a person in substance use disorder treatment and recovery;	Yes
(e) Crisis response procedures; and	Generally covered in ICC/MCC training, covered in more detail in a special topics training offered by the COE
(f) De-escalation techniques and an understanding of how the individuals own behavior can impact the behavior of others.	No

Section 10: Data and Quality

Electronic Health Record and Data Exchange Requirements

Each CME will be responsible for maintaining an electronic health record which supports the requirements for documentation, storage and transmission of member data to and from Aetna, with specific emphasis on integration with the i2i data exchange platform. The CME will ensure their electronic health record system maintains compatibility with i2i data exchange specifications as provided by Aetna, including any updates or modifications to these specifications.

Data Reporting and Exchange Requirements

The CME is responsible for reporting data to and sharing data with Aetna through the i2i data exchange in alignment with the OhioRISE Plan provider agreement with ODM, including adherence to required data sets and submission of data within required timeframes. Data reporting requirements include, but are not limited to:

- As-needed data elements as specified by Aetna;
- Daily data submissions as specified by Aetna;
- Quarterly data submissions via secure file transfer protocol (SFTP) or specified by Aetna.

Aetna reserves the right to modify data requirements as necessary to meet regulatory obligations, improve care coordination, or enhance program effectiveness, with reasonable notice to CMEs.

All data submissions must meet quality standards established by Aetna, including completeness, accuracy, and consistency requirements.

System Changes and Notifications

CMEs must provide written notification to Aetna a minimum of ninety (90) days, with a target of six (6) months, prior to implementing any changes to their electronic health record system that may affect the i2i data exchange. Notification shall include:

- Description of the planned changes;
- Expected impact on data exchange processes;
- Implementation timeline;
- Testing and validation plan;
- Contingency plan in case of unexpected issues.

The CME is responsible for all costs associated with maintaining i2i connectivity during and after system changes, including any development work, testing, or validation required by i2i to maintain connections. Aetna reserves the right to require testing and validation of any system changes prior to implementation to ensure continued data exchange functionality.

Emergency Downtime Procedures

CMEs are required to maintain emergency downtime policies and business continuity procedures to ensure access to data and reporting at times when their electronic health record or i2i connection may be inoperable. The CME must submit Emergency Downtime Policies to Aetna for approval. These policies must ensure continued compliance with all reporting requirements to the Ohio Department of Medicaid, including adherence to all required timeframes, even during system outages. The CME must notify Aetna immediately upon discovery

of any unplanned system outage affecting i2i data exchange and provide regular status updates until resolution.

Quality Improvement and Population Health Initiatives

The OhioRISE Quality Improvement Program is designed to monitor and continuously improve the medical care, member safety, behavioral health services, and the delivery of services to members, including ongoing assessment of program standards to determine the quality, accessibility and appropriateness of care, and care coordination.

A key focus of the OhioRISE Quality Improvement Program is improving the member's biological, psychological, psychosocial and social well-being with an emphasis on quality of care and the non-clinical aspects of all services. This includes monitoring social determinants of health (SDOH) identified to impact the health and well-being of youth enrolled in OhioRISE. Additionally, Aetna continually monitors member access to care and health outcomes to identify and address potential gaps in care (both regionally and statewide).

OhioRISE is committed to supporting the care of all youth served. The OhioRISE Plan recognizes both that some youth served have serious and complex behavioral health needs (often with one or more co-occurring conditions) and that care is individualized. While some may achieve full recovery, others, due to the complexity or severity of their conditions and needs may require lifelong supports and interventions. For these youth, the OhioRISE Plan strives to implement and support a care plan that enables them to live safely in the least restrictive setting.

The OhioRISE Plan utilizes a Quality Framework that incorporates continuous quality improvement (CQI) concepts. Using this approach, the OhioRISE Plan Quality Improvement Program is comprehensive and integrated throughout the OhioRISE Plan (at all levels and crossing all functions of both Aetna, the CMEs and their subdelegates) and the provider network. A variety of OhioRISE performance metrics are utilized to monitor the effectiveness and efficiency of OhioRISE services to ensure youth both have (1) timely and appropriate access to care coordination and other needs services and supports; and (2) that services and supports provided through the OhioRISE plan are improving health outcomes of youth enrolled in OhioRISE. ODM, Aetna, CMEs and CABHCOE share responsibilities for implementing CQI activities to monitor CME, subdelegate, process and service functions, as well as to collect, analyze and evaluation the effectiveness of the overall OhioRISE program to meet its stated goals, which include:

- Reducing unnecessary hospitalizations and emergency room visits.
- Decreasing involvement with the juvenile justice and corrections systems.
- Reducing out-of-home and out-of-state placements (residential care and foster care).
- Increasing school attendance and performance.
- Reducing custody relinquishment for children, youth, and families.

Data collection, monitoring, analysis, and shared learning is essential to the success of OhioRISE. CMEs both develop CME-level Quality Improvement Frameworks to day-to-day monitor CME and subdelegate care coordination practice operations and regularly and actively collaborate with ODM, Aetna and the CABHCOE to support quality improvement initiatives, capacity building and shared learning to identify opportunities for performance improvement and develop, implement, and monitor quality improvement strategies designed to address noted issues or concerns and continually improve the effectiveness and efficiency of OhioRISE care coordination and other covered services. The OhioRISE Program shall be an environment for CMEs and other entities to learn from each other to improve their care coordination processes and health outcomes.

As part of the Quality Improvement Program, CMEs will actively partner with Aetna, the CABHCOE, ODM or ODM's designee to establish a OhioRISE Quality Framework to measure performance, identify best practices and develop, implement, and measure quality improvement activities.

The scope of the OhioRISE Quality Framework shall include, at a minimum:

- Analyzing membership characteristics to ensure the OhioRISE Program is enrolling and retaining children or youth and families/caregivers from all communities across Ohio.
- Monitoring engagement activities and time frames with children or youth and families/caregivers.
- Measuring child or youth and their family/caregiver's satisfaction.
- Monitoring adherence to the OhioRISE Program care coordination requirements.
- Ongoing measurement of fidelity to the National Wraparound Initiative Standards of Care.
- Ongoing measurement of outcomes for children, youth, and families.
- Monitoring quality of CANS assessments.
- Reporting and analysis of living arrangements, sentinel events and critical incidents.
- Participating in quality improvement projects.
- Measurement of service provider performance on ODM's Healthy Children Quality measures.

As part of the OhioRISE Quality Framework, each CME will be responsible for creating, monitoring and reporting out on an annual quality improvement strategy and workplan that monitors CME and subdelegate (when applicable) performance and is reflective of their catchment area(s)' needs.

OhioRISE CME Reporting

Aetna is responsible for overseeing the ongoing operations of the OhioRISE Program. A major focus for these oversight efforts are the ongoing review of care coordination efforts performed by the CMEs and subdelegates (when applicable). Aetna, in partnership with the CMEs, collects and reviews important information to determine if CME care coordination is provided consistently with the vision and standards governing OhioRISE and both the provision of high-fidelity wraparound and moderate and intensive care coordination. As part of ongoing OhioRISE day-to-day operations, CMEs are required to collect, monitor and report important information to Aetna regarding care coordination efforts. Much of the data collected is used to develop a monthly CME Monthly Oversight Report.

While care coordination capacity and ICC and MCC caseload compliance is monitored through self-report data provided by CMEs in Monthly Oversight Reports, Dynamo and data exchange are used to collect and generate data for the remaining sections of the CME Monthly Oversight Report.

Aetna Better Health of Ohio submits the CME Monthly Oversight Reports to ODM by the 15th of each month. The CME Relationship Managers are responsible for collecting self-report data from the CMEs, which is due by the 7th of each month. The Relationship Manager will review the data with CMEs at regular check-ins. This will provide the CME with critical information regarding the previous month's performance on key structural measures and assess improvement trends over time.

Additionally, CMEs are provided with various performance metrics on a monthly basis. The CME Relationship Manager reviews results with CME leadership at regular monthly meetings. The CME Relationship Manager collaborates with the CME leaders to identify opportunities for improvement, develop action plans to address any noted concerns, connect the CME with any needed Aetna resources and supports needed to implement the action plan, and monitor the effect of the action plan using a quality improvement approach.

Aetna OhioRISE also collaborates with the CMEs to monitor statewide capacity to serve new OhioRISE members, including youth assigned on the Member Alignment File (MAF), IP referrals, and community referrals. Any CME who cannot immediately accept and assign a new member to active care coordination (upon consent) must

report to their assigned Relationship Manager on a weekly basis. If a CME has assigned members waiting to begin care coordination, the CME must submit a written report weekly which includes the names and MMID of all members awaiting service, the actions being taken to support these youth while they are on awaiting service, and a plan to eliminate any wait time for service. When capacity issues or concerns are noted, the CME leadership and Relationship Manager collaborate to develop an action plan to increase CME capacity, to ensure all eligible OhioRISE members, in all catchment areas across Ohio, have timely and appropriate access to needed OhioRISE programs and services, including moderate and intensive care coordination.

