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Benefit and Service Development Work Group

October 11th, 2017

Behavioral Health Redesign

October 11th, 2017 Agenda

- Welcome and Opening Remarks
- Beta Testing Update
- Finalized IT Documents
- CNS/CNP Prior Authorization Exemption
- Managed Care Provider Agreement Updates
- Prior Authorization Overview
- IMD FAQs Update
- MCP Forums Update
- Rules Update
- Details on Upcoming 501 Trainings
- Upcoming Meetings

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Beta Testing Update

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Beta Test Scenarios

Beta Test Scenarios Available

- Providers should review the spreadsheet of beta scenarios at: http://bh.medicaid.ohio.gov/manuals
- Providers should test all scenarios applicable to their provider type and array of services rendered.
- While State-defined scenarios must be used for beta testing, ***providers are encouraged to submit additional test claims for any scenarios that could be billed in their practice.***

Recently released MITS Bits detailing this information can be found here:
http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits_09272017.pdf

Medicaid Transmittal Letter can be found here:
http://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/MedicaidPolicy/NonInst/MHTL-334-17-07.pdf?ver=2017-09-28-152158-733

Beta Testing: SUD Residential

Provider Specialty 954 (SUD residential)

- The beta scenarios available on the BH Redesign website include 7 scenarios specific to SUD residential.
- In order to test the SUD residential scenarios, providers **must** have the new MITS provider specialty 954 added to their Ohio Medicaid provider record in MITS*

*Information on enrolling SUD residential treatment programs in MITS and adding the 954 specialty can be found here:
http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits_7-31-2017.pdf

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Finalized IT Documents

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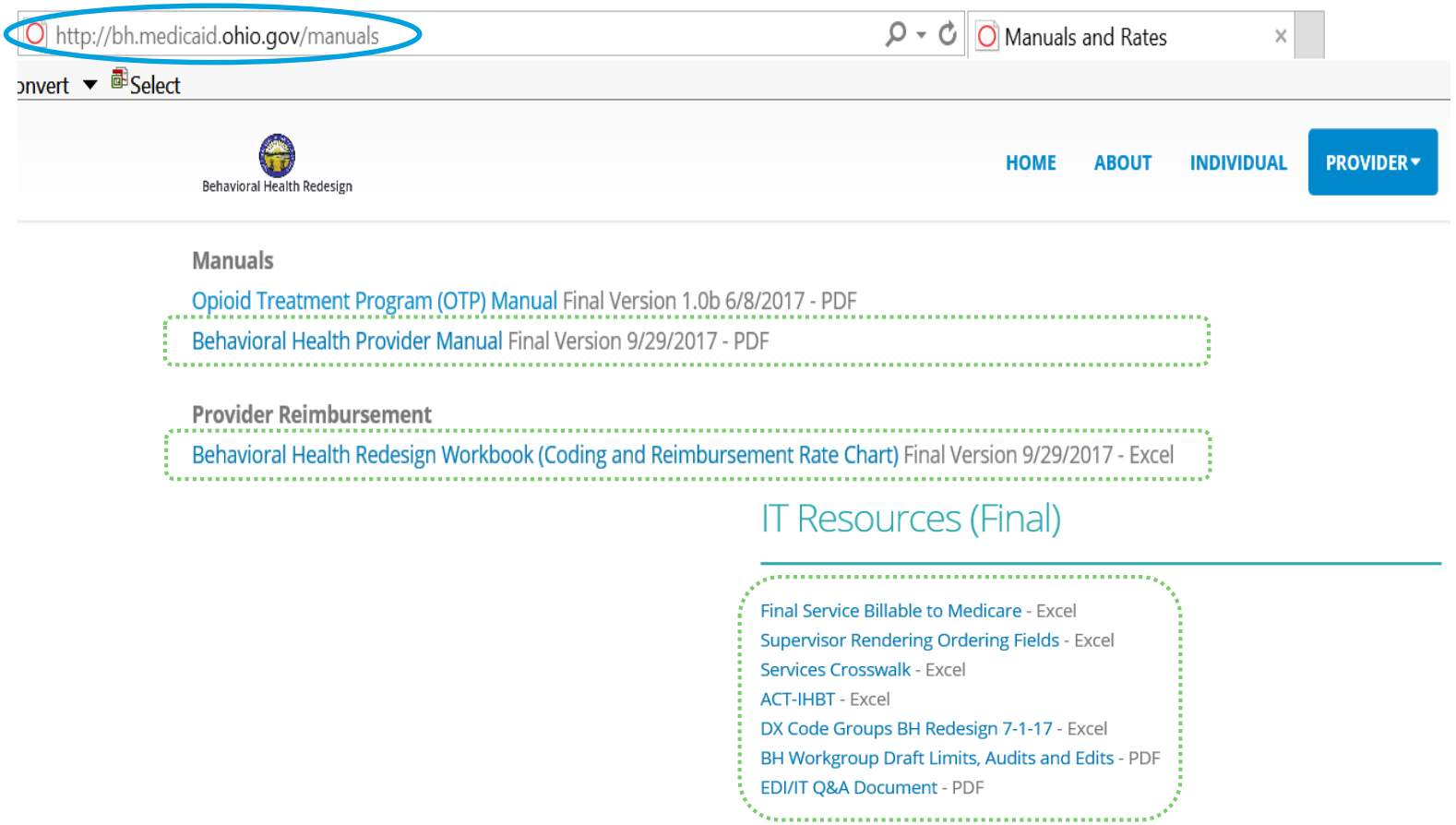
Finalized IT Documents – *BH.Medicaid.Ohio.Gov*

