Question ID #	Submission Date	Entity Name	Question	Final Answer
1	10/8/2021	Cincinnati Children's	Do the estimated numbers for each catchment area represent all three tiers?	Catchment area numbers provided in slide deck on 10/18/2021 apply to Tier 2 and Tier 3 
2	10/8/2021	Cincinnati Children's	Can we be provided the numbers/percentages of members anticipated to meet criteria for ICC and the numbers/percentages for members anticipated to meet MCC criteria for each catchment area?	ODM anticipates OhioRISE to enroll between 50,000 and 60,000 children and youth by end of year one. Anticipated Tier 2 population, 50 to 60%, total population Anticipated Tier 3 population, 15 to 25%, total population Anticipated Tier 1 population, 20%, total population
3	10/8/2021	Cincinnati Children's	What are the predicted and/or goal engagement numbers or percentages for tier 2 and tier 3 members?	ODM anticipates OhioRISE to enroll between 50,000 and 60,000 children and youth by end of year one. Anticipated Tier 2 population, 50 to 60%, total population Anticipated Tier 3 population, 15 to 25%, total population Anticipated Tier 1 population, 20%, total population Estimated projections are based on full engagement, CMEs will be responsible for continuing to try to engage families that are not yet ready to engage, and some families that aren't ready to engage will be moved to Tier 1 CC (included in the 20% assumption)
4	10/8/2021	Cincinnati Children's	Will the draft OhioRISE Care Coordination rules be final prior to the RFA?	No. The draft rules have not been finalized per ODM.
5	10/15/2021	The Centers	What outcome measures are required of the MCE for ICC and MCC?	Section 11 of the Appendix outlines the required metrics to be included in the CME contract. The Appendix is included on the Aetna OhioRISE CME Landing page. The Ohio CANS will be used to measure progress over time. Actionable items on Ohio CANS Domains (Emotional/Behavioral Needs; Risk Behaviors; Life Functioning; Strengths; and specific additional CANS modules as indicated - for example Traumatic Stress Symptoms) can be used as part of the metric measurement.

6	10/15/2021	The Centers	Will ICC/MCC be paid Per Member Per Month?	Yes. ODM is setting rates for ICC/MCC as blended “case rates” billed per client per month on a retrospective reimbursement (not prospective) basis. Proprated rates will be paid for partial months of enrollment, which are most likely to occur during the first and last month of CME assignment. Draft rates have been established and are subject to the rulemaking process as part of the OhioRISE services reimbursement rule. Please see slide 21 within this presentation: https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/34ef1b1c-1097-4f62-adfeded6e809bdd4/OhioRISE_Service+Rates+Update_2021.08.05.pdf?MOD=AJPERES&CVID=nImlY9c
7	10/15/2021	The Centers	Is there a cap on number of ICC/MCC clients that will be served per agency/catchment area?	3000. This is the projected maximum caseload size of a CME. Actual enrollment may vary from projections.
8	10/15/2021	The Centers	If a catchment area requires 2 MCE providers, will the area be geographically split between CME’s?	Refer to map and zip code listing. 64AD74A1.pdf 1A30237D.pdf
9	10/15/2021	The Centers	What are the technology requirements? Call center? Do we need a state or Aetna database?	This information is located in the appication
10	10/15/2021	The Centers	Do you have information to share on how other states have successfully implemented a similar project around care coordination for youth?	A number of states have imlemented system of care approaches and high-fidelity wraparound / wraparound-informed care coordination models. States with the longest history of this work are described in the "sustainability phase" in this SAMHSA report: https://store.samhsa.gov/sites/default/files/d7/priv/samhsa-state-community-profiles-05222019-redact.pdf
11	10/15/2021	The Centers	What is the maximum caseload size per CME?	3000. This is the projected maximum caseload size of a CME. Actual enrollment may vary from projections.
12	10/15/2021	The Centers	If OhioRISE projects to serve 55,000-60,000 youth within the first year, how many youth are anticipated to need ICC/MCC? Do you have projections for the catchment areas that could be shared?	ODM anticipates OhioRISE to enroll between 50,000 and 60,000 children and youth by end of year one. Anticipated Tier 2 population, 50 to 60%, total population Anticipated Tier 3 population, 15 to 25%, total population Anticipated Tier 1 population, 20%, total population *For catchment area anticipated projections see slide deck from 10/18/2021 presentation. Projected CME assignments are only for children who will enroll in Tiers 2 and 3.

13	10/15/2021	The Centers	Is ICC/MCC expected to be a mobile face to face in person service or could care coordination also be provided via telehealth, phone, Zoom etc?	F2F expected w/in 7 days for Tier 2 and within 2 days for Tier 3 for initial visit. For ongoing Care Coordination, from CME rule, "CMEs must ensure care coordination activities provided are provided via telehealth only when it is the youth or family's choice for service delivery via telehealth." Care coordination is a face to face service. Phone and telehealth are adjunct modalities.
14	10/15/2021	The Centers	When will COE offer the High-Fidelity Wraparound and Wraparound Informed trainings? How much time is required?	"Trainings to take place between Feb 2022 - April 2022 CORE Training Series (ICC and MCC): 3 days Initial Orientation: 2 hours. Core supervisor training series: 2 days Aetna Orientation training will also occur and will be approximately 16 hours."
15	10/15/2021	The Centers	Will Aetna cover care coordination for youth that are identified as Tier 1?	Yes, Aetna will cover the care coordination for Tier 1 members
16	10/15/2021	The Centers	What are the minimum qualifications of an ICC/MCC team?	Please see the draft rules, included in the Appendix on the Aetna OhioRISE CME landing page. **https://www.aetnabetterhealth.com/ohio/cmeapplication**
17	10/15/2021	Child & Family Health Collaborative of Ohio	Does the estimated annual number of kids figures reflect only those who would be enrolled in care management entities, or does it also include those receiving less intensive care management directly from Aetna?	Catchment area numbers provided apply to Tier 2 and Tier 3
18	10/15/2021	Child & Family Health Collaborative of Ohio	For regions L, M, and N, which are all in Franklin County, could the same applicant potentially win all three of the regions if they separately applied?	The map has been updated and Franklin is now divided into two catchment areas, K and L. The updated map is included within the RFA and Appendix on the Aetna OhioRISE CME landing page. A CME can apply for more than one catchment area within separate applications. It is possible that one CME may win both catchment areas for Franklin County.
19	10/15/2021	Child & Family Health Collaborative of Ohio	For regions L, M, and N, which are all in Franklin County, please explain the methodology of how OhioRISE members residing in Franklin County would be attributed to either of the three CMEs.	The map has been updated and Franklin is now divided into two catchment areas, K and L. The updated map is included within the RFA and Appendix on the Aetna OhioRISE CME landing page. Zip Codes will be the methodolgy utilized to assign to the CME within the catchment areas that include more than one CME. The list of zip codes for each catchment area are included in the powerpoint located on the Aetna OhioRISE landing page. Family choice could override zip code based assignment.

20	10/15/2021	Child & Family Health Collaborative of Ohio	For regions F and G, please explain how OhioRISE members residing in Hamilton County would be attributed to the region F CME versus region G.	Zip Codes will be the methodolgy utilized to assign to the CME within the catchment areas that include more than one CME. The list of zip codes for each catchment area are included in the powerpoint located on the Aetna OhioRISE landing page. Family choice could override zip code based assignment. **https://www.aetnabetterhealth.com/ohio/cmeapplication**
21	10/15/2021	Child & Family Health Collaborative of Ohio	For region G, please explain how the CME would be attributed OhioRISE members from Hamilton County given the region F CME would also be attributed members from Hamilton County.	Zip Codes will be the methodolgy utilized to assign to the CME within the catchment areas that include more than one CME. The list of zip codes for each catchment area are included in the powerpoint located on the Aetna OhioRISE landing page. Family choice could override zip code based assignment. **https://www.aetnabetterhealth.com/ohio/cmeapplication**
22	10/15/2021	Child & Family Health Collaborative of Ohio	Could consortiums potentially be eligible applicants? If so what provider type, if any, should they identify as in the application?	Yes, Consortiums would be eligible. There would be a lead agency who subconcontracts with additional providers. The lead agency would need to be an eligible provider type. Please outline their organizational structure / relationships in the application.
23	10/15/2021	Child & Family Health Collaborative of Ohio	Could an administrative entity of a consortium of otherwise eligible applicants potentially be an eligible applicant?	Only providers who are MCD enrolled or are eligible and can be contracted w/in 2 wks can apply. Please outline their organizational structure / relationships in the application.
24	10/15/2021	Child & Family Health Collaborative of Ohio	Must applicants be enrolled Medicaid providers prior to submitting the CME application?	Only providers who are MCD enrolled or are eligible and can be contracted w/in 2 wks can apply.

25	10/15/2021	Child & Family Health Collaborative of Ohio	Are waiver services providers eligible applicants? If so please define waiver services provider.	CME provider eligibility requirements are described in OAC rule 5160-59-03.2. For CMEs selected by Aetna that already have an existing Medicaid provider agreement, ODM will add the CME speciality to their existing provider agreement. For CME entities selected by Aetna that do not have an existing Medicaid provider agreement and cannot enroll as another Medicaid provide type, ODM will work to enroll these entities using the provider type category currently called "Waiver Services Provider" (Type 45) and assign the CME speciality. The requirements to be a CME are the same whether the entity has an existing Medicaid provider agreement or not. The waiver services provider type is simply being used by ODM to enroll those entities that do not otherwise exist under a different Medicaid provider type. ODM uses the waiver services provider type for a variety of provider types, that are then uniquely identified by a specialty - each of which has specific provider requirements described in OAC, as will be in place for CMEs based on the requirements in rule 5160-59-03.2. Selected CMEs enrolling through this provider type 45 pathway still need to meet basic Medicaid provider enrollment requirements, including those outlined in OAC 5160-1-17 through 5160-1-17.8 (i.e., maintain records, fraud, waste, and abuse, etc.)
26	10/18/2021	Partners for Kids and Nationwide Childrens Hospital	Can you clarify the performance measures - where can we find the exact metrics and defintions? Application references an appendix that is not attached	Section 11 of the Appendix outlines the required metrics to be included in the CME contract. The Appendix is included on the Aetna OhioRISE CME Landing page.
27	10/18/2021	Partners for Kids and Nationwide Childrens Hospital	Do measures include all members in the catchment area of the CME, or only those recieving services?	Outcome measures are required for any member receiving services from the CME.
28	10/18/2021	Andra Powell	Can you provide a link to the Aetna Medicaid Market Fee Schedule (AMMFS)?	Aetna will comply with 100% of the Medicaid fee schedule. Some of the services have not been finalized yet through the ODM rule process. We will contract at 100% of Medicaid. Value Based Contract arrangements will be persued.
29	10/18/2021	Signature Health	Will CMEs be the provider of IHBT and MRSS?	Only OhioRISE will be covering IHBT. All plans will cover MRSS. CMEs are not required to be an IHBT or MRSS provider. CMEs offering other BH services must have a firewall between CC functions and delivery of other services, including IHBT and MRSS. Aetna will be carefully monitoring CME referral paterns.

