OhioRISE, Specialized Behavioral Health Care from Aetna Better Health of Ohio

Care Management Entity (CME)

Appendix A

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Appendix A

Table of Contents

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The following sections of Appendix A provide resources and additional explanation to support completion and submission of the OhioRISE CME Request for Application**.**

Section 1: System of Care and High-Fidelity Wraparound Resources

The word wraparound can have a variety of meanings in different settings and systems. The resources below are included to assist in the OhioRISE response. Please utilize these resources as reference, as needed.

A. ***Updating the System of Care Concept and Philosophy*** https://gucchdtacenter.georgetown.edu/resources/Call%20Docs/2010Calls/SOC_Brief2010.pdf (Stroul, Blau, & Friedman, 2021)
B. ***Wraparound Ohio Website*** *https://wraparoundohio.org/*
C. ***Ten Principles of the Wraparound Process*** *https://nwi.pdx.edu/NWI-book/Chapters/Bruns-2.1-(10-principles-of-wrap).pdf* (Regional Research Insititute, School of Social Work, Portland State University, 2021)
D. ***National Wraparound Initiative*** *https://nwi.pdx.edu/*
E. ***National Wraparound Implementation Center*** *http://www.nwic.org/*
F. ***Child and Adolescent Needs and Strengths (CANS)*** *https://praedfoundation.org/tcom/tcom-tools/the-child-and-adolescent-needs-and-strengths-cans/*
G. ***Wraparound and Natural Supports*** *http://wraparoundohio.org/wp-content/uploads/2017/01/WA-and-Natural-supports-1.pdf*

Section 2: OhioRISE Resources

A. ***OhioRISE Medicaid Managed Care Rules Package***
https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/acbeee4d-8e70-483c-8d47-34e026716706/ODM+OhioRISE+First+Rule+Package+Draft+-+Amended_2021.08.10.pdf?MOD=AJPERES&CVID=nIN3-jZ

B. ***OhioRISE Ohio Department of Mental Health and Addiction Services Rules Package *DRAFT***
https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/c0ae8b3d-8a85-46ea-8dce-a13b45adee1a/MHAS+OhioRISE+First+Rule+Package+Draft+-Amended+8-10-21.pdf?MOD=AJPERES&CVID=nIN50Gb

C. ***OhioRISE FAQ***
https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/a041dcfc-78ed-45eb-a916-99e512537f9b/OhioRISE+FAQ_version+1_2021.07.29.pdf?MOD=AJPERES&CVID=nHP-dcx

D. ***OhioRISE Public Kickoff Webinar Presentation***
https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/a5dee539-f638-4809-acc24c1f7c245a57/OhioRISE+December+Stakeholder+Meeting+December+18%2C+2020.pdf?MOD=AJPERES&CVID=nrkDrWF (Medicaid, 2020)

E. ***OhioRISE Seventh CANS and Care Coordination Workgroup Meeting PowerPoint***
https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/10ddb08a-b9ab-4d5f-9717-f7fb721144fa/OhioRISE_Seventh+CCC+Workgroup_2021.06.24.pdf?MOD=AJPERES&CVID=nE.bpaT

Section 3: Ohio Family and Children First Council Resource

Ohio Child and Family First Council
https://www.fcf.ohio.gov/

Section 4: CME Business Process Resources

A. Step by Step Referral Process to Access OhioRISE:

1. Child is identified through caregivers, MCO, OhioRISE, school, providers, state agency staff, PCSAs, MRSS, or is admitted to psychiatric IP/PRTF.
2. The MCO, MRSS provider and/or OhioRISE initiate referral for CANS – same day. For IP/PRTF, the child's admission is reported to the CANS IT System for automatic enrollment in OhioRISE as a result of the admission.
3. The CANS assessor must complete the Brief CANS within 3 calendar days of referral. A MRSS provider is approved to complete the CANS as contracted to the MCO.
4. OhioRISE eligibility is determined when the CANS assessment is submitted in ODM's CANS IT System.
5. If eligible for OhioRISE enrollment, ODM enrolls the child and informs OhioRISE of the enrollment within 2 business days of receipt of the CANS assessment.
6. Within two business days, OhioRISE assigns the care coordination tier, notifies the caregiver, and notifies the CME if the member is assigned to Tier 2 or Tier 3 care coordination.
7. The CME has two business days to outreach and engage the child and caregiver. For children referred by a MRSS provider due to a crisis, outreach must occur within 24 hours. For children referred due to an IP/PRTF admission, outreach must occur within two calendar days.

