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

Care Management Entity (CME)

Request for Application

Released October 18, 2021

aetna

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1 INTRODUCTION

As part of Governor Mike DeWine's overarching goal to improve care for children with complex needs, the State of Ohio designed a reimagined Medicaid system and structure of services to better serve multisystem youth, other children and youth with complex behavioral health needs and their families/caregivers. The Ohio Resilience through Integrated Systems and Excellence (OhioRISE) Program was jointly developed and will be governed by the Ohio Department of Medicaid (ODM), the Governor's Office of Children's Initiatives, and other state agencies serving this population. OhioRISE aims to improve care and outcomes for children and youth with complex behavioral health needs and their families/caregivers by:

1. Creating a seamless delivery system for children and youth, families/caregivers, and system partners;
2. Providing a "locus of accountability" by offering community-driven comprehensive care coordination; and
3. Expanding access to critical services needed for this population and assisting families, state and local child serving agencies, and other health providers to locate and use these services when necessary.

Aetna Better Health of Ohio was selected by ODM to serve as the single statewide OhioRISE Managed Care Plan (OhioRISE Plan). The OhioRISE program is based on an innovative vision that must be implemented with a progressive approach to whole-child and whole-family health and well-being. The OhioRISE Plan will work with ODM and the Governors' Family and Children First Cabinet Council, providers, and community organizations to implement a child and family/caregiver-centric model based on System of Care principles and values for children and youth with serious behavioral health challenges.[1] OhioRISE features new and enhanced Medicaid coverage of targeted behavioral health services and comprehensive care coordination. The OhioRISE Plan will coordinate and collaborate with the Child and Adolescent Behavioral Health Center of Excellence (CABHCOE), the state's Medicaid managed care organizations (MCOs) and the new single pharmacy benefit manager (SPBM) to ensure that medical and pharmaceutical services and supports are integrated with the services and care coordination provided through OhioRISE.

1.1 SYSTEM OF CARE

Children and youth have complex needs crossing the various domains of life, and therefore interact with various agencies and service systems. System of Care principles and values have been developed over the past 40 years as best practice standards for how to serve these children and youth and their families/caregivers most appropriately. A System of Care is defined by Stroul, Blau and Friedman[2] as "A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life."

[1] https://gucchdtacenter.georgetown.edu/resources/Call%20Docs/2010Calls/SOC_Brief2010.pdf

[2] Stroul, Blau & Friedman, 2021

The System of Care is guided by three Core Values:

1. Family driven, and youth guided, with the strengths and needs of the youth and family determining the types and mix of services and supports provided.

2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of community-level structures, processes, and relationships.

3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care[3].

1.2 High-Fidelity Wraparound

OhioRISE' s Care Coordination program will provide the foundation of support, services, collaboration, and communication for child or youth, and their families/caregivers through three tiers of care coordination, all delivered in alignment with the principles of High-Fidelity Wraparound (HFW)[4]:

- Tier 3, Intensive Care Coordination (ICC), will be delivered by the Care Management Entities (CMEs) procured by the OhioRISE Plan and will provide care coordination using the HFW model.
- Tier 2, Moderate Care Coordination (MCC) will also be delivered by the CMEs and will be a less intensive model of care coordination based on HFW Principles.
- Tier 1, Limited Care Coordination, will be delivered by the OhioRISE Plan in alignment with HFW principles.

The National Wraparound Initiative defines High Fidelity Wraparound as a comprehensive, holistic, youth and family-driven way of responding when children or youth experience serious mental health or behavioral challenges. Wraparound puts the child or youth and family at the center. With support from a team of professionals and natural supports, the family's ideas and perspectives about what they need and what will be helpful drive all of the work in Wraparound[5] . High Fidelity Wraparound operationalizes ten principles when working with child or youth and family/caregivers:

1. **Family/Caregiver Voice and Choice**: Family/caregiver and youth perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family/caregiver perspectives, and the team strives to provide options and choices such that the plan reflects family/caregiver values and preferences.
2. **Team based**: The wraparound team consists of individuals agreed upon by the family/caregiver and committed to the family/caregiver through informal, formal, and community support and service relationships.
3. **Natural supports**. The team actively seeks out and encourages the full participation of team members drawn from family/caregiver networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

[3] Stroul, Blau & Friedman, 2021
[4] National Wraparound Initiative https://nwi.pdx.edu/

[5] National Wraparound Initiative https://nwi.pdx.edu/

4. **Collaboration**. Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.
5. **Community based**. The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote youth and family/caregiver integration into home and community life.
6. **Culturally competent**. The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the youth and family/caregiver, and their community.
7. **Individualized**. To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.
8. **Strengths based**. The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the youth and family/caregiver, their community, and other team members.
9. **Unconditional**. A wraparound team does not give up on, blame, or reject youth or their family/caregiver. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family/caregiver and towards achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.
10. **Outcome based**. The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

OhioRISE aims to keep more children or youth in their homes, schools and communities and reduce the number of children and youth who are served in out-of-home care by creating new access to in-home and community-based services for those with the most complex behavioral health challenges. The OhioRISE program's children or youth and family/caregiver-centric delivery system recognizes the need to specialize services and supports for this unique group of children and youth and families/caregivers. The OhioRISE Plan will partner with ODM, other state agencies, providers, families/caregivers, and other stakeholders to develop and implement new access to critical services.

1.3 OhioRISE Population

OhioRISE will serve children or youth with complex needs that are already involved with, or at risk for involvement with, multiple child and youth-serving systems. The program is specifically designed to improve outcomes for children who have behavioral health challenges and are involved with the children's services system, intellectual/developmental disabilities system, and/or correction system. Data informing the selection of the program's target population includes:

- Ohio's children's services system serves approximately 15,000 youth per year. Of these, over 13% of youth are in in congregate residential programs. For youth ages 15 and over, that percentage increases to 40%.
- More than 140 children are receiving care out of state every day, reflecting a 200% increase compared to 2016 in children leaving Ohio for care.
- 58% of children on a Development Disability waiver are prescribed psychotropic medications.

ODM anticipates OhioRISE to enroll between 50,000 and 60,000 children and youth by end of year one, which includes up to 1,000 children or youth who will be served via the OhioRISE 1915(c) home and community-based services waiver. (See Section F below for projected population by CME Catchment Area.) Children and youth eligible for OhioRISE must be under the age of 21, enrolled in Ohio Medicaid (managed care or fee for service) and require significant behavioral health services as identified by the Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS) tool. (See Section II.A below)

1.4 Covered Services

Covered services[6] available through OhioRISE will be delivered through a network of providers, including regional CMEs, maintained by the OhioRISE Plan. These services include:

- Intensive Care Coordination (ICC): Delivered by CMEs using the High-Fidelity Wraparound (HFW) model
- Moderate Care Coordination (MCC): Delivered by CMEs as a less intensive model of care coordination based on HFW principles.
- Limited Care Coordination (LCC): Delivered by the OhioRISE Plan in alignment with HFW principles.
- Intensive Home-Based Treatment (IHBT): OhioRISE will include enhancements to existing IHBT services to recognize multiple service delivery models and alignment with the Family First Prevention Services Act (FFPSA).
- Psychiatric Residential Treatment Facility (PRTF): The addition of PRTF services will help to ensure that children or youth needing this level of care can remain in-state and closer to their families/caregivers and support systems.
- Mobile Response and Stabilization Service (MRSS). MRSS is a structured intervention and support service provided by a mobile response and stabilization service team that is designed to promptly address a crisis situation; with young people who are experiencing emotional symptoms, behaviors, or traumatic circumstances that have compromised or impacted their ability to function within their family, living situation, school, or community.
- Behavioral Health Respite: provides short-term, temporary community-based relief to the primary caregiver(s) of an OhioRISE plan enrolled child or youth, in order to support and preserve the primary caregiving relationship.
- Inpatient behavioral health acute hospital services that include inpatient substance use disorder services, including withdrawal management.
- Opioid Treatment Program (OTP) delivered by community SUD programs licensed by Ohio Department of Mental Health and Addiction Services as a methadone administration program and/or certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an OTP.
- Primary Flex Funds, which can be used to purchase select services, equipment, or supplies not otherwise covered by the Medicaid program when needed to support implementing a child and family-centered care plan.

[6] See draft OAC 5160-59-03, in Appendix A, Section 2.A

- Nearly all other outpatient behavioral health services, with the exception of emergency department services. (Appendix A, Section 2A)

For those children and youth enrolled in OhioRISE' s 1915(c) waiver, the following additional services will be available:

- Out-of-home respite;
- Transitional services and supports;
- Therapeutic mentoring; and
- Secondary Flex Funds.

1.5 Care Management Entities (CMEs) Roles

1.5.1 Care Coordination

The OhioRISE Plan will create a network of regionally located Care Management Entities (CMEs) that will serve as the "locus of accountability" for children and youth with complex challenges and their families/caregivers by delivering Intensive Care Coordination (ICC) and Moderate Care Coordination (MCC).

The OhioRISE Plan will select CMEs with demonstrated expertise providing care coordination using High-Fidelity Wraparound, or the ability to develop this expertise, and with sufficient capacity to serve OhioRISE Plan members.

