Behavioral Health Re-Design
The Head Joins the Body!

Our Sordid Past……………….

- The Devil Made Me Do It….You're possessed!
- If You Keep Making That Face It Will Stay That Way……You're being punished….
- You need to be isolated in an asylum…..

Along comes Dorothy…..

- Dorothy Dix…1840…Institutionalization is the solution!!!!
- Got U.S. to fund 32 State Hospitals…Far…Far…Away…
- Toledo State Hospital….3,000 patients and a piggery to boot!
- Friday night in Lima Ohio….
- The “rendering providers”…FMG's in OB-GYN….

Here Comes The Judge…..

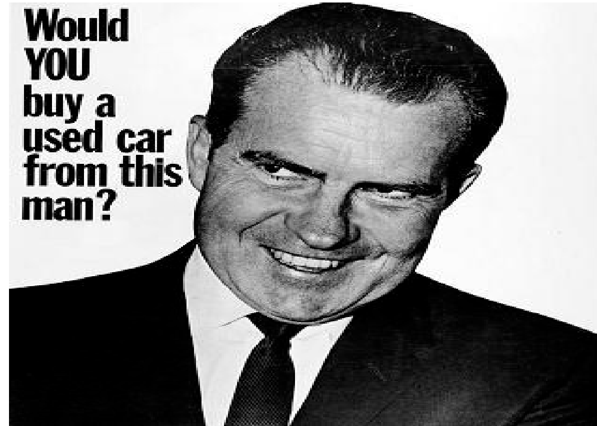
O'Connor v. Donaldson, 422 U.S. 563 (1975). Mentally ill plaintiff was confined without treatment for 15 years…..Ooops…..

- **Souder v. Brennan** (Patient-workers of non-federal hospitals, homes, institutions for mentally retarded or mentally ill individuals are entitled to minimum wage and overtime compensation)…..You're Fired!!!!
- **John Kennedy**….. On October 31, 1963, President John F. Kennedy signed into law the Community Mental Health Act (also known as the Mental Retardation and Community Mental Health Centers Construction Act of 1963), which drastically altered the delivery of mental health services and inspired a new era of optimism in mental healthcare. This law led to the establishment of comprehensive community mental health centers throughout the country. It helped people with mental illnesses who were "warehoused" in hospitals and institutions move back into their communities.

Head for the Exits…..

- Empty the Asylums….Send them to the "community"….Or…Under the bridge…
- 339 beds per 100,000 in 1955 to 22 per 100,000 in 2000
- Today "Northcoast" has a shade over 100 beds…3% of 1970….
- Ohio has some 700 Community Behavioral Health Centers
- Is the care better?…Maybe….More compassion…Better Rx….Still isolated…physically ill….poor living conditions/social determinants

Tricky Dicky to the Rescue….



- With support from a broad coalition in Congress, President Nixon secured the passage of the HMO Act of 1973….
- Initially, they were seen as a way to reign in spiraling costs and yet deliver quality care….
- In the late 1960s and early 1970s political conservatives embraced the HMO concept as an alternative to socialized medicine…
- HMO enrollment exploded from 3 million in 1970 to over 80 million in 1999…

But What About The Mentally Ill???

- Shut out again…..This is way too complicated to worry about them….
- Carve them out….Magellan….Value Options…Full Risk…
- Trifecta….Pissed off the Providers…The Members…and The Health Plan…..
- Carve them back in….1998…..
- Parity…..Dental before Mental!!!!

Along Comes Medicaid…..

- In 2013 Medicaid goes statewide with Managed Care
- 5 Plans manage the whole person….EXCEPT…..BH Outpatient….
- Are you kidding me?……Why not?
- Unique codes…Our reputation…Too big to mess with….Momentum and politics….
- The effect….MCP's only manage what they can see….Problems with prevention and post-hospital integration…
- Disjointed integration between BH and Physical Health….
- Health Homes…A good idea….BUT….

Why is Everyone So Bloody Nervous?

- BC/BS and The “Advanced Plan”……We’re in Charge Now…
- We are going to reduce providers…..NOT……
- We are going to cut rates…….NOT…..
- We are going to PA them to death…..NO WAY……
- We are going to search for ways to DENY claims…..JUST THE OPPOSITE…
- We won’t allow filing claims going back a year….YES WE WILL….
- We won’t pay promptly and put providers out of business…NOPE
- We will make everyone do things 5 different way…Wrong Again!

Re-Design Circa 2015

Rebuilding Community BH System Capacity

- **Recode Medicaid BH services to achieve alignment with national coding standards** (AMA, HCPCS, Medicare, NCCI/MUE)
- **Disaggregate certain existing services** (Community Psychiatric Supportive Treatment, Case Management and Health Home services) and **provide for lower acuity service coordination** and support services
- **Develop new services for people with high intensity needs under the Medicaid Rehabilitation Option:** Assertive Community Treatment, Intensive Home Based Treatment, residential treatment for substance abuse
- Achieve cost neutrality in making these changes

Why Are We Doing This?

