

The Ohio departments of Medicaid (ODM) and Mental Health & Addiction Services (OhioMHAS) are evaluating the early effects of Behavioral Health (BH) Redesign and managed care integration on the comprehensive behavioral health system.

As a first step in this process, ODM and OhioMHAS evaluated results of the January 2019 provider survey as well as progress towards the one-on-one technical assistance plans being established between providers and the managed care plans. The Departments have also initiated a comprehensive set of data analyses to evaluate the impact of Behavioral Health Redesign and managed care integration. Data is being analyzed on both a system (macro) and individual (micro) level. The data analysis is ongoing and will continue over the coming weeks. On February 6, 2019 the Departments presented the first round of this analysis to the Behavioral Health Integration Task Force. The content on the following slides is what was presented at the February 6th meeting.

As next steps the Departments will be focusing efforts on addressing payment and policy challenges and look to design solutions aimed at best serving Ohioans with mental illness and addiction treatment needs.



Department of Medicaid  
Department of Mental Health and Addiction Services

# **BH Integration Task Force**

February 6<sup>th</sup>, 2019

# Data Recap and Review: Macro

# Non-Acute, Non-Emergent Behavioral Health Services

## Services & Expenditures Include:

- Behavioral health procedure codes (different code sets applicable before & after January 2018) by outpatient and/or professional providers
- Services with Pay To Provider Types: Community Mental Health Centers (CMHCs) and Substance Use Disorder treatment centers (SUDs)
- Claims with a primary Behavioral Health diagnosis
- Services with a Behavioral Health Place of Service
- Services with a Behavioral Health Revenue Center Code
- Outpatient services with an HE modifier on/after August 2017
- **Excludes Emergency Department & Inpatient claims**

## Providers Include:

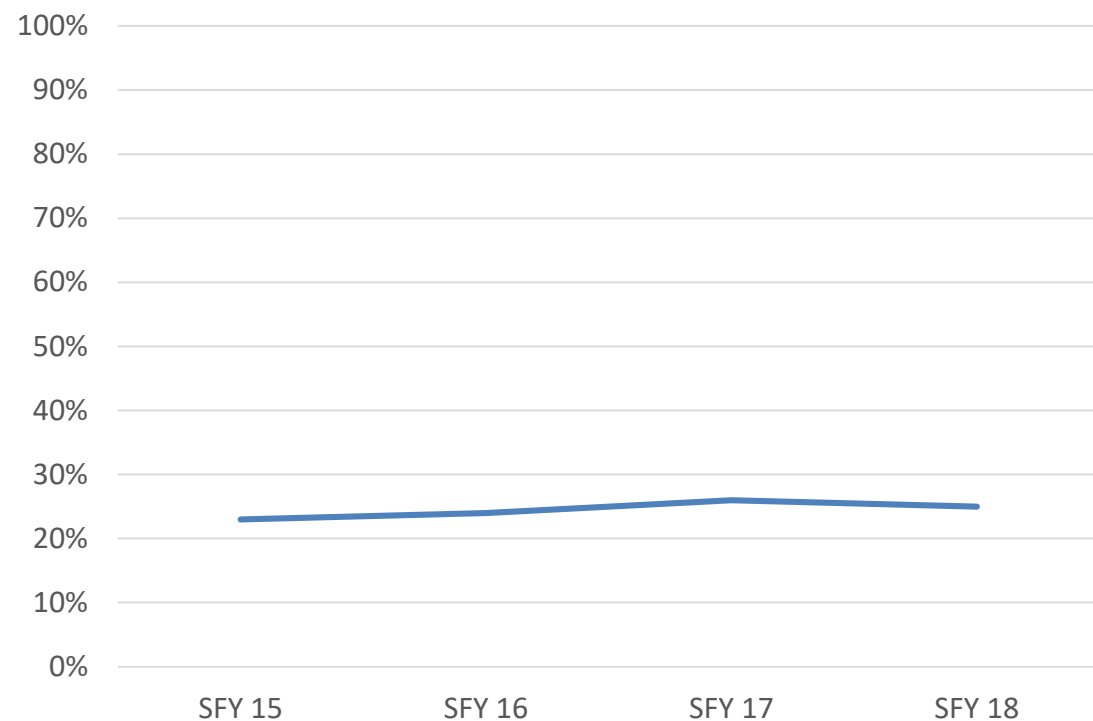
- » CMHCs
- » SUDs
- » Outpatient facilities
- » Independent Practitioners (e.g., Psychiatrists, Psychologists, Licensed Social Workers, etc.)
- » Other Practitioners (e.g., Primary Care Providers)