- ✓ The BH Provider Manual, BH Workbook Code Chart, and IT guides are finalized and have been re-posted to the BH Redesign site here: http://bh.medicaid.ohio.gov/manuals



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Clinical Nurse Specialist (CNS) / Certified Nurse Practitioner (CNP) Prior Authorization Exemption

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CNS/CNP Prior Authorization Exemption

Budget Language

Language set forth in Am. Sub. House Bill 49, Sec. 5167.12:

The department shall not permit a health insuring corporation to impose a prior authorization requirement when the drug is prescribed by:

"(c) A certified nurse practitioner, as defined in section 4723.01 of the Revised Code, who is certified in psychiatric mental health by a national certifying organization approved by the board of nursing under section 4723.46 of the Revised Code;

(d) A clinical nurse specialist, as defined in section 4723.01 of the Revised Code, who is certified in psychiatric mental health by a national certifying organization approved by the board of nursing under section 4723.46 of the Revised Code."

Certification

The three qualifying national certifications from the American Nurses Credentialing Center include:

- Psychiatric-Mental Health NP
- Adult Psychiatric-Mental Health CNS
- Child-Adolescent Psychiatric-Mental Health CNS

The State is currently working through a solution. More details will be forthcoming.

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Managed Care Provider Agreement Updates

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Managed Care Provider Agreement Updates

Provider Agreement

Timely Filing

- Until June 30, 2019 (December 31, 2018 for MyCare Plans), the MCP must accept provider claims for BH services described in OAC Chapter 5160-27 for no less than 180 days and not to exceed 365 days after the service is provided. An MCP may negotiate timely filing requirements within these limitations through their contract with the BH provider.

Network Adequacy

- This requirement in the MCP provider agreement refers to provider locations per county.

BH Clinical Director and BH Administrative Director

- After additional discussions, ODM has decided to remove the full-time psychiatrist requirement from the MCP provider agreement.

Note: ODM will be updating dates throughout the provider agreement as a result of the 'carve-in' date being moved to July 1, 2018.

