HEALTH MANAGEMENT ASSOCIATES

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

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MILLIMAN RESEARCH REPORT

Potential economic impact of integrated medical-behavioral healthcare

Updated projections for 2017

January 2018

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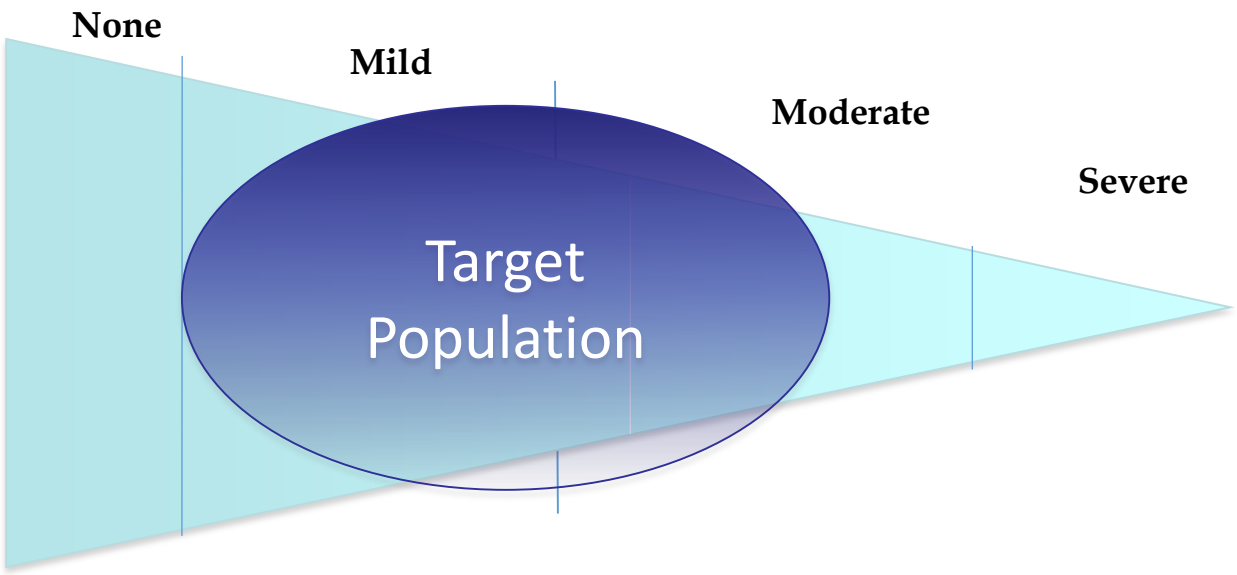
FIGURE 14: IMPACT OF BEHAVIORAL COMORBIDITIES, MEDICAID POPULATION, 2017 TOTAL PMPM COSTS

