



# HEALTH MANAGEMENT ASSOCIATES



## Financing for Behavioral Health Integration: Fee- for-Service and ACOs

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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

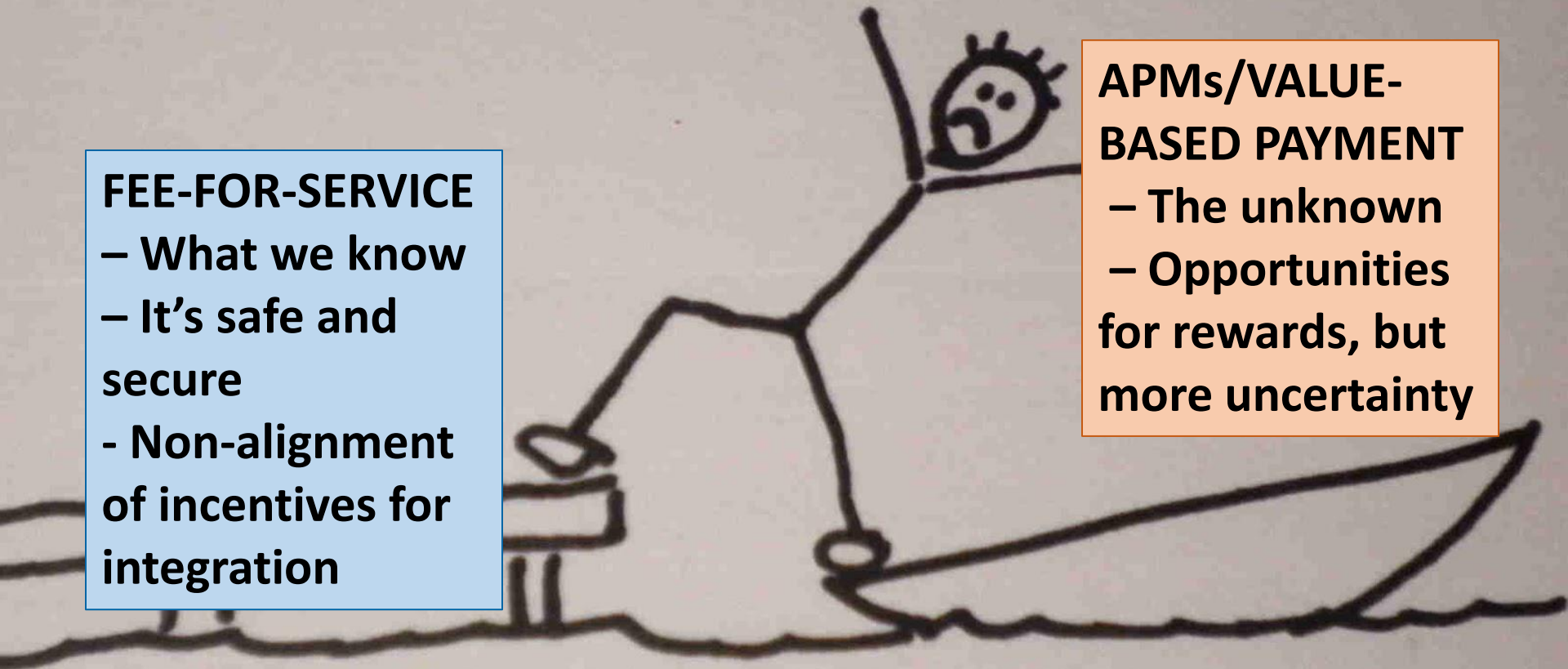
## NAVIGATING TWO WORLDS – THE CHALLENGING FINANCES OF BEHAVIORAL HEALTH INTEGRATION

### **FEE-FOR-SERVICE**

- What we know
- It's safe and secure
- Non-alignment of incentives for integration

**APMs/VALUE-BASED PAYMENT**

- The unknown
- Opportunities for rewards, but more uncertainty



## ■ 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

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Today we are going to focus primarily on billing in the fee-for-service world:

- + 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 Massachusetts 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

## ■ 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)
  - Family therapy?
  - Couples therapy?
- + Must be able to meet documentation requirements/compliance standards
- + Chronic care management codes (CCM)

## ■ 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.”*

## 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.
  - Mass Health does not reimburse for these codes except in the context of Pediatric Early Intervention.

