Project: **Behavioral Health Redesign-1915i**

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Project Purpose

The Executive Budget continues the effort to rebuild community behavioral health system capacity. It modernizes the Medicaid behavioral health benefit and establishes a clear path to achieve better coordination and integration of physical health and behavioral health care services. It also invests in prevention services and non-Medicaid supports that help people sustain their recovery, such as housing, employment and peer services, and creates an opportunity to partner with local systems on these unmet needs. Most importantly, it sets priorities for both programs in combination, and focuses resources where the need is greatest.

Modernize the Medicaid Behavioral Health Benefit

The Medicaid behavioral health population in Ohio represents 27 percent of Medicaid members but accounts for almost half (47 percent) of Medicaid spend. The most expensive five percent account for over half of behavioral health expenditures. Only 50 percent of the behavioral health population on Medicaid is seen through the Mental Health and Addiction Services (MHAS) system. People with serious and persistent mental illness who are not in the behavioral health system often receive care in nursing homes, prisons and psychiatric inpatient hospitals. By making some key program reforms to the Medicaid program, and focusing where the need is greatest, Ohio can better serve individuals with high-end mental health and addiction needs while also bending the cost curve in the long run for these same individuals.

The Executive Budget makes a significant investment through Medicaid to provide a more comprehensive behavioral health service package and improve care coordination. It invests an additional $34.4 million ($12.9 million state share) in 2016 and $112.4 million ($42.3 million state share) in 2017:

 Redefines Medicaid Behavioral Health Services and Establish Additional Services. Beginning in FY 2016, current behavioral health services will be redefined to update coding and definitions to align with national standards and support integration, including the identification and discrete pricing of specific service activities. An urgent need exists to redefine and code mental health Pharmacological Management and alcohol and other drug Medical/Somatic so community mental health and addiction providers can better integrate with the rest of the health care world. Ohio Medicaid and MHAS will redefine codes to align with national standards effective July 1, 2015. The remaining behavioral health services will be redefined beginning in January 2016 when new services are introduced. The overall redesign will be budget neutral and focused on aligning services according to a person's acuity level and need. The specific components of community psychiatric supportive treatment, case management, and health home services will be disaggregated, defined and priced accordingly in order to give providers greater flexibility to meet a person's clinical need.

Lower acuity service coordination and support services will be defined for people with less intensive service needs. New services will be developed for people with high intensity service need, including Assertive Community Treatment (ACT), Intensive Home Based Treatment (IHBT), high-fidelity wraparound, peer services, supportive employment, and Substance Use Disorder (SUD) residential services. Some of these services for adults with severe and persistent mental illness will be covered under a 1915i Medicaid waiver, described below.

 Creates a special benefit program for adults with severe mental illness. As a result of the new single disability determination process proposed in the Executive Budget (see *Simplify Eligibility Determination*), the majority of people whose income will be above the Medicaid need standard adopted under the new system are adults with severe and persistent mental illness (SPMI). These Ohioans will have access to basic health care services through Medicare or private insurance. However, neither Medicare nor private insurance pay for a range of service coordination and community support activities currently covered in the Medicaid program. In order to ensure continued access to these services, Ohio Medicaid will seek a state plan amendment under section 1915(i) of the Social Security Act to provide for eligibility for adults with SPMI with income up to 225 percent of poverty (300 percent of the Federal Benefit Rate) who are not eligible under another Medicaid category and who meet diagnostic and needs assessment criteria established by the state. Ohio will also identify home and community based services needed by this population to be covered as services under the 1915(i) authority. MHAS will contract with a vendor pursuant to requirements established by Ohio Medicaid to validate the diagnostic and needs assessments conducted by qualified behavioral health providers. These assessments will be used to authorize eligibility and services under 1915(i). This provision costs $34.4 million ($12.9 million state share) in 2016 and $43.5 million ($16.4 million state share) in 2017.

 Implements a Standardized Assessment Tool to Prioritize Need. Access to high-severity services such as ACT, IHBT, high-fidelity wraparound and SUD residential, peer services, and supported employment will be assured through implementation of standardized assessment tools. These tools will be integrated in qualified provider organizations and performed in conjunction with the clinical assessment performed by qualified staff within the provider organizations. The standardized assessment will be independently validated by MHAS or an MHAS vendor authorized by Ohio Medicaid. The independent validation will be required for service authorization. The tools will include an assessment of housing needs and employment related supports not covered by Medicaid.

 Facilitates access to non-Medicaid housing supports for people most in need. People with severe mental illness and substance use disorders frequently experience longer than necessary stays in institutional settings such as hospitals and nursing facilities because of a lack of supportive housing options. An array of housing options is needed for this population, including permanent supportive housing, rental assistance for independent living, licensed group homes, transitional housing, crisis housing, and recovery housing. The housing needs of people with severe mental illness and addiction disorders identified through the assessment tools described above will assist MHAS and county boards to plan and allocate available resources to meet these needs.

