Behavioral Healthcare Reimbursement Design in Ohio

Current and Future States

A long time ago in a galaxy far, far away….

History of Behavioral Healthcare in Ohio and formation of Community Mental Health Centers

- National Mental Health Act of 1946
  - Support research related to the cause, diagnosis, and treatment of mental illness
  - Provide fellowships and grants for training mental health professionals
  - Award grants to states to establish clinics and other treatment centers, and to promote demonstration studies that would further the national understanding of mental illness and treatment

- Mental Retardation and Community Mental Health Centers Construction Act of 1963
  - Construction of Community Mental Health Centers took place at a much slower pace than planned
- Ohio House Bill 648 , July 1967
  - Created county and multi-county board for mental health
- Mental Health Systems Act of 1980 / Omnibus Budget Reconciliation Act of 1981
- State Comprehensive Mental Health Services Act of 1986

Ohio State Psychiatric Hospital Utilization

Source: A Report of Ohio's Acute Mental Health Care: An Update Report of the 2004 "Crisis in Ohio's Acute Mental Health Care." by Sandra Stephenson

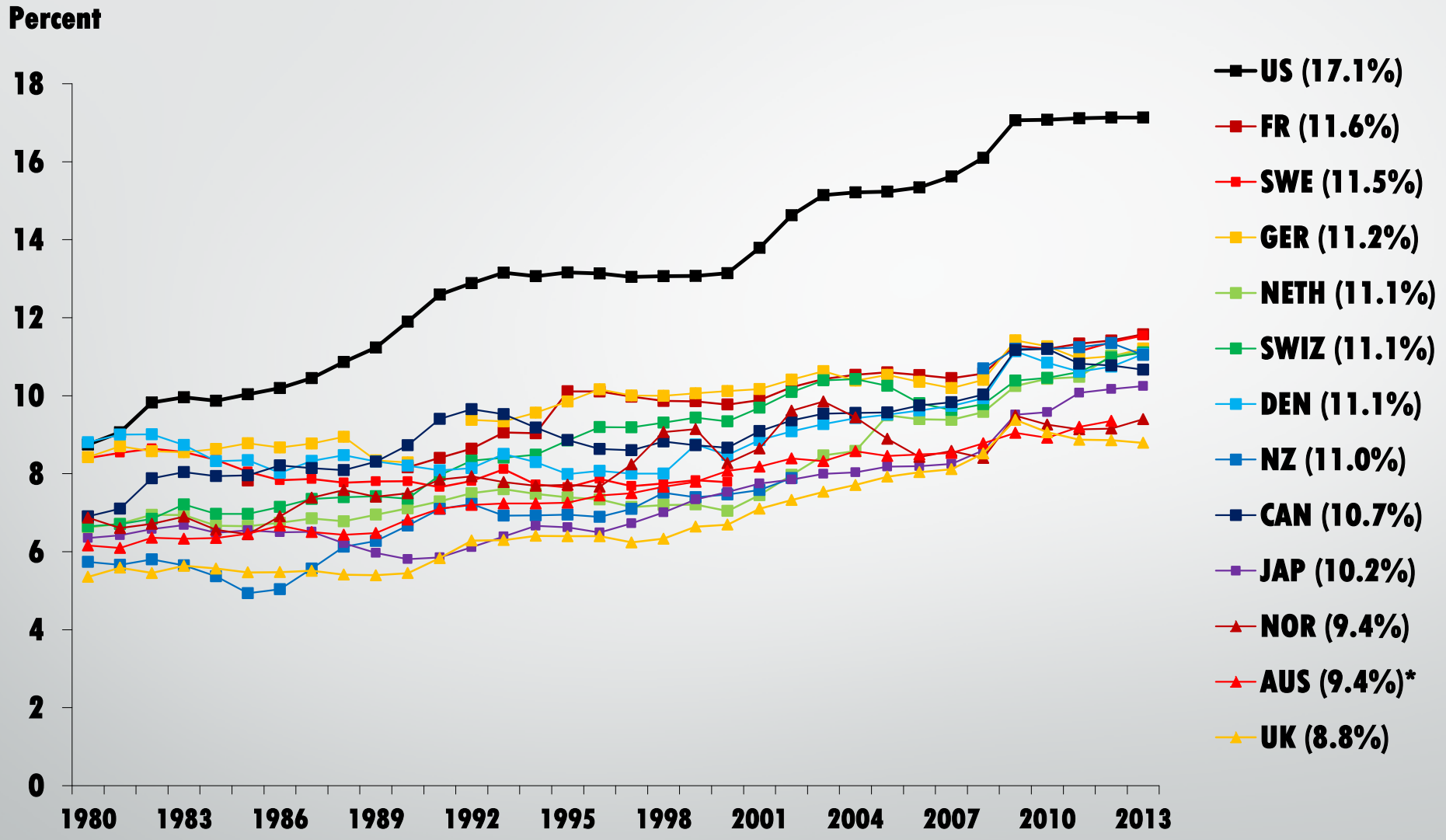
How did the Dollars flow to the CMHC's?

