OhioRISE Program
2023 Member Handbook

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OhioRISE | aetna®

Aetna Better Health® of Ohio

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

Website
AetnaBetterHealth.com/OhioRISE

Hours of operation
7 a.m. to 8 p.m. Monday - Friday

Address
PO Box 818051
Cleveland, OH 44181-8051

Personal Information

My member ID number

My OhioRISE Provider(s) and their phone number(s)

My Primary Care Physician (PC) and their phone number

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Important Contacts

OhioRISE Plan Member Services	**1-833-711-0773 (TTY: 711)** Representatives available from 7 a.m. to 8 p.m. Monday through Friday.
24-hour Nurse Line for members enrolled in a managed care organization	Contact your managed care organization. Their 24/7 nurse line phone number is on your ID card. If you need help with getting this information, call OhioRISE Member Services at **1-833-711-0773 (TTY: 711)**.
Prior Authorization	**1-833-711-0773 (TTY: 711)**
Language Services	**1-833-711-0773 (TTY: 711)** Representatives available from 7 a.m. to 8 p.m. Monday through Friday.
Appeals and Grievances	**1-833-711-0773 (TTY: 711)**
Medicaid Consumer Hotline	**1-800-324-8680 (TTY: 711)**
Crisis Behavioral Hotline (Ohio CareLine) and Mobile Response Support Services (MRSS)	Ohio CareLine: **1-800-720-9616** MRSS: **1-888-418-MRSS (6777)**

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

Aetna Better Health
7400 W Campus Rd, Suite 200
New Albany, OH 43054
Phone: **1-833-711-0773 (TTY: 711)**
Email: **MedicaidCRCoordinator@aetna.com**

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

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-800-368-1019, TDD: **1-800-537-7697**

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

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

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

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

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

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

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

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

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

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

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

PASHTO: په دي خبرتيا د پوهيدو په برخه کي ستاسو سره د مرستي لپاره، د غوښتني په صورت کي د ژبي اړوند مرسته، د ژباړي خدمتونه، او مرستندويه کومکونه او خدمتونه پرته له کوم لګښت څخه شتون لري. په شته خدمتونو کي شفاهي ژباړه، ليکلي ژباړه، او مرستندويه کومکونه شامل دي، خو تر دي پورې محدود ندي. تاسو کولی شئ د Aetna Better Health د غړو خدمات ته په **1-833-711-0773 (TTY: 711)** تليفون کولو سره د دي خدماتو او/يا فرعي مرستو غوښتنه وکړئ.

DARI:
برای کمک به درک و فهم این اطلاعیه، کمک زبان، خدمات ترجمه، و کمک‌ها و خدمات کمکی بدون هیچ هزینه‌ای برای شما در دسترس هستند. خدمات موجود شامل ترجمه شفاهی، ترجمه کتبی و مساعدت های کمکی، اما محدود به آن نمی شود. می توانید این خدمات و/یا مساعدت های کمکی را با تماس گرفتن با Aetna Better Health Member Services به شماره **1-833-711-0773 (TTY: 711)** درخواست کنید.

TURKISH:
Bu bildirimi anlamaniza yardimci olmak için, dil yardimi, tercüme hizmetleri ve destekleyici yardim ve hizmetler talep etmeniz halinde size ücretsiz olarak sunulmaktadir. Mevcut hizmetler arasında, bunlarla sınırlı olmamak üzere, sözlü çeviri, yazılı çeviri ve yardımcı araçlar yer almaktadır. **1-833-711-0773 (TTY: 711)** numaralı telefondan Aetna Better Health Üye Hizmetlerini arayarak bu hizmetleri ve/veya yardımcı araçları talep edebilirsiniz.

UZBEK: Bu bildirishnomani tushunishingizga yordam berish uchun so‘rovingiz asosida til bo‘yicha yordam, tarjimon xizmatlari, yordamchi vositalar va xizmatlar sizga bepul taqdim etiladi. Xizmatlar quyidagilarni o‘z ichiga oladi, lekin faqat shular bilan cheklanmaydi: og‘zaki tarjima, yozma tarjima, yordamchi vositalar. Bu xizmatlar va/yoki yordamchi vositalarni **1-833-711-0773 (TTY: 711)** raqami orqali Aetna Better Health a’zolarga yordam xizmatiga telefon qilish orqali so‘rashingiz mumkin.

HAITIAN CREOLE: Pou ede w konprann avi sa a, gen asistans lengwistik, sèvis entèpretasyon, ak èd ak sèvis oksilyè ki disponib sou demann, gratis, pou ou. Sèvis ki disponib yo gen ladan yo, san se pa sa yo sèlman, tradiksyon oral, tradiksyon ekri, ak èd oksilyè. Ou ka mande sèvis sa yo ak/oswa èd oksilyè yo lè w rele Sèvis ki disponib pou Manm Aetna Better Health yo nan **1-833-711-0773 (TTY: 711)**.

Welcome

Welcome to the OhioRISE Plan (OhioRISE) by Aetna Better Health of Ohio. OhioRISE is a specialized Medicaid program for youth with complex behavioral health needs. This program provides behavioral healthcare services to eligible youth. Children and youth who are eligible are under the age of 21 and demonstrate the need for additional behavioral health care as identified through the Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS) assessment or a recent inpatient admission for mental health or substance use disorder services. OhioRISE aims to expand access to in-home and community-based services. This will ensure eligible children and youth and their families have the tools and supports they need to grow and thrive.

It is important to remember that you must receive services covered by OhioRISE from facilities and providers in the OhioRISE network. Providers in our network agree to work with OhioRISE to give you needed care.

The only time you can use providers that are not in the OhioRISE network is for:

- Emergency services.
- Federally qualified health centers (FQHC)/rural health clinics (RHC).
- An out of network provider that OhioRISE has approved you to see.

The Provider Directory lists all our network providers you can use to receive services. You can request a printed Provider Directory by calling Member Services at **1-833-711-0773 (TTY: 711),** or by returning the flyer you received with your new member materials. You also can visit our website at **AetnaBetterHealth.com/OhioRISE** to view up-to-date provider network information or call Member Services at **1-833-711-0773 (TTY: 711)** from 7 a.m. to 8 p.m. Monday through Friday for help.

Member Services

Member Services is here to help you. We are here from 7 a.m. to 8 p.m. Monday through Friday. Our toll-free phone number is **1-833-711-0773 (TTY: 711)**.

Call if you have questions about being an OhioRISE Plan member, what kind of care you can get, or how to get care.

Member Services can:

- Explain your rights and responsibilities as an OhioRISE Plan member.
- Help you find a provider.

- Assist you with filing a complaint about your health plan or providers.
- Help you get services, answer your questions, or solve a problem you may have with your care.
- Assist with getting documents in other formats or languages.
- Update your personal information.
- Tell you about your benefits and services (what is covered and not covered).
- Assist you in making appointments.
- Let you know the help available to you and your family based on where you live.
- Tell you about fraud, waste and abuse policies and procedures and help you report fraud, waste and abuse.

