Department of Medicaid
Department of Mental Health and Addiction Services

Benefit and Service Development Work Group

July 12th, 2017

Behavioral Health Redesign

July 12th, 2017 Agenda

- **Welcome and Opening Remarks**
- **Budget and Timeline Update**
- **Policy Updates**
- **Prior Authorization**
- **FFS Testing Update**
- **Testing, Contracting, and Credentialing with Plans**
- **Enrollment and Affiliation Update**
- **ODM Updates to Provider Agreements with Medicaid Managed Care Plans**
- **Institution for Mental Diseases (IMD)**
- **Care Coordination Workgroup Update**
- **Upcoming Meetings**

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Budget and Timeline Update

Behavioral Health Redesign

2018-2019 Budget

BUDGET UPDATE

Updated Timeline Per Budget Bill

8/1: Hospitals transition to new BH code set

10/1: Community BH Final Rules in place

1/1: Transition to new BH code set for managed care, MyCare Ohio, and FFS. BH services carved into managed care

Aug | Oct | Jan | Apr | Jul | Oct | Dec

2017 | 2018 | 2018

FFS prior authorization policies and rates to continue under MCPs and MyCare Ohio plans for 12 months

- Plans will follow state benefit administration policies for one year.
- Benefit year is the calendar year (Jan-Dec).
- Any prior authorizations approved by Medicaid prior to carve-in will be honored by the plans, and the plans will assume the responsibility for the prior authorization process when authorizations under FFS expire.

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Policy Updates

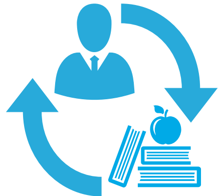
Behavioral Health Redesign

Rules Updates Made as a Result of the June 14th Interested Parties Meeting

Changes Include:

- ✓ Update place of service (POS) definitions in rule;
- ✓ Work with Social Worker, Marriage and Family Therapist, Counselor Board on TBS definition;
- ✓ Add “when applicable” to documentation requirements that may not occur in every visit to 5160-8-05;
- ✓ Clarify the reference to rates in 5160-1-60 by adding it to every line in section (D) of reimbursement rule 5160-27-03;
- ✓ Clarify that TBS/PSR will not be stepped on 50% when provided outside of the office in reimbursement rule 5160-27-03;
- ✓ Clarify language if needed in (C) of SUD rule 5160-27-09.

Policy Update: Board Licensed School Psychologists



Enrollment Update

Effective July 13, 2017, Board licensed school psychologists are eligible to enroll in Ohio Medicaid as independently licensed practitioners, classified in MITS as provider type/provider specialty 42/421.

- These school psychologists are licensed by the Ohio Board of Psychology and must operate within the scope of practice as defined in section 4732 of the Revised Code.
- Board licensed school psychologists who are employed by 84s/95s will have to be enrolled.

A MITS Bits detailing this information is in process of being released

Policy Proposal: Dependently Licensed Practitioners

Issue

- NCCI edits apply to rendering practitioners. Ohio MITS populated rendering with billing ID when service is rendered by dependently licensed and trainees/assistants. There are 18 combinations of mental health service codes that could trigger NCCI edits even though different practitioners delivered the services.

Proposed Solution

- State has decided to move forward with the enrollment of dependently licensed staff (LSW, LMFT, LPC, LCDC II,III).
- Dependently licensed individuals can begin the process by obtaining an NPI now if they do not currently have one.
- More information to follow once IT Build timeline is established.

Moving Forward

- This approach is applicable to both MH & SUD.
- State may consider a similar solution for unlicensed staff: trainees, assistants, CMSs, QMHSs, and peer recovery supporters.
- A MITS Bits with more detail to follow.

