OHIO BEHAVIORAL HEALTH

Report to the Ohio Department of Insurance: A Comparison of Mental Health and Substance Use Disorder Benefits in the Medicaid and Fully Insured Commercial Health Insurance Markets

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Executive Summary

Purpose of this Report

The Ohio Department of Insurance (ODI) hired NovaRest to analyze and determine the differences between mental health/substance use disorder (MH/SUD) services provided by Ohio Medicaid Managed Care Organizations (Medicaid MCOs) and the fully insured health benefit plans in the Ohio commercial market (fully insured market). The Medicaid MCO market includes approximately 3.2 million members, compared with fewer than 1.0 million members covered by fully insured individual, small group, and large group health benefit plans.[1]

NovaRest was also tasked with determining the cost of differences in coverage, where Medicaid MCO coverage was determined to be better or more favorable to the consumer. Specifically, NovaRest reviewed services provided by Medicaid MCOs to determine whether these services are covered in the fully insured market, and to estimate the cost differences, if any.

This study was motivated by reports from providers of MH/SUD services and those navigating coverage that Medicaid MCO coverage of MH/SUD benefits in Ohio is better than the coverage of those benefits in the fully insured market. Therefore, ODI requested that NovaRest review the following areas for potential differences between the Medicaid MCO and fully insured markets with respect to MH/SUD services:

- Types of benefits and services covered
- Types of medications covered
- Service limitations, such as the number of visits
- Networks
- Prior authorization and other utilization management protocols

By design, the study was limited to the fully insured commercial market in Ohio compared to Ohio Medicaid MCOs.

Annette James, Richard Cadwell and Donna Novak are the actuaries responsible for the statements, opinions, and conclusions in this document. We are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries regarding this report's subject and content. We acknowledge the significant contributions of Amanda Rocha to this work.

[1] Based on the 2021 member months reported in the carrier survey we performed divided by 12.

Key Findings

- NovaRest reviewed the benefits and prescription drugs covered by fully insured health plans compared to those covered by Medicaid MCOs. We used the Ohio Medicaid Behavioral Health State Plan Services Provider Requirements and Reimbursement Manual[2] (Medicaid BH Manual) to determine what services were provided by Medicaid MCOs. We then analyzed utilization patterns and had discussions with carriers and MH/SUD providers to determine if those services or similar services were also covered in the fully insured market. NovaRest's analysis showed the benefits covered by Medicaid MCOs are also generally covered by the fully insured health plans. However, we did not analyze covered benefits at an individual level and acknowledge there are differences in access to coverage from a person to person and plan to plan depending on billing practices, provider differences, and utilization management protocols, including those noted below.

- We analyzed the utilization of services reported by Medicaid MCOs for the CPT[3]/HCPCS[4] medical service codes in the Medicaid BH Manual and compared them to the utilization of services with the same codes in the commercial fully insured market.

- NovaRest determined that many coverage differences could be explained by how services were coded, and the location of the services administered. For example, some services are covered by Medicaid MCOs as an integrated bundle of services, whereas the carriers in the fully insured market reported that the same services were available as separate a la carte benefits.

- NovaRest found higher utilization of MH/SUD services by the under 18 population in the fully insured market than the Medicaid MCOs, despite the fully insured market reporting a much lower percentage of enrollees under age 18 (approximately 18% of the fully insured market population were under age 18 while Medicaid MCOs reported approximately 43%). This suggests that children (under 18) in the fully insured population use disproportionately more MH/SUD services even though overall MH/SUD services are underutilized in that market.

- NovaRest also concluded there were no significant differences in the number of covered visits provided by Medicaid MCOs and covered by the fully insured market.

[2] https://bh.medicaid.ohio.gov/Portals/0/Providers/Manual/BH%20Manual%20v%201_23.pdf?ver=Cp9iA-gL0HuNnBEwVPf9CQ%3d%3d

[3] Current Procedural Terminology (CPT) codes are alphanumeric codes used to document and report surgical, medical, and diagnostic procedures.

[4] The Healthcare Common Procedure Coding System (HCPCS) is a collection of codes that represent procedures, supplies, products, and services, and are used for billing for services used by Medicare & Medicaid patients. HCPCS codes primarily correspond to services, procedures, and equipment not covered by CPT® codes.

- There were differences in other areas, however, that could impact access to covered services and have a significant impact on the consumer experience. This includes:
    - **Utilization management protocols**, such as prior authorization, concurrent review, and retrospective review.
        - The concurrent and retrospective review protocols are generally aligned between Medicaid MCOs and carriers in the fully insured market.
        - Prior authorization is generally aligned for routine outpatient MH/SUD services, inpatient MH/SUD services, and emergency MH/SUD services. However, Medicaid MCOs are less likely to apply prior authorization to intensive outpatient services[5] than carriers in the fully insured market.

    - **Network differences.** There were differences in the networks used by Medicaid MCOs compared to those used in the fully insured markets.
        - Size of network. Based on the information provided by the carriers, we noted significant differences in the total number of MH/SUD practitioners in the Ohio fully insured market, compared to Medicaid MCOs. Medicaid MCO networks included more MH/SUD providers than the fully insured market, with the individual market having the fewest MH/SUD providers. However, when enrollment in Medicaid MCOs versus the fully insured market is taken into consideration, the difference between the two markets relative to the number of providers per thousand members is not as significant.
        - Types of providers included in the networks. The Ohio Department of Medicaid allows certain MH/SUD services to be provided by non-licensed MH/SUD professionals such as trainees, assistants, and other practitioners who are supervised by licensed MH/SUD professionals.
            - The services usually provided by these non-licensed MH/SUD professionals on behalf of Medicaid MCOs may be covered by another type of professional in the fully insured market.
            - Fourteen of twenty carriers operating in the fully insured market (46% of the fully insured market membership) reported that they do not explicitly cover services provided by non-licensed MH/SUD professionals, or at least do not directly contract with them, reducing the number of MH/SUD providers in the fully insured networks compared to Medicaid MCO networks. Of the six carriers in the fully insured market that directly contract with non-licensed MH/SUD professionals, only one of them does not participate in the Medicaid MCO market.

[5] ASAM level 2.1, commonly defined as over 9 hours per week of outpatient services.

- **The criteria used to determine the level of SUD care needed.** Medicaid MCOs are required to use the American Society of Addiction Medicine (ASAM) criteria[6] for determining the appropriate level of care for individuals in need of SUD services.
  - While some carriers that offer only fully insured products (one individual market carrier, five small group market carriers, and four large group market carriers) use ASAM criteria to define the level of care needed for SUD, most used other criteria, such as InterQual, MCG[7], and LOCUS/CALOCUS[8] for SUD benefits.
  - Based on conversations with MH/SUD providers, ASAM criteria appears to be more specific than other criteria and allows for more precise placement of SUD patients, particularly those who need the highest care levels, compared to the other criteria.

Overview

First, we determined if the MH/SUD services provided by Medicaid MCOs are also covered by carriers in the fully insured market. The MH/SUD services provided by Medicaid MCOs are identified in the Medicaid BH Manual by service code.[9] We surveyed the carriers operating in the fully insured market for the usage of these same service codes to identify differences between the two groups related to MH/SUD services.

We also compared:

- networks
- cost sharing
- utilization management
- formulary information

The following sections describe:

- carriers participating in the study
- the Medicaid MCO MH/SUD landscape in Ohio
- a comparison of the Medicaid MCO and fully insured environments
- a cost analysis of the major differences between the two markets' coverage of MH/SUD benefits.

[6] https://www.asam.org/asam-criteria/asam-criteria-software/asam-continuum/knowledge-base/details/knowledge-base-continuum/2015/05/13/what-are-the-asam-levels-of-care
[7] https://www.mcg.com/care-guidelines/care-guidelines/
[8] The Level of Care Utilization System (LOCUS) https://cchealth.org/mentalhealth/pdf/LOCUS.pdf
[9] https://bh.medicaid.ohio.gov/Portals/0/BH%20Manual%20v%201_24.pdf

Health Insurance Carriers Participating in the Study

This study reflects information provided by twenty-one carriers in total. This includes twenty health carriers offering fully insured health benefit plans in the state of Ohio as of January 1, 2022. Four of these carriers also provided services in the Medicaid MCO market while one carrier provided services only as a Medicaid MCO. Note that as of July 1, 2022, there is a new Medicaid MCO, and new MH/SUD resources are available to Medicaid recipients. Neither of these changes in the Medicaid landscape are reflected in this study since they occurred after January 1, 2022, and are therefore outside the scope of the study.

