Behavioral Health Care Coordination

Re-opening of enrollment webinar
January 15, 2019
Introduction to today’s webinar

• Ohio Medicaid and Ohio Mental Health and Addiction Services have been working closely with a group of clinicians and the Medicaid managed care plans to develop an innovative behavioral health care coordination (BHCC) program designed to meet the needs of Medicaid members with severe behavioral health conditions.

• Service start for the BHCC program will begin on July 1st, 2019.

• The first round of enrollment occurred in July 2018. After some of you expressed interest in joining the BHCC program, we have decided to re-open enrollment from January 21st to February 1st for participation in July 1st service start.

• We’re excited about the opportunity to improve care for eligible members and to deepen support to qualified behavioral health entities (QBHEs) participating in the program.

• The purpose of today’s session is to share information about the program design and discuss the application process.
Provider webinar agenda

Overview of the BHCC program and member/provider benefits

BHCC implementation plan and progress
BHCC program design
Reporting
Applying to the BHCC program and next steps
Q&A
Reminder: Behavioral Health Redesign Strategic Plan

1. **Elevation (2012)** – shift Medicaid match to the state to ensure more consistent provision of treatment services statewide, supported by Departments of Medicaid and Mental Health and Addiction Services

2. **Expansion (2014)** – extended Medicaid coverage to more than 630,000 very low-income Ohioans with behavioral health needs who previously relied on county-funded services or went untreated

3. **Modernization (January 1, 2018)** – expand Medicaid services for individuals with the most intense need and update Medicaid billing codes for behavioral health providers to align with national standards

4. **Integration (July 1, 2018)** – coordinate physical and behavioral health care services within Medicaid managed care to support recovery for individuals with a substance use disorder or mental illness
Our goal is to fulfill BH redesign and create a coordinated BH care system

- Require health plans to delegate components of care coordination to qualified behavioral health centers (“Model 2” commitment)
- Care management identification strategy for high risk population

- Mutual Accountability
- Alignment on care plan, member relationship, transitions of care, etc.
- Common identification of needs and assignment of care coordination

- Require health plans to financially reward practices that keep people well and hold down total cost of care, including behavioral health
- Care coordination defaults to primary care unless otherwise assigned by the plan

Medicaid Managed Care Plan

Qualified Behavioral Health Center

Comprehensive Primary Care (CPC)
How will care coordination change?

How can the State, MCPs and providers best support members with behavioral health needs?

- **70%** of members with BH needs are being appropriately managed through primary care.
- **30%** currently receive more intensive support or are eligible for additional services under BH Redesign.
- **5-10%** of the BH population require intensive care coordination.

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1 Members who have been diagnosed with and treated for a behavioral health condition
2 “Currently receiving intensive support” is defined as those currently in health homes or receiving TCM, but not those receiving CPST; “Eligible for additional services under BH redesign” includes those eligible for ACT and IHBT, but not SRS
Overview of BH Care Coordination program

Qualified BH Entities form a care team, supporting the members and being held accountable both behavioral and physical health outcomes

Members matched with Qualified Behavioral Health Entities (QBHEs)

Member preference
Geographic proximity
Provider specialty
Benefits of BH Care Coordination for members

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship with the provider best equipped to serve member needs</td>
<td>through advanced member-provider matching</td>
</tr>
<tr>
<td>More integration between physical and behavioral health care providers</td>
<td>through new tools to facilitate data sharing and increased presence of care coordinators</td>
</tr>
<tr>
<td>Support for member choice</td>
<td>through member-focused care model</td>
</tr>
<tr>
<td>Reduced inpatient and ED admission frequency</td>
<td>through greater utilization of preventative health programs such as depression screening</td>
</tr>
<tr>
<td>Fewer disruptions to care</td>
<td>through increased collaboration between PCP/ CPC/MCP/QBHE before and after transitions to care</td>
</tr>
<tr>
<td>Assistance with fighting substance use disorder</td>
<td>through increased communication and collaboration with recovery services</td>
</tr>
<tr>
<td>Enhanced chronic condition management</td>
<td>through care coordinators and expanded role of provider in developing comprehensive care plans</td>
</tr>
<tr>
<td>Enhanced access to specialty providers</td>
<td>by reducing barriers to scheduling appointments</td>
</tr>
<tr>
<td>Improved treatment adherence</td>
<td>through measurement of treatment adherence and increased member follow-up</td>
</tr>
</tbody>
</table>
BHCC program benefits - providers

- Improve access by connecting more members to qualified behavioral health entities (QBHEs) to provide care coordination
- Create a more flexible payment structure, shifting away from 15 min FFS payments to a single monthly rate
- Reward high performing providers through connections with new members and a bonus payment
- Increase data sharing to aid QBHEs in better serving their members
- Improve care through better integration of primary care and behavioral health care
- Strengthen coordination and best practice sharing among entities, plans, and the State through regular touchpoints
Provider webinar agenda

Overview of the BHCC program and member/provider benefits

BHCC implementation plan and progress

BHCC program design

Reporting

Applying to the BHCC program and next steps

Q&A
# Progress made to date

### Regulatory
- Rule effective as of January 10th, 2019
- Have been meeting with SAMHSA and CMS to discuss the BHCC program and finalizing drafts of SPA and pre-print for submission to CMS

### Financing
- Incorporating BHCC program into ODM budget narrative

### Provider readiness
- 82 providers applied July 2018 for participation in the BHCC program. These providers will be notified of their enrollment status by January 18th
- Enrollment is re-opening January 21st-February 1st, with a webinar on January 15th
- Meeting with providers who applied in July 2018 to discuss workplan, program design, and how to read reports that are being released