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Prior Authorization Overview

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Prior Authorization Overview

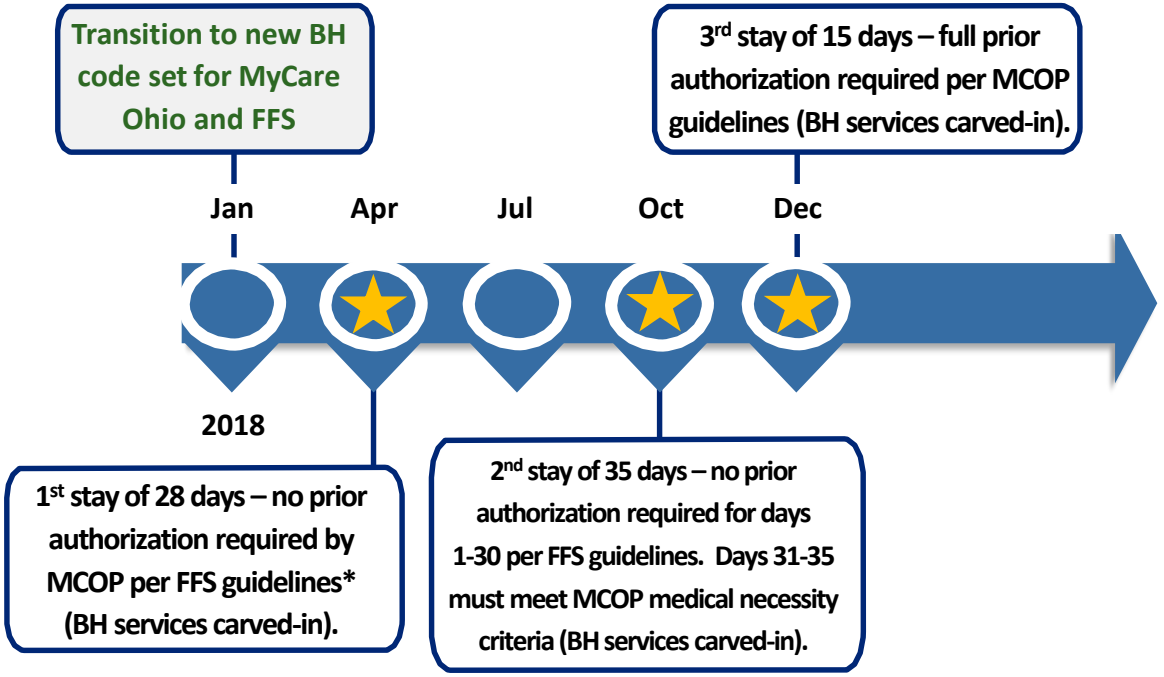
Honoring Prior Authorizations for Managed Care Carve-In

- The MCP shall follow the Medicaid fee-for service (FFS) behavioral health coverage policies through June 30, 2019. The MCP may implement less restrictive policies than FFS. After one year, the MCP may conduct a medical necessity review pursuant to OAC rule 5160-26-03.1.
  - *Any prior authorization approved by ODM prior to carve-in will be honored by the plans, and the plans will assume responsibility of the prior authorization process when the FFS authorizations expire.*

Prior Authorization Example: SUD Residential and MyCare

Updated following 9/13 BSD workgroup meeting

Service	Benefit Period	Authorization Requirement
SUD Residential	Calendar year	Up to 30 consecutive days without prior authorization. Prior authorization then must support the medical necessity of continued stay. If not authorized, only the initial 30 consecutive days are reimbursed. Applies to first two stays; any stays after that would be subject to full prior authorization.



Event

**MCOP must follow FFS prior authorization policies and rates for 12 months post go-live.*

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Institution for Mental Diseases (IMD) FAQs Update