- Ohio sought and received a waiver under the Rehabilitative Services provision of the federal Medicaid program for more comprehensive behavioral health & social services delivery outside of institutions
- Community Mental Health Centers, certified by the state, at first divided into specific catchment areas, were funded for 7 services: Counseling, Crisis, Prehospital Screening, Assessment, Medication/Somatic, Partial Hospitalization, and Community Support
- Services were billed at the lesser of budgeted costs per unit or the rate cap established by the 95th percentile of the actual costs reported 2 years prior
- Services were billed in units of time
- Rate caps were frozen after the 7/1/1997 adjustment, and the 1997 rate caps were then put into place as fixed rates in 2012 with the elimination of cost reconciliation
- Outpatient services for mental health CPT codes were not reimbursable to providers, only bundled codes and only for those with OMHAS certification

Services and rates bundled traditional healthcare with social services

Actual costs used in order to include both components of care

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013

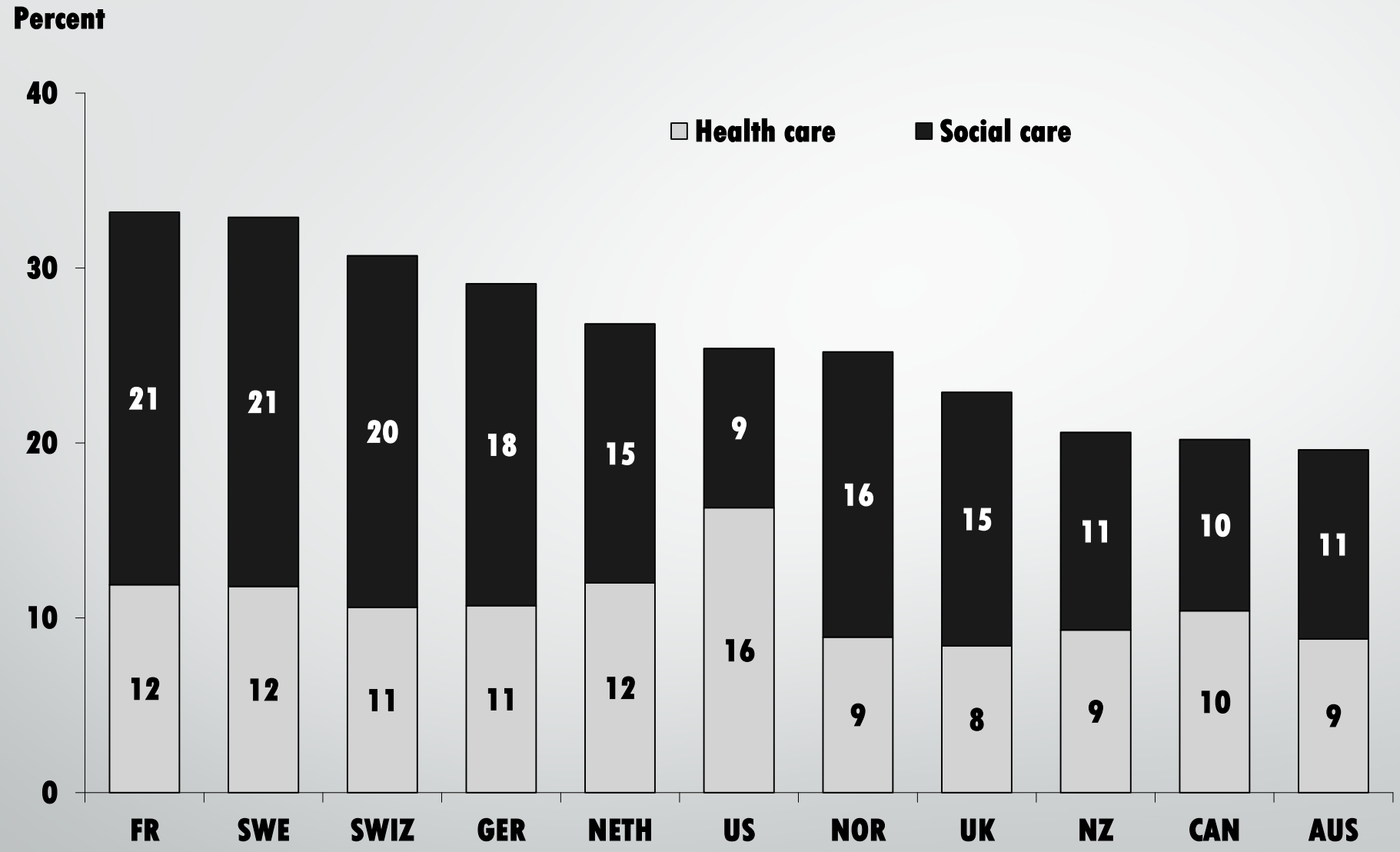


* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

Exhibit 8. Health and Social Care Spending as a Percentage of GDP



Notes: GDP refers to gross domestic product.