### Contracting
- Provider agreement is updated to reflect the BHCC program
- MCPs will begin contracting with providers who applied July 2018 and are accepted into program

### Plan readiness
- Plans configuring their systems per provided BHCC program specifications

### Attribution and reporting
- Initial reports being shared with providers who applied for the program in July 2018. These reports will be refreshed on a quarterly basis
- Providers who apply in the re-opened enrollment period will receive their reports in June ahead of July service start

### Payment
- Designed monthly activity payment and bonus payment methodology
Provider webinar agenda

- Overview of the BHCC program and member/provider benefits
- BHCC implementation plan and progress
- **BHCC program design**
  - Reporting
  - Applying to the BHCC program and next steps
- Q&A
BHCC program design

- Provider requirements
- Target population
- Attribution
- Payment
Provider requirements

Initial eligibility requirements

- Entities must meet 100% of requirements
- Re-assessed during annual enrollment period

Activity requirements

- Entities must meet 100% of requirements
- Assessed annually for each provider

Performance requirements

- Entities must meet 50% of quality and 50% of efficiency requirements
- Reports released quarterly; performance evaluated annually. Data published on a six month lag
Initial eligibility requirements (1/2)

**Provider eligibility**

Provider must:

- Satisfy certification requirements set forth in paragraph (A)(1) of rule 5160-27-01 of the Administrative Code and in calendar year 2017 or later have provided both mental health (type 84) and substance use disorder (type 95) treatment services
- Or meet the requirements stated in (G)(2)(a) of rule 5160-2-75 of the Administrative Code if an outpatient hospital provider

**Personnel**

- One individual who serves as key point of contact for MCPs/State to discuss performance
- Identification of a care team, including the following roles:
  - Case manager to lead care coordination relationship, serving as primary point of contact for member and family
  - Registered Nurse(s) or licensed practical nurse to consult and coordinate with member’s other medical providers
  - Program administrative contact to act as the single point of contact to fulfill records requests and perform other administrative activities
- At the time of submitting an enrollment application to become a QBHE, have at least one practitioner from each of the following categories affiliated with the entity:
  - A practitioner with prescribing authority in the state of Ohio;
  - A registered nurse or licensed practical nurse; and
  - An other licensed professional as described in rule 5160-8-05 of the Administrative Code
- Specific staffing ratios will not be mandated, but a recommended range can be given to providers
QBHEs will have the ability to:

- Share, receive, and use electronic data from a variety of sources with other health care providers, ODM, and the MCPs;
- Use consent forms containing elements necessary to support the full exchange of health information in compliance with all applicable state and federal laws;
- Submit prescriptions electronically;
- Implement and actively use an electronic health record (EHR) in clinical services;
- Send, receive, and use continuity of care records through the use of standard electronic formats such as FHIR and C-CDA.
  - If QBHE enrolled in the BHCC program prior to July 1, 2019, QBHE will be prepared within six months of July 1, 2019 service start (January 2020);
  - If QBHE enrolled in the BHCC program after July 1, 2019, QBHE will be prepared at the time of application.

Entity meets one of the following requirements:

- Have an ownership or membership interest in a primary care organization where primary care services are fully integrated and embedded;
- Enter into a written integrated care agreement such as a contract or memorandum of understanding with a primary care provider; or
- Achieve implementation of primary physical health care standards by a national accrediting entity as an integrated primary care-behavioral health provider, primary care medical home or behavioral health home.
Activity requirements of QBHEs and corresponding G-codes

**G9012**: Conduct population health management, including the continuous identification of highest risk members and alignment within organization to focus resources and interventions

**G9011**: Engage supportive services, including facilitating access to community supports and communicating member needs to community partners

**G9010**: Engagement with and access to appropriate care, including support for scheduling and engaging directly with the member’s other providers

**G9004**: Lead initial outreach and engagement, including performing initial outreach to the member and building a trust-based relationship

**G9005**: Develop care plan, including leading development of the integrated care plan by gathering input from the member, other providers, and the member’s social support system

**G9006**: Lead ongoing relationship and engagement, including regular check-ins with the member to support treatment adherence, and high-touch support in crisis situations

**G9007**: Ease transitions of care, including monitoring and communicating about transition needs
## Role of QBHE, MCP, and CPC/PCP: Outreach and engagement

### QBHEs support members through care coordination activities

<table>
<thead>
<tr>
<th>Initial outreach/Engagement</th>
<th>Care plan</th>
<th>Ongoing engagement &amp; relationship</th>
<th>Access to care</th>
<th>Transition of care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population health management</td>
<td>Engaging supportive service</td>
<td>Population health management</td>
<td>Engaging supportive service</td>
<td>Population health management</td>
</tr>
</tbody>
</table>

### Role of QBHEs

- Leads initial member outreach, including education on program benefits and necessary enrollment activities
- Leads initial outreach with member’s CPC/PCP to share information regarding program participation and care plan development
- Builds trust-based relationship to understand member’s preferences and goals and begins engaging with family or social support system (e.g., schools, youth services)

### Role of MCPs

- As needed, provides data to BH entity to assist with identification of highest risk members, including timely updates regarding patient utilization of behavioral and physical health services

### Collaborating with CPCs/PCPs

- Shares physical health information relevant to program participation and development of the care plan
- May identify members who meet the claims-based definition for program participating