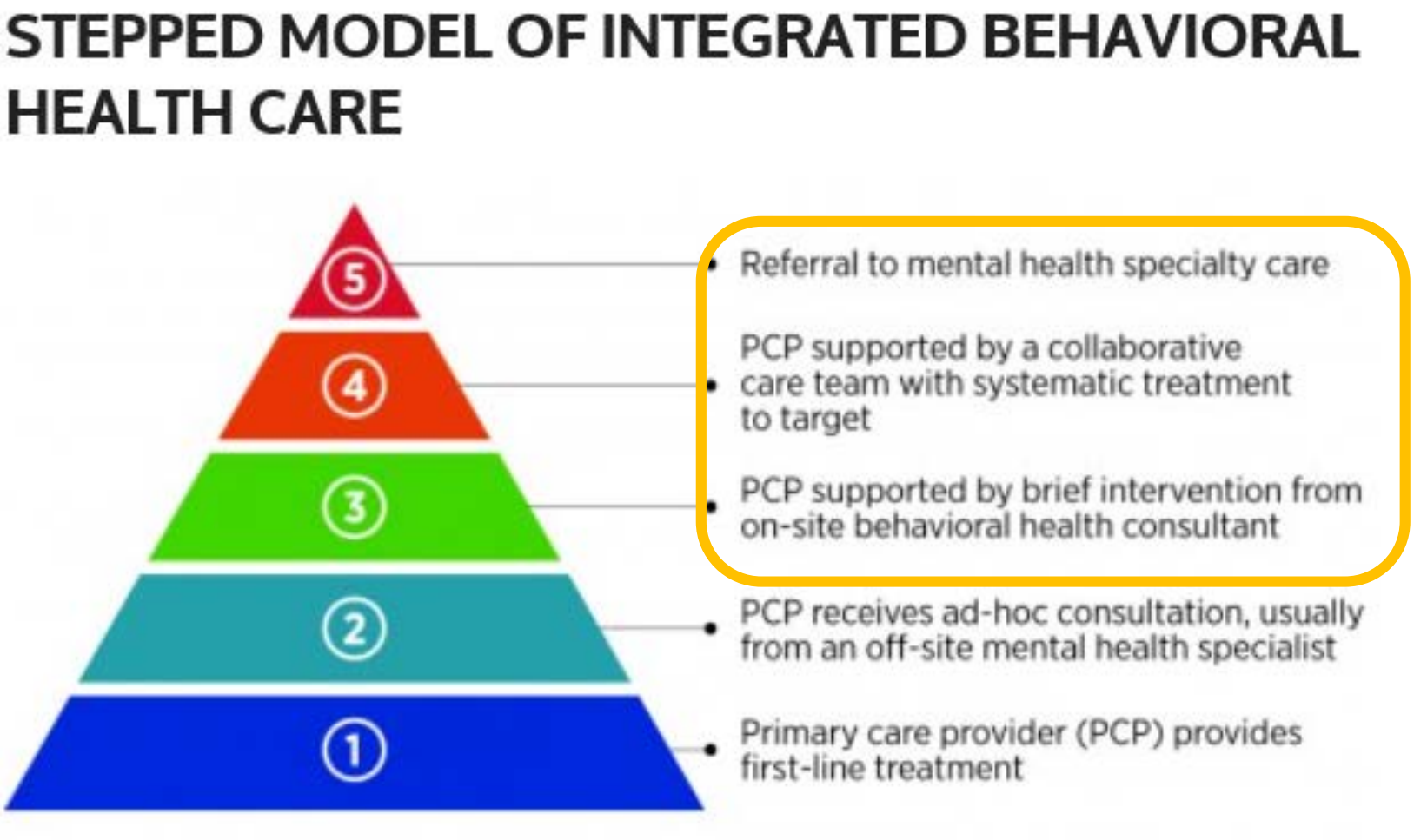
BODY SYSTEM (CONDITION)	NO MH/SUD	MH/SUD
BENIGN/IN SITU/UNCERTAIN NEOPLASM	$922	$2,123
CARDIORESPIRATORY ARREST	$6,445	$6,896
CEREBROVASCULAR	$2,756	$4,432
COGNITIVE DISORDERS	$3,115	$4,772
DIABETES	$1,432	$3,181
EARS, NOSE, AND THROAT	$656	$1,954
EYES	$789	$2,182
GASTROINTESTINAL	$1,132	$2,595
GENITAL SYSTEM	$889	$2,066
HEART	$1,375	$2,867
HEMATOLOGICAL	$1,906	$4,034
LIVER	$1,784	$3,444
LUNG	$990	$2,568
MALIGNANT NEOPLASM	$2,569	$4,278
MUSCULOSKELETAL AND CONNECTIVE TISSUE	$931	$2,181
NEUROLOGICAL	$1,982	$3,177
NUTRITIONAL AND METABOLIC	$1,095	$2,583
PREGNANCY-RELATED	$1,540	$2,242
SKIN AND SUBCUTANEOUS	$804	$2,379
URINARY SYSTEM	$1,449	$3,217
VASCULAR	$2,428	$4,533
TOTAL (INCLUDING THOSE WITHOUT ANY MEDICAL CONDITIONS)	$494	$1,708

