Counting The Cost Of Behavioral health Integration

SIM/TCPi Webinar Series:

Moving Into Value Based Models

December 13th 2017

12pm – 1pm MT

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If we are going to look to develop a high-performing health care system that deals with the totality of medical costs—ignoring mental health and substance use as drivers of costs and human suffering will not work. These illnesses are too big to ignore and too important.

—Paul Summergrad, M.D., American Psychiatric Association president

Learning Objectives

- ✓Create A Sustainable Behavioral Health program
- ✓Sustainability tool kit
- ✓Validated Screening and Measurement Tools
- ✓Optimize coding/billing opportunities
- ✓Connect Behavioral Health with Outcomes

Recipe for Successful Implementation

Ingredients TEMP

Team that consists at a minimum of a PCP, BHP and psychiatric consultant
Evidence-based behavioral and pharmacologic interventions
Measuring care continuously to reach defined targets
Population is tracked in registry, reviewed, used for quality improvement
Accountability for outcomes on individual and population level

Process of Care Tasks

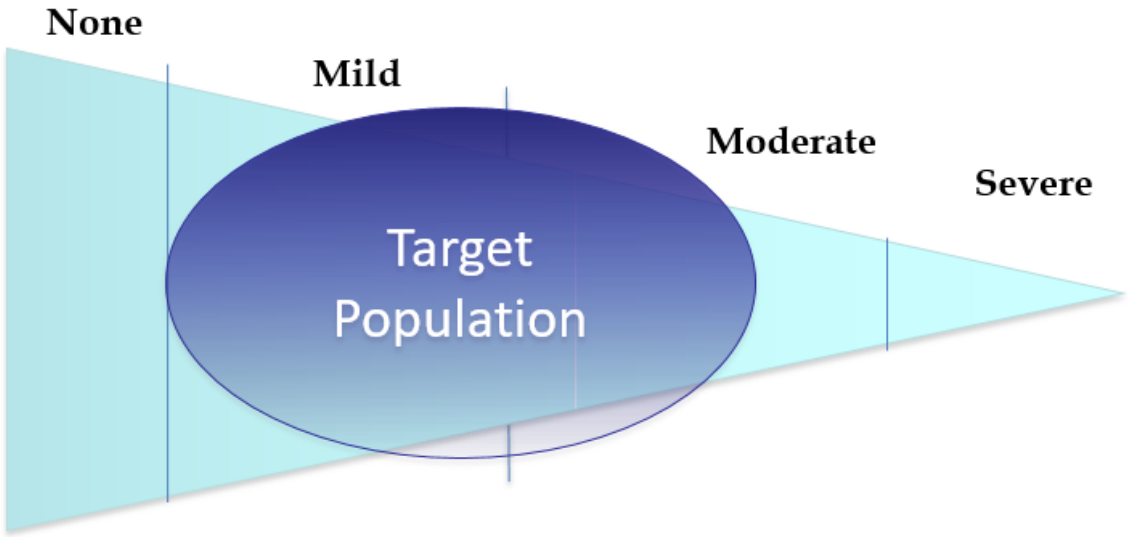
- ***2*** or more contacts per month by BHP
- Track with registry
- Measure response to treatment and adjust
- Caseload review with psychiatric consultant

Secret Sauce *Whitebird Brand*

- Strong leadership support
- A strong PCP champion and PCP buy-in
- Well-defined and implemented BHP/Care manager role
- An engaged psychiatric provider
- Operating costs are not a barrier

Raney, L: Elements of Effective Design and Implementation in Integrated Care: A Guide for Effective Implementation, APPI, 2017

Go Upstream: "Sweet" Spot in Primary Care



- Issues with depression and substance abuse can be pre-empted, rather than progressing to diagnosis
- Goal is to detect early and apply early interventions to prevent from getting more severe

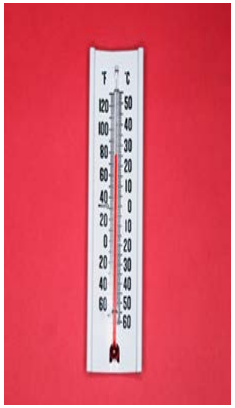
Collaborative Care

Collaborative Care is a specific type of integrated care that operationalizes the principles of the chronic care model to improve access to evidence based mental health treatments for primary care patients.