1 Additional discussion required for responsibility in Q1
QBHEs support members through care coordination activities

**Initial outreach/Engagement**

- Population health management
- Engaging supportive service
- Access to care
- Transition of care

**Care plan**

- Ongoing engagement & relationship

**Role of QBHEs**

- Leads creation and maintenance of integrated care plan, including leading outreach to CPC/PCP to incorporate inputs for physical health section
- Develops specific inputs for behavioral health section of care plan

**Role of MCPs**

- Provides input to care plans as necessary

**Collaborating with CPCs/PCPs**

- Provides input to integrated care plan by developing section for members’ physical health needs

**Role of QBHE, MCP, and CPC/PCP: Care plan**
Role of QBHE, MCP, and CPC/PCP: Ongoing engagement and relationship

<table>
<thead>
<tr>
<th>QBHEs support members through care coordination activities</th>
<th>Role of QBHEs</th>
<th>Role of MCPs</th>
<th>Collaborating with CPCs/PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population health management</td>
<td>▪ Serves as primary point of contact for member communication about behavioral and physical health needs</td>
<td>▪ Notifies members regarding program eligibility as necessary</td>
<td>▪ Educates member and their family on physical health, self-care, and treatment adherence, with understanding of behavioral health conditions</td>
</tr>
<tr>
<td>Engaging supportive service</td>
<td>▪ Leads member and family education on behavioral health, including self-care and adherence to treatment plan</td>
<td>▪ Educates members, families, and other social supports about the program and benefits of program participation</td>
<td>▪ Provides information to members related to their physical health needs</td>
</tr>
<tr>
<td>Access to care</td>
<td>▪ Leads follow ups with member on behavioral health care and updates the care plan and CPC/PCP as appropriate</td>
<td>▪ Leads follow ups with member on physical health care and updates the care plan and qualified BH entity as appropriate</td>
<td></td>
</tr>
</tbody>
</table>
Role of QBHE, MCP, and CPC/PCP: Transition of care

QBHEs support members through care coordination activities

- Initial outreach/Engagement
- Care plan
- Ongoing engagement & relationship
- Population health management
- Engaging supportive service
- Access to care

Role of QBHEs

- Leads outreach to CPC/PCP after major behavioral health events (e.g., inpatient stay) and discusses implications for physical healthcare
- Follows up with CPC/PCP following major physical health related events and discusses implications for behavioral health care as well as transition needs (e.g., transportation, medication restrictions)
- Establishes relationships with EDs and hospitals, and monitors admissions and discharges. Accountable for focus on admissions and discharges related to behavioral health treatment
- Notify the member’s MCP in the event of a transition into and out of SUD residential, ACT, and IHBT as potentially duplicative services
- If needed, transitions member’s care plan to new QBHE

Role of MCPs

- Answers questions related to eligible benefits to support transitions of care (e.g., questions about potential providers to refer to)
- Coordinate with the QBHE during the member’s transition into and out of SUD residential, ACT, and IHBT to prevent the duplicative billing of services
- Assist the member, in the event of need, to find a new QBHE based on member preference, visit history, and geo-proximity
- Notify the member’s MCP in the event of a transition into and out of SUD residential, ACT, and IHBT as potentially duplicative services
- If needed, transitions member’s care plan to new QBHE

Collaborating with CPCs/PCPs

- Leads outreach to qualified BH entity after major physical health events (e.g., inpatient stay) and discusses implications for behavioral health care
- Follows up with qualified BH entity following major behavioral health events (e.g., inpatient stay) and discusses implications for physical health care
- Accountable for focus on admissions and discharge for physical health related treatment
Role of QBHE, MCP, and CPC/PCP: Engagement with and access to appropriate care

QBHEs support members through care coordination activities

- Initial outreach/Engagement
- Care plan
- Ongoing engagement & relationship
- Access to care
- Transition of care
- Population health management
- Engaging supportive service

Role of QBHEs

- Leads scheduling with guidance from CPC/PCP, works with member to reduce barriers to attendance for appointments
- Leads follow-ups with CPC/PCP to understand implications from ambulatory or acute encounters (e.g., treatment adherence)
- Engages directly with member’s physical and other BH providers as well as community resources to support care, including updates to care plan
- Accountable for referral decision support and scheduling for behavioral health care in IP, OP, and ED settings
- Stabilizes crises by gathering information from member, CPC/PCP, social support system (e.g., schools, youth services), and other medical providers and formulates a response for immediate intervention and/or stabilization

Role of MCPs

- Addresses challenges to appropriate access to care, and escalates to State as appropriate

Collaborating with CPCs/PCPs

- Provides primary care
- Supports scheduling with guidance from qualified BH entity and works with member to reduce barriers to attendance
- Follows up with BH care coordinator to understand implications for physical health from behavioral health encounters (e.g., medication management)
- Accountable for referral decision support and scheduling for PH care in inpatient, outpatient, and emergency settings
Role of QBHE, MCP, and CPC/PCP: Engage supportive services

QBHEs support members through care coordination activities

- **Initial outreach/Engagement**
- **Population health management**
- **Engaging supportive service**
- **Care plan**
- **Ongoing engagement & relationship**
- **Access to care**
- **Transition of care**

**Role of QBHEs**
- Facilitates access to community supports by working with supportive services partners to address member needs

