



Questions and Answers on Medicaid Cost Containment strategies in FY 2012-13 Budget

May 19, 2011

The Ohio Department of Mental Health intends to implement benefit package changes and cost containment strategies effective July 1, 2011. In an effort to educate providers about these changes, ODMH is providing answers to the following questions it has received. Additionally, regional trainings are planned around the state during June. Visit the link below question 2 on this page to learn more.

Additional questions may be directed to the ODMH Medicaid office at Medicaid@mh.ohio.gov to inform future updates to this FAQ.

Section 1: General Questions

- 1. What is the Multi-Agency Community Services Information System (MACSIS) web portal? How will the web portal be tested to ensure it works before being rolled out? Have providers piloted the MACSIS web-portal? Is there a pilot option? Will there be any resources to cover the costs of provider system upgrades?**

The MACSIS web portal will give providers the ability to inquire into a client's benefit allotment, usage and remaining services for Medicaid-reimbursable care. The web-portal will be tested by state staff to assure accessibility and verify that the correct allotment, usage and remaining service counts are correct in the MACSIS system.

Providers have not piloted the MACSIS web-portal and there is no pilot option. The MACSIS web portal is a resource that providers can use. However, it is not mandatory that providers use it.

There should be no costs to providers for system upgrades. The web portal is accessed via the Internet and will be tested in various browsers (Chrome, Firefox, Mozilla and Internet Explorer). Browser upgrades are free.

- 2. Will ODMH provide training on the benefit limits, prior authorization, and implementation?**

Yes, ODMH is conducting regional training sessions. Information related to these trainings has been sent to both community mental health centers as well as ADAMHS/CMH boards. It is also posted on our web page:

<http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/medicaid/index.shtml>

- 3. Has the Centers for Medicare and Medicaid Services (CMS) approved ODMH's proposed benefit limits and use of prior authorization for Community Psychiatric Support Treatment (CPST) and Partial Hospitalization (PH)?**

Not yet, a state plan amendment is pending.

- 4. How and when will the benefit limits and cost containment strategies be communicated to Medicaid covered clients and/or their parent/legal guardian?**

The Ohio Department of Job and Family Services (ODJFS), as the Medicaid single state agency, will communicate these changes via letter to Medicaid consumers 30 days prior to implementation.

5. Does ODMH intend to communicate this change to other stakeholders such as child welfare, education, law enforcement, juvenile justice, DRC, housing organization, etc?

Information about cost containment measures has been widely communicated with stakeholders and is available at the Governor's Office of Health Transformation (OHT) web site:

<http://www.healthtransformation.ohio.gov/>

6. What is the process for implementing these changes through rule?

ODMH is working with ODJFS on changes to the Ohio Administrative Code (OAC), which will happen via a rule promulgated by ODJFS. Plenty of opportunity is afforded for input on administrative rules. ODJFS has a clearance process and all rules are posted on the JFS website (<http://www.odjfs.state.oh.us/clearances/public/index.aspx>) for feedback before submitted for review by the Joint Committee on Agency Rule Review – JCARR - (<https://www.jcarr.state.oh.us/>). Anyone can sign up to receive rule clearances via the ODJFS website. Once submitted to JCARR, agencies must conduct a public hearing to obtain feedback. Finally, the rule will have a public hearing before JCARR itself before it can go into effect.

Due to the length of the JCARR process, ODJFS will also seek emergency rule authority from the Governor to implement changes effective July 1, 2011. With an emergency rule filing, the rule will go into effect for 90 days, during which time ODJFS will follow the rule process described in the preceding paragraph.

Section 2: Community psychiatric supportive treatment (CPST) Reimbursement Changes

1. How will the new CPST payment methodology work?

Each community mental health agency shall maintain a schedule of usual and customary charges for all community mental health services it provides. The program shall use its usual and customary charge schedule when billing Medicaid for rendered services. Reimbursement for community mental health services shall be the lesser of the charged amount or the Medicaid maximum amount.

For all community mental health services except CPST, the Medicaid maximum amount is equal to the unit rate for the service according to the department's service fee schedule multiplied by the number of units rendered.

For CPST services, the Medicaid maximum amount is calculated as follows:

1. If the total number of service units rendered by a provider per date of service is less than or equal to six, the Medicaid maximum amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units rendered. A service unit equals 15 minutes.
2. If the total number of services units rendered by a provider per date of service is greater than six, the Medicaid maximum amount is equal to the sum of:
 - a. The unit rate according to the department's service fee schedule multiplied by six; and
 - b. Fifty percent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units rendered minus six.