There was some difficulty receiving clean data from participating carriers. After several rounds of questions and answers, we believe the data we received is reasonable. However, we do not have alternate data sources on MH/SUD claims, providers, or formularies to compare against the carrier responses we have received. In addition, not all carriers' systems had the ability to provide data at the level requested. In particular, some carriers were unable to:

- Separate premiums, claims, or membership data for under age 18 or age 18 and older.
- Separate provider counts for MH and SUD.
- Provide utilization data and drug counts on a basis consistent with the Medicaid BH Manual.

Medicaid MCO MH/SUD Landscape

This section provides an overview of the MH and SUD services provided by Medicaid MCOs.

Services

According to the Ohio Administrative Code (OAC) rule 5160-26-03, Medicaid MCOs must cover MH/SUD services described in OAC Chapter 5160-27, and ensure members have timely access to all applicable medically necessary services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under fee-for-service (FFS) Medicaid.

In addition to the services Medicaid MCOs are required to provide, they may also provide additional benefits (value-added services). It is our understanding that none of the Medicaid MCOs provide value-added services related to the treatment of MH or SUD conditions. Therefore, only the core MH/SUD services required pursuant to OAC Chapter 5160 were included in this study.

Mental Health Services[10]

The following is a list of the major Mental Health services provided by Medicaid MCOs.

- Psychological testing
- Individual, group, and family Therapeutic Behavioral Services (TBS)
- Psychosocial Rehabilitation (PSR)
- Mental Health RN and LPN Nursing Services
- Individual and Group Community Psychiatric Supportive Treatment (CPST)
- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Assertive Community Treatment (ACT)
- Intensive Home-Based Treatment (IHBT)

Substance Use Disorder (SUD) Services

The following is a list of SUD services Medicaid MCOs are required to provide. All Medicaid MCOs must follow American Society of Addiction Medicine (ASAM) level of care placement criteria for SUD services (see Appendix I).

- Assessment
- Peer recovery support
- Group counseling
- Targeted case management
- Urine Drug Screening (on-site rapid test)
- RN and LPN Nursing Services
- Intensive outpatient and partial hospitalization group counseling
- Withdrawal management with extended on-site monitoring
- Residential treatment, not including room and board.
- Opioid Treatment Programs (OTPs)[11]

Utilization Management

The primary utilization management method used for MH/SUD services appears to be prior authorization. Prior authorization means a patient must receive approval from the carrier prior to a service being performed. Tables 1-5 in the Medicaid BH Manual include current fee-for-service (FFS) services that require prior authorization, and Medicaid MCOs have some flexibility on when prior authorization maybe used. While there are similarities to the FFS prior authorization list, we relied on Medicaid MCO carrier surveys and the prior authorization guides provided on the carrier websites to determine the services subject to prior authorization. Generally, in-network outpatient services are not subject to prior authorization up to a defined number of services. Prior authorization is most commonly applied to out-of-network services and in-network inpatient services.

[10] Medicaid BH Manual: https://bh.medicaid.ohio.gov/Portals/0/Providers/Manual/BH%20Manual%20v%201_23.pdf?ver=Cp9iA-gL0HuNnBEwVPf9CQ%3d%3d

[11] See the Opioid Treatment Program (OTP) Manual for further details: https://bh.medicaid.ohio.gov/Portals/0/Providers/Manual/January 1 OTP Manual Final Version 1_3 1-28-20.pdf?ver=2020-02-14-161807-580

According to our carrier data survey, Medicaid MCOs also implement concurrent and retrospective reviews.

Concurrent review refers to ongoing evaluation of a course of treatment during a member's care. Medicaid MCOs generally initially approve a certain number of services at a time and use concurrent review to determine if additional services are required.

Retrospective review refers to an evaluation of care provided after services were performed. Retrospective review is primarily used for emergency services when there is not sufficient time for prior authorization. Two carriers reported retrospective review for out-of-network services even with prior authorization. One carrier indicated retrospective review was used for experimental and investigational treatments.

Network Overview

Networks

Medicaid MCOs are required to ensure that their networks satisfy the Ohio Department of Medicaid's network adequacy requirements, which include maximum time and distance standards.

Professional Types

Medicaid MCOs contract with a large variety of MH/SUD providers. Providers may include:

- **Medical MH/SUD Practitioners**. This category includes physicians, clinical nurse specialists (CNS), certified nurse practitioners (NP), registered nurses (RN), and licensed practical nurses (LPN), physician assistants and pharmacists.
  - **Licensed Independent MH/SUD Practitioners**. This includes psychologists and school psychologists, licensed professional clinical counselors (LPCC), licensed independent social workers (LISW), licensed independent marriage and family therapists (LIMFT), as well as licensed independent chemical dependency counselors (LICDC).
  - **Dependently Licensed MH/SUD Practitioners**. Practitioners in this category typically work under the supervision of a licensed independent MH/SUD practitioner and include licensed professional counselors (LPC), licensed social workers (LSW), and licensed marriage and family therapists (LMFT).
  - **Trainees/Assistants**. This includes practitioners in the process of achieving their licenses, such as school psychology assistant/intern/trainees, counselor trainees, social work trainees and assistants, marriage and family therapist trainees, and chemical dependency counselor assistants.
  - **Unlicensed/Paraprofessional Practitioners**. This includes peer recovery supporter (PRS) and qualified MH/SUD specialists.

Commercial Fully Insured Market: Comparison of Services Provided by Medicaid MCOs

Appendix II provides a list of Medicaid MCO covered MH/SUD service codes, and the percentage of market membership represented by carriers who showed usage of each service code. For example, if four carriers in a market, which represent 80% of a market's membership, show usage of a service code, Appendix II will show 80% for the market and service code. We used this methodology for two primary reasons.

- First, there are several differences between the Medicaid MCO and fully insured market which could cause differences in utilization. These include but are not limited to, the size of the markets, network requirements, covered provider type requirements, and member cost sharing requirements for services.
- The second reason is concern related to data quality and consistency. Due to carrier data system limitations, we did not receive some of the data we requested. For example, some carriers track utilization differently (by number of visits or claims per 1,000) and some could not provide data separately by requested categories. These factors made it very difficult to definitively compare the level of utilization of a service between carriers and across markets.

Where the utilization analysis presented in Appendix II indicated the carriers that showed usage of a service code represented less than 50% of the membership in a market, we used follow-up discussions with carriers and MH/SUD providers, as well as research to determine if similar services were provided.

The MH/SUD services covered by the Medicaid MCOs are also covered by a majority of carriers in the fully insured market. For each service code, at least 15 of the 20 carriers in the fully insured market cover the professional service either by covering the exact service code, covering a similar service under a different code, or covering the service at a different site of service.[12]

NovaRest's task was to determine if carriers in the fully insured market cover the same MH/SUD services as the Medicaid MCOs. Because Medicaid MCO services are described in the Medicaid BH manual, we surveyed Ohio carriers in the fully insured market on those specific service codes. We **did not** survey the Medicaid MCOs on services covered by the fully insured market. Carriers in the fully insured market may be offering other MH/SUD services that were not captured under our data call. An analysis of services not covered by Medicaid MCOs is out of scope for this report.

[12] Site of service means where the service is administered, e.g., in a hospital, outpatient facility, or at home setting.

Service Codes

Our analysis of service code utilization by carriers in the fully insured market identified several codes which required additional follow-up to determine if the service code or similar service was covered by carriers in the fully insured market. Appendix III indicates why we believe each code is covered.

The following MH/SUD service codes did not initially appear to be covered in the fully insured market because less than three carriers in the fully insured market showed any usage. In response to our follow-up questions related to these services, carriers indicated that the professional services associated with these service codes were in fact covered in the fully insured market, but under different service codes, or at different sites of service. Several of these codes are ASAM specific codes. As we will discuss later in this report, not all carriers in the fully insured market use the ASAM criteria to determine a member's level of care, which is one explanation for the low usage for these particular service codes.

Screening Brief Intervention and Treatment (G0396 and G0397)

This is a screening for alcohol and/or SUD (other than tobacco) by use of a structured assessment and brief intervention of 15 to 30 minutes (G0396), typically administered by a medical professional or licensed independent MH/SUD practitioner. Assessments requiring more than 30 minutes are recorded under the G0397 clinical code and administered by medical and licensed independent MH/SUD practitioners and as well as MH/SUD paraprofessionals. The utilization for these service codes was low for both the Medicaid MCOs and the fully insured market. Representatives from Medicaid verified this code is very rarely used, and other screening codes are much more common. Carrier form filing information indicates screening services are generally covered.