More details to follow at the next Aug. 9 Benefit & Service Development Work Group

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Prior Authorization

Behavioral Health Redesign

Prior Authorization under BH Redesign

Description and Code	Benefit Period	Authorization Requirement
Assertive Community Treatment (ACT) H0040	Based on prior authorization approval	ACT must be prior authorized and all SUD services must be prior authorized for ACT enrollees. See service description for additional information.
Intensive Home Based Treatment (IHBT) H2015	Based on prior authorization approval	IHBT must be prior authorized. See service description for additional information.
SUD Partial Hospitalization (20 or more hours per week)	Calendar year	Prior authorization is required for this level of care for adults and adolescents.
Psychiatric Diagnostic Evaluations 90791, 90792	Calendar year	1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization for any additional services within the calendar year.
Psychological Testing 96101, 96111, 96116, 96118	Calendar year	Up to 12 hours/encounters per patient per calendar year for 96101, 96111, and 96116, and 8 hours of 96118. Prior authorization for any additional services within the calendar year.
Screening Brief Intervention and Referral to Treatment (SBIRT) G0396, G0397	Calendar year	One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95. Prior authorization for any additional services within the calendar year.
Alcohol or Drug Assessment H0001	Calendar year	2 hours per patient per calendar year per billing agency. Prior authorization for any additional services within the calendar year.
SUD Residential H2034, H2036	Calendar year	Up to 30 consecutive days without prior authorization. Prior authorization then must support the medical necessity of continued stay, if not, only the initial 30 consecutive days are reimbursed. Applies to first two stays; any stays after that would be subject to full prior authorization.
Any service or ASAM level of care not listed in this table is not subject to prior authorization.		

Prior Authorization – BH Services Rendered by Outpatient Hospitals

Service Date On or After	Medicaid Delivery System	BH Services provided through outpatient benefit package
8/1/2017	FFS	KEPRO
	Managed Care	KEPRO
	MyCare	MyCare Ohio Plan
1/1/2018	FFS	KEPRO
	Managed Care	Managed Care Plan
	MyCare	MyCare Ohio Plan

Note: For Provider Types 01 & 02

Prior Authorization – Services Rendered by Community BH Providers

Service Date On or After	Medicaid Delivery System	Behavioral Health services provided through community benefit package
Current*	FFS	Permedion
	Managed Care	Permedion
	MyCare	MyCare Ohio Plan
1/1/2018	FFS	KEPRO
	Managed Care	Managed Care Plan
	MyCare	MyCare Ohio Plan

*Current benefit year is the fiscal year. Benefit year will switch to calendar year on 1/1/18 with carve-in.

Note: For Provider Types 84 & 95

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FFS Testing Update

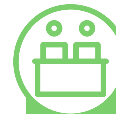
Behavioral Health Redesign

FFS Testing and Rapid Response Team Information

Testing was open for all May 12th through June 23rd.

FFS Testing

- On June 23rd, ODM temporarily closed FFS trading partner testing for EDI files using the new behavioral health codes and policy.
- User acceptance testing for FFS will resume on October 25th and run through November 29th.



Rapid Response Team

- The rapid response room will be closed until October 25th, but the below email will continue to be monitored and questions will be responded to within one business day.
  - Email: BH-Enroll@medicaid.ohio.gov
- On October 25th, the rapid response room will re-open through January 1st, 2018.

Recently released MITS Bits update on Medicaid BH Redesign and Trading Partner Testing:

http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits_6-22-2017.pdf

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Testing, Contracting, and Credentialing with Plans

Behavioral Health Redesign

MyCare Ohio Managed Care Plans

AETNA BETTER HEALTH® OF OHIO

BH Services are "CARVED IN"

- *Ohio **Medicare and Medicaid** recipients enrolled in a MyCare Ohio Plan receive community behavioral health services through their MyCare Ohio Plan.*

*Aetna is a MyCare Ohio Plan **but not** a Medicaid Managed Care Plan*

Expectations for Testing with MyCare Ohio Plans

Providers should begin testing the new BH Benefit Package with MyCare Ohio Plans as soon as they are able.

IMPORTANT NOTES

- ✓ ***MyCare Ohio providers with established contracts should be testing now.***
  - ✓ Providers should ensure contracts extend to all lines of business.
- ✓ Testing can begin as soon as providers have established contact with the plans to verify billing information and obtain testing access if necessary.
- ✓ Providers do not have to be fully credentialed to begin testing with the plans.
- ✓ Trading partners are not required to have an agreement with the plans in order to test as long as the MyCare Ohio Plan has accurate billing information from the provider.

