OhioRISE Program 2026

Provider Manual

OhioRISE, specialized behavioral health care from Aetna Better Health® of Ohio

AetnaBetterHealth.com/OhioRISE

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Section I – Introduction

Welcome

Welcome to Aetna Better Health® of Ohio Inc., an Ohio corporation, d/b/a Aetna Better Health of Ohio, the OhioRISE plan. Our ability to provide excellent service to our members is dependent on the quality of our provider network. By joining our network, you are helping us serve those Ohioans who need us most.

About Aetna Better Health

Aetna Better Health is Aetna's Medicaid managed care plan. Backed by over 30 years of experience managing the care of those with a broad array of healthcare needs, our Medicaid plans have demonstrated that getting the right help when members need it is essential to better health. That's why Aetna Medicaid plans include the guidance and support needed to connect our members with the right coverage, resources, and care.

Experience and Innovation

We are dedicated to enhancing member and provider satisfaction, using tools such as predictive modeling, care coordination and state-of-the art technology to achieve cost savings and help members attain the best possible health, through a variety of service models.

We work closely and cooperatively with physicians and hospitals to achieve durable improvements in service delivery. We are committed to building on the dramatic improvements in preventive care by facing the challenges of health literacy and personal barriers to healthy living.

Today, Aetna owns and administers Medicaid managed health care plans for more than three million members. In addition, Aetna provides care coordination services to hundreds of thousands of high-costs, high-need Medicaid members. Aetna utilizes a variety of delivery systems, including fully capitated health plans, complex care management, and administrative service organizations.

OhioRISE

OhioRISE (Ohio Resilience through Integrated Systems and Excellence) program is a specialized managed care program for youth with complex behavioral health and multisystem needs.

OhioRISE aims to expand access to in-home and community-based services for enrollees.

Aetna Better Health of Ohio care coordinators and care coordinators with our regional contracted care management entities (CME) ensure OhioRISE members and families have the resources they need to navigate their interactions with multiple systems such as juvenile justice, child protection, developmental disabilities, mental health and addiction, education, and others. An individual who is enrolled in the OhioRISE program keeps their managed care organization (MCO) or fee-for-service (FFS) enrollment for their physical health benefit. A member's MCO is included in their care coordination.

The Ohio Department of Medicaid (ODM), state agencies, the Child and Adolescent Behavioral Health Center of Excellence (CABHCOE), providers, families, Aetna, and local child serving stakeholders are engaging through an advisory council and workgroups to develop and implement major components of OhioRISE and the new and improved services. OhioRISE features a 1915(c) waiver. The waiver aims to reduce risks and prevent negative health and life outcomes for children and youth with serious emotional disturbances and functional impairments.

OhioRISE Eligibility

Children and youth who may be eligible for OhioRISE are:

- Be determined Medicaid eligible – either managed care or fee for service,
- Under the age of 21,
- Not enrolled in a MyCare plan, and
- Meet a functional needs threshold for behavioral healthcare, as identified by the Child and Adolescent Needs and Strengths (CANS) assessment tool, or an inpatient admission for a behavioral health service.

OhioRISE Services

All OhioRISE covered services are outlined in the Ohio Administrative Code rule 5160-59-03, including existing behavioral health services and the following new and improved services available through OhioRISE:

- **Care coordination at three different levels:**
  - Tier 1: Limited Care Coordination (LCC) is delivered by Aetna and is for children or youth needing lower intensity care coordination.
  - Tier 2: Moderate Care Coordination (MCC) is delivered by contracted regional care management entities (CMEs) and includes strategies informed by wraparound principles.
  - Tier 3: Intensive Care Coordination (ICC) is delivered by contracted regional CMEs and is consistent with principles of High-Fidelity Wraparound. Tier 3 is for children and youth with the greatest behavioral health needs.
- **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**) – PRTF services are covered when children or youth need this level of care from facilities located inside and 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. Ohio continues to open and expand PRTF facilities to keep members in state and closer to home, allowing families to be more involved. As the program matures, in-state PRTFs will be used to encourage less reliance on out of state facilities.
- **Behavioral Health Respite** – Provides short-term, temporary relief to the primary caregiver(s) of an OhioRISE plan enrolled youth, to support and preserve the primary caregiving relationship.
- **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 45 for more information on primary flex funds.
- **Mobile Response Stabilization Services (MRSS)** – MRSS provides rapid care when a child or youth is experiencing significant behavioral or emotional distress. It's available in the home,

school, or at another location in the community. It may also provide up to 42 days of intensive, in-home services and linkages to on-going supports. This service is available to any child or youth in Ohio.

OhioRISE Waiver Eligibility

The purpose of a Medicaid home- and community-based services (HCBS) 1915(c) waiver is to provide services to members who have a Level of Care that would make them eligible to receive services in an institutional facility. The OhioRISE waiver services are linked to Inpatient Psychiatric type of institution/facility. The waiver is designed to provide members who meet Inpatient Psychiatric Level of Care criteria, along with the additional eligibility criteria, with the supports needed to live in the community instead of an institution.

In addition to meeting Medicaid and OhioRISE program eligibility, a child or youth must also meet the following requirements to be eligible for the OhioRISE Waiver:

- Have an Inpatient Psychiatric Level of Care.
- Have a diagnosis of a Serious Emotional Disturbance (also known as SED).
- Have documented functional limitations[1].
- Need at least one of the OhioRISE waiver services.
- Have waiver needs which are less than or equal to the waiver service cost limit of $15,000

OhioRISE eligibility at the time of initial enrollment is limited to children and youth ages 20 or younger. However, once enrolled, a young person can continue enrollment in the OhioRISE Waiver through age 22.

Once an individual chooses to apply for the OhioRISE Waiver, they will go through the waiver eligibility assessment process, which will be conducted by a care management entity (CME). ODM will determine waiver eligibility based on the assessment conducted by the CME.

If the waiver eligibility assessment shows a child or youth is eligible for the OhioRISE Waiver and they are currently enrolled in Medicaid, they will be enrolled in the waiver by the Ohio Department of Medicaid (ODM), and if they are not already enrolled in a managed care organization (MCO) they will be assigned to a MCO for enrollment. If the waiver eligibility assessment shows a child or youth is not eligible for the OhioRISE Waiver, a denial notice with hearing rights will be issued to their mailing address.

If a child or youth is not eligible for the waiver and they are already enrolled in Ohio Medicaid, eligibility for the OhioRISE Program that is separate from the OhioRISE Waiver can be explored for them. If the waiver eligibility assessment shows a child or youth is eligible for the OhioRISE Waiver, but they are not already enrolled in Medicaid, a Medicaid application needs to be submitted for them. ODM will determine Medicaid eligibility.

- If the young person is determined to be eligible for Medicaid, ODM will enroll them in Medicaid, the OhioRISE Program, the OhioRISE Waiver, and the young person and their caregivers will be

[1] Functional limitations are certain intensive behaviors a child or youth has that leads to health and safety concerns for them and individuals around them, including in their home and community. These limitations and behaviors substantially limit or interfere with the child or youth's role in their family, school, or community and tend to result in institutionalization or custody relinquishment to the custody of the child welfare system.

asked to select an MCO.

- If the young person is determined to not be eligible for Medicaid, a denial notice with hearing rights will be issued to the child or youth's mailing address
- Remember, members cannot be enrolled in both the OhioRISE Waiver and another 1915(c) waiver, such as the Ohio Home Care Waiver, at the same time.

OhioRISE Waiver Services

In addition to all other OhioRISE services, Waiver members also receive three supplemental services which are:

- **Out-of-Home Respite:** A service provided outside of the youth's home that will provide short-term temporary relief to the primary caregiver or caregivers of an OhioRISE plan enrolled youth.
- **Transitional Services and Supports**: Services to support youth and their families who are experiencing changes in circumstances/locations or other qualifying conditions.

  Secondary Flex Funds: Services, equipment, or supplies, not otherwise provided through the waiver or through the Medicaid state plan, that are designed to meet a need of the youth to address behaviors.

About this Provider Manual

The Provider Manual serves as a resource and outlines operations for Aetna Better Health of Ohio. Through the Provider Manual, providers should be able to locate information on the majority of issues that may affect working with us. If you have a question, problem, or concern that the Provider Manual does not fully address, please call our Provider Experience Department at **1-833-711-0773 (option 2)** for concerns.

Our Provider Experience Department will update the Provider Manual at least annually and will distribute bulletins as needed to incorporate any revisions/changes. Please check our website at www.aetnabetterhealth.com/OhioRISE for the most recent version of the Provider Manual and/or updates. The OhioRISE Provider Manual is available at no charge in hard copy form, or on CD-ROM. Please contact Provider Services at **1-833-711-0773 (option 2)** to request a copy.

Disclaimer

Providers are contractually obligated to adhere to and comply with all terms of the OhioRISE plan, and with your Aetna Better Health of Ohio Provider Agreement, including all requirements described in this manual, in addition to all state and federal regulations governing a provider.

While this manual contains basic information about Aetna Better Health of Ohio, ODM providers are required to fully understand and apply any additional Ohio Department of Medicaid (ODM) or federal requirements when administering covered services.

Please refer to ODM's Medicaid Managed Care website for further information: **https://managedcare.medicaid.ohio.gov/home.**

Section II – Basic Plan Information

Contact Information

Providers who have additional questions can refer to the following Aetna Better Health of Ohio phone numbers:

Important Contacts	Phone Number	Hours and Days of Operation (Excluding Aetna Better Health of Ohio holidays)
Aetna Better Health of Ohio	**833-711-0773** (Follow the prompts to reach the appropriate departments)	7 a.m. – 8 p.m. EST Monday-Friday
Aetna Better Health of Ohio Compliance Hotline for Fraud, Waste or Abuse	**833-865-0278**	24 hours a day, 7 days a week through voicemail inbox
Aetna Better Health of Ohio Special Investigations Unit (SIU) for Fraud, Waste or Abuse)	**800-338-6361**	24 hours a day, 7 days a week

Aetna Better Health of Ohio Department	Phone Number
Member Services	**833-711-0773**
Provider Services and Provider Claim Disputes	**833-711-0773**
Care Coordination (includes behavioral health services)	**833-711-0773**
Medical Prior Authorization	**833-711-0773**
Pharmacy Prior Authorization	OhioRISE covers provider administered medications given in the office to treat mental health and substance use disorders. For all OhioRISE members, all other pharmacy services and benefits are provided through Gainwell Technologies. Their member support line is **833-491-0344 (TTY711)**.

Community Resource	Contact Information
Mobile Response Support Services (MRSS) Individuals aged 20 and under who are experiencing a behavioral or mental health crisis – and their families – can contact **988** for immediate support. Trained responders are available to provide on-site behavioral health services in the home or at another safe location.	Call or text 988 Chat online at **988Lifeline.org**

Contractors	Phone Number	Hours and Days of Operation
Interpreter Services (Language interpretation services, including sign language, special services for the hearing impaired, oral translation, and oral interpretation.)	Please contact our Member Services Department at **833-711-0773** for more information on how to schedule these services in advance of an appointment.	7 a.m. – 8 p.m. EST Monday-Friday

Agency Contacts and Important Contacts	Phone Number	Hours and Days of Operation
The Ohio Department of Medicaid (ODM) Main Website: **medicaid.ohio.gov/** Provider Website: **https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing** 50 West Town Street, Suite 400 Columbus, Ohio 43215 **Note:** ODM Integrated Help Desk - If you have questions or need assistance with your Ohio Medicaid enrollment, call the ODM Provider Hotline at **800-686-1516** through the Interactive Voice Response (IVR) system. It provides 24 hour, 7 days a week access to information regarding provider information. Provider representatives are available via the IVR system Monday through Friday from 8 a.m. through 4:30 p.m. to assist providers.	Integrated Help Desk **800-686-1516**	8 a.m. – 4:30 p.m. EST Monday-Friday
Office Ally Support: **https://cms.officeally.com/**	Representative Hotline: **360-975-7000**	24 hours a day, 7 days a week
Ohio Attorney General Complaints Hotline	**800-282-0515**	8 a.m. – 7 p.m. EST Monday-Friday (Excluding holidays and weekends. Voicemail service will be available whenever the hotline is closed.)
Ohio Auditor of State	**866-372-8364**	24 hours a day, 7 days a week
The Federal Office of Inspector General in the U.S. Department of Health and Human Services (Fraud)	**800-HHS-TIPS (1-800-447-8477)**	24 hours a day, 7 days a week

Important Links and/or Addresses Links and Addresses	
Aetna Better Health of Ohio Disputes (Participating Providers)	**apps.availity.com/availity/Demos/Registration/index.htm** Disputes are filed online through Availity.
Aetna Better Health of Ohio Appeals (Participating Providers)	**apps.availity.com/availity/Demos/Registration/index.htm**
Aetna Better Health of Ohio Appeals/Disputes (Non-Participating Providers)	Aetna Better Health of Ohio Provider A&G Mail Aetna Better Health of Ohio PO Box 81040 5801 Postal Road Cleveland, OH 44181
Claim Submission	Claims submission to occur through Office Ally ID: 45221 **https://www.aetnabetterhealth.com/ohiorise/providers/file-submit-claims.html**

ODM's Contracted Medicaid Vendors			
Agency Contacts & Important Contacts	**Phone Number**	**Website**	**Contact**
United Healthcare Community Plan of Ohio	**800-600-9007**	**uhcprovider.com/**	NA
Humana Health Plan of Ohio	**877-856-5707**	**Humana.com/HealthyOH**	OHMedicaidProviderRelations@humana.com
Molina Health Plan of Ohio	**855-322-4079**	**molinahealthcare.com/providers/oh/medicaid/home.aspx**	OHContractRequests@MolinaHealthCare.com
AmeriHealth of Ohio	**833-296-2259**	**amerihealthcaritas.com/providers**	ProviderRecruitmentOH@amerihealthcaritas.com
Anthem Blue Cross and Blue Shield	**1-844-912-1226**	**anthem.com/provider/getting-started/**	OHMedicaidProviderQuestions@Anthem.com
CareSource Ohio	**800-488-0134**	**caresource.com/oh/providers/education/become-caresource-provider/**	Ohio_Provider_Contracting@caresource.com
Buckeye Community Health Plan	**866-246-4356**	**buckeyehealthplan.com/providers.html**	OHNegotiators@CENTENE.COM

Provider Representative information – Provider Experience Department overview

Our Provider Experience Department serves as a liaison between Aetna Better Health of Ohio and the provider community. Our staff is comprised of Network Relation Managers and Network Relation Consultants, as well as Provider Experience Representatives. Our Network Relations team conducts onsite provider training, problem identification and resolution, provider office visits, and accessibility audits.

