Medicaid and Supportive Housing

Ohio MHAS “Housing University”
Sept 16, 2019

Mary Haller & Megan Powell
Ohio Department of Medicaid
Ohio Medicaid Overview
What is Medicaid?

Medicaid = Health Insurance

Ohio Medicaid is the largest Health Insurer in the State:
  • The most covered lives
    • 3 million Ohioans
    • 1/3 of all Ohio children *(Is this right?)*
  • SFY 2020 Annual budget = $25.3 Billion (37% of entire Ohio Budget!)
  • 90% of Medicaid enrollees are enrolled in Managed Care Plans

Medicaid is a Federal/State Partnership
  • 60% funding is federal; 40% state GRF or other non Federal $
  • States must follow Federal Medicaid law and rules
  • Must offer Federally required services and follow federal eligibility guidelines
  • May seek waivers if they choose to offer additional services or use different eligibility criteria
What is Medicaid? (continued)

Medicaid funding requires:

- The delivery of health care services, not “social services”
- To a Medicaid enrolled consumer with a “medical necessity” for health care
- Services must be delivered by a qualified Medicaid enrolled health care provider. Qualifications include:
  » Professional License or credential = to services rendered
  » Medicare certification (agencies and some individual practitioners)
  » Meets ethical and criminal background checks
  » Limited enrollment of trained paraprofessionals & peers, under supervision
What Can Medicaid Pay For?

Health care treatment - physician or extender or RN
Hospital ER, Inpatient Admissions & outpatient
Home Health Care
Prescription Medication
Medical equipment
Dental, Vision, Chiropractic, Podiatry
Transportation to medical appointments

Counseling, assessment, treatment planning from a licensed clinician
What Medicaid Cannot Pay For:

- Housing*
- Rental assistance*
- Relocation costs, down payments, household furnishings*
- Room and board costs (except in institutional settings: Hospital, Nursing Facility, ICF/DD)
- Services
  - to non-Medicaid enrolled individuals **
  - rendered by non Medicaid enrolled practitioners
  - that are not medically necessary
  - not included in the Medicaid benefit package (except for unique circumstances among MCP enrollees)

* Ohio Medicaid was approved to pay for some of these costs for certain Medicaid beneficiaries under the Home Choice demonstration program which ends in 2020.

** Ohio Medicaid does allow ‘presumptive eligibility’ under certain circumstances
Ohio Medicaid Eligibility Expansion
Affordable Care Act Allowed Expanded Medicaid Eligibility for Low Income Individuals

- Optional for State Medicaid Programs
- In 2014 Governor Kasich made the decision to request Federal approval of an increase Medicaid eligibility to 138% of Federal Poverty Level
- Ohio General Assembly required ODM to analyze potential benefits of the 2016 Medicaid expansion for new enrollees
- Expansion population designated “Group IIIV”
Key Findings: Medicaid working to improve lives

- **89%** of participants in 2016 had no health insurance at the time of enrollment.
- **1,180,940*** individuals accessed health care as a result of Ohio Medicaid expansion.
- **692,000** Average number of individuals enrolled in SFY 2018, down from 721,000 in SFY 2017.

*Includes coverage for more than **630,000** individuals to date with behavioral health needs who previously relied on county-funded services or went untreated.
Expansion

In general, Medicaid expansion has been beneficial to Ohio Group VIII enrollees by*:

1) facilitating continued employment, new employment, and job-seeking;
2) increasing primary care and reducing emergency department use;
3) lessening medical debt and financial hardship;
4) improving mental health;
5) assisting in addressing unhealthy behaviors such as tobacco use; and
6) enabling enrollees to act as caregivers for family members.

Compared to the 2016 Group VIII Assessment, a higher percentage of all Group VIII enrollees are now employed, access primary care providers, use emergency department services less, report better mental health, and are optimistic about their individual functioning.

* 2018 Ohio Medicaid Group VIII Assessment, Executive Summary: A Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment
   August 2018
Medicaid Behavioral Health Redesign
Medicaid Behavioral Health & Redesign 1/1/2018

What was Medicaid BH Redesign?