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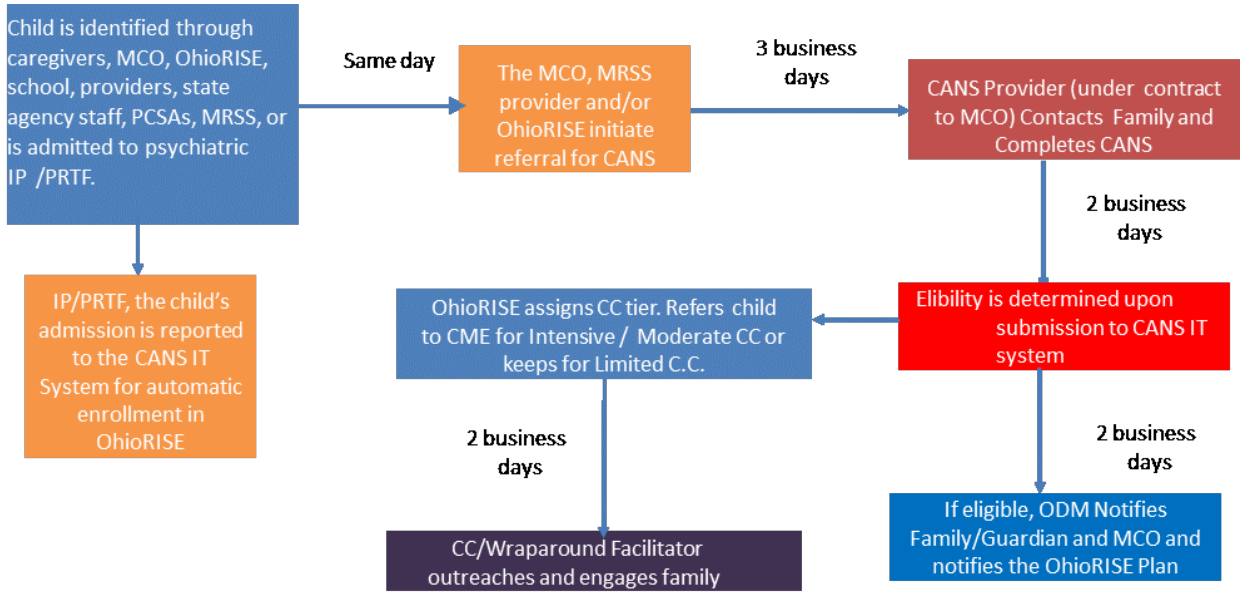

B. Bi-directional Data Sharing and Family Connect Care Coordination Portal:

The OhioRISE Plan's care coordination portal, Family Connect, will provide the foundational infrastructure to monitor all aspects of care planning at the individual and population levels to support youth and family/caregiver-centered care planning consistent with System of Care principles and High-Fidelity Wraparound practices. The OhioRISE plan will collect, integrate, and analyze data from multiple data sources including the MCOs, the Care Coordination Entities, ODM and the CME. Collaborative efforts will occur with these entities to develop streamlined data entry, retrieval and exchange capabilities.

For those entities that do not yet have these capabilities, the OhioRISE Plan will provide technical assistance to build this capacity. The bidirectional data sharing between the OhioRISE plan and the CME may include but not be limited to:

- OhioRISE child and family-centered care plan data elements
- Informal/Formal Supports
- Unmet Supports
- Self-reported Medications
- Conditions actively being managed
- Child and Family Team Participants
- Member Address Updates
- Member Preferences
- OhioRISE Interval Risk Screener

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- OhioRISE Supplemental Comprehensive assessment
- Trauma Screening Questionnaire
- Adverse Childhood Experiences screener
- Sentinel Events
- Critical Incident events
- Outreach Attempts
- Outreach outcomes
- New member assignment notifications/tasks
- Face to Face Visits
- Notice of Members refusing CC
- Notice of change in member tier
- Case Rounds dates
- Dates/times of contact with members receiving MRSS
- Dates of Child and Family Team meetings
- CME Individual Staff assignments
- Data required to support quality initiatives including those outlined in Section 11 of the appendix: **MCO Measures required by OhioRISE Plan**
- Data required to support the OhioRISE plan's monitoring and oversight requirements

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Section 5: CME Catchment Area Map

Twenty CME Catchment areas will serve the OhioRISE population across the State. The catchment areas are based on the projected population of OhioRISE enrollment and geography. The chart below includes the number of and specific Counties in the CME area, projected number of children to be served in the first year of the program and geographic area covered.