Freedom from conflicts is essential to the integrity and fidelity of a high-fidelity wraparound or wraparound-informed care coordination. Conflict-free care coordination is also required for administration of all home and community-based (HCBS) waiver programs, including the OhioRISE 1915(c) waiver. All organizations serving as OhioRISE CMEs must ensure their care coordination services for OhioRISE members are provided in a conflict-free manner, with particular attention to ensuring their care coordination services and functions are separated from other 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. CMEs will be required to establish policies and procedures to ensure care coordination functions are separate and firewalls are established. Policies and procedures must be submitted to the OhioRISE Plan for review and approval. The OhioRISE Plan will monitor CMEs' implementation of their policies and procedures as well as the number of referrals to CMEs' parent or affiliated organizations.

1.5.2 Community Resource Development

In addition to individual work with children and youth and their caregivers, the CMEs will work with community partners (service providers, local governmental agencies that serve children and other stakeholders) to develop the local system of care. This includes leveraging a variety of resources to monitor and develop needed services and supports as well as creating collaborative processes with other entities to support Wraparound care coordination.

ICC and MCC, using the principles of High-Fidelity Wraparound, will work with children or youth and family/caregivers, their friends, other family and formal and informal community resources to support the child or youth's optimal development and well-being. Building on individual, family, community and service system strengths, ICC and MCC Child and Family Teams (CFTs) will develop sustainable plans to support the

child or youth's functioning, motivation and development as well as the family/caregiver's well-being and capacity to parent.

To support the CFTs, CMEs need to identify and develop new formal and informal resources. Some of these will be useful for many child or youth and families/caregivers, and others may need to be developed to meet the unique needs of a single child or youth.

OhioRISE Plan and CMEs will collaborate to develop and leverage formal and informal resources within four primary groups:

1. Longstanding Medicaid-covered mental health and substance use disorder services such as outpatient and inpatient care;
2. New and enhanced Medicaid-covered services such as Intensive Home-Based Treatment, Mobile Response and Stabilization Services, the behavioral health community-based respite service, and the OhioRISE 1915(c) waiver services;
3. Individualized resources purchased with local resources and other flexible funds (camperships, participation in arts or athletic programs); and
4. Free or low-cost community resources through city and town recreational programs, the YMCA, Boys and Girls Clubs, volunteer parent support groups, etc.

Importantly, in all four of these categories there is a need to develop culturally responsive services for racial, ethnic and LGBTQ+ communities in each catchment area.

The OhioRISE Plan is responsible for developing and maintaining sufficient provider networks for the Medicaid-covered services, including the OhioRISE 1915(c) waiver services, in OhioRISE and will be responsible in ensuring network adequacy for resources outlined in groups 1 and 2 above. CMEs will be essential partners with the OhioRISE Plan as they learn about service access and quality in their area and identify promising partners for developing new service capacity.

CMEs are responsible for developing and maintaining informal resources outlined in groups 3 and 4 above. CMEs will identify existing and emerging resources, gather child or youth and family/caregiver feedback about these resources and work with local leaders and stakeholders to expand informal resources. 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.

1.6 Care Management Entities (CMEs) Catchment Areas and Projected Enrollment

Twenty (20) CME catchment areas will serve children and youth enrolled in OhioRISE across the State. Catchment areas were developed to serve a projected annual population of OhioRISE enrollees. The table below describes each catchment area and the projected annual population size within that catchment area. Counties were grouped to ensure multi/combined-county children's services agencies and mental health and addiction services boards are contained within a single catchment area. In many circumstances, counties with large amounts of behavioral health provider resources were grouped with counties that have fewer resources. Ohio's three most populous counties are divided into multiple catchment areas to accommodate population maximum limitations of a CME and to provide an opportunity for more than one

organization to become a CME within the most populous counties. The counties impacted in this manner include Cuyahoga, Franklin, and Hamilton. (See Map in Appendix A, Section 5). The chart below includes the number of and specific Counties in the CME area, projected number of children to be served over the course of the first year, and the geographic area covered.

OhioRISE Catchment Areas including Counties and projected annual participation

Color	CME	Projected Annual Assignment (estimate for 12 months)	Count of Counties in CME Region	Counties in CME
	A	2920	9	Williams, Defiance, Fulton, Henry, Putnam, Paulding, Van Wert, Mercer, Lucas
	B	1650	11	Wood, Ottawa, Erie, Sandusky, Seneca, Wyandot, Hancock, Huron, Crawford, Marion, Union
	C	2100	11	Allen, Auglaize, Hardin, Darke, Shelby, Miami, Logan, Champaign, Clark, Green, Madison
	D	2350	2	Preble, Montgomery
	E	2180	3	Butler, Warren, Clinton
	F	2430	1	**Hamilton**
	G	2750	6	**Hamilton**, Clermont, Brown, Adams, Scioto, Lawrence
	H	2070	11	Fayette, Pickaway, Highland, Ross, Pike, Hackson, Gallia, Meigs, Hocking, Vinton, Athens
	I	1750	8	Fairfield, Perry, Muskingum, Morgan, Noble, Guernsey, Coshocton, Washington
	J	2920	8	Monroe, Belmont, Harrison, Tuscawaras, Carroll, Jefferson, Columbiana, Stark
	K, L	2600, 2500	1, 1	**Franklin**
	M	1350	4	Licking, Knox, Morrow, Delaware
	N	1430	2	Lorain, Medina
	O	1310	4	Ashland, Richland, Wayne, Holmes
	P, Q	2400, 2400	1, 1	**Cuyahoga**
	R	1660	4	**Cuyahoga**, Lake, Geauga, Ashtabula
	S	2300	2	Summit, Portage
	T	2450	2	Trumbull, Mahoning

2 CME Service Specifications

2.1 Care Coordination Overview

CMEs will serve as the OhioRISE Plan's implementing partners in the delivery of ICC and MCC. CMEs, at a minimum, must be compliant with draft OAC 5160-59-03.2 (Appendix A, Section 2 A) which lays out minimum standards for providing ICC and MCC. CMEs will ensure initial face-to-face contact and in-home community-based contact within time standards set forth by ODM in this rule. The initial in-home assessment required by this rule will be informed by a CANS assessment and other information determined necessary to complete the development of an initial and ongoing crisis/safety plan for incorporation into the Child and Family-Centered Care Plan.

CMEs are charged with the creation and implementation of an individualized, strengths-based Child and Family-Centered Care Plan. It is the responsibility of the CME to monitor this plan to ensure services, including OhioRISE 1915(c) waiver services, are delivered in accordance with the plan and natural supports are leveraged. The CME ensures the Child and Family-Centered Plan is administered through OhioRISE plan procedures. The CME submits the Child and Family-Centered Care Plan to the OhioRISE Plan for review and approval within required timeframes and adheres to HFW Standards. OhioRISE will monitor CMEs on the development, implementation and monitoring activities of the Child and Family-Centered Care Plan. The CME is required to work with the OhioRISE Plan to improve the quality of the Child and Family-Centered Care planning process and the quality of the Child and Family-Centered Care Plans.

The CME is required to convene and facilitate the Child and Family Team (CFT), to suit the specific needs of each child or youth and their family/caregiver, within required timelines. The CFT works with the child or youth and their family/caregiver to develop and implement the Child and Family-Centered Plan, utilizing natural supports and formal services as appropriate. The CME will ensure the child or youth and family/caregiver voice is incorporated into the activities of the CME and will work to ensure its partners also incorporated child/youth and family/caregiver voice into the services and supports they receive.

2.2 OhioRISE Eligibility

2.2.1 General Program Eligibility

In accordance with criteria established by ODM in draft OAC 5160-59-02 and 02.1 (Appendix A, Section 2.A), youth who are eligible for OhioRISE must be under the age of 21, be determined eligible for Ohio Medicaid prior to enrollment in the OhioRISE plan (managed care or fee for service), not enrolled in a MyCare Ohio plan and meet the following clinical criteria as identified and documented by the Ohio Children's Initiative CANS tool:

1. For youth age 6 through 20, have an Ohio Brief or Comprehensive "child and adolescent needs and strengths" (CANS) assessment, available on www.medicaid.ohio.gov (October 1, 2021), completed by a certified Ohio CANS assessor within 90 days of eligibility determination, indicating:

a) Behavioral/emotional needs that require action to ensure that the identified need is addressed, and the need is interfering with functioning; or the need is dangerous or disabling and requires immediate or intensive action; and either

b) Risk behaviors require action to ensure that the identified need is addressed, and the need is interfering with functioning; or the need is dangerous or disabling and requires immediate or intensive action; or

c) Life functioning needs require action to ensure that the identified need is addressed, and the need is interfering with functioning; or the need is dangerous or disabling and requires immediate or intensive action.

2. For youth age birth through 5, have an Ohio Brief or Comprehensive "child and adolescent needs and strengths" (CANS) assessment, available on www.medicaid.ohio.gov (October 1, 2021), completed by a certified Ohio CANS assessor within 90 days of eligibility determination, indicating:

a) Early childhood challenges that require action to ensure that the identified need is addressed, and the need is interfering with functioning; or the need is dangerous or disabling and requires immediate or intensive action; and either

b) Caregiver resources and needs that require action to ensure that the identified need is addressed, and the need is interfering with functioning; or the need is dangerous or disabling and requires immediate or intensive action; or

c) Caregiver resources and needs indicate safety is an identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement."

