Behavioral Health in Ohio: A New Paradigm

October 19th, 2016

Center for Evidence-Based Practices Annual Conference
Ohio Medicaid Behavioral Health Redesign Initiative

The Redesign Initiative is an integral component of Ohio’s comprehensive strategy to rebuild community behavioral health system capacity.

The Initiative is based on key Medicaid behavioral health reforms implemented in four steps:

- **Elevation**: Financing of Medicaid behavioral health services moved from county administrators to the state.

- **Expansion**: Ohio implemented Medicaid expansion to extend Medicaid coverage to more low-income Ohioans, including 400,000 residents with behavioral health needs.

- **Modernization**: ODM and OhioMHAS are charged with modernizing the behavioral health benefit package to align with national standards and expand services to those most in need.

- **Integration**: Post benefit modernization, the Medicaid behavioral health benefit will be fully integrated into Medicaid managed care.
Ohio Medicaid Behavioral Health Redesign Initiative -
Where We Are Today

- **Elevation** – *Completed* as of July 1, 2012.
- **Expansion** – *Completed* as of January 1, 2014.

**Modernization** – Underway, ODM and OhioMHAS are modernizing the community behavioral health benefit package to align with national standards and expand services to those most in need. *Implementation on target for July 1, 2017.*

**Integration** – Post benefit modernization, the community Medicaid behavioral health benefit will be fully integrated into Medicaid managed care. *Implementation on target for January 1, 2018.*
Why is Ohio Changing?

Current State
- Limited billing codes for all of behavioral health
- Lack of detail on specific services rendered and reimbursed for
- Outdated billing code structure
- Not compliant with national coding standards
- Rates not tied to provider type
- Little information regarding billing practitioner available
- Limited ability of practitioners to practice at the top of their scope of professional practice
- Historically Fee-for-Service
- Difficult to coordinate care
- Physical and behavioral health treated separately
- Difficult to transition to managed care

Vision and Outcomes
- All providers practice at the top of their scope of professional practice
- Integration of behavioral health & physical health services
- High intensity services available for those with SPMI and SED, and addiction
- Improved health outcomes for Ohioans with mental illness and/or addictions
- Services and supports available are sustainable with budgeted resources
- Implementation of value-based payment methodology
- Coordination of benefits across payers
State Agency Goals for BH Redesign

Ensure Sustainability
All changes and stakeholder engagement are intended to ensure changes to the Behavioral Health program are sustainable into the future.

Provide Training and Support
Numerous training and technical assistance opportunities have been provided to support the goal of sustainability.

Encourage Organizational Awareness
Organizations must also be attentive to changes and adjust business models where necessary.

Ensure Access
The state will collaborate with boards, providers, and other local entities to ensure ongoing access to services and continuity of care for individuals.

Ongoing activities related to BH Redesign will continue throughout 2017.
Behavioral Health Redesign Updated Timeline

The BH Redesign is composed of numerous initiatives with different implementation dates and milestones.