## Behavioral Health & Developmental Disability Conditions

- Behavioral Health Diagnoses include:
  - » Depression
  - » Anxiety
  - » ADHD
  - » Autism
  - » Mood Disorders
  - » Adjustment Disorders
  - » Substance Abuse Disorders
  - » Bipolar Disorder
  - » Impulse Control Disorder
  - » Schizophrenic Disorder
  - » Psychoses
  - » Delirium or Dementia
  - » Personality Disorder
  - » Suicide/Self-Injury
- Developmental Disability diagnoses EXCLUDED from Behavioral Health definition:
  - » Mental retardation with and without impairment of behavior
  - » Intellectual disability
  - » Speech and language
  - » Scholastic skills
  - » Motor function
  - » Pervasive developmental disorders

## Non-Acute, Non-Emergent Behavioral Health Services Medicaid Recipients, SFYs 2015-2018\*

Percent of Medicaid Recipients\* with Non-Acute,  
Non-Emergent Behavioral Health Services

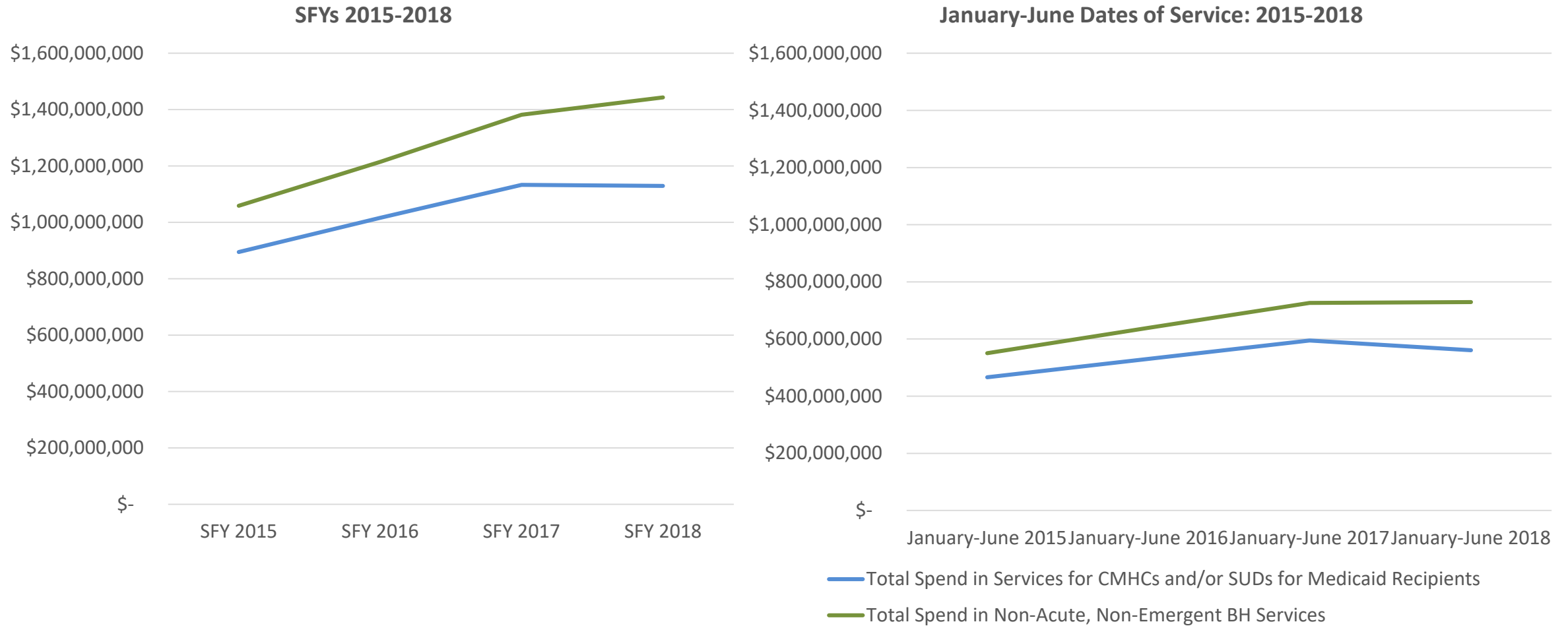


Service Period	Medicaid Recipients*	Medicaid Recipients* with Non-Acute, Non-Emergent Behavioral Health Services	Percent of Medicaid Recipients* with Non-Acute, Non-Emergent Behavioral Health Services
SFY 15	3,181,140	729,977	23%
SFY 16	3,386,427	811,137	24%
SFY 17	3,353,217	878,749	26%
SFY 18	3,320,905	843,694	25%

Data Source: December 2018 BIAR Data Files, claims run out for 2018 is incomplete. Includes only Non-Dual Medicaid data.