30	10/18/2021	Pressley Ridge	How soon after the contract start date do you anticipate most CME's reaching the expected capacity or near capacity?	Some children assigned to CMEs near the start of the program based on draft OAC 5160-59-02.1 OhioRISE First Day Eligibility and Enrollment. Enrollments following day one eligibility will ramp up across the first year of the program. We cannot predict monthly ramp up, but project the CME may meet the full projected assignment by the end of the first program year.
31	10/18/2021	Jodi Harding Lighthouse Youth & Family Services	we would have to be a subcontracted provider with the local CME to provide IHBT?	IHBT providers will need to be contracted with Aetna OhioRISE.
32	10/18/2021	Mary Burton Cincinnati Children's Hospital	Will members be referred to the CME only after they have had CANs to determine level of care coordination?	Yes, after CANS or after PRTF, or inpatient
33	10/18/2021	Pressley Ridge	Do you anticipate a "phased in" start up period to account for the flow of referrals over a period of time?	There will be a ramp up that will take the entire first year to reach full capacity.
34	10/18/2021	CareStar	If we are applying for all catchements, you are expecting 20 separate emails?	This is correct. One application for each catchment area.
35	10/18/2021	BHP of Central Ohio	So we're applying to work with Tier 2 and Tier 3 clients only?	Yes, Tier 2 and Tier 3 only. Aetna will be handling Tier 1.
36	10/18/2021	TAC Inc	To Clarify, can non-CME's provide IHBT?	CMEs will not be responsible for paying directly for other Medicaid-covered behavioral health services, and CMEs will not be required to provide any services beyond those included in the RFA / their contract with Aetna. Providers eligible to be an IHBT provider can contract with Aetna to provide IHBT services to Medicaid members.
37	10/18/2021	The Ohio Counsel	To clarify, the CME doesn't have to provide IHBT or MRSS, but will make sure clients have access to those services?	Correct. CMEs offering other BH services must have a firewall between CC functions and delivery of other services, including IHBT and MRSS. Aetna will closely monitor CME referral paterns.
38	10/18/2021	Lighthouse Youth & Family Services	But we would have to e a subcontracted provider with the local CME ot provide IHBT?	CMEs will not be responsible for paying directly for other Medicaid-covered behavioral health services. Providers eligible to be an IHBT provider can contract with Aetna to provide IHBT services to Medicaid members.
39	10/19/2021	Alta Care Group	Has the 25% rule for self-referrals from the CME been lifted?	Yes the 25% specification has been lifted although the expectation to prevent only self-referrals remains. Aetna will closely monitor CME referral paterns.
40	10/19/2021	Alta Care Group	If two organizations collaborate to be the CME, are both leads, or is one the lead and subcontracts the other?	One would be the lead and the other subcontracts
41	10/19/2021	Alta Care Group	In a collaborative CME application between two organizations, will both bill separately and be reimbursed directly for CME services by Medicaid?	Only the lead agency receives payment and subcontractor arrangements are managed by the lead agency.

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<tr><td>42</td><td>10/19/2021</td><td>Alta Care Group</td><td>Will a CME be expected to be fully staffed to meet the projected number of OhioRise youth in their catchment area on day one (7/1/22)?</td><td>No. CMEs will need to work toward full staffing as part of the OhioRISE program's ramp-up period. Projected CME volume is anticipated to be reached over the course of the first year. Appropriate staffing for "day one" will be part of the readiness review process.</td></tr>
<tr><td>43</td><td>10/19/2021</td><td>Alta Care Group</td><td>To maintain CME Caseload fidelity for ICC (1:10) and MCC (1:25), are these maximum limits independent or combined? Specifically, can one FTE have 10 ICC cases and 25 MCC cases, for a total caseload at one time of 35?</td><td>There are case load limits as outlined in the draft rules, ICC 1:10 and MCC 1:25. However, it is anticipated there will be blended case loads in which one care coordinator may have ICC members and MCC members at the same time. The following formula, provided by the COE, can be utilized to assist in determining how to determine case load size when one care coordinator is covering both ICC and MCC cases: for every 1 ICC case a care coordinator may cover 2.5 MCC cases. For example, if a care coordinator has 4 ICC members, the same care coordinator can have 15 MCC cases for a total of 19 members on a case load. Case load sizes will need to be averaged to account for the partial case of .5.

Mixed Caseload Calculations

Formula: Ratio 1: 2.5

<table><tr><th>Mixed Total</th><th>ICC 1:10</th><th>MCC 1:25</th></tr><tr><td></td><td>1:10</td><td>1:25</td></tr><tr><td>11.5</td><td>1:9</td><td>1:2.5</td></tr><tr><td>13</td><td>1:8</td><td>1:5</td></tr><tr><td>14.5</td><td>1:7</td><td>1: 7.5</td></tr><tr><td>16</td><td>1:6</td><td>1:10</td></tr><tr><td>17.5</td><td>1:5</td><td>1:12.5</td></tr><tr><td>19</td><td>1:4</td><td>1:15</td></tr><tr><td>20.5</td><td>1:3</td><td>1:17.5</td></tr><tr><td>22</td><td>1:2</td><td>1:20</td></tr><tr><td>23.5</td><td>1:1</td><td>1:22.5</td></tr></table></td></tr>
<tr><td>44</td><td>10/19/2021</td><td>Dayton Children's Hospital</td><td>What is the plan if there are no applicants for a catchment area?</td><td>If this happens, Aetna would look to closest CME's for members. Aetna will look for flexible solutions to handle in the best way possile for the children in the catchment area, including outreach to other CMEs and consideration of alternative models to provide ICC/MCC services.</td></tr>
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45	10/19/2021	Ohio Children's Alliance	Please clarify if the Type 45 waiver services provider is the correct/appropriate provider type for stand-alone CME applicant entities to apply under	For CMEs selected by Aetna that already have an existing Medicaid provider agreement, ODM will add the CME speciality to their existing provider agreement. For CME entities selected by Aetna that do not have an existing Medicaid provider agreement, ODM will enroll those entities using the provider type category "Waiver Services Provider" (Type 45) and assign the CME speciality. The waiver services provider type is simply being used by ODM to enroll those entities that do not otherwise exist under a different Medicaid provider type. ODM uses the waiver services provider type for a variety of provider types, that are then uniquely identified by a specialty - each of which has specific provider requirements described in OAC, as will be in place for CME based on the requirements described in 5160-59-03.2. Selected CMEs enrolling through this provider type 45 pathway still need to meet basic Medicaid provider enrollment requirements, including those outlined in OAC 5160-1-17 through 5160-1-17.8 (i.e., maintain records, fraud, waste, and abuse, etc.).
46	10/19/2021	Ohio Children's Alliance	Please clarify if the CME administrative budget is strictly funded from the PMPM case rates, or if there is a seperate funding stream from Aetna to the CME to pay for their initial and ongoing CME adminstration costs	The case rates established for ICC and MCC by ODM include administrative overhead and individual staff overhead costs.
47	10/19/2021	Ohio Children's Alliance	Please clarify what is required for CMEs to comply with the minimum “firewall” requirements for conflict-free care coordination	The minimum requirement is for the CME to provide specific policies and procedures regarding how the CME will ensure conflict-free care coordination occurs within their organization, including specific activities performed to ensure care coordinators are not consistently referring to services within the CME organization when other service options are available and meet the youth and family/caregiver's needs.
48	10/19/2021	Signature Health	The catchment areas have an estimated number of annual enrollments per catchment. What is the average length of stay in MCC and ICC that Aetna and/or Medicaid projected in during the ramp up year and then how many once we reach full speed? In other words how many member months are projected in year 1, 2, 3?	Yes, updated map has been provided on landing page in RFA and appendix. LOS is based on the youth's identfied needs. The average expected LOS for ICC: 12 months and for MCC: 9 months
49	10/19/2021	Dayton Children's Hospital	Is a hospital providing this service a conflict?	No, this is not a conflict. However, should other BH services be offerred remember the firewall that is expected.
50	10/19/2021	Dayton Children's Hospital	The bidders' confernence materials to not define what aetna's role is in this initiative nor what the funding will be for CME's. How will that be disseminated?	ODM contracted w/ Aetna to oversee OhioRISE. The MCP - Aetna will pay all the BH services including CME's. The funding is a pmpm for Tier 2 and Tier 3. Aetna will also support CME develoment, monitoring of CME performance and child/family outcomes.

51	10/19/2021	Signature Health	Do CMEs have to submit a medical claim to be paid the PMPM or will the CME be paid based off the enrolled panel? If it is claims based are CMEs required to see each child prior to submitting a claim?	Claim submission will be required for each child enrolled in and receiving ICC/MCC. CMEs must meet ICC/MCC service specifications and fidelity requirements to bill for services provided to the child/youth. Additional biling specifications will be provided at a later date. ODM is setting rates for ICC/MCC as blended “case rates” billed per client per month on a retrospective reimbursement (not prospective) basis. Proprated rates will be paid for partial months of enrollment, which are most likely to occur during the first and last month of CME assignment.
52	10/19/2021	Unison Health	If there is not a formal MOU in place, would it beneficial to include letters of support from entities with whom the CME works with?	Yes.
53	10/19/2021	Rebbeca Meyer	Will a recording of this be available for later viewing/sharing?	The 10.19.2021 session was not recorded.
54	10/19/2021	The Children's Home	Aside from the inital face to face visit, CANS and care plan is there an expected frequency of visits for the MCC or ICC?	Yes, there are requirements for phone and FTF depending on if member is ICC or MCC. Available in the draft rules.
55	10/19/2021	Cincinnati Children's Hospital Medical Center	Our mental health agency also has an MST program, the only program in the area; is this a conflict?	No. CMEs offering other BH services must have a firewall between CC functions and delivery of other services, including IHBT and MRSS.
56	10/19/2021	Cincinnati Children's Hospital Medical Center	Can you talk about the aetna portal and if it links to EPIC and other EHR's?	Currently, for clinical practice data, we can leverage both local HIE and national EMR (eg. Athena) capabilities to collect and expose ADT and clinical care data. From a systems roadmap standpoint, we have conducted a pilot and are assessing the DataLink platform to further enhance our population health capabilities.
57	10/19/2021	Lima UMADAOP	Was yesterday’s recorded and did you have handouts from yesterday’s be printed out.	Due to technical issues 10/18/2021 was not recorded. 10/19/21 was not recorded. All materials are available on the Aetna OhioRISE CME landing page.
58	10/19/2021	Cincinati Children's Hosptial Medical Center	has the portal been connected in past to any EMR	Currently, for clinical practice data, we can leverage both local HIE and national EMR (eg. Athena) capabilities to collect and expose ADT and clinical care data. From a systems roadmap standpoint, we have conducted a pilot and are assessing the DataLink platform to further enhance our population health capabilities.
59	10/19/2021	Alta Care	Just to clarify- there is no 25% limitation for providers to be the CME entity and the provider. You indicated "originally"- did this change?	Correct
60	10/19/2021	Wingspan Care Group	Are there minimum qualifications for Care Coordinators and Care Coordinator supervisors	Yes. Please see the draft rules referenced in the Appendix.
61	10/19/2021	CareStar	If awarded more than one catchment area are staff allowed to cross catchment areas within their caseloads?	Staffing must meet the requirements for ICC/MCC within their caseloads if travel isn't prohibitive.