<table>
<thead>
<tr>
<th>Date</th>
<th>Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2016</td>
<td><strong>Specialized Recovery Services</strong>&lt;br&gt;• Peer Recovery Support&lt;br&gt;• Individual Placement and Support — Supported Employment&lt;br&gt;• Recovery Management</td>
</tr>
<tr>
<td>JANUARY 2017</td>
<td><strong>Opioid Treatment Programs</strong>&lt;br&gt;The following will be available for opioid treatment programs (OTPs) on January 1st, 2017:&lt;br&gt;• Daily and weekly administration of buprenorphine and methadone&lt;br&gt;• Naloxone – (Narcan) overdose rescue drug&lt;br&gt;• Injectable and oral naltrexone</td>
</tr>
<tr>
<td>JULY 2017</td>
<td><strong>Updated Benefit Package</strong>&lt;br&gt;• Office and home-based primary care services&lt;br&gt;• Full range of psychotherapy services&lt;br&gt;• Psychological testing and diagnostic assessment&lt;br&gt;• Mental health day treatment&lt;br&gt;• Restructuring SUD benefit package according to ASAM levels of care&lt;br&gt;• SUD residential treatment&lt;br&gt;Mental health rehabilitation services available:&lt;br&gt;• Assertive Community Treatment (for adults, includes peer support)&lt;br&gt;• Intensive Home Based Treatment— (for youth)&lt;br&gt;• Therapeutic behavioral services&lt;br&gt;• Psychosocial rehabilitation&lt;br&gt;<strong>Children Intensive Behavioral Services</strong>&lt;br&gt;• Updating codes for services for children with autism spectrum disorders&lt;br&gt;• Provided by Ohio-certified behavioral analysts and other qualified practitioners&lt;br&gt;<strong>Improvement of Program Performance</strong>&lt;br&gt;• Alignment of behavioral health with National Correct Coding standards.&lt;br&gt;• Alignment of CPT and HCPCS codes with AMA standards&lt;br&gt;• Ensure Medicaid is payer of last resort (maximize TPL and Medicare cost-avoidance).&lt;br&gt;• Require Medicare participation for providers serving Medicare enrollees.&lt;br&gt;<strong>IMD Services</strong>&lt;br&gt;• Inclusion of IMD services for Managed Care regulations</td>
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<tr>
<td>JANUARY 2018</td>
<td><strong>Managed Care</strong>&lt;br&gt;• Behavioral health services carved into Managed Care as of January 2018.&lt;br&gt;• 12 month continuation of behavioral health policies</td>
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2016 Continuous Training and Stakeholder Engagement
Updated Benefit Package

- ACT and IHBT: Added evidence-based/state-best practices and associated payments
- ASAM Levels of Care: Aligned SUD Benefit with ASAM levels of care
- Children’s BH Services: No diagnosis edits for children’s services provided by licensed practitioners
- EKGs: Monitoring of cardiac health for individuals receiving BH medications through use of EKG
- Psychotherapy Codes: Covered entire psychotherapy code set, including family psychotherapy.

- Expanded code set and practitioner list (e.g., physician-administered J-codes) to more accurately represent services and practitioners
- Inclusion of certain clinical laboratory tests and vaccinations
- Registered Nurse and Licensed Practical Nurse coding solution
- Compliance with national correct coding
- MH para-professionals with 3+ years of experience (on or before June 30th, 2017) will be able to provide Therapeutic Behavioral Services
- Added psychological testing codes
# Updated Benefit Package

**Expanded coverage to include buprenorphine-based medication dispensing and administration.**

**Introduced peer recovery support as a covered Medicaid service.**

**Added MH day treatment hourly and per diem codes and rates as replacements to MH partial hospitalization code and rate.**

**Added Screening, Brief Intervention and Referral to Treatment to the mental health benefit package as a best practice.**

**ASAM Outpatient Level of Care is available to everyone (not subject to prior authorization; limited only by total hours).**

**Per diem payments are available for SUD residential levels of care, including withdrawal management. Providers only need access to a psychiatrist.**

**SUD and MH payment rates are the same for common codes/activities (e.g., E&M, nursing, psychotherapy).**

**Implementing Specialized Recovery Services program for adults identified with a SPMI.**

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**Total investment into the BH System of $37.5M above budget neutrality**
ACT – Fidelity Measurement

1. Fidelity Measures to qualify for ACT billing methodology were built on recommendations and discussions from November 2015

For additional reference on DACTS:
Dartmouth ACT Fidelity Scale Protocol (1/16/03)

For additional reference on TMACT:
Tool for Measurement of Assertive Community Treatment (TMACT) Summary Scale Version 1.0

SAMHSA-approved ACT Fidelity Scale Toolkit
IHBT – Fidelity Measurement

1. Fidelity Measures to qualify for the IHBT billing methodology were built on premises similar to ACT

IHBT Fidelity Document
Specialized Recovery Services Program

- Individualized Placement and Support-Supported Employment (IPS-SE)
  - Available to all individuals enrolled in SRS program

- Recovery Management (RM)
  - Required for all individuals enrolled in SRS program

- Peer Recovery Support (PRS)
  - Available to all individuals enrolled in SRS program

SRS
Specialized Recovery Services Program

To be eligible for enrollment an individual must:

• Be at least 21 years of age
• Be determined financially eligible for Medicaid
• Receive Social Security Disability Benefits
• Be diagnosed with a severe and persistent mental illness as set forth in the attachment to rule 5160-43-02 of the OAC
• Score at least a 2 in one of the items in the “mental health needs” or “risk behaviors” section or score a 3 on at least one of the items in “life domains section” of the ANSA
• Demonstrate needs related to the management of the behavioral health condition
Specialized Recovery Services Program