CMEs are responsible for monitoring and reporting on all youth assigned to the CME who are placed out-of-home. This monthly "Out of Home Placement Report" is due on the 15th of each month and includes information about the youth and where they are currently placed.

CMEs may be required to submit additional data or reports in order to monitor program effectiveness and performance.

Population Health Measures

CMEs will implement quality improvement activities related to the CME's performance consistent with ODM's population health management strategy. In alignment with the Population Health approach outlined by ODM, Aetna's population health strategy is rooted in understanding and addressing the factors that influence the health of a population at the socio-cultural, economic, and individual level. Through data analysis and sharing, community engagement, and strategy alignment, Aetna Better Health of Ohio will work in collaboration with all the OhioRISE key partners, including the CMEs to evaluate the population health needs of those enrolled in OhioRISE. The goals of Population Health will be achieved through the use of data analysis, stakeholder feedback, and best practice implementation.

Each CME will be supported by Aetna's Population Health Team. The Aetna Population Health Team will share data and information with the CMEs through the established bi-directional data sharing methods, committees, and ad-hoc meetings/interactions regarding health and diagnostic trends, service utilization, social determinates of health, and health disparities. Aetna and the CME will engage in collaborative efforts to develop and implement initiatives to improve health outcomes, reduce disparities and improve service delivery for OhioRISE enrolled members, the system of care, and the catchment area(s) they serve.

Many of the youth enrolled in the OhioRISE Program will also be enrolled in one of ODM's Managed Care Organizations. MCOs have a responsibility to track and improve the Population Health of all children enrolled in Medicaid, including youth in the OhioRISE Program. MCOs are responsible for tracking and reporting critical measures to ODM. This includes, but is not limited to:

- Metabolic Monitoring for Youth and Adolescents on Antipsychotics.
- Antidepressant Medication Management.
- Follow-Up Care for Youth Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication - Initiation Phase & Continuation and Maintenance Phase.
- Follow-up 7 days after hospitalization for mental illness.
- Child and Adolescent Well-Care Visits.
- Behavioral Health Inpatient Length of Stay.
- PRTF Length of Stay.
- Emergency Department Utilization.

In addition, MCOs, with support from ODM, track other important population health measures for youth including:

- Medicaid School Program (MSP) Data.

- Kindergarten readiness.
- Achieving 3rd grade reading levels.
- Graduation rates.
- Curbing chronic absenteeism from schools.

CMEs primarily focus on coordinating the necessary services and supports for youth and families who are receiving moderate or intensive care coordination. As such, CMEs play a critical role in the lives of these children and families through their ability to engage members and their Child and Family Team and monitor member needs through frequent contact, including in-person visits, with members, caregivers and other key persons in the youth's treatment. CMEs provide a value-added function for youth and families by coordinating a multi-system treatment team to work collaborative to address the youth and family's stated behavioral health treatment goals and preferences, making referrals, connecting youth with needed services, resources and supports, and tracking and reminding youth and/or caregivers about important behavioral health appointments. Additionally, CME care coordination efforts have been designed to facilitate the necessary services and supports to provide a positive impact on a youth's readiness and participation in school. Therefore, it is important for each CME to have critical information on key measures tracked by the MCO for youth participating in care coordination offered by the CME.

The OhioRISE Plan meets with the CMEs within 10 business days of receiving this information on an annual basis from the MCOs, to review progress and strategize around improvement measures, if necessary. Additionally, the MCEs and CMEs explore alignment efforts at the system and individual engagement level. This information is used by the CME to support the development of the child and family centered care plans.

In addition, CME care coordination efforts have been designed to facilitate the necessary services and supports to provide a positive impact on a youth's ability to have meaningful academic engagement and performance. Through access to the key non-healthcare related population health measures tracked by the MCEs and shared with the CMEs, the data are leveraged to provide child centered interventions and support. A full list of these measures is available in the OhioRISE Plan Provider Agreement in Appendix N.

Aetna works with the CMEs and other OhioRISE key stakeholders to identify, understand, and develop targeted initiatives to meet the needs of the sub-populations.

While CMEs are primarily focused on coordinating the necessary services and supports for youth and families who are receiving moderate or intensive care coordination, CMEs play a critical role in helping inform and drive meaningful population health and equity improvement strategies at the individual level.

Fidelity Monitoring

As indicated in Section 6, the National Wraparound Initiative provides a foundational role in the model and standards created for CMEs. Therefore, all CMEs are expected to adhere to the National Wraparound Initiative model and standards. The CABHCOE and Aetna Better Health of Ohio work with CMEs to measure adherence to the wraparound-informed model for youth with moderate behavioral health needs (moderate care coordination) and a high-fidelity wraparound approach for youth that have the greatest behavioral needs (intensive care coordination). The focus of these efforts are to ensure the CMEs provide care coordination consistent with National Wraparound standards. The CABHCOE utilizes the Wraparound Fidelity Index (WFI-EZ) that will review the CMEs fidelity to these national standards. The tool will be focused on several key CME functions:

- Coordination of child and family team.
- Care planning approach.
- Presence and quality of crisis plans.

- Understanding, use, and development of informal / natural supports and community-based supports.
- How family voice and choice were incorporated into the CME care coordination process.

CMEs are expected to fully cooperate with and actively participate in the fidelity review process. These reviews will occur at least annually, but may occur more frequently, as needed, based on the outcomes of the fidelity review, if requested by the CME, or recommended by Aetna, ODM or CABHCOE.

Upon completion of these reviews, the CABHCOE will provide each CME with a summary of the findings from the fidelity review. The CABHCOE and assigned Relationship Manager will meet with the CME leadership within 10 business days of the date the report is provided to the CME to discuss the findings from review and discuss any strategies (if needed) to improve performance. As requested by the CME, ODM and/or recommended by Aetna, a referral will be made to the CABHCOE for additional technical assistance to improve performance.

The CABHCOE may also conduct additional practice quality reviews using additional tools, and CMEs are expected to fully cooperate with and actively participate in these reviews.

Reporting of Sentinel Events

A major quality indicator for the OhioRISE program is the frequency and intensity of sentinel events. Aetna has defined sentinel events to include:

- Behavioral health inpatient hospitalizations/rehospitalizations.
- Emergency department visits for behavioral purposes.
- Identified gaps in care (service).
- Admissions to out-of-home placement, including psychiatric residential treatment facilities (PRTFs), residential treatment centers, American Society of Addiction Medicine (ASAM) Level III residential programs, therapeutic group homes, therapeutic foster care and Qualified Residential Treatment Programs (QRTPs).
- Discharges from all out-of-home placement.
- Youth initiating MRSS.

CMEs are required to report sentinel events the OhioRISE plan/ Aetna Better Health of Ohio care through the OhioRISE Care Coordination Portal or other method requested by Aetna.

CMEs should also ensure that the CFT is provided information regarding these sentinel events as needed to determine if and when a CFT meeting should occur to address the sentinel event. In many instances, these sentinel events will be a major change in condition and should precipitate a new plan of care developed and approved by the CFT.

Reporting of Critical Incidents

The state has an established system for reporting, reviewing, analyzing, and conducting remediation for all critical incidents. Most youth served by the OhioRISE Program are served not just by the Ohio Department of Medicaid (ODM). They receive and benefit from services provided by other state agencies and local county partners. Ohio has robust reporting and investigation mechanisms for critical incidents, especially those concerning abuse and neglect through Public Children Services Agencies (PCSAs). The objective of reporting and managing critical incidents is to work in conjunction with various delivery systems to ensure the health and welfare of the child. In addition, tracking critical incidents can:

- Support other investigative entities in open and ongoing critical incident cases.
- Ensure immediate health and welfare of the OhioRISE youth.
- Be used to analyze the root cause of a critical incident for each specific case for the purposes of informing preventative practices.

- To analyze, track and trend patterns for the purposes of developing meaningful oversight and best practices for serving youth with multi-system needs.