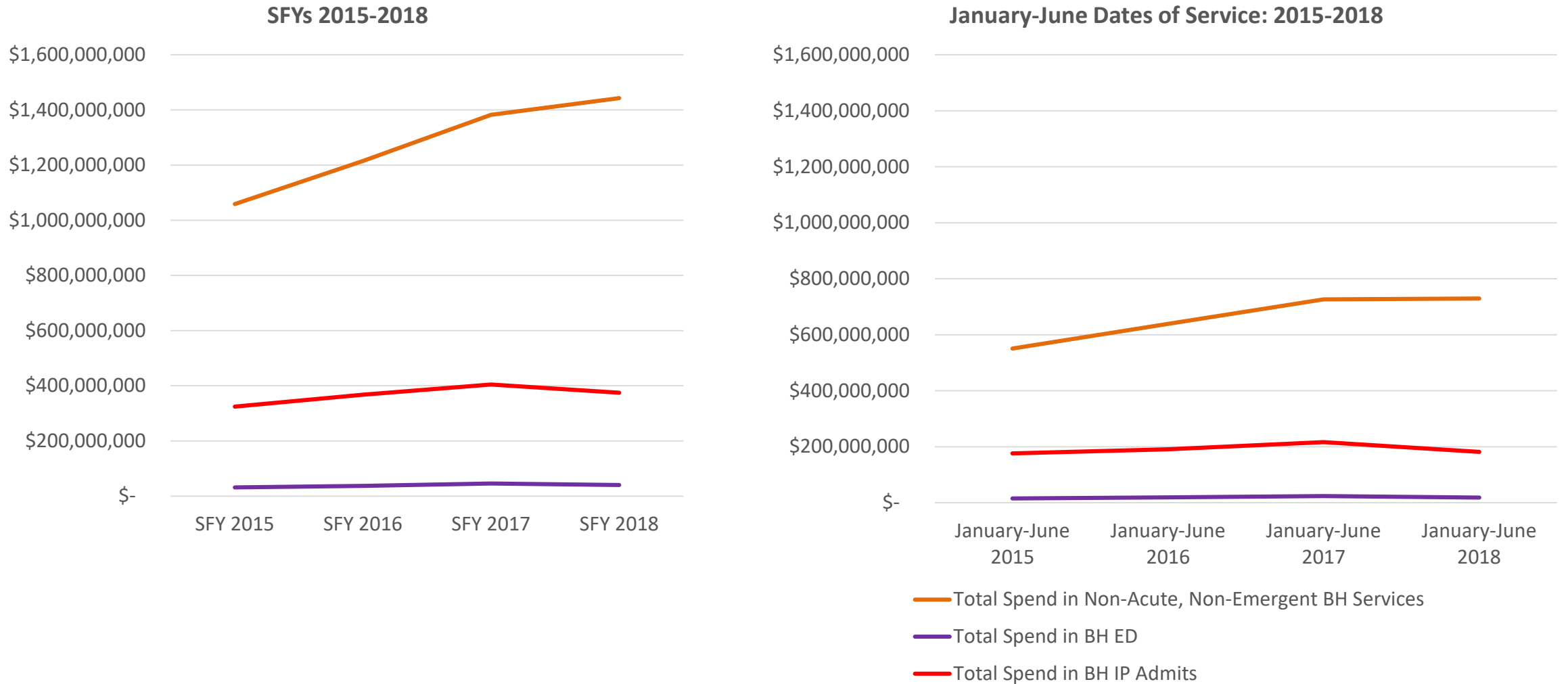


# Total Medicaid Expenditures\* with Non-Acute, Non-Emergent Behavioral Health Services: Provided in CMHCs & SUDs and Other Outpatient Settings



Data Source: December 2018 BIAR Data Files, claims run out for 2018 is incomplete. Includes only Non-Dual Medicaid data.