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Section 6: Roles and Responsibilities of State Partners

A. OhioRISE Governance

1. OhioRISE is governed by ODM, the Governor's Office of Children's Initiatives, and Ohio's Family and Children First Cabinet Council. Council members include:
    a. Ohio Department of Mental Health and Addiction Services (MHAS)
    b. Ohio Department of Job and Family Services (ODJFS)
    c. Department of Youth Services (DYS),
    d. Ohio Department of Rehabilitation and Correction (DRC)
    e. Ohio Department of Health (ODH)
    f. Ohio Department of Developmental Disabilities (DODD)
    g. Ohio Department of Education (ODE),
    h. The Office of Family & Children First

B. Ohio Department of Medicaid

1. ODM will maintain overall authority over the OhioRISE program, including provision of oversight and monitoring of OhioRISE Plan.
2. ODM will screen, enroll, and credential all providers as necessary in accordance with 42 CFR 455 subpart e as if 7/1/2022. The OhioRISE Plan shall review ODM's Provider Network Management (PNM) module (the system of record) for eligible and active providers.
3. ODM will monitor access and availability using multiple data sources, including but not limited to member complaints, member grievances, appeals, member satisfaction surveys, provider complaints, quality data, performance measures, utilization data, demographic data, and results from other oversight and monitoring activities.
4. ODM sets quality and performance measures of OhioRISE program
5. ODM defines the rules of the OhioRISE program
6. ODM will monitor Grievance and Appeals process including those associated with the OhioRISE Plan
7. ODM will support Stakeholder engagement and facilitate the OhioRISE Advisory Committee

C. OhioRISE Plan Roles and Responsibilities

1. The OhioRISE Plan is responsible for ensuring the goals of the OhioRISE program are met, including contracting with providers to expand access to the new and expanded services of OhioRISE.
2. The OhioRISE Plan will implement and manage OhioRISE by:
    a. Contracting for care coordination through the CMEs
    b. Contracting for other OhioRISE services with local service providers
    c. Supporting the development of capacity in the behavioral health service delivery system

d. Providing information and educational materials to members and families, stakeholders, and providers on the OhioRISE program, services available and benefits of Care Coordination
e. Determining appropriate Care Coordination Tiers, using criteria set by ODM (see Appendix A, Section 2.a)
f. Making timely referral to CMEs
g. Monitoring CME Performance and supporting quality improvement activities
h. Collaborating with the CABHCOE to leverage data and training and learning opportunities
i. Providing SHINE University, Healing Connections Suite and other Aetna resources to support technical assistance, training and quality improvement opportunities for CMEs
j. Training CMEs to enter and review data in the Family Connects Care Coordination portal
k. Supporting ODMs population health efforts and support CME efforts in this area; and
l. Developing of a portal for sharing information between Aetna, MCOs, CCEs; and Assist CMEs in locating local community resources.

D. OhioRISE Advisory Council

1. The OhioRISE Advisory Council represents a diverse range of expertise and experience. The council includes local system partners, associations and providers of services and youth and family with lived experiences.
   a. Offer specific advice, expert opinions and suggestions to Directors and staff regarding the OhioRISE program
   b. Provide clinical and programmatic input on key components of new and enhanced services
   c. Review rule development and changes
   d. Provide critical technical feedback regarding initial implementation activities and OhioRISE operations

E. Child and Adolescent Behavioral Health Center of Excellence (CABHCOE)

1. 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.
2. The CABHCOE and OhioRISE Plan will collaborate to ensure training, professional development and quality improvement needs of OhioRISE CMEs are both coordinated and met.

3. The CABHCOE will provide training in the areas of
    a. Child and Adolescent Strengths and Needs (CANS)
    b. Mobile Response Stabilization Services
    c. Intensive Home-Based Treatment
    d. ICC and MCC utilizing High Fidelity Wraparound
    e. Multisystemic Therapy
        f. Functional Family Therapy (conducted by FFT, LLC)

For additional detail on OhioRISE roles and responsibilities please refer to:
OhioRISE Plan Provider Agreement
https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/218bc9bb-34e6-4913-9551-f7fc9aaa7e89/OhioRISE+Provider+Agreement_6-29-21.pdf?MOD=AJPERES&CVID=nGHQBVA

Section 7: OhioRISE Definitions

OhioRISE Provider Services Agreement, Appendix A Section 6: C

Listed below are definitions of terms and acronyms used in this Agreement. Terms are consistent with federal and state requirements and must be construed and interpreted as follows for this Agreement.

Additional terms specific to OhioRISE can be found in ODMs Draft OhioRISE Rule OAC 5160-26-01. A list to this Draft Rule can be found in the Appendix, Section 2.A.

- **Abuse** – As defined in OAC rule 5160-26-01, provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary, or that fail to meet professionally recognized standards for health care. Abuse also includes member practices that result in unnecessary cost to the Medicaid program.
- **Abuse (of a member**) – The injury, confinement, control, intimidation, or punishment of a member by another person that has resulted, or could reasonably be expected to result, in physical harm, pain, fear, or mental anguish. Abuse includes but is not limited to physical, emotional, verbal, and/or sexual abuse, and use of restraint, seclusion, or restrictive intervention that results in, or could reasonably be expected to result, in physical harm, pain, fear, or mental anguish to the member.
- **Acquisition** – Transaction in which one company acquires controlling interest of all another targeted company's assets, capital, or stock.

