Ohio | Department of Medicaid

Multi-System Youth Updates

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The DeWine Administration's Children's Initiative is taking bold steps to give kids a platform for lifelong success.

- Elevating the importance of children's programming in Ohio and drive improvements within the many state programs that serve children.
- Advancing policy related to home visiting, early intervention services, early childhood education, foster care, and child physical and mental health.
- Initiating and guiding enhancements to the early childhood, home visiting, foster care, education, and pediatric health systems.
- Improving communication and coordination across all state agencies that provide services to Ohio's children.
- Engaging local, federal, and private sector partners to align efforts and investments in order to have the largest possible impact on improving outcomes.

ODM's Key Cross-Agency Partners in Meeting Children's Initiative Aims

Department of Education

Department of Youth Services

Department of Health

Department of Developmental Disabilities

Department of Job and Family Services

Department of Mental Health and Addiction Services

Continuum of Multi-System Work

Prevention

- Preventive interventions (vaccines, education)
- Screenings (behavioral health, development, family psychosocial, social determinants of health)

CPC for Kids

ODH Home visiting

Early Intervention – Single System

- Direct intervention / treatment
- Consultation
- Coordination
- Linkage to services

CPC for Kids

DODD Early Intervention Programs

Multi-Dimensional Care

- May involve team-based care
- Silos of care are manageable and do not cause harm

BH Counseling

Psych prescription through primary care

IEP at school

Multi-System Care

- Single system cannot meet needs
- Require systems to work together in synergistic manner

Interventions through juvenile justice, child protection

Residential BH treatment

Ohio Medicaid's Historical and Current Multi-System Work

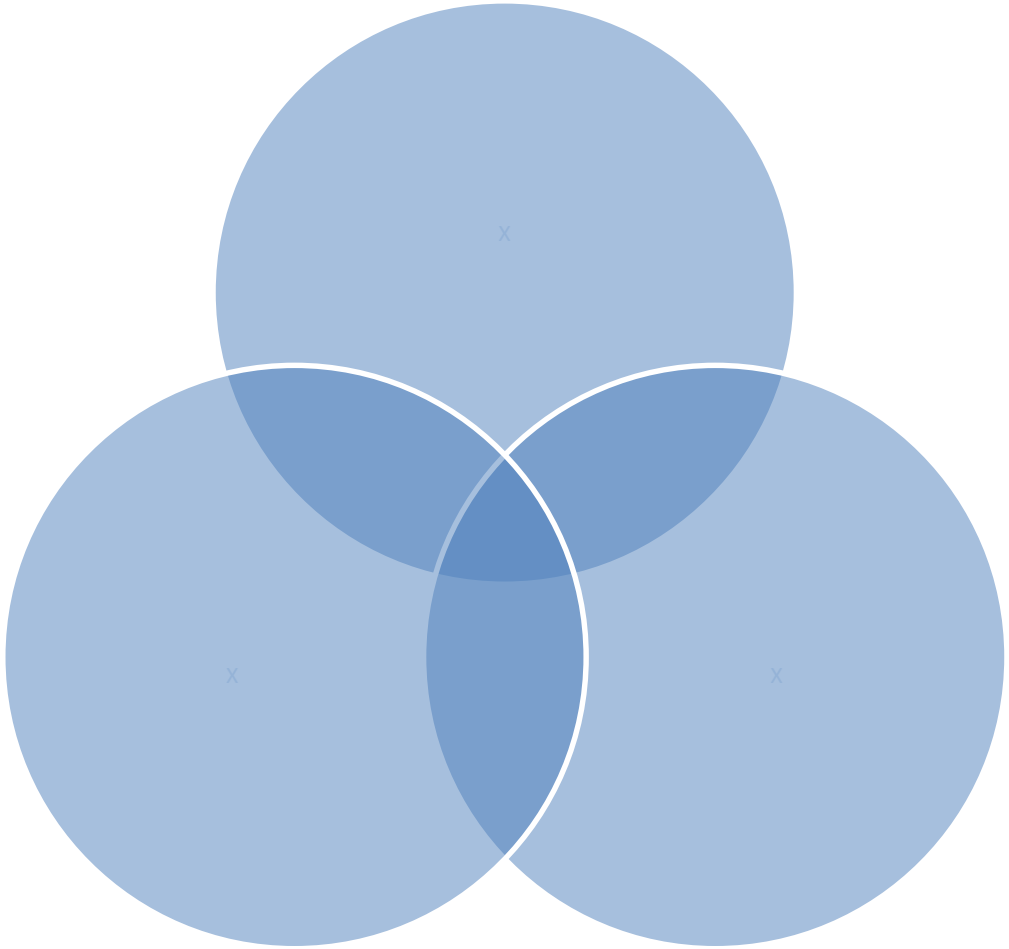
- **Many children with multi-system needs have Medicaid coverage**
  - » All kids in children's services custody and children receiving adoption assistance
  - » All kids who have Medicaid Developmental Disabilities waivers
  - » Many other families served by other state and local systems

- **Medicaid covers a wide variety of services for kids**
  - » EPSDT: The **E**arly and **P**eriodic **S**creening, **D**iagnostic and **T**reatment benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid
  - » Screenings, diagnosis, treatment for physical, behavioral, and developmental needs

- **Ohio Medicaid has longstanding relationships with other systems; joint mission to improve child and family outcomes**
  - » Coordinate with ODH's Bureau of Children with Medical Handicaps (BCMH) system
  - » Collaborate with JFS and other sister agencies to implement the Family First Prevention Services Act (FFPSA)
  - » Work with ODE to develop school report cards with Medicaid data

- **ODM administers the Multi-System Youth Custody Relinquishment State Program**
  - » Multi-state agency team provides technical assistance and funding to prevent custody relinquishment, help kids transition back home from child protection custody

Which kids have complex behavioral health & multi-system needs that could be better met?



