Behavioral Health Integration Beyond Co-location:

Practical Implementation of New Medicare Services

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Disclosures

No conflicts of interest

Upon completion of this session you should be able to:

- ✓ **Define** Behavioral Health Integration and Collaborative care model
- ✓ **Explain the requirements** for Medicare behavioral health integration services in your practice setting
- ✓ **Outline the practical steps** to implement team-based behavioral health integration

Medicare Payment for Behavioral Health Integration in 2017

What are the models?

What is the evidence?

How to implement?

Medicare introduces payment for two new services in 2017:

General Behavioral Health Integration (General BHI)

Psychiatric Collaborative Care Management (PsyCoCM)

Medicare Learning Network Fact Sheet: Behavioral Health Integration Services
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf January 2018

What is the reimbursement?

Time-based

Reasonable payment

≈ $145 per hour

Medicare CPT Payment Summary 2018

CPT	Description	Payment/Pt (Non-Facilities) Primary Care Settings	Payment/Pt (Fac) Hospitals and Facilities
99492	Initial psych care mgmt, 70 min/month - CoCM	$161.28	$90.36
99493	Subsequent psych care mgmt, 60 min/month - CoCM	$128.88	$81.72
99494	Initial/subsequent psych care mgmt, additional 30 min CoCM	$66.60	$43.56
99484	Care mgmt. services, min 20 min – General BHI Services	$48.60	$32.76

FQHC and RHC Payment Summary

Code	Description	Payment
G0511	General Care Management Services - Minimum 20 min/month	$62.28
G0512	Psychiatric CoCM - Minimum 70 min initial month and 60 min subsequent months	$145.08

Used with permission from the University of Washington AIMS Center, 11/20/18, https://aims.uw.edu/resource-library/cms-collaborative-care-payment-cheat-sheet and http://aims.uw.edu/sites/default/files/CMS_FinalRule_FQHCs-RHCs_CheatSheet.pdf

What are the models?

What is the evidence?

What is Integrated Behavioral Health?

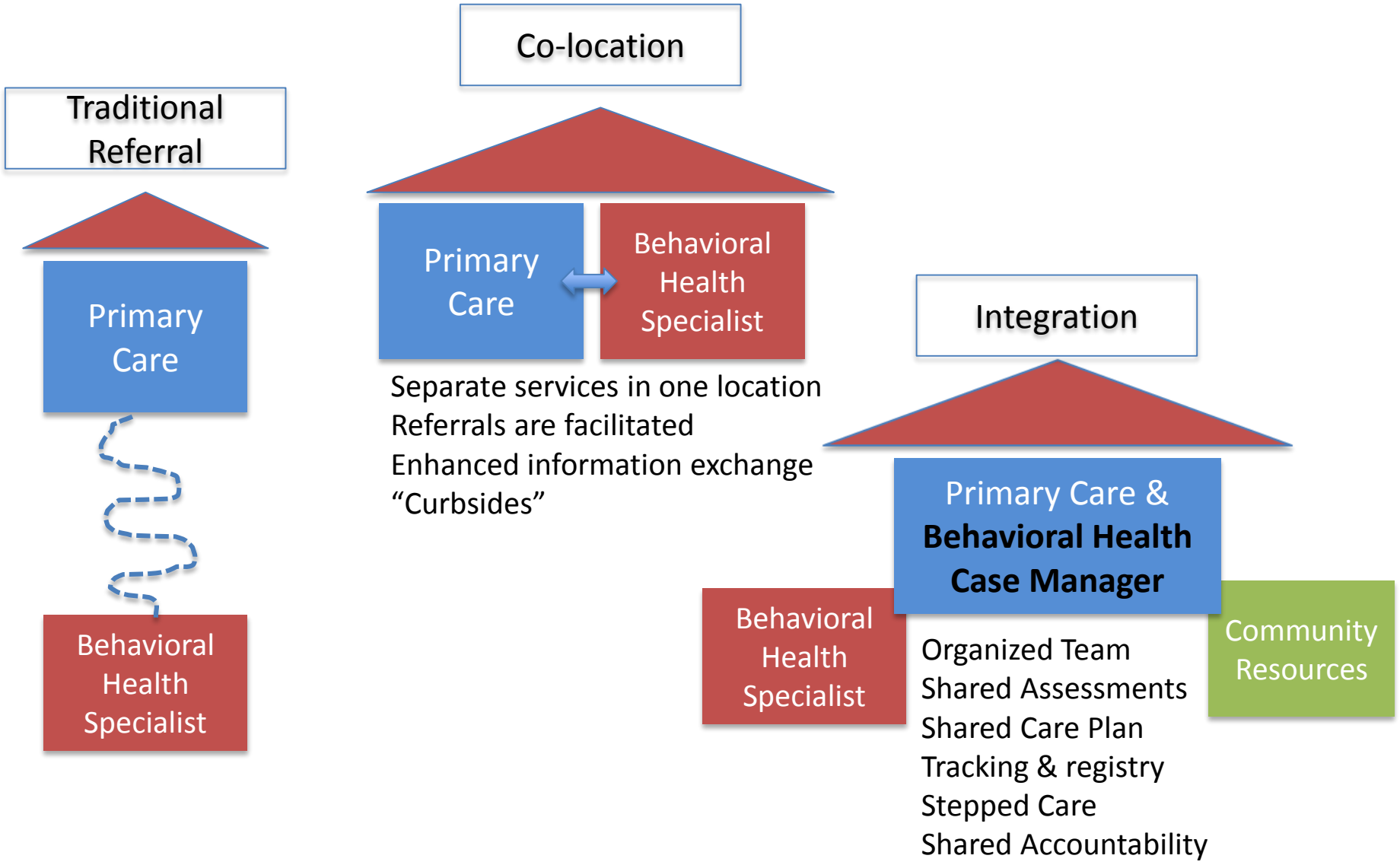
Integrated Behavioral Health is…

The care that results from a practice team of **primary care** and **behavioral health clinicians**, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

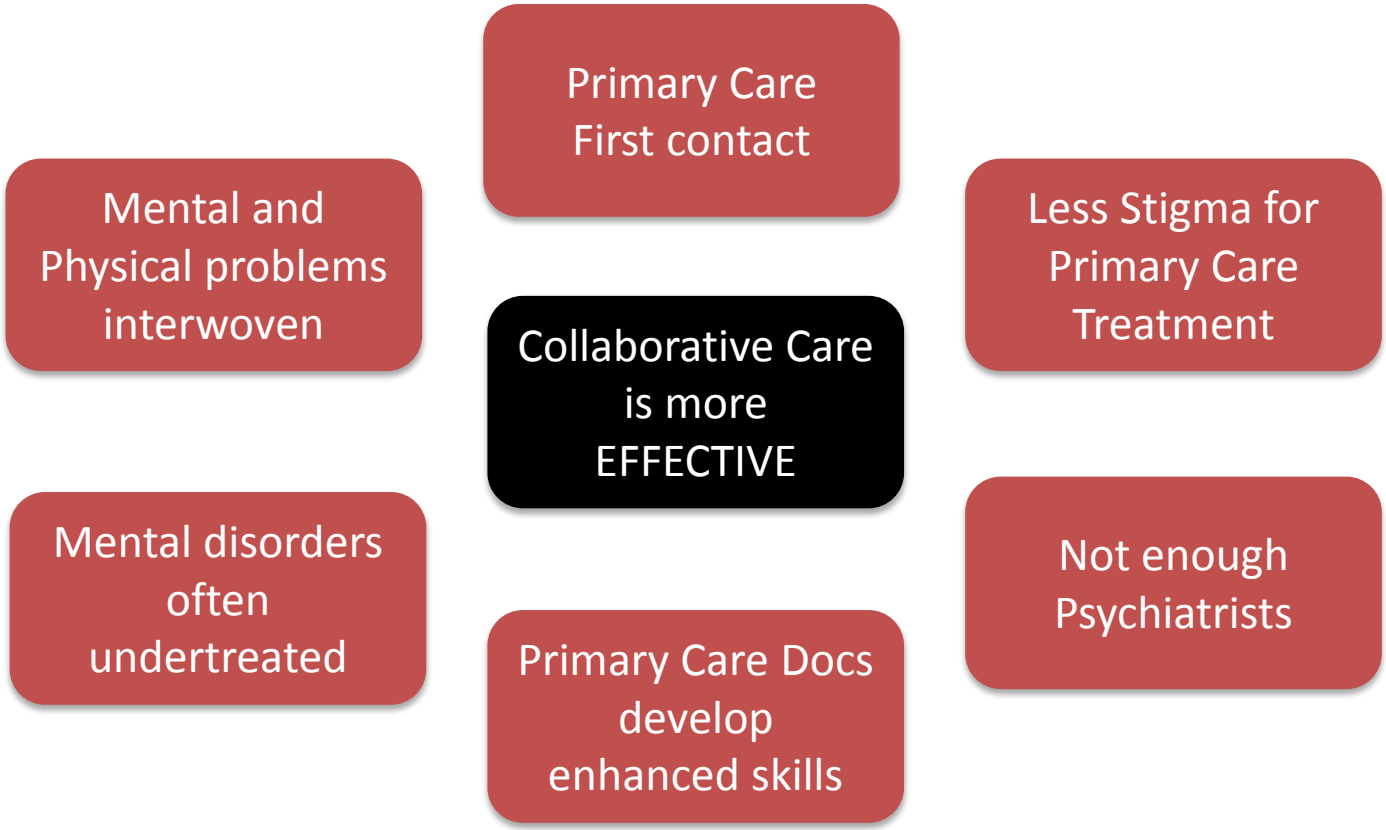
Teams may include:

- *physicians*
- *physician assistants, nurse practitioners,*
- *nurses, medical assistants*
- *licensed social workers,*
- *psychologists and*
- *other bachelor-level providers*

SAMHSA-HRSA, March 2014, Essential elements of effective integrated primary care and behavioral health teams, www.integration.samhsa.gov


Traditional Referral
Primary Care
Behavioral Health Specialist
Co-location
Primary Care
Behavioral Health Specialist
Separate services in one location
Referrals are facilitated
Enhanced information exchange
"Curbsides"
Integration
Primary Care & Behavioral Health Case Manager
Behavioral Health Specialist
Community Resources
Organized Team
Shared Assessments
Shared Care Plan
Tracking & registry
Stepped Care
Shared Accountability

Many reasons to consider integrated care:



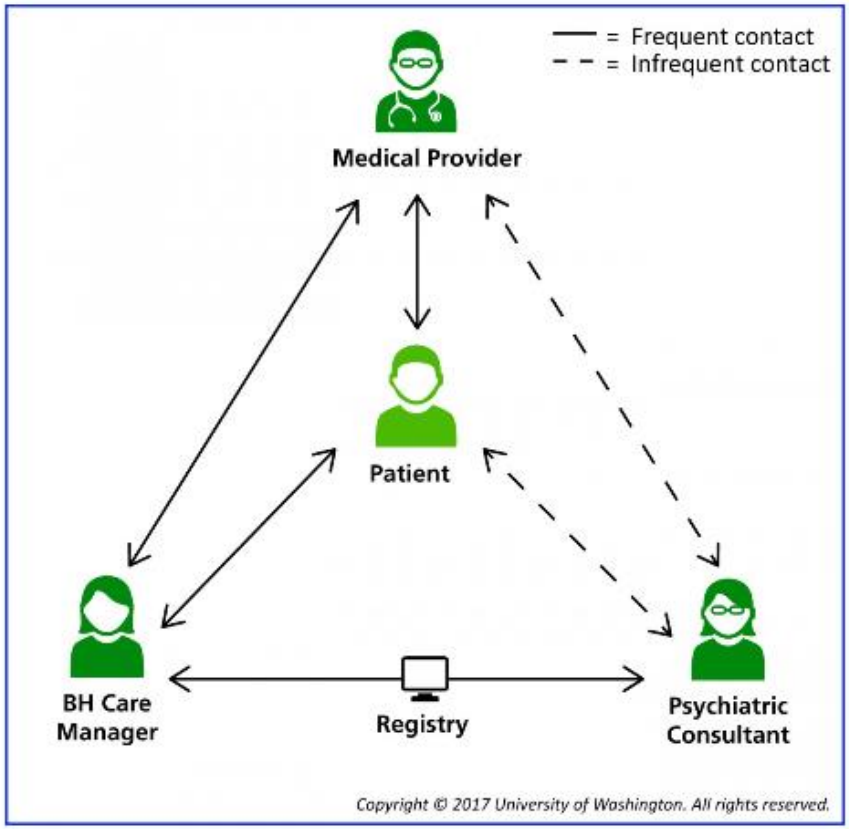
Collaborative Care Model

a specific model of integrated care

Primary Care Physician
leads the treatment team

Behavioral Health Case Manager
manages care

Psychiatric Consultant
provides regular case review
and indirect care



Used with permission from the University of Washington AIMS Center, 11/21/18, https://aims.uw.edu/collaborative-care/team-structure

Core Principles of Collaborative Care:

Patient-Centered Team Care

Shared care plans include patient goals; provided in primary care setting

Population-Based Care

Registry to track and insure follow-up

Structured case-load review with mental health specialists

Measurement-Based Treatment to Target

Outcomes are measured with Validated scales

Evidence-Based Care

Stepped care approach

Accountable Care

Team shares responsibility for outcomes

Adapted from works created by the University of Washington AIMS Center, 11/21/18, https://aims.uw.edu/collaborative-care/principles-collaborative-care

What's the evidence for Collaborative Care model?

"IMPACT Model"

"Improving Mood-Promoting Access to Collaborative Treatment for Late-Life Depression"

1998 – 2003

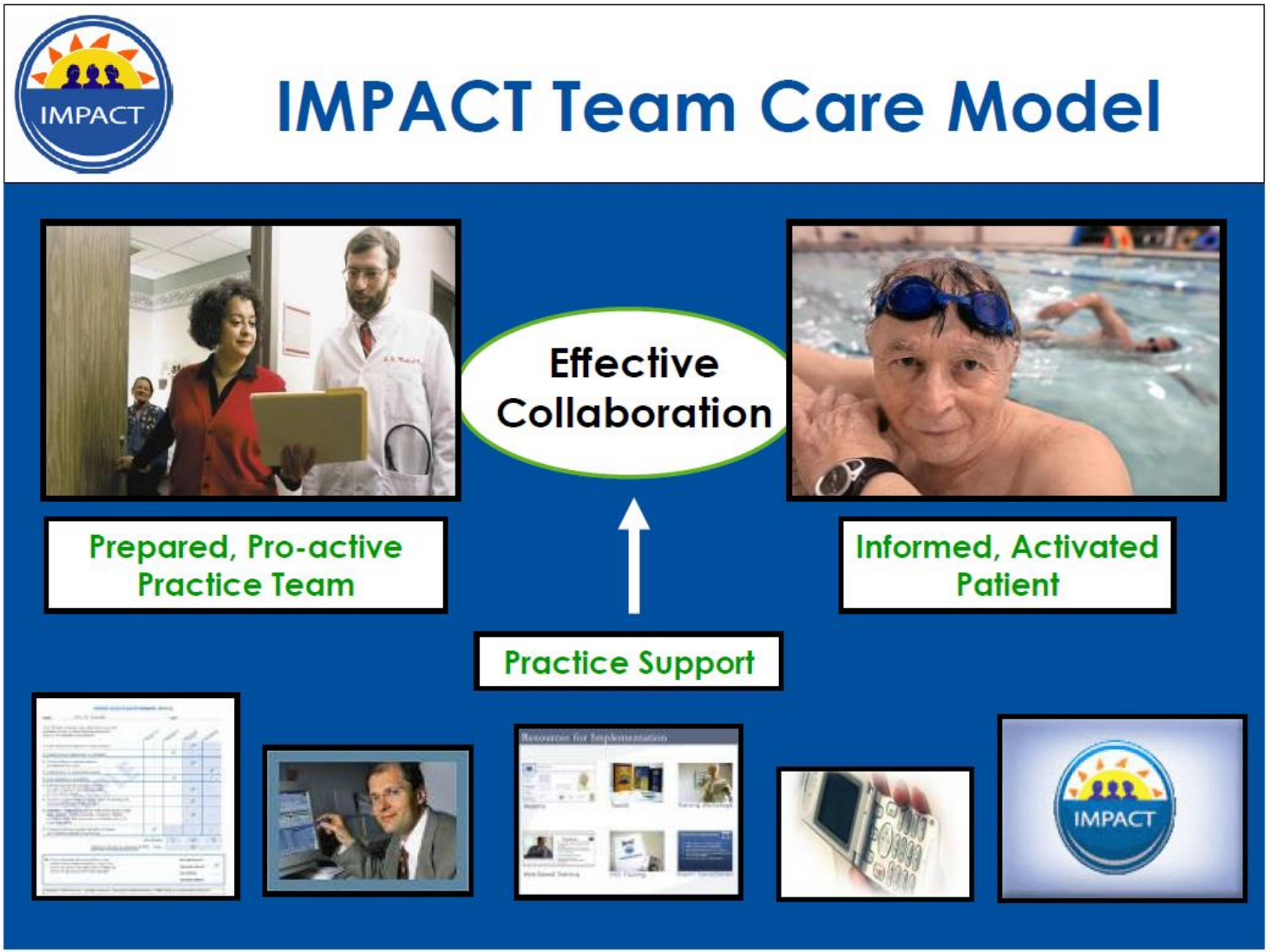
1,801 depressed older adults in primary care

