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

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Principal
Potential economic impact of integrated medical-behavioral healthcare

Updated projections for 2017

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### FIGURE 14: IMPACT OF BEHAVIORAL COMORBIDITIES, MEDICAID POPULATION, 2017 TOTAL PMPM COSTS

<table>
<thead>
<tr>
<th>BODY SYSTEM (CONDITION)</th>
<th>NO MH/SUD</th>
<th>MH/SUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>BENIGN/IN SITU/UNCERTAIN NEOPLASM</td>
<td>$922</td>
<td>$2,123</td>
</tr>
<tr>
<td>CARDIORESPIRATORY ARREST</td>
<td>$6,445</td>
<td>$6,806</td>
</tr>
<tr>
<td>CEREBROVASCULAR</td>
<td>$2,756</td>
<td>$4,432</td>
</tr>
<tr>
<td>COGNITIVE DISORDERS</td>
<td>$3,115</td>
<td>$4,772</td>
</tr>
<tr>
<td>DIABETES</td>
<td>$1,432</td>
<td>$3,181</td>
</tr>
<tr>
<td>EARS, NOSE, AND THROAT</td>
<td>$656</td>
<td>$1,954</td>
</tr>
<tr>
<td>EYES</td>
<td>$789</td>
<td>$2,102</td>
</tr>
<tr>
<td>GASTROINTESTINAL</td>
<td>$1,132</td>
<td>$2,595</td>
</tr>
<tr>
<td>GENITAL SYSTEM</td>
<td>$889</td>
<td>$2,066</td>
</tr>
<tr>
<td>HEART</td>
<td>$1,375</td>
<td>$2,867</td>
</tr>
<tr>
<td>HEMATOLOGICAL</td>
<td>$1,906</td>
<td>$4,034</td>
</tr>
<tr>
<td>LIVER</td>
<td>$1,784</td>
<td>$3,444</td>
</tr>
<tr>
<td>LUNG</td>
<td>$990</td>
<td>$2,568</td>
</tr>
<tr>
<td>MALIGNANT NEOPLASM</td>
<td>$2,569</td>
<td>$4,278</td>
</tr>
<tr>
<td>MUSCULOSKELETAL AND CONNECTIVE TISSUE</td>
<td>$931</td>
<td>$2,181</td>
</tr>
<tr>
<td>NEUROLOGICAL</td>
<td>$1,982</td>
<td>$3,177</td>
</tr>
<tr>
<td>NUTRITIONAL AND METABOLIC</td>
<td>$1,095</td>
<td>$2,583</td>
</tr>
<tr>
<td>PREGNANCY-RELATED</td>
<td>$1,540</td>
<td>$2,242</td>
</tr>
<tr>
<td>SKIN AND SUBCUTANEOUS</td>
<td>$804</td>
<td>$2,379</td>
</tr>
<tr>
<td>URINARY SYSTEM</td>
<td>$1,449</td>
<td>$3,217</td>
</tr>
<tr>
<td>VASCULAR</td>
<td>$7,428</td>
<td>$4,533</td>
</tr>
<tr>
<td><strong>TOTAL (INCLUDING THOSE WITHOUT ANY MEDICAL CONDITIONS)</strong></td>
<td><strong>$494</strong></td>
<td><strong>$1,708</strong></td>
</tr>
</tbody>
</table>

Potential calculated savings with IC $175 billion
• Issues with depression and substance abuse must be pre-empted, rather than treated once advanced.

• Goal is to detect early and apply early interventions to prevent from getting more severe
STEPPED MODEL OF INTEGRATED BEHAVIORAL HEALTH CARE

1. Primary care provider (PCP) provides first-line treatment
2. PCP receives ad-hoc consultation, usually from an off-site mental health specialist
3. PCP supported by brief intervention from on-site behavioral health consultant
4. PCP supported by a collaborative care team with systematic treatment to target
5. Referral to mental health specialty care

https://aims.uw.edu/
Collaborative Care

**Population-Based Care**
- Systematic Screening and Track in registries
- Regular caseload review to identify treatment gaps
- Utilize data for targeted interventions and demonstrate accountability

**Measurement-guided Care**
- Measure Care Provided and Treat to Defined Targets
- Identify Patients who are not getting better and adjust treatment
THE COLLABORATIVE CARE MODEL