Medicaid Youth: Behavioral Health vs. Non-Behavioral Health, SFY 2019

Sub-Population	#	% total	BH Spend/ Member	Non-BH Spend/ Member	% BH Spend vs. Total Spend for Sub-Population
Aged, Blind, Disabled	69,879	5%	$2,553	$10,217	20%
Covered Families and Children	1,328,171	88%	$494	$1,233	29%
Adoption Assistance	20,949	2%	$1,560	$1,897	45%
Foster Care	28,059	1%	$3,088	$1,820	63%
DD Waiver	6,659	0.4%	$4,529	$36,383	11%
Local DD Medicaid Services	8,484	0.5%	$3,727	$10,722	26%
Opioid Use Disorder	4,177	0.3%	$5,841	$17,040	26%
Substance Use Disorder	18,206	1%	$4,155	$3,152	57%
Mental Health Diagnosis	332,676	22%	$2,358	$3,044	44%
Serious Emotional Disturbance	158,828	11%	$3,371	$2,686	56%

Data Source: GRC BH SAS Code Vendor files, October, 2019

Comparison of Youth Taking Behavioral Health Pharmaceuticals, SFYs 2015-2018

Number of Youth Taking BH Pharmaceutical

Year	BH Condition	Foster Care/ Adoption Assistance	DD Waiver	SED
SFY '15	251,928	11,102	4,500	19,714
SFY '16	253,783	11,089	4,405	22,611
SFY '17	245,365	12,368	4,778	24,913
SFY '18	228,390	13,953	4,567	25,646

Percentage of Youth Taking BH Pharmaceutical

Year	BH Condition	Foster Care/ Adoption Assistance	DD Waiver	SED
SFY '15	16%	31%	59%	71%
SFY '16	15%	30%	59%	69%
SFY '17	15%	28%	59%	68%
SFY '18	14%	29%	58%	66%

Medicaid Youth: 20 Most Prevalent Primary Diagnosis for ED Visits, SFY 2019

Covered Families & Children

Principal Diagnosis	# Pt.	Pt. / Pop
Acute upper respiratory infection, unspecified	54,665	4.12%
Acute pharyngitis, unspecified	26,885	2.02%
Fever, unspecified	26,783	2.02%
Viral infection, unspecified	20,735	1.56%
Streptococcal pharyngitis	20,383	1.53%
Influenza due to other identified influenza virus w oth resp	14,128	1.06%
Nausea with vomiting, unspecified	13,261	1.00%
Unspecified injury of head, initial encounter	12,783	0.96%
Otitis media, unspecified, right ear	11,951	0.90%
Otitis media, unspecified, left ear	11,132	0.84%
Cough	10,950	0.82%
Headache	10,936	0.82%
Rash and other nonspecific skin eruption	10,920	0.82%
Unspecified abdominal pain	10,880	0.82%
Vomiting, unspecified	10,594	0.80%
Constipation, unspecified	10,195	0.77%
Urinary tract infection, site not specified	10,047	0.76%
Noninfective gastroenteritis and colitis, unspecified	8,964	0.67%
Acute obstructive laryngitis [croup]	8,534	0.64%
Influenza due to unidentified influenza virus w other resp	7,962	0.60%

Denominator: Total CFC (1,328,171)

Aged Blind Disabled

Principal Diagnosis	# Pt.	Pt. / Pop
Acute upper respiratory infection, unspecified	2,630	3.82%
Acute pharyngitis, unspecified	1,328	1.93%
Fever, unspecified	1,269	1.84%
Viral infection, unspecified	957	1.39%
Streptococcal pharyngitis	936	1.36%
Nausea with vomiting, unspecified	900	1.31%
Headache	885	1.28%
Constipation, unspecified	842	1.22%
Unspecified abdominal pain	806	1.17%
Suicidal ideations	802	1.16%
Unspecified injury of head, initial encounter	751	1.09%
Vomiting, unspecified	709	1.03%
Unspecified convulsions	708	1.03%
Cough	696	1.01%
Influenza due to other identified influenza virus w oth resp	687	1.00%
Unspecified asthma with (acute) exacerbation	638	0.93%
Oth chest pain	609	0.88%
Urinary tract infection, site not specified	578	0.84%
Major depressive disorder, single episode, unspecified	555	0.81%
Pneumonia, unspec organism	540	0.78%

Denominator: Total ABD (69,879)

Data Source: QDSS, October, 2019

Medicaid Youth: 20 Most Prevalent Primary Diagnosis for ED Visits, SFY 2019

Foster Care

Principal Diagnosis	# Pt.	Pt. / Pop
Acute upper respiratory infection, unspecified	722	2.57%
Suicidal ideations	611	2.18%
Fever, unspecified	331	1.18%
Major depressive disorder, single episode, unspecified	319	1.14%
Unspecified injury of head, initial encounter	298	1.06%
Other symptoms & signs involving appearance & behavior	254	0.91%
Acute pharyngitis, unspecified	224	0.80%
Viral infection, unspecified	205	0.73%
Acute bronchiolitis, unspecified	193	0.69%
Streptococcal pharyngitis	180	0.64%
Otitis media, unspecified, right ear	163	0.58%
Vomiting, unspecified	147	0.52%
Laceration without foreign body of other part of head, initial	147	0.52%
Influenza due to other identified influenza virus w oth resp	139	0.50%
Cough	137	0.49%
Rash and other nonspecific skin eruption	137	0.49%
Acute obstructive laryngitis [croup]	136	0.48%
Unspecified abdominal pain	135	0.48%
Nausea with vomiting, unspecified	134	0.48%
Urinary tract infection, site not specified	132	0.47%

Denominator: Total Foster Care (28,059)

Developmental Disabilities Waiver

Principal Diagnosis	# Pt.	Pt. / Pop
Unspecified convulsions	115	1.73%
Acute upper respiratory infection, unspecified	106	1.59%
Epilepsy, unspecified, not intractable, without status epilepticus	80	1.20%
Constipation, unspecified	74	1.11%
Suicidal ideations	69	1.04%
Other symptoms & signs involving appearance & behavior	64	0.96%
Fever, unspecified	61	0.92%
Pneumonia, unspec organism	54	0.81%
Autistic disorder	51	0.77%
Unspecified abdominal pain	51	0.77%
Vomiting, unspecified	47	0.71%
Acute pharyngitis, unspecified	45	0.68%
Unspecified injury of head, initial encounter	45	0.68%
Major depressive disorder, single episode, unspecified	44	0.66%
Restlessness and agitation	43	0.65%
Conduct disorder, unspecified	40	0.60%
Cough	39	0.59%
Nausea with vomiting, unspecified	38	0.57%
Influenza due to other identified influenza virus w oth resp	37	0.56%

Denominator: Total DD Waiver (6,659)

Data Source: QDSS, October, 2019

Medicaid Youth: 20 Most Prevalent Primary Diagnosis for ED Visits, SFY 2019

Serious Emotional Disturbance

Principal Diagnosis	# Pt.	Pt. / Pop
Suicidal ideations	7,792	4.90%
Acute upper respiratory infection, unspecified	6,281	3.95%
Major depressive disorder, single episode, unspecified	5,061	3.18%
Acute pharyngitis, unspecified	4,622	2.91%
Streptococcal pharyngitis	2,833	1.78%
Nausea with vomiting, unspecified	2,739	1.72%
Headache	2,725	1.71%
Unspecified abdominal pain	2,721	1.71%
Urinary tract infection, site not specified	2,519	1.59%
Viral infection, unspecified	2,488	1.57%
Unspecified injury of head, initial encounter	2,374	1.49%
Fever, unspecified	2,260	1.42%
Oth chest pain	2,140	1.35%
Other symptoms & signs involving appearance & behavior	2,003	1.26%
Constipation, unspecified	1,907	1.20%
Generalized abdominal pain	1,720	1.08%
Influenza due to other identified influenza virus w oth resp manifest	1,556	0.98%
Cough	1,442	0.91%
Right lower quadrant pain	1,433	0.90%
Rash and other nonspecific skin eruption	1,391	0.88%