## Behavioral Health Expenditures\*: Non-Acute, Non-Emergent vs. Inpatient and Emergency

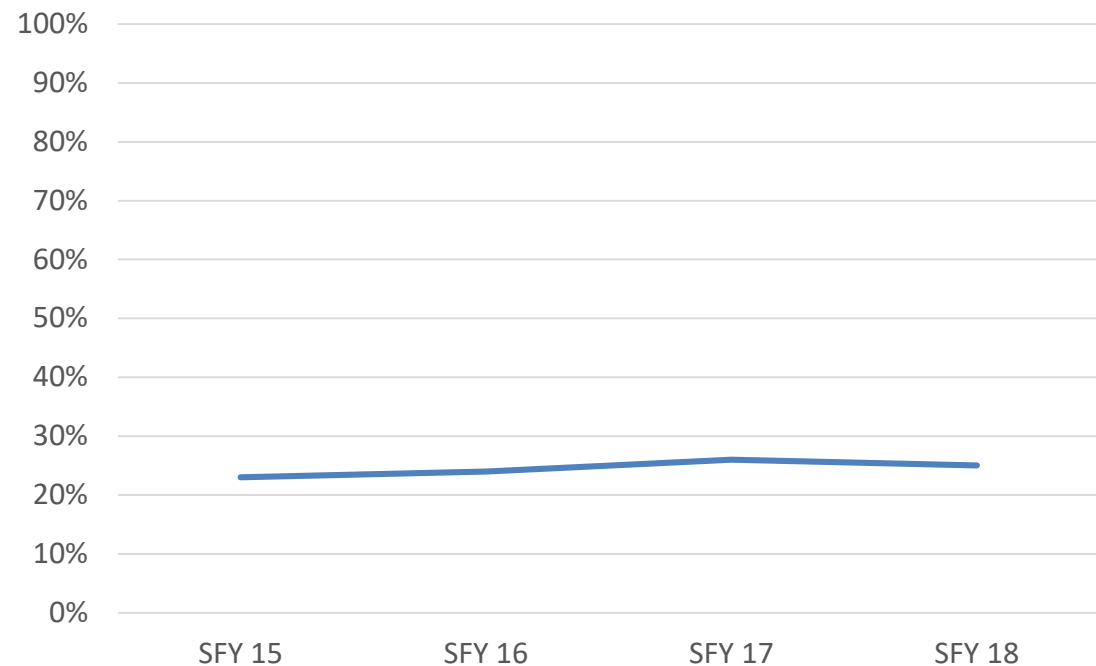


Data Source: December 2018 BIAR Data Files, claims run out for 2018 is incomplete. Includes only Non-Dual Medicaid data.



## Non-Acute, Non-Emergent Behavioral Health Services Medicaid Recipients\* 21 & Under , SFYs 2015-2018

Percent of Medicaid Recipients\* 21 & Under with  
Non-Acute, Non-Emergent Behavioral Health  
Services



Service Period	Medicaid Recipients* 21 & Under	Medicaid Recipients* 21 & Under with Non-Acute, Non-Emergent Behavioral Health Services	Percent of Medicaid Recipients* 21 & Under with Non-Acute, Non-Emergent Behavioral Health Services
SFY 15	1,586,663	358,250	23%
SFY 16	1,645,508	390,569	24%
SFY 17	1,620,397	427,079	26%
SFY 18	1,601,131	395,988	25%

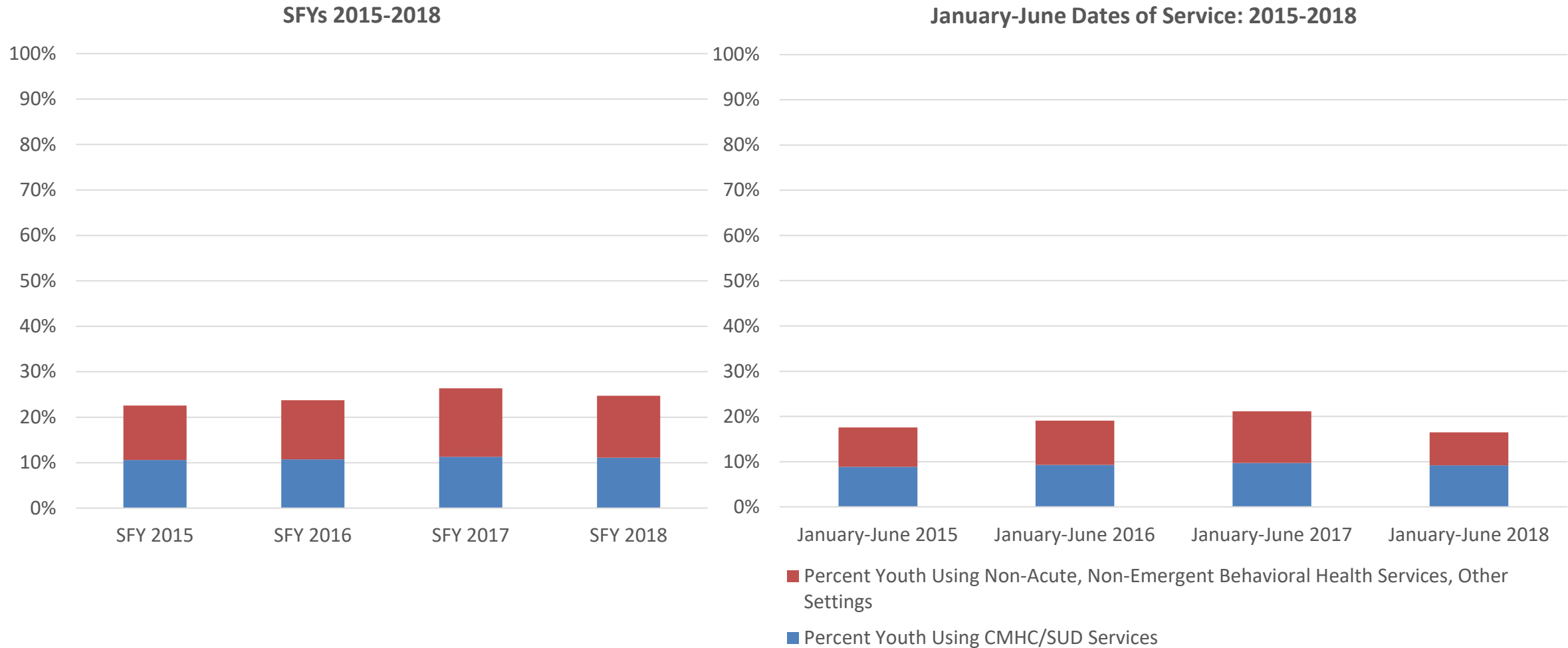
Data Source: December 2018 BIAR Data Files, claims run out for 2018 is incomplete. Includes only Non-Dual Medicaid data.