CMEs are required to submit critical and reportable incidents to the Aetna OhioRISE Quality team via the established Microsoft Form. The following are identified as critical incidents (apart from natural death), in accordance with OAC Rule 5160-44-05:

- Abuse – the injury, confinement, control, intimidation or punishment of a youth that results in physical harm, pain, fear or mental anguish. Abuse includes but is not limited to physical, emotional, verbal or sexual abuse or the use of restraint, seclusion or the use of restrictive interventions implemented without authorization by the OhioRISE Plan on the Crisis Safety Plan. Abuse also includes peer-to-peer assaults that require the member to seek outside medical treatment.
- Neglect – where there is a duty to do so, failing to provide a youth with any treatment, care, goods or services needed to maintain the health or welfare of the individual.
- Exploitation – unlawful or improper act of using an individual or individual's resources through the manipulation, intimidation, threats, deception, coercion for monetary or personal benefit, profit or gain.
- Misappropriation (over $500) – act of depriving, defraud or otherwise obtain money, real or personal property (including prescription medications) of an individual by any means prohibited by law that could potentially impact the health and welfare of the individual.
- Unnatural or accidental death – death that could not have been reasonably expected, or the cause of death is not related to any known medical condition, including inadequate oversight of prescribed medications or misuse of prescription medications. *Natural deaths must also be reported but have a three-day timeline in which to be entered into the Incident Management System versus one day for all other incidents.*
- Self-harm or suicide attempt – self-harm or suicide attempts resulting in physical injury or a physical attempt without injury that results in an emergency room visit, inpatient observation or hospital admission. (Note - All other forms of self-harm, suicide attempts and suicidal ideation are *not* reportable.)
- Health and welfare of the individual is at risk due to an individual being lost or missing – in instances where there is imminent or serious risk of harm to the youth due to them being lost or missing (applies only to those enrolled in PRTFs.)

CMEs must report incidents in accordance with rule 5160-44-05 of the OAC. All CME staff must report critical incidents using the protocol developed by Aetna. Aetna will review the submission, determine if the submission is complete and meets incident reporting criteria, and submit the incident into the Incident Management System.

The responsibilities of CME Care Coordinators to report Critical Incidents are as follows:

- **Immediately notify supervisor (or designee)**
- **Within one business day of notification of the incident**, the Care Coordinator must complete the following:
    - Identify the incident.
    - Assure the immediate health and safety of the Individual.
    - Report the incident as described above, including the following details:
        - Name, DOB and Medicaid ID
        - Name and role of person(s) suspected of participating in event
        - Name of guardian
        - Incident type and description of incident
        - Types and dates of notifications (including JFS/CPS, DODD, DBH, Law Enforcement, etc.)

- Current status of youth, including health, safety and welfare actions
- Follow-up or changes made due to incident
- Additional information that may assist in the investigation
- If prevention planning information is already known, it may be entered in the form.

If follow-up is requested, the submitter will have five business days to respond to a general information request.* ***A health, safety, and welfare request will be due within two hours*. If more time is needed to ensure HSW, please relay that additional time is needed.*

Within 14 business days or per the request of ODM, whichever comes first, the case submitter will be contacted by OhioRISE QM staff to request prevention plan information. Prevention plans describe strategies and activities that will be taken to mitigate risk to the member and prevent the incident from happening again.

Five quality criteria for Prevention Plans are:

- Care Coordination Activities – The Prevention Plan strategies and activities specify what the care coordinator will do to assist the member. This may include referrals for community resources, added services, counseling or education.
- Potentially Effective – This is a good chance that, if implemented, the Prevention Plan strategies will help prevent another similar incident from happening.
- Person-Centered – The prevention Plan strategies are trauma informed, reflect the member's unique strengths, interests, cultural considerations, abilities, preferences, resources, and desired outcomes as they related to the individual's support needs.
- Realistic – The Prevention Plan strategies and activities are doable, feasible, and can be accomplished.
- Addresses Root Causes – The Prevention Plan strategies address the contributing factors and root causes which help explain why the incident happened.

If a prevention plan has been completed prior to outreach being received from OhioRISE QM staff or additional information needs to be relayed, it may be emailed to:

- OhioRISEIMS@Aetna.com (general critical incident related prevention plans that are not potential quality of care concerns and not for a PRTF member)
- PRTFIMS@Aetna.com (if member is in a PRTF)
- RISEPQOC@Aetna.com (for information that constitutes a PQoC)

The Prevention Plan must be documented by QM in the Incident Management System within seven (7) business days from the conclusion of the ODM IMS investigation, or it will be considered noncompliant.

Similar to sentinel events, CMEs must ensure members of the youth's CFT is provided information regarding the critical incidents, as necessary and appropriate, to determine when the CFT should meet, and how CFT members can collaborate to best support the needs of the youth. In many instances, these incidents may precipitate a major change in the youth's behavioral health condition/symptoms, level of functioning, treatment or care coordination needs. In these instances, due to a change in circumstance, the CME care coordinator should complete a change in circumstance CANS assessment, update the Crisis Safety Plan and work with the CFT to complete a Care Plan Update with revised goals, OhioRISE services and interventions, as needed and appropriate.

Section 11: Claims Submission

General claims submission guidance

- CMEs may only submit claims for three types of services under their ORE provider type specialty:
  - Care coordination (ICC and MCC).
  - Initial supplemental assessments.
  - CANS assessments.
- CMEs are expected to bill using typical Medicaid provider claims submission processes. Details of the billing process are available in the provider manual at: https://www.aetnabetterhealth.com/ohiorise/index.html.
- All claims must be submitted within 365 days of rendering the service to be considered timely.
  - CMEs are required to submit claims directly to ODM through an EDI trading partner.
- Aetna will have staff available to assist CMEs with initial set-up of Claims and Billing.
  - For ongoing support, we encourage you to contact your CME Relationship Manager.
- For additional information on claims and billing please refer to the Aetna Provider Manual available at AetnaBetterHealth.com/OhioRISE or by calling 1-833-711-0773 (TTY: 711).

Billing and Coding Information

Practitioner Abbreviations

Practitioner abbreviations are used in the service charts provided in the remaining sections of this document. The chart below may be used as a reference to these abbreviations:

MD/DO	Physician	LSW	Licensed social worker
CNS	Clinical nurse specialist	LMFT	Licensed marriage and family therapist
CNP	Certified nurse practitioner	LPC	Licensed professional counselor
PA	Physician assistant	LCDC II or LCDC III	Licensed chemical dependency counselor II or III
PSY	Psychologist	SW-A	Social worker assistant
LISW	Licensed independent social worker	SW-T	Social worker trainee
LIMFT	Licensed independent marriage and family therapist	MFT-T	Marriage and family therapist trainee
LPCC	Licensed professional clinical counselor	C-T	Counselor trainee
LICDC	Licensed independent chemical dependency counselor	CDC-A	Chemical dependency counselor assistant
Licensed school PSY	Board licensed school psychologist	CMS	Care management specialist
PSY assistant	Psychology assistant, intern or trainee	QMHS	Qualified mental health specialist

- Billing Provider: Care Management Entities (CMEs) must have the "ORE" specialty added to the CME's the Ohio Department of Medicaid (ODM) enrollment to submit claims for the billing codes below

- Rendering Provider: Required on the claim. Must have an NPI and Medicaid ID, be affiliated with the billing CME in ODM's Provider Network Management (PNM) system and be a Rendering Provider Type listed below

- Billing for ICC or MCC may begin on the date of first ICC/MCC outreach to youth/family

- When submitting claims, CMEs have the option to submit on the same or a separate claim activity codes (see ICC/MCC Activity Reporting table) documenting the types of encounters for ICC/MCC fidelity purposes.

ICC/MCC Coding Information

OhioRISE Care Coordination Coding Billing Provider is Required to have the "ORE" Specialty							
Service	**Rendering Provider Type**	**Practitioner Modifier –** DO NOT USE	**Code**	**Procedure Modifier - REQUIRED**	**Unit Value**	**Date of service**	**Fee Schedule Rate**
Moderate Care Coordination (MCC) – Full Month	MD/DO CNS CNP PA PSY LISW LIMFT LPCC LICDC Lic school PSY LSW LMFT LPC LCDC II, III Psy assistant SW-T SW-A MFT-T C-T CDC-A <u>QMHS/Education</u> High School/Associate's Bachelor's Master's 3 years' experience <u>CMS/Education</u> High School/Associate's Bachelor's Master's	DO NOT USE	T2022	U1	1 month	Entire calendar month, ex: - 7/1/2022 - 7/31/2022	$577.30
Moderate Care Coordination (MCC) – Partial Month		DO NOT USE	T2022	U2	1 service day	Number of service days in calendar month.	Prorated from $577.30
Intensive Care Coordination (ICC) – Full Month		DO NOT USE	T2023	U1	1 month	Entire calendar month, ex: - 7/1/2022 - 7/31/2022	$1168.72
Intensive Care Coordination (ICC) – Partial Month		DO NOT USE	T2023	U2	1 service day	Number of service days in calendar month.	Prorated from $1168.72
Permitted POS	Any valid place of service code, except POS 02 or 10, may be used						
Billing Notes	• First date of service for first month of billing should be the date of initial engagement • GT modifier is required when service rendered via telehealth • Any valid ICD-10 diagnosis code may be used. • Procedure modifier is REQUIRED; do NOT use a practitioner modifier on ICC/MCC claims.						