Denominator: Total SED (158,828)

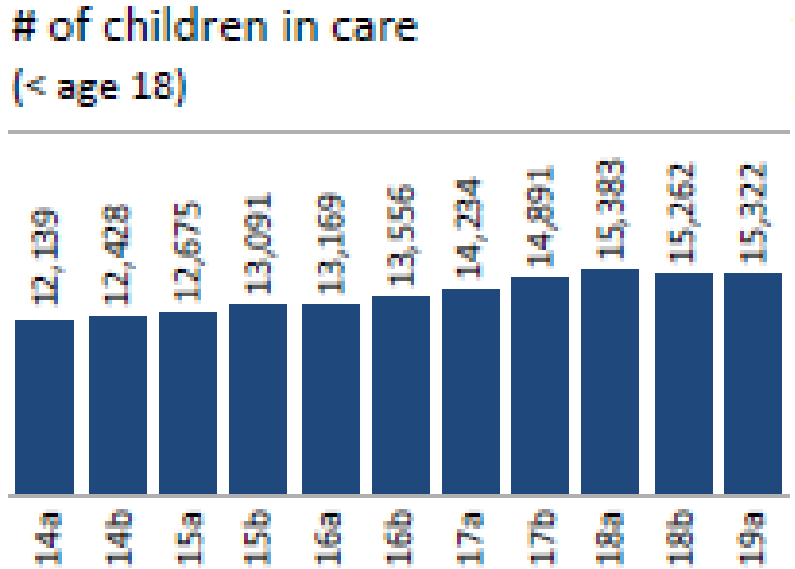
Substance Use Disorder

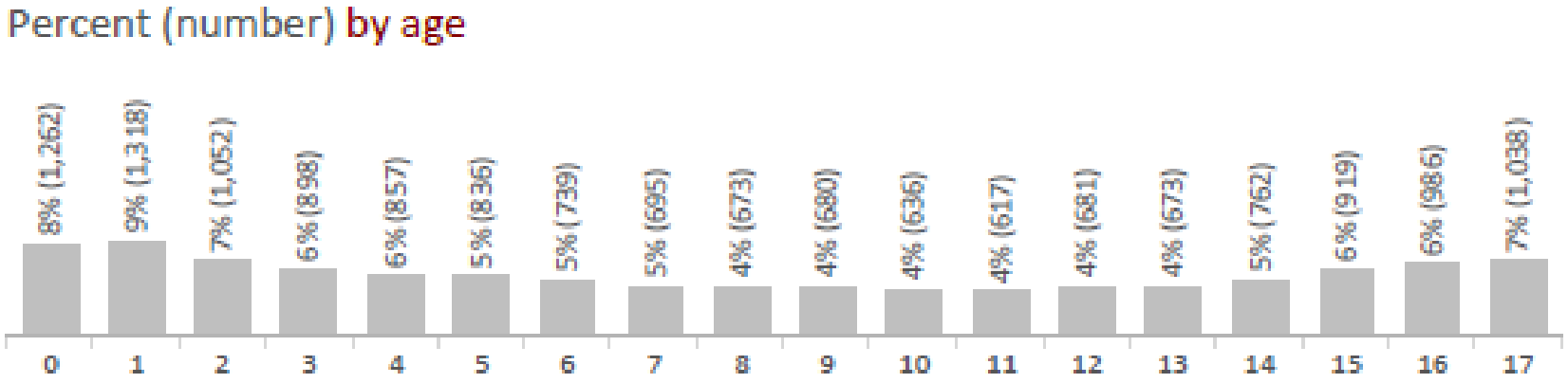
Principal Diagnosis	# Pt.	Pt. / Pop
Suicidal ideations	1,132	6.21%
Major depressive disorder, single episode, unspecified	804	4.41%
Acute upper respiratory infection, unspecified	699	3.84%
Nausea with vomiting, unspecified	633	3.47%
Acute pharyngitis, unspecified	627	3.44%
Urinary tract infection, site not specified	548	3.01%
Unspecified abdominal pain	501	2.75%
Other chest pain	469	2.57%
Headache	411	2.26%
Alcohol abuse with intoxication, unspecified	401	2.20%
Unspecified injury of head, initial encounter	393	2.16%
Generalized abdominal pain	327	1.79%
Other psychoactive substance abuse, uncomplicated	324	1.78%
Cannabis abuse, uncomplicated	292	1.60%
Chest pain, unspecified	276	1.51%
Other specified pregnancy related conditions, first trimester	269	1.48%
Contact w & (suspect) expos to infect w predom sexual mode tranSEDssion	257	1.41%
Epigastric pain	252	1.38%
Anxiety disorder, unspecified	251	1.38%
Contusion of right hand, initial encounter	243	1.33%

Denominator: Total SUD (18,218)

Data Source: QDSS, October, 2019

Ohio Child Welfare Data, March 2019

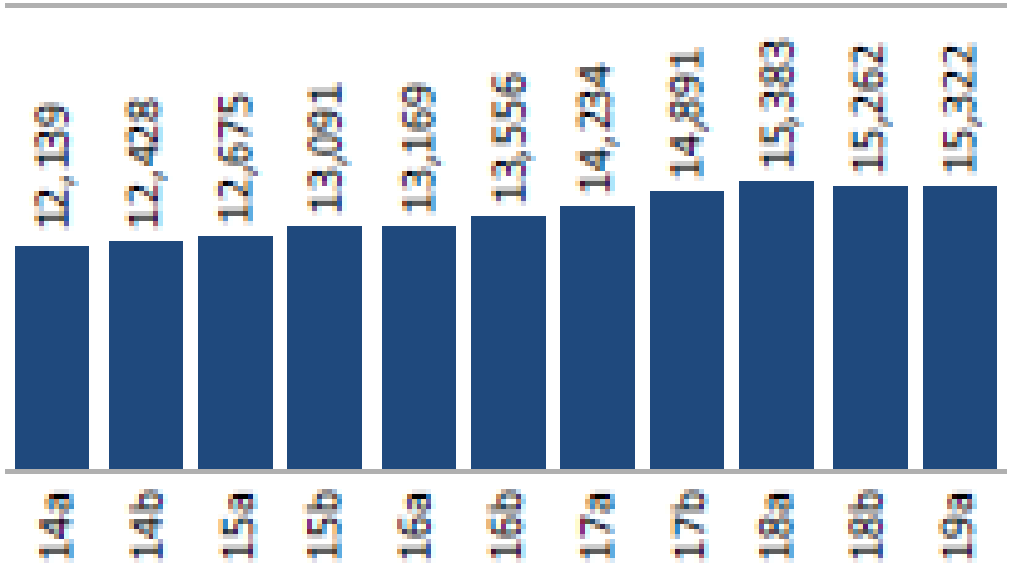




Sources: Data Basics: Ohio (Casey Family Programs, 2019)