18 primary care clinics - 8 health care organizations in 5 states

- Diverse health care systems (FFS, HMO, VA)
- 450 primary care providers
- Urban and semi-rural settings
- Capitated and fee-for-service

Funded by
John A. Hartford Foundation; California HealthCare Foundation; Robert Wood Johnson Foundation; Hogg Foundation

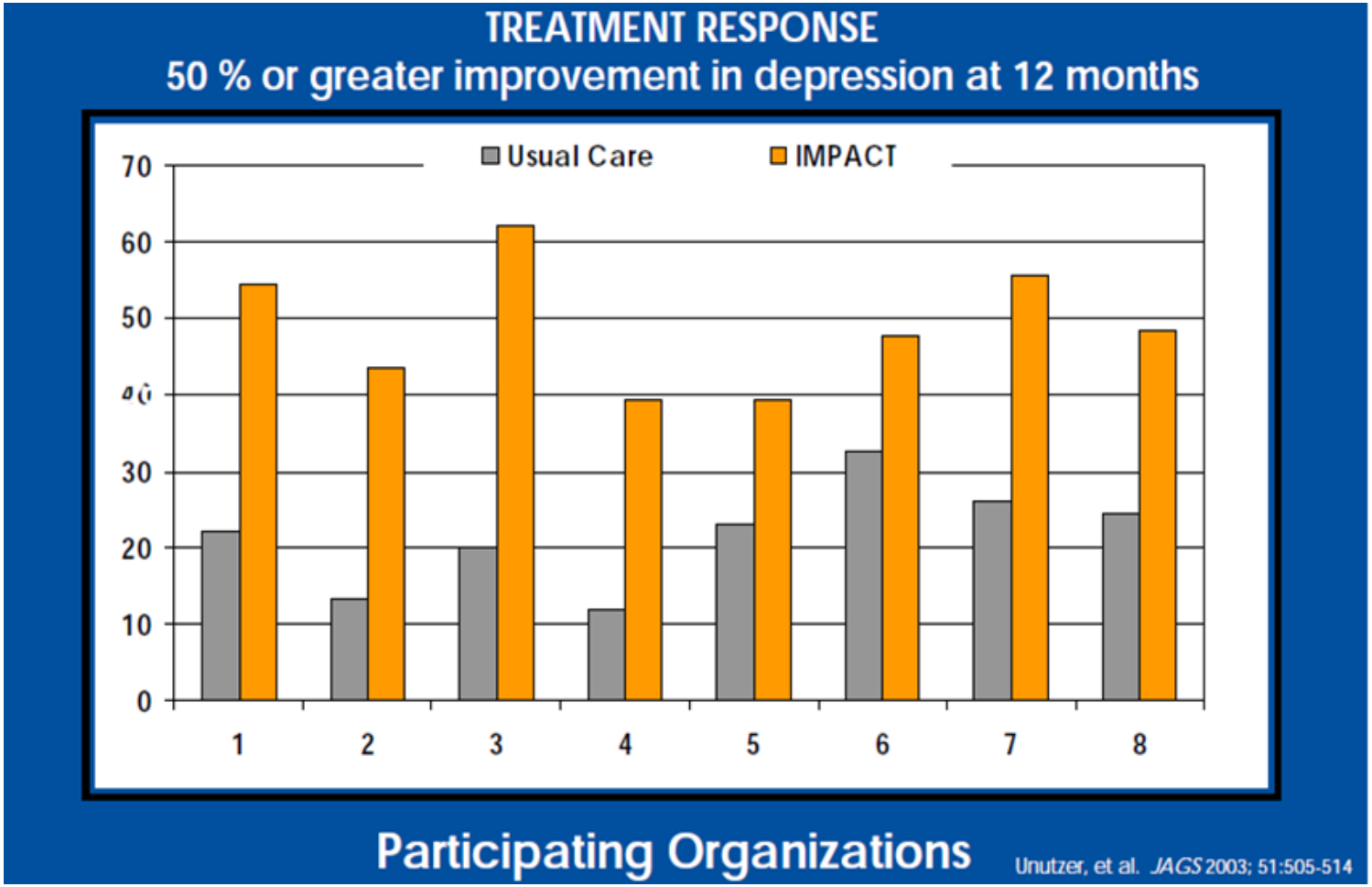
Unutzer J et al, JAMA 2002



Evidence-based 'team care' for depression

TWO PROCESSES	TWO NEW 'TEAM MEMBERS' Supporting the Primary Care Provider (PCP)	
	Care Manager	Consulting Psychiatrist
1. Systematic diagnosis and outcomes tracking e.g., PHQ-9 to facilitate diagnosis and track depression outcomes	-Patient education / self management support -Close follow-up to make sure pts don't 'fall through the cracks'	- Caseload consultation for care manager and PCP (population-based) - Diagnostic consultation on difficult cases
2. Stepped Care a) Change treatment according to evidence-based algorithm if patient is not improving b) Relapse prevention once patient is improved	- Support anti-depressant Rx by PCP - Brief counseling (behavioral activation, PST-PC, CBT, IPT) - Facilitate treatment change / referral to mental health - Relapse prevention	- Consultation focused on patients not improving as expected - Recommendations for additional treatment / referral according to evidence-based guidelines