In the event a CME serves a youth for a time period less than the full calendar month, the monthly case rate will be pro-rated. For ease of administration, OhioRISE will calculate the pro-rated case rate based on the number of days in a year **(365) divided by number of months (12)** in a year to determine an appropriate per day rate.

Do not use a practitioner modifier on ICC/MCC claims. CMEs are required to bill with procedure modifier U1 to indicate full month or procedure modifier U2 to indicate partial billing for a given month. A full month is defined in terms of a calendar month and is paid at the ODM case rate. As the case rate accounts for the full calendar month the quantity billed will be one unit. A partial month is defined as either (1) number of service days less than the calendar month in which the services were provided or (2) level of care coordination consists of a mix of moderate care coordination (T2022) and intensive care coordination (T2023) during the same calendar month. As a partial month payment rate is pro-rated at a per day rate, the quantity billed will be the number of service days. Please refer to below four scenarios for further clarification.

ICC/MCC Sample Scenarios

Scenario 1 – Full calendar month with same care coordination level

- A youth received moderate care coordination beginning on January 1 thru January 31.
- Claim should be billed on one line using HCPCS code T2022 (moderate care coordination) with modifier U1 (full month) using quantity 1 (one) for one month. The claim will pay at the monthly case rate for moderate care coordination.

Scenario 2 – Partial calendar month with same care coordination level

- A youth receives intensive care coordination beginning January 15 through January 31.
- Claim should be billed on one line using HCPCS code T2023 (intensive care coordination) with modifier U2 (partial month) using quantity 17 (seventeen) for seventeen days of service. The claim will pay at the per diem rate for intensive care coordination.

Scenario 3 – Full calendar month with different care coordination levels

- A youth receives moderate care coordination beginning January 1 through January 15 and then receives intensive care coordination beginning January 16 through January 31.
- The claim should be billed on two lines. The first line should be billed using HCPCS code T2022 (moderate care coordination) with modifier U2 (partial month) using 15 (fifteen) for fifteen days of service. The second line should be billed using HCPCS code T2023 (intensive care coordination) with modifier U2 (partial month) using 16 for sixteen days of service. Line one will pay at the per day rate for moderate care coordination and line two will pay at the per day for intensive care coordination.

Scenario 4 – Partial calendar month with different care coordination levels

- A youth receives moderate care coordination beginning January 15 through January 22 and then receives intensive care coordination beginning January 23 through January 31.
- The claim should be billed on two lines. The first line should be billed using HCPCS code T2022 (moderate care coordination) with modifier U2 (partial month) using 8 for eight days of service. The second line should be billed using HCPCS code T2023 (intensive care coordination) with modifier U2 (partial month) using 9 for nine days of service. Line one will pay at the per day rate for moderate care coordination and line two will pay at the per day rate for intensive care coordination.

Per 5160-59-03, additional informational coding must be included on claims for ICC and MCC to report care coordination activities performed throughout the month.

CMEs working to engage new members within 90 days following <u>initial</u> referral for ICC/MCC services.

- CMEs should conduct initial engagement work within the timeframes outlined in the care coordination rule.
- CMEs will receive a series of up to three referrals for ICC/MCC services. In total, CMEs have a maximum of 90 days to engage the youth and gain consent for care coordination services. Referrals occur as follows:
    - An initial referral after determining someone needs ICC or MCC services
    - A second referral if the youth has not yet been engaged after 30 days following the first referral, and
    - A third referral if the youth has not yet been engaged after another 30 days.
- CMEs may consider billing during each of the referral periods, for a total of 90 days of service, as they work to engage youth and their caregivers.
    - To consider billing for a youth your CME has not yet successfully engaged during this time period, a CME should consider how they are completing or documenting inability to complete the care coordination activities outlined in the care coordination rule.
    - As suggested in the CME program manual, CMEs should consider making three outreach attempts on different days and times during each 30-day period following referral to maximize engagement activities. Per the guidance in the CME Program Manual, a CME would make at least nine engagement attempts over a 90-day period: three engagement efforts in the initial 30-day period, three engagement attempts in the first 30-day extension period, and three engagement attempts in the final 30-day extension period.
    - After 90 days from initial referral, if care coordination engagement and consent are not received, the youth will need to be sent to Aetna for continued persistent outreach. After being referred back to Aetna for persistent outreach, the CME no longer holds responsibility for the youth's care coordination and cannot bill for care coordination services.
    - If Aetna makes contact with a youth in persistent outreach status and receives care coordination consent, the youths that need ICC or MCC services will be referred back to the CME for care coordination. Upon receiving the referral, the CME can engage in care coordination activities and consider appropriate billing for those services.

CMEs working to <u>re-engage</u> youth following ICC/MCC services.

- 30 days of trying to re-engage with family and you and continue to bill for 30 days of continued outreach
- After 30 days you may return to Aetna or continue outreach for another 60 days without billing
- If at any point after 30 you're able to re-engage, start billing again
- At 90-day mark with no engagement, CME must return to Aetna for persistent outreach

CME Documentation

As CME Care Coordinators are completing care coordination activities during the month, they should have a mechanism for documenting all activities in their electronic health record (EHR) for quality purposes. For example, all face-to-face interactions, phone calls, outreach to families, CFT meetings, and other documentation as outline in the CME manual, should be documented to account for those activities for each youth during the time they are receiving care coordination services. It is the responsibility of each CME to provide quality reviews of documentation within their own Care Coordination programs.

ICC/MCC Activity Reporting

Care Coordination Activities Submitted with ICC/MCC Claims					
Service Component	**Activity**	**Code**	**Procedure Modifier**	**Unit Value**	**Date of Service**
Initial Engagement	Telephonic engagement	G9002	U1	Encounter	Date of encounter
	Text message engagement		U2	Encounter	Date of encounter
	Email engagement		U3	Encounter	Date of encounter
	Mailed letter engagement		U4	Encounter	Date of encounter
	Visit to the home		U5	Encounter	Date of encounter
	Research Activities		U6	Encounter	Date of encounter
Face-to-face contact	Initial contact	G9006	U1	Encounter	Date of encounter
	Monthly contact		-	Encounter	Date of encounter
	Crisis response contact		UC	Encounter	Date of encounter
	Discharge planning contact		UD	Encounter	Date of encounter
Child and Family Teaming	Initial convening and facilitation	G9007	U1	Encounter	Date of encounter
	Additional convening and facilitation and monthly phone contacts		-	Encounter	Date of encounter
	Crisis convening and facilitation		UC	Encounter	Date of encounter
	Discharge planning convening, facilitation		UD	Encounter	Date of encounter

	and service engagement				
Care Planning	Develop the initial CFCP	G9005	U1	Encounter	Date completed
	Review and update the CFCP	G9009	U1	Encounter	Date of encounter
Consultation	Psychiatric care coordination consultation	G9008	-	Encounter	Date of encounter
Billing Notes	• **GT modifier** is required when activity is completed via telehealth. In this instance, a phone contact can be considered telehealth. • When identifying monthly phone contacts under the Service Component "Child and Family Teaming" please include the GT modifier to differentiate between additional convening and facilitation. • Modifier GT may not be used with G9002. • Procedure modifiers are required, when applicable, based on the activity descriptions in this table. • Do NOT use practitioner modifiers with care coordination activity codes. • If any of the care coordination activities occur on the same date of service (ex: the initial engagement and the initial face-to-face contact occurred in the same visit) report both G codes with the same date of service on the claim.				