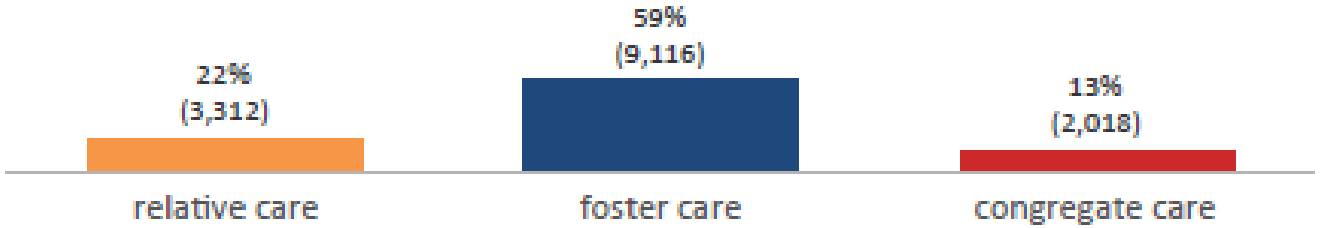
Ohio Child Welfare Data, March 2019

of children in care (< age 18)



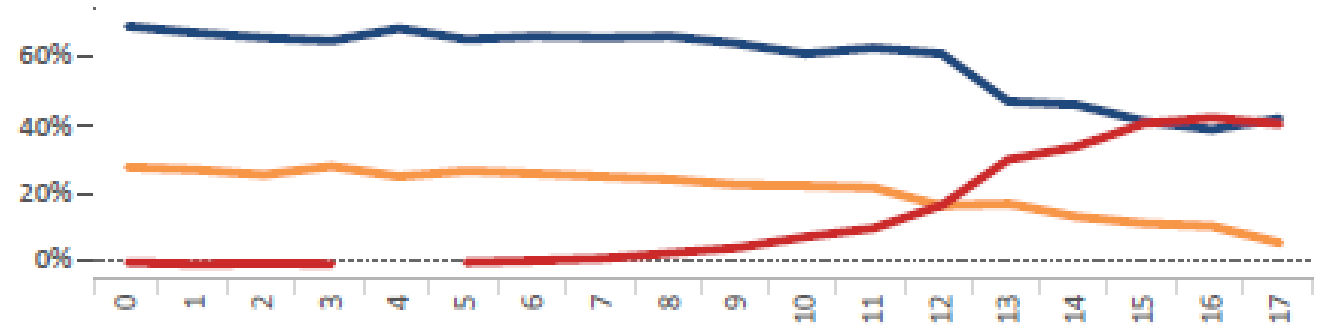
Percent (number) by placement setting

(note: only 3 greatest placement settings included)



Percent by placement setting & age

(note: only 3 greatest placement settings included)

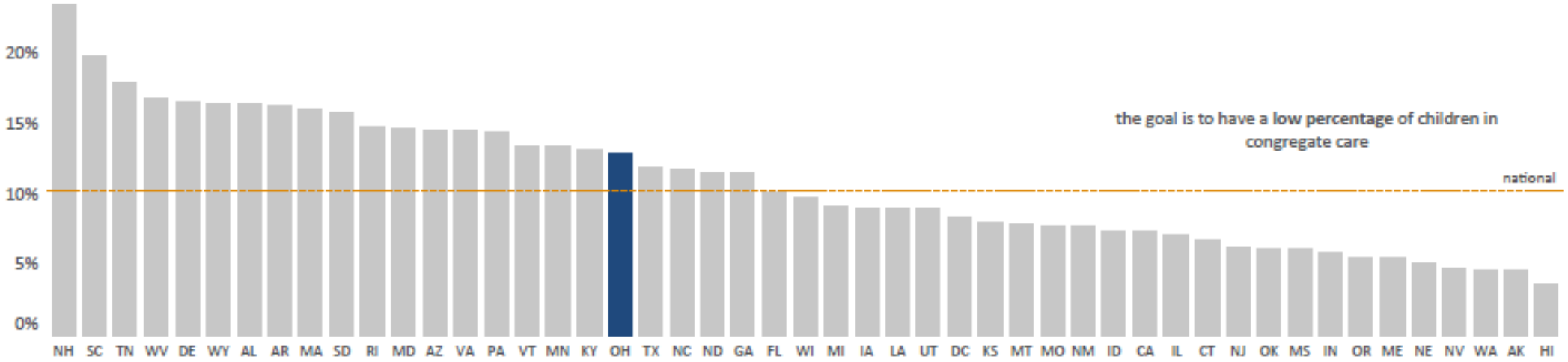


Sources: Profile of children in care: Ohio (Casey Family Programs, 2019)

Ohio Child Welfare Data

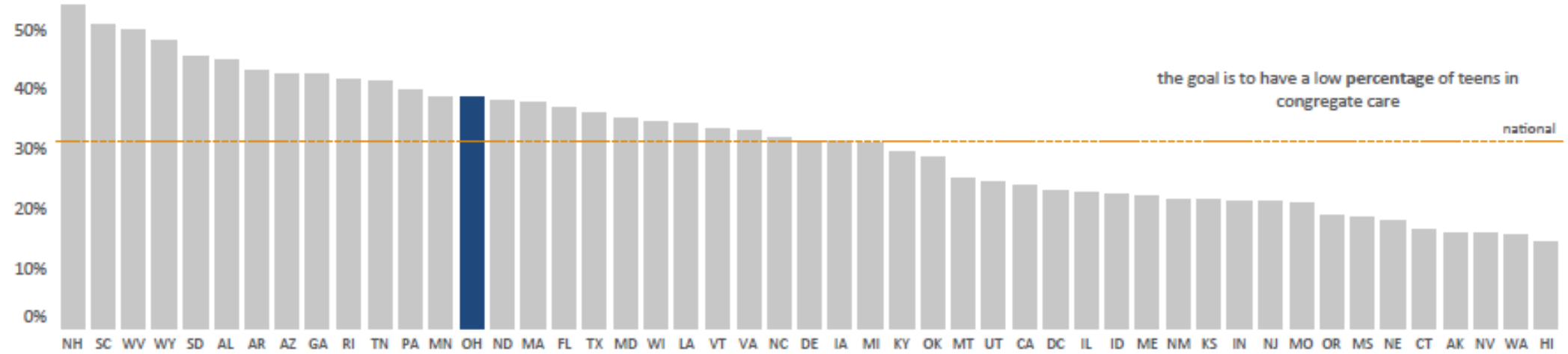
Percent of children in congregate care (all ages)

of all children in care on 3/31/2019, what percent were placed in a group home or residential treatment facility? (2019A)



