CSI - Ohio
The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Mental Health

Regulation/Package Title: Health Home Service

Rule Number(s): 5122-25-03; 5122-25-04; ~~5122-25-05;~~ 5122-29-33

Date: 22 June 2012, Amended 17 July 2012, and Amended 15 August, 2012

Rule Type:

- X New
- X Amended
- 5-Year Review
- Rescinded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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Rule 5122-29-33 is a proposed new mental health service. The other rules are being amended to support the addition of 5122-29-33 as a certified mental health service.

5122-25-03 describes the deemed status process for ODMH to recognize an agency's behavioral health accreditation in place of ODMH standards, and the exemptions. It is being amended to state that ODMH will not accept accreditation in place of ODMH standards for health home service.

5122-25-04 describes the process for an agency seeking ODMH certification, and is being amended to allow ODMH to collect additional documentation as part of the certification process if a service is not covered under the deemed status provision.

5122-29-33 The State will establish Medicaid health homes for beneficiaries who meet the State's definition of serious and persistent mental illness (which includes adults with serious mental illness [SMI] and children with serious emotional disturbance [SED]), initially using a regional approach. A health home is not a building; it is a coordinated, person-centered system of care. An individual who is eligible for health home services can obtain comprehensive medical, mental health and drug and/or alcohol addiction treatment, and social services that are coordinated by a team of health care professionals. Ohio's Community Behavioral Health Centers (CBHCs) will be eligible to apply to become Medicaid health homes for Medicaid beneficiaries with SPMI. The goals of Ohio's CBHC health homes for Medicaid beneficiaries with SPMI are aligned with those of CMS. They are as follows; improve the integration of physical and behavioral health care; lower the rates of hospital emergency department (ED) use; reduce hospital admissions and re-admissions; reduce healthcare costs; decrease reliance on long-term care facilities; improve the experience of care, quality of life and consumer satisfaction and improve health outcomes. Moreover, we fully expect to achieve better care coordination and management of health conditions as well as increase the use of preventive and wellness management services.

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

   Sections 5119.61; 5119.611 and 5119.612 of the O.R.C.

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.

   The Centers for Medicaid and Medicare Services (CMS) offers states the option to implement health home service as a Medicaid reimbursable service. The State of Ohio

has submitted a Medicaid State Plan Amendment to the Centers for Medicaid and Medicaid Services requesting approval to cover the Health Home service for persons with SPMI beginning October 1, 2012 and to receive an enhanced (90%) federal medical assistance percentage for the first eight quarters that the state health home service state plan is in effect.

ODMH is required by CMS under the State Plan Amendment to have a process for assuring agency compliance with the standards. 5122-25-03 and 5122-25-04 are being amended to allow ODMH to meet this responsibility.

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

   The health home service includes State selected quality measures that exceed the CMS required core set of quality measures. CMS lists a minimum of seven required core quality measures (outcomes), and also asks states to identify measurable goals of their health home model and intervention. Once a State has identified their measurable goals, CMS asks the state to identify quality measures that operationalize as well as map to the goals articulated by the State for the health home. Following CMS' above mentioned guidance, ODMH has identified 8 measurable goals and 19 additional quality measures based on the input of diverse stakeholders and content experts, and the scientific data. To the extent possible, ODMH has aligned the additional quality measures with other State and Federal requirements and selected quality measures that can be drawn from claims data in order to minimize potential burden and cost on the providers and the state. ODMH has strived to propose a health home model and the quality measures that were necessary to meet the state's goals for achieving good health outcomes and savings as well as meeting the federal requirements and eliciting a favorable response from CMS. The state will collect, aggregate and analyze the data and make it available to providers to be able to respond to the health needs of the defined population as a whole.

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 Centers for Medicare and Medicaid Services requires ODMH implement regulatory standards in order to approve adding a service to the State of Ohio Medicaid Plan as a covered service under the community mental health Medicaid program. O.R.C. 340.09 requires a service to be Certified by ODMH if a Board wants to pay for a service using non-Medicaid (local) public funds. Providers of health home service that do not wish to either bill the federal community mental health Medicaid program, or

enter into a contract with the local community mental health board are not required to follow the standards established by ODMH.