Collaborative Care is:

- **T**eam-based effective collaboration and Patient-centered
- **E**vidence-based and practice-tested care
- **M**easurement-based care, treat to target
- **P**opulation-based care – registry, systematic screen

- **A**ccountable care



Collaborative Care

Informed, Activated Patient

Effective Collaboration

PRACTICE SUPPORT

PCP supported by Behavioral Health Care Manager

Measurement-based Treat to Target

Psychiatric Consultation

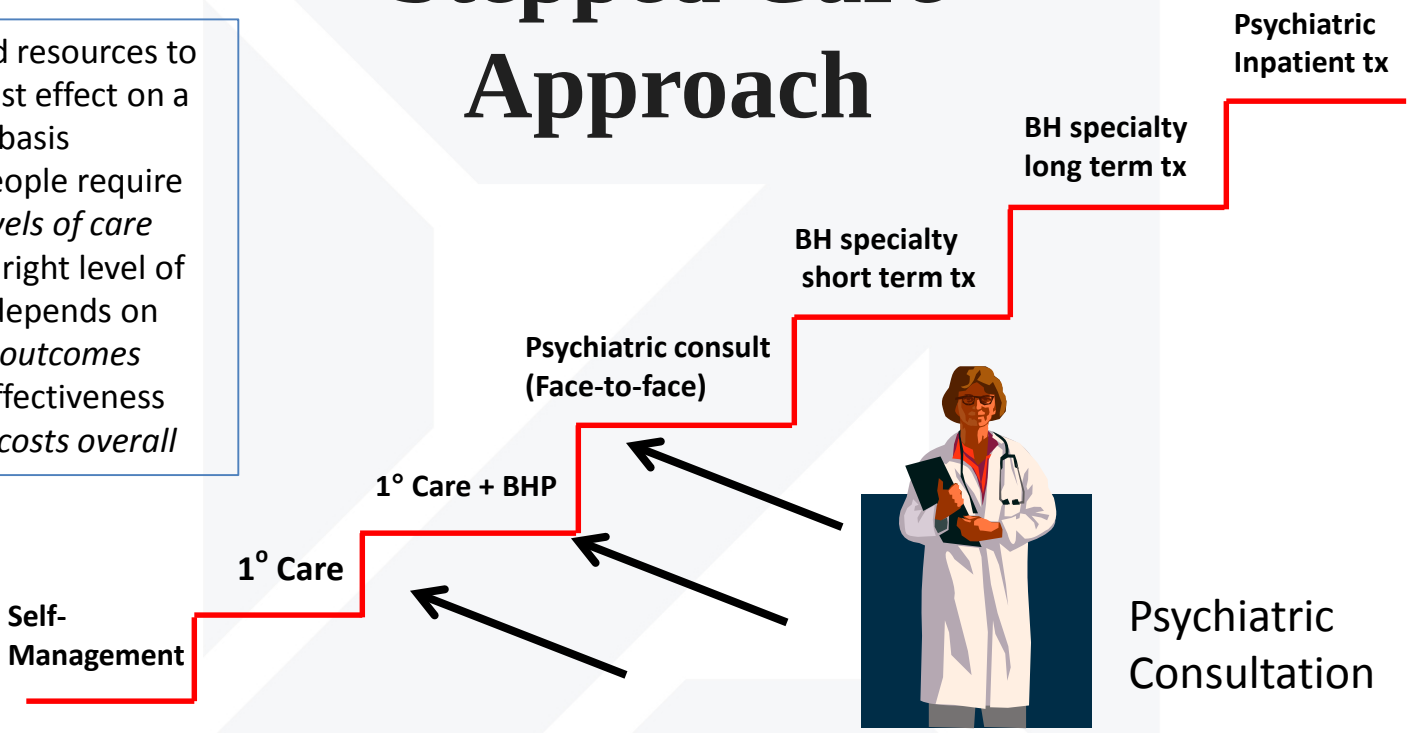
Caseload-focused Registry review

Training

Used with permission, AIMS Center

Stepped Care Approach

- Uses limited resources to their greatest effect on a population basis
- Different people require *different levels of care*
- Finding the right level of care often depends on *monitoring outcomes*
- Increases effectiveness and *lowers costs overall*