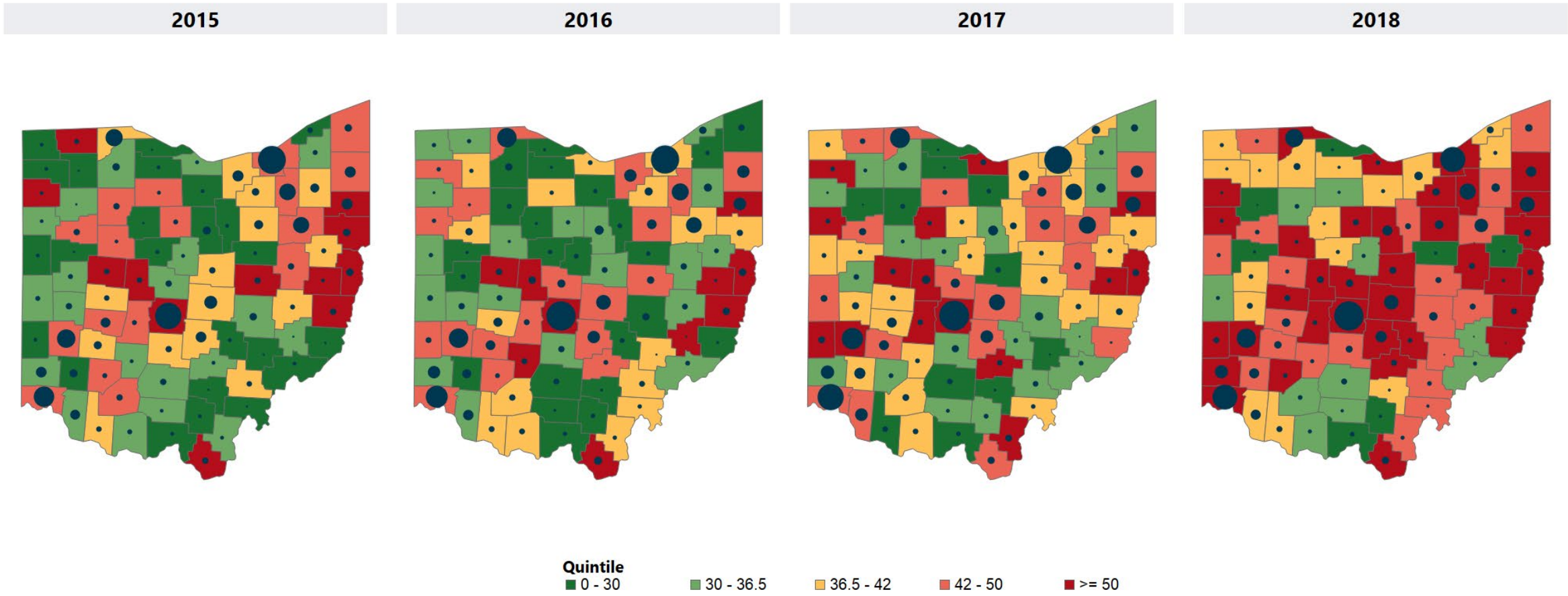
Percent of children in congregate care (teens ages 13-17)

of all teenagers in care on 3/31/2019, what percent were placed in a group home or residential treatment facility? (2019A)



Sources: Comparison of basic measures: Ohio (Casey Family Programs, 2019)

Foster Care/Adoption Assistance ED Visit Rate by County, SFYs 2015 - 2018



Ohio Kids in Custody in Out of State Treatment Facilities

Year Entered OOS Placement	Total Placements
2012	3
2013	0
2014	6
2015	99
2016	115
2017	161
2018	175
2019	Pending final analysis
Total	Well Over 700

From 2016-2018 (2019 data analysis not yet complete)

- Kids in custody from >35 counties were placed out of state for treatment
- Placed in 70 facilities in 17 states
- Average length of stay per placement = nearly 9 months
- Approximately 13% of the kids had *more than one* out of state treatment placement over the 3 year period

MSY State Level Program Statistics 10/8/19 - 2/10/20

- Grant Agreements complete or pending: 83 (of 88 total)
- Applications Received: 128
  - » Technical Assistance Only: 22
- Cases Funded: 69, total over $1,462,000
- Counties receiving funding to date (35):
  - Athens
  - Auglaize
  - Butler
  - Carroll
  - Champaign
  - Clermont
  - Crawford
  - Darke
  - Defiance
  - Delaware
  - Franklin
  - Gallia
  - Greene
  - Hancock
  - Jackson
  - Jefferson
  - Lake
  - Licking
  - Logan
  - Madison
  - Marion
  - Morgan
  - Noble
  - Ottawa
  - Perry
  - Richland
  - Scioto
  - Seneca
  - Stark
  - Summit
  - Tuscarawas
  - Union
  - Wayne
  - Wood
  - Wyandot

Medicaid Youth Family Risk Factors SFY 2018

Categories of Youth	Count	% of Overall Youth
Overall Youth (20 & under)	1,555,495	
# of Parents with Eligibility Relationship to Youth	914,960	58.8%
# of Siblings with Eligibility Relationship to Youth	1,227,078	78.9%
Youth with Parents/Caretakers taking MAT for OUD	111,673	7.2%
Youth with Parents/Caretakers with primary or secondary diagnoses for OUD or taking MAT for OUD	184,718	11.9%
Youth with Parents/Care Takers with SUD Primary DX Only	284,704	18.3%
Youth with Parents/Care Takers with SED Primary Diagnosis	268,661	17.3%
Youth with Siblings taking MAT for OUD	8,110	0.5%
Youth with Siblings with primary or secondary diagnosis for OUD or taking MAT for OUD	19,321	1.2%
Youth with Siblings with SUD	60,977	3.9%
Youth with Siblings with SED Primary Diagnosis	202,888	13.0%
Youth with Siblings with Cancer	1,459	0.1%
Youth with Families with History OUD, SUD and/or SED Primary Diagnosis	591,160	38.0%
Youth with Parents with History OUD or SUD	309,831	19.9%

Data Source: Medicaid claims primary diagnosis, QDSS Eligibility Relationship Table OHHS, May, 2019

What does Ohio's data tell us?