62	10/19/2021	Pathing	Is there an expectation to have CME staff located in the county where they are providing the service (i.e. a rural county)?	No, but must be able to meet ICC/MCC requirements outlined in the rule, including face to face delivery of services in community of children/youth. Must also have a "physical presence" in the catchment area"
63	10/19/2021	Pathing	Is there an expectation to have CME staff located in the county where they are providing the service (i.e. a rural county)?	No, but must be able to meet ICC/MCC requirements outlined in the rule, including face to face delivery of services in community of children/youth. Must also have a "physical presence" in the catchment area"
64	10/19/2021	Calland J	Are there any start-up funds available for CMEs to get up and running?	ODM announced grant funding will be in early 2022 to accelerate CME start-up and service delivery. CMEs selected by Aetna will have an opportunity to receive OhioRISE Transition Grants based on their level of need to meet immediate organizational growth goals. Applicants should identify their specific needs for grant funding (ex HIE, EHR, start up CC staff) in their CME application. Additional details about the grant funding opportunity are forthcoming.
65	10/19/2021	Alta Care Group	Is there a projected/estimated length of care for an individual receiving ICC/MCC? In other words, how can we project the number of FTE's needed in our catchment area?	LOS is based on the youth's identfied needs. The average expected LOS for ICC: 12 months and for MCC: 9 months
66	10/19/2021	Zepf Center	is there a maximum distance limit for the providers within a catchment area, e.g. must be within 25 miles?	No maximum distance built in to requirments. Must be able to render ICC/MCC per ODM rule requirements.
67	10/19/2021	Zepf Center	when the Medicaid rates are determined, will Aetna follow those reimbursment rates?	Aetna will comply with 100% of the Medicaid fee schedule. Some of the services have not been finalized yet through the ODM rule process. We will contract at 100% of Medicaid. Value Based Contract arrangements will be persued.
68	10/19/2021		I have a question about the catchment areas if you are allowed to respond. The catchment area list has an estimated number of children expected to be covered. For example, the Cuyahoga west is 2200, Cuyahoga Central is also 2200 and Cuyahoga East/Lake/Geauga/Ashtabula is 2120. I also heard Tracy say that the payments are a PMPM. So my question is do those numbers represent patients per month or the total number of patients per year. If it is patients per year, how many months have been estimated that each child will remain in either MCC or ICC? We need a number of member months to estimate revenue/staffing and program design. For example, if I need to plan for 2000 kids a month even if they were all at MCC level, I would need 80 care coordinators to keep the 1:25 ratio. But if it's 2000 kids a year and they are only going to stay 3 months then I only need 20 care coordinators. Of course, the PMPM works the same way. If its 2000 a month X $400 = $800,000 a month. But, if it's 2000 kids a year and they are expected to stay 3 months then we are talking more like $200,000 a month. Can you shed any light on the scope of what we are designing the program for?	The projections for each catchment area are for estimated number of patients per year. LOS is based on the youth's identfied needs. The average expected LOS for ICC: 12 months and for MCC: 9 months. We cannot provide estimated member months at this time, but do expect the enrolled population to ramp-up throughout the first year of the program.

69	10/19/2021	Ohio Children's Alliance	I wanted to know if providers must have national Accreditation for Case Management to be CME?	No it is not required.
70	10/21/2021	Cincinnati Children's	From CME Agreement: 2.1.2 Service Provider agrees that it will: (n) provide real-time or on demand clinical and psychiatric consultation for youth engaged in ICC or MCC **Question: Can you provide the operational definitions for clinical and psychiatric consultation specific to this requirement? Is this an expectation of unlicensed Care Coordinators?**	CMEs must have clicinal and psychiatric consultation available to care coordinators to ensure Child and Family-Centered Care Plans are consistent with clinical and psychiatric needs of children. While consultation may not be needed on most cases, consultation must be available to assist care coordinators with understanding and planning for child and family clinical and psychiatric needs as part of the overall care plan. Care coordinators are also responsible to coordinate care and facilitate access to direct behavioral health services, including access to clinical and psychiatric services as identified in the Child and Family-Centered Care Plan.
71	10/21/2021	Cincinnati Children's	(o) respond to the youth and family twenty-four hours a day **Question: Please provide details for this requirement in regards to care coordination. Can this be met by a service outside of the care coordination team?**	A crisis safety plan is to be developed within 14 calendar days of referral to ICC or MCC. This plan will outline any service that may be needed outside of normal business hours, including if needed 24 hours a day. This plan should include formal supports, informal supports, and natural supports the child/youth and family/caregiver may need access to 24 hours a day. CMEs must have resources (staff, contractors, etc.) available to respond to ICC/MCC members' specific care coordination needs twenty four hours a day. Additionally, a crisis safety plan is to be developed within 14 calendar days
72	10/21/2021	Cincinnati Children's	(q) ensure that all care coordination services are provided conflict-free, meaning that care coordination functions are separated from service delivery functions. If the CME has both lines of business, the CME must establish firewalls between its care coordination function and its service delivery function **Question: I understand that having policies and transparent data for referral patterns and processes to demonstrate that families are given a choice will be required, is there also a requirement to restrict the exchange of health information accessibility between providers and the CME should they be part of the same system?**	Health information exchange should be limited to instances when the CME and service providers within the organization are serving the same child/youth and family/caregiver. All HIPAA regulations are expected to be enforced.

73	10/21/2021	Cincinnati Children's	From Aetna Bidders Conference presentation: •Each CME is projected to serve approximately 1,000 – 3,000 children during the first year of OhioRISE operations. **Question: Do these numbers represent expected engagement? If not, what are the expected/anticipated engagement goals?** •ABHCOE will train CMEs February-April **Question: If Care Coordination referrals and staffing can ramp-up over a period of time, will this training be offered at a later date?** •A comprehensive CANS assessment within 30 days and updates every 90 days **Question: Does the CME bill for CANS assessments done by the care coordinators?**	These numbers represent the expected assignment for the first year. CMEs must work to engage all children/youth and families/caregivers assigned to them for ICC/MCC. Yes, training will be offered on an ongoing basis to accommodate ramp up as well as assist with CME staff transition needs. No, the CME Care Coordinator is not a service provider for the children and youth on their ICC or MCC case load. Certified CANS assessors working within CMEs can bill separately for conducting CANS assessments (outside of the ICC/MCC case rate).
74	10/21/2021	Crossroads Health	How will the ICC/MCC case rates will work? Is it a monthly rate/client?	ODM is setting rates for ICC/MCC as blended “case rates” billed per client per month on a retrospective reimbursement (not prospective) basis. Prorated rates will be paid for partial months of enrollment, which are most likely to occur during the first and last month of CME assignment. Draft rates have been established and are subject to the rulemaking process as part of the OhioRISE services reimbursement rule. Please see slide 21 within this presentation: https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/34ef1b1c-1097-4f62-adfeded6e809bdd4/OhioRISE_Service+Rates+Update_2021.08.05.pdf?MOD=AJPERES&CVID=nImlY9c

75	10/21/2021	Child & Family Health Collaborative of Ohio	Please explain the eligibility pathway(s) for consortiums to use to apply	CME provider eligibility requirements are described in OAC rule 5160-59-03.2. For CMEs selected by Aetna that already have an existing Medicaid provider agreement, ODM will add the CME specialty to their existing provider agreement. For CME entities selected by Aetna that do not have an existing Medicaid provider agreement, ODM will enroll those entities using the provider type category currently called "Waiver Services Provider" and assign the CME specialty. The requirements to be a CME as the same whether the entity has an existing Medicaid provider agreement or not. The waiver services provider type is simply being used by ODM to enroll those entities that do not otherwise exist under a different Medicaid provider type. ODM uses the waiver services provider type for a variety of provider types, that are then uniquely identified by a specialty - each of which has specific provider requirements described in OAC, as will be in place for CMEs based on the requirements described in 5160-59-03.2. Selected CMEs enrolling through this provider type 45 pathway still need to meet basic Medicaid provider enrollment requirements, including those outlined in OAC 5160-1-17 through 5160-1-17.8 (i.e., maintain records, fraud, waste, and abuse, etc.).
76	10/22/2021	Child & Family Health Collaborative of Ohio	When eligible CME providers develop consortiums to apply, is it permissible that their CME Administrative Entity serves as the applicant, even if they are not currently a registered ODM Medicaid provider?	For CMEs selected by Aetna that already have an existing Medicaid provider agreement, ODM will add the CME specialty to their existing provider agreement. For CME entities selected by Aetna that do not have an existing Medicaid provider agreement, ODM will enroll those entities using the provider type category currently called "Waiver Services Provider" and assign the CME specialty. The requirements to be a CME as the same whether the entity has an existing Medicaid provider agreement or not. The waiver services provider type is simply being used by ODM to enroll those entities that do not otherwise exist under a different Medicaid provider type. ODM uses the waiver services provider type for a variety of provider types, that are then uniquely identified by a specialty - each of which has specific provider requirements described in OAC, as will be in place for CMEs based on the requirements described in 5160-59-03.2.Selected CMEs enrolling through this provider type 45 pathway still need to meet basic Medicaid provider enrollment requirements, including those outlined in OAC 5160-1-17 through 5160-1-17.8 (i.e., maintain records, fraud, waste, and abuse, etc.).

77	10/23/2021	Child & Family Health Collaborative of Ohio	Please explain all pathways for consortiums or health care networks to apply for this procurement as a Type 45 Waiver Services Provider.	CME provider eligibility requirements are described in OAC rule 5160-59-03.2. For CMEs selected by Aetna that already have an existing Medicaid provider agreement, ODM will add the CME specialty to their existing provider agreement. For CME entities selected by Aetna that do not have an existing Medicaid provider agreement, ODM will enroll those entities using the provider type category currently called "Waiver Services Provider" and assign the CME specialty. The requirements to be a CME as the same whether the entity has an existing Medicaid provider agreement or not. The waiver services provider type is simply being used by ODM to enroll those entities that do not otherwise exist under a different Medicaid provider type. ODM uses the waiver services provider type for a variety of provider types, that are then uniquely identified by a specialty - each of which has specific provider requirements described in OAC, as will be in place for CMEs based on the requirements in rule 5160-59-03.2. Selected CMEs enrolling through this provider type 45 pathway still need to meet basic Medicaid provider enrollment requirements, including those outlined in OAC 5160-1-17 through 5160-1-17.8 (i.e., maintain records, fraud, waste, and abuse, etc.).
78	10/22/2021	Catholic Charities	IHBT requires that all treatment services be provided by the one staff only and other services need to stop while IHBT is involved. The ICC role under CMEs seems like an overlap with CPST and what IHBT is providing. Will the IHBT requirement change?	No, the IHBT requirement will follow the draft rules for IHBT services posted to the OhioRISE CME Landing page. https://www.aetnabetterhealth.com/ohio/cmeapplication ICC and MCC care coordinators are not service providers. A care coordinator coordinates care to ensure a youth and family/caregiver receives the needed services, formal supports and natural supports identified on the Child and Family-Centered Care Plan. IHBT service may be one of the services identified on the CFCCP. The ICC/MCC care coordinator will facilitate referral to an IHBT provider, ensure appointments are scheduled, ensure the youth and family/caregiver are accessing the service and assist in removing any barriers to access the service.