Center for Integrated Health Solutions    NATIONAL COUNCIL FOR BEHAVIORAL HEALTH    SAMHSA

State: Massachusetts, 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	T1015 plus CPT code	Physician, PA, NP, Midwife, Optometrist, RN, Osteopath.	
	99211 - 99215 Est. Pt.					T1015 plus CPT code		
Health and Behavior (HABI)	96150 Assessment	Services are secondary to a physical health diagnosis	Yes	PhD Psychologist at this time; excludes LMSW	No			
	96151 Reassessment		Yes		No			
	96152 Individual TX		Yes		No			
	96153 Group TX		Yes		No			
	96154 Family TX w/ PT		Yes		No			
	96155 Family TX w/o PT		No		No			



# THE COLLABORATIVE CARE MODEL



**Informed,  
Activated Patient**



***PRACTICE  
SUPPORT***



**PCP supported by Care Manager**



**Measurement-based  
Treat to Target**



**Psychiatric  
Consultation**

Patient ID	Name	DOB	Gender	Race	Ethnicity	Primary Dx	Secondary Dx	Medication	Follow-up
10000001	John Doe	12/12/1980	M	W	W	Major Depressive Disorder	Generalized Anxiety Disorder	SSRI	12/15/2023
10000002	Jane Smith	03/05/1975	F	W	W	Major Depressive Disorder	Bipolar II Disorder	Mood Stabilizer	12/10/2023
10000003	Robert Johnson	07/18/1990	M	W	W	Major Depressive Disorder	Substance Use Disorder	Antidepressant	12/20/2023
10000004	Emily White	01/22/1985	F	W	W	Major Depressive Disorder	Generalized Anxiety Disorder	SSRI	12/18/2023
10000005	Michael Brown	09/10/1970	M	W	W	Major Depressive Disorder	Generalized Anxiety Disorder	SSRI	12/12/2023

**Caseload-focused  
Registry review**



**Training**

## ■ NEW MEDICARE CODES FOR CoCM REQUIRE ATTENTION TO DETAIL

G0502 (Initial month, CoCM) - \$143

G0503 (Subsequent month, CoCM) - \$126

G0504 (Add'l 30 mins, CoCM) - \$66

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.

## MEDICARE BILLING CODES FOR CoCM – 1<sup>st</sup> MONTH

HCPCS Code	Long Descriptor	CY 2016 Work RVU	Proposed CY 2017 Work RVU	Final CY 2017 Work RVU	Rate
G0502	<p>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:</p> <ul style="list-style-type: none"> <li>• outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional;</li> <li>• initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan;</li> <li>• review by the psychiatric consultant with modifications of the plan if recommended;</li> <li>• 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</li> <li>• provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.</li> </ul>	NEW	1.59	1.70	<p>\$142.84 (non-facility)</p> <p>\$90.08 (fac)</p>

## MEDICARE BILLING CODES FOR CoCM – SUBSEQUENT MONTHS

HCPSC Code	Long Descriptor	CY 2016 Work RVU	Proposed CY 2017 Work RVU	Final CY 2017 Work RVU	Rate
G0503	<p>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:</p> <ul style="list-style-type: none"> <li>• tracking patient follow-up and progress using the registry, with appropriate documentation;</li> <li>• participation in weekly caseload consultation with the psychiatric consultant;</li> <li>• 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;</li> <li>• additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;</li> <li>• provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies;</li> <li>• 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.</li> </ul>	NEW	1.42	1.53	<p>\$126.33 (non facility)</p> <p>\$81.11 (fac)</p>