To be eligible for enrollment an individual must:

• Have at least one of the following risk factors prior to enrollment:

  • One or more psychiatric inpatient admissions at an inpatient psychiatric hospital; or
  • A discharge from a correctional facility with a history of inpatient or outpatient behavioral health treatment while residing in that facility; or
  • Two or more emergency department visits with a psychiatric diagnosis; or
  • A history of treatment in an intensive outpatient rehab program for greater than ninety days. The ninety days does not need to be contiguous.
Specialized Recovery Services Program

To be eligible for enrollment an individual must:

• Reside in an HCBS setting
• Demonstrate a need for SRS, and not otherwise receive those services
• Have needs that can be safely met in a HCBS setting
• Participate in the development of a person-centered care plan
Specialized Recovery Services Program

To be eligible for enrollment an individual must:

• Meet at least one of the following:
  • Have a need for a SRS to maintain stability, improve functioning, prevent relapse, be maintained in the community and if not for the provision of the SRS the individual would decline to a prior level of need; or
  • Previously have met the eligibility criteria and but for the provision of the SRS, would decline to a prior level of need
Rate Development

**Rate Example**

Specific procedure codes may not be reimbursed above Medicare according to State law (ORC 5164.70) and in accordance with federal policies, which impacts the rates we are able to pay for nursing services.

- Can only pay 85% of the physician rate for services delivered by advanced practice nurses

Due to Medicare’s limited coverage for RN and LPN services, Medicaid chose additional procedure codes that are not covered under Medicare and have a Medicaid specific rate

This may require agencies to modify their current business models
Changes in Behavioral Health Care Models

• The field of BH has moved forward and Ohio wants to reflect progressive changes in recovery and resiliency through the services purchased, including Evidence-Based Practices like ACT.
• The opioid epidemic requires a strong and immediate response like the use of the nationally developed version of ASAM and the inclusion of more medical personnel in staffing

Purchasing based on Goals

• In all businesses, what is purchased should reflect changes in the field.
• The State wants to purchase the best services possible, and the providers need to be nimble enough to make changes to match what we want to buy

Forecasting Revenue under the Restructured Rates

• The providers, who will financially succeed, will be the providers who can provide the types of services the State will purchase in the future
State Commitment

The State wants to change how it purchases Mental Health and Substance Use Disorder services to align with the redesign vision.

Commitment of funds

- The State has committed to invest over $37 million into the system to ensure continued access from our budget neutral point in time.
- The State is also cognizant of the current workforce and wants to support the development of an effective workforce that reflects the types of services demonstrated to achieve changes for individuals in recovery.

Commitment of revisiting after implementation

- Even more, the State is committed to reviewing the overall system impact after implementation to ensure that the new rate structure begins to pay for services based on the State’s desired outcomes.
- ODM/MHAS anticipates that providers will need to make business changes to manage under the new system.
Approach to Budget Modeling

1. Based on aggregate-level State-wide modeling
2. Reflects new services, fees and policies
3. Based on informed assumptions
4. Iterative changes made based on stakeholder feedback
Budget Model Process

**Assumptions**
- Provider survey
- Feedback from stakeholders
- State purchasing decisions
- Clinical judgment about service changes

**New Rate Structure**
- Not one-to-one correspondence with former structure
- Estimates were made

**Utilization mapping plus added spend**
- All MH and SUD SFY 2014 service utilization was mapped
- Additional “below the line adjustments” for ACT and urine drug screening; separate utilization mapping process for SUD residential
Budget Model Assumptions

The Budget Model is an Educated Estimate

- Overall estimate of the rate restructuring on the State budget and different sectors of the provider community.
- Does not reflect any one provider’s expected budget.
- Forecasting the expected aggregate results at the system level.

Assumptions will not match each individual Provider’s experience

- Iterative process with initial assumptions informed more heavily by survey results from 77 providers; subsequent changes as a result of stakeholder input.
- The model will overstate or understate revenues for a particular provider.
- The model will not reflect any individual provider’s revenues.
- Different providers have given opposite feedback on the same services (e.g., 99215)
BH Redesign Feedback & Training Timeline

Stakeholders were given numerous opportunities to provide feedback as well as many training opportunities to understand the changes coming to Ohio’s BH system.