Our Provider Experience Representatives are available by hone or email to provide telephonic or electronic support to all providers. Below are some of the areas where we provide assistance:

- Contracting status.
- Provide information on how to update location/address via the Provider Network Management (PNM) module.
- Information about recent health plan policy and/or regulatory updates.

- Assistance on how to locate forms.
- Assistance with reviewing claims or remittance advices including questions surrounding claims and billing.
- Information on provider denials.
- Instructions for providers needing to file a complaint and/or challenging or appealing the failure of the health plan to provide covered services (including state services).
- Information on member grievance and appeals.
- Information on translation/interpreter services.
- Information about member covered services.
- Instruction on how to submit a prior authorization and/or cover determination (including exceptions).
- Information on how to look up services that need a prior authorization.
- Information about provider orientations.
- Information about coordination of services.
- Information about provider responsibilities.
- Assistance with checking member eligibility.
- Assistance with reviewing member information on the Member Care Portal.
- Instructions on how to locate a participating provider or specialist in our network.
- Instructions on how to locate the Ohio Department of Medicaid's (ODM) managed care organization (MCO) provider web search pages.
- Instructions on how to search the ODM Unified Preferred Drug List.
- Instructions on how to contact Availity.

Section III – Provider Resources

Provider Portal

Aetna Better Health of Ohio Disputes (Participating Providers)	**apps.availity.com/availity/Demos/Registration/index.htm** Disputes are filed online through Availity.

Claims Payment Systemic Errors (CSPE) Report

Claims Payment Systemic Errors (CPSE) are claims that were submitted to Aetna, but adjudication occurred incorrectly. These claims were either: under paid, overpaid, or denied due to systemic error. To fall into the category of a CPSE, impact must have occurred for five or more providers.

If a CPSE error occurs, notification to Ohio Department of Medicaid (ODM) will be sent. The notification will include:

- Definition of the error.
- Date error occurred.
- Provider types which are impacted.
- Number of impacted claims.
- Timeline to fix systemic issue.
- Tentative date correction will be made.

Aetna will provide ODM monthly updates on the status of error and completion of resolution. The information for CPSE will be posted on our website and updated monthly for the provider community to review the status for each CPSE. Providers can find this information at **AetnaBetterHealth.com/OhioRISE**

Aetna Provider Advisory Council (PAC)

The purpose of the Provider Advisory Council (PAC) is for the OhioRISE plan to gather input, discuss and learn about issues affecting providers, identify challenges and barriers, problem- solve, share information, and collectively find ways to improve and strengthen the healthcare service delivery system. The PAC would review the Annual Provider Satisfaction Survey questions and provide input for changes/edits/updates prior to those surveys being executed. The council would focus an ongoing review of the program's operation, identification of potential program enhancements and opportunities for improvement.

Aetna Better Health of Ohio Policies and Procedures

Our comprehensive and robust policies and procedures are in place throughout our entire health plan to make certain all compliance and regulatory standards are met. Our policies and procedures are reviewed on an annual basis and required updates are made as needed. In the event of a policy change, Aetna Better Health will notify providers 30 days before implementation. Our policies are captured throughout this Provider Manual in addition to being available online at: **AetnaBetterHealth.com/OhioRISE**.

Provider Services (Call Center) Information Provider Toll-Free Help Line

The Provider Toll-free Help Line, **833-711-0773** (option 2), will be staffed by Provider

Experience Representatives between the hours of 7 a.m. and 8 p.m., EST, Monday through Friday, excluding the following Aetna Better Health of Ohio holidays:

- New Year's Day
- Martin Luther King, Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

An automated system and secure voicemail will be available to providers between the hours of 8:01 p.m. and 6:59 a.m., EST, Monday through Friday, and 24 hours on weekends and holidays. Voicemails will be returned in a timely manner by our Provider Services staff.

Provider Complaints

Ohio Department of Medicaid Provider Complaint Form	**https://providercomplaints.ohiomh.com/ComplaintForm.aspx?forceredirect=true**
Provider Hotline	**1-800-686-1516**

Provider Orientation and Trainings

Our Provider Experience Department provides initial orientation for newly contracted providers. Providers are required to attend an orientation session within 75 calendar days after joining our network. In follow-up to initial orientation, our Provider Experience Department provides a variety of forums for ongoing provider training and education, such as routine office/site visits, webinars, group or individualized training sessions on select topics, (e.g., appointment availability standards, claims coding, member benefits, and website navigation), distribution of periodic provider newsletters and bulletins containing updates and reminders, and online resources through our website at **AetnaBetterHealth.com/OhioRISE**.

Forms

Ohio Department of Medicaid form page	**https://medicaid.ohio.gov/stakeholders-and-partners/legal-and-contracts/forms/forms**
Consent Form	Consent forms can be updated directly in **Dynamo.** Template located in **Dynamo**: **Care Coordination Consent Event.docx (aetna.com)** **Non-Dynamo** users contact Care Coordination **OhioRISECareCoordination@Aetna.com** with the information required to fill out the event.

Standardized Appeal Form

Aetna Better Health of Ohio Disputes (Participating Providers)	**apps.availity.com/availity/Demos/Registration/index.htm** Disputes are filed online through Availity.
Aetna Better Health of Ohio Appeals (Participating Providers)	**apps.availity.com/availity/Demos/Registration/index.htm**

Provider specific appeal forms

Aetna Better Health of Ohio Appeals (Non-Participating Providers)	Aetna Better Health of Ohio Provider A&G Mail Aetna Better Health of Ohio PO Box 81040 5801 Postal Road Cleveland, OH 44181
Claim Submission	Claims submission to occur through Office AllyPayer ID: 45221 **https://cms.officeally.com/**

Medicaid Addendum

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the managed care organizations and providers and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. Attachment A is needed to identify the providers' capacity and service location. Attachment B is only required for hospital providers to identify services or religious/moral objections. Attachment C is only required when the contract between the managed care entity and the provider includes less specialties than the provider identified in the Provider Network Management System. The most current Medicaid Addendum is posted on the ODM website here: **https://medicaid.ohio.gov/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program-addenda**

The addendum must be completed along with your OhioRISE plan provider contract.

Section IV – Provider Responsibilities

Health Insurance Portability and Accountability Act of 1997 (HIPAA)

The Health Insurance Portability and Accountability Act of 1997 (HIPAA) has many provisions affecting the healthcare industry, including transaction code sets, privacy, and security provisions. HIPAA impacts what is referred to as covered entities; specifically, providers, managed care organizations (MCOs), and healthcare clearinghouses that transmit healthcare information electronically. HIPAA has established national standards addressing the security and privacy of health information, as well as standards for electronic healthcare transactions and national identifiers. All providers are required to adhere to HIPAA regulations. For more information about these standards, please visit: **hhs.gov/ocr/hipaa/**.

In accordance with HIPAA guidelines, providers may not interview members about medical or financial issues within hearing range of other patients.

Providers are contractually required to safeguard and maintain the confidentiality of data that addresses medical records, confidential provider, and member information, whether oral or written in any form or medium. To help safeguard patient information, we recommend the following:

- Train your staff on HIPAA.
- Consider how to ensure privacy if you're using a patient sign-in sheet.
- Keep patient records, papers, and computer monitors out of view.
- Have an electric shredder or locked shred bins available.

Providers' offices and other sites must have mechanisms in place that guard against unauthorized or inadvertent disclosure of confidential information to anyone outside of Aetna Better Health of Ohio.

Release of data to third parties requires advance written approval from the Ohio Department of Medicaid (ODM), except for releases of information for the purpose of individual care and coordination among providers, releases authorized by members or releases required by court order, subpoena, or law.

The following member information is considered confidential:

- "Individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI). The Privacy Rule, which is a federal regulation, excludes from PHI employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.
- "Individually identifiable health information" is information, including demographic data, that relates to:
    - The individual's past, present or future physical or mental health, or condition.
    - The provision of healthcare to the individual.
    - The past, present, or future payment for the provision of healthcare to the individual and information that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.
    - Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, or Social Security Number).

Additional privacy requirements are located throughout this manual. Please review the "Medical Records" section for additional details surrounding safeguarding patient medical records.

Breach of Protected Health Information (PHI)

If a provider and or the provider's staff discovers a breach (i.e., when the incident that involves the impermissible use or disclosure of PHI becomes first known), a notification will need to be sent to affected patients without unreasonable delay and in no case later than sixty (60) calendar days after the date of the breach (unless requested by law enforcement). The sixty (60) day period should be seen as an outer limit. So, if the risk analysis and the necessary information to provide notification is completed earlier, waiting until day sixty (60) would be an unreasonable delay. However, if during the sixty (60) day period a prompt risk analysis and investigation is conducted and it is concluded that no breach occurred, then no notification is necessary.

The breach notification should be sent to patients in written form by first-class mail at the last known address. If a patient agrees to receive a notification via e-mail and this agreement has not been rescinded, then the written notification can be sent electronically. In the case of minors or patients who lack legal capacity due to a mental or physical condition, the parent, personal representative, and/or authorized representative should be notified. If the provider knows that a patient is deceased, the notification should be sent to the patient's next of kin or personal representative (i.e., a person who has the authority to act on behalf of the decedent or the decedent's estate), if the address is known. In urgent situations where there is a possibility for imminent misuse of the unsecured PHI, additional notice by telephone or other means may be made. However, direct written notice must still be provided.

Substitute notice must be provided if contact information is not available for some or all the affected patients, or if some notifications that were sent are returned as undeliverable. The form of the substitute notice is based on the number of patients for whom contact information was unavailable or out-of-date. If the number of patients is fewer than ten (10), the provider should choose a form that can be reasonably calculated to reach the individual who should be notified. Possible forms may be an e-mail message, a phone call (keeping in mind that sensitive information should not be left on voicemail or in messages to other household members), or possibly a web posting if no other contact information is available, and this is reasonably calculated to reach the patient. If the number of patients is ten (10) or more, the provider should place a conspicuous notice that includes a toll-free number: (1) on its homepage or a hyperlink that conveys the nature and important of the information to the actual notice, or (2) in major print or broadcast media in geographic areas where the affected individuals of the breach likely live. If the provider can update the contact information and provide written notice to one or more patients so as to bring the total number of patients for whom contact information is unavailable or out-of-date to less than ten, then the conspicuous notice requirement can be avoided. For additional details surrounding media coverage and notification to the Secretary of the Department of Health and Human Services, please visit the following site at:

For additional training or Q&A, please visit the following site at:
aspe.hhs.gov/admnsimp/final/pvcguide1.htm

Providers must notify Aetna Better Health of Ohio if a breach occurs regardless of the number of patients impacted.

Member Privacy Requests

Members may make the following requests related to their protected health information ("privacy requests") in accordance with federal, state, and local law:

- Make a privacy complaint.
- Receive a copy of all or part of the designated record set.
- Amend records containing protected health information (PHI).
- Receive an accounting of health plan disclosures of PHI.
- Restrict the use and disclosure of PHI.
- Receive confidential communications.
- Receive a Notice of Privacy Practices.

A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that they are authorized to make the request on behalf of the member or the deceased member's estate.

Except for requests for a health plan Notice of Privacy Practices, requests from members or a member's representative must be submitted to Aetna Better Health of Ohio in writing.