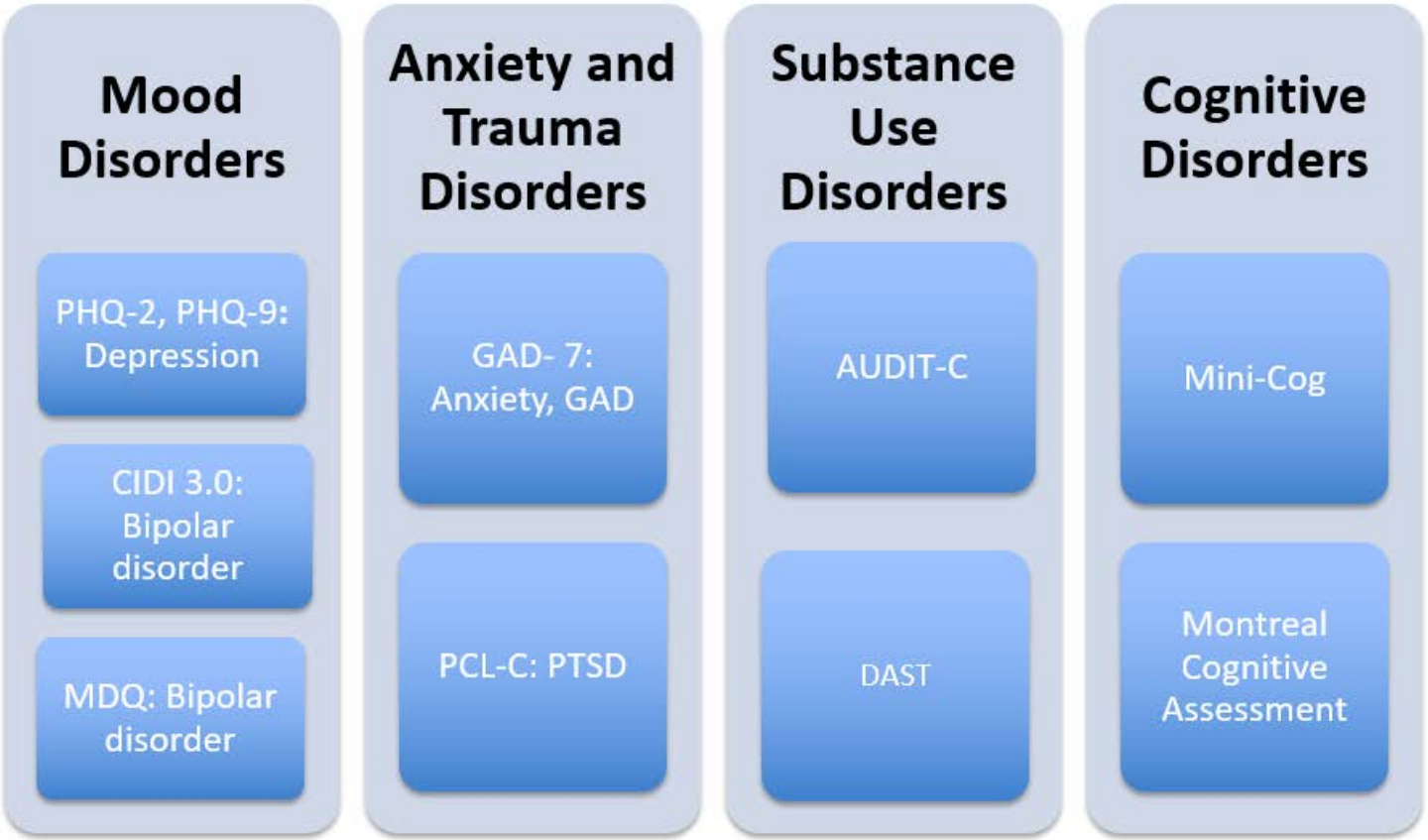


Van Korff et al 2000

Validated

SCREENING AND MEASUREMENT TOOLS

Validated Tools



Validated Measurement tool

PHQ - 2

Over the last 2 weeks, how many days have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

