



Governor's Office of
Health Transformation

Overview of Ohio's Redesign of Community Behavioral Health Medicaid Program

***OACBHA Sponsored Community Forums
5/5, 5/6, 5/10, 5/11, 5/17
2016***



Behavioral Health Redesign

Behavioral Health Redesign Website Live!



Go To:
bh.medicaid.ohio.gov

Sign up online for the
BH Redesign Newsletter.

The screenshot shows the homepage of the Behavioral Health Redesign website. At the top, there is a navigation bar with the Ohio Department of Medicaid logo, the title "Behavioral Health Redesign", and a search bar. The main navigation menu includes links for HOME, ABOUT, INDIVIDUALS, PROVIDERS, NEWSLETTERS, and CONTACT US. Below the navigation is a large hero image of two men in a clinical setting. To the right of the image is a dark grey box with the text "Helping Your Patients" and "Modernizing business practices to improve patient outcomes." Below the hero image is a section titled "What is Ohio's Behavioral Health Redesign?" which contains a paragraph describing the initiative and a date "Changes begin July 1, 2016." Below this text are three white boxes with blue borders, each containing a category name and a "learn more" link: "About", "Individuals", and "Providers". At the bottom of the page, there are three columns of information: "Newsletter Sign-up", "Partners", and "Contact Us:". The footer contains the Ohio Department of Medicaid logo, the Ohio Mental Health and Addiction Services logo, and the Governor's Office of Health Transformation logo, along with copyright and legal information.

Agenda

Ohio's Priorities for Behavioral Health Redesign

Rebuilding Community Behavioral Health Capacity

Evidence Based Practices Update

Substance Use Disorder Benefit

Pharmacological Management and Medical/Somatic Transition to Medical Services

Coordination of Benefits

DRAFT Budget Models

Code and Rate Chart

Managed Care

LUNCH BREAK

Specialized Recovery Services (SRS) program (1915(i)) for SPMI Adults

SRS program and MyCare/Managed Care Intersection Overview



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Ohio's Priorities for Behavioral Health Redesign



Behavioral Health Redesign

Behavioral Health Redesign Vision

OUTCOMES & VISION:

- » All Providers: Follow NCCI & practice at the top of their scope of practice
- » Integration of Behavioral Health & Physical Health services
- » High intensity services available for those most in need
- » Developing new services for individuals with high intensity service and support needs;
- » Services & supports available for all Ohioans with needs: Services are sustainable within budgeted resources
- » Implementation of value-based payment methodology
- » Coordination of benefits across payers
- » Improving health outcomes through better care coordination; and
- » Recoding of all Medicaid behavioral health services to achieve alignment with national coding standards.

Ohio's Priorities for Behavioral Health (BH) Redesign

1915(i) PROGRAM FOR ADULTS WITH SPMI

- **Ensure continued access to care for ~4-6K adults with SPMI** who meet *financial and clinical / needs criteria and who are at risk of potential loss of eligibility for Medicaid
 - **Cover new services** such as Recovery Management, IPS Supported Employment and Peer Recovery Support
-

REBUILDING COMMUNITY BH SYSTEM CAPACITY

- **Recode Medicaid BH services to achieve alignment with national coding standards** (AMA, HCPCS, Medicare, NCCI/MUE)
 - **Redesigning certain existing services** (Community Psychiatric Supportive Treatment, Case Management and Health Home services) and **provide for lower acuity service coordination** and support services
 - **Develop new services for people with high intensity needs under the Medicaid Rehabilitation Option:** Assertive Community Treatment, Intensive Home Based Treatment, residential treatment for substance abuse
 - **Services are sustainable** within budgeted resources
-

MANAGED BEHAVIORAL HEALTH CARE

- **Addition of BH services to Managed Care Plan contract**, with specific requirements for MCPs to delegate components of care coordination to qualified Community Behavioral Health providers
-

PAYMENT INNOVATION

- **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

*300% of SSI, includes \$20 personal needs disregard (\$2,219 in CY 2015); Clinical includes diagnostic (diagnostic (schizophrenia, bipolar or major depressive affective disorders-severe) and score on Adult Needs and Strengths Assessment) tool

Ohio

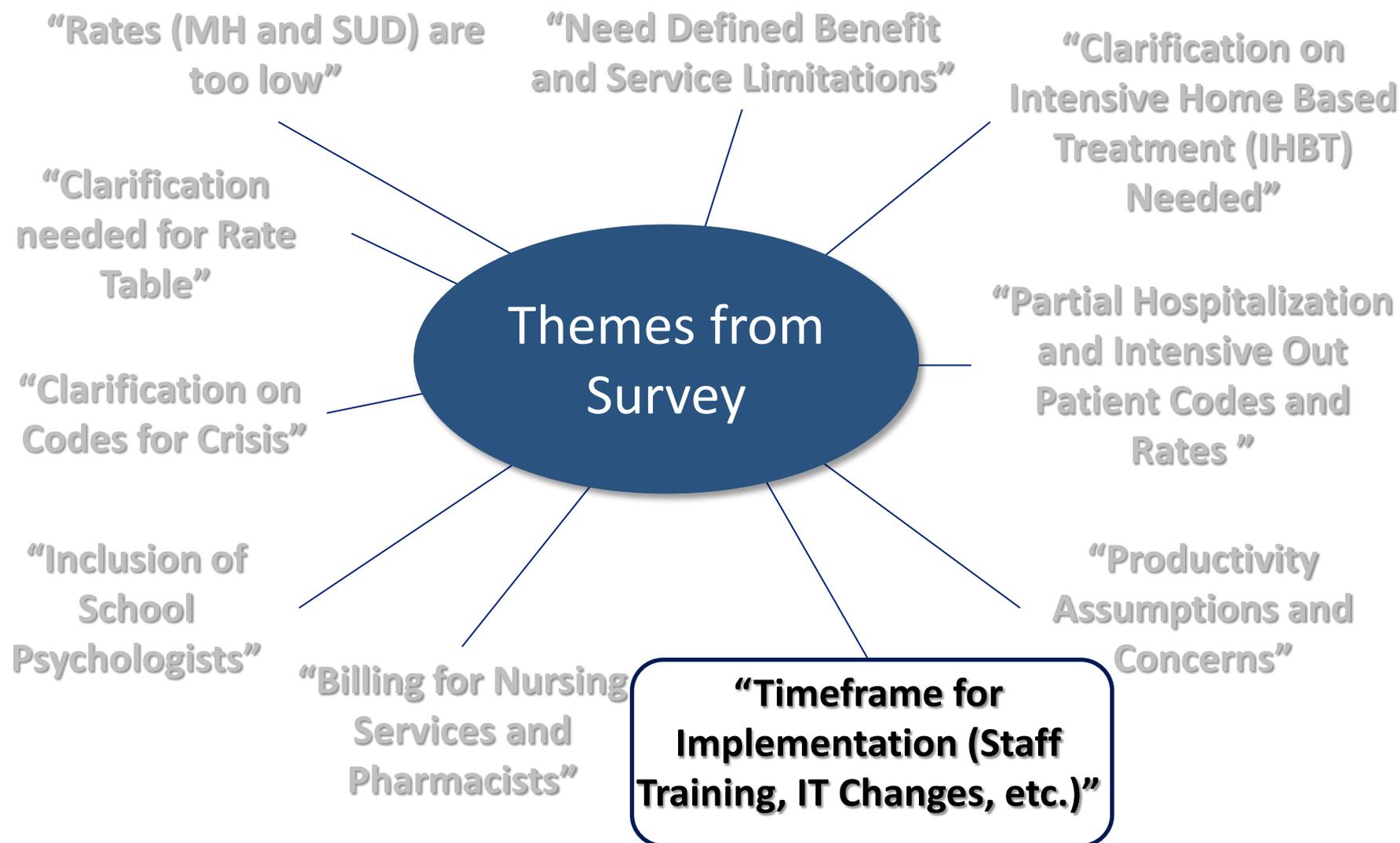
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Rebuilding Community Behavioral Health Capacity



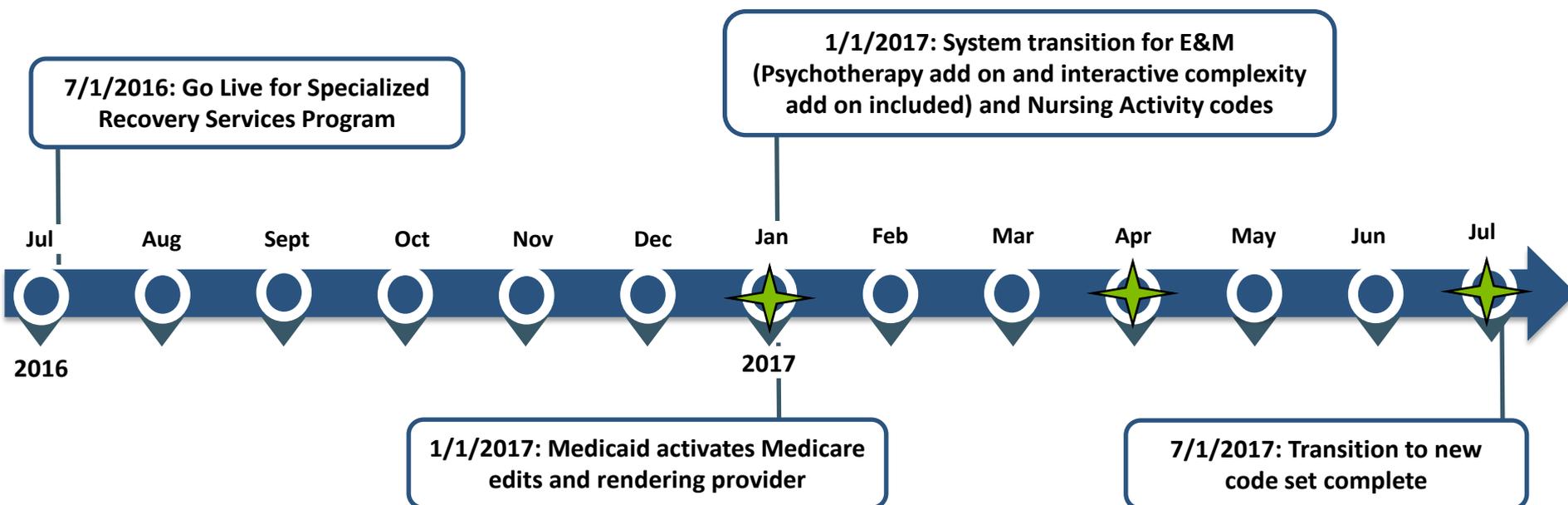
Behavioral Health Redesign

Key Themes from Stakeholder Survey December 2015



Question: Please provide additional feedback on the rates, codes or budget models presented during the February 10th Core Team and Benefit and Service Development Work Group meeting.

