HEALTH MANAGEMENT ASSOCIATES

Financing for Behavioral Health Integration: Fee-for-Service and New Approaches

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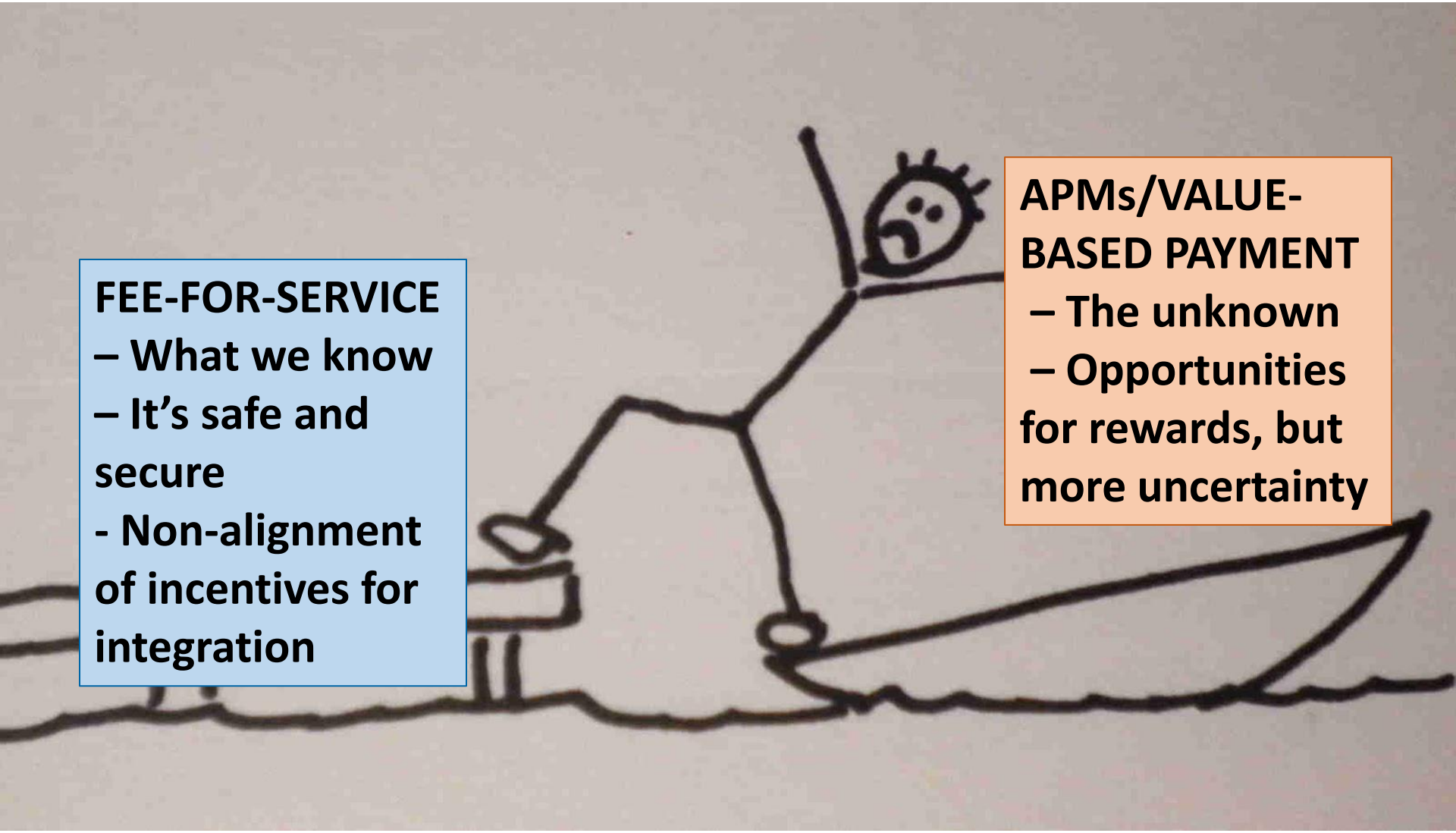
AGENDA

- HOW TO SUPPORT BH INTEGRATION IN FEE-FOR-SERVICE SYSTEM
- HOW TO SUPPORT BH INTEGRATION IN VALUE-BASED PAYMENT SYSTEM
- CONSIDERATIONS FOR FINANCIAL SUSTAINABILITY

