Welcome and thank you for attending the May 29 Behavioral Health Stakeholder Update and Discussion Meeting.

The meeting will start at 9:30 am and end at 4:30 pm.

• The webinar will be recorded. The recording and the slides will be posted at BH.Medicaid.Ohio.Gov.

• We will break at approximately 11:45 am for a 90 minute lunch. We will reconvene promptly at 1:15 pm.

• Throughout the day, we will use “Poll Everywhere” Software to poll your opinion and allow you to ask questions of presenters. More specifics will follow in later slides...
## Meeting Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:30 – 9:35 am</td>
<td>Intro from State Highway Patrol</td>
</tr>
<tr>
<td>9:35 – 10:30 am</td>
<td>OhioMHAS and Ohio Medicaid Directors Lori Criss and Maureen Corcoran</td>
</tr>
<tr>
<td>10:30 – 11:00 am</td>
<td>Update on Medicaid Behavioral Health Redesign</td>
</tr>
<tr>
<td>11:00 - 11:45 am</td>
<td>Update on Ohio Medicaid SUD 1115 Waiver</td>
</tr>
<tr>
<td>11:45 am – 1:15 pm</td>
<td>Lunch on your own – see restaurant list</td>
</tr>
<tr>
<td>1:15 – 1:45 pm</td>
<td>Stakeholder questions and discussion about morning topics</td>
</tr>
<tr>
<td>1:45 – 2:30 pm</td>
<td>Update on Behavioral Health Care Coordination (BHCC)</td>
</tr>
<tr>
<td>2:30 – 3:15 pm</td>
<td>Youth in or at risk of out-of-home placement and involved with multiple systems</td>
</tr>
<tr>
<td>3:15 - 3:45 pm</td>
<td>Managed care plan procurement</td>
</tr>
<tr>
<td>3:45 - 4:30 pm</td>
<td>Wrap up and next steps</td>
</tr>
</tbody>
</table>
Meeting Logistics

• Silence your phones, please
• Lunch break will be from 11:45 am to 1:15 pm. See restaurant list in registration packet
• Please return promptly to begin afternoon session
• Each presentation topic will end with an opportunity for questions and comments
• Webinar participants will be muted but can ask questions using the “Poll Everywhere” software
Ohio Behavioral Health Resources

- The following resources were sent electronically via email to all registrants:
  - Ohio Behavioral Health Concept/Vision, May 2019 Draft
  - Ohio Medicaid SUD 1115 Waiver – Submitted January 2019; To be revised Summer 2019
  - Ohio Medicaid/OhioMHAS budget white papers re: behavioral health and services for youth
  - Recovery Ohio Recommendations, March 2019
  - Fact sheet about federal definition of institutions for mental disease
  - Two latest editions of MITS BITS related to behavioral health
  - Parking map for State Highway Patrol Academy

All resources documents are posted at [BH.Medicaid.Ohio.Gov/overview](https://BH.Medicaid.Ohio.Gov/overview)

- 5/29 Stakeholder Resources is the last drop down tab on the Provider Overview page
Meeting Participant Feedback and Polling

High Tech Option
Using a web enabled device (smart phone, laptop, tablet) open an internet browser and type in “PollEV.com/ODMtraining930” Then enter your name and select “continue.”
This will give you access to “Poll Everywhere” software so that participants (on site and via webinar) can use their “smart device” to:
• Vote on opinion questions asked by presenters throughout the day
• Ask questions of presenters

Low Tech Option
On site attendees: Raise your hand to ask questions or make comments at the end of each presentation section

We will respond to as many questions and comments as possible at the meeting; afterwards, we will post Frequently Asked Questions to BH.medicaid.ohio.gov/overview
<table>
<thead>
<tr>
<th>Segment</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Medicaid Consumers or their Families</td>
<td>1%</td>
</tr>
<tr>
<td>Child Protection Services Agency</td>
<td>4%</td>
</tr>
<tr>
<td>Child-Serving or Multi-System Youth Provider</td>
<td>5%</td>
</tr>
<tr>
<td>Mental Heath Treatment Provider</td>
<td>22%</td>
</tr>
<tr>
<td>SUD Treatment Provider</td>
<td>8%</td>
</tr>
<tr>
<td>Both MH and SUD Provider</td>
<td>35%</td>
</tr>
<tr>
<td>State, County or Local Government</td>
<td>14%</td>
</tr>
<tr>
<td>Trade Association</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
</tr>
</tbody>
</table>
Framing Today’s (and Future) Discussion:

**Director Lori Criss**  
Ohio Mental Health and Addiction Services

**Director Maureen Corcoran**  
Ohio Department of Medicaid
Governor DeWine’s Directives

Addressing Ohio’s public health crisis:
• RecoveryOhio
• Elevating prevention
• Children’s initiatives
• Reforming Ohio’s child protection system
RecoveryOhio
RecoveryOhio: Addressing Mental Illness and Addiction

• Make treatment available to Ohioans in need
• Provide support services for those in recovery and their families
• Offer direction for the state’s prevention and education efforts
• Work with local law enforcement to provide resources to fight illicit drugs at the source
1. Stigma and education
2. Parity
3. Workforce development
4. Prevention
5. Harm reduction
6. Treatment and recovery supports
   • Early intervention
   • Crisis support
   • Treatment
   • Recovery support
7. Specialty populations
   • Individuals involved in the criminal justice system
   • Youth
   • Other
8. Data measurement and system linkage
OhioMHAS Priorities

• Prevention and treatment across the lifespan
• Children, youth and families
• Trauma-informed care
• Building Ohio’s behavioral health workforce
• Quality care in integrated settings
• Helping adults with severe and persistent mental illness thrive in their communities rather than cycling through jails, prisons, hospitals and homelessness
OhioMHAS Priorities

• Preventing Ohio’s overdose death and suicide crisis
• Mental illnesses and substance use disorders are chronic diseases needing long-term responses and support
• Delivering excellent care in state psychiatric hospitals
• Transferring research into practice to support communities
• Ensuring safe and quality care for everyone served in Ohio’s behavioral health system
State Health Improvement Plan

• Priority topic: mental health and addiction
• Reduce suicide deaths
• Reduce depression prevalence
• Reduce unintentional overdose deaths
• Reduce past-year drug dependence or abuse among ages 12+
Age-Adjusted Rate of Suicide Deaths by year, US and Ohio

![Graph showing the age-adjusted suicide rate per 100,000 people from 2007 to 2017 for the US and Ohio. The graph compares the suicide rates with a line for each country, showing a general increase over the years.](image-url)
Number of Suicide Deaths by Year and Sex, Ohio

Number of Suicides

Year


Female Male

Number of Suicides
Number of Youth Suicide Deaths by Year, Ohio

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Suicides</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>174</td>
</tr>
<tr>
<td>2008</td>
<td>201</td>
</tr>
<tr>
<td>2009</td>
<td>182</td>
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<tr>
<td>2010</td>
<td>186</td>
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<td>2011</td>
<td>206</td>
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<td>176</td>
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<tr>
<td>2014</td>
<td>197</td>
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<tr>
<td>2015</td>
<td>224</td>
</tr>
<tr>
<td>2016</td>
<td>215</td>
</tr>
<tr>
<td>2017</td>
<td>271</td>
</tr>
</tbody>
</table>
Unintentional Drug Overdoses & Distribution Rates of Prescription Opioids in Grams Per 100,000 Population, Ohio

Number of Unintentional Drug Overdose Deaths Involving Prescription Opioids

Percentage of Unintentional Drug Overdose Deaths Involving Prescription Opioids

*Prescription opioids reflect ICD-10 codes T40.2-T40.4, T40.6. Deaths are captured in this category only if there is no mention of fentanyl and related drugs (reflected in T40.4 and T40.6) on the death certificate, even if the death involved natural & semi-synthetic opioids (T40.2) or methadone (T40.3).

Unintentional Drug Overdose Deaths Involving Selected Drugs and Age-Adjusted Death Rate

*Prescription opioids reflect ICD-10 codes T40.2-T40.4, T40.6. Deaths are captured in this category only if there is no mention of fentanyl and related drugs (reflected in T40.4 and T40.6) on the death certificate, even if the death involved natural & semi-synthetic opioids (T40.2) or methadone (T40.3).