Effective Collaboration

Informed, Activated Patient

PCP Supported by Care Manager

Practice Support

Measurement-based Treat to Target

Psychiatric Consultation

Caseload-focused Registry Review

Training/Implementation Support

https://aims.uw.edu/
50% or greater improvement in depression at 12 months

Participating Organizations

Unützer et al., JAMA 2002
Over 80 Randomized Controlled Trials


Collaborative care is consistently more effective than care as usual.
#### BUSINESS CASE: REDUCES HEALTH CARE COSTS

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>4-year costs in $</th>
<th>Intervention group cost in $</th>
<th>Usual care group cost in $</th>
<th>Difference in $</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMPACT program cost</td>
<td></td>
<td>522</td>
<td>0</td>
<td>522</td>
</tr>
<tr>
<td>Outpatient mental health costs</td>
<td>661</td>
<td>558</td>
<td>767</td>
<td>-210</td>
</tr>
<tr>
<td>Pharmacy costs</td>
<td>7,284</td>
<td>6,942</td>
<td>7,636</td>
<td>-694</td>
</tr>
<tr>
<td>Other outpatient costs</td>
<td>14,306</td>
<td>14,160</td>
<td>14,456</td>
<td>-296</td>
</tr>
<tr>
<td>Inpatient medical costs</td>
<td>8,452</td>
<td>7,179</td>
<td>9,757</td>
<td>-2578</td>
</tr>
<tr>
<td>Inpatient mental health / substance abuse costs</td>
<td>114</td>
<td>61</td>
<td>169</td>
<td>-108</td>
</tr>
<tr>
<td>Total health care cost</td>
<td><strong>31,082</strong></td>
<td><strong>29,422</strong></td>
<td><strong>32,785</strong></td>
<td><strong>-$3,363</strong></td>
</tr>
</tbody>
</table>


**Savings**

**ROI**

$6 : $1
Multi-Condition Collaborative Care

- Diabetes nurse educators
- Caseload supervision
  - Depression: psychiatrist
  - Diabetes and CAD: family doctor
  - E-mail to diabetologist for complex cases

Cost Savings
$600-1100/patient

WHAT CAN YOU BILL NOW in FFS? TRADITIONAL THERAPY

+ Diagnostic Evaluations – 90791 (90792 if psychiatric provider sees patient)
+ Brief therapy
  • 90832 (30 minutes)
  • 90834 (45 minutes)
  • Group therapy
+ Must be able to meet documentation requirements/compliance standards for CPT coding
+ SOAP/DAP documentation
+ Initial evaluation components
+ Medical necessity
+ Chronic care management codes (CCM) for 20 minutes each month
REIMBURSEMENT OPTIONS – HBAI CODES

+ Health Behavior Assessment and Intervention (HBAI) 96150-155 – psychologists – NOT PAID IN DELAWARE

+ 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.
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.”**
COMPASS

- Depression – 60% improved
- Uncontrolled DM – 21% controlled
- Cardiovascular Disease – HTN 40% in control

The project described is supported by Cooperative Agreement Number 1C1CMS331048-01-00 from the Department of Health and Human Services, Centers for Medicare & Medicaid Services, ACA 2010
NEW MEDICARE CODES FOR CoCM REQUIRE ATTENTION TO DETAIL

99492 (Initial month, CoCM) - $161
99493 (Subsequent month, CoCM) - $129  Billed once a month by the PCP
99494 (Add’l 30 mins, CoCM) - $69
99484 – other models of BHI - $48

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 – code for FQHCs $135/month starting January 1, 2018
**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:
<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
</tr>
</thead>
</table>
| 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

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
</tr>
</thead>
</table>
| 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

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>99494</td>
<td>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).</td>
</tr>
</tbody>
</table>
50-80 patients/caseload
2 hrs psych/week/care manager
= a lot of patients getting care
# OTHER MODELS OF INTEGRATED CARE

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Long Descriptor</th>
</tr>
</thead>
</table>
| 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.  
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. |
### COMMON PERFORMANCE MEASURES FOR ACOs, VALUE-BASED PAYMENT

