Behavioral Health Redesign
Ohio Department of Medicaid

Policy Number: PG0042
Last Review: 04/10/2018

PARAMOUNT

HMO & PPO
MARKETPLACE
MEDICARE – ELITE,
MAP & PROMEDICA

IMPORTANT | **Paramount medical policies only apply to Paramount Advantage Medicaid claims with dates of service before Feb. 1, 2023.** Please contact Anthem, for Medicaid claims with dates of service on or after Feb. 1, 2023.

GUIDELINES

- **This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.**
- **Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.**
- **This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.**

SCOPE

X Professional
X Facility

DESCRIPTION

Under the leadership of the Governor's Office of Health Transformation, the Ohio Department of Mental Health and Addiction Services (Ohio MHAS) and the Ohio Department of Medicaid (ODM) are collaborating to implement reforms and enhance the quality of care delivered to residents of Ohio. Behavioral Health Redesign is a transformative initiative aimed at rebuilding Ohio's community behavioral health system capacity. Key proposals include adding new services for people with high intensity service and support needs and aligning the procedure codes used by Ohio's behavioral health providers to better integrate physical and behavioral healthcare.

Behavioral Health Redesign was implemented on January 1, 2018, on a fee-for-service basis for all Medicaid enrollees other than MyCare Ohio members, who receive their redesign benefits via their MyCare Ohio plan. The traditional managed care plans, such as Paramount Health Care, will begin covering the behavioral health services for their members on July 1, 2018, when "carve-in" takes place.

Benefits of Behavioral Health (BH) Care Coordination for members:

- Relationship with the provider best equipped to serve member needs through advanced member-provider matching
- More integration between physical and BH care providers through new tools to facilitate data sharing and increased presence of care coordinators
- Support for member choice through member-focused care model
- Reduced inpatient and emergency department admission frequency through greater utilization of preventative health programs such as depression screening

- Fewer disruptions to care through increased collaboration between primary care provider (PCP), comprehensive primary care (CPC), and managed care plan (MCP) qualified entity before and after member handoffs
- Assistance with fighting substance use disorder through increased communication and collaboration with recovery services
- Enhanced chronic condition management through care coordinators and expanded role of provider in developing comprehensive care plans
- Enhanced access to specialty providers by reducing barriers to scheduling appointments
- Improved treatment adherence through measurement of treatment adherence and increased member follow-up
- Improved recovery supports through enhanced collaboration between providers

Substance Use Disorder (SUD)
A diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance. The diagnosis of a substance use disorder is based from criteria defined in the current ICD-10 diagnosis codes manual and can be applied to all 10 classes of drugs including: alcohol; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants; tobacco; and other (or unknown) substances.

Institute for Mental Disease (IMD)
Medicaid recipients ages 21 through 64, who receive their Medicaid benefits through a MCP, to receive inpatient treatment in an Institution for Mental Disease (IMD). As a result of this policy, Medicaid recipients, ages 21 through 64, enrolled and receiving their Medicaid services through an MCP, such as Paramount Health Care, will have access to medically necessary and reimbursable treatment in an IMD setting. It is Paramount's intent to contract with all Ohio IMD's and cover medically necessary services rendered to our members.

Assertive Community Treatment (ACT)
Assertive community treatment (ACT) is a collaborative, multidisciplinary team approach that shall include, at a minimum, behavioral health counseling and therapy service, mental health assessment service, pharmacologic management service, community psychiatric supportive treatment (CPST) service, self-help/peer support service, mental health crisis response service, substance abuse services, and supported employment services.

Intensive Home Base Treatment (IHBT)
Services assist individuals in achieving their recovery and rehabilitation goals. The program aims to reduce psychiatric and addiction symptoms and to assist in developing community living skills. The services may include coordination of services, support during a crisis, development of system monitoring and management skills, monitoring medications, and help in developing independent living skills.

Therapeutic Behavioral Services (TBS)
Therapeutic Behavioral Services (TBS) is an intensive, individualized, one-to-one behavioral coaching program available to children/youth up to age 21 that are experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.

Psychosocial Rehabilitation (PSR)
Restoration of community functioning and well-being of an individual diagnosed in mental health or mental or emotional disorder and who may be considered to have a psychiatric disability.

Screen, Brief Intervention and Referral to Treatment (SBIRT)
- Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- Brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- Referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

POLICY

This policy only refers to Paramount Advantage Medicaid members.

Prior to July 1, 2018, behavioral healthcare services are non-covered for Advantage.

Effective July 1, 2018, behavioral healthcare services may require prior authorization for Advantage.

For further information and questions about Behavioral Health Design refer to the ODM website.

COVERAGE CRITERIA
Paramount Advantage Medicaid
For Dates of Service Prior to July 1, 2018
Behavioral healthcare services are non-covered by the Managed Care Plan.
Note: Some behavioral healthcare services may be payable by the Ohio Department of Medicaid (ODM) through Ohio Medicaid Behavioral Health Services carved out to the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS).