Source: Ohio Department of Health, Bureau of Vital Statistics; analysis conducted by ODH Violence and Injury Prevention Program. Multiple drugs are usually involved in overdose deaths. Individual deaths may be reported in more than one category.
Governor DeWine’s Directives

- RecoveryOhio
- Children’s initiatives
  - Especially behavioral health and multi-system youth
  - Infant mortality and racial disparity
- Reforming Ohio’s child protection system and FFPSA
- Procuring new managed care services
Overview and Environmental Scan

• New administration, new cabinet directors, new Governor’s Office point people
• Hit the “reset button” on several policy issues – take a time out
• Biennial Budget
  » Still a major policy and financing vehicle for Ohio Medicaid and OhioMHAS
  » Very abbreviated timeframe
  » Supportive General Assembly
  » But no huge expansion of funding – money still is a limited resource
Values of the DeWine Administration

• Listen
• Tell the truth
• Be transparent – no surprises
• Ask difficult questions and seek realistic answers
• Accountability to and with the Ohio General Assembly and Ohio citizens
• Keep your eye on the vision; continually make progress
• Measure activities and use data to make corrections
• Work collaboratively across agency boundaries and “silos”
• Think and work strategically and systemically not project by project
Family Meeting
Building a House

OUR MISSION IS TO FOCUS ON THE INDIVIDUAL RATHER THAN ON THE BUSINESS OF MANAGED CARE
Questions?
Update on Behavioral Health Redesign
Topics

• Update on work underway
  » System-level work
  » Individual providers

• Transition requirement for managed care organizations

• Other items from the “fix it” list and other managed care policy updates

• Repayment/recoupment
Work underway

» System-level work

» Individual provider

» This work will continue with the same urgency and priority as has occurred in recent months

» Providers should feel free to self refer
Behavioral Health - Transition of Care Requirements

• As we continue to work through the challenges of Behavioral Health Redesign, individuals may continue to see their current provider, regardless if they have contracted with the managed care organization (e.g., in- or out-of-network providers) until further notice
  » Helps to maintain access to care, continuity of services and treatment capacity

• Managed care organizations (MCOs) will continue to follow Medicaid fee-for-service (FFS) behavioral health coverage policies (including rates and utilization management) until further notice

• MCOs have the ability to be less restrictive but cannot be more prescriptive than FFS; this includes both managed care and MyCare.
Managed Care Issues from Fix It List

• SUD Residential: Examining MCO prior authorization practices and timeframes

• Delays in credentialing practitioners/provider agencies
  » Short term: we are assessing credentialing timeframes with MCOs
  » In the works: single credentialing function to serve all MCOs

• Timely filing of claims
  » Timely filing will remain 365 days, until further notice
Managed Care Issues from Fix It List

• Prompt Pay Guidelines
  » Effective July 1, MCOs must pay claims within the timeframes below (*this only applies to BH claims)*:
    • 90% of clean behavioral health claims within 15 days
    • 99% of clean behavioral health claims within 60 days

• CBHC Roster Processing
  » MCOs shall accept the universal roster from CBHCs
  » MCOs must confirm receipt of a CBHC universal roster
  » MCOs must process universal rosters (including any updates required in the plan system) within 10 business days
  » MCOs will communicate when updates have been completed to the CBHC
BH Redesign Fix It List (Continued)

- Previously communicated changes:
  - Revised provider manual with several updates on 4/23/19
  - Updated policy for billing more than one unit of H0005 (SUD group counseling) and H0006 (SUD case management) on 4/30/19 (> 1 unit per day is allowed)
- Lab testing:
  - Issued draft urine drug screen policy to stakeholders on 5/21/19 (see later slides for details)
  - Adding pregnancy tests as covered in CLIA-waived settings
- IHBT:
  - Considering options to allow non-licensed practitioners as part of IHBT teams to expand access
- ACT:
  - Revising provider qualifications for ACT to allow for QMHS+3 participation in team
  - Removing ACT monthly face-to-face requirement for clients to see physicians, physicians assistants or advanced practice registered nurses
BH Redesign Fix It List (Continued)

• Crisis: temporarily allowing a subset of community BH crisis services to be delivered in emergency department place of service for one year, pending other work on crisis
  » Crisis: system capacity, including mobile
• Nursing: updating rules to clarify when orders are required for nursing services
• Background checks: updating rules to align with the OhioMHAS list of disqualifying offenses for non-licensed practitioners
BH Redesign Fix It List

Policy & Rates
• Therapeutic behavioral service – psychosocial rehabilitative service – community psychiatric supportive treatment, including allowable practitioner
• Variety of Scope of Practice/enlarging the allowable provider group

