

CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Behavioral Health Services and Medications

Rule Number(s): Rescind: 5160-27-01, 5160-27-02, 5160-27-05, 5160-30-01, 5160-30-02, 5160-30-03, 5160-30-04

New: 5160-27-01, 5160-27-02, 5160-27-03, 5160-27-04, 5160-27-05, 5160-27-06, 5160-27-08, 5160-27-09, 5160-27-10, 5160-27-11, 5160-27-12

Date: 3/17/2017

Rule Type:

New

5-Year Review

Amended

Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. Please briefly describe the draft regulation in plain language.

Please include the key provisions of the regulation as well as any proposed amendments.

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This rule package implements comprehensive reform of the Medicaid benefit for mental health and substance use disorder treatment services. The initiative supported by this rule package is anecdotally known as “Behavioral Health Redesign.” Behavioral Health Redesign is a jointly sponsored project of the Ohio Department of Medicaid (ODM), the Ohio Department of Mental Health and Addiction Services (OhioMHAS), and the Governor’s Office of Health Transformation (OHT). The fundamental goals are to modernize Ohio’s Medicaid behavioral health services and prepare Ohio’s behavioral health provider network for integration into Medicaid managed care.

Key Provisions of the BH Redesign include:

- Develop new services for Medicaid recipients with high intensity service and support behavioral health needs
- Integrate physical and behavioral health care for Medicaid recipients
- Improve health outcomes for Medicaid recipients with behavioral health diagnoses
- Comply with federal health care requirements including: the National Correct Coding Initiative, program integrity requirements in federal law, and Mental Health Parity and Addiction Equity Act
- Encourage practitioners to work at the top of their professional scope of practice
- Encourage provider agencies to support higher educational opportunities for employees such as qualified unlicensed practitioners.
- Prepare Ohio’s Medicaid behavioral health providers for business relationships and selective contracting with Medicaid managed care plans when BH benefits are “carved in” to managed care.
- Enforce commercial third party liability and coordination of benefits with the Medicare program and other payers as required by the centers for Medicare and Medicaid
- Further ODM’s pursuit of health care value purchasing
- Achieve these changes while remaining within Medicaid budgeted resources.

Extensive information about this initiative can be found at bh.medicaid.ohio.gov/, the dedicated internet site established by ODM and OhioMHAS to instruct and inform key stakeholders.

Descriptions of the proposed OAC rules contained in this rule package are below:

New rules:

The proposed new rule 5160-27-01 “Eligible provider for behavioral health services” defines and describes the eligible providers that can provide the behavioral health services defined in Chapter 5160-27 of the Administrative Code. Licensing and other requirements, as applicable, are stated.

The proposed new rule 5160-27-02 “Coverage and limitations of behavioral health services” describes, as applicable, any service provision limits and Medicaid coverage requirements, such

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as medical necessity. Options to exceed service provision limits through an approved prior authorization are also presented.

The proposed new rule 5160-27-03 “Reimbursement for community behavioral health services” describes the Medicaid reimbursement policies for the behavioral health services defined in Chapter 5160-27 of the Administrative Code. Individual service reimbursement rates are located in Appendix DD of rule 5160-1-60 of the Administrative Code.

The proposed new rule 5160-27-04 “Mental Health Assertive Community Treatment Service” describes an evidence-based practice that Medicaid will cover for the first time. The rule also defines the criteria for receiving this service as well as requirements that providers must meet in order to render the service.

The proposed new rule 5160-27-05 “Mental Health Intensive Home Based Service” describes a service for which Medicaid will cover for the first time. The rule also defines the criteria for receiving the service as well as requirements that providers must meet in order to render the service.

The proposed new rule 5160-27-06 “Mental Health Day Treatment” describes a new service for which Medicaid will cover for the first time. The rule also states eligible providers of the service, service provision limitations and billing requirements.

The proposed new rule 5160-27-08 “Mental Health Therapeutic Behavioral Services and Psychosocial Rehabilitation” describes two new services for which Medicaid will cover for the first time. The rule also states eligible providers of the service, service provision limitations and the eligible providers for the two services.