**Role of MCPs**
- As needed, provides information regarding relevant supportive services

**Collaborating with CPCs/PCPs**
- Engages with supportive services as required to support physical health care

**PROVIDER REQUIREMENTS**
Role of QBHE, MCP, and CPC/PCP: Population health management

QBHEs support members through care coordination activities

<table>
<thead>
<tr>
<th>QBHEs support members through care coordination activities</th>
<th>Role of QBHEs</th>
<th>Role of MCPs</th>
<th>Collaborating with CPCs/PCPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial outreach/Engagement</td>
<td>Continuous identifies highest risk members and aligns resources and interventions accordingly</td>
<td>As needed, provides data to BH entity to assist with identification of highest risk members, including timely updates regarding patient utilization of behavioral and physical health services</td>
<td>As needed, provides input to BH entity to assist with identification of highest risk members, including timely updates regarding changes in physical health condition(s) and/or level of acuity (e.g., uptick in inpatient stays for physical health conditions)</td>
</tr>
<tr>
<td>Care plan</td>
<td></td>
<td></td>
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<tr>
<td>Engaging supportive service</td>
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<td></td>
<td></td>
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<tr>
<td>Ongoing engagement &amp; relationship</td>
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</table>
Quality & efficiency metric guiding principles

Reminder: Guiding principles

- To the extent possible, maintain consistency with both CPC and behavioral health metrics in provider agreements
- Include a balanced set of behavioral and physical health metrics
- Select a focused number of metrics that:
  - Best enable providers to drive improvement
  - The majority of QBHEs will have sufficient volume to be scored
  - Draw from claims based sources where possible to increase operational feasibility
- Include efficiency metrics closely tied to total cost of care
- Include metrics applicable to both adult and pediatric entities
## BHCC program performance metrics

<table>
<thead>
<tr>
<th>Measure name</th>
<th>Must pass 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult health</strong></td>
<td></td>
</tr>
<tr>
<td>- Adult BMI assessment</td>
<td></td>
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<tr>
<td>- Controlling high blood pressure</td>
<td></td>
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<tr>
<td>- CDC - Eye exam (retinal) performed</td>
<td></td>
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<tr>
<td>- CDC - HbA1c Poor Control (&gt;9.0%)</td>
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<tr>
<td>- CDC - HbA1c Testing</td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral health</strong></td>
<td></td>
</tr>
<tr>
<td>- Adolescent well-care visits</td>
<td></td>
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<tr>
<td>- Weight assessment and counseling for nutrition and physical activity for children/adolescents: BMI documentation</td>
<td></td>
</tr>
<tr>
<td>- Percent of live births weighing less than 2,500 grams</td>
<td></td>
</tr>
<tr>
<td>- Prenatal &amp; postpartum care – timeliness of prenatal care</td>
<td></td>
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<tr>
<td>- Prenatal &amp; postpartum care – postpartum care</td>
<td></td>
</tr>
<tr>
<td>- Tobacco use: screening and cessation</td>
<td></td>
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<tr>
<td>- Follow-up after hospitalization for mental illness (7-day)</td>
<td></td>
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<tr>
<td>- Follow-up after emergency department visit for AOD (7-day)</td>
<td></td>
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<tr>
<td>- Follow-up after emergency department visit for mental illness (7-day)</td>
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<tr>
<td>- Antidepressant medication management: continuation</td>
<td></td>
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<tr>
<td>- Initiation and engagement of AOD treatment: engagement</td>
<td></td>
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<tr>
<td>- Adherence to antipsychotic medications for individuals with schizophrenia</td>
<td></td>
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<tr>
<td>- Metabolic monitoring for children and adolescents on antipsychotics</td>
<td></td>
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<tr>
<td>- Use of multiple concurrent antipsychotics in children and adolescents</td>
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<tr>
<td><strong>Opioids-related</strong></td>
<td></td>
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<tr>
<td>- Use of opioids at high dosage (&gt;80 MED / day)</td>
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<tr>
<td>- Opioid-related ED visits per 1,000 member months</td>
<td></td>
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<tr>
<td><strong>Efficiency</strong></td>
<td>Must pass 50%</td>
</tr>
<tr>
<td>- Emergency department visits per 1,000 member months</td>
<td></td>
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<tr>
<td>- BH-related inpatient admits per 1,000 member months</td>
<td></td>
</tr>
<tr>
<td>- Inpatient discharges per 1,000 member months (does not include BH admits)</td>
<td></td>
</tr>
<tr>
<td>- All-cause readmissions</td>
<td></td>
</tr>
</tbody>
</table>
The BHCC program target population

In partnership with clinicians, we have developed a claims-based definition that focuses on identifying individuals who have a behavioral health condition and a high likelihood of either:

**Significant utilization of behavioral health services** – members of the target population have a behavioral health PMPM $520 higher\(^1\) than other members who seek behavioral health services.

**An adverse event (e.g., attempted suicide) as a result of the behavioral health condition** – members of the target population have ~24x more BH-related IP visits\(^2\) than other members who seek behavioral health services.