In addition, youth under the following conditions automatically meet the clinical eligibility criteria:

3. Be an inpatient in a hospital with a primary diagnosis of mental illness or substance use disorder;

4. Be an inpatient in a psychiatric residential treatment facility (PRTF), as described in 42 CFR 441.150 through 42 CFR 441.184 (October 1, 2021); or

Once ODM establishes a child or youth's eligibility for OhioRISE, the OhioRISE Plan will use the CANS assessment, the tier of care coordination recommended by the CANS decision support model, and other relevant information to determine the appropriate tier of care coordination for each child or youth. The OhioRISE Plan will refer children or youth in need of ICC or MCC to the CME located in the area where the child or youth and family/caregiver live and will send referral information to the appropriate CME. CMEs must have a "no eject, no reject" policy when serving children or youth referred by the OhioRISE Plan: they are required to accept all referrals of OhioRISE eligible youth made by the OhioRISE Plan, and they must continue serving the child or youth until defined outcomes and discharge criteria are met, unless the family opts for discharge from the CME's care coordination services.

If there is more than one CME located within the area where the child or youth and family/caregiver live, the zip code will indicate the CME to provide the ICC or MCC service.

2.2.2 OhioRISE 1915(c) Waiver Eligibility and Level of Care Assessments

CMEs will play a key role in the process of determining eligibility for the OhioRISE 1915(c) waiver by:

- Completing initial waiver Level of Care assessments for individuals requesting enrollment in the OhioRISE 1915(c) waiver.
- Completing annual Level of Care redetermination assessments in a timely manner for individuals enrolled in the OhioRISE Waiver who have Tier 2 or Tier 3 Care Coordination.
- Referring children or youth and their family/caregivers to ODM's Central Processing Team to completed further waiver eligibility determination steps.

To complete initial and redetermination waiver Level of Care assessments, CMEs will conduct a Comprehensive CANS assessment and work with the child or youth and their family/caregiver to determine and document additional level of care criteria described in draft OAC 5160-59-04: OhioRISE home and community-based services waiver: eligibility and enrollment. Additional Level of Care criteria outlined in the draft rule that will be assessed by the CME include:

- The presence of the child or youth's diagnosis of serious emotional disturbance (SED) as defined in rule 5122-24-01 of the Administrative Code;
- A known risk factor regarding for custody relinquishment and either risk of institutional placement or was placed in an institutional setting within the past six months; and
- The child or youth's projected need for waiver services will not exceed the maximum annual waiver cost.

CMEs will document complete Initial and redetermination waiver Level of Care assessments within ODM's CANS IT system prior to referring the child or youth and their family/caregiver to ODM's Central Processing Unit to complete additional steps in the waiver eligibility determination process. Children and youth who obtain waiver eligibility will be enrolled in the OhioRISE Plan by ODM, and the OhioRISE Plan will refer these children and youth to CMEs when they require Tier 2 and Tier 3 care coordination services.

While ODM retains final authority and oversight of the OhioRISE 1915(c) waiver eligibility determination process, the OhioRISE Plan will contribute to quality monitoring and oversight of the CMEs' role in this process by:

- Overseeing CME 1915(c) waiver enrollment activities to ensure consistent application of Level of Care eligibility criteria and assessments.
- Ensuring CMEs perform 1915(c) waiver Level of Care assessments for the purposes of all initial waiver eligibility determinations in a timely manner
- Ensuring CMEs perform 1915(c) annual redeterminations in a timely manner for individuals enrolled on the OhioRISE 1915(c)Waiver who are receiving Tier 2 or Tier 3 Care Coordination

2.3 Care Coordination Tiers

The Ohio RISE Plan will assign a care coordination tier for every child or youth enrolled in OhioRISE, based on the CANS assessment and tier of care coordination recommended by the CANS decision support model and other clinical documentation and in accordance with draft OAC 5160-03.2. Care coordination tiers may be changed based on changes in child or youth and family/caregiver needs. Family/caregivers may also choose a less intense tier than the one indicated by the criteria below:

1. Intensive care coordination (ICC) using high-fidelity wraparound is utilized when a 'child and adolescent needs and strengths' (CANS) assessment and other clinical documentation indicates:

   a) Significant behavioral health challenges that require an action or immediate intensive action to ensure that the identified behavioral health needs, risk behaviors, life functioning and caregivers needs are addressed; and

   b) The youth requires the majority of care coordination activities be delivered in the community; and one of the following:

      (i) The youth demonstrates at risk behaviors or other psychosocial factors which place the youth at high likelihood for out of home treatment or psychiatric hospitalization.;

      (ii) The youth is awaiting out of home behavioral health treatment;

      (iii) The youth is being discharged or has recently been discharged from a psychiatric residential treatment facility (PRTF), as described in inpatient psychiatric hospitalization or other residential treatment facility and is returning to a community setting; or

         (iv) The youth has had multiple episodes of inpatient psychiatric hospitalization, or other institutional or residential community-based treatment facility stays within the past 12 months.

2. Moderate care coordination (MCC) using a wraparound informed model is utilized when a CANS assessment and other clinical documentation indicates:

   a) Moderate behavioral health challenges that require an action or immediate intensive action to ensure that the identified behavioral health needs, risk behaviors, and life functioning are addressed; and one of the following:

      (i) The youth demonstrates at risk behaviors or other psychosocial factors which place the youth at moderate risk for out of home treatment or psychiatric hospitalization.;

      (ii) The youth has had an episode of inpatient psychiatric hospitalization, or other institutional or community based behavioral health treatment facility stay within the past 12 months; or

      (iii) The youth is currently involved with two or more child serving systems, which includes either child welfare, detention, or juvenile justice.

3. Denials of enrollment in ICC or MCC are subject to the appeal process described in OAC rule 5160-26-08.4.

4. Limited care coordination delivered by the OhioRISE plan is utilized when a CANS assessment and other clinical documentation indicate that the child or youth's needs do not meet the ICC or MCC criteria, or for children or youth that meet criteria for ICC or MCC but decline to participate in ICC or MCC.

Links to the CANS documents are on the OhioRISE website and are located in Appendix A Section 2.E.

2.4 Service Standards[7]

2.4.1 Care Management Entities (CMEs)

1. ICC and MCC are delivered by CMEs designated by the OhioRISE Plan. CMEs will:

   a) Maintain an active, valid Medicaid provider agreement and comply with applicable provider requirements in rule 5160-1-17.2 of the Administrative Code;

   b) Participate in initial and ongoing training, coaching, and supports from the CABHCOE to ensure consistency in delivering care coordination;

   c) Participate in the required readiness review process, including completion of the initial readiness review with the OhioRISE Plan within sixty days of billing for ICC or MCC;

   d) Ensure that all child and family-centered care plans (including initial plans, changes to plans, and transition plans) are submitted to the OhioRISE plan for review and approval;

   e) Exchange electronic, bidirectional data and other information regarding the youth and family receiving ICC and MCC with the OhioRISE plan

   f) Report the incidents consistent with ODM policies in accordance with rule 5160-59-06 of the Administrative Code;

   g) Implement quality improvement activities related to the CME's performance consistent with ODM's population health management strategy;

   h) Provide all staff with training regarding cultural and trauma-informed care competency within three months of date of hire and annually thereafter;

   i) Conduct virtual, in-person or telephonic outreach to the youth's family within one business day of referral to ICC or MCC to explain the service and obtain consent;

   j) Have administrative and program staff, in sufficient quantity to meet all the CME requirements to achieve the quality, performance, and outcome measures set by ODM;

   k) Ensure care coordination staff and supervisors have the experience necessary to manage complex cases and the ability to navigate state and local child serving systems;

[7] From draft OAC Rule 5160-59-01 through 5160-59-03.2. A link to these OACrules is in Appendix A, Section 2.A

l) Have sufficient care coordination staff to meet care coordinator-to-youth ratios assessment frequency and timeliness and contact frequency requirements in the rule;

m) Have supervisory personnel to provide coaching and support for ICC and MCC care coordinators, not to exceed the supervisor ratio described in the rule;

n) Provide real-time or on demand clinical and psychiatric consultation for youth engaged in ICC or MCC;

o) Respond to the youth and family twenty-four hours a day;

p) Ensure child or youth and family choice is incorporated regarding the services and supports they receive and from whom;

q) Ensure that all care coordination services are provided conflict-free, meaning that care coordination functions are separated from service delivery functions. The CME must establish firewalls between its care coordination function and its service delivery function;

r) 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;

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;

t) For child or youth and family/caregivers who do not respond to the CME's ongoing care coordination efforts, track and report the number of attempts to reach the child or youth or family/caregiver. OhioRISE will work with the CMEs to develop strategies when children or youth and their families/caregivers are difficult to engage. These strategies will be tracked once developed;

u) Ensure that CME care coordination staff contact the member as identified in the Child and Family-Centered Plan, but not less frequently than the ODM-approved minimum contact schedule;

v) Ensure the CME care coordinators report the incidents consistent with ODM policies in accordance with rule 5160-59-06 of the Administrative Code

w) For members with intellectual disabilities and developmental disabilities and receiving care coordination through the Individual Options Waiver (OAC 5160-40), Level One Waiver (OAC 5160-41) and the Self-Empowerment Life Funding Waiver (OAC 5160-41) or Targeted Case Management through local County Boards of Developmental Disabilities, ensure the CME's care coordinators submit incidents for these individuals in accordance with OAC 5123-17-02.

