

Behavioral Health Joint Medicaid Oversight Committee Briefing

October 17, 2019

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Department of
Medicaid



Department of Mental Health
and Addiction Services

Recovery Ohio Behavioral Health Redesign Update

Behavioral Health Redesign Update

Immediately after taking office, the DeWine Administration identified several key priorities for individuals with behavioral health (BH) needs and their families that require collaborative policy development and planning across key state agencies. The Ohio Department of Medicaid (ODM) and the Ohio Department of Mental Health and Addiction Services (OMHAS), in partnership with Recovery Ohio, share a common goal to maintain and support a robust continuum of BH services and supports for individuals and families.



Stabilizing the Behavioral Health System

- Systems and data work to inform areas of needed intervention
- Focus has been on addressing claims payment delays and billing/coding issues
- Achieving stability in claims payment processes with the MCPs
- Support and technical assistance to individual providers with billing changes
- Transition requirements for MCOs
- Addressing stakeholder feedback concerns regarding BH Redesign
- Recoupment/Repayment of provider advance payments
- Other managed care policy updates

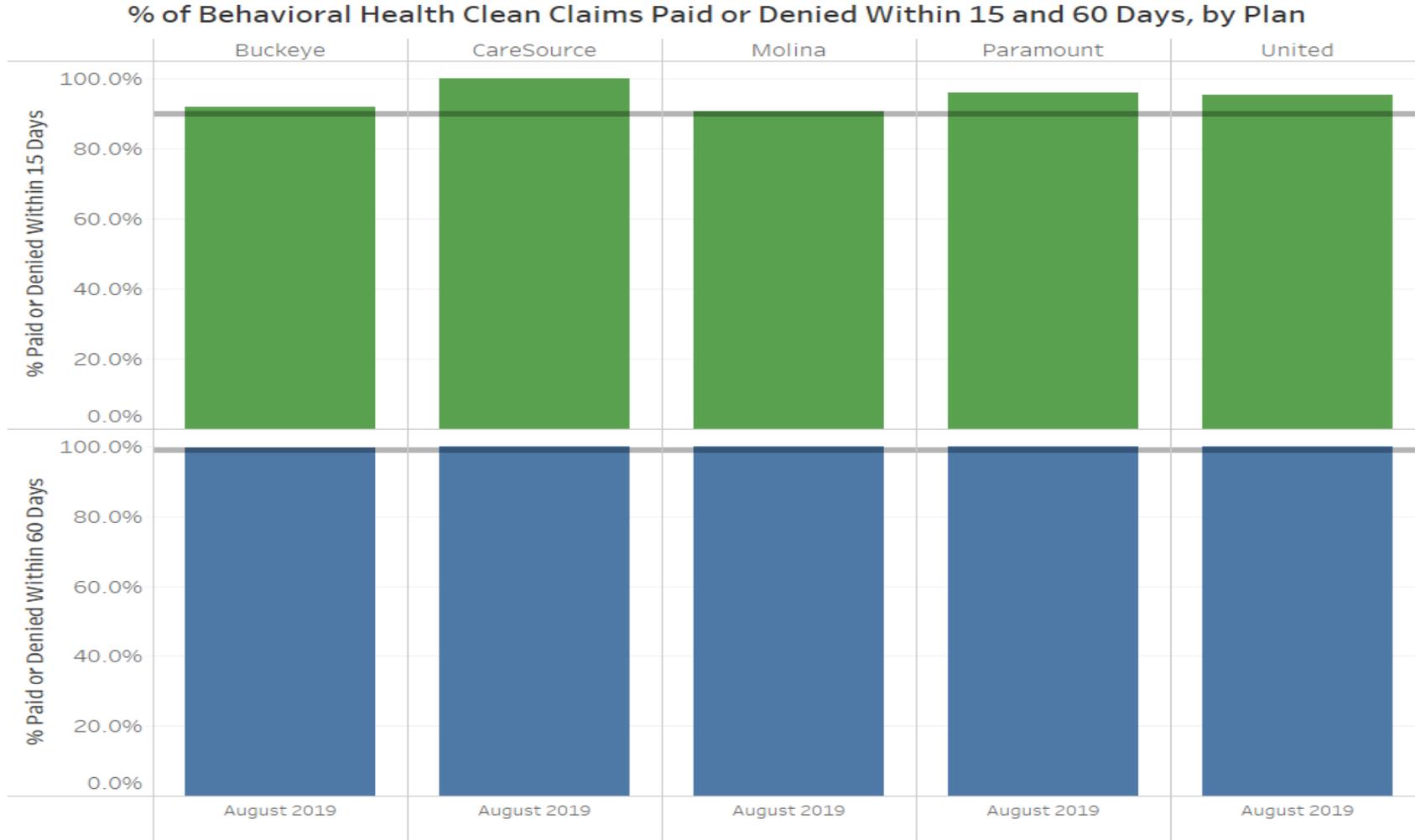
Behavioral Health Emergency Rule Filing

- **Effective August 1st, 2019**
- **Rate increases to stabilize system**
 - » Crisis Services for mental health and substance use disorders
 - » Group psychotherapy and group therapeutic behavioral services (TBS) for MH, and group counseling for SUD
 - » Evaluation and management services and psychiatric diagnostic evaluations rendered by certain providers increased to 100 percent of the Medicaid maximum rate
- **New billing codes to enhance integration of physical and behavioral health care**
 - » Smoking cessation counseling
 - » Pregnancy testing
- **Increased flexibility for providers**
 - » Allow nurses to render nursing regimens without requiring a physician order, consistent with nursing scope of practice
 - » Allow licensed mental health practitioners to render Therapeutic Behavioral Services (TBS)
- **Estimated annual increase of \$50 million**

Managed Care Provider Agreement Updates

- BH redesign transition of care patient protection requirements continued, including:
 - » Medicaid rates as the floor,
 - » 365 day timely filing,
 - » Medicaid BH policies are followed (i.e. prior authorization criteria and requirements), and
 - » Members may continue to see out-of-network providers if they were patients prior to BH Integration.
- Revised prompt pay standards for BH claims to require MCPs to pay 90% clean claims within 15 days. (July 1, 2019)
- Added requirement for MCPs to notify providers of the status of submitted claims (paid, denied, pended) within one month of receipt by the MCP or its designee. (July 1, 2019)
 - » Notification made in the form of a claim payment/remittance advice
 - » Produced on a routine monthly, or more frequent, basis.
- Revised notification requirements for paid, denied and pended claims to include a batch inquiry process. (January 1, 2020)
- Coordination of Benefits - ODM and the MCPs have increased the frequency of data exchange for third party liability in attempt to align TPL data across Medicaid and MCPs. Additional resources have been made available online related to COB.
- Universal Roster implemented and will be discontinued as we transition to using the MITS-generated Provider Master File to simplify enrollment of CBHC practitioners.

Plan Prompt Pay Compliance



Beginning July 1, 2019, plans are required to pay or deny 90% of behavioral health clean claims within 15 days and 99% within 60 days. The results in this slide are preliminary.