- Ohio Medicaid pays for treatment services to people with mental health (MH) needs or substance use disorders (SUD) *
- Collectively these services are referred to as “Behavioral Health Treatment Services”
- BH Redesign expanded and modernized the way that Ohio Medicaid pays for mental health and addiction treatment services

* Substance use disorders include addiction or dependence on alcohol or other prescription or illegal drugs
How were Medicaid Consumers Affected by BH Redesign:

- All Medicaid consumers with a medical need are eligible to request and receive mental health or SUD treatment services.
- Medicaid target population is adults and youth receiving service from community mental health or substance use treatment provider agencies.
- BH Redesign expanded the benefit package available to Medicaid consumers, including some new services for adults and children with severe mental illness or a need for residential SUD treatment.
How Were Provider Agencies of MH and SUD Services Affected by BH Redesign

- Community Mental Health and Substance Use Disorder Agencies are a subset of Ohio Medicaid’s 114,000 enrolled providers. There are about 650 of these agencies in every county in Ohio.

- Distinguished by:
  - Having Licensure/Certification from the Ohio Department of Mental Health and Addiction Services (OhioMHAS).
  - Primary function is treating behavioral health conditions; other health care (e.g. primary care) is secondary.
  - Tend to treat Medicaid consumers with more serious or chronic conditions (e.g. Schizophrenia & opiate addiction).
  - In MITS, identified as provider types 84 and 95.
  - Only provider type able to render and bill for the benefits in BH Redesign (Exception: a few Ohio Hospitals).
Behavioral Health Redesign Vision

» Provider Agencies Follow National Correct Coding requirements

» Practitioners practice at the top of their professional scope

» Integrate Behavioral Health & Physical Health services

» Develop new services for individuals with high intensity service and support needs

» Coordinate benefits across health care payers – Assure Medicaid is the last payer

» Improve Medicaid program integrity

  • Know which practitioners are rendering which services;
  • Assure practitioners are practicing within their professional licenses;
  • Require all practitioners to enroll in Ohio Medicaid
  • Align Medicaid payment with qualifications of the rendering practitioner

» Position Medicaid BH for value-based payment methodology

GOAL: Change should be TRANSPARENT FOR CONSUMERS except for access to new services
## Expanded Medicaid Behavioral Health Service Codes

### Before BH Redesign
- 8 service codes for MH & 10 service codes for SUD
- Limited access to primary care services
- Payment rates based on provider reported costs; not parallel with other Medicaid rates
- MANY practitioners render each service, but rates are the same regardless of practitioner credentials
- No indication of which practitioner rendered the service
- Units can be billed in decimals
- No enforcement of billing Medicare or third party health insurer before billing Medicaid

### After BH Redesign
- Expanded CPT and HCPCS codes; all standardized with national coding
- SUD benefit aligned with ASAM criteria
- Services added to MH and SUD benefit package, including:
  - CLIA waived testing
  - Vaccines and administration
- Payment rates scaled to credentials of rendering practitioner
- Rendering practitioner on claims
- Third Party Liability enforced on all claims, assuring Medicaid is the last payer

### Added Medicaid Funding for:
- Assertive Community Treatment (adults)
- Intensive Home Based Treatment (youth)
- Buprenorphine administration (OTPs)
- SUD Residential & Detox

---

Many aspects were not aligned with national health care coding standards
### Medicaid MH Benefit Beginning January 1, 2018