NAVIGATING TWO WORLDS – THE CHALLENGING FINANCES OF BEHAVIORAL HEALTH INTEGRATION



CASH FLOW IN FFS VS. A VALUE-BASED ENVIRONMENT

Fee-for-Service World

- Provider performs a service and receives payment for it in a quantifiable period of time (30 – 90 days)
- Reimbursement is certain if billing requirements are met
- Steady cash flow throughout the year
- Traditionally no payment for care coordination, integration, quality

Value-Based Payment World

- Provider performs a service and may receive a FFS payment for some portion of the service
- Payments based on contract performance (managing total cost of care and quality measures) are received after the measurement period, and cannot be quantified at the time service is rendered
  - Some payments may be PMPM
- Uncertain cash flow with delays from time service delivered
- Providers/systems rewarded for quality and metrics that integrated care addresses
  - Alignment of incentives around achieving better outcomes

FOCUS OF THE PRESENTATION

- Which staff and/or services you can bill for, and which payers pay for those services
- Documentation needed to receive timely payment
- Types of encounters

HOWEVER, as the landscape in states and nationwide continues to move toward APMs/value-based payments, we will also look at:

- Revenue opportunities through achieving excellent outcomes on quality metrics including P4P, Value Based Payment contracts
- Demonstrated savings in Total Cost of Care for patients with co-morbid medical and BH conditions

APPENDIX P

Short-term Behavioral Health Services in a Primary Care Setting

In order to support the availability of a full continuum of behavioral health services, the Department is promoting the provision of short-term behavioral health services within primary care settings for brief episodic conditions.

Behavioral health practitioners in a primary care setting may provide up to six (6) sessions of the short-term behavioral health services listed in this appendix, in any combination, per episode of care without prior authorization from the Contractor. These sessions will not require a covered behavioral health diagnosis.

Low-acuity Behavioral Health Service Procedure Codes

90791	Diagnostic Evaluation without Medical Services
90792	Diagnostic Evaluation with Medical Services
90832	Psychotherapy-30 minutes
90834	Psychotherapy-45 minutes
90837	Psychotherapy-60 minutes
90839	Psychotherapy for crisis-60 minutes
90840	Psychotherapy for crisis-each additional 30 min
90853	Group Psychotherapy
90846	Family Psychotherapy (w/o patient)
90847	Family Psychotherapy (with patient)

The services listed above are reimbursed fee-for-service when they are billed in a primary care place of service. Practitioners must request authorization from the Contractor to continue to provide more than six (6) behavioral health services in a primary care setting.

Appropriate Documentation

- Diagnosis-PCP or 90791/2
- SOAP or DAP note
  - Subjective (CC), objective (MSE), assessment (Dx), plan
- Results of measurement tools
- Therapeutic approach
- Care coordination discussions documented
- Time - half plus 1
- Episode?
- Interval?
- Prior authorization for more?

REIMBURSEMENT OPTIONS – HABI CODES

- Health Behavior Assessment and Intervention (HBAI) 96150-155 – psychologists
  - Developed by CMS in 2002 to support determining the biological, psychological, and social factors affecting the patient's physical health and any treatment problems, and related interventions by psychologists.

State: Alaska, July 2014

CPT Code		Diagnostic Code	Community Health Center					
			Medicare		State Medicaid			
			Paid?	Credentials	Paid?	Code	Credentials	Comments
E & M Codes	99201-99205 New Pt	May be used for behavioral health or physical health services	Yes	MD, PA, ANP	Yes	99201-99205 New Pt	MD, PA, ANP	All CPT codes must be reported, but services are reported at the FQHC rate
	99211 - 99215 Est. Pt.					99211 - 99215 Est. Pt.		
Health and Behavior (HABI)	96150 Assessment	Services are secondary to a physical health diagnosis	Yes	PhD Psychologist at this time; excludes LMSW	Yes	96150 Assessment	Psychologist and Licensed Clinical Social Worker	All CPT codes must be reported, but services are reported at the FQHC rate
	96151 Reassessment		Yes			96151 Reassessment		
	96152 Individual TX		Yes			96152 Individual TX		
	96153 Group TX		Yes			96153 Group TX		
	96154 Family TX w/ PT		Yes			96154 Family TX w/ PT		
	96155 Family TX w/o PT		No			96155 Family TX w/o PT		
Tele-medicine	90791 GT Psych eval w/o medical services	Psychiatric diagnosis	Yes	Physician, NP, PA, CNS, Clinical Psychologist, Clinical Social Worker	Yes	90791 GT Psych eval w/o medical services	Physician, PA, NP, CNS	
	90792 Psych eval w/ medical services			Physician, NP, PA, CNS				
	90832-38 GT Therapy Services			Psychiatrist, CNP, Clinical Psychologist, Clinical Social	Yes	90832-38 GT Therapy Services	Physician, PA, Clinical Psychologist, NP, CNS, CSW	
	99201-99215 Office or other OP services	Both MH & PH diagnosis	Yes	Physician, NP, PA, CNS	Yes	99201-99215 GT Office or other OP services	Physician, PA, Clinical Psychologist, NP, CNS	
	96150-54 HABI							