79	10/22/2021	Catholic Charities	Are there new billing codes and rates for ICC or is everything proposed in the RFA under the same Fee schedule under ODM? Will they need to be QMHS credentialed? And/or will they bill and provide CPST as indicated on a treatment plan? Would a youth/family have a CPST staff in addition to a ICC staff? Is the ICC only allowed to provide ICC or can they have other duties within their scope and job description?	1. ODM is setting rates for ICC/MCC as blended “case rates” billed per client per month on a retrospective reimbursement (not prospective) basis. Prorated rates will be paid for partial months of enrollment, which are most likely to occur during the first and last month of CME assignment. Draft rates have been established and are subject to the rulemaking process as part of the OhioRISE services reimbursement rule. Please see slide 21 within this presentation: https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/34ef1b1c-1097-4f62-adfeded6e809bdd4/OhioRISE_Service+Rates+Update_2021.08.05.pdf?MOD=AJPERES&CVID=nImlY9c 2. ICC/MCC care coordinators must meet the requirements in the CME care coordination rule, which includes the following: "An ICC or MCC care coordinator 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," 3. Billing for ICC/MCC activities will occur through the case rate described in #1 above. 4. Primary care coordination for children/youth enrolled in OhioRISE will be provided by Aetna (Tier 1) or CMEs (Tiers 2 and 3). It is possible other services providers involved in the child's case may have reason to bill CPST for conducting CPST services. These services and providers must be outlined in the Child and Family-Centered Care Plan. 5. An individual who serves as a care coordinator for ICC and
80	10/22/2021	Catholic Charities	Is there reimbursement available for the increased administrative tasks with quality management and outcome data entry and management? And travel costs? Or Are we setting our own rates in the budget?	The ICC/MCC case rates set by ODM include administrative overhead and travel.
81	10/22/2021	Catholic Charities	Will youth be eligible for the OHRise waiver regardless of household income?	No. A youth applying for enrollment on the OhioRISE 1915(c) waiver must meet Medicaid financial and OhioRISE programmatic requirements. Financial eligibility may be found in 5160:1 of the Ohio Administrative Code (OAC). In certain situations, a child may be found to meet Medicaid financial requirements under a Medicaid eligibility category known as the “Special Income Level” or “SIL” per OAC 5160:1-6-03 and 5160:1-6-03.1.
82	10/22/2021	Catholic Charities	Will youth have to change MCOs to receive OHRise services?	No, OhioRISE is in addition to the physical healthcare MCO
83	10/22/2021	Catholic Charities	Will all CMEs be given the same outcomes measures across all catchment areas?	Yes

84	10/22/2021	Catholic Charities	What is the funding structure for CMEs? Fee for service, PMPM, case rate by tier level? Are there start up funds available?	ODM is setting rates for ICC/MCC as blended “case rates” billed per client per month on a retrospective reimbursement (not prospective) basis. Prorated rates will be paid for partial months of enrollment, which are most likely to occur during the first and last month of CME assignment. Draft rates have been established and are subject to the rulemaking process as part of the OhioRISE services reimbursement rule. Please see slide 21 within this presentation: https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/34ef1b1c-1097-4f62-adfeded6e809bdd4/OhioRISE_Service+Rates+Update_2021.08.05.pdf?MOD=AJPERES&CVID=nImlY9c ODM announced grant funding will be in early 2022 to accelerate CME start-up and service delivery. CMEs selected by Aetna will have an opportunity to receive OhioRISE Transition Grants based on their level of need to meet immediate organizational growth goals. Applicants should identify their specific needs for grant funding (ex EHR, HIE, start up staff) in their CME application. Additional details about the grant funding opportunity are forthcoming.
85	10/22/2021	Catholic Charities	Will all CMes be given the Client Satisfaction surveys and what is the method and frequency of distribution?	"The OhioRISE Plan will partner with children or youth and families/caregivers, providers, community partners, the CABHCOE, CMEs, the MCOs, and ODM to develop the Quality Oversight and Improvement process. A specific client satisfaction survey, method and distribution process as not been developed."
86	10/22/2021	Catholic Charities	Can you tell us if the Family connect portal is compatible with AVATAR or netsmart products?	We are open to evaluating partnerships with one or both of these platforms in the future.
87	10/22/2021	Harbor/Lighthouse/The Central Community Health Board	Given the current challenges state (and nation) wide with behavioral health staffing vacancies, what consideration and planning is taking place with Aetna and ODM as we add a new layer of service with CME Care Coordination? Are there plans to ensure that current youth behavioral health provider agencies are not negatively impacted as staff move from being a direct treatment provider to become a CME Care Coordinator?	ODM is hosting a implementation and operations workgroups that may discuss this matter.

88	10/22/2021	Harbor/Lighthouse/The Central Community Health Board	Section 8.1.6, VII asks for a two-year budget projection. Is any consideration being given to compensate for upfront costs incurred by CMEs? For example, training will be required for CME Care Coordination staff before the July 2022 Go-Live. Will CME's receive payment or reimbursement prior to July 2022 for incurred costs so they are ready for the Go-Live?	Include in your start up costs in your budget as part of your application. Yes, state-sponsored training will be required and provided at no cost to CMEs. ODM announced grant funding will be in early 2022 to accelerate CME start-up and service delivery. CMEs selected by Aetna will have an opportunity to receive OhioRISE Transition Grants based on their level of need to meet immediate organizational growth goals. Applicants should identify their specific needs (EHR, HIE, start up CC staff) for grant funding in their CME application. Additional details about the grant funding opportunity are forthcoming.
89	10/22/2021	Harbor/Lighthouse/The Central Community Health Board	Will CANS training be offered on an ongoing basis?	Yes. The State of Ohio is covering the cost of CANS training and certification through 2022.
90	10/22/2021	Ravenwood Health	How many of the attributed children in a catchment area will be ready to receive services in July 2022?	Additional information about start-up in July 2022 will be available at a later date.
91	10/22/2021	Ravenwood Health	Can there be a "ramp" up time – based on the number of children ready to start in July 2022? If half the children are ready - hire half the staff and add as the number increases?	Yes, there will be a ramp up time. Additional information about start-up in July 2022 will be available at a later date.
92	10/22/2021	Ravenwood Health	Can we ask for implementation cost? Based on the number of children attributed, we will need to hire over 100 new staff members. They will need training and orientation – so before they can begin, we will possible a couple of months of salary before we can begin billing PMPM.	Projected annual enrollment for each catchment area should dictate the staffing plan the CME will need to reach by the end of the first year. Enrollment in OhioRISE and assignment to CME care coordination will ramp up across the first year of the program. ODM announced grant funding will be in early 2022 to accelerate CME start-up and service delivery. CMEs selected by Aetna will have an opportunity to receive OhioRISE Transition Grants based on their level of need to meet immediate organizational growth goals. Applicants should identify their specific needs (EHR, HIE, start up CC staff) for grant funding in their CME application. Additional details about the grant funding opportunity are forthcoming.
93	10/22/2021	Ravenwood Health	What is the education/ experience requirements for the Care Managers?	Please see the draft rules, included in the Appendix on the Aetna OhioRISE CME landing page. https://www.aetnabetterhealth.com/ohio/cmeapplication
94	10/22/2021	Ravenwood Health	What is the education / experience requirements for the Supervisor?	Please see the draft rules, included in the Appendix on the Aetna OhioRISE CME landing page. https://www.aetnabetterhealth.com/ohio/cmeapplication

95	10/22/2021	Merakey	In response to the CME RFP, Merakey has the following questions: •Are all of the positions listed under rates required or can staffing vary depending on need? •Is the per diem rate for each day an individual is in our care or is it only days when services are provided? •What are the minimum service requirements to bill the case rate? •Can you provide additional information on supervision requirements? •Are providers able to propose any alternatives to the service descriptions for specialized populations?	1: Please see draft rules, included in the Appendix on the Aetna OhioRISE CME landing page to provide ICC and MCC requirements for positions. Staff can vary to meet needs as long as the ICC and MCC requirements for staffing are met. 2: PMPM rate 3: see number 5. 4: see number 5. 5: Please see the draft rules, included in the Appendix on the Aetna OhioRISE CME landing page. https://www.aetnabetterhealth.com/ohio/cmeapplication
96	10/25/2021	Wingspan	Is participation in the COE training paid or included in the PMPM payment?	ODM's rate models for ICC and MCC included significant time annually for initial and ongoing care coordinator training.
97	10/25/2021	Wingspan	I want to confirm my understanding that CME eligibility can include a Medicaid provider that is not a provider type 95 or 84?	Providers who are currently medicaid enrolled or able to be in enrolled within 2 weeks are eligible to apply.
98	10/25/2021	The Ohio Council	The RFA speaks to CMEs developing formal and informal resource lists in their catchment areas. This seems to imply that referrals will be predominately expected to remain within the CME catchment area. How will youth and family choice be honored and managed when a family, particularly one living near a catchment area border, prefers to access formal or informal services and supports in a neighboring community? (For example, a family living in southern Delaware county attends church in Dublin, sees PCP in Powell, has BH services in Worthington, and attends Dublin schools, all of which are in Franklin County?) How will this be managed in Cuyahoga, Franklin, and Hamilton Counties which have multiple CMEs? Will CMEs use a similar format for developing resource lists that can be shared across catchment areas?	Members are referred to CME's in their catchment areas. Members are able to receive services anywhere. If a family expresses a desire to access resources in a different county, the CME is responsible for helping the family do so. We would recommend the CME work with the CMEs in other counties to identify appropriate resources when needed or requested.
99	10/25/2021	The Columbus Organization	Are CMEs able to apply to other catchment areas after award?	No this will not be necessary.
100	10/25/2021	Clermont County Ohio Gretchen Behimer	Can we get a break down in numbers for a specific catchment area? Some are large & it would be good to know the numbers by specific counties in the catchment area.	See zip code map  49E6DEF9.pdf
101	10/25/2021	The Columbus Organization	Are you planning a scheduled review period to check ongoing performance of awarded CMEs for a particular area? If so, what would be the timeline and criteria?	Please see the Quality Oversight and Improvement Section in the Appendix as well as the Application. Also in the ODM Draft rules.
102	10/25/2021	The Columbus Organization	Can an approved CME be disapproved? If so, would the catchment area open up for other approved CMEs?	We are committed to selecting the best applications for each catchment area and are fully committed to supporting the CME's success. We will however, discontinue language due to fraud, abuse, waste, safety, health welfare issues.