- Ultra brief screening
- Commonly used in primary care
- Scoring:
  - 0-2: Negative
  - 3 or Higher: Positive and patient needs further assessment

Validated Screening and Measurement Tools

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: John Q. Sample DATE:

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	✓	3
2. Feeling down, depressed, or hopeless	0	✓	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	✓	3
4. Feeling tired or having little energy	0	1	2	✓
5. Poor appetite or overeating	0	✓	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	✓	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	✓	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	✓	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	✓	1	2	3
add columns:	2	+ 10	+	3
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:		15		

SAMPLE

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult ✓
- Very difficult
- Extremely difficult

PHQ 9 > 9

- < 5 – remission
- 5 - mild
- 10 - moderate
- 15- moderate severe
- 20 - severe

Generalized Anxiety Disorder 7-item (GAD-7) scale

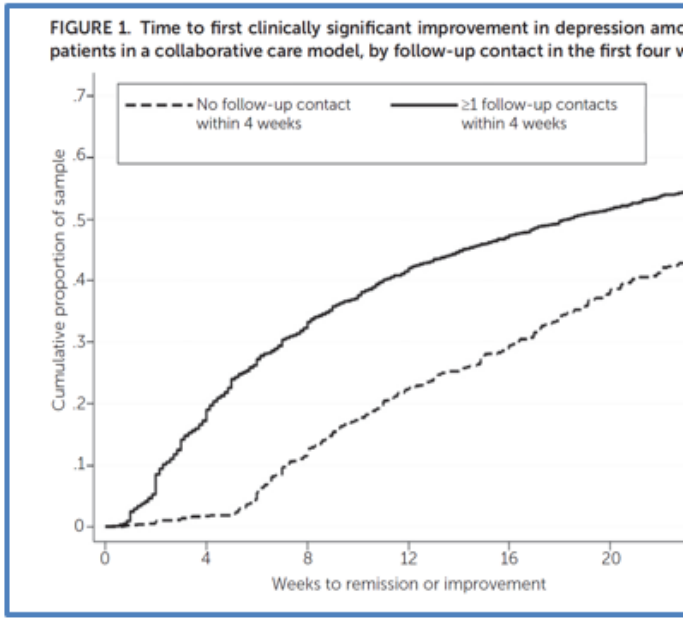
Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =	Score ≥ 10 indicates possible diagnosis			

Behavioral Care Manager Interventions

Evidence-based Brief Interventions

- Motivational Interviewing
- Distress Tolerance Skills
- Behavioral Activation
- Problem Solving Therapy

Frequent, Persistent Follow-up



Bao et al: Psych Serv 2015

HMA

Measurement-based Care: Tracking and Adjusting Care

CONNECT BEHAVIORAL HEALTH WITH OUTCOMES

Caseload Overview

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! indicates that the most recent contact was over 2 months (60 days) ago				✓ indicates that the PHQ-9 score is at target (less than 5 or decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ indicates that the GAD-7 score is at target (less than 10 or decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	! 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	! 12/2/2015	14	10	-29%	! 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

- FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

Registries to Track Progress, Change Treatment

Patient | Caseload | Program | Tools | Logout — Search Patient : — Hello, Jurgen (unutzer)