Example 1: Indicates Proper Submission of Claim

An OhioRISE member is receiving treatment in a Qualified Residential Treatment Program (QRTP) and is enrolled in ICC. The care coordinator meets with the youth in the QRTP during the first week of the month (G9006); with the family in the home the second week of the month (G9006); with a potential step-down provider in the community to coordinate services upon return home during the third week of the month (G9007 UD); and with the school to get youth enrolled upon return from residential during the last week of the month (G9007 UD). Additionally, the care coordinator provides the appropriate amount of phone contacts (G9006 GT) for ICC during the month. The CME provides care coordination services for the youth for the entire month, therefore bills for the entire month of ICC services. Additionally, the Care Coordinator documents their successful face-to-face contacts, phone contacts and service engagement activities. Here's an example for the care coordination and activity reporting for the month described:

- Intensive Care Coordination = T2023 U1 with full month as date of service
- Face-to-face Contacts = G9006 x2 with dates of encounters
- Phone calls = G9006 GT x4 with dates of encounters
- Service Engagement = G9007 UD x2with dates of encounters

Example 2: Indicates Proper Submission of Claim and Supporting Documentation

An OhioRISE youth is currently receiving ICC. The youth is living at home with their family, and the care coordinator has been able to consistently meet with the youth or the family four times a month in the home or the community. It is the end of the month, and Mom reports the youth has been sick and they would like to skip

their fourth face-to-face meeting this week and will follow up next week. The Care Coordinator documents their three successful face-to-face contacts (G9006), and the four phone contacts for the month (G9006 GT). Additionally, the care coordinator documents the one attempted face-to-face contact and barriers to being able to meet with the family for the fourth time during the month in their EHR. The claim for the month would include:

- Intensive Care Coordination = T2023 U1 with full month as date of service
- Face-to-face Contacts = G9006 x3 with dates of encounters
- Phone calls = G9006 GT x4 with dates of encounters

Initial Supplemental Assessment – Coding Information

Initial Supplemental Assessment Billing Provider is Required to have the "ORE" Provider Specialty				
Service	**Rendering Provider Type**	**Code**	**Procedure Modifier**	**Fee Schedule Rate**
Initial Supplemental Assessment	MD/DO	H2000	TG	$667.29
	PA CNS CNP	H2000	TG	$411.06
	PSY LISW LIMFT LPCC LICDC Lic school PSY	H2000	TG	$215.96
	LSW LMFT LPC LCDC II LCDC III	H2000	TG	$209.11
	Psy assistant SW-T SW-A MFT-T C-T CDC-A QMHS/Education High School/Associate's Bachelor's Master's 3 years' experience CMS/Education High School/Associate's Bachelor's Master's	H2000	TG	$187.26

Unit Value	Encounter
Permitted POS	Any valid place of service code, except POS 02 or 10, may be used
Billing Notes	• Telehealth allowed with GT modifier. GT modifier is required when service rendered via telehealth. • May only be billed once per OhioRISE enrollment span. • Any valid ICD-10 diagnosis code may be used.

Child and Adolescent Needs and Strengths assessment (CANS) – Coding Information

CANS Assessment Rendering Provider is Required to have the "ORC" Provider Specialty				
Service	**Rendering Provider Type**	**Code**	**Procedure Modifier**	**Fee Schedule Rate**
Child and Adolescent Needs and Strength (CANS) Assessment	MD/DO	H2000	-	$594.47
	PA CNS CNP	H2000	-	$366.07
	PSY LISW LIMFT LPCC LICDC Lic school PSY	H2000	-	$192.16
	LSW LMFT LPC LCDC II LCDC III	H2000	-	$186.04
	PSY assistant SW-T SW-A MFT-T C-T CDC-A QMHS/Education High School/Associate's Bachelor's Master's 3 years' experience CMS/Education High School/Associate's Bachelor's Master's	H2000	-	$166.55
Unit Value	Per Assessment (Brief or Comprehensive)			

Permitted POS	Any valid place of service code, except POS 02 or 10, may be used
Billing Notes	• If the CANS is completed over multiple dates of service, the claim date of service is the date the CANS was completed. • Telehealth allowed. GT modifier is required when service rendered via telehealth. • Diagnosis code is required. Any valid ICD-10 diagnosis code may be used.

The CANS is completed at prescribed intervals or whenever there is a significant change in a youth's condition or circumstances. CANS assessors should aim to conduct minimally invasive practice and maintain the best interest of youth/caregivers throughout the assessment process. Accordingly, assessors should not over-assess youth/caregivers or ask them to tell their stories multiple times. The Ohio Children's Initiative CANS assessment and the state CANS IT system support the practice of building upon what is already known about the youth/caregiver's story and avoiding over-assessment. Prior to engaging the youth/caregiver in the CANS assessment process, the CANS assessors should access the CANS IT System to determine if a recent CANS assessment has been completed with the youth/caregiver. If a recent CANS assessment is available in the CANS IT system, the assessor should use their professional judgement to determine if an update needs to occur or if the most recent assessment can be used.

Requirements for Billing:

- Rendering practitioner must be appropriately certified and trained in the administration of the Ohio Children's Initiative CANS assessment
- The rendering practitioner must have an NPI, be enrolled in Medicaid, add the "ORC" specialty to the Ohio Medicaid enrollment and be affiliated with the billing provider
- CANS assessments must be entered in Ohio's CANS IT system to establish and maintain OhioRISE eligibility
- To be eligible for payment, all CANS assessments must be submitted in the CANS IT system. Aetna will perform monthly audits to verify that claims for CANS assessments comply with this rule. CMEs will be subject to recoupment for any CANS claim where the completed assessment was not submitted in the CANS IT portal. Aetna expects CMEs to enter all CANS in the CANS IT system no more than 30 days from the date of the assessment.

Practitioner Modifiers on CME Claims submitted to Aetna OhioRISE

Aetna does not require practitioner modifiers on community behavioral health professional and outpatient claims unless the rendering practitioner has multiple licenses/certifications with differing scopes of practice. Inclusion of a practitioner modifier on an ICC/MCC claim may result in an incorrect claim payment or claim denial. Practitioner modifiers should not be used on claims for the following CME services:

- Intensive Care Coordination and Moderate Care Coordination (T2022, T2023)
- Care Coordination Activity Reporting codes (G9002, G9005, G9006, G9007, G9008, G9009)

The following CME services require practitioner modifiers only when the rendering practitioner has a dual license/certification with differing scopes of practice:

- Initial Supplemental Assessment (H2000 TG)
- CANS (H2000)

Aetna practitioner modifiers (to be used by CMEs on claims for CANS and Initial Supplemental Assessments)

Practitioner	Modifier	Practitioner	Modifier
LPC	U2	MFT-T	UA
LCDC II or LCDC III	U3	CMS (High School/Associates)	HM
LSW	U4	CMS (Bachelors)	HN
LMFT	U5	CMS (Masters)	HO
PSY assistant	U1	QMHS (High School/Associates)	HM
CDC-A	U6	QMHS (Bachelors)	HN
C-T	U7	QMHS (Masters)	HO
SW-A	U8	QMHS (3 yrs experience)	UK
SW-T	U9		

Diagnosis Codes on CME Claims

The CME that is submitting the claim is responsible for the accuracy of the claim. All CMEs have clinical leadership and should be training care coordinators and individuals submitting claims on appropriate use of diagnosis codes on claims. CMEs should develop internal processes for this and have that process documented. Each CME may have different processes depending on how they are staffed, and some may choose to involve a coder or clinical supervisor reviewing or signing off on diagnosis code assignment in cases where one is not already on file.

For some OhioRISE youth there may not be an established diagnosis at the time of the service. In these circumstances a “Z-code” ICD-10 diagnosis code may be acceptable for initial presentation. Once a relevant diagnosis is established (typically within 30-60 days from initial presentation), the appropriate diagnosis code should be used on the claim to support the service rendered. Please note the following when considering appropriate diagnosis coding:

- Z-codes are "reasons for encounters" and do not require a formal diagnosis to be rendered.
- CMEs and their care coordinators may also use diagnoses that were established by other clinicians. In these cases, the clinician that established the diagnosis did the diagnosing, but the agency is relying on that available clinical information for claim reporting to support the care coordination service rendered/billed.

Section 12: Resources

Links to key resources used in the development of the OhioRISE program.

Updating the System of Care Concept and Philosophy
Wraparound Ohio Website Wraparound Ohio Website:
Ten Principles of the Wraparound Process Ten Principles of the Wraparound Process:
(Regional Research Insititute, School of Social Work, Portland State University, 2021)
National Wraparound Initiative National Wraparound Initiative:
National Wraparound Implementation Center National Wraparound Implementation Center:
Child and Adolescent Needs and Strengths (CANS) Child and Adolescent Needs and Strengths (CANS)
Wraparound and Natural Supports Wraparound and Natural Supports

Link to guidance materials to be used for OhioRISE implementation.
Ohio Department of Medicaid Behavioral Health Provider Manual
Aetna OhioRISE Provider Manual Aetna OhioRISE Provider Manual
OhioRISE Plan Provider Agreement OhioRISE Plan Provider Agreement

OhioRISE Governance

OhioRISE is governed by ODM, the Governor's Office of Children's Initiatives, and Ohio's Family and Children First Cabinet Council. Information about each agency partner can be found at:

Department of Behavioral Health

Ohio Department of Job and Family Services (ODJFS)

Department of Youth Services (DYS),

Ohio Department of Rehabilitation and Correction (DRC)

Ohio Department of Health (ODH)

Ohio Department of Developmental Disabilities (DODD)

Ohio Department of Education (ODE),

The Office of Family & Children First

Ohio Administrative Code Regulations

All OhioRISE-related rules can be viewed at the Register of Ohio website.