2. **Is it correct that the full rate is paid for 90 minutes of individual CPST and 90 minutes of group CPST delivered per client, per provider organization, per day?**

Yes.

3. **Does the 90-minute daily limit apply to each individual clinician providing service in a day?**

No. Providers do not bill MACSIS at the clinician level; they bill at the provider (UPI) level. The limit will apply to the service received no matter which provider provides the service. The 90-minute limit does not limit the provider to 90-minutes of CPST in a day. The limit or 90-minutes means the first 90-minutes of CPST will be paid at 100% while anything over 90-minutes will be reimbursed at 50% of the Medicaid maximum or the provider's usual/customary charge; whichever is lower.

4. **Will there be a prior authorization process to provide more than 90 minutes of CPST in a day – particularly when a client is in a crisis and more intensive services will avert hospitalization?**

There is not a limit of 90-minutes of CPST per day.

5. **Will CPST phone call be included in the 90-minute limit?**

There is not a limit of 90-minutes of CPST per day. All claims payable under the Healthcare Common Procedure Coding System (HCPCS) billing code of H0036 will be counted toward the CPST payment methodology as discussed in question #3.

6. **How will phone calls and contact with collaterals (those individuals essential to the consumer) be counted toward the 90-minute daily limit?**

There is not a limit of 90-minutes of CPST per day. All claims payable under the Healthcare Common Procedure Coding System (HCPCS) billing code of H0036 will be counted toward the CPST payment methodology as discussed in question #3.

7. **Are boards able to apply the CPST payment methodology to non-Medicaid services and/or non-Medicaid clients?**

The proposed changes apply to Medicaid only.

8. **Historically, Medicaid and non-Medicaid services could be priced the same. Can the boards benefit plans for non-Medicaid clients continue to be the same?**

The proposed changes apply to Medicaid only.

Section Three: Benefit Limits

1. **How is the benefit year defined? Fiscal year, calendar year, rolling 12 months?**

The benefit year is defined as a State Fiscal Year (July 1 of any given year to June 30 of the subsequent year). The benefit resets each State Fiscal Year.

2. **Will the annual limit be pro-rated if the client enters treatment mid-year? For example if a client enters treatment in July, will the client only be able to receive 26 hours of counseling?**

No, the limits will not be pro-rated.

3. **Do the benefit limits apply to Medicaid and non-Medicaid services? If these limits do not apply to non-Medicaid, can the Boards apply the same limits to non-Medicaid? If the Board applies the same benefit limits including requirements for prior authorization, does this place the Board in an insurance plan type of role, which is prohibited under the Health Insuring Corporation statutes?**

The proposed changes apply to Medicaid only.

4. **Can the pre-authorization module be opened to the board so they can use it to authorize non-Medicaid services?**

The proposed changes apply to Medicaid only.

5. **When are benefit limits triggered?**

The benefit starts accumulating when the first claim makes it into the system and receives a claim number. It will not accumulate for denied claims. Benefit rules are applied during the adjudication process.

6. **How does the CPST payment methodology work with the annual service limit?**

The CPST rate change applies at the provider level. The benefit package applies to the consumer.

7. **Is the annual service limit available to each provider organization providing services to a client?**

No. The annual service limit rules are not provider specific. The limit applies to the client no matter where they receive service. Example: client receives 10 units of CPST in Franklin County and then receives 10 units of CPST from Licking County; client now has accumulated 20 units towards the annual service limit for CPST.

8. **What is meant by the “soft” authorization process for children? To what does the modifier refer?**

The “SC” modifier stands for: Medically Necessary Service/Supply. Putting the “SC” in the modifier 3 position on a claim for certain services will bypass the service limits set for that claim, making the claim payable.

9. **Why is the “soft” authorization process only available for services to children? What is EPSDT?**

Soft authorization allows Ohio to comply with Early, Periodic, Screening, Diagnosis and Treatment (EPSDT), a federal program that is the children’s health component of Medicaid. It is required in every state and is designed to improve the health of low-income children by financing appropriate and necessary pediatric services. Under the provisions of EPSDT, children are entitled to services which are medically necessary and authorized by a practitioner of the healing arts. Therefore, we are using the SC modifier to allow claims for children to go beyond the limits for certain services. There is no similar federal provision for adults.