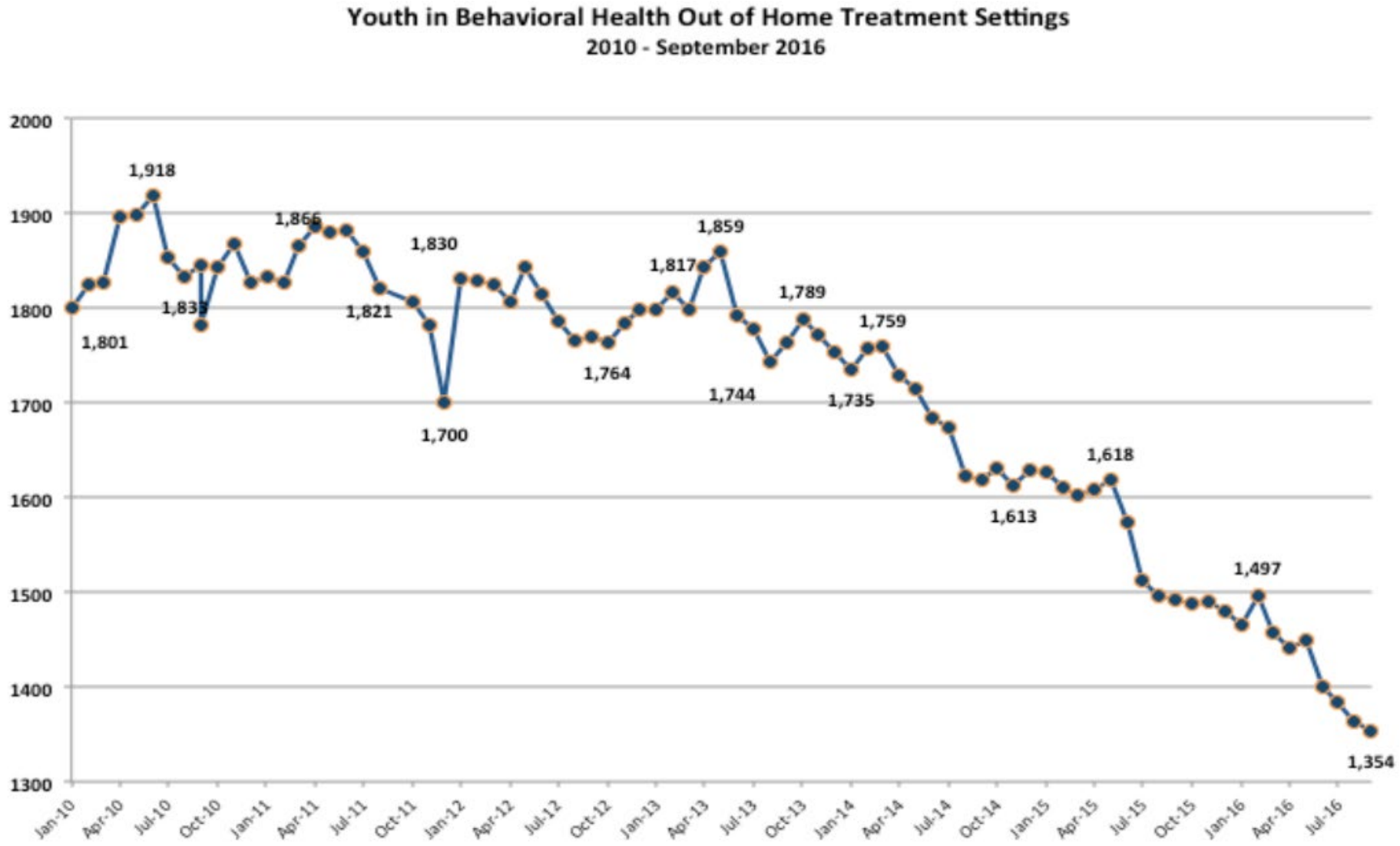
- Kids with multi-system factors (i.e. in foster care, having a DD, SUD, or SED diagnosis) use services differently and often seek emergency care.
- Foster care, out of state data indicate we need to build in-state capacity for kids with the most complex needs in facilities that can treat them.
- Foster care data tells us we have an over-reliance on congregate care - we need to build significant in-state / statewide capacity in homes and communities.
- Kids are products of their families – we need to consider more than direct treatment services for kids.

What does the evidence tell us?

1. **Kids with the most complex multi-system needs require a very different type of care coordination.**
   - Studies show that intensive community-based care coordination that is driven by kids and their families can have a significant impact on inpatient and ED us, moves between homes, etc.

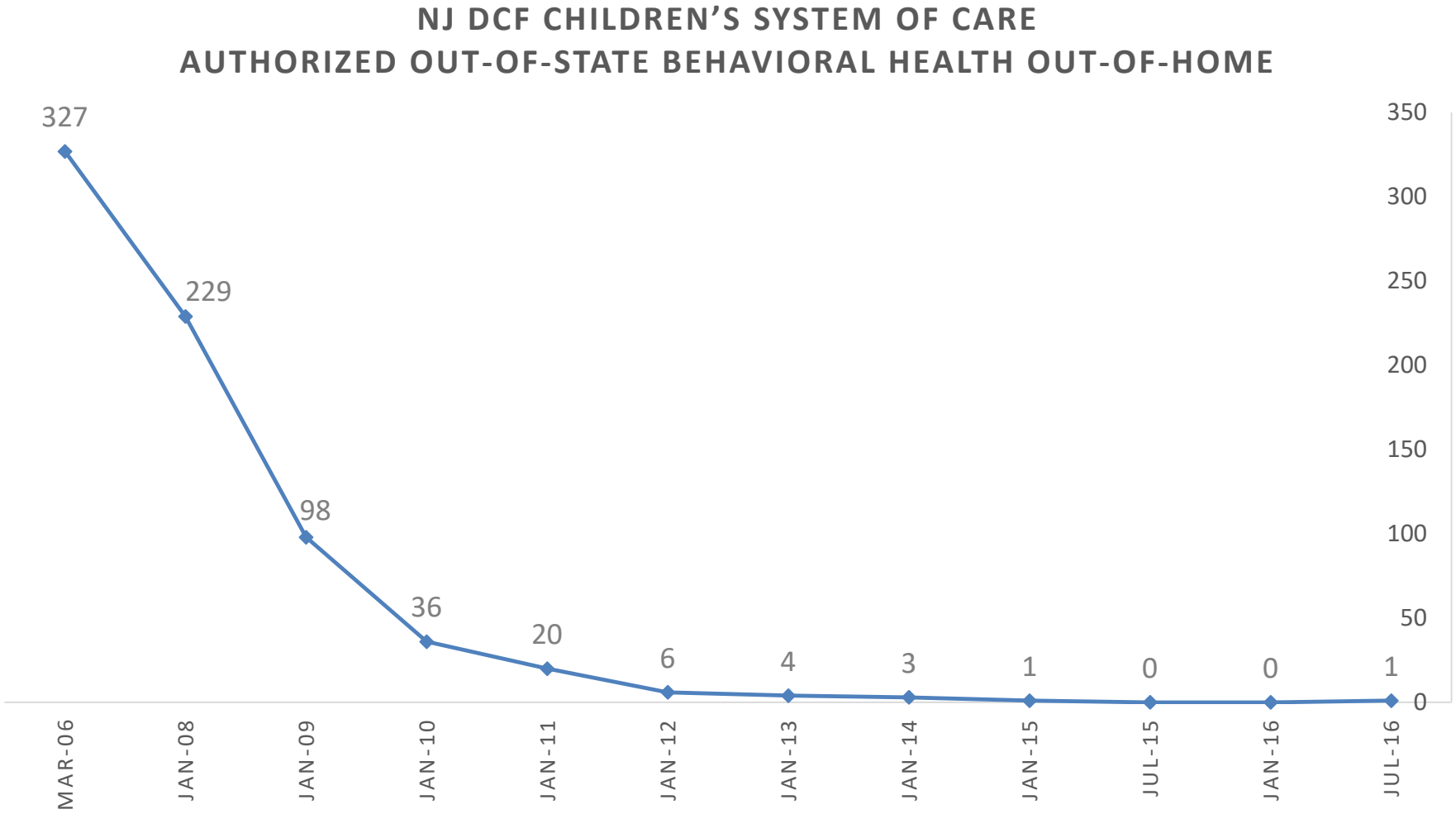
2. **Kids with the most complex multi-system needs require a different service array to stabilize them in their families.**
   - Mobile crisis response, intensive home-based treatments, therapeutic foster care, family and youth peer supports

