Ohio Administrative Code

Rule 5160-1-73 Behavioral health care coordination.

Effective: January 10, 2019

(A) For the purpose of this rule, the following definitions apply.

(1) "Attributed individual" is the Ohio medicaid covered individual for whom a qualified behavioral health entity eligible under this rule has accountability for providing behavioral health care coordination.

(2) "Attribution" is the process through which medicaid covered individuals are assigned to a specific qualified behavioral health entity. The Ohio department of medicaid (ODM) is responsible for attributing eligible individuals.

(3) "Behavioral health care coordination" (BHCC) is an evidence-based comprehensive care coordination model that connects qualified behavioral health entities with an assigned panel of eligible members with high-need behavioral health conditions.

(4) "Comprehensive primary care initiative" (CPC) is the ODM implementation of a patient-centered medical home (PCMH) model as established through rules 5160-1-71 and 5160-1-72 of the Administrative Code.

(5) "Consolidated clinical document architecture" (C-CDA) is an implementation guide developed and maintained by "Health Level Seven International" (HL7) which specifies a library of templates and prescribes their use for a set of specific document types for the purpose of electronic exchange of health care information.

(6) "Eligible member" is the medicaid covered individual who meets the diagnosis and service utilization criteria that enables them to receive BHCC from a qualified behavioral health entity to which they have been attributed.

(7) "Fast healthcare interoperability resources" (FHIR) is a standard developed by HL7 for

exchanging healthcare information electronically.

(8) "Healthcare effectiveness data and information set" (HEDIS) is a tool developed by the national center for quality care (NCQA) to measure performance on dimensions of care and service.

(9) "Medication-assisted treatment" (MAT) is the combined provision of behavioral therapy and medications for the treatment of substance use disorders. All medications must be approved by the United States food and drug administration (FDA) for the treatment of a substance use disorder.

(10) "National quality forum" (NQF) refers to the performance measures endorsed by the national quality forum.

(11) "Performance and quality improvement" (PQI) refers to the standards developed by the council on accreditation (COA) that measure effective quality improvement plans.

(12) "Primary care practice" (PCP) is a practice led by primary care practitioners who comprehensively manage the health needs of individuals.

(13) "Qualified behavioral health entity" (QBHE) is the participating entity which has attributed individuals and is responsible for the BHCC activities.

(B) A QBHE must:

(1) Meet the certification requirements set forth in paragraph (A)(1) of rule 5160-27-01 of the Administrative Code and in calendar year 2017 or later have provided both mental health and substance use disorder treatment services under the same ownership; or

(2) Meet the requirements stated in paragraph (G)(2)(a) of rule 5160-2-75 of the Administrative Code if an outpatient hospital provider; and

(3) Within ninety calendar days of approval to participate as a QBHE, have an active provider contract with each medicaid managed care plan (MCP);

(4) Submit an application to become a QBHE. ODM reserves the right to deny any QBHE enrollment application it determines is not in compliance with the requirements of this rule. A QBHE may seek reconsideration pursuant to rule 5160-70-02 of the Administrative Code to challenge a decision by ODM to deny a QBHE enrollment application;

(5) At the time of submitting an enrollment application to become a QBHE, have at least one practitioner from each of the following categories affiliated with the entity:

(a) A practitioner with prescribing authority in the state of Ohio;

(b) A registered nurse or licensed practical nurse; and

(c) An other licensed professional as described in rule 5160-8-05 of the Administrative Code.

(6) For the practitioner types defined in paragraph (B)(5) of this rule, continue to have such practitioners affiliated with the participating QBHE at all times to maintain eligibility as a QBHE.

(7) Demonstrate an organizational commitment to integration of physical and behavioral health care at the date of application to become a QBHE. The entity must meet one of the following:

(a) Have an ownership or membership interest in a primary care organization where primary care services are fully integrated and embedded;

(b) Enter into a written integrated care agreement such as a contract or memorandum of understanding with a primary care provider; or

(c) Achieve implementation of primary physical health care standards by a national accrediting entity as an integrated primary care-behavioral health provider, primary care medical home or behavioral health home.

(C) The QBHE must attest to the following at the time of application:

(1) That it has the ability to share, receive, and use electronic data from a variety of sources with

other health care providers, ODM, and the MCPs;

(2) That it uses consent forms containing elements necessary to support the full exchange of health information in compliance with all applicable state and federal laws.