Revised Transition Schedule

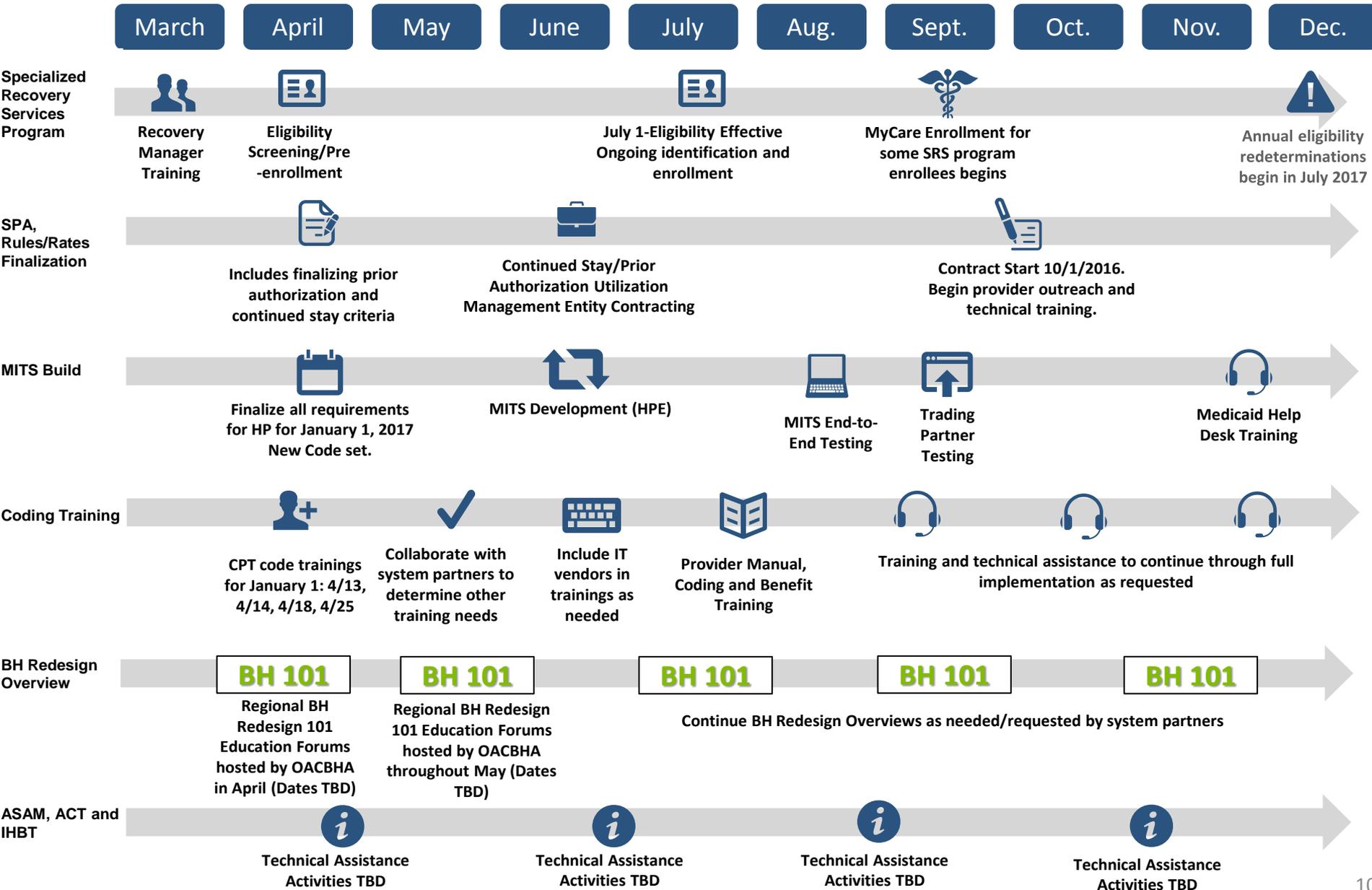


Key Dates

1. Specialized Recovery Services Program implementation remains 7/1/2016
2. Rendering provider requirement starts 1/1/2017 (Publicized to stakeholders in October 2016 – will not pay claims without rendering provider starting 1/1/2017)
 - a. LICDC can enroll as a provider at this point
3. Voluntary transition schedule selections: 1/1/2017 and 4/1/2017
4. Full code set transition remains 7/1/2017

Transition points

2016





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Rebuilding Community Behavioral Health Capacity

Targeted Topics/Workgroups



Behavioral Health Redesign

Behavioral Health Redesign Project Scope

The below table lists the key topics that are within scope for overall BH Redesign moving forward

Behavioral Health Redesign Scope

Solutions Identified

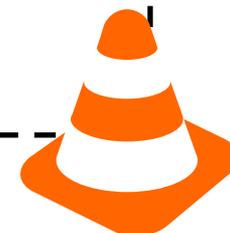
- ✓ ASAM Levels of Care
- ✓ Genetic Testing (E&M Services)
- ✓ Psychological Testing
- ✓ SBIRT
- ✓ School Psychologists
- ✓ Crisis
- ✓ Opioid Treatment Programs
- ✓ Partial Hospitalization, Day Treatment and Intensive Outpatient
- ✓ Peer Recovery Support
- ✓ SUD Group Counseling
- ✓ SUD Residential

Solutions Under Development

- Pharmacists
- Early Childhood, Early Intervention
- MCP and Provider Interaction
- High Fidelity Wraparound for Kids
- Labs, Vaccines and Provider Administered Medications
- Benefit Packages, Prior Authorization and Continued Stay Criteria
- Care Coordination
- CPT Rate Adjustments
- ACT and IHBT
- Benefit Packages, Prior Authorization and Continued Stay Criteria



Additional information on topics in green are located in the appendix





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Targeted Topics/Workgroups:

Therapeutic Behavioral Services



Behavioral Health Redesign

Therapeutic Behavioral Services Small Group Debrief

Bill: CPT Codes

Physicians (Or
equivalent)



CPT Codes Would Include the Following Types of Services:

- ✓ Assessments
- ✓ Psychological Testing
- ✓ Individual/Group/ Family Therapy
- ✓ Crisis



Gap Identified for Licensed Practitioners:

- ✓ Behavioral Health Intervention / Skills Development (when not considered Psychotherapy by practitioner)

Licensed
Practitioners



Bill: HCPCS Codes – Unlicensed Practitioners

Unlicensed
TBS (H2019)

MAs⁺¹
BAs⁺²



HCPCS Code Would Include the Following Types of Services:

- ✓ Development of Treatment plan
- ✓ Service Planning
- ✓ Care coordination
- ✓ Collateral contacts
- ✓ Identify triggers/Interventions
- ✓ Individual/Group/Family Therapy
- ✓ EBPs



Key Consideration for Unlicensed Practitioners:

- ✓ Collateral contacts are allowed and billable under TBS (H2019)

Unlicensed
PSR (H2017)

QMHS – HS
Masters or Bach. No
experience



HCPCS Code Would Include the Following Types of Services:

- ✓ Implement the plan established
- ✓ EBPs

Providers cannot bill Medicaid for phone call time, as time spent on phone calls is built into rate as indirect cost



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Rebuilding Community Behavioral Health Capacity

Targeted Topics/Workgroups:

Children's Mental Health



Behavioral Health Redesign

Children's Mental Health Topics

- ✓ Respite
- ✓ Psychological Testing
- ✓ Early Intervention
- ✓ Day Treatment
- ✓ Evidence Based Practices
- ✓ High Fidelity Wraparound
- ✓ Crisis Intervention
- ✓ Partial Hospitalization

Children's MH Update

The state is continuing to work through the following items in regards to key Children's BH services



- *Identifying Timeline*
- *Identifying Options for Federal Authorities*
- *Managed Care Implementation*

High Fidelity Wraparound



Respite

- *Exploring options for expanding eligibility and types of respite in (b)(3) waiver by January 2017*
- *Continuing to work through alternative options in the future*



Early Intervention

- *Exploring the use of expanded qualifying diagnoses for 0-6*
- *EPSDT compliance*



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Targeted Topics/Workgroups:

***Psychological Testing
and School Psychologists***



Behavioral Health Redesign

Psychological Testing

The following codes were added to the rate chart and are currently covered under Medicaid, today (will continue post January 2017):

96101

96111

96116

96118

Additional Rate and Limitation Guidance

Code	Description	Limitation	Rate
96101	Psychological testing with interpretation and report, per hour.	8 hours/year, any combination of the four psychological testing codes	\$59.26
96111	Developmental testing; extended with interpretation and report		\$56.11
96116	Neurobehavioral status exam per hour of the psychologist's or physician's time, both face-to-face time with the patient and time interpreting test results and preparing the report		\$64.10
96118	Neuropsychological testing battery with interpretation and report, per hour		\$78.31

School Psychologists

	ODE Certification	Psychology Board Licensure
 <p>Education</p>	<p>Must have a Master's Degree in School Psychology</p>	<p>Must meet the following criteria: 4 years of experience as a school psychologist (which can include master's program internship year), Pass the PRAXIS exam and Pass the Ohio Board of Psychology Oral Exam</p>
 <p>Scope/Location</p>	<p>Limited to school psychology within the scope of employment by a board of education or by a private school meeting the standards under division (D) of section 3301.07 of the Revised Code, or while acting as a school psychologist in a program for children with disabilities established under ORC Chapter 3323 or 5126.</p>	<p>Can practice school psychology independently under ORC 4732.01 (E)</p> <ul style="list-style-type: none"> Examples: Private practice, independently in a CMHC, hospital, etc.
 <p>Psychologist and CBHC Interaction</p>	<p>ADDITIONALLY – School Psychologists may work as a School Psychology Assistant, Trainee, or Intern when working in the community under the supervision of a Board Licensed School Psychologist or Psychologist. Psychologist must be registered with the Psychology Board.</p>	<p>Board Licensed Independent School Psychologist</p>



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Targeted Topics/Workgroups:

Crisis Services



Behavioral Health Redesign

UPDATED: Additional Guidance on Crisis

Licensed Practitioner Providing Crisis Services

Licensed practitioners may provide crisis care regardless of:

- Whether or not the individual is on their case load;
- or whether or not the individual is a current patient with the agency (i.e., not requiring a recommendation of care).
- If a licensed practitioner is providing the intervention, 90839 is billed. +90840 can be billed for each additional 30 minutes.

Unlicensed Practitioner Providing Crisis Services

For unlicensed practitioners, crisis may only be billed to Medicaid if the recipient of the intervention is known to the system, currently carried on the unlicensed practitioner's caseload and a licensed practitioner has recommended care.

If an unlicensed practitioner is providing the service to someone on their caseload, the practitioner will bill:

- MH Crisis - IITS (H2019) or PSR (H2017)
- SUD Crisis - Individual counseling (H0004) or individual counseling IOP level of care (H0015)

The state is working through assuring this is the standard model of crisis care for behavioral health



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Rebuilding Community Behavioral Health Capacity

Targeted Topics/Workgroups:

Evidence Based Practices for MH



Behavioral Health Redesign

Mental Health MROs Reference Matrix

See the ACT and IHBT Fidelity Measurements on slide 25 and 27 for additional information



	General State Plan Services		State Designated Best Practice	National Evidence Based Practices (EBP)
	Intensive Individual Treatment Services (IITS)	Psychosocial Rehabilitation (PSR)	Intensive Home Based Treatment (IHBT)	Assertive Community Treatment (ACT)/TMACT
Definition	A goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual's individualized treatment plan. IITS contacts may occur in community or residential locations where the person lives, works, attends school, and/or socializes.	PSR assists individuals with implementing interventions outlined on a treatment plan to compensate for or eliminate functional deficits and interpersonal and/or environmental barriers associated with an individual's diagnosis. PSR is an individual face-to-face intervention with the individual and includes restoration, rehabilitation and support of daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living. Additional PSR is used to assist with restoration and implementation of daily living skills and daily routines critical to remaining successfully in home, school, work, and community	IHBT is a mental health service designed to meet the needs of youth with serious emotional disturbances who are at risk of out-of-home placement or who are returning home from placement. The goal of IHBT is to provide the necessary mental health services and supports to enable youth to live in their homes in the least restrictive, most normative setting possible. IHBT services are provided in the home, school, and community where youth live and function. These services focus on the mental health issues that put the youth at risk, while promoting positive development and health family functioning.	A treatment approach that improves outcomes for people with severe mental illness who are most at-risk of homelessness, psychiatric hospitalization, and institutional recidivism. A multidisciplinary team approach for people with severe mental illness who are most at-risk of homelessness, psychiatric hospitalization and institutional recidivism using assertive outreach in the community.

Multi-Systemic Therapy and Functional Family Therapy have been removed from the matrix because IHBT and ACT are the EBPs that will be implemented Jan 1, 2017.

ACT – Fidelity Measurements

Please see the printout (Fidelity Rating Tool for ACT) for reference and review

ACT Fidelity Measurements

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

ACT Fidelity Document – [Click](#) on Document to Open or See Printout

Program _____ Reviewer _____ Date _____

Provisional and Basic Fidelity Recommendations
Minimum of 3.0 average for entire TMACT
with minimum averages/scores for certain
subscale measures

**Tool for Measurement of Assertive Community Treatment (TMACT)
Summary Scale
Version 1.0**

NOTE: This document represents only a summary of the TMACT items, definitions, and anchored ratings. A TMACT fidelity evaluation should not be completed without using the TMACT Protocol (Parts I and II) and Appendices.

Monroe-DeVita, M., Moser, L.L., & Teague, G.B. (2013). The tool for measurement of assertive community treatment (TMACT). In M. P. McGovern, G. J. McHugo, R. E. Drake, G. R. Bond, & M. R. Meurers, (Eds.), *Implementing evidence-based practices in behavioral health*. Center City, MN: Hazelden.

For questions regarding the TMACT, including training and consultation in administering this fidelity measure, contact:
Maria Monroe-DeVita, PhD: mmdv@bv.edu
Lorna Moser, PhD: lorna_moser@med.unc.edu CR
Gregory Teague, PhD: teague@just.edu.

