



Department of Medicaid  
Department of Mental Health and Addiction Services

# Benefit and Service Development Work Group

May 23<sup>rd</sup>, 2018



Behavioral Health Redesign

# May 23<sup>rd</sup>, 2018 Agenda

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**Welcome and Opening Remarks**

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**Behavioral Health Care Coordination**

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**FFS Prior Authorization Update**

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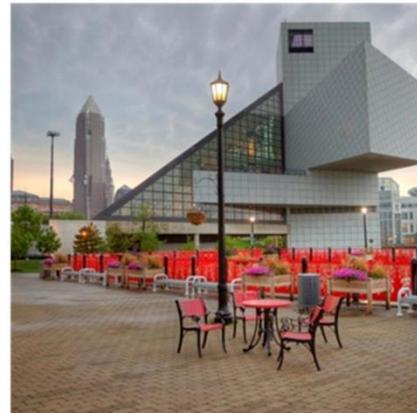
**Preparing for Medicaid Managed Care - OAHP**

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# BH Care Coordination

BSD Workgroup | May 2018

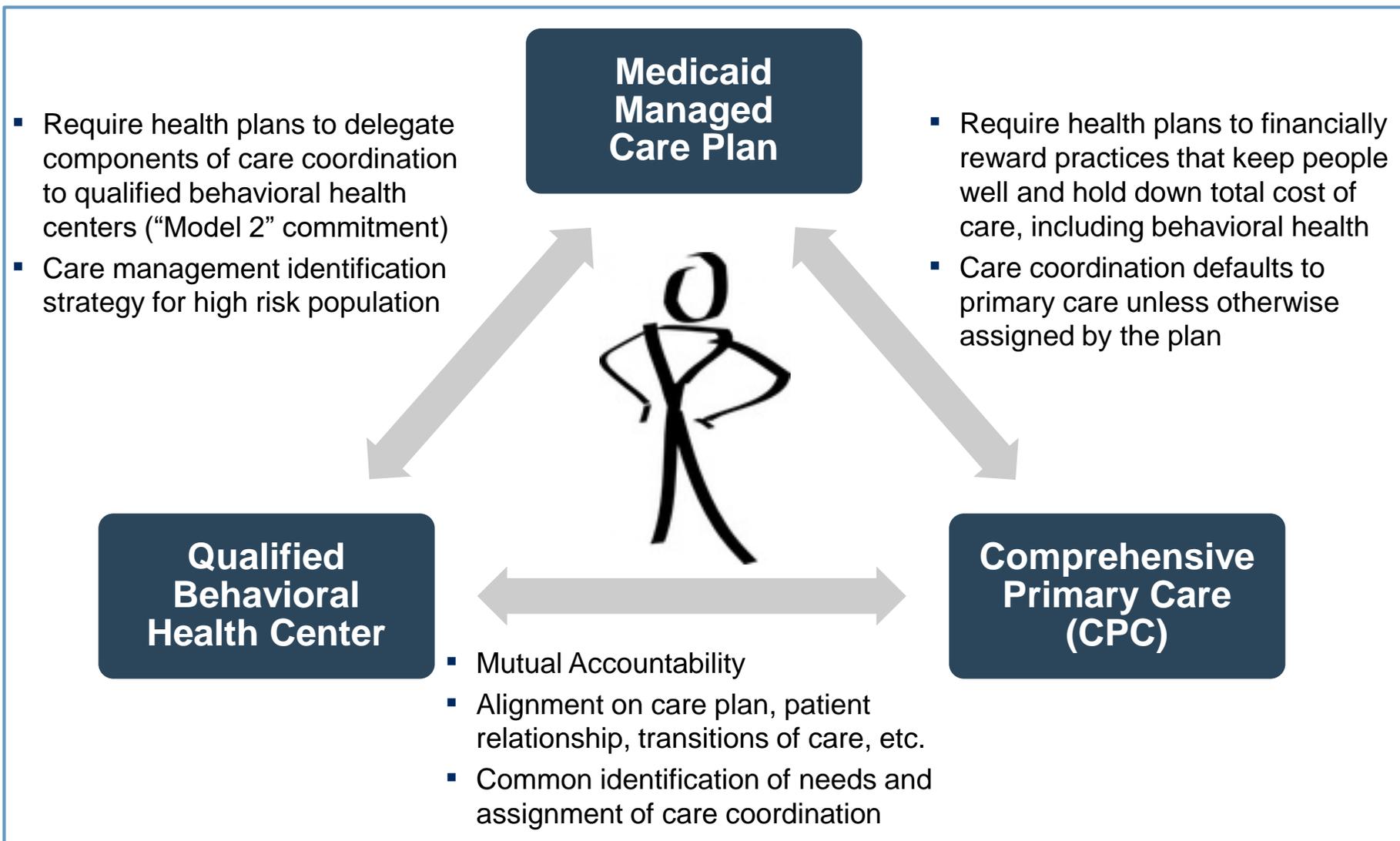


**Ohio** | Governor's Office of Health Transformation

# Agenda for today's discussion

- Discuss program overview and timeline
- Review key design features:
  - Target population
  - Activity requirements
  - Performance measurement
  - Member attribution
  - Payment structure
- Discuss decisions around other care coordination models
- Next steps and questions

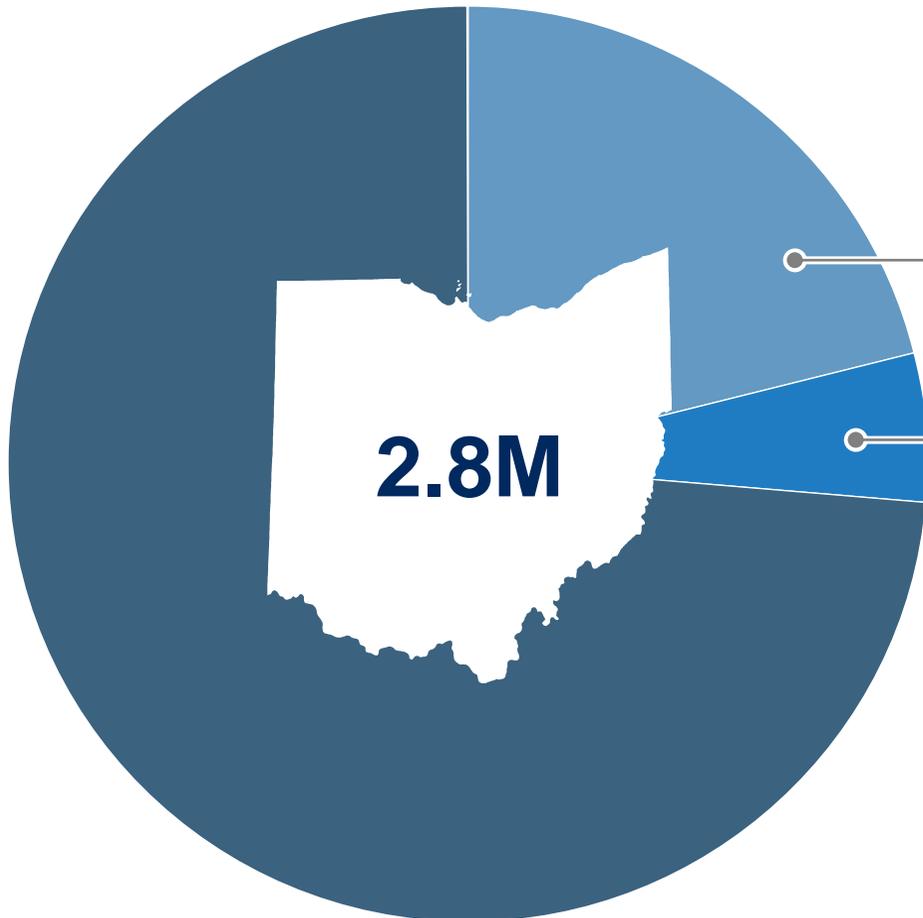
# Our goal is to design a BH care coordination program that fulfills the “Model 2” promise