Source: E. H. Bradley and L. A. Taylor, *The American Health Care Paradox: Why Spending More Is Getting Us Less*, Public Affairs, 2013.

Example of treatment received without social service component

A 45 year old male presents himself in urgent care complaining of left shoulder pain
The following services are provided:

- Initial assessment by an Advanced Practice Nurse including review of systems and symptoms, no significant findings, patient does report has been off maintenance medication for 30 days for an unrelated condition, does not want to answer more questions, time spent 10 minutes, reimbursement $150
- X-ray of shoulder, no abnormal findings, reimbursement $200
- MRI of shoulder, no abnormal findings, reimbursement $4,000
- Patient is sent home with Ibuprofen 800mg and a 14 day supply of maintenance medication, advised to see primary care physician for follow-up
- Patient reports at time of discharge his shoulder still hurts.

- Total reimbursement under fee for service $4,350

Example of treatment received with social service component

A 45 year old male presents himself in urgent care complaining of left shoulder pain
The following services are provided:

- Initial interview, 5 minutes, by a LPN trained in psychiatric care, patient doesn't want to answer many questions. Does report hasn't eaten in the last 24 hours.
- Meal provided to patient
- LPN tries initial interview again and spends 25 minutes. Interview includes questions about daily living activities including housing, meals, employment, and family support systems. Client is now cooperative with answering questions.
- Advanced Practice Nurse updated from LPN as to interview findings.
- Initial assessment by an Advanced Practice Nurse including review of systems and symptoms, no significant findings.

- APN asks the patient why he has been sleeping for the past week on a park bench per the interview report from the LPN. Patient reports that he hasn't taken his medication for a psychiatric disorder in the last 30 days because he didn't like the side effects and had a fight with his family. He left his home and has been sleeping on a park bench for 3 nights. APN considers this may be the cause of his shoulder pain.
- Patient is sent to a mental health crisis residential unit for 2 nights while staff contacts family.
- Patient sees psychiatrist next day on rounds. Psychiatrist discusses unfavorable side effects of medication patient stopped taking, and starts client on a modified medication schedule.
- Family comes in for counseling with the patient over the next 2 days and a plan is developed to return the client back home and receive follow-up services.
- Patient is sent home reporting no pain in shoulder, with updated maintenance medication and scheduled follow up visits.

- Total reimbursement for services (assume client has Medicaid):
  - Bundled CMHC reimbursement from Medicaid $1,021
  - Grant from county to cover room & board $544
  - Total cost $1,565

Which of the above was the better value to the payer?

Which of the above would you have preferred to receive yourself or for a loved one?

Is Behavioral Health redesign going to make this Better? Worse? Or the Same?

Ohio Behavioral Health Redesign

- Standardize Codes to match traditional healthcare billing so can be assumed by managed care
- Keep cost within current state spend

Step 1: Change Code Set

Healthcare Equivalents

- Those services that there are current CPT codes under which billing can occur
  - Physician Services
  - Counseling Services
- Currently available CPT codes to be utilized
- Time ranges or procedure based

Comprehensive Services

- Those services that combine healthcare elements with social service elements
  - Therapeutic Behavioral Services and Psychosocial Rehabilitation
  - Nursing Services
  - Day Treatment
  - Community Supportive Treatment
  - SBIRT, ACT, IHBT
- HCPCS Codes to be utilized
- Time length or day billings

Step 2: Set Rates

Healthcare Equivalents

- Based as a percentage of current Medicare fee schedule
  - Percentage varies by code
  - Reduction for those licensed individuals not at MD/PhD level, although not necessarily consistent with Medicare
- State also added abundant use of modifiers and added additional rate variance due to place of service codes

Comprehensive Services

- Rates set by the Department of Medicaid
  - Do not necessarily correlate to a national rate or actual costs reported
  - Reimbursement varies not only by license, but for unlicensed staff by educational level and/or years of experience
- State also added abundant use of modifiers and added additional rate variance due to place of service codes


That's all Folks!
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CLOSE

BUT

NOT

QUITE …

Expansion of Behavioral Health Services to Hospital Providers

- Hospitals were given access to the new codes and rates effective August 1, 2017
- No additional certification through OMHAS is required
- Do not need to credential non-independently licensed and non-licensed providers
- May bill non-independently licensed and non-licensed providers under independently licensed supervisor