## MEDICARE BILLING CODES FOR CoCM – EXTRA TIME

HCPCS Code	Long Descriptor	CY 2016 Work RVU	Proposed CY 2017 Work RVU	Final CY 2017 Work RVU	Rate
G0504	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 GPPP3 in conjunction with GPPP1, GPPP2).	NEW	0.71	0.82	\$66.04 (non fac)  \$43.43 (fac)

## ■ 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](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 G0502-0507 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



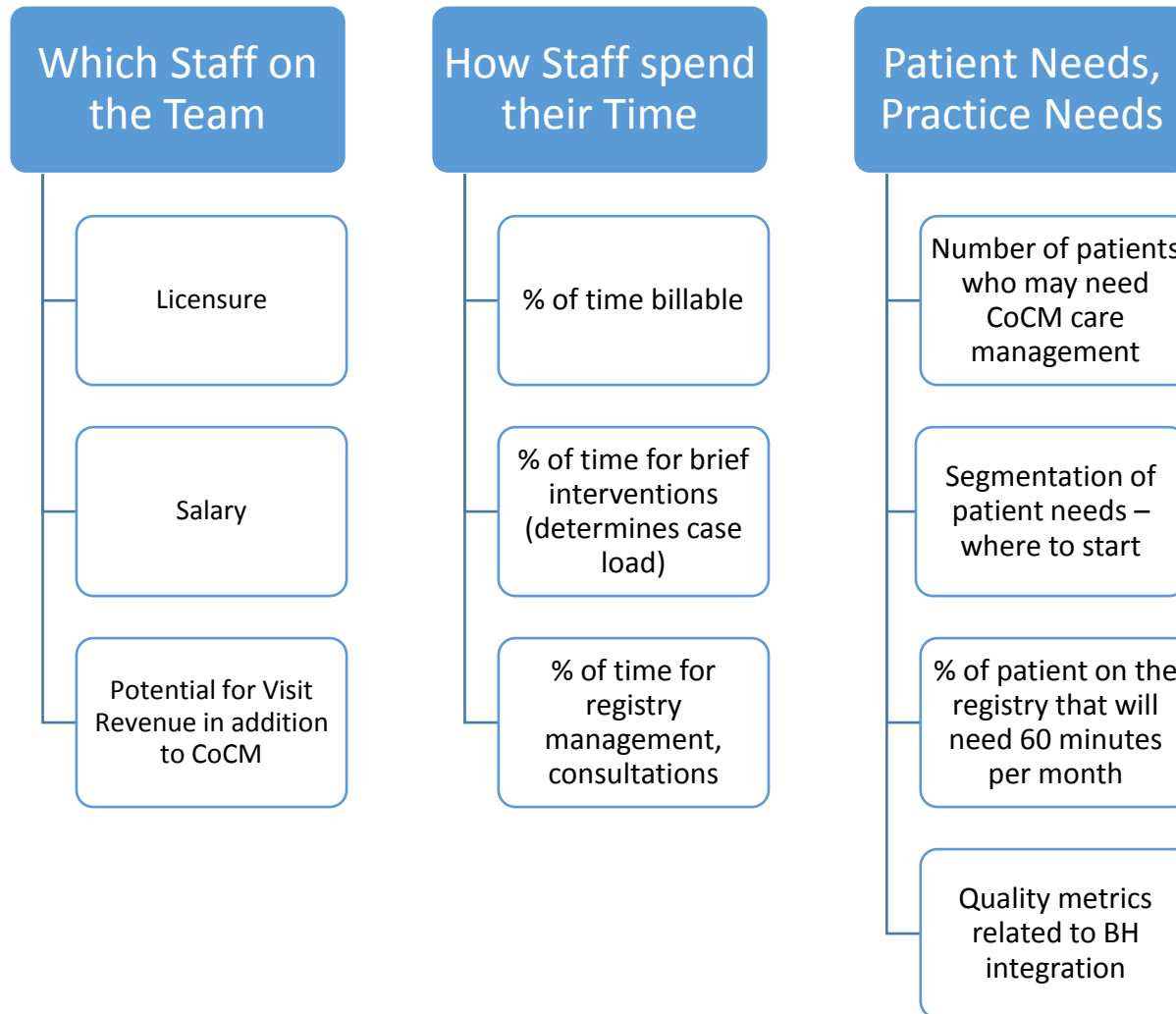
## ■ PROVISION OF ADDITIONAL PSYCHIATRIC SERVICES