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

   The State will report seven core measures to CMS based on information submitted by health home providers and monitor an additional 19 measures to assess overall health home goals and objectives. Additionally, the State will calculate cost savings that resulted from improved care coordination and managements achieved through the health home service. ODMH will also monitor success by tracking the number of agencies which obtain certification to provide health home service.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   Revisions to the other three rules in the packet are made as a result of adding health home service. If applicable, please include the date and medium by which the stakeholders were initially contacted.

   In 2011, the Ohio Department of Mental Health invited a wide variety of stakeholders, including providers, consumers, advocates, and Medicaid Managed Care Plans, using a variety of mediums – e-mail, other committee meetings, face-to-face, etc. This The following organizations actively participated in discussions regarding this proposal: Ohio Departments of: Mental Health, Job and Family Services, and Alcohol and Drug Addition Services, Office of Health Transformation, Ohio Association of County Behavioral health Authorities, The Ohio Council of Behavioral Health & Family Services Providers, The Ohio Empowerment Coalition for Mental Health Recovery, the National Alliance on Mental Illness Ohio, Ohio Association of Child Caring Agencies, Inc., Ohio Hospital Association, Ohio Association of Health Plans, Public Children Services Association of Ohio, and National Association of Social Workers. In addition, the draft rules were made available for comment on the ODMH website from June 15 – June 20, and ODMH certified agency executive directors, stakeholders, and subscribers to an agency listserv were notified by e-mail of this opportunity to provide input.

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

   Prior to developing this rule for the health home service for persons with serious and persistent mental illness, Ohio held targeted discussions in the following areas:

- **Documentation, Billing & Other Regulatory Requirements**
- **Reimbursement**
- **Health Information Technology/Health Record Integration/Treatment Plan Integration**
- **Staffing Arrangements & Team Composition**
- **Consumer/Family Engagement and Buy-in**
- **Quality Improvement: Performance Measures & Outcomes**

Additionally, all workgroup minutes and work products and presentations were posted on the Ohio Department of Mental Health web page including the draft State Plan Amendment submitted to Center for Medicare and Medicaid services. The feedback was actively solicited from these stakeholders and was taken into account in the program design and rule development.

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?**

The measurable outcomes selected for health home service are standardized measures from the nationally recognized sources such as National Committee for Quality Assurance, National Quality Forum, Agency for Healthcare Research and Quality, and Substance Abuse and Mental Health Services Administration. The measurable outcomes of the rule were developed based on information and scientific data obtained through a review of the scientific literature and the following Ohio-specific research studies:

The Ohio Department of Mental Health (ODMH), in conjunction with Case Western Reserve University, investigated the causes of deaths of seriously mentally ill consumers who died between 2004 and 2007 and who were served by the Ohio state-operated psychiatric hospitals and/or community-based mental health programs (pending publication). When compared to decedents in Ohio's general population over the study's time frame, only 32% of the seriously mentally ill consumers were 65 years or older at the time of their deaths, compared to 75% of the general Ohio population.

An earlier Ohio study examined mortality and medical comorbidity among patients with serious mental illness admitted to an Ohio public mental health hospital between 1998 and 2002. Heart disease (21%) was the leading cause of death. The mean age at death for decedents with Ohio public mental health hospital admission was 47.7 years, corresponding to an average of 32 years of potential life lost per patient (Miller et al., 2006).

In a recent study funded by the Northeast Ohio Medical University's BeST Center and the Health Foundation of Greater Cincinnati and conducted by Health Management Associates and the Ohio Colleges of Medicine Government Resource Center it was found that in Ohio:

- **Adults with serious mental illness (SMI) represented about 10% of the Medicaid population and 26% of total Medicaid expenditures.**
- **The rate of co-occurring chronic physical health conditions is higher among individuals with SMI and particularly among individuals with schizophrenia and psychosis.**
- **Adults with SMI have approximately twice the rate of hospitalization and ED visits for many ambulatory care sensitive conditions including diabetes, COPD, pneumonia and asthma.**
- **Adults with schizophrenia have over twice the rate of hospital emergency department (ED) visits for hypertension and diabetes.**

In addition to the Ohio specific statistics above, the numerous national studies in clinical settings support behavioral health treatment approaches can contribute to high risk health conditions: second generation anti-psychotic medications are highly associated with weight gain, diabetes, abnormal cholesterol levels and metabolic syndrome.