Collaborative care twice as effective as usual care



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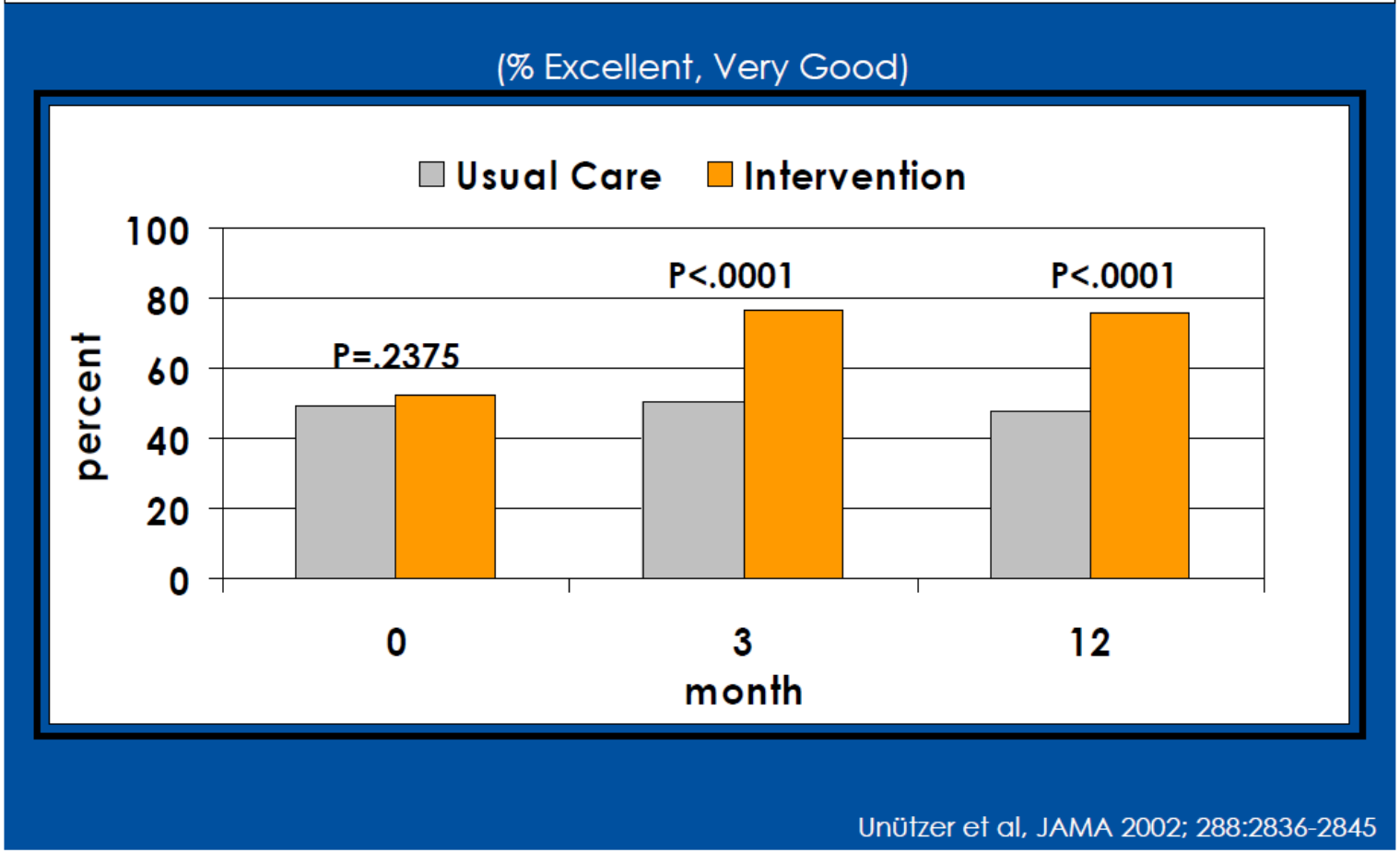
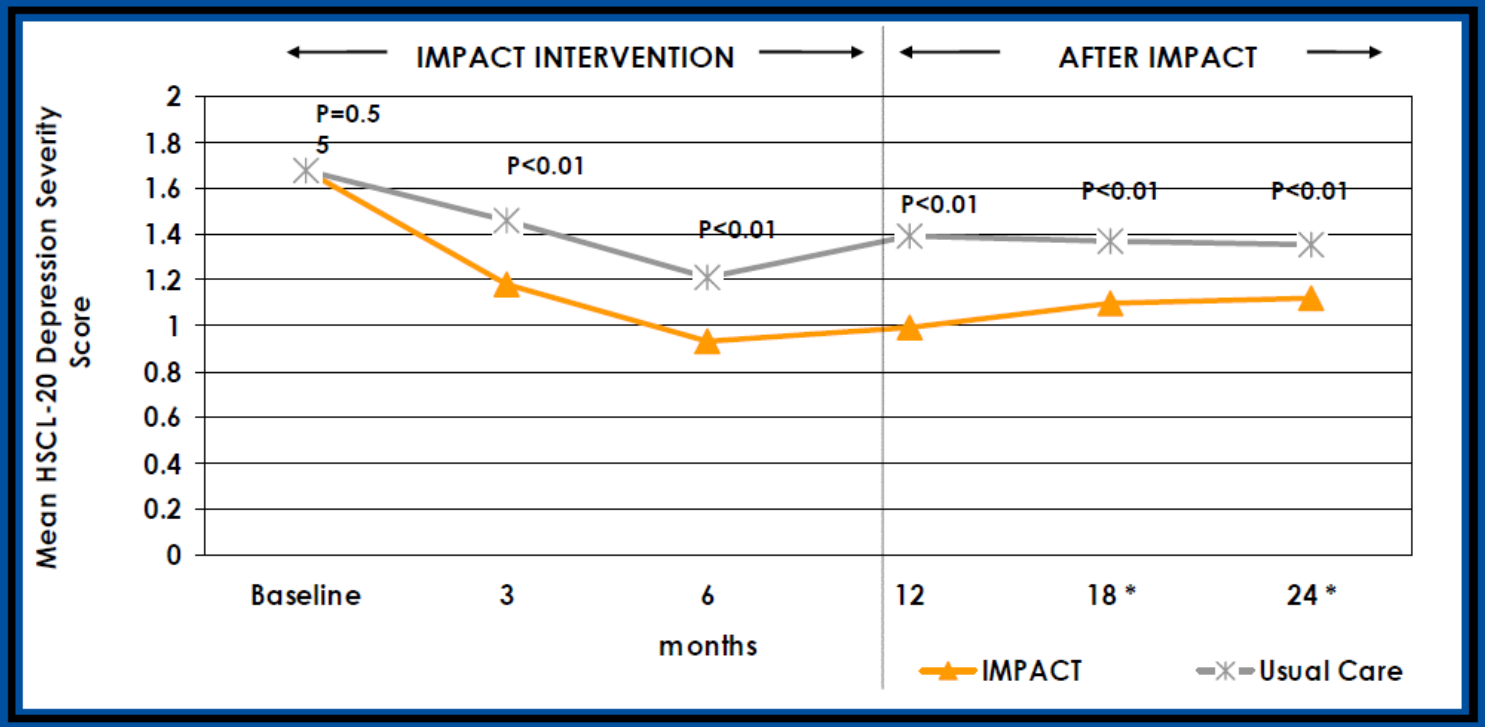
Improved Satisfaction with Depression Care



Effects persist even 1 year after the program ends



Hunkeler et al, *BMJ*, 2006.

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Cochrane Library

Cochrane Database of Systematic Reviews

Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P.
Collaborative care for depression and anxiety problems.
Cochrane Database of Systematic Reviews 2012, Issue 10. Art. No.: CD006525.
DOI: 10.1002/14651858.CD006525.pub2.

www.cochranelibrary.com

Collaborative care for depression and anxiety problems (Review)

- 79 randomized controlled trials with 24,308 participants
- Conclusions:
  - Significant improvement in depression outcomes in adults
  - Significant improvement in anxiety in adults
  - Improved secondary outcomes including medication use, mental health quality of life, patient satisfaction

How to implement Medicare BHI?

Two types of Medicare BHI:

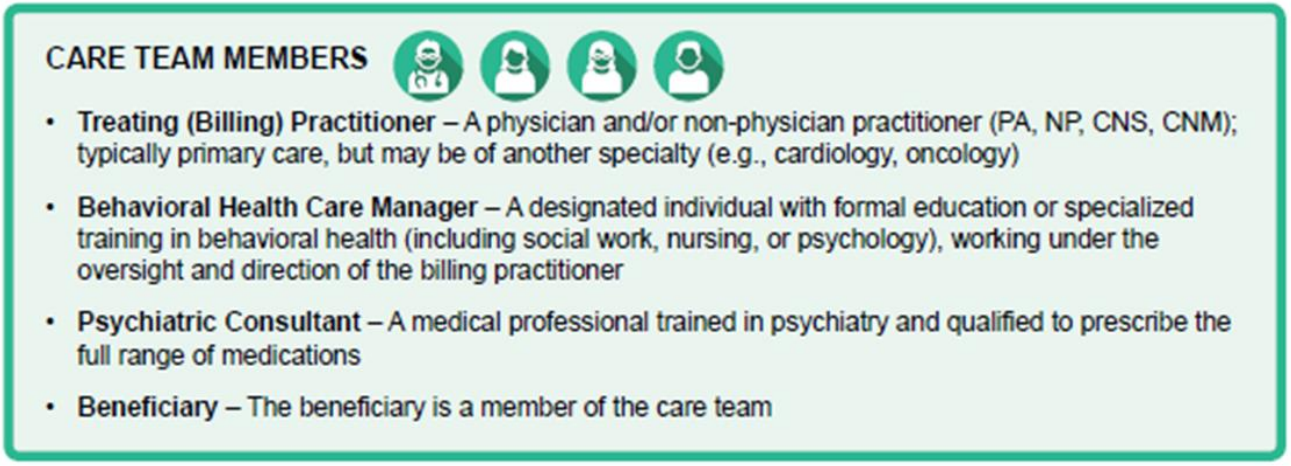
Psychiatric Collaborative Care Management (PsyCoCM)

General Behavioral Health Integration (General BHI)

Eligibility for Medicare BHI services

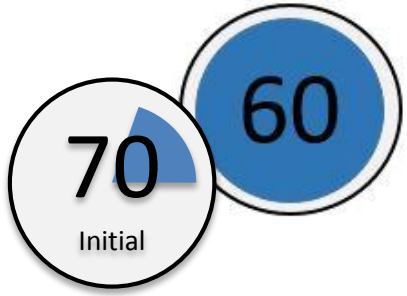
- Eligible if
  - **Original "fee-for-service" Medicare** Part B
  - Has **any behavioral health condition including substance use** even if no co-morbid conditions
  - BHI is warranted in the judgement of the billing practitioner
- Must have had visit in the last 12 months with billing practitioner
- **Verbal consent includes:**
  - **Permission to consult** with relevant specialists including psychiatric consultant
  - Only one practitioner can bill per calendar month
  - **Cost sharing** applies (even for non-face-to-face services)
  - Right to stop the service at any time (effective end of month)