Provider obligations for oral translation, oral interpretation, and sign language services in accordance with OAC rule 5160-26-05.1

Interpretation and Translation Requirements

Providers are required to identify the language needs of members and to provide oral translation, oral interpretation, and sign language services to members. To assist providers with this, we make our telephonic language interpretation service available to providers to facilitate member interactions. These services are free to the member and to the provider. However, if the provider chooses to use another resource for interpretation services, the provider is financially responsible for associated costs. The Ohio Relay number is available for members by calling **711**. Our Member Services staff are trained and available to take TTY phone calls from members.

Our language interpreter vendor provides interpreter services at no cost to providers and members. Language interpretation services are available for use in the following scenarios:

- For face-to-face meetings, our staff (e.g., care coordinators) can conference in an interpreter to communicate with a member in their home or another location.
- Providers can call Aetna Better Health of Ohio Member Services Department at **833-711-0773,** option 2 to connect to OhioRISE, then select "2" or "hold on the line" to be connected with a Member Services Staff Member. From the next menu press "7" to link with an interpreter.
- For outgoing calls, our Member Services Staff dials the language interpretation service and uses an interactive voice response system to conference with the member and the interpreter.

We provide alternative methods of communication for members who are visually or hearing impaired, including large print and/or other formats. If a member has a question about alternative formats, please have them contact our Member Services Department at **833-711-0773 (option 2).**

We strongly recommend the use of professional interpreters, rather than family or friends. Providers must also deliver information in a manner that is understood by the member.

Cultural competency information as well as languages spoken by office location will be collected in ODM's Provider Network Management (PNM) system and will be utilized to populate ODM's centralized provider directory. Additionally, this information for credentialed providers will be transmitted to the managed care organizations on a weekly basis for them to align their directories with the information contained in the PNM.

Office Administration Changes and Training

Procedure to notify the OhioRISE plan of changes to provider practice in accordance with OAC rule 5160-26-05.1

Providers are responsible to notify our Provider Experience Department on any changes in professional staff at their offices (physicians, physician assistants, or nurse practitioners). Administrative changes in office staff may result in the need for additional training. Contact our Provider Experience Department to request additional staff training and our Provider Experience Department will work with you and your office to schedule training.

Providers are also responsible for notifying Aetna Better Health of Ohio and the Ohio Department of Medicaid (ODM) of address, phone number, acceptance of new patients, and office hour changes. Please notify Aetna Better Health's Provider Experience Department within two weeks of these changes. Please update your changes in the PNM module as well.

Cultural competency and linguistics services

Cultural competency is the ability of individuals, as reflected in personal and organizational responsiveness, to understand the social, linguistic, moral, intellectual, and behavioral characteristics of a community or population, and translate this understanding systematically to enhance the effectiveness of healthcare delivery to diverse populations.

Members are to receive covered services without concern about 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. We expect our providers to treat all members with dignity and respect as required by federal law. Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance, such as Medicaid.

We have effective provider education programs that encourage respect for diversity, foster skills that facilitate communication within different cultural groups, and explain the relationship between cultural competency and health outcomes. These programs provide information on our members' diverse backgrounds, including the various cultural, racial, and linguistic challenges that members encounter, and we develop and implement acknowledged methods for responding to those challenges.

Providers receive education about such important topics as:

- The reluctance of certain cultures to discuss mental health issues and of the need to proactively encourage members from such backgrounds to seek needed treatment.
- The impact that a member's religious and/or cultural beliefs can have on health outcomes

(e.g., belief in non-traditional healing practices).

- Promoting health literacy and the importance of providing patients with information in a way that is meaningful and understandable (e.g., simple diagrams, communicating in the vernacular, etc.).
- Physical and programmatic barriers that impact people with disabilities accessing meaningful care.

Our Provider Experience Representatives will reference the cultural competency training during provider orientation meetings and explain how providers can access the education.

Cultural competency information as well as languages spoken by office location will be collected in ODM's Provider Network Management (PNM) system and will be utilized to populate ODM's centralized provider directory. Additionally, this information for credentialed providers will be transmitted to the managed care organizations on a weekly basis for them to align their directories with the information contained in the PNM.

Access and Availability Standards

Providers are required to schedule appointments for eligible members in accordance with the minimum appointment availability standards and based on the acuity and severity of the presenting condition, in conjunction with the member's past and current medical history. Our Provider Experience Department will routinely monitor compliance and seek Corrective Action Plans (CAP), such as panel or referral restrictions, from providers that do not meet accessibility standard. Providers are contractually required to meet the Ohio Department of Medicaid (ODM) and the National Committee for Quality Assurance (NCQA) standards for timely access to care and services, taking into account the urgency of and the need for the services. Providers are required to notify Aetna Better Health of Ohio within 3 business days if they are not able to comply with access and availability standards.

The table below shows appointment wait time standards for Behavioral Health providers.

Type of Visit	Description	Minimum Standard
Emergency Service	Services needed to evaluate, treat, or stabilize an emergency due to a behavioral health condition.	24 hours, 7 days/week
Urgent Care for Behavioral Health Conditions	Care provided for a non-emergent illness or injury with acute symptoms that require immediate care. This includes acute illness or substance dependence that impacts the ability to function but does not present imminent danger.	24 hours, 7 days/week within 48 hours of request

Behavioral Health Non-Life-Threatening Emergency	A non-life-threatening situation in which a member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral Health Routine Care	Requests for routine mental health or substance abuse treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
CANS Initial Assessment	Assessment for the purposes of OhioRISE eligibility	Within 72 hours of identification
CANS Ongoing Assessment	Assessment of functional progress within the course of OhioRISE Plan treatment as facilitated by the CME.	Every 90 days or when a change in member's condition warrants a re-assessment
ASAM Residential/Inpatient Services – 3: 3.1, 3.5, 3.7	Initial screening, assessment, and referral to treatment.	Within 48 hours of request
ASAM Medically Managed Intensive Inpatient Services – 4	Services needed to treat and stabilize a member's behavioral health condition.	24 hours, 7 days/week
Psychiatric Residential Treatment Facilities	Initial screening for admission.	Within 48 hours of request
Specialty Behavioral Health Care Appointment	Care provided for a non-emergent/non-urgent illness requiring consultation, diagnosis, and/or treatment from a specialist (e.g., eating disorders, fire-setting).	Within 6 weeks

Provider participation in the twice a year appointment availability surveys is mandatory and critical to ensure you remain compliant. We follow a 5-communication channel approach at different times of the year to remind you of the standards and the surveys:

- Conduct and record annual training on Access & Availability requirements and post on our website
- Include an annual reminder in our Provider Newsletter
- Send an annual notification to existing providers via Blast Fax
- Include requirements in the Provider Onboarding Training Manual
- Educate the provider within 30 days of effective date

Failure to participate in the studies and comply with appointment availability standards may result in progressive enforcement action that could lead to termination of our agreement with you.

OhioRISE Quality Management – Program Purpose

Aetna Better Health's Quality Management program provides the structure and processes necessary to identify and improve clinical quality, maximize safe clinical practices, and enhance member and provider satisfaction across the various settings of care within the care delivery system.

The Quality Management Program strives to ensure that the services provided to OhioRISE members conform to the standards and requirements of regulatory and accrediting agencies, including the Ohio Department of Medicaid (ODM) and the National Committee for Quality Assurance (NCQA).

Further, the purpose of the Quality Management Program is to establish standards and criteria and provide processes, procedures, and structures to review and monitor the care and service delivered, including accessibility, availability, and continuity of care. The quality department staff coordinates organizational participation in the assessment of quality of care, identification of issues and strategies to mitigate as well as follow-up activities and documentation.
The purpose of the quality management program includes the following:

- Promotion of improvement in the quality of care provided to enrolled members through established processes, including:
    - Monitoring, evaluating, and identifying areas for improvement in the service delivery system and provider network.
    - Implementing action plans and activities to correct deficiencies and/or improve overall quality in the process of care and clinical operations.
    - Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, utilization management reviews, etc.
- Compliance with federal and state requirements.
- Executive and management staff participation in the quality management and performance improvement processes.
- Development and implementation of quality management and performance improvement activities that include contracted provider participation and information provided by members, their family/representative and/or caregiver.
- Identification of the best practices for quality management and performance improvement.
- Continuous review, evaluation and improvement in the quality and safety of clinical care and services considering demographic groups, races, ethnicities, members with special or complex health needs, care settings and types of services provided to a culturally and linguistically diverse membership.
- Analyze SDOH factors and root causes of health disparities impacting the behavioral health of members and barriers to care by region to target strategies and interventions.

Scope of Program

The quality management program applies to all OhioRISE departments and staff, members and providers including:

- All member populations, age groups, disease categories, and special health care needs groups for both physical and behavioral health.
- All sites and facilities where contracted and/or non-contracted providers deliver health care or services to members.
- The OhioRISE network as well as out-of-network practitioners and providers who deliver care to OhioRISE members.
- Internal OhioRISE operations (e.g., Programs and services, such as prior authorization, utilization management, care management, member services and provider experience.)
- All services, both clinical and non-clinical, provided to members by network or out-of-network providers or delegated entities at any point in the continuum of care and at any level of care.
- All customer interactions.
- Processes by which providers and members provide OhioRISE with feedback and recommendations for improving services.

OhioRISE integrates quality management and performance improvement processes into all departments, with each department responsible for selected processes, functions, and monitoring activities. The OHRP also communicates and collaborates with other ODM entities. Additionally, Staff perform monitoring activities as a part of routine operations and report results to the appropriate internal departments, committees or external agencies as required.

Quality Management Oversight Committees

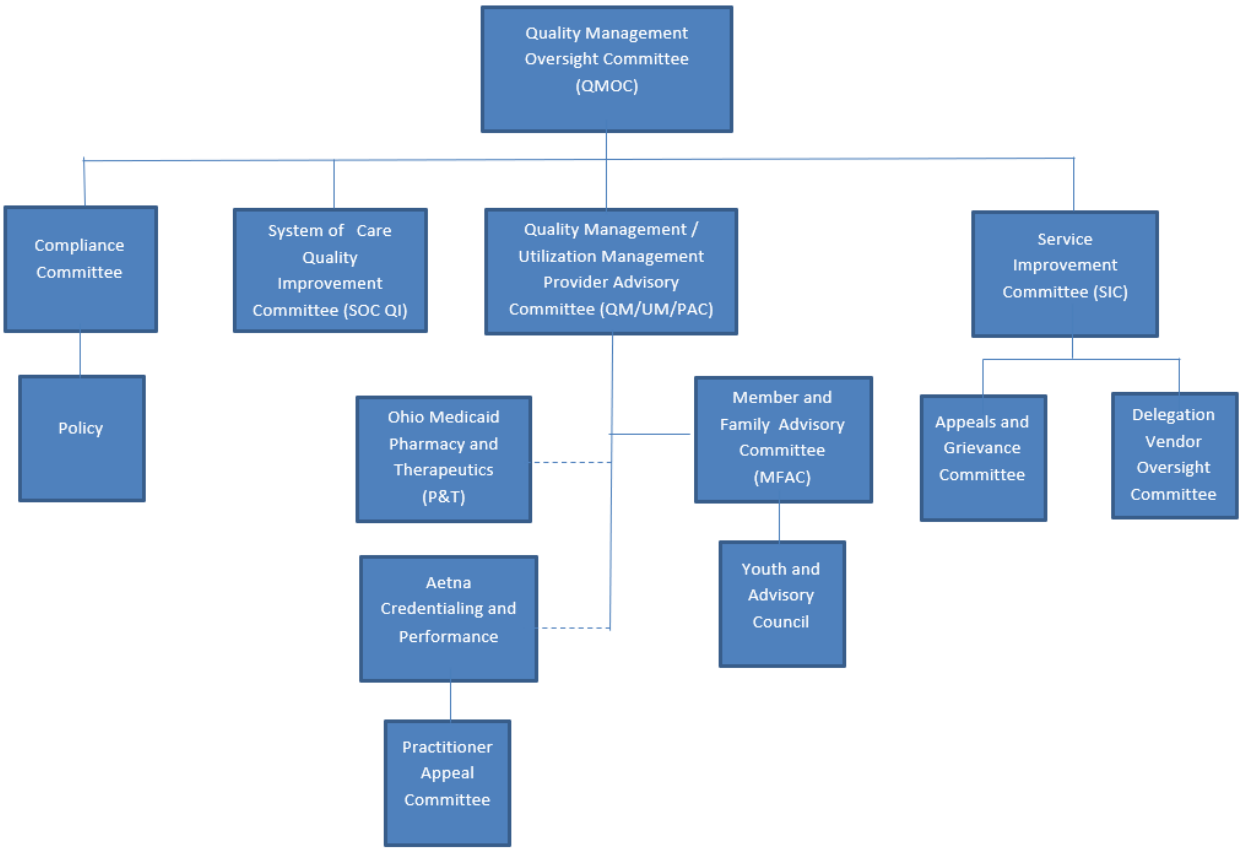
Formal committees, subcommittees and ad hoc work groups advise and guide the Quality Management process. The committee members sustain a Quality Improvement (QI)culture, foster collaborative partnerships and integrate OhioRISE medical functions, operations departments, the provider network, and members into the Quality Management program through their participation on one or more committees, overlapping membership and leadership responsibilities, and integrated reporting requirements. The quality management department provides the administrative support for the coordination of committee meetings, meeting preparations, and follow-up activities. The QMOC provides executive oversight of quality activities and their integration across the plan through its receipt and review of reports and minutes from the committees.