ACT 'Small Team' Monthly Billing Summary

ACT w/ MD/DO:
Code - H0040

Unit Rates

ACT w/APRN:
Code - H0040

MD/DO 	\$662.60	\$383.75	 APRN
Masters 	\$282.80		 Masters
Bachelors 	\$221.41		 Bachelors
Bachelors 	\$221.41		 Bachelors
Peer Recovery Supporter 	\$178.50		 Peer Recovery Supporter
Total: <u>\$1,566.72</u>			Total: <u>\$1,287.87</u>

Under TMACT, 5th unit of bachelors can be billed for Supported Employment

IHBT – Fidelity Measurements

Please see the printout (IHBT Fidelity Rating Tool) for reference and review

IHBT Fidelity Measurements

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

IHBT Fidelity Overview – [Click](#) on Document to Open or See Printout

Minimum rating to qualify for Medicaid billing.
Case Recommendations
State Recommendations

IHBT Fidelity Rating Tool Version V

Rating	1	2	3	4	5
1) Intensity of service	Averages one or less service hours per week and less than 1 contact per week for each IHBT consumer. Intensity is insufficient to meet mental health needs of youth	Averages 2 or less service hours per week and 1 face-to-face contact per week for each IHBT consumer.	Averages 3 service hours per week and 2 face-to-face contacts per week, one of which has to be with the youth and family during the intensive phase. Intensity is adequate in meeting mental health needs of youth.	Averages 4 service hours per week and a minimum of 2 face-to-face contacts with the youth and family and collaterals per week during the intensive phase.	Averages 5 or more service hours per week and 3 or more face-to-face contacts with the youth, family, and collaterals per week during the intensive phases of IHBT. Intensity matches presenting mental health needs of youth and family and is modified during course of treatment as needed.
2) Location of service	49% or less of IHBT services delivered in home & community	50 to 74% of IHBT delivered in home and community	75% to 90% of IHBT service is delivered in home & community	90% to 99% of IHBT service is delivered in home & community	100% of IHBT service is delivered in home & community
3) Caseload	For single provider: Averages 12 or greater For team of two: Averages 20 or greater Mixed caseloads (non-IHBT and IHBT)	For single provider: Averages 9 to 11 For team of two: Averages 17 to 19 Mixed caseloads (non-IHBT & IHBT)	For single provider: Averages 8 cases. For team of two: Averages 15 to 16 Serve IHBT cases only	For single provider: Averages 7 cases For team of two: Averages 13 to 14 Serve IHBT cases only	Small caseloads. Providers serve IHBT cases only. For single provider: caseload averages 4 to 6 youth/families For team of two: Caseload averages 8 to 12
4) Crisis response and availability	IHBT service not on-call; No outreach availability. Coordination of crisis response is delegated to a third party.	24 hour agency on-call system or county-wide on-call system. IHBT team notified of crisis call. No immediate crisis response available. Follow up done the next day.	24 hour crisis response is available through agency on-call system At least one IHBT staff is accessible and is available to client and family around the clock. Face to face response as needed.	Provider on-call during office hours 5 days a week. IHBT team or agency on-call system rotates on-call after hours and on weekends IHBT team backup available. Face-to-face response as needed. Program has comprehensive crisis protocols & policies.	24/5 or 24/7 on-call by provider with IHBT team rotating weekend on-call. IHBT team backup available. Face-to-face response available as needed. Program has comprehensive crisis protocols & policies. Immediate response to crisis calls

Intensive Home-Based Treatment Fidelity Rating Tool Version V (10-14)

1



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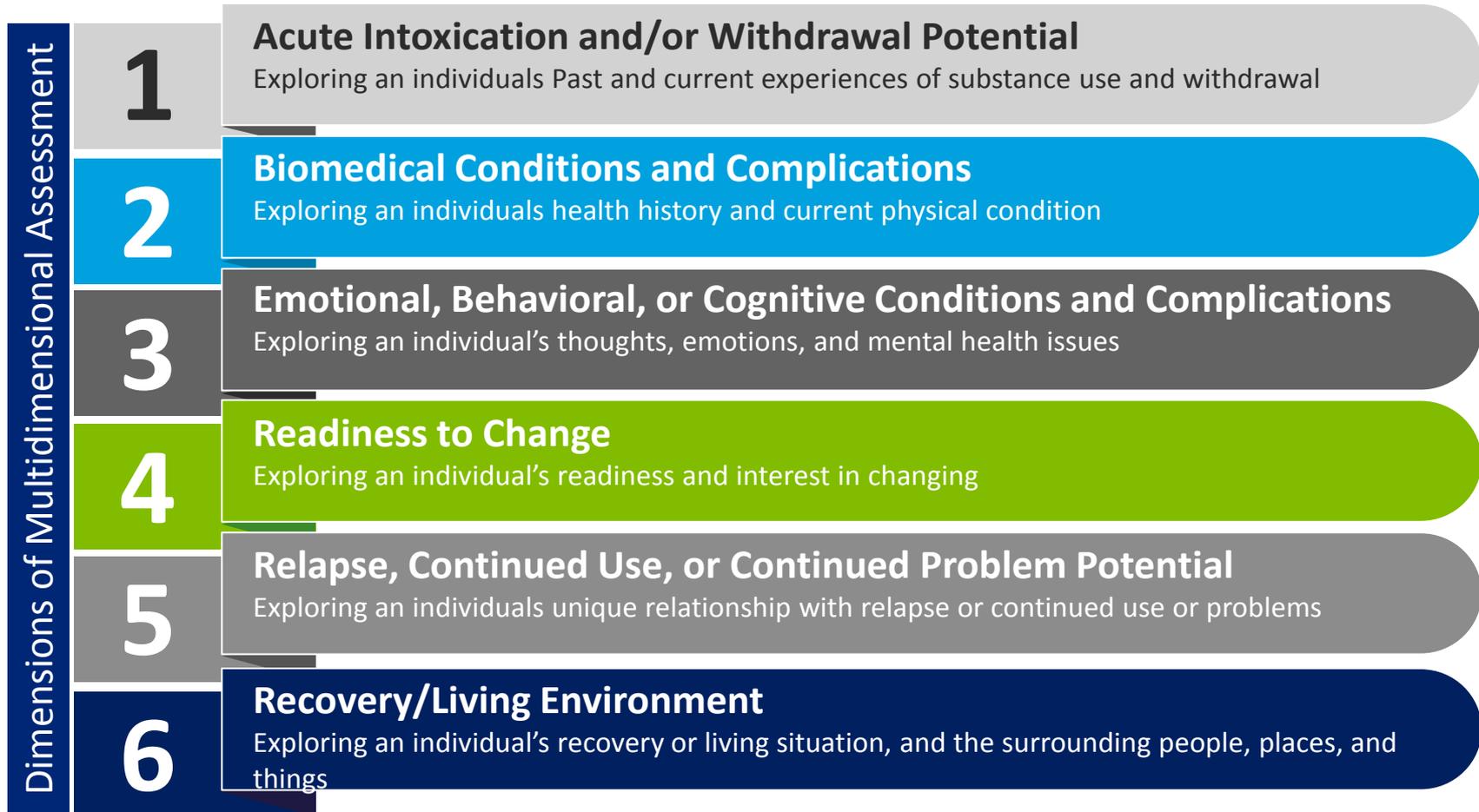
Substance Use Disorder (SUD) Benefit

ASAM Criteria



Behavioral Health Redesign

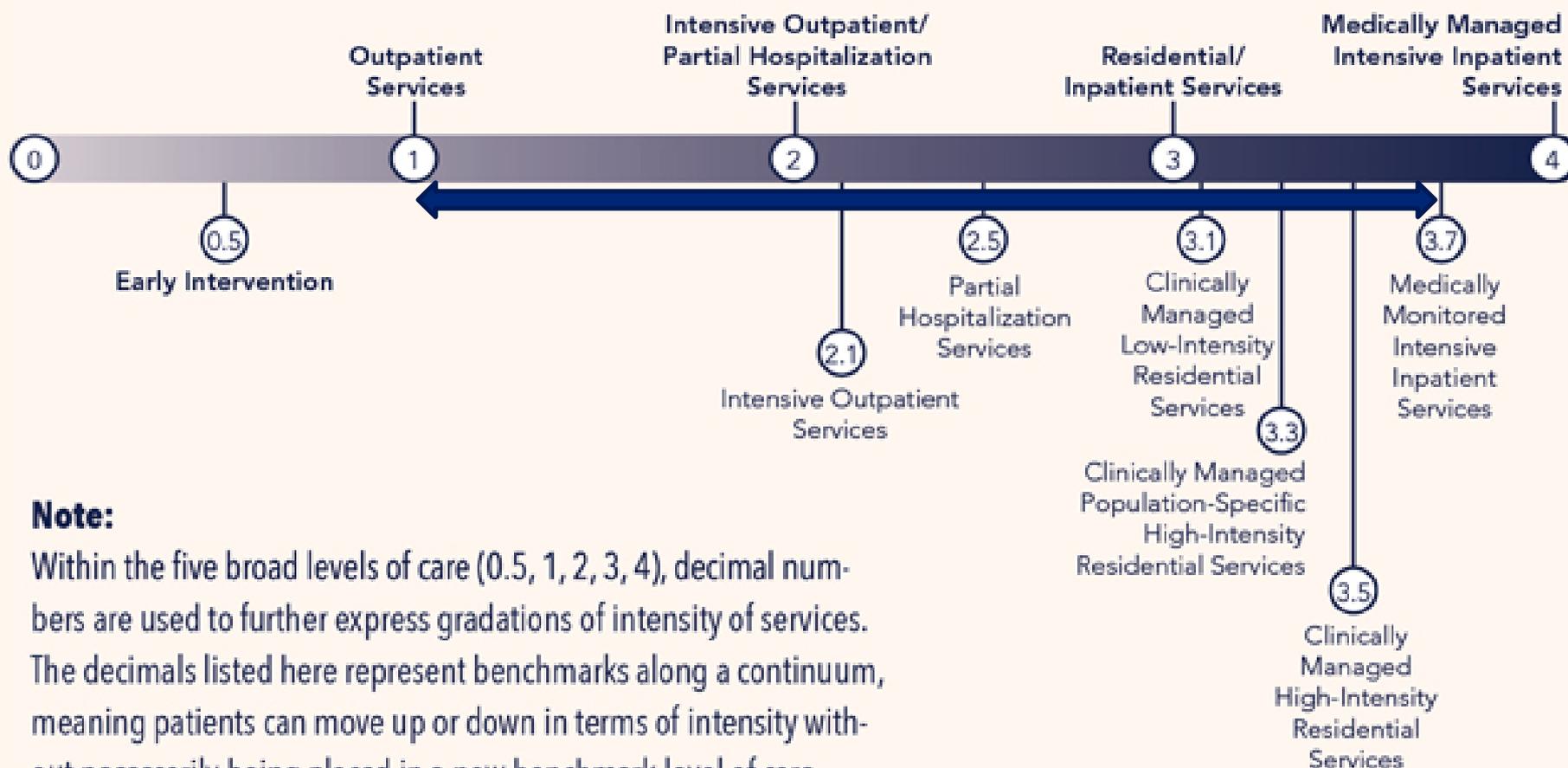
ASAM Criteria



ASAM's Criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care.

ASAM Levels of Care

REFLECTING A CONTINUUM OF CARE



The blue double ended arrow represents scope of Levels of Care in Redesign.

SUD SPA and Provider Manual

	SUD State Plan Amendment	SUD Medicaid Provider Manual
Goal	<ul style="list-style-type: none"> Overall Goal: <ul style="list-style-type: none"> Generally define Ohio's Community Medicaid SUD Benefit. 	<ul style="list-style-type: none"> Overall Goal: <ul style="list-style-type: none"> Provide details on ASAM qualifying criteria for levels of care Provide details on qualified practioners Provide additional practice/policy guidance
Services	<ul style="list-style-type: none"> Levels of Care referenced rather than discrete services 	<ul style="list-style-type: none"> All services matched across all levels with coding options
Target Population	<ul style="list-style-type: none"> Services will be targeted to those individuals with a clinical need <ul style="list-style-type: none"> Clinical criteria Standardized assessment tools ASAM criteria Success measured through clinical outcomes and service utilization 	<ul style="list-style-type: none"> Services will be targeted to those individuals with a clinical need <ul style="list-style-type: none"> Clinical criteria Standardized assessment tools ASAM criteria Success measured through clinical outcomes and service utilization
Coding & Reimbursement	<ul style="list-style-type: none"> General description of the methodology used to determine service (at the code level) rates. 	<ul style="list-style-type: none"> Appendices Will have full listing of billing codes, modifiers, fee schedule, and diagnosis codes.