2.4.2 Tier 3 Intensive Care Coordination (ICC)

1. CMEs delivering ICC will:
   a) Provide structured service planning and care coordination through high-fidelity Wraparound as established by the National Wraparound Initiative, found at https://nwi.pdx.edu (October 1, 2021), including:

      (i) An initial face-to-face contact will be offered within two calendar days of referral for ICC; and

      (ii) An initial comprehensive assessment within fourteen calendar days of the youth's referral to ICC that includes:

      (a) Information from a new CANS assessment or existing CANS assessment that was completed within the ninety calendar days prior to the comprehensive assessment; and

      (b) Other tools as determined necessary that inform and result in the development of the child and family-centered care plan;

      (iii) A completed Ohio comprehensive CANS assessment within thirty calendar days of referral to ICC;

      (iv) Updating the CANS assessment at a minimum of every ninety calendar days or whenever there is a significant change in the youth's needs or circumstances;

      (v) Convening and facilitating the child and family team within thirty calendar days of referral for ICC that will:

      (a) Develop and implement the initial child and family-centered care plan within the thirty-calendar day period; and

      (b) Review the child and family-centered care plan every thirty calendar days, and whenever there is a significant change in the youth's needs or circumstances.

      (vi) Developing a crisis safety plan, within fourteen calendar days of referral for ICC, for incorporation into the child and family-centered care plan;

      (vii) Monitoring the child and family-centered care plan to ensure that services are delivered in accordance with the plan;

      (viii) Performing referrals and linkages to appropriate services and supports, including natural supports, along the continuum of care;

      (ix) Facilitating discharge planning activities for youth admitted to a psychiatric residential treatment facility or an inpatient behavioral health facility.; and

      (x) Facilitating transition activities for youth transitioning amongst and between all facility and community-based settings.

   b) Have documentation of annual fidelity review, monitoring, and adherence to high-fidelity Wraparound by an independent validation entity recognized by ODM. The fidelity review will assess for consistent use of high-fidelity wraparound standards established by the national wraparound initiative.

c) Submit the child and family-centered care plan to the OhioRISE plan within one business day of completion of the child and family-centered care plan.

2.4.3 Tier 2 Moderate Care Coordination (MCC)

2. CMEs delivering MCC will:

a) Provide structured service planning and care coordination based on Wraparound principles, as established by the National Wraparound Initiative, found at https://nwi.pdx.edu (October 1, 2021), including;

(i) An initial face-to-face contact will be offered within seven calendar days of referral for MCC; and

(ii) An initial comprehensive assessment within fourteen calendar days of the youth's referral to MCC that includes:

(a) Information from a new CANS assessment or existing CANS assessment completed within the ninety days prior to the comprehensive assessment; and

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

(iii) A completed Ohio comprehensive CANS assessment within thirty calendar days of referral to MCC;

(iv) Updating the CANS assessment at a minimum of every ninety calendar days or whenever there is a significant change in the youth's behavioral health needs or circumstances;

(v) Convening and facilitating the child and family team within thirty calendar days of referral for MCC that will:

(a) Develop and implement the initial child and family-centered care plan within the thirty-calendar day period; and

(b) Review the child and family-centered care plan every sixty calendar days, and whenever there is a significant change in the youth's needs or circumstances.

(vi) Developing a crisis safety plan, within fourteen calendar days of referral for MCC, for incorporation into the child and family-centered plan;

(vii) Monitoring the child and family-centered care plan to ensure that services are delivered in accordance with the plan;

(viii) Performing referrals and linkages to appropriate services and supports, including natural supports, along the continuum of care;

(ix) Facilitating discharge planning activities for youth admitted to a psychiatric residential treatment facility or an inpatient behavioral health facility; and

(x) Facilitating transition activities for youth transitioning between facility and community-based settings.

b) Have documentation of annual fidelity review, monitoring, and adherence to MCC by an independent validation entity recognized by ODM. The fidelity review will assess for consistent application of system of care principles adherence to the MCC planning process and service components.
c) Submit the child and family-centered care plan to the OhioRISE plan within one business day of completion of the child and family-centered care plan.

2.4.4 Transition of Care

As the needs of children or youth and their families/caregivers change, transitions of care within OhioRISE will occur. These transitions will include movement between higher and lower level of care services, to and from providers, from one tier of care coordination to another tier, from one MCO to another MCO, and eventual discharge and transition out of OhioRISE.
If a child or youth and family/caregiver needs to change care coordination tiers because of changing needs or a preference for a lower care coordination tier, the CME will make the request to the OhioRISE plan within two business days, including a CANS assessment updated within 90 days of the transition date.

Children and youth receiving out of home treatment, including treatment within inpatient and residential facilities, are likely to be enrolled in ICC or MCC. CMEs must maintain compliance with all ICC or MCC standards while youth are receiving out of home treatment. As part of delivering ICC or MCC for these children and youth, the child or youth's care coordinator should engage with the facility as soon as possible after learning of the child or youth's admission, continue to facilitate CFT meetings when appropriate and include the facility in these meetings, and participate in the facility's discharge/transition planning process. The care coordinator must obtain a copy of the discharge/transition plan, arrange, and confirm services are authorized, scheduled, and delivered in accordance with the transition/discharge plan. The Following discharge, the CME will continue to communicate with the facility and participate in their aftercare processes to ensure services are provided.

For any transition that occurs between providers, the CME will ensure the child or youth and their family/caregivers' consent to the change, have been provided choice for the new provider whenever choice is possible, that appointments are secured, and that necessary information is communicated between all parties. The child or youth and their family/caregiver will be asked if they are willing to add the new provider to the CFT and if they consent to allowing the new provider to have access to the Child and Family-Centered Care Plan. The CME will then invite the new provider, once approved by the child or youth and their family/caregiver, to the next CFT meeting.

Because the CME is the point of contact for the family/caregiver to ensure seamless coordination of care, when child or youth and/or families/caregivers move from one Managed Care Organization (MCO) to another, CMEs must have processes for helping the youth and family/caregiver through this transition. These processes should include at a minimum:

1. Ensuring the name and contact information for any assigned MCO Care Manager Plus or Care Guide Plus is available to the child or youth and family/caregiver;
2. Reaching out to any Care Manager Plus or Care Guide Plus at the new MCO within a reasonable timeframe as specified by ODM; and

3. Supporting the family/caregiver to contact the new MCO and appropriate care coordination resources as needed. as a part of the MCO-to-MCO transition.

Eventually, the child or youth will graduate the OhioRISE program. This plan to transition from OhioRISE is a decision that occurs within the CFT, guided by the updated CANS assessment and by child or youth and their family/caregiver. The CFT will initiate a transition plan as part of the Child and Family-Centered Care Plan. The CME will be responsible to ensure the transition plan is enacted. All follow up appointments and services will be secured prior to transition from the OhioRISE program. The CME will ensure the MCO is notified of the transition so the MCO care management program can assume the primary care coordination for the child or youth.

2.4.5 Additional 1915(c) OhioRISE Waiver Responsibilities

In addition to assisting with determining and redetermining OhioRISE 1915(c) waiver eligibility, as outlined in section B.2. above, and delivering Tier 2 and Tier 3 care coordination services to children enrolled in the OhioRISE 1915(c) waiver, CMEs will also be responsible for the following waiver-related activities for children and youth who are assigned to Tier 2 and Tier 3 care coordination:

1. Submitting prior authorization requests when the CME believes a child or youth enrolled in the waiver needs access to waiver services beyond established service limits.
2. Assisting children or youth and their authorized representatives with connecting with the waiver's established Financial Management Services entity (either the OhioRISE plan or its designee) to exercise budget authority as needed when the child or youth has a documented need for Secondary Flex Funds as offered under the 1915(c)-waiver program.
3. Assuring children or youth receiving Tier 2 or Tier 3 care coordination who are disenrolling from the OhioRISE 1915(c) are carefully transitioned out of the program by identifying needed supports for ninety calendar days following disenrollment from the OhioRISE program.

While ODM retains final authority and oversight of the OhioRISE 1915(c) waiver program, the OhioRISE Plan will contribute to quality monitoring and oversight of the CMEs' waiver-related responsibilities by reviewing CMEs' Child and Family-Centered Care Plans and care planning processes to ensure appropriate HCBS person-centered planning is occurring locally, and to assure the child or youth's health and safety is maintained while enrolled on the waiver.