Potential calculated savings with IC $175 billion

"SWEET" SPOT FOR INTEGRATED CARE & THE COLLABORATIVE CARE MODEL



- 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



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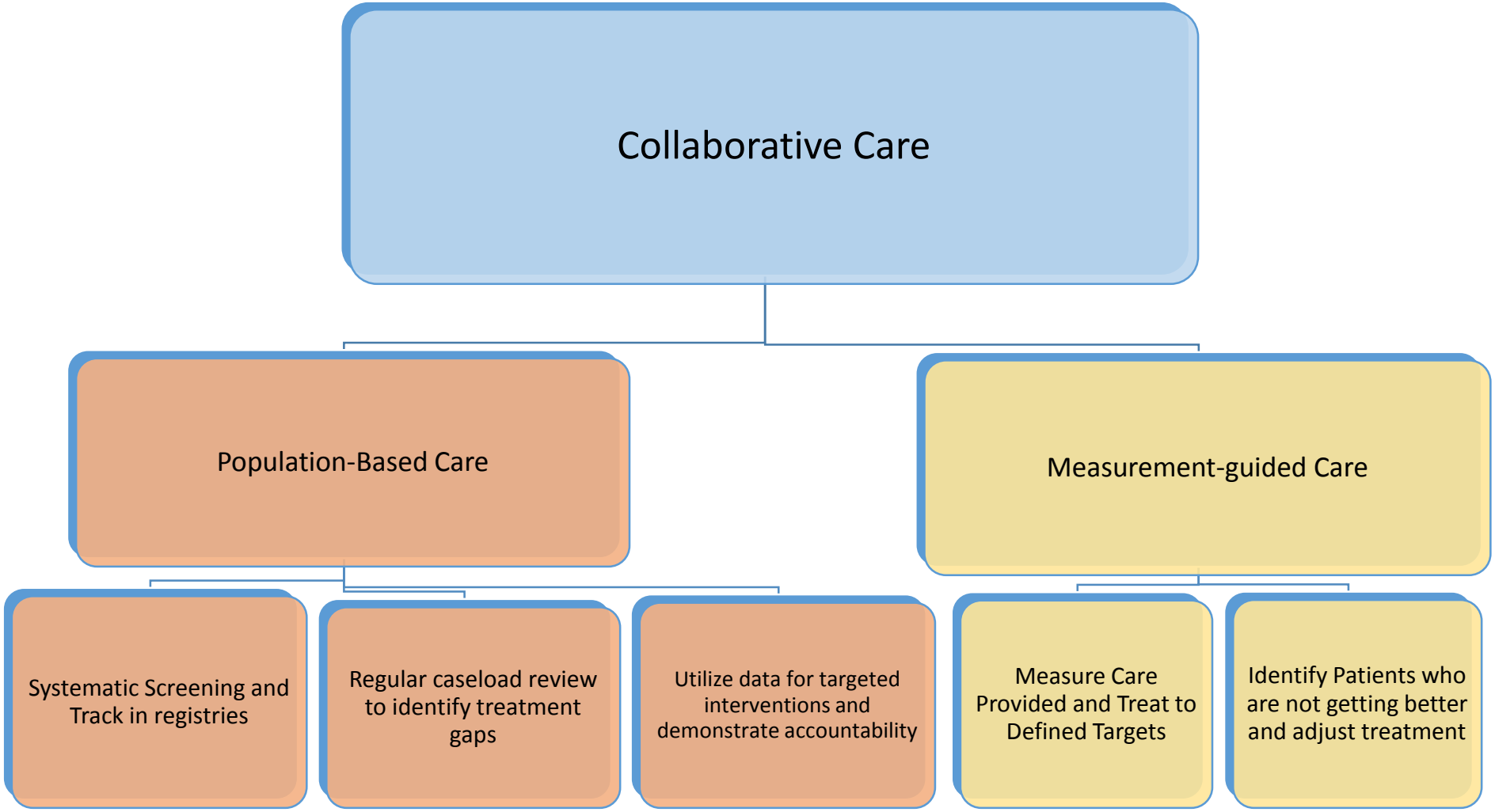
COLLABORATIVE CARE COMPONENTS