Rates
• Group counseling
• Nursing
• Psychological testing
• ACT

Timeline: Rate related decisions by mid June
Recoupment/Repayment

• The work identified on the preceding slides will continue with the same urgency and priority as has occurred in recent months
• MITS BITS Medicaid Advanced Payment Agreements and the initiation of repayment 5/24/19
• This includes advanced payments negotiated between providers and MCOs in the summer 2018
• X

NEXT STEPS
• ODM will begin contacting individual providers to have a facilitated discussion with each MCO
• Providers will have the opportunity to work individually with ODM and each MCO to finalize agreements, including amounts and timelines.
Managed Care Policy Updates

• ODM will require the MCPs to follow new urine drug screening guidelines effective July 1, 2019
• Guidance being finalized now
  » Developed in coordination with the Clinical Advisory Group of the OMHAS to help continue to support those receiving substance use disorder treatment
  » Accounts for patient safety, acuity, risk of relapse/overdose, level of care, and sustained abstinence
  » Divided into three treatment phases (initial, intermediate, and prolonged recovery) and delineating UDS screens between presumptive and definitive urine tests
• Guidance being finalized now
Urine Drug Screen Guidance

The table below summarizes an acceptable standard for the average patient receiving evidence-based care as well as reduce the administrative barriers associated with prior authorizations.

<table>
<thead>
<tr>
<th>Treatment Phase</th>
<th>Presumptive Urine Drug Screen</th>
<th>Definitive Urine Drug Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-30 days (initial)</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>31-90 days (intermediate)</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>First 90 days of treatment</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>91-180 days (prolonged)</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>181-360 days (prolonged)</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>&gt;90 days to 360 days</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>First full year of treatment</td>
<td>30</td>
<td>12</td>
</tr>
</tbody>
</table>
IMD—“In Lieu of”/Short stay Policy Updates

• Starting July 1, 2017, Ohio implemented 42 CFR 438.6(e) which allows for states to make a capitation payment to a MCP on behalf of an enrollee age 21-64 who has a **short-term** IMD stay, not exceeding **15 days** in a calendar month.

• ODM received additional CMS guidance in April 2019 regarding court ordered admissions:
  » A civil commitment often follows a period of emergency hospitalization, during which an individual is held for a relatively short duration (e.g. up to 96 hours) in a treatment facility for evaluation and stabilization by mental health professionals who may then determine whether further civil commitment is appropriate or necessary.
Managed Care Policy Updates

- MCPs must be contacted during the period of any emergency hospitalization to determine if the admission is anticipated to be 15 days or less and to meet the requirements of offering “in lieu of services” at the option of the MCP and enrollee.

- If the managed care plan (or physician) believes that a stay of longer than 15 days is necessary or anticipated for an enrollee, the use of this specific in-lieu-of service is likely inappropriate and **not consistent with the Final Rule**

- In the case of emergency hospitalizations, the MCP shall cover an evaluation and stabilization period in an IMD for up to 96 hours.

- Individuals enrolled in fee-for-service Medicaid who have a short term stay in an IMD are NOT covered by this policy.
Questions?
1115 Medicaid Waiver for Substance Use Disorders
Impact of SUDs on Medicaid

• Medicaid is now the largest payer of SUD services – projected to finance 28% of national SUD treatment spending by 2020
• Two of top 10 reasons for Medicaid readmissions involve SUD
• Two-out-of-three members with an SUD did not receive treatment within 14 days following inpatient or residential withdrawal management
• Medicaid beneficiaries account for nearly 40% of adults with OUD
  » Higher rates of OUD
  » Higher risk of overdose
  » Twice as likely to be prescribed opioid pain relievers
  » Complex health profiles and greater expenditures (co-morbidity)
• Medicaid beneficiaries are at high risk for overdose deaths—however, the curve is bending; Medicaid expansion reduces mortality from drug overdoses and increases access to SUD treatment
What Opportunities Were Created to Address SUD/OUD?