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- **Actuary** – As defined in 42 CFR 438.2, an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board.
- **Adverse Benefit Determination** – As defined in OAC rule 5160-26-08.4, the OhioRISE plan's:
    - Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
    - Reduction, suspension, or termination of services prior to the member receiving the services previously authorized by the OhioRISE Plan;
    - Denial, in whole or part, of payment for a service;
    - Failure to provide services in a timely manner as specified in OAC rule 5160-59-03.1;
    - Failure to act within the resolution timeframes specified in this rule; or
    - Denial of a member's request to dispute a financial liability, including cost sharing, co-payments, premiums, deductibles, coinsurance, and other member financial liabilities, if applicable.
- **Appeal** – As defined in OAC rule 5160-26-08.4, a member's request for the OhioRISE Plan's review of an adverse benefit determination.
- **Authorized Representative** – Consistent with OAC rule 5160:1-1-01, a person, who is at least 18 years old, or a legal entity who stands in place of the individual. Actions or failures of an authorized representative will be accepted as the action or failure of the individual. If an individual has designated an authorized representative, all references to "individual" regarding an individual's responsibilities include the individual's authorized representative.
- **Business Associate** – Consistent with 45 CFR 160.103, a person or entity that, on behalf of a covered entity, maintains, performs, or assists in the performance of a function or activity that involves the use or disclosure of "Protected Health Information."
- **Business Day** – Monday through Friday, except for state of Ohio holidays.
- **Calendar Day** – All seven days of the week, including state of Ohio holidays.
- **Care Coordination** – A strategy that will be deployed by OhioRISE Program to deliberately organize and support children, 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 children, 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**.
- **Certificate of Authority** – Document issued by the Ohio Department of Insurance pursuant to ORC section 1751.05 that recognizes the OhioRISE Plan as a Health Insuring Corporation with the powers as articulated in ORC section 1751.06.
- **Change in Ownership** – Any change in the possession of equity in the capital, stock, profits, or voting rights with respect to a business such that there is a change in the persons or entities having the controlling interest of an organization, such as changes that result from a merger or acquisition, or, with respect to non-stock corporations (e.g., non-profit corporations), a change in the members or sponsors of the corporation or in the voting rights of the members or sponsors of the corporation.
- **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.
- **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.
- **Clean Claim** – A claim that can be processed without obtaining additional information from the provider of a service or from a third party. Clean claims do not include payments made to a provider of service or a third party where the timing of the payment is not directly related to submission of a completed claim by the provider of service or third party (e.g., capitation). A clean claim also does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.
- **Client Contact Record** – As defined in OAC rule 5160-26-01, the record containing demographic health-related information provided by an eligible individual, member, or the Ohio Department of Medicaid (ODM) that is used by the Ohio Medicaid consumer hotline to process membership transactions.
- **Control Charts** – A type of statistical process control tool that uses the relationship of observations to the mean and control limits to study how a process changes over time, also known as Shewhart charts.
- **Covered Entity** – A health plan, a health care clearinghouse, or health care provider under 45 CFR 160.103.
- **Covered Services** – As defined in OAC rule 5160-26-01, the medical services set forth in OAC rule 5160-59-03 or a subset of those services.
- **Cultural Humility** – An approach that incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations.
- **Date of Payment** – The date of the check or date of electronic payment transmission.

- **Date of Receipt** – The date the OhioRISE Plan receives the claim, as indicated by its date stamp on the claim.
- **Downstream Entity** – Any party that enters a written arrangement, acceptable to ODM, with a first tier or related entity or below the level of a first tier or related entity to provide administrative services for Ohio Medicaid-eligible individuals. These arrangements continue down to the level of the ultimate provider of the administrative services.
- **Electronic Health Record (EHR)** – A record in digital format that is a systematic collection of electronic health information. EHRs may contain a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, and billing information.
- **Eligible Individual** – Consistent with OAC rule 5160-26-01, any Medicaid recipient who is a legal resident of the state of Ohio and is in one of the categories eligible for OhioRISE Plan enrollment as provided in OAC rule 5160-59-02.
- **Emergency Medical Condition** – As defined in OAC rule 5160-26-01, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.
- **Emergency Services** – As defined in OAC rule 5160-26-01, covered inpatient services, outpatient services, or medical transportation that are provided by a qualified provider and are needed to evaluate, treat, or stabilize an emergency medical condition.
- **External Medical Review** – The review process conducted by an ODM-identified, independent, external medical review entity that is initiated by a provider that disagrees with the MCO's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity.
- **External Quality Review Organization (EQRO)** – As defined in 42 CFR 438.320, an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs EQR, other EQR-related activities as set forth in 42 CFR 438.358, or both.
- **Family** – A child'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.
- **First Tier Entity** – Any party that enters a written arrangement, acceptable to ODM, with the MCO to provide administrative services for Ohio Medicaid-eligible individuals.
- **Fraud** – As defined in OAC rule 5160-26-01, any intentional deception or misrepresentation made by an individual or entity with the knowledge that the deception could result in some unauthorized benefit to the individual, the entity, or some other person. This includes any act that constitutes fraud under federal or state law. Member fraud means the altering of