# How will care coordination improve?

PRELIMINARY

**Approximately 26 percent (lighter blue) of the total Medicaid population has been diagnosed with and treated for a behavioral health condition**



- **90-95%** of members with BH needs will receive care coordination through the existing 5 Medicaid managed care plans
- **5-10%** of members with the most intensive BH needs will receive care coordination from a behavioral health center that is specifically qualified to integrate and manage physical and BH services

# Overview of BH Care Coordination program

Members matched with Qualified Behavioral Health Entities

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



# Benefits of BH Care Coordination for members



## Relationship with the provider best equipped to serve member needs

through advanced member-provider matching



## More integration between physical and behavioral health care providers

through new tools to facilitate data sharing and increased presence of care coordinators



## Support for member choice through member-focused care model



## Reduced inpatient and ED admission frequency

through greater utilization of preventative health programs such as depression screening



## Fewer disruptions to care through increased collaboration between PCP/CPC/MCP/Qualified Entity before and after member handoffs



## Assistance with fighting substance use disorder

through increased communication and collaboration with recovery services



## Enhanced chronic condition management

through care coordinators and expanded role of provider in developing comprehensive care plans



## Enhanced access to specialty providers

by reducing barriers to scheduling appointments



## Improved treatment adherence

through measurement of treatment adherence and increased member follow-up



## Improved recovery supports

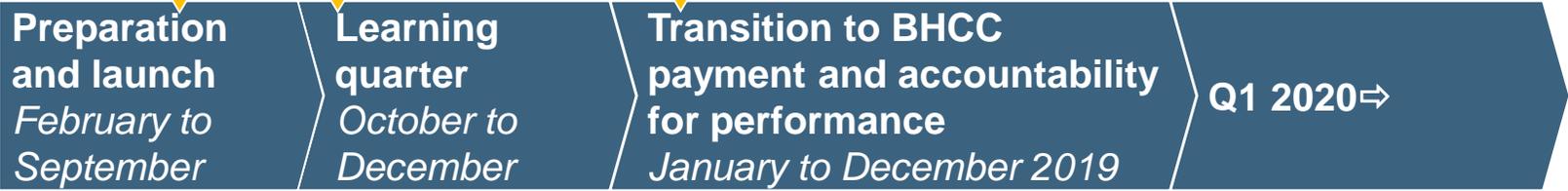
through enhanced collaboration between providers

# BHCC timeline

July – Provider enrollment

October – reporting begins

January – Transition to BHCC payment



Qualified entities

All BH providers

Single, integrated monthly payment that covers full scope of care coordination activities and is dependent on member engagement

Accountability for performance measures begins

Bonus payment introduced

▲ ▲ ▲ ▲ ▲ ▲ ▲ ▲ ▲

Attribution and quarterly performance measurement reporting released

Integrate with payment integrity/FW&A efforts (e.g., monitor inappropriate use of care coordination services, duplicative payments across services and providers)

# Defining the 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 \$550 higher<sup>1</sup>** 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 ~4x more IP visits<sup>2</sup>** than other members who seek behavioral health services

<sup>1</sup>Target population had an average \$729 PMPM in CY16; other BH members had an average of \$167 PMPM in the same period

<sup>2</sup>Target population had an average of 7.7 IP visits per 1,000; other BH members had an average of 1.9 IP visits in the same period

# Claims-based definition of target population

## Criteria

### Presence of the following diagnosis<sup>1</sup>...

- Schizophrenia
- Bipolar disorder with psychosis
- Major depression with psychosis
- Attempted suicide or self-injury
- Homicidal ideation
- Substance use with pregnancy or one year postpartum

### OR a claim with a procedure for

- Injection antipsychotics

**Group 1:  
Diagnostic  
criteria  
only  
(~67k  
members)**

**Or**

**Group 2:  
Diagnostic  
and  
utilization  
criteria  
(~25k  
members)**

### One or more behavioral health-related utilization

- Inpatient visit
- Crisis unit visit
- Residential facility visit
- Rehab facility visit
- Medication-assisted treatment for substance use
- Partial hospitalization (members under 21)

### AND presence of one of the following diagnoses<sup>1</sup>

- Bipolar disorder without psychosis
- Major depression without psychosis
- Other depression
- PTSD
- Substance use
- Conduct disorder
- Personality disorders
- Psychosis
- ODD
- Eating disorders

## Alternate pathways for inclusion

Members not in managed care to be included after transition to managed care; members in residential treatment facilities or nursing facilities who have resided there for > 90 days to be included upon exit

## Excluded from analysis

Members with third-party liability, partial eligibility, less than 6 months eligibility, duals, or death during the year

**For both Group 1 and Group 2 members, there will also be a referral channel (with appropriate MCP review) to provide faster access than is available through claims review**

<sup>1</sup> Diagnosis in primary field on the claim  
Note: Both Groups 1 and 2 have a 12-month lookback period for diagnoses and utilization

# Initial provider eligibility requirements

## Provider type

- Have been enrolled in the Medicaid Information Technology System (MITS) as both an active provider type 84 and an active provider type 95 during calendar year 2017. The MITS provider type 84 and provider type 95 must share the same federal Tax Identification Number issued by the Internal Revenue Service.
- Hospital outpatient providers who meet the requirements identified in (G)(2)(a) of rule 5160-2-75 of the Administrative Code are also eligible to participate
  - At the time of submitting an enrollment application to become a QBHE, have at least one practitioner from each of the following type categories affiliated in MITS with both the MITS provider type 84 and provider type 95 as defined in paragraph 1.
    - A practitioner that has medication prescribing authority in the state of Ohio
    - A Registered Nurse or a Licensed Practical Nurse
    - An other licensed professional as defined in rule 5160-8-05 of the Ohio Administrative Code
    - An unlicensed practitioner as defined in rule 5160-27-01 of the Ohio Administrative Code
  - The practitioner types, as defined in paragraph 2, must continue to be affiliated with the providers as defined in paragraph 1 at all times during participation in the behavioral health care coordination program.