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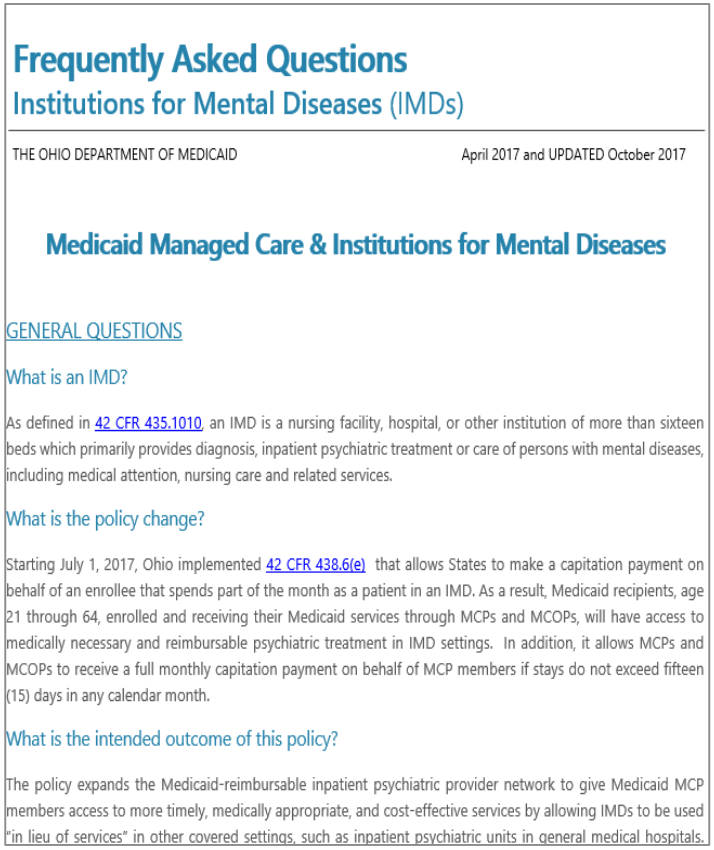
IMD FAQs Update

UPDATE

The IMD FAQs have been finalized, shared with the plans, and are now uploaded to the BH website under the Trainings tab at: http://bh.medicaid.ohio.gov/training

IMD FAQs



Frequently Asked Questions
Institutions for Mental Diseases (IMDs)

THE OHIO DEPARTMENT OF MEDICAID — April 2017 and UPDATED October 2017

Medicaid Managed Care & Institutions for Mental Diseases

GENERAL QUESTIONS

What is an IMD?

As defined in 42 CFR 435.1010, an IMD is a nursing facility, hospital, or other institution of more than sixteen beds which primarily provides diagnosis, inpatient psychiatric treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

What is the policy change?

Starting July 1, 2017, Ohio implemented 42 CFR 438.6(e) that allows States to make a capitation payment on behalf of an enrollee that spends part of the month as a patient in an IMD. As a result, Medicaid recipients, age 21 through 64, enrolled and receiving their Medicaid services through MCPs and MCOPs, will have access to medically necessary and reimbursable psychiatric treatment in IMD settings. In addition, it allows MCPs and MCOPs to receive a full monthly capitation payment on behalf of MCP members if stays do not exceed fifteen (15) days in any calendar month.

What is the intended outcome of this policy?

The policy expands the Medicaid-reimbursable inpatient psychiatric provider network to give Medicaid MCP members access to more timely, medically appropriate, and cost-effective services by allowing IMDs to be used "in lieu of services" in other covered settings, such as inpatient psychiatric units in general medical hospitals.

IMD FAQs – Notable Updates

What does "in lieu of services" mean?

- For a person needing medically appropriate inpatient psychiatric care, in order to meet the federal "in lieu of services" requirements, inpatient psychiatric services must be offered in a general hospital psychiatric unit or psychiatric hospital less than 17 beds in order to offer inpatient psychiatric services in an IMD. This ensures inpatient psychiatric services are provided "in lieu of services" covered under the state plan (e.g., general hospital psychiatric unit, psychiatric hospital less than 17 beds).

How is the "in lieu of services" provision documented?

- When a Medicaid managed care plan enrollee is in need of inpatient psychiatric care, the Medicaid managed care plan must be contacted for triage, level of care determination, and setting options. The MCP/MCOP ensures and documents inpatient psychiatric services are provided "in lieu of services" covered under the state plan. In instances in which the MCP/MCOP could not be contacted and has deferred the triage to the provider, the provider ensures and documents inpatient psychiatric services are provided "in lieu of services" covered under the state plan.

IMD FAQs – Notable Updates, Continued

Is the admitting IMD responsible for assuring and documenting that "in lieu of services" settings have been considered prior to admission?

- No, the IMD is not responsible for assuring or documenting that this requirement has been met.

If the emergency department or practitioner recommending an inpatient level of care is not able to contact the MCP/MCOP, will that practitioner be able to choose an IMD even if there may be beds available in the hospital or in a private facility with less than 17 beds?