<table>
<thead>
<tr>
<th>Process Metrics</th>
<th>Outcome Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Percent of patients screened for depression</td>
<td>• Percent with 50% reduction PHQ-9 – Clinical Response at 6 and 12 months</td>
</tr>
<tr>
<td>• Percent with follow-up with care manager within 2 weeks</td>
<td>• Percent reaching remission (PHQ-9 &lt; 5) at 6 and 12 months</td>
</tr>
<tr>
<td>• Percent not improving that received case review and psychiatric recommendations</td>
<td></td>
</tr>
<tr>
<td>• Percent treatment plan changed based on advice</td>
<td></td>
</tr>
<tr>
<td>• Percent not improving referred to specialty BH</td>
<td></td>
</tr>
</tbody>
</table>

**NQF 712**

**NQF 1884 and 1885 (benchmark > 40%)**  
**NQF 710 and 711 (benchmark > 20%)**

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**Experience**— patient and provider  

**Functional**— work, school, homelessness  

**Utilization/Cost**  

• ED visits, 30 day readmits, med/surg/ICU, overall cost

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Raney, Lasky, Scott, *Integrated Care: A Guide to Effective Implementation*; APPI; 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.

Unützer et al., 2012
<table>
<thead>
<tr>
<th>Domain of CoCM</th>
<th>Phase 1 VBP Target</th>
<th>Fidelity Measure</th>
<th>% Returned when fidelity measure met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic follow-up</td>
<td>1. Maintain minimum monthly caseload</td>
<td>1. At least one contact a month</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>2. &gt;50% of caseload receives ≥ 2 contacts from BHP a month</td>
<td>2. Same as above</td>
<td>5%</td>
</tr>
<tr>
<td>Measurement-based care</td>
<td>&gt; 75% of the caseload has at least one PHQ9 recorded each month</td>
<td>At least one PHQ9 administered in a 4 week period</td>
<td>5%</td>
</tr>
<tr>
<td>Stepped care</td>
<td>1. Care coordinator reviewed ≥ 50% of caseload with the psychiatric consultant each month</td>
<td>1. At least one psychiatric consultation of the case in each 4 week period</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>2. Registry documents current psychiatric medications in ≥ 75% of caseload</td>
<td>2. Medications included in the registry</td>
<td>5%</td>
</tr>
</tbody>
</table>

Modified from Bao et al., 2018
### ATTESTATION FOR COLLABORATIVE CARE MODEL

**Attestation for Collaborative Care Model (CoCM)**

This attestation is for any single provider* or provider group to attest that they are actively providing care consistent with the Collaborative Care Model (CoCM) as described in the agency's Collaborative Care Model Guidelines.

Submission on behalf of Individual Provider* or Group Practice:
- Individual provider* –

**Billing address:**

<table>
<thead>
<tr>
<th>Billing address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone number</td>
</tr>
<tr>
<td>Email</td>
</tr>
</tbody>
</table>

*NOTE: requires each billing provider* submit an attestation*

**Provider Name:**

- Group Practice –

  *NOTE: attestation must cover all billing provider* within the practice and ensure new providers are trained in CoCM

**Billing provider name:**

<table>
<thead>
<tr>
<th>Billing provider name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Billing NPI:</td>
</tr>
<tr>
<td>Billing address</td>
</tr>
<tr>
<td>Phone number</td>
</tr>
<tr>
<td>Email</td>
</tr>
</tbody>
</table>

For practices with multiple sites, each site must have its own attestation. If there are multiple providers* within the practice, you are attesting that those individuals being identified as the servicing provider on the claim, billing the CoCM codes, are trained and following the agency guidelines for the CoCM Model. I attest that my practice is actively providing care in a Collaborative Care Model as described in the agency guidelines. This CoCM includes the following required principles:

- Patient Center Team Care
  - Primary care/medical provider
  - Behavioral health care manager
  - Psychiatric consultation
  - Beneficiary-client

- Team structure with staff identified in the guideline
- Measurement-Based Treatment to Target using validated tools
- Accountable Care using a Registry

I have received and reviewed the CoCM guidelines, understand them, have received training and implemented the CoCM consistent with said guidelines and agree to comply with said guidelines. By signing this attestation, you attest that your individual or group practice is actively practicing a collaborative care model consistent with that described in the agencies CoCM guideline. If at any time your individual or group practice no longer meets the requirements for CoCM, you will immediately notify the agency by contacting provider enrollment at XXX.
HMA