Clinically Managed Withdrawal Management ASAM 3.2 WM (H0010)

This is a medically monitored residential detox treatment (ASAM Level 3.7-D) provided by licensed independent MH/SUD practitioners. These services were typically covered in the fully insured market with 16 of the 20 carriers covering this service using the H0010 medical code and the remaining four using different medical codes for similar services. The utilization for these service codes was low for both the Medicaid MCOs and the fully insured market.

Withdrawal Management Per Diem ASAM 2 WM (H0012)

This is a medically managed outpatient addiction treatment (ASAM Level II) program with services provided by medical MH/SUD practitioners. These services were typically covered by carriers in the fully insured market, with 16 of the 20 carriers covering this service using the H0012 code and the remaining four using different clinical codes for similar services. The utilization for this service code was low for both the Medicaid MCOs and the fully insured market.

Assertive Community Treatment (H0040)

This is a set of highly specialized and personalized services provided in a specific location or coordinated locations for treatment, rehabilitation, and support needs for adults. Services are provided 24 hours per day, seven days per week, in a community-based setting by a variety of providers, including medical MH/SUD practitioners, licensed independent MH/SUD practitioners, and paraprofessionals with backgrounds in social care, nursing, psychology, drug abuse recovery and case management. Medicaid MCOs provide these services as a bundled set in a community-based setting. Fully insured plans provide treatment, rehabilitation, and other SUD support services under alternative clinical codes at physicians' offices or other locations, rather than as a bundled set of services coordinated in a community setting. The utilization for this service code was low for both the Medicaid MCOs and the fully insured market. Of the 20 carriers in the fully insured market, 7 cover the same clinical codes used by the Medicaid MCOs, 10 use alternative clinical codes for similar services, and 3 indicated services were not covered and did not cover alternate clinical codes or sites of service. We found that typically, these services are administered by medical and independent MH/SUD practitioners in the fully insured market, while Medicaid MCOs also provide services in this category provided by MH/SUD paraprofessionals.

Intensive Home-Based Treatment (H2015)

Intensive Home-Based Treatment (IHBT) provides the necessary MH services and support to enable youth to live in their homes in the least restrictive, most normative setting possible. IHBT is a strength-based and family-driven MH service designed to meet the needs of youth with serious emotional disturbances who are at risk of out-of-home placement or who are returning home from out-of-home placement. This is a set of support services for children, similar to the adult services provided under the H0040 clinical code by licensed independent MH/SUD practitioners. The utilization for this service code was low for both the Medicaid MCOs and the fully insured market. Of the 20 carriers in the fully insured market, only 5 cover the services under the H2015 clinical code, 10 cover similar services under different codes, 2 indicated they have never been billed this code, and 3 carriers indicated that these services were not covered.

Clinically Managed Low Intensity Residential Treatment ASAM 3.1 (H2034)

This is treatment of alcohol and/or drug abuse in a halfway house setting by licensed independent MH/SUD practitioners on a per diem basis. No carriers (fully insured or Medicaid MCOs) cover room and board.

While fully insured plans do not cover halfway house services, residential detox services are covered under other transitional inpatient or outpatient sites of service and clinical codes. In the fully insured market, 8 of the 20 carriers cover the services under the H2034 clinical codes, 10 provide services under alternative but similar codes, and 2 carriers indicated services were not covered.

Commercial Fully Insured Market: Comparison of Prescription Drugs Provided by Medicaid MCOs

We compared the number of drugs covered in both markets by US Pharmacopeia class within each therapeutic category and found no significant differences between the MH/SUD drugs provided by Medicaid MCOs and those covered by carriers in the fully insured market.

Comparison of Non-Benefit Aspects of MH/SUD

Although the MH/SUD services provided by the Medicaid MCOs are generally provided by carriers in the fully insured market, there were significant differences in the utilization of services, size of networks (measured by the number of MH/SUD practitioners in the respective networks), and the types of MH/SUD practitioners utilized.

Utilization by Service Category

Appendix IV illustrates that even though there are no significant differences in the services covered, there are significant differences in the utilization patterns reported between the fully insured market and Medicaid MCOs. In general, the fully insured market experienced lower utilization of services compared to the Medicaid MCO population. This could be attributed to factors such as the size and attributes of the different populations, availability of services and size of networks, or other factors related to the access to care.

Utilization Management

Our analysis indicated that there were no significant differences in the use of concurrent or retrospective review between the fully insured market and Medicaid MCOs. However, we did find differences in prior authorization protocols between carriers in the fully insured market and Medicaid MCOs. Please note that we requested a summary of utilization management procedures at each ASAM level of care, and not an exhaustive list of service codes subject to utilization management. Carriers provided more information on prior authorization than on concurrent and retrospective review. Additionally, some carriers provided more detail than others.

Prior authorization is generally required for out-of-network services, community-based treatment, home-based treatment, and inpatient treatments for both Medicaid MCOs and carriers in the fully insured market. However, prior authorization is not required for routine outpatient services or emergency services[13] for either Medicaid MCOs or carriers in the fully insured market.

For Mental Health services, Medicaid MCOs generally require prior authorization for screening, brief intervention, referral to treatment (SBIRT), and psychological testing. SBIRT was not listed by carriers in the fully insured market as requiring prior authorization. The fully insured market carriers do require prior authorization for transcranial magnetic stimulation (TMS) and non-emergency transport, which do not appear to be subject to prior authorization for Medicaid MCOs.

[13] There would not be sufficient time for prior authorization for emergency services, which may be subject to concurrent or retrospective review.

For Substance Use Disorder services, Medicaid MCOs require prior authorization above ASAM Level 2.1 and typically do not require prior authorization on outpatient (routine or intensive[14]) services up to a defined limit. Most carriers in the fully insured market also do not require prior authorization on routine outpatient services up to a defined limit, although two carriers in the fully insured market indicated prior authorization for all MH/SUD services. However, at least nine carriers in the fully insured market require prior authorization on intensive outpatient services. One carrier (which only participates in the fully insured market) indicated no prior authorization requirements for any services because they use concurrent and retrospective review instead of prior authorization.

Provider Networks

Carriers reported offering a variety of provider networks (networks) in the fully insured market. Some of these networks only cover select counties in the state, with services outside those counties either not covered or covered with out-of-network cost sharing, which is higher for the consumer. In the fully insured market, 11 of 20 carriers offered networks that cover the entire state, meaning the remaining 9 carriers do not offer statewide networks. As of January 1, 2022, four of the five current Medicaid MCOs use networks that service the entire state.

For non-statewide networks, the network area can vary significantly. NovaRest did not receive information on the number of counties each network covers. The Medicaid MCO non-statewide network has more practitioners than the non-statewide fully insured market networks in all categories except medical SUD practitioners (which includes the fewest providers), and licensed independent SUD practitioners (which includes the second-highest number of providers). However, this comparison still does not account for the geographic reach of the network. Therefore, for a more representative comparison, we considered only networks that cover the entire state. We requested carriers indicate if each network was intended to service the entire state and relied on those responses for this analysis.

[14] ASAM Level 2.1, commonly defined as over 9 hours of outpatient treatment per week.

Table 1 below shows the member weighted average number of practitioners per network in the fully insured market (for the statewide networks) compared to the weighted average number of practitioners per network in Medicaid MCO. We weighted by membership to provide a more accurate representation of the number of practitioners that most members would have access to. If we did not weight by membership, the analysis would be skewed by networks where very few members enroll.

Table 1 – Average Number of Practitioners per statewide network (weighted by membership)[15]				
Type of Practitioner	**Individual**	**Small Group**	**Large Group**	**Medicaid MCO**
MH - Medical	2,530	1,934	1,894	2,805
MH - Licensed Independent	6,836	10,201	9,898	15,011
MH - Paraprofessional/ Dependent	4,881	102	210	20,087
SUD - Medical	2,376	1,903	1,796	2,805
SUD - Licensed Independent	6,595	3,394	6,006	13,298
SUD - Paraprofessional/ Dependent	4,807	102	210	16,777

We see slightly higher numbers of practitioners on the MH side compared to the SUD side, particularly in the fully insured group markets, although many carriers reported overlap in providers between MH and SUD. We note that there is overlap between the MH and SUD categories as some medical providers provide services related to both, and some carriers were unable to distinguish between MH and SUD providers.

Medicaid MCOs reported more practitioners in their networks, across all categories of practitioners compared to the fully insured market statewide networks. There are significant differences between the Medicaid MCO and fully insured markets for licensed independent practitioners and still larger differences in the paraprofessional/dependent categories. Although Medicaid covers non-medical services such as transportation, we do not believe these professionals were reported by the carriers under the paraprofessional/dependent professionals' category. Our carrier survey requested carriers report paraprofessional/dependent practitioners consistent with the Medicaid BH Manual, which only discusses MH/SUD health practitioners.

