Behavioral Health Redesign and Integration – Ongoing Assistance for Behavioral Health Providers

As we work to complete the transition to managed care billing through Behavioral Health Integration, the Department of Medicaid (ODM) has facilitated a series of regional meetings around the state to gather feedback, hear concerns and brainstorm ideas with the provider community and county boards. Based upon those conversations, ODM has worked with the managed care plans to maintain robust technical assistance programs, rapid response teams, and has also developed additional strategies and guidelines to help resolve any outstanding billing issues.

ODM continues to closely monitor the implementation of Behavioral Health Redesign and assess any impacts on member access to critical behavioral health services. We are confident that through a partnership with members, providers, and those valued stakeholders who have engaged with us on this journey, that we will continue with forward progress in improving services to Ohio Medicaid members.

Several strategies have been identified to help providers and managed care plans resolve challenges that may have resulted in outstanding accounts receivable. These strategies include:

Delay Repayment of Contingency Payments

Repayment for contingency plan advances may be delayed beyond January 2019 as a result of one-on-one discussions between managed care plans and providers. Please refer to the managed care plan contact information referenced below to schedule a one-on-one call or in-person meeting.

Extend behavioral health redesign 'transition of care patient protection' requirements that managed care plans must follow to sustain access to care, continuity of services, and treatment capacity.

- Extend the requirement to maintain current Fee-for-Service payment rates, covered benefits and prior authorization requirements from June 30, 2019, to December 31, 2019.
- Extend timely claims submission period from 180 days to 365 days through December 31, 2019, for Medicaid managed care.
- Extend requirement for payment to out-of-network providers. Members who are currently receiving services from a provider who is not in network with a managed care plan, may continue to receive services from that provider until June 30, 2019. The managed care plan may prior authorize these services, where appropriate, or assist the member to access services through a network provider when any of the following occur:
    - o   the member's condition stabilizes, and the managed care plan can ensure no interruption to services;
    - o   the member chooses to change to a network provider;
    - o   the member's needs change to warrant a change in service;
    - o   or quality concerns are identified with the provider.

This will also allow for additional time for MCPs and providers to collaboratively complete contracting, provider credentialing, contracting loading, and final contract execution.

Ensuring Access and Capacity to Critical Services

- Psychological Testing: Maintain rates so there is no loss of access and there is no reduction in the service as delivered currently. Recent changes in federal HCPCS codes required ODM to set new rates; however, as announced in the MITS Bits issued December 26, 2018, the rates have been revised with the intent of no reduction in payment due to the new coding structure.

- ACT: Revise the financial structure; eliminate the face-to-face requirement for the prescribing team member; continue to require the four contacts per month; and keep the provider and service requirements, fidelity expectations, and prior authorizations as is. ODM is working to determine an implementation date given there will be rule amendments as well as possible system configuration changes.

Additional opportunities for one-on-one technical assistance for providers experiencing complications with claims processing and payment is available.

For claims submitted between July 1, 2018, and December 31, 2018, the managed care plans will have until February 1, 2019, to:

- develop a collaborative plan with providers through one-on-one technical assistance to fix claims that have been submitted with errors in order to reprocess those claims; and/or
- pay providers for claims that are being held due to managed care plan system issues.

In order for this to be successful, providers who are experiencing hardships or challenges with billing or claims payment must reach out directly to the identified contacts for each managed care plan for one-on-one assistance. The Plans will examine various provider specific strategies to help mitigate these challenges.

In limited circumstances, additional dollars may be available through the MCPS to providers who qualify. This determination will be made on a case-by- case basis. Factors to be considered may include, but are not limited to:

- Whether or not the provider is billing.
- Whether or not the provider is contracted with the managed care plan.
- Whether or not the provider has been paid less through claims than they received in advance payments between July – October.

Please refer to the contact information referenced below to schedule a one-on-one call or in-person meeting. This information is in follow up to, and replaces, the information communicated in the November 15, 2018 MITS Bits Provider Information Release.