## Commitment to integration

- Entity demonstrates an organizational commitment to integration of physical and behavioral health care at the date of application to become a QBHE. The entity must:
  - Have an ownership or membership interest in a primary care organization where primary care services are fully integrated and embedded; or
  - Enters into a written integrated care agreement which is a contract, memorandum of understanding, or other written agreement with an Ohio Medicaid primary care provider; or
  - Achieve implementation of primary physical health care standards by a national accrediting entity as a primary care medical home, or behavioral health home

## Tools

- At time of enrollment, has the capacity to share data with ODM and contracted managed care plans (MCPs)
- At time of enrollment, has the consent forms containing the elements necessary to support the full exchange of health information in conformance with federal and state law, including recent changes to 42 CFR Part 2
- At time of enrollment, uses e-Prescribing capabilities
- At time of enrollment, has and actively uses an Electronic Health Record (EHR) that is certified for Meaningful Use
- By July 1st 2019, has the ability to send, receive and use information in C-CDA format or through FHIR technology

## Personnel

- One individual who serves as key point of contact for MCPs/State to discuss performance
- Identification of a care team, including:
  - Case managers to lead care coordination relationship, serving as primary point of contact for member and family
  - Registered Nurse(s) or Licensed Practical Nurse(s), to consult and coordinate with member's other medical providers

# BHCC activity requirements (1/2)

In the language below, “PCP” refers to Primary Care Practice, inclusive of Comprehensive Primary Care Practices

## Initial outreach and engagement

- Conduct initial outreach and engagement with attributed members
- Lead initial outreach with a member’s primary care provider to share information regarding BHCC program participation and care plan development
- Build trust-based relationship to understand member’s preferences and goals and begin engaging with family or social support system
- Lead development of outreach plan that ensures alignment with PCP and MCP on process for information exchange and each stakeholder’s role in coordinating care
- Establish relationships and collaborations with full spectrum of providers and payers as appropriate
- Educate other providers and payers on BHCC service and on the value of collaborating to deliver on service components

## Care plan

- Develop comprehensive care plans for a member’s BH and physical health needs
- Lead for creating and maintaining comprehensive care plan, including leading outreach to PCP to incorporate inputs for physical health section
- Develop specific inputs for behavioral health section of care plan

## Ongoing relationship and engagement

- Maintaining an ongoing relationship with each member through regular check-ins, educational activities, and additional intensive support, as needed
- Serve as the primary point of contact for member communication about behavioral and physical health needs
- Lead member and family education on behavioral health, including self-care and adherence to treatment plan
- Lead follow ups with member on behavioral health care and update the care plan and PCP as appropriate

# BHCC activity requirements (2/2)

## Transitions of care

- Ensure successful member transition between providers or sites of care
- Lead outreach to PCP after major BH events (e.g., inpatient stay) and discuss implications for physical healthcare
- Follow up with PCP following major physical health related events and discuss implications for behavioral health care as well as transition needs (e.g., as transportation, medication restrictions, etc.)
- Establish relationships with EDs and hospitals, and monitor admissions and discharges. Accountable for focus on admissions and discharges related to behavioral health treatment

## Engagement with and access to appropriate care

- Improve member access to appropriate care by addressing barriers, such as assistance with scheduling appointments or connecting the member to transportation
- Lead scheduling with guidance from PCP and work with member to reduce barriers to attendance for appointments
- Lead follow-ups with PCP to understand implications from ambulatory or acute encounters (e.g., treatment adherence)
- Engage directly with member's health care providers as well as community resources to support care, including updates to care plan
- Be accountable for referral decision support and scheduling for behavioral health care in inpatient and outpatient settings
- Stabilize crises by gathering information from member, PCP, social support system, and other medical providers and formulating a response for immediate intervention and/or stabilization

## Engage supportive services

- Facilitate access to community supports (e.g, essential benefits, housing or vocational services), including scheduling and follow through
- Communicate member needs to community partners and other social resources

## Population health management

- Identify high-risk members and utilize the appropriate resources to deliver specialized interventions to those members

# Program requirements: Detail on performance measurement

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<b>Initial eligibility requirements</b>	 <b>Provider type</b>	 <b>Commitment to integration</b>	 <b>Tools</b>	 <b>Personnel</b>
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<b>Ongoing requirements</b>	<p><b>Activity requirements</b></p> <ul style="list-style-type: none"> <li>▪ Initial outreach and engagement</li> <li>▪ Care plan</li> <li>▪ Ongoing relationship and engagement</li> <li>▪ Transitions of care</li> <li>▪ Engagement with and access to appropriate care</li> <li>▪ Engage supportive services</li> <li>▪ Population health management</li> </ul>	<p><b>Efficiency measures</b></p> <ul style="list-style-type: none"> <li>▪ ED visits per 1,000 members</li> <li>▪ Behavioral Health-related IP Admits / 1,000 Members</li> </ul>	<p><b>Clinical and quality measures</b></p> <ul style="list-style-type: none"> <li>▪ Behavioral health measures (e.g., use of multiple concurrent antipsychotics in children &amp; adolescents)</li> <li>▪ Physical health measures (e.g., adolescent well-care visits)</li> </ul>
	<b>MEASURES ARE ILLUSTRATIVE</b>		

<b>Re-verification</b>	<ul style="list-style-type: none"> <li>▪ Annual assessment to confirm that eligibility requirements are met and that provider is performing sufficiently against activity, efficiency, and clinical measures</li> <li>▪ Based on results of assessment, providers may be deemed ineligible or experience changes in payment in the following year</li> </ul>
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# Overview of quality and efficiency measures

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Measures		Example measures
To determine eligibility and payment	Adult health	<ul style="list-style-type: none"> <li>• Adult BMI assessment</li> </ul>
	Behavioral health	<ul style="list-style-type: none"> <li>• Follow-Up After ED Visit for Alcohol and Other Drug Dependence, Total, 7-day &amp; 30-day</li> </ul>
	Pediatric health	<ul style="list-style-type: none"> <li>• Adolescent well-care visits</li> </ul>
	Women’s health	<ul style="list-style-type: none"> <li>• Prenatal and Postpartum Care - Timeliness of Prenatal Care</li> </ul>
	Efficiency	<ul style="list-style-type: none"> <li>• Ambulatory Care – ED visits</li> </ul>
For informational purposes only	Engagement and treatment adherence	<ul style="list-style-type: none"> <li>• Percentage of members engaged</li> </ul>
	Social determinants	<ul style="list-style-type: none"> <li>• Percentage of members with employment income</li> </ul>
	Opioid risk factors	<ul style="list-style-type: none"> <li>• Use of opioids at high dosage</li> </ul>