SUD Residential

1

The state and selected SUD providers met on April 6th, 2016 to review the SUD Residential budgeting data inputs and assumptions and garner feedback to take into account for the next budget model iteration.



2

Of the feedback, staffing aligned in the ASAM levels within the budget model was something that most providers were interested in addressing and the State agreed that providers could perform an 'as is' vs. proposed staffing analysis to send to the state.



3

The SUD provider agencies sent back an analysis of staffing aligned with the ASAM levels for comparison to the states current model.



4

The state will use the staffing analysis and incorporate feedback into a new budget model if necessary.

Opioid Treatment Program Request Update

DRAFT OTP Response

(See Printed Version for Complete Information)

Draft response to 2.26.2016 Request From Opioid Treatment Programs (OTPs)
Re: Medicaid Coverage of Buprenorphine MAT and ECG/EKGs for Methadone patients
For Review at 4.19.16 Meeting

1. Medicaid payment for daily medication administration and observation associated with Buprenorphine based medications.

In early versions of the draft coding and rate chart developed to support the Ohio Medicaid Behavioral Health Redesign project, Healthcare Common Procedure Coding System (HCPCS) code H0033 – “oral medication administration, direct observation” was included by the state as a placeholder. In subsequent versions, this code was removed due to redundancy. OTPs have identified the removal of H0033 and have requested that Medicaid reinstitute H0033 as a billing code specifically for OTPs to use when providing daily medication administration of Buprenorphine based medications. Ohio Medicaid is revising its coverage policy associated with Buprenorphine based medications to include, beginning with services provided on and after January 1, 2017, covering the medication and professional component associated with daily administration of Buprenorphine based medications performed by OTPs.

a. Evaluation and Management (E/M) Office Visit Services in conjunction with administering a Buprenorphine based medication.

When a client is being seen by a medical practitioner for an E/M office visit and a daily dosage of a Buprenorphine based medication is administered, the OTP should bill the appropriate E/M code within the ranges 99211-99215 for an established patient. 99201-99205 (for a new patient) would be used for the induction phase of medication assisted treatment using Buprenorphine based medications. If the rendering medical practitioner is a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), then the only E/M code available for billing their nursing services encounter when a Buprenorphine based medication is also administered is 99211. However, if the RN or LPN is working to assist a higher level medical practitioner (MD, DO, APRN or PA) and their nursing activities are “incident to” the higher level medical practitioner, then the E/M code should be billed with the higher level medical practitioner as the named “rendering” provider. The Buprenorphine based medication being administered should be billed in addition to the E/M

Additional Background

- OTPs have requested a code to bill for direct observation of oral administration of a medication assisted therapy.
 - ✓ The state agrees and is currently working through the policy and operational guidance moving forward.
- See current draft (printed) policy letter for complete information



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***Pharmacological Management and
Medical/Somatic Transition to
Medical Services***

January 1, 2017 Transition



Behavioral Health Redesign

CPT Rate Chart – Evaluation and Management (E&M), Psychotherapy and Interactive Complexity

E&M CPTs

		CPT Code	*2016 Medicare Rate
MH and SUD Patients	New Patients	99201	\$41.97
		99202	\$71.97
		99203	\$104.49
		99204	\$160.23
		99205	\$201.38
	Established Patients	99211	\$18.96
		99212	\$41.62
		99213	\$70.42
		99214	\$103.93
		99215	\$140.37

*Note – Medicare rates decreased slightly due to change from federal Medicare rates to the Ohio Specific Medicare Rates

E&M and Psychotherapy Add Ons

CPT Add On Code	2016 Medicare Rate
Psychotherapy	
+90833	\$65.37
+90836	\$83.03
+90838	\$109.53
Interactive Complexity with Psychotherapy**	
+90785	\$13.81
Prolonged Service	
+99354	\$76.43
+99355	\$75.87

** Interactive complexity is an add on code to the add on psychotherapy codes. It can not be added on to an Office Visit Evaluation and Management code only.

The goal is to use these rates and codes to hold spending relatively constant for medical services provided by Physicians, Physician Assistants and Advance Practice Registered Nurses

MH CPT and HCPCS for Services Provided from January 2017 to June 30th, 2017

Until a provider transitions to the new code set the codes listed below will remain the same for billing purposes.

Mental Health Service	Code	Unit Definition
BH Counseling-Group	H0004	15 Minutes
BH Counseling - Individual	H0004	15 Minutes
CPST - Group	H0036	15 Minutes
CPST Individual	H0036	15 Minutes
Crisis Intervention	S9484	Hour
Mental Health Assessment	H0031	Hour
SPMI Health Home	S0281	Month
Partial Hospitalization	S0201	Day
Psych. Diagnostic Evaluation	90792	Hour

MH CPT and HCPCS for Certain Services Provided on and after January 2017

With the sun-setting of the MH Pharm Management code 90863, the table below for BH and MH Services is the replacement coding structure.

Behavioral Health Service	Code		Unit Definition
Evaluation and Management Services Provided by: Physicians Physician's assistants Advance Practice Registered Nurses	New Patients: 99201, 99202, 99203, 99204, 99205	Established Patients: 99211, 99212, 99213, 99214, 99215	Encounter
Prolonged Service Add On to Medical Services Provided by: Physicians Physician Assistants Advance Practice Registered Nurses	99354 – Prolonged service in the office – first hour 99355 – Prolonged service in the office – each additional 30 minutes		Encounter
Psychotherapy Add On to E&M provided by: Physicians Physicians assistants Advance Practice Registered Nurses Interactive complexity add on to PT Add on	Psychotherapy Add On to E&M 90833 for 30 (16-37*) Minutes 90836 for 45 (38-52*) minutes 90838 for 60 (53+*) minutes Interactive complexity Add On: 90785		Encounter *Per CPT Time Rule
Nursing Activities Performed by: Registered Nurses	99211 or else H2019		99211: Encounter H2019: 15 minutes
Nursing Activities Performed by: Licensed Practical Nurses	99211 or else H2017		99211: Encounter H2017: 15 minutes

SUD HCPCS for Services Provided from January 2017 to June 30th, 2017

Until a provider transitions to the new code set the below codes will remain the same for billing purposes.

Substance Use Disorder Service	Code	Unit Definition
Ambulatory Detoxification	H0014	Day
Assessment	H0001	Hour
Case Management	H0006	Hour
Crisis Intervention	H0007	Hour
Group Counseling	H0005	15 Minutes
Individual Counseling	H0004	15 Minutes
Laboratory Urinalysis	H0003	Screen
Methadone Administration	H0020	Dose
Intensive Outpatient	H0015	Day

Changes: SUD CPT and HCPCS for Certain Services Provided on and after January 1, 2017

With the sun-setting of the SUD Medical/Somatic code H0016, providers should use the table below as guidance for SUD Services .

Behavioral Health Service	Code		Unit Definition
Evaluation and Management Services Provided by: Physicians Physician's assistants Advance Practice Registered Nurses	New Patients 99201, 99202, 99203, 99204, 99205	Established Patients 99211, 99212, 99213, 99214, 99215	Encounter
Prolonged Service Add On to Medical Services Provided by: Physicians Physician Assistants Advance Practice Registered Nurses	99354 – Prolonged service in the office – first hour 99355 – Prolonged service in the office – each additional 30 minutes		Encounter
Psychotherapy add on to E&M provided by: Physicians Physicians assistants Advance Practice Registered Nurses	Psychotherapy Add On to E&M 90833 for 30 (16-37*) Minutes 90836 for 45 (38-52*) minutes 90838 for 60 (53+*) minutes		Encounter *Per CPT Time Rule
Interactive complexity add on to PT Add on Nursing Activities Performed by: Registered Nurses	Interactive complexity add on 90785 99211 else H2019		99211: Encounter H2019: 15 minutes
Nursing Activities Performed by: Licensed Practical Nurses	99211 else H2017		99211: Encounter H2017: 15 minutes

Registered Nurses and Licensed Practical Nurses

For services provided on and after January 1, 2017, three CPT/HCPCS codes will be available for nursing activities rendered by RNs or LPNs as a replacement for MH pharmacological management (90863) and SUD medical/somatic (H0016) for all agencies, there will be no exceptions:

Behavioral Health Codes for Nursing Activities



H2017

99211

H2019



Key Takeaways



- 1 Registered Nurses and Licensed Practical Nurses will need to enroll with Ohio Medicaid because they will be expected to be a rendering provider
- 2 Rendering type and education will be what drives this rate
- 3 These codes and the associated rates will be used during rate setting methodology

Added to State Plan Amendment (TBS): Nursing assessments and group medication education may only be performed by a registered nurse or a licensed nurse practicing with a Bachelor's degree within their current scope of practice.

CPT and HCPCS – Nursing Activities by RNs and LPNs

The below matrix provides examples of how components of nursing activities rendered by LPNs and RNs can be coded. LPNs must be supervised by a higher level medical practitioner.

Nursing Activity	Behavioral Health Interaction
Nursing Assessment (RN Only) 	<p>RN: 99211 should be used if the activity meets the criteria. Only use H2019 when 99211 is not appropriate or services are delivered outside of the office setting.</p> <p>LPN: 99211 should be used if the activity meets the criteria. Only use H2017 when 99211 is not appropriate or services are delivered outside of the office setting.</p>
Medication Assessment and Education 	
Symptom Management 	



Reminder



The previous slides *lists the codes* that will be used starting January 1, 2017.

There are **additional service codes that will be available** when providers transition on January 1, 2017, April 1, 2017 or July 1, 2017 (July 1, 2017 is a mandatory transition date). Some examples are:



Intensive Outpatient



Standalone Psychotherapy



Intensive Home Based
Therapy



Assertive Community Treatment



Psychological Testing

Above examples are not comprehensive of all codes to be available July 1, 2017



Governor's Office of
Health Transformation

***Pharmacological Management and
Medical/Somatic Transition to
Medical Services***

***January 1, 2017 Transition
Laboratory Services and Vaccines***



Behavioral Health Redesign

Laboratory Services and Vaccinations

As health care continues to evolve, the State recognizes that there is a level of appropriateness for certain general health care services that a BH provider should be able to perform

Scenario 1

An established patient (child) comes in for a scheduled appointment with their parent/guardian and there is no evidence that they have ever received a mumps/measles vaccination, what can a provider do?



Discuss the benefits of vaccinations and offer a measles/mumps vaccination



Scenario 2

An established patient (woman) comes in to the CBHC for a regularly scheduled medical appointment and reveals that she may be pregnant, what can a provider do?



Discuss pregnancy in relation to psychotropic medication(s) and treatment for her MH condition and offer a pregnancy test.

Why are we doing this?

To aid in health and welfare of our consumers using sound medical judgment and practice

CLIA – Clinical Laboratory Improvement Amendments

CLIA requires all facilities that perform even one test, including waived tests, on “materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings” to meet certain Federal requirements.