- When a Medicaid managed care plan enrollee is in need of inpatient psychiatric care, the Medicaid managed care plan must be contacted for triage, level of care determination, and setting options. This includes MyCare Ohio plans when an enrollee has exhausted their lifetime Medicare inpatient psychiatric benefit.
- If a plan is not able to be reached prior to admission, the MCP/MCOP has deferred its triage, level of care determination, and placement authority to the clinical judgment of the practitioner recommending inpatient psychiatric care. Admissions must meet medical necessity criteria.

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Managed Care Plan (MCP) Forums Update

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Managed Care Plan Forums Update

Themes:

1. Providers in the MyCare regions have asked more detailed questions, seem to be more involved with the BH Redesign project, and are more advanced with contracting

2. Providers and the plans appear ready for the July 1, 2018 managed care carve-in implementation date

3. Providers appreciate the efforts to standardize tools and resources (e.g., the uniform prior authorization form and the managed care plans resource guide).

The MCP tools and resources can be found here:
http://bh.medicaid.ohio.gov/Provider/Medicaid-Managed-Care-Plans

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Rules Update

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Rules Update

ODM Rules

- On September 18th, the Joint Legislative Committee on Agency Rule Review (JCARR) hearing included testimony on the ODM rules.
- That hearing cleared the way for final filing the rules for a January 1, 2018 effective date.
- ODM rules were final filed on September 29th.

The Medicaid OAC rules can be found at the Register of Ohio: http://www.registerofohio.state.oh.us/jsps/publicdisplayrules/processPublicDisplayRules.jsp?agencyNumberString=5160&actionType=final&doWhat=GETBYFILINGAGENCY&Submit=Search

OhioMHAS Rules

- The JCARR hearing for the OhioMHAS rules was held on May 30th.
- OhioMHAS rules were final filed on September 29th for a January 1, 2018 effective date.
- The certification crosswalk is complete and will be posted at http://mha.ohio.gov/Default.aspx?tabid=743

The OhioMHAS OAC rules can be found at the Register of Ohio: http://www.registerofohio.state.oh.us/jsps/publicdisplayrules/processPublicDisplayRules.jsp?agencyNumberString=5122&actionType=all&doWhat=GETBYFILINGAGENCY&Submit=Search

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Details on Upcoming 501 Trainings

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Details on Upcoming 501 Trainings

- **ODM and OhioMHAS, in cooperation with OACBHA, will be holding 501 trainings on BH Redesign throughout the State in late October and November.**
- **Further details will be provided in an upcoming MITS Bits.**

501 DATES AND LOCATIONS	
October 27, 2017 Central Ohio Xenos Cafe Auditorium 1394 Community Park Drive Columbus, Ohio 43229	**October 30, 2017 Southeast** Zane State / Ohio University Campus Center 1555 Newark Road Zanesville, Ohio 43701
November 1, 2017 Southwest Top of The Market 32 Webster Street Dayton, Ohio 45402	**November 3, 2017 Northeast** The Natatorium 2345 Fourth Street Cuyahoga Falls, Ohio 44221
November 8, 2017 Northwest Church of the Nazarene 1617 Milan Road Sandusky, Ohio 44870	*A webinar will be held at the end of the in-person trainings and will be recorded. The webinar recording will be made available at: http://bh.medicaid.ohio.gov/training.*

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Upcoming Meetings

Behavioral Health Redesign

Meeting Schedule

Upcoming Meetings

- ✓ **Benefit and Service Development Workgroups**

  November 15th 10:00 am – 12:00 pm
  December 13th 10:00 am – 12:00 pm

- ✓ **EDI/IT Workgroup**

  November 8th 11:30 am – 12:30 pm

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Appendix

Behavioral Health Redesign

Beta Testing Process

Per the requirements set forth in House Bill 49, ODM will conduct a beta test to demonstrate provider readiness to go-live with Behavioral Health Redesign on January 1, 2018.