# Reminder: Reports being launched as part of BHCC

## Report type

## Format

## Description

## Level of detail

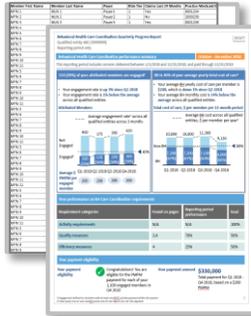
Attribution file

1 .csv file

- Member-level detail for members attributed to an entity for the upcoming performance period that will include information such as:
  - Member-level demographic information
  - Clinical data flags regarding behavioral health and chronic conditions

- Primarily member-level

Provider performance report



1 PDF file  
1 .csv file

- Provider-level summary and member-level detail for members in the current performance period that will include information such as:
  - Member engagement
  - Performance on quality and efficiency measures
  - Total and BH cost of care
  - Opioids-specific measures

- Tax ID, Medicaid ID and member-level

Additional information to support patient-centric care

TBD – under design

- Data on non-clinical factors important for member care for the current performance period

- TBD: data may contain both member-level detail as well as other data available at higher levels of detail

# Approach to attribution

## Attribution is...



- Matching members with a qualified entity best positioned to deliver care by:
  - Identifying opportunities to connect members not currently in care with entities that best meet their needs
  - Preserving continuity of care in cases where relationships already exist with qualified entities

## Attribution is not...

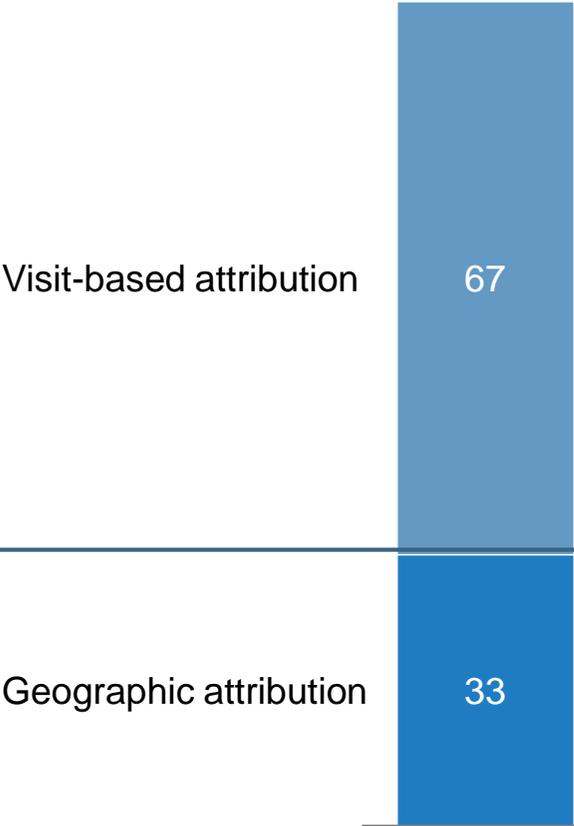


- NOT a limitation on member choice
- NOT a gatekeeper restricting choice of provider when utilizing other BH services

# Attribution: High-level overview

### Members attributed by method (%):

### Factors considered:



- Most recent BH care coordination visits
- Most recent BH outpatient visits
- Most BH care coordination visits
- Most BH outpatient visits
- Presence of SUD
- Current CPC attribution

- Distance between members (assessed at Medicaid ID level) and entities
- Member age and presence of SUD and entity adult / pediatric specialty and practice type

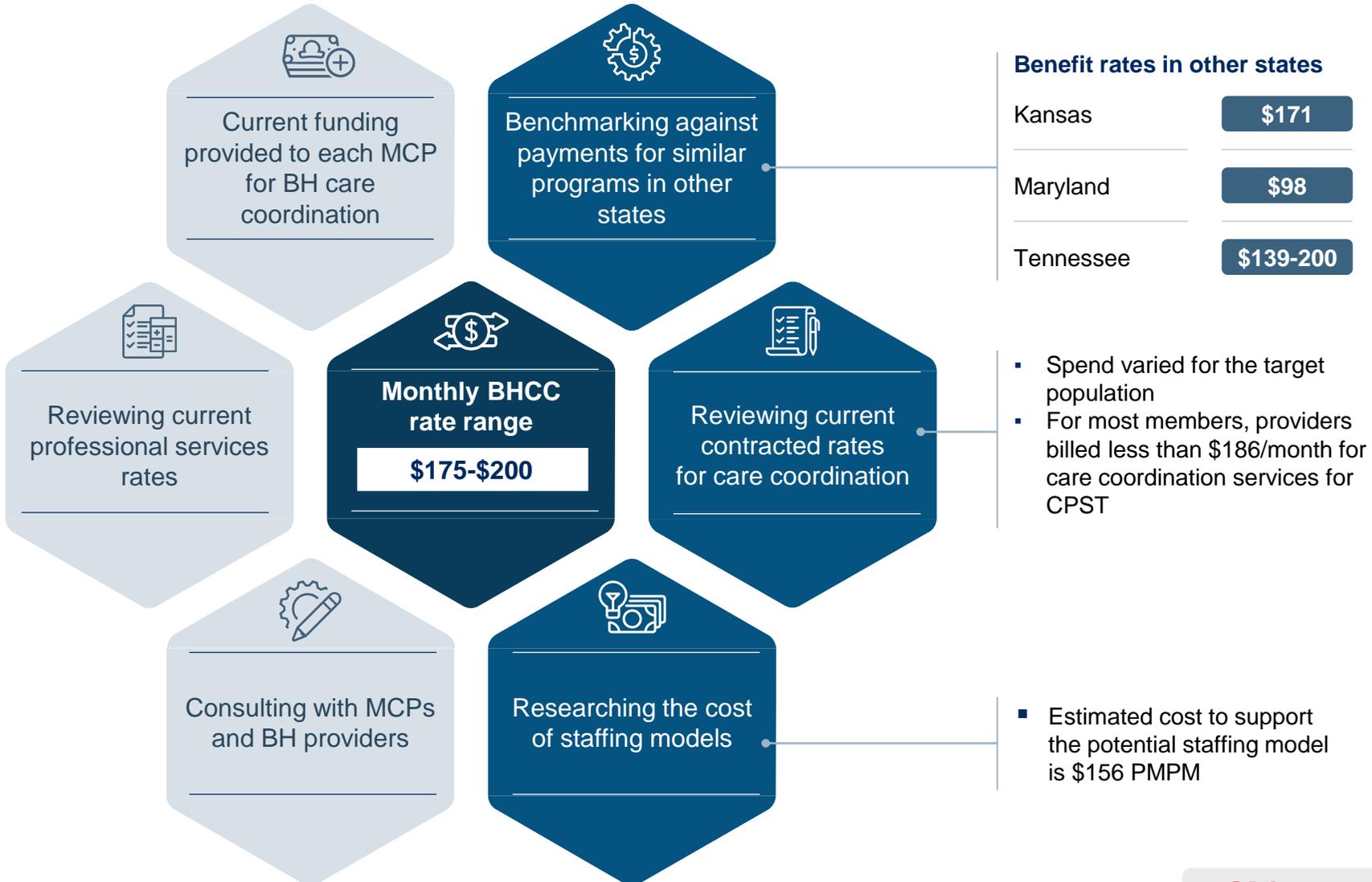
# Overview of support available to providers