Types of CLIA Certificates

Certificate of Waiver	Certificate issued to laboratory to perform only waived tests
Certificate of Provider-Performed Microscopy Procedures	Certificate issued to lab with a physician/midlevel practitioner or dentist and performs only microscopy procedures
Certificate of Registration	Certificate issued to a lab that allows for moderate or high complexity lab testing or both until deemed in compliance with CLIA
Certificate of Compliance	Certificate issued to lab after inspection finds lab to be in compliance with CLIA
Certificate of Accreditation	Certificate issued to a lab on the basis of the lab's accreditation by an organization approved by HCFA

Ohio

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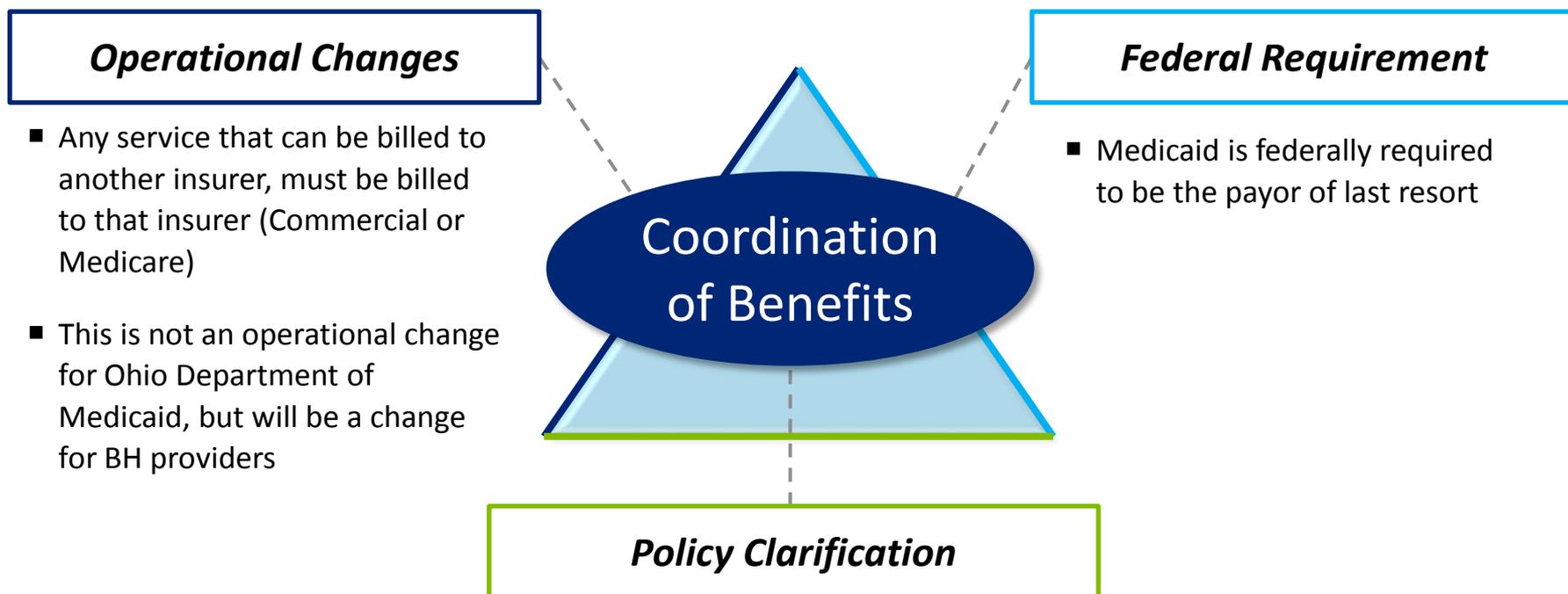
Coordination of Benefits



Behavioral Health Redesign

Medicaid Coordination of Benefits

For behavioral health services provided on or after January 1, 2017, Ohio Medicaid will enforce the policy of Medicaid as the 'payor of last resort'



- BH Medicaid claims have not been required to comply with federal regulations re: coordination of benefits. ODM policy will correct this 1/1/2017.

Medicare Certification vs. Medicare Participation

Medicare Certification

- ✓ CMHCs have the option to enroll as an institutional provider to deliver Medicare services such as partial hospitalization.
- ✓ Certification requires accreditation or survey performed by the CMS designated state survey agency (In Ohio, ODH).

Dates of
Service
Jan 1, 2017



Medicare Participation

- ✓ CBHCs (MH, SUD or both) have the option to enroll as a group practice.
- ✓ Eligible practitioners employed by CBHCs should also enroll as individual practitioners (to be listed as the rendering provider on claim).
- ✓ Once the Medicare Administrative Contractor (MAC) has received an application it has 60 days to review and approve or deny it. In Ohio, the MAC is CGS Administrators LLC.

Medicare Participation Overview

The below chart has been developed to provide additional billing guidance for CBHCs employing the impacted practitioners.

Rendering Provider	Guidance
Physician Advance Practice Registered Nurse Physicians Assistant Psychologist Licensed Independent Social Worker	A CBHC employing any of these rendering providers must bill the Medicare program prior to billing Medicaid.
Licensed Professional Clinical Counselor Independent Marriage and Family Therapist Licensed Independent Chemical Dependency Counselor	For dates of service 1/1/2017 – 12/31/2017, a CBHC employing any of these rendering providers may submit the claim directly to Medicaid.
Licensed Professional Counselor Marriage and Family Therapist Licensed Chemical Dependency Counselor Licensed Social Worker School Psychologists	A CBHC employing any of these rendering providers will receive additional guidance via the manual which will be based on consultation with the professional regulatory boards.

Medicaid Enrollment of Rendering Providers

- Practitioners (chart below) who are employed by MH or SUD providers should begin enrolling with Ohio Medicaid as an individual practitioner as soon as possible

Rendering Practitioner	Rendering Practitioner
Physicians (MD/DO), Psychiatrists	Licensed Independent Social Workers
Advanced Practice Registered Nurses	Licensed Professional Clinical Counselors
Certified Nurse Practitioners	Licensed Independent Marriage and Family Therapists
Clinical Nurse Specialists	Licensed Independent Chemical Dependency Counselors (LICDC)** enroll eff 7/1/2016
Physician Assistants	Registered Nurses
Licensed Psychologists	Licensed Practical Nurses

Exception: Prescribers already registered with ODM as Ordering, Referring or Prescribing providers need not re-register.

- Beginning in October 2016 MH and SUD agencies should use the MITS self service portal to affiliate their agency with rendering practitioners listed above
- Agencies will also need to “un-affiliate” rendering practitioners listed above when necessary
- Effective for dates of service January 1, 2017, all BH Medicaid claims (both old and new code sets) must include rendering practitioner as listed above



Governor's Office of
Health Transformation

DRAFT Budget Models



Behavioral Health Redesign

Budget Model 4

Revised budget neutral modeling scenario

- Fees under the budget neutral modeling scenario
 - Modeled fees are generally set at the **upper bound** of the fee range, with the following exceptions:
 - Peer support – set equal to 1915(i) fees at 85th percentile
 - Individual and group counseling services – set at 50th percentile
 - Fees for services that continue from the current system including H0006 (Case Management) are unchanged except for H0036 (CPST) which was updated to be consistent with H0006.
 - Fees for CPT codes **excluding E&M, Interactive Complexity, and Psychotherapy Add-ons** are set at a **revised Medicaid maximum of 77.4% of Medicare (124.8% of current Medicaid maximum)** for physicians, nurse practitioners, and licensed psychologists and 85% of the revised Medicaid maximum for other licensed practitioners who are able to bill CPT codes.
 - Fees for **E&M, Interactive Complexity, and Psychotherapy Add-ons** CPT codes are set at **100% of the Medicare fee schedule**.

DRAFT

Budget Model 4

Revised budget neutral modeling scenario

Projected Increase / (Decrease) under the budget neutral modeling scenario

	Adults	Children	Total
MH Services	\$284,165,515	\$360,402,232	\$644,567,748
	(\$14,524,804)	\$3,997,077	(\$10,527,727)
	-5.1%	1.1%	-1.6%
SUD Services	\$125,354,235	\$32,683,029	\$158,037,264
	\$4,861,657	\$5,666,070	\$10,527,727
	3.9%	17.3%	6.7%
All Services	\$409,519,751	\$393,085,261	\$802,605,012
	(\$9,663,147)	\$9,663,147	\$0
	-2.4%	2.5%	0.0%

DRAFT

Budget Model 5

Revised budget plus modeling scenario

- Assumes a \$10.0 million investment in children's mental health services
- Fees are consistent with the budget neutral modeling scenario
- Fees under the budget plus modeling scenario
 - Modeled fees are generally set at the **upper bound** of the fee range, with the following exceptions:
 - Peer support – set equal to 1915(i) fees at 85th percentile
 - Individual and group counseling services – set at 50th percentile
 - Fees for services that continue from the current system including H0006 (Case Management) are unchanged except for H0036 (CPST) which was updated to be consistent with H0006.
 - Fees for CPT codes **excluding E&M, Interactive Complexity, and Psychotherapy Add-ons** are set at a **revised Medicaid maximum of 77.4% of Medicare (124.8% of current Medicaid maximum)** for physicians, nurse practitioners, and licensed psychologists and 85% of the revised Medicaid maximum for other licensed practitioners who are able to bill CPT codes.
 - Fees for **E&M, Interactive Complexity, and Psychotherapy Add-ons** CPT codes are set at **100% of the Medicare fee schedule.**

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Budget Model 5

Revised budget plus modeling scenario

Projected Increase / (Decrease) under the budget neutral modeling scenario

	Adults	Children	Total
MH Services	\$284,165,515	\$360,402,232	\$644,567,748
	(\$14,524,804)	\$13,997,077	(\$527,727)
	-5.1%	3.9%	-0.1%
SUD Services	\$125,354,235	\$32,683,029	\$158,037,264
	\$4,861,657	\$5,666,070	\$10,527,727
	3.9%	17.3%	6.7%
All Services	\$409,519,751	\$393,085,261	\$802,605,012
	(\$9,663,147)	\$19,663,147	\$10,000,000
	-2.4%	5.0%	1.2%

DRAFT

Goal for Next Budget Model – 3.23.16

Maintain Consistency:

- Fees for **E&M, Interactive Complexity, and Psychotherapy Add-ons CPT codes** are set at **100% of the Medicare fee schedule**
- Fees for services that continue from the current system including **H0006 (Case Management)** are unchanged except for **H0036 (CPST)** which was updated to be consistent with H0006
- Peer support: **\$15.51 (Individual)** and **\$1.94 (Group)**

Available for Adjustment:

- **SUD Individual and Group Counseling**
- Fees for CPT codes excluding E&M, Interactive Complexity, and Psychotherapy Add-ons - see next slide

State's Promise and Behavioral Health Investment:

- Additional **\$10M** targeted for children's mental health, as previously discussed
- Additional **\$25M** targeted for fees
- Total of **\$35M** above budget neutrality point



Rate Updates Based on Revised Budget Models

Code	February 24 th Rate		Increase/ Decrease	March 9 th Rate	
	Medical BH Practitioners	Licensed BH Practitioners		Medical BH Practitioners	Licensed BH Practitioners
90791 (Psych. Diagnostic Eval.)	\$119.36	\$101.46	Increase	\$128.63	109.34
90792 (Psych. Diagnostic Eval. w/Medical)	\$99.78	\$84.81	Increase	\$107.54	\$91.41
90832 (Psychotherapy – 30 minutes)	\$49.78	\$42.31	Increase	\$53.65	\$45.60
90834 (Psychotherapy – 45 minutes)	\$64.72	\$55.01	Increase	\$69.75	\$59.29
90837 (Psychotherapy – 60 minutes)	\$94.94	\$80.70	Increase	\$102.32	\$86.97
90839 (Crisis psychotherapy)	\$108.12	\$91.90	Increase	\$116.53	\$99.05
+90840 (Crisis psychotherapy each addit. 30 mins)	\$51.94	\$44.15	Increase	\$55.97	\$47.57
90845 (Psychoanalysis)	\$61.14	NA	Increase	\$65.89	NA
90846 (Family psychotherapy w/out patient)	\$64.69	\$54.99	Increase	\$69.71	\$59.25
90847 (Family Psychotherapy w/patient present)	\$79.45	\$67.53	Increase	\$85.63	\$72.79
90849 (Multiple family group psychotherapy)	\$24.68	\$20.98	Increase	\$26.59	\$22.60
90853 (Group)	\$22.31	\$18.96	Increase	\$24.05	\$20.44
96372 (Ther., proph., or diag. injection)	\$16.87	\$14.34	Increase	\$18.18	\$15.45
+99354 (Prolonged service 1 st hour)	\$70.92	\$60.28	Increase	\$76.43	\$64.97
+99355 (Prolonged service each addit. 30 mins.)	\$70.39	\$59.83	Increase	\$75.87	\$64.49

Code	February 24 th Rate	Increase/Decrease	March 9 th Rate
H0036 (CPST)	\$21.33 (15 minute)	Decrease	\$19.54 (15 minute)
H0036 (group – CPST)	\$9.81 (15 minute)	Decrease	\$8.99 (15 minute)

All other rates remain the same since the February 24th Benefit and Service Development Work Group

Budget Model Assumptions Small Group Update

Goal



Focus on obtaining feedback on the budget model and the related assumptions that are incorporated into the budget models and draft rates

Meeting Activities

- Looked at the current pathways to care that individuals follow when seeking and/or receiving services that may be impacted by redesign or may need to be adjusted.
- Discussed the assumptions regarding what is included in the current per diem and what is not
- Discussed the following key topics:



Staffing and practitioner levels



Community vs. office based



Client ratios



*Anticipated frequency of the use of add on codes



Hours of programming



Costs



Governor's Office of
Health Transformation

Code and Rate Chart



Behavioral Health Redesign

Finding the Code and Rate Workbook



Behavioral Health Redesign

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Behavioral Health Redesign

The SFY 2016/17 State Budget continued the Kasich Administration's commitment to modernize Ohio's Medicaid program. At the center of this effort is a proposal to rebuild community behavioral health system capacity across the state. The legislation provided targeted investments to support initiatives such as:

- Developing new services for individuals with high intensity service and support needs;
- Improving health outcomes through better care coordination; and
- Recoding of all Medicaid behavioral health services to achieve alignment with national coding standards.