information or documents to fraudulently receive unauthorized benefits or to knowingly permit others to use the member's identification card to obtain services or supplies.

- **Grievance** – As defined in OAC rule 5160-26-08.4, a member's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include but are not limited to the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievance includes a member's right to dispute an extension of time proposed by the OhioRISE Plan to make an authorization decision.
- **Health Care Effectiveness Data and Information Set (HEDIS)** – Set of standardized performance measures developed, supported, and maintained by the National Committee for Quality Assurance (NCQA) designed to allow reliable comparison of health plan performance.
- **Health Disparity** – A particular type of health difference closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on characteristics historically linked to discrimination or exclusion (e.g., race or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical challenges; sexual orientation; or geographic location).
- **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.
- **Health Information Exchange (HIE)** – As defined in ORC chapter 3798, any person or governmental entity that provides in this state a technical infrastructure to connect computer systems or other electronic devices used by covered entities to facilitate the secure transmission of health information. Health information exchange excludes health care providers engaged in direct exchange, including direct exchange using a health information service provider.
- **Health Insuring Corporation** – As defined by ORC section 1751.01(H), a corporation, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.
- **HealthTrack** – Database operated by the Ohio Department of Medicaid that tracks member and provider complaints.
- **HUB** – Network of community-based organizations that hire and train community health workers to reach out to those at greatest risk, identify their risk factors, and assure that they connect to medical, social, and behavioral health services to reduce their risk.
- **In Lieu of Services** – Consistent with the requirements in 42 CFR 438.3(e)(2), services the OhioRISE Plan may cover for members that are in lieu of services covered under the Ohio Medicaid state plan and that ODM determines are medically appropriate and cost-effective substitutes for the covered service under the Ohio Medicaid state plan.

- **Incident** – As defined in OAC 5160-44-05, an alleged, suspected, or actual event that is not consistent with the routine care of, and/or service delivery to a member.
- **Indian** – Any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12.
- **Intensive care coordination** (ICC) – As defined in **5160-59-03.2,** ICC is a high fidelity wraparound model that is utilized when a "child and adolescent needs and strengths" (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.
- **Limited English Proficiency (LEP)** – Eligible individual or member who does not speak English as their primary language and who has a limited ability to read, write, speak, or understand English.
- **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, statewide pharmacy benefits manager, and the OhioRISE Plan.
- **Medicaid** – As defined in OAC rule 5160-26-01, medical assistance as defined in ORC section 5162.01.
- **Medicaid Contracted Entities** – Entities, such as the OhioRISE Plan, MCOs, the single pharmacy benefit manager (SPBM), and the Fiscal Intermediary that are under contract with ODM.
- **Medicaid Fraud Control Unit (MFCU)** – Consistent with OAC rule 5160-26-01, the unit of the Ohio Attorney General's Office responsible for the investigation and prosecution of fraud and related offenses within Medicaid.
- **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.
    - 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.
- **Medicare** – As defined in OAC rule 5160-26-01, the federally financed medical assistance program defined in 42 USC 1395.
- **Medication Therapy Management** – A process that promotes safe and effective use of medications, including prescription and over-the counter drugs, vitamins, and herbal supplements.
- **Member** – As defined in OAC rule 5160-26-01, a Medicaid eligible individual who has been assigned to the OhioRISE Plan for the purpose of receiving health care services.
- **Member Materials** – Items developed by or on behalf of the OhioRISE Plan to fulfill OhioRISE Plan program requirements or to communicate to all members or a group of members. Member materials include member education, member appreciation, and member incentive program information. Member health education materials produced by a source other than the OhioRISE Plan, and which do not include any reference to the OhioRISE Plan are not considered to be member materials.
- **Merger** – A transaction in which two companies join to form a single entity, using both companies' assets or stock, or, for non-stock corporations (e.g., non-profit corporations), the conversion of memberships, sponsors, or their voting rights. Both companies cease to

exist separately, and new stock is issued for the resulting organization or, for non-stock corporations (e.g., non-profit corporations), memberships or sponsors are combined, or their voting rights are transferred to the new corporation.