- Community Mental Health and Addiction Services Centers will be required to use only the new codes effective January 1, 2018
- Must still obtain and maintain additional certification through OMHAS although deemed status remains for JCAHO, CARF certified agencies
- Need to credential all staff, including effective July 1, 2018 non-licensed staff
- Many not bill under supervisor

Community Mental Health Centers Requirement to Contract with Managed Care Insurers

- Effective July 1, 2018, Community Mental Health Centers may no longer bill Medicaid services directly to the state, but must instead contract with and bill services to an client/patient's individual managed care Medicaid insurer
- Managed care Medicaid companies will not be required to contract with individual Community Mental Health Centers
- Length of time to accept claim may be shortened to 180 days
- May change fee for service polices starting July 1, 2019
- Prompt payment requirements of 90% of claims within 90 days and 99% within 90 days


winners
&losers

Higher and lower reimbursement rates under redesign

Higher

- Physician Services
- Psychotherapy Services
- SUD Services (they were previously reimbursed at lower rates than comparable MH services based upon rates set at actual cost reporting)

lower

- Nursing services
- Care Management Services (some variation though depending on place of service and training level of staff)
- Crisis Services

Common Concerns from CMHC's

- Rate decrease for some services
- Providers who only serve the low intensity clients leaving only high intensity clients for the CMHC's to serve
- Cash flow shortages due to increase in time from clean claim to payment
- Additional administrative burden to credential staff and to contract with multiple managed care companies
- Lack of recognition of some of the services in the new code set (i.e. crisis and mobile crisis)
- Complexity of requirements of multiple modifiers and place of service codes
- Unified billing submission replaced by need to bill individual managed care insurers
- Negative impact on already scarce workforce at a time when service demand is extremely high due to coverage expansion and Opioid epidemic


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Why are Community Mental Health Centers so Vulnerable??

- Decades of cost or cost less reimbursement from Medicaid, their biggest payer
- Grant based funding typically also does not allow a profit and must be renewed annually
- Commercial insurers typically paid below Medicare rates for behavioral healthcare services
- Codes, or lack there of…..

Why Fee for service alone does not work in psychiatric care for many patients

- Current fee for service codes (CPT&HCPCS) don't factor in the human service aspect of client care (social determinants) often needed in psychiatric care, particularly for the more severely ill patients
- In other healthcare specialties reimbursement goes up for more complex cases when more procedures are added to E&M codes, psychiatric care lacks such add on codes with the exception of interactive complexity
- Diagnostics done by machines have codes with generous fees and generally aren't done in psychiatry
- Severely and Persistently Mentally ill individuals commonly have co-occurring disorders that require additional care coordination time

Which came first the chicken or the egg? Which came first the SERVICE CODE or the Reimbursement?

Medical coding originated when most psychiatric care was performed primarily in an inpatient setting. Due to carve outs (Separate arrangements for the payment of psychiatric care versus other types of care) when these services moved to outpatient in the late 70's, and 80's, many of the needed codes were not developed in the same manner as other medical care.

Most important code/rate missing from the BH redesign schedule?

- Rates that adequately reimburse for care that transitions between the highest intensity (hospitalization) to the lowest intensity (outpatient) care and rates to care for the most severely ill. (i.e. mental health crisis residential)

- Rates to care for Severely and Persistently Mentally Ill Adults and Severely Emotionally Disturbed Youth

Benefits of Behavioral Health Redesign

- Common code set
- Ability to coordinate payment between multiple payers
- Continues the path to integrate psychiatric care with primary care and other specialties
- Supports further the need to build a continuum of care that includes hospitals and community mental health centers
- Ability to gain fuller understanding of the actual workforce and the shortage of providers

Going forward

- REDESIGN IS GOING TO HAPPEN
- IN ORDER TO GAIN PARITY WITH OTHER MEDICAL AREAS, BEHAVIORAL HEALTH HAS TO MOVE TOWARDS COMMON CODE SETS WITH OTHER HEALTHCARE
- CONTINUE TO WORK TO ADD CODES THAT DEFINE WHAT SERVICES ARE IN BEHAVIORAL HEALTH AND RECOGNIZE THE VALUE OF A TRAINED PROFESSIONAL'S OBSERVATIONAL AND INTERVIEW SKILLS – THIS IS ALSO CRITICAL TO PRIMARY CARE
- LOOK AT THE FULL ARRAY OF CODES AND POTENTIAL SERVICE OFFERINGS AVAILABLE

Episodic Value Based Payment

Value-Based Payment (VBP) is a strategy used by purchasers to promote quality and value of health care services. The goal of any VBP program is to shift from pure volume-based payment, as exemplified by fee-for-service payments to payments that are more closely related to outcomes.

Important to advocate for the proper balance between funding for human service, medical service, and pharmaceutical substance components in our health & wellness system

Population Health

Recognition of Social Determinants of Health

http://bh.medicaid.ohio.gov/manuals

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