- ✚ 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 BCHM on activities for services reported separately may NOT be included in the services reported using time applied to G0502, G0503, and G0504.
- ✚ In other words, the BCHM 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 BCHM, the time may not be billed using multiple codes.

## **MEDICARE PAYMENT FOR OTHER MODELS OF INTEGRATED BEHAVIORAL HEALTH SERVICES**

- ✚ Beginning in 2017, CMS will provide a separate payment for integrated behavioral health services that are delivered under other delivery models, such as the behavioral health consultation model or primary care behavioral health model:
- ✚ **G0507 – 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.
- ✚ G0507 can only be reported by a treating provider and cannot be independently billed. For G0507, a behavioral health care manager with formal or specialized education is not required. CMS rules allow “clinical staff” to provide G0507 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](http://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

### 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

Experience – patient and provider

Functional – work, school, homelessness

### Utilization/Cost

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

**NQF 712**

**NQF 1884 and 1885 (benchmark > 40%)**

**NQF 710 and 711 (benchmark > 20%)**

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

## ■ MASSHEALTH ACO/MCO QUALITY METRICS (Current, as of June 2017)

Measure
<b>Integration (11 measures)</b>
Utilization of BH community partner care coordination services
Utilization of outpatient BH services
Hospital admissions for SMI/SUD populations
ED utilization for SMI/SUD populations (obs to exp)
ED care coordination of ED boarding population
Utilization of LTSS community partners
All cause readmission among LTSS CP eligible
Social service screening
Utilization of flexible services
Care plan collaboration across: PC, BH, LTSS, and SS providers
Community Tenure

Measure
<b>Avoidable Utilization (3 measures)</b>
Potentially preventable admissions (obs to exp)
All condition readmission (obs to exp)
Potentially preventable ED visits (obs to exp)
<b>Member Experience</b>
Patient Experience Survey: PC survey BH survey LTSS survey

## ■ MASSHEALTH ACO/MCO QUALITY METRICS (Cont., Current, as of June 2017)

Measure
<b>Prevention &amp; Wellness (10 measures)</b>
<i>Pediatrics</i>
Well child visits in first 15 months of life
Well child visits 3-6 yrs
<i>Adolescent</i>
Adolescent well-care visit
Weight assessment and counseling for nutrition and physical activity for children/adolescents
Immunization for adolescents
<i>Maternity</i>
Prenatal care
Postpartum care
<i>Oral</i>
Oral evaluation, dental services
<i>Adult (emphasis on SDH)</i>
Tobacco use screening and cessation intervention
Adult BMI assessment

Measure
<b>Chronic Disease Management (5 measures)</b>
Controlling high blood pressure
COPD or asthma admission rate in older adults (obs to exp)
Asthma medication ratio
Comprehensive diabetes care: A1c poor control
Diabetes short-term complications admission rate
<b>Behavioral Health / Substance Abuse (9 measures)</b>
Developmental screening for behavioral health needs: Under age 21
Screening for clinical depression and follow-up plan: Age 12+
Depression remission at 12 months
Initiation/Engagement of alcohol & other drugs (AOD) treatment
Opioid addiction counseling
Follow-up after hospitalization for mental illness (7-day)
Follow-up care for children prescribed ADHD medication (Initiation/Continuation)
<b>Long Term Services and Supports (1 measure)</b>
Patients received age-appropriate LTSS assessment



