Signature HEALTH

When you need help now.

Joint Medicaid Oversight Committee Testimony

Jonathan Lee, CEO
Signature Health

September 22, 2016

Chairman Burke and Honorable Members of the JMOC Committee

First, I want to thank you for the honor of the invitation to submit written testimony and appear before the committee to testify in person regarding the behavioral health redesign effort.

My name is Jonathan Lee, and I am the CEO of Signature Health, Inc which is an Ohio certified and CARF accredited community mental health center and addiction treatment facility with locations in Ashtabula, Lake and Cuyahoga counties. Our staff of roughly 350 professionals care for approximately 13,000 Ohio residents that have a mental illness or the disease of addiction.

I was asked to address four major areas in my testimony, specifically detailing the major challenges I see, how we are preparing for those challenges, how we are integrating with primary care and finally what tools or information would be helpful in successfully completing the redesign.

Before I address those specific issues, I want to thank Director Moody and the Office of Health Transformation (OHT) as well as Directors McCarthy and Plouck for appointing me to the behavioral health redesign committee. This has been an enormous undertaking by the departments and I have been gratified by the honor of serving and that my thoughts and suggestions have been not only taken into consideration but acted upon during this process.

I want to underscore from the beginning that I fully support and welcome the redesign effort as well as the commitment of additional resources to support behavioral health services. Although I was not asked to address the areas of consensus, there are many elements of the redesign project that are very helpful to our ability to care for our patients. In reviewing my testimony about my concerns, it would be easy for you or the departments to dismiss what I have to say as simply highly biased whining by a provider. That is not my intent. I am offering my testimony and thoughts as constructive feedback on how to improve the redesign effort.

What are the major challenges?

Although the departments and the committee have made major progress on a whole host of issues the remaining major challenges include negative work force impacts, targeted service capacity impacts, complexity concerns, concerns about the cost plus actuarial assumptions and managed care integrations issues.

38882 Mentor Avenue
Willoughby, Ohio 44094

T: 440.953.9999
F: 440.918.3839
W: www.signaturehealthinc.com

Signature HEALTH

When you need help now.

It is widely known and acknowledged by both the departments and providers alike that one of the most difficult issues facing the redesign committee was the unraveling of the doctor/nurse team based care model that uses a blended rate with time based billing and changing it to a procedure based coding model. The Department of Medicaid has been as aggressive as possible in setting the rates for prescribers at the Medicare maximum rates in order to minimize the impact of this unraveling. This was critical because all providers already have to subsidize our psychiatrists. However, there has clearly been a substantial decrease in the investment in this area mostly for nurses (RN/LPN).

I am grateful for Director McCarthy's commitment to reinvest the unused dollars from these psychiatric services into other behavioral health services. Unfortunately though, even when the dollars are moved to other areas, the nurses themselves often do not have the appropriate credentials to provide those other services and will therefore be displaced (laid off) in favor of staff who are appropriately credentialed. Even more important than the disruption to those individual staff members, the nurses act as physician extenders and therefore by laying off nurses I am lowering the overall capacity of my agency to provide psychiatric medications to my patients. This issue is particularly acute in many rural areas of the state that have large difficulties in recruiting appropriately credentialed staff.

Another significant work force impact is the design of the payment structure for mental health case management and recovery support services which are being sub-divided into three similar mental health services, therapeutic behavioral service (TBS), psychosocial rehabilitation (PSR) and community psychiatric treatment service (CPST). The Departments have attempted to design a system that provides a greater investment for services provided by more highly credentialed staff, an objective that I generally support. However, mental health case management and recovery support, currently covered as CPST, is often the entry level position that new paraprofessionals use to enter the field. They often are in school or have completed an Associates degree when they enter the field. Currently approximately 40% of my CPST staff do not have an undergraduate degree. It is in this entry level position that some go on to finish their undergraduate degree and potentially get a license, however many don't. By not creating a permanent ability for agencies to provide comprehensive case management and recovery support services that are reimbursed at the highest rates by non-degreed paraprofessionals, I will naturally no longer be willing to hire staff who don't already have their undergraduate degrees completed. This eliminates a large pool of potential employees, drives up wages for degreed professionals and cuts off a pipeline of new professionals into the field. This is a challenge for my organization and is also particularly impactful to agencies in more rural areas who don't have access to as many potential employees with degrees.