Link to MITS Bits for MyCare Ohio Plan Testing Information:

http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits-Trading-Partner-Testing_5-12-17.pdf

Medicaid Managed Care Plans

BH Services are "CARVED OUT" Until January 1, 2018

- *Ohio* ***Medicaid*** *recipients enrolled in a Medicaid managed care plan can receive community behavioral health services through any fee for service participating Medicaid BH provider agency. Services are billed to FFS.*

- ***Two Exceptions: Respite and all inpatient psychiatric services as of July 1, 2017 (including Institutions for Mental Diseases-IMDs)***

Paramount is a Medicaid Managed Care Plan ***but not*** *a MyCare Ohio Plan*

Expectations for Testing with Managed Care Plans

Providers should begin testing the new BH Benefit Package with Managed Care Plans as soon as they are able.

IMPORTANT NOTES

- ✓ **Behavioral Health providers should begin contracting with the Managed Care Plans to prepare for carve-in if they have not already done so.**
- ✓ Testing can begin as soon as providers have established contact with the plans to verify billing information and obtain testing access if necessary.
- ✓ Providers do not have to be fully credentialed to begin testing with the plans.
- ✓ Trading partners are not required to have an agreement with the plans in order to test as long as the Managed Care Plan has accurate billing information from the provider.

Readiness Preparations

Readiness Reviews

On-site readiness reviews in October that will involve comprehensive system testing

Hospitals

ODM has shared lists of hospitals with the plans. The plans are reaching out to hospitals regarding readiness opportunities.

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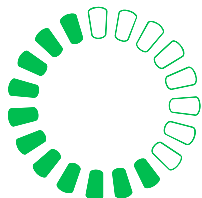
Enrollment and Affiliation Update

Behavioral Health Redesign

Provider Enrollment Applications and Revalidations



Status

As of July 5th

Total Enrolled	Provider Types - Oldest dated application	Applications in "Submit Status"	Applications Returned to Provider
2,276	LISW (Type 37) 6/14/2017	45	47
2,406	LPCC (Type 47) 6/14/2017	29	59
55	LIMFT (Type 52) 6/6/2017	8	4
435	LICDC (Type 54) 6/15/2017	23	18
1,191	Nurses (Type 38) 5/19/2017	85	123
Total: 6,363		**190**	**251**

- Report of Affiliated Practitioners by agency is updated weekly and posted to the BH Redesign website here: http://bh.medicaid.ohio.gov/manuals
- **As of July 10th, there were 108 agencies with no affiliated practitioners** (approximately 45 of these agencies have no claims activity for 2017 dates of service)
- The April 11th MITS Bits issue provides links to enrollment and affiliation resources: http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS-Bits-BH-Redesign-Update_4-11-17.pdf

Medicaid Provider Enrollment Webinar can be found at: **http://bh.medicaid.ohio.gov/training**

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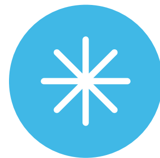
ODM Updates to Provider Agreements with Medicaid Managed Care Plans

Behavioral Health Redesign

Managed Care Provider Agreements

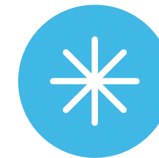
Provider Agreements

- Behavioral health specific language was added to the new 7/1/17 ODM agreements with Medicaid MCPs.
- The MCP provider agreements will be amended for 1/1/18 to add additional BH Redesign and Managed Care carve-in language.



The MyCare Ohio provider agreement is located here:

http://medicaid.ohio.gov/PROVIDERS/ManagedCare/IntegratingMedicareandMedicaidBenefits.aspx



The Managed Care provider agreement is located here:

http://medicaid.ohio.gov/PROVIDERS/ManagedCare/ProgramResourceLibrary/CombinedProviderAgreement.aspx

MCP Provider Agreements – 7/1/17 BH Updates

Language Revisions

- ✓ Added staffing readiness requirement
- ✓ Added requirements around BH Medical Director
- ✓ Added behavioral health to CM director functions
- ✓ Added requirements around employee and subcontractor training
- ✓ Added or updated language around behavioral health crisis for 1/1/18
- ✓ Added BH advance directive requirements for 1/1/18
- ✓ Added transition of care requirements for BH Redesign and carve-in
- ✓ Added Mental Health Parity and Addiction Equity Act (MHPAEA) language
- ✓ Updated BH contracting language
- ✓ Added CBHC laboratory language
- ✓ Added Prior Authorization Timeframes for certain BH services
- ✓ Updated dates associated with Health Homes

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Institution for Mental Diseases (IMD)

Behavioral Health Redesign

IMD Policy Effective July 1, 2017

Federal Policy

Guidance

With implementation of 42 C.F.R. 438.6, the State may make a monthly capitation payment to an MCP for a member age 21 through 64 receiving inpatient treatment in an Institution for Mental Diseases (IMD).