Behavioral Health Managed Care Advanced Payments

- MCPs made advanced payments to BH providers in July 2018.
- 173 providers received advance funds to be paid back to the MCPs.
- ODM is actively working with providers to develop individualized repayment plans.
- Each provider has been assigned an ODM contact person and a SME to guide them through the process.
- In order to develop feasible repayment plans, providers are being asked to provide financial data which ODM will use to inform individualized repayment plans specific to the provider's situation.
- Providers will have the opportunity to work individually with ODM and MCPs to finalize repayment agreements, including amounts and timelines.

Progress on Recoupment of Provider Advance Payments

Aggregate MCO
Repayment Status

Original Advance	# of CBHCs that received Advance	Recoupment by MCOs prior to May 1	Repayment Plan Finalized	% of Advance Recouped or Repayment Plan Agreed	Advance Payments Uncollected and no Repayment Plan	% of Original Advance Uncollected & no Repayment Plan	Estimated Projections	
							Advance Recouped by December 2020	Percentage Recouped by December 2020
\$179,141,498	177	\$53,229,618	\$73,315,959	70.6%	\$52,595,922	29.4%	\$125,166,462	69.9%

Ongoing ODM efforts for Repayment of Advance Payments

Repayment Plan Finalized	Longer Term Repayment Plans awaiting MCO Approval	Repayment Plans in Process	Other*	Potential Write-Offs (13 CBHCs)
\$73,315,959	\$21,105,072	\$12,959,583	\$18,531,267	\$9,455,276

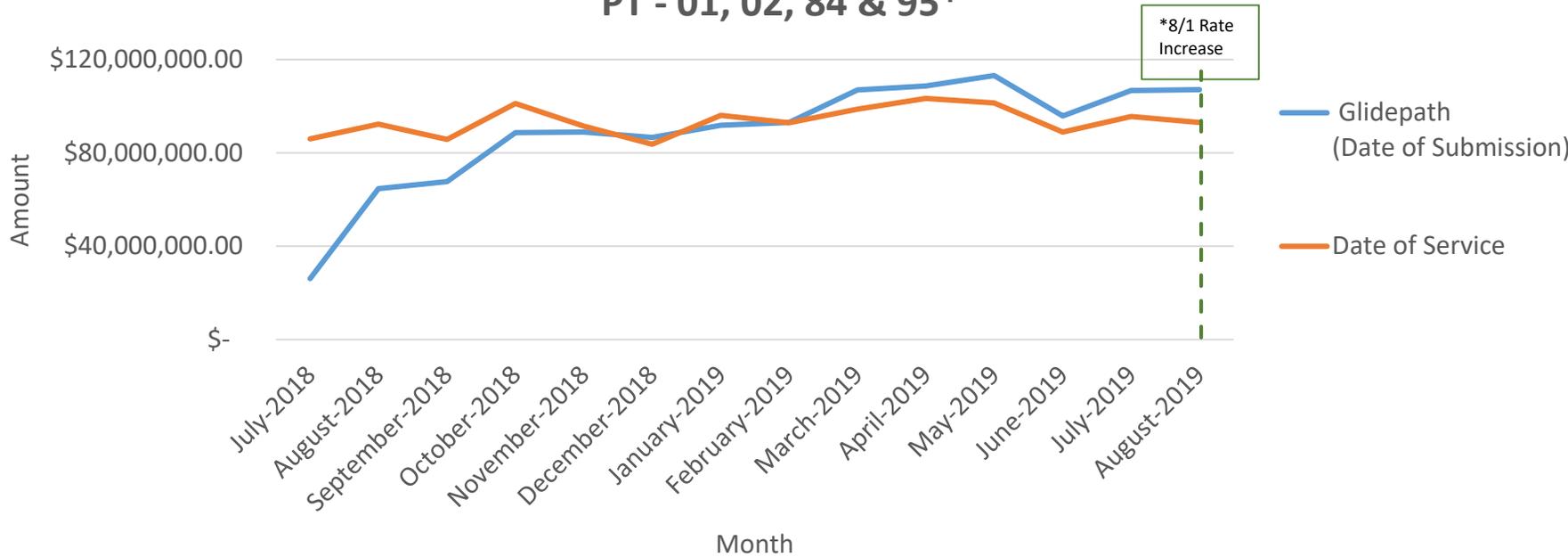
***Other include:**

- 1) One agency that has shutdown
- 2) Potential write-offs (also noted in separate column above)
- 3) Agencies that want to hold repayment until ARs are resolved
- 4) Unresponsive Agencies

Behavioral Health Payments Data

Month	Glide Path (Date of Submission)	Date of Service
Jul-2018	\$26,068,242	\$86,040,005
Aug-2018	\$64,691,825	\$92,394,449
Sep-2018	\$67,767,435	\$85,844,487
Oct-2018	\$88,690,589	\$101,249,239
Nov-2018	\$88,961,777	\$91,534,571
Dec-2018	\$86,610,854	\$83,733,591
Jan-2019	\$91,893,187	\$96,093,987
Feb-2019	\$93,102,684	\$92,902,520
Mar-2019	\$106,983,452	\$98,819,436
Apr-2019	\$108,772,691	\$103,389,645
May-2019	\$113,199,571	\$101,447,174
Jun-2019	\$95,801,595	\$88,992,849
Jul-2019	\$106,808,546	\$95,648,710
Aug-2019	\$107,135,788	\$93,025,714
Total	\$1,246,488,236	\$1,311,116,378

Payments Comparison between Glide Path & Date of Service Data
PT - 01, 02, 84 & 95*



Note: The Glide Path data represents payments to community BH agencies and outpatient hospital behavioral health providers made since July 2018 for claims submitted in the reported month. The Date of Service (DOS) data represents payments made since July 2018 for services rendered in the reported month.

For example: if a service was rendered in July, billed in August and then paid by the MCO in September. The payment for this claim would be reflected in August in the Glide Path report but in July on the DOS report. All data reflects payments made by the MCOs for paid claims.