OUTCOMES & VISION:

» **All Providers:** Follow NCCI & practice at the top of their scope of practice

» Integration of Behavioral Health & Physical Health services

» High intensity services available for those most in need

» **Services & supports available for all Ohioans with needs:** Services are sustainable within budgeted resources

» Implementation of value-based payment methodology

» Coordination of benefits across payers

Any other Reasons?

- Total cost of care for those with BH diagnosis=3 x's those without…
- But…the spend is in the co-morbidities
- Trying to reign in the 5% of beneficiaries who account for 50% of the spend….

What’s Really Going To Happen

- MCP’s manage the whole person….Yipeeeeeeeeeeeeeeee!!!!!
- We get to provide case management and care coordination to effect population health outcomes….
- The new codes are aligned with the rest of health care….plus some home grown….
- We add some new services…e.g…ACT and IHBT that are expensive, intensive, and EVIDENCED BASED!!!!!
- We know who’s doing what to whom….Alphabet Soup….
- But isn’t the Medicaid benefit still inadequate?

Who's Doing the Doing? The Rendering Licensed

- Physicians (MD/DO), Psychiatrists (20) Licensed Independent Social Workers (37) Certified Nurse Practitioners (72) Licensed Professional Clinical Counselors (47) Clinical Nurse Specialists (65) Licensed Independent Marriage and Family Therapists (52) Physician Assistants (24) Licensed Independent Chemical Dependency Counselors (54) Registered Nurses (38-384) Licensed Practical Nurses (38-385) Licensed Psychologists (42

Anyone Else Saving Lives?

- Licensed professional counselor LPC U2 Licensed chemical dependency counselor III LCDC III U3 Licensed chemical dependency counselor II LCDC II U3 Licensed social worker LSW U4 Licensed marriage and family therapist LMFT U5 Psychology assistant, intern, trainee PSY assistant U1 Chemical dependency counselor assistant CDC-A U6 Counselor trainee C-T U7 Social worker assistant SW-A U8 Social worker trainee SW-T U9 Marriage and family therapist trainee MFT-T UA QMHS – high school QMHS HM QMHS – Associate's QMHS HM QMHS – Bachelor's QMHS HN QMHS – Master's QMHS HO QMHS – 3 years' experience QMHS UK Care management specialist – high school CMS HM Care management specialist – Associate's CMS HM Care management specialist – Bachelor's CMS HN Care management specialist – Master's CMS HO Peer recovery supporter – high school PRS HM 17 | Peer recovery supporter – Associate's PRS HM Peer recovery supporter – Bachelor's PRS HN Peer recovery supporter – Master's PRS HO

Prior Authorization…If You Must Ask…

- Assertive Community Treatment (ACT) H0040 Based on prior authorization approval ACT must be prior authorized and all SUD services must be prior authorized for ACT enrollees. See service description for additional information
- Intensive Home Based Treatment (IHBT) H2015 Based on prior authorization approval IHBT must be prior authorized. See service description for additional information.
- SUD Partial Hospitalization (20 or more hours per week) Calendar year Prior authorization is required for this level of care for adults and adolescents.
- Psychiatric Diagnostic Evaluations 90791, 90792 Calendar year 1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization once limit is reached.
- Psychological Testing 96101, 96111, 96116, 96118 Calendar year Up to 12 hours/encounters per patient per calendar year for 96101, 96111, and 96116, and 8 hours of 96118. Prior authorization once limit is reached

And on it Goes…………..

- Screening Brief Intervention and Referral to Treatment (SBIRT) G0396, G0397 Calendar year One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95. Prior authorization once limit is reached.
- Alcohol or Drug Assessment H0001 Calendar year 2 hours per patient per calendar year per billing agency. Does not count toward ASAM level of care benefit limit. Prior authorization once limit is reached
- SUD Residential H2034, H2036 Calendar year Up to 30 consecutive days without prior authorization. Prior authorization then must support the medical necessity of continued stay, if not, only the initial 30 consecutive days are reimbursed. Applies to first two stays; any stays after that would be subject to full prior authorization

What isn’t Prior Authorized No Limits….CPST=$19.54/15 min…H.S.

- Any service or ASAM level of care not listed in this table is not subject to prior authorization…….That’s the vast majority of SUD services…..
- CPST….. (A) Community psychiatric supportive treatment (CPST) service provides an array of services delivered by community based, mobile individuals or multidisciplinary teams of professionals and trained others. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CPST services is to provide specific, measurable, and individualized services to each person served. CPST services should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community.