FEE FOR SERVICE: WHAT DO WE HAVE TROUBLE BILLING FOR?

- Brief interventions
- Stress/no diagnosis
- Huddles
- Hallway conversations/consultations
- Warm hand-offs
- Curbside consultations with psychiatric consultants
- Phone calls to patients
- Repeating rating scales
- Interdisciplinary team meetings
- Registry management

***Payment approaches are necessary for these services that do not work in a typical FFS environment. "What works can't be coded."*

THE COLLABORATIVE CARE MODEL

Informed,
Activated Patient

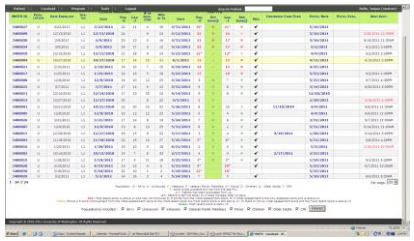
Effective Collaboration

PRACTICE SUPPORT

PCP supported by Care Manager

Measurement-based
Treat to Target

Psychiatric
Consultation



Caseload-focused
Registry review

Training

NEW MEDICARE CODES FOR CoCM REQUIRE ATTENTION TO DETAIL

99492 (Initial month, CoCM) - $161

99493 (Subsequent month, CoCM) - $129

99494 (Add'l 30 mins, CoCM) - $69

99484 – other models of BHI - $48

Billed once a month by the PCP

Codes cover:

- Outreach and engagement by BH Provider or Care Manager
- Initial assessment of the patient, including administration of validated rating scales
- Entering patient data in a registry and tracking patient follow-up and progress
- Participation in weekly caseload review with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

- GCCC2 – proposed new code for FQHCs $135/month starting January 1, 2017

BILLING CODES FOR CoCM – 1st MONTH

HCPCS Code	Long Descriptor
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: • outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; • initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; • review by the psychiatric consultant with modifications of the plan if recommended; • entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and • provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.

BILLING CODES FOR CoCM – SUBSEQUENT MONTHS

HCPCS Code	Long Descriptor
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: • tracking patient follow-up and progress using the registry, with appropriate documentation; • participation in weekly caseload consultation with the psychiatric consultant; • ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; • additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; • provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; • monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

BILLING CODES FOR CoCM – EXTRA TIME

HCPCS Code	Long Descriptor
99484	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure). (Use G0504 in conjunction with G0502, G0503).

MEDICARE CoCM BILLING MUST HAVES

- These codes are billed by the medical provider (primary care provider) once a month
- Needs an initiating visit – new patients unless seen in the past year
- Must have weekly caseload reviews with a psychiatric consultant
- Broad consent obtained
- Co-pays apply
- Must be able to show time spent – how to time stamp your work?
- MEDICARE ONLY for now

For a helpful reference, see:
http://aims.uw.edu/sites/default/files/CMS_FinalRule_2017_CheatSheet.pdf

INITIATING VISIT, CONSENT AND CO-PAYMENTS

- CMS expects an Initiating Visit prior to billing for the 99492-99494 codes.
  - This visit is required for:
    - New patients, and
    - Those who have not been seen within a year of commencement of integrated behavioral health services.
  - This visit will include:
    - The treating provider establishing a relationship with the patient,
    - Assessing the patient prior to referral, and
    - Obtaining broad beneficiary consent to consult with specialists that can be verbally obtained but must be documented in the medical record.
  - Medicare will require beneficiaries to pay any applicable Part B co-insurance for these billing codes.