## ■ CONSIDERATIONS IN CoCM TO MITIGATE RISKS OF VBP UNKNOWNNS

### + Staffing models

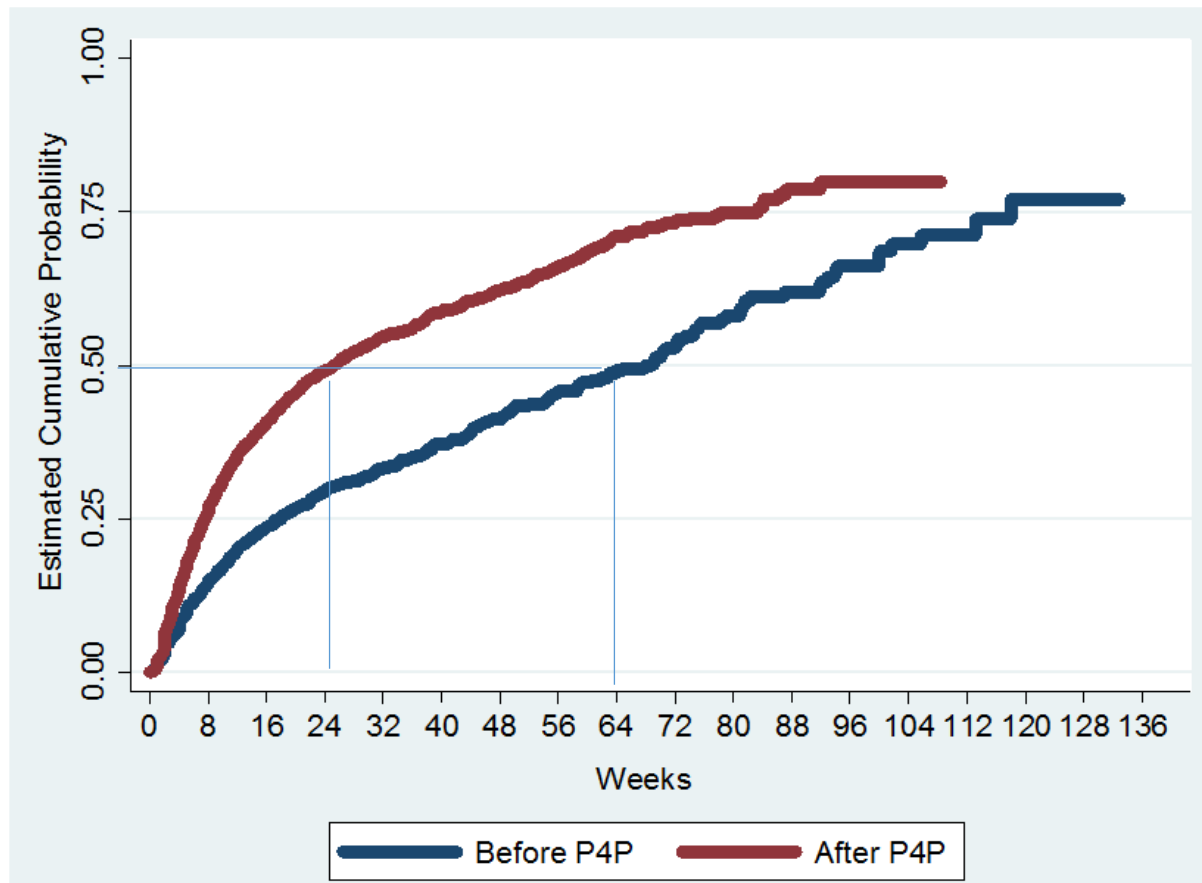
- Who are the right staff in your practice to perform care management functions
- How to apply lessons learned about “working at the top of one’s license”
- Billable visits in addition to care management?

### + Stratification of patient needs

- Which patients would benefit most from CoCM interventions?
- Stepped care model

## 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