

Behavioral Health System Reform April 2008 Update

Current System:

➤ *System Financing Structure*

- The existing model for financing the behavioral health system is not based on consumer access, needs and choices.
- The current formula used by ODMH to distribute ALI 408 is based on historical hospitalization usage/prevalence and Seriously Mentally Disturbed/Seriously Emotionally Disturbed (SMD/SED) data from the mid 1980's. These outdated factors have created an inequitable distribution of these dollars given Ohio's current population demographics and fiscal resources. This financing structure is based on an institutionally-based system of the past and not the community-based system we have today.
- The current formula used by ODADAS to distribute funding within funds 401 and 4750 rely on county population demographics and not upon board Medicaid caseloads.
- Many Boards utilize local levy funds as Medicaid match for mental health and AOD services. The demand for the local share of Medicaid match has increased significantly in the last five years. According to OACBHA data, county boards used \$78.5 million in local levy funds to match Medicaid in SFY 2005.
- Increased reliance on local levy funds to meet Medicaid match has limited local discretion and community planning for those local dollars.
- This financing structure creates an inherent system inequity that results in varying levels of access for consumers based upon county/Board area of residence.
- Medicaid rate ceilings have not been raised for roughly ten years system wide.

➤ *Reimbursement Methodology*

- The current prospective cost-based and subsequently reconciled provider reimbursement system does not support a viable system of care and does not promote quality and efficiency.
- Providers have a disincentive to be efficient. Any efficiency realized does not equate to actual dollar savings for the provider. The efficiency incentive for most businesses is the ability to reinvest savings into needed technology and/or workforce development. This incentive does not exist for behavioral health providers.
- The cost-based system doesn't allow providers to provide uncompensated care because it would lower their per-unit cost and result in a lower reimbursement.

➤ *Medicaid utilization review for Behavioral Health*

- Section 1902(a)(30) of the Social Security Act requires each state operating a Medicaid program to have a utilization review/control (SUR) program for all covered services. This is further described in 42 CFR 456.3 "Statewide surveillance and utilization control program. The Medicaid agency must implement a statewide surveillance and utilization control program that — (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; (b) Assesses the quality of those services; (c) Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and (d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part."
- Ohio's Medicaid program does not currently perform utilization review (UR) on covered behavioral health services, as it does on general Medicaid. This UR process is required of all services approved by the Center for Medicare and Medicaid Services through the state

plan and amending process. As the SSA for Medicaid, ODJFS has the authority and obligation to implement UR.

Memoranda of Understanding Background Information:

- In July 2007, representatives of the Ohio Department of Job and Family Services, the Ohio Department Mental Health, the Ohio Department Alcohol and Drug Addiction Services, the Ohio Council of Behavioral Healthcare Providers, the Ohio Association of County Behavioral Health Authorities, the Mental Health and Recovery Board of Clark, Greene and Madison Counties and TCN Behavioral Health Services Inc. signed a memorandum of understanding (MOU) resulting in the dismissal of a lawsuit originally filed by TCN Behavioral Health Services, Inc. on October 29, 2001.
- The MOU is a culmination of negotiations whereby all the signatories have agreed to continue system reform work to resolve issues regarding Medicaid such as provider due process, compliance and utilization review, and claims processing and auditing. The compliance and utilization review commitment is time limited to a 12 month period; acceptable progress must be made by July, 2008 otherwise the lawsuit may be re-filed.

Future System Model:

➤ *Financial Restructuring*

This Biennium (SFY 08-09)

- Identify Medicaid match funding. This will provide greater transparency and accountability for the system as a whole.
- ODADAS & ODMH will implement a financial reporting process to verify amounts and sources of Medicaid match within the system which will allow for financial modeling to occur.

[See Attachment B - Certified Public Expenditure (CPE) Process]

- A plan will be developed by July 1, 2008 for a recommendation for financial sustainability, with a focus on increased consumer access and choice, to be implemented for SFY 10-11. Stakeholders will be involved in the development of the plan.

Next Biennium (SFY 10-11)

- Monitor and address Medicaid growth within a specified line item in both ODADAS and ODMH budgets.
- Adjust current allocation formulas used by ODADAS and ODMH.
- Shift risk for Medicaid match to the state level. Eliminate the Medicaid match liability for county boards.
- Restore county boards' discretion to utilize levy funds to meet local needs according to their community plan rather than using them to fund Medicaid match.
- State funding dedicated to Medicaid services will no longer be tied to rigid and stagnant formula distribution methods.
- Post implementation, the funding in ODADAS' and ODMH's budgets associated with Medicaid services would operate similar to ODJFS' 525 funding.