- Length of IMD stay is short term, no more than 15 days during the period of a monthly capitation payment
- The State determines it is medically appropriate
- The approved services are authorized and identified in the MCP contract and will be offered to enrollees at the option of the MCP and enrollee

State Policy

Goals

- ✓ Increased access to intensive mental health treatment
- ✓ Services closer to home
- ✓ Community alternatives
- ✓ Fewer re-admissions
- ✓ Expands provider network
- ✓ Continuity of care
- ✓ Coordination of care

Note: State hospitals are a safety net for inpatient psychiatric care.

IMD Policy Communication Strategy

The State worked with MCPs to communicate IMD policy in the following ways:

Trainings / forums hosted by MCPs

IMD FAQs document
http://bh.medicaid.ohio.gov/Portals/0/Providers/IMD-FAQ.pdf?ver=2017-04-17-162324-870

IMD MITS Bits
http://mha.ohio.gov/Portals/0/assets/Funding/MACSIS/MITS-BITS/BH-MITS%20Bits-MCP-IMD-coverage-starts-July-1-2017.pdf

Upcoming 7/20 Webinar
https://attendee.gotowebinar.com/register/5437462246490109 46

Plan Process for Inpatient Psychiatric Care

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 has deferred its triage, level of care determination, and placement authority to the clinical judgment of the practitioner recommending inpatient psychiatric care.**

Person presents and inpatient psychiatric care is medically appropriate ***(assessment)***

→ MCP contacted for triage and level of care determination, **not** for prior authorization purposes**

→ Enrollee must be offered #1 or #2 in order to be offered #3 or #4 *(under new IMD setting options policy)*

→ #1 Private general hospital *(no new IMD policy implications)*

→ #2 Private <17 bed facility *(no new IMD policy implications)*

→ #3 Private IMD *(new IMD policy)*

→ #4 Public state hospital *(new IMD policy)* ***(board authorization and/or assessment)***

** MCPs may review LOC, assessments and other pertinent information to authorize the length of stay, setting, etc. based on medical necessity

For a person needing medically appropriate inpatient psychiatric care, they must be offered #1 or #2 to then be offered #3 or #4.

- This ensures inpatient psychiatric services are provided “in lieu of services” covered under the state plan (#1 and #2)

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Care Coordination Workgroup Update

Behavioral Health Redesign

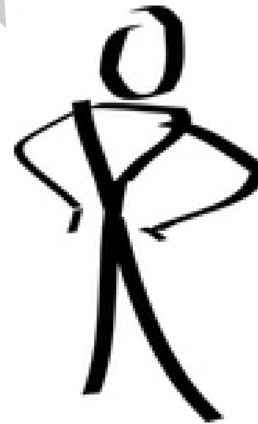
Context: Accountability for care coordination

Reminder: We are designing a BH care coordination that fulfills the "Model 2" promise

Medicaid Managed Care Plan

- Require health plans to delegate components of care coordination to qualified behavioral health centers **("Model 2" commitment)**
- Care management identification strategy for high risk population

- Require health plans to financially reward practices that keep people well and hold down total cost of care, including behavioral health
- Care coordination defaults to primary care unless otherwise assigned by the plan