New Jersey Out-of-Home Census



https://www.nj.gov/dcf/about/divisions/dcsc/CSOC_15.Year.Conference.Presentation.pdf

New Jersey's – Increasing In State Capacity & Community-Based Services



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Massachusetts Outcomes

Over three years:

- 32% reduction in inpatient hospitalization
- 30% reduction in days spent in hospital (prior to system of care reforms, inpatient psych hospitalization increasing)
- 11% decrease in per member per month expense for inpatient psych
- Significant decline in use of ER
- Increase in availability and use of community based intervention (from 0 to 42% use)

https://nwi.pdx.edu/pdf/ReturnonInvestmentinSOCsReport6-15-14.pdf

Wraparound Milwaukee Outcomes

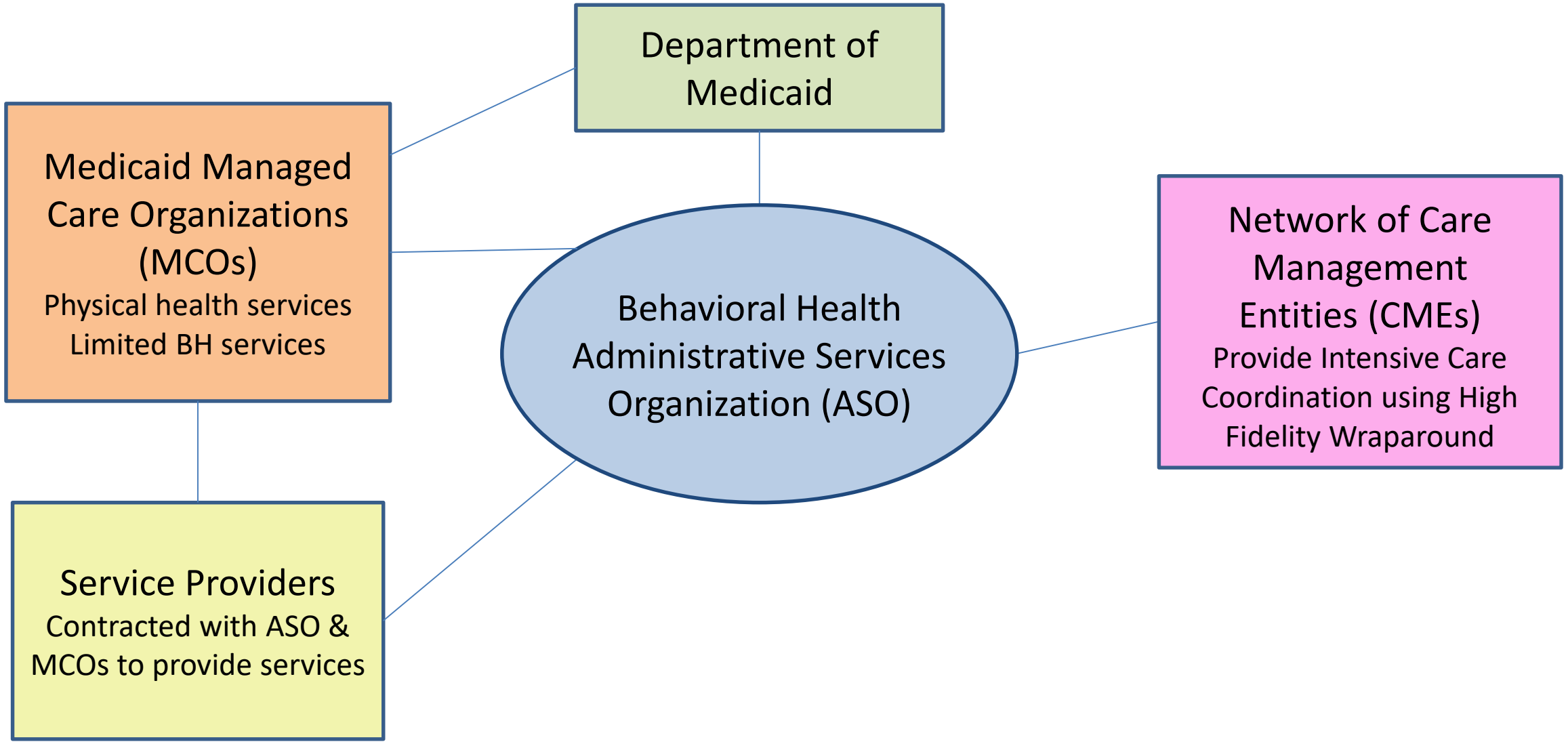
- Reduced average daily residential treatment facility population from 375 to 110
- 14.1% recidivism rate in Milwaukee vs. 41% rest of state
- Decreased average LOS in residential treatment from 14 to 4 months
- 40% increase in school attendance from time of enrollment to disenrollment
- Family results:
  - 91% of families/caregivers felt they and their child were treated with respect
  - 91% of families felt staff were sensitive to their cultural, ethnic and religious needs
  - 72% felt there was an adequate crisis/safety plan in place
  - 64% felt empowered to handle challenges situations in the future

http://clmhd.org/img/uploads/Wraparound%20Milwaulkee.pdf

ODM Approach

- **The State recognizes that there are gaps and some unevenness in the availability of services** needed by children, youth, and families supported by multiple state systems, and particularly for children with complex behavioral health needs.