Analyzing non-medical services is outside the scope of this report. NovaRest did not audit the responses, however, we see large discrepancies in the number of paraprofessional/dependent practitioners even among carriers offering in both the fully insured market and Medicaid MCO market. We therefore believe the carriers reported similar provider types in the paraprofessional/dependent practitioner categories between the fully insured and Medicaid MCO markets, and paraprofessional/dependent practitioners are more likely to be covered in the Medicaid MCO market.

[15] We weighted by membership to show the number of in-network providers accessible to a typical member under the networks reported as servicing the entire state.

The paraprofessional/dependent practitioner type is almost non-existent in the fully insured group markets, although there is some network inclusion in the individual market. The four Medicaid MCOs with statewide service all reported participating in the individual fully insured market, but none participate in the group markets. We suspect that is driving the higher number of paraprofessional/dependent providers reported in individual fully insured market compared to the group market. However, when we analyze the carriers that offer both Medicaid MCO and individual market coverage, we still see significant differences in the number of network providers.

Table 2 provides the average number of practitioners per 1,000 members per statewide network. We acknowledge that the Medicaid MCO market is three times larger than the combined fully insured market when considering membership. Therefore, while the Medicaid MCOs cover a significantly larger number of providers, they also cover a significantly larger number of members. The following table presents the number of providers per 1,000 members.

Table 2 – Average Number of Practitioners per 1,000 members per statewide network (weighted by membership)[16]

Type of Practitioner	Individual	Small Group	Large Group	Medicaid MCO
MH - Medical	18	44	10	1
MH - Licensed Independent	48	232	54	6
MH - Paraprofessional/ Dependent	34	2	1	8
SUD - Medical	17	43	10	1
SUD - Licensed Independent	46	77	33	6
SUD - Paraprofessional/ Dependent	34	2	1	7

Table 2 shows members in the fully insured markets have more practitioners available per 1,000 members than the Medicaid MCO market, except for the small and large group paraprofessional/dependent practitioners. The individual market practitioners appear well represented in all carriers which may reflect qualified health plan (QHP) standards for carriers offering on the health insurance exchange.

Table 2 should not be interpreted to mean that the fully insured market does or does not have an adequate network. Network adequacy was not analyzed as part of this study. It is important to consider Table 1 in conjunction with Table 2. While Table 1 illustrates that the fully insured market has on average fewer providers in their networks which could negatively impact the consumers' experiences, Table 2 illustrates that when the markets sizes by membership are taken into consideration, the fully insured market, in most categories, has more providers per one thousand members.

[16] We weighted by membership to show the number of in-network providers accessible to a typical member under the networks reported as servicing the entire state.

Table 3 below shows the difference in the number of providers reported in-network for statewide networks for the three carriers that offer both Medicaid MCO and individual market coverage. We believe this illustrates the notable differences in the number of available providers for Medicaid MCOs compared to the individual fully insured market.

Table 3 – Range of Number of Practitioners per statewide network (three carriers that offer both Medicaid MCO and individual market coverage)		
Type of Practitioner	**Individual**	**Medicaid MCO**
MH - Medical	174-6,482	854-7,681
MH - Licensed Independent	1,171-15,778	13,546-17,814
MH - Paraprofessional/ Dependent	76-17,007	15,584-20,565
SUD - Medical	209-6,482	854-7,681
SUD - Licensed Independent	748-15,778	10,818-17,814
SUD - Paraprofessional/ Dependent	69-14,971	12,094-15,584

Utilization of Services by Age

We asked carriers to provide information on services covered and cost-sharing for members under age 18 and the age 18 and over members. We found no material differences in the services covered, utilization management practices, or the cost sharing for MH/SUD between these two groups. However, we did find differences in utilization patterns between the under 18 group and the 18 and over group.

We note that four carriers in the fully insured market did not provide membership information separately for under 18 and age 18 and up (two of these four were able to provide utilization separately as discussed above). All Medicaid MCOs were able to provide the breakdown of membership by age as requested.

The fully insured market shows higher utilization by the under age 18 population than the Medicaid MCOs, even though the fully insured market reported about 18% of their enrollees were under age 18, while Medicaid MCOs reported 43% of their population was under age 18. This suggests that children (under 18) in the fully insured population use disproportionately more MH/SUD services even though overall MH/SUD services are underutilized in that market.

NovaRest also found differences in the type of services used by each age group. In both the fully insured market and Medicaid MCOs, the under age 18 group reports higher utilization of services for family psychotherapy and interactive complexity.[17] The under age 18 population in the fully insured market also reported higher utilization for multiple-family group psychotherapy, psychotherapy for crisis, and various testing/evaluation categories. However, Medicaid MCOs did not report higher utilization of services for these categories and generally reported fewer testing/evaluation categories and individual treatment for the under age 18 population.

[17] According to the Medicaid BH Manual: "Interactive complexity refers to specific communication factors that complicate the delivery of a psychiatric procedure and occur during the delivery of the service. Common factors include more difficult communication with discordant or emotional family members and engagement of young and verbally undeveloped or impaired patients."

Utilization of Services by Practitioner Type in the Fully Insured Market

Table 4 below shows that in the fully insured market, the category of practitioner most used is the Medical MH/SUD practitioner, and the paraprofessional/dependent practitioner is the category used the least. On the other hand, for Medicaid MCOs, more MH/SUD paraprofessionals and dependent practitioners are used compared to medical MH/SUD practitioners.

Table 4 - % of Market Utilization by Type of Provider					
Type of Practitioner	**Individual Fully Insured**	**Small Group Fully Insured**	**Large Group Fully Insured**	**Total Fully Insured Market**	**Medicaid MCO**
Medical MH/SUD Practitioners	20%	66%	47%	52%	13%
Licensed Independent MH/SUD Practitioners	75%	32%	50%	45%	40%
MH/SUD Paraprofessional/ Dependent Practitioners	5%	2%	3%	3%	47%

Criteria used to determine the level of care needed

Carriers used a variety of criteria to determine the level of MH care needed. There is no requirement for either Medicaid MCOs or carrier in the fully insured market to use a specific criteria for MH services. The most popular criteria used to determine the level of care needed for MH services are InterQual, MCG, and LOCUS/CALOCUS. NovaRest did not have information to compare these criteria.

While there are differences between the criteria used by different carriers, each carrier uses the same criteria for all markets where they offer business. Because there is no specific required criteria in either the Medicaid MCO or fully insured market for MH services, we found no material differences in the level of care criteria between Medicaid MCOs and carriers in the fully insured market regarding MH services.

Regarding SUD services, the Ohio Department of Medicaid requires all Medicaid MCOs to use the ASAM criteria to determine the level of care. The ASAM criteria is specific to SUD and is not used for MH services. The criteria used by different carriers in the fully insured market may still vary, although they use the same criteria for all markets where they offer business. ASAM, InterQual, MCG, and LOCUS/CALOCUS are the most popular criteria used by fully insured carriers for SUD services. 10 of 20 carriers in the fully insured market use the ASAM criteria to determine the level of care for SUD services. Four of these carriers are also Medicaid MCOs and are required to use the ASAM criteria in that market. The ASAM criteria appears more exact than other criteria and allows for more precise placement of patients according to our discussions with MH/SUD providers. Therefore, we believe there is a difference in the level of care criteria of the services covered between carriers in the fully insured market and Medicaid MCOs.

Cost Analysis

Utilization Management Practices

Carriers report a variety of utilization management practices. Most of the carriers did not report visit limits on MH/SUD services. Carriers reported prior authorization, concurrent review, and retrospective review as utilization management practices for MH/SUD services. For concurrent review and retrospective review, there do not appear to be material differences in the utilization management practices between Medicaid MCOs and carriers in the fully insured market. We did identify some differences in prior authorization protocols between Medicaid MCOs and carriers in the fully insured market.

In response to NovaRest's survey, carriers in the fully insured market reported that, for emergency services, prior authorization is waived in favor of concurrent or retrospective review. Additionally, 8 carriers in the fully insured market indicated that non-emergency out-of-network services are subject to prior authorization. The utilization management protocols discussed below are related to non-emergency in-network services.

None of the Medicaid MCOs we surveyed required prior authorization on routine outpatient MH/SUD services. This is generally in alignment with the fully insured market, with only 2 of the 11 carriers in the individual market, 1 of the 13 carriers in the small group market, and 1 of the 13 carriers in the large group market mentioning prior authorization on MH/SUD services, which includes routine outpatient MH/SUD services.

