Session # I4

Steps to Sustainability: Building Financially Reimbursable Models for Primary and Specialty Integrated Care

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Faculty Disclosure

The presenters of this session have NOT had any relevant financial relationships during the past 12 months.

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Conference Resources

Slides and handouts shared by our conference presenters are available on the CFHA website at https://www.cfha.net/page/Resources_2019 and on the conference mobile app.

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Conference Resources

To participate in Poll Everywhere, text AUBRYKOEHLER163 to 37607

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Learning Objectives

At the conclusion of this session, the participant will be able to:

- Identify barriers to and opportunities for financial sustainability of integrated care in primary and specialty settings.
- Discuss case studies from primary and specialty integrated care programs in the process of becoming financially sustainable.
- Explore ways in which steps towards financial sustainability could be applied to clinical setting at home institution.

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Learning Assessment

- A learning assessment is required for CE credit.
- A question and answer period will be conducted at the end of this presentation.

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Background

- **What is integrated care worth to a system?**
- Different ways of quantifying/seeking sustainability
  - Grant funding
  - Use of BH interns/fellows
  - Medical cost offsets
  - Reimbursement for billing codes

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Background

- Ross et al., 2018, found diabetes initiative (SHAPE) saved practices that had this initiative a total of $1.08M when compared with practices that didn't
- Serrano et al., 2018, found PCBH model was associated with an 11.3% decrease ratio in ED visits to primary care encounters when compared to control

- **Bottom line: we should be billing in addition to demonstrating an offsets**

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Why is this so difficult?

- Medical settings = round holes
- BH services = square peg

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Why is this so difficult?

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Models of Integrated Care

- Primary Care Behavioral Health
- Collaborative Care Model, IMPACT
- Screening, Brief Intervention, & Referral to Treatment
- ECHO
- Co-located BH services

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Models of Integrated Care

MeHAF Score	1 Usual Care	2	3	4	5	6	7	8	9	10 Full Integration
Program or Model Typology	-	Program				SBIRT Model/ Collaborative Care Model			PCBH Model	
Six Levels Crosswalk	1 Minimal Collaboration	2 Basic Collaboration at a Distance			3 Basic Collaboration Onsite	4 Close Collaboration Onsite/ Some System Integration		5-6 Full Collaboration/ Transformed practice		
Population Penetration (Four Quadrants)	Variable					I Low BH/ Low PH	I & III Low BH/ Low PH and/or Low BH/ High PH		I-IV All Quadrants	

Center of Excellence for Integrated Care, 2015

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Contracting and Credentialing

- Contracting
  - Process by which site is added to (contracted with) insurance company's panel of sites where care can be provided
  - If institution you are a part of is already contracted with insurance company, you will likely need to go through a "site add" process for your particular location/dept
- Credentialing
  - Process by which individual provider at contracted site is credentialed with insurance company to provide specific services at contracted site.

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Contracting and Credentialing

- Crash course on getting empaneled
  - Private
  - Medicaid
    - LME-MCOs, contracting/credentialing, BH carve out, needs list
  - Medicare
- Make friends with staff in your institution's contracting/credentialing department. Or, at nearby institutions contracting/credentialing dept. Just make friends.

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Billing

- Psychotherapy codes
- Health & Behavior codes
- Incident to
- CCM

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Psychotherapy Codes

- MH/DSM-5 diagnosis
- Billed to Behavioral Health plan
- Pro – Better reimbursement and wRVUs values
  - Might help to justify financial sustainability of integrated care
  - Must bill for service rendered and not due to payment
- Con – patients might feel stigmatized by MH diagnosis
- Intake, treatment, assessment, crisis CPT codes

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Health & Behavior Codes

- Address the psychological, behavioral, emotional, cognitive, and interpersonal factors in the assessment, treatment, and management of patients diagnosed with physical health problems
- Use with issues:
  - Adherence
  - Symptom management
  - Health promoting behaviors
  - Health-related risk-taking behaviors
  - Adjustment to physical illness

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Health & Behavior Codes, continued

- Assessment
  - 96150, 96151
  - Clinical interview
  - Behavioral observations
  - Psychophysiological monitoring
  - Health-oriented questionnaires

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Health & Behavior Codes, continued