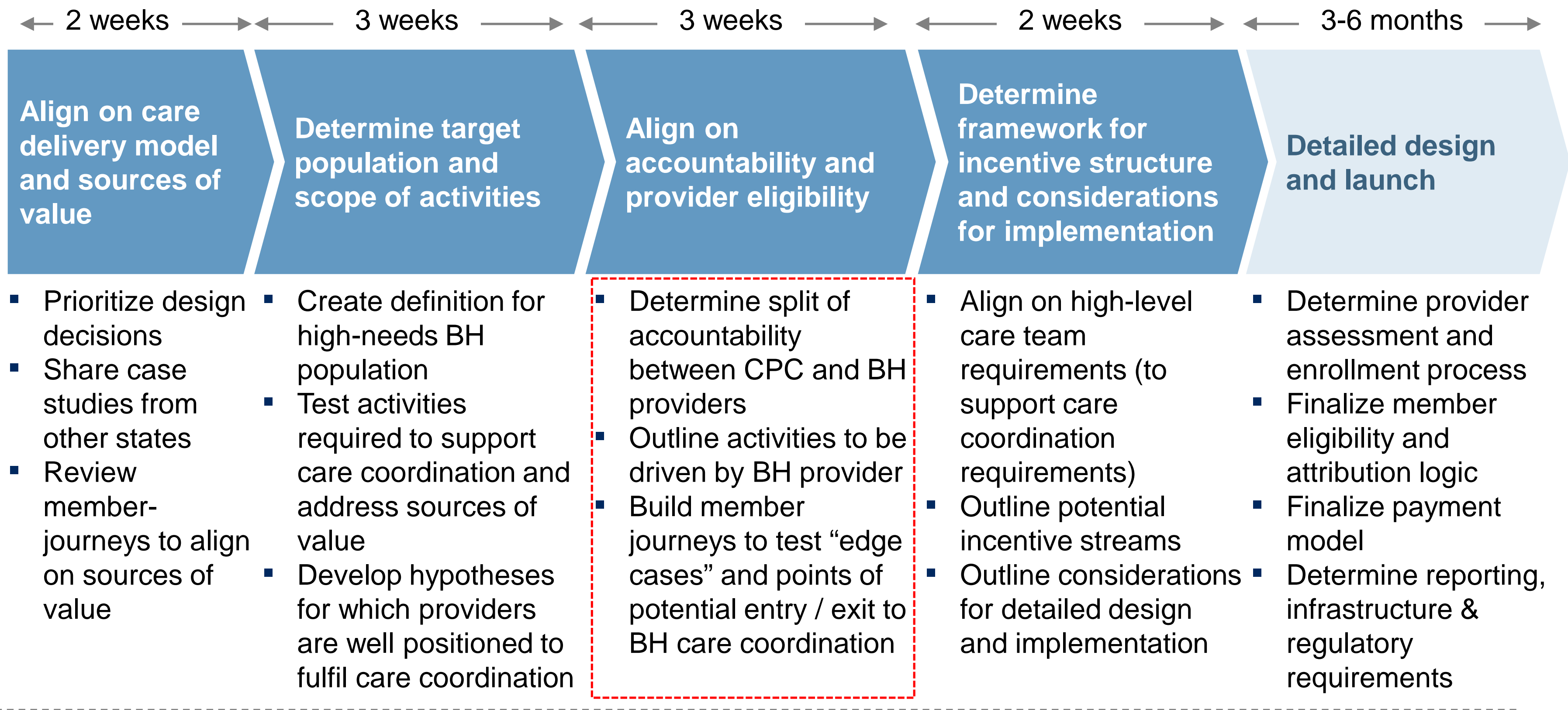


Qualified Behavioral Health Center

Comprehensive Primary Care (CPC)

- Mutual Accountability
- Alignment on care plan, patient relationship, transitions of care, etc.
- Common identification of needs and assignment of care coordination

Overall BH care coordination workplan



External engagement

		▪ BH Redesign Group (7/12)	▪ BH Redesign Group (8/9)	▪ BH Redesign Group (9/13)
		▪ SIM Core (7/13)	▪ SIM Core (8/10)	▪ SIM Core (9/14)
	▪ BH Focus Group (6/21)	▪ BH Focus Group (7/26)	▪ BH Focus Group (8/23)	▪ BH Focus Group (9/27)

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We are prioritizing 7 key design decisions

■ Prioritized design decisions

Area	Description	Design decisions
Care delivery model	Foundational decisions for **BH care coordination approach within the ecosystem**	A Target population B Care delivery improvements & sources of value C Integration approach with CPC
Payment model	Model to **encourage and finance transformation, fund new care and operations, and reward value**	D Provider eligibility requirements E Activity requirements F Quality and efficiency measures G Incentive streams for care delivery improvements H Requirement monitoring and compliance I Financial impact and risk mitigation J Member attribution K Scale-up target
Infra-structure	**Technology and data required** to enable changes in payment, reporting, and HIE	L Provider infrastructure M Payor infrastructure N State system infrastructure
Practice performance improvement	Support, resources, or activities to enable practices to **adopt the BH care coordination model, sustain transformation and maximize impact**	O Practice transformation support P Workforce Q Legal/regulatory environment R Performance transparency S Ongoing support T Evaluation and continuous improvement