Psychiatric CoCM Service Requirements



- ✓ **Initial Assessment with validated rating scales** by primary care team
- ✓ **Care Planning** by primary care team with the patient
- ✓ **Pro-active systematic follow-up** using validated scales and registry by case manager
- ✓ **Weekly case load review with psychiatric consultant**

PsyCoCM Time & Billing



- Primary Care practitioner bills for this service (not psychiatrist)
- Billing based on care coordination **time per calendar month**
  - 70 minutes minimum first month
  - 60 minutes subsequent months
  - Each additional 30 minutes (added time not option for FQHC or RHC)
- Behavioral Health Case Manager performs most of the service
  - Need not be licensed to bill psychiatric evaluation and therapy codes
  - If licensed, may bill for additional services but not count the time twice
- Psychiatric consultant
  - Provides indirect care
  - May bill for face-to-face additional services but not count the time twice

General BHI Service Requirements

CARE TEAM MEMBERS

- **Treating (Billing) Practitioner** – A physician and/ or non-physician practitioner (PA, NP, CNS, CNM); typically primary care, but may be of another specialty (e.g., cardiology, oncology, psychiatry).
- **Beneficiary** – The beneficiary is a member of the care team.
- **Potentially Clinical Staff** – The service may be provided in full by the billing practitioner. Alternatively, the billing practitioner may use qualified clinical staff to provide certain services using a team-based approach. These clinical staff may- but are not required to- include a designated behavioral health care manager or psychiatric consultant.

No psychiatric consultant required
Qualified Clinical staff may perform
No formal education in Behavioral Health required

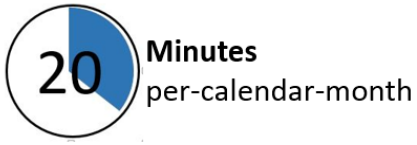
Minutes
per-calendar-month

Service components

- Initial assessment
- Systematic assessment & monitoring using ***validated scales***
- Behavioral Health care planning by primary care team with the patient
- Facilitate, coordinate treatment for behavioral health
- Continuous relationship with a designated care team member

FQHC and RHC Unique requirements for BHI

Code	Description	Payment
G0511	General Care Management Services - Minimum 20 min/month	$62.28
G0512	Psychiatric CoCM - Minimum 70 min initial month and 60 min subsequent months	$145.08



- General Care Management
  - OPTION B: Eligible if any behavioral or psychiatric condition including substance use that warrants BHI services in judgement of practitioner
  - Otherwise same requirements as General BHI

Note: OPTION A is Chronic Care Management for multiple conditions with other requirements

- Psychiatric CoCM
  - No added reimbursement beyond 70 minutes initial month or 60 minutes subsequent months
  - Otherwise same requirements

Supervision and "Scope of Practice"

- Billing Practitioner:
  - Need not be in the office--General supervision of the services performed by the team
  - Provides ongoing oversight, management, collaboration and reassessment
  - Billing practitioner may provide General BHI in its entirety.
- Case Manager may be off-site -available to come to site as needed
- Services provided by care team members are subject to
  - State Law
  - Licensure
  - Scope of Practice
- Clerical and administrative staff time cannot be counted.

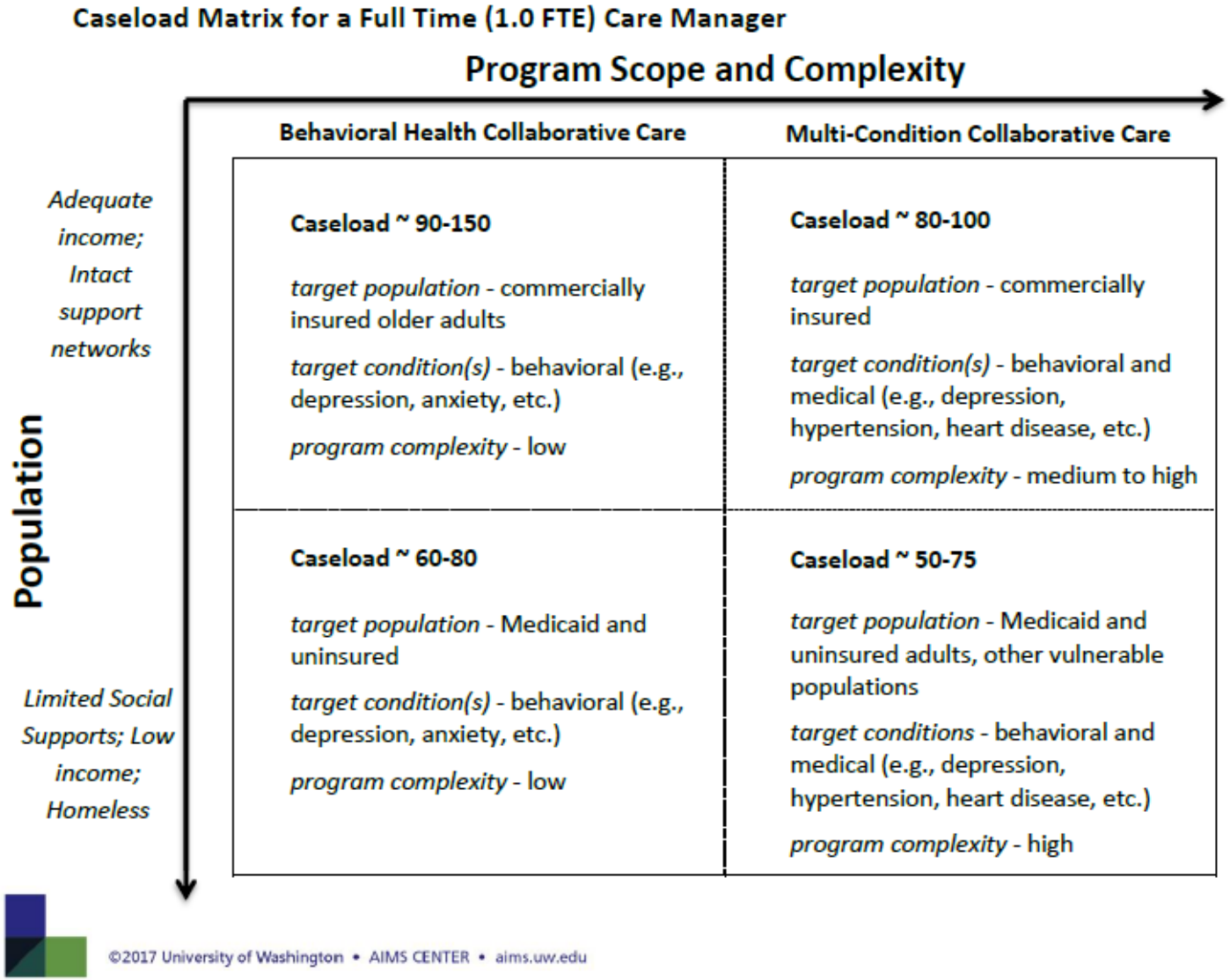
Steps to Implement PsyCoCM

1. Assess your panel
2. Assemble & train your team
3. Create team workflows
4. Begin weekly case review meetings
5. Enroll and track patients
6. Evaluate outcomes & improve

Step1: Assess your panel

- Determine how many original Medicare patients in your practice panel.
- Include patients with Medicare Advantage plans that cover BHI.
- Assess prevalence of serious mental health conditions in your panel.
- Consider partnerships with others (especially if small panel)

Sufficient patients for a full-time or part-time BH case manager?
Assume typical full case load = 50-150 patients