## Total Medicaid Expenditures\* for Medicaid Recipients 21 & Under Non-Acute, Non-Emergent Behavioral Health Services Provided in CMHCs & SUDs and Other Outpatient Settings



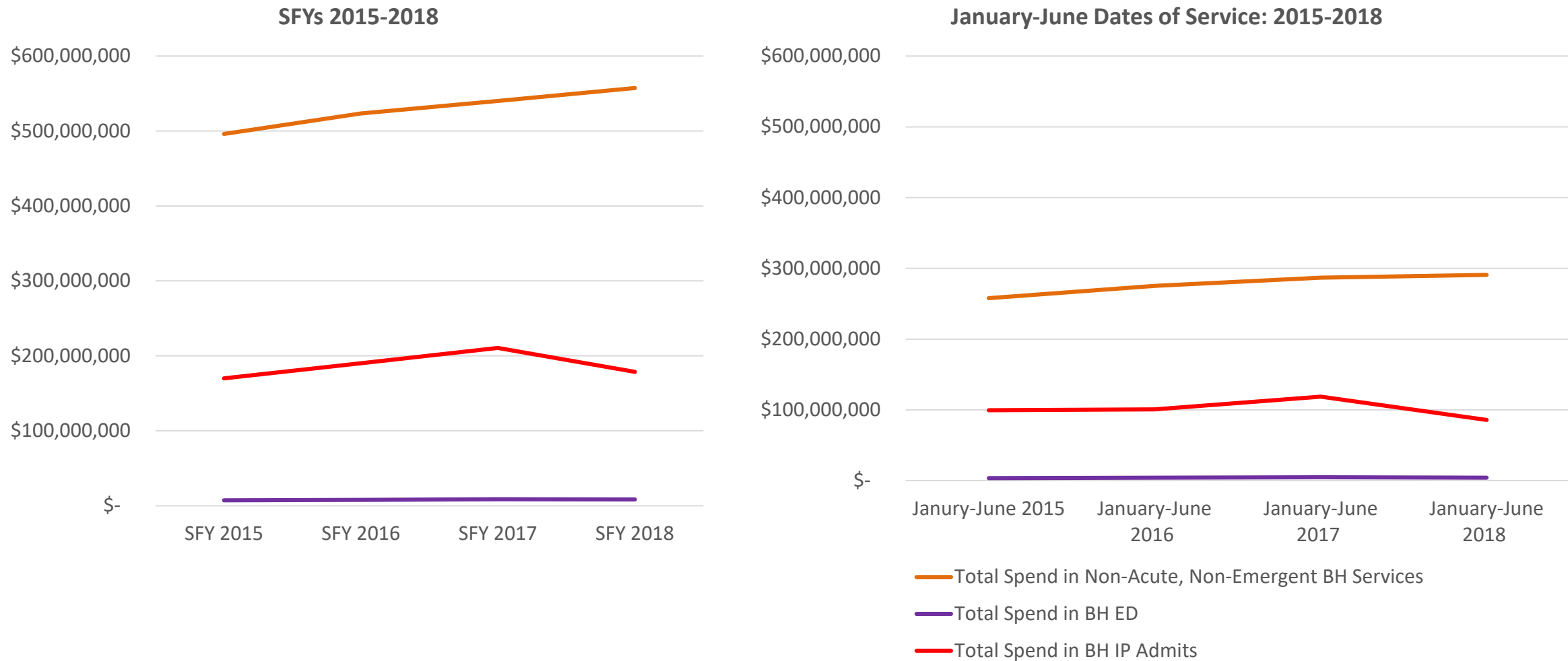
Data Source: December 2018 BIAR Data Files, claims run out for 2018 is incomplete. Includes only Non-Dual Medicaid data.