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy CPT Codes</td>
<td>Individual, group, family and crisis</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Evaluation</td>
<td>Assessing treatment needs &amp; developing a plan for care</td>
</tr>
<tr>
<td>Medical</td>
<td>Medical practitioner services provided to MH patients</td>
</tr>
<tr>
<td>Assertive Community Treatment (ACT)</td>
<td>Comprehensive team based care for adults with SPMI</td>
</tr>
<tr>
<td>Intensive Home-Based Treatment (IHBT)</td>
<td>Helping SED youth remain in their homes and the community</td>
</tr>
<tr>
<td>Group Day Treatment</td>
<td>Teaching skills and providing supports to maintain community based care</td>
</tr>
<tr>
<td>Crisis Services</td>
<td>Covered under crisis psychotherapy and other HCPCS codes</td>
</tr>
<tr>
<td>Community Psychiatric Supportive Treatment (CPST)</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>Screening, Brief Intervention and Referral to Treatment (SBIRT)</td>
<td>Screening and brief interventions for substance use disorder(s)</td>
</tr>
<tr>
<td>Therapeutic Behavioral Service (TBS)</td>
<td>Provided by paraprofessionals with Master’s, Bachelor’s or 3 years experience</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>Provided by paraprofessionals with less than Bachelor’s or less than 3 years experience</td>
</tr>
<tr>
<td>Respite for Children and their Families</td>
<td>Providing short term relief to caregivers</td>
</tr>
<tr>
<td>Office Administered Medications</td>
<td>Long Acting Psychotropics</td>
</tr>
<tr>
<td>Psychological Testing</td>
<td>Neurobehavioral, developmental, and psychological</td>
</tr>
</tbody>
</table>
# Medicaid Substance Use Disorder (SUD) Benefit Through 12/31/2017

## Outpatient
- Ambulatory Detoxification
- Assessment
- Case Management
- Crisis Intervention
- Group Counseling
- Individual Counseling
- Intensive Outpatient
- Laboratory Urinalysis
- Medical/Somatic
- Methadone Administration

## Residential
- Ambulatory Detoxification
- Assessment
- Case Management
- Crisis Intervention
- Group Counseling
- Individual Counseling
- Intensive Outpatient
- Laboratory Urinalysis
- Medical/Somatic
“Carve In” of Medicaid BH to Managed care
July 1, 2018

• Medicaid managed care plans became responsible for
  the financing and delivery of behavioral health benefits
  for all members. (Brought BH in line with the rest of
  Medicaid health care services.)

• Approximately 10% of Medicaid enrollees will continue
  to receive their benefits through fee-for-service
  Medicaid.
Medicaid Managed Care
Medicaid Managed Care Plans

- Paramount serves as a Medicaid Managed Care Plan
- Buckeye Health Plan
- UnitedHealthcare
- Molina Healthcare
- CareSource
- Aetna
- Aetna Better Health* of Ohio

» ODM holds a provider agreement (contract) with each plan.
» Each plan is assigned a Contract Administrator for oversight and compliance monitoring.
What is Managed Care?

• Under a managed care model, the state pays plans a set monthly amount for each member.
  » This is known as a per member/per month (PM/PM) capitation payment.
  » Plans then pay providers based on their contracts with those providers.
  » Plans “manage” or arrange for the provision of Medicaid benefits for members.

• If the cost of care for a member is greater than the PMPM amount, the plan is responsible for covering the additional costs.
  » Rates paid to the plans are updated at least annually, are risk adjusted, and are actuarially sound.
Populations Served by Managed Care

• The majority of Ohio’s Medicaid population is required to enroll in a managed care plan including:
  » Children and families
  » Adult expansion (extension population)
  » Aged, Blind and Disabled (ABD) adults and children
  » Children in custody or receiving adoption assistance
  » Children receiving services through the Bureau for Children with Medical Handicaps (BCMH)
  » Breast and Cervical Cancer project enrollees
  » Individuals on a developmental disabilities (DD) waiver have the option to enroll
Populations Not Enrolled in Managed Care

• Individuals not receiving full Medicaid benefits such as Medicare Payment Assistance Program (MPAP).
• Individuals receiving long-term care benefits (i.e. waiver services or nursing facility) except adult extension.
• Individuals who are incarcerated (Except for the pre-release program).
• Individuals who are only eligible for time-limited or episode-based benefits such as, presumptive or Alien Emergency Medical Assistance (AEMA).
• Individuals who are dually eligible and not residing in a MyCare Ohio county.
What is MyCare Ohio?

• Initially a three year demonstration project that integrates Medicare and Medicaid into one program operated by a Medicare Medicaid Plan.