MHITS ID	Popu-lation	Date Enrolled	Sta-tus	Clinical Assessment			# of Sess-ions	Wks in Tx	Last PHQ-9						Continued Care Plan	Psych. Note	Psych. Eval.	Next Appt.
				Date	PHQ-9	GAD-7			Date	PHQ-9	Dep Impr	GAD-7	Anx Impr	Med				
3400027	U	3/22/2011	L1	3/22/2011	22	21	4	10	5/31/2011	19*		21*		✓		5/16/2011		
3400009	U	12/13/2010	L1	12/13/2010	24		9	24	5/12/2011	23		16		✓		5/16/2011		5/26/2011 12:30PM
3400020	U	2/9/2011	L1	2/9/2011	23	13	5	16	5/31/2011	21		17		✓		5/16/2011		6/14/2011 11:30AM
3400024	U	3/9/2011	L1	3/9/2011	24	17	5	12	5/16/2011	22		17		✓		5/2/2011		6/1/2011 2:00PM
3400010	U	12/13/2010	L1	12/13/2010	21	18	9	24	5/23/2011	12*		12*		✓		4/4/2011		6/2/2011 2:30PM
3400004	U	10/27/2010	L1	10/27/2010	17	14	12	31	6/1/2011	12		13		✓		4/11/2011		6/15/2011 3:00PM
3400021	U	2/10/2011	L1	2/10/2011	19	16	7	15	4/19/2011	14		15		✓		4/25/2011		
3400017	U	1/25/2011	L1	1/25/2011	22	15	5	18	5/23/2011	17		19		✓		5/23/2011		6/2/2011 1:00PM
3400008	U	12/8/2010	L1	12/8/2010	16	10	12	25	5/24/2011	3		7		✓		5/23/2011		6/7/2011 4:30PM
3400023	U	3/7/2011	L1	3/7/2011	17	14	6	12	5/31/2011	9		8		✓		3/14/2011		6/20/2011 5:00PM
3400011	U	12/14/2010	L1	12/14/2010	17	13	10	24	4/14/2011	9		8		✓		12/20/2010		
3400012	U	12/27/2010	L1	12/27/2010	25		8	22	5/5/2011	2				✓		2/28/2011		5/18/2011 2:30PM
3400001	U	10/21/2010	L1	10/21/2010	22	20	15	31	5/26/2011	8		10		✓	11/10/2010	4/4/2011		6/9/2011 11:30AM
3400005	U	12/8/2010	L1	12/8/2010	10	12	12	25	5/23/2011	6		4		✓		4/4/2011		6/6/2011 11:00PM
3400026	U	3/21/2011	L1	3/21/2011	17	14	8	10	5/24/2011	7		8		✓		3/31/2011		6/7/2011 11:00AM
3400007	U	12/8/2010	L1	12/8/2010	13	8	13	25	5/31/2011	8		2		✓		5/31/2011		6/14/2011 11:00AM
3400013	U	12/28/2010	L1	12/27/2010	19	15	9	22	5/17/2011	3		4		✓	4/19/2011	1/20/2011		6/14/2011 5:00PM
3400003	U	11/18/2010	L1	11/18/2010	22	18	10	27	5/25/2011	5*		8*		✓		5/31/2011		6/8/2011 4:30PM
3400016	U	1/20/2011	L1	1/20/2011	19	10	5	18	4/21/2011	2		5		✓		5/2/2011		5/19/2011 10:00AM
3400002	U	10/14/2010	L1	10/13/2010	14	7	8	33	2/17/2011	4		4		✓	2/17/2011	2/22/2011		
3400015	U	1/18/2011	L1	1/18/2011	17	4	11	19	5/25/2011	4*		5*		✓		1/24/2011		6/1/2011 4:30PM
3400028	U	4/19/2011	L1	4/19/2011	14	14	4	6	5/31/2011	9*		10*		✓		5/23/2011		6/7/2011 10:00AM
3400030	U	5/18/2011	L1	5/18/2011	22	10	1	2	5/19/2011	22*		10*				5/23/2011		
3400029	U	5/2/2011	L1	5/2/2011	24	16	3	4	5/24/2011	7		5		✓		5/16/2011		6/6/2011 8:30AM