The proposed new rule 5160-27-09 “Substance Use Disorder Treatment Services” describes new services for which Medicaid will cover for the first time and how the services are structured under the American Society of Addiction Medicine levels of care criteria. The rule also states service provision limitations and residential staffing requirements.

The proposed new rule 5160-27-10 “Substance Use Disorder Targeted Case Management” describes a service currently covered by Medicaid. The rule also states the eligible providers of the service and service provision limitations.

The proposed new rule 5160-27-11 “Behavioral Health Nursing Services” describes nursing services for which Medicaid will cover. The rule also states the eligible providers of BH nursing services and describes service provision limitations.

The proposed new rule 5160-27-12 “Behavioral Health Crisis Intervention Provided by Unlicensed Practitioners” describes a service currently covered by Medicaid. The rule also states the eligible providers of the service and service provision limitations.

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The following rules are to be rescinded as they are being replaced by the new rules:

Current rule 5160-27-01 “Eligible providers for community mental health services” states who may provide and bill Medicaid for rendered community mental health services.

Current rule 5160-27-02 “Coverage and limitations of Medicaid community mental health services” lists service provision limits, non-reimbursable activities, and restrictions regarding the provision of services by video conferencing.

Current rule 5160-27-05 “Reimbursement of community mental health medicaid services” states the reimbursement methodology for selected mental health services as well as health home services.

Current rule 5160-30-01 “Eligible provider for alcohol and other drug treatment services” states who may provide and bill Medicaid for rendered community alcohol and drug treatment services.

Current rule 5160-30-02 “Coverage and limitation policies for alcohol and other drug treatment services” lists medications and services for which Medicaid will provide reimbursement.

Current rule 5160-30-03 “Billable services” states the requirements for the provision of alcohol and drug treatment services that will be reimbursed by Medicaid. This rule is being rescinded as part of behavioral health redesign.

Current rule 5160-30-04 “Reimbursement for community medicaid alcohol and other drug treatment services” states the reimbursement methodology for selected alcohol and drug treatment services.

2. Please list the Ohio statute authorizing the Agency to adopt this regulation.

Ohio Revised Code sections 5162.02, 5162.05, 5164.02

3. Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program? If yes, please briefly explain the source and substance of the federal requirement.

Yes. The Behavioral Health Redesign will bring Ohio Medicaid in line with several federal requirements including the National Correct Coding Initiative (NCCI), program integrity requirements of the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and federally required third party liability and coordination of benefits with Medicare. Since Ohio’s Medicaid program operates under the authority of the Federal Centers for Medicare

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and Medicaid Services (CMS), the proposed changes in Behavioral Health Redesign are necessary to assure ongoing federal approval of Ohio's Medicaid program and federal financial participation which funds approximately 60% of all Ohio Medicaid spending.

4. If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.

The proposed regulation does not exceed the provisions allowed under federal law.

5. What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?

The public purpose of these rules is to modernize Ohio's Medicaid behavioral health services, to prepare Ohio's Medicaid provider network for integration into Medicaid managed care on January 1, 2018, and to make Ohio compliant with several federal requirements. In addition, the rule package is intended to accomplish several other public policy goals described in question 1 above.

6. How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?

ODM and OhioMHAS are developing short and long term outcome measures for this initiative and will monitor the impact of these initiatives very closely pre- and post-July 1, 2017. The major information sources for reviewing outcome measures will be Medicaid claims and reports from key stakeholders.

Some examples of key outcome measures pre- and post-implementation are as follows:

1. Changes in Medicaid spending for mental health and substance use disorder treatment services
2. Changes in consumer utilization of mental health and substance use disorder treatment services
3. Changes in provider network including agency merger or providers entering or leaving the Ohio market and the impact of this on consumer access to care.
4. Comparison of Medicaid behavioral health spending to predicted budget model.
5. Improved health outcomes of Medicaid consumers of behavioral health services including reduced emergency room utilization, reduced hospital lengths of stay, symptom reduction, and greater community stability.