OhioRISE Committee Structure

The Executive Leadership committee receives quality management and performance improvement activities reports from the following committees:

- Quality Management Oversight Committee (QMOC)
    - System of Care Quality Improvement Committee
    - Member and Family Advisory Council (MFAC)
    - Youth Advisory Council

- Quality Management/Utilization Management Provider Advisory Committee (QM/UM/PA Committee)
- Service Improvement Delegation Vendor Oversight Committee (SI/DVOC)
    - Appeals and Grievance Committee
- Compliance Committee (CC)
- Policy Committee
- Aetna National Pharmacy and Therapeutics (P&T)



Supporting Quality Improvement (QI) Activities

The OhioRISE plan may use provider performance data for quality improvement activities. Providers must adhere to the provisions for the use of provider performance data. In support of these efforts, providers are required to allow the plan to use their performance data and cooperate with QI activities.

OhioRISE Member Rights

Providers will be aware of and observe the rights afforded to OhioRISE members as follows:
As a member of OhioRISE, patients 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 41 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).
- 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.

Section V – Provider Enrollment, Credentialing, and Contracting

Provider Enrollment (ODM Functions) – Credentialing/Recredentialing

Ohio Department of Medicaid (ODM) is partnering with all managed care entities (MCEs) to centralize the credentialing function. All current policy requires credentialing to occur through ODM and not Aetna.

Credentialing adheres to the National Committee for Quality Assurance (NCQA) and the Centers for Medicare and Medicaid Services (CMS) federal guidelines for both processes and the types of providers who are subject to the credentialing process. Please note, you are not able to render services to Medicaid members until you are fully screened, enrolled, and credentialed (if required) by the Ohio Department of Medicaid (ODM). For a complete list of provider types that require credentialing, please refer to Ohio Administrative Code rule 5160-1-42.

For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through the credentialing process. Medical students, residents, fellows, and providers who practice strictly in an inpatient setting are exempt from credentialing. It is recommended that you begin the contracting process with the OhioRISE plan while you are enrolling and being credentialed at ODM, in order to render services as of your effective date.

The Universal Credentialing DataSource program allows practitioners to use a standard application and a common database to submit one application, to one source, and update it on a quarterly basis to meet the needs of all health plans and hospitals participating in the Council for Affordable Quality Healthcare (CAQH) effort. Health plans and hospitals designated by the practitioners obtain the application information directly from the database, eliminating the need to have multiple organizations contacting the practitioner for the same standard information. Practitioners update their information on a quarterly basis to ensure data is maintained in a constant state of readiness.

The CAQH gathers and stores detailed data from more than 600,000 practitioners nationwide.

Initial Credentialing Individual Practitioners

All provider enrollment applications must be submitted using Ohio Medicaid's Provider Network Management (PNM) module: **ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspx**.

The PNM module is the single point for providers to complete provider enrollment, centralized credentialing, and provider self-service.

For more information about the PNM please visit:
managedcare.medicaid.ohio.gov/managedcare/centralized-credentialing/pnm-centralized-credentialing

Every provider is required to undergo the enrollment process, but credentialing is not mandatory for all providers. For initial credentialing and recredentialing, the application is paired with the enrollment or revalidation application. For more information, please refer to:
https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing

Recredentialing Individual Practitioners

Aetna Better Health of Ohio recredentials practitioners on a regular basis (every thirty-six (36) months based on state regulations) to ensure they continue to meet health plan standards of care along with meeting legislative/regulatory and accrediting bodies (such as National Committee for Quality

Assurance NCQA and Utilization Review Accreditation Commission) requirements (as applicable to the health plan). Termination of the provider contract can occur if a provider misses the thirty-six (36) month timeframe for recredentialing.

Facilities Recredentialing

As a prerequisite for participation or continued participation in our network, all facilities must be contracted under a facility agreement and satisfy applicable assessment standards. Prior to participation in the network, and every three years thereafter, Aetna Better Health of Ohio Credentialing (or entity to which Aetna Better Health of Ohio has formally delegated credentialing to) will confirm that each organizational provider meets assessment requirements.

General Provider Information/Enrollment Information

Pursuant to 42 Code of Federal Regulations (CFR) 438.602, the Ohio Department of Medicaid (ODM) is required to screen, enroll, and revalidate all managed care entities' (MCE) network providers. This provision does not require an MCE network provider to render services to fee-for- service (FFS) beneficiaries.

There are many resources available on the ODM website about the requirements to become a participating provider. Please visit **medicaid.ohio.gov/resources-for-providers/enrollment- and-support/enrollment-and-support** for several useful documents that answer relevant questions.

Organizational provider types will be required to pay a fee. The fee applies to organizational providers only; it does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFS 445.460 and in OAC 5160:1-17.8. The fee for 2026 is $730 per application and is not refundable. The fee will not be required if the enrolling organizational provider has paid the fee to either Medicare or another state Medicaid agency within the past five years. However, Ohio Medicaid will require that the enrolling organizational providers submit proof of payment with their application. (See OAC 5160:1-17.8(A)(1))

Termination, Suspension, or Denial of ODM Provider Enrollment

For a list of termination, suspension and denial actions initiated by the State of Ohio against a provider or applicant that allow for hearing rights, please refer to Ohio Revised Code section 5164.38.

For a list of termination, suspension, and denial actions initiated by the State Medicaid agency against a provider or applicant that allows for reconsideration, please refer to Ohio Administrative Code 5160-70-02.

Loss of Licensure

In accordance with Ohio Administrative Code rule 5160-1-17.6, a Medicaid provider agreement will be terminated when any license, permit, or certification that is required in the provider agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited, and the provider has been afforded the opportunity for a hearing in accordance with the hearing process established by the official, board, commission, department, division, bureau, or other agency of state or federal government.

Enrollment and Reinstatement After Termination or Denial

If a provider's Medicaid provider agreement is terminated or an applicant's application is denied, the applicant/provider should contact Ohio Medicaid via the Provider Enrollment Hotline (800-686-1516) to

discuss the requirements to reapply. This process may include conversations with the ODM Compliance Unit who will provide specific instruction on reinstatement requirements, if applicable.

Provider Maintenance

The PNM system serves as the system of record for provider data for ODM and the MCEs. As a result, data in the PNM system is used in both claims payment, the OHRP's provider directory, and ODM provider directory. To ensure provider information remains current it is important for providers to keep their information up to date in the PNM system. Please remember, as an ODM provider and in accordance with your provider agreement, providers are responsible for notifying ODM of changes within 30 days (see OAC 5160-1-17.2 F).

Updating the PNM system: When there is a change in a provider's information, please log in to the PNM system, choose the provider you are editing, and click the appropriate button to begin an update. Self-service functions include, but are not limited to location changes, specialty changes, and key demographic (e.g., name, NPI, etc.) changes. Once information is accepted into the PNM system, accepted information is sent to the OHRP daily for use in their individual directories. The provider must update their information in the PNM system first. The OHRP is required to direct providers back to the PNM system if there are changes.

ODM Provider Call Center

If you have questions or need assistance with your Ohio Medicaid enrollment, call the ODM Integrated Help Desk at **800-686-1516** through the Representatives are available weekdays from 8:00 a.m. through 4:30 p.m.

Helpful Information

Medicaid Provider Resources

- **https://medicaid.ohio.gov/resources-for-providers/enrollment-and-support**

Federal guidelines for enrollment and screening (42 CFR 455 Subpart E)

- **https://www.law.cornell.edu/cfr/text/42/part-455/subpart-E**

Ohio Revised Code for medical assistance programs

- **https://codes.ohio.gov/ohio-revised-code/chapter-5160**
- **https://codes.ohio.gov/ohio-revised-code/chapter-3963**

Ohio Administrative Code for OhioRISE and the Ohio Department of Medicaid

- **https://codes.ohio.gov/ohio-administrative-code/chapter-5160-59**
- **https://codes.ohio.gov/ohio-administrative-code/5160**

Complaints

Both network and out-of-network providers may file a complaint verbally or in writing, directly to us regarding our policies, procedures, or any aspect of our administrative functions. Providers can file a verbal complaint with us by calling **833-711-0773**.

To file a complaint in writing, providers should write to:

Aetna Better Health of Ohio
PO Box 81040 5801 Postal Road
Cleveland, OH 44181

The Grievance System Manager assumes primary responsibility for coordinating and managing provider complaints and for disseminating information to the provider about the status of the complaint.

An acknowledgement letter will be sent within five (5) business days summarizing the complaint and will include instruction on how to:

- Revise the complaint within the timeframe specified in the acknowledgement letter.
- Withdraw a complaint at any time until Grievance Committee review.

If the complaint requires research or input by another department, the Grievance System Manager will forward the information to the affected department and coordinate with the affected department to thoroughly research each complaint using applicable statutory, regulatory, and contractual provisions and Aetna Better Health of Ohio's written policies and procedures, collecting pertinent facts from all parties. The complaint, with all research, will be presented to the Grievance Committee for decision. The Grievance Committee will include a provider with the same or similar specialty if the complaint is related to a clinical issue. The Grievance Committee will consider the additional information and will resolve the complaint within fifteen (15) business days. The Grievance System Manager will send written notification within fifteen (15) business days of the resolution.

Provider Contracting (OhioRISE plan functions) Information about contracting process Provider Experience Department Overview

Our Provider Experience Department serves as a liaison between Aetna Better Health of Ohio and the provider community. Our staff is comprised of Network Relation Managers and Network Relation Consultants, as well as Provider Experience Representatives. Our Network Relations team conducts onsite provider training, problem identification and resolution, provider office visits, and accessibility audits.

Our Provider Experience Representatives are available by phone or email to provide telephonic or electronic support to all providers. Below are some of the areas where we provide assistance:

- Contracting status.
- Provide information on how to update location/address via the PNM.
- Information about recent health plan policy and/or regulatory updates.
- Assistance on how to locate forms.
- Assistance with reviewing claims or remittance advices including questions surrounding claims and billing.
- Information on provider denials.
- Instructions for providers needing to file a complaint and/or challenging or appealing the failure of the health plan to provide covered services (including state services).
- Information on member grievance and appeals.

- Information on translation/interpreter services.
- Information about member covered services.
- Instruction on how to submit a prior authorization and/or cover determination (including exceptions).
- Information on how to look up services that require prior authorization.
- Information about provider orientations.
- Information about coordination of services.
- Information about provider responsibilities.
- Assistance with checking member eligibility.
- Assistance with reviewing member information on the Member Care Portal.
- Instructions on how to locate a participating provider or specialist in our network.
- Instructions on how to locate the Ohio Department of Medicaid's (ODM) managed care organization (MCO) provider web search pages.
- Instructions on how to contact the Single Pharmacy Benefit Manager (SPBM), Gainwell Technologies (coming in late 2022).
- Instructions on how to search the ODM Unified Preferred Drug List.
- Instructions on how to contact Availity.

A sample contract can be found at
https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/ohio-rise/pdf/abhohiorise_provider_agreement_contract.pdf

Medicaid Addendum

The ODM Medicaid Addendum supplements the Base Contract or Agreement between the managed care organization and provider and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. The most current Medicaid Addendum is posted on the ODM website here:
https://medicaid.ohio.gov/wps/portal/gov/medicaid/stakeholders-and-partners/legal-and-contracts/forms/forms.
The addendum must be completed along with your OhioRISE plan provider contract.

Termination, Suspension, or Denial of ODM Provider Enrollment Termination, Suspension, or Denial of ODM Provider Enrollment

If you or your organization is denied a contract with Aetna Better Health of Ohio for OhioRISE, you may:

- **Submit a Written Appeal including:**
  - A clear explanation of why you believe the denial should be reconsidered.
  - Any supporting documentation (e.g., licensure, credentialing materials, service capacity).
- **Send Your Appeal To**:
  Aetna Better Health of Ohio
  Attn: Grievance System Manager

PO Box 81040
5801 Postal Road
Cleveland, OH 44181

Or submit via:

- **Fax**: 833-928-1259
- **Email**: As listed in your provider portal or contracting correspondence.

- **Timeframe** – Appeals must be submitted **within 60 calendar days** of receiving the denial notice.

Enrollment and Reinstatement After Termination or Denial

Due to the multiple number of reasons that a provider may be terminated or have an application denied, it is highly advised that the applicant/provider contact the ODM Integrated Helpdesk (800-686-1516) to discuss the specific requirements needed to reapply. This process may include conversations with our Compliance Unit who will provide specific instruction on reinstatement requirements, if applicable.