- The beta test will be held between October 25th – November 30th.
- ODM posted scenarios that must be used for beta testing on September 25th to the BH.medicaid.ohio.gov website
- Any provider who wishes to participate may do so.
- Providers must notify ODM of their intent to participate by sending an email with the subject-line "Intent to Beta Test" to BH-Enroll@medicaid.ohio.gov with the following information:
  - Agency name
  - All agency national provider identifier (NPI) numbers involved in testing;
  - The names of every MyCare Ohio plan with which the agency has or intends to have a contract;
  - If the agency uses a third-party vendor for information technology related to claims payment, the identity of that vendor; and
  - A point of contact, including name and telephone number, for the agency (unless info already provided to Rick Tully).
- On October 25th, the ODM Rapid Response room will re-open for providers and trading partners to quickly address any questions or concerns.

Beta Testing Requirements

Per House Bill 49, at least half of the providers participating in the beta test must be able to submit a clean claim for community behavioral health services that is properly adjudicated.

ODM will use the following parameters to calculate the beta test results:

- "Clean claims" will be defined as claims that can be adjudicated properly without seeking additional information from the provider.
- Beta providers must test with both ODM as well as the MyCare Ohio plans with whom they do business.
- Providers must test using scenarios defined at: http://bh.medicaid.ohio.gov/manuals.
  - Provider type 84s (CMHCs) may test any of 84-related scenarios and
  - Provider type 95s (SUD providers) may test any 95-related scenarios
  - Provider specialty 954s (SUD residential providers) may test any 954-related scenarios.
- Providers must submit test files via EDI.
- Providers must submit files by November 30th to be included in the beta test.

OhioMHAS Certification Process

What is **NOT** changing?

- OhioMHAS certifies community behavioral health agencies by types of service(s) and/or programs.
- Agencies with appropriate BH accreditation issued by TJC, CARF, COA, or DNV will be granted deemed status.
- For full deemed status, an agency must have all of its eligible services certified.
- ODM requires OhioMHAS provider certification as a condition of obtaining a Medicaid provider agreement.
- For agencies without accreditation, OhioMHAS will conduct a comprehensive certification review.
- OhioMHAS will continue to review and investigate complaints.
- Providers will continue to report MUIs.
- Providers will continue to report seclusion and restraint data.

What is changing?

- With Redesign, providers will determine billing codes used by Medicaid using ODM administrative rules and Manual.
- With Redesign, the rendering practitioner will be identified for each service.

Continuity of Certification

- ✓ There will be continuity of certification on January 1, 2018.
- ✓ OhioMHAS will issue a certification crosswalk between the current services and the new services and provide additional guidance on certification in relation to Redesign.
- ✓ If a provider intends to provide a new service, beyond a service that is being changed due to Redesign, then the existing process with the OhioMHAS Office of Licensure and Certification should be followed.
- ✓ Providers currently certified to provide CPST will also be certified for TBS and PSR on January 1, 2018.
- ✓ TCM certifications will remain unchanged.

Points of Contact

Aetna

- 24/7 Notification Phone Line: 1-855-364-0974 , option 2, then 4
- 24/7 Notification Fax Line: 1-855-734-9393
- Escalation/Other Questions: KilincA@AETNA.com

Buckeye

- 24/7 Nursewise Line 1-800-244-1991
- 24/7 OH Notification Fax Line 1-866-535-6974
- Escalation/Other Questions: Amber.Bundy@envolvehealth.com

CareSource

- 24/7 Notification Fax Line: 937-487-1664
- 24/7 Notification Email: mm-bh@caresource.com
- Escalation/Other Questions: Stephanie.Randazzo@caresource.com

Molina

- 24/7 Notification Fax Line: (877) 708-2116
- 24/7 Notification Email: OHBehavioralHealthReferrals@MolinaHealthcare.com
- Escalation/Other Questions: Emily.Higgins@MolinaHealthcare.com

Paramount

- 24-hour Call Center: 419-887-2557
- PHCReferralManagement@ProMedica.org
- Escalation/Other Questions: hy.kisin@promedica.org
  Behavioral Health fax: 567-661-0841

UnitedHealthcare

- 24/7 Provider Line to request authorizations: 1-866-261-7692
- 24/7 Submit online authorization requests via Provider Portal: www.providerexpress.com and www.UnitedHealthcareOnline.com
- Escalation/Other Questions: tracey.izzard-everett@optum.com