- Medical diagnosis (ICD-10)
- Billed to medical insurance plan
- CPT 96150-96155 (current)
- Not reimbursable for MS licensure in NC
- Lower reimbursement and wRVUs to date
  - 1 unit 96150 = .5 wRVU
  - Reimbursement rate $20.00 ± $3.00 per 15 min. unit
- Reimbursable by Medicare, Medicaid, Private/Commercial?
  - Medicare reimburses for 96150-96154
  - Medicaid (not in NC)
  - Private/Commercial – Variable

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Health & Behavior Codes Documentation

- Document appropriately to get paid $
  - Onset and history of physical illness
  - Rationale why assessment is required
  - Mental status
  - Assessment outcome
  - Measurable specific goals
  - Treatment interventions
  - Expected duration of treatment
  - Rationale for frequency and duration of services
  - Response to intervention

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Health & Behavior Codes 2020

- Proposal and legislation to improve H/B code values in 1/20 (APA)
  - Commensurate with Medicare psychotherapy code wRVU values
  - 96156 (assessment) = 2.10 wRVU
    - Not time-based
  - 96158 + 96159 (individual) = 1.45 + .50 wRVU
  - 96164 + 96165 (group) = .21 + .10 wRVU
  - 96167 + 96168 (family with pt present) = 1.55 + .55 wRVU
  - 96170 + 96171 (family w/o pt present) = 1.50 + .54 wRVU

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Incident to

- Applies only when billing Medicare
- Incident to a provider's professional services = services are furnished as an integral, although incidental, part of the provider's personal professional services in the course of diagnosis or treatment of an injury or illness.
- Bill under attending provider's NPI #
- Person billing under Medicare provider's NPI does not have to be separately enrolled as a Medicare practitioner.

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Incident to, continued

- Attending provider must:
  - First evaluate pt and initiate the course of treatment.
    - Establish the diagnosis, plan of care, and medical necessity of the service
    - Service must be listed on active treatment plan
  - Supervise the service
    - Must be in the same office suite and building
    - Can supervise >1 rendering provider at a time
    - Supervising provider can be different than the provider who initiated treatment plan
  - Actively participate in the management of treatment (Care Plan Oversight)
    - Document review of notes
    - Ongoing brief direct contact with patient
  - File claim
    - Services billed under attending provider's NPI #

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Incident to, continued

- Incident to coverage of psychological services applies to:
  - Doctoral psychologists
  - MS level psychological providers
  - LCSW
    - May not supervise incident to in NY state
  - Clinical nurse specialists; NP
  - Other
- Incident to services are paid at 100% of physician fee schedule as if physician provided the service.
- Incident to services supervised by non-physicians, except clinical psychologists, are reimbursed at 85% of the physician fee schedule.

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Incident to, continued

- Scope of practice consistent between supervising and rendering providers.
- Authorized CPT codes: 90785, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90849, 90853, 90880, 90899
  - NPs and Clinical Nurse Specialists may bill certain EM services and injections.
- Place of service:
  - 11 (office)
  - 52 (Community Mental Health Center)
- Trainees – Interns and postdoctoral graduate students do not qualify for billing incident to services under Medicare.
  - Possible exception: Licensed at Masters level; faculty appointment

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Medicare

- It’s complicated!
- ≥ 65 yo
- < 65 yo
  - ESRD with dialysis and kidney transplant
  - Other disabilities

