MEMORANDUM

TO: Tommi Potter, Ohio Department of Medicaid

FROM: Tess Eckstein, Regulatory Policy Advocate

DATE: April 14, 2017

RE: **CSI Review – Behavioral Health Services: Other Licensed Professionals, Behavioral Health Services and Medications (OAC 5160-8-05, 5160-27-01 to 5160-27-06, 5160-27-08 to 5160-27-12, 5160-30-01 to 5160-30-04)**

On behalf of Lt. Governor Mary Taylor, and pursuant to the authority granted to the Common Sense Initiative (CSI) Office under Ohio Revised Code (ORC) section 107.54, the CSI Office has reviewed the abovementioned administrative rule packages and associated Business Impact Analyses (BIA). This memo represents the CSI Office's comments to the Agency as provided for in ORC 107.54.

Analysis

These rule packages consist of one amended,[1] seven rescinded, and 11 new rules being proposed by the Ohio Department of Medicaid (ODM). Both rule packages were submitted to the CSI Office on March 17, 2017, and their comment periods closed on March 31, 2017; after ODM, at the request of stakeholders, extended the comment periods beyond their original closing date of March 24. Since the rule packages are so closely related, and because many stakeholders submitted comments for both in a single correspondence, the CSI Office is addressing both packages in one memorandum.

The proposed rules are being reviewed as part of a Behavioral Health Redesign initiative coordinated with the Ohio Department of Mental Health and Addiction Services (OhioMHAS). While the OhioMHAS rules address service definitions related to mental and behavioral health and drug and alcohol addiction services, the rules in ODM's packages set forth coverage and payment provisions for behavioral health services provided by licensed professionals; define eligible providers; describe service provision limits and Medicaid coverage requirements; set forth Medicaid reimbursement policies; and describe a variety of services provided by eligible behavioral health service providers.

[1] OAC 5160-8-05 is being amended by more than 50 percent. The Legislative Service Commission requires that the rule be rescinded and replaced with a new rule with the same number.

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The 11 proposed new rules replace seven rescinded rules, though six of the services described in the rules are services that Medicaid will cover for the first time: Mental Health Assertive Community Treatment Service (ACT), Mental Health Intensive Home-Based Treatment Service (IHBT), Mental Health Day Treatment, Mental Health Therapeutic Behavioral Services (TBS), Mental Health Psychosocial Rehabilitation (PSR), and Substance Use Disorder Treatment Services (SUD). Rule 5160-8-05, which addresses behavioral health services provided by licensed professionals, is being amended to, among other things, add school psychologists licensed by the Ohio State Board of Psychology as eligible providers and to clarify required levels of supervision for practitioners.

These rules impact approximately 625 provider agencies of mental health and/or SUD treatment in Ohio who are Medicaid providers, as well as any future providers. The rules also impact the employees of these provider agencies who serve as rendering practitioners. While not an exhaustive list, these employees include practitioners such as physicians, physician assistants, advanced practice registered nurses, licensed social workers, and registered chemical dependency counselor trainees.

Potential adverse impacts of the rules include completing an online enrollment process (for new enrollees) to be eligible for Medicaid reimbursement; fulfilling documentation requirements and maintaining medical records; providing proper supervision to practitioners who are not yet licensed to practice independently; updating information technology (IT) and claims payment systems to successfully submit claims for services that are part of the proposed new benefit package; ensuring that Medicaid is the payer of last resort for healthcare services provided to patients with commercial or Medicare health insurance coverage, which could, for instance, necessitate that an agency serving Medicare enrollees, and its practitioners who render Medicare-billable services, enroll with the Medicare program; registering all agency-employed or contracted practitioners with Ohio Medicaid, and ensuring that these practitioners are associated with their agencies in the Medicaid Information Technology System (MITS); and training staff to be able to comply with new regulations, which involves attending training sessions and transferring new information to all affected agency staff.