(3) That it has the ability to submit prescriptions electronically;

(4) That it implements and actively uses an electronic health record (EHR) in clinical services; and

(5) If QBHE enrolled in the BHCC program prior to July 1, 2019, QBHE will have the ability, within six months of July 1, 2019 service start (January 2020), to send, receive, and use continuity of care records through the use of standard electronic formats such as FHIR and C-CDA. If QBHE enrolled in the BHCC program after July 1, 2019, QBHE will have the standard electronic formats prepared at the time of application.

(D) Eligible individual requirements.

(1) Except for the following populations, all medicaid covered individuals who meet the diagnostic and utilization criteria set forth in this rule will be attributed to a QBHE:

(a) Individuals who have been receiving inpatient care at a hospital or residing in a nursing facility for more than ninety days.

(b) Individuals who are currently receiving another care coordination service that substantially duplicates those activities provided through BHCC.

(2) Eligible individuals who meet the criteria in one of the following groups are eligible for BHCC and will be attributed to a QBHE:

(a) Group 1. Claims utilization in the twelve months preceding attribution identifies at least one of the following diagnostic criteria or diagnoses as identified in appendix A to this rule:

(i) A primary diagnosis of schizophrenia;

(ii) A primary diagnosis of bipolar disorder with psychosis;

(iii) A primary diagnosis of major depression with psychosis;

(iv) A primary diagnosis indicating attempted suicide or self-injury;

(v) A reported condition of homicidal ideation;

(vi) A reported condition of suicidal ideation;

(vii) A primary diagnosis of substance use with pregnancy or one year postpartum; or

(viii) Receipt of an injectable antipsychotic.

(b) Group 2. Claims utilization in the twelve months preceding attribution identifies a combination of the following diagnostic and utilization criteria:

(i) One or more of the following services, service locations or medications for a behavioral-health related condition:

(a) Inpatient hospital visit;

(b) Crisis unit visit;

(c) A nursing facility visit;

(d) A rehabilitation facility visit;

(e) A medication as identified in appendix B to this rule that was administered as a component of MAT for treatment of a substance use disorder; or

(f) For individuals under the age of twenty-two, a therapeutic behavioral group service per diem; and

(ii) One or more of the following primary diagnoses as identified in appendix C to this rule:

(a) Bipolar disorder without psychosis;

(b) Major depression without psychosis;

(c) Post traumatic stress disorder;

(d) Substance use disorder;

(e) Conduct disorder;

(f) Personality disorder;

(g) Psychosis;

(h) Oppositional defiance disorder;

(i) Eating disorder; or

(j) Other depression.

(3) For medicaid covered individuals who do not have sufficient claims history to substantiate the eligibility criteria for BHCC, any provider may make a referral to the MCP to request enrollment in BHCC and attribution to a QBHE. The provider must provide sufficient documentation to demonstrate the individual meets the BHCC eligibility criteria as defined in this rule. Each referral is subject to review and approval by the MCP.

(4) Eligible members who are in foster care and meet the eligibility criteria in paragraph (D)(2) of this rule will be attributed to a QBHE only after the guardian is notified of eligibility by ODM or its designee, and the guardian provides consent for the individual in foster care to receive BHCC.

(5) For eligible members who are also receiving substance use disorder (SUD) residential treatment, the following applies:

(a) The eligible member will be attributed to or maintain attribution with a QBHE during the SUD residential treatment period.

(b) The QBHE will not be eligible for BHCC payments during the eligible member's SUD residential treatment period because BHCC is duplicative of the care coordination responsibilities of the SUD residential treatment program.

(c) The QBHE will immediately re-engage the eligible member for BHCC upon discharge from the SUD residential treatment period.

(6) For eligible members who also meet criteria for assertive community treatment (ACT) or intensive home based treatment (IHBT) as defined in Chapter 5160-27 of the Administrative Code, the following applies:

(a) The eligible member will be attributed to or maintain attribution with a QBHE.

(b) If the QBHE is certified to deliver ACT or IHBT, it shall provide ACT or IHBT in lieu of BHCC as long as ACT or IHBT is medically necessary. When the ACT or IHBT service is no longer medically necessary, the eligible member shall be transitioned to BHCC.

(c) If the QBHE is not an eligible provider of ACT or IHBT, the eligible member may choose to either receive BHCC from the QBHE or opt-out and receive ACT or IHBT from a provider eligible to deliver ACT or IHBT.

(E) Attribution.