# Percent of Medicaid Recipients\* 21 & Under with Non-Acute, Non-Emergent Behavioral Health Services Provided in CMHCs & SUDs vs. Other Outpatient Settings



Data Source: December 2018 BIAR Data Files, claims run out for 2018 is incomplete. Includes only Non-Dual Medicaid data.

## Behavioral Health Expenditures\* for Medicaid Recipients 21 & Under Non-Acute, Non-Emergent vs. Inpatient and Emergency



Data Source: December 2018 BIAR Data Files, claims run out for 2018 is incomplete. Includes only Non-Dual Medicaid data.

# Next Steps in Examining Potential Gaps in Care Post Behavioral Health Re-Design

- Focus on high and/or consistent utilizers of CMHCs & SUDs Pre-Behavioral Health Re-Design who later had low/inconsistent/no services with CMHCs & SUDS Post-Behavioral Health Re-Design
  - » What is driving change in utilization?
    - Drilling down on:
      - Age- youth vs. adults
      - Geographic Analysis- County/Zip
      - Providers
      - Other Behavioral Health providers- shifting patterns of care?
      - Physical & Behavioral Health conditions

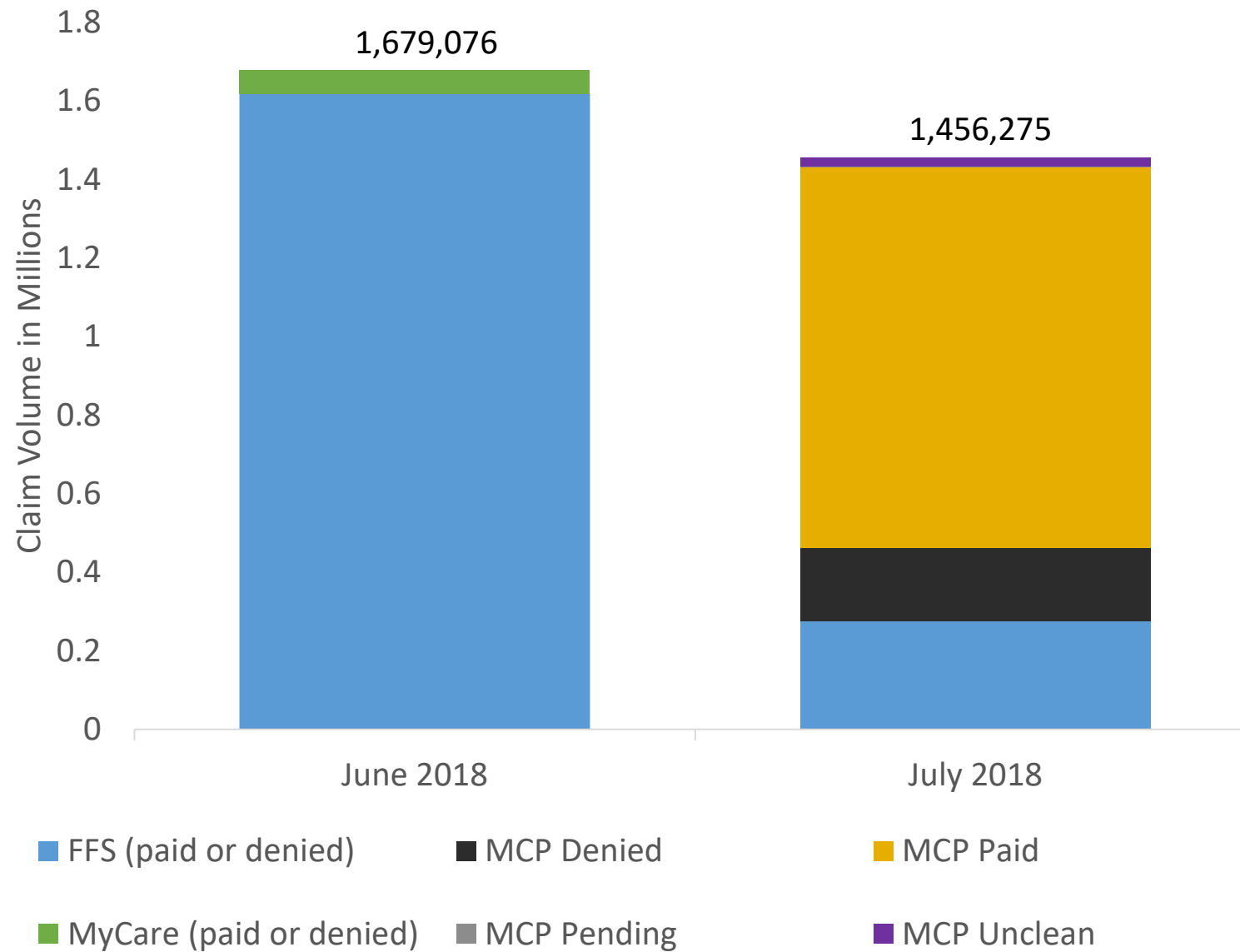
## GlidePath Summary: July – December 2018\*