Prioritized design decisions: Key questions

Care delivery model: Foundational decisions for BH care coordination approach within the ecosystem

	Decision	Key questions
A	Target population	▪ What are the characteristics of the population in need of assistance? ▪ What data inputs will we need? ▪ Should other program inclusions / exclusions be considered?
B	Care delivery improvements & sources of value	▪ What are the potential sources of value addressed through improved BH care coordination? ▪ Which activities and services will unlock the identified sources of value? ▪ How prescriptive should the State be in care model definition?
C	Integration approach with CPC and other providers	▪ What role should different providers in the ecosystem play? ▪ What should be the division of accountability between CPC and BH care coordination providers?

Payment model: Model to encourage and finance transformation, fund new care and operations, and reward value

	Decision	Key questions
D	Provider eligibility requirements	▪ What providers are qualified to coordinate care for a BH member? ▪ What non-personnel or clinical factors should be required? ▪ Do we expect this model to be state-wide in year 1?
E	Activity requirements	▪ What activities are required under the program? ▪ What should be the relationship between the BH coordinator and the member?
G	Incentive streams for care delivery improvements	▪ What should the payment model look like? ▪ Will BH care coordination payments need to be coordinated with CPC payments? ▪ Are there other payments that should be aligned (e.g., other existing care coordination payments)?
J	Attribution	▪ What is the attribution methodology (e.g., based on outpatient claims)? ▪ What will be the role of the different stakeholders in attribution (e.g. , MCOs, state)?

Target population: Working answer regarding size and characteristics of the target population

DRAFT

Updated based off provider focus group feedback

The target population for BH care coordination will be a small subset of the overall BH population

Key questions	Working answer
▪ What are the characteristics of the population that would benefit from care coordination?	▪ Focus on individuals who have a behavioral health condition **with a high likelihood of either:** – Significant utilization of behavioral health services – An adverse event (e.g., attempted suicide) **as a result of their behavioral health condition** ▪ In addition, we will consider whether individuals are affected by one or more social determinants of health (e.g., homelessness, food insecurity)
▪ What is the approximate size of the target population?	▪ We should aim for an initial target population that is a small subset of the overall BH population with potential to increase given clear and demonstrated need

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Care model improvements and sources of value: working answer

Updated based off provider focus group feedback | DRAFT

Key questions	Working answer
What sources of value are addressed through improved BH care coordination?	Major sources of value should address full range of physical and behavioral health opportunities
Which activities and services will unlock the identified sources of value?	Create integrated care plan Improve management of ongoing patient relationship Improve transitions of care Increase engagement with other medical providers More seamless BH care access Engage supportive services Employ population health management and supportive capabilities
How prescriptive should the State be in care model definition?	Identify and require a set of core high-impact activities, but allow providers flexibility in determining how to deliver those activities, allowing for continuous improvement

Potential sources of value from improved care coordination

Cross cutting sources of value (behavioral and physical health)

- **Appropriateness of care setting and level of services**
- **Increased access to care** (e.g., 24/7 call line, connection to specialists and community resources)
- **Improved transitions of care** (e.g., coordinating hospital discharge with admission to inpatient facility)
- **Improved treatment adherence** (e.g., adherence to mood stabilizer regiment, adherence to scheduled PCP visits)
- **Improved medication reconciliation and management** (e.g. specialty medications)
- **Enablement of self-sufficiency** (e.g., investing in home modifications, facilitating mode of transportation to work)

Behavioral health sources of value

- **Engagement with high-value behavioral health providers**
- **Facilitate utilization of full range of BH services** (e.g., step-down facilities during workplace reentry)

Physical health sources of value[1]

- **Enhanced chronic condition management** (e.g., more frequent monitoring of A1c for diabetics)
- **Appropriateness of treatment for physical health conditions**
- **Reduced admission frequency** through effective follow-up and transition management

1 BH providers would have ability to influence settings of care outside of physical health (e.g., inpatient hospital stays) through chronic behavioral health condition management