Provider Appeals

A provider may file an appeal, a formal request to reconsider a decision (e.g., utilization review recommendation, administrative action), with us verbally or in writing, in writing no later than 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later. The expiration date to file an appeal is included in the Notice of Action. Providers can file a verbal appeal with us by calling 833-711-0773. All verbal appeals must be followed up in writing. Providers can also submit appeals online at **apps.availity.com/availity/Demos/Registration/index.htm**

Via mail to the following:
Aetna Better Health of Ohio PO Box 81040
5801 Postal Road
Cleveland, OH 44181

The Grievance System Manager assumes primary responsibility for coordinating and managing provider appeals, and for disseminating information to the provider about the status of the appeal.

An acknowledgement letter will be sent within five (5) business days summarizing the appeal and will include instruction on how to:

- Revise the appeal within the timeframe specified in the acknowledgement letter.
- Withdraw an appeal at any time until Appeal Committee review.

The appeal with all research will be presented to the Appeal Committee for decision. The Appeal Committee will include a provider with the same or similar specialty. The Appeal Committee will consider the additional information and will issue an appeal decision within fifteen (15) business days for claims related appeals and thirty (30) business days for all other non-claim related appeals. The Grievance System Manager will send written notification within two (2) business days of the resolution.

Non-contracted providers or Unenrolled Providers

Contracting and enrollment are two separate processes. Both should be completed if you want to provide services to managed care enrolled Medicaid beneficiaries. Contracting is the process a

provider completes with the OHRP whereas enrollment is a process completed with the ODM. All providers who are billing for services for Medicaid managed care enrolled beneficiaries should enroll with ODM through our PNM system. 42 CFR § 438.602 requires ODM to "screen and enroll, and periodically revalidate, all network providers of the OHRP". Federal regulations allow for a 120-day temporary agreement for providers who require more time to enroll in the PNM System. To complete the temporary 120 agreement while you wait for your ODM enrollment to process you must complete the ODM 10295 form.

Provider education and training resources for PNM, including how to enroll, are located here: PSE Provider Registration Portal - Resources (maximus.com)

https://ohpnm.omes.maximus.com/OH_PNM_PROD/Resources.aspx

Out of Network Providers – Transition of Care

We will authorize service through an Out-of-Network Provider Agreement when a member with a special need or service is not able to be served through a contracted provider. Our Medical Management team will arrange care by authorizing services to an out-of-network provider and facilitating transportation through the member's managed care organization (MCO) when there are no providers that can meet the member's special need available in a nearby location. If needed, our Provider Experience Department will negotiate a Single Case Agreement (SCA) for the service and refer the provider to our Network Development Team for recruitment to join the provider network. The member may be transitioned to a network provider when the treatment or service has been completed or the member's condition is stable enough to allow a transfer of care.

Aetna Better Health Provider Call Center Provider Toll-Free Help Line

The Provider Experience Toll-free Help Line, **833-711-0773** (option 2), will be staffed by Provider Experience Representatives between the hours of 7 a.m. and 8 p.m., EST, Monday through Friday, excluding the following Aetna Better Health of Ohio holidays:

- New Year's Day
- Martin Luther King, Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

An automated system and secure voicemail will be available to providers between the hours of 8:01 p.m. and 6:59 a.m., EST, Monday through Friday, and 24 hours on weekends and holidays. Voicemails will be returned in a timely manner by our Provider Experience staff.

Section VI – Covered Services

List of covered services in accordance with 5160-26-03, including any additional benefits like value-added services, pilot, and trial incentive programs, and in lieu of services

OhioRISE members will receive medically necessary Medicaid-covered behavioral health services at no cost. OhioRISE provides access to all inpatient and outpatient behavioral health services noted in the **Ohio Medicaid Behavioral Health Manual** OhioRISE also offers additional services that are only available to OhioRISE members.

https://medicaid.ohio.gov/resources-for-providers/bh?ver=Cp9iA-gL0HuNnBEwVPf9CQ%3D%3D

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 **833-711-0773 (TTY: 711).** Representatives are available from 7 a.m. to 8 p.m. Monday through Friday.

Some behavioral healthcare is covered only when it is approved before the service is provided (prior authorization). See page 46 on getting prior approval for services. Emergency services do not require prior authorization. Providers 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. Providers can also call **833-711-0773 (TTY: 711)** to request the most current list of services that need prior authorization.

Services Only Covered by OhioRISE

OhioRISE offers behavioral health services that are only available through the plan. These services are growing across the state. Providers can call OhioRISE Member Services at **833-711-0773** (TTY: 711) for details.

OhioRISE members are assigned a care coordinator experienced in working with children, youth, and families/caregivers. They help members:

- Learn what services or community supports that members or their family/caregivers may need that OhioRISE can help connect them with.
- Get services and resources.
- Make sure that all doctors and healthcare providers are aware and involved with the member's OhioRISE care plan.
- Intensive Home-Based Treatment (IHBT) – Intensive home-based treatment services in accordance with 5160-59—03.3. Intensive, short-term services within the member's home to help stabilize and improve their health.
- Psychiatric Residential Treatment Facilities (PRTFs) - Psychiatric residential treatment facility (PRTF) service in accordance with 5160-59-03.6. Provides intensive treatment for young people with behavioral health needs. PRTFs work with the member and their family to develop the knowledge and skills to safely manage their needs in the community.
- Behavioral Health Respite Services – Behavioral health respite services in accordance with 5160-59-03.4. Provides short-term relief for member's primary caregivers in their home or community. If the member is eligible for respite services, they could get help from someone who is licensed to help with their daily activities at home and transportation to activities in their community.

- Primary Flex Funds – Primary flex funds in accordance with 5160-59-03.5. Up to $1,500 in a 365-day period to buy services or supplies to help the member:
- Reduce the need for other services
- Keep the member and their family safe at home.
- Help the member be better integrated into their community
- OhioRISE home and community-based services waiver services and providers, including transitional services and supports and secondary flex funds in accordance with 5160-59-05 – 5160-59-05.3

Regional Mobile Response and Stabilization Services (Regional MRSS)

Ohio has implemented a "firehouse model" funding approach to support a regional MRSS system. This model is designed to ensure a stable and predictable funding stream that enhances the efficiency, availability, and accessibility of crisis response services for youth and young adults across the state.

The MRSS program provides immediate, in-person behavioral health interventions for individuals aged 20 and under experiencing emotional or behavioral crises. Services are delivered by Regional MRSS Providers (RMPs) and are available in home or community settings, with telehealth options when appropriate.

Comprehensive information regarding service descriptions, eligibility criteria, clinical requirements, and service limitations is outlined in the Ohio Administrative Code:

- **Rule 5160-27-13** (Ohio Department of Medicaid): Covers provider eligibility, service coverage, and reimbursement guidelines
- **Rule 5122-29-14** (Ohio Department of Behavioral Health):
  Details certification standards, service delivery expectations, team composition, and quality assurance requirements

Additional resources, including MRSS Practice Standards and provider tools, are available on the DBH website:
Mobile Response and Stabilization Services (MRSS) | DBH

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	Covered	No prior approval needed

Rural Health Clinic (RHC)		
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 in and out of state	Prior approval needed
Psychological Testing	Covered 20	No prior approval needed

	visits per calendar year	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 90 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-Centered Care Plan review process

Requirements regarding the submission and processing of requests for specialist referrals in accordance with OAC rule 5160-26-05.1

Documenting Referrals

Providers are responsible for initiating, coordinating, and documenting referrals to specialists, including mental health/substance abuse (MH/SA) providers, within our network. Providers must follow the respective practices for emergency room care, second opinion, and noncompliant members.

Telehealth

OhioRISE will cover applicable behavioral health telehealth services as specified in the *ODM Telehealth Services: Guidelines for Managed Care Organizations* manual (**Telehealth-Services- guidelines-for-MCOs-Version-3.pdf**). OhioRISE will implement any changes outlined in this manual within 30 calendar days of being notified by the Ohio Department of Medicaid (ODM) of change.

OhioRISE will educate members and providers about the availability of telehealth, considerations of using telehealth versus in-person visits, applicable requirements, and how to access telehealth options.

The OhioRISE Provider Directory will clearly identify providers that offer telehealth, and if so, when telehealth is available.

Transportation

OhioRISE members do have access to transportation. The member's OhioRISE care coordinator can help with transportation questions and issues. The member or their family can contact OhioRISE Member Services at **833-711-0773** (**TTY: 711**) for assistance.

The member's managed care organization (MCO) can provide transportation to and from a OhioRISE service. The member or their family can call their MCO for more information (on page 10) and/or to schedule a ride.

If the member is enrolled in traditional Medicaid, the County Department of Job and Family Services (CDJFS) provides transportation through the Non-Emergency Transportation (NET) program. The member or their family can call CDJFS for more details and/or to schedule a ride. Contact information can be found at this link: **jfs.ohio.gov/about/local-agencies-directory**

Non-Covered Benefits

Aetna Better Health of Ohio will not pay for services or supplies received that are not covered by OhioRISE:

- Physical health services
- All services or supplies that are not medically necessary.
- Paternity testing.
- Services to find cause of death (autopsy) or services related to forensic studies.
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual.

Financial Responsibility for Services Provided to OhioRISE children and youth (Mixed Services Protocol)

The OhioRISE Mixed Services Protocol clarifies financial responsibility for behavioral health services

provided to children and youth who:

- Are enrolled in the OhioRISE plan.
- Become enrolled in the OhioRISE plan as of the date of admission to an inpatient behavioral health stay on or after OhioRISE program implementation (July 1, 2022). Youth who become enrolled in the OhioRISE program must have been determined eligible for Ohio Medicaid per ORC 5160.01(D)(1), which is distinct from other medical assistance programs or time limited benefits offered by the agency.

This protocol includes services that are covered by both the OhioRISE plan and the Managed Care Organization (MCO). It excludes the enhanced or new services that are only covered by the OhioRISE plan. Services that are not behavioral health (dental, transportation, etc.) are not OhioRISE covered services and remain the responsibility of the individual's MCO (or fee-for-service (FFS) Medicaid). Financial responsibility for behavioral health services provided to children and youth who are not enrolled in the OhioRISE plan remains the responsibility of the recipient's managed care organization or fee-for-service Medicaid.

Providers can use this document to identify the entity to which claims should be submitted if a child or youth is enrolled in the OhioRISE plan. Services are defined in the column on the left, while the entity to which the claim should be routed, dependent on the date of service, is in the column on the right.

Please note that inpatient behavioral health admissions for children and youth under age 21 on the admission date result in OhioRISE enrollment effective the date of admission, regardless of whether the eligibility systems demonstrate OhioRISE enrollment at the time the child or youth is admitted. Therefore, inpatient behavioral health hospital admissions, as described in this document, are the responsibility of the OhioRISE plan. The full document can be found at **https://tinyurl.com/4phd2mhb**

Member Grievance System Overview

Aetna Better Health of Ohio takes grievances and appeals very seriously. We want to know what is wrong so we can make our services better. Members can file a grievance or appeal if they are not satisfied. A network provider, acting on behalf of a member and with the member's written consent, may file a grievance, appeal, and a state hearing as applicable.

A member or their authorized representative may request a state hearing through the Ohio Department of Job and Family Services (ODJFS) after the appeal process.

In accordance with the grievance, appeal, and state hearing procedures and time frames provided in OAC rule 5160-26- 05.1, we inform members of the complaint/grievance, appeal, and state hearing procedures. This information is contained in the Member Handbook and within this Provider Manual, including being available on our website at **AetnaBetterHealth.com/OhioRISE**. When requested, we provide members reasonable assistance in completing forms and taking other procedural steps.

Grievances

Members or their representatives may submit grievances orally or in writing to any OhioRISE staff person. Standard grievances may be filed at any time. Expedited grievances related to the denial of expedited prior authorization or appeal processing, related to OhioRISE taking an extension on the decision-making timeframe for a prior authorization, or an appeal must be requested within sixty (60)

calendar days of the Expedited Processing letter or the Extension letter.

Grievance Extension

If we are unable to resolve a standard grievance within the specified timeframe, we may ask to extend the grievance decision date by fourteen (14) calendar days. We will only take an extension if it is in the member's best interest. In these cases, we will provide information describing the reason for the delay in writing to the member and to the Ohio Department of Medicaid.

Expedited Grievance Resolution

Grievances will be resolved within the following time frames, and the member will be notified orally the same day as resolution for expedited grievances and in writing within seventy-two (72) hours of resolution for all grievances, unless an extension of time is warranted. The timeframe for the disposition of a grievance and notice to the affected parties is as follows:

- Within seventy-two (72) hours of receipt for:
    - Clinically urgent situations.
    - Grievances related to when OhioRISE extends the timeframe for decision making.
    - When the grievance is the result of the denial of expedited appeal decision making.
- Within two (2) business days of receipt if the grievance is regarding access to services.
- Within thirty (30) calendar days of receipt for non-claims related grievances.
- Within sixty (60) calendar days of receipt for claims related grievances.

Regulatory Complaints

At any time throughout the appeal or grievance process, or instead of the appeal and grievance process, the member may file a complaint with a regulatory body for any reason including dissatisfaction with the outcome of an appeal or grievance. Regulatory complaints may be received from any area in the State of Ohio. For example, complaints can be filed through the Ohio Department of Insurance via their website **insurance.ohio.gov/home** or through the Ohio Attorney General using their website as well **ohioattorneygeneral.gov/Individuals-and- Families/Consumers/File-A-Complaint**.