• “Dual Eligible” (Medicaid & Medicare) individuals age 18 and older.

• Plan responsibilities are outlined in the 3-way contract with ODM, CMS and the plan as well as the provider agreement.

• MyCare Ohio includes physical and behavioral health services, and long-term services and supports (LTSS) through the MyCare Ohio Home and Community-Based Services (HCBS) Waiver or in a nursing facility.
MyCare Ohio Regions

- MyCare Ohio operates in 7 geographic regions serving more than 119,000 members
- 5 MCOPs coordinate services in 29 Ohio counties
- Each region has at least 2 plans (NE region has 3)

*This presentation focuses on traditional Managed Care.*
Managed Care Day One

• Implemented on January 1, 2018.
• Newly eligible individuals are assigned to an MCP* effective the first day of the month in which they are determined Medicaid eligible.
  » Previously took an average of 45 days to be enrolled on an MCP.
• No longer a FFS time period for most individuals.
  » Retroactive eligibility will be covered by FFS.
• Individuals receive an enrollment notice informing them of their enrollment and that they have the ability to switch plans within the first 3 months of enrollment.

*MyCare Ohio enrollment process includes a CMS required 60-day delay in enrollment to allow individuals to choose an MCOP before being assigned.
DRC Pre-release

• Individuals incarcerated in state facilities are able to apply for Medicaid approximately 120 days prior to their release.
• Individuals select a managed care plan at the time of their Medicaid application.
• ODM determines the Medicaid eligibility and their managed care enrollment is made effective the month of their release.
• Once enrolled, the managed care plans reach out to individuals with certain high risk factors to begin care management activities.
• Since 2014, approximately 31,000 Ohioans have participated in this program.
Ohio Medicaid Consumer Hotline

• The Medicaid Hotline is Ohio’s customer service agent and managed care enrollment broker.
• The Hotline assists over 400,000 callers each month with their Medicaid questions and managed care enrollment.
• The Hotline website allows individuals to search for managed care providers and enroll in or change plans online.
• The Hotline manages Ohio’s Managed Care Provider Network (MCPN) which is a data warehouse containing all the managed care plans provider networks and is used by plans and ODM.
• The Hotline can be contacted at 1-800-324-8680 Monday – Friday 7 a.m. to 8 p.m. and Saturday 8 a.m. to 5 p.m. and online at www.ohiomh.com.
How Can Medicaid Help Residents in Supportive Housing Settings
Considerations of Housing Providers
Re: Medicaid for Their Residents

• Medicaid beneficiaries are entitled to medically necessary Medicaid health care services

• Question for Housing providers is **how to facilitate residents getting Medicaid health care services:**
  » Assist residents to transport to provider office location
  » Negotiate/Contract with Medicaid providers to serve residents in the Supportive Housing location
  » Housing provider pursue becoming a Medicaid provider
    • Must Meet Medicaid provider qualifications for the corporation and the individual rendering practitioner employees
    • Must be able to bill Medicaid and maintain medical records
    • Undertake with careful consideration!
Becoming a Medicaid Provider of Behavioral Health

1. Agencies must meet Certification Requirements of the Ohio Dept of Mental Health and Addiction Services

2. Enroll with the Ohio Department of Medicaid (ODM) - Under 42 CFR 438.602 All Managed Care Network Providers must enroll with ODM.

3. Contract with Managed Care Plans to be a network provider of services. (The MC provider agreement includes network adequacy standards for BH services.)
Resources

• Managed Care Plan Provider Agreements
  https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans#1910238-managed-care-agreements

• MyCare Ohio Plan Provider Agreements
  https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans#1910239-mycare-ohio-agreements

• FAQs https://medicaid.ohio.gov/Managed-Care/For-Managed-Care-Plans#1910242-frequently-asked-questions

• Healthchek https://medicaid.ohio.gov/FOR-OHIOANS/Programs/Healthchek

• OAC Rules - 5160-26 http://codes.ohio.gov/oac/5160-26