 Focus of discussion today

		Objective	Support	Categories of support
BHCC	Monthly activity payment	<ul style="list-style-type: none"> <li>Compensate for ongoing activities performed by BHCC providers</li> </ul>	<ul style="list-style-type: none"> <li>Monthly activity payment for providers meeting activity and member engagement requirements</li> </ul>	<ul style="list-style-type: none"> <li>Service areas included for purposes of payment include:                             <ul style="list-style-type: none"> <li>Initial outreach and engagement</li> <li>Care plan</li> <li>Ongoing relationship and engagement</li> <li>Transitions of care</li> <li>Engagement with and access to appropriate care</li> <li>Engage supportive services</li> <li>Population health management</li> </ul> </li> <li>This payment will replace CPST/TCM for eligible members</li> <li>Members remain eligible for ACT, IHBT and SUD residential; while members receive ACT, IHBT, and SUD residential, providers can no longer bill for BHCC</li> </ul>
	Bonus payment	<ul style="list-style-type: none"> <li>Encourage improvements in quality and efficiency outcomes and reward high performers</li> </ul>	<ul style="list-style-type: none"> <li>Bonus payment based on outcome measures</li> </ul>	<ul style="list-style-type: none"> <li>Performance measured against a mix of quality and efficiency metrics to determine the magnitude of outcome based payment</li> </ul>
Existing payments	Other claims-based payments	<ul style="list-style-type: none"> <li>No change to existing reimbursement process</li> </ul>	<ul style="list-style-type: none"> <li>Payments tied to discrete care services rendered</li> </ul>	<p>The following services remain paid through other claims-based payments:</p> <ul style="list-style-type: none"> <li>Evaluation and management</li> <li>Assessment and testing</li> <li>SUD</li> <li>Therapy</li> <li>Med management</li> <li>Recovery support (e.g., PSR,TBS)</li> </ul>

# Reminder: Sources of insight to determine behavioral health care coordination payment level

 Details included



# Key considerations to determine rate

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## Considerations

### A State budget

- **Leverage available Federal funds** (e.g., 90-10 match)
- Maintain **fiscal responsibility**

### B Impact on qualified entities

- **Understand impact on Qualified Entities' revenue** based on anticipated changes to members' care patterns
- On average, providers may have:
  - ~15% of members already consistently receiving care coordination
  - ~55% of members who have received at least 1 behavioral health outpatient visit, but limited care coordination
  - ~30% new members attributed through geographical attribution
- Entities may have opportunity **to expand care coordination** to 85% of members new to care coordination
- Entities may be able to **serve new, geographically attributed members** with an average BH outpatient spend of ~ \$3,000/year

# Guiding principles and working answer on approach to IHBT, ACT, and SUD Residential treatment

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## Guiding principles for overlapping services

- **Ensure the most appropriate level of care** for members by directing them to services that best fit their needs while maintaining care continuity
- **Preserve member voice** by giving members the opportunity to exercise choice at each step in the process
- **Encourage transparency of outcomes** by ensuring providers receive the information needed to improve care

## Working answer on approach to IHBT, ACT, and SUD Residential

- Members who are eligible for IHBT, ACT, or SUD residential treatment and are attributed to a BH Care Coordination provider certified to deliver the service will receive IHBT, ACT, or SUD residential treatment in place of BH Care Coordination
- All members are free to opt-out of the BHCC program at any time and may receive IHBT, ACT, or SUD residential treatment from a non-qualified entity
- Even in cases where a member defaults to IHBT, ACT, or SUD residential treatment, key elements of BH Care Coordination (e.g., attribution, performance measurement, accountability) will be retained
- Additionally, to help providers optimize care, IHBT, ACT, or SUD residential treatment members will be included in provider performance reporting, with their participation flagged in the member-level files

# High-Fidelity Wraparound and BHCC

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High-Fidelity Wraparound is a team-based approach to meeting the needs of a member and their family. By engaging child and family-serving agencies and systems such as social services, education, and health care, High-Fidelity Wraparound creates a coordinated approach to best serve member needs.

The Behavioral Health Care Coordination program takes a similar approach. Qualified behavioral health entities form care teams to support member needs and are responsible improving behavioral and physical health outcomes. Due to the similarities in the program, BHCC's launch is a unique opportunity to expand support for High-Fidelity Wraparound throughout Ohio.

## How are High-Fidelity Wraparound and BHCC similar?

The activities required for High-Fidelity Wraparound overlap significantly with BHCC. Both programs:

- Engage and build trusting relationships members, their families, their providers and communities
- Develop comprehensive care plans for a member's needs
- Ease transitions between levels of care, providers and/or systems
- Improve member access to care and supportive services to meet member needs

## How do BHCC and High-Fidelity Wraparound support one another?

- Qualified entities can, at their option, apply some/all of the **BHCC payment of \$200/month** to support High-Fidelity Wraparound
- Opportunity to receive a **bonus payment** that rewards high performing providers
- **Increased data sharing** to aid entities in better serving their members
- **Strengthened coordination** across entities, plans and State through regular touchpoints
- Opportunity to **expand support for members** through leveraging High-Fidelity Wraparound

**For more information on Behavioral Health Care Coordination please visit [bh.Medicaid.ohio.gov](https://bh.Medicaid.ohio.gov)**

# Next steps

## Key dates

- **5/30:** Provider webinar #2
  - Time: 2:00-3:30pm
  - Register here:  
<https://attendee.gotowebinar.com/register/7048053543088401667>
  - Please share broadly
- **7/1:** Enrollment opens
- **August:** Entities notified of enrollment decisions
- **October:** BHQEs receive first attribution file and baseline report

## Key activities

- Continue to solicit provider and MCP feedback on BHCC program
- Finalize enrollment process and prepare providers and MCPs for enrollment

# Questions?





Department of Medicaid  
Department of Mental Health and Addiction Services

# ***FFS Prior Authorization Update***



Behavioral Health Redesign

# FFS Prior Authorization – Q1 2018



- 4,500: Total number of BH-related PAs submitted since Dec. 1<sup>st</sup>, 2017, through Mar. 31<sup>st</sup>, 2018.
- Of those, 90% were approved as submitted, including:

Service	Requests Billed	Approved	Approval %
ACT	536	462	86%
IHBT	412	396	96%
SUD Partial Hospitalization	2,127	1,833	86%*
SUD Residential	1,425	1,379	97%**

\*[Plus another 242 were approved after modification (11%)]

\*\*[Plus another 8 were approved after modification (<1%)]



- After accounting for requests that were approved after modification, there were only 180 total denials (4%).
- 420 PA requests were cancelled by the providers (not included in the above numbers).
- There have only been 2 hearing requests (both ACT).