- **Misappropriation** – Depriving, defrauding, or otherwise obtaining the money, or real or personal property (including medication) of a member by any means prohibited by law.
- **Moderate care coordination** (MCC) – As defined in **5160-59-03.2,** MCC 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.
- **Neglect** – When there is a duty to do so, the failure to provide goods, services, and/or treatment necessary to assure the health and welfare of a member.
- **Network Provider** – Consistent with 42 CFR 438.2, any provider, group of providers, or entity that has a network provider contract with the OhioRISE Plan and receives Medicaid funding directly or indirectly to order, refer, or render covered services because of ODM's provider agreement with the OhioRISE Plan. A network provider is not necessarily a subcontractor by virtue of the network provider contract.
- **Notice of Action** – As defined in OAC rule 5160-26-08.4, the written notice the OhioRISE Plan must
provide to members when an adverse benefit determination has occurred or will occur.
- **Oral Interpretation Services** – Services provided to an eligible individual or member with limited English proficiency to ensure that the eligible individual or member receives MCO information that is orally translated into their primary language.
- **ODM Approved Entity** – For the purpose of this Agreement, an ODM Approved Entity is for Quality Improvement Training Requirements. Examples include the Institute for Healthcare Improvement, the Intermountain Healthcare Leadership Institute, the Cincinnati Children's Hospital, Anderson Center for Health System Excellence, the NC Center for Public Health Quality, the American Society for Quality's Learning Institute, the Deming Institute, and the National Association for Healthcare Quality.
- **Pending Member** – As defined in OAC rule 5160-26-01, an eligible individual who will be enrolled in the OhioRISE Plan but whose OhioRISE Plan membership is not yet effective.
- **Performance Improvement Project (PIP)** – A type of quality improvement (QI) project in which the OhioRISE Plan works collaboratively with the ODM-contracted clinical lead, QI lead, and recruited practices to improve an outcome. The OhioRISE Plan will conduct one PIP per year in a topic chosen by ODM. PIPs are validated by ODM's contracted EQRO in accordance with 42 CFR 438.330.
- **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.
- **Prepaid Inpatient Health Plan (PIHP)** – As defined in 42 CFR 438.2, a PIHP is an entity that 1) provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates; 2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and 3) does not have a comprehensive risk contract.
- **Primary Care Provider (PCP)** – As defined in OAC rule 5160-26-01, an individual physician (M.D. or D.O.), a physician group practice, an advanced practice registered nurse as defined in section 4723.01 of the Revised Code, an advanced practice nurse group practice within an acceptable specialty, or a physician assistant who meets the requirements of OAC rule 5160-4-03 contracting with an MCO to provide services as specified in OAC rule 5160-26-03.1. Acceptable PCP specialty types include family/general practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYNs).
- **Protected Health Information (PHI)** – Information received from or on behalf of ODM that meets the definition of PHI as defined by 45 CFR. 160.103.
- **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.
- **Provider Claim Dispute Resolution** – Established process for OhioRISE Plan network and out-of-network providers to challenge OhioRISE Plan claim payments or denials.
- **Provider-Preventable Condition** – As defined in 42 CFR 447.26, a condition that meets the definition of a "health care-acquired condition" (a condition occurring in any inpatient

hospital setting, identified as a health care-acquired condition by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the Ohio Medicaid state plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis /Pulmonary Embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients) or an "other provider-preventable condition" (a condition occurring in any health care setting) that meets the following criteria:

  - Is identified in the Ohio Medicaid state plan;
  - Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
  - Has a negative consequence for the beneficiary;
  - Is auditable;
  - Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

- **Quality Assessment and Performance Improvement (QAPI) Program** – A requirement by 42.CFR 438.330 that the OhioRISE Plan implement an ongoing quality assessment and performance improvement (QAPI) program for all services it furnishes to its members, ensuring the delivery of quality health care.
- **QAPI Template** – The ODM template that the OhioRISE Plan submit annually to demonstrate the content of their QAPI program and describe how they have executed ODM's quality improvement requirements.
- **Quality Improvement Culture** – Shared beliefs, perceptions, norms, values, and expectations of individuals and the organization regarding quality improvement (QI) and customer satisfaction. When a quality culture is achieved, all employees, from senior leadership to frontline staff, have infused QI into the way they do business daily. Employees continuously consider how processes can be improved, and QI is no longer seen as an additional task but a frame of mind in which the application of QI is second nature. The components of a sustainable QI culture include leadership commitment, a QI infrastructure, employee empowerment, a customer (member, provider, stakeholder) focus, teamwork and collaboration, and a focus on continually learning and improving.
- **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, MCOs, the OhioRISE Plan, SPBM, and state and county entities.
- **Related Entity** – Any related party to the OhioRISE Plan by common ownership or control under an oral or written arrangement to perform some of the administrative services under the OhioRISE Plan's contract with ODM. A related party includes but is not limited to agents,

managing employees, individuals with an ownership or controlling interest in the contractor and their immediate families, subcontractors, wholly owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any such entities or individuals.