103	10/25/2021	The Ohio Council	The Case Management Service Agreement make reference to the “Service Provider” or “CME” and then makes reference to the CMEs “Network of Providers”. Is the assumption that the CME will be contracting with other organizations to preform care coordination and that payment and compliance referenced in the service agreement is limited to the provision of ICC/MCC activities between the CME and its contracted organizations? The use of the phase “Network Providers” is confusing and could also be interpreted as the CME will be contracting for all services performed under OhioRISE since all contracted providers are referred to as “Network Providers”.	The CME is contracted for care coordination services only. Aetna will contract with all providers for all services. The CME may subcontract with additional care coordination providers.
104	10/25/2021	Margaret Osborne	As I understand, a CME will be able to contract with a Family & Children First Council (FCFC) to provide the HFWA services. The FCFC does not have to be a Medicaid biller, the CME will do the billing correct?	Correct. In this circumstance, all ICC/MCC practitioners, even those working at different organizations, would be required to enroll as Medicaid providers and affiliate with the "bill-to" CME organization.
105	10/25/2021	The Ohio Council	In the scoring and selection process, is there a minimum score required to become a CME? Or, if only one entity applies to be the CME in a catchment area will that entity automatically be selected?	There is not a minimum score. The CME applying demonstrate they are able to implement all of the requirements to become a CME as required in the ODM draft rules.
106	10/26/2021	Ohio Behavioral Healthcare Provider Network	I wanted to inquire about our ability to apply as a CME as a network. Yesterday on the call it was mentioned that one of the requirements be that the applicant have a Medicaid ID. OBHPN, the network, doesn’t hold a Medicaid ID – but our members do. We have coverage in 61 of Ohio’s 88 counties. If our individual members hold a Medicaid ID – would we be able to approach this as a network, submitting application for each catchment area as outlined, of course.	For CMEs selected by Aetna that already have an existing Medicaid provider agreement, ODM will add the CME specialty to their existing provider agreement. For CME entities selected by Aetna that do not have an existing Medicaid provider agreement, ODM will enroll those entities using the provider type category currently called "Waiver Services Provider" and assign the CME specialty. The requirements to be a CME as the same whether the entity has an existing Medicaid provider agreement or not. The waiver services provider type is simply being used by ODM to enroll those entities that do not otherwise exist under a different Medicaid provider type. ODM uses the waiver services provider type for a variety of provider types, that are then uniquely identified by a specialty - each of which has specific provider requirements described in OAC, as will be in place for CMEs based on the requirements in rule 5160-59-03.2.Selected CMEs enrolling through this provider type 45 pathway still need to meet basic Medicaid provider enrollment requirements, including those outlined in OAC 5160-1-17 through 5160-1-17.8 (i.e., maintain records, fraud, waste, and abuse, etc.).

107	10/26/2021	Pressley Ridge	QUESTION: When looking at the Regional charts, does the column entitled "projected annual assignment" reflect the estimated average daily population in each Region by the end of the first year? Or does the number reflect the total number of referrals expected annually? In the first chart you shared that showed the number of MCC and ICC Care Coordinators in each Region, it could be concluded that the average daily population of a Region with 2600 as the "projected annual assignment" would be approximately 1310 youth per day. For instance: ICC- 21 staff @ 10 youth = 210 youth daily MCC- 44 staff @ 25 youth – 1100 youth daily Total daily population- 1310 youth daily Which is the correct interpretation? The answer would be important in determining the annual revenue estimates particularly in year 2.	Yes that is the estimated target for the end of the year. We cannot the predict the ramp up for the number of youth referred monthly only the end of the year targets.
108	10/28/2021	CCHMC	Please define the local FCFC's role in OhioRISE. While Hamilton County has basically no FCFC at all, Butler and Clermont both have extremely active ones and will probably endorse or not endorse who they want to be the CME in their communities.	OhioRISE allows CME flexibility to develop contractual relationships and staffing models that fit the catchment area / community. The CME organization must be enrolled as a Medicaid provider, and all rendering practitioners who are delivering ICC/MCC services must also be enrolled as Medicaid providers and affiliated with the CME (might be helpful to think of the ICC/MCC practitioner is the "rendering" provider and the CME is the "pay-to" provider.) Some CMEs may have all ICC/MCC staff be employees of the CME organization. In other circumstances, a CME may staff all or some ICC/MCC practitioners through contractual relationships. CMEs have responsibility for overseeing and assuring the quality of the care provided by all ICC/MCC practitioners, even if those practitioners are contractors. An overview of the information above is documented in the bullets slide 23 of this presentation: https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/2be956a0-ad5f-4b4a-b1cd-63c114729081/OhioRISE_First+SOC+and+CME+Workgroup_2021.09.16.pdf?MOD=AJPERES&CVID=nLPTCKj
109	10/29/2021	Buckeye Ranch	1.3 OhioRISE Population page 6: • The RFA references 140 youth placed out of state. Will these youth be assigned a CME and if so, will the expectation be face to face meetings?	These youth will be assigned to county of custody CME. Expectation is that may occur via video.

110	10/29/2021	Buckeye Ranch	1.4 Covered Services: •Will there be an approval process to use primary flex funds, and will there be a monetary cap per family per a certain time frame? •Will there be a prior auth process to get approval or out of home respite? (page 8) •Therapeutic mentoring: is there a certain model? Is this mentoring for youth, guardians, or both? •Secondary Flex funds. Can you clarify the different between primary and secondary flex funds?	1: Yes, the criteria is part of the 1915 Waiver rules. Rule 5160-59-03.5 2: For both waiver, respite and general covered services that will require a prior auth. 3: Per the 1915c Rule "Intended to assist individuals enrolled in the OhioRISE 1915(c) Waiver program and their families by providing supports to enable them to function to the highest degree within their family unit and their community. " Mentoring is for youth and their families. OhioRise 1915c will follow the Therapeutic Mentoring rule (5160 59 05.3). 4: Primary Flex funds are defined in OAC rule 5160-59-03.5. This rule applies to all individuals on the OhioRISE Program. Secondary flex funds are defined in OAC rule 5160-59-05.4. This rule only applies to service coverage, eligible providers, and limitations to the service available under the OhioRISE 1915(c) waiver.
111	10/29/2021	Buckeye Ranch	1.5.1 Care Coordination •Policies and Procedures must be submitted to the OhioRISE plan for approval- is this with proposal submission or after selection?	Policies and procedures must be submitted after selection
112	10/29/2021	Buckeye Ranch	2.2.1 General Program Eligibility •Prior to PRTF implementation on 1.1.23, will youth in QRTP level of care automatically be approved for care coordination?	No. Children receiving a QRTP level of care still require a CANS assessment for OhioRISE eglibility, enrollment, and as part of assignment to a tier of care coordination.
113	10/29/2021	Buckeye Ranch	2.4.1 Service Standards/ Care Management Entities (CME) page 15 •Page 15 (b) Is this training expected to occur prior to July 1st, 2022. •Will this training be free to CME's? •After July 1st will training be required for care coordinators prior to them being able to have any case assignment? •Page 15 (f) How will incidents be reported to ODM? •Page 15 (h) How many hours per year will be required within 3 months and annually? •Page 16 (s) Ensure care coordination activities provided are provided via telehealth only when it is the child or youth or family's/caregiver's choice for service delivery via telehealth; •Is there established protocol on how to obtain consent for telehealth services? •Are there any performance/quality measures tied to the frequency of in person versus telehealth contacts with members? •Does an offer of a Face-to-Face appointment include synchronous telehealth?	1: Yes 2: Yes 3: They have to have training within 60 days of hire. They can have case assignments within that 60 days with proper supervision. 4: All incidents need to be reported to Aetna. Aetna reports to ODM. 5: Reviewing training time 6: The initial training will be 40 hours. The booster trainings have not yet been calculated in hours. 7: ODM is working on a Program Manual that specifies the frequency of contacts of care coordation of F2F per tier. Draft estimates are 8: No. F2F is the preferred method of service delivery.
114	10/29/2021	Buckeye Ranch	2.4.2 Tier 3 Care Coordination •Page 17 (b) Who is responsible for payment of the annual fidelity review? oSame question for MCC (page 19): Will there be fidelity requirements for MCC since this is not strictly following the Hi Fidelity Wraparound model?	The state is supporting fidelity reviews for both ICC and MCC through its contract with the Child and Adolescent Behavioral Health Center of Excellence.

115	10/29/2021	Buckeye Ranch	2.4.5 Additional 1915(c) OhioRISE Waiver Responsibility •(2) page 20 What is the difference between primary and secondary flex funds	Primary Flex funds are defined in OAC rule 5160-59-03.5. This rule applies to all individuals on the OhioRISE Program. Secondary flex funds are defined in OAC rule 5160-59-05.4. This rule only applies to service coverage, eligible providers, and limitations to the service available under the OhioRISE 1915(c) waiver.
116	10/29/2021	Buckeye Ranch	2.4.7 Community Resource Development page 21 •(5) Will SACWIS checks for employees be waived so we can hire parent and peer supports if they have a SACWIS hit?	Individual CME-employed care coordinators will be subject to the Medicaid screening requirements found in OAC rule 5160-1-17.8.
117	10/29/2021	Buckeye Ranch	3 Referral, Enrollment, Care Planning •There is a 24-hour required response to crisis referrals from MRSS. Does this include weekends? •Are ICC staff expected to be on call 24 hours?	1: Yes 2: The CME must have a crisis response process in place to address any family issue 24hrs a day as per the rules.
118	10/29/2021	Buckeye Ranch	4.1.2 Quality Oversight and Improvement page 26 •Paragraph one references the OhioRISE plan will partner with CMEs and CABHCOE to develop the quality framework. is the QIP still under development? Does the CME need to assign a specific Quality Improvement contact to the plan? What will be the expectation of CME QI teams in the framework development?	Still under development. The CME's will have an opportunity to participate in the framework development.
119	10/29/2021	Buckeye Ranch	5 Electronic Medical Record and Data Reporting Requirements •Will baseline date be provided? •Are required measurements and data/outcomes reviewed annually? •Will previous year be reviewed? •Is there the expectation that measurements are improved? If so, oBy how much? oWill the expectation be for each case or will the expectation for improvement be aggregated/averaged?	Please see the Quality Oversight and Improvement sections within the RFA and the Appendix as well as the DRAFT Rules. There are minimum data requirements listed in these sections. The overall activities will be developed in a collaborative process with Aetna, the COE, the CMEs and ODM.
120	10/29/2021	Buckeye Ranch	6 Implementation Support and Readiness Review •Will there be available funds prior to July 1st to ensure the necessary Operational and Capacity readiness assessments are completed. This would require hiring at least one staff member after the announcement to begin collaboration with Aetna to help develop the program. We would also need to hire at least 30-45 days in advance of July 1st to orient and train each care coordination prior to service delivery starting July 1st.	ODM announced grant funding will be in early 2022 to accelerate CME start-up and service delivery. CMEs selected by Aetna will have an opportunity to receive OhioRISE Transition Grants based on their level of need to meet immediate organizational growth goals. Applicants should identify their specific needs (EHR, HIE, start up CC staff) for grant funding in their CME application. Additional details about the grant funding opportunity are forthcoming.
121	10/29/2021	Buckeye Ranch	8.1.4 Plan to Achieve and Retain Staffing Capacity to Function as CME page 32 •Do we know the timeline for ramp up?	The CME must have a plan to ramp up to full capacity to serve the projected number of children by the end of the first year.