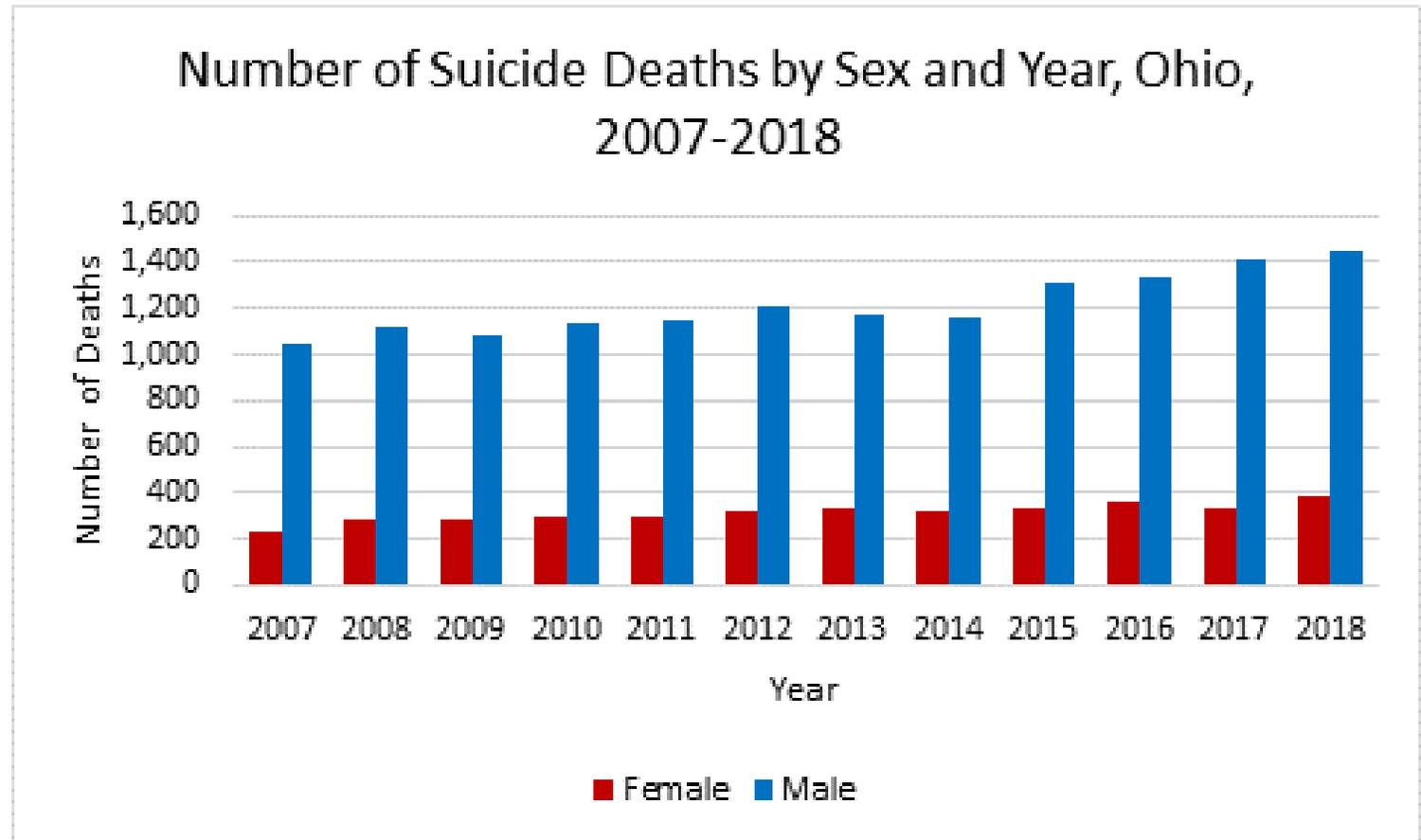
8/1 Rate Increase: On August 1, 2019, Medicaid increased the rates for crisis and group treatment services as well as evaluation and management and diagnostic assessment for some practitioners.

*Reflects payments to Community Behavioral Health Agencies and Outpatient Hospital Behavioral Health services

Substance Use Disorders and Mental Illness in Ohio

Prevalence and Consequence of Mental Illness

- 23% of adult Ohioans have received a diagnosis of depression.
- 8% of adult Ohioans experienced a major depressive episode in 2017.
- Over 230,000 Ohio adults and youth were treated for severe mental illness or severe emotional disorders in 2017.
- Suicide rates in Ohio continue to climb, with over 1400 completed suicides in 2018.



Illicit Drug Trends

- Availability of prescription opiates for illicit use continues a downward trend.
- Availability of heroin, cocaine, fentanyl, marijuana, and methamphetamines remain high across the state.
- Unintentional heroin and prescription opioid overdose deaths are down.
- Unintentional overdose deaths related to cocaine / fentanyl combinations are increasing dramatically, with a disproportionate number of these deaths occurring among African Americans.
- Between mid-September and mid-October of 2019, Ohio's hospitals treated more than 3700 people for suspected drug overdose in their emergency rooms.

What do we know from national Medicaid data about Substance Use Disorders?

- Medicaid is now the largest payer of SUD services—projected to finance 28% of national SUD treatment spending by 2020.
- Two of top ten reasons for Medicaid hospital readmissions involve SUD.
- Two out of three members with an SUD did not receive treatment within 14 days following inpatient or residential withdrawal management.
- Medicaid beneficiaries account for nearly 40% of adults with OUD.
 - » Higher rates of OUD
 - » Higher risk of overdose
 - » Twice as likely to be prescribed opioid pain relievers
 - » Complex health profiles and greater expenditures (co-morbidity)
- Medicaid beneficiaries are at high risk for overdose deaths—however, the curve is bending—Medicaid expansion reduces mortality from drug overdoses and increases access to drug treatment.

OhioMHAS Initiatives

OhioMHAS Policy Priorities

Prevention and treatment across the lifespan

Children, youth, and families

Trauma-informed care

Building Ohio's behavioral health workforce

Quality care in integrated settings

Helping adults with SPMI thrive in communities

Preventing overdose deaths and suicides

Long-term responses and support

Delivering excellent care in our state psychiatric hospitals

Transferring research into practice to support communities

Ensuring safe and quality care in Ohio's behavioral health system

Improving Access Across the Continuum

- Improving Licensure and Certification
- Empowering families and communities
- Investing in citizen providers
- Recruiting, training, and retaining workforce
- System needs evaluation and data modeling
- Building Ohio's crisis response infrastructure

I N V E S T I N G I N

Ohio's FUTURE



BUDGET OF THE STATE OF OHIO | FISCAL YEARS 2020 - 2021



- Crisis services
- K-12 Prevention
- OhioSTART
- Statewide media campaigns
- Expanded specialty dockets
- Workforce development
- Licensure & Certification

ODM & OhioMHAS

Improving the System & Services

Short Term Objectives: Behavioral Health & Medicaid

- Increase Medicaid enrollee access to addiction and mental health treatment
- Stabilize the BH service provider network
- Add flexibility to support patient access and address workforce capacity
- Adjusted payment rates for a few key BH services
- Continue the BH Stabilization work
- Set the stage for future changes:
 - » SUD 1115 Waiver
 - » Care Coordination
 - » Services to support multi-system youth and their families

Collaborative Systems Improvement

- Build out the crisis services continuum
- Augment the system of care for children and youth
- Support childhood early identification and linkage to behavioral health services
- Promote school-community partnerships aimed at ensuring that children who are exposed to trauma in their home, school or community receive appropriate interventions
- Workforce development
- Use of technology

Collaborative Service Enhancements

- Ensuring adequate access to medication assisted treatment (MAT) for individuals with Opioid Use Disorders.
- Support for pregnant and parenting women and families
- Behavioral Health Care Coordination
 - » Ohio Medicaid and OhioMHAS are committed to a behavioral health provider model of care coordination for adults and kids
 - » Goal: individualize care for the people who need it - looking at critical needs for:
 - Adults with serious and persistent mental illness
 - Adults and adolescents with substance use disorders
 - Multi-system youth and children with serious emotional disturbances
- Applied Behavioral Analysis (ABA) Service for Autism Spectrum Disorders

System Performance Following BH Redesign

BH Provider Terminology

- Numbers used to indicate Medicaid provider “TYPE”
- Type 84 community mental health provider
- Type 95 community substance use disorder provider
- “Community BH” Providers = 84 + 95
- “Acute care” means private hospital
- “Emergent care” means emergency room care
- Non-acute, Non emergent care includes all types of “community” services
 - » Community BH, 84 + 95
 - » Similar services from outpatient hospital
 - » Individual practitioners-psychiatry physician group, group of therapists or counselors