Month	No. of Claims	No. Paid	No. Denied	No. Pended	Total Amt. Paid	No. Unclean
July	339,272	273,212	65,151	909	\$26,462,467	8,310
August	778,620	673,437	104,959	224	\$64,323,017	13,659
September	841,639	723,321	117,863	455	\$66,714,794	13,790
October	1,094,389	931,601	161,927	861	\$86,302,204	19,814
November	1,074,481	933,310	140,000	1,171	\$86,961,785	12,938
December	1,019,088	888,748	124,006	6,334	\$84,000,821	14,750
<b>Totals</b>	<b>5,147,489</b>	<b>4,423,629</b>	<b>713,906</b>	<b>9,954</b>	<b>\$414,765,088</b>	<b>83,261</b>

\*All data as of January 18, 2018

# Data Recap and Review: Micro

# Date of Service Analysis – Claim Volume





# Medicaid Recipients Receiving BH Services by Month

A. How many Medicaid recipients received BH services (provider type=84&95) in each month?							Carve-In	
	January	February	March	April	May	June	July	August
January Cohort	233,792	182,812	176,509	168,944	158,687	139,318	113,886	114,658
February Cohort		47,990	26,821	25,553	25,485	20,545	16,397	17,261
March Cohort			34,948	19,327	17,640	16,042	11,488	11,525
April Cohort				24,783	14,806	12,166	9,192	8,672
May Cohort					20,829	12,110	8,686	8,127
June Cohort						17,222	8,865	7,752
July Cohort							14,292	9,099
August Cohort								14,287
Total	233,792	230,802	238,278	238,607	237,447	217,403	182,806	191,381

# How Many Didn't Receive a BH Service in Subsequent Months?

B. How many in cohort A did not receive a BH service (provider type=84&95) in any of the following months?											Carve-In			
	February		March		April		May		June		July		August	
	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%
January Cohort	50,980	21.8%	57,283	24.5%	64,848	27.7%	75,105	32.1%	94,474	40.4%	119,906	51%	119,134	51%
February Cohort			21,169	44.1%	22,437	46.8%	22,505	46.9%	27,445	57.2%	31,593	66%	30,729	64%
March Cohort					15,621	44.7%	17,308	49.5%	18,906	54.1%	23,460	67%	23,423	67%
April Cohort							9,977	40.3%	12,617	50.9%	15,591	63%	16,111	65%
May Cohort									8,719	41.9%	12,143	58%	12,702	61%
June Cohort											8,357	49%	9,470	55%
July Cohort													5,193	36%

## How Many Were Not Enrolled?

B1. For those who did not get a BH service (provider type=84&95) in any of the following months, how many were no longer active?											Carve-In			
	February		March		April		May		June		July		August	
	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%
January Cohort	3,387	6.6%	5,351	9.3%	7,600	11.7%	9,866	13.1%	12,939	13.7%	16,807	14%	18,856	16%
February Cohort			1,105	5.2%	1,574	7.0%	2,068	9.2%	2,726	9.9%	3,578	11%	4,018	13%
March Cohort					889	5.7%	1,344	7.8%	1,844	9.8%	2,492	11%	2,898	12%
April Cohort							620	6.2%	1,039	8.2%	1,541	10%	1,853	12%
May Cohort									584	6.7%	1,076	5%	1,367	7%
June Cohort											511	6%	812	9%
July Cohort													304	6%

## How Many Received Services Elsewhere?

B2. For those who did not get a BH service (provider type=84&95) in any of the following months, how many had any other claims not an 84/95?											Carve-In			
Month when recipients didn't have service	February		March		April		May		June		July		August	
	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%
January Cohort	25,873	51%	27,510	48%	29,006	45%	33,323	44%	37,204	39%	53,146	44%	56,011	47%
February Cohort			11,515	54%	11,290	50%	10,725	48%	12,152	44%	14,326	45%	14,519	47%
March Cohort					8,166	52%	8,464	49%	7,988	42%	10,588	45%	10,934	47%
April Cohort							5,043	51%	5,412	43%	7,130	46%	7,464	46%
May Cohort									3,870	44%	5,665	47%	5,869	46%
June Cohort											4,399	53%	4,885	52%
July Cohort													2,672	51%