 Improves Care Coordination and Outcomes through Managed Behavioral Healthcare. In order to improve care coordination and behavioral health and overall health outcomes for people with mental health and addiction service needs, Ohio Medicaid and MHAS will restructure all Medicaid-reimbursed behavioral health services under some form of managed care. Providers in the new network will include community behavioral health organizations, inpatient hospitals, clinics, and specialty practitioners. Ohio Medicaid and MHAS will use one year of fee-for-service experience for the services redefined above and the data from identifying the high risk/high severity population in the planning and rate setting for organizing these services under managed care. Ohio Medicaid and MHAS have not made any final decisions on the specific requirements for care coordination and the types of managed care entity or entities that will be contracted with for this purpose, but will develop structured processes for stakeholder input to occur during March 2015 and make final decisions soon after. This provision costs $68.9 million ($25.9 million state share) in FY 2017.

PROJECT TEAM

Name	Department
Angie Bergefurd	MHAS
Karin Hoyt	ODM
Rick Tully	OHT
Peggy Smith	ODM
Jody Lynch	MHAS
Douglas Day	MHAS
Betsy Truex-Powell	ODM
Beth Ferguson	MHAS
Mary Haller	ODM
Matthew Loncaric	MHAS
Daniel Hecht	ODM
Sara Zolinski	ODM
Christi Pepe	ODM
Sarah Curtin	ODM

Updated 2-19-2015

Operating Protocol

A. Applicability. This Operating Protocol is developed pursuant to O.R.C. Sections 191.01-191.06 and is applicable to following state agencies: Ohio Department of Mental Health and Addiction Services (MHAS) and the Ohio Department of Medicaid (ODM).

B. Purpose. This Operating Protocol is for the purpose of policy development related to a 1915(i) state plan amendment(s) for Medicaid eligibility continuity for severe and persistently mentally ill (SPMI) persons. It will also be used for policy development related to the Medicaid behavioral health services redesign. This Operating Protocol constitutes agreement by the Directors of the participating state agencies with the funding, personnel, workflow, and data sharing responsibilities specified herein.

C. Funding Responsibilities.

1. The funding sources identified for the time period specified in the table below are committed to the (project).

Operating Protocol Funding Table for:					
Time Period:					
Agency	Fund Source-Fund	Fund Source-ALI	Amount	CFDA No.	Will Funds B Sub-Granted

2. If the table above indicates any federal funds are to be sub-granted to lower level sub-recipients, the agency issuing the sub-grant will be responsible for communicating federal and state compliance requirements governing program funding. Such requirements include, but are not limited to, 45 CFR 92, OMB Circular A-133 and cost principles outlined within 2 CFR 220, 2 CFR 225 or 2 CFR 230 as applicable to the sub-recipient.

B. Personnel. Personnel identified for the time period specified in the table below are committed to the (project).

Operating Protocol Personnel Table for:				
Time Period:				
Agency	Staff Person Name	Position	FTE Value	Function

C. Workflow. Key workflow process transactions for the Behavioral Health Redesign-1915i initiative are described below.

1.
2.
3.
4.

D. Data Sharing.

1. Data sources and elements to be shared for the Behavioral Health Redesign-1915i initiative for the time period specified are shown in the table below:

*Please note: The data being shared is for a specific population investigation and policy development (for a 1915i eligibility option and behavioral health system redesign). The work is iterative and collaborative. Specific tables and fields are not presently specified; such specifications are not presently known and limitations at this time could be detrimental or a hindrance. The work will include staff for MHAS, ODM, and Mercer (a business associate who presently has access to Medicaid data). If Mercer will be accessing MHAS data that includes PHI, it will enter into a business associate agreement with MHAS. Files will be shared so that each team can continue their work, while still being consistent in the investigation definitions. Each team assures that information will be protected in compliance with HIPAA and other applicable federal and state laws.

Operating Protocols Data Sharing Table for:				
Time Period: 2-13-2015-6-30-2016				
Agency	Data Source	Description of Data Elements	Is Data Protected Health Information?	Description of Data Sharing Procedures
ODM	Various	Eligibility and claim detail and payment.	Yes	HIPAA compliant transfers, storage on protected systems
MHAS	Various	Eligibility and claim detail and payment.	Yes	HIPAA compliant transfers, storage on protected systems

2. If a participating agency reasonably determines that its protected health information shared with another agency has been maintained, used or disclosed in violation of state or federal law, the agency may cease sharing access to the information until the matter is satisfactorily resolved among the agencies and the Governor's Office of Health Transformation.