2.4.6 Staffing and Supervision

All care coordination staff employed/contracted by CMEs must be skilled at engaging and working with children or youth with significant behavioral health needs and their families/caregivers. These staff will also need a thorough understanding of local communities, be skilled at developing working relationships with community agencies, be able to identify potential community supports for development to assist families/caregivers and work collaboratively with the Child and Family Teams. Care Coordination staff employed/contracted by CMEs must be in Ohio and preferably live in the CME assigned catchment area. The OhioRISE Care Coordination rule, draft OAC 5160-59-03.2, requires CMEs to:

1. Ensure staff and supervisors have the experience necessary to manage complex cases and the ability to navigate state and local child serving systems;
2. Ensure care coordination is provided by CMEs within the youth and family/caregiver's community;

3. Have the capacity to meet care coordinator-to-youth and family/caregiver ratio requirements of 1:10 for ICC and 1:25 for MCC;
4. Have the capacity to offer adequate supervision and coaching to support care coordinators, not to exceed the supervisor ratio of 1:8;
5. Have the capacity to provide real-time or on demand clinical and psychiatric consultation for child or youth engaged in care coordination;
6. Have the ability to respond to member needs twenty-four hours a day
7. Ensure child or youth and families/caregivers have a voice and choice of assigned care coordinator. Care coordination staff should not be related by blood or marriage to the child or youth or family/caregiver, or any paid caregiver, financially responsible for the member, or empowered to make financial or health related decision on behalf of a child or youth and family/caregiver;
8. Have sufficient administrative and program staff to meet all the CME requirements to achieve the quality, performance, and outcome measures set by ODM;
9. All CME care coordination staff will complete the ICC or the MCC HFWA certification training with the COE.

2.4.7 Community Resource Development

CMEs are responsible for working with local stakeholders, while being supported by the OhioRISE Plan and state partners, to develop needed services and supports in the community. Specifically, the CMEs shall:

1. Identify formal and informal resources in their catchment area, initially and on an ongoing basis, paying particular attention to the availability of culturally responsive resources for children or youth and family/caregivers of the various racial and ethnic communities in the area. These shall include, but are not limited to, affiliations with informal or natural helping networks such as neighborhood and civic associations, faith-based organizations, and recreational programs.
2. Refer identified service providers who are not currently contracted with the OhioRISE Plan to the Plan for enrollment as an Ohio Medicaid provider if not already enrolled, for contracting with OhioRISE or to develop a Single Case Agreement (SCA).
3. Capture information on resources in a useable format such as a database and make it accessible to Care Coordinators, Child and Family Teams (CFT) and child or youth and family/caregivers.
4. Collect and use feedback on resources from child or youth, family/caregivers and CFT members.
5. Develop the capacity to support and use peer and/or parent supports. Identify current peer and/or parent supports available as well as work to develop new peer and parent support options.
6. Determine the need for additional capacity and/or new resources. 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. Report to and work with the OhioRISE Plan, providers and community leaders to identify gaps of services if only one provider is available for a specific service in a specific area.
7. Prepare an annual resource development plan according to criteria developed by the OhioRISE Plan to be shared with the OhioRISE Plan and ODM.
8. Establish policies and procedures and firewalls for conflict free referrals, to be submitted to the OhioRISE Plan for approval. The Plan will monitor CMEs' implementation of their policies and procedures.

2.4.8 Collaboration with Child-Serving State Agencies and Schools

Delivery of High-fidelity Wraparound will require the CME to establish strong partnerships and collaborative working relationships with local government and community-based agencies. The CMEs will be expected to leverage established local systems of care and stakeholder partnerships. Successful CMEs will address how they will collaborate with local child-serving systems to improve care coordination and reduce the burden on children or youth and families/caregivers.

As part of collaboration with these community partners, local government and community-based agencies and providers, the CME will invite members of these entities to join the CFT as appropriate to the needs of the child or youth and their family/caregiver. In preparation of adding a new member to the CFT, the care coordinator will ask the parent/caregiver to provide a release of information to contact these providers after the child or youth is enrolled to explain the role of CME and to request a copy of the most recent treatment plans.

Partnering with these entities may need to be creative and understanding of their time constraints. For example, engagement in the CFT may need to occur through email, phone calls, or other communication methods. This flexibility will ensure these entities are looped into the CFT and have access to the Child and Family-Centered Care Plan through FamilyConnect or the CME will provide a copy of the Plan.

1. Collaboration with Children's Services System

   Collaboration with children's service and custodial agencies is essential to achieve the goals of OhioRISE. CMEs will establish relationships with all local Title IV-E Agencies, including Public Children's Services Agencies (PCSAs) and IV-E courts, that serve in the CME's catchment area to ensure all parties are informed of programming and services available, eligibility standards and processes for enrollment.

   CMEs will be expected to work with Title IV-E Agencies in the course of work on behalf of individual children or youth and their families/caregivers and through ongoing communication between CME and Title-IV E Agency leaders. CME care coordinators, in collaboration with child or youth and family/caregivers, will be expected to make every effort to include Title IV-E Agency staff in Child and Family Teams.

a) Invite Title IV-E Agency staff to join a child or youth's CFT. If Title IV-E Agency is not the guardian of the child or youth, CME care coordinators will ask the parent or legal guardian, as appropriate, to sign a release to allow the care coordinator to contact Title IV-E Agency staff, explain the role of the CME in OhioRISE and ICC or MCC process, ask for a copy of the most recent service plan and invite them to join the CFT.

b) Children and youth in the custody of Title IV-E agencies will be assigned to CMEs based on the custodial county of the Title IV-E Agency. The CME will work with the Title IV-E Agency to determine appropriate caregivers (foster parents, kin, biological parents) to include in the CFT. 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.

2. Collaboration with County Boards of Developmental Disabilities

   The CMEs will establish relationships with the county board(s) of developmental disabilities (CBDD) that serve in the CME's catchment area to ensure all parties are informed of programming and services available, eligibility standards and processes for enrollment. For OhioRISE children or youth with intellectual disabilities and developmental disabilities who receive care coordination through their CBDD, including those participating in home and community-based services waivers and those receiving targeted case management, the CME care coordinators are expected to collaborate with the CBDD and through inclusion in CFT meetings and sharing of the Child and Family-Centered Care Plan.

3. Collaboration with Local Corrections/Court Systems
   The CMEs will establish relationships with local courts and correctional agencies in the CME's catchment area to ensure the parties are informed of OhioRISE, the services available, eligibility standards and processes for enrollment.

   The HFW care planning process will include an assessment of and planning regarding a child or youth's involvement in the juvenile or adult corrections systems, if any. Whether there is specific involvement from court staff or probation or corrections staff in the child or youth's CFT will depend on the status of the legal proceedings and advice of the child or youth's and family/caregiver's legal counsel.

   CMEs will work with the child or youth and family/caregiver and CFT to identify natural supports in effort to prevent reentry into the juvenile corrections system or entry into the adult corrections system. 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.

4. Collaboration with Schools

   To ensure a child or youth's needs are met in the educational setting, CMEs are expected to engage school systems in the Child and Family-Centered Care Planning process. The CME will ask the parent/caregiver to provide a release of information authorizing the exchange of service information, including any Individual Education Plan, between the care coordination provider and school personnel working with the child or youth and family/caregiver.

5. Collaboration with Family and Children First Councils
   Ohio Family and Children First (OFCF) is a partnership of state and local government, communities and families that enhances the well-being of Ohio's children and families by building community capacity, coordinating systems and services, and engaging families. Established in 1993, Ohio Family and Children First (OFCF) serves as the Governor's Children's Cabinet with the purpose of streamlining and coordinating government services for children and families. In addition, each Ohio county is home to a local Family and Children First Council that works to eliminate redundancy and bring resources together for planning, monitoring and improving outcomes for child or youth and families/caregivers. The mission of County FCFCs is to increase the access, capacity, and

effectiveness of services for vulnerable children or youth and their families/caregivers whose needs extend beyond any one youth-serving program. FCFCs are critical stakeholders in local Systems of Care, and some have been engaged in Ohio's High-Fidelity Wraparound efforts.

CMEs are expected to establish relationships with each FCFC in their catchment area. CMEs must collaborate with local FCFCs in each county. At a minimum, CMEs will consult with local FCFCs to understand local resources and collaboratively develop capacity for community and natural supports. CMEs and local FCFCs may also choose to develop additional methods of collaboration.

When working with children and youth who are involved with local FCFC service coordination prior to enrolment in OhioRISE, CMEs must collaborate with the FCFC and their service coordination if desired by the child or youth and family/caregiver. Collaboration should include inclusion of the service coordinator in the CFT and sharing of Child and Family-Centered Care Plans.

6. Collaboration with MCOs

   The CMEs will be expected to establish working relationships with all MCOs and their care managers. MCOs will continue coordinating physical health services, including preventive services. The CMEs will be expected to include any physical health needs as part of the Child and Family-Centered Care Plan as appropriate. The CME will invite the MCO care manager to participate within the CFT with consent of the child or youth and their family/caregiver.

7. Collaboration with Other Providers of Behavioral Health Services

   The CME is responsible for assisting the OhioRISE child or youth in accessing medically necessary covered services. As part of this role, the CME behavioral health service providers should be considered CFT members and regularly invited to attend CFT meetings.