Behavioral Health Provider Capacity

Total Behavioral Health Provider Capacity (not just Medicaid, includes SUD residential, excludes type 1,2 and 3)

Provider Type	Oct 2016	Oct 2017	Oct 2018	Oct 2019
Behavioral Health Providers	749	771	837	849

Medicaid Behavioral Health Provider Capacity

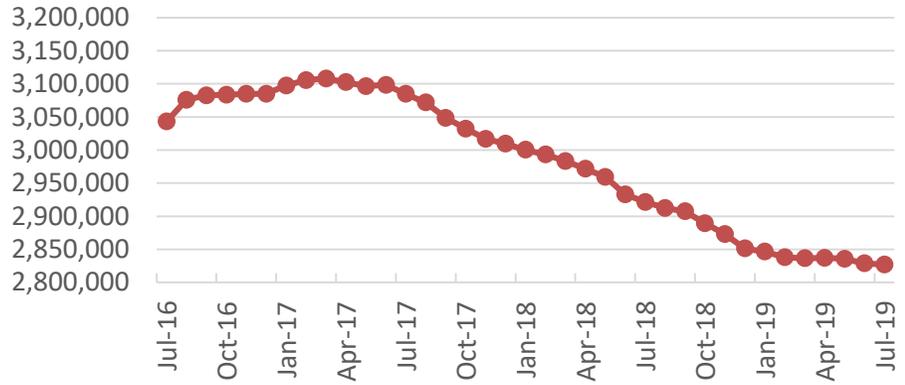
- The number of community BH providers increased by 41 providers (+10%) since Jan 2017
- A total of 23 Hospitals provide community/behavioral health services

Period	Provider Type 84 (excluding hospitals)	Provider 95 (excluding hospitals)	Total 84/95	Unduplicated
January 2017	307	266	573	398
April 2018	331	305	636	439
October 2019	384	338	686	494

