April 27, 2015
Rebuilding Community Behavioral Health System Capacity

Introduction

Governor Kasich's proposed SFY 2016/2017 Executive Budget supports the implementation of an initiative to rebuild community behavioral health system capacity. Key elements of this initiative include the following:

- Recode all Medicaid behavioral health services to achieve alignment with national coding standards;
- Develop new services for people with high intensity service and support needs;
- Disaggregate certain existing services and provide for lower acuity service coordination and support services; and
- Achieve cost neutrality in making these changes.

Recode all Medicaid behavioral health services to achieve alignment with national coding standards

Behavioral health services will be redefined to update coding and definitions to align with national standards (AMA, HCPCS, Medicare, NCCI/MUE) in support of integration and Parity. . Community behavioral health agency rendering practitioners who are able to enroll as independent providers in the Medicaid program will need enrolled with Medicaid so they can be reported on claims submitted to the Ohio Department of Medicaid (ODM) for payment.

With these changes in coding that will support appropriate claiming of Medicare services, it is expected that community behavioral health agencies will become Medicare certified and use Medicare certified practitioners to serve Medicare beneficiaries. In these circumstances, Medicaid will become the payer of last resort.

MH pharmacologic management and SUD medical/somatic services will collectively be redefined as medical services. This is in alignment with the January 1, 2013 AMA elimination of CPT codes historically used in Ohio.

Develop new services for people with high intensity service and support needs

Additional services are expected to be covered under Medicaid for people with high intensity service and support needs, such as Assertive Community Treatment for adults with serious and persistent mental illness and significant support needs, Intensive Home Based Treatment for severely emotionally disturbed children, and residential treatment for substance use disorders. These services will be covered under the Medicaid Rehabilitation Option. Additionally, three services will be covered under the 1915i State Plan Amendment: Recovery Management and Behavioral and Primary Healthcare Coordination, IPS Supported Employment; and Peer Recovery Support. Evidence based practice services must demonstrate fidelity to that model. These services will be targeted to those beneficiaries with a clinical need determined through a combination of clinical criteria and standardized assessment tools such as ANSA, CANS and the

ASAM Criteria. Treatment success will be measured through clinical outcomes and changes in service utilization. Linkage to non-Medicaid services and supports such as housing will be recognized in the development of these services.

Disaggregate certain existing services and provide for lower acuity service coordination and support services

The discrete service activities within the existing Community Psychiatric Supportive Treatment (CPST), Case Management, and Health Home services will be defined and priced accordingly 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.

Achieve cost neutrality

The cost of the new MRO and 1915i services will be offset largely by reduced costs attributable to the disaggregation of CPST and Case Management and Health Home services, definition and coding alignment changes for pharmacologic management and medical/somatic services, and coding alignment changes that allow Medicaid to become payer of last resort. The costs of all the changes to the Medicaid behavioral health benefit will be calculated against the Medicaid behavioral health services Executive baseline cost projection for FY 2016 and FY 2017 to determine if the changes are cost neutral. There are likely to be several iterative steps in this fiscal modeling process.

Implementation Process and Status

Key activities include the following:

- Redefined services are under development now through work at OhioMHAS and ODM, including consultation with CMS and Mercer.
- Team is planning changes to Medicaid Rehabilitation Option (MRO) and Targeted Case Management (TCM) state plan sections along with supporting Ohio Administrative Code and provider manuals to reflect new benefits.
    - Public review:
        - OAC changes through the public rule making process.
        - MRO and provider manuals though this group and other stakeholders. Provider manual should be the focus.
- Target implementation to coincide with new Ohio Integrated Eligibility System and change in Ohio Medicaid eligibility standards ("209 B" to "1634" – removing spend down and consolidating disability determination under OOD Bureau of Disability Determination). Target date is January 2016.