Development of the Regulation

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7. Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.

If applicable, please include the date and medium by which the stakeholders were initially contacted.

ODM, in partnership with OHT and OhioMHAS, engaged many diverse stakeholders in behavioral health redesign and implementation. Beginning in July 2015, a formal group of stakeholders (including those listed below) met monthly (later bimonthly) for hundreds of hours of meetings to review proposed Medicaid policy and to offer revisions and suggestions. Stakeholders include:

- The Joint Medicaid Oversight Committee of the Ohio General Assembly
- Public Children Services Association of Ohio
- Ohio Association of Health Plans
- National Alliance on Mental Illness - Ohio
- Ohio Psychological Association
- The Ohio Council of Behavioral Health & Family Service Providers and its member agencies
- The Ohio Association of County Behavioral Health Authorities and its member ADAMHS Boards
- Ohio Association of Child Caring Agencies and its member agencies
- Ohio Hospital Association and its members
- Ohio Children's Hospital Association and its members
- Northern Ohio Recovery Association
- Ohio Alliance of Recovery Providers
- Case Western Reserve University
- Mental Health & Addiction Advocacy Coalition
- Ohio Citizen Advocates for Addiction Recovery
- Vorys Health Care Advisors
- Ohio Family and Children First
- The following Medicaid managed care plans:

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- CareSource
- United Healthcare
- Aetna
- Buckeye Health Plan
- Molina
- Paramount

In addition to outreach to the aforementioned stakeholder groups, ODM and OhioMHAS also accomplished stakeholder outreach through the creation of a dedicated internet site for this initiative (bh.medicaid.ohio.gov) and held more than 20 regional training sessions, conducted surveys, and developed webinar training sessions. Also ODM leadership personally made trips to various counties in the state to respond to state legislators' enquiries.

8. What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?

Since May 2015, key stakeholders and their trade associations provided input through active participation in hundreds of hours of committee meetings, written comments, and numerous regional face to face and webinar training sessions. For example, the most common topic of discussion included Medicaid payment rates and budget assumptions. Consequently, ODM and OhioMHAS developed 19 budget models from May 2015 to the present, with each subsequent model reflecting input from key stakeholders. Transparency and iterative design were repeated throughout the entire initiative including topics such as the array of services contained within the Medicaid behavioral health benefit package, definitions of those services, and practitioners eligible to render them. In the vast majority of cases, stakeholder input resulted in modification to the state's proposed policies and regulations.

Examples of stakeholder input:

A request to delay implementation of behavioral health redesign which was granted, from July 1, 2016 to July 1, 2017.

Multiple requests to increase the reimbursement rates for various services were granted.

Certain service provision limitations which were initially developed by ODM and OhioMHAS were removed.

Support was given to permit provider agencies' continued reliance on unlicensed practitioners for some service provision. This was accomplished by the development of reimbursement rates that would permit the use of unlicensed practitioners.

9. What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?

Ohio Medicaid claims data were the main source of information used to guide the policy and budget models that undergird this initiative. In addition, ODM surveyed key stakeholders with regard to staffing patterns and workforce characteristics, and used that information to inform budget modeling. Finally, ODM procured the services of Mercer Consulting to assist with the budget modeling and the development of the new behavioral health service benefit package.

10. What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?

ODM enforces requirements through the use of rules in the Ohio Administrative Code (OAC) which is specific to a particular subject. No other ODM rules, with the exception of rule 5160-8-05, which was reviewed, specifically address behavioral health services reimbursed by ODM.

11. Did the Agency specifically consider a performance-based regulation? Please explain. Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

ODM did not consider a performance-based regulation, because the regulations described in these rules do not lend themselves to a performance base standard.

12. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

ODM partnered with OhioMHAS, Ohio's regulatory body for mental health and addiction treatment services, in every step of Behavioral Health Redesign process. Special attention has been paid to ensure the ODM and OhioMHAS proposed OAC rules are complementary and not duplicative. Throughout this process, both agencies maintained parallel listings of

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OAC rules to be modified. In many cases, proposed ODM rules in Chapter 5160-27 refer to OhioMHAS rule chapters for reference to provider and service standards and definitions.