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1 Target population had an average PMPM of $665 in CY17; other BH members had an average PMPM of $145 in the same period.
2 Target population had an average of 3.9 bh-related IP visits per 1,000; other BH members had an average of 0.2 bh-related IP visits in the same period.
Definition of target population

<table>
<thead>
<tr>
<th>Criteria</th>
<th>OR a claim with a procedure for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of the following diagnosis[^1]...</td>
<td>Injection antipsychotics</td>
</tr>
<tr>
<td>• Schizophrenia</td>
<td></td>
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<tr>
<td>• Bipolar disorder with psychosis</td>
<td></td>
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<tr>
<td>• Major depression with psychosis</td>
<td></td>
</tr>
<tr>
<td>• Attempted suicide or self-injury</td>
<td></td>
</tr>
<tr>
<td>• Homicidal ideation</td>
<td></td>
</tr>
<tr>
<td>• Substance use with pregnancy or one year postpartum</td>
<td></td>
</tr>
</tbody>
</table>

| One or more behavioral health-related utilization | |
| • Inpatient visit | |
| • Crisis unit visit | |
| • Residential facility visit | |
| • Rehab facility visit | |
| • Medication-assisted treatment for substance use | |
| • Day treatment (members under 21) | |

**AND presence of one of the following diagnoses[^1]**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar disorder without psychosis</td>
<td></td>
</tr>
<tr>
<td>Major depression without psychosis</td>
<td></td>
</tr>
<tr>
<td>Other depression</td>
<td></td>
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<tr>
<td>PTSD</td>
<td></td>
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<tr>
<td>Substance use disorder</td>
<td></td>
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<tr>
<td>Conduct disorder</td>
<td></td>
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<tr>
<td>Personality disorders</td>
<td></td>
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<tr>
<td>Psychosis</td>
<td></td>
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<tr>
<td>ODD</td>
<td></td>
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<tr>
<td>Eating disorders</td>
<td></td>
</tr>
</tbody>
</table>

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1 Diagnosis in primary field on the claim
2 Additional details on following page

We expect the majority of members to be identified using claims identification; however, additional referral channels (with appropriate MCP review) will be available to provide faster access than is available through claims review[^2]
Non-claims based eligibility

<table>
<thead>
<tr>
<th>Target population</th>
<th>Provider referral of member</th>
<th>Member self-identification</th>
<th>MCP identification of member</th>
<th>Member opt-out</th>
<th>MITS updates to eligibility and attribution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If a provider identifies a member that is newly eligible for the BHCC program, the provider must refer the member to the member’s MCP, providing the relevant documentation to support the member’s eligibility; the MCP will then confirm or deny the member’s eligibility.</td>
<td>If a member, or a member’s authorized representative, believes themselves eligible for the BHCC program, then the member/authorized representative should contact or be directed to contact their MCP to be validated for eligibility.</td>
<td>If an MCP identifies a member as newly eligible, then the MCP will notify ODM and help the member find a QBHE based on member preference, visit history, and geo-proximity.</td>
<td>A member can opt-out at any time as long as the MCP receives a verbal confirmation from the member.</td>
<td>Providers can contact MCPs or search eligibility and attribution in MITS, which will be updated as frequently as claims are submitted as well as once a month when MCPs submit their monthly add/delete files; Attribution report downloads will be updated quarterly.</td>
</tr>
</tbody>
</table>
## Approach to attribution

<table>
<thead>
<tr>
<th>Attribution is...</th>
<th>Attribution is NOT...</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Matching members with a QBHE best positioned to deliver care by:</td>
<td>• A limitation on member choice</td>
</tr>
<tr>
<td>– Identifying opportunities to connect members not currently in care with entities that best meet their needs</td>
<td>• A gatekeeper restricting choice of provider when utilizing other BH services</td>
</tr>
<tr>
<td>– Preserving continuity of care in cases where relationships already exist with QBHEs</td>
<td></td>
</tr>
</tbody>
</table>

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**Notes:**
- QBHE: **Behavioral Health Entity**
- BH: **Behavioral Health**
The attribution logic uses the following hierarchy to attribute members to providers:

- **BH care coordination visits**: Identify care coordination visits with BHCC program entities in the past 6 months
- **BH OP visits**: Identify outpatient visits with BHCC program entities in the past 18 months
- **CPC relationship**: Identify BHCC program entities who also have attributed members under CPC and maintain this relationship
- **Geographic proximity**: Identify BHCC program entities closest to the member who may best serve the member’s needs

A member can request to switch QBHEs at any time by contacting their MCP. The QBHE to which the member is attributed on the 1st of the month can bill for the month (further detail in the payment section).

After becoming a QBHE of the BHCC program, if a **QBHE wishes to opt out** from the BHCC program, they must give notice 60 days prior to quarter end and continue providing BH care coordination until the members can be reattributed in quarterly attribution. If the QBHE misses the 60 day deadline, then it is to continue providing BH care coordination until the end of the next quarter.
### Overview of payment structure

<table>
<thead>
<tr>
<th>BHCC</th>
<th>Objective</th>
<th>Support</th>
<th>Categories of support</th>
</tr>
</thead>
</table>
|      | • Compensate for ongoing activities performed by BHCC providers | • Monthly activity payment for providers meeting activity and member engagement requirements | • Service areas included for purposes of payment include:  
  — Outreach and engagement  
  — Care plan  
  — Ongoing relationship and engagement  
  — Transitions of care  
  — Engagement with and access to appropriate care  
  — Engagement of supportive services  
  — Population health management  
|      | • Monthly activity payment for providers meeting activity and member engagement requirements | • Service areas included for purposes of payment include:  
  — Outreach and engagement  
  — Care plan  
  — Ongoing relationship and engagement  
  — Transitions of care  
  — Engagement with and access to appropriate care  
  — Engagement of supportive services  
  — Population health management  
|      | • Encourage improvements in quality and efficiency outcomes and reward high performers | • Bonus payment based on outcome measures | • Magnitude of the QBHE’s bonus payment will be calculated based on overall program savings, QBHE performance, and other QBHE criteria  
• Will not take place until September of 2020, with the performance period running from January 1st to December 31st, 2019  
|      | • No change to existing reimbursement process for payments tied to discrete care services rendered | • Payments tied to discrete care services rendered | The following services remain paid through other claims-based payments:  
  • Evaluation and management  
  • Assessment and testing  
  • SUD  
  • Therapy  
  • Med management  
  • Recovery support (e.g., PSR, TBS)  