8. Collaboration with Primary Care

   The CME will engage the primary care provider as part of the CFT. The care coordinator will ask the caregiver for a release of information authorizing the exchange of service information between the primary care provider (PCP), CME provider, and any other relevant service provider, as appropriate.

   The care coordinator will engage and coordinate with other physical health providers and physical health specialists as these providers are engaged with the child or youth. As appropriate, these physical health providers may also participate within the CFT with consent of the child or youth and their family/caregiver.

3 Referral, Enrollment, Care Planning

OhioRISE will establish a "no wrong door" approach to identifying and enrolling children and youth in the program by creating multiple pathways for children or youth and families/caregivers to seek and access care. A child or youth's parent or caregiver may self-refer to the OhioRISE Plan or, with the parent/caregiver's consent, may be referred by a community agency, MCO, behavioral health provider (including CMEs), state or local agency staff, physical health provider, school staff member, crisis response

provider, hospital, or Psychiatric Residential Treatment Facility. Eligibility for OhioRISE is determined through an Ohio Children's Initiative Child and Adolescent Needs Assessment (CANS) process using the Brief or comprehensive CANS. This is an initial functional assessment includes the core items necessary to determine OhioRISE eligibility. The child or youth's parent/caregiver, or any referring party, can seek an appointment with an Ohio Children's Initiative trained CANS assessor to receive a Brief or Comprehensive CANS assessment. With consent of the parent/caregiver, the CANS assessor will submit the CANS assessment to ODM, which will determine the child or youth's eligibility for OhioRISE and, if eligible, will inform the OhioRISE Plan of the enrollment. The OhioRISE Plan will use the CANS assessment, and other documentation as appropriate, to determine and assign the Care Coordination Tier (see Appendix A Section 4 A.) If the child or youth needs ICC or MCC, the Plan will make the referral to the CME covering the child or youth's catchment area or the custodial county of the Title IV-E Agency who is the guardian of the child or youth. Once the CME receives the referral, the CME has one business days to outreach and engage the child or youth and family/caregiver. For children referred by a MRSS provider due to a crisis, outreach must occur within 24 hours. For children referred due to an IP/PRFT admission, outreach must occur within two calendar days.

After the child or youth's assignment to the CME, the Comprehensive CANS will be used for ongoing assessment, expanding upon the items in the Brief CANS to inform care planning and coordination.

4 Training and Quality Oversight and Improvement

4.1.1 Training

The OhioRISE Plan will partner with the Child and Adolescent Behavioral Health Center of Excellence (CABHCOE) to provide staff training to CME staff on High Fidelity Wraparound and the Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS) tool. The Plan, the CMEs and CABHCOE will collaboratively identify other training and coaching needs on an ongoing schedule. Other training opportunities will be available through both Aetna Better Health of Ohio's SHINE University. This training collaborative will engage multiple stakeholders, community-based organizations, providers, members and their families/caregivers to identify training needs, develop curriculum and offer training opportunities.

CMEs will participate in initial and ongoing training, coaching, and supports from CABHCOE on High-Fidelity Wraparound and the Ohio Children's Initiative CANS Assessment tools.

CMEs will ensure all staff complete training regarding health equity/health disparities and trauma-informed care according to standards set by ODM, within three (3) months of hire and annually thereafter.

CMEs will ensure care coordination staff complete training to be able to educate the child or youth and families/caregivers on the availability, convenience, difference in modalities, and pros and cons of telehealth services so children or youth and families/caregivers can make informed choices about telehealth.

4.1.2 Quality Oversight and Improvement

Quality improvement is a strengths-based process that aligns with the Wraparound Model. It involves a systematic approach to understanding current performance and designing, testing, implementing, and monitoring interventions to improve performance. Quality improvement principles and organizational

learning should be the basis of all aspects of CME activities including practice, documentation, finance, and policy.

The overall goals of OhioRISE are to keep children or youth at home, in school and in their community. The OhioRISE Plan will partner with children or youth and families/caregivers, providers, community partners, the CABHCOE, CMEs, the MCOs, and ODM to ensure that children or youth and their family/caregivers get what they need, when they need it and in the most efficient and effective manner possible. The OhioRISE Plan's Quality Oversight and Improvement process will support these goals by partnering with the CABHCOE and CMEs to develop an OhioRISE Quality Framework to measure performance, identify best practices and develop, implement and measure quality improvement activities.

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

1. Analyzing membership characteristics to ensure the OhioRISE program is enrolling and retaining children or youth and families/caregivers from all communities within the catchment area.
2. Monitoring engagement activities and time frames with children or youth and families/caregivers
3. Measuring child or youth and their family/caregiver satisfaction
4. Monitoring adherence to OhioRISE and CME Rules (draft OAC 5160-59-01 – 5160-59-03)
5. Ongoing measurement of fidelity to the National Wraparound Initiative Standards of Care
6. Measurement of the CME's performance on ODM's Health Children Quality measures (Appendix A, Section 11).

5 Electronic Medical Record and Data Reporting Requirements

The OhioRISE Plan will work with the selected CMEs to assess their current and future ability to provide data in an electronic format (e.g., EHR) to the OhioRISE care coordination portal and the OhioRISE Plan will provide the necessary technical assistance to participate in Ohio's two Health Information Exchange (HIE). Focus will include key elements such as existing/planned EHR capabilities, existing/planned data exchange capacity, ability to track contract requirements such as timeliness of activities, frequency of contacts and caseload, and ability to use data to track and inform community resource development.

The OhioRISE care coordination portal, called Family Connect, is an electronic population health management platform that will incorporate member-level data from CMEs and other entities engaged in the coordination of care. CMEs will be responsible for reporting and sharing data to the OhioRISE plan in alignment with the OhioRISE Plan provider agreement with ODM (Appendix A, Section 4 B).

6 Implementation Support and Readiness Review

The CME will possess the organizational capacity and infrastructure to support implementation and daily operations of an OhioRISE CME. The CME will be expected to become an active Medicaid provider within two weeks of notification of CME selection. The CME will have administrative and program staff in sufficient quantity to meet all the CME requirements to achieve the quality, performance, and outcome measures set by ODM and the OhioRISE plan.

The OhioRISE plan and the CME will assess Operational and Capacity Readiness 60 to 90 days in advance of go-live to ensure CMEs are well supported for go-live and are ready to serve the children and youth in the OhioRISE program. The OhioRISE plan readiness assessment of CMEs will focus on the staffing, training, and data exchange capabilities. This collaborative process will work to support the CMEs through technical assistance to resolve issues and potential risks prior to go-live. Ongoing technical assistance and support will be provided for the CMEs through assigned OhioRISE liaisons. The liaisons will assist with any continued risks and areas of concern.

7 PROPOSAL

7.1 OVERVIEW

The OhioRISE Plan will select up to twenty-one CME's, each serving one or more of the catchment areas defined in Appendix A. The selection process will assess prospective applicants' capacity to (1) perform HFW care coordination functions, and (2) develop and use community resources within their catchment area. Applicant's proposals are expected to specifically address how they will meet the behavioral health and social needs of the OhioRISE population within the geography of the catchment area the CME is seeking to serve, If an applicant seeks to serve as a CME in more than one catchment area, the applicant must submit a separate response for each catchment area and demonstrate a physical presence in that area.

A narrative response including answers to each question outlined below is expected to clearly address the respondent organization's ability to meet the CME Required Responsibilities and Minimum Qualifications. CMEs will also be required to respond to a Case Scenario to demonstrate how a child and family will receive care coordination from the CME. Selected CMEs will be notified of selection by 01/19/2022.

7.2 PRE-SELECTION TIMELINE

The OhioRISE Plan will hold an interested entity bidders conference via webinar to discuss the RFA on October 18, 2021 , October 19th, 2021 and October 25th, 2021. The virtual meetings are an opportunity for interested entities to learn about the Plan's approach to a successful implementation of OhioRISE, including the Plan's framework for care coordination, CME expectations and CME supports. Additionally, we will provide details on the selection process. Bidders are HIGHLY encouraged to attend the conference but are not mandated to be in attendance to submit a proposal. The RFA will be released immediately following this conference. Interested applicants are encouraged to submit questions to CMEapplication@aetna.com by Friday October 29, 2021.

Please include "Question" in the subject line: *Question_Organization Name_CatchmentArea.*

Responses to questions will be distributed to the CME Application Page no later than Friday November 5th, 2021. Application responses are due to the Plan by 5:00 PM EST on Wednesday Dec 8, 2021.

Activity	Date
Bidders Conference	October 18th , 19th and 25th

Issue RFA	Monday, October 18th 4:30 pm
Questions Due	Friday, October 29nd by 5 pm
Aetna responses to questions	Friday, November 5th
Applicant Response due	Wednesday December 8st by 5 pm
Anticipated notification of selected CMEs	Wednesday January 19th

7.3 Post-Selection Timeline

The Plan will sign contracts with CMEs by January 19, 2022. The Plan and the CABHCOE will begin working with CMEs upon selection to provide training and technical assistance in preparation for Readiness Reviews. Readiness Reviews will take place not less than 60 days prior to July 1, 2022 go-live. The OhioRISE Plan Readiness Review will take place not later than June 1, 2022.