➤ *Fee-Based Reimbursement Methodology*

- Pay providers on a fee schedule basis rather than the current cost-based/reconciliation methodology. The addition of appropriate provider financial incentives will allow providers to focus on consumers and clinical decisions.
- The fee-based Medicaid reimbursement system will implement incentives for providers to increase efficiencies and base service delivery on consumer needs and choices.
- Fee-based reimbursement equalizes Medicaid consumer access to services across Ohio.

- A fee schedule does not penalize providers who provide uncompensated care. This will improve access for consumers who do not have a payor source.
- Administrative rule changes are required to implement the fee schedule reimbursement mechanism. ODJFS filed four rules regarding Medicaid coverage of AoD and MH services on April 16, 2008. MH services are rules– 5101:3-27-05 and 5101:3-27-07, and AoD rules are – 5101:3-30-04 and 5101:3-30-06.
- State Plan Amendments (SPAs) – ODJFS has drafted two state plan amendments to submit to CMS to update Ohio’s Medicaid state plan to include a change to a fee schedule payment methodology for AoD and MH services. The SPAs are modeled after existing state plan language related to the physician fee schedule coverage in Ohio.
[See Attachment C - Fee Schedule Rate Setting Rationale]

➤ *Implement Medicaid utilization review for Behavioral Health*

- Implement a utilization review process for Medicaid covered behavioral health services under the authority of ODJFS’ Surveillance and Utilization Review process.
- A fully functioning statewide surveillance and utilization review program removes provider concern about unnecessary administrative intrusions unless the provider is truly operating outside of the norm.
- Evolving the system from a financial focus to a consumer centric focus requires the immediate support of the federally required Utilization Review process. UR demands accountability from providers by monitoring consumer access regarding duplicative and/or unnecessary services.
- The state will not be able to implement a shift in reimbursement methodology without a viable utilization review program.

Summary of Previous Rate Setting & Utilization Review Initiatives

	House Bill 215 Work Group, Management Tools for Community Medicaid, Report 1 (September 30,1997)	Ohio Access (February 2001 and 2004 *)	State of Ohio Community Behavioral Health Medicaid Business Plan (August 2004)
Rate Setting	<ul style="list-style-type: none"> develop fixed payment schedule (p. 11) 	<ul style="list-style-type: none"> implement a fixed fee schedule standardize uniform cost reporting 	<ul style="list-style-type: none"> implement provider-specific fixed rates for SFY 07 implement uniform cost reporting for SFY 2005 (accomplished for SFY 2006)
Utilization Review	<ul style="list-style-type: none"> based on level of care protocols (ODADAS has, ODMH needs to develop) performance standards for UR develop and pilot UM statewide criteria would require general authorizing reference in ORCs 3793, 5119 and 340 along with administrative rules (p. 23) can not affect a Medicaid consumers access to treatment, use of available services or case specific payment (p. 23) 	<ul style="list-style-type: none"> implement statewide utilization review criteria for Medicaid and non-Medicaid services 	<ul style="list-style-type: none"> need administrative rules to implement based on ODADAS' adult and youth versions of LOC protocols <p>The original design description in the MCD BP is no longer applicable. The MBP steering committee/Board association adopted overlaying the ODJFS SUR model onto the BH system.</p>

Certified Public Expenditure (CPE) Process for Medicaid Claims

Payments to non-governmental, private mental health and alcohol and drug addiction treatment providers of services provided under Section 1905(a)(13) of the Social Security Act will be generated through State and/or local taxes. In order to receive payment, providers will submit claim files to local government entities, referred to as Alcohol, Drug Addiction and Mental Health Services Boards (ADAMHS), Community Mental Health Service Boards (CMHS) and Alcohol and Drug Addiction Services Boards (ADAS). The ADAMHS, CMHS and ADAS Boards are responsible for forwarding the provider claim files to the state. The state processes these claim files into the claim payment system (Diamond 725). Once claims are fully adjudicated in Diamond, the state creates the HIPAA required electronic 835 HealthCare Payment files and makes them available to the Boards.