Medicaid MCOs appear less likely to require prior authorization for MH/SUD intensive outpatient services than carriers in the fully insured market, which is consistent with our discussions with MH/SUD providers. According to our survey, only 1 of the 5 carriers in the Medicaid MCO market reported requiring any prior authorization for intensive outpatient MH/SUD services. This is compared to prior authorization requirements for 6 of the 11 carriers in the individual market, 8 of the 13 carriers in the small group market, and 9 of the 13 carriers in the large group market.[18] We do not have enough information to determine the cost impact of removing prior authorization requirements for intensive outpatient services for fully insured plans.

The Medicaid BH Manual indicates that, after an initial number of visits, (which may vary by service), prior authorization is required for outpatient services such as SBIRT, psychiatric diagnostic evaluations, psychological testing, alcohol or drug assessment, and TBS group per diem. However, in response to our survey, only one Medicaid MCO reported requiring prior authorization for SBIRT and psychological testing. Other Medicaid MCOs and all fully insured carriers did not report prior authorization for these services.

One carrier in the individual market, and four carriers in the small and large group market identified TMS as requiring prior authorization. This was not reported by any of the Medicaid MCOs. Two carriers in the large group market also identified non-emergency transport as requiring prior authorization, which is not reported by any of the Medicaid MCOs.

[18] Many of the carriers in the fully insured market (2 in the individual market, 4 in the small group market and 4 in the large group market) indicated prior authorization was only applied to specific services or out-of-network services.

For **inpatient services**, there do not appear to be material differences in the prior authorization practices between Medicaid MCOs and carriers in the fully insured market. One Medicaid MCO indicated no prior authorization requirement on initial inpatient stays under 30 days and 1 carrier in the individual market does not appear to use prior authorization, in favor of concurrent and retrospective review. All other carriers required prior authorization on all inpatient services.

Network Differences

Size of Network

Based on carrier responses, NovaRest found that MH/SUD networks in the fully insured market were significantly smaller than in the Medicaid MCO market. This has an impact on cost. According to a 2017 study[19], premium costs for plans with narrow networks are 16% less on average than plans with broader networks.

The impact of broadening the MH/SUD network in the fully insured market will vary by carrier and market, since it is closely related to provider reimbursement rates. Carriers without a large enough market presence may not be able to contract at favorable rates, which may limit their ability to expand their networks. Since we were not able to collect reimbursement data, we could not quantify the impact for this study. However, we note that carriers in the fully insured market can negotiate reimbursement rates while Medicaid MCOs are compensated using rates set by the state.

Types of Providers Included in the Networks

The Medicaid BH Manual indicates that services can be provided by trainees, assistants, and other unlicensed specialists defined by the Medicaid BH Manual under the guidance of licensed MH/SUD professionals. We refer to these types of providers as MH/SUD paraprofessional/dependent practitioners.

- Twelve of the total twenty carriers in the fully insured market reported that they did not explicitly cover services provided by these categories of professionals, or at least do not specifically contract with them.
- Four of the remaining eight carriers that cover services provided by MH/SUD paraprofessional/dependent practitioners are also Medicaid MCOs.
- However, even among carriers that operate in both the Medicaid MCO and fully insured markets, less paraprofessional/dependent practitioners are included in the fully insured market networks.

NovaRest did not interview carriers on why services provided by paraprofessional/dependent practitioners are not specifically covered, but it may be related to the credentialing process or reimbursement rates. We believe there will be a cost impact if the carriers in the fully insured market are required to cover services provided by these types of professionals.

The utilization data provided for individual, small group and large group was much lower than Medicaid MCO utilization for MH/SUD paraprofessional/dependent practitioners, which is consistent with our understanding that fully insured plans do not typically cover services provided by these professionals. Due to the low credibility of the utilization experience data in the fully insured

[19] https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1669.

market, we could not model costs solely using the fully insured market utilization. Instead, we based our analysis on Medicaid MCO utilization levels.

Reimbursement Rates

MH/SUD paraprofessional/dependent practitioners are reimbursed at a lower rate than other providers in the Medicaid BH Manual. If carriers in the fully insured market were required to cover services provided by MH/SUD paraprofessional/dependent practitioners, we would expect an increase in utilization and increased premiums. This outweighs the savings from using licensed professionals. Additionally, MH/SUD paraprofessional/dependent practitioners are not qualified to perform many of the services that a licensed professional can perform. Therefore, we considered the additional utilization is due to an increase in the number of paraprofessional/dependent practitioners as filling an unmet need as opposed to shifting utilization from the licensed categories.

We did not have access to reimbursement rates in the fully insured market by services and type of provider, so we relied on the reimbursement rates provided in the Medicaid BH Manual, considering three separate scenarios:

1. fully insured reimbursement is 150% of Medicaid MCO
2. fully insured reimbursement is 120% of Medicaid MCO
3. fully insured reimbursement is 90% of Medicaid MCO

The result was in a range of impact from 0.14% to 0.24% of premiums in the individual market. Overall, for the fully insured market, the range of impact was from 0.13% to 0.21% of premiums, which is similar to the impact on the large group market. The impact to the small group market is slightly lower at 0.11% to 0.19% of premiums. Higher reimbursement rates produce a larger impact to premiums.

If carriers are required to contract with paraprofessional/dependent practitioners, we expect it would take time to build up the network and the total impact would not occur immediately, but over time. Therefore, for this analysis, we assumed an immediate cost impact based on a 15% increase in fully insured utilization.

Difference in the ASAM Care Guidelines

Requiring the ASAM criteria to be used to determine the level of care for SUD services instead of the other commonly used criteria, such as InterQual, MCG, LOCUS, and CALOCUS criteria, would impact premiums. The InterQual/MCG/LOCUS/CALOCUS criteria are proprietary and could not be directly compared to ASAM. Based on discussions with MH/SUD professionals, our understanding is that the ASAM criteria is more granular, allowing providers to support member placement for a higher level of care. This means ASAM criteria may result in higher costs.

Several of the SUD services in the Medicaid BH Manual use HCPC codes that are specific to ASAM services, and not commonly used by carriers in the fully insured market. Therefore, we believe the utilization levels reported in the fully insured market have low credibility. Like the cost analysis for type of practitioners used, we considered Medicaid MCO utilization as the baseline for the analysis.

We did not have information on reimbursement rates in the fully insured market by services and type of provider, so we relied on the reimbursement rates provided in the Medicaid BH Manual, considering three separate scenarios:

1. fully insured reimbursement is 150% of Medicaid MCO
2. fully insured reimbursement is 120% of Medicaid MCO
3. fully insured reimbursement is 90% of Medicaid MCO

Lastly, since we estimated the impact of an increase in utilization to the higher levels of care, we used the Medicaid BH Manual to determine the next level of care for each service and estimated 10% to 30% of utilization moving to these higher levels of care, i.e., 10% to 30% more services will be performed at a higher level of care.[20] This resulted in a range of impact from 0.22% to 0.37% of premiums in the individual market. Overall, for the fully insured market, the range of impact was from 0.20% to 0.33% of premiums, which is similar to the impact on the large group market. The impact to the small group market is slightly lower at 0.17% to 0.29% of premiums. Larger reimbursement rates produce a larger impact to premiums.

Our analysis did not reflect the time and additional administrative costs associated with switching to the ASAM criteria.

Reliance

In developing the findings and opinions in this report, we relied upon information obtained from and/or provided by other sources. We have reviewed this information for reasonableness and applicability but have performed no audits of the information. These include: [21]

- Information provided by Ohio Medicaid MCOs and carriers in the individual, small group, and large group fully insured health insurance market.
- Information provided by the Ohio Department of Medicaid related to the MH/SUD services provided by the Medicaid MCOs as of January 1, 2022.
- Ohio health carrier rate filings approved by the Ohio Department of Insurance for the 2021 and 2022 plan years.
- Interviews with Ohio MH/SUD providers.

Limitations

This report and the conclusions and opinions herein have been developed for the exclusive use of The Ohio Department of Insurance. Other uses of this report and its comments and opinions may not be appropriate. NovaRest assumes no obligation or liability for such inappropriate use.

[20] Approximately one third of carriers currently use the ASAM criteria. For these carriers, implementing ASAM would have no impact on premium.
[21] The large group market is significantly larger (more membership) than the individual and small group markets, so the total commercial market impact is close to the large group market impact.