Reminder: Activities for behavioral health care coordination

Updated based off provider focus group feedback

DRAFT

Initial outreach and engagement	▪ **Perform initial outreach to member,** including any efforts required to contact member ▪ **Explain benefits of program** and perform necessary enrollment activities ▪ Begin building trust-based relationship to understand member preferences and goals
Care plan	▪ **Compile comprehensive assessment** to inform care plan ▪ **Create an integrated care plan** within 30 days of member engagement and incorporate input from member, CPC / PCP, social support system, and other medical providers
Ongoing relationship and engagement	▪ **Continue delivery of currently reimbursable services** ▪ **Check in with member** to support treatment adherence ▪ **Provide high-touch support** to ensure treatment and medication adherence ▪ **Provide additional high touch support in crisis situations** when other resources are unavailable ▪ **Educate the member and his/her family** on independent living skills with attainable and increasingly aspirational goals
Transitions of care	▪ **Ensure successful handoff between care providers** by monitoring admissions and discharges, transportation, communication of medication restrictions, etc.
Engage medical care providers	▪ **Support scheduling and reduce barriers to adherence for medical appointments**, including in-person accompaniment to some appointments; follow up and outreach with PCP
Engage behavioral health providers	▪ **Support scheduling and reduce barriers to adherence for behavioral health appointments** and follow up with behavioral health provider
Engage supportive services	▪ **Facilitate access to community supports** including scheduling and follow through ▪ **Communicate member needs to community partners** and other social resources
Population health management	▪ **Continuously identify highest risk members** and align with organization to focus resources and interventions

Feedback from the provider focus group

Target population	▪ Group was aligned on the overarching approach to identifying the target population ▪ Additional factors were proposed for consideration: – Physical health conditions or utilization that have an association with future risks of a BH adverse event – Social determinants of health (e.g., homelessness, food insecurity) – Comorbid BH and SUD conditions ▪ Group encouraged focus on *prospective* models that can predict high-need rather than just retrospective analyses
Care delivery improvements & sources of value	▪ Providers said attention should be paid to increasing and incentivizing communication between BH and primary care providers ▪ The group noted that given potential overlaps with CPC, there is a need to clearly define how care coordination will be divided between a new program and CPC ▪ Member experience was raised, with particular focus on how the state can help facilitate greater member engagement
Implementation and operational considerations	▪ Many providers said that the program should carefully consider provider core competencies to ensure that eligible providers are equipped to implement the care model ▪ Push to consider capacity constraints in the current system (e.g., number of available BH providers), particularly in rural areas ▪ The group encouraged an increased focus on ensuring care is delivered by the most appropriate provider (e.g., physical conditions treated by the PCP) ▪ Substance-use providers noted that in implementing care model changes, awareness of the clinical and social impacts of SUD/BH comorbidities will be critical ▪ Several providers noted that there is a need to increase data sharing between PCPs and behavioral health providers, particularly in light of recent legal changes

Next steps

- Reconvene this group on August 9th, and discuss two additional aspects of the BH care coordination work:
  - Provider eligibility
  - Activity requirements
- Incorporate feedback from this group into decisions about target population and care model
- Analyze claims data for the target population, in order to better understand:
  - BH population demographics by age (adults vs. children)
  - Geographic distribution of members
  - Overlap with members participating in other models such as health homes
  - Number of members in the target population with co-occurring conditions
  - Patterns of utilization and characteristics that are predictive of high BH needs
- Continue additional analysis to inform conversations on provider eligibility, activity requirements, and attribution methodology

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Upcoming Meetings

Meeting Schedule

Upcoming Meetings

✓ **Benefit and Service Development Workgroups**

- August 9th, 2017 10:00 am – 12:00 pm
- September 13th, 2017 10:00 am – 12:00 pm
- October 11th, 2017 10:00 am – 12:00 pm
- November 15th, 2017 10:00 am – 12:00 pm
- December 13th, 2017 10:00 am – 12:00 pm

✓ **Next EDI/IT Workgroup**

- July 19th, 2017 11:30 am – 12:30 pm

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Appendix

Behavioral Health Redesign

Department of Medicaid
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IMD MCP-Specific Slides

Behavioral Health Redesign

IMD Discussion Topics for Aetna Better Health of Ohio

Network Capacity

- Providers can locate network facilities through our online directory: https://www.aetnabetterhealth.com/ohio
- Aetna meets panel requirements for general acute care hospitals
- Contracted IMDs (10 currently, ongoing negotiations with others)

Contracting Efforts

- Contract negotiations ongoing with additional IMDs
- Targeting new IMDs identified as being built or newly opening