Section VII – Care Coordination

Aetna Better Health of Ohio focuses on relationship building, promoting the voice and choice among members and caregivers; and assisting in the coordination of the full continuum of behavioral health and services and supports. The objective is to make certain that members receive care in the most integrated, least-restrictive community setting compatible with optimal functioning and personal preferences.

Identifying Members Needs

The OhioRISE plan offers care coordination to all members enrolled in the OhioRISE program. Care coordinators are experienced at working with children, youth, and families and they know what services are available for a member through the OhioRISE program, from the member's Medicaid managed care organization (MCO), and within the community. Every OhioRISE member is contacted soon after they enroll. Based on the assessment that was done to determine eligibility for the OhioRISE program, the member will be assigned an initial level of care coordination, called a tier.

For members who are placed in Tier 2 (moderate) or Tier 3 (intensive) care coordination, the care coordination services will be provided by a care management entity (CME). CMEs are contracted with the OhioRISE plan to provide care coordination. For moderate and intensive levels, the CME will assign a care coordinator. CMEs and their care coordinators are located in the area where the members live and know what services are available. They have experience in working with the child-serving systems in the state and will be your partner in care decisions to improve the member's behavioral health outcomes. If a member is assigned to Tier 1 (limited), the care coordination will be provided directly by the OhioRISE Plan care coordinator.

Once members are enrolled in the plan, the assigned care coordinator will schedule an initial visit at the member's home or a place of choice. During this first and subsequent visit, the member, the care coordinator, and family members or responsible parties will:

- Complete an initial assessment. This assessment lets us learn more about behavioral and medical healthcare needs. We also obtain information about the member's past health care and what services they are currently receiving.
- Review and discuss member's current behavioral health concerns to learn more about the needs.
- Help the member/family to learn more about their condition(s).
- Talk about what level of care coordination (tier) may be needed and most beneficial and whether the member/family agree or disagree with that level.
- Identify who the member/family wants to participate in the Child and Family Team (CFT).

Role of the Provider in Care Coordination

Providers play a key role in care coordination for OhioRISE. They help identify children and youth who may benefit from the program, complete assessments like the CANS (Child and Adolescent Needs and Strengths), and work closely with care coordinators to develop and carry out individualized care plans. Providers also help connect families to services across systems—such as behavioral health, developmental disabilities, education, and child welfare—ensuring that care is well-organized and meets the child's unique needs. Their collaboration helps reduce gaps in care and supports better outcomes for youth and families.

- Work together on a Child and Family-Centered Care Plan (CFCP) which makes sure that the member's behavioral health needs are met.
- Explain how to get services for crisis situations.
- Set up a schedule for regular contacts through visits and telephone calls.
- Identify what services the member/family need help with arranging and how the care coordinator can assist.
- Learn how the care coordinator will help with referrals to specialist care, work with healthcare providers, state child-serving agencies, and organizations.
- Learn how to contact their assigned care coordinator.
- Explain what to do if the member/family want to change assigned care coordinator or assigned care management entity (CME).

OhioRISE 1915(c) Waiver Services

- **Out-of-Home Respite:** A service provided outside of the youth's home that will provide short-term temporary relief to the primary caregiver or caregivers of an OhioRISE plan enrolled youth.
- **Transitional Services and Supports**: Services to support youth and their families who are experiencing changes in circumstances/locations or other qualifying conditions.
- **Secondary Flex Funds:** Services, equipment, or supplies, not otherwise provided through the waiver or through the Medicaid state plan, that are designed to meet a need of the youth in order to address behaviors. Additional information on the OhioRISE 1915(c) waiver services is available in chapters: **5160-59-05 OhioRISE HCBS waiver: covered services and providers; 5160-59-05.1 OhioRISE HCBS waiver: out-of-home respite; 5160-59-05.2 OhioRISE HCBS waiver: transitional services and supports; and 5160-59-05.3 OhioRISE HCBS waiver: secondary flex funds**

A primary care physician (PCP), assigned care coordinators, members of the Child and Family Team (CFT), or treating practitioners/providers are responsible for initiating and coordinating a member request for authorization through Aetna's Secure web portal, Availity, or they may need to contact the Aetna Better Health of Ohio's Prior Authorization Department directly to verify or confirm a prior authorization.

The requesting provider is responsible for complying with our prior authorization requirements, policies, and request procedures, and for obtaining an authorization number to facilitate reimbursement of claims.

Utilization Management (UM) decision making is based on appropriateness of care and service and existence of coverage. Aetna does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

For those services requiring prior authorization, participating and nonparticipating providers must obtain pre-service authorization from us before providing clinical services, procedures, or hospitalizations which require prior authorization. Noncompliance with pre-service authorization policies and procedures may result in denial or delay of reimbursement. A list of services that require prior authorization can be found on our website. Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment. All out-of-network services require authorization (see

below for exceptions). Unauthorized services will not be reimbursed, and authorization is not a guarantee of payment.

Role of Provider in Care Coordination and Care Management Programs

Role of provider in care coordination and care management programs in accordance with OAC rule 5160-59-03.2.

Care Coordination Delegation Information Mental Health/Substance Abuse Services

In order to meet the needs of our members, Aetna Better Health of Ohio will provide a continuum of behavioral health services to members at risk of or suffering from mental, addictive, or other behavioral disorders. We are an experienced behavioral healthcare organization and have contracted with providers who are experienced in providing behavioral health services to the Ohio population.

Referral Process for Members Needing Mental Health/Substance Abuse Assistance

Members are able to self-refer to any participating mental health/substance abuse (MH/SA) provider within our network without a referral from their primary care provider (PCP).

Coordination of Mental Health and Physical Health Services

Led by each member's assigned care coordinator, we coordinate mental health care services for members through our Child and Family Teams (CFT). Through this team, we organize screenings, evaluations, and evidence-based treatments. These treatments can include services or referrals for care for physical health needs, behavioral health needs, substance use disorder, dual or multiple diagnoses, and developmental disabilities. Additionally, with the member's permission, our care coordination staff can facilitate care coordination for substance abuse screening, evaluation, and treatment. We also work with the member's managed care organization to coordinate physical health needs.

Members seen in the primary care setting may present with a behavioral health condition, which the primary care provider (PCP) must be prepared to recognize. PCPs are encouraged to use behavioral health screening tools, treat behavioral health issues that are within their scope of practice and refer members to behavioral health providers when appropriate. Members seen by behavioral health providers must be screened for co-existing medical issues. Behavioral health providers must refer members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the member's consent.

Behavioral health providers may also provide physical health care services if they are licensed to do so. Mental Health/Substance Abuse (MH/SA) providers are asked to communicate any concerns regarding the member's medical condition to the PCP, with the members consent if required, and work collaboratively on a plan of care.

Section VIII – Utilization Management

Behavioral health services covered by OhioRISE that require Prior Authorization:

Service	Coverage/ Limitations*	Prior Approval
Assertive Community Treatment for Adults	Covered	No prior approval needed for first 180 days.
Diagnostic Evaluation and Assessment	Covered/1 per year for certain evaluations	No prior approval needed unless limitation met
Electroconvulsive therapy	Covered	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.
Mobile Response Stabilization Services	Covered	Prior approval is needed beyond six weeks.
Psychiatric Residential Treatment Facility (PRTF) Services	Covered in and out of state	Prior approval needed
Psychological Testing	Covered 20 visits per calendar year.	No prior approval needed for first 20 visits per year.
Behavioral Health Respite Services	Covered	Prior approval needed only after first 90 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
Substance Use Assessment	Covered/ 2 assessments per year	No prior approval needed unless limit is met

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
Primary Flex Funds	Covered	Primary flex funds will need prior approval through the Child and Family-Centered Care Plan review process

Prior authorization submission process – process and format

How to Request Prior Authorizations

Prior authorizations may be obtained through Aetna's Secure Web Portal, Availity. Providers can access Availity directly at the web address below, or by going through our OhioRISE webpage **apps.availity.com/availity/Demos/Registration/index.htm**

Timeframes for Responding to standard and expedited PA requests

Decision	Decision/notification timeframe	Notification to	Notification method
Urgent pre-service approval	Forty-eight (48) hours from receipt of request	Practitioner/Provider	Oral or Electronic/Written
Urgent pre-service denial	Forty-eight (48) hours from receipt of request	Practitioner/Provider/ Member	Oral or Electronic/Written
Non-urgent pre-service approval	Ten (10) Calendar Days from receipt of the request	Practitioner/Provider	Oral or Electronic/Written
Non-urgent pre-service denial	Ten (10) Calendar Days from receipt of the request	Practitioner/Provider/ Member	Electronic/Written
Urgent concurrent approval	Forty-eight (48) hours of receipt of request	Practitioner/Provider	Oral or Electronic/Written

Urgent concurrent denial	Forty-eight (48) hours of receipt of request	Practitioner/Provider	Oral or Electronic/Written
Post-service approval	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider	Oral or Electronic/Written
Post-service denial	Thirty (30) calendar days from receipt of the request.	Practitioner/Provider/ Member	Electronic/Written
Termination, Suspension, Reduction of prior authorization	At least fifteen (15) Calendar Days before the date of the action.	Practitioner/Provider/ Member	Electronic/Written

Provider Appeal Procedures Peer-To-Peer Consultations

When an adverse benefit determination has been issued, Aetna Better Health will notify the provider of the option to request a peer-to-peer consultation. A peer-to-peer consultation can be requested by calling **800-711-0773,** Monday through Friday, 8 a.m. to 5 p.m. ET. If the peer-to- peer consultation request is pertaining to a pre-service denial, the provider has five (5) business days from the date of notification of the adverse benefit determination to request the consultation. For subsequent reviews, the provider has two (2) business days from the date of notification of the adverse benefit determination to request a peer-to-peer consultation. Medical Management Staff will coordinate the peer-to-peer consultation between the Aetna Better Health Medical Director and the requesting provider.

External Medical Review

External Medical Review (EMR) –The review process conducted by an independent, external medical review entity that is initiated by a provider who disagrees with the OhioRISE Plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity.

EMR will be conducted by Permedion. This vendor has a contract with ODM to perform the EMR.

To request an EMR, providers must first appeal the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using the OhioRISE's internal provider appeal or claim dispute resolution process. Failure to exhaust OhioRISE's internal appeals or claim dispute resolution process will result in the provider's inability to request an EMR.

EMR is only available to providers for services delivered to members enrolled in Medicaid managed care and/or OhioRISE. The EMR process is not currently available in the MyCare Ohio and the Single Pharmacy Benefit Manager (SPBM) programs.

An EMR can be requested by a provider as a result of:

1. Denials, limitations, reductions, suspensions, or terminations that required clinical documentation or medical record review in making the decision to deny (includes pre-service, concurrent, and retrospective reviews).
2. Denials, limitations, reductions, suspensions, or terminations that involved clinical judgement or medical decision-making (i.e., request was referred to a licensed practitioner for review); and

3. Denials, limitations, reductions, suspensions, or terminations based on not meeting a clinical standard or medical necessity requirement (e.g., InterQual®, MCG®, ASAM, or OAC rule 5160-1-01, including EPSDT criteria).

The OhioRISE Plan's service authorization denial, limitation, reduction, suspension, or termination based on lack of medical necessity include, but are not limited to decisions made by the plan where:

- Clinical documentation or medical record review is required in making the decision to deny (includes pre-service, concurrent, and retrospective reviews).
- Clinical judgement or medical decision making (i.e., referred to a licensed practitioner for review) is involved.
- A clinical standard or medical necessity requirement (e.g., InterQual®, MCG®, ASAM, or OAC 5160-1- 01, including Early and Periodic Screening, Diagnostic, and Treatment criteria, and/or the OHIORISE's clinical coverage or utilization management policy or policies) is not met.

The OhioRISE Plan is required to notify providers of their option to request an EMR as part of any denial notification.

How to Request External Medical Review

The request for an EMR must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals or provider claim dispute process has been exhausted.

Providers must complete the "Ohio Medicaid MCE External Review Request" form located at **www.hmspermedion.com** (select Contract Information and Ohio Medicaid) and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters from the OhioRISE Plan (initial and appeal)
- All medical records, statements (or letters) from treating health care providers, or other information that provider wants considered in reviewing case.

Providers must upload the request form and all supporting documentation to Permedion's provider portal located at **ecenter.hmsy.com** (new users will send their documentation through secured email at **IMR@gainwelltechnologies.com** to establish portal access).

Note: When requesting an EMR, providers may submit new or other relevant documentation as part of the EMR request. If the OhioRISE Plan determines the provider's EMR request is not eligible for an EMR and the provider disagrees, ODM or its designee will determine if an EMR is appropriate. The EMR process does not interfere with the provider's right to request a peer-to- peer review, or a member's right to request an appeal or state hearing, or the timeliness of appeal and/or state hearing resolutions. Once the provider has submitted the EMR request, they do not need to take further action.