Member Services needs your help too. We value your ideas and suggestions on ways to improve our service to you. Do you have an idea on how we can work better for you? Please call Member Services at **1-833-711-0773 (TTY: 711)** or write to:

Aetna Better Health of Ohio
c/o OhioRISE Plan
Attention: Member Services
PO Box 818051
Cleveland, OH 44181-8051

At times you will be invited to attend special member events to learn about the OhioRISE Plan. We'll let you know about each ahead of time, and we hope to see you when you're free. The events will help you get to know the OhioRISE team and learn about your healthcare services.

The Member Services department will be closed on these holidays:

- New Year's Day
- Martin Luther King Day
- Memorial Day
- Independence Day
- Labor Day
- Columbus Day
- Thanksgiving Day
- The day after Thanksgiving
- Christmas Day

Identification (ID) Cards

If you are enrolled in an Medicaid managed care organization (MCO), you should have received a member ID card from your MCO that shows your OhioRISE enrollment. Use this card for physical and behavioral health services. The card is good as long as you are a member of OhioRISE. Please contact your MCO if:

- You have not received your card yet.
- Any of the information on the card is wrong.
- You lose your ID card.

Below is managed care organizations (MCOs) information:

Managed Care Organization	Phone Number	Website
Amerihealth Caritas	1-833-764-7700	**amerihealthcaritasoh.com**
Anthem BCBS	1-800-462-3589	**anthem.com/oh**
Buckeye	1-866-246-4358	**buckeyehealthplan.com**
CareSource	1-800-488-0134	**caresource.com**
Humana	1-877-856-5702	**Humana.com/HealthyOhio**
Molina	1-855-665-4623	**molinahealthcare.com**
United	1-800-895-2017	**uhccommunityplan.com**

If you are enrolled in fee for service (FFS) Medicaid, you should have received a member ID card from the Ohio Department of Medicaid (ODM) that shows your OhioRISE enrollment. You will use this card for your behavioral health services. This card is good as long as you are a member of OhioRISE. You will continue to use your (FFS) card for physical health services. Please contact the Medicaid Consumer Hotline at **1-800-324-8680 (TTY: 711)** if:

- You have not received your card yet.
- Any of the information on the card is wrong.
- You lose your card.

Always Keep Your ID Card(s) With You
You will need your card each time you get behavioral healthcare services. This means that you need your card when you:

- See a provider for counseling.
- Get psychological testing.
- Go to a hospital for inpatient psychiatric services.
- Get crisis intervention services.

Eligibility for the OhioRISE Plan

Young people may qualify for the OhioRISE Plan if you meet these requirements:

- Under the age of 21.
- Enrolled in Ohio Medicaid.
- Have one of the following:
    - Certain needs for behavioral healthcare, identified by the Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS) assessment
    - Have a recent inpatient hospital stay for mental illness or substance use disorder

Getting Care

You need to use one of our network providers to get behavioral healthcare services.

Provider directory
You can request a printed copy of our provider directory. Just call Member Services **at 1-833-711-0773 (TTY: 711)**.

The provider directory is also online at **AetnaBetterHealth.com/OhioRISE**. Click on the 'Find a Provider' ribbon on the top righthand side of the page. From there, you can search behavioral health providers, specialists and facilities in your area. The online provider directory gives the provider's name, address, telephone numbers, professional credentials, specialty and board certification status.

If you want help finding a provider for any of our services, call Member Services at **1-833-711-0773 (TTY: 711)**. We will be happy to help you. You also can call Member Services if you want a provider to be added to our network. We will try to make that happen.

You may see an out-of-network provider if you need special care and we do not have a network provider with the right specialty. The provider must first get approval from us to see you, or you may be billed. See pages 13-15 on getting prior approval (prior authorization) for services.

If you are unable to leave your home
If you can't leave your home to get care, we can help. Call Member Services at **1-833-711-0773 (TTY: 711)**. We will have a care coordinator work with you to make sure you get the care you need.

New Member Information

If you have behavioral healthcare services already approved or scheduled, it is important that you call Member Services immediately.

In certain situations, and for a specified time after you enroll, you may be allowed to receive care from a provider that is not an OhioRISE network provider. **You must call OhioRISE before you receive the care**. If you do not call us, you may not be able to receive the care and/or the bill may not be paid. For example, you need to call Member Services if you have the following services already approved or scheduled:

- Home or office visits with behavioral health providers.
- Psychotherapy and counseling.

- Substance use services.
- Medication-assisted treatment for addiction.
- Inpatient or residential psychiatric services.
- Assertive Community Treatment.

Physical Healthcare

Your physical healthcare needs are covered by your managed care organization (MCO) or fee-for-service (FFS) Medicaid. These services include dental services, vision services, shots (immunizations), and visits to your primary care provider.

If you are a member of an MCO, refer to the MCO member handbook or contact your MCO for information. If you are not a member of an MCO, contact the Medicaid Consumer Hotline at **1-800-324-8680 (TTY: 711)** for information.

Services Covered by OhioRISE

As an OhioRISE member, you will receive medically necessary Medicaid-covered behavioral health services at no cost to you. OhioRISE provides access to all of the inpatient and outpatient behavioral healthcare services you get through Ohio Medicaid today, and also offers you access to new and improved behavioral health services.

OhioRISE will not pay for services that are not covered by Medicaid or are not medically necessary. If you have a question about whether a service is covered, please call Member Services at **1-833-711-0773 (TTY: 711)**. Representatives are available from 7 a.m. to 8 p.m. Monday through Friday.

Some behavioral health services is covered only when it is approved before the service is provided (prior authorization). See pages 13-15 on getting prior approval for services. You don't need to get approval or prior authorization for emergency services. Your provider can get a full listing of services that need prior authorization on the Aetna Better Health of Ohio provider portal. This list may change from time to time. Either you, or your provider can also call **1-833-711-0773 (TTY: 711)** to request the most current list of services that need prior authorization.