#### Monthly activity payment ($200 per month activities rendered)  
- This payment will replace CPST/TCM for eligible members  
- Members remain eligible for ACT, IHBT and SUD residential; while members receive ACT, IHBT, and SUD residential, providers can no longer bill for BHCC  

#### Bonus payment  
- Encourage improvements in quality and efficiency outcomes and reward high performers  
- Bonus payment based on outcome measures  

#### Existing payments  
- No change to existing reimbursement process for payments tied to discrete care services rendered  

#### Other claims-based payments  
- Payments tied to discrete care services rendered  

- The following services remain paid through other claims-based payments:  
  • Evaluation and management  
  • Assessment and testing  
  • SUD  
  • Therapy  
  • Med management  
  • Recovery support (e.g., PSR, TBS)
Methodology for BHCC monthly activity payment

- Current funding provided to each MCP for BH care coordination
- Consulting with MCPs and BH providers
- Reviewing current professional services rates
- Monthly BHCC rate: $200
- Benchmarking against payments for similar programs in other states
- Reviewing current contracted rates for care coordination
- Researching the cost of staffing models
- Example rates in other states:
  - Kansas: $171
  - Maryland: $98
  - Tennessee: $139-200

- Spend varied for the target population
- For most members, providers billed less than $186/month for care coordination services for CPST
- Estimated cost to support the potential staffing model is $156 PMPM
Billing structure

Guiding principles

• QBHEs will receive a **rate of $200 for each engaged member each month** required activities for initial and ongoing payment are delivered (detail follows). This will be in place of current FFS reimbursement for BH care coordination.

• Entities **can only submit a single monthly claim**. For the claim to be paid, the claim must include the BHCC program S-code for billing, at least one G-code for activities rendered that do not overlap with duplicative services (detail on service overlaps follows), and the relevant modifiers. G-codes should be dated the date the service was rendered, and S-codes should be dated the same as the first rendered G-code.

• The claim **cannot be submitted until the first day of the month following when activities were delivered**.
### Billing codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>S0281</td>
<td>For initial and ongoing payment of BHCC activities</td>
<td>$200/month</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Activity</th>
<th>Member or Collateral</th>
<th>Face-to-Face or Indirect</th>
</tr>
</thead>
<tbody>
<tr>
<td>G9004</td>
<td>Outreach and engagement</td>
<td>UA: Member</td>
<td>UC: Face-to-Face</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UB: Collateral</td>
<td>UD: Indirect</td>
</tr>
<tr>
<td>G9005</td>
<td>Comprehensive care plan</td>
<td>UA: Member</td>
<td>UC: Face-to-Face</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UB: Collateral</td>
<td>UD: Indirect</td>
</tr>
<tr>
<td>G9006</td>
<td>Ongoing relationship maintenance</td>
<td>UA: Member</td>
<td>UC: Face-to-Face</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UB: Collateral</td>
<td>UD: Indirect</td>
</tr>
<tr>
<td>G9007</td>
<td>Individual transition</td>
<td>UA: Member</td>
<td>UC: Face-to-Face</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UB: Collateral</td>
<td>UD: Indirect</td>
</tr>
<tr>
<td>G9010</td>
<td>Individual engagement and access to appropriate care</td>
<td>UA: Member</td>
<td>UC: Face-to-Face</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UB: Collateral</td>
<td>UD: Indirect</td>
</tr>
<tr>
<td>G9011</td>
<td>Engaging supportive services</td>
<td>UA: Member</td>
<td>UC: Face-to-Face</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UB: Collateral</td>
<td>UD: Indirect</td>
</tr>
<tr>
<td>G0912</td>
<td>Population health management</td>
<td>UA: Member</td>
<td>UC: Face-to-Face</td>
</tr>
<tr>
<td></td>
<td></td>
<td>UB: Collateral</td>
<td>UD: Indirect</td>
</tr>
</tbody>
</table>

### Claims submissions

- A BHCC program **claim is complete if it includes the program S-code** (dated as the first rendered activity), **at least one G-code without service overlap**, and the **relevant modifiers** (UA, UB; UC, UD)
Minimum activity requirements for payment – initial vs. ongoing

<table>
<thead>
<tr>
<th>Initial payment</th>
<th>Ongoing payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum activity requirements for payment</td>
<td>The entity has rendered one or more of the 7 BHCC program G-codes</td>
</tr>
</tbody>
</table>
| ▪ The entity has rendered (at a minimum) the required activities for **outreach / engagement**:  
  — Conduct initial outreach and engagement with attributed individuals upon enrollment in the BHCC program  
  — Lead initial outreach with the attributed individual's PCP to share information regarding the BHCC program participation and care plan development  
  — Build trust-based relationships to understand the preferences and goals of the attributed individual and begin engaging with the individual's family or social support system  
  ▪ **Within 30 days of the first BHCC activity conducted, begin development of an integrated care plan** that addresses the individual’s BH and PH needs | ▪ The entity has rendered **one or more of the 7 BHCC program G-codes**  
  — **G9004** Outreach and engagement  
  — **G9005** Comprehensive care plan  
  — **G9006** Ongoing relationship maintenance  
  — **G9007** Individual transition of care  
  — **G9010** Individual engagement and access to appropriate care  
  — **G9011** Engaging supportive services  
  — **G0912** Population Health Management |
| ▪ Minimum G-codes and allowable modifiers | ▪ One or more of the 7 BHCC program G-codes (G9004, G9005, G9006, G9007, G9010, G9011, and/or G0912)  
  — UA: Member or UB: Collateral  
  — UC: Face-to-face or UD: Indirect |
|            | ▪ **G9004**: Outreach and engagement  
  — UA: Member or UB: Collateral  
  — UC: Face-to-face or UD: Indirect  
  ▪ **G9005**: Care plan  
  — UA: Member or UB: Collateral  
  — UC: Face-to-face or UD: Indirect |