Rule	Subject
5160-27-02	BH Coverage Limitations
5160-27-13	ODM Mobile Response and Stabilization Service (MRSS)
5122-29-14	OhioDBH Mobile Response and Stabilization Service (MRSS)
5160-59-01	OhioRISE: Definitions
5160-59-01.1	OhioRISE: Application of General Managed Care Rules
5160-59-02	OhioRISE: Eligibility and Enrollment

Rule	Subject
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 (IHBT)
5160-59-03.4	OhioRISE: Behavioral Health Respite Services
5160-59-03.5	OhioRISE: Primary Flex Funds (renamed from wraparound supports)
5160-59-03.6	OhioRISE PRTF: Psychiatric Residential Treatment Facility (PRTF) Service
5160-59-04	OhioRISE waiver: Eligibility and Enrollment
5160-59-05	OhioRISE waiver: Covered Services
5160-59-05.1	OhioRISE waiver: Out of Home Respite
5160-59-05.2	OhioRISE waiver: Transitional Support Services
5160-59-05.3	OhioRISE waiver: Secondary Flex Funds (renamed from wraparound supports)
5160-59-07	OhioRISE PRTF: Psychiatric Residential Treatment Facility (PRTF) Cost Reports

Section 13: Definitions

Care Coordination – A strategy that will be deployed by OhioRISE Program to deliberately organize and support youth and their families by addressing needs to achieve better health outcomes.

Care Coordination Entity (CCE) – A local community agency (that is not a CME) that provides care coordination to specific populations in the Medicaid program.

Care Coordinator-A licensed or non-licensed profession responsible for organizing and supporting youth and families by organizing and supporting addressing their needs to achieve better health.

Care Management Entity (CME) – A local community agency contracted with the OhioRISE Plan that provides behavioral health care coordination to OhioRISE Plan enrolled members.

Caseworker - PCSA caseworker means an individual employed by a public children services agency as a caseworker.

Child and Adolescent Needs and Strengths (CANS) – A multiple purpose information integration tool developed for children's services to support decision-making, including level of care and service planning, facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. CANS is designed to be the output of a functional assessment process.

Child and Family-Centered Care Plan (CFCP) - The individualized, child-centered, strength-based, and family-focused plan of services and supports developed by the child and family team (CFT), the care management entity (CME), the OhioRISE Plan, or a combination thereof.

Child and Family Team (CFT) - A group of people including the OhioRISE member and their family/caregiver(s), natural supports (relatives, friends, neighbors, etc.), and formal helpers (teachers, therapists, other professionals, etc.) who are involved with the child and family and who play an important role in the child's life.

Claim – A bill from a provider for health care services assigned a unique identifier. A claim does not include an encounter form. A claim can include any of the following: (1) a bill for services; (2) a line item of services; or (3) all services for one member within a bill.

Family – A youth's family or caregiver may include biological, adoptive, or foster parents, as well as extended family or non-biological adults who have a role in the care for and support of a child or youth.

Health Equity – Exists when everyone has a fair opportunity to attain their full health potential and that no one is disadvantaged from achieving this potential.

Intensive care coordination (ICC) – As defined in 5160-59-03.2**,** ICC is a high fidelity wraparound model that is utilized when a **C**hild and **A**dolescent **N**eeds and **S**trengths (CANS) assessment and other clinical documentation indicates: Significant behavioral health challenges that require an action or immediate intensive action to ensure that the identified behavioral health need(s), risk behavior(s), life functioning and caregiver(s) needs are addressed; and the youth requires the majority of care coordination activities be delivered in the home setting; and one of the following:

- The youth demonstrates at-risk behaviors or other psychosocial factors which place the youth at high likelihood for out-of-home treatment or psychiatric hospitalization.
- The youth is being discharged or has recently been discharged from a psychiatric residential treatment facility, as described in rule 5160-59-03.6 of the Administrative Code, or other inpatient psychiatric hospitalization.

Managed Care Organization (MCO) – An entity that meets the requirements of 42 CFR 438.2 and is a health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM.

Managed Care Entities (MCEs) – Entities that include managed care organizations, single pharmacy benefits manager, and the OhioRISE Plan.

Medically Necessary or Medical Necessity – Has the same meaning as OAC rule 5160-1-01:

Medical necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease, or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.

Medical necessity for individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability, and without which the person can be expected to suffer prolonged, increased, or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

- Conditions of medical necessity are met if all the following apply:
    - Meets generally accepted standards of medical practice.
    - Clinically appropriate in its type, frequency, extent, duration, and delivery setting.
    - Appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome.
    - Is the lowest cost alternative that effectively addresses and treats the medical problem.
    - Provides unique, essential, and appropriate information if it is used for diagnostic purposes; and not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.
    - Not provided primarily for the economic benefit of the provider nor for the convenience
    - of the provider or anyone else other than the recipient.
    - The fact that a physician, dentist, or other licensed practitioner render, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself, make the procedure, item, or service medically necessary and does not guarantee payment for it.
    - The definition and conditions of medical necessity articulated in this rule apply throughout the entire Medicaid program. More specific criteria regarding the conditions of medical necessity for categories of service may be set forth within ODM coverage policies or rules.

Moderate care coordination (MCC) – As defined in 5160-59-03.2**,** MCC is a wraparound informed model that is utilized when a CANS assessment and other clinical documentation indicates moderate behavioral health challenges that require an action or immediate intensive action to ensure that the identified behavioral health need(s), risk behavior(s), and life functioning are addressed; and the youth demonstrates at-risk behaviors or other psychosocial factors which place him or her at high likelihood for out of home treatment or psychiatric hospitalization.

Performance Measure – An assessment tool that aggregates data to assess the structure, processes, and outcomes of care within and between entities; typically, specifies a numerator (what/how/when), denominator (who/where/when), and exclusions (not).

Population Health – The health outcomes of a group of individuals, including the distribution of such outcomes within the group. Within Ohio Medicaid, these groups may be defined by health care service utilization,

common diagnoses, physical or behavioral health need, demographic characteristics, geography, or social determinants (e.g., homelessness).

Population Health Management – An approach to maintain and improve physical and psychosocial well-being and address health disparities through cost-effective, person-centered health solutions that address members' health needs in multiple settings at all points along the continuum of care.

Post-Stabilization Care Services – As defined in OAC rule 5160-26-01, covered services related to an emergency medical condition that a treating provider views as medically necessary after an emergency medical condition has been stabilized to maintain the stabilized condition, or under the circumstances described in 42 CFR 422.113 to improve or resolve the member's condition.

Provider – As defined in OAC rule 5160-26-01, a hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed or certified appropriate individual or entity that is authorized to or may be entitled to reimbursement for health care services rendered to an OhioRISE Plan member.

Provider Agreement – As defined in OAC rule 5160-26-01, a formal agreement between ODM and the OhioRISE Plan for the provision of medically necessary services to Medicaid members.

Provider Network or Network – Consistent with "Provider Panel" as defined in OAC rule 5160-26-01, the OhioRISE Plan's contracted providers available to the OhioRISE Plan's members.

Psychiatric Residential Treatment Facility - A facility that is not a hospital that provides intensive psychiatric treatment to youth under the age of 21, in accordance with Subpart D of 42 C.F.R. 441, Subpart G of 42 C.F.R. 483, and chapters 5160-59 and 5122-41 of the OAC.

Quality Improvement Project (QIP) – Collaborative undertaking that uses rapid-cycle continuous quality improvement methods to identify and address root causes of poor outcomes which prioritize and test interventions, monitor intervention results, and sustain and scale up interventions found through testing to improve health outcomes, quality of life and satisfaction of providers and members. Typically, ODM initiated improvement projects involve entities at multiple levels within the health system, including health care providers, MCEs, the OhioRISE Plan, SPBM, and state and county entities.

Regional Mobile Response and Stabilization Services Providers (RMP) - Ohio's regional MRSS provider structure leverages regional and local resources to accelerate the expansion and sustainability of MRSS services. The Regional MRSS Provider (RMP) is responsible for the delivery of high quality in-person MRSS services as defined in rule and practice standards for the entire regional catchment that they are assigned to. RMPs are selected through a state Request for Proposal (RFP) solicitation and are the only entity eligible to bill Medicaid for MRSS services. The RMP is responsible for providing the functions outlined in Ohio Administrative Code and practice standards for the entire coverage area assigned.

Single Pharmacy Benefit Manager (SPBM) – The state Medicaid pharmacy benefit manager selected under ORC section 5167.24 that is responsible for processing all pharmacy claims for OhioRISE Plan members.