Markets Excluded from the Study

Commercial – Self-Insured MEWAs

Ohioans are enrolled in plans sponsored by self-insured Multiple Employer Welfare Arrangements (MEWAs), which were not included in this study. Therefore, to the extent these excluded plans offer different benefits, and serve a substantial number of Ohio residents, the conclusions may be different if this market were included.

Self-funded Health Benefit Plans

The self-funded employer market offers health benefit plans to Ohioans and was excluded from the study. Therefore, the results of this study may differ significantly if this market were included.

Medicaid Fee For Service

Medicaid Fee For Service (FFS) arrangements are excluded from this study since FFS membership is restricted to certain Medicaid-eligible individuals, pursuant to Ohio Administrative Code section 5160-26-02(B)(4), and the membership and utilization patterns are not representative of the fully insured market.

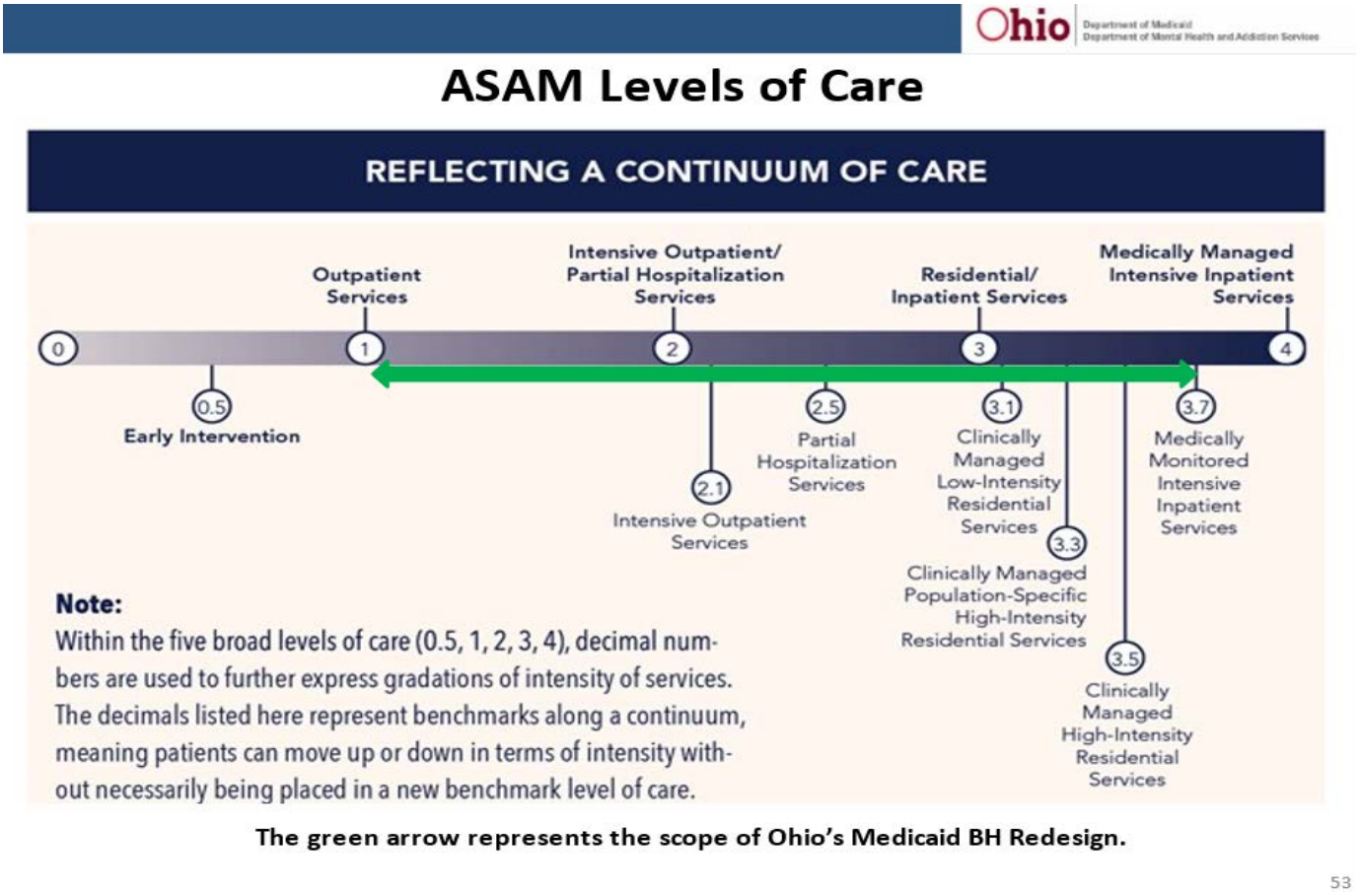
Measurement Period

This report is based on the benefits offered in the fully insured health insurance and Medicaid MCO markets as of January 1, 2022. Since that date, there have been changes in the Medicaid MCO landscape that may impact this analysis. As of July 1, 2022, two carriers previously offering plans only in the fully insured market have entered the Medicaid MCO market, and this may impact the way services are covered in the fully insured market. We note this may impact the type of professionals that offer covered services as well as the standard of care with which they comply. Specifically, the ASAM criteria will need to be used by those carriers for their Medicaid MCO plans, and thus may carry over to their fully insured plans as well.

Effective March 1, 2022, pursuant to OAC rule 5160-59-03[22], the Ohio RISE plan will provide new services to eligible Medicaid MCO recipients. This will increase the level and breadth of services offered to eligible individuals. Therefore, the use of a different measurement date may result in different conclusions.

[22] OAC rule 5160-59-03.

Appendix I – Ohio Medicaid MCO SUD Services by ASAM* Levels of Care



The green arrow represents the scope of Ohio's Medicaid BH Redesign.

*American Society of Addiction Medicine

Appendix II –Medicaid MCO MH/SUD Market Share for Carriers with Usage of Service Code by Market

The red highlighting indicates where carriers showing any usage of a service code represent less than 50% of the market membership.

The yellow highlighting represents the service codes we requested further information from carriers to determine if the code or similar services were covered.

% of Membership Market Share Represented by Carriers Showing Usage of Service Code						
CPT/ HCPCS Service Code	**Service**	**Individual**	**Small Group**	**Large Group**	**Total Fully Insured**	**Medicaid MCO**
90785	Interactive Complexity	100%	100%	100%	100%	100%
90791	Psychiatric Diagnostic Evaluation w/o Medical	100%	100%	100%	100%	100%
90792	Psychiatric Diagnostic Evaluation w/ Medical	100%	96%	100%	99%	100%
90832	Individual Psychotherapy – 30 minutes	100%	100%	100%	100%	100%
90833	Individual Psychotherapy w/ E&M Service	100%	100%	100%	100%	100%
90834	Individual Psychotherapy – 45 minutes	100%	100%	100%	100%	100%
90836	Individual Psychotherapy w/ E&M Service	82%	99%	100%	95%	100%
90837	Individual Psychotherapy – 60+ minutes	100%	100%	100%	100%	100%
90838	Individual Psychotherapy w/ E&M Service	87%	90%	96%	92%	100%
90839	Psychotherapy for Crisis – first 60 minutes	97%	92%	100%	97%	100%
90840	Psychotherapy for Crisis – add'l 30 minutes	92%	89%	94%	92%	100%
90846	Family Psychotherapy w/o patient – 50 minutes	98%	99%	100%	99%	100%
90847	Family psychotherapy (conjoint, w/ patient present) – 50 minutes	100%	100%	100%	100%	100%
90849	Multiple-family group psychotherapy	33%	85%	89%	73%	100%
90853	Group Psychotherapy (not multi-family group)	90%	94%	100%	96%	100%
93000	Electrocardiogram - at least 12 leads w/ interpretation and report	67%	94%	84%	81%	57%
93005	Electrocardiogram tracing only w/o interpretation and report	33%	91%	84%	71%	81%
93010	Electrocardiogram interpretation and report only	42%	94%	86%	75%	100%
96112	Developmental Testing	95%	63%	94%	88%	89%
96113	Developmental Testing	32%	61%	90%	68%	89%
96116	Neurobehavioral Status Exam	81%	91%	89%	87%	89%
96121	Neurobehavioral Status Exam	84%	88%	85%	85%	89%
96130	Psychological Testing Evaluation	90%	95%	100%	96%	100%
96131	Psychological Testing Evaluation	97%	95%	99%	98%	100%
96132	Neuropsychological Testing Evaluation	99%	95%	100%	98%	89%
96133	Neuropsychological Testing Evaluation	96%	91%	100%	97%	89%
96136	Psychological Testing Administration	99%	99%	99%	99%	100%