A minimum of one G-code per monthly claim must have a modifier of UA: Member in order to be paid
Billing and service overlaps

- Billing for CPST and TCM is prohibited for attributed members.
- CPST/TCM providers are encouraged to check MITS or with a member’s MCP prior to billing for CPST/TCM.
- BHCC payment is paused while a member is in ACT/IBHT.
- MCPs will be monitoring to prevent billing overlap.
- BHCC claims can still be paid to QBHEs who deliver the minimum required activities on service dates before a member’s entry into ACT/IBHT as well as after discharge.

Pause BHCC payment

<table>
<thead>
<tr>
<th>May not be billed for attributed members</th>
<th>CPST/TCM</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Billing for CPST and TCM is prohibited for attributed members</td>
<td></td>
</tr>
<tr>
<td>▪ CPST/TCM providers are encouraged to check MITS or with a member’s MCP prior to billing for CPST/TCM</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACT / IHBT</th>
<th>SUD Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ BHCC payment is paused while a member is in ACT/IBHT</td>
<td></td>
</tr>
<tr>
<td>▪ MCPs will be monitoring to prevent billing overlap</td>
<td></td>
</tr>
<tr>
<td>▪ BHCC claims can still be paid to QBHEs who deliver the minimum required activities on service dates before a member’s entry into ACT/IBHT as well as after discharge</td>
<td></td>
</tr>
<tr>
<td>▪ BHCC payment is paused while a member is in SUD residential</td>
<td></td>
</tr>
<tr>
<td>▪ QBHEs are required to notify MCPs within 24 hours of a member entering SUD residential and within 24 hours of a member being discharged from SUD residential</td>
<td></td>
</tr>
<tr>
<td>▪ BHCC claims can still be paid to QBHEs who deliver the minimum required activities on service dates before a member’s entry into SUD residential as well as after discharge</td>
<td></td>
</tr>
</tbody>
</table>

1 Upon implementation of the SUD 1115 waiver, MCPs will be monitoring prior authorization requests for SUD residential and the 24 hour notice will not be necessary.
Provider webinar agenda

Overview of the BHCC program and member/provider benefits

BHCC implementation plan and progress

BHCC program design

**Reporting**

Applying to the BHCC program and next steps

Q&A
### Overview of BHCC program reports

#### Attribution file
Contains member-level detail on an entity’s attributed members and associated information (e.g., demographics, payer and provider information, conditions, utilization)

<table>
<thead>
<tr>
<th>Files included</th>
<th>Data lag</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 quarterly (.csv) file</td>
<td>3 months</td>
</tr>
</tbody>
</table>

#### Performance reports
Contain an entity-level summary and a member-level detail of Ohio BHCC program performance over a rolling 12-month period for an entity’s attributed members

<table>
<thead>
<tr>
<th>Files included</th>
<th>Data lag</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 quarterly (PDF) file</td>
<td>6 months</td>
</tr>
<tr>
<td>1 quarterly (.csv) file</td>
<td></td>
</tr>
</tbody>
</table>

#### Opioids reports
Contain an entity-level summary and a member-level detail of key statistics related to opioid use disorder prevention and treatment over a rolling 12-month period for an entity’s attributed members

<table>
<thead>
<tr>
<th>Files included</th>
<th>Data lag</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 quarterly (PDF) file</td>
<td>6 months</td>
</tr>
<tr>
<td>1 quarterly (.csv) file</td>
<td></td>
</tr>
</tbody>
</table>
Provider webinar agenda

Overview of the BHCC program and member/provider benefits

BHCC implementation plan and progress

BHCC program design

Reporting

Applying to the BHCC program and next steps

Q&A
July 2018 provider applications

- **82 providers** applied in the July 2018 enrollment period
- These providers **include the following:**
  - 69 providers with sites that serve pediatric patients
  - 10 high-fidelity wrap around providers
  - 7 type 01 hospital providers
- The providers that applied cover ~**80% of all counties** in Ohio and are **within 20 miles of the majority of targeted members**
How to apply for the BHCC program

Website details

• From January 21st to February 1st, providers interested in joining the BHCC program may apply to do so through the application portal located on the BHCC website at http://bh.medicaid.ohio.gov/Provider/BHCC

• There you will see a button

• This will take you to the application for the BHCC program (details to follow)
  − The BHCC program application aims to confirm the provider’s initial eligibility, commitment to the activities required of the QBHE, and ability to perform the role of the QBHE effectively

• Please email BHCareCoordination@medicaid.ohio.gov if you have any questions about the enrollment process of the BHCC program more broadly
### BHCC program application (1/3)

#### Behavior Health Care Coordination Provider Enrollment

**Application Reference:** OWJ-Q3

**Submit Timestamp:** 01/03/2019 11:23:29

Please ensure all responses are accurate as of 1/3/2019. **The Ohio Department of Medicaid reserves the right to conduct additional verification** for the submitted responses.