THE COLLABORATIVE CARE MODEL

Informed,
Activated Patient

Effective Collaboration

PRACTICE SUPPORT

PCP Supported by Care Manager

Measurement-based
Treat to Target

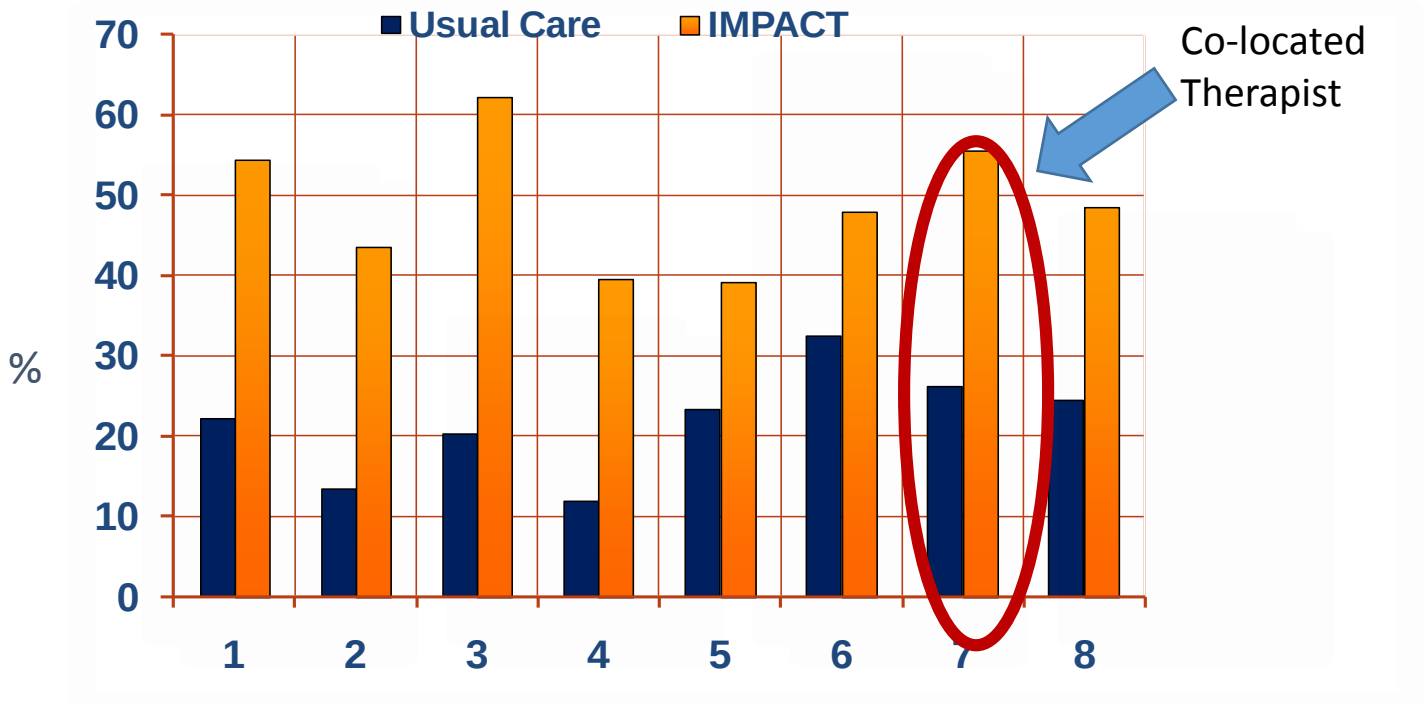
Psychiatric
Consultation

Caseload-focused
Registry Review

Training/Implementation
Support
https://aims.uw.edu/

DOUBLES EFFECTIVENESS OF CARE FOR DEPRESSION

50 % or greater improvement in depression at 12 months



Unützer et al., JAMA 2002

CUMULATIVE RESEARCH EVIDENCE OVER PAST DECADE

Over 80 Randomized Controlled Trials

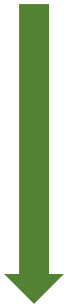
- Cochrane meta analysis: Collaborative care for people with depression and anxiety. Archer J et al. 2012: 79 RCTs.
- Community Preventive Services Task Force. Recommendation from the community preventive services task force for use of collaborative care for the management of depressive disorders. *Am J Prev Med.* 2012; 42(5):521-524: 69 RCTs.
- Gilbody S. et al. *Archives of Internal Medicine*; Dec 2006: Collaborative care (CC) for depression in primary care (US and Europe): 37 RCTs.

Collaborative care is consistently more effective than care as usual.