Behavioral health services covered by OhioRISE:		
Service	Coverage/ Limitations*	Prior Approval
Assertive Community Treatment for Adults	Covered	No prior approval needed for first 180 days
Behavioral Health Emergency Services provided in an emergency room	Covered by your physical health benefit	No prior approval needed
Behavioral Health Services provided through a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC)	Covered	No prior approval needed
Care Coordination	Covered	No prior approval needed
Community Psychiatric Supportive Treatment	Covered	No prior approval needed
Crisis Services	Covered	No prior approval needed
Diagnostic Evaluation and Assessment	Covered/1 per year for certain evaluations	No prior approval needed unless limitation met
Drug Testing and Other Select Laboratory Services	Covered	No prior approval needed
Electroconvulsive therapy	Covered	Prior approval needed
Health Behavior Assessment and Intervention	Covered	No prior approval needed
Home Visits with Behavioral Health Providers	Covered	No prior approval needed
Inpatient Hospital Substance Use Disorder Services	Covered	Prior approval needed
Inpatient Hospital Psychiatric Services	Covered	Prior approval needed
Intensive Home-Based Treatment for Children/Adolescents	Covered	No prior approval needed for first 180 days

Medication-Assisted Treatment for Addiction	Covered	No prior approval needed
Mobile Response Stabilization Services	Covered	Prior approval is needed beyond six weeks
Behavioral Health Nursing Services	Covered	No prior approval needed
Office Visits with Behavioral Health Providers	Covered	No prior approval needed
Opioid Treatment Program (OTP) Services	Covered	No prior approval needed
Physician or Pharmacist Administered Drugs	Covered	No prior approval needed
Psychiatric Residential Treatment Facility (PRTF) Services	Covered	Prior approval needed
Psychological Testing	Covered 20 visits per calendar year	No prior approval needed for first 20 visits per year
Psychosocial Rehabilitation	Covered	No prior approval needed
Psychotherapy and Counseling	Covered	No prior approval needed
Psychiatry Services	Covered	No prior approval needed
Behavioral Health Respite Services	Covered	Prior approval needed only after first 50 days
Screening Brief Intervention and Referral to Treatment (SBIRT)	Covered/1 of each screening type per year	No prior approval needed unless limit is met
Smoking and Tobacco Use Cessation	Covered	No prior approval needed
Substance Use Assessment	Covered/2 assessments per year	No prior approval needed
Substance Use Case Management	Covered	No prior approval needed

Substance Use Intensive Outpatient	Covered	No prior approval needed
Substance Use Partial Hospitalization	Covered	Prior approval needed
Substance Use Peer Recovery Support	Covered/Up to 4 hours per day	No prior approval needed unless limit is met
Substance Use Residential Treatment	Covered/Up to 30 consecutive days for the first 2 stays	No prior approval needed unless limit is met
Substance Use Therapy	Covered	No prior approval needed
Substance Use Withdrawal Management	Covered	No prior approval needed
Telehealth Services for Behavioral Health	Covered	No prior approval needed
Therapeutic Behavioral Service	Covered	No prior approval needed
Primary Flex Funds	Covered	Primary flex funds will need prior approval through the Child and Family Care Plan Review process

Please see below for more information on certain new and improved services that are only covered by OhioRISE. If you have any questions regarding covered services, contact Member Services at **1-833-711-0773 (TTY: 711)**.

- **Intensive and Moderate Care Coordination –** Depending on a child or youth's needs, they will receive one of three levels or "tiers" of care coordination. Tiers two and three of this service (moderate and intensive) will be delivered by a local Care Management Entity (CME), which are contracted by Aetna Better Health of Ohio. Aetna Better Health of Ohio will provide care coordination for children or youth in tier one.
- **Improved Intensive Home-Based Treatment (IHBT) –** Provides intensive, time-limited behavioral health services for children, youth, and families that help stabilize and improve the child or youth's behavioral health functioning.
- **In-state Psychiatric Residential Treatment Facilities (PRTFs) –** This service will be available in-state beginning in late 2023. Today it's covered when

children or youth need this level of care from facilities located outside Ohio. Ohio's PRTF service will keep children and youth with the most intensive behavioral health needs in-state and closer to their families and support systems.

- **Behavioral Health Respite Services –** Provides short-term, temporary relief to a child or youth's primary caregivers in a home or community-based environment.
- **Primary Flex Funds –** Provides funding to purchase services, equipment, or supplies not otherwise provided through Medicaid that addresses a need in a child or youth's service plan. Funds must be used to purchase services/items that will reduce the need for other Medicaid services, keep kids and families safe in their homes, or help the child or youth be better integrated into the community. See page 25 for more information on primary flex funds.

Another new Ohio Medicaid service you can use is **Mobile Response and Stabilization Services (MRSS)**. It provides rapid in-person care when a child or youth is experiencing significant behavioral or emotional distress. It's available 24 hours a day, 365 days a year, and is delivered in the home, school, or at another location in the community. This service is available to any child or youth covered by Ohio Medicaid. Call the **Ohio CareLine at 1-800-720-9616** to reach the MRSS in your community.

Services Not Covered By OhioRISE Unless Medically Necessary

OhioRISE will not pay for services that are not covered by Medicaid **unless determined medically necessary**. Services not covered by Medicaid include:

- Biofeedback services.
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice.

Telehealth

Telehealth is the direct delivery of healthcare using audio and/or video. Instead of driving to an office for your appointment, you stay at home and use your smartphone, tablet or computer to see and talk to your behavioral health professionals.

There is no cost to use telehealth and telehealth may remove the stress of going to a visit in person. You can see health professionals via telehealth for many common behavioral health conditions, follow-up appointments and screenings.

Check with your providers to see if they offer telehealth.

Emergency Services

What are emergency services?
Emergency services are services for a medical or behavioral problem or condition that must be treated right away by a provider. Some examples of conditions where emergency medical services are needed include:

- Thinking about suicide or a suicide attempt.
- Doing harm to yourself or someone else.
- Out of control behavior.
- Seeing or hearing things that are not there.
- Drug or medication overdose.
- Post-stabilization services related to an emergency medical condition.

Who pays for emergency services?
Ohio Medicaid covers care for emergencies and post-stabilization services.

- Your managed care organization (MCO) or fee-for-service (FFS) Medicaid covers physical and behavioral health emergencies provided in an emergency room (ER).
- OhioRISE will cover any other behavioral health emergencies.

How are emergency services accessed?
If you have an emergency that requires you to go to an ER, call 911 or go to the nearest ER or other appropriate care setting.

If you think you may need emergency services, but need advice on your situation, you can:

- Call your doctor.
- Contact your Medicaid managed care organization's (MCO) 24-hour nurse line. Your MCO's nurse line is available to help answer your medical questions. This number is available 24 hours a day, 7 days a week and is staffed by medical professionals. Please look on your Medicaid ID card for the number of your

MCO's nurse line. If you need help getting this information, you can call OhioRISE Member Services toll free at **1-833-711-0773 (TTY: 711)**.

- Call the **Ohio CareLine Behavioral Health Crisis Hotline at 1-800-720-9616**. They can talk to you about your medical problem and give you advice on what you should do.
- Reach out to the **Mobile Response and Stabilization Services (MRSS)** in your region. MRSS services can come to you wherever you are located. Call the **Ohio CareLine at 1-800-720-9616** to reach the MRSS in your community.

Transportation

If you **must** travel 30 miles or more from your home to receive covered healthcare services and want assistance, your managed care organization (MCO) can provide transportation to and from the provider's office. Call your MCO for more information (on page 11) and to schedule a ride.

If you are not enrolled in an MCO, the County Department of Job and Family Services (CDJFS) provides transportation through the Non-Emergency Transportation (NET) program. Call your CDJFS for more information and to schedule a ride.