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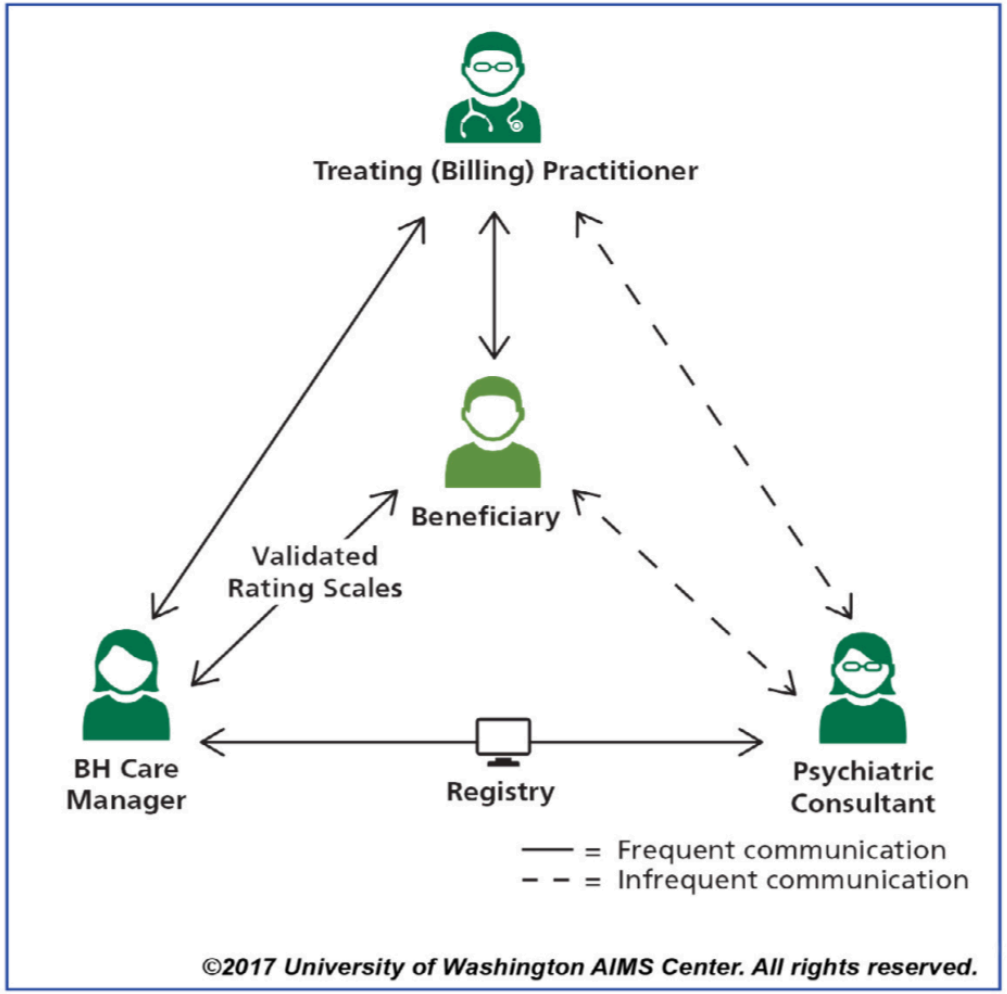
Collaborative Care Model



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Collaborative Care Model

- Enhances “usual” primary care, esp for patients whose conditions are not improving
- A team of three individuals provide CCM
  - Behavioral Health Care Manager – e.g., psychologist, SW, nurse
  - Psychiatric Consultant who prescribes medication
  - Treating/Billing Practitioner – e.g., PCP
- Care management support for patients receiving BH treatment
- Regular psychiatric inter-specialty consultation

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Collaborative Care Model Service Components

- Initial assessment
  - Initial visit (if needed, billed separately)
  - Administration of applicable validated rating scale(s)
- Systematic assessment and monitoring, using applicable validated clinical rating scales
- Care planning by the primary care team with revision as needed
- Facilitation and coordination of behavioral health treatment
- Continuous relationship with a designated member of the care team

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Collaborative Care Model Billing

BHI CODING SUMMARY

BHI CODE	BEHAVIORAL HEALTH CARE MANAGER OR CLINICAL STAFF THRESHOLD TIME	ASSUMED BILLING PRACTITIONER TIME
CoCM First Month (99492)	70 minutes per calendar month	30 minutes
CoCM Subsequent Months** (99493)	60 minutes per calendar month	26 minutes
Add-On CoCM (Any month) (99494)	Each additional 30 minutes per calendar month	13 minutes
General BHI (99484)	At least 20 minutes per calendar month	15 minutes
BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M)†	N/A	Usual work for the visit code

**CoCM is furnished monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).
†Annual Wellness Visit (AWV), Initial Preventive Physical Examination (IPPE), Transitional Care Management services (TCM).