The EMR Review

After the EMR request has been submitted, Permedion will share any documentation shared by the provider with the OhioRISE Plan. Following its review of this information the OhioRISE Plan may reverse its denial, in part or in whole. If the OhioRISE Plan reverses any part of its decision the provider will receive a written decision within one business day for expedited prior authorization requests and 5 business days for standard prior authorization requests and notify the EMR entity. If the OhioRISE Plan decides to reverse its decision in part, the remaining will continue as an EMR.

Permedion has 30 calendar days for a standard request and three business days for an expedited request to perform its review and issue a decision.

If the decision reverses the OhioRISE Plan's coverage decision in part or in whole, that decision is final and binding on the OhioRISE Plan.

If the decision agrees with the OhioRISE Plan’s decision to deny, limit, reduce, suspend, or terminate a service, that decision is final.

For reversed service authorization decisions, the OhioRISE Plan must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when the OhioRISE Plan receives the EMR decision.

For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), the OhioRISE Plan must pay for the disputed services within the timeframes established for claims payment in Appendix L of the Provider Agreement.

For more information about the External Medical Review, please contact Permedion at **800-473-0802**, and select Option 2.

Section IX – Claims Information

Process and requirements for the submission of claims

Provider Network Management (PNM) System Overview

The PNM module serves as the single-entry point for secure portal functions such as claims submissions, prior authorizations, and member eligibility verification. Providers may submit eligibility inquiries through the PNM system.
For more information, please visit
https://ohpnm.omes.maximus.com/OH_PNM_PROD/Account/Login.aspxn

Billing Encounters and Claims Overview

Providers must use valid International Classification of Disease, 10th Edition, Clinical Modification (ICD-10 CM) codes, and code to the highest level of specificity. Complete and accurate use of the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's (AMA) Current Procedural Terminology (CPT), 4th Edition, procedure codes are also required. Hospitals and providers using the Diagnostic Statistical Manual of Mental Disorders, 4th Edition, (DSM IV) for coding must convert the information to the official ICD-10 CM codes. Failure to use the proper codes will result in diagnoses being rejected in the claim processing system.

Again, failure to use current coding guidelines may result in a delay in payment and/or rejection of a claim.

When to Bill a Member

All providers must adhere to federal financial protection laws and are prohibited from balance billing any member beyond the member's cost sharing.

- A member may be billed only when the member knowingly agrees to receive non-covered services under the OhioRISE plan.
- Provider MUST notify the member in advance that the charges will not be covered under the program.
- Provider MUST have the member sign a statement prior to the services being rendered agreeing to pay for the services and place the document in the member's medical record.

When to File a Claim

All claims are to be submitted electronically to through the ODM Fiscal Intermediary/EDI using the Payer ID#: 45221. Before submitting a claim through your clearinghouse, please make sure your clearinghouse is compatible with the FI.

Clean Claims

We require clean claim submissions for processing. A "clean claim" is defined as one that can be processed (adjudicated) without obtaining additional information from the service provider or from a third party. It does not include claims submitted by providers under investigation for fraud or abuse or those claims under review for medical necessity.

Timely Filing of Claim Submissions

In accordance with contractual obligations, claims for services provided to a member must be received

in a timely manner. Providers will have 365 days to timely file a claim, including any timely filing exceptions, in accordance with OAC rule 5160-1-19. Our timely filing limitations are as follows:

Participating Providers:

- **New Claim Submissions** – Please consult your contract for your contractual timely filing limit for new claims. For hospital inpatient claims, date of service means the date of discharge of the member.
- **Claim Disputes and Resubmissions** – Please consult your contract for your contractual timely filing limit for disputes and corrected claims. For hospital inpatient claims, date of service means the date of discharge of the member.

Non-Participating Providers New Claim Submissions

- Claim submissions must be filed within 365 days from the date of provision of the covered service or eligibility-posting deadline, whichever is later. For hospital inpatient claims, date of service means the date of discharge of the member.
- **Claim Disputes and Resubmissions** – Claim disputes and corrected claims must be filed within 365 days from the date of provision of the covered service or eligibility-posting deadline, whichever is later. For hospital inpatient claims, date of service means the date of discharge of the member.

Failure to submit claims and encounter data within the prescribed time period may result in payment delay and/or denial.

Injuries Due to an Accident

Medicare and Medicaid laws only permit subrogation in cases where there is a reasonable expectation of third-party payment. In cases where legally required insurance (i.e., auto-liability) is not actually in force, we are required to assume responsibility for primary payment.

How to File a Claim

Providers may submit claims, eligibility inquiries, claim status inquiries and associated attachments using Electronic Data Interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM authorized TP. **https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners**

Important Points to Remember

We do not accept direct Electronic Data Interchange (EDI) submissions from our providers. We do not perform any 837 testing directly with our providers but perform such testing with the Fiscal Intermediary (FI).

Correct Coding Initiative

We follow the same standards as Correct Coding Initiative (CCI) policy and perform CCI edits and audits on claims for the same provider, same recipient, and same date of service. For more information on this initiative, please feel free to visit: **cms.hhs.gov/NationalCorrectCodInitEd/** . We utilize ClaimsXten® as our comprehensive code auditing solution that will assist payers with proper reimbursement. Correct Coding Initiative guidelines will be followed in accordance with CMS and pertinent coding information received from other medical organizations or societies.

Additional information will be released shortly regarding provider access to our unbundling software through Clear Claim Connection™.

Clear Claim Connection is a web-based, stand-alone code auditing reference tool designed to mirror our comprehensive code auditing solution through ClaimsXten. It enables us to share with our providers, the claim auditing rules, and clinical rationale inherent in ClaimsXten.

Providers will have access to Clear Claim Connection through our website (**https://medicaidportal.aetna.com/sso/clearclaim/default.aspx**) and a secure login. Clear Claim Connection coding combinations can be used to review claim outcomes after a claim has been processed. Coding combinations may also be reviewed prior to submission of a claim, so that the provider can view claim auditing rules and clinical rationale prior to submission of claims.

Correct Coding

Correct coding means billing for a group of procedures with the appropriate comprehensive code. All services that are integral to a procedure are considered bundled into that procedure as components of the comprehensive code when those services:

- Represent the standard of care for the overall procedure.
- Are necessary to accomplish the comprehensive procedure.
- Do not represent a separately identifiable procedure unrelated to the comprehensive procedure.

Incorrect Coding

Examples of incorrect coding include:

- "Unbundling" – Fragmenting one service into components and coding each as if it were a separate service.
- Billing separate codes for related services when one code includes all related services.
- Breaking out bilateral procedures when one code is appropriate.
- Down coding a service in order to use an additional code when one higher level, more comprehensive code is appropriate.

Modifiers

In order to communicate detailed information in an efficient, standardized way, modifiers are two-character suffixes that healthcare providers or coders attach to a CPT or HCPCS code to provide additional information about the practitioner or procedure. It is extremely important to accurately report modifiers as they are used to count towards soft limits, price services, and adjudicate claims. Procedure modifiers designated to practitioner type and licensure level are required for OhioRISE in order to describe specific circumstances and align appropriate rate pricing.

Applicable behavioral health provider type and specialty modifiers can be found in the Provider Requirements and Reimbursement Manual. Please see this reference for more information: **bh.medicaid.ohio.gov/Portals/0/2-1-2022%20BH%20Manual%20FV%201_21.pdf**

Claim Disputes and Resubmissions

Providers claim disputes are any provider inquiries, complaints, appeals, or requests for reconsiderations

ranging from general questions about a claim to a provider disagreeing with a claim denial.

- Providers may file a claim dispute within 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later.
- Providers may submit claim disputes verbally or in writing, including through the provider portal.
- After exhausting OhioRISE's provider claims dispute resolution process, a provider may request an external medical review (EMR) if the claim payment denial, limitation, reduction, suspension, or termination was based on medical necessity. For more information on EMR, please see the Utilization Management section of this manual.

Please consult your contract for your contractual timely filing limit for disputes and corrected claims. For hospital inpatient claims, date of service means the date of discharge of the member.

Claim Resubmission

Non-participating providers have 365 days from the date of service to resubmit a revised version of a processed claim. Participating providers should refer to their contract for timely filing and resubmission timeframes. The review and reprocessing of a claim do not constitute a reconsideration or claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors. Resubmissions must be submitted electronically with a frequency code of 7 or 8.

Checking Status of Claims

Providers may check the status of a claim by accessing our secure website **AetnaBetterHealth.com/Ohio** or by calling the Claims Inquiry Claims Research (CICR) Department **1-833-711-0773 (option 2)**.

Online Status through our Secure Web Portal

We encourage providers to take advantage of using online status, as it is quick, convenient, and can be used to determine status for multiple claims.

Monitoring Claims and Explanation of Benefits

Provider Remittance Advice

We generate checks weekly. Claims processed during a payment cycle will appear on a remittance advice ("remit") as paid, denied, or reversed. Adjustments to incorrectly paid claims may reduce the check amount or cause a check not to be issued. Please review each remit carefully and compare to prior remits to make certain proper tracking and posting of adjustments. We recommend that you keep all remittance advices and use the information to post payments and reversals and make corrections for any claims requiring resubmission.

Providers who are interested in receiving electronic remittance advices from the new EDI will need to sign up. Providers must have enrolled using the ODM-06306 835 designation form which is located at **Authorized Trading Partners (ohio.gov)**. By using this form, providers will receive all 835 electronic remittance advices (ERA) from all payers, i.e., Change Healthcare and MCEs. The PDF versions of the

remittance advices from all payers will be available via the PNM portal.

The Provider Remittance Advice (remit) is the notification to the provider of the claims processed during the payment cycle. A separate remit is provided for each line of business in which the provider participates.

Information provided on the remit includes:

- The Summary Box found at the top right of the first page of the remit summarizes the amounts processed for this payment cycle.
- The Remit Date represents the end of the payment cycle.
- The Beginning Balance represents any funds still owed to Aetna Better Health of Ohio for previous overpayments not yet recouped or funds advanced.
- The Processed Amount is the total of the amount processed for each claim represented on the remit.
- The Discount Penalty is the amount deducted from, or added to, the processed amount due to late or early payment, depending on the terms of the Provider Agreement.
- The Net Amount is the sum of the Processed Amount and the Discount/Penalty.
- The Refund Amount represents funds that the provider has returned to Aetna Better Health of Ohio due to overpayment.
- Reversed amounts are included in the Processed Amount above. Claims that have refunds applied are noted with a Claim Status of "REVERSED" in the claim detail header with a non-zero Refund Amount listed.
- The Amount Paid is the total of the Net Amount, plus the Refund Amount, minus the Amount Recouped.
- The Ending Balance represents any funds still owed to Aetna Better Health of Ohio after this payment cycle. This will result in a negative Amount Paid.
- The Check # and Check Amount are listed if there is a check associated with the remit. If payment is made electronically, then the Electronic Funds Transfer (EFT) Reference # and EFT Amount are listed, along with the last four digits of the bank account to which the funds were transferred. There are separate checks and remits for each line of business in which the provider participates.

The Benefit Plan refers to the line of business applicable for this remit. TIN refers to the tax identification number.

The Claim Header area of the remit lists information pertinent to the entire claim. This includes:

- Member Name
- ID
- Birth Date
- Account Number
- Authorization ID, if obtained

- Provider Name
- Claim Status
- Claim Number
- Refund Amount, if applicable
- The Claim Totals are totals of the amounts listed for each line item of that claim.
- The Code/Description area lists the processing messages for the claim.
- The Remit Totals are the total amounts of all claims processed during this payment cycle.
- The Message at the end of the remit contains claims inquiry and resubmission information, as well as grievance rights information.

An electronic version of the Remittance Advice can be obtained. In order to qualify for Electronic Remittance Advice (ERA), you must submit claims through Electronic Data Interchange (EDI) submissions and receive payment for the claim by Electronic Funds Transfer (EFT). You must also have the ability to receive ERA through 835 files. We encourage our providers to take advantage of EDI, EFT, and ERA, as it shortens the turnaround time for you to receive payment and reconcile your outstanding accounts. Please contact our Provider Experience Department for assistance with this process.

Payment in Full Information

The OhioRISE payment for any covered services constitutes payment in full and OhioRISE will ensure its subcontractors do not charge members, their custodians, or ODM any additional co- payment, cost sharing, down payment, or similar charge, refundable or otherwise.

Payment of Claims

We process claims and notify providers of outcomes using remittance advice. Providers may choose to receive checks through the mail or electronically. We encourage providers to take advantage of receiving Electronic Remittance Advices (ERA), which are received much sooner than remittance advice received through the mail, enabling you to post payments sooner.

All managed care claims submitted by trading partners must be sent to the new Electronic Data Interchange (EDI), flow through the FI, and then route to the selected MCEs for processing and payment. Providers who submit managed care claims through direct data entry (DDE) will do so via the appropriate managed care portal. Aetna will conduct the usual adjudication of the claim.