- Through the managed care procurement, including phases of activities following contract implementation, **ODM, in cooperation with other state child serving agencies, plans to customize the structure and design of the Medicaid program to tailor services to meet the needs of children, particularly for children involved in multiple state systems** (e.g., juvenile justice, child protective services, intellectual/developmental disabilities) or other youth with complex behavioral health needs


Department of Medicaid
Medicaid Managed Care Organizations (MCOs)
Physical health services
Limited BH services
Behavioral Health Administrative Services Organization (ASO)
Network of Care Management Entities (CMEs)
Provide Intensive Care Coordination using High Fidelity Wraparound
Service Providers
Contracted with ASO & MCOs to provide services

MCOs

- Responsible for physical health services for all children
- Responsible for behavioral health services and care management for children with less intense behavioral health needs.

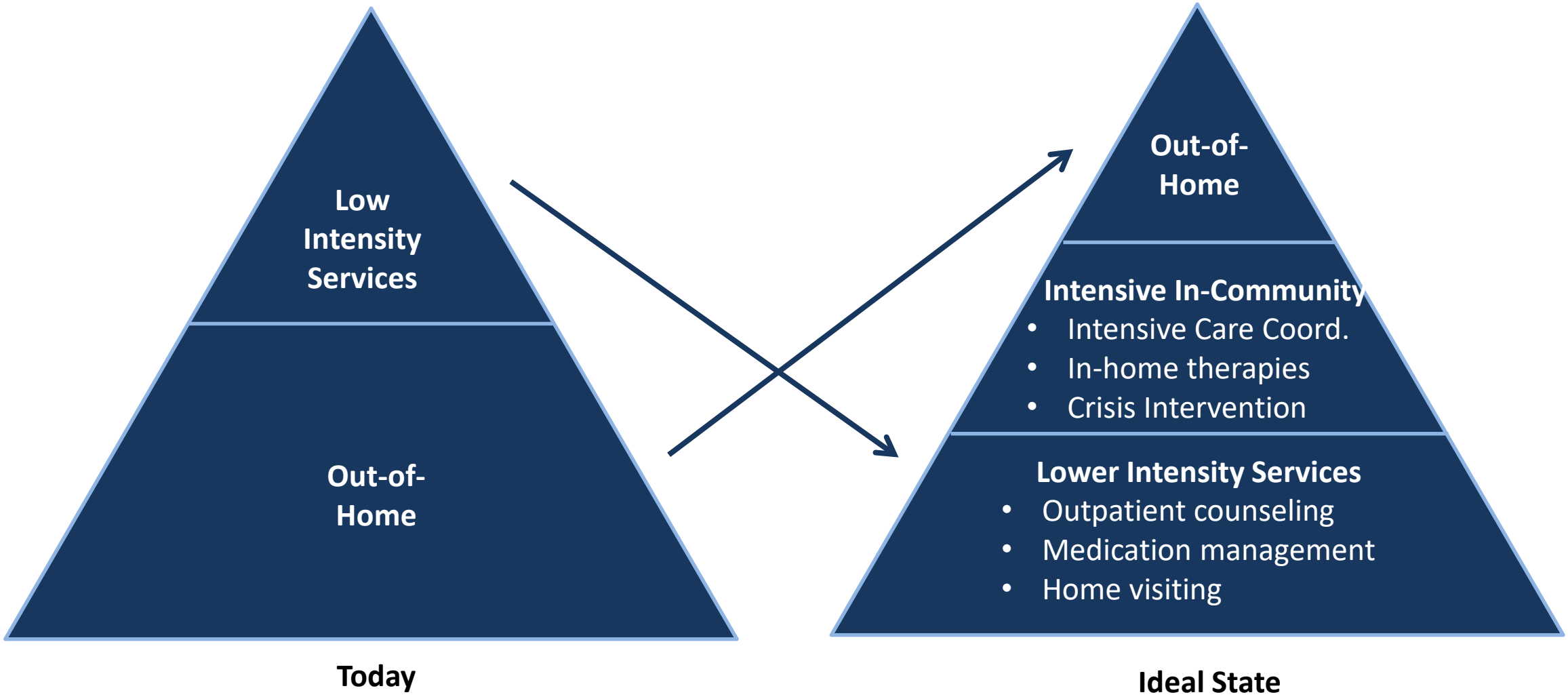
Statewide BH-ASO

- Responsible for children involved in multiple state systems or with other complex behavioral health needs.
- May not be the primary provider of care coordination; will contract for care coordination and other services with local service providers.
- Responsible for developing and managing a full continuum of behavioral health network providers, to include regional Care Management Entities, with the specific expertise necessary to effectively serve this population.
- Will develop the necessary data infrastructure to support providers and coordinate with the MCOs to ensure integration of physical health and behavioral health services

Network of Regionally Located Care Management Entities

- Serve as the “locus of accountability” for children with complex challenges and their families who are involved in navigating multiple state systems.
- Responsible for providing and/or coordinating the provision of intensive care coordination, community-based services, and other services and supports to improve health outcomes.

Must Build Significant Capacity to Shift the System



Based on: https://www.nj.gov/dcf/about/divisions/dcsc/CSOC_15.Year.Conference.Presentation.pdf

Care Coordination Approach

- Interested in developing an Intensive Care Coordination model using a High-Fidelity Wraparound approach - will develop a Medicaid reimbursable service that supports this approach.
  - » Build upon existing care coordination efforts that currently exists in various localities across Ohio.
- Considering:
  - » Two levels of care coordination.
  - » The need for a selective contracting model to ensure that only providers with the pre-requisite competencies can be reimbursed for Intensive Care Coordination.
  - » The relative benefits and drawbacks of establishing geographical boundaries for providers of Intensive Care Coordination, whereby these providers would be responsible for serving certain areas of the State

RFI #2 Questions

A. Which subsets of children and youth may benefit from the approach outlines above?
B. Which populations of children and youth should receive Intensive Care Coordination Using High Fidelity Wraparound? Please include suggestions for operationalizing eligibility for Intensive Care Coordination Using High Fidelity Wraparound.
C. What suggestions can you offer to build and expand network capacity to deliver Intensive Care Coordination Using High Fidelity Wraparound?
D. Which populations should not receive Intensive Care Coordination using High Fidelity Wraparound, but instead would benefit from a less-intensive type of care coordination? How should this level of care coordination differ from what children and youth receive today?

RFI #2 Questions

E. How might ODM and its state partners develop and use centers of excellence to assist the State in its system and practice transformation efforts? What other strategies have been effective in workforce development and practice transformation?

F. In this proposed model, wherein physical health services are managed by the MCO and intensive behavioral health services are managed by the BH-ASO, what can ODM do to ensure whole person, integrated care? Describe the roles, responsibilities and collaboration between involved entities to ensure care access and continuity for individuals.

G. In an ODM-contracted BH-ASO model, what contractual and operational structures should ODM consider to achieve ODM's goals?