10. **Are services provided under the “soft” authorization process the only services that are subject to retrospective review? What is the process and criteria that would trigger a retrospective review?**

No, all Medicaid-reimbursed services are subject to retrospective review. Currently, there are a variety of ways a retrospective review may be initiated, including but not limited to referrals to ODJFS surveillance and utilization review, and referrals from other entities such as the Ohio Attorney General, Auditor of State and various licensing boards.

11. If an advanced practice nurse (APN) provides the diagnostic assessment, will this be counted toward the physician service limit or the MH assessment service limit?

A diagnostic assessment by an APN shall be billed as “mental health assessment--non-physician.”

12. Does the BH Counseling limit include both individual and group treatment services?

Yes. It includes both individual and group.

13. Since the tiered rate applies to individual and group CPST separately, does this mean the CPST limit is 104 hours of individual and 104 hours of group per year?

The CPST rate change applies at the provider level. The benefit package applies to the consumer. The annual service limit of 104 hours (416 units) per year limits the number of hours of CPST (group and individual combined) a client can receive per fiscal year from all providers statewide.

14. Do PH and CPST services need to be prior authorized before initiating the service?

No. The only time these services need a prior authorization is when it is determined the client needs more than the benefit allows. If you know the client has already reached the limit (CPST – 104 hours, Partial-60 days), providing the service before you have received an authorization could result in non-payment if the authorization request is denied. The authorization number (if the authorization is approved) must be present on the 837P claim file, or the claim will deny.

15. Do Medicare/Medicaid crossover claims count toward a clients annual benefit limit?

No. Crossover claims are not billed in MACSIS. These limits only apply to services billed through the MACSIS system.

16. How will a provider know what services a client has used in the benefit year?

All providers will have access to the MACSIS web-portal to look-up any individual by the MACSIS unique client identifier (UCI) number and view the allotments that client has by service, the hourly units used and the remaining hourly units. (All 15-minute service units will be converted to hourly units.) This web-portal does not guarantee payment; it can only base the usage and remaining units on claims that have already been billed to MACSIS. There may be services that have been provided but not billed.

17. How will the client or parent/legal guardian know how much service he or she has used during the benefit year? Who is responsible for informing the client of this information? How frequently with the client or parent/legal guardian, receive information about his or her benefit?

The service provider may provide this information at the request of the client.

18. Will the benefit limit be based on date of service or date of paid claim?

The benefit year is defined as a State Fiscal Year and dates of *service* determine within which fiscal year the claim falls within.

- 19. Will MACSIS be able to provide access to real time data? Will ODMH require Boards to submit claims more frequently? Will ODMH batch claims more than every 2 weeks? Will MACSIS be able to show claims that are “pending” but not yet paid?**

The MACSIS web-portal will provide access to real time claims data currently in MACSIS.

By the time the Cost Containment processes are implemented, the EDI Claims Module will be live. Each provider claim file will be processed independently; not batched. There is no restriction on how frequently boards can submit claim files.

ODMH has never batched claims every two weeks. Prior to the implementation of the EDI Claims Module, each board had a weekly processing day; not bi-weekly.

The MACSIS web-portal will show all payable claims. Denied claims will not be counted towards any service limit or CPST payment methodology.

- 20. What happens for an adult client if medically necessary services (i.e. counseling, pharm. mgmt.) are needed and the benefit limit has been exhausted for the benefit year?**

It is incumbent upon all service providers to assess clinical need and deliver services based on the service package. While benefit limits are new to mental health Medicaid, they are used throughout health care and Medicaid in general. Providers are expected to manage these limits in a similar manner as they do other payer requirements and limits.

- 21. What are the options if an adult client has exhausted their annual benefit and needs medication management and counseling to step down from inpatient psychiatric hospitalization or crisis stabilization to return to the community?**

See answer to question number 20.

- 22. What are the options when a client is seen in crisis, has exhausted the annual benefit, and needs to re-establish services in order to safely remain in the community? Where are Medicaid clients to be referred until the benefits renew at the start of the next benefit year?**

There are no limits assigned to crisis intervention. See answer to question number 20.

- 23. If a Medicaid client exhausts his or her annual benefit and additional services in the middle of treatment, does ODMH anticipate Boards may use non-Medicaid funds to pay for additional services?**

See answer to question number 20.