(1) At any time, the eligible member may choose a specific QBHE or request to be re-attributed to a different QBHE by submitting a request to the member's MCP.

(2) If no choice has been identified by the eligible member, attribution will be completed using

claims utilization data and the member's visit history, provider specialty, and geographic proximity between the member and provider.

(3) Eligible individuals may opt-out of receiving BHCC and may opt-in at any time by making a request to the MCP.

(F) A participating QBHE must perform the following activities as needed for their attributed individuals:

(1) "Outreach and engagement" activities which includes:

(a) Conducting initial outreach and engagement with attributed individuals upon enrollment in the BHCC program;

(b) Leading initial outreach with the attributed individual's PCP to share information regarding the BHCC program participation and care plan development;

(c) Building trust-based relationships to understand the preferences and goals of the attributed individual and begin engaging with the individual's family or social support system;

(d) Leading development of the outreach plan that ensures alignment with the individual's PCP and the MCP to establish a process for information exchange and to identify each stakeholder's role in coordinating care;

(e) Establishing relationships and collaborations with a full spectrum of providers and payers as appropriate; and

(f) Educating other providers and payers about the BHCC program and the value of collaborating to deliver medically necessary services.

(2) "Comprehensive care plan" activities in which the QBHE must:

(a) Within thirty days of the first BHCC activity conducted, begin developing a comprehensive care

plan that addresses the individual's behavioral and physical health needs;

(b) Act as the lead for creating and maintaining the comprehensive care plan, including leading outreach to the PCP to incorporate inputs for physical health components in the comprehensive care plan; and

(c) Develop the behavioral health components of the comprehensive care plan.

(G) "Ongoing maintenance" activities must be performed by the QBHE including, but not limited to, the following:

(1) Relationship maintenance activities in which the QBHE must, as a primary contact for communication about behavioral health and physical health needs of the attributed individual, conduct regular check-ins, educational activities and additional intensive support as needed which include the following:

(a) Directing individual and family education on behavioral health, including self-care and adherence to the comprehensive care plan; and

(b) Conducting follow ups with the individual on behavioral health care and updating, as appropriate, the comprehensive care plan, CPC practice, or PCP.

(2) "Individual engagement and access to appropriate care" activities in which the QBHE must:

(a) Improve access to appropriate care by addressing barriers such as assistance with scheduling appointments or connecting the attributed individual to transportation;

(b) Lead scheduling with guidance from the CPC practice or PCP and work with the attributed individual to reduce barriers to attendance for appointments;

(c) Lead follow-ups with the CPC practice or PCP to understand implications from ambulatory or acute encounters such as treatment adherence;

(d) Engage directly with the attributed individual's health care providers as well as community resources to support care and make necessary updates to the comprehensive care plan;

(e) Be accountable for referral decision support and scheduling for behavioral health care in both inpatient and outpatient settings; and

(f) Stabilize crises by gathering information from the attributed individual, CPC practice or PCP, social support systems, and other medical providers and formulating a response for immediate intervention or stabilization.

(3) "Engaging supportive services" activities in which the QBHE must facilitate access to needed community services such as housing or vocational services.

(4) "Population health management" activities in which the QBHE must use appropriate data to identify high-risk individuals and utilize the appropriate resources to deliver specialized interventions.

(5) "Individual transition" activities in which the QBHE must:

(a) Ensure the attributed individual's successful transition between providers or sites of care including triaging the individual to medically necessary services not available at the attributed QBHE;

(b) Lead outreach to the CPC practice or PCP after major behavioral health events such as an inpatient stay and discuss implications for physical healthcare;

(c) Follow up with the CPC practice or PCP following major physical health related events and discuss implications for behavioral health care as well as transition needs of the attributed individual such as transportation and medications; and

(d) Monitor the attributed individual's admission and discharges related to behavioral health treatment by establishing relationships with hospitals and hospital emergency departments.

(H) An enrolled QBHE will be evaluated based upon its population of attributed individuals meeting

the identified thresholds for the following HEDIS, NQF, and PQI measures, as applicable, quarterly and at the end of each calendar year by ODM or the MCP. More detailed information regarding these requirements can be found on the ODM website, www.medicaid.ohio.gov.