Your Aetna Better Health of Ohio, OhioRISE care coordinator, or care management entity (CME) can help with transportation issues, like scheduling a ride. Please contact OhioRISE Member Services at **1-833-711-0773 (TTY: 711)** for assistance.

Pharmacy services (Prescription Drugs)

Pharmacy Services

OhioRISE covers medications your doctor gives you in the office to treat mental health and substance use disorders. All other pharmacy services and benefits are provided through Gainwell Technologies. Call Gainwell Member Services at **1-833-491-0344 (TTY: 1-833-655-2437)** for more information.

Coordinated Services Program

Youth and young adults who have a pattern of taking medications incorrectly may be required to use only one pharmacy to fill their medications or one provider to write prescriptions. This is called the Coordinated Services Program.

If you are identified for the Coordinated Services Program, you are able to choose one pharmacy or provider to get your prescriptions. If you do not pick a pharmacy or provider, one will be selected for you. By using one pharmacy or provider, we can better help you with your healthcare needs. Your pharmacist can work with your doctor if problems with medications occur.

Aetna Better Health of Ohio provides care coordination services to all members in the Coordinated Services Program. Your care coordinator will provide you with information about the program. If you want to choose a different pharmacy or provider, your care coordinator will help you. The Aetna Pharmacy and Medical Directors will regularly review medication reports and may recommend that a member be signed up for the Coordinated Service Program. If that happens, you, your Child and Family Team, and your Medicaid managed care plan (MCE) will be part of that discussion and decision to recommend the Coordinated Service Program.

You will get a letter telling you if you are in the Coordinated Services Program. If you do not agree with our decision, you have the right to a state hearing. See pages 34-35 of this handbook to learn more.

Care Coordination Services

OhioRISE offers care coordination services. Our care coordinators are experienced in working with children/youth and their families to improve member health. You will be assigned a care coordinator who knows what services are available through the OhioRISE program and your Medicaid managed care organization (MCO) or fee-for-service (FFS) Medicaid. The care coordinator also knows the services and programs are offered in your local community.

The goal of care coordination is to ensure you have access to the care and services you need. Your care coordinator helps you decide on who you want on your

Child and Family Team (CFT) and will set up meetings that will include the individuals you chose. Learn more about the CFT on page 22. Your Child and Family Care Team will work with you and your family on building a **Child and Family-Centered Care Plan (CFCP)** that is based on your choices, goals and preferences.

Your care coordinator provides you and your family/caregiver with information on how to take care of yourself and how to get services. They will also work with your managed care organization, providers and community organizations.

The OhioRISE care coordination approach is based on Wraparound guiding principles which include:

- Making sure that you and your family have a voice during all phases of care coordination and that your choices are our priority.
- Planning is done by you, your family, and your Child and Family Team (CFT) and includes services agreed to by you and your family.
- Your input is the basis for planning. Your care coordinator and the CFT provides the options and choices based on what you say you want and need.
- Your care coordinator will work with the team and help develop your service plan, make sure the services are in place and meeting your needs, and help make changes if they are needed.
- Your team makes sure that the services you receive take place in a setting that is inclusive, provides easy access, and is committed to keeping you safe. Whenever possible, your team will help you live in a home environment.
- Care coordination efforts recognize you as an individual and will always respect you and your family's values, beliefs, culture, and identity.
- Your care coordinator will continue to work with you and your family while you achieve the goals that were set in your Child and Family-Centered Care Plan.
- Your care coordinator will talk to and provide information to others service providers who are involved in your care, such as your primary care provider (PCP).

You or your family can call Aetna Better Health of Ohio if you have questions or want to speak with your care coordinator. Please contact Member Services at **1-833-711-0773 (TTY: 711)** for help.

Care Coordination Tier Assignment

OhioRISE offers care coordination at a few levels called tiers. These tiers line up with your strengths and needs when you enroll in the OhioRISE program and they can be updated as your situation changes. You will be assigned an initial tier for care coordination based on your results from the **Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS)**.

OhioRISE's care coordination tiers:

- Tier 3 – Intensive Care Coordination for children and youth with high behavioral health needs.
- Tier 2 – Moderate Care Coordination for children and youth with moderate behavioral health needs.
- Tier 1 – Limited Care Coordination for children and youth who have lower behavioral health needs.

If you are placed in Tier 2 (moderate) or Tier 3 (intensive), your care coordination services will be provided by a care management entity (CME). CMEs are regional providers contracted with Aetna Better Health of Ohio to deliver care coordination for OhioRISE. CMEs and their care coordinators are in the area where you live and know what services are available to you right in your community and throughout the state. They have experience working with child-serving agencies and will be your partner in care decisions to improve your health outcomes. If you are assigned to Tier 1 (limited), your care coordination will be provided directly by an Aetna Better Health of Ohio care coordinator.

Changing Care Coordinators

You and your family have a choice in choosing your care coordinator, whether provided by Aetna (Tier 1) or by a CME (Tiers 2 and 3). You can speak with your care coordinator or ask to talk with their supervisor if you want to make a change and they will be happy to help you.

Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS)

The **Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS)** is a tool used to determine your eligibility for OhioRISE and to help with your care coordination. It gathers you and your family's story to understand your needs and strengths, and to help us determine the best ways to provide help. Your Ohio Children's Initiative CANS assessment is updated regularly to aid with your ongoing care planning.

Child and Family Team (CFT)

The Child and Family Team (CFT) is a group of people that includes you, your family and caregiver(s), behavioral health providers, your care coordinator, and anyone important in your life. You and your family decide who else you want to be on your team. For example, teachers, other family members, friends, healthcare providers, coaches, community providers and even people from where you worship.

The number of people, responsibilities and involvement of each team member is decided by the goals that you set, the needs of you and your family, and the resources needed to be sure that your Child and Family-Centered Care Plan is working. People can join or leave the team as needed, to make sure you get the best care.

During the first visit with your care coordinator

You are given member materials to review in addition to learning about the following:

- How the system of care and wraparound model work.
- Information to help you decide on your Child and Family Team members.
- The care planning process.
- Identifying people who currently supports you and getting your consent to reach out to them.
- Setting up your Child and Family Team meetings.

Child and Family-Centered Care Plan (CFCP)

With the help of your care coordinator, one of the responsibilities of the Child and Family Team is to work with you on building your **Child and Family-Centered Care Plan (CFCP).** Your care plan will be written with your care coordinator, reflecting your choices and the goals and preferences of you and your family. It also will identify covered and non-covered services and supports that will help you.

The Child and Family-Centered Care Plan includes:

- Family Vision
    - Where your family wants to be in the future.
    - Provides a focus for activities and to measure progress.
    - Includes input from every member of your team.

