Governor's Office of
Health Transformation

Behavioral Health Redesign

1. Progress toward transformation
2. Readiness to go live January 1, 2018
3. Contingency plan for provider payment

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Behavioral Health Redesign

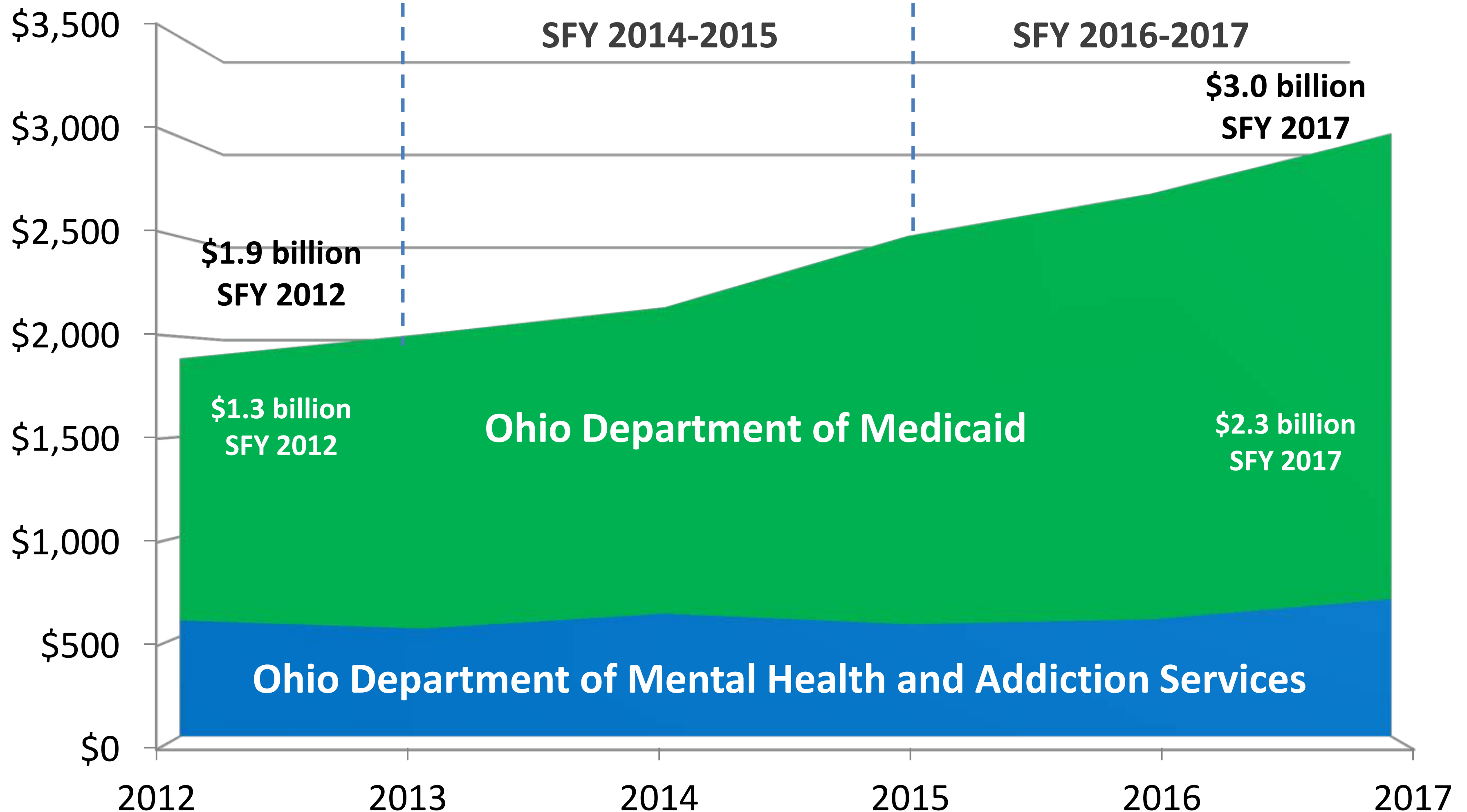
The goal is to integrate physical and behavioral health care services to support recovery for individuals with a substance use disorder or mental illness.

http://bh.medicaid.ohio.gov

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

Ohio's Behavioral Health System Capacity



Source: Ohio Departments of Medicaid and Mental Health and Addiction Services (January 2017).

Distribution of Behavioral Health Clients by Spending

Millions of dollars
100 percent = $1.2 billion

$600
$500
$400
$300
$200
$100
$0

Top 5 percent account for 52 percent of spending…

Each bar represents:
5 percent of clients
≈30,000 individuals

$0 $1 $1 $2 $3 $3 $4 $5 $7 $9 $12 $15 $20 $28 $37 $52 $73 $107 $169 $600

5% least costly clients

5% most costly clients

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Source: Ohio Medicaid claims, including claims with diagnosis code of ICD9 290-314 excluding 299 and dementia codes in 294; does not include pharmacy claims (August 2012-July 2013).