- Mental health and addiction parity
- Medicaid expansion
- State targeted response/State Opioid Response Grants
- SUPPORT Act
- 1115 SUD guidance
Why is Ohio Pursuing an 1115 Waiver – The Challenge

• In 2018, CMS approached Ohio Medicaid regarding our payment model for SUD residential treatment services

• CMS strongly urged Ohio Medicaid to pursue an 1115 waiver to ensure continued Medicaid federal financial participation of individuals in residential treatment

• Ohio Medicaid and OhioMHAS hit the pause button to evaluate the situation
Federal Definition of IMD

(See white paper posted with resource materials)

• IMD definition
• Prohibition of Medicaid coverage
• Determined by overall character...maintained primarily for care & treatment of mental diseases
• Includes substance use disorder, with exceptions for lay counseling and social support
• IMD determination criteria—there are 5 criteria
• Common ownership totaling > 16 beds
• 1115 SUD authority-allow states to pursue service delivery system transformation
• Exceptions those
  » > 65 years old, and
  » Those under 21 years IF treated in an inpatient psych hospital or PRTF
Why is Ohio Pursuing an SUD 1115 Waiver – The Opportunity:

Improve Access and Quality
Rebalance Residential/Community Service Capacity

- Begin to make residential treatment facility size and nature of services consistent with recent federal discussions and guidance.
- Revisit Ohio’s “continuum of treatment” for SUD, especially re: the role of residential treatment in that continuum.
- Pursue a recovery housing strategy paired with outpatient services and supports.
- Expand treatment for pregnant and post partum women with addictions and their newborn babies.
- Propose to extend Medicaid eligibility for post partum mothers.
# Ohio’s SUD 1115 Medicaid Waiver: Then and Now

<table>
<thead>
<tr>
<th>2018 SUD 1115 Waiver Submission</th>
<th>2019 SUD 1115 Waiver Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prior authorize SUD residential stays on day one.</td>
<td>• Continue current Medicaid PA policy until sufficient data collected to revise UM policy.</td>
</tr>
<tr>
<td>• Site visits to each SUD residential provider</td>
<td>• Site visits to each SUD residential provider to collect information about facility and offer technical assistance on ASAM Levels of Care</td>
</tr>
<tr>
<td>• Require all SUD residential facilities to assure patient access to medication assisted treatment</td>
<td>• Require all SUD residential facilities to assure patient access to Medication Assisted Treatment</td>
</tr>
<tr>
<td>• Implementation timeframes</td>
<td>• Expand focus on residential treatment for pregnant and post-partum women AND their babies</td>
</tr>
<tr>
<td></td>
<td>• Propose 12 month post birth Medicaid eligibility extension for post partum women</td>
</tr>
<tr>
<td></td>
<td>• Implementation timeframes moved back</td>
</tr>
</tbody>
</table>
What do you view as the most important reason for Ohio to pursue an SUD 1115 Medicaid waiver?

When poll is active, respond at PollEv.com/odmtraining930

- Access to critical levels of care: 13%
- Evidence-based, SUD-specific patient placement criteria: 6%
- Evidence-based, SUD-specific program standards for residential treatment provider qualifications: 4%
- Sufficient provider capacity at each level of care (including MAT): 15%
- Comprehensive prevention and treatment strategies: 12%
- Improved care coordination and transitions: 5%
- All of the above: 45%
Questions?
Key lessons learned from the first five states to implement 1115 SUD Waivers
Lessons Learned from Other State Experience

- Strengthen the full continuum; without coverage and networks for evidence-based outpatient care, SUD residential will be costly and ineffective
- Closely support providers to use assessment instruments to develop appropriate treatment recommendations
- Ensure Medicaid managed care partners have the expertise with the designated assessment instruments and understand clinical and program standards
- Establish a clear process to review compliance with program standards — coordinate efforts with existing on-site reviews
- Establish an initial and ongoing process to ensure new providers have the ability to participate in the Medicaid program — and invest in helping providers meet network requirements
- Develop clear protocols that clearly delineate providers responsibilities for arranging access to medication-assisted treatment — and that they deliver additional evidence-based practices as well
Lessons Learned from Other State Experience (continued)

- Staff in state Medicaid agencies and SUD providers may be developing working relationships for the first time and need time to understand each other’s worlds.
- State Medicaid agencies need to develop fluency with addiction treatment program standards, medical necessity criteria and performance monitoring.
- States need adequate time and resources to integrate residential SUD providers into the Medicaid network.
Partnership with Arnold Ventures on Enhancing Medication Assisted Treatment

