

Ohio's Medicaid Behavioral Health Redesign

Governor Kasich initiated comprehensive reforms to expand access to mental health and addiction treatment services in the State of Ohio. The actions taken during the Kasich Administration have stabilized the system and rebuilt the safety net, resulting in an increased number of individuals who are able to receive treatment and support for mental illness and substance abuse disorders.

Ohio's strategy to rebuild community behavioral health system capacity

As one of its first priorities, the Kasich Administration developed a comprehensive strategy to rebuild community behavioral health system capacity. The goal is to integrate physical and behavioral health care services to support recovery for individuals with a substance use disorder or mental illness. The path toward that goal is based on key Medicaid reforms implemented in four steps:

- 1. ELEVATION.** Governor Kasich's first budget enacted June 2011 shifted the responsibility to provide Medicaid matching funds from local mental health and addiction treatment systems to the state. As a result of "elevating" Medicaid match requirements, the state now ensures a more consistent provision of Medicaid treatment services statewide.
- 2. EXPANSION.** Governor Kasich's second budget proposed and the legislature's Controlling Board later approved extending Medicaid coverage to more low-income Ohioans, including 400,000 residents with behavioral health needs who previously relied on county-funded services or went untreated. The combination of elevating match responsibility for clinical services to the state and then extending Medicaid coverage to more people added more than \$1 billion to Ohio's behavioral health system capacity and created a once-in-a-generation opportunity to improve access to mental health and addiction treatment, as well as freed up local systems to focus on local needs, like housing and employment supports.
- 3. MODERNIZATION.** Governor Kasich's third budget enacted June 2015 provided for a more comprehensive Medicaid behavioral health benefit package. It also required the Ohio Departments of Mental Health and Addiction Services (MHAS) and Medicaid to work together to modernize Medicaid behavioral health insurance codes to align with national standards and expand services for individuals with the most intense needs.
- 4. INTEGRATION.** The budget enacted June 2015 also authorized Ohio Medicaid to enroll every individual with behavioral health needs in a private-sector Medicaid managed care plan beginning January 1, 2018. After Ohio Medicaid and MHAS modernize the benefit package, it will be moved into managed care to ensure better integration in the provision of physical health and behavioral health care services.

The first two steps have been accomplished and work is underway on modernization and integration. In May 2015, the Governor's Office of Health Transformation (OHT) created a *Behavioral Health Redesign Team* comprised of experts from across Ohio to advise the state on how to modernize benefits and integrate services. That team's progress is described below.

Modernize Medicaid behavioral health benefits

Medicaid members needing treatment for mental health or substance abuse disorders represent 27 percent of Ohio Medicaid enrollment but account for 47 percent of Medicaid spending. Only half of the behavioral health population on Medicaid is seen through the community behavioral health system. Individuals with severe and persistent mental illness (SPMI) who are not receiving care from community MHAS providers often default to receiving care in nursing homes and hospitals, or lack a connection to treatment due to chronic homelessness, criminal justice involvement, or social isolation. Uncoordinated health care for people with chronic illness is dangerous for them and expensive for taxpayers. The following reforms modernize how services are administered and expand some services to fill gaps, both of which is necessary to further integrate physical and behavioral health care.

- ***Recode services.*** The Medicaid billing codes used by behavioral health providers are antiquated and need to be updated to align with current health care payment standards that will support coordination of benefits and integrate behavioral and physical health care. The Ohio Departments of Medicaid and MHAS are working together to recode and reprice all Medicaid behavioral health services. This work includes:
 - aligning all billing codes to national standards,
 - redefining mental health pharmacologic management and substance use disorder medical/somatic services as medical services,
 - separating and repricing certain existing services (e.g., community psychiatric supportive treatment, case management, and health home services) and providing for lower acuity service coordination and support services,
 - requiring rendering practitioners employed by community behavioral health agencies to enroll in Medicaid and be reported on Medicaid claims (these practitioners must be enrolled by January 1, 2017 to be paid by Medicaid), and
 - requiring providers to submit claims first to Medicare or other health care insurers before seeking Medicaid payment.

The recoding project is complex but proceeding on track. Provider agencies may voluntarily transition to the new code set beginning January 1, 2017, and only claims billed using the new code set will be paid for dates of service after June 30, 2017.