The scientific data were used to support all components of the health home including the development of the program goals and design, the provider standards, and the selection of the outcome measures. The data will also be used to evaluate the effectiveness and impact of the regulation in the future.

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?**

    None. The health home service delivery model is a new approach and at this point, no alternatives to regulate this service exist.

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.***

    The Ohio Department of Mental Health will be requiring the performance measures as described in response to question 6 to measure the performance of rule requirements.

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

    The Ohio Department of Jobs and Family Services, which administers the Ohio Medicaid Program, is promulgating rules to authorize billing Medicaid for the new Health Home service. ODMH worked in tandem with the ODJFS to develop rules which are complementary rather than duplicative.

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.**

    Chapters 5122-25 to 5122-29-30 of the Administrative Code define that certification process that is the same for all providers. ODMH has conducted multiple webinars and regional forums. ODMH will conduct additional training/forums for providers of the service.

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;**
       Any currently certified community mental health providers which voluntarily chooses to add health home service to its existing ODMH Certification, or any new provider which want to become certified by ODMH and provide health home service.
    b. **Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and**
       ODMH Certification is required in order to bill Community Mental Health Medicaid or receive a contract with the local community mental health board to receive local public funds to pay for health home service. There is no fee for ODMH certification. The Health Home service rule does require providers to be certified by ODMH for four other Medicaid billable services. Certification for those four services requires an agency to first obtain appropriate behavioral health accreditation by one of three national accrediting bodies, which do charge an accreditation fee. In addition, agencies will have a limited time (up to 4 years depending on accrediting body and accreditation cycle) after obtaining ODMH Certification to add accreditation/recognition/certification in integrated behavioral health/physical health care. Agencies will also need to dedicate staff time to implement the standards.
    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.

Accreditation fees vary based upon accrediting body; agency size including budget, number of locations, consumers served and staff; number of services accredited, etc. Average fees range from $6895 to $20,000 for a 3 or 4 year accreditation, although fees can be higher or lower. This is based upon fee schedules provided by the accrediting bodies. Agencies may or may not incur an additional accreditation fee when adding when adding accreditation for integrated behavioral health/physical health. This is dependent upon the accrediting body standards, and agency size, and ODMH is unable to estimate the cost of an increase, if applicable. The amount of additional staff time to implement the standards is difficult to estimate, based upon the expertise of employees within the agency. An agency can build a portion of its costs into its rate. An agency with a history of providing integrated care will require less staff time than an agency implementing these services for the first time. For the physical health component, some mental providers already provide physical health services. Some may be adding this as a service, while others will contract with a provider of physical health services.

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

    ODMH is not able to add a service as a community mental health Medicaid covered service without implementing standards and the ability to assure compliance.

Regulatory Flexibility

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

    No, the regulation does not provide exemptions or alternative means of compliance for small businesses. An agency may request a waiver or a variance pursuant to OAC 5122-25-06.

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?**

ODMH's general practice is to require a written plan of correction, whereby a provider identifies how it will correct a violation that cannot be immediately corrected. If a provider is non-compliant with the certification application process, ODMH will notify the provider of such, and allow the provider to correct the issue, e.g. submit missing documentation, correct paperwork, etc. The OAC rules do not authorize assessing a fine. ODMH does have the authority to issue a probationary Certificate in place of a full certificate when (a) Serious deficiencies are found during the department's determination of an agency's compliance with the certification standards; or (b) The agency's documented corrective action(s) is not approved by the department. There is no penalty associated with issuing a probationary certificate, i.e. the agency may still provide and bill for the service as long as the service is medically necessary and documented. ODMH does not have the authority to allow expenditure of public funds for services which are not medically necessary and documented.

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

ODMH has staff available to provide technical assistance in explaining the standards. ODMH also conducted webinars and regional state-wide forums to discuss health home service. ODMH and/or ODJFS plan to establish learning communities for providers of health home service. ODMH sponsors yearly CARF and Joint Commission training for providers to assist with maintaining conformance to accrediting body standards. By contracting directly with the accrediting bodies, ODMH is able to offer the training at fees of approximately $200 - $400 less per person, and eliminate out-of-state travel costs.