Activity	Date
The OhioRISE Plan and CMEs sign contract	Wednesday January 19th, 2022
The OhioRISE Plan and CABHCOE begin to work with selected CMEs	Wednesday January 19th, 2022
CABHCOE will train CMEs	February-April
CME OhioRISE Plan Readiness Review	April-May
CME go-live	July 2022

7.4 Review Committee

The OhioRISE Plan will convene a Review Committee of subject matter and operations experts to assess and evaluate the CME respondent's capability to meet the requirements outlined in the Request for Application. The Review Committee will examine each application in accordance with the criteria described in this document. All reviewers will complete a conflict-of-interest form. Those individuals with conflicts or the appearance of a conflict will be disqualified from participation in the review process. The members of the Review Committee will evaluate and then score the proposals individually, and then deliberate as a group to assign a collective score to responses to determine the final selection decisions. Responses will be evaluated by each CME catchment area. To address any scoring tie between one or more CME applicant, the OhioRISE Plan may request that applicants present their proposal in person for final scoring.

7.5 Response Format

The narrative portion of the proposal must be single paged, double-spaced with margins of 1 inch on the top and bottom and 1½ inches on the left and right. The font must be no smaller than 12 points. Responses must fully address how the respondent will meet the minimum requirements and address the narrative questions. There is a 50-page limitation for the narrative response, excluding the required attachments. Any pages exceeding the 50-page limit will not be reviewed or scored. The narrative response must be organized using the outline below and respond to the questions listed for each section. Five (5) points will be deducted for each missing required appendix. Appendix A, Section 9, includes a checklist of required documents. If the deductions total 20 points or more, the proposal shall be rejected as non-responsive.

Attachments shall be limited to those included in the required documents and up to 3 additional documents of the applicant's choice. These attachments are not part of the narrative response and do not count within the page limit. Proposals must be submitted to CMEapplication@aetna.comby the deadline of December 1st, 2021 at 5:00 pm. The submission format is (1) electronic copy of the proposal in pdf format. If multiple applications are being submitted for multiple catchment areas, please submit only one application per email.

Please include in the subject line of the email, your organization's name and the catchment area for which you are applying.

CME Application_Organization Name_CatchmentArea

7.6 Proposal Scoring

The scoring will be based on the respondent's ability to clearly articulate the organization's experience and its plan to meet the required expectations outlined in the selection document, supported by data and evidence. The Case Scenario response will be included in the scoring matrix. The maximum potential score is 100 points. Weighted values will be assigned to each of the components, as noted in the table below. Scoring will encompass the narrative sections and the required attachments included within the appendix.

Response Domain **Each Domain will include sub-sections, multiple questions contained within the Subsection inform the score of the sub-section.**	**Response Total Maximum Score - 100 points**
Organizational Structure Domain	**Domain Total maximum Score 30 points**
• History, Mission, Governance Structure, Conflict of Interest Disclosure Sub-section	Sub-section maximum score 4 points
• Staffing capacity to function as CME Sub-section	Sub-section maximum score 6 points
• Race, Equity, and Inclusion Sub-section	Sub-section maximum score 10 points maximum
• Implementation Plan Sub-Section	Sub-Section maximum score 5 points
• Financial viability and CME Budget Sub-Section	Sub-Section maximum score 5 points
Wraparound and System of Care Readiness Domain	**Domain total maximum Score - 43 points**
• High-Fidelity Wraparound experience and capacity Sub-section	Sub-section maximum score 9 points
• Experience with Family/Caregiver-Driven, Youth Guided Care Sub-section	Sub-section maximum score 9 points

• Experience with System of Care Principles and Values and with Child-Serving Systems Sub-section	Sub-section maximum score 9 points
• Care Coordination Capacity and Experience Sub-section	Sub-section maximum score 8 points
• Community Resource Development Capacity and Experience Sub-section	Sub-section maximum score 8 points
Information Technology Domain	**Domain total maximum Score – 10 points**
• EHR and ability to connect to HIE Sub-section	Sub-section maximum score 5 points
• Ability to track contract requirements for timeliness, contact requirements and caseloads	Sub-section maximum score 5 points
Quality Management Capacity and Experience Domain	**Domain total maximum score – 12 points**
• Quality improvement infrastructure and the major activities of your quality team include a recent successful measurable improvement for your organization.	Sub-section maximum score 2 points
• Data collection and analysis capacity and how it uses the data it collects to inform care planning and to improve performance at the staff, program, organizational levels and the required CME and care coordination activities described in draft OAC 5160-59-02	Sub-section maximum score 4 points
• Ability to provide information and data to current managed care organizations, CCEs, or State or local child-serving agencies.	Sub-section maximum score 2 points
• Experience in having parents or consumers participate in quality monitoring.	Sub-section maximum score 2 points
• Describe your organization's experience in monitoring disparities in access, utilization and outcomes data by race and ethnicity, and in using data to strengthen cultural and linguistic competence and capacity.	Sub-section maximum score 2 points
Case Scenario Response	**5 points maximum**

8 SOLICITATION RESPONSE QUESTIONS

8.1 ORGANIZATIONAL STRUCTURE

8.1.1 History, Mission, Governance Structure, Conflict of Interest Disclosure

Briefly describe your organization's history, mission, and overall structure. Briefly describe how your organization's mission aligns with the philosophy and vision of the OhioRISE program, addressing family-driven and youth guided practice, diversity and inclusion, community-based care, use of community and natural supports, and coordination of services and supports across providers, including child-serving state agencies and schools. If the CME will be a new legal entity, briefly describe the affiliation with any existing child-serving agency or agencies.

Please provide and sign the following conflict of interest statement:

I affirm that my firm, its officers, employees, and members have not nor will they acquire any interest, whether personal, business, direct or indirect, that is incompatible, in conflict with, or would compromise the discharge and fulfillment of the firm's functions and responsibilities under this RFA. If my firm, its officers, employees, or members acquire any incompatible, conflicting, or compromising interest, I agree that my firm will immediately disclose the interest in writing to Aetna Better Health of Ohio, 7400 West Campus Road, New Albany, OH 43054. I further agree that the person with the conflicting interest will not participate in any deliverables until Aetna Better Health of Ohio determines that participation would not be contrary to public interest.

8.1.2 Proposed Catchment Areas

Describe the catchment area your organization is applying for, if you have an existing presence within the area, your plan for engagement and growth, and the reasons your organization is well suited to serve within this catchment area. If your organization is applying for more than one catchment area, you must submit a separate RFA for each catchment area. Please include the catchment area for which you are applying in the email header. You will submit one application per email.

8.1.3 Organizational Documents

Attach in the Appendices of your response the following required documents:

a) Organizational Chart for CME, including reporting relationships to the leadership of the bidding entity
b) Job descriptions and minimum qualifications for the following positions:
    a. Care Coordinator – MCC positions and ICC positions
    b. Care Coordinator Supervisors for MCC positions and ICC positions
    c. Leadership and Organizational Team
c) Current/dated list of Board Members and their terms of office

d) Three years of Organization Financial Statements (P&L, Balance Sheet and Cash Flows) and YTD Actual Performance against Budget
e) Anticipated CME Budget (include anticipated start-up and ongoing)
f) Current certifications, licenses, and accreditation status

8.1.4 Plan to Achieve and Retain Staffing Capacity to Function as CME

I. Describe your organization's capacity to perform the CME functions in the OhioRISE Program. Please include the plan for hiring and retaining your CME staff including the management team, supervisors, care coordinators and others. Please describe your planned staffing ratios for ICC and MCC levels of care coordination, your ratio of supervisors to staff and include as attachments job descriptions and minimum qualifications for care coordinators, supervisors, and the CME management team, including educational and experience requirements.

II. Describe how your organization will collaborate with the OhioRISE Plan and with the CABHCOE to ensure that CME staff receive required OhioRISE trainings.

8.1.5 Diversity Equity, and Inclusion

I. Describe the diversity, equity, cultural and linguistic needs within your chosen catchment area.
II. Describe any mechanisms for consultation with stakeholders in diverse, racial, and ethnic communities you serve to get feedback on the cultural sensitivity and appropriateness of your services, gaps in services and supports and ideas for quality improvement to serve people from these communities equitably and effectively.
III. Describe your organization's efforts and plans to ensure race equity and inclusion in staffing and service provision within your chosen catchment areas.
IV. Describe the diversity, racial and ethnic composition of your Board, any relevant advisory committees, senior management team, supervisors, and staff, particularly related to the racial and ethnic communities your organization serves in the proposed catchment area.

8.1.6 Implementation

Provide a start-up implementation plan and timeline for your organization to become a fully functioning CME within your identified catchment area. Describe major tasks anticipated to implement this program. A narrative overview is required in this section of your response, and the full implementation plan should be included in the appendix to the application. Please include:

I. How your agency will prepare to deliver High Fidelity Wraparound in the context of System of Care Principles and Values.
II. Steps and timeframes your organization will take to ensure care coordination coverage and crisis response outside of regular business hours.
III. Your plans to ensure that your organization, if selected as a CME, can provide culturally sensitive, appropriate, and effective services to the major cultural and linguistic communities in your Catchment Area.
IV. Your plans to implement data connectivity through the HIE to the OhioRISE Plan

V. Based on the anticipated population of OhioRISE members within your chosen Catchment Area by the end of the first year, describe your organization's plan to grow the system of care across the catchment area, including your understanding of the growth needs for community and natural supports.