13. Please describe the Agency’s plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

ODM and OhioMHAS have already conducted more than 20 regional training sessions for key stakeholders, with emphasis on implementation training for behavioral health providers. ODM and OhioMHAS will hold additional training sessions in March and April of 2017. Both agencies continue to monitor and respond to questions submitted to the bh.medicaid.ohio.gov web site. ODM is prepared to offer training and technical assistance as needed to the Medicaid behavioral health provider community in order to ensure successful and consistent implementation of the new regulations. Once the initiative begins on July 1, 2017, ODM and OhioMHAS will closely monitor the implementation of new regulations by reviewing patterns of Medicaid claims and utilization and anecdotal reports from key stakeholders. ODM and OhioMHAS will establish a rapid response team that will be available beginning in July 2017 to provide technical assistance six days a week for any issues related to claims payment or processing time. Both ODM and OhioMHAS are fully engaged in monitoring the implementation process, including during and after the transition of the Behavioral Health Redesign benefits package to the Medicaid managed care plans.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

The proposed rule package will affect approximately 625 provider agencies of mental health and/or substance use disorder treatment in Ohio who are Medicaid providers. Future Medicaid mental health and/or substance use disorder treatment providers will also be affected.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

The Behavioral Health Redesign will bring Ohio Medicaid in line with several federal requirements including the National Correct Coding Initiative (NCCI), program integrity requirements of the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and federally required third party liability and coordination of

benefits with Medicare. As a result, Ohio’s behavioral health provider agencies who have chosen to participate in the Ohio Medicaid program will be required to comply with the aforementioned federal health care requirements.

Information Technology and Billing System Updates

Participating Ohio Medicaid provider agencies will be required to update providers’ information technology and claims payment systems to successfully submit claims for payment for services in the new benefit package. This will require providers to use NCCI coding standards set by the federal Centers for Medicare and Medicaid and the American Medical Association. Providers of substance use disorder treatment services will be required to comply with the guidelines of the American Society of Addiction Medicine (ASAM) in their patient treatment decisions. Accomplishing these IT and billing system updates will prepare provider agencies for the “carve in” of behavioral health services to Medicaid managed care and will also enable providers to increase their participation in the commercial health care marketplace. During the initial six months prior to the transition to Medicaid Managed Care, behavioral health providers who don’t submit claims via the electronic file transmission process may continue to submit claims without charge through the Ohio MITS claims portal. The portal is available 24/7 for claims submission and providers will be able to use the portal option should they experience IT systems issues.

Coordination of Health Care Benefits/Third Party Liability

All Ohio behavioral health providers will also be required to ensure that Medicaid is the payer of last resort for health care services to patients with commercial or Medicare health insurance coverage, bringing them into compliance with federal regulations as required by all Ohio Medicaid providers. This requires agencies serving Medicare enrollees to enroll with the Medicare program. Additionally, agency employees who can render Medicare billable services must also enroll with Medicare. Additionally, provider agency billing systems must be capable of submitting service claims for patients with third party coverage to the appropriate health care payer before they are submitted to Ohio Medicaid for cost sharing. These requirements apply to all Medicaid providers.

Federally Required Program Integrity Provisions

Provider agencies will be required to register with Ohio Medicaid their employed or contracted physicians, nurse practitioners, physician assistants, psychologists, and counselors or social workers with independent scopes of practice. Practitioner registration will be accomplished by enrolling these practitioners in Ohio Medicaid as

rendering practitioners. Once actively enrolled in Ohio Medicaid, provider agencies must ensure their practitioners are affiliated with their agencies in the Medicaid Information Technology System (MITS.) This requirement will bring these provider agencies into compliance with provider integrity sections of the Affordable Care Act that are designed to ensure program compliance and to protect tax payer dollars. This change will also align behavioral health providers with the rest of the Ohio Medicaid program and the commercial health insurance market by ensuring claims are paid based on the credentials of the rendering practitioner.