CARE MANAGER QUALIFICATIONS

- CMS states that the behavioral health care manager:
  - Must have formal education or specialized training in behavioral health
    - This could include a range of disciplines including social work, nursing, and psychology
  - Do NOT need to be licensed to bill traditional psychotherapy codes for Medicare

Time Stamping – per Month

- Minutes spent talking to patient (in person or phone)
- Minutes spent talking to the PCP
- Minutes spent talking to the psychiatric consultant
- Minutes spent coordinating care
- Minutes spent documenting anything or scoring
- Minutes spent reviewing charts/documentation
- Minutes spent talking to referral source
- ETC! Get it all.
- After break of 15 minutes (between 60 and 75 minutes) start the clock for 99484 (30 minutes) and again and again if needed

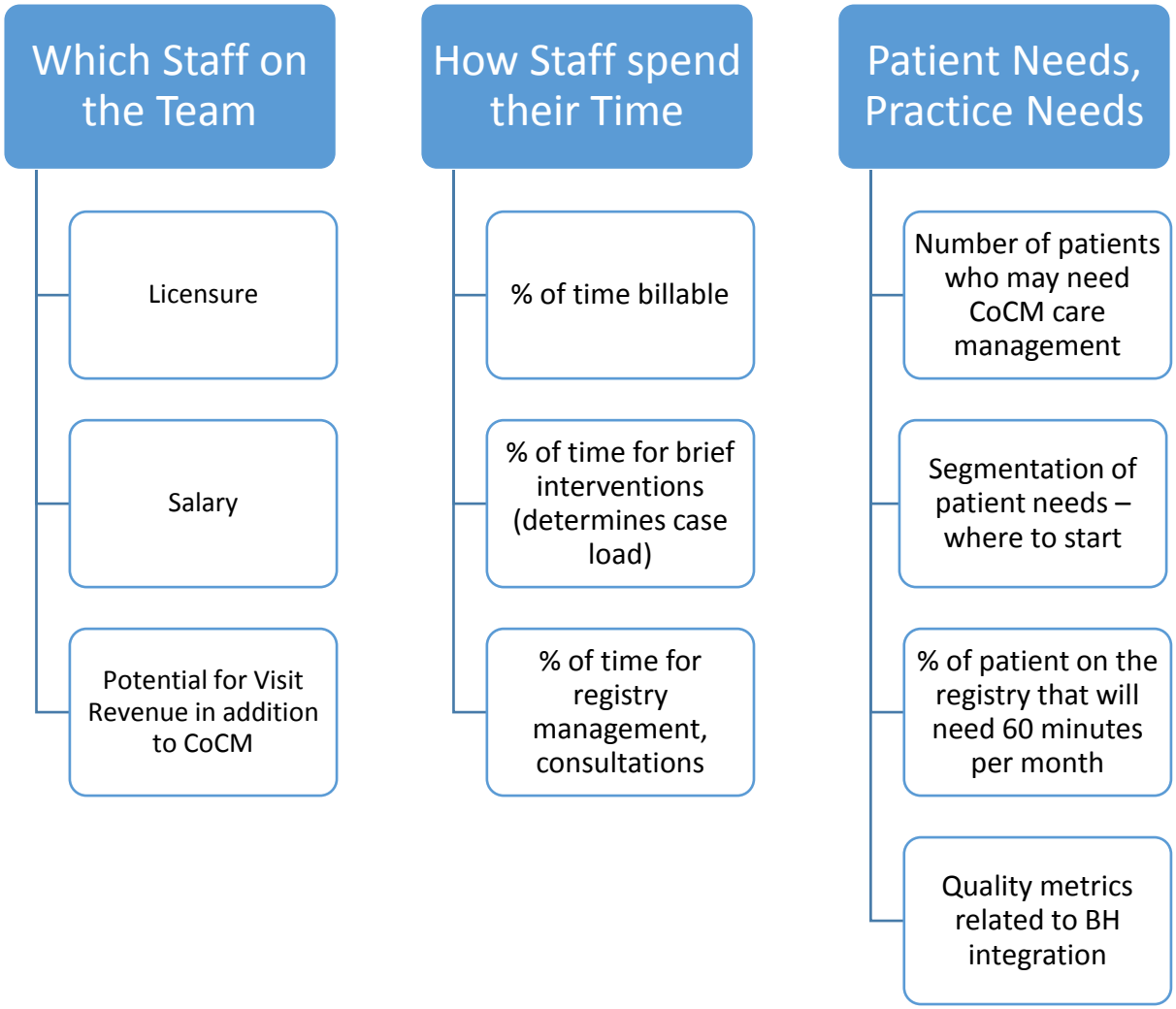
PROVISION OF ADDITIONAL PSYCHIATRIC SERVICES