For Dates of Service on or After July 1, 2018
Paramount will follow ODM's Behavioral Health Redesign. This will apply to provider types 84 (Community Mental Health Centers) and 95 (MHAS Certified Substance Use Disorder Treatment Agencies) and some practitioners that are affiliated with 84s or 95s.

Overview of Provider Eligibility Requirements
Potentially qualified entities are those entities that meet the provider type requirement for program participation:
- Classified as both an 84 (comprehensive) and 95 at the Tax ID level
- Comprehensiveness for type 84 is defined as ability to administer 4 core services:
  - BH counseling and therapy
  - Mental health assessment
  - Community psychiatric support treatment
  - Pharmacological management
- In addition, the entity must have the ability to provide crisis management support and/or establish an agreement with another provider to deliver those services

Commitment to Integration:
- Each provider site must have a stated commitment of collaboration with a CPC or Medicaid-enrolled PCP
- Additional activity requirements related to coordinating with the full panel of members' PCPs, aligned with CPC approach
- No additional commitment required if BH provider has an ownership or membership interest in a primary care organization where primary care services are fully integrated and embedded

Tools:
- Capacity to share data with ODM and contracted MCPs
- Consent forms must contain the elements necessary to support the full exchange of health information in conformance with federal and state law, including recent changes to 42 CFR Part 2
- Ability to use e-Prescribing capabilities
- Electronic Health Record (EHR)
- Ability to send, receive, and use the continuity of care documents

Personnel:
- One individual who serves as key point of contact for MCPs/State to discuss performance
- Identification of a care team, including:

- Case managers to lead care coordination relationship, serving as primary point of contact for member and family
- Registered nurse(s), to consult and coordinate with member's other medical providers

- Specific staffing ratios will not be mandated, but a recommended range will be given to providers

Approach to attribution
Matching members with a qualified entity best positioned to deliver care by:

- Identifying opportunities to connect members not currently in care with entities that best meet their needs
- Preserving continuity of care in cases where relationships already exist with qualified entities

Attribution: Guiding principles
In developing an approach to attribution, 6 guiding principles were followed:

- Honor member choice. At any point, a member may elect the qualified entity of their choosing
- Maintain continuity of care. Where there is evidence of an existing relationship with a qualified entity, assign a member to that entity
- Reward high performers. The State may use attribution as an opportunity to signal to providers the benefits of good performance by giving preference to providers that achieve success on engagement and outcomes
- Build in points of integration with CPC. When a member does not have a visit-based relationship with a qualified entity, attribute to the qualified entity where the member is attributed for CPC
- Consider geographic proximity. In cases where a member does not have a visit-based relationship with a qualified entity, attribute to the qualified entity closest to them best positioned to provide appropriate care
- Consider provider specialty. In cases where a member cannot be attributed based on a visit-based relationship, prefer those providers whose specialty best matches member needs (e.g., pediatric providers, providers who specialize in SUD services)

Overview of Payment Structure:

- Qualified providers receive a comprehensive monthly activity payment (PMPM) to compensate for care coordination activities performed
- PMPM is contingent on demonstrating engagement with attributed members, with ODM defining what constitutes sufficient engagement
- After year one (1), there are 2 additions to the payment structure
  - Starting year two (2), PMPM will be contingent on providers meeting thresholds on quality and efficiency metrics
  - Additional outcome-based incentive payments may be added in subsequent years
- For the members in the target population, the PMPM is inclusive of all care coordination activities. The payment structure for the rest of the BH population will remain unchanged

For further information and questions about Behavioral Health Design refer to the ODM website.

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to https://www.paramounthealthcare.com/services/providers/medical-policies/ .

REVISION HISTORY EXPLANATION
ORIGINAL EFFECTIVE DATE: 02/01/2006

Date	Explanation & Changes
01/01/2007	• No changes
01/01/2008	• No changes
02/15/2009	• Added codes, clarified denial
02/01/2011	• No changes
06/09/2015	• Title of policy changed from Alcohol and Drug Abuse Treatment Services to Behavioral Healthcare Services

	• Note code H2036 may have contractual exceptions • Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
04/10/2018	• Title changed from Behavioral Healthcare Services to Behavioral Health Redesign Ohio Department of Medicaid (ODM) • This policy now only refers to Advantage members • For dates of service on or after July 1, 2018, Paramount will follow ODM's Behavioral Health Redesign • All codes removed from policy • Policy created to reflect most current clinical evidence per Medical Policy Steering Committee
12/14/2020	• Medical policy placed on the new Paramount Medical Policy Format
08/01/2023	• Medical Policy reviewed and end-date 02/01/2023 as pertains to Paramount Advantage Medicaid.

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Ohio Department of Medicaid

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets

U.S. Preventive Services Task Force, http://www.uspreventiveservicestaskforce.org/
Industry Standard Review

Hayes, Inc.

Industry Standard Review