In addition to the work force and service capacity impacts above there are a few other targeted service capacity impacts I would like to draw your attention to. In addition to the unravelling of the doctor/nurse billing model, unfortunately Crisis Intervention, Group Therapy, and Urine Toxicology tests are also areas where investments were curtailed in favor of other services in the system.

38882 Mentor Avenue
Willoughby, Ohio 44094

T: 440.953.9999
F: 440.918.3839
W: www.signaturehealthinc.com

Signature HEALTH

When you need help now.

My immediate concern focuses on agencies such as Signature Health that are charged with the task of providing 24/7 crisis intervention services to area hospitals, jails, schools and in the community as gatekeepers to the state hospital system. As a part of that service we also provide Forensic monitoring services of patients who are not guilty by reason of insanity or incompetent to stand trial. Like the Police and Fire Department that hope you never need, we are a part of the safety net that ensures that people who are actively hallucinating, suicidal or homicidal, or in the throes of addiction are able to access the care they need when they need it. I am concerned that Signature Health will not be able to sustain this service post redesign implementation. I believe this is a different level of service that needs to be considered differently than standard office based crisis counseling. Presently, the proposed rate results in a 25% – 30% percent rate reduction for this vital safety net service. I also believe that the Departments recognize this concern and plans to convene work to develop additional services in the future. I look forward to participating in those discussions but urge a solution within the BH Redesign project to address the immediate issue and potential loss of capacity.

As for group therapy and urine toxicology tests, these are some of the most effective and widely used treatment modalities for addiction treatment, particularly for aftercare and relapse prevention. The substantially reduced investment (60% reduction for a 2 hour group and 80% reduction per toxicology test) in these service areas in the face of the growing opiate epidemic is highly ill advised in my opinion because it will naturally precipitate a curtailment in the availability of these services.

In transitioning from our current coding system to the new coding system there is significantly more complexity. Most of this additional complexity is manageable and provides welcome flexibility to how we provide and code our services. Naturally, we need the detailed technical specifications and sufficient time for our various IT vendors to change our electronic health record systems to accommodate the added complexity. The one area of complexity that is troubling is specifically with the mental health case management and recovery support (TBS, PSR, & CPST) services. While the Departments are considering these as basically the same service, only provided by staff with different credentials (paraprofessional vs. licensed staff) they plan on using three different codes to delineate between different education and credential levels. This raises a number of complex documentation and Medicaid compliance issues. In light of common sense regulation initiatives, I would suggest collapsing of these codes into one code that uses modifiers already in the coding model to indicate the different credential (license or education) levels not only for Medicaid compliance reasons but for IT and administrative simplification reasons.

As for the cost impact and Medicaid's targeted investment above budget neutrality, I am calling for the Department to continue their commitment to transparency. Early on we met with Mercer, the actuarial consultant, to review their assumptions and we found many inaccurate assumptions that had significant impacts on the overall budget impact analysis using the budget neutral plus modeling. After several updates to rates, credentials and other factors, virtually every provider I have spoken to is projecting a loss even though The Ohio Department of Medicaid has often told us that they are adding substantial additional dollars to the

38882 Mentor Avenue
Willoughby, Ohio 44094

T: 440.953.9999
F: 440.918.3839
W: www.signaturehealthinc.com

system. Both things may be true if providers and the department are using different assumptions. Hence, I have asked to review the updated actuarial analysis and assumptions the Department is using.