Staff Training and Organizational Transformation

ODM and OhioMHAS have offered numerous regional and internet based training opportunities for Ohio's behavioral health provider network. These training opportunities will continue through implementation on July 1, 2017. In order to learn about the new requirements, provider agencies will need to spend time attending training sessions, sharing this information within their organizations and using it to guide business decisions to maximize the opportunities of new billable services and competitive payment rates. Agencies have the discretion to decide which services they will provide given their employed workforce and they will need to invest adequate time to fully understand and implement the needed changes to their business models.

c. Quantify the expected adverse impact from the regulation.

The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a “representative business.” Please include the source for your information/estimated impact.

Quantifying the cost of providing any of these new services is difficult because of the significant variance of business design, number of service locations, agency workforce, client caseload, and business acumen among Ohio's 625 Medicaid enrolled providers of behavioral health services. Anecdotal information from providers and colleagues at OhioMHAS indicates that many sophisticated, multi-site providers are well equipped to comply with the requirements of this rules package. In fact, these provider organizations view Behavioral Health Redesign as a welcome change and opportunity to grow their business in line with the rest of the US health care market. They believe that the opportunities resulting from the adopting the

Behavioral Health Redesign benefit package will outweigh the cost of implementation. ODM has also communicated with smaller, less sophisticated providers as well as larger providers. ODM acknowledges the varying degrees of preparedness among providers and has worked with stakeholders to identify areas where additional support for providers may be needed to ensure successful implementation. Both ODM and Ohio MHAS have committed to monitoring the implementation of the BH Redesign changes at the provider level and are ready to make the necessary investment to assure success and that Medicaid recipients continue to have access to needed care.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The Behavioral Health Redesign will make Ohio Medicaid compliant with several federal requirements including the National Correct Coding Initiative (NCCI), program integrity requirements of the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and federally required third party liability and coordination of benefits with Medicare and other payers. Failure to implement these changes will leave Ohio Medicaid at risk of audit and decreased funding since Ohio's Medicaid program operates under the authority of the Federal Centers for Medicare and Medicaid Services (CMS). The proposed changes in Behavioral Health Redesign are necessary to assure ongoing federal approval of Ohio's Medicaid program and federal financial participation which funds approximately 60% of all Ohio Medicaid spending. In addition, to bringing Ohio behavioral health providers in line with federal health care standards, ODM's proposed rule changes will further our goals of improved program integrity and value based purchasing. Currently, ODM has no way of knowing the credentials or licensure of the provider agency staff person who rendered a service and pays the same rate regardless of whether the service was provided by a licensed physician, licensed independent social worker, or a qualified mental health specialist with just a high school diploma. It will also accomplish the goal of integrating primary care services within a behavioral health setting. This is critically important for Medicaid recipients with a co-occurring medical and behavioral diagnosis.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

To ensure uniform and consistent treatment of Medicaid providers, the proposed rules do not offer any exemptions or alternate means of compliance based on a provider's size. Both

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ODM and Ohio MHAS are willing to make the necessary investment to ensure success and that recipients have access to needed care by committing to an implementation plan for Behavioral Health Redesign changes at the provider level. Extensive technical assistance has been made available to providers and will continue beyond the July 1, 2017 effective date of these rules.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

This regulation does not apply to this rules package because it does not impose any fine or penalty for a paperwork violation.

18. What resources are available to assist small businesses with compliance of the regulation?

Medicaid providers in need of technical assistance can contact Medicaid Provider Assistance telephone line at 1-800-686-1516. Providers also have unlimited access to detailed information regarding BH redesign and the proposed rules package by visiting the dedicated internet site: bh.medicaid.ohio.gov. This web site allows visitors to submit questions which are monitored and responded to weekly by ODM and OhioMHAS staff. Finally providers have had and will continue to have access to regional training sessions and webinars on this initiative offered by ODM and OhioMHAS staff.