General Readiness

- UM Clinical Review staff training by Supervisor and Medical Director, ongoing
- IMD Coordination Process for UM-CM complete
- IMD Report template has been created for submission in October

Communication Process

- Internal monitoring is being developed for tracking IMD admissions
- Participation in OAHP Regional Provider Forums
- Participation in State Webinars
- Provider communication via fax blasts and site visits

IMD Discussion Topics for Buckeye Health Plan

Network Capacity

- Providers can locate network facilities through our online directory: www.buckeyehealthplan.com
- Buckeye meets panel requirements for general acute care hospitals
- Contracted IMDs (9 currently, ongoing negotiations with others)

Contracting Efforts

- Contract negotiations ongoing with additional IMDs
- Targeting new IMDs identified as being built or newly opening

General Readiness

- UM Clinical Review staff training by Supervisor and Medical Director, ongoing
- IMD Coordination Process for UM-CM complete
- IMD Report template has been created for submission in October

Communication Process

- Internal monitoring is being developed for tracking IMD admissions
- Participation in OAHP Regional Provider Forums
- Participation in State Webinars
- Provider communication via fax blasts and site visits

IMD Discussion Topics for CareSource

Network Capacity

- Providers can locate network facilities through our online directory: www.Caresource.com
- CareSource meets panel requirements for general acute care hospitals
- Contracted IMDs (10 currently, ongoing negotiations with others)

Contracting Efforts

- Contract negotiations ongoing with additional IMDs
- Targeting new IMDs identified as being built or newly opening

General Readiness

- UM Clinical Review staff training by Supervisor and Medical Director, ongoing
- IMD Coordination Process for UM-CM complete
- IMD Report template has been created for submission in October

Communication Process

- Internal monitoring is being developed for tracking IMD admissions
- Participation in OAHP Regional Provider Forums
- Participation in State Webinars
- Provider communication via fax blasts and site visits

IMD Discussion Topics for Molina

Network Capacity

- Providers can locate network facilities through our online directory: www.molinahealthcare.com
- Molina meets panel requirements for general acute care hospitals
- Contracted IMDs (10 currently, ongoing negotiations with others)

Contracting Efforts

- Contract negotiations ongoing with additional IMDs
- Targeting new IMDs identified as being built or newly opening

General Readiness

- UM Clinical Review staff training by Supervisor and Medical Director, ongoing
- IMD Coordination Process for UM-CM complete
- IMD Report template has been created for submission in October

Communication Process

- Internal monitoring is being developed for tracking IMD admissions
- Participation in OAHP Regional Provider Forums
- Participation in State Webinars
- Provider communication via fax blasts and site visits

IMD Discussion Topics for Paramount

Network Capacity

- Providers can locate network facilities through our online directory: www.paramounthealthcare.com
- Paramount meets panel requirements for general acute care hospitals
- Contracted IMDs (2 currently, ongoing negotiations with others)

Contracting Efforts

- Contract negotiations ongoing with additional IMDs
- Targeting new IMDs identified as being built or newly opening

General Readiness

- UM Clinical Review staff training by Supervisor and Medical Director, ongoing
- IMD Coordination Process for UM-CM complete
- IMD Report template has been created for submission in October

Communication Process

- Internal monitoring is being developed for tracking IMD admissions
- Participation in OAHP Regional Provider Forums
- Participation in State Webinars
- Provider communication via fax blasts and site visits

IMD Discussion Topics for UnitedHealthcare

Network Capacity

- Providers can locate network facilities through our online directory:
  - UnitedHealthcare Connected for MyCare Ohio (Medicare-Medicaid Plan): Click here
  - Ohio Medicaid: Click here
- UHC meets panel requirements for general acute care hospitals
- Contracted IMDs (2 currently, ongoing negotiations with others)

Contracting Efforts

- Contract negotiations ongoing with additional IMDs
- Targeting new IMDs identified as being built or newly opening

General Readiness

- UM Clinical Review staff training by Supervisor and Medical Director, ongoing
- IMD Coordination Process for UM-CM complete
- IMD Report template has been created for submission in October

Communication Process

- Internal monitoring is being developed for tracking IMD admissions
- Participation in OAHP Regional Provider Forums
- Participation in State Webinars
- Provider communication via fax blasts and site visits

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

CareSource

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

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

Molina

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

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