Third Party Liability (TPL)

ODM has established a TPL taskforce and is working with managed care plans and providers to improve the process to update TPL information so that both ODM and managed care plan systems reflect more accurate information. The taskforce will also develop best practices and resources to assist providers in navigating TPL requirements and coordination of benefits. ODM is committed to working collaboratively with the managed care plans and providers to identify areas to operationalize efficiencies within the boundaries of federal regulation by January 31, 2019, and implement those strategies by April 1, 2019.

Provider Enrollment and Affiliation

All claims must include both the agency/billing and rendering National Provider Identifier (NPI). The managed care plan shall adjudicate the claim for payment consistent with timely payment requirements. Managed care plans shall not deny claims when an agency/billing or rendering NPI on the claim is not known in MITS. Additionally, plans are not required to ensure the individual rendering practitioner is affiliated to their agency at this time. Plans shall not deny a

claim when the practitioner is not affiliated to the agency/billing provider. The claim should continue to be denied when no agency/billing or rendering NPI is submitted on the claim. This approach shall be taken until ODM and the managed care plans complete the work to implement the universal roster and/or ODM generated provider enrollment report.

For more information on Behavioral Health Redesign and Integration, visit http://bh.medicaid.ohio.gov. We value your feedback and questions; submit inquiries at http://bh.medicaid.ohio.gov/Contact-Us

Providers having persistent issues with a Managed Care Plan may follow the link below to register a complaint for Ohio Medicaid to investigate.

https://medicaid.ohio.gov/Provider/ManagedCare/ProviderComplaint

Managed Care Plan Technical Assistance Contacts

Aetna:
Provider Assistance Resources:
Rapid Response Team: OH_BH_Redesign@AETNA.com
Prior Authorization Questions: 1-855-364-0974, option 2, then 4
24/7 Notification Fax: 1-855-734-9393
Provider Services: 1-855-364-0974, option 2, then 5
Escalation/Other Questions: Afet Kilinc, 959-299-7278, 614-254-3229, KilincA@AETNA.com

Buckeye:
Provider Assistance Resources:
Rapid Response Team: BehavioralHealth@centene.com
Provider Relations: 1-866-246-4356, ext 24291
24/7 Prior Authorization Line: 1-800-224-1991
24/7 OH Notification Fax: 1-866-535-6974
Escalation/Other Questions: Natalie A. Lukaszewicz, Natalie.A.Lukaszewicz@CENTENE.COM,
866-246-4356, ext 24783

CareSource:
Provider Assistance Resources:
Rapid Response Team: 1-800-488-0134
24/7 Notification Fax: 1-937-487-1664
24/7 Notification Email: OhioBHinfo@caresource.com
Escalation/Other Questions: Terry Jones, 614-225-4613, Terry.Jones@caresource.com

Molina:
Provider Assistance Resources:
Rapid Response Team: BHProviderServices@MolinaHealthcare.com
Provider Services/Prior Authorization Questions: 1-855-322-4079
24/7 Notification Fax: 1-866-449-6843
Care Management Referrals: OHBehavioralHealthReferrals@MolinaHealthcare.com
Escalation/Other Questions: Deanna Putman, 888-562-5442, ext 212340,
Deanna.Putman@MolinaHealthCare.Com

Paramount:
Provider Assistance Resources:
Rapid Response Team: 1-419-887-2564
Rapid Response Email: PHCBehavioralHealth@ProMedica.org
24/7 Notification Fax: 1-844-282-4901
Provider Relations Email: Paramount.ProviderRelations@promedica.org
Behavioral Health Fax: 1-567-661-0841
Escalation/Other Questions: Linda Nordahl, 419-887-2279, Linda.Nordahl@promedica.org

United:
Provider Assistance Resources:
Rapid Response Team: OhioNetworkManagement@optum.com
24/7 Phone Line: 1-800-600-9007
24/7 Provider Prior Authorization Request: 1-866-261-7692
24/7 Online Prior Authorization Request via Provider Portal: www.providerexpress.com and
www.UnitedHealthcareOnline.com
Escalation/Other Questions: Tracey Izzard-Everett, 614 698-5837, Tracey.izzard-everett@optum.com