- ***Expand Medicaid Rehabilitation Options.*** Ohio Medicaid will expand Medicaid rehabilitation options for individuals with the highest intensity needs, including assertive community treatment for adults with SPMI and significant support needs, intensive home based treatment for youth with serious emotional disorders, and residential

treatment for substance use disorders. Ohio Medicaid will submit a state plan amendment to the federal Centers for Medicare & Medicaid Services (CMS) seeking approval to cover these additional services for individuals with high intensity needs beginning January 1, 2017 and fully implemented by July 1, 2017.

- **Create a new Specialized Recovery Services Program.** The Executive Budget enacted in June 2015 invested \$125 million over two years to create a new Specialized Recovery Services (SRS) program for adults with SPMI who have monthly income below \$2,199 but are not otherwise eligible for Medicaid. Approximately 5,500 individuals in this situation currently can “spend down” to the \$643 monthly income limit and qualify for Medicaid. However, on July 31, 2016, Ohio Medicaid is ending the spend down program and these individuals may no longer qualify for Medicaid.

SRS is designed to assure that Ohioans with SPMI retain full Medicaid benefits. Ohio has requested approval from the Centers for Medicare & Medicaid Services (CMS) to create the SRS program. To be eligible, individuals must meet income and diagnosis criteria and cannot live in a nursing facility, hospital or similar setting. Individuals enrolled in SRS will receive full Medicaid benefits plus recovery management care coordination services, assistance to find and keep a job, and support from others with similar life experiences.

Ohio Medicaid requested approval to create the SRS program from the Centers for Medicare & Medicaid Services (CMS) and CMS is reviewing Ohio’s request. CareStar, the Council on Aging of Southwest Ohio, and CareSource will perform eligibility evaluations for the non-financial requirements of the SRS program and provide the recovery management services that support individuals receiving services. Ohio Medicaid and MHAS will work with recovery management agencies and community behavioral health providers to contact every beneficiary who might be eligible for SRS and assist them to enroll in the program when it becomes available in August 2016.

Integrate physical and behavioral health care services

In order to improve care coordination and overall health outcomes for individuals with mental health and addiction service needs, Ohio Medicaid and MHAS will restructure all Medicaid reimbursed behavioral health services under managed care and explore new ways to pay for those services that reward providers who improve outcomes while holding down costs.

- **Coordinate care.** The Executive Budget enacted in June 2015 moves all Medicaid behavioral health services into managed care effective January 1, 2018. Ohio Medicaid will add behavioral health services to Ohio’s current Medicaid managed care plan contracts and require the health plans to provide comprehensive care coordination including, when appropriate, coordination provided by qualified community behavioral health providers. Providers in the new network will include community behavioral health organizations, inpatient hospitals, clinics, and specialty practitioners. Prior to

implementation, Ohio Medicaid will clarify the state's expectations for health plan performance measures, care management strategies for high risk populations, billing and coding methodologies, and benefit design. These details will be developed by the Ohio Departments of Medicaid and MHAS with input from the *Behavioral Health Redesign Leadership Team*.

- **Enhance primary care.** In May 2015, OHT convened a Patient-Centered Medical Home (PCMH) Design Team to develop a payment model that financially rewards primary care practices that hold down the total cost of care by preventing disease and managing chronic conditions. With input from 800+ stakeholders, including behavioral health system providers, OHT developed a PCMH payment model for adoption across Medicaid and commercial health insurance throughout Ohio. The model specifically identifies the importance of behavioral health collaboration in primary care. The PCMH model will be available statewide in January 2018, the same time Medicaid behavioral health benefits are carved into managed care. The goal is to enhance the state's primary care capacity in a way that complements the integration of physical and behavioral health services.
- **Report provider performance.** In March 2015, Ohio's largest health insurance plans began measuring and reporting provider performance on high-cost episodes of care using definitions and measures developed jointly with OHT. The goal of the episode-based payment model is to reduce the incentive to overuse unnecessary services within each episode and financially reward better health outcomes and cost savings through improvement. OHT and the Ohio Departments of Medicaid and MHAS recently announced that the next wave of episodes will include behavioral health care. The episode design process, which is extensive, will begin in July 2016. The goal is to define and begin reporting performance on a package of behavioral health episodes beginning in January 2018, the same time Medicaid behavioral health benefits are carved into managed care and the state's PCMH model takes effect.

These efforts in combination – integrating physical and behavioral health care services, primary care and prevention, and financially rewarding providers that improve patient outcomes while holding down the total cost of care – create an unprecedented opportunity to improve Ohio's overall health system performance, and get the right services at the right time to the Ohioans who need them to support recovery and maintain health.

updated June2016