BUSINESS CASE: REDUCES HEALTH CARE COSTS

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

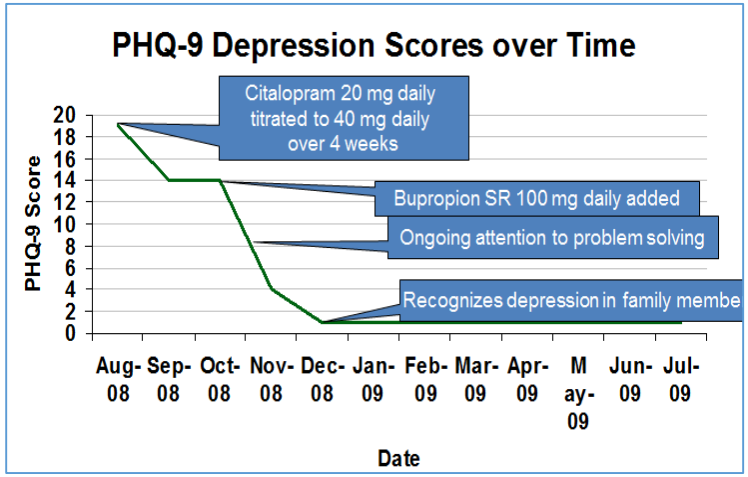
Savings

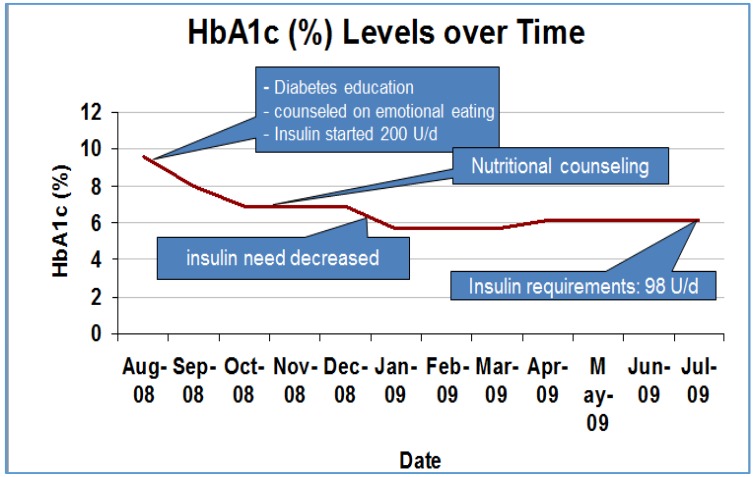


ROI
$6 : $1

Unützer et al., *Am J Managed Care 2008*.

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

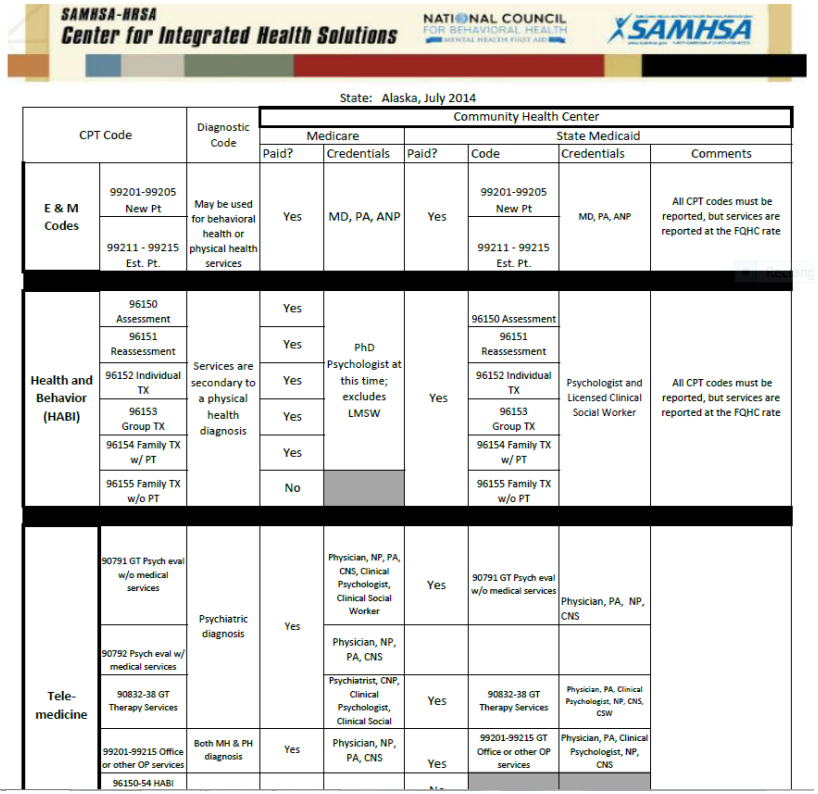
Katon et al NEJM 2010, Katon et al Archives of General Psychiatry 69 (5), 2013

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.