• Research, advocacy and evidence-based policy efforts to address the opioid epidemic
• Payer policy focus: expand access to evidence-based treatment (i.e., MAT)
• Scaling best practices from states that increased MAT availability, provision and quality outcomes
• Technical assistance pilot with Ohio, Louisiana, West Virginia
• Arnold Ventures’ areas of focus:
  » Addressing barriers (e.g., restrictive utilization management policies, limited networks)
  » Developing sustainable team-based care models (e.g., OBOT with nursing and behavioral health supports)
  » Leveraging hospitals and emergency departments to start MAT and facilitate warm hand-offs
  » Increasing the value delivered by OTPs
Partnership with Arnold Ventures on Enhancing Medication Assisted Treatment

Phase 1: Planning (~3 months)
- Due diligence
- Site visit
- Concept paper and budget development

Phase 2: Implementation (~9 months)
- Program, policy, and payment planning
- Program, policy, and payment implementation
- Provider training and practice transformation support
Next Steps

- By late July, we will have stakeholders in to discuss priorities and next steps
- Target date for behavioral health care coordination will be by July 1, 2020
- We will create a workgroup of providers, MCOs and other stakeholders to identify and work on issues identified during implementation
Questions?
Behavioral Health Care Coordination
Why is Ohio Pursuing Behavioral Health Care Coordination?

• The state recognizes that care coordination should be tailored to address population-specific needs using a clear model based on research or promising practices

• Ohio Medicaid and OhioMHAS are committed to a behavioral health provider model of care coordination

• There is not a “one size fits all” approach across and within these populations
Key Considerations Developing an Effective Care Coordination Response

• How does this help us individualize care for the individual?
  » Better and more timely identifications of co-occurring conditions
  » Addressing the lack of access to medical providers for these distinct co-occurring conditions
  » Ensuring a single point of accountability in the community that will engage the individual, families and treating providers
  » Early and frequent engagement of children and youth that are high risk for out-of-home placement—early interventions versus reactive responses
  » Reducing reliance on emergency departments for medical conditions that could be managed in non-hospital based settings
  » Improving the experience of care for individuals seeking and receiving services
Key Considerations Developing an Effective Care Coordination Response

• Shape outcomes and determine if what you develop is working
  » Shape the models of care that will be needed to address the approach
    • What is the right approach based on what we know (evidence and data)?
    • Who are the team members?
      – Individuals that have the knowledge of identifying and treating the co-morbid conditions
      – Individuals that the individual and family can relate to—family and consumer peers
  • What are the service expectations
    – Caseload ratio
    – Frequency of contacts
    – Response expectations (especially when the individual is experiencing a behavioral health/medical crisis)
    – Linkages with other systems and services
      » Children and families—BH providers, child welfare staff and juvenile court systems
      » Adults—specialty medical community, ACT, other MH service providers
Key Considerations Developing an Effective Care Coordination Response

• Why is knowing this information important?
  » This will help shape the technical assistance needed by the care coordination agencies
  » Better identify when it's feasible to implement—some models may take longer than others to design and implement
  » Shape the reimbursement strategy; consider alternative payment mechanisms
  » Be more concise in our asks to CMS for authority to implement these models
Next Steps / Takeaway on Behavioral Health Care Coordination

• Seeking out individuals who may be difficult to engage is a key goal
• More clarity about our priorities is one reason that we paused the work
• BHCC is an important component of the SUD waiver for some adults and youth with SUD
• Looking at critical needs for adults with serious and persistent mental illness and multi-system youth and children with serious emotional disturbances
• By late July, we will gather stakeholders for discussion about priorities and next steps
Questions?
90-Minute Lunch Break
Developing Systems of Care for High Need Children, Youth and their Families
Why Ohio is Targeting Interventions for High Need and Multi-System Youth and Their Families

• Move from youth-serving silos to a system of care
• Must occur at both state level and local/county level
  » Build on the legacy of Family and Children First Councils
  » Collaboration among state agencies and funding systems

Driving Forces:
• Flood of youth in custody due to parental addiction
• Family First Prevention and Services Act
• Urging from Governor DeWine and Ohio General Assembly
A System of Care is

A spectrum of effective, community-based services and supports for children and youth with or at-risk for mental health or other challenges and their families that...