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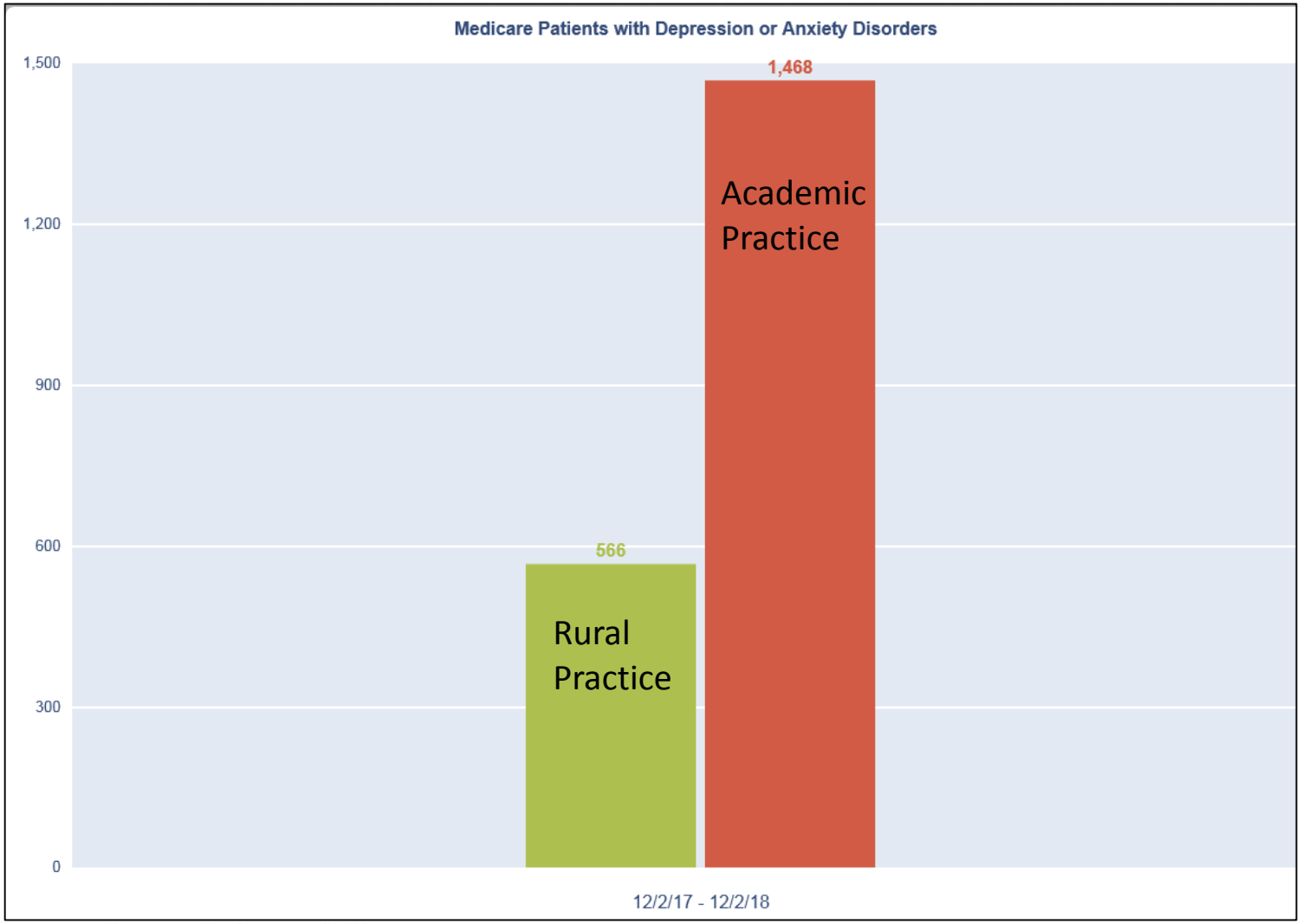
EHR reports to assess Medicare panels



Step 2: Assemble your Team

- Primary Care Physician –lead physician
- BH Case Manager
  - Nurse, Social Worker, Licensed counselor or Psychologist
  - New hire or current staff?
  - Part time versus Full time assignment?
  - Space and resource needs
- Psychiatric Consultant
  - Contract for services.
  - Estimate $225 per hour ($2700 per month for full caseload).
  - Business Associate Agreement for HIPAA

Psychiatric Consultant will require 3 hours per week (0.075 FTE) to assist each full-time BH case manager with full caseload.

AIMS Center has excellent resources on team structure and roles.
http://aims.uw.edu/collaborative-care/

Team Resources

- AIMs Center Advancing Integrated Mental Health Solutions
  - https://aims.uw.edu
  - Billing Cheat Sheets, Job descriptions and Caseload estimates
  - Multi-modal Training resources for each team role

- SAMHSA-HRSA Center for Integrated Health Solutions
  - https://www.integration.samhsa.gov
  - “Essential Elements of Effective Integrated Primary Care and Behavioral Health Teams” March 2014

- AHRQ Integrating Behavioral Health and Primary Care
  - https://Integrationacademy.ahrq.gov

Develop a "business case" for Team

Scenario: A group practice with 1000 original Medicare Beneficiaries.
200 with active behavioral health conditions
Plan to offer BHI for new and serious mood disorders

Estimate Cost:

LCSW social worker

- annual compensation $70,000
- 50% job assignment as BH case manager costs= $2900 per month
- Other 50% for other billable services

Psychiatrist

- Contract at $225 per hour
- 12 hours = $2700 per month

Cost = $5600 per month

Estimate Revenue:

SERVICE	Time in hours	PAYMENT	#	Billable Time	REVENUE
Initial PsyCoCM	1.17	$161.00	10	11.7	$1,610.00
Subseq PsyCoCM	1	$128.00	20	20	$2,560.00
Add'l 30 mins	0.5	$66.00	10	5	$660.00
General BHI	0.33	$45.00	20	6.6	$900.00
TOTAL				**43.3**	**$5,730.00**

Find your "break-even" point with feasible plan.

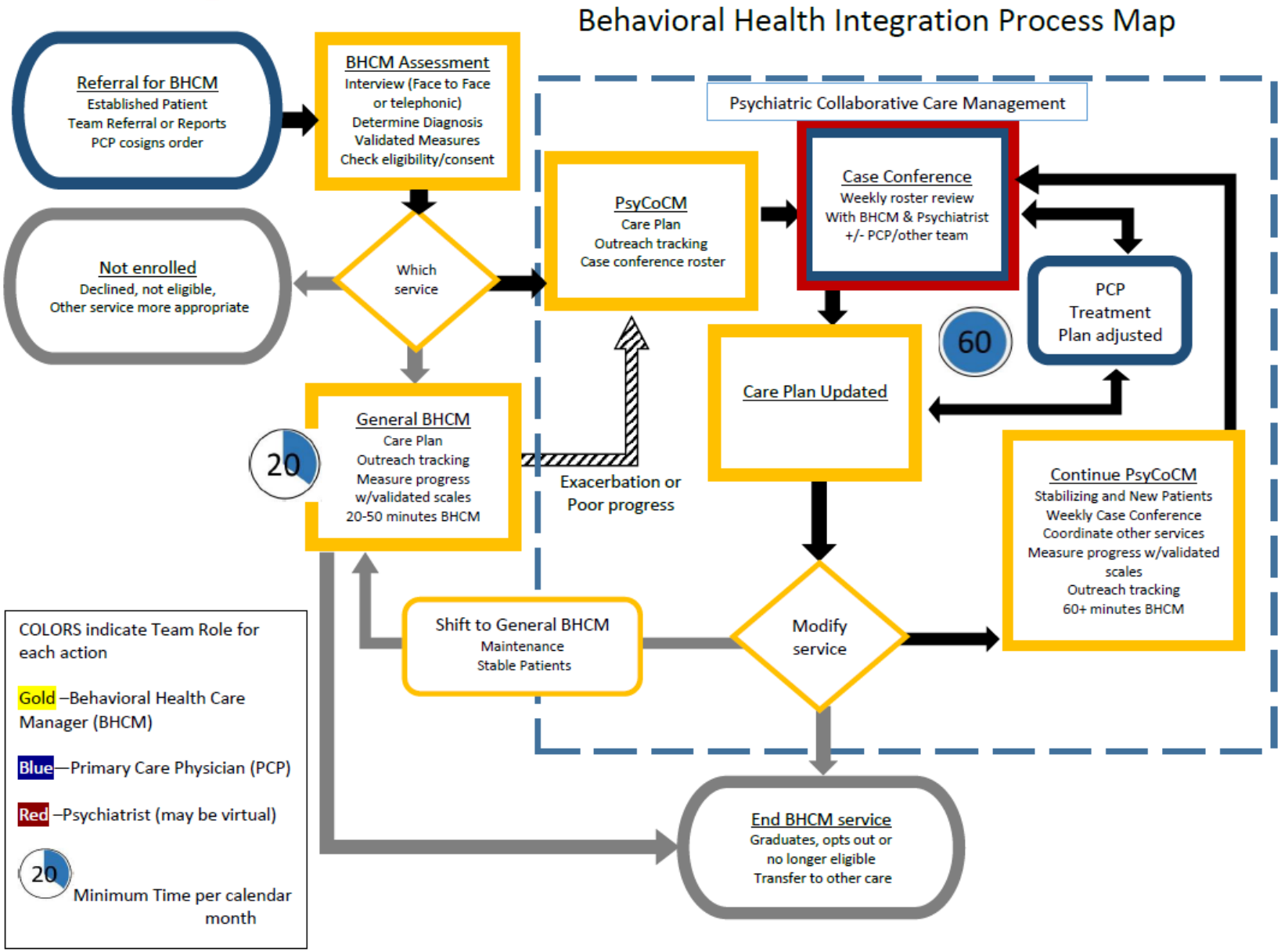
Gross Revenue	$5,730.00
Cost	$5,600.00
Net Revenue	$130.00