# Preparing for Medicaid Managed Care

Benefit and Service Development Work Group Meeting  
May 23, 2018

# Who is Enrolled in Managed Care?

- Approximately 90% of Medicaid recipients are enrolled in managed care or MyCare Ohio. (OAC Rules 5160-26-02 and 5160-58-02.)
- Most individuals are required to enroll in a plan. Individuals enrolled in a DODD-administered HCBS waiver may voluntarily enroll.
- Individuals excluded from enrollment are those who:
  - Reside in ICF–IID Facility;
  - Are enrolled in PACE;
  - Reside in a nursing facility except when enrolled in MyCare Ohio;
  - Receive HCBS waiver services when not enrolled in MyCare Ohio;
  - Are dually eligible for both Medicaid and Medicare when they do not reside in a MyCare Ohio Demonstration County.
- All individuals with Group 8 (Expansion) eligibility are required to enroll in a plan even when residing in an nursing facility or on an ODM-administered HCBS waiver. There are a few other small populations of individuals who are not required to enroll at this time.

# What is Managed Care Day 1?

- Newly eligible individuals are assigned to an MCP effective the first day of the month in which they are found Medicaid eligible.
- No longer a FFS period for most individuals.
- Example:
  - Application received by CDJFS on 3/4/2018.
  - On 3/5/2018, individual is determined to be eligible for Medicaid effective 3/1/2018.
  - Managed care enrollment is effective 3/1/2018.
- Once enrolled in managed care, individuals may switch plans within the first 90 days.

# When can members change plans?

- **Managed Care**

- **Between Day 1 and Day 90:** Individuals are enrolled in a managed care plan (MCP) on day 1 and have 90 days to change plans from the first date of the month following enrollment.
- **Open Enrollment:** After initial enrollment, MCP members may change plans during the open enrollment period in November of each year.

- **MyCare Ohio**

- **Opt-In:** Individuals enrolled in a MyCare Ohio plan may change plans on a monthly basis if they are opt-in.
- **Opt-Out:** If they are opt-out, they follow the MCP timeframes above.

# Transition of Care

- MCPs must allow the member to continue with out-of-network providers for 6 months post BH MC integration. **This timeframe was extended to include an open enrollment period.**
- To ensure continuity of care, MCPs will:
  - Work with the service provider to add the provider to their network;
  - Implement a single case agreement with the provider; and/or
  - Assist the member in finding a provider currently in the MCP's network.

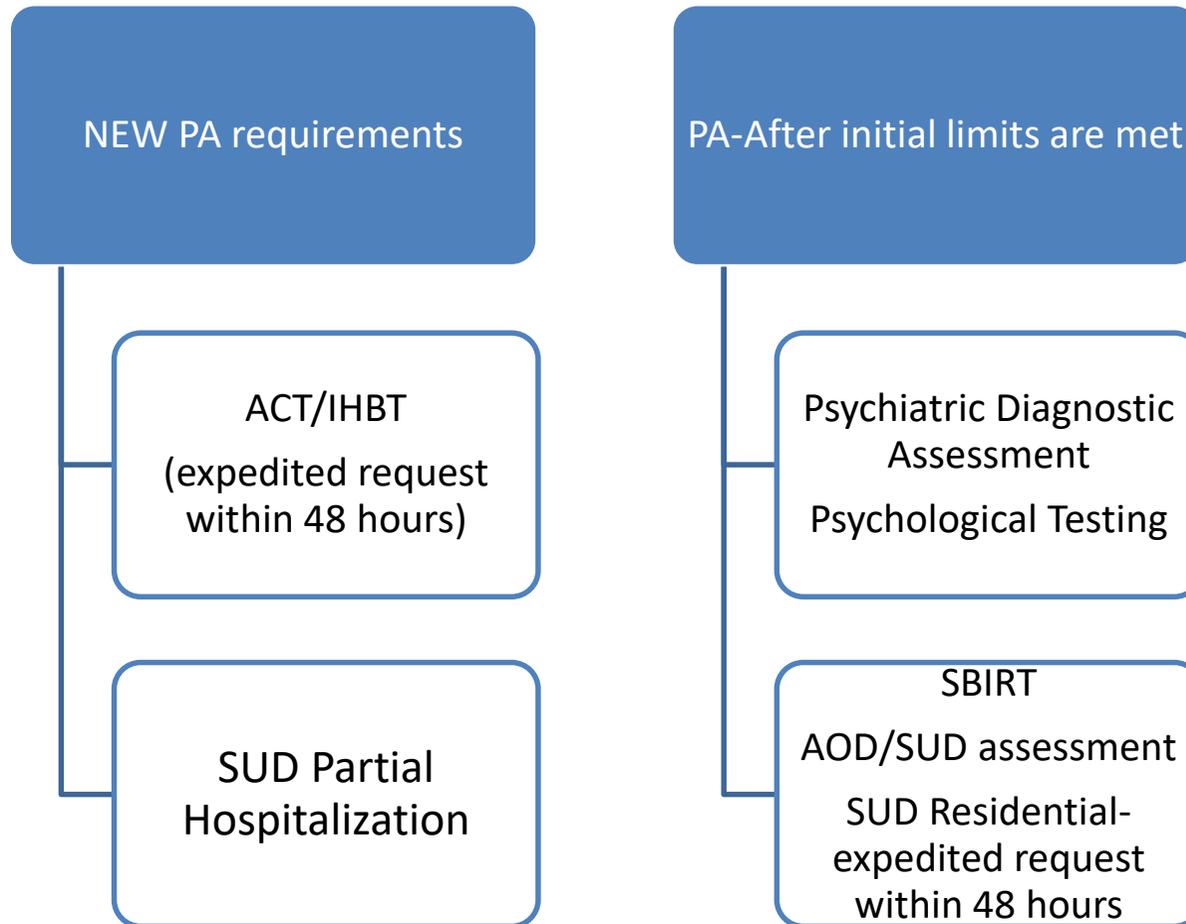
<http://bh.medicaid.ohio.gov/manuals> &  
<http://bh.medicaid.ohio.gov/Provider/Medicaid-Managed-Care-Plans>

- **Medicaid Managed Care Plan Resource Guide**  
Ohio Medicaid and MyCare plans have developed a comprehensive resource document identifying individuals who will serve as points of contact for provider inquiries regarding MCP operations, billing, prior authorization, and pharmacy.  
[MCO Resource Guide](#) 1/16/2018 – Excel
- **MyCare/Medicaid Uniform PA Form**  
The Ohio plans have developed a uniform prior authorization form for community BH services.  
[Uniform PA Form](#) 5/4/2018 - PDF