- Behavioral health care managers (BHCM) qualified to bill traditional psychiatric evaluation and therapy codes for Medicare recipients MAY bill for additional psychiatric services in the same month.
- However, time spent by the BHCM on activities for services reported separately may NOT be included in the services reported using time applied to 99492, 99493, and 99494.
- In other words, the BHCM can furnish psychotherapy services in addition to collaborative care activities, but may not bill for the same time using multiple codes.
- The psychiatric consultant may also furnish face-to-face services directly to the patient but, like the BHCM, the time may not be billed using multiple codes.

MEDICARE PAYMENT FOR OTHER MODELS OF INTEGRATED BEHAVIORAL HEALTH SERVICES

- **99484 – Care management services for behavioral health conditions, at least 20 minutes of clinical staff time per calendar month.** Must include:
  - Initial assessment or follow-up monitoring, including use of applicable validated rating scales;
  - Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
  - Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
  - Continuity of care with a designated member of the care team.
- 99484 can only be reported by a treating provider and cannot be independently billed. For 99484, a behavioral health care manager with formal or specialized education is not required. CMS rules allow "clinical staff" to provide 99484 services using the same definition of "clinical staff" as applied under the Chronic Care Management benefit.

BRING THE PIECES TOGETHER: BUILD A FINANCIAL MODEL THAT MAKES SENSE FOR YOUR PRACTICE AND NEEDS



For additional information, see: https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook

VALUE-BASED PAYMENT MODELS POSITIONED TO SUPPORT INTEGRATION

ANNUAL COST OF CARE: COMMON CHRONIC MENTAL ILLNESSES WITH COMORBID MENTAL CONDITIONS

Patient Groups	Annual Cost of Care	Illness Prevalence	% with Comorbid Mental Condition*	Annual Cost of Mental Condition	% Increase with Mental Condition
All Insured	$2,920		10-15%		
Arthritis	$5,220	6.6%	36%	$10,710	**94%**
Asthma	$3,730	5.9%	35%	$10,030	**169%**
Cancer	$11,650	4.3%	37%	$18,870	**62%**
Diabetes	$5,480	8.9%	30%	$12,280	**124%**
CHF	$9,770	1.3%	40%	$17,200	**76%**
Migraine	$4,340	8.2%	43%	$10,810	**149%**
COPD	$3,840	8.2%	38%	$10,980	**186%**

Courtesy: Cartesian Solutions, Inc.™--consolidated health plan claims data, Roger Kathol, MD

*Melek S et al APA 2013 www.psych.org

KEY FEATURES OF APMs/VALUE-BASED PAYMENT MODELS

- Incentives to improve value and reduce unnecessary costs
- Patients' behavioral health needs are identified and treated early on in the cycle of care
- Performance measures are important component
- Tracking essential
- Shared savings can be reinvested

APMs are often made available in the context of **accountable care organizations (ACOs).**

What is an ACO? A group of physicians, hospitals or other providers that share the goal of improving care delivery through better:

- Care coordination and integration,
- Access to services, and
- Accountability for quality outcomes and costs.