SAMHSA-HRSA Center for Integrated Health Solutions — National Council for Behavioral Health — SAMHSA

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."*

(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

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 – 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:
http://aims.uw.edu/sites/default/files/CMS_FinalRule_2017_CheatSheet.pdf

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
99494	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).

PSYCHIATRIC CONSULTANTS SUPPORTING TEAMS

Care Manager 4

Care Manager 1

Care Manager 3

Care Manager 2

50-80 patients/caseload
2 hrs psych/week/ care manager
= a lot of patients getting care

OTHER MODELS OF INTEGRATED CARE

HCPCS Code	Long Descriptor
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.

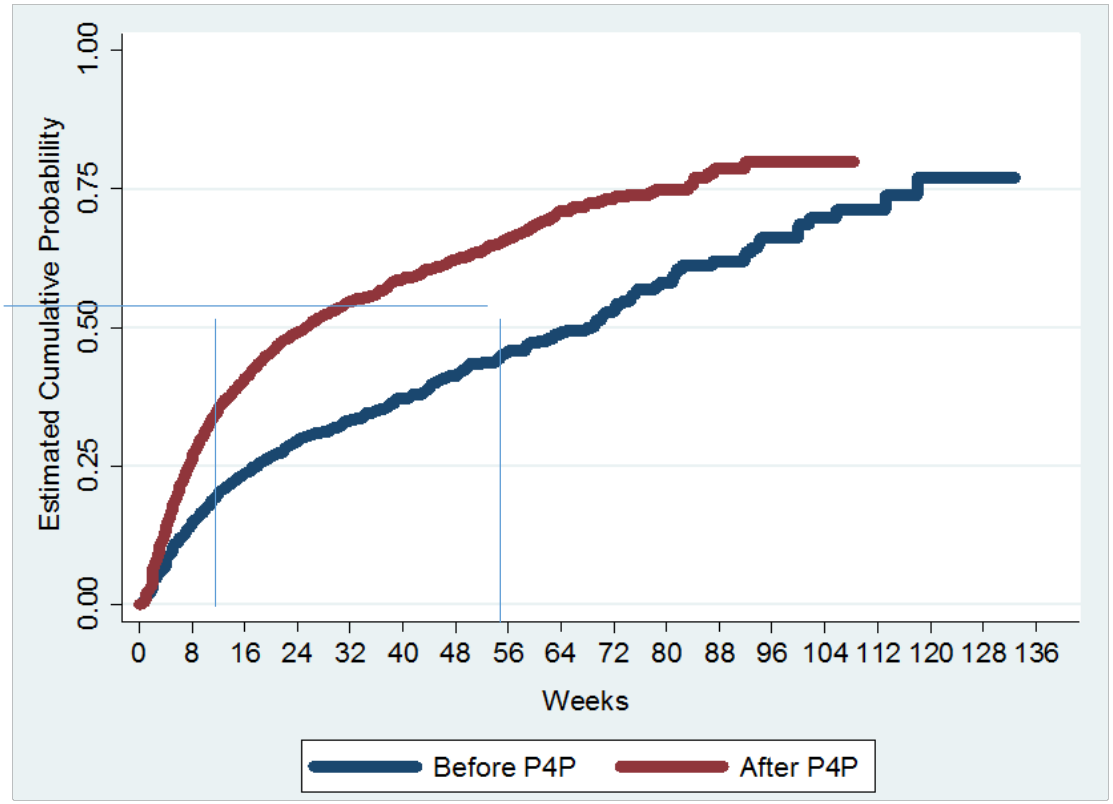
COMMON PERFORMANCE MEASURES FOR ACOs, VALUE-BASED PAYMENT

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 • Percent reaching remission (PHQ-9 < 5) at 6 and 12 months	**NQF 1884 and 1885 (benchmark > 40%)** **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	

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



+ Cut median time to depression response In half

Unützer et al., 2012

VBP EXAMPLE – 25% WITHHOLD

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

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:	Billing NPI number:
	Phone number:
	Email:

NOTE: requires each billing provider* submit an attestation

Provider Name:

☐ Group Practice –_____

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

Billing provider name:	Billing NPI:
Billing address:	Tax ID number:
	Phone number:
	Email:

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

i. Primary care/medical provider
ii. Behavioral health care manager
iii. Psychiatric consultation
iv. 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.

WA Medicaid 2018 – signed by physician, nurse practitioner, or physician's assistant


HMA