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Screening

- Standard of care
- Contributes to understanding psychosocial factors contributing to medical issues
- Must have system in place to address issues that come up during screening (e.g., abuse, suicide)
- CPT 96127 (very little reimbursement and no wRVUs)
- CPT 96136 – must be 16-30 minutes of assessment/scoring

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Not all licensure types created equal

- ONLY Psychologists & LCSWs can bill Medicare
  - Some Private insurance companies follow suit
- Typically call fully licensed BHPs can bill Medicaid
- State by state differences in reimbursing provisionally licensed providers
- BHPs canNOT bill E&M codes (physicians, APPs, psychiatric NPs CAN)

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Poll Everywhere

What model of care are you currently using?

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Poll Everywhere

What integrated care model is best for your site clinically?

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Poll Everywhere

What integrated care model is best for your site financially?

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Breakout #1

- Break into groups: scramble!
- Discuss the overlap or discrepancy between what you are doing currently and what you think is best for your site clinically vs. financially?
- How do you reconcile these differences?

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Our state: North Carolina

- Medicaid Regions
- No Medicaid expansion
- Medicaid Transformation > Privatized
  - Four plans selected, roll out Feb 2020
  - “Standard plans” – cover mild/moderate BH needs
- BH carve out ending
  - Vertical carve out for “tailored plans” for special populations with high BH needs

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Aubry's site

- Family Medicine Residency training clinic (primary care)
- PCBH-type model
  - Routine screenings: PHQ9, GAD7
  - Warm hand-offs
  - Follow-ups onsite
- Provider-Based Clinic (can't bill hospital facility codes)
- Grant funded through HRSA
- Penetration rates: 6.6% 2018, 5.6% 2019

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Aubry's site: successes

- Incredible dept chair/champion
  - 3 out of 4 BHPs on departmental budget; funding for pre-doc BH fellow
- Provider and patient satisfaction
- Getting empaneled with Medicaid, Medicare, Private
- Foot-in-the-door with LME-MCO
  - If closed network, check needs list and make a case for a contract/site add
- Billing ETA Jan 2020

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Aubry's site: challenges

- LME-MCO closed network
- LMFT, LPC, and LCAS clinicians who cannot bill Medicare
- Physician-as-gatekeeper approach
  - Currently not scrubbing schedules
- High level of follow-up care

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Linda's site

- Pediatric GI integrated care
- Hospital-based
- Routine screenings:
  - PHQA, GAD7, CRAFFT, SCOFF, BEARS
- Warm hand-offs
- Assessment, recommendations, referrals, psychoeducation
- Retain a minority for treatment

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Linda's site: successes

- ID BH issues contributing to physical symptoms and health
- Provider satisfaction
- Patient satisfaction?
- Billing for services
- Increased clinical productivity
  - Justification of hiring additional psychologist
  - Scribe services

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Linda's site: challenges

- Site adds with Medicaid LMEs
- Expanding sites with medical team
- Patient consent for BH services

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Planning strategically: individual/clinic-level

- With regard to your current IC model:
  - What has been working?
  - What hasn't been working?
- Which insurance panels are you on?
  - Keep in mind that most large commercial plans contract with other BH insurance plans (i.e., not every BCBS pt will have BH coverage)
  - H&B codes are billed through the medical side

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Planning strategically: institutional-level

- Is your/your team members' salary/salaries tied to productivity?
- How is productivity measured?
- What does your boss/champion/institution want you to do with regards to integrated care?

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Planning strategically: state-level

- What codes are turned on in your state?
- Does your state have a BH carve out for Medicaid?

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Breakout #2: Thinking through Barriers

- Break off into groups with home institution colleague or people from the same state/region if possible
- What are your top 3 barriers (real or anticipated) to making integrated care financially sustainable at your home institution?
- What is your #1 success story or tip (yours or someone else's) for making integrated care financially sustainable?
- Turn in one a barrier notecard and a success notecard per group

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Take homes

- Make friends with people (especially in your state) who are doing well what you want to be doing
- Know your state's limitations with regard to IC billing
- At the same time, advocate for change through your state-level professional and licensure organizations. Consider reaching out to state government representatives

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Take homes, continued

- Start where you are. Tie your plan to
  - Specific BHPs
  - Specific site
  - Specific services/codes
  - Specific patient population
- Work hand-in-hand with someone who has worked through a similar plan, ideally in the same state

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Session Survey

Use the CFHA mobile app to complete the survey/evaluation for this session.

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