<table>
<thead>
<tr>
<th>Stakeholder Meetings</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
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<tbody>
<tr>
<td>Manuals &amp; Coding Chart</td>
<td></td>
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<tr>
<td>Initial Code Chart Shared</td>
<td>Revised Version Shared</td>
<td>Revised Version Shared</td>
<td>2/12</td>
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<tr>
<td>Trainings</td>
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<tr>
<td>CPT code training</td>
<td>BH 101 Trainings</td>
<td>BH Regional Trainings</td>
<td>CPT code trainings</td>
</tr>
<tr>
<td>4/14</td>
<td>7 sessions in April &amp; May</td>
<td>10 sessions in July &amp; August</td>
<td>3 sessions in August &amp; September</td>
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## Stakeholder Engagement

The Ohio Department of Medicaid and Department of Mental Health and Addiction Services has consistently and continually engaged stakeholders throughout the BH redesign process.

<table>
<thead>
<tr>
<th>Addiction Roundtable Co-Chair</th>
<th>Clark County Department of Job and Family Services</th>
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<tbody>
<tr>
<td>Aetna</td>
<td>Coalition of Homelessness and Housing in Ohio</td>
</tr>
<tr>
<td>Alcohol Drug and Mental Health (ADAMH) Board</td>
<td>Common Ground Family Services</td>
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<tr>
<td>BASIC</td>
<td>Connections Cleveland</td>
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<td>Beech Brook</td>
<td>Consumer Support Services</td>
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<td>Buckeye Health Plan</td>
<td>CSAO</td>
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<td>Buckeye Ranch</td>
<td>CSH</td>
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<tr>
<td>Care Source</td>
<td>Franklin County Children Services</td>
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<tr>
<td>Care Star</td>
<td>Greater Cincinnati Behavioral Health Services</td>
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<tr>
<td>Case Western Reserve University Center for Evidence Based Practices</td>
<td>Hamilton County Job &amp; Family Services</td>
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<tr>
<td>Catholic Charities Dioceses of Cleveland</td>
<td>Harbor</td>
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<tr>
<td>Cenpatico Behavioral Health</td>
<td>Homes for Kids</td>
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<tr>
<td>Children’s Advantage Family Behavioral Health Services</td>
<td>Joint Medicaid Oversight Committee</td>
</tr>
<tr>
<td>Children’s Home of Cincinnati</td>
<td>Knox County Department of Job and Family Services</td>
</tr>
<tr>
<td>Cincinnati Children's Hospital Medical Center</td>
<td>Lake County Alcohol, Drug Addiction and Mental Health Services Board</td>
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Stakeholder Engagement

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| Magnolia Club House                          | Ohio Association of Child Caring Agencies |
| Mental Health & Recovery Board of Clark, Greene and Madison Counties | Ohio Association of County Behavioral Health Authorities |
| Mental Health and Addiction Advocacy Coalition | Ohio Association of Health Plans |
| Molina Healthcare                           | Ohio Children’s Hospital Association |
| Montgomery County Department of Job and Family Services | Ohio Citizen’s Advocates |
| Morrow County Public Children Services Agency | Ohio Community Corrections Association |
| Murtis Taylor                               | Ohio Council of Behavioral Health & Family Services Providers |
| NAMI Ohio                                   | Ohio Department of Developmental Disabilities |
| National Association of Social Workers      | Ohio Department of Job and Family Services |
| Nationwide Children's Hospital              | Ohio Empowerment Coalition |
| NCH                                         | Ohio Family and Children First |
| Northern Ohio Recovery Association          | OhioGuidestone |
| Ohio Judicial Conference                    | Ohio Hospital Association |
| Ohio Alliance of Recovery Providers         | Ohio Hospital for Psychiatry |
## Stakeholder Engagement