- **Reorganization** – An arrangement where a company attempts to restructure its business to ensure it can continue operations. A company restructuring may work with its creditors to restate its assets and liabilities, which may be an attempt to avoid a bankruptcy.
- **Service Area** – As defined in OAC 5160-26-01, the geographic area specified in the OhioRISE Plan's provider agreement where the OhioRISE Plan agrees to provide Medicaid services to members residing in those areas.
- **Single Pharmacy Benefit Manager (SPBM)** – The state 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.
- **State Hearing** – The process set forth in 42 CFR Part 431, Subpart E, and OAC section 5101:6.
- **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.
- **Unexplained Death** – A member death for which the circumstances or the cause of death are not related to any known medical condition of the member, or someone's action or inaction may have caused or contributed to the member's death, including but not limited to inadequate oversight of medications or misuse of medications.

- **Validation** – As defined in 42 CFR 438.320, the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.
- **Value-Added Services** – Consistent with 42 CFR 438.3(e)(1)(i), any services that the OhioRISE Plan voluntarily agrees to provide that are in addition to those covered under the Ohio Medicaid state plan, although the cost of these services cannot be included when determining payment to the OhioRISE Plan.
- **Warm Transfer** – Process by which the person answering the original call stays on the phone with the caller while facilitating the transfer of the call to a third party, announces the caller and issue, and remains engaged as necessary to provide assistance.
- **Waste** – As defined in OAC rule 5160-26-01, payment for or the attempt to obtain payment for items or services when there may be no intent to deceive or misrepresent, but poor or inefficient billing or treatment methods result in unnecessary costs.
- **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 childand 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 Administrative Code.
- **Written Translation** – Translation in writing of OhioRISE Plan documents and materials into the primary language of an eligible individual or member with limited English proficiency.

Section 8: OhioRISE Acronyms

Acronym	Definition
ABD	Aged, Blind, and Disabled
ADAMH	Alcohol, Drug Addiction, and Mental Health or County Board of Alcohol, Drug Addiction, and Mental Health
AMA	American Medical Association
APM	Alternative Payment Model
APRN	Advanced Practice Registered Nurse
ASAM	American Society of Addiction Medicine
BDD	County Board of Developmental Disabilities
CAHP	Consumer Assessment of Healthcare Providers
CANS	Child and Adolescent Needs and Strengths

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CCE	Care Coordination Entity
CDJFS	County Department of Job and Family Services
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CICIP	Care Innovation and Community Improvement Program
CIO	Chief Information Officer
CMHC	Community Mental Health Center
CME	Care Management Entity
CMO	Chief Medical Officer
COA	Certificate of Authority
COE	Center of Excellence
CPC	Comprehensive Primary Care
CPSE	Claims Payment Systemic Error
CSP	Coordinated Services Program
CY	Calendar Year
DME	Durable Medical Equipment
DODD	Department of Developmental Disabilities
DYS	Ohio Department of Youth Services
EAPG	Enhanced Ambulatory Patient Grouping
eCQM	Electronic Clinical Quality Measure
EDI	Electronic Data Interchange
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
ESC	Educational Service Center
EVV	Electronic Visit Verification
FCFC	Family and Children First Council
FDR	First Tier, Downstream, and Related Entities
FFS	Fee for Service
FQHC	Federally Qualified Health Center

OhioRISE, Specialized Behavioral Health Care from Aetna Better Health of Ohio

FWA	Fraud, Waste, and Abuse
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act
IHBT	Intensive Home-Based Treatment
ICC	Intensive Care Coordination
IMD	Institution for Mental Disease
LISW	Licensed Independent Social Worker
LPCC	Licensed Professional Clinical Counselor
LSW	Licensed Social Worker
MAGI	Modified Adjusted Gross Income
MAT	Medication Assisted Treatment
MCC	Moderate Care Coordination
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MHPAEA	Mental Health Parity and Addiction Equity Act
MISP	Maternal and Infant Support Program
MPS	Minimum Performance Standards
MRSS	Mobile Response and Stabilization Services
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
OAC	Ohio Administrative Code
ODE	Ohio Department of Education
ODH	Ohio Department of Health
ODJFS	Ohio Department of Job and Family Services
ODRC	Ohio Department of Rehabilitation and Correction
OFCF	Ohio Family and Children First
OMHAS	Ohio Department of Mental Health and Addiction Services
OMES	Ohio Medicaid Enterprise System
ORC	Ohio Revised Code
ORP	Ordering, Referring, and Prescribing
PCP	Primary Care Provider