- Strengths, includes your:
    - Activities.
    - Interests.
    - Natural abilities.
    - How to use your strengths to make changes.
- Needs
    - Your safety.
    - Risks.
    - Emotional and/or clinical needs.
    - Other needs, such as housing, recreation, financial, medical, legal and spiritual.
    - Educational.
    - Planning to permanently stay with family.
    - Community safety.
    - Family and caregiver support.
    - Transition needs.
- Ohio Children's Initiative Child and Adolescent Needs and Strengths (CANS)
    - Your Child and Family Team will work with you and your family to decide which findings from the Ohio Children's Initiative CANS assessment need action to help you feel better.
- Planning/Strategies
    - Considers your strengths and includes your family vision while addressing identified needs.
    - Identify who is responsible for what actions.
    - Identify how to help you build skills for long-term stability.
- Safety and Crisis Planning
    - An initial safety and crisis plan is completed.
    - Updates to your safety and crisis plan as strengths, needs and new information is obtained.
    - Includes information about when to call your care coordinator, when to call Mobile Response Stabilization Services (MRSS), when to call the police, etc.
- Ongoing Individualized Planning
    - Includes you and your family's strengths.
    - Develops short-and long-term strategies.

- Plans for everyday living and not just behavioral health.
- Encourages and supports service in the least restrictive environment.
- Will change for you and your family as you move closer to your vision.

How your managed care organization and OhioRISE care coordinators work together

If you are a member of a managed care organization (MCO), your physical health benefits are covered under that plan. This includes things like rides to healthcare visits and other general physical health benefits. Contact your MCO or as your care coordinator if you have questions about this coverage.

Your OhioRISE care coordinator will work with your MCO to coordinate non-behavioral healthcare services, assist with referrals, care coordination, and transitions of care.

If you are enrolled in care coordination with your Medicaid MCO, your MCO care coordinator will:

- Be part of or provide information to the Child and Family Team for care planning.
- Work with Aetna Better Health of Ohio or the Care Management Entity (CME) in care coordination efforts, such as arranging for rides to healthcare visits and accessing physical health services.
- Participate in sharing information that supports care coordination activities.
- Work with your Aetna care coordinator to coordinate services during transitions.

Aetna Better Health of Ohio's transition of care process partners with your MCO when you experience transitions between care settings, providers, child-serving systems, and community providers. We will work with your MCO care coordinator to be sure that ongoing care is not interrupted and that you receive the care that you need during a change.

If you are not a member of a Medicaid MCO, your Aetna Better Health of Ohio care coordinator or Care Management Entity (CME) will work with your Medicaid providers to make sure that you receive the care and services that are right for you.

Primary Flex Funds

Primary flex funds are used for services, equipment, or supplies that are not covered by Medicaid but are recommended by your Child and Family Team as something to benefit you and help you achieve your goals.

Your care coordinator is responsible for talking about primary flex funds with you, your family, and your Child and Family Team. They will explain how to ask for primary flex funds through the care coordination process. The total amount for primary flex funds you may use in a 365-day period is $1,500.

For primary flex funds to be approved, they need to meet the following:

- Reduce the need for other Medicaid services.
- Support and encourage your participation in the community.
- Increase your safety in the home.

Your Child and Family Team will work with you to identify the service, equipment, or supply, show that it meets the requirements, and recommend a specific provider or vendor. Your care coordinator will include this information in your child and family-centered care plan and send it to Aetna Better Health of Ohio for approval.

When approved, Aetna Better Health of Ohio will work with your care coordinator and the provider or vendor to arrange for the item or service. To be approved for primary flex funds, you cannot have the ability to buy the service or item with other funds or resources.

OhioRISE Waiver

The OhioRISE program includes a 1915(c) home and community-based services waiver. The waiver aims to reduce risks and prevent negative health and life outcomes for children with serious emotional disturbances and functional impairments.

If you are being enrolled onto the OhioRISE 1915(c) Waiver, you are eligible to receive waiver services in addition to your existing OhioRISE plan services. You can review the waiver services in the OhioRISE 1915(c) Waiver Member Handbook. Your care coordinator will help you plan for and access waiver services.

Additional Resources

OhioRISE also offers the following extra resources to our members.

Benefit name	Who is eligible	Benefit reward
Healthy Living for Children	Members ages 6 to 20 with an obesity diagnosis or who are prescribed certain behavioral medications that cause weight gain	$50 gift card you can use on home exercise, gym memberships, or supplies that will increase physical activity.
	Parents of members ages 6 - 16 with a weight concern or who are prescribed certain behavioral medications that cause weight gain	$20 for completing each nutritional counseling sessions ($20 for completing both sessions) and the ability to qualify for $100 towards home exercise or sports supplies, gym memberships, and more.
My Maternity Matters™	Pregnant members	$25 gift card you can use for diapers, wipes, and formula when we're told of your pregnancy. Also, a member from our team will reach out to you to see how we can support you and coordinate care.
Behavioral Health	Age 13+	Online/mobile app platform with tools to help emotional health including stress, depression, anxiety, substance misuse and chronic pain.

	Age 6+ who have a behavioral health follow-up visit with a mental health provider within 7 days post-discharge.	Earn a $20 gift card by simply following up with your mental health provider. You will receive funds you can use towards health-related items, including healthy foods.
Calming Comfort Collection	Members dealing with sadness or worry or a score of 2 or higher on the Child and Adolescent Strengths and Needs (CANS) assessment in the Anxiety Doman.	$50 worth of calming supplies per year such as a sound machine, weighted blankets and more.
Connections for Life™	Members ages 13-20 who are in the custody of a Public Children's Service Agency.	Ages 13-17 can receive a tablet. Ages 18-20 can receive a laptop.
Career and Life Skills Training and GED Support	Members ages 16+ with a High School Diploma or High School Equivalency Diploma (GED, HISET)	Online jobs & life skills training platform to discover new career paths, earn credentials and certifications, and highlight those skills to local employers actively looking for talent. We'll also pay for your GED if you pass the GED online class

Your Membership Rights

As a member of OhioRISE, you have the following rights:

- To receive all information and services that OhioRISE must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information is kept private.
- To be given information about your health. This information may also be available to someone who you have legally approved to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To discuss medically necessary treatment options for your condition(s), no

matter the cost or benefit coverage.

- To participate with providers in making decisions relating to your healthcare.
- To be able to take part in decisions about your healthcare as long as the decisions are in your best interest.
- To get information on any medical care treatment, given to you in a way that you can understand.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal and state regulations.
- To ask, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To say "yes" or "no" to having any information about you given out unless OhioRISE must do so by law.
- To say "no" to treatment or therapy. If you say no, the provider or an OhioRISE care coordinator must talk to you about what could happen, and they must put a note in your medical record about it.
- To file an appeal, a grievance (complaint) or state hearing. See page 33 of this handbook to learn more.
- To get help free of charge from OhioRISE and its providers if you do not speak English or need help in understanding information.
- To get all written member information from OhioRISE:
    - At no cost to you.
    - In the prevalent non-English languages of members in OhioRISE's service area.
    - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To get help with sign language if you are hearing impaired.
- To be told if the healthcare provider you see is a student and to be able to refuse their care.
- To be told of any of the care you might get is experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See page 29 to learn more about advance directives.
- To file any complaint about not following your advance directive with the Ohio Department of Health.

