CHAPTER 8: ASSESSMENT OF THE IMPACT OF OBH REDESIGN

8.1 Introduction .................................................................................................................................................. 381

8.2 The Medicaid redesign changed how behavioral health is funded .......................................................... 381

8.3 Responses from executive directors (N=34) ........................................................................................... 382

8.4 Responses from providers (N= 61) ......................................................................................................... 384

8.5 Conclusion .................................................................................................................................................. 385
CHAPTER 8: ASSESSMENT OF THE IMPACT OF OBH REDESIGN

Medicaid Behavioral Health Redesign in Cuyahoga County

The survey asked Executive Directors and providers an open-ended question on how the Medicaid Redesign impacted their services. The following background is provided as context for these responses.

8.1 Introduction

The Medicaid Redesign Initiative began in Ohio in 2017. Medicaid Redesign in Ohio has been designed to modernize the community behavioral health benefit package to align with national standards and to expand services to those most in need. An additional goal was to integrate behavioral health into Medicaid managed care. The vision and desired outcomes of Medicaid Redesign are:

- All providers practice at the top of their scope of professional practice
- Integrate behavioral and physical health services
- Make high intensity services available for those with SPMI and SED, and addiction
- Improve health outcomes for those with mental illness and/or addiction
- Services and supports that are sustainable with budgeted resources
- Implement a value-based payment method
- Coordinate benefits across payers
- Expand community-based rehabilitation

8.2 The Medicaid redesign changed how behavioral health is funded

During the initial period when the emphasis of treatment modalities shifted from State Mental Hospitals to community-based treatment, agencies received annual grants, with minimal reporting requirements. This was followed by a move towards fee-for-service billing, with a minimal service code set, to align community behavioral health funding more closely with private sector healthcare reimbursement practices.

At the beginning of the fee-for-service initiatives, both Medicaid and non-Medicaid claims flowed through the ADAMHS Board utilizing a State mandated system call MACSIS. During this era, the ADAMHS Board noted that the fee-for-service billing requirements exposed service delivery inefficiencies and some poor business practices. To put this in perspective, many smaller agencies tend to focus on service delivery
rather than billing systems, and were not prepared, and perhaps even resisted assuming a “business” perspective to their operations.

In 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) was passed, as part of the American Recovery and Reinvestment Act of 2009 (ARRA). Provider billing requirements in MACSIS were modified to align with the HITECH Act’s electronic billing standards. In addition, the “Money Follows the Person” demonstration, included as part of the Patient Protection and Affordable Care Act (P.L. 111-148), the Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39) impacted the way agencies were reimbursed for services. Through this demonstration, states, including Ohio, could rebalance their long-term services and supports system so that individuals have a choice of where they live and receive services. The “Money Follows the Person/Client” (MFP) initiative may be seen as helpful to Ohio in balancing its budget, and to clients, by allowing them more choice in where they receive services. From the agencies’ perspectives, the MFP means they may receive less than their annual contract. By this time, electronic billing, and fee-for-service had become routine.

Following passage of the Affordable Care Act, the State gives notice that only claims for non-Medicaid eligible clients and locally funded non-Medicaid billable services will be billed directly to the ADAMHS Board. The State of Ohio assumed responsibility for Medicaid match requirements and mandated all Medicaid-eligible services were to billed through Medicaid HMO’s. Medicaid claims are billed using the BH Redesign code set.

In July 2019, the ADAMHS Board deployed a new claims processing system named GOSH. Providers were required to bill for services back to January 1, 2019. Effective July 1, 2019, the Board fully implemented the Behavioral Health Redesign code set. This code set replicates the Medicaid code set, and the Board’s payment structure mirrors the Medicaid rate structure. Non-Medicaid non-treatment services retained the previous MACSIS code set. Billing complexity for behavioral health providers now roughly approximates those of physical health providers.

8.3 Responses from executive directors (N=34)

All Executive Directors and key administrators participating in the survey responded to the question on the extent that Medicaid Redesign impacted service delivery. Most Executive Directors (74%) indicated that Medicaid Redesign impacted the delivery of services either quite a lot (47%), or somewhat (27%).

Respondents were also asked to comment on how they perceived Medicaid Redesign to have impacted service delivery. Not all respondents provided feedback on this
question. While most comments spoke to the increased complexity and cumbersome billing, there were some positive responses. Specifically, Medicaid redesign allows for improved reimbursement for ancillary care and care management services. One agency reported having more flexibility in hiring and that TBS services could be offered as either a stand-alone or support for some outpatient clients. Allowing psychiatric nurse practitioners to be once more billed at the same rate as psychiatrists was seen as helpful. Rate change for psychotherapy and Day Treatment was also welcome change, and the addition of family therapy is a plus for many programs. Additionally, it was noted that the Redesign allowed more individuals to receive Medicaid benefits.

In terms of drawbacks, most focused on billing and reimbursement, though there were some drawbacks noted in terms of services as well.