# Prior Authorization

- MCPs follow the Medicaid fee-for service (FFS) behavioral health coverage policies through June 30, 2019.
- MCPs will begin accepting Prior Authorization requests 30 days prior to BH MC integration (June 1, 2018).
- A Prior Auth Form is available that encompasses Medicaid and MyCare Prior Authorization requests – **Ohio Uniform Authorization Form – Community Behavioral Health Services available at:**  
<http://bh.medicaid.ohio.gov/Provider/Medicaid-Managed-Care-Plans>.
- MCPs must honor Prior Authorization approved by ODM through the expiration of the authorization.
- Prior Authorization Turn-Around Deadlines:
  - Routine requests are within 10 days
  - Urgent (expedited) requests are within 48 hours (ACT, IHBT, and SUD Residential after 30 days/1<sup>st</sup> day of third stay)

# Prior Authorization Requirements



Refer to the May 16<sup>th</sup> MITS Bits on Prior Authorization and BH Integration at:  
<http://bh.medicare.ohio.gov/Provider/Overview#55454-mits-bits>

# Contracting and Credentialing

- Contracting typically takes 90 days
- Credentialing occurs at the CMHC Group level by location
- Providers are enrolled and affiliated with Group via rostering & ODM Provider Master File (PMF)
  - All network provider agencies must be enrolled with ODM.
  - Each rendering provider must be enrolled with ODM and affiliated with their agency.
- In the absence of a contract, transition of care requirements are in place for 6 months
- A single case agreement may be executed as needed

# Billing and Testing

- Current testing opportunities for BH Managed Care Integration
- Clearinghouse requirements
- Claims submission:
  - CMS 1500 Claim Form
  - EDI (837), portal and paper
- EDI 270/271
  - 270 Transaction Set is used to transmit Health Care Eligibility Benefit Inquiries from health care providers and can be used to make an inquiry about managed care plan coverage.
  - 271 Transaction Set is the appropriate response mechanism from ODM for Health Care Eligibility Benefit Inquiries.
- Refer to July 1 IT specifications spreadsheet:  
<http://bh.medicaid.ohio.gov/manuals> under “Billing and IT Resources”
- Timely Filing Deadline: A minimum of 180 days for the first 12 months of BH Managed Care Integration

# Common Denial Reasons for MyCare Ohio

- No enrollment for claim dates of service
- Exact duplicate claim/service
- Missing prior insurance carrier EOB, or COB information not received
- Incorrect Modifier or missing NPI/Modifier
- Precertification/authorization absent

# Buckeye

## Current Testing Opportunities

- Testing of claims begins again March 1st through June 30<sup>th</sup> at <https://sites.edifecs.com/index.jsp?centene>
- Click here for a list of trading partners Buckeye works with <https://www.buckeyehealthplan.com/providers/resources/electronic-transactions.html>
- Weekly Webinar opportunities on Tuesdays at 9:00AM and Thursdays at 12:00PM. RSVP at <https://www.buckeyehealthplan.com/providers/behavioral-health.html>

## Contracting Information

- Allow 90 days for the contracting/credentialing process-*please start now*
- Contact: <https://www.buckeyehealthplan.com/providers/become-a-provider/join-our-network.html>

# CareSource

## Current Testing Opportunities

- Join us on Wednesdays from 3 to 4pm ET for instructions and status updates
- CareSource is accepting test EDI files through our trading partners
- Use the ODM Beta Testing Scenarios
- Use active CS Members
- Use DOS > January 1, 2018
- Submit test EDI files before June 1 2018.

## Contracting Information

- Complete the **New Health Partner Contract Form @**  
<https://www.caresource.com/providers/join-our-network/>
- Allow 90-days for the contracting/credentialing process
- Be prepared with the following materials:
  - W-9 tax form
  - Tax ID number
  - NPI number(s) for both Provider Type 84 and/or 95 related certifications
- Questions/Concerns: Call CareSource's Rapid Response Team - 800.488.0134

# Molina Healthcare

## Current Testing Opportunities

- Contact [BHProviderServices@MolinaHealthCare.com](mailto:BHProviderServices@MolinaHealthCare.com) to obtain an intake form and testing guidance
- We work with all participating clearinghouse to submit EDI claims
- Webinar opportunities are posted on our website in our newsletter: [Provider Bulletins](#)
- Testing is currently open

## Contracting Information

- Allow 90 days for the contracting/credentialing process-*please start now*
- Contact: Ellen Landingham at (614) 557-3041 or [Ellen.Landingham@molinahealthcare.com](mailto:Ellen.Landingham@molinahealthcare.com)

# Paramount Health Care

## Current Testing Opportunities

- Contact [PHCBehavioralHealthTesting@ProMedica.org](mailto:PHCBehavioralHealthTesting@ProMedica.org) to engage in claims testing
- We work with all participating clearinghouse to submit EDI claims <http://www.paramounthealthcare.com/documents/provider/clearinghouse-list.pdf>
- Intensive provider consultation available upon request (prior/post testing)
- Testing claims are currently being accepted and will remain open through July 1, 2018 BH Redesign Implementation

## Contracting Information

- Allow 90 days for the contracting/credentialing process- *please start now*
- Contact: [PHCProvider.Contracting@ProMedica.org](mailto:PHCProvider.Contracting@ProMedica.org)

# UnitedHealthcare

## Current Testing Opportunities

- Contact [Ohionetworkmanagment@optum.com](mailto:Ohionetworkmanagment@optum.com) to get member assignments-*begins now*
- We work with all participating clearinghouse to submit EDI claims
- Three (3) live webinar opportunities scheduled: 2/19; 2/21; 2/23 with one recorded/posted end of Feb.
- Testing Medicaid claims begins week of March 7th through June 30th

## Contracting Information

- Allow 90 days for the contracting/credentialing process-*please start now*
- Be prepared with the following materials:
  - W-9 tax form
  - Tax ID number
  - NPI number(s) for both Provider Type 84 and/or 95 related certifications
- Contact: [OhioNetworkManagment@optum.com](mailto:OhioNetworkManagment@optum.com)