A further comment about the budget neutral plus rate modeling methodology. The Department's approach has been budget neutrality (plus) on a system basis which essentially means investing more heavily in some areas while withdrawing investment in others. But this fails to recognize one basic unintended consequence. No one runs a business that way. You don't passively take a loss on one service because you are making it up in another. Instead, you analyze each service to make sure each one is sustainable. The ones that aren't, you curtail and the ones that are you attempt to do more of. Even in the face of the clear clinical evidence of effectiveness it would be managerial malpractice not to closely manage or diminish services that had poor financial performance. Therefore it is most troubling that the Department chose to exacerbate the losses on the very services that get patients the medications they need.

The last major challenge I wanted to highlight are my concerns about integration with Managed Care. Currently the BH redesigned system is to go into effect on July 1st, 2017 and the behavioral health carve out will end with managed care integration on January 1, 2018. To date there has been no assurances that the managed care plans will follow the service provision codes and rate guidelines mandated by the redesign. It is conceivable that providers will do a tremendous amount of work hiring staff, changing/adding programs etc. for the redesign only to have it change six months later. This level of uncertainty can and should be addressed by the Departments when contracting with the Plans. An additional issue with integration into managed care involves the speed of the payment of clean claims. Currently MITS pays clean claims within six calendar days and Medicare pays in ten business days, yet the plans are held to a thirty calendar day standard. It is bewildering to me that the public sector is more efficient than the private sector. Despite my astonishment, unless the plans are contractually obligated to match the claims payment performance of the public sector it will require me to save twenty five days of cash flow to finance the additional accounts receivable which for Signature Health would be approximately $1.6 Million dollars. Considering the razor thin margins most agencies operate under this is an unnecessary enormous obstacle.

How are we preparing for the changes?

To prepare for these changes at Signature Health we have developed and implemented a plan with seven elements as follows:

1. Instituted a ban on hiring case managers without an undergraduate degree.
2. Planned layoff of 17 nurses (50% reduction) on 7-1-17
3. Invested in E&M coding training for medical staff
4. Begin Saving $1,600,000 to finance receivables post managed care integration
5. Hired a Pathologist and 2 lab techs and purchased extremely expensive equipment to start our own lab
6. Applied for FQHC Status
7. Began merger negotiations with two other agencies and have been approached by three others

38882 Mentor Avenue
Willoughby, Ohio 44094

T: 440.953.9999
F: 440.918.3839
W: www.signaturehealthinc.com

Some of the above listed steps are more straight forward than others. Naturally, we have already stopped hiring new case managers who do not already have an undergraduate degree so that we can earn the maximum possible rates. We plan to layoff 50% of our nursing staff upon implementation of the redesign initiative. We are working with our current EMR vendor to implement the changes (while we search for one that supports integrated medicine). We are saving for projected cash flow impacts and we are investing in the ongoing training of our physicians in the new coding system so they properly document and accurately code their services based on complexity of the visit.

Starting a lab, applying for FQHC status and merging with other organizations are extremely complex preparations we are making. Signature Health was fortunate enough to have the ability to diversify by making an enormous investment to start our own on site lab. This is well beyond the capabilities of most of the agencies in Ohio and therefore should not be considered a typical preparation step all agencies will make.

While our process of qualifying as an FQHC began prior to the redesign effort, we consider it one of the most important preparations we are making. FQHC status requires us to diversify our service array and affords us a federal grant, the 340b program as well as access to National Health Service recruiting tools, and federal tort claims act program. These elements of FQHC program may help our agency to defray the financial impact of the redesign effort. Unfortunately for most provider agencies in Ohio this really isn't an option.

Lastly, there has been a large spike in mergers and consolidations in the behavioral health industry and many of my peers are considering this option as one of the preparations for the redesign effort and subsequent integration with managed care six months later. We have announced our intended merger with Connections which is another agency in the Cleveland area and have begun early discussions with a second organization. Similarly, we have been approached by three other organizations, some of whom are billion dollar agencies from outside Ohio regarding merging. I predict that the combination of the redesign project and the interface with managed care will spark a large wave of agency consolidation that will continue for several years.