The BIA prepared by ODM states that the rules are justified because they ensure program integrity, establish and update coverage and payment policies for medical goods and services, and set limits on the types of entities that are eligible to receive Medicaid payment for these goods and services. Moreover, the proposed rules were expressly designed to increase access to care and improve health outcomes for Medicaid recipients with behavioral health diagnoses; encourage practitioners to work at the top of their professional scopes, by compensating them based on experience and credentialing, thereby benefiting the patients they serve; and integrate physical and behavioral healthcare for Medicaid recipients. In addition, the proposed Behavioral Health Redesign will bring Ohio Medicaid in line with several federal requirements, including the National Correct Coding Initiative, program integrity requirements of the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, and federally-required third-party liability and coordination benefits with Medicare. Finally, proposed changes assure ongoing federal approval of Ohio's Medicaid program and federal financial participation, which funds approximately 60 percent of Ohio Medicaid spending.

Beginning in May 2015, ODM and OhioMHAS engaged many diverse stakeholders in formulating

ideas for the redesign of behavioral health services, as well as methods of implementation. Early on, a formal group of stakeholders—including health plans, a variety of impacted associations, service providers, hospitals, research institutions, and Medicaid managed care plans—met monthly and later bimonthly to review Medicaid policy and to offer suggestions and revisions. Later in the outreach process, ODM and OhioMHAS involved stakeholders by creating a dedicated Internet site for the Behavioral Health Redesign initiative, which it advertised widely. This website continues to provide impacted stakeholders with important white papers, webinar trainings and other videos, and billing-related resources. The Department also distributed newsletters, conducted surveys, and held dozens of regional training sessions, which it continues to organize and publicize.

As a result of these outreach efforts, key stakeholders and trade associations provided input through active participation in the form of meetings, written comments, and many face-to-face and webinar training sessions. In the majority of cases, stakeholder input resulted in changes to proposed policies and regulations. For example, stakeholder input led to clarification of supervision requirements, delayed implementation of the Behavioral Health Redesign by one year (July 1, 2016 to July 1, 2017), increased reimbursement rates for a variety of services, elimination of certain service provision limitations, and development of reimbursement rates that permit the use of unlicensed practitioners.

During the CSI public comment period, a total of 72 stakeholder comments were submitted. After preparing detailed responses to each comment, ODM responded to stakeholder concerns and recommendations by making revisions to several rules, while also providing rationale for not implementing other recommendations. Furthermore, following countless discussions with the CSI Office, as well as a meeting between ODM staff and State Representative Robert Sprague, ODM implemented several additional revisions to the rules.

Key revisions made to the rules during the CSI review process include removing language requiring documentation in the form of narratives or checklists; revising language to reflect that services provided during transportation are eligible for reimbursement, even though the transportation itself is not billable; expanding the definition of collateral supports to include any individual who plays a significant role in a Medicaid recipient's life, rather than having it be limited to family and friends; adding the ability to bill for both nursing services and evaluation and management services in the same day (in this case, nursing services will be reimbursed using a new code set specifically developed to address workforce issues identified by service providers); clarifying that all services within the scope of practice of a Registered Nurse or Licensed Practical Nurse, as determined by the Ohio Board of Nursing, are billable under the new nursing codes, while also noting that services provided via telephone are only reimbursable under certain authorities; and removing all staffing references in the SUD rule as they relate to residential treatment services.

Additional revisions include permitting billing for other group services on the same day as Mental Health Day Treatment services are billed; incorporating definitions for both general and direct supervision; modifying rule 5160-8-05 to require, at a minimum, general supervision (supervisors are immediately available and interruptible) for trainees and assistants, as opposed to direct supervision

(in-person supervision), while still maintaining the option to provide direct supervision at an increased reimbursement rate; removing the 50 percent rate reduction for TBS and PSR services that are provided outside the office; increasing the number of places outside the office, including in an emergency room and in the community, that are settings in which services performed by eligible practitioners may be billed to Medicaid; and eliminating all hard limits on services, even though soft limits will sometimes be applied (i.e., needing to obtain prior authorization for continuation of services that are medically necessary beyond a specified period of time).

As mentioned, ODM also explained its rationale for not making other requested revisions. A rule-specific example includes clarifying that an independent contractor with some form of employment contract with an agency provider is considered an "employee" for reimbursement purposes. As it relates to the Behavioral Health Redesign initiative more broadly, there were three topics of concern that showed up most frequently in comments submitted during the CSI public comment period: timeline, workforce, and language consistencies between proposed ODM and OhioMHAS rules.