Under the leadership of the [Governor's Office of Health Transformation](#), the [Ohio Department of Mental Health and Addiction Services](#) and the [Ohio Department of Medicaid](#) are collaborating to implement these reforms and enhance the quality of care delivered to residents of our state. In doing so, state partners have enlisted the help and expertise of various stakeholders to serve on the Behavioral Health Redesign Core Team to further inform and guide this work.

Be sure to bookmark bh.medicaid.ohio.gov to stay informed and sign up for the [BH Redesign Newsletter](#) for regular updates about this exciting effort.



Reform focuses on improving health outcomes while staying accountable to taxpayers

[Core Team Materials](#)
[Core Team Member List](#)
[Testimony](#)
[Resource Materials](#)

Please note that details are constantly evolving through the work of the Behavioral Health Redesign Core Team and its workgroups. Therefore, materials linked here reflect Core Team deliberations at specific points of time and should not be considered as final policy. These resources are provided to allow interested parties to follow the work in progress.

[Benefit and Service Development Work Group Presentation - Mar. 23, 2016](#)
[Benefit and Service Development Work Group Presentation - Mar. 9, 2016](#)
[PDF Version of DRAFT Overall Coding Chart - Mar. 9, 2016](#)
[Excel Version of DRAFT Overall Coding Chart - Mar. 9, 2016](#)
[Revised Transition Schedule - March 2016](#)


MH and SUD CPT and HCPCS Rates for Services Provided on and After Jan 1, 2017

Code	Rate
SUD Codes	
Methadone Administration (H0020)	\$16.38
SUD Case Management (H0006)	\$78.17
Specialized Recovery Services Program Codes	
IPS SE (H2023, H2025)	\$19.53
Peer Recovery Support Services (H0038)	\$15.51
Peer Recovery Support Services – Group (H0038 +HQ)	\$1.94
Mental Health Codes	
Screening, Brief Intervention and Referral to Treatment (SBIRT - G0396 and G0397)	G0396: \$25.05 G0397: \$47.68
SBIRT Services: One of each of the services per year, per person, per agency	



Additional Codes Finalized Listed Below *(See Coding Chart for Details)*

**Pharmacy and
Laboratory Codes**

Vaccinations

**Office Administered
Medications (J Codes)**



Coverage and Limitations Guidance

Topic	Current Coverage and Limitations
 <p data-bbox="401 358 672 454">MH Partial Hospitalization</p>	<ul data-bbox="923 386 1624 425" style="list-style-type: none"> ✓ One H0035 per diem, per patient, per day
 <p data-bbox="369 629 710 668">ASAM: Outpatient</p>	<ul data-bbox="923 582 1831 715" style="list-style-type: none"> ✓ Adults: <9 hours per week of skilled treatment services ✓ Adolescents: <6 hours per week of skilled treatment services

H0015 Applies to Both IOP and PH – Billed Once Per Day, Per Patient

 <p data-bbox="382 958 691 1053">ASAM: Intensive Outpatient</p>	<ul data-bbox="923 886 1856 1125" style="list-style-type: none"> ✓ Adults: 9-19.9 hours per week of skilled treatment services ✓ Adolescents: 6-19.9 hours per week of skilled treatment services ✓ One per diem, per patient, per day
 <p data-bbox="407 1215 678 1310">ASAM: Partial Hospitalization</p>	<ul data-bbox="923 1215 1682 1310" style="list-style-type: none"> ✓ Adults and Adolescents: >20 hours per week ✓ One per diem, per patient, per day

Coverage and Limitations Guidance

Topic	Current Coverage and Limitations
 <p>Psychological Testing</p>	<ul style="list-style-type: none"> ✓ 8 hours annually (prior authorization to exceed)
 <p>Screening, Brief Intervention and Referral to Treatment</p>	<ul style="list-style-type: none"> ✓ One per patient, per provider, per code, per year (G0396 and G0397). ✓ Cannot be billed by provider type 95
 <p>Evaluation and Management Codes (New and Existing Patient)</p>	<ul style="list-style-type: none"> ✓ 1 per day, per practitioner, per patient (NCCI) – may be subject to SURS review if in excess of 24 visits per calendar year across all billing providers
 <p>Specialized Recovery Services Program: Individualized Placement Support: Supported Employment</p>	<ul style="list-style-type: none"> ✓ Must be provided in accordance with the approved Person Centered Care Plan
 <p>Specialized Recovery Services Program: Peer Recovery Support</p>	<ul style="list-style-type: none"> ✓ No more than 4 hours daily; and ✓ Must be provided in accordance with the approved Person Centered Care Plan



Governor's Office of
Health Transformation

Managed Care Design Dimensions

Stakeholder Feedback May and June 2015



Behavioral Health Redesign

Key Design Dimensions for Consideration:

Managed Care Design

Key Design Dimension	Description
Network Adequacy	<ul style="list-style-type: none">• Assure access to needed services and supports which should include organizational contracts and access to care requirements• Define clear expectation for network adequacy, including measures specific to access to services.• Recognize longstanding Child Protective Services relationship with community providers and unique needs of the client population would impact a continuum of services, considering EPSDT requirements, psychotropic medication management, parent treatment, and timeliness of service• Providers of children's BH services, especially for seriously emotionally disturbed kids, are a very specialized group.
Integration	<ul style="list-style-type: none">• General - Integrating physical health, behavioral health and other needed services and supports
Timeline	<ul style="list-style-type: none">• Patient education and active engagement, continuity of care and patient choice of providers, recognition of current MHAS Certified provider's base level capacity, limit prior authorization to inpatient psychiatric services, partial hospitalization, detoxification services, and recognize existing FFS payment rates• Make consistent with integration of physical health care for child protective services population and sufficient time for CPS infrastructure and workforce changes and training of foster kinship and adoptive parents

Key Design Dimensions for Consideration:

Managed Care Design

Key Design Dimension	Description
<p>Standardization</p>	<ul style="list-style-type: none"> • Economies of scale in development of IT infrastructure, mutual data sharing, and data analytics. • Define specific expectations around IT as the data element inconsistency is the biggest driver for rising costs and variations. • Define the MCP Prior Authorization, Billing, Claims Processing & Payment Requirements • Define unique needs relative to prior authorizations, grievances and appeals, protocol for transportation and residential care for Child Protective Services • Ensure unique needs of Child protection population outcomes are met and aligned with existing mandated measures
<p>Quality Indicators</p>	<ul style="list-style-type: none"> • Child Protective Services BH indicators should not be limited to hospitalizations but should also be ability to learn, stay out of jail, and achieve and sustain successful community living. • Establish standard provider quality metrics and performance targets to be achieved during and after transition period
<p>Funding Structure and Revenue Cycle Mgmt.</p>	<ul style="list-style-type: none"> • Based on how MITS pays claims, the revenue cycle could potentially be impacted by a large amount of money. • Children's services funding should be structured to support braided funding for child welfare, juvenile justice, education, and developmental disabilities. • Establish expectations for provider payment incentive models (shared and/or full risk options). Requirements to transition to value based purchasing.

Key Design Dimensions for Consideration:

Managed Care Design

Key Design Dimension	Description
Stakeholder Involvement	<ul style="list-style-type: none">• Involve Consumers, MCPs, Providers, Boards & Others in design process• Develop Plans need to be transparent in the drugs they cover and the services they cover. There should be a way to compare plans.• Recognize unique needs of child protective system for adequate stakeholder involvement
Accountability	<ul style="list-style-type: none">• Define MCP & provider roles & responsibilities• How will legally or judicially required services be provided for Child Protective Services?
Care Management	<ul style="list-style-type: none">• Define care management functionality & accountability at appropriate levels• Delegate care management focused on integration of physical, behavioral, social, and recovery services and supports• Clarify MCP role with child protection case worker, mandated duties and provider CPST roles specifically for Child Protective Services BH

Key Design Dimensions for Consideration:

Managed Care Design

Key Design Dimension	Description
Credentialing, Contracting and Experience	<ul style="list-style-type: none">• Define the credentialing process for providers of certain services• Establish clear understanding between stakeholders of allowed contracting and rules/regulations behind contracting• Assure adequate MCP experience and expertise with individuals who have been diagnosed with SPMI, SMI & SUD• Ensure Managed Care Plans are educated to the child protective population unique needs, including high rates of trauma and the need for more services sensitive to their chronic behavioral health disorders
Care Coordination	<ul style="list-style-type: none">• Define roles for care coordination and coordinated care delivery.
Data	<ul style="list-style-type: none">• Assure capacity & developing infrastructure
Outcomes	<ul style="list-style-type: none">• Focus on outcomes not process

Key Design Dimensions for Consideration:

Managed Care Design

Key Design Dimension	Description
Additional Services Offered	<ul style="list-style-type: none">Expand array of behavioral health services consistent with SAMHSA's description of a Good & Modern Addiction Treatment and Mental Health System.
Target Utilization	<ul style="list-style-type: none">Target utilization management to health outcomes and consider parity.
Medical Loss Ratio	<ul style="list-style-type: none">Define medical loss ratio specifically for BH services – (90%).
Provider Requirements	<ul style="list-style-type: none">Identify specific MHAS certification of services, Population specific (MH, SUD, Adult, Child), Population health approach (not just SPMI and SED), Data reporting, outcome measures, Single point of accountability, Integrated care planning and service delivery
Client Centered	<ul style="list-style-type: none">Work towards towards achieving end-user goals (all participants in system)Ensure customer is satisfied with their services as this relates directly to effectiveness of treatment.

Managed Care Design Decisions To-Date

- Carve in Ohio's Medicaid behavioral health services to Ohio's current Medicaid managed care plan contract no earlier than Jan 1 2018 (per ORC)
- Require MCPs to delegate components of care coordination to qualified community behavioral health providers

Standardized Approach	Align in Principle	Differ by Design
<ul style="list-style-type: none"> • Clinical outcomes and plan performance measures • Care management identification strategy for high risk population • Billing and coding methodologies • Benefit design 	<ul style="list-style-type: none"> • Real time data sharing and use of EHR, where possible • Require value based purchasing/contracting • Utilization management strategies (e.g. prior authorizations, forms, process, etc.) 	<ul style="list-style-type: none"> • Purchase services to enhance expertise in behavioral health service coordination/delivery • Payment strategies • Selective contracting



Governor's Office of
Health Transformation

Specialized Recovery Services

Disability Determination Redesign



Behavioral Health Redesign

Section 209(b) and Spend Down

Individuals can meet the Spend Down in various ways:



Recurring

Person has established monthly costs or unpaid past medical bills that meet the spend down. Person gets their Medicaid card monthly without additional action on their part



"Pay in"

Spend Down is considered met as of the first of the month, even if the payment was made on the 15th of the month.



Delayed

The person "incurs" costs in the amount of the Spend Down. Cost is "incurred" whether the person pays up front or receives an itemized bill for services

Individuals can group expenses into certain months so that they meet the spend down in those months

The 1634 Option

The 1634 option **allows states to accept the Social Security Administration's decision** for SSI:

- » In Ohio, **Opportunities for Ohioans with Disabilities** will make decision that a person is eligible for SSI.
- » SSI beneficiaries are **automatically enrolled on Medicaid**.
- » The state **does not reconsider** the determination.

The 1634 Option

Fairness in the 209(b) and MAGI (Modified Adjusted Gross Income) adult world:

- A person under 65 without Medicare can get MAGI adult coverage with income up to 138% Federal Poverty Level (FPL).
- A person 65 or older, or with Medicare, has to Spend Down to 64%
- Two people with the same Spend Down amount may have very different results based on what treatment they need from what provider.
 - In one case, the provider never actually attempts to collect on the “incurred” bill.
 - In another case, the person has to pay up front to get services

Administrative simplification:

- No more Spend Down calculation or collection

Disability Determination Redesign

- ✓ On June 30, 2016, Ohio Medicaid will eliminate the program that allows individuals to “spend down” a portion of their income to qualify for Medicaid as a result of the state’s initiative to streamline the disability determination process from two systems into one.
 - ✓ It is important to note that although the change in disability determination will take place on July 1, 2016, an individual on spend down will not lose their Medicaid benefit on that date
 - ✓ At the point of conversion, every individual who would have been eligible for Medicaid ABD under the current system, including individuals who qualified by spending down to the income limit in any month during the previous year, will be automatically enrolled in full Medicaid without spend down.
- ✓ Ohio Medicaid requested, from CMS, a six-month waiver of ABD renewals to ensure that every current beneficiary who is potentially impacted has time to transition to other sources of Medicaid, including the SRS program or, if they are no longer eligible for Medicaid, to seek other sources of coverage.
 - ✓ Medicaid eligibility renewals will resume on January 1, 2017 and, from that date forward, the new eligibility criteria will apply to individuals seeking Medicaid ABD renewals.