Caseload Trends by Population July 2016-July 2019

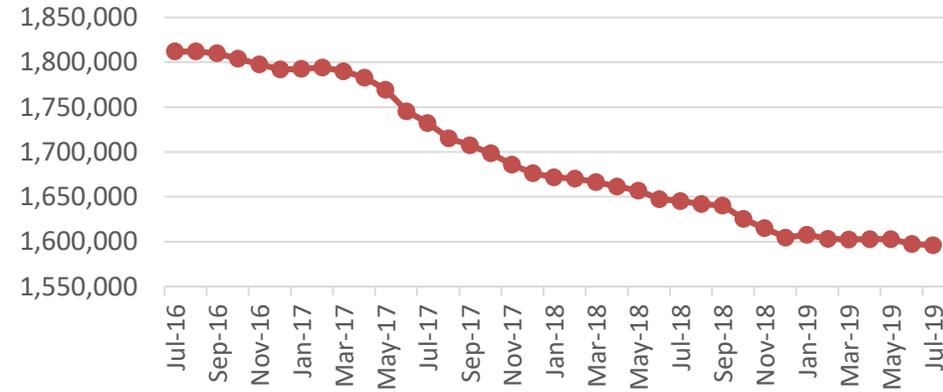
TOTAL

Total Medicaid Caseload



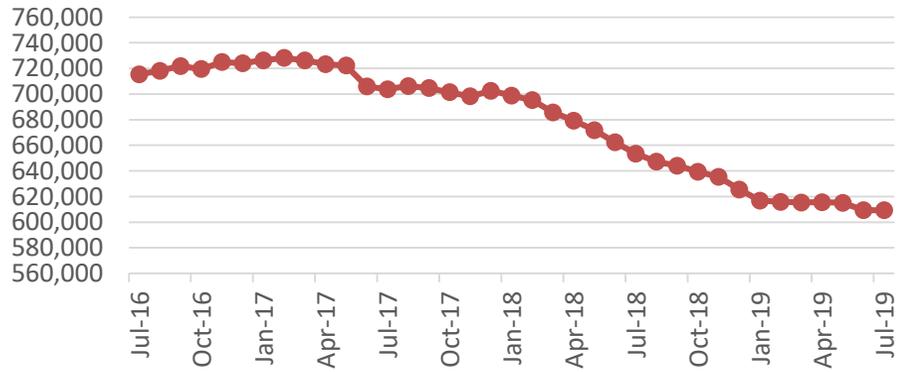
CFC

Covered Families and Children (CFC) Caseload



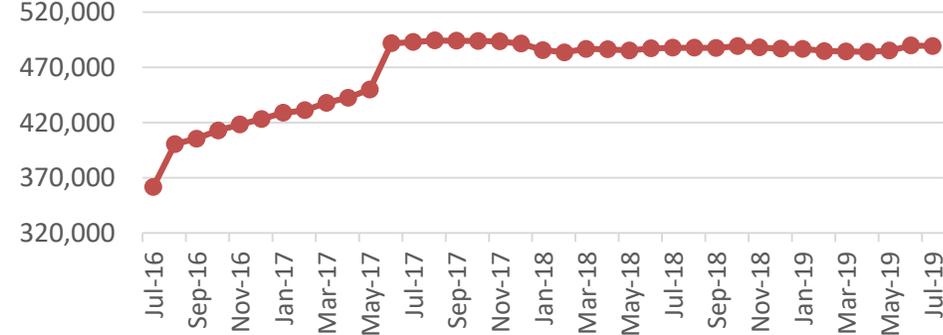
GROUP 8

Group VIII Caseload



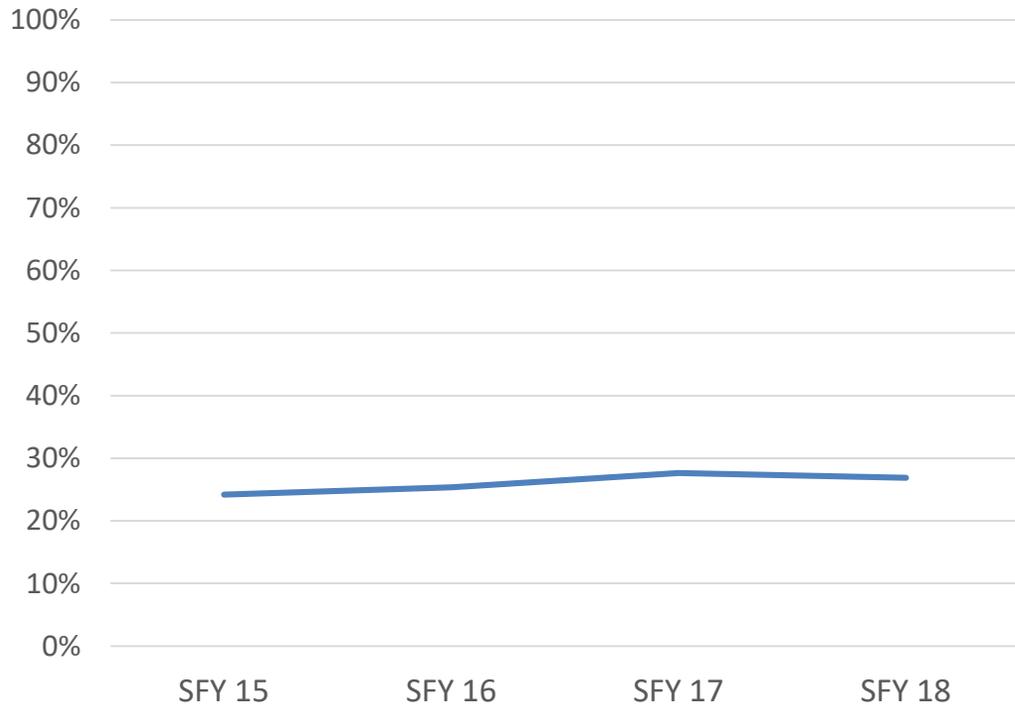
ABD

ABD/MBIWD/Dual Caseload



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

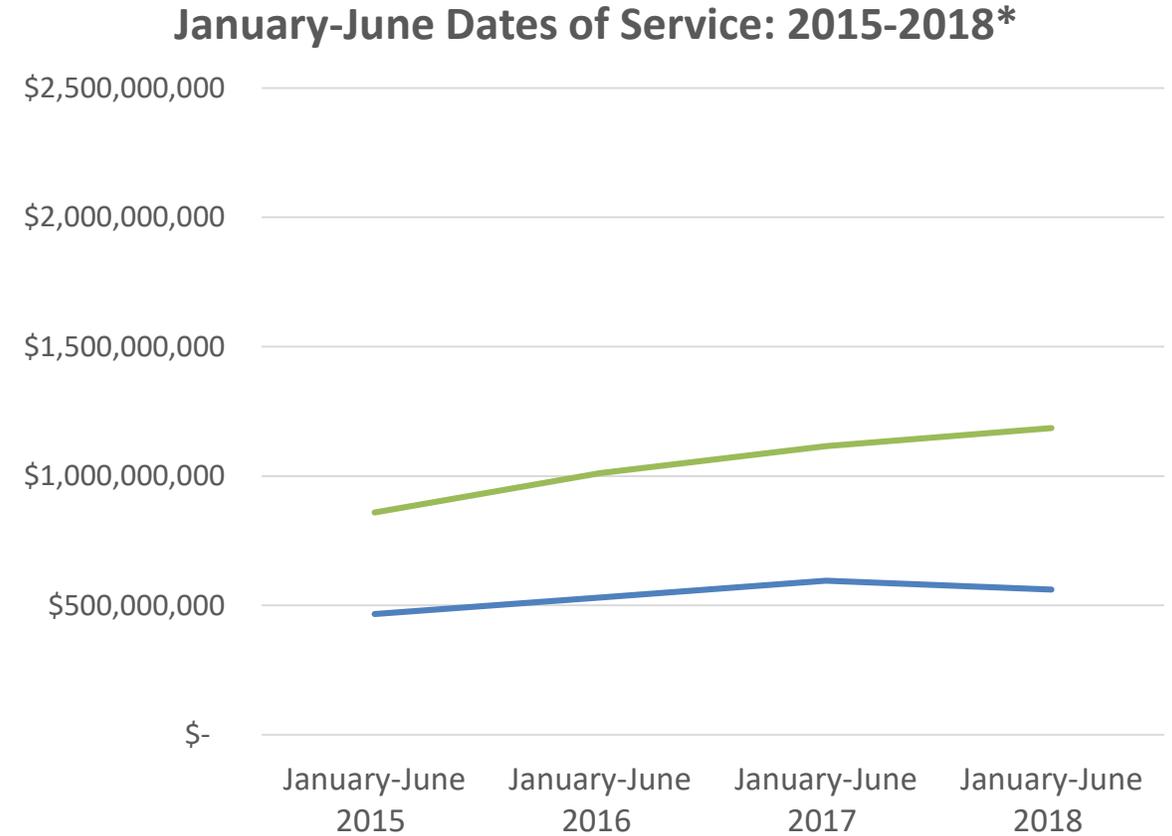
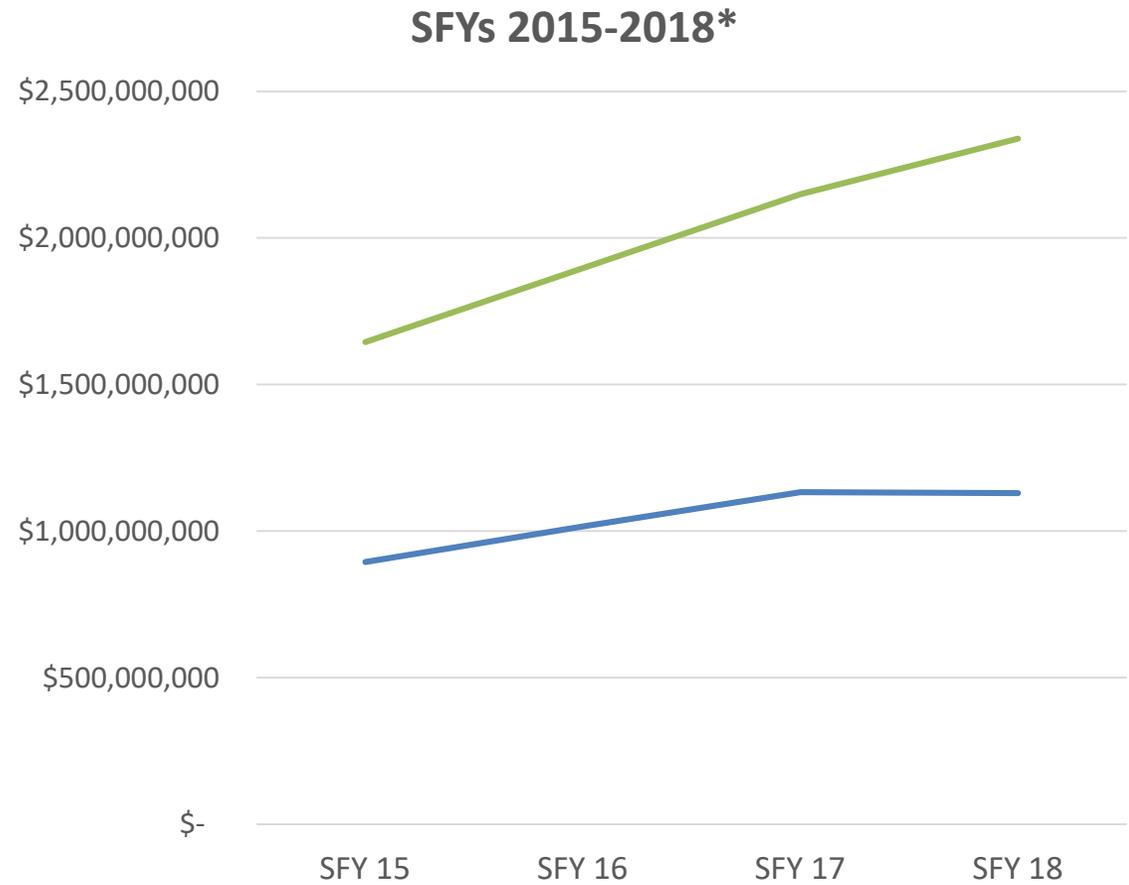
Percent of Medicaid Recipients*