Regarding billing, it was noted Medicaid HMOs are not paying enough for residential treatment. Additionally, one respondent noted that residential treatment centers do not get paid on days where patients have appointments for other medical or mental health needs. This comment may reflect the “money follows the person” initiative, included as part of the Patient Protection and Affordable Care Act (P.L. 111-148), and the Sustaining Excellence in Medicaid Act of 2019 (P.L. 116-39). When Ohio implemented these changes, it provided the state with more opportunity to balance its budget, and overall, allows clients more choice in where they receive services. From agencies’ perspective, the MFP means they may receive less than their annual contract.

Residential treatment centers are not able to complete intake assessments while patients are admitted. In terms of billing, the assumption may be that an intake occurs before admission, providing rationale for such an admission.

There is less community provider contact when patient is hospitalized due to billing constraints - much more focus on medical necessity. Reduced reimbursement to the point that it threatens the financial viability of many agencies. Heavily strained the few IT resources that non-profit agencies have. Slowed reimbursement down so severely that many agencies are teetering on the edge and may close. It has become more cumbersome and time intensive to bill. The impact has been both positive and negative. On the negative side it significantly limited what we can bill under assessment. Assessments are now more streamlined than before Medicaid Redesign and we do continued assessment under psychotherapy. This has left many clinicians feeling like they could not take the time or multiple sessions to get a thorough assessment up front. With psychological testing they did start allowing us to bill some hours for writing but their significant cuts to the rates have made it harder to break even on testing. Their removal of RNs from billing psychotherapy has eliminated our ability to allow Psychiatric
NP students (they all have RNs) to do a treatment placement while working on their degree. Our services are not Medicaid billable. Reduced reimbursement rates, MCOs do not adhere to rates, MCO's cut short length of services through redesign, difficulty in billing, lack of consistency, information varies. The redesign has allowed for the further implementation of the Clubhouse Model of Psychiatric Rehabilitation which is potentially transformative to our community mental health care system. the need for Prior Authorization with MCOs. we stopped billing due to the challenges. Qualifications and credentialing of those allowed to provide the service. The change in reimbursement rates.

8.4 Responses from providers (N= 61)

Almost all respondents (61 of 64) responded to the question regarding the extent that Medicaid Redesign impacted service delivery. Of these, over 70% of providers indicated that Medicaid Redesign impacted the delivery of services either quite a lot (48%), or somewhat (23.3%). Twenty-eight providers provided additional feedback on how Medicaid Redesign affected services.

In terms of assessment, it changed how they were able to bill for assessment. Reimbursement for assessments decreased significantly. Clients are high-risk and high need and our assessments are done for the court. These usually takes two to three hours to gather quality clinical information to make an informed diagnosis and wealth of information for the court, but we are only paid for one hour. We are capped at 60 minutes for Diagnostic Assessment.

It impacts who can be served and for how long. It limits the number of sessions. They want short sessions and more results.

Many services had to be realigned for the benefit of the funder rather than for the benefit of the client needs or could benefit from. Medicaid Redesign changed our target population strategy as more providers were retaining Medicaid clients and not referring to us.

Reimbursement has always been a strain; just waiting for reimbursement. Now it is worse because the amount that can be charged for services has decreased. Pre-authorization and concurrent reviews affect reimbursement. We are now billing under individual practitioner NPIs and are spending administrative time ensuring all practitioners have valid and active NPIs and Medicaid numbers.
The MCOs were not ready to reimburse. They do not have the reports aligned with the EHR that my agency is using. Billing is more complex. There is a loss of funding. We have been given different information at different times. We are at the mercy of the MCOs and they are not being held to the standards that the State thinks they are saying.

Medicaid Redesign has been a fiasco, has rendered reimbursement ridiculous. There seems to be a higher presence of awareness about opioid addiction. One benefit is that there is now access to a broader array or needed specialty services. We can bill for individuals who were not billable in the past. We are grateful that residential treatment and other previously not paid services are now covered. However, MCO’s are applying adult models of care to youth. While 30 days of treatment may be sufficient for an adult, that number of days is not often the number that youth need. We have to spend multiple hours to complete paperwork, have doctor to doctor reviews, appeal denials that are arbitrary just to get a few days of treatment covered. We are also able to connect clients to psychiatry who we were not able to connect in the past. The ability to provide psychiatric services (medication management) via telephone has dramatically improved our attendance rates. It has greatly improved access to much needed services and removed the barrier of transportation. We have many success stories of people with agoraphobia or the like who would never come into the office but have now been receiving services. Overall, many more Ohio residents can access mental health and substance use services.

8.5 Conclusion

This chapter provided a brief overview of Medicaid Redesign and rationale for Medicaid Redesign in Ohio. Following this, the chapter summarizes feedback from Executive Directors and providers on how they perceive the Redesign impacted services. Most Executive Directors and Providers indicated that Medicaid Redesign had impacted service delivery quite a lot, or somewhat. Both groups identified what they see as drawbacks, and also described benefits for clients.

- The main drawback was how Redesign impacted the reimbursement process and the way services were able to be reimbursed.
- The main benefit for both groups is that more services were being provided and more clients now have access to services.