Boards are responsible for downloading the electronic 835 files and processing claims pursuant to the reimbursement rate promulgated under the state plan. Each Board will certify its public expenditures and submit the signed CPE statement to each 835 file containing Medicaid claims to the ODMH Office of Medicaid or the ODADAS Medicaid Services Unit. The ODMH Office of Medicaid or the ODADAS Medicaid Services Unit will review the CPE statements and provide the ODMH Office of Information Systems (OIS) or ODADAS OIS with a list of Boards which have submitted CPE statements.

ODMH OIS or ODADAS OIS will then submit claims to ODJFS for adjudication but only for the Boards which have submitted CPE statements for all electronic 835 files containing Medicaid claims. Any Board that does not submit all necessary CPE statements will have all Medicaid claims held until the outstanding statements are received by the ODMH Office of Medicaid or the ODADAS Medicaid Services Unit.

Fee Schedule Rate Setting Rationale

In order to determine the appropriate payment rates to implement the fee schedule for community mental health services, an analysis of recent cost data was conducted. Based on an analysis SFY 2005 cost data, after removing outliers, the median unit cost for each Medicaid service fell very close to the current rate ceilings. For each service the median unit cost was at or slightly above the current rate ceiling, with the largest variance being about three percent. This means that for each service, more than half of the providers reported unit costs equal to or above the current rate ceilings with the remaining providers having a unit cost less than the current rate ceiling. The analysis also compared the average unit cost to the current rate ceilings. Although the average unit cost for each service was higher than the median, the results suggest that transitioning the current rate ceilings to the fee schedule is reasonable as a starting point for implementation. Using the current rate ceilings as the fee schedule ensures access is maintained since most providers will not see a change in reimbursement and no provider will be paid less for any service. Additionally, implementing fee schedule rates that are slightly less than the average unit cost provides balance necessary to manage anticipated changes in utilization due the elimination of cost reconciliation.

A similar analysis was conducted for alcohol and other drug treatment services using SFY 2006 cost data. For most services the analysis showed that the current rate ceilings were within a reasonable range when compared to both the average and median unit cost, with some falling below and some falling above depending on the service. The two services where the variance between the rate ceiling and the average unit cost was the greatest were ambulatory detoxification and methadone administration. For both of these services the number of providers is small, which makes analysis based on median and average unit costs more difficult. For ambulatory detoxification, the average unit cost was significantly greater than the current rate ceiling, but only one of the three providers included in the analysis had an actual unit cost greater than the current rate ceiling. The same was true for methadone administration, where only one of the six providers included in the analysis reported an actual unit cost above the rate ceiling. In summary, while there were some differences across services in the relationship of the average and median unit costs to the current rate ceilings, using the current rate ceilings as the fee schedule for the initial fee schedule roll out appears to be reasonable and ensures access to services.

Service	Current Rate Ceiling	Median Unit Cost	Average Unit Cost
Partial Hospitalization	\$ 116.81	\$ 117.39	\$ 122.37
Pharmacological Management	\$ 210.87	\$ 213.76	\$ 223.10
CPST-Individual	\$ 21.33	\$ 21.88	\$ 23.76
CPST-Group	\$ 9.81	\$ 9.89	\$ 13.09
Crisis Intervention	\$ 154.35	\$ 154.40	\$ 165.26
Mental Health Assessment	\$ 129.99	\$ 129.99	\$ 132.37
Psychiatric Diagnostic Interview	\$ 210.87	\$ 211.69	\$ 218.67
BH Counseling-Group	\$ 9.87	\$ 10.17	\$ 11.00
BH Counseling-Individual	\$ 22.50	\$ 23.21	\$ 25.13
Ambulatory Detoxification	\$ 193.87	\$ 177.41	\$ 287.92
Assessment	\$ 96.24	\$ 97.45	\$ 102.83
Case Management	\$ 78.17	\$ 78.62	\$ 80.33
Crisis Intervention	\$ 129.59	\$ 130.72	\$ 138.38
Group Counseling	\$ 9.52	\$ 9.06	\$ 8.43
Individual Counseling	\$ 21.82	\$ 22.35	\$ 23.26
IOP	\$ 136.90	\$ 115.33	\$ 109.64
Laboratory Urinalysis	\$ 60.00	\$ 47.20	\$ 46.15
Medical/Somatic	\$ 176.28	\$ 182.92	\$ 201.48
Methadone Administration	\$ 16.38	\$ 9.01	\$ 10.81