# How Many Received BH Services From a Non-PT 84/95?

B3. For those who did not get a BH service (provider type=84&95) in any of the following months, how many had any other BH claims? (%=B3/B)											Carve-In			
Month when recipients didn't have service	February		March		April		May		June		July		August	
	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%	Distinct #	%
January Cohort	4,953	9.7%	5,424	9.5%	5,982	9.2%	6,802	9.1%	7,708	8.2%	19,041	16%	19,928	17%
February Cohort			2,059	9.7%	2,029	9.0%	2,055	9.1%	2,166	7.9%	3,811	12%	4,029	13%
March Cohort					1,478	9.5%	1,609	9.3%	1,558	8.2%	2,887	12%	2,983	13%
April Cohort							1,099	11.0%	1,118	8.9%	2,261	15%	2,257	14%
May Cohort									924	10.6%	1,974	16%	1,956	15%
June Cohort											1,787	21%	1,760	19%
July Cohort													743	14%

# Technical Assistance Survey Results (due Jan. 30<sup>th</sup>)

ODM issued a brief survey to providers that focused on technical assistance and claims reimbursement opportunities. Results are as follows:

150 Providers Submitted Responses	Buckeye	CareSource	Molina	Paramount	UHC	Not Requested/None
Requested Assistance	54%	65%	47%	45%	55%	25%
Requested Assistance (Reported by MCP)	34%	16%	31%	9%	38%	-
Received Assistance	30%	46%	27%	30%	31%	26%
Received Assistance (Reported by MCP)	62%	23%	54%	13%	68%	-
Established Assistance Plan	20%	27%	17%	17%	14%	35%
Identified Pending Claims due to MCP Issues	46%	57%	38%	36%	48%	28%
Received Payment for Pended Claims	12%	19%	12%	14%	15%	62%
Subject to Recoupment of Contingency Payments	5%	11%	8%	6%	7%	79%

# Technical Assistance as Reported by Plans (as of Jan. 31<sup>st</sup>)

In addition to the provider survey, ODM asked the Plans to supply a technical assistance (TA) update. Results are as follows:

# of Providers	Buckeye	CareSource	Molina	Paramount	UHC
Requested Technical Assistance	36	40	58	42	43
TA Plan in Process	11	21	40	11	15
TA Plan Established	25	0	9	10	9
TA Plan Not Yet Started	0	19	9	21	19

Note: Plans continue to provide outreach as requests for 1:1 technical assistance are received.

# Missing Claims Volume

The chart below depicts providers that experienced a drop in expected volume of paid claims between June and July 2018

	Buckeye	CareSource	Molina	Paramount	UHC
<b>0*</b>	68	86	64	13	70
<b>1-20%</b>	18	19	17	2	17
<b>21-40%</b>	29	24	24	4	22
<b>41-60%</b>	24	46	32	3	34
<b>61-80%</b>	62	106	89	11	72
<b>81-90%</b>	46	40	57	7	60
<b>91-100%</b>	41	50	43	3	42
<b>100%+</b>	242	346	246	407	210

*\*Provider billed in June but did not bill in July.*



# Strategy Moving Forward

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*i*

## *Strategies*

*i*

- MCPs have been directed to delay recoupment of advanced payments until further notice
- MCPs and providers should continue to work through and implement the technical assistance plans that are being developed
- An effort is underway to identify providers' outstanding accounts receivables and determine next steps

## Example: Identifying Accounts Receivable

The table below is an example of how ODM will analyze claims data and identify outstanding accounts receivable

	Paid Claim Lines	Est. Claim Lines Denied Appropriately (70%)	Est. Claim Lines Denied Needing Correction (30%)	Avg. Payment per Claim Line	Estimated AR due to Under Payments	Estimated AR due to Denials
Provider 1	1,031	22	9	\$69	\$12,372	\$729
Provider 2	121	3	1	\$62	\$2,299	\$81

# Appendix

# Definitions

**Clean Claim** is defined pursuant to 42 CFR 447.45(b) as a claim that can be processed without obtaining additional information from the provider of service or from a third party. Clean claims include claims with errors originating in the payer's claims system.

**Clean Pended Claim** means a clean claim that is received during the reporting period but that has not yet been processed to payment or denial by the report due date.

**Denied Claim** means an adjudicated claim that results in zero payment to the provider due to a claims adjudication system edit or manually determined by MCP staff and has had a remittance advice issued.

**Paid Claim** means an adjudicated claim that is paid either in full or in part (a multi-line claim when not all claim lines are payable). A paid claim includes a claim that shows a payment of \$0 only when \$0 is the appropriate payment (e.g., COB) and has had a check issued or for \$0 payments a remittance advice issued.

**Unclean Claim** means a claim that does not meet the clean claim definition (i.e., cannot be processed without obtaining additional information from the provider of service or from a third party). For example, a claim that required the MCP to obtain medical records from the provider and is under review for medical necessity. Unclean claims also include claims for a provider under investigation for fraud or abuse.