What am I doing to Integrate with Primary Care

The primary initiative Signature Health is undertaking to integrate with primary care is pursing designation as an FQHC, a process that was underway before the redesign effort. This has led us to adding primary medicine physicians and nurse practitioners, medical assistants, exam rooms, EKG machines, oxygen machines etc. The most important element of integration currently is to find a new electronic health record that will support integrated medicine well. Most EMRs do either behavioral health or physical health well but not both. Further, with investing in the lab and saving for expected cash flow impacts of redesign we are not able to afford top tier systems like EPIC.

One significant barrier we have been working through is difficulties contracting with managed care entities for primary medicine. The Plan's computer systems have us loaded as a behavioral health provider and they have claimed that it is difficult to add other areas of medicine to the contracts and have them pay correctly and credential correctly.

38882 Mentor Avenue
Willoughby, Ohio 44094

T: 440.953.9999
F: 440.918.3839
W: www.signaturehealthinc.com

Signature HEALTH

When you need help now.

What Tools or Information Would Be Helpful?

I have mentioned throughout my testimony above my suggestions for redesign changes. But to reiterate it would be helpful for the Departments and this honorable committee to do the following:

1. Make a permanent the grandfathering of non-degreed paraprofessionals to bill the highest rates after 3 years of experience to maintain the current workforce and pipeline of future staff.
2. Collapse the use of TBS, PSR, and CPST into 1 code with credential modifiers for administrative simplification.
3. Make revised actuarial assumptions available and align budgetary assumptions between providers and the departments to resolve the discrepancy between providers view of a 8-15% cut while the Department is asserting that they are adding substantial resources to the system.
4. Require MCOs pay clean claims within 10 days, and maintain the rates, regulations and preauthorization requirements of the redesign effort post integration with managed care in order to prevent significant financial disruptions.
5. Require MCOs to contract with CMHCs for primary care services to enable integrated care.
6. Approve the exemption from IMD for Medicaid MCOs for stays 15 days or less in facilities that have 40 beds or less to increase the availability of detox and psychiatric beds for Medicaid recipients.
7. Reconsider and augment the proposed rates 24/7 Crisis Intervention, Group Therapy and urine screens so as to not reduce the capacity for these services.

In addition to the four questions I was asked to respond to, I was also invited to add any additional thoughts that I felt important to convey to the committee.

My primary feedback is that the behavioral health redesign effort has only changed the billing code set that providers will use to be reimbursed and although there are new codes and services that providers could potentially bring on line such as ACT or IHBT there is nothing inherent in the billing project that will compel providers to bring those new investments nor impact care and outcomes of behavioral medicine. Therefore I believe we have either missed or delayed an enormous opportunity.

If we truly want to impact the total cost of care and the outcomes of the behavioral health system I believe future efforts should focus on:

1. Value based reimbursement such as fee for service plus incentive models, case rates payment methodologies etc.
2. Developing and mandating a system of comprehensive emergency room diversion and developing a psychiatric urgent care system in the state to avoid costly hospitalizations that are unnecessary
3. Developing a system of statewide reporting of arrest and conviction records that are linked to Medicaid recipients so we can measure and manage the impact of behavioral health on the total spend in criminal justice

38882 Mentor Avenue
Willoughby, Ohio 44094

T: 440.953.9999
F: 440.918.3839
W: www.signaturehealthinc.com

Signature HEALTH

When you need help now.

4. Developing and mandating a system where all managed care plans upload claims data daily that is accessible by all providers and other plans to enable highly informed coordination of care. It is silly that I cannot log into (or have my EMR integrate) with a statewide database and get all Medicaid claim and prescription data so I know exactly the diagnosis, care, lab results etc of my patients. This leaves us in a positon of operating blindly which leads to both duplication of care, and ineffective interventions.

Respectfully,

Jonathan Lee

38882 Mentor Avenue
Willoughby, Ohio 44094

T: 440.953.9999
F: 440.918.3839
W: www.signaturehealthinc.com