- To be free to carry out your rights and know that OhioRISE, OhioRISE's providers or the Ohio Department of Medicaid will not hold this against you.
- To know that OhioRISE must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- To get a second opinion from a qualified provider in OhioRISE's network. If a qualified provider is not able to see you, OhioRISE must set up a visit with a provider not in our network.
- To get information about OhioRISE from us.

To contact the Ohio Department of Medicaid and/or the United States Department of Health and Human Services Office of Civil Rights at the addresses below with any complaint of discrimination based on race, ethnicity, religion, gender, gender identity, sexual orientation, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

The Ohio Department of Medicaid
Office of Human Resources, Employee Relations
P.O. Box 182709
Columbus, Ohio 43218-2709
E-mail: **ODM_EmployeeRelations@medicaid.ohio.gov**
Fax: **614-644-1434**

Office for Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave. – Suite 240
Chicago, Illinois 60601
Ph: **1-312-886-2359 (TTY: 1-312-353-5693)**

Advance directives

Your provider may ask if you have an advance directive. Advance directives are instructions adults can make about their medical care. They are used when you can't say what you want or speak for yourself due to an accident or illness.

You will get medical care even if you don't have an advance directive. You have the right to make your medical decisions. You can refuse care. Advance directives help providers know what you want when you can't tell them. There are four types of advance directives in Ohio. It is up to you whether you want to have all or just one.

A living will
A living will (or an instruction directive) lists your wishes for medical treatment if you're very ill and may not recover, or you can't speak for yourself. It tells your doctors what treatment you do or don't want. This could include treatment or care that would keep you alive when there's no chance of recovery.

Declaration for mental health treatment
A declaration for mental health treatment is more focused on mental health care. It allows you to pick a person who will make mental health treatment decisions for you if you're unable to make them yourself. The person can decide on medication and treatment for you.

Do not resuscitate order
A Do Not Resuscitate Comfort Care (DNRCC) and Do Not Resuscitate Comfort Care-Arrest (DNRCC-Arrest) allow you to make your choices about CPR known to emergency services staff, health care facilities and doctors.

A durable power of attorney for medical care
It's a document you use to choose your "health care representative." This is the person who will make health care decisions for you if you're unable to make them yourself. They'll speak for you based on what you want, or what is in your best interests. This goes into effect whether you're unable to make health care decisions for the short-term, or the long- term.

Advance directives are important for everyone, they let you say what type of end of life care you do and do not want for yourself. However, you must be at least 18 or older to set them up.

If you have an advance directive:

- Keep a copy of your advance directive for yourself.
- Give a copy to the person you choose to be your medical power of attorney.
- Give a copy to each one of your providers.
- Take a copy with you if you have to go to the hospital or the emergency room.
- Keep a copy in your car if you have one.

You also can talk to your provider if you need help or have questions. We will help you find a provider that will carry out your advance directive instructions. You can file a complaint if your advance directive is not followed.

Call Member Services at **1-833-711-0073 (TTY: 711)** for help. You may also visit **Ohio Hospital Association | Ohio Hospital Association (ohiohospitals.org)** for information on advanced directives. If the state law changes, we will tell you about it no later than ninety (90) days after the effective date of the change.

Appeals and Grievances

If you are unhappy with OhioRISE or our providers, or do not agree with a decision we made, contact us as soon as possible. You, or someone you want to speak for you, can contact us. If you want someone to speak for you, you will need to let us know. OhioRISE wants to help.

To contact us, you can:

- Call Member Services at **1-833-711-0773 (TTY: 711)**.
- Fill out the Standard Appeal form in your member handbook on page 32. You can call Member Services to ask for a printed copy.
- Visit our website at **AetnaBetterHealth.com/OhioRISE**.
- Write a letter telling us what you are unhappy about. Please include your first and last name, the number from the front of your member ID card, your address, and your telephone number. You should also send any information that helps explain your problem.

Mail the form or your letter to:

Aetna Better Health of Ohio
c/o OhioRISE Plan
Appeal and Grievance Department
PO Box 81139
5801 Postal Road
Cleveland, OH 44181
Fax: **1-833-928-1259**

OhioRISE will send you something in writing if we decide to:

- Deny a request to cover a service for you,
- Reduce, suspend, or stop services before you receive all the services that were approved, or
- Deny payment for a service you received that is not covered by OhioRISE.

We will also send you something in writing if we did not:

- Decide on whether to cover a service requested for you, or give you an answer to something you told us you were unhappy about.

Ohio Medicaid Managed Care Entity

Member Appeal Form

If you do not agree with a decision made by your managed care entity (MCE), you should contact the MCE as soon as possible. You, or someone you want to speak for you can contact the MCE using this form.

Instructions: Complete Sections I and II of this form entirely, describe the issue(s) in as much detail as possible, and submit the completed form to the appropriate MCE. To ensure a decision can be made by the MCE, the following documentation should be submitted with the form:

- Attach *copies* of any records you wish to submit (do not send originals).
- If you have someone else submit for you, you must give your consent below.

Section I - Member Information		
Member Name		**Date of Request** (mm/dd/yyyy)
Member ID Number	**Member Phone Number**	**Date of Birth** (mm/dd/yyyy)
Member Address		
Reason For Request ☐ Service(s) denied, reduced, or ended ☐ Untimely decision on prior authorization request ☐ Payment or claim denied ☐ Other (explain):		
☐ I believe waiting on this decision could seriously jeopardize my life, physical or mental health, or ability to attain, maintain or regain maximum function. I understand by checking this box that it may reduce the amount of time that myself and/or provider have to send in additional information regarding my appeal unless an extension is requested. If no extension is requested and meets criteria, I will receive a decision within 72 hours. ☐ I believe waiting on this decision would not jeopardize my health. Unless an extension is requested, I will receive a decision on my appeal within 15 calendar days.		
Section II - Description of Specific Issue *Please state all details relating to your request including names, dates, places, provider information, and prior authorization request number if known. Attach another sheet of paper to this form if more space is needed.*		
By signing below, you agree that the information provided is true and correct.		
Member's Signature		**Date** (mm/dd/yyyy)
If someone else is completing this form for you, you are giving written consent for the person named below to submit on your behalf. By signing below, your authorized representative agrees that the information provided is true and correct.		
Member's Authorized Representative Name (if applicable)		**Relationship to Member**
Authorized Representative Signature (if applicable)		
☐ *Check this box if you are a provider submitting this form on behalf of a member. In accordance with Ohio Administrative Code rule 5160-26-08.4, any provider acting on the member's behalf must have the member's written consent to file an appeal. The MCE will begin processing the appeal upon receipt of written consent.*		
Contact and Submission Information		
<MCE contact information will be inserted here (fax or email information to be gathered from MCEs at later date>		

Appeals
If you do not agree with the decision or action listed in the response letter, you can contact us **within 60 calendar days** to ask that we change our decision or action. This is called an **appeal**.