122	10/29/2021	Buckeye Ranch	Appendix A •Pg. 4 When is the expected date of the CANS IT system launch? Family Connect system? •Pg. 4 (7) States provider has two days for engage however on pg. 15 of RFA, it states the CME has 1 business day from receipt of referral to reach out and obtain consent. •Pg 5 OhioRise Interval Risk Screener… can you explain what this is and how often this would need to occur? •Pg. 6 Trauma Screening Questionnaire… Is there a specific questionnaire that has been established that CME must use? •Pg 6: Sentinel events and Critical Incident events… Please provide examples of these events and what would be the stipulations on how and when to report. •Pg.23/24 Section 11 MCO measures required by OhioRISE plan for inclusion in CME contracts – Are these being provided to CMEs or CMEs need to collect this data?	1: Family Connect will be incorporated as part of readiness review. The CANS IT system will launch prior to the launch of OhioRISE. 2: The RFA specifies what is listed in the draft rules. 3: Interval Risk Screener will be shared with CME for use. 4: Trauma Screening Questionnaire will be shared with CME for use. 5: Report the incidents consistent with ODM policies in accordance with rule 5160-44-05 of the Administrative Code. 6: Part of the Quality Improvement oversight that is in development.
123	10/29/2021	Buckeye Ranch	Slide 21 – Staffing and supervisions states: have the ability to respond to member needs twenty-four hours a day. Does this mean that the care coordinator must be available 24 hours a day for their own specific cases with caseload sizes of 1:10 for ICC and 1:25 for MCC? •If the care coordinator is requested to be available 24 hours a day for their own cases, will this standard be tied to OhioRISE Quality Framework for performance measures, quality measures that will be developed between the OhioRISE plan, the CABH COE and the CME? •Are any of the OhioRISE Quality Framework and measurements established as of now? If yes, can those be shared?	The CME must provide a process that allows the family to have access to care coordination support 24 hours a day. This process does not require the child's assigned care coordinator to be on call 24 hours a day. The process developed could engage a team approach or a rotating on call schedule. Metrics involving crisis and safety engagment, including after hour engagement, may be part of the overall quality measures once the framework is developed in collaboration with the OhioRISE plan, COE, CME and ODM. Please see the Quality Oversight and Improvement section of the RFA, the Appendix and the DRAFT rules for current and minimum expectations for metrics.
124	10/29/2021	Buckeye Ranch	Slide 38 – Implementation: It states that 60 to 90 days in advance of go-live a readiness assessment will be completed to include staffing, data exchange, and training. At that assessment, is there a staffing threshold established (example: 90% of established staffing ratio met) to meet the assessment requirement based on each catchment area?	No. Additional information about day-one staffing and the readiness review is forthcoming. There is an expected ramp up for enrollment over the course of the first year.

125	10/29/2021	Buckeye Ranch	Slide 12 – Catchment Areas: In the Franklin County catchment areas, is there a predicted breakdown of ICC case versus MCC cases? General Questions •The contract seems to use service provider to describe both CME functions as well as Service provider functions interchangeably at times although they have made distinction between care coordination and service provision multiple times. It also appears the CME provider will have responsibilities to ensure the network service providers are meeting expectations. For example page 8 of contract 2.5 member billing "Service Provider agrees that it will and will require Network providers to comply with the following...." who is managing that oversight? •In reading the contract draft, there are numerous paragraphs which makes it seem like the CME is required to have a network of direct service providers and those service providers would bill the CME for OhioRISE services (.e.g. IHBT, MST, FFT, PRTF, or other OhioRISE authorized services). (And then the CME would bill Aetna???) Our initial understanding was that, as a CME, we would do the care coordination, and all related admin functions, and we would be paid the PMPM which covers that cost. We would also make any referrals of clients for direct services to other providers, and those providers would bill OhioRISE (Aetna) directly for those services. Please describe and clarify the relationship and billing arrangements between Aetna, the selected CME (Service Provider, per the contract) and other agencies who are service providers (Network Providers, per the contract).	1: ICC will be estimated at 15%. MCC will be estimated at 50-60%. Of the over all anticipated enrollment. 2: CME is managing the oversight of the indivdiually subcontracted care coordinators. Aetna manages a network of service providers for all BH services. 3: The CME is responsible for developing a local system of care which may include providers who contract with Aetna to deliver BH services. Example: HBT, MST, FFT, PRTF those BH service providers would bill Aetna directly. 4: Yes, that is correct 5: Aetna pays the CME for care coordination on a PMPM basis. Aetna pays BH CMHC's for their sevices rendered. The CME is not responsible to pay for counseling services, for example. The CME does pay any subcontractors who deliver care coordination on behalf of the CME.
126	10/29/2021	Central Clinical Behavioral Health	Considering the systems of care coordination and partnerships that have been in place long term within Hamilton County, could the division of Hamilton County be re-evaluated to be combined into one catchment area?	No, we do not anticipate any reevaluation of catchment areas.
127	10/29/2021	Central Clinical Behavioral Health	Do the Catchment areas, expected enrollments of 2,700, include low, moderate, and high coordination, or just the moderate and high?	Moderate and High
128	10/29/2021	Central Clinical Behavioral Health	Who is managing the non-traditional/Non-Medicaid eligible providers and payment of those services, the CME or Aetna?	All providers will need to be Medicaid eligible within 2 wks of award and the oversight will be provided by both Aetna and ODM
129	10/29/2021	Central Clinical Behavioral Health	Is the cost of placement, when qualified and needed, absorbed by the CME, Aetna, or ODM?	We're not entirely sure what this question means.Medicaid and its managed care plans can only pay for medically necessary services. Outside of institutional settings (hospitals,etc.), the cost of "room and board" or "maintenance" in a placement is not a Medicaid-covered service and is paid by the custodian.

130	10/29/2021	Central Clinical Behavioral Health	Will the $25 million grant opportunity for startup costs be split amongst all CMEs that apply/are awarded? What is the limit on the startup grant?	ODM announced grant funding will be in early 2022 to accelerate CME start-up and service delivery. CMEs selected by Aetna will have an opportunity to receive OhioRISE Transition Grants based on their level of need to meet immediate organizational growth goals. Awards will be based on need and not on equal division among CMEs. Applicants should identify their specific needs for grant funding (ex HIE, EHR, start up CC staff) in their CME application. Additional details about the grant funding opportunity are forthcoming.
131	10/29/2021	The Columbus Organization	In reference to 7.1 Overview, what does it mean to demonstrate a physical presence in each catchment area?	You should have staff and/or offices within the catchment area
132	10/29/2021	The Columbus Organization	In reference to 7.1 Overview, does “physical presence” mean an office location is set up in each area?	You should have staff and/or offices within the catchment area
133	10/29/2021	The Columbus Organization	(General) Can we have one office location and still go after multiple catchment areas?	You must have a physical presence in each catchment area
134	10/29/2021	The Columbus Organization	In reference to 7.1 Overview, what exactly do you mean by "physical presence in each catchment area"?	You should have staff and/or offices within the catchment area
135	10/29/2021	The Columbus Organization	In reference to Appendix A, Section 9: Response Requirements Check List, is the "CME Submission Checklist" in item "d" the same as the Response Requirements Check List or is there a separate checklist form that must be submitted?	It is the same checklist
136	10/29/2021	The Columbus Organization	In reference to Section 8.2.2 Experience with Family Driven, Child or Youth Guided Care, does "Experience with System of Care Principles, Values and with Child-Serving Systems and schools" fall under this section or are these separate sections?	These are separate sections.
137	10/29/2021	The Columbus Organization	In Section 8.2.3. Care Coordination Capacity and Experience, "Describe your organization’s familiarity and approach to the development of child and family-centered care plans and coordination of the CFT process as required in Appendix A, Section 4 B of this RFR." Is "RFR" a typo, meant to be "RFA"?	Yes, it is meant to be RFA.
138	10/29/2021	The Columbus Organization	In reference to Section 7.5 Response Format, will OhioRISE consider the narrative portion of the proposal to be 1.5 spacing as opposed to double-spaced?	No, proposal needs to be double spaced.
139	10/29/2021	The Columbus Organization	(General) Can OhioRISE provide more detailed data for each catchment area, such as delineating whether the catchment area is primarily suburban, urban, or rural?	Map has been provided
140	10/29/2021	The Columbus Organization	In lieu of providing specific history in the state of Ohio that correspond with the previous work outlined in Section 8.2.2 Experience with System of Care Principles, Values and with Child-Serving Systems and schools, would OhioRISE Plan accept a respondent's history in other states that correspond with this type of work?	Yes
141	10/29/2021	The Columbus Organization	(General) For evaluation and selection of prospective CMEs, is preference given to Ohio-based provider organizations that have familiarity and/or experience serving a particular catchment area?	See scoring sheet
142	10/29/2021	The Columbus Organization	(General) Are you planning a scheduled review period to check ongoing performance of awarded CMEs for a particular area? If so, what would be the timeline and criteria?	Please review Quality Oversight and Improvement section of RFA and the Appendix.
143	10/29/2021	The Columbus Organization	(General) Can an approved CME be disapproved? If so, would the catchment area open up for other approved CMEs?	We are committed to selecting the best applications for each catchment area and are fully committed to supporting the CME's success. We will however, discontinue language due to fraud, abuse, waste, safety, health welfare issues.

144	10/29/2021	Nationwide Children's Hospital	The application asks for a list of current certifications/licensures/accreditations – is this at the organization level or the individual provider level?	It is at the organization and the individual provider level.
145	10/29/2021	Nationwide Children's Hospital	Does the administrative fee (27%) built into the rate structure account for community resource development expenses or only expenses related to care coordination?	The 27% admin fee was developed for all admin expenses.
146	10/29/2021	Nationwide Children's Hospital	With the newly announced grant funding available for CME start-up expenses, should applicants be identifying how these potential funds would be used in the application?	ODM announced grant funding will be in early 2022 to accelerate CME start-up and service delivery. CMEs selected by Aetna will have an opportunity to receive OhioRISE Transition Grants based on their level of need to meet immediate organizational growth goals. Awards will be based on need and not on equal division among CMEs. Applicants should identify their specific needs for grant funding (ex HIE, EHR, start up CC staff) in their CME application. Additional details about the grant funding opportunity are forthcoming.
147	10/29/2021	Positive Education Program	If a child/youth who is identified as eligible for OhioRISE is already receiving services from the CME, may those continue?	Yes. Aetna will be monitoring CMEs' referral paterns.
148	10/29/2021	Positive Education Program	If an OhioRISE child/youth is referred to one of CME's services (such as Group TBS) by an outside entity (not related to ICC/MCC) may the CME accept that referral?	Yes. Aetna will be monitoring CMEs' referral paterns.
149	10/29/2021	Positive Education Program	Does family voice and choice trump the CME's duty to limit self-referrals?	Yes. Aetna will be monitoring CMEs' referral paterns.
150	10/29/2021	Positive Education Program	Is the Care Coordinator permitted to deliver both Care Coordination and other services (e.g., TBS/CPST/Psychotherapy) to the families they serve or families served by other Care Coordinators of the CME?	No, the care coordinator is fully dedicated to CME care coordination.
151	10/29/2021	Positive Education Program	Can siblings access wrap funding if they are not identified as a OhioRISE client?	Medicaid services are intended for the sole benefit of the Medicaid enrollee.
152	10/29/2021	Positive Education Program	If additional services are needed outside of Care Coordination, such as interpreters, will OhioRISE cover the cost or will the CME be responsible for paying for the service(s)?	OhioRISE will cover the cost of these services using our contracted interpreters. Access through Member Services.
153	10/29/2021	Positive Education Program	Do you envision kids who are in Ohio Rise also needing a case manager or will the care coordinator serve as the case manager?	The Care Coordinator is the Case Manager. Only therapeutic services are allowed to be billed for outside of care coordination.
154	10/29/2021	Positive Education Program	In 2.4.1 (g), it states that "*the CME needs to implement quality improvement activities related to the CME's performance consistent with ODM's population health management strategy."* Would you please provide a link to the specific strategy document, or provide detail on the expectations for the CME?	We anticipate the CME's involvement in creating our Population Health Management Strategy. Information about the OhioRISE Plan's required population health activities can be found in the OhioRISE 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