Disability Determination Redesign

Full Governor's Office of Health Transformation Whitepaper is available at:

<http://healthtransformation.ohio.gov/LinkClick.aspx?fileticket=nwrdsnOoQqo%3D&tabid=117>



Governor's Office of
Health Transformation

Specialized Recovery Services program

Medicaid 1915(i) State Plan Program for SPMI Adults

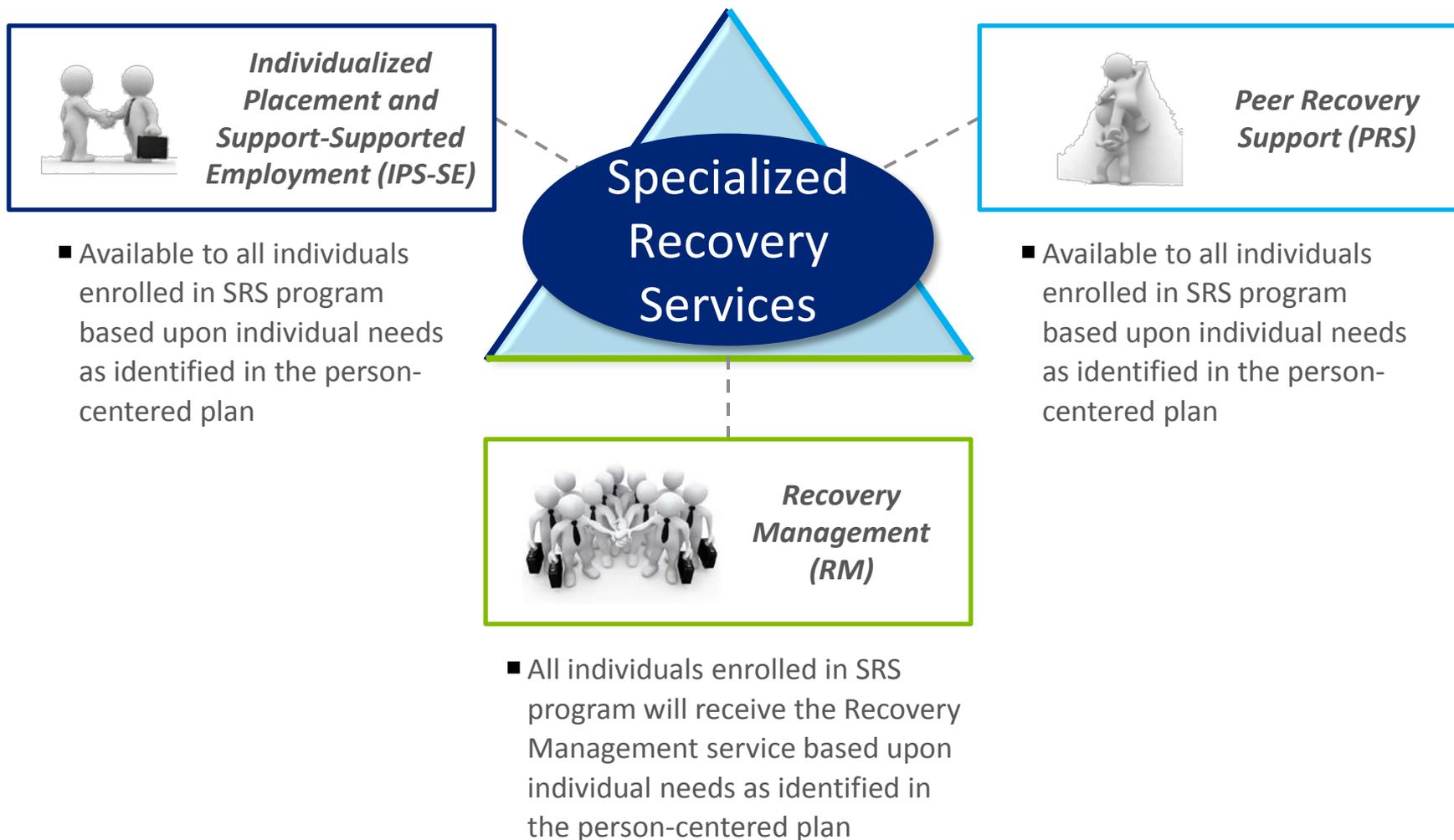


Behavioral Health Redesign

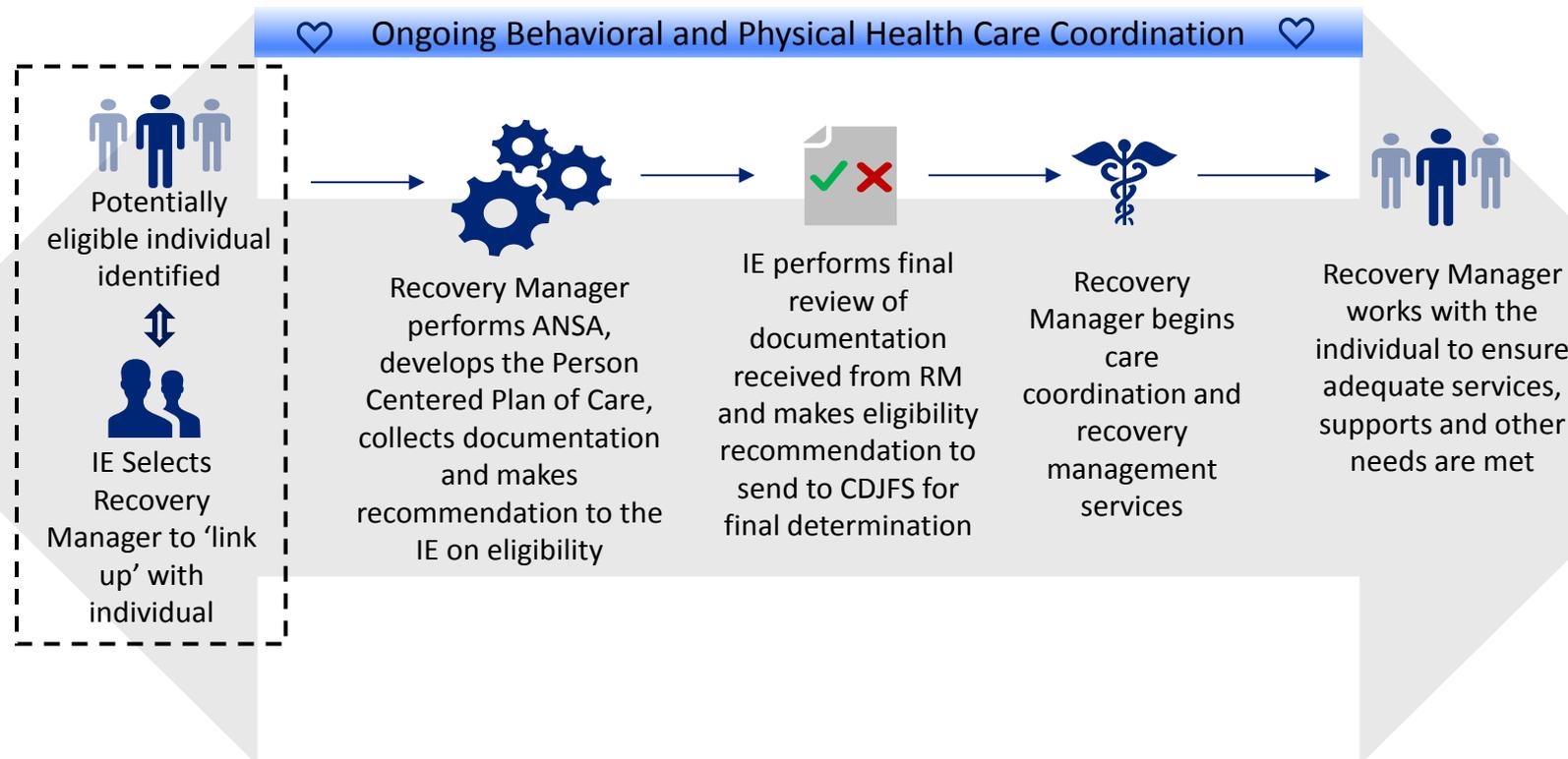
Specialized Recovery Services Program

- Ohio has developed a 1915(i) state plan program to help the estimated 4,000 – 6,000 individuals with SPMI who would otherwise lose Medicaid eligibility to maintain Medicaid eligibility.
- 1915(i) state plan programs are Home and Community Based Services (HCBS) programs and must comply with federal HCBS requirements.

Specialized Recovery Services Program



Recovery Manager and IE Interaction



The above visual explains the interaction between the Recovery Manager and the IE to enroll an individual into the Specialized Recovery Services Program

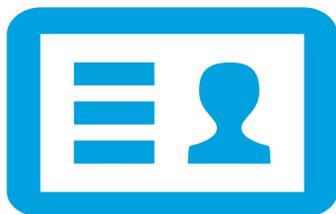
Recovery Manager Overview

Why have a Recovery Manager?



- Facilitates the initial eligibility determination and streamlines overall enrollment process
- Supports the Person-centered planning process

What is a *Recovery Manager?



- Works with the individual to perform care coordination
- Works with individual to develop the person centered plan of care and documents individuals desires, needs, and goals.
- Performs the ANSA to assess the needs and strengths of the individual

What are the Qualifications to be a Recovery Manager?

- 1 Bachelor's degree in social work, counseling, psychology, or similar field
- 2 Trained in administering ANSA
- 3 Trained in evaluating HCBS living arrangements
- 4 Minimum of 3 years post degree experience working with individuals with serious mental illness (SMI)
- 5 Trained in person centered planning
- 6 Trained in incident reporting and Meet state conflict of interest standards

Specialized Recovery Services Program

Recovery Management

Recovery management activities include:

- Face-to-face eligibility evaluation, including:
 - Administration of the ANSA;
 - Verification of the individual's residence in a home and community-based setting as described in rule 5160-44-01 of the Administrative Code. See ODM HCBS Checklist in clearance: <http://medicaid.ohio.gov/Portals/0/Resources/LegalandContracts/Rules/DR-NonBIA/W03212016.pdf>
 - Verification of the individual's qualifying behavioral health diagnoses as described in the appendix to rule 5160-43-02 of the Administrative Code; and
 - Evaluation of all other eligibility criteria as described in paragraph (A) of rule 5160-43-02 of the Administrative Code.
 - Person-centered care planning, monitoring and updating the care plan, as described in rule 5160-44-02 of the Administrative Code.



Specialized Recovery Services Program

Recovery Management

Procedure Code for Recovery Management

- T1016 – Case Management

Billing and Certification Information

- Billed in 15 minute increments
- Recovery Management providers are selectively contracted with ODM and **are not** certified by OhioMHAS. RM providers will be enrolled in Ohio Medicaid as a provider type 45.



Specialized Recovery Services Program

Individualized Placement and Support-Supported Employment

IPS-SE activities include:

- Benefits planning;
- Development of a vocational plan;
- General consultation, including advocacy and building and maintaining relationships with employers;
- Individualized job supports, including regular contact with the individual's employer(s), family members, guardians, advocates, treatment providers, and other community supports;
- Job coaching;
- Job development and placement;
- Job seeking skills training



Specialized Recovery Services Program

Individualized Placement and Support-Supported Employment

IPS-SE activities (Cont'd) include:

- On-the-job training and skill development;
- Vocational rehabilitation guidance and counseling;
- Time unlimited vocational support; and
- Vocational assessment.



Specialized Recovery Services Program

Individualized Placement and Support-Supported Employment

Procedure Codes for IPS-SE

- H2023-Initial Visit
- H2025-Ongoing Visits

Billing and Certification Information

- Billed in 15 minute units
- Agencies providing IPS-SE are certified by the Ohio Department of Mental Health and Addiction Services and enrolled in Medicaid under provider type 84.