...is organized into coordinated networks;
...builds meaningful partnerships with families and youth;
...addresses cultural and linguistic needs

...in order to help families function better at home, in school, in the community and throughout life

System of care is, first and foremost, a set of values and principles that provides an organizing framework for systems reform on behalf of children, youth and families.


The promise of effective community care can only be attained when we understand how new practices fit with the needs and strengths of local communities and their existing care systems, and we adapt clinical and administrative practices to provide care that changes in response to community context.

### System of Care Core Values

| Family-driven and youth-guided | Home- and community-based | Strengths-based and individualized | Trauma-informed | Culturally and linguistically competent | Connected to natural helping networks | Data-driven, quality and outcomes oriented |

Enrollment in a SOC yields significantly improved clinical outcomes

- Improvement in behavioral and emotional symptoms
- Fewer internalizing and externalizing symptoms
- Improvements in levels of clinical impairment
- Fewer suicidal thoughts and attempts
Youth in a system of care were less likely to be arrested
Involvement with Juvenile Justice System
After Youth Received System of Care Services

Reference: The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances, Evaluation Findings, Report to Congress (2012–2013), Substance Abuse and Mental Health Services Administration, page 15
Youth receiving system of care services experience reduced arrests and suicide attempts

Reference: The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances, Evaluation Findings, Report to Congress (2012–2013), Substance Abuse and Mental Health Services Administration, Appendix I, Page 1
Children being served in systems of care were less likely to visit an emergency room

Enrollment in a system of care resulted in improved educational outcomes

- Higher rates of educational achievement
- Improved school attendance
- Fewer suspensions and expulsions

Reference: The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances, Evaluation Findings, Report to Congress (2012–2013), Substance Abuse
Systems of care work and cost savings are realized as a result of...

- Fewer out-of-home placements/diversion from higher levels of care
- Fewer ER visits; fewer arrests
- Greater capacity for caregivers to work
- Youth are less likely to receive psychiatric inpatient services; from six months prior to 12-month follow up, the average cost per child served for inpatient services decreased by 42%
- Youth are less likely to be arrested, resulting in a 55% reduction in average per-youth arrest-related costs
Questions?
What Services Are Needed to Support a System of Care?
Home- and Community-Based Treatment and Support Services

- Assessment and evaluation
- Individualized, intensive care coordination using Wraparound
- Outpatient therapy – individual, family, group
- Medication management
- Intensive in-home services
- Substance use intensive outpatient services
- Mobile crisis response and stabilization
- Family peer support
- Youth peer support
- Respite services
- Therapeutic behavioral aide services
- Therapeutic mentoring

Out-of-Home Treatment Services

- Behavior management skills training
- Youth and family education
- Mental health consultation
- Therapeutic nursery/preschool
- School-based behavioral health services
- Supported education and employment
- Supported housing
- Transportation

Specific evidence-informed interventions and culture-specific interventions can be included in each type of service.

Link with System Partners
Ohio’s Approach

• Intensive care coordination using high fidelity wraparound approach
• Intensive home-based treatment (multi-systemic therapy, function family therapy, et al)
• Mobile crisis services
• Parent mentors/peer supporters
• Respite care for families
Opportunities of the Family First Prevention and Services Act

• Expanded flexibility in how Title IV-E funding can be used
• Regarding services, the interplay between Medicaid and FFPSA will be critical
• Review of the need for residential placement
• Quality-of-care standards for qualified residential treatment program
  » Requirement for trauma-informed care, family involvement, clinical staff
Rebalancing Residential /Community Services Capacity

• Services for children with behavioral health conditions and multi-system needs that are licensed, certified and regulated by OhioMHAS, ODJFS, Ohio Medicaid, ODYS, DODD

• Qualified Residential Treatment Program (QRTP designation under Family First Legislation) requires review of all regulations
Rebalancing Residential /Community Services Capacity (continued)

• Create in-state psychiatric residential treatment facilities (PRTFs) to keep Ohio youth closer to home (vs. sending out of state)

• Ohio Medicaid to develop some limited in-state PRTF capacity and associated community services
  » Correctly define most intensive residential treatment settings
  » Develop UM strategy to promote discharge planning at admission

• DODD, OhioMHAS and Ohio Medicaid exploring intensive residential services for multi-system youth with BH and IDD related needs
Stay Tuned

- Director Cornyn and Cabinet members are developing priorities for implementing Governor DeWine’s priorities

- Ohio’s Family and Children First Council Director LaTourette is focusing efforts on coordinating services, building capacity and engaging families

- Kristi Burre, Director of Children Services Transformation building team and developing transformational strategy in partnership with county child protection and state sister agencies

- Planning underway for implementing Family First Prevention and Services Act
What services are most needed in your community for children and families?