Social Determinants of Health (SDOH) – The complex, integrated, and overlapping social and economic risk factors that impact health outcomes and health status.

Social Risk Factors – Economic and social conditions that may influence individual and group differences in health and health outcomes. These factors may include age, gender, income, race, ethnicity, nativity, language, sexual orientation, gender identity, disability, geographic location, and many others.

Subcontract – As defined in OAC rule 5160-26-01, a written contract between the OhioRISE Plan and a third party, including the OhioRISE Plan's parent company or any subsidiary corporation owned by the OhioRISE Plan's

parent company, or between the third party and a fourth party, or between any subsequent parties, to perform a specific part of the obligations specified under the OhioRISE Plan's provider agreement with ODM.

Subcontractor – As defined in OAC rule 5160-26-01, any party that has entered a subcontract to perform a specific part of the obligations specified under the OhioRISE Plan's provider agreement with ODM. A network provider is not a subcontractor by virtue of the network provider contract with the OhioRISE Plan.

System of Care – A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, to help them to function better at home, in school, in the community, and throughout life.

Telehealth – As defined in OAC rule 5160-1-18, is the direct delivery of health care services to a patient via secure, synchronous, interactive, real-time electronic communication comprised of both audio and video elements.

Wraparound supports- As defined in rule 5160-59-01, the services, equipment, or supplies not otherwise provided through the Medicaid State Plan Benefit or the OhioRISE program that address a youth's identified need as documented in the child and family-centered care plan. Wraparound supports are intended to enhance and supplement the array of services available to a youth enrolled on the OhioRISE program and are discussed, recommended, and implemented through the care coordination process as described in rule 5160-59-03.2 of the Ohio Administrative Code.

Section 14: Acronyms

Acronym	Definition
Aetna	Aetna Better Health of Ohio
ACT	Assertive Community Treatment
ADAMH	Alcohol, Drug and Mental Health Board
ASAM	American Society of Addiction Medicine
BH	Behavioral Health
CABHCOE	Child and Adolescent Behavioral Health Center of Excellence
CANS	Child and Adolescent Needs and Strengths
CCE	Care Coordination Entity
CFCP	Child and Family-Centered Care Plan
CFR	Code of Federal Regulations
CFT	Child and Family Team
CME	Care Management Entity
CMS	Centers for Medicare and Medicaid Services
COE	Center of Excellence
CPT	Central Processing Team
CSP	Coordinated Services Program
DBH	Department of Behavioral Health
DCY	Department of Children and Youth
DEW	Department of Education and Workforce
DODD	Department of Developmental Disabilities
DOJFS	Department of Job and Family Services
DYS	Department of Youth Services
EHR	Electronic Health Record

Acronym	Definition
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
FCFC	Family and Children First Council
FFS	Fee for Service
FFT	Functional Family Therapy
GT	Telehealth Modifier
HCBS	Home and Community Based Services
HIPAA	Health Insurance Portability and Accountability Act
HIC	Health Insuring Corporation
ICC	Intensive Care Coordination
IEP	Individualized Education Plan
IHBT	Intensive Home-Based Treatment
ISBH	Integrated Services for Behavioral Health
LCC	Limited Care Coordination
LISW	Licensed Independent Social Worker
LSW	Licensed Social Worker
LPCC	Licensed Professional Clinical Counselor
LSW	Licensed Social Worker
MATS	MSY Application Tracking System
MCC	Moderate Care Coordination
MCE	Managed Care Entity
MCO	Managed Care Organization
MRSS	Mobile Response and Stabilization Services
MST	Multisystemic Therapy

Acronym	Definition
MSY	Multi-System Youth Custody Relinquishment Prevention Program
NPI	National Provider Identifier
OAC	Ohio Administrative Code
ODH	Ohio Department of Health
ODJFS	Ohio Department of Job and Family Services
ODM	Ohio Department of Medicaid
ODRC	Ohio Department of Rehabilitation and Correction
OFCF	Ohio Family and Children First
ORC	Ohio Revised Code
PAC	Promoting Active Connections
PCP	Primary Care Provider
PCSA	Public Children Services Agency
PHMS	Population Health Management Strategy
PNM	Provider Network Management System
PRTF	Psychiatric Residential Treatment Facility
QI	Quality Improvement
QIP	Quality Improvement Project
QMHS	Qualified Mental Health Specialist
QRTP	Qualified Residential Treatment Program
RMP	Regional Mobile Response and Stabilization Services Providers
SDOH	Social Determinants of Health
SED	Serious Emotional Disturbance
SFTP	Secure File Transfer Protocol
SIL	Special Income Level

Acronym	Definition
SOC	System of Care
SPBM	Single Pharmacy Benefit Manager
SUD	Substance Use Disorder
TSS	Transitional Services and Supports
UM	Utilization Management

Section 15: Aetna Better Health of Ohio's Non-Discrimination Notice

Aetna Better Health® of Ohio follows state and federal civil rights laws that protect you from discrimination or unfair treatment. We do not treat people unfairly because of a person's age, race, color, national origin, religion, sex, gender identity, sexual orientation, religion, marital status, mental or physical disability, medical history, health status, genetic information, evidence of insurability, or geographic location.

If you would like to file a complaint, please contact Aetna Better Health by either:

Mail:

Aetna Better Health
7400 W Campus Rd, Suite 200
New Albany, OH 43054

Phone:

1-833-711-0773 (TTY: 711)

Email:

OhioRISEMemberServices@Aetna.com

If you would like to file a complaint with Health and Human Services Office for Civil Rights, please go to **https://ocrportal.hhs.gov/ocrsmartscreen/main.jsf** or by mail or phone at:

Mail:

U.S. Department of Health and Human Services
200 Dependence Avenue, S.W.
Washington, D.C. 20201

Phone:

1-800-368-1019, TDD: 1-800-537-7697

Language Assistance, Interpretation Services, and Auxiliary Aids

ENGLISH: To help you understand this notice, language assistance, interpretation services, and auxiliary aids and services are available upon request at no cost to you. Services available include, but are not limited to, oral translation, written translation, and auxiliary aids. You can request these services and/or auxiliary aids by calling Aetna Better Health Member Services
at **1-833-711-0773 (TTY: 711)**

SPANISH: Para ayudarle a entender este aviso, disponemos de asistencia lingüística, servicios de interpretación y ayudas y servicios auxiliares si los solicita, sin costo alguno para usted. Los servicios disponibles incluyen, entre otros, traducción oral, traducción escrita y ayudas auxiliares. Puede solicitar estos servicios o ayudas auxiliares llamando al Departamento de Servicios para Miembros de Aetna Better Health al **1-833-711-0773 (TTY: 711)**.

NEPALI: यो सूचना तपाईंलाई बुझ्न सहायता गर्न तपाईंको निम्ति निःशुल्क रूपमा आग्रह गर्नुभएअनुसार भाषाको सहायता, अनुवादका सेवाहरू र थप सहायता र सेवाहरू उपलब्ध छन्। समावेश भएका सेवाहरू उपलब्ध छन् तर मौखिक अनुवाद, लिखित अनुवाद र थप सहायतामा सीमित छैनन्। तपाईंले **1-833-711-0773 (TTY: 711)** मा Aetna Better Health सदस्य सेवाहरूमा फोन गरेर यी सेवाहरू र/वा थप सहायता आग्रह गर्न सक्नुहुन्छ।

مساعدتك في فهم هذا الإخطار، تتوفر المساعدة اللغوية وخدمات الترجمة الفورية والمساعدات والخدمات المعينة عند الطلب مجانًا. تشمل الخدمات المتاحة، على سبيل المثال لا الحصر، الترجمة الشفوية والترجمة الكتابية والمساعدات المعينة. يمكنك طلب هذه الخدمات و/ أو المساعدات الإضافية عن طريق الاتصال بخدمات أعضاء Aetna Better Health على الرقم 711-0773—833-1 **(TTY: 711)**

SOMALI: Si lagaaga caawiyo fahanka ogaysiiskan, kaalmada luqadda, adeegyada turjumaada hadalka ah, iyo qalabka kaalmada naafada iyo adeegyada waxaa la heli karaa marka la codsado iyagoon kharash kugu taagnayn adiga. Adeegyada la heli karo waxaa ku jira, laakiin kuma xadidna, turjumaada hadalka, turjumaada qoran, iyo qalabka kaalmada naafada. Waxaad codsan kartaa adeegyada iyo/ama qalabka kaalmada naafada addoo soo wacaya Adeegyada Xubinta Aetna Better Health lambarka **1-833-711-0773 (TTY: 711)**