## BH REDESIGN – RAPID RESPONSE TEAMS & TA RESOURCES

<b>MIT'S FFS Rapid Response Team</b>	
<ul style="list-style-type: none"> <li>Medicaid Provider Hotline: 1-800-686-1516, Option 9 (behavioral health claims issues)</li> <li>Ohio Medicaid Policy Rapid Response: <a href="mailto:bh-enroll@medicaid.ohio.gov">bh-enroll@medicaid.ohio.gov</a></li> </ul> <p style="text-align: right;">Mon – Fri: 7:30 AM – 7:00PM Sat: 9:00AM – 1:00PM</p>	
<p style="text-align: center;"><b>AETNA – MYCARE ONLY</b></p> <ul style="list-style-type: none"> <li>Rapid Response Team: <a href="mailto:OH_BH_Redesign@AETNA.com">OH BH Redesign@AETNA.com</a></li> <li>Prior Authorization Questions: 1-855-364-0974, option 2, then 4</li> <li>24/7 Notification Fax: 1-855-734-9393</li> <li>Provider Services: 1-855-364-0974, option 2, then 5</li> <li>Escalation/Other Questions: <a href="mailto:KilincA@aetna.com">KilincA@aetna.com</a></li> </ul> <p><b>Technical Assistance:</b> <a href="#">Aetna Rapid Response Team and TA Resources</a> Monthly provider webinars scheduled and Provider Relations Liaisons available for onsite visit.</p>	<p style="text-align: center;"><b>BUCKEYE</b></p> <ul style="list-style-type: none"> <li><b>Rapid Response Team:</b> <a href="mailto:BehavioralHealth@centene.com">BehavioralHealth@centene.com</a></li> <li>Provider Relations: 1-866-246-4356 ext. 24291</li> <li>24/7 Notification Phone Line: 1-866-296-8731</li> <li>24/7 OH Notification Fax: 1-866-535-6974</li> <li>Escalation/Other Questions: <a href="mailto:lpaynter@centene.com">lpaynter@centene.com</a></li> </ul> <p><b>Technical Assistance Resources:</b> <a href="#">Buckeye BH Redesign Webinar Registration</a> Provider webinars available every Tuesday at 9:00 and Thursday at Noon.</p>
<p style="text-align: center;"><b>CARESOURCE</b></p> <ul style="list-style-type: none"> <li><b>Rapid Response Team:</b> 1-800-488-0134 or <a href="mailto:OhioBHInfo@caresource.com">OhioBHInfo@caresource.com</a></li> <li>24/7 Notification Fax: 1-937-487-1664</li> <li>24/7 UM Notification e-mail: <a href="mailto:mm-bh@caresource.com">mm-bh@caresource.com</a></li> <li>Escalation/Other Questions: <a href="mailto:terry.jones@caresource.com">terry.jones@caresource.com</a></li> </ul> <p><b>Technical Assistance:</b> BH Redesign Rapid Response Weekly Webinars Each Wednesday, 3:00 – 4:00 PM. To register, contact at <a href="mailto:Sherron.Jefferson@CareSource.com">Sherron.Jefferson@CareSource.com</a> or call 614-255-4620 and include organization name and NPI number along with names and e-mail address of individuals planning to participate.</p>	<p style="text-align: center;"><b>MOLINA</b></p> <ul style="list-style-type: none"> <li><b>Rapid Response Team:</b> <a href="mailto:BHProviderServices@MolinaHealthcare.com">BHProviderServices@MolinaHealthcare.com</a></li> <li>24/7 Notification Phone Line: 1-855-322-4079</li> <li>24/7 Notification Fax: 1-866-449-6843</li> <li>24/7 Notification e-mail: <a href="mailto:OHBehavioralHealthReferrals@MolinaHealthcare.com">OHBehavioralHealthReferrals@MolinaHealthcare.com</a></li> <li>Escalation/Other Questions: <a href="mailto:Emily.Higgins@MolinaHealthcare.com">Emily.Higgins@MolinaHealthcare.com</a></li> </ul> <p><b>Technical Assistance Resources:</b> <a href="#">BH Redesign Provider Bulletin</a> Multiple provider TA webinars scheduled throughout the year. Details and registration in the Provider Bulletin.</p>
<p style="text-align: center;"><b>UNITED HEALTHCARE/OPTUM</b></p> <ul style="list-style-type: none"> <li><b>Rapid Response Team:</b> <a href="mailto:OhioNetworkManagement@optum.com">OhioNetworkManagement@optum.com</a></li> <li>24/7 Notification Phone Line: 1-800-600-9007</li> <li>24/7 Provider Prior Authorization Request: 1-866-261-7692</li> <li>24/7 Online Prior Authorization Request via Provider Portal: <a href="http://www.providerexpress.com">www.providerexpress.com</a> and <a href="http://www.UnitedHealthcareOnline.com">www.UnitedHealthcareOnline.com</a></li> <li>Escalation/Other Questions: <a href="mailto:tracey.izzard-everett@optum.com">tracey.izzard-everett@optum.com</a></li> </ul>	<p style="text-align: center;"><b>PARAMOUNT – MEDICAID ONLY</b></p> <ul style="list-style-type: none"> <li><b>Rapid Response Team/Testing Assistance:</b> <a href="mailto:ParamountBehavioralHealthTesting@ProMedica.org">ParamountBehavioralHealthTesting@ProMedica.org</a></li> <li>24/7 Notification Phone Line: 1-419-887-2557 or 1-888-891-2564</li> <li>24/7 Notification Fax: 1-567-661-0841</li> <li><a href="mailto:PHCReferralManagement@ProMedica.org">PHCReferralManagement@ProMedica.org</a></li> <li>Escalation/Other Question: <a href="mailto:hy.kisin@promedica.org">hy.kisin@promedica.org</a></li> </ul>

# How To Contact Us

## **UNITED HEALTHCARE (OPTUM)**

Primary Contact: Tracey Izzard

Phone: (614) 410-7592

[tracey.izzard-everett@optum.com](mailto:tracey.izzard-everett@optum.com)

## **CARESOURCE**

Primary Contact: Terry R. Jones

Phone: (614) 255-4613

[Terry.Jones@caresource.com](mailto:Terry.Jones@caresource.com)

## **AETNA BETTER HEALTH – MYCARE ONLY**

Primary Contact: Afet Kilinc

Phone: (959) 299-7278; (614) 254-3229 cell

[KilincA@AETNA.com](mailto:KilincA@AETNA.com)

## **MOLINA HEALTHCARE**

Primary Contact: Emily Higgins

Phone: (614) 212-6298

[Emily.Higgins@MolinaHealthcare.com](mailto:Emily.Higgins@MolinaHealthcare.com)

## **BUCKEYE (CENPATICO)**

Primary Contact: Laura Paynter

Phone: (866) 246-4356 ext. 24446

[lpaynter@centene.com](mailto:lpaynter@centene.com)

## **PARAMOUNT – MEDICAID ONLY**

Primary Contact: Hy Kisin

Phone: (419) 887-2251

[Hy.Kisin@Promedica.org](mailto:Hy.Kisin@Promedica.org)

# Managed Care Complaint Form

- Providers are encouraged to reach out directly to the managed care plans first with any questions or issues.
- If providers continue to experience challenges, providers may reach out directly to ODM by submitting a complaint via the Provider Complaint Form at:  
<http://medicaid.ohio.gov/PROVIDERS/ManagedCare/ProviderComplaint.aspx>.
- Complaints filed at this link will be reviewed by ODM staff and ODM will follow-up with the MyCare Ohio Plans as well as with the provider who files the complaint.

# Questions?