Service Period	Total Medicaid Recipients*	Non-Acute, Non-Emergent Behavioral Health Services	
		No. of Individuals	Percentage
SFY 15	3,181,140	770,059	24%
SFY 16	3,386,427	857,989	25%
SFY 17	3,353,217	927,433	28%
SFY 18	3,320,905	892,805	27%

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



— Total Spend in Services for CMHCs and/or SUDs for Medicaid Recipients
— Total Spend in Non-Acute, Non-Emergent BH Services

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

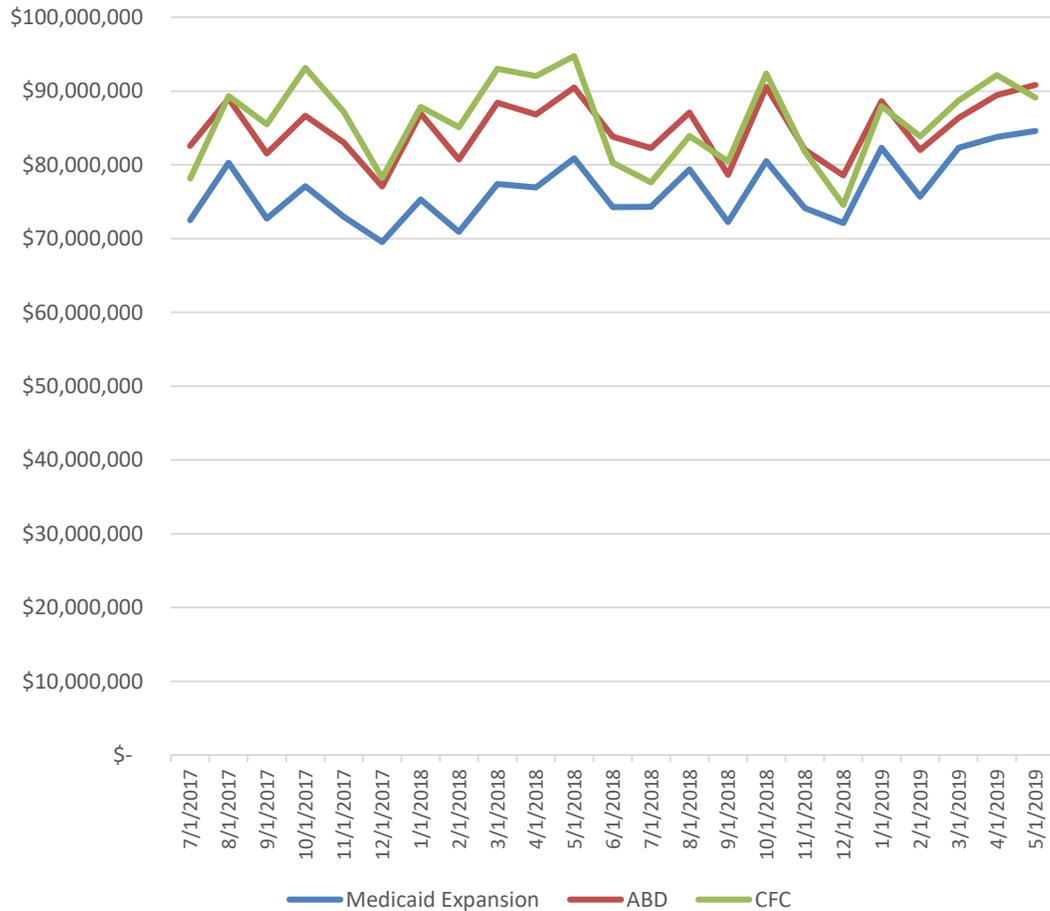
Patient Experience Impacted by Closing 84/95 Facilities*

	Members enrolled w provider*	Recd. Care this month	Any Health Care Service	Any BH Service	Only 84/95	BH Rx
Jan 2018	1,122	954	85%	59%	53%	57%
Apr 2018	1,162	989	85%	62%	57%	56%
Jul 2018	1,182	989	84%	60%	53%	56%
Oct 2018	1,209	1,065	88%	67%	60%	61%
Jan 2019	1,238	1,123	91%	74%	69%	62%
Apr 2019	1,235	1,122	91%	70%	64%	68%
Jul 2019	1,178	984	84%	51%	41%	60%

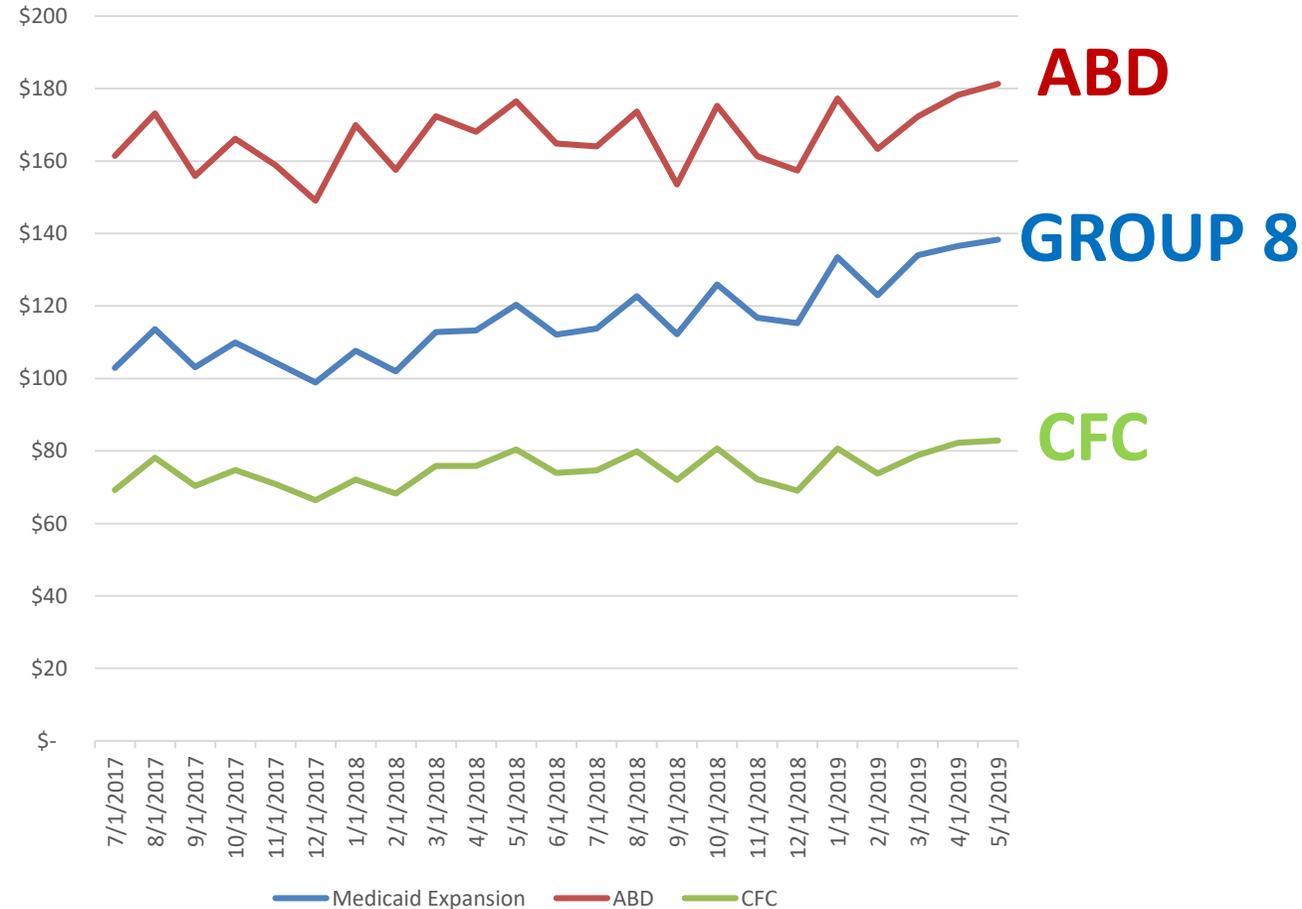
Behavioral Health Expenditures (Per Month)