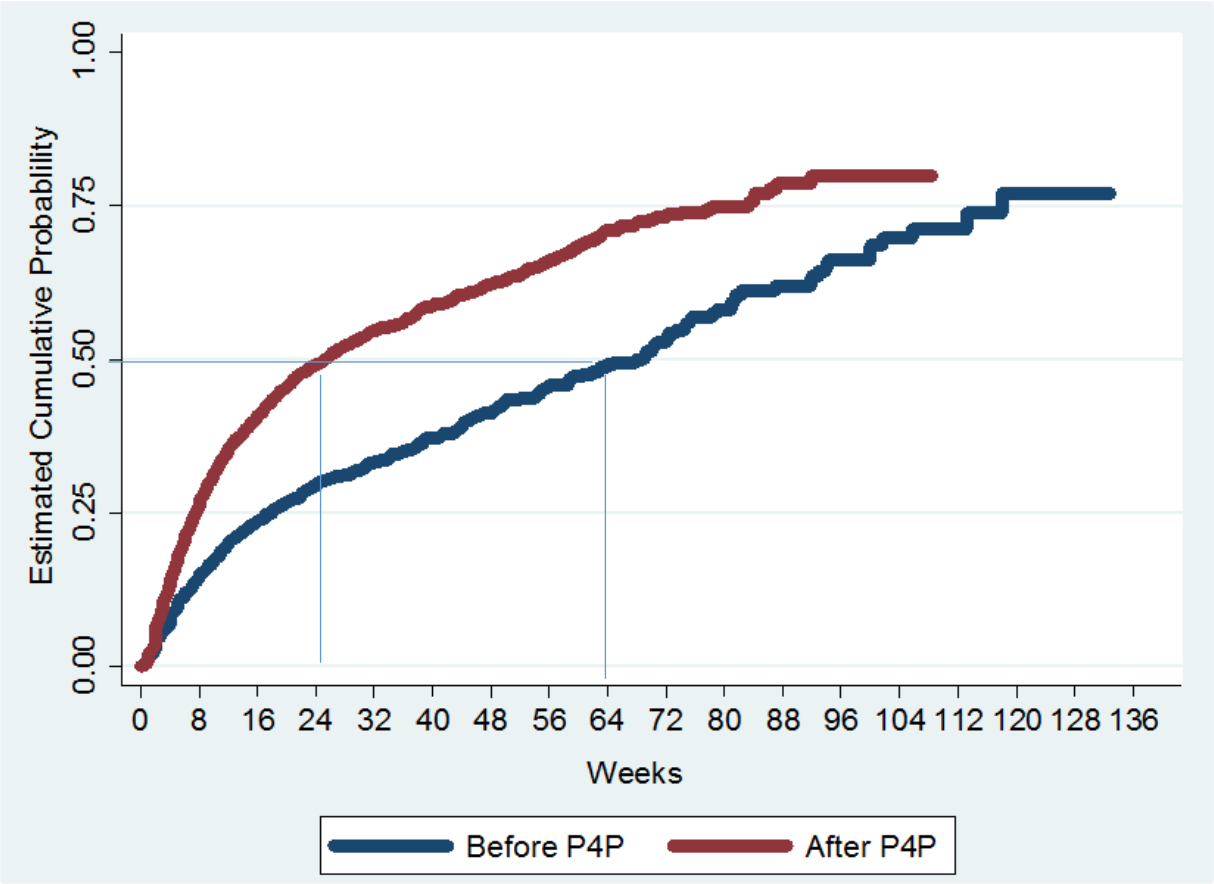
COMMON PERFORMANCE MEASURES FOR ACOs, VALUE-BASED PAYMENT

Process Metrics • Percent of patients screened for depression • Percent with follow-up with care manager within 2 weeks • Percent not improving that received case review and psychiatric recommendations • Percent treatment plan changed based on advice • Percent not improving referred to specialty BH	**NQF 712**
Outcome Metrics	
• Percent with 50% reduction PHQ-9 – Clinical Response at 6 and 12 months	**NQF 1884 and 1885 (benchmark > 40%)**
• Percent reaching remission (PHQ-9 < 5) at 6 and 12 months	**NQF 710 and 711 (benchmark > 20%)**
Experience– patient and provider	
Functional – work, school, homelessness	
Utilization/Cost	
• ED visits, 30 day readmits, med/surg/ICU, overall cost	

Source: Lori E. Raney et al, Integrated Care: A Guide to Effective Implementation; American Psychiatric Association Press; 2017.

PAY-FOR-PERFORMANCE SUCCESSFULLY INCENTS IMPROVEMENTS

American Psychiatric Association found that when P4P arrangements were in place, median time to depression treatment response was reduced by half



- Cut median time to depression response In half

Unützer et al., 2012

CONSIDERATIONS IN CoCM TO MITIGATE RISKS OF VBP UNKNOWNS

- Staffing models
  - Who are the right staff in your practice to perform care management functions
  - How to apply lessons learned about “working at the top of one’s license”
  - Billable visits in addition to care management?

- Stratification of patient needs
  - Which patients would benefit most from CoCM interventions?
  - Stepped care model

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