% of Membership Market Share Represented by Carriers Showing Usage of Service Code						
CPT/ HCPCS Service Code	**Service**	**Individual**	**Small Group**	**Large Group**	**Total Fully Insured**	**Medicaid MCO**
96137	Psychological Testing Administration	99%	99%	99%	99%	89%
99201	E&M New Patient	0%	10%	0%	2%	10%
99202	E&M New Patient	87%	91%	89%	89%	100%
99203	E&M New Patient	81%	91%	96%	91%	100%
99204	E&M New Patient	91%	96%	100%	97%	100%
99205	E&M New Patient	97%	100%	100%	99%	100%
99211	E&M Established Patient	59%	96%	100%	88%	72%
99212	E&M Established Patient	69%	100%	100%	92%	72%
99213	E&M Established Patient	100%	99%	100%	100%	100%
99214	E&M Established Patient	96%	100%	100%	99%	100%
99215	E&M Established Patient	96%	100%	100%	99%	100%
99341	E&M New Patient	7%	0%	21%	13%	0%
99342	E&M New Patient	7%	0%	21%	13%	38%
99343	E&M New Patient	7%	36%	25%	22%	46%
99344	E&M New Patient	7%	40%	21%	21%	46%
99345	E&M New Patient	7%	0%	10%	7%	38%
99347	E&M Established Patient	7%	0%	21%	13%	38%
99348	E&M Established Patient	8%	12%	36%	24%	57%
99349	E&M Established Patient	7%	38%	25%	23%	46%
99350	E&M Established Patient	12%	12%	29%	21%	46%
99354	Prolonged Visit – First 60 minutes	92%	81%	99%	94%	100%
99355	Prolonged Visit – Each Additional 30 Minutes	81%	48%	55%	61%	100%
99401	Preventive Medicine Counseling 15 Minutes	37%	45%	85%	64%	53%
99402	Preventive Medicine Counseling 30 Minutes	4%	14%	49%	29%	53%
99406	Smoking and Tobacco Use Cessation Counseling – Intermediate: Greater than 3 minutes and up to 10 minutes	83%	91%	86%	86%	100%
99407	Smoking and Tobacco Use Cessation Counseling – Intensive: Greater than 10 minutes	50%	88%	84%	75%	89%
99415	Prolonged Visit - First 60 minutes	25%	0%	20%	17%	38%
99416	Prolonged Visit - Each Additional 30 Minutes	25%	0%	8%	11%	38%
99417	Prolonged Visit – Each Additional 15 Minutes	61%	98%	100%	89%	100%
G0396	Screening, Brief Intervention and Referral to Treatment (SBIRT)	24%	27%	37%	31%	89%
G0397	Screening, Brief Intervention and Referral to Treatment (SBIRT)	0%	0%	0%	0%	53%
G2212	Prolonged Visit – Each Additional 15 Minutes	90%	64%	80%	80%	89%
H0001	SUD Assessment	2%	0%	11%	6%	100%
H0004	Individual Counseling	17%	27%	15%	18%	100%

% of Membership Market Share Represented by Carriers Showing Usage of Service Code						
CPT/ HCPCS Service Code	**Service**	**Individual**	**Small Group**	**Large Group**	**Total Fully Insured**	**Medicaid MCO**
H0005	Group Counseling	54%	73%	67%	65%	100%
H0006	SUD Case Management	57%	73%	69%	66%	100%
H0010	Clinically Managed Withdrawal Management ASAM 3.2 WM	4%	0%	0%	1%	100%
H0011	Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM	3%	0%	0%	1%	100%
H0012	Withdrawal Management Per Diem ASAM 2 WM	0%	0%	0%	0%	100%
H0014	Withdrawal Management Hourly ASAM 2 WM	0%	27%	23%	18%	89%
H0015	Group Counseling IOP Level of Care	50%	41%	85%	67%	100%
H0036	Community Psychiatric Supportive Treatment	29%	40%	39%	36%	100%
H0038	SUD Peer Recovery Support	0%	2%	10%	6%	100%
H0040	Assertive Community Treatment	0%	0%	0%	0%	100%
H0048	Urine Drug Screening – collection, handling and point of service testing	29%	45%	46%	41%	100%
H2012	TBS Group Service (Day Treatment) per hour less than 2.5 hours	55%	50%	55%	54%	100%
H2015	Intensive Home Based Treatment (IHBT)	0%	0%	21%	11%	100%
H2017	Nursing Services – Individual	21%	10%	44%	31%	100%
H2019	Group Therapeutic Behavioral Services (TBS) – 15 minutes	68%	89%	90%	84%	100%
H2020	TBS Group Service (Day Treatment) or more hours (per diem)	25%	10%	25%	22%	100%
H2033	Multi-Systemic Therapy for Juveniles (MST)	0%	0%	0%	0%	0%
H2034	Clinically Managed Low Intensity Residential Treatment ASAM 3.1	0%	0%	0%	0%	100%
H2036	Clinically Managed Population-Specific High Intensity Residential Treatment ASAM 3.3 (Adults)	4%	12%	36%	22%	100%
T1002	Nursing Services	3%	16%	36%	23%	100%
T1003	Nursing Services	0%	16%	32%	20%	61%

Appendix III – Service Codes with Low Utilization in the Fully Insured Market

Service Codes with Low Usage in the Fully Insured Market		
CPT/ HCPCS Service Code	**Service**	**NovaRest Determination of Coverage in the Fully Insured Market**
90849	Multiple-family group psychotherapy	Covered – Carriers representing a majority of membership in fully insured market reported usage. Low usage reported in individual market, however, both individual and small group ACA plans must follow the EHB Benchmark Plan. Therefore, we assume the benefit is covered considering usage by carriers representing a majority of membership in small group market.
93005	Electrocardiogram tracing only w/o interpretation and report	
93010	Electrocardiogram interpretation and report only	
96113	Developmental Testing	
99201	E&M New Patient	Covered – Alternative codes include 99202, 99203, 99204, and 99205 which carriers representing a majority of membership in all fully insured markets reported usage. Low usage reported for these service codes in the Medicaid MCO market as well.
99341	E&M New Patient	
99342	E&M New Patient	
99343	E&M New Patient	
99344	E&M New Patient	
99345	E&M New Patient	
99347	E&M Established Patient	Covered – Alternative codes include 99211, 99212, 99213, 99214, and 99215 which carriers representing a majority of membership in all fully insured markets reported usage. Low usage reported for these service codes in the Medicaid MCO market as well.
99348	E&M Established Patient	
99349	E&M Established Patient	
99350	E&M Established Patient	
99355	Prolonged Visit – Each Additional 30 Minutes	Covered – Carriers representing a majority of membership in fully insured market reported usage. Low usage reported in small group market, however, both individual and small group ACA plans must follow the EHB Benchmark Plan. Therefore, we assume benefit is covered considering usage by carriers representing a majority of membership in individual market.
99401	Preventive Medicine Counseling 15 Minutes	Covered – Carriers representing a majority of membership in fully insured market reported usage for the 15 minute code. 15 minute code more reported more usage in all markets. Multiple other counseling codes are available. Usage in Medicaid MCO market represents barely over 50% of market.
99402	Preventive Medicine Counseling 30 Minutes	
99415	Prolonged Visit - First 60 minutes	Covered – Alternative codes include 99354 and 99355 which carriers representing a majority of membership in fully insured markets reported usage. Low usage reported for these service codes in the Medicaid MCO market as well.
99416	Prolonged Visit - Each Additional 30 Minutes	
G0396	Screening, Brief Intervention and Referral to Treatment (SBIRT)	Covered – Discussions with medical providers indicate usage of these codes is rare, and other screening codes are much more common. Carrier form filing information indicates screening services are generally covered.
G0397	Screening, Brief Intervention and Referral to Treatment (SBIRT)	