Non-Acute, Non-Emergent BH (outpatient & BH pharmaceuticals): Comparing CFC, ABD, and Medicaid Expansion

Medicaid Expenditures



Medicaid Expenditures Per Member



Group VIII Members Who Are Working and Receiving BH Services

	Group8 Members who are working*	Working Group8 w/Doctor Visits	% with any Physician Visit	% with BH Rx claims	% with BH Services	% with Tx Commtty BH** Provider
Jan 2018	168,112	101,446	60%	23%	11%	7%
Apr 2018	171,140	103,050	60%	23%	12%	7%
Jul 2018	173,640	104,422	60%	23%	12%	6%
Oct 2018	184,721	113,156	61%	24%	12%	7%
Jan 2019	198,124	117,989	60%	23%	12%	7%
Apr 2019	210,214	126,377	60%	24%	12%	7%
Jul 2019	212,865	128,798	61%	25%	12%	6%
 Aug 2019	206,060	120,211	58%	25%	9%	5%

Aug. Group Total Enrollment 605,933

Note: claims run out for August

*Eligible members from Aug 2019 looking back to Jan 2018. Not all members from previous time periods are accounted for.

** Inc. types 84 & 95, community mental health and community SUD

1115 Medicaid Waiver for Substance Use Disorders

1115 Substance Use Disorder Services Waiver

- Continued federal financial participation for SUD services
- Significant enhancements to Medicaid’s care coordination services for individuals with SUDs
- Improve clinical consistency while measuring service outcomes and performance
- Work to improve care for pregnant women with opioid use disorder and their infants



Ohio's SUD 1115 Waiver: Goals

- Increase rates of identification, initiation, and engagement in treatment for SUD.
- Increase adherence to and retention in treatment.
- Reduce overdose deaths, particularly those due to opioids.
- Reduce preventable or medically inappropriate use of emergency department and inpatient hospital settings for treatment by increasing access to other services.
- Reduce readmissions to inpatient hospitals or higher levels of care when the readmission is preventable or medically inappropriate.
- Improve access to care for physical health conditions among individuals with an SUD.

Ohio's SUD 1115 Waiver: Background

- An Institution for Mental Disease (IMD) is defined in section 1905(i) of the Social Security Act as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services.
- The Federal Medicaid program does not provide for coverage of any services, inside or outside an IMD, for any individual age 21-64 who is a patient in an IMD.

Ohio has an opportunity to improve access to and quality of residential treatment and rebalance residential and community service capacity with the SUD 1115 waiver.

What is the IMD exclusion?

- Prohibition of federal Medicaid funds for services provided to IMD residents.
- IMD defined in federal statute, regulations, and guidance:
 - » Hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.
- Determined by overall character per criteria.
- Common ownership totaling >16 beds.
- Exceptions:
 - » SUD facilities based on lay counseling and social support (i.e. not billable).
 - » Hospital, nursing facility, and intermediate care facilities for members > 65 or under 21 years old.
 - » Inpatient psychiatric hospital services for members <21 years old.
 - » 15-day inpatient stays under “in lieu of” managed care policy.

Ohio is Taking a Strategic Approach

1. Ensure sustainability for community-based SUD and MH treatment coupled with enhanced housing strategies
2. Provider assessment will serve as a starting point for IMD assessments (as well as level of care for SUD):
 - » Single facilities that are greater than 16 beds who are providing treatment within the facility or common ownership in excess of 16 beds
 - » Includes facilities specific to providing SUD and mental health (children and adults)
 - » Information from these assessments will create a “foundation” for change
3. Provide Technical Assistance and Learning Opportunities to:
 - » Enhance recovery and housing continuum (supportive housing, recovery housing)
 - » Develop workable models and strategies to enable conversion from current design
 - » Make revisions to the Behavioral Health Redesign and other criteria
 - » Create diversification opportunities for IMD providers
 - » Enhance community services to divert from residential services

THE FIRST STEP IS THE ASSESSMENT...WE HAVE FIVE YEARS TO WORK THIS OUT

Kids Behavioral Health & Multi System Youth

Opportunity for Every Ohio Kid

Medicaid's Multi-System Youth Access to Care and Medicaid Expenditures for Behavioral Health Services Before and After January 2018

For Medicaid's multi-system youth, before and after Behavioral Health Redesign implementation (January 2018):

- **Access/utilization** for non-acute, non-emergent **behavioral health services** in outpatient settings **remained consistent**.
- **Access/utilization** for **behavioral health pharmaceuticals** remained **consistent**.
- Inpatient admissions and emergency department rates for behavioral health conditions remained consistent (**no increase in acute or emergent behavioral health services**).
- **Total Medicaid expenditures to behavioral health providers** in non-acute, non-emergent outpatient settings **increased**.
- Total Medicaid expenditures for **non-acute, non-emergent behavioral health services were between 2 up to 7 times higher** than the Medicaid expenditures for **behavioral health emergency department visits and inpatient admissions**, with this proportion increasing over time for the different groups of multi-system youth included in this analysis.

Modernize Systems of Care for Multi-System Youth Families

- **State Level Program: \$8 million**
 - » Goal: prevent custody relinquishment, get kids who have been relinquished back home
 - » FCFCs can apply for ***technical assistance and funding*** for care coordination, in-home and community supports, and residential treatment costs
- **Funding for PCSAs: \$20 million**
 - » Goal: prevent the relinquishment of custody to a PCSA, support costs of care for kids in custody of the agency who are placed in residential treatment facilities who have been relinquished
 - » Funding through formula, 15% (*currently in clearance for comment*) must be used to establish local resources and ensure multi-disciplinary coordination
- **Family and Children First Action Plan & FCFC Modernization: \$3 million**
 - » Goal: evaluate existing local FCFC infrastructure, current practices across the state, and service needs for multi-system youth
 - » Funding will be available for sustainability and technical assistance

More information at: <https://www.fcf.ohio.gov/MSY-TA-Funding-Requests>

Questions can be sent to: MSY@medicaid.ohio.gov

Additional ODM Children’s Initiatives with Behavioral Health Components

- **Comprehensive Primary Care (CPC) for Kids**
 - » Builds on current CPC program, begins January 2020
 - » Currently ~680,000 children enrolled in CPC practices
 - » New 2020 activity requirement for all CPC practices for “behavioral health care integration”
 - » Kids bonus payment tied to behavioral health measures
- **Interim funding for two entities while statewide Medicaid services are designed**
 - » Brigid’s Path – interim funding while developing mom/baby dyad care model
 - » Positive Education Program – interim funding while developing intensive care coordination for children with multi-system (including BH) needs