Current Challenges	and Redesign Solutions
• Provider-centered care	• Patient-centered care
• Antiquated billing codes	• National coding standards
• Insufficient code set (17 codes)	• Transparency (120 codes)
• Rates not tied to provider type	• Rates reflect qualifications
• Different rates for MH and SUD	• One fee schedule for MH and SUD
• Rendering practitioner is unknown	• Rendering practitioner is clear
• Limited rehabilitation options	• Array of rehabilitation options
• Limited access to community behavioral health services	• Extensive network also including hospitals and primary care
• Multiple, separate providers	• Collaboration among providers
• Intense needs not coordinated	• Coordinate most intensive needs

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Modernize Medicaid behavioral health benefits

Expand services for individuals with the highest intensity needs

- Opioid Treatment Program (OTP)
- Assertive Community Treatment (ACT)
- Intensive Home-Based Treatment (IHBT)
- Enhance Substance Use Disorder (SUD) benefit
- Adopt SUD level of care framework
- Improve care coordination

Update billing codes to support expanded services

- Align billing codes to national standards, separate and reprice some services, support and require appropriate claiming for Medicare services, and clarify requirements for rendering practitioners to bill
- Providers submit claims using the new codes beginning January 1, 2018.

Beta testing requirements and results

House Bill 49 as enacted, Section 5164.761. *“*Before the department of Medicaid or department of mental health and addiction services updates Medicaid billing codes or Medicaid payment rates for community behavioral health services as part of the behavioral health redesign …

Requirement	Results
“The departments shall conduct a beta test of the updates.	***Beta testing took place Oct. 25 to Nov. 30, 2017.***
“Any Medicaid provider of community behavioral health services may volunteer to participate in the beta test.	***100% of all providers were invited to test.*** • 77 participated in testing 953 FFS claim scenarios • 7 participated in testing 94 MyCare claim scenarios
“An update may not begin to be implemented outside of the beta test until at least half of the Medicaid providers participating in the beta test are able to submit under the beta test a clean claim for community behavioral health services …	***Every provider that participated was able to submit a clean claim*** • 77 (100%) submitted a clean FFS test claim • 7 (100%) submitted a clean MyCare claim ***More than half of all test claims paid on the first try*** • 519 (54%) of FFS claims paid on the first try (430 denied due to provider error, 4 due to other reasons) • 52 (55%) of MyCare claims paid on the first try (42 denied due to provider error, 0 due to other reasons)
“… that is properly adjudicated not later than thirty days after the date the clean claim is submitted.”	***The state system accurately adjudicated most claims*** • 949 (99%) of the FFS claims adjudicated properly • 94 (100%) of the MyCare claims adjudicated properly

SOURCE: Ohio Medicaid BH Redesign Beta Testing Results (December 2017).

Contingency plans

- The state system has been thoroughly tested and adjudicates claims with better than 99 percent accuracy
- Any delay is costly for providers who have been ready for months to submit claims using the new billing codes
- The priority for the state is to avoid any disruption in access to care for individuals receiving behavioral health services
- The state is partnering with NAMI and others to provide extra support for individuals in accessing current or new services
- However, we recognize that some providers may not be able to submit claims using the new billing codes on day one
- Therefore, the state will implement a payment contingency plan for providers during the transition

Behavioral Health Redesign payment options

Beginning January 1, 2018, community behavioral health providers will have three options to submit Medicaid claims:

1. Submit claims through the new beta tested system – this option is expected to accommodate the majority of claims
2. Submit claims directly through the MITS portal – this option is labor intensive and only practical for very small providers
3. Participate in a time-limited, cash-flow contingency plan

Time-limited, cash-flow contingency plan

Community behavioral health providers that are not ready to submit claims using the new billing codes in January 2018, will be eligible for contingency payments under the following conditions:

1. The provider must attest by January 15 that it is not prepared to submit claims using the new codes and apply for advance payment[1]
2. Medicaid will advance a monthly payment for January, February and March equal to the state share (27.3 percent[2]) of the provider's average monthly Medicaid reimbursement in calendar year 2016
3. At any point, a provider may connect to the system and bill for services provided after January 1
4. Medicaid will recover the advance payment by offsetting claims paid between April 1 and June 30, 2018

1. Ohio Medicaid Behavioral Health Redesign Provider Advance Payment Application (December 2017).
2. 27.3 percent is the actual blended state matching rate for Medicaid behavioral health providers in calendar year 2016.

Provider Support

A rapid response team will be available to provide technical assistance six days a week to ensure a successful transition to the new code set and behavioral health benefit package

- For claims errors or policy concerns: Call the Medicaid provider hotline (1-800-686-1516) and select Option 9 OR email BH-Enroll@Medicaid.ohio.gov
- For electronic data interchange processing: Call the Medicaid provider hotline (1-800-686-1516) and select Option 4 OR email OhioMCD-EDI-Support@dxc.com
- Testing through the MITS certification system will reopen January 1 for all providers
- Each MyCare plan also will have provider support available

SOURCE: http://bh.medicaid.ohio.gov/Portals/0/Providers/MCO-Resource-Document-CBHC_092017_rev.xlsx

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