RUSSIAN: Если вам нужна помощь в понимании данного уведомления, вы можете обратиться за языковой поддержкой, услугами устного перевода, а также вспомогательными средствами и услугами, которые по запросу оказываются бесплатно. Доступные услуги включают, помимо прочего, устный перевод, письменный перевод и вспомогательные средства. Вы можете обратиться за данными услугами и/или вспомогательными средствами в отдел обслуживания участников Aetna Better Health по телефону **1-833-711-0773 (TTY: 711)**

FRENCH: Pour vous aider à bien comprendre cet avis, vous pouvez faire appel à des services gratuits d'interprétation et d'aide auxiliaire. Par exemple, vous pouvez vous faire traduire un texte par oral ou par écrit, ou encore bénéficier d'autres services auxiliaires. Pour solliciter ces services et/ou une aide auxiliaire, appelez le service réservé aux membres Aetna Better Health au
1-833-711-0773 **(TTY : 711)**

VIETNAMESE: Để giúp quý vị hiểu thông báo này, hỗ trợ ngôn ngữ, dịch vụ thông dịch, và các dịch vụ và hỗ trợ phụ trợ được cung cấp miễn phí theo yêu cầu cho quý vị. Các dịch vụ có sẵn bao gồm, nhưng không giới hạn, dịch nói, dịch văn bản và các hỗ trợ phụ trợ. Quý vị có thể yêu cầu các dịch vụ này và/hoặc hỗ trợ phụ trợ bằng cách gọi cho Dịch vụ Hội viên của Aetna Better Health theo số
1-833-711-0773 **(TTY: 711)**

SWAHILI: Ili kukusaidia kuelewa ilani hii, usaidizi wa lugha, huduma za ukalimani na vifaa vya kusikia na huduma zinapatikana ukiomba bila malipo yoyote. Huduma hizi ni pamoja na, bila kuishia kwa hizi tu, tafsiri ya mdomo, tafsiri ya maandishi na vifaa vya kusikia. Unaweza kuomba huduma hizi na/au vifaa vya kusikia kwa kupigia simu Aetna Better Health Member Services kwa nambari **1-833-711-0773 (TTY: 711)**

UKRANIAN: Щоб допомогти вам зрозуміти це повідомлення, за запитом вам безкоштовно може надаватися мовна допомога, послуги перекладу, а також допоміжні засоби й послуги. Такі послуги включають, крім іншого, усний переклад, письмовий переклад та допоміжні засоби. Ви можете замовити ці послуги та/або допоміжні засоби, зателефонувавши в службу підтримки учасників Aetna Better Health за номером **1-833-711-0773 (TTY: 711)**

CHINESE (TRADITIONAL): 為幫助您理解本通知，我們可應您的要求免費提供語言協助、口譯服務以及輔助設備和服務。提供的服務包括但不限於口譯、筆譯以及輔助設備。您可致電 Aetna Better Health 會員服務部，要求獲得這些服務和/或輔助設備，電話號碼為：**1-833-711-0773（TTY：711）**

KINYARWANDA: Kugira ngo ufashwe gusobanukirwa neza iri tangazo, ubufasha mu by'ururimi, serivisi z'ubusemuzi n'ibikoresho bifasha abafite ubumuga bwo kutumva na serivisi bijyanye biboneka bisabwe kandi nta mafaranga wishyuzwa. Serivisi ziboneka harimo, ariko ntabwo zigarukira gusa ku, busemuzi, ubusemuzi bw'inyandiko n'ibikoresho bifasha abafite ubumuga bwo kutumva. Ushobora gusaba izo serivisi cyangwa ibikoresho bifasha abafite ubumuga bwo kutumva uhamagaye Aetna Better Health Member Services kuri **1-833-711-0773 (TTY: 711)**

CHINESE (SIMPLIFIED): 为帮助您理解本通知，我们可应您的请求免费提供语言援助、口译服务以及辅助设备和服务。提供的服务包括但不限于口译、笔译以及辅助设备。您可致电 Aetna Better Health **会**员服务部，请求获得这些服务和**/或**辅助设备，电话号码为：**1-833-711-0773 (TTY: 711)**

(TTY: 711) د غړو خدمات ته په Aetna Better Health 1-833-711-0773 شامل دي، خو تر دي پوري محدود ندي. تاسو کولی شئ د په خبرتیا د پوهیدو په برخه کي ستاسو سره د مرستي لپاره، د غوښتني په صورت کي د ژبي اړوند مرسته، د ژباړي خدمتونه، او مرستندویه کومکونه او خدمتونه پرته له کوم لګښت څخه شتون لري. په شته خدمتونو کي شفاهي ژباړه، لیکلي ژباړه، او مرستندویه کومکونه تلیفون کولو سره د دي خدماتو او/یا فرعي مرستو غوښتنه وکړئ

AMHARIC: ይህን ማሳሰቢያ እንዲረዱት ሊያግዝዎ የሚያስችሉ የቋንቋ እርዳታ፣ የትርጉም አገልግሎቶች፣ እና ተያያዥ ድጋፎች እና አገልግሎቶች ሲጠይቁ እርስዎ ምንም ወጪ ሳያወጡ ማግኘት ይችላሉ። ያሉት አገልግሎቶች የቃል ትርጉም፣ የጽሁፍ ትርጉም፣ እና ተያያዥ ድጋፎች እና ሌሎችን ይጨምራል። እነዚህን አገልግሎቶች እና/ወይም ተያያዥ ድጋፎችን ወደ Aetna Better Health የአባል አገልግሎቶች በ **1-833-711-0773 (TTY: 711)** በመደወል መጠየቅ ይችላሉ።

GUJARATI: આ સૂચનાને સમજવામાં તમારી મદદ કરવા માટે, ભાષા સહાય, દુભાષિયા સેવાઓ અને વધારાની સહાય અને સેવાઓ વિનંતી કરવા પર તમારા માટે કોઈપણ ખર્ચ વિના ઉપલબ્ધ છે. ઉપલબ્ધ સેવાઓમાં મૌખિક અનુવાદ, લેખિત અનુવાદ અને વધારાની સહાયનો સમાવેશ થાય છે, પરંતુ સેવાઓ એટલા સુધી મર્યાદિત નથી. તમે Aetna Better Health Member Servicesને **1-833-711-0773 (TTY: 711)** પર કૉલ કરીને આ સેવાઓ અને/અથવા વધારાની સહાયની વિનંતી કરી શકો છો

Appendix A: CME Contact List

CME Name	Contact	Email	Phone Number
Cadence	Nikunj Patel, COO	nikunj.patel@cadencecare.org	330-503-3554
Cadence	Lori Shelby, CME Director	lori.shelby@cadencecare.org	330-984-1867
CareStar	Rebecca Brookover, CME Director	rbrookover@carestar.com	614-729-6323
Choices	Esther Urick, CME Director	eurick@choicesccs.org	326-203-9005
Cincinnati Children's HealthVine	Nicole Geier-Lindsey, CME Director	Nicole.Geier-Lindsey@cchmc.org	513-803-6262
Coleman	Steve Case, Senior Executive Director, Care Management	Steve.case@colemanservices.org	330-676-6906
Harbor	Melissa Ebling, Regional Director - Care Coordination	mebling@harbor.org	419-230-4840
IAB	Toni Ramierez, CME Director	tramirez@iamboundless.org	614-226-6019
ISBH	Cory D'Ambrosio, Managing Director	cdambrosio@isbh.org	614-596-7499
Jefferson	Courtney Mason	cmason@jcesc.org	740-408-0513
Lighthouse	Isaiah Febus, CME Director	ifebus@lys.org	513-478-2586
NYAP	Danielle Greiner, CME Director	dgreiner@nyap.org	419-810-6240
Ohio Guidestone	Andrea O'Brien, CME Director	andrea.obrien@ohioguidestone.org	440-666-4301
PEP	Jill Koenig, CME Director	jkoenig@pepcleve.org	216-276-4643
Ravenwood	Donna Cook, CME Director	cookd@ravenwoodcme.org	440-447-4309
The Buckeye Ranch	Margrit Springer, VP of Integrated Care	mspringer@buckeyeranch.org	614-875-2371
The Buckeye Ranch	Rachel Bowen, CME Director	rbowen@buckeyeranch.org	614-284-8667
The Village Network	Traci McCarty, VP of Care Management	tmccarty@thevillagenetwork.com	614-600-0288
The Village Network	Jennifer Porter, CME Director	jporter@thevillagenetwork.com	330-641-6753

Unison	Erika Jay, Director, OhioRISE CME Region A	ejay@unisonhealth.org	419-936-7595
Wingspan	Joyce DeMichele, CME Director	demichelej@wingspancg.org	216-320-8646