155	10/29/2021	Positive Education Program	2.4.1 (e), 5, 8.1.6 and 8.3 mention bidirectional data sharing, the Family Connect portal, and connectivity to a HIE. Would you please provide examples of how data has flowed from/to the CME based on the other states where you have implemented this functionality?	HIE, EMR, labs and other clinical data is received and loaded into our Informatics databases where this data is consolidated and updated to the members profile on FamilyConnect. The CME's will access this data via the FamilyConnect portal. The flow of HIE and EMR data into FamilyConnect is unique to each states specific program and requirements.
156	10/29/2021	Positive Education Program	If an organization submits multiple applications because their current care coordination work is provided in those areas, is the expectation that the organization must move forward with serving all areas awarded, or may the organization work with Aetna to serve/accept the area(s) most aligned to its work?	It is our anticipation that CME's would only apply for area's they are committed to working within.
157	10/29/2021	Positive Education Program	How many concurrent clients do you anticipate the CME serving at any one point in time? For example, if the Projected Annual Assignment is 2000 for the 12 months, would you anticipate 50% of that at any given time due to movement to a lower level of care or out of care coordination?	ODM anticipates OhioRISE to enroll between 50,000 and 60,000 children and youth by end of year one. Anticipated Tier 2 population, 50 to 60%, total population Anticipated Tier 3 population, 15 to 25%, total population Anticipated Tier 1 population, 20%, total population Estimated projections are based on full engagement, CMEs will be responsible for continuing to try to engage families that are not yet ready to engage, and some families that aren't ready to engage will be moved to Tier 1 CC (included in the 20% assumption)
158	10/29/2021	Cincinnati Children's HealthVine	ASSESSMENT Will the CANs replace the HRA requirement for members who qualify for OhioRise? The CANs reference guide contains suggested questions, will there be requirements to report member/caregiver responses to specific questions from the CANs similar to the HRA reporting requirement?	The CANS does not replace the HRA, but the use of either one of these completed assessments may be helpful in completing the other. The HRA is not a condition into the OhioRISE program, but it is a requiremen of the managed care organizations' provider agreement with ODM.
159	10/29/2021	Cincinnati Children's HealthVine	24 HOUR COVERAGE Can CME 24-hour, 7-day per week coverage be provided by existing systems such as MCO 24-hour nurse line, PCPs, MRSS and IHBT 24-hour coverage? If our system has an existing 24-hour mental health crisis line for all mental health patients, can that serve as the CME line as well?	Yes, The family just needs access to the care coordination service 24/7.

160	10/29/2021	Cincinnati Children's HealthVine	ENGAGEMENT GOALS AND EXPECTATIONS What support will be provided by Aetna to the CME if statewide workforce shortages negatively impact the rate of ramp-up? Of the previously cited estimated population for each catchment area and breakdown between ICC and MCC, is there an anticipated percentage of the eligible population you expect to actually enroll in CM with the CME? Or, conversely, an estimate of the percentage of patients likely to not to engage or to decline CM with the CME? We understand based on previous questions and answers that the catchment population estimates are based on expected patient engagement over the course of a year. Can you provide an estimate of patients expected to be engaged in each month? This is critical to staffing and budgeting.	1: State agencies, including ODM and OhioMHAS, as well as the Ohio Medicaid Managed Care Entities (Including the OhioRISE plan) are monitoring and supporting workforce develpment. All parties will monitor the impact of workforce challenges on OhioRISE ramp-up. 2: We cannot predict the choices or behaviors of a family. CMEs are expected to work to engaged all children and youth assigned to Tier 2 and Tier 3 care coordination. We would encourage active strategies, motivational interviewing to encourage full participation. 3: Due to the unpredictible nature of starting a new program, monthly estimates cannot be provided.
161	10/29/2021	Cincinnati Children's HealthVine	SPECIFIC SERVICE DELIVERY/CLINICAL MODEL Will CPTS/TBS still be reimbursed services once OhioRISE launches? When a member is in a QRTP or PRTF, we understand there will be a role in discharge planning, but do overall contact hour expectations change during this time? If a member is in PRTF, does that individual still count towards the caseload? Can an organization who is a delegated care management entity for an MCO who also becomes an OhioRISE CME provide integrated care coordination (physical and behavioral health) rather than staffing with 2 separate Care Managers?	1: Yes. Although SUD CM will not be reimbursible when a child is enrolled in ICC/MCC. 2: No, overall contact hours do not change. 3: Yes, as long as required ICC/MCC activities are being conducted for the child / youth in a PRTF. 4: The Care Coordinator for OhioRISE must be separate and distinct from any other service provider. While Aetna is not familiar with the delegated relationships between MCOs and network providers, CMEs must assure all CME activities are conducted with appropriate fidelity for assigned members. CME activities must not duplicate other activities for which the entity is receiving reimbursment.
162	10/29/2021	Cincinnati Children's HealthVine	CONTRACTING, RATES, AND RULES The RFA did not specifically reference the CME agreement. When will we have an opportunity to complete a legal review and negotiate mutually acceptable terms? We have heard/read that the CME contract will be a 3-year term as well as that it would be a 1-year contract with a 180-day out after the first year. Can you clarify which is accurate? What is the impact of the OhioRISE carve-out on Medicaid PMPM rates? When will the new rates be released?	1: A draft contract is available on the landing page. 2: Our DRAFT contract does state "This Agreement begins on the Effective Date, continues for an initial term of [one (1) year], and then automatically renews for consecutive one (1) year terms, but in any case shall conform with the terms of Company's contract for the OhioRISE Program. The Agreement may be terminated by either Party at any time after the initial term, or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least [one hundred and eighty (180)] days' advance written notice to the other Party. Additional termination provisions are included in this Agreement." 3: ODM sets capitation rates for all of its managed care entities (MCO, OhioRISE, SPBM).

163	10/29/2021	CareStar	Section 8.4 (II) states, in part, "…to report the required CME and care coordination activities described in draft OAC 5160-59-02." The draft section of the OAC 5160-59-02 does not seem to correspond to the content of this question. Please confirm that this draft reference is correct, and if not, what is the intended draft OAC reference.	Please see Draft OAC 5160-59-03.2.
164	10/29/2021	Wingspan Care Group	Will the CME be expected to use a boilerplate contract for network provider engagement provided by ODM?	A copy of the DRAFT contract is available on the website. The OhioRISE contract is a separate additional contract from the Medicaid Addendum. https://www.aetnabetterhealth.com/ohio/cmeapplication
165	10/29/2021	Wingspan Care Group	Contract Language: "Service Provider provides access to a network of Network Providers that provide certain ICC and MCC Covered Services." This seems to say the CME can delegate MCC/ICC activities to a network provider. Is this what is intended? Also, is the required Network comprised solely of BH providers, or is the network required to be broader, including pharmacy/hospital/primary and specialty care providers also?	Yes, the CME may subcontract and delegate ICC/MCC case coordination services provided the care coordinators get an individual Medicaid provider ID and affiliates with the CME. The CME maintains responsibility for overseeing all ICC/MCC and CME functions, even if they are conducted by delegated care coordinators.
166	10/29/2021	Wingspan Care Group	What are the applicable credentialing/recredentialing requirements for CME's – will they be part of centralized credentialing? What role, if any, does the CME play in the credentialing of its network providers?	As a Medicaid provider CME's will eventually be part of centralized credenitaling. For subcontractors, CME's are responsible to assure proper background checks and individual Medicaid provider id's are maintained.
167	10/29/2021	Wingspan Care Group	Contract language "Unless disclosed in advance to Company and the affected Member, neither Service Provider nor any Network Provider will accept any referral from persons or entities that have a financial interest in them, or make any referrals to persons or entities in which they have a financial interest" This would appear to prohibit the CME from referring any clients to the service programs it has without first receiving approval from the CME. Is this what is intended?	It is meant to inform the member and give them choice.
168	10/29/2021	Wingspan Care Group	Contract language "(b) that [CME] is solely responsible for and will promptly pay all Network Providers for services rendered; that it will require all Network Providers to look solely to Service Provider, and not to Company, Payer or a Member (except for any applicable Plan Member copayments, coinsurance and/or deductibles) for payment; and that failure to require Network Providers to look solely to Services Provider for payment as specified above shall be deemed a material breach of this Agreement. Without limiting any other rights of Company under this Agreement, in the event that Company pays any Network Provider for services provided under this Agreement, it shall be entitled to collect all paid sums from Service Provider and/or to offset any future payments to Service Provider" Do CME network providers bill the CME for the Medicaid services provided and not OhioRISE?	Correct. Only the CME bills Aetna for the PMPM and the CME would pay any subcontractor though contractual agreements the CME determines.
169	10/29/2021	Wingspan Care Group	Contract Language: Utilization Management. Service Provider agrees that it and/or Network Providers shall be subject to utilization management (including, as applicable, prospective, concurrent and retrospective review) in accordance with Company Policies and that payment may be adjusted or denied for the inefficient delivery of services. What does "inefficient" mean? Can you please provide more information about how a CME's performance may impact its payment?	In this context, inefficient means that the basic, required elements are missing from the Care Plan, the services requested do not align with the needs & clinical information provided on the Care Plans, or the goals & objectives outlined on the Care Plan are not connected to the needs outlined by the OhioRise member and their familial/social/guardian support system.

170	10/29/2021	Wingspan Care Group	Are the background check requirements for the network providers and/or the CME different than the current background requirements for Medicaid behavioral healthcare providers? The contract seems to require a more robust database check and broader exclusionary criteria. Also, please provide more information about the required screening interview – what is it, what roles is it required for?	No, the background checks are not different. All individuals providers must go throught the Medicaid enrollment process and background checks to get a Medicaid ID number. We will revise the language in our final contract.
171	10/29/2021	Wingspan Care Group	When network providers participate in the YFT can they bill TBS/CPST for their time?	We anticipate that separate and distinct service providers, not the CME, will bill for services.
172	10/29/2021	Wingspan Care Group	Contract language B. Other Compensation Terms. The Capitation Payment shall be based on the number of Members assigned to Company on the first day of the month and shall be issued to Service Provider by the fifteen (15th) of the month. Service Provider agrees that it shall not pay any Network Provider more or less than 100% of the State Medicaid Fee Schedule without prior written approval from Company. Company has the right to recover payments for individuals that Company later determines are not Members. This reads like the CME is a pass through and will be expected to receive claims from network providers. Is this what is intended?	Aetna will receive claims to release the PMPM to CME's on a monthly basis. The contract is being updated to reflect this. The CME is not a pass through for other BH services but may serve as a pay to for ICC/MCC services provided by the CME contractors.
173	10/29/2021	Wingspan Care Group	The OhioRISE System of Care team and CME liaisons will collaborate with the CMEs to identify and develop informal supports. Guidance from the Member and Family Advisory Council, the Youth Advisory Council, the Provider Advisory Council and the Governance Council will assist in the development of informal and natural supports. Are the care team members and liaisons available in each of the 21 catchment areas? What are their performance requirements? Are they Aetna employees? How are the various councils put together – who does this?	Yes, they are available in the 20 catchment areas. They are Aetna employees and Aetna puts the council together in collaboration with ODM and Stakeholder Engagement.
174	10/29/2021	Wingspan Care Group	What happens if the child or youth's projected need for waiver services exceeds the maximum annual waiver cost?	To enroll in the OhioRISE 1915c home and community-based waiver, the child or youth's projected need for waiver services must not exceed the maximm annual waiver cost. Children or youth who would be projected to exceed the waiver cost cap would not be able to enroll on the waiver. The CME would be expected to connect children and youth to other resources (state MSY program, local DD board) if they are not eligible for the waiver for this reason.
175	10/29/2021	Wingspan Care Group	Identify and inform the OhioRISE Plan of unmet needs and barriers to effective care and assist in developing community resources to meet youth and families' needs Can you provide an example of what this would look like?	It is anticipated that CME applicants will provide current experience in anticipated need in identifying and developing resources to meet needs for Youth and Families. Example: 30% of youth need access to summer. The CME would work to develop community resource to meet that need.
176	10/29/2021	Wingspan Care Group	If a child is in a residential placement can the contractually required residential meetings be combined with the CFT meetings?	Yes, this is acceptable.