1 - 24 of 24 — Per page: 200

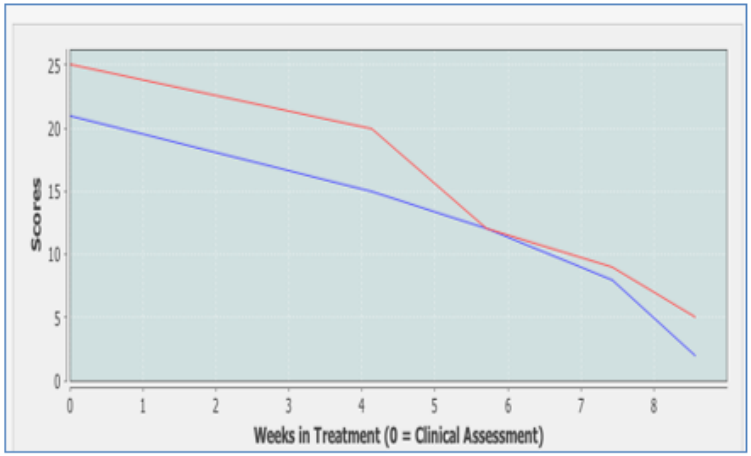
Population : G - GA-U, U - Uninsured, V - Veterans, F - Veteran Family Members, M - Moms, C - Children, O - Older Adults, I - CMI
*: score is last available but not from the last F/U.
L1↑: Patient has been graduated from L2.
L2#: Patient is still not taken by a Case Manager after 14 days.
Red: Most recent score is above 10 and has not improved by 5 points from the initial assessment score. Or if initial assessment is the only assessed score and is above 10
Yellow: Shows a 5 point improvement from the initial assessment score to the most recent score but most recent score is still above 10. Or there is not an initial assessment score and the most recent score is above 10
Green: Most recent score is below 10

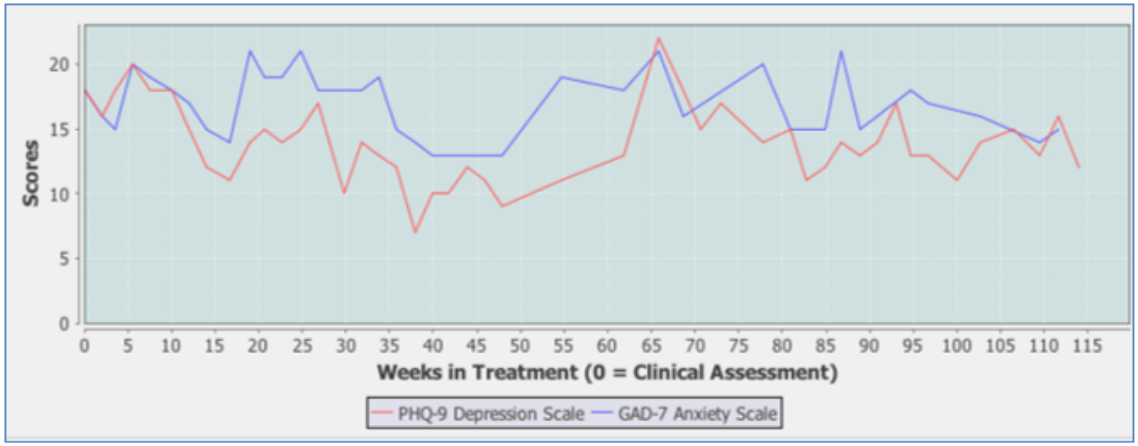
Population(s) included : ☑ GA-U ☑ Uninsured ☑ Veterans ☑ Veteran Family Members ☑ Moms ☑ Children ☑ Older Adults ☑ CMI Reload

Start | Inbox - Outlook Express | Calendar - Microsoft Outl... | Removable Disk (F:) | Unutzer - IOM Policy Jun... | Lunch- IMPACT for Psyc... | MHITS - Caseload - W... | 1:54 PM

AIMS Center: http://aims.uw.edu

Measurement Based Treatment To Target





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Performance Measures: Accountability

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

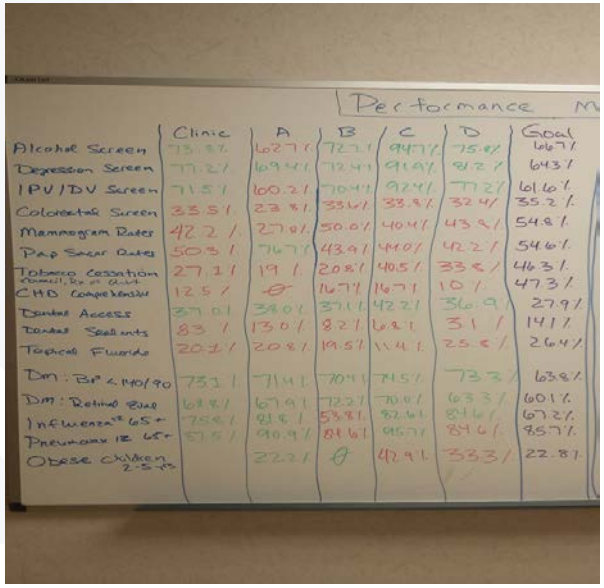
- Percent with 50% reduction PHQ-9 – Clinical Response
- Percent reaching remission (PHQ-9 < 5) NQF 710 and 711