- 24. If a Medicaid client exhausts his or her annual benefit in the middle of treatment and needs additional medically necessary service, is the client responsible for paying the provider’s usual and customary rate? Will providers be expected to apply the sliding fee schedule for services with the Board subsidizing care? Will providers be expected to seek payment for additional services from child welfare, courts, etc., even though the client has Medicaid and services are medically necessary?**

See answer to question number 20.

25. **If a Medicaid client requires additional medically necessary treatment and the annual benefit limit has been reached and the client is unable to pay for these services, what options does a provider have? Where can the client be referred for additional services? Will ODMH consider this to be an involuntary termination of services if the client is discharged from treatment?**

See answer to question number 20. Certification requirements are a separate area from Medicaid reimbursement and coverage requirements.

26. **Are state hospitals or private hospitals that bill Medicaid, and provide service such as assessment, psychiatric care or counseling while a client is under inpatient care, included in these limits – or does it apply only to service that would be billed via MACSIS?**

The benefit is specific to community mental health Medicaid services and does not include inpatient services.

Section Four: Prior Authorization

1. **What is the process for prior authorization?**

ODMH is in the process of working with the Ohio Department of Administrative Services to issue an RFP for a statewide vendor to perform the prior authorization process.

2. **Will Boards have a role in prior authorization for Medicaid?**

No

3. **If a Board implements the same benefit limit and prior authorization for non-Medicaid, will it use the same process ODMH uses for Medicaid? Will ODMH have oversight of the Board's prior authorization process, continued stay criteria and appeals process? Does this place a Board in an insurance plan role, which is in violation of the Health Insuring Corporation statutes?**

The proposed changes apply to Medicaid only.

4. **What is the continued stay/continued service criteria for CPST? PH? How was the criteria established?**

The criteria are based on current medical necessity standards as well as other applicable state and federal rules and requirements. ODJFS' standard for medical necessity is outlined in Ohio Administrative Code section [5101:3-1-01](#).

5. **How much additional service will the vendor be permitted to prior authorize? 5 hours? 10 hours? 15 days? 30 days? 60 days? Unlimited?**

This is dependent on clinical need and the documentation submitted by the provider during the prior authorization process. The provider can request the number of units that medical necessity supports. The vendor then determines what will be authorized.

6. **When can a provider request prior authorization? Does the client need to have used up most of the service benefit before a request for prior authorization would be approved?**

The provider uses its own discretion in terms of the timing of prior authorization. ODMH strongly encourages providers to plan ahead and *not wait* until the benefit has been expended.

7. **What information will be required when requesting prior authorization of CPST and PH?**

The specific information and documentation will be determined once a vendor has been selected.

8. **Is the prior authorization approval provider specific? Will additional units of services be authorized for the client (global) or for the specific provider requesting prior authorization for the client?**

The prior authorization is client and service specific, and belongs to the provider making the request, based on individual client need.

9. **What is the claims process for billing a service that has been approved through prior authorization?**

The claims process remains the same. The provider bills the service on the 837P claim file by entering the authorization number in the appropriate field.

10. **What is the appeal process if a prior authorization request is denied? Who has the right to appeal – the client? Provider? Both?**

The client has the right to appeal. The appeal process will be developed with the contracted vendor and in accordance with ORC 5101:6-1.

11. **How will the client be notified if a request is denied? Appeal denied?**

Written notice. The notice shall contain a clear and understandable statement of the action the vendor has taken and the reasons for it, cite the applicable regulations, explain the client's right to and the method of obtaining a state hearing.

12. **If parents are requesting a second opinion, is that still considered in the limit on 90801s?**

Yes. Anything that is billed under 90801 is subject to the limit.

13. **We assume that prior authorization, when indicated, applies to Community Medicaid as well as to traditional and Medicaid HMOs. Is that assumption correct?**

The prior authorization is specific to the community mental health Medicaid benefit billed through MACSIS. It does not apply to other Medicaid benefits administered by ODJFS either as fee-for-service or under a managed care arrangement.

14. **With respect to our Partial Hospitalization defined limits: Does 60 days mean 60 units or 60 calendar days? (i.e., we bill two units of PHP per day, does that count as two days or just one?)**

For children, two units of partial hospitalization may be billed per day. For adults, one unit of PH may be billed per day. The limit is set at 60 days.