Step 3: Develop Team Workflows

- Create a team forum (virtual and/or in-person)
- Define Team Roles
  - Routine and urgent communication
  - Documentation responsibilities
  - Tracking method (registry)
- Create process for engaging patients & obtaining consent
- Define general approach to assessment and care plans
- Plan for case conference

Other Workflow Considerations

- Electronic Health Record considerations
  - Time tracking
  - Need for new templates or encounter types?
  - Psychiatric consultant access to EHR
  - Policy considerations for privacy e.g. “Break the Glass”
- Billing & Coding/ Compliance
  - Time tracking
  - Documentation requirements
  - Billing practitioner attestation


Behavioral Health Integration Process Map
Referral for BHCM
Established Patient
Team Referral or Reports
PCP cosigns order
BHCM Assessment
Interview (Face to Face or telephonic)
Determine Diagnosis
Validated Measures
Check eligibility/consent
Not enrolled
Declined, not eligible,
Other service more appropriate
Which service
Psychiatric Collaborative Care Management
PsyCoCM
Care Plan
Outreach tracking
Case conference roster
Case Conference
Weekly roster review
With BHCM & Psychiatrist
+/- PCP/other team
PCP Treatment Plan adjusted
60
Care Plan Updated
20
General BHCM
Care Plan
Outreach tracking
Measure progress w/validated scales
20-50 minutes BHCM
Exacerbation or Poor progress
Continue PsyCoCM
Stabilizing and New Patients
Weekly Case Conference
Coordinate other services
Measure progress w/validated scales
Outreach tracking
60+ minutes BHCM
Shift to General BHCM
Maintenance
Stable Patients
Modify service
End BHCM service
Graduates, opts out or no longer eligible
Transfer to other care
COLORS indicate Team Role for each action
Gold –Behavioral Health Care Manager (BHCM)
Blue—Primary Care Physician (PCP)
Red –Psychiatrist (may be virtual)
20
Minimum Time per calendar month

Validated Measures

Depression

- PHQ-9
- Geriatric Depression Scale
- Center of Epidemiological Studies-Depression CED-D

Anxiety

- GAD-7

Physical Health Quality

- WHO Quality of Life
- RAND 36-item Health Survey

Substance Use Disorders

- AUDIT-C
- CAGE
- Drug Abuse DAST
- WHO ASSIST

How will team document and view results?
Does your EHR have options now?
Discrete data is better!

See AHRQ Integration Playbook, Clinical Outcome Measures
http://integrationacademy.ahrq.gov/node/3134

AIMS Caseload Tracker

Measure and Track to Target

Patient information		Treatment Status & Reminders			Contacts				Measurements				Contact Notes and Psychiatric Case Review		
MRN	Name	Treatment Status	Tickler	Episode Number (Episode of care/tx)	Follow-up Contact Number	Date Follow-up Due	Actual Contact Dates	Type of Contact	PHQ-9 Score (Target is < 5 within 5-7 months of initial elevated PHQ-9)	% Change in PHQ-9 score (Target is -50% within 5-7 months of initial elevated PHQ-9)	GAD-7 Score (Target is < 10 within 5-7 months of initial elevated GAD-7)	% Change in GAD-7 score (Target is -50% within 10 weeks of tx initiation or change)	Care Manager Contact Notes and Flag for Psychiatric Case Review (Include notes about appointment reminder calls, referrals to specialty services, etc.)		Date of Psychiatric Case Review (Date of most recent Psychiatric Case Review automatically populates at top)
1234	**Joe Smith**	Active		1	Current Episode Initial Assessment	2-week follow-up schedule	9/9/17		15		11				11/13/17
1234	Joe Smith	Active		1	Initial Assessment		9/9/17	In person at clinic	15	0%	11	0%			10/9/17
1234	Joe Smith	Active		1	1		9/23/17	In person at clinic	13	-13%	11	0%			11/13/17
1234	Joe Smith	Active		1	2		10/7/17	In person at clinic	15	0%	9	-18%			
1234	Joe Smith	Active		1	3		10/21/17	Phone	12	-20%	6	-45%			
1234	Joe Smith	Active		1	4		11/4/17	In person at clinic	11	-27%	7	-36%			
1234	Joe Smith	Active		1	5		11/18/17	In person at clinic	9	-40%	7	-36%			
1234	Joe Smith	Active		1	6		12/4/17	In person at clinic	8	-47%	4	-64%			
1234	Joe Smith	Active	Past Due			12/18/17			.		.				