Satisfaction – patient and provider

Functional –work, school, homelessness

Utilization/Cost

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



Sustainability Checklist

The Sustainability Checklist provides important elements of your practice organization that need to change to support integration.

- Use it to identify the work that must be done to accomplish integration
- Identifying up to five items for your team to focus on first
- Rank your selected items with a score of 1 to 5, for 1 being the items you want to focus on first

Source: integration.samhsa.gov

MGMA HEALTH CARE CONSULTING GROUP

CODING FOR INTEGRATED BEHAVIORAL HEALTH

OPTIMIZE CODING/BILLING OPPORTUNITIES

MGMA
Medical Group Management Association

2018 CPT Codes for Collaborative Care:

G0502 becomes **99492** (Initial month, CoCM) - $161

G0503 becomes **99493** (Subsequent month, CoCM) - $129

G0504 becomes **99494** (Add'l 30 mins, CoCM) - $69

Billed once a month by the PCP

G0507 becomes **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.

BILLING CODES FOR CoCM – 1st MONTH formerly G0502

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 - Formerly G0503

MGMA HEALTH CARE CONSULTING GROUP

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 Formerly G0504

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.

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

- **G0507 becomes 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.

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

New FQHC Care Management Services

- *Effective January 1, 2018, FQHCs can receive payment for psychiatric Collaborative Care Model (CoCM) services when 70 minutes or more of initial psychiatric CoCM services or 60 minutes or more of subsequent psychiatric CoCM services are furnished and G0512 is billed either alone or with other payable services on an FQHC claim.*
- Effective January 1, 2018, FQHCs can receive payment for Chronic Care Management (CCM) or general Behavioral Health Integration (BHI) services when 20 minutes or more of CCM or general BHI services are furnished and G0511 is billed either alone or with other payable services on an FQHC claim.

New FQHC Care Management Services

- CCM services furnished on or before December 31, 2017 will continue to be processed and paid when CPT code 99490 is billed alone or with other payable services on an FQHC claim. Service lines reported with CPT code 99490 will be denied for dates of service on or after January 1, 2018.

- https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

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.

Colorado Medicaid BH Appendix P

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.

Colorado Medicaid BH Appendix P

Widespread implementation of CoCM and other effective BHI services could substantially improve outcomes for millions of Medicare beneficiaries and produce savings for the Medicare program.

n engl j med 376;5 nejm.org February 2, 2017

Commercial Payers

- Know your contracts to see if BH is covered, in what manner, which product lines and which codes.
- The codes trigger any insurance company to act. They are covered or not covered; the plan dictates the coverage.

Documentation

- Structured care plans. Clinicians create and maintain a care plan that outlines treatment, describes plans for follow-up, and ensures that the patient and all involved clinicians are on the same page.
- The plan provides access to patient information and identifies who's responsible for addressing specific healthcare needs and goals.

Documentation

Benefits of Using the EHR for Behavioral Health Providers:

- See what other providers see
- Participate more closely in care
- Ability to use note templates
- Allows use of Consult Tracking
- Allows for notes to be electronically signed

Resources

PCPCI Tool Kit For BH Integration

http://www.pcpci.org/sites/default/files/resources/PCBH%20Implementation%20Kit_FINAL.pdf

AHRQ Tool Kit

https://integrationacademy.ahrq.gov/research/literature-collection/literature/primary-care-behavioral-health-toolkit

Polling Question

As a result of the session: *Counting The Cost Of Behavioral health Integration* I will :

A. ___Improve the integrated BH services I already have

B. ___Consider implementing integrated BH services

C. ___Discontinue integrated BH services