VI. Describe your capacity to achieve required staffing levels, either with existing staff and/or through recruitment of new staff.

VII. Describe your organization's plan and budget for this program. Please include your proposed budget based on the anticipated number of members expected within your chosen catchment area, your anticipated startup costs to hire and train staff, anticipated source of accessible funding, i.e., existing reserves, line of credit, a two-year budget projection, and proposed timeline to achieve full capacity.

8.1.7 Conflict Free Referrals

Provide a plan to ensure conflict-free referrals to services within and outside of your organization. This conflict mitigation plan should explain any perceived unavoidable conflict(s) due to provider capacity in the CME's catchment area, and include detailed processes to:

I. Ensure child or youth and family/caregiver choice of care coordinator within the CME

II. Ensure child or youth and family/caregiver choice of service providers for services included in the child and family care plan.

III. Track and resolve any concern raised by a child or youth and families/caregivers specific to the choice of care coordinator or service provider

8.2 Wraparound and Systems of Care Readiness

8.2.1 High-Fidelity Wraparound Experience and Capacity

I. Describe your organization's experience, if any, in implementing and providing High Fidelity Wraparound or other defined methods of involving children or youth and families/caregivers in care planning such as family group conferencing or shared decision-making.

II. Provide information on the number and types of staff who are currently certified in High-Fidelity Wraparound care coordination, if any.

III. Discuss any "lessons learned" from your organization's experience in delivering care High Fidelity Wraparound. If your organization has not had any experience in implementing Wraparound values, approaches, and programs, describe your plan for how you will change the culture of your organization so that families/caregivers and children or youth are full participants in care planning.

8.2.2 Experience with Family Driven, Child or Youth Guided Care

I. Describe specific ways your organization promotes and supports caregiver and child or youth voice in both developing plans of care and in quality improvement activities.

II. Describe your organization's efforts to deliver services that are convenient for children or youth and family/caregivers to ensure appropriate access.

III. Describe your organization's experience in engaging and service children or youth and family/caregivers like those to be served through OhioRISE in your services, including child or youth and family/caregivers from diverse and ethnic communities, those who may have cultural and linguistic needs, and needs of LGBTQ+ child or youth and family/caregivers in your proposed catchment area.

IV. Describe how your organization identifies and resolves child or youth and family/caregiver complaints.

Experience with System of Care Principles, Values and with Child-Serving Systems and schools

I. Describe how your organization works to improve its capacity to meet the unique social, geographic, cultural, health and behavioral health needs of the child or youth and family/caregivers in the OhioRISE Catchment Area(s) you propose to serve.
II. Describe the extent of your organization's work with children's services agencies and their caseworkers (may include Public Children's Services Agencies and/or IV-E Courts)) in your catchment area. Please describe an example of successful collaboration between your organization and a local children's services organization, producing a positive result for the child or youth and caregiver.
III. Describe the extent of your organization's work with juvenile corrections systems in your catchment area to support diversion or transition from detention for children or youth with behavioral health challenges.
IV. Describe the extent of your organization's work with county, and regional agencies (such as the Ohio Department of Mental Health and Addiction Services, Alcohol, Drug Addiction and Mental Health Services Boards and local behavioral health providers) to serve children or youth with co-occurring mental health and SUD challenges. Describe the extent of your organization's work with the courts and correctional systems for court-involved youth and young adults (such as the Ohio Juvenile Courts and the Ohio Department of Youth Services (DYS), as well as the Ohio Department of Rehabilitation and Correction).
V. Describe the extent of your organization's work with Children and Family First Councils (FCFCs) in your catchment area that enhance services for children or youth and families/caregivers. In your response, please provide and an example of meaningful collaboration to improve services in your area.
VI. Describe the extent of your organization's work with County Boards of Developmental Disabilities (CBDD) and their Service and Support Administrators (SSAs) to serve children and youth with co-occurring behavioral health and intellectual/developmental disabilities in your catchment area. Please describe an example of successful collaboration between your organization and the CBDD producing a positive result for the child or youth and their family/caregiver.

8.2.3 Care Coordination Capacity and Experience

I. Describe your organization's familiarity with and use of the CANS assessment and requirements in Section III, Referral, Enrollment, Care Planning of this RFA.
II. 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.

III. Describe how your organization intends to implement a no eject/no reject philosophy into service development and delivery of care coordination.
IV. Describe your organization's experience identifying and collaborating with other provider agencies and partners who deliver non-clinical formal and informal supports for children or youth and families/caregivers, including recreational programs, social activities for parents and children or youth, support groups and assistance with food and housing needs.

8.2.4 Community Resource Development Capacity and Experience

Describe the approach your organization will undertake, in partnership with the OhioRISE Plan, state and local child-serving agencies, providers, children or youth and families/caregivers and other stakeholders in your catchment area to identify and develop new resources in the following categories. For each category, please address how you would work to increase the availability of culturally responsive services for the diverse and ethnic communities, those who may have cultural and linguistic needs, and needs of LGBTQ+ child or youth and family/caregivers in your proposed catchment area.

I. Traditional Medicaid-covered behavioral health services, such as outpatient and inpatient care for mental health and substance use disorders
II. New and enhanced Medicaid-covered services such as Intensive Home-Based Treatment and Mobile Response and Stabilization Services
III. Peer and/or parent supports.
IV. Individualized resources purchased with flexible funds (camperships, participation in arts or athletic programs)
V. Free or low-cost community resources through city and town recreational programs, the YMCA, Boys and Girls Clubs, volunteer parent support groups, etc.

As a part of the Community Partner and Natural Supports Engagement Plan, please provide in the appendix a description of existing community partnerships with agencies or other stakeholders and include any MOUs with these partners as appropriate.

8.3 Information Technology

I. Does your organization have an Electronic Health Record (EHR) system? If so, which one?
II. If your organization has an EHR, is it connected to Ohio's Health Information Exchanges (HIEs)?
III. If your organization does not have an EHR, or, if it isn't connected to the HIEs, do you have plans to develop these capabilities? Please describe your plans and timelines.
IV. Describe the system(s) and tools your organization will use to track CME contract requirements such as timeliness for assessments, Child and Family-Centered Care Plans, CFT meetings, member/family/caregiver contacts and caseloads for staff, as well as how your organization will track information about community and natural supports that will support children or youth within the OhioRISE program.
V. Describe how your organization will capture information on resources in a useable format such as a database and make it accessible to Care Coordinators, Child and Family Teams (CFT) and children or youth and family/caregivers.

8.4 Quality Management Capacity and Experiences

I. Describe your organization's current quality improvement infrastructure and the major activities of your quality team, include a recent successful measurable improvement for your organization, including the steps that were implemented to improve the issue.
II. Describe your organization's data collection and analysis capacity and how it uses the data it collects to inform care planning and to improve performance at the staff, program, and organizational levels, include your organization's plan, your staffing model, to report the required CME and care coordination activities described in draft OAC 5160-59-02.
III. Describes your organization's current ability to provide information and data to current managed care organizations, CCEs, or State or local child-serving agencies.
IV. Describe your organization's experience in having parents or consumers participate in quality monitoring and improvement activities.
V. Describe your organization's experience in monitoring disparities in access, utilization and outcomes data by race and ethnicity, and in using data to strengthen cultural and linguistic competence and capacity.

8.5 Case Scenario

Please respond to the following Case Scenario, describing the care coordination your organization would deliver as an OhioRISE CME:

The OhioRISE Plan is notified of an admission to a PRTF of a 14-year-old African American boy, Dennis. He was not previously enrolled in the OhioRISE Plan and is now enrolled in OhioRISE due to the PRTF admission. The admission into the PRTF was court-ordered and recommended by the PCSA, who is the custodian. Dennis was removed from his home and placed in foster care at age 10, after experiencing physical and emotional abuse from his stepfather and neglect on the part of his mother, who was living in extreme poverty in a neighborhood plagued by violence. He has a history of multiple extended placements in residential treatment centers and group homes, authorized and paid for by the PCSAs and Medicaid, where he has been prescribed various types of antipsychotic medications. When not in residential settings, Dennis lives with his aunt Joyce in a kinship placement, after experiencing multiple foster care placements. Joyce wants to keep him at home but is unable to manage his behavioral health challenges, which include extreme anger, aggressive behaviors, and possible substance use. She also worries about his influence over her younger 11-year-old son. Dennis has had some involvement with the juvenile corrections system and has had repeated trouble at school, which he often skips. Dennis meets the qualifications to be in the ICC tier of care coordination. In your response, please describe:

I. Your initial engagement strategies with Dennis, his guardian and caregivers, the PRTF and other agencies and individuals connected with his life.
II. Strategies to initiate and carry out transition strategies for Dennis and his caregiver.
III. Identification and facilitation of State and local resources to address Dennis and his caregiver's needs at transition. Delineate the resources needed if Dennis transitions to a home environment versus a congregate care environment.
IV. Ongoing strategies for the CME to undertake post-transition.