Many stakeholders submitted comments to the CSI Office contending that implementation of the initiative would be flawed, and agencies would not be able to adapt to proposed rate changes and service provision limitations in time, unless the effective date was pushed back anywhere from six to 12 months from July 1, 2017. In response to these concerns, the Department pointed to several important factors driving its desire to keep the initiative on track for a July 1 effective date. First, unlike with MyCare Ohio, which required standing up an entirely new system, the Behavioral Health Redesign was designed to modify an existing system, with the primary focus being paying providers for their experience levels and meeting national coding standards which allow billing that is specific to the provided service and the practitioner providing it. Second, concerns about not being able to update IT systems in time for the official rollout can be addressed from several angles.

For starters, ODM has pledged impressive support teams that will be available to assist provider agencies up to six days per week both during and after the two-month period between May 1, the date on which providers may begin testing new billing codes, and the July 1 effective date. These teams will be able to address issues related to claims payment and processing time, and will even include retired providers with relevant experience in the affected field. In addition, it is important to consider that besides the notable amount of IT work needed to add hundreds of new billing codes to agency systems, there is no significant change in the process for submitting claims. In fact, prior to January 1, 2018, providers who do not submit claims via the electronic file transmission process may continue to submit claims without charge through the Ohio MITS claims portal, which is available 24 hours per day, seven days per week. Providers will be able to use the portal option should they experience IT system issues. By doing this, they will have the ability to enter claims directly into the MITS portal, with no associated fees or penalties, and receive real time feedback on them. ODM is furthermore prepared to offer training and technical assistance as needed to the behavioral health provider community in order to ensure successful and consistent implementation.

Delaying the July 1 effective date to accommodate providers that have waited to update their systems and train staff until final versions of the proposed rules go into effect will also significantly

disadvantage any providers that did spend the time and money to prepare their systems and staff for on-time implementation. It is also important to note that although several individual codes, definitions, and limitations have been revised since, no core fundamentals have been changed in the provider manual since it was released in January 2017. Finally, delaying the effective date by six months, the most widely agreed upon amount of time, would lead to another issue. ODM is statutorily required to carve behavioral health benefits into Medicaid managed care on January 1, 2018. An effective date of July 1 provides six months of claims experience in a predominately fee-for-service Medicaid model prior to integration into Medicaid managed care. Having collected no data prior to January 1, 2018, could be detrimental to all of Ohio's behavioral healthcare providers.

Another predominant stakeholder concern was that the necessary workforce is not readily available. Again, ODM provided many reasons to justify its proceeding with the Behavioral Health Redesign initiative. First, to prevent budgetary shortfalls, the Department has repeatedly pledged to invest an additional $54 million into ensuring that implementation is seamless and providers are not negatively impacted. Second, the initiative was specifically designed to help ameliorate staffing challenges, and thus improve patient access to care, by reimbursing practitioners based on their experience and credentialing. This enables providers to attract highly qualified practitioners, who would otherwise be attracted to higher paying jobs elsewhere. In fact, revised rates will reimburse more than the Medicare state maximum for highly qualified practitioners. The guarantee of higher reimbursement rates for qualified practitioners will also incentivize providers to encourage already-practicing practitioners to pursue higher levels of education and licensure. Lastly, in instances where other workforce concerns have been raised (e.g. reimbursing providers who employ Qualified Mental Health Specialists, high school graduates with three or more years of experience), changes have been built into the redesign model to accommodate services provided by unlicensed practitioners. The proposed rules will allow for professionals, both licensed and unlicensed, to be paid at the rate their experience deserves.

Finally, inconsistencies between the ODM and OhioMHAS rules that were identified by stakeholders can be justified by recalling that OhioMHAS rules are agnostic to payer, while ODM rules are specific to the Medicaid program and Medicaid reimbursed services, thereby explaining why they may in some instances be more stringent than similar requirements in the OhioMHAS rules.

After thoroughly reviewing all stakeholder concerns alongside the Department's ensuing proposed revisions, and having had informed conversations with both ODM staff and impacted stakeholders, the CSI Office has determined the purpose of the rules to be justified.

Recommendations

For the reasons discussed above, the CSI Office does not have any recommendations for this rule package.

Conclusion

Based on the above comments, the CSI Office concludes that the Ohio Department of Medicaid should proceed with the formal filing of this rule package with the Joint Committee on Agency Rule Review.