Free downloadable tool or licensed web-application

WVU Medicine BHI Pilot

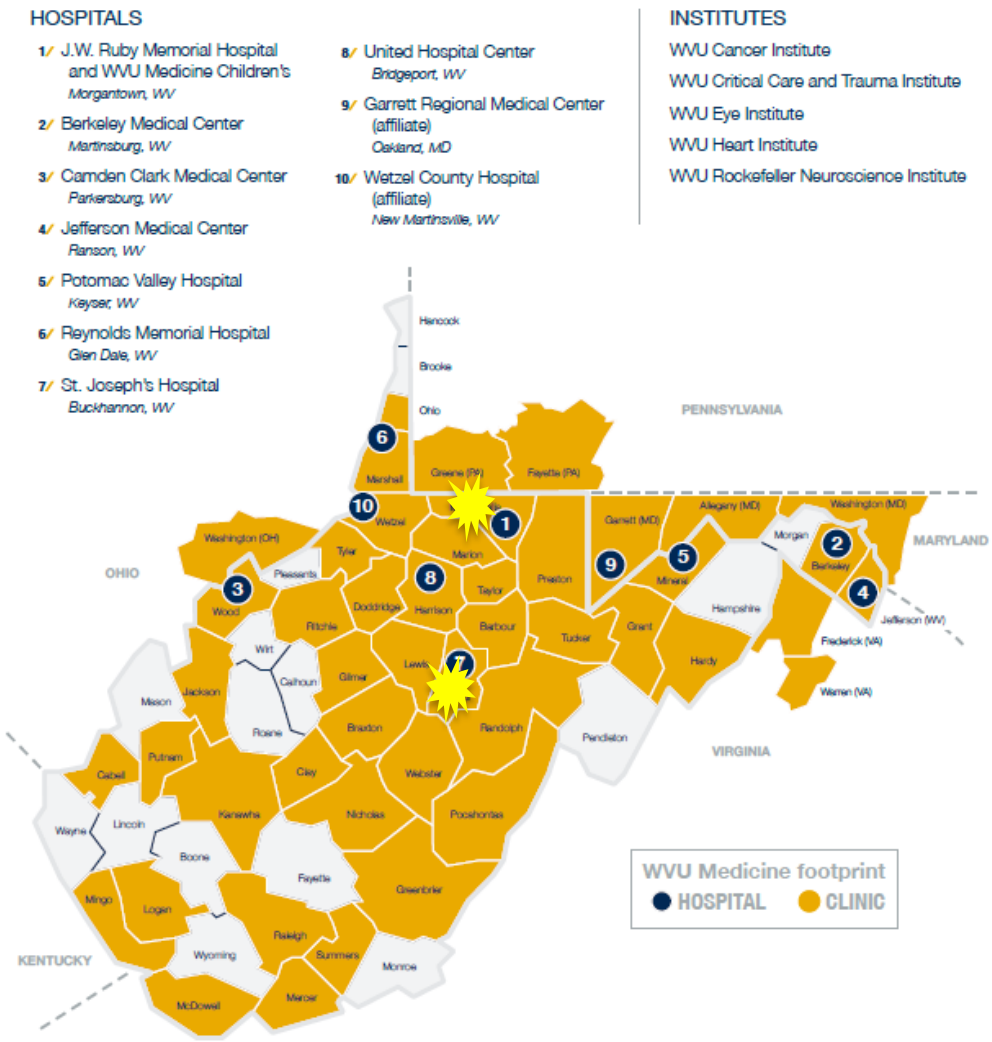
Large Integrated Health System

20,000 employee beneficiaries insured by the health system

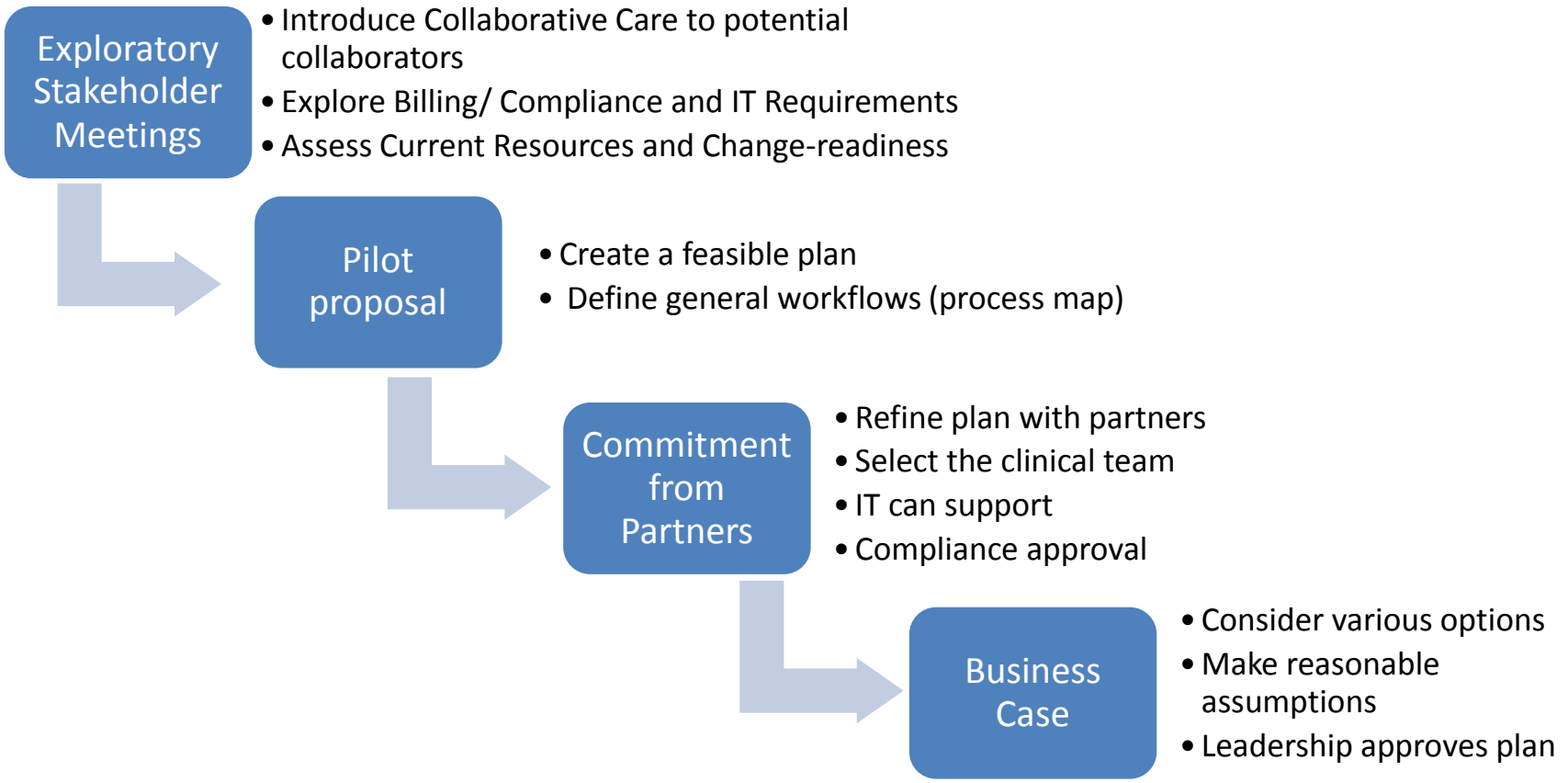
Medicare ACO with 16,000 beneficiaries

60 primary care practice clinics across northern West Virginia and Pennsylvania

One psychiatric hospital with behavioral health outpatient services

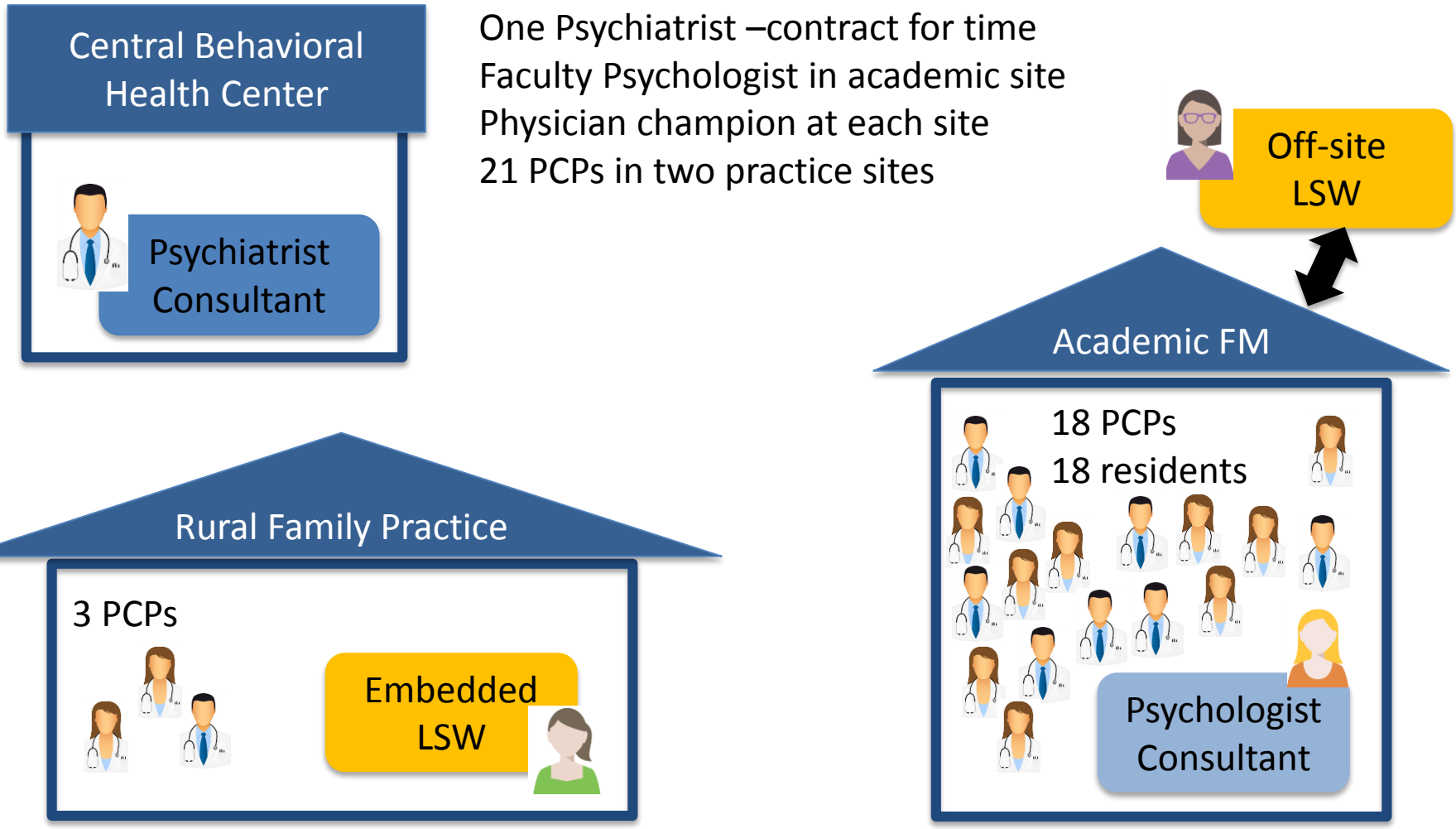


Steps for Larger Organization Implementation



WVU Medicine BHI Team

Two Social Workers (LSW) full-time employed by System
One Psychiatrist –contract for time
Faculty Psychologist in academic site
Physician champion at each site
21 PCPs in two practice sites



Next Steps

- Weekly Team Meetings
- Identify potential patients for enrollment
- Complete updates to EHR
- Enroll a few patients …scale up over 3 months

Key “Take Aways”

- Collaborative care is an evidence-based Primary Care intervention that can improve patient outcomes.
- Medicare payment can provide sufficient revenue for expanded primary care teams.
- Implementing complex new Medicare services is do-able with a step-by-step approach!

Discussion

Questions

Tips or Tricks

Best Practices

Please evaluate this presentation using the conference mobile app! Simply click on the "clipboard" icon  on the presentation page.