More No Limits…
Therapeutic Behavioral Services….
$19.96/15 minutes with B.A.

- (1) TBS service activities include, but are not limited to the following:
- (a) Consultation with a licensed practitioner or an eligible provider pursuant to paragraph (C) of this rule, to assist with the individual's needs and service planning for individualized supports or care coordination of healthcare, behavioral healthcare, and non-healthcare services and development of a treatment plan;
- (b) Referral and linkage to other healthcare, behavioral healthcare, and non-healthcare services to avoid more restrictive levels of treatment;
- (c) Interventions using evidence-based techniques;
- (d) Identification of strategies or treatment options;
- (e) Restoration of social skills and daily functioning; and,
- (f) Crisis prevention and amelioration.

And Finally……
Psychosocial Rehabilitation
$15.84/15 minutes

- PSR service activities include, but are not limited to the following
- (a) Restoration, rehabilitation and support of daily functioning to improve self- management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily functioning;
- (b) Restoration and implementation of daily functioning and daily routines critical to remaining successfully in home, school, work, and community; and,
- (c) Rehabilitation and support to restore skills to function in a natural community environment.
- (C) Eligible providers.
- (1) Eligible providers of TBS are those practitioners who have:
- (a) A bachelor's or master's degree in social work, psychology, nursing, or in related human services, or
- (b) A high school diploma with a minimum of 3 years of relevant experience.
- (2) Eligible providers for PSR services are those practitioners who have a high school diploma and specific training related to persons with mental health conditions or needs.

The Opiate Crisis
How did this happen?

- It's everyone's fault….Pharma….Providers….Insurance……Drug Cartels….
- Starts with Rx…..Moves to Heroin/Fentanyl…Cheaper and plentiful…..Yankee stadium last year…Now more starting with heroin than Rx…
- 1/2of mentally ill Rx'd 2 or more vs. 20% of non-mentally ill
- What are we doing about it?
- MAT
- Drug Courts
- Changing Rx to daily dosage/length limits
- Pain program for Addicted
- ASAM Criteria

What else are we doing?

Ohio's Yearly Opiate Conference in Columbus-attended by over a thousand providers, legislatures, law enforcement officials and health partners.

- Ohio's Recovery Conference in Columbus-attended by over a thousand providers and people in recovery
- Coordinated Services Program (ODM Mandated)
- We have just been invited to participate in the Governor's Opiate Task Force
- County Opiate Coalitions-we have been at the table in two counties (Lucas, Franklin)
- Participated in the MOMS (Maternal Opiate Medical Support) Pilot programs around the state
- We have our own case management program for women who are pregnant and addicted to opiates (we are expanding this population to include any addiction and/or Serious Mental Illness)
- We are beginning our third round of provider forums aross the state (Cleveland/Akron, Cincinnati/Dayton, Athens, Toledo, Columbus) where all CMHC's and ODADAS certified agencies are invited to attend-this is related to carve in which also includes recovery services
- We have begun to build relationship with judges and courts around the state to collaborate on getting people who are involved with the court system related to addiction issues into treatment programs.
- And then of course all the great work our case managers do daily to support those in recovery and their families as well as to help educate providers on our services and ways we can collaborate.

The Bad News

- We can't change anything…Rates….PA's…etc. for one year….
- We have no idea what this is going to cost….
- We're hopeful this will drive outcomes…but don't really know…

The Good News

- We can gather data…..and prepare for year two….
- There is greater alignment between ODM's outcome measures….MCP's population health initiatives…CPC measures/BH Coordination….HEDIS…
- We can and will engage in Value Based Contracts….Shared incentives…Maybe even full risk….Pay for outcomes…The $ is on the physical medicine side…..
- We are finally managing the whole person….
- We are starting to address the social determinants…

Social Determinants

- Toledo rated 99th out of 100 communities in the Gallup Well-Being Index.
- 70 percent of adults were overweight.
- 36 percent of low-income families were concerned about having enough food.
- Lucas County, of which Toledo is the county seat, ranked last among Ohio's 88 counties for infant mortality and low birth weight babies.
- 28 percent of youth reported they felt sad or hopeless two weeks in row.

Food Insecurity

- Opened Food Pharmacy in 2015 to address Food Insecurity and Food Desserts
- Among the 4,000 Medicaid patients completing a screen and food pharmacy referral in 2016, ProMedica found that emergency department usage dropped 3 percent, readmission rates dropped 53 percent, and primary care visit rates increased 4 percent.

A Peak at the Future

- **TOLEDO, Ohio, October 17, 2017** – Today, ProMedica announced a 10-year, $50 million program to help revitalize metro Toledo and surrounding communities. The Ebeid Promise is a community initiative to strengthen neighborhoods by addressing the social determinants of health (SDOH) with a key focus on health, education, jobs and family stability.

THE END!!!!