PCSA	Public Children Services Agency
PHI	Protected Health Information
PIP	Performance Improvement Project
PMPM	Per Member Per Month
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
RHC	Rural Health Clinic
SDOH	Social Determinants of Health
SFTP	Secure File Transfer Protocol
SFY	State Fiscal Year
SIU	Special Investigative Unit
SPA	State Plan Amendment
SPBM	Single Pharmacy Benefit Manager
SSA	Social Security Act
SUD	Substance Use Disorder
TPL	Third Party Liability
UM	Utilization Management
US	United States
USC	United States Code

Section 9: Response Requirements Check List

A. Response Requirements Check List

1. The following documents are required to accompany the submission of the CME application and must be submitted in totality by the submission deadline 12/8/2021
   a. Title Page
   b. Table of Contents
   c. Executive Summary
   d. CME Submission Checklist
   e. Narrative to Application Questions
   f. Organizational Chart for CME, including reporting relationships to the leadership of the bidding entity
   g. Job descriptions and minimum qualifications for the following positions:
      i. Care Coordinator – MCC positions and ICC positions

ii. Care Coordinator Supervisors for MCC positions and ICC positions

h. Leadership and Organizational Staff
i. Current/dated list of Board Members and their terms of office
j. Three years of Organization Financial Statements (P&L, Balance Sheet and Cash Flows) and YTD Actual Performance against Budget
k. Anticipated CME Budget (include anticipated start-up and ongoing)
l. Current certifications, licenses, and accreditation status

Section 10: Required Response Attachments

A. Required Response Attachments

1. The following required attachments are not part of the narrative response and do not count within the page limit.
   a. Organizational Chart for CME, including reporting relationships to the leadership of the bidding entity
   b. Job descriptions and minimum qualifications for the following positions:
      i. Care Coordinator – MCC positions and ICC positions
      ii. Care Coordinator Supervisors for MCC positions and ICC positions
      iii. Leadership and Organizational Team
   c. Current/dated list of Board Members and their terms of office
   d. Three years of Organization Financial Statements (P&L, Balance Sheet and Cash Flows) and YTD Actual Performance against Budget
   e. Anticipated CME Budget (include anticipated start-up and ongoing)
   f. Current certifications, licenses, and accreditation status

Section 11: MCO Measures required by OhioRISE Plan for inclusion in CME Contracts

Table I.3. MCO Measures that the OhioRISE Plan must include in Contracts with CMEs. State Fiscal Years 2023,2024, and 2025 Performance Measures, Measurements Sets, and Measurement Years

Measure	Measurement Set	SFY 2023 Minimum	SFY 2023 Measurement	SFY 2024 Minimum	SFY 2024 Measurement Year	SFY 2025 Minimum	SFY 2025 Measurement
Quality Strategy Population Stream: **Healthy Children**							

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Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	NCQA/ HEDIS	QW for MCO	MY 2022	QW for MCO	MY 2023	QW for MCO	MY 2024
Adolescent Well-Care Visits	NCQA/ HEDIS	QW for MCO	MY 2022	QW for MCO	MY 2023	QW for MCO	MY 2024
Kindergarten Readiness	ODM	Collaboration Only	MY 2022	Collaboration Only	MY 2023	Collaboration Only	MY 2024
Chronic Absenteeism	ODM	Collaboration Only	MY 2022	Collaboration Only	MY 2023	Collaboration Only	MY 2024
3rd Grade Reading	ODM	Collaboration Only	MY 2022	Collaboration Only	MY 2023	Collaboration Only	MY 2024
Graduation Rates	ODM	Collaboration Only	MY 2022	Collaboration Only	MY 2023	Collaboration Only	MY 2024
Annual Dental Visits, Total Rate[4]	NCQA/ HEDIS	Collaboration Only	MY 2022	Collaboration Only	MY 2023	Collaboration Only	MY 2024
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Percentile Documentation	NCQA/ HEDIS	QW for MCO	MY 2022	QW for MCO	MY 2023	QW for MCO	MY 2024

Note: No standard will be established, or compliance assessed for the measures designated 'reporting only' or'QW' in the Minimum Performance Standard column for the corresponding year.

*** = Minimum Performance Standard will be established for the subsequent state fiscal year*
TBD = Minimum Performance Standard is yet to be determined
QW = Quality Withhold measure (MCO for reference only)