The 60-day period begins on the day after the mailing date on the letter. If we have decided to reduce, suspend, or stop services before all the approved services are received, your letter will tell you how you can keep receiving the services if you choose and when you may have to pay for the services.

Unless we tell you a different date, we must give you an answer to your appeal in writing within 15 calendar days from the date you contacted us. If we do not change our decision or action because of your appeal, we will notify you of your right to request a state hearing. **You may only request a state hearing after you have gone through the OhioRISE appeal process.**

If you or your provider believes that waiting 15 calendar days to decide your appeal could seriously risk your life or health, you or your provider should tell us this when asking for an appeal. If we agree, we will make a decision sooner (within 24 hours of receiving all required information) on your appeal. This is called an **expedited appeal**. You do not have to request an expedited appeal in writing. We will notify you and your provider of our decision orally and in writing.

Grievances
If you are unhappy with OhioRISE or our providers, this is called a **grievance**. OhioRISE will give you an answer to your grievance by phone, or by mail if we can't reach you by phone. We will give you an answer within the following time frames:

- Two working days for grievances about not being able to get medical care.
- Thirty calendar days for all other grievances except grievances about getting a bill for care you have received.
- Sixty calendar days for grievances about getting a bill for care you have received.

If we need more time to make a decision for either an appeal or a grievance, we will send you a letter telling you that we need to take up to 14 more calendar days. That letter also will explain why we need more time. If you think we need more time to make a decision on your appeal or grievance, you can also ask us to take up to 14 calendar days.

You also have the right to file a complaint **at any time** by contacting the:

Ohio Department of Medicaid
Bureau of Managed Care Compliance and Oversight
P.O. Box 182709
Columbus, Ohio 43218-2709
1-800-324-8680 (TTY: 711)

Ohio Department of Insurance
50 W. Town Street
3rd Floor – Suite 300
Columbus, Ohio 43215
1-800-686-1526

State Hearings

A state hearing is a meeting with you or someone you want to speak on your behalf along with representatives from the County Department of Job and Family Services, OhioRISE, and the hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). In this meeting, you will explain why you think OhioRISE did not make the right decision and OhioRISE will explain the reasons for making our decision. The hearing officer will listen and then make a decision based on the rules and the information given.

OhioRISE will notify you of your right to request a state hearing if:

- We do not change our decision or action because of your appeal.
- A decision is made to deny your request to change your OhioRISE Coordinated Services Program provider.

You may only request a state hearing after you have gone through OhioRISE's appeal process.

If you want a state hearing, you, or someone you want to speak on your behalf, must request a hearing within **90 calendar days**. The 90-day periods begin on the mail date included on the hearing form. If your appeal was about a decision to reduce, suspend, or stop services before all the approved services are received, your letter will tell you how you can keep receiving the services if you choose to and when you may have to pay for the services.

To request a hearing you can:

- Sign and return the state hearing form to the address or fax number listed on the form.
- Call the Bureau of State Hearings at **1-866-635-3748**.
- Submit your request via e-mail at **bsh@jfs.ohio.gov**.
- Submit your request through the Bureau of State Hearings SHARE Portal at **https://hearings.jfs.ohio.gov/SHARE**. (Log into the SHARE Portal using your Ohio Benefits ID and password to submit your request.)

If you need legal assistance, you can ask your local Legal Aid program for free help with your case. Contact your local Legal Aid office by calling **1-866-LAW-OHIO (1-866-529-6446)** or by searching the Legal Aid directory at **http://www.ohiolegalhelp.org/find-legal-help** on the internet.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, OhioRISE or the Bureau of State Hearings may decide that the health condition meets the criteria for an expedited decision. An expedited decision will be issued as quickly as needed, but no later than three business days after the request is received. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize your life, your health, or your ability to attain, maintain or regain maximum function.

Fraud, waste and abuse

Sometimes people choose to commit fraud, waste and abuse. The following acts are the most common types of fraud, waste and abuse:

- Members selling or lending their Medicaid ID card to someone else.
- Members trying to get drugs or services they do not need.
- Members forging or altering prescriptions they receive from their providers.
- Providers billing for services they didn't give.
- Providers giving services members do not need.
- Verbal, physical, mental or sexual abuse by providers.

Call our fraud, waste and abuse hotline to report these types of acts right away. You can do this confidentially. We do not need to know who you are. You can call us to report fraud, waste and abuse at **1-833-711-0073 (TTY: 711)**. You can also report suspected fraud, waste or abuse to:

- Aetna Better Health online at **AetnaBetterHealth.com/OhioRISE**.

- Ohio Attorney General's Office Medicaid Fraud Control Unit (MFCU) by phone at **1-800-282-0515** or **1-614-466-0722** or online at **http://www.ohioattorneygeneral.gov/Individuals-and-Families/Victims/Submit-a-Tip/Report-Medicaid-Fraud**.
- The Ohio Auditor of State (AOS) by phone at **1-866-FRAUD-OH** or email **fraudohio@ohioauditor.gov**.

Child Abuse and Neglect

You should contact your county Child Protective Services Agency to report the abuse or neglect of children and youth. Ohio has a central number that will link you to child welfare or law enforcement in your county. The statewide number is **1-855-O-H-CHILD (855-642-4453)**. If abuse or neglect happened in your family, communicate this with your care coordinator. Your care coordinator will need to report and document the incident. They also will work to support you and your family to prevent future incidents and to assure the health and safety of members.

Accidental Inquiry or Illness (Subrogation)

If you have to see a doctor for a behavioral health condition that was caused by another person or business, you must call Member Services to let us know. For example, if you are hurt in a car accident and need specialized behavioral healthcare which was related to the accident, another insurance company may have to pay for the care or services you received. When you call us, give the name of the person at fault, their insurance company, and the name(s) of any attorney(s) involved.

Other Health Insurance (Coordination of Benefits – COB)

If you have health insurance with another company, it is **very important** that you call Member Services and your local County Department of Job and Family Services about the insurance. For example, if you have health insurance through a parent, your parent/legal guardian needs to call Member Services. It is also important to tell Member Services and your local County Department of Job and Family Services if you have lost health insurance that you previously reported. Not giving us this information can cause problems with getting care and with payment of medical bills.

Anytime you lose health insurance, you should receive a notice, known as a certificate of creditable coverage, from your old insurance company. This notice says you no longer have insurance. Keep a copy of this notice for your records because you might be asked to provide a copy.

Loss of Medicaid Eligibility

It is important that you keep your appointments with the County Department of Job and Family Services. If you miss a visit or don't give them the information they ask for, you can lose your Medicaid eligibility. If this happens, you will be disenrolled from OhioRISE and you would no longer have access to the OhioRISE benefits.