---

### Identifying practice information

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Tax Id</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample Practice</td>
<td>123456789</td>
</tr>
</tbody>
</table>

### Medicaid IDs and site locations

For every brick and mortar site associated with each Medicaid ID, please list the address (street, city, and zip code) and whether the site specializes in treatment of adults, pediatric members or both.

<table>
<thead>
<tr>
<th>Medicaid ID</th>
<th>Location</th>
<th>Site Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>1234567</td>
<td>50 W Town St Columbus</td>
<td>Adult</td>
</tr>
<tr>
<td>9876543</td>
<td>124 E Broad St Columbus</td>
<td>Child</td>
</tr>
<tr>
<td>1479635</td>
<td>12 Olentagy Rd Columbus</td>
<td>Adult &amp; Child</td>
</tr>
</tbody>
</table>

### Designated point of contact for State communications

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Email</th>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selva S Chandramani</td>
<td><a href="mailto:selva.chandramani@medicaid.ohio.gov">selva.chandramani@medicaid.ohio.gov</a></td>
<td>50 W Town St Suite 200 Columbus OH 43215</td>
</tr>
<tr>
<td>Phone: 1234567890</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Provider Eligibility

**Please attest that your practice:**
- ✔ Satisfies certification requirements set forth in paragraph (A)(1) of rule 5160-27-01 of the Administrative Code and in calendar year 2017 or later have provided both mental health (type 84) and substance use disorder (type 95) treatment services
- ☐ Meets the requirements stated in (G)(2)(a) of rule 5160-2-75 of the Administrative Code if an outpatient hospital provider
- ☐ Neither of the above

### Activity requirements

**Please attest that your practice will adhere to the following activity requirements:**
- ✔ Conduct and lead outreach to members and PCPs
- ✔ Engage care providers and address barriers to appropriate care for members
- ✔ Engage with and facilitate member access to supportive services
- ✔ Maintain ongoing relationship with members and their families
- ✔ Lead development of comprehensive care plan for members, with input from PCPs and MCPs
- ✔ Identify high-risk members and ensure delivery of targeted interventions to improve population health
- ✔ Ensure successful member transitions between providers and sites of care

### Tools

**The capabilities below are all required for program eligibility. All items below must be selected.**
- ✔ My practice has the capacity to share data with ODM, contracted managed care plans, and other healthcare providers
- ✔ My practice has obtained the consent forms needed to share medical information across providers in accordance with federal and state laws
- ✔ My practice uses e-prescribing capabilities
- ✔ My practice has and actively uses and electronic health record in clinical services
- ✔ My practice has or will have within 6 months of July 1st, 2019 service start (January 2020) the ability to send, receive and use continuity of care records through the use of standard electronic formats, such as C-CDA or FHIR technology
### Commitment to integration

Meeting at least one of the indicators below is required for program eligibility. Please complete any combination of the following that apply:

- ✓ My practice has an ownership or membership interest in a primary care organization (Medicaid Id: 9845465) where primary care services are fully integrated and embedded
- ✓ My practice has written commitment of collaboration with a Medicaid enrolled PCP or CPC (Medicaid Id: 6523546) that covers all site locations
- ✓ My practice has achieved implementation of primary physical health care standards by a national accrediting entity as a primary care medical home, or behavioral health home

**Accreditation body:** Commission on Accreditation of Rehabilitative Facilities

### Personnel

Please attest that your practice meets the following personnel requirements:

- ✓ My practice has identified a care team that includes care managers who lead care coordination relationships and serve as primary points of contact for members and family, and Registered Nurses who consult and coordinate with other medical providers
- ✓ My practice has identified at least one practitioner with prescribing authority in the state of Ohio, at least one registered nurse or licensed practical nurse, and at least one other licensed professional as described in rule 5160-8-05 of the Ohio Administrative Code

### Additional comments (optional)

Using this form to test the new changes requested for 2019 enrollment.

### Certification of Accuracy

I, **Selva S Chandramani** certify the information on this application is true and subject to review by the Ohio Department of Medicaid
Next steps

- **Tomorrow, January 16th:** How to read your attribution report webinar (optional)
- **January 21st – February 1st:** Provider enrollment re-opens on January 21st and closes February 1st
- **January 30th:** How to read your Performance report webinar (optional)
- **February – March:** Qualified entities who enroll in re-opened period will be notified of enrollment decisions on a rolling basis
  - Once QBHEs have been notified of acceptance into the program, MCPs will have 90 days to contract
- **June:** Reporting begins for January 2019-applied providers
- **July 1st:** Service start of the BHCC program
Appendix
# Staffing and salary example assumptions

<table>
<thead>
<tr>
<th>Annual salary</th>
<th>Staffing ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manager = $57,500</td>
<td>1 per 1,000 patients</td>
</tr>
<tr>
<td>Registered Nurse = $52,000</td>
<td>1 per 250 patients</td>
</tr>
<tr>
<td>Case manager = $31,300</td>
<td>1 per 45 patients</td>
</tr>
<tr>
<td>Program administrative contact = $28,500</td>
<td>1 per 200 patients</td>
</tr>
</tbody>
</table>

- Staffing assumptions builds up to a monthly rate of ~$160/month per member
- These average staffing ratios are not required; QBHEs may choose to use other staffing models based on their operational needs

1 Based on Ohio average salary