* Agency providers will be responsible for assuring IPS-SE employees whose services are billed to Medicaid meet the participation requirements, including offense exclusions for Medicaid. Public Consulting Group (PCG), a contractor to ODM, will check professional requirements during structural review visits. See <http://ohiohchs.pcgus.com/>.



Specialized Recovery Services Program

Peer Recovery Support

Peer Recovery Support is the only Specialized Recovery Service with a limit. A person can receive no more than four hours of peer recovery support per day.

Peer Recovery Support activities include:

- Assisting the individual with accessing and developing natural support systems in the community;
- Attending and participating in care team meetings;
- Conducting outreach to connect individuals with resources;
- Coordinating and/or assisting in crisis interventions and stabilization needed;
- Developing and working toward achievement of the individual's personal recovery goals;
- Facilitating development of daily living skills;
- Modeling personal responsibility for recovery;
- Promoting coordination among similar providers;



Specialized Recovery Services Program

Peer Recovery Support

Peer Recovery Support activities (Cont'd) include:

- Providing group facilitation that addresses symptoms, behaviors, and thought processes to assist an individual in eliminating barriers to seeking and maintaining recovery, employment, education, and housing;
- Supporting individuals in achieving personal independence as identified by the individual; and
- Teaching skills to effectively navigate the health care delivery system to utilize services.



Specialized Recovery Services Program

Peer Recovery Support

Procedure Code for Peer Recovery Support

- H0038 – individual
- H0038/HQ - group

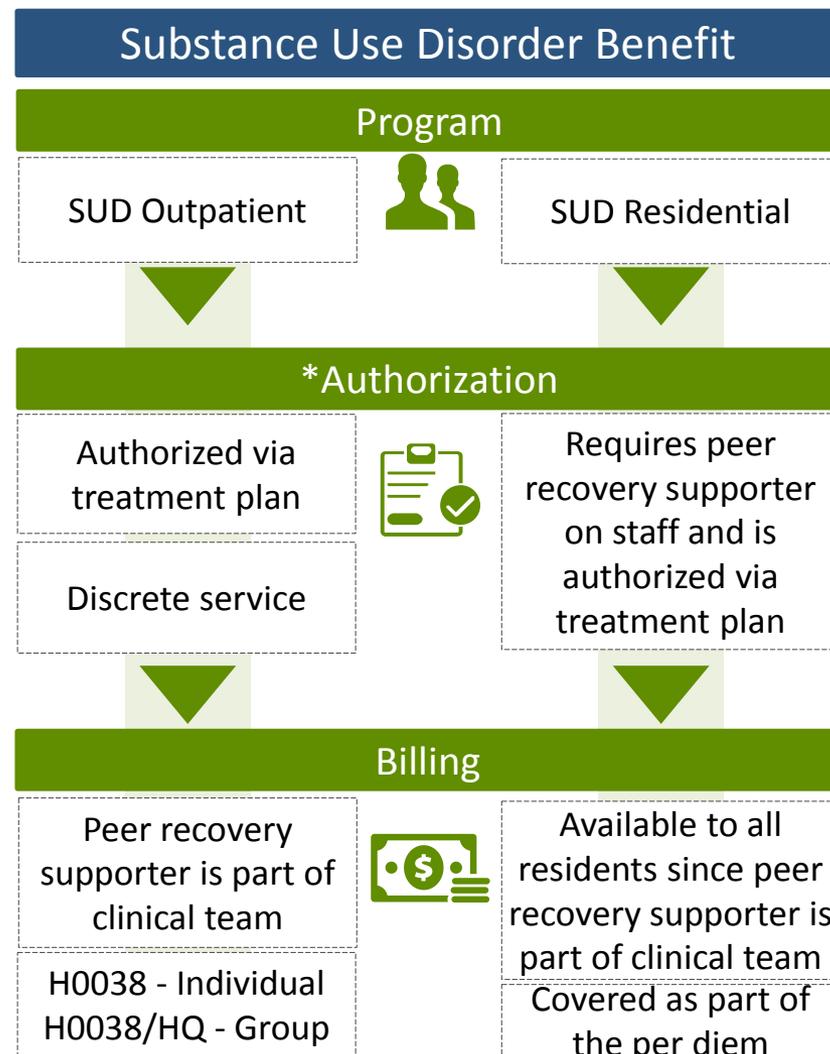
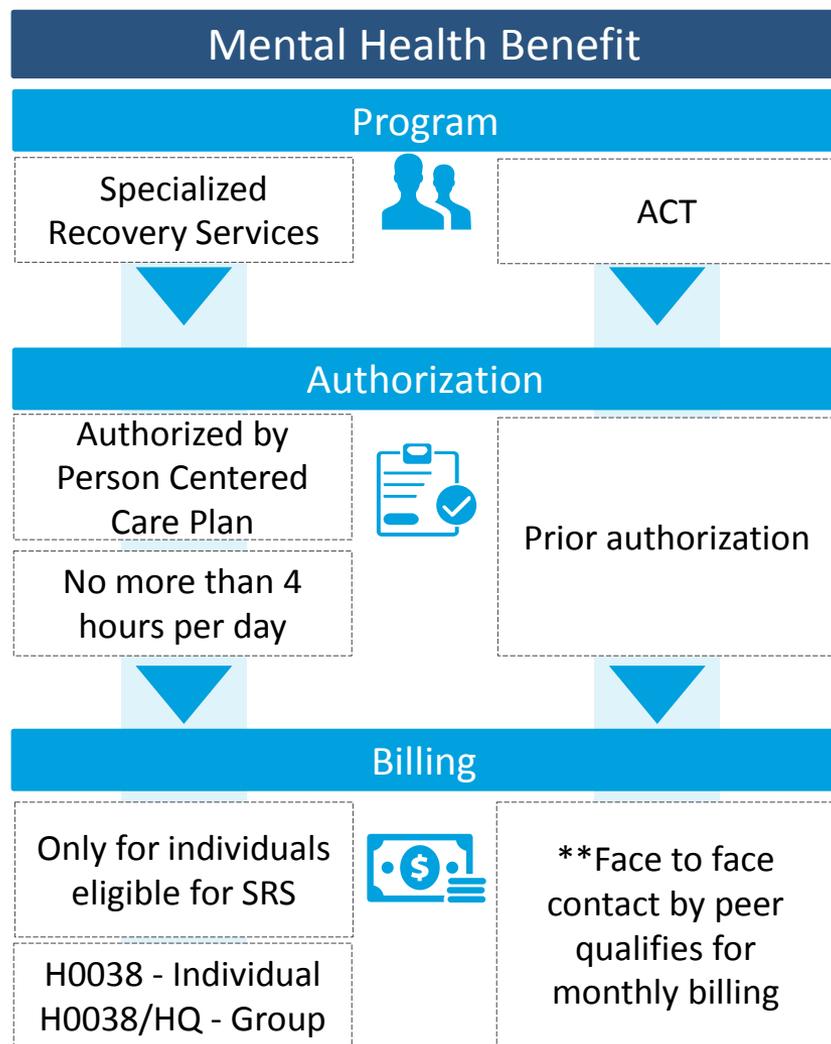
Billing and Certification* Information

- Billed in 15 minute increments
- Agencies providing Peer Recovery Support are certified by the Ohio Department of Mental Health and Addiction Services and enrolled in Ohio Medicaid as a provider type 84.
- Agencies must employ individuals who are professionally qualified to provide PRS.

* There are differences between the Ohio Medicaid offense exclusions (OAC 5160-43-09) and the OhioMHAS offense exclusions for peer recovery support professionals (OAC 5122-29-15.1). Agency providers will be responsible for assuring PRS employees whose services are billed to Medicaid meet the participation requirements, including offense exclusions for Medicaid. Public Consulting Group (PCG), a contractor to ODM, will check professional requirements during structural review visits. See <http://ohiohcbs.pcgus.com/>.



Peer Recovery Support Coverage



*Please keep in mind that the SUD State Plan affords the State the ability to prior authorize SUD services.

**See previous ACT billing guidance provided on February 12, 2016 for additional clarification

Specialized Recovery Services Program

- The SRS program budget is independent from the budget for the overall BH Redesign. Recovery Management is a selectively contracted service and not reflected below.



Individual Peer Recovery Support

\$15.51 per 15 minute unit



Group Peer Recovery Support

\$1.94 per 15 minute unit



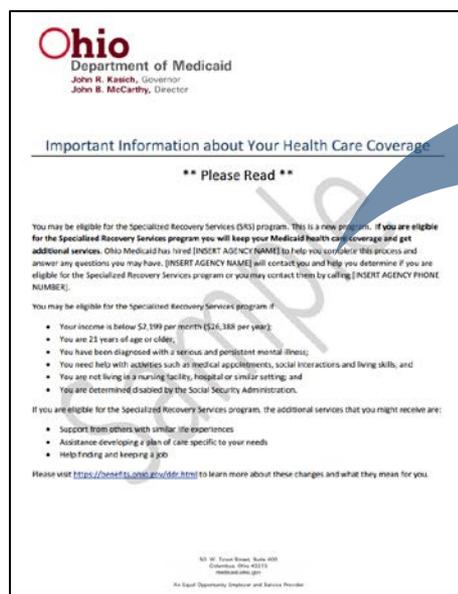
Individual Placement and Support-Supported Employment

\$19.53 per 15 minute unit

Specialized Recovery Services - Consumer Letter and Informational Video

SRS Consumer Letter

(See Printed Version for Complete Information)



Key Takeaways

- ✓ Individuals will keep current Medicaid benefits and will receive new service(s)
- ✓ Lists the recovery management agency
- ✓ Gives phone number to call if the individual has questions
- ✓ Lists high level eligibility criteria
- ✓ Lists new services available to those who are eligible

Link to DDR Landing Page: <https://benefits.ohio.gov/ddr.html?lang>

Link to Video - https://www.youtube.com/watch?v=KYVIGD2_K4Q

Specialized Recovery Services Program: Providers

- ✓ Coming soon, consumers who have been identified as possibly eligible for the Specialized Recovery Services (SRS) program will be receiving notification from the Ohio Department of Medicaid about how to enroll in this new program. Notification will come via a letter that explains the program, its new benefits, and how to enroll.
- ✓ If a provider believes an individual to be eligible for the SRS program, but that person has not received a letter, the provider should contact the Ohio Department of Medicaid, via an electronic process soon to be announced. Medicaid will then connect the person to an assigned recovery manager to begin program enrollment.
- ✓ Please stay tuned to <http://bh.medicaid.ohio.gov> for more information and for upcoming tools that providers may use to assist with enrollment and education of consumers in the SRS program. These tools will include a provider toolkit and an educational video. Also, please make sure are signed up for our BH Redesign newsletter for all of the latest information:
<http://bh.medicaid.ohio.gov/Newsletters>

Specialized Recovery Services Program – MyCare Managed Care

MyCare Responsibilities

- 1 Individuals enrolled in the SRS program may be enrolled in MyCare Ohio and vice versa
 - Transition of care requirements will apply to individuals enrolled in SRS who then subsequently enroll in MyCare
- 2 MyCare Ohio Plans may prior authorize SRS program services in accordance with 42 CFR 438.210
- 3 My Care Ohio Plans are responsible for the payment of SRS program services
- 4 MyCare Ohio Plans will need to contract with these providers in their networks
 - Plans are not permitted to perform recovery management services-they must contract with at least 1 of the recovery management providers in each region

Specialized Recovery Services Program – MyCare Managed Care

MyCare Responsibilities Cont'd

5

Care Management:

- Recovery Manager will be included as part of the individual's MyCare Ohio trans-disciplinary team
- The SRS plan will be integrated into the individual's comprehensive care plan

6

Incident Management

- Reporting of incidents in accordance with policy

7

The IE will perform annual eligibility re-determinations for SRS program continued enrollment

Specialized Recovery Services Program - non-MyCare Managed Care

Responsibilities of Medicaid Managed Care

- Managed Care Plans must coordinate with the Recovery Manager and IE for individuals enrolled in traditional managed care
- Managed Care Plans are not financially responsible for SRS program services until behavioral health is carved into managed care

Key Takeaways

- Specialized Recovery Services Program will be its own benefit plan with MITS.
- Assessment and service plan data will be sent from the IE to the plans.
 - » A process similar to what is used for Waiver/MyCare may be used



Questions?

bh.medicaid.ohio.gov – Contact Us



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1-800-324-8680

Frequently Asked Questions

As questions come in, they will be routed appropriately for an answer. Many people may have similar questions, so the most frequently asked questions (FAQs) and their answers will be posted on this site soon.