If you lose your Medicaid eligibility but it is started again within 90 days, you will automatically become an OhioRISE member again.

Can OhioRISE End My Membership?

OhioRISE may ask the Ohio Department of Medicaid to end your membership for certain reasons. The Ohio Department of Medicaid must okay the request before your membership can be ended. The reasons OhioRISE can ask to end your membership are:

- For no longer meeting eligibility requirements, such as not meeting the eligibility criteria of the Ohio Children's Initiative Child and Adolescent Strengths and Needs (CANS) assessment.
- Loss of Medicaid eligibility.
- Incarceration.
- For fraud or for misuse of your member ID card.
- For disruptive or uncooperative behavior to the extent that it affects OhioRISE's ability to provide services to you or other members.

For youth that are disenrolled from the OhioRISE Plan, the OhioRISE Plan will identify members who have ongoing care that cannot be interrupted. The OhioRISE Transition of Care coordinators will work with other health plans, practitioners, providers, and care management entities (CMEs) to ensure continuation of the member's care. These Transition of Care coordinators will help with the transition and provide you information about available resources and how to receive care.

Just Cause Request

You may believe you need to end your membership with OhioRISE. This is called Just Cause. Before you can ask for a Just Cause request, you must first call OhioRISE and give us a chance to resolve the issue. If we cannot resolve the issue, you can ask for a Just Cause by calling the Medicaid Hotline at **1-800-324-8680 (TTY: 711)** for one of the following reasons:

- You moved and OhioRISE is not available where you live.
- OhioRISE does not, for moral or religious objections, cover the service that you need.
- Your doctor has said that some of the services you need must be received at the same time and the services are not all in OhioRISE's network. Your doctor also has stated that receiving these services separately would put you at unnecessary risk.
- You have concerns that you are not receiving quality care and the services you need are not available from another provider in OhioRISE's network.
- You do not have access to medically necessary Medicaid-covered services or do not have access to providers that are experienced in dealing with your special health care needs.
- The individual has been enrolled in the program for 365 days and they have not:
  - Had a CANS assessment meeting the eligibility criteria; or
  - Have not utilized any of the covered services (except care coordination) provided through the OhioRISE plan.

The Ohio Department of Medicaid will review your request and decide if you meet a Just Cause reason. You will receive a letter to inform you of the decision. If your Just Cause request is denied, the Ohio Department of Medicaid will send you information that explains your state hearing right for appealing the decision.

Other Information

OhioRISE provides services to our members because of a contract that OhioRISE has with the Ohio Department of Medicaid. If you want to contact the Ohio Department of Medicaid, you can call or write to:

Ohio Department of Medicaid
Office of Strategic Initiatives
P.O. Box 182709
Columbus, Ohio 43218-2709
Phone: **1-800-324-8680 (TTY: 711)**

You can also visit the Ohio Department of Medicaid on the web at **www.medicaid.ohio.gov.**

Definitions

The list below includes definitions for healthcare terms.

Advanced Directive	A document that tells your healthcare provider and family how you wish to be cared for.
Appeal	A request that you, your provider or representative can make when you do not agree with OhioRISE's decision to deny, reduce and/or end a covered benefit or service.
Behavioral Health Services	Mental health and substance use services which are provided to members with emotional, psychological, substance use, psychiatric symptoms and/or disorders. These services are provided in the member's primary care physician (PCP) office by the member's PCP as part of primary care service.
Child and Family Team (CFT)	A CFT is a team that is comprised of family members, friends, foster parents, legal custodians, community specialists and other interested people identified by the child or youth and their family. These individuals join together to empower, motivate and strengthen the child or youth and their family. The CFT also develops a plan of care and protection together. This plan aims to achieve child and youth safety, permanency, and well-being.
Coordinated Services Program (CSP)	CSP is a health and safety program which protects members who exceed expected use**.** Members are assigned to and must use designated providers for their healthcare services, including prescription medication. Individuals eligible for Ohio Medicaid may be selected for enrollment in the CSP.
Covered Services (Covered Care/Care)	Medical care services or supplies which OhioRISE will pay. This care is described in this Handbook.
Emergency medical condition	A medical condition that has acute symptoms such as severe pain that must be treated right away by a provider.
Emergency Services	Services for a medical or behavioral problem that must be treated right away by a provider.

Experimental/ Investigational	Care or a supply is experimental or investigational if it includes, but is not limited to, any of the following: • It is in the testing stage or in early field trials on animals or humans. • It is under clinical investigation by health professionals or is undergoing clinical trial by any governmental agency.
Fee-for-Service	A traditional method of paying for medical services covered by Medicaid in which providers are paid for each service they provide.
Grievance	When you let us know you are not satisfied with a provider, OhioRISE, or a benefit, you can file a grievance in writing or tell us verbally. Someone you appoint can file a grievance for you.
Managed Care Organizations (MCO)	MCOs are contracted with the Ohio Department of Medicaid (ODM) to provide physical health services.
Medically Necessary (Medically Needed/Needed)	Medically necessary means you need the services to prevent, diagnose, or treat a health condition. It is the use of services or supplies by a provider that are needed to find or treat a member's illness or injury. The OhioRISE plan must also be sure that the care is: • Consistent with the symptoms, diagnosis, and treatment of the member's condition, disease, ailment or injury. • Appropriate with regards to standards of good medical practice. • Not solely for the convenience of the member or their provider. • The most appropriate supply or level of service that can be safely given to the member. For members in the hospital, it also means the member's medical symptoms or condition cannot be diagnosed or treated safely outside of a hospital.
Member	Any person who gets services from ODM and who has OhioRISE coverage.
Member Handbook (Handbook)	This book as well as any amendment or related document(s) sent together with this book that tell you about your coverage and your rights.

Member Services	OhioRISE staff that can answer questions about your benefits. The toll-free number is **1-833-711-0773 (TTY: 711)**.
Post-stabilization care services	Covered services related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or to improve or resolve the member's condition.
Prior authorization/ Preauthorized	OhioRISE prior approval needed to pay for certain services.
Primary Care Physician (PCP)	The doctor who gives you your primary healthcare. This doctor will arrange for most other care you need as well. Since OhioRISE only provides your behavioral health services, your PCP is not covered as part of this plan.
Provider Directory	A list of providers that have contracted OhioRISE to provide care to OhioRISE members.
Service Area	The geographic area where you can get care under the OhioRISE program.
Specialized Behavioral Health Services	Include services provided by psychiatrists, psychologists, licensed clinical social workers, licensed professional counselors, licensed addiction counselors, mental health clinics, mental health rehabilitation service providers (public or private) and rehabilitation substance use centers.
Specialty Care Doctor/Specialist	A doctor with a specific area of expertise, who gives healthcare to members within their field.
State Hearing	This is a meeting with you or someone you want to speak on your behalf, someone from the County Department of Job and Family Services, someone from OhioRISE, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS).
You, Your	Refers to a member.

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