177	10/29/2021	Wingspan Care Group	Do I understand correctly that every child in OhioRISE will also remain enrolled in a MCO to provide the physical health care but billing all BH services move from the MCO to OhioRISE?	No. Children who meet OhioRISE eligibility criteria will be mandatorily enrolled into the OhioRISE managed care plan. Children enrolled in OhioRISE will maintain physical health coverage through the mechanism they had for physical health coverage prior to enrolling in OhioRISE (fee for service or managed care). All children who enroll in Medicaid through the OhioRISE 1915(c) home and community based services waiver will be mandatorily enrolled in both the OhioRISE program for behavooral health services and managed care for physical health.
178	10/29/2021	Wingspan Care Group	Are primary flex funds for Medicaid clients and secondary flex funds for waiver clients? Is there a cap/limit? Is there a criteria that must be met beyond it being included in the plan? How does the CME access these funds?	1: All children in OhioRISE may be eligible for primary flex funds when meically necessary. Children enrolled in the OhioRISE waiver may also be able to access secondary flex funds. 2: The cap on primary flex funds is $1,500 per year. The cap on secondary flex funds is an additional $2,000 per year. 3: Draft rules for primary and secondary flex funds were posted on ODM's website for OAC rule clearance earlier this year. Primary flex fund requirements were outlined in draft OAC 5160-59-03.5. Secondary flex fund requirements were outlined in draft OAC 5160-59-05.4. 4: CME roles and responsibilities are outlined in the draft OAC rules referenced above.
179	10/29/2021	Wingspan Care Group	Does the CME get the PMPM payment for the 90 days it is still involved after disenrolling from OhioRISE?	CMEs must develop a transition plan that will last at least 90 days following disenrollment from Tier 2 or Tier 3 care coordination. The CME does not need to complete activities after the disenrollment is executed.
180	10/29/2021	Wingspan Care Group	CMEs are responsible for ensuring that children or youth and caregivers have a choice between at least two providers of a needed Medicaid covered service. How does this work?	The CME will provide the Child, Youth and Caregiver a list of providers available to facilitate choice.
181	10/29/2021	Wingspan Care Group	If the child or youth in custody is placed outside of the Title IV-E Agency's county and CME catchment area, including in a residential treatment facility or an out of state treatment facility, the CME, and the OhioRISE Plan care coordinator if requested by the CME, will support the CME to coordinate scheduling of the CFT and ensure all members are able to attend and receive copies of the Child and Family-Centered Care Plan. Title IV-E agency may also request that the child or youth's CME assignment be switched to the catchment area where the child or youth is placed. Can the CME make this request? Also, please describe the expectation of the CME when a child is placed out of state?	1: Youth, Family, Guardian will be able to make a request of which catchment area serves the youth. The CME does not make the request. Circumstances will be factored when youth and family does not have a preference. For example, if the youth is across the state and reuinifcation is a likely goal in the near term staying within the home catchment area may be the best option. Conversly, in the same scenario if reunification is not likely swithching to the new catchment area may be the ideal option. 2: When a child is out of state F2F expectations will be virtual.

182	10/29/2021	Wingspan Care Group	CMEs will receive support though the OhioRISE Plan's Juvenile Justice Engagement Team regional liaisons who work at the intersection of the legal, corrections, health care, and child welfare systems and provides technical assistance for CMEs and stakeholders. What are these?	The regional liaisons are Aetna employees.
183	10/29/2021	Wingspan Care Group	What remedies are available to a CME if OhioRISE is late making the PMPM payment?	There are billing procedures that are to be followed. These include appeals and grievances. The OhioRISE provider manual will provide this specific information.
184	10/29/2021	SH Inc Shannon Majoras	How will the RFAs be evaluated? Is there a point system?	Please see scoring sheet in the RFA. https://www.aetnabetterhealth.com/ohio/cmeapplication
185	10/29/2021	SH Inc Shannon Majoras	Since the rates have been predetermined, what are the factors that will differentiate competing proposals in a service area?	Please see scoring sheet in the RFA. https://www.aetnabetterhealth.com/ohio/cmeapplication
186	10/29/2021	SH Inc Shannon Majoras	When will CMEs be chosen?	Please see posted timeline on CME Landing page. https://www.aetnabetterhealth.com/ohio/cmeapplication
187	10/29/2021	SH Inc Shannon Majoras	Can you please provide a copy of the CME contract? If it is not already complete, will the contract be subject to negotiation by each CME?	Please see DRAFT contract on CME Landing page. https://www.aetnabetterhealth.com/ohio/cmeapplication
188	10/29/2021	SH Inc Shannon Majoras	Can you please specify how you will evaluate the required firewall and measure the 25% patient threshold that ensures conflict free care coordination? Will the firewall requirements include separation of documentation of CME activities from other patient care activities within the entity's electronic health record system? In light of the requirements for CMEs to conduct a CANS assessment, document the care coordination in a medical record, and potentially consult a psychiatrist each child appears to be a patient of the CME so how is the 25% patient threshold determined?	The 25% threshold has been removed. The minimum requirement is for the CME to provide specific policies and procedures regarding how the CME will ensure conflict-free care coordination occurs within their organization, including specific activities performed to ensure care coordinators are not consistently referring to services within the CME organization when other service options are available and meet the youth and family/caregiver's needs. Aetna will monitor CMEs' referral paterns.
189	10/29/2021	SH Inc Shannon Majoras	Does the consultation with a psychiatrist require a board-certified child/adolescent psychiatrist?	The DRAFT rules do not specify what type of psychiatrist.
190	10/29/2021	SH Inc Shannon Majoras	Does participation in the initial and ongoing training and coaching from the independent validation entity represent a cost to the CME? If so, what is the estimated cost?	The state is supporting training and coaching at no cost to the CME through its contract with the Child and Adolescent Behavioral Health Center of Excellence.
191	10/29/2021	SH Inc Shannon Majoras	Does the annual fidelity review represent a cost to the CME? If so, what is the estimated cost?	The state is supporting training and coaching at no cost to the CME through its contract with the Child and Adolescent Behavioral Health Center of Excellence.
192	10/29/2021	SH Inc Shannon Majoras	How will turnover effect the staff to child ratio? If a position is vacant while waiting for hire, will the CME be considered out of compliance for the 1:10 or 1:25 ratio?	No the CME will not be considered out of the compliance as long as active hiring is evident to fill the position.
193	10/29/2021	SH Inc Shannon Majoras	Will there be any consideration for shared savings or other value-based payments with either upside or downside risk?	Our goal is to pursue value based payment arrangments with the CME's if not in year one, by year two.

194	10/29/2021	SH Inc Shannon Majoras	What outcomes will the CME be measured against? Will the CMEs be measured or scored on any downstream quality metrics for the partners that the CME makes referrals to or be expected to limit referrals to partners that may have lower quality outcomes?	Please see the Quality Oversight and Improvement section of the RFA, the Appendix and the DRAFT rules for information regarding quality expectations. We will also be monitoring that the CME's conflict free policies and processes are being adhered to.
195	10/29/2021	SH Inc Shannon Majoras	What are the technical specifications of the data transfers that are required?	These will be determined once the CME's are chosen as part of Readiness Review.
196	10/29/2021	SH Inc Shannon Majoras	Are the published rates for ICC and MCC payable for all attributed patients paid at the beginning of each month, end of each month, or only upon a claim being generated as the result of a documented care coordination activity?	ODM is setting rates for ICC/MCC as blended “case rates” billed per client per month on a retrospective reimbursement (not prospective) basis. Proprated rates will be paid for partial months of enrollment, which are most likely to occur during the first and last month of CME assignment. Draft rates have been established and are subject to the rulemaking process as part of the OhioRISE services reimbursement rule. Please see slide 21 within this presentation: https://managedcare.medicaid.ohio.gov/wps/wcm/connect/gov/34ef1b1c-1097-4f62-adfeded6e809bdd4/OhioRISE_Service+Rates+Update_2021.08.05.pdf?MOD=AJPERES&CVID=nImlY9c
197	10/29/2021	SH Inc Shannon Majoras	What are the estimates of children per service area based on and is there any commitment to paying for those cases regardless of engagement, particularly during the start-up phase?	Estimates are based on a proxy population of children in Medicaid who likely have similar needs to those who are expected to enroll in OhioRISE. Estimated projections are based on full engagement of children and youth who will be assigned to Tier 2 and Tier 3 care coordination. CMEs will be responsible for continuing to try to engage families that are not yet ready to engage.
198	10/29/2021	SH Inc Shannon Majoras	Will catchment areas be redrawn in the future if not enough children engage or too many children engage in MCC or ICC to keep them at roughly 2000-2500?	Aetna and ODM will monitor CME implementation, including CME volume, and may revisit catchment areas in the future to facilitate program imporvement.
199	10/29/2021	SH Inc Shannon Majoras	If the ICC and MCC fees must be billed via claims, can you please provide the detailed claims specifications?	Not at this time. This information will be available once ODM finalizes the fee schedule.
200	10/29/2021	SH Inc Shannon Majoras	Will there be an inflationary adjustment to the rates annually?	ODM will monitor implementation of OhioRISE new and enhanced services rates for potential future adjustments

201	10/29/2021	SH Inc Shannon Majoras	What is the term of the CME contract and how will renewals be determined? Will there be an annual RFP process?	This Agreement begins on the Effective Date, continues for an initial term of [one (1) year], and then automatically renews for consecutive one (1) year terms, but in any case shall conform with the terms of Company's contract for the OhioRISE Program. The Agreement may be terminated by either Party at any time after the initial term, or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least [one hundred and eighty (180)] days' advance written notice to the other Party. Additional termination provisions are included in this Agreement. There will not be an annual RFP process.
202	10/29/2021	SH Inc Shannon Majoras	Is it possible for children to be involved with ICC or MCC and care coordination with the local FCFC?	For purposes of OhioRISE, care coordination is procured through the catchment area CME. The CME may subcontract with the FCFC for services. The goal of OhioRISE is to work on collaboration as one. OhioRISE Care Coordination is intended to be the primary care coordination for children/youth and their families/caregivers enrolled in the program. It would be duplicating services and possibly confusing to the member to receive care coordination from two separate entities. Since OhioRISE Care Coordination is based on High Fidelity Wraparound principles that honor family voice and choice, families may choose to include various parties (BH service providers, other family members and supporters, FCFC staff) in their Child and Family Team. Children/youth and families/caregivers may also chose to decline OhioRISE care coordinatoin; if this occurs, the OhioRISE Plan and/or CMEs will be responsible for continuing to attempt to engage the child/youth and family/caregiver in care coordination activities.