Comparison of Multi System Youth in Medicaid (ages 21 & under) SFYs 2015-2018

**a) with Behavioral Health Conditions b) Foster Care/Adoption Assistance c) Developmental Disability Waiver
OR d) Severe Emotional Disturbance (SED)**

Year	Total Medicaid Kids	Medicaid Kids w/ any BH Condition	Medicaid Kids with SED	Medicaid Kids in Foster Care/Adoption Assistance	Medicaid Kids Developmental Disability Waiver
SFY 2015	1,586,663	450,852	29,491	35,974	7,613
SFY 2016	1,645,508	478,752	34,376	37,452	7,525
SFY 2017	1,620,397	503,817	38,307	44,340	8,100
SFY 2018	1,601,131	460,166	40,278	47,352	7,892

Comparison of Percent of Youth Taking Behavioral Health Pharmaceuticals SFYs 2015-2018

Number of Youth Taking BH Pharmaceutical

Year	Youth with BH Condition	Youth in Foster Care/Adoption Assistance	Youth on DD Waiver	Youth with SED
SFY 2015	251,928	11,102	4,500	19,714
SFY 2016	253,783	11,089	4,405	22,611
SFY 2017	245,365	12,368	4,778	24,913
SFY 2018	228,390	13,953	4,567	25,646

Percentage of Youth Taking BH Pharmaceutical

Year	Youth with BH Condition	Youth in Foster Care/Adopt Assistance	Youth on DD Waiver	Youth with SED
SFY 2015	16%	31%	59%	71%
SFY 2016	15%	30%	59%	69%
SFY 2017	15%	28%	59%	68%
SFY 2018	14%	29%	58%	66%

Focus on Multi-System Youth, Kids in Foster Care

- Many children with multi-system needs, all kids in children's services custody, and children receiving adoption assistance have Medicaid coverage.
- Medicaid covers a wide variety of treatment services for kids- these services can help prevent placement in out-of-home placements.
 - » ODM also covers treatment in residential settings, including in some out-of-state placements.
- ODM & ODMHAS coverage and access to behavioral health services support parents and help to prevent out-of-home placements.
- ODMHAS, ODM and DODD are partnering with ODJFS as we work to implement the Family First Prevention Services Act (FFPSA), with a priority on enhancing support in Ohio's child protection system and preventing relinquishment due to the inability to get service needs addressed

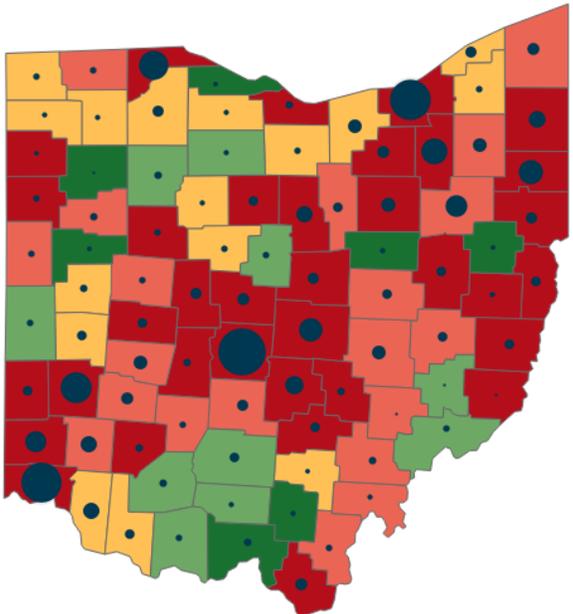
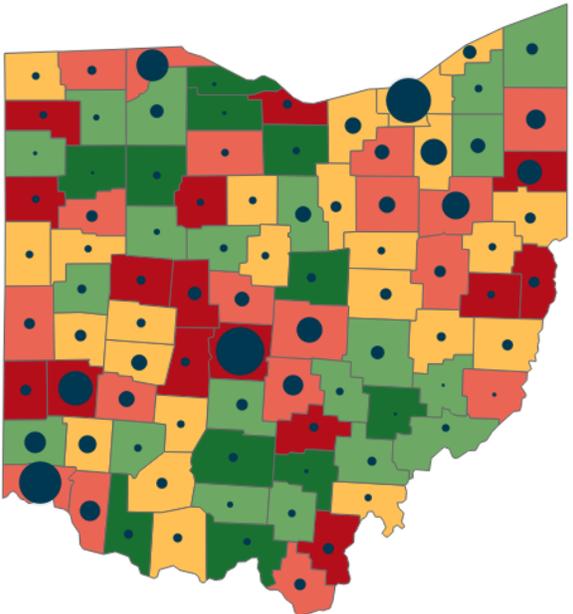
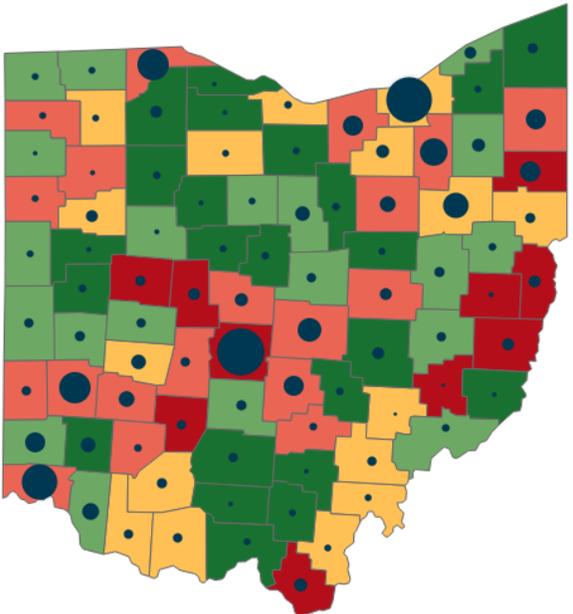
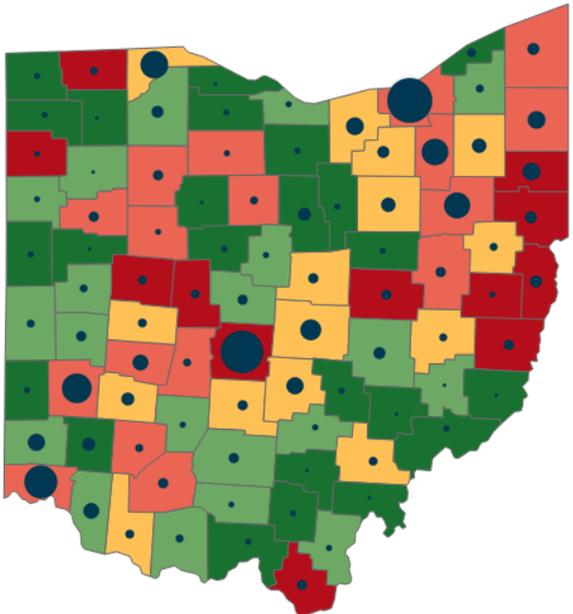
Foster Care/Adoption Assistance ED Visit Rate by County SFYs 2015 - 2018

2015

2016

2017

2018



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