Through Electronic Funds Transfer (EFT), providers have the ability to direct funds to a designated bank account. We encourage you to take advantage of EFT. Since EFT allows funds to be deposited directly into your bank account, you will receive payment much sooner than waiting for the mailed check. Payment from the OhioRISE plan will be made on separate check.

Aetna Better Health of Ohio is partnering with ECHO (**https://enrollments.echohealthinc.com/EFTERADirect/AetnaBetterHealth)** to introduce the new EFT Registration Services (EERS), a better and more streamlined way for our providers to access payment services. EERS will offer providers a standardized method of electronic payment while also expediting the payee enrollment and verification process. Providers will be able to use the Change Healthcare tool to manage EFT with multiple payers on a single platform.

EERS will give payees multiple ways to set up EFT in order to receive transactions from multiple payers.

If a provider's tax identification number (TIN) is active in multiple states, a single registration will auto-enroll the payee for multiple payers. Registration can also be completed using a national provider identifier (NPI) for payment across multiple accounts.

Process and requirements for appeal of denied claims Provider Claims Dispute Process

Claim Resubmission

Non-participating providers have 365 days from the date of service to resubmit a revised version of a processed claim. Participating providers should refer to their contract for timely filing and resubmission timeframes. The review and reprocessing of a claim do not constitute a reconsideration or claim dispute.

Providers may resubmit a claim that:

- Was originally denied because of missing documentation, incorrect coding, etc.
- Was incorrectly paid or denied because of processing errors.

Resubmissions must be submitted electronically with a frequency code of 7 or 8.

Section X – Reporting

Member Medical Records – the OhioRISE plan's documentation, legibility, confidentiality, maintenance, and access standards for member medical records; member's right to amend or correct medical record in accordance with OAC rule 5160-26-05.1

Medical Records Review

Our standards for medical records have been adopted from the NCQA and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within our provider network. Below is a list of our medical record review criteria. Consistent organization and documentation in patient medical records is required as a component of our Quality Management initiatives to maintain continuity and effective, quality patient care.

Provider records must be maintained in a legible, current, organized, and detailed manner that permits effective patient care and quality review. Providers must make records pertaining to Aetna Better Health of Ohio members immediately and completely available for review by the Ohio Department of Medicaid (ODM) and/or federal officials at the provider's place of business, or forward copies of records to the ODM upon written request without charge.

Medical records must reflect the different aspects of patient care, including ancillary services. The member's medical record must be legible, organized in a consistent manner and must remain confidential and accessible to authorized persons only. Medical records must also comply with Ohio Administrative Code rule 5160-26-05.1.

All medical records, where applicable and required by regulatory agencies, must be made available electronically. All providers must adhere to national medical record documentation standards. Below are the minimum medical record documentation and coordination requirements:

- Member identification information on each page of the medical record
- Documentation of identifying demographics including the member's name, address, telephone number, employer, Member identification number, gender, age, date of birth, marital status, next of kin, and, if applicable, guardian or authorized representative.
- Complying with all applicable laws and regulations pertaining to the confidentiality of member medical records, including, but not limited to, obtaining any required written member consents to disclose confidential medical records for complaint and appeal reviews.
- Hospital discharge summaries. (Discharge summaries are included as part of the medical record for (1) hospital admissions that occur while the patient is enrolled in Aetna Better Health of Ohio and (2) prior admissions as necessary.)
- Mental health/substance abuse (MH/SA) health history and MH/SA health referrals and services provided, if applicable, including notification of MH/SA providers, if known, when a member's health status changes or new medications are prescribed.
- Documentation as to whether an adult member has completed advance directives and location of the document. (Advance directives include Living Will and Mental Health Treatment Declaration Preferences and are written instructions relating to the provision of healthcare when the individual is incapacitated.)

- Documentation related to requests for release of information and subsequent releases, and
- Documentation that reflects that diagnostic, treatment, and disposition information related to a specific member was transmitted to the treating physician) and other providers, including MH/SA providers, as appropriate, to promote continuity of care and quality management of the member's healthcare.
- Entries – Entries will be signed and dated by the responsible licensed provider. The responsible licensed provider should countersign care rendered by ancillary staff. Alterations of the record will be signed and dated.
- Provider identification – Entries are identified as to author.
- Legibility – Again, the record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.

Medical Records Standards

Medical records must reflect all aspects of patient care, including ancillary services. Participating providers and other health care professionals must agree to maintain medical records in a current, detailed, organized, and comprehensive manner in accordance with customary medical practice, applicable laws, and accreditation standards. Medical records must reflect all aspects of patient care, including ancillary services. Detailed information on Medical Records Standards can be found in Chapter 4 of this manual.

Medical Records

The advance directive must be prominently displayed in the adult patient's medical record. Requirements include:

- Providing written information to an adult patient regarding each individual's rights under state law to make decisions regarding medical care and any provider written policies concerning advance directives (including any conscientious objections).
- Documenting, in the member's medical record, whether the adult patient has been provided the information, and whether an advance directive has been executed.
- Not discriminating against a member because of their decision to execute, or not execute, an advance directive and not making it a condition for the provision of care.
- Educating staff on issues related to advance directives, as well as communicating the member's wishes to attending staff at hospitals or other facilities.
- Educate patients on advance directives.

For additional information about medical record requirements, please visit Chapter 10 of this manual.

As a prerequisite for participation or continued participation in our network, all providers must maintain advance directive policies and make them available to Aetna Better Health of Ohio upon request.

OhioRISE plan policies and procedures in response to undelivered, inappropriate, or substandard health care services

Aetna Better Health of Ohio has an aggressive, proactive Fraud, Waste, and Abuse (FWA) Program that complies with state and federal regulations. Our program targets areas of healthcare related fraud and abuse including internal fraud, electronic data processing fraud and external fraud. Our Special

Investigations Unit (SIU) is a key element of the program. The SIU detects, investigates, and reports any suspected or confirmed cases of fraud, waste, or abuse to the appropriate state and federal agencies as mandated by Ohio Administrative Code rule 5160- 26-06. During the investigation process, the confidentiality of the patient and or people referring the potential fraud and abuse case is maintained.

We use a variety of mechanisms to detect potential fraud, waste, and abuse. All key functions including Claims, Provider Experience, Member Services, Medical Management, as well as providers and members, share the responsibility to detect and report fraud. Our review mechanisms include audits, review of provider service patterns, hotline reporting, claim review, data validation, and data analysis.

Special Investigations Unit (SIU)

Our Special Investigations Unit (SIU) conducts proactive monitoring to detect potential fraud, waste, and abuse, and is responsible to investigate cases of alleged fraud, waste, and abuse. With a total staff of over 100 individuals, the SIU is comprised of experienced, full-time Investigators; Field Fraud (claims) Analysts; a full-time, a dedicated information technology organization; and supporting management and administrative staff.

The SIU has a national toll-free fraud hotline for providers who may have questions, seek information, or want to report potential fraud, waste, or abuse. The number is **1-800-338-6361**. The hotline has been acknowledged as an effective tool, and we encourage providers and contractors to use it.

To achieve its program integrity objectives, the SIU has state-of-the-art technology and systems capable of monitoring Aetna's huge volume of claims data across health product lines. To help prevent fraud, it uses advanced business intelligence software to identify providers whose billing, treatment, or member demographic profiles differ significantly from those of their peers. If it identifies a case of suspected fraud, the SIU's Information Technology and investigative professionals collaborate closely, both internally with the Compliance Department, and externally with law enforcement as appropriate, to conduct in-depth analyses of case-related data.

Reporting Provider Preventable Conditions (PPCs)/Hospital Acquired Conditions (HACs)

Medicaid funding is not permitted to be used for any provider-preventable condition (PPC). Aetna Better Health of Ohio is responsible for ensuring that the prohibition will not negatively affect the loss of access to care or services of a member. In addition, ODM reporting is required for all PPCs regardless of the reason for the event.

Incident Reporting

Providers are required to ensure the immediate health and safety of members when becoming aware of abuse, neglect, exploitation, misappropriation greater than $500, and accidental/unnatural deaths. Examples of actions that providers may take to assure the immediate health and safety of the member include calling police or EMS, reporting to County Adult Protective Services (APS), the County Public Child Services Agency (PCSA) or regulatory agencies such as the Ohio Department of Health. Providers are required to report these types of incidents to the OhioRISE plan within 24 hours of becoming aware of the incident.

Information to Report

When reporting the incident, please be prepared to provide the following information if applicable:

- The identity of the person making the report and where they can be found.
- The name and address of the healthcare facility.
- The names of the operator and administrator of the facility, if known.
- The name of the subject of the alleged physical abuse, mistreatment, or neglect, if known.
- The nature and extent of the physical abuse, mistreatment, or neglect.
- The date, time, and specific location of the occurrence.
- The names of next of kin or sponsors of the subject of the alleged physical abuse, mistreatment, or neglect, if known.
- Any other information which the person making the report believes would be helpful to assist in investigating the incident.

Reporting Party	Suggested Reporting Timeframes	Agency	Additional Agency
Children and youth 21 years of age or younger)	Immediately if in danger	Contact **855- OHCHILD (855-642-4453**) through the Department of Children and Youth. An automated telephone directory will link caller directly to a child welfare or law enforcement office in their county. Reports can be anonymous. **https://childrenandyouth.ohio.gov/help-center/child-safety-concerns/child-safety-concerns**	Local police department (**911**)

All Others	Within 24 hours	If the incident and/or events that cause the reasonable suspicion do not result in serious bodily injury to a resident, the covered individual shall report the suspicion not later than 24 hours after forming the suspicion. (Section 1150B of the Social Security Act) Ohio Department of Health (ODH) Hotline **800-342-0553**	N/A
Domestic Violence	N/A	The State of Ohio requires that healthcare providers handle reports of domestic violence in a specific manner. If the victim presents with felony-level injuries, such as gunshot wounds, stabbings, second- or third-degree burns, or other serious injuries, healthcare workers providing aid to these victims are required to report these injuries to law enforcement. For additional reporting details, please visit the following website**:** **familysafetyandhealing.org/site/assets/files/1404/odvn_protocol.pdf**	N/A

Section XI – Next Generation Managed Care Program

Medicaid Managed Care Program

Ohio Medicaid's Next Generation managed care program advances many of the goals through the Ohio Department of Medicaid's (ODM's) population health approach to achieve optimal outcomes for the holistic well-being of individuals receiving Medicaid. Medicaid managed care provides healthcare benefits for individuals enrolled in the Ohio Medicaid program. In Ohio, most people who approved for Medicaid are automatically eligible for Medicaid managed care plan. Children and youth aged 20 and younger can be enrolled in a managed care plan for their physical health, as well as OhioRISE for their behavioral health needs. Once enrolled with a managed care plan, the plan sends a permanent member ID card for use when seeking services from providers. The ID card will indicate OhioRISE enrollment if the individual is enrolled in both programs.

Additional information regarding managed care eligibility, enrollment, and covered services is available in chapter 5160-26 of the Ohio Administrative Code. Information for providers to determine to which entity to submit claims is located in the OhioRISE Provider Enrollment and Billing Guidance and the OhioRISE Mixed Services Protocol on the OhioRISE website **https://dam.assets.ohio.gov/image/upload/v1743449666/managedcare.medicaid.ohio.gov/OhioRISE/OhioRISE_Mixed_Services_Protocol_20250401.pdf**

Single Pharmacy Benefit Manager (SPBM)

The Single Pharmacy Benefit Manager (SPBM) is a specialized managed care program operating as a Prepaid Ambulatory Health Plan (PAHP) that will provide pharmacy benefits for the entire Medicaid Managed Care population (excluding MyCare members). ODM has selected Gainwell Technologies to serve as the SPBM. An additional integral component to the new pharmacy model is the Pharmacy Pricing and Audit Consultant (PPAC), which conducts actual acquisition cost

surveys, cost of dispensing surveys, and perform oversight and auditing of the SPBM. ODM has selected Myers and Stauffer LC as the PPAC vendor.

The SPBM consolidates the processing of retail pharmacy benefits and maintains a pharmacy claims system that will integrate with the Ohio Medicaid Enterprise System (OMES), the OhioRISE plan, pharmacies, and prescribers. The SPBM will also work with pharmacies to ensure member access to medications, supporting ODM's goals of providing more pharmacy choices, fewer out-of-network restrictions, and consistent pharmacy benefits for all managed care members. SPBM will also reduce provider and prescriber administrative burden, by utilizing a single set of clinical policies and prior authorization procedures, as well as a single pharmacy program point of contact for all members.

All Medicaid Managed Care members will be automatically enrolled with the SPBM. Additionally, Gainwell Technologies will be required to contract with all enrolled pharmacy providers that are willing to accept the SPBM contract terms, resulting in a broad pharmacy network that will ensure access for all members statewide.

SPBM will provide coverage for medications dispensed by contracted pharmacy providers. Provider-administered medications supplied by non-pharmacy providers (such as hospitals, clinics, and physician practices) will continue to be covered by the OhioRISE plan, as applicable.

For more information about the SPBM or PPAC initiatives, please email: MedicaidSPBM@medicaid.ohio.gov or visit **https://spbm.medicaid.ohio.gov**