(1) Adult body mass index (BMI) assessment;

(2) Controlling high blood pressure;

(3) Comprehensive diabetes care; eye exam (retinal) performed;

(4) Comprehensive diabetes care; HbA1c poor control (greater than nine per cent);

(5) Comprehensive diabetes care; HbA1c testing;

(6) Tobacco use; screening and cessation;

(7) Follow-up within seven days after hospitalization for mental illness;

(8) Follow-up within seven days after an emergency department visit for mental illness;

(9) Follow-up within seven days after an emergency department visit for alcohol or other drug dependence;

(10) Antidepressant medication management;

(11) Initiation and engagement of alcohol and other drug dependence treatment;

(12) Adherence to antipsychotic medications for individuals with schizophrenia;

(13) Metabolic monitoring for children and adolescents on antipsychotics;

(14) Use of multiple concurrent antipsychotics in children and adolescents;

(15) Emergency department visits;

(16) Behavioral health-related inpatient admissions;

(17) Inpatient discharges;

(18) All-cause readmissions;

(19) Adolescent well-care visits;

(20) Weight assessment and counseling for nutrition and physical activity for children and adolescents including BMI documentation;

(21) Per cent of live births weighing less than two thousand five hundred grams;

(22) Prenatal care including timeliness of care;

(23) Postpartum care;

(24) Use of opioids at high dosage (greater than eighty morphine equivalent dose per day); and

(25) Rate of opioid-related emergency department visits per one-thousand member months.

(I) Additional requirements for enrolled QBHEs.

(1) The QBHE must assign at least one individual who serves as the point of contact for the MCP and ODM or its designee to discuss performance of BHCC quality measures.

(2) The QBHE must identify a care team that includes the following roles:

(a) Case manager to lead the care coordination relationship and serve as the primary point of contact for the individual and their family.

(b) Registered nurse or licensed practical nurse to consult and coordinate with the eligible member's other medical providers.

(c) Program administrative contact to act as the single point of contact to fulfill records requests and perform other administrative activities.

(3) The QBHE must maintain records that meet the requirements set forth in rule 5160-1-17.2 of the Administrative Code.

(4) For eligible members or attributed individuals who opt-out of the BHCC program, the QBHE must document in the medical record the circumstances regarding the individual's decision and notify the member's MCP of this decision by no later than the end of the following business day.

(5) If a participating QBHE chooses to terminate its designation as a QBHE, it must provide notice to ODM and the MCPs in accordance with rule 5160-26-05 of the Administrative Code.

(J) Reimbursement.

(1) QBHEs are authorized under this rule to provide the identified BHCC activities on a monthly basis to attributed individuals and obtain a monthly payment rate as found in appendix D to this rule for each calendar month the BHCC specific activities are performed.

(2) To be eligible for payment under this rule, BHCC activities must be separate and distinct from other medicaid-covered services provided within the same calendar month.

(3) If the member is attributed prior to July 1, 2019, the QBHE may begin submitting claims for BHCC for dates of service in July 2019 no earlier than August 1, 2019. If the member is attributed after July 1, 2019 for the first program year, the QBHE may begin submitting claims for BHCC in the calendar month following the month in which the eligible member was attributed to the QBHE. QBHEs will not be reimbursed for BHCC services prior to July 1, 2019.

(4) The BHCC activities performed must be identified on claims for BHCC using the procedure codes and modifiers identified in appendix D to this rule.

(5) The QBHE may bill for BHCC once per calendar month per attributed individual when the following requirements are met:

(a) For the initial payment, the QBHE may submit a claim for the BHCC service if it has completed, at a minimum, the activity requirements set forth in paragraphs (F)(1)(a) to (F)(1)(c) of this rule and begin developing the comprehensive care plan as specified in paragraph (F)(2) of this rule.

(b) For ongoing payment, the QBHE may submit a claim for BHCC if it has completed in the same calendar month, at least one of the activity requirements set forth in paragraph (F) or (G) of this rule. Other activities stated in paragraphs (F) and (G) of this rule must be provided as needed.

(c) At least one activity is performed every month that involves contact with the attributed individual.

(6) For attributed individuals in the BHCC program, payments for community psychiatric supportive treatment (CPST) and targeted case management as described in Chapter 5160-27 of the Administrative Code will not be made as these are considered duplicative of the BHCC program activities.

(K) Penalties.

(1) The QBHE must continue to meet all requirements as defined in this rule. If these requirements are not met upon evaluation, payment under this rule is subject to termination.

(2) A QBHE may seek reconsideration pursuant to rule 5160-70-02 of the Administrative Code to challenge decisions by ODM to terminate payments described in this rule.