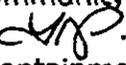




**Department of
Mental Health**

John R. Kasich, Governor
Tracy J. Plouck, Director

April 26, 2011

Memorandum To: Ohio Mental Health Community Stakeholders
From: Tracy Plouck, Director 
Subject: FY 12 Medicaid Cost Containment Proposal

The purpose of this communication is to provide a summary of final decisions pertaining to Medicaid cost containment strategies for State Fiscal Year 2012. The Ohio Department of Mental Health (ODMH) will move forward to plan and implement strategies described in the memo for an effective date of July 1, 2011.

These cost containment decisions were made using thorough data analysis, research on the experience of other states and on similar approaches within Ohio Medicaid. Feedback was received from consumers, providers, boards, and families. Consideration was given to the legal framework of benefit limitations and the availability of information technology support for implementation. Overall, this method of cost containment was considered preferable to across the board rate cuts.

A collaborative process has been undertaken to establish these new policy initiatives. ODMH has attempted to be responsive to the concerns we've heard and has made adjustments accordingly in order to ensure that individuals with mental illness will be able to access the benefits they need. I recognize that this will be an adjustment for providers and the individuals receiving services, but these limits will serve the overall interest of trying to preserve benefits for the large non-Medicaid population.

While I do not anticipate any changes to the cost containment proposals as outlined in this memo, I am respectful that the state budget process continues to evolve. I also want to be clear that this does not end our on-going dialogue on this issue. We are committed to continuing to work with the field on implementation and to answer questions that arise. To that end, we plan to release a FAQ document in the near future to provide clarification on commonly asked questions that we receive. If you have any questions you would like to see addressed in an FAQ, please feel free to contact Missy Craddock, ODMH Legislative Policy Director, at Melissa.Craddock@mh.ohio.gov.

Please feel free to contact me or Angie Bergefurd, Assistant Deputy Director for Medicaid, at any time with questions and concerns moving forward.

Establishing mental health as a cornerstone of overall health

30 East Broad Street
Columbus, Ohio 43215
mentalhealth.ohio.gov

614 | 466-2596
614 | 752-9696 TTY
614 | 752-9453 Fax

Behavioral Health Service Utilization – effective July 1, 2011

Defined Benefit Package:

Service	Limits Eff. 7/1/11	Percentile Using Proposed Limits	Adult FY Averages	Kids FY Averages
CPST	104 hrs.	96-97 th	Ind. – 18.2 hrs* Gp. – 26.9 hrs*	Ind. – 16.7 hrs. ** Gp. – 21.8 hrs. **
Pharm. Mgt.	24 hrs.	Just under 99 th	3.2 hrs.	2.8 hrs.
Counseling	52 hrs.	97 th	Ind. – 6.6 hrs. Gp. – 16.5 hrs	Ind. - 10.1 hrs. Gp. - 25.5 hrs
Diagnostic Assessment by an MD	2 hrs.	95 th	.95 hrs.	1.2 hrs.
Diagnostic Assessment	4 hrs.	90-95 th	1.7 hrs.	2.2 hrs.
Partial Hospitalization	60 days		27 days	77 days
<i>*Daily average for adult CPST service is .92 hrs. individual and 1.7 hrs. group **Daily average for kids CPST service is .99 hrs. individual and 1.6 hrs. group</i>				

For all services for children, with the exception of partial hospitalization and CPST, a “soft” authorization process will be used to override maximum service limits in instances where the service is medically necessary in order to comply with federal EPSDT provisions. Each provider of services will be able to override a client’s maximum service limit by utilizing a modifier on claims in excess of the maximum when medical necessity requirements are met. All services will be subject to retrospective review on medical necessity as they are today.

For partial hospitalization and CPST for both kids and adults, a more traditional approach of prior authorization will be employed to allow services over the cap to individuals with additional need. ODMH plans to contract with an outside vendor to complete the prior authorization process. Training materials and other information will be available prior to July 1st in order to help ensure a seamless transition to a prior authorization process.

Tiered Rates:

For Community Psychiatric Supportive Treatment (CPST), tiered rates will be implemented. The initial 90 minutes will occur at the current rate, with subsequent units being reimbursed at 50%. This approach is specific to the same provider (UPI) and will not be implemented across providers. Group CPST and individual CPST will be counted separately rather than combined for the purposes of counting toward the 90 minute initial units at full reimbursement.

Limit Use of Certain V-Codes:

The use of certain V-codes for crisis intervention and diagnostic assessment will be limited. Medicaid requires the use of valid diagnoses codes, but V-codes are situational descriptors rather than actual diagnosis codes. The following “V” codes will be accepted when associated with claims for mental health assessment only: V61.20 Parent child relationship problems, V61.21 Neglect, Physical Abuse, or Sexual Abuse of Child, and V62.82 Bereavement. Edits will

be established in MACSIS to disallow any other billings to occur with the exception of crisis intervention.

Reimbursement of Mental Health Services Provided to Long-Term Residents of Nursing Facilities:

Reimbursement policy for mental health services provided to long-term residents of nursing facilities will be clarified through rule. The only mental health services that will be reimbursed separately through the community mental health benefit will be those associated with admission and discharge planning purposes. Community mental health providers will be able to continue to provide services to this population for non-admission and discharge purposes by contracting with the nursing home for provision, as reimbursement is provided for in the per diem facilities receive.

To be clear, an individual in need of bridge services on their way into and out of a nursing home on a short-term stay should continue to have access to the mental health services provider with whom they have a relationship. This would pertain to individuals with mental illness who are already receiving services who need to go into a nursing home for a physical problem or rehabilitative stay.

cc: Greg Moody, Office of Health Transformation
John McCarthy, State Medicaid Director