When poll is active, respond at PollEv.com/odmtraining930

- Individualized, intensive care coordination: 40%
- Outpatient therapy - individual, family, group: 11%
- Mobile crisis response and stabilization: 16%
- Family peer support: 11%
- Youth peer support: 5%
- Respite services: 13%
- Behavior management skills training: 6%
Questions?
Managed Care Procurement
Managed Care Mission Statement

OUR MISSION IS TO FOCUS ON THE INDIVIDUAL RATHER THAN ON THE BUSINESS OF MANAGED CARE

Because we want to do better for the people we serve
Some of our goals with this procurement are to:

- Improve the quality of services and care to those we serve
- Use best practices to expand quality services and improve health outcomes
- Improve the provider experience in managed care

We want to think outside the box and explore innovative ideas.

Shifting our the focus to individuals is a priority for Governor DeWine and Director Corcoran.
Stakeholder Engagement Objectives and Strategies

• Broadly engage external and internal stakeholders to design a program that improves the experiences of individuals, families and providers in managed care
• Be transparent and ensure information is widely available
• Effectively manage communications
We Want to Hear from You

We are doing things differently.

✓ Engaging stakeholders early in the process
✓ Listening to individuals and providers first
✓ Providing many ways for stakeholders to share input

1 IDEAS
We want to hear your ideas and solutions

2 PERSPECTIVE
What is your experience with the current managed care program?
What works and what doesn’t?

3 FEEDBACK
What else should we be thinking about?
Examples of What We Have Heard So Far

- **Claims payment**
- **Credentialing process**
- **Navigating prior authorization rules**

- **Need to ensure appropriate care coordination and case management**
- **Ensuring access to care and supportive services**

- **Need to improve care for children served by multiple agencies**
- **Concerns about access to children’s behavioral health services, including respite**
- **Need to improve how services are delivered and coordinated for children in foster care**

- **Claims payment**
- **Improved partnership with community-based organizations**
• Begin researching other states’ recent activity in managed care procurement (ongoing)
• Secure vendor to assist in preparing the Request for Application (RFA) for new procurement

• Begin stakeholder outreach and information gathering sessions (ongoing)
• Begin drafting RFI #1

• MC Procurement kickoff meeting with Ohio Medicaid staff

• Begin rolling review and identification of key concepts from RFI #1 responses
• Begin requirements gathering for RFI #2 and RFA

February

March

April

May

June

• Begin planning for a Request for Information (RFI) to solicit insight from individuals, providers and other stakeholders

• Finalize and publish RFI #1

*Timeline is subject to change based on legislative activity or at the direction of Executive Leadership
TENTATIVE TIMELINE | State Fiscal Year 2020

*Timeline is subject to change based on legislative activity or at the direction of Executive Leadership*

**PROGRAM DESIGN AND DEVELOPMENT**
- RFI #2
  - Target - Draft and review RFA and Provider Agreement

**SOLICITATION AND AWARD**
- Target - Post RFA
- Begin development of Administrative Code rules for 1/1/21
- Proposal scoring and selection, protest period
• Implement new Agreements (Target: go live – 1/1/21)

• Target - Award notification
• Submit draft Administrative Code Rules to CSIO

• File Administrative Code Rules with JCARR (by 9/1/2020)

• Post-implementation monitoring

• Target - Conduct readiness review
• Target - Transition period

• Implement new Agreements (Target: go live – 1/1/21)

*Timeline is subject to change based on legislative activity or at the direction of Executive Leadership*
Next Steps

• Additional opportunities to provide feedback
  » Email James.Tassie@Medicaid.ohio.gov
  » Email Cassandra.Buxton@Medicaid.ohio.gov

• How we will keep you informed
  » New procurement webpage – currently under construction
  » Regular updates via social media
  » Other forums
Questions?
Wrap up and Next Steps
Thank you

For today’s resources, visit:

BH.medicaid.ohio.gov/overview

We want to hear from you!
You will receive a link to a survey to provide us with additional information and feedback