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<thead>
<tr>
<th>Ohio Psychiatric Physicians Association</th>
<th>South Community Inc.</th>
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<tr>
<td>Vorys Health Care Advisors</td>
<td>Stark County Child &amp; Adolescent Behavioral Health</td>
</tr>
<tr>
<td>Wingspan</td>
<td>Stark County Mental Health and Recovery Services Board</td>
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<tr>
<td>Youth Advocate Services (YAS)</td>
<td>Summa Health</td>
</tr>
<tr>
<td>Zepf Center</td>
<td>Summit County ADM Board</td>
</tr>
<tr>
<td>Ohio Psychological Association</td>
<td>Summit County Children Services</td>
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<tr>
<td>Ohio State University Wexner Medical Center (OSUMC)</td>
<td>Talbert House</td>
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<tr>
<td>Ohio University</td>
<td>The Batchelder Company</td>
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<tr>
<td>Paramount Health Plans</td>
<td>The Ohio Council of Behavioral Health and Family Services Providers</td>
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<tr>
<td>Positive Leaps</td>
<td>The Peer Center</td>
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<tr>
<td>ProMedica Health Systems</td>
<td>Trumbull County Children Services</td>
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<tr>
<td>Public Children Services Association of Ohio (PCSAO)</td>
<td>UMCH Family Services</td>
</tr>
<tr>
<td>Public Health – Dayton &amp; Montgomery County</td>
<td>United Healthcare</td>
</tr>
<tr>
<td>Quest Recovery and Prevention Services</td>
<td>Rainbow Babies Hospital</td>
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<tr>
<td>Quest Smith House</td>
<td>Signature Health, Inc.</td>
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</table>
The Ohio Department of Medicaid and Department of Mental Health and Addiction Services has consistently and continually engaged stakeholders throughout the BH redesign process.

Ohio has engaged 91 provider agencies and advocacy groups and 51 county boards.

The Ohio Departments of Medicaid and Mental Health and Addiction Services have partnered with the following consulting firms as part of BH Redesign:

Deloitte, Mercer, and Milliman
Stakeholder Communication Approach

Communication Tools Utilized

A centralized behavioral health redesign website acts as a single, two-way communication resource.

Newsletters are frequently sent to stakeholders. Newsletters cover general policy and detailed technical information.

Whitepapers were published on the website explaining Ohio’s behavioral health redesign background and future changes.

Detailed billing-related resources and manuals are posted on the website.

Stakeholders are able to submit questions and concerns via the website.

All trainings are posted on the website as reference for providers and stakeholders who are unable to participate.

Videos were developed and posted on the website to actively and visually engage stakeholders.
Additional Topics: Next Steps

Mobile Crisis and BH Urgent Care Work Group will reconvene in the fall of 2016

Work Group will reconvene in the fall of 2016

High Fidelity Wraparound

Design and implement new health care delivery payment systems to reward the value of services, not volume.
Develop approach for introducing episode based payment for BH services.
  - Focusing on ADHD and ODD

Payment Innovation

Managed Care Transition

Working with stakeholders to prepare for January 2018
Next Steps

Policy and Regulatory

• Seek State Plan Amendment approvals from CMS
• Begin the Ohio Rules process

Stakeholder Meetings, Trainings, and Ongoing Communications

• Upcoming stakeholder meetings: October 6th and November 30th
• BH 201 Trainings: Eight sessions throughout October and November
• Ongoing communication with stakeholders

Provider Manuals

• Finalize the January 1 Provider Manual
• Continue to refine the July 2017 Provider Manual
Behavioral Health Redesign Website

Go To: bh.medicaid.ohio.gov

Sign up online for the BH Redesign Newsletter.

Go to the following OhioMHAS webpage: http://mha.ohio.gov/Default.aspx?tabid=154 and use the “BH Providers Sign Up” in the bottom right corner to subscribe to the BH Providers listserv.
Behavioral Health Redesign Website

Go To: bh.medicaid.ohio.gov

Click on the PROVIDERS tab.

Scroll through this webpage to find updated materials for BH providers. Materials include such topics as trainings, manuals, the Rate Chart, MITS Bits uploads, and new program information.

For Providers

The codes used by behavioral health providers to bill the Medicaid program are antiquated and in need of updating.

Taking action to modernize the coding system is essential to integration of behavioral and physical health care.

In addition, coverage might be changing for the individuals you serve.

Here, you can learn how to help them understand those changes, and find details on policy and rate changes.

Innovative efforts reward better quality in health care for all Ohioans
Questions?