Service Codes with Low Usage in the Fully Insured Market		
CPT/ HCPCS Service Code	**Service**	**NovaRest Determination of Coverage in the Fully Insured Market**
H0001	SUD Assessment	Covered - Medical provider discussion indicate this is a low use code. Very low usage reported for this service codes in the Medicaid MCO market as well.
H0004	Individual Counseling	Covered – Multiple other counseling codes are available. Very low usage reported for this service codes in the Medicaid MCO market as well.
H0010	Clinically Managed Withdrawal Management ASAM 3.2 WM	Covered – ASAM code, not commonly used by carriers in the fully insured market. Follow-up with carriers indicate these services were typically covered in the fully insured market with 16 of the 20 carriers covering this service using the H0010 medical code and the remaining four using different medical codes for similar services.
H0011	Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM	Covered – ASAM code, not commonly used by carriers in the fully insured market. This level of care is considered emergency medically necessary, which would be covered under alternative codes.
H0012	Withdrawal Management Per Diem ASAM 2 WM	Covered – ASAM code, not commonly used by carriers in the fully insured market. Follow-up with carriers indicate these services were typically covered in the fully insured market with 16 of the 20 carriers covering this service using the H0012 medical code and the remaining four using different medical codes for similar services.
H0014	Withdrawal Management Hourly ASAM 2 WM	Covered – ASAM code, not commonly used by carriers in the fully insured market. Higher usage in the fully insured market than H0012, which is a similar service on a per diem basis.
H0015	Group Counseling IOP Level of Care	Covered – Carriers representing a majority of membership in fully insured market reported usage. Low usage reported in small group market, however, both individual and small group ACA plans must follow the EHB Benchmark Plan. Therefore, we assume benefit is covered considering usage by carriers representing a majority of membership in individual market. Multiple other counseling codes may be used.
H0036	Community Psychiatric Supportive Treatment	Covered - Multiple other counseling codes may be used.
H0038	SUD Peer Recovery Support	Covered - Multiple other counseling codes may be used.
H0040	Assertive Community Treatment	Covered – After follow-up with carriers, of the 20 carriers in the fully insured market, 7 cover the same clinical codes used by the Medicaid MCOs, 10 use alternative clinical codes for similar services, and 3 indicated services were not covered and did not cover alternate clinical codes or sites of service.
H0048	Urine Drug Screening – collection, handling and point of service testing	Covered - Multiple other screening codes may be used.

Service Codes with Low Usage in the Fully Insured Market		
CPT/ HCPCS Service Code	**Service**	**NovaRest Determination of Coverage in the Fully Insured Market**
H2012	TBS Group Service (Day Treatment) per hour less than 2.5 hours	Covered – Carriers representing a majority of membership in fully insured market reported usage. Low usage reported in small group market, however, both individual and small group ACA plans must follow the EHB Benchmark Plan. Therefore, we assume benefit is covered considering usage by carriers representing a majority of membership in individual market.
H2015	Intensive Home Based Treatment (IHBT)	Covered -After follow-up with carriers, of the 20 carriers in the fully insured market, only 5 cover the services under the H2015 clinical code, 10 cover similar services under different codes, 2 indicated they have never been billed this code, and 3 carriers indicated that these services were not covered.
H2017	Nursing Services – Individual	Covered – According to medical provider discussion, commercial more likely to use non-BH specific nursing codes.
H2020	TBS Group Service (Day Treatment) or more hours (per diem)	Covered – Alternate codes include H2012 and H2019. Carriers in fully insured market less likely to use per diem according to discussions with medical providers.
H2033	Multi-Systemic Therapy for Juveniles (MST)	No usage by any market, including Medicaid MCO
H2034	Clinically Managed Low Intensity Residential Treatment ASAM 3.1	Covered – After carrier follow-up, while fully insured plans do not cover halfway house services, residential detox services are covered under other transitional inpatient or outpatient sites of service and clinical codes. In the fully insured market, 8 of the 20 carriers cover the services under the H2034 clinical codes, 10 provide services under alternative but similar codes, and 2 carriers indicated services were not covered.
H2036	Clinically Managed Population-Specific High Intensity Residential Treatment ASAM 3.3 (Adults)	Covered – ASAM code, not commonly used by carriers in the fully insured market. This level of care is considered emergency medically necessary, which would be covered under alternative codes.
T1002	Nursing Services	Covered – According to medical provider discussion, commercial more likely to use non-BH specific nursing codes.
T1003	Nursing Services	Covered – According to medical provider discussion, commercial more likely to use non-BH specific nursing codes.

Appendix IV – Comparison of Utilization between Fully Insured Market and Medicaid MCOs

Utilization by Market (Utilization measured as visits, procedures, days, etc., consistent with the Medicaid BH Manual)		
Service	**Fully Insured Market**	**Medicaid MCO**
Assertive Community Treatment	None	Very High
Clinically Managed High Intensity Residential Treatment ASAM 3.5	Very Low	Very High
Clinically Managed Low Intensity Residential Treatment ASAM 3.1	None	Very High
Clinically Managed Population-Specific High Intensity Residential Treatment ASAM 3.3 (Adults)	Very Low	Very High
Clinically Managed Withdrawal Management ASAM 3.2 WM	Very Low	Very High
Community Psychiatric Supportive Treatment	Very Low	Very High
Developmental Testing	Very High	Very Low
E&M Established Patient	High	Low
E&M New Patient	Very High	Very Low
Electrocardiogram - at least 12 leads w/ interpretation and report	Very High	Very Low
Electrocardiogram interpretation and report only	Very High	Very Low
Electrocardiogram tracing only w/o interpretation and report	Very High	Very Low
Family psychotherapy (conjoint, w/ patient present) – 50 minutes	High	Low
Family Psychotherapy w/o patient – 50 minutes	High	Low
Group Counseling	Very Low	Very High
Group Counseling IOP Level of Care	Very Low	Very High
Group Psychotherapy (not multi-family group)	Low	High
Group Therapeutic Behavioral Services (TBS) – 15 minutes	Very Low	Very High
Individual Counseling	Very Low	Very High
Individual Psychotherapy – 30 minutes	Medium	Medium
Individual Psychotherapy – 45 minutes	Medium	Medium
Individual Psychotherapy – 60+ minutes	High	Medium
Individual Psychotherapy w/ E&M Service	High	Low
Intensive Home-Based Treatment (IHBT)	Very Low	Very High
Intensive Home-Based Treatment (other than MST or FFT)	None	Very High
Interactive Complexity	Medium	Medium
Medically Monitored Inpatient Withdrawal Management ASAM 3.7 WM	Very Low	Very High
Medically Monitored Intensive Inpatient Treatment (Adults) and Medically Monitored High Intensity Inpatient Services (Adolescent) ASAM 3.7	Very Low	Very High
Multiple-family group psychotherapy	Very High	Very Low
Multi-Systemic Therapy for Juveniles (MST)	None	None
Neurobehavioral Status Exam	Very High	Very Low
Neuropsychological Testing Evaluation	Very High	Very Low
Nursing Services	Very Low	Very High

Utilization by Market (Utilization measured as visits, procedures, days, etc. consistent with the Medicaid BH Manual)		
Service	**Fully Insured Market**	**Medicaid MCO**
Nursing Services – Individual	Very Low	Very High
Preventive Medicine Counseling 15 Minutes	Very High	Very Low
Preventive Medicine Counseling 30 Minutes	Very High	Very Low
Prolonged Visit – Each Additional 15 Minutes	High	Low
Prolonged Visit - Each Additional 30 Minutes	Medium	Medium
Prolonged Visit – Each Additional 30 Minutes	Medium	Medium
Prolonged Visit - First 60 minutes	Very High	Very Low
Prolonged Visit – First 60 minutes	Medium	Medium
Psychiatric Diagnostic Evaluation w/ Medical	High	Low
Psychiatric Diagnostic Evaluation w/o Medical	High	Medium
Psychological Testing Administration	Very High	Very Low
Psychological Testing Evaluation	Very High	Very Low
Psychosocial Rehabilitation	Very Low	Very High
Psychotherapy for Crisis – add'l 30 minutes	Medium	Medium
Psychotherapy for Crisis – first 60 minutes	High	Low
Screening, Brief Intervention and Referral to Treatment (SBIRT)	Low	High
Smoking and Tobacco Use Cessation Counseling – Intensive: Greater than 10 minutes	Medium	Medium
Smoking and Tobacco Use Cessation Counseling – Intermediate: Greater than 3 minutes and up to 10 minutes	Medium	Medium
SUD Assessment	Very Low	Very High
SUD Case Management	Very Low	Very High
SUD Peer Recovery Support	Very Low	Very High
TBS Group Service (Day Treatment) or more hours (per diem)	Very Low	Very High
TBS Group Service (Day Treatment) per hour less than 2.5 hours	Low	High
Urine Drug Screening – collection, handling and point of service testing	Very Low	Very High
Withdrawal Management Hourly ASAM 2 WM	Low	High
Withdrawal Management Per Diem ASAM 2 WM	None	Very High

Scale as a % of total combined Fully Insured Market and Medicaid MCO utilization per 1,000 (measured as visits, procedures, days, etc. consistent with the Medicaid BH Manual)	None: 0%	0% < Very Low < 10%
	10% < Low < 25%	25% < Medium < 75%
	75% < High < 90%	90% < Very High