Understanding the Proposed Medicare Physician Fee Schedule for Behavioral Health/Primary Care Integration

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Behavioral Health Integration: Making Sense and Moving Forward
Changing legislative & regulatory landscape

More Americans have coverage than ever before.

Most health plans and Medicaid must offer MH/SUD benefits at parity.

Billing code revisions support integrated, coordinated care

Performance pay is permeating more payment models.
CMS Proposed Rule

“Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model”
CMS Proposed Rule

Addresses Medicare payment for patients with:

✓ Multiple chronic conditions
✓ Mental and behavioral health Issues
✓ Cognitive impairment
✓ Mobility-related disabilities
Behavioral Health Integration

Medicare broadly defines BHI as:

“The care and management for Medicare beneficiaries with behavioral health conditions that may include extensive discussion, information sharing and planning between a primary care physician and a specialist.”

**BUT** - CPT coding until this point has not accurately described or facilitated this type of care
<table>
<thead>
<tr>
<th>COORDINATED</th>
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<tbody>
<tr>
<td>KEY ELEMENT: COMMUNICATION</td>
<td>KEY ELEMENT: PHYSICAL PROXIMITY</td>
<td>KEY ELEMENT: PRACTICE CHANGE</td>
</tr>
<tr>
<td>LEVEL 1</td>
<td>LEVEL 2</td>
<td>LEVEL 3</td>
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**Behavioral health, primary care and other healthcare providers work:**

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- **Have separate systems**
- **Communicate about cases only rarely and under compelling circumstances**
- **Communicate, driven by provider need**
- **May never meet in person**
- **Have limited understanding of each other’s roles**

- **Have separate systems**
- **Communicate periodically about shared patients**
- **Communicate, driven by specific patient issues**
- **May meet as part of larger community**
- **Appreciate each other’s roles as resources**

- **Have separate systems**
- **Communicate regularly about shared patients, by phone or e-mail**
- **Collaborate, driven by need for each other’s services and more reliable referral**
- **Meet occasionally to discuss cases due to close proximity**
- **Feel part of a larger yet ill-defined team**

- **Have separate systems**
- **Communicate in person as needed**
- **Collaborate, driven by need for consultation and coordinated plans for difficult patients**
- **Have regular face-to-face interactions about some patients**
- **Have a basic understanding of roles and culture**

- **Actively seek system solutions together or develop work-a-rounds**
- **Communicate frequently in person**
- **Collaborate, driven by desire to be a member of the care team**
- **Have regular team meetings to discuss overall patient care and specific patient issues**
- **Have an in-depth understanding of roles and culture**

- **Have resolved most or all system issues, functioning as one integrated system**
- **Communicate consistently at the system, team and individual levels**
- **Collaborate, driven by shared concept of team care**
- **Have formal and informal meetings to support integrated model of care**
- **Have roles and cultures that blur or blend**
Key domains and components of integrated care emerge across diverse models of primary care-behavioral health integration

| Identification of patients and referral to care | Screening and assessment |
| Multi-professional team approach to care | Referral facilitation and tracking |
| Ongoing care management | Care management function |
| Systematic quality improvement | Use of quality metrics for program improvement |
| Multi-professional team approach to care | Care team |
| Systematic team based caseload review and consultation |
| Availability for interpersonal contact between PCP and BH specialist/psychiatrist |
### Key domains and components of integrated care – cont.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Component</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decision support for measurement-based, stepped care</strong></td>
<td>Evidence-based guidelines/treatment protocols</td>
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<tr>
<td></td>
<td>Use of pharmacotherapy</td>
</tr>
<tr>
<td></td>
<td>Access to evidence-based psychotherapy treatment with BH specialist</td>
</tr>
<tr>
<td><strong>Self-management support</strong></td>
<td>Tools utilized to promote patient activation and recovery</td>
</tr>
<tr>
<td><strong>Information tracking and exchange among providers</strong></td>
<td>Clinical registries for tracking and coordination</td>
</tr>
<tr>
<td></td>
<td>Sharing of treatment information</td>
</tr>
<tr>
<td><strong>Linkages with community/social services</strong></td>
<td>Linkages to housing, entitlement and other social support services</td>
</tr>
</tbody>
</table>
Collaborative Care Model (CoCM)

CMS will begin making separate payment for services furnished using the CoCM on January 1, 2017.

CPT has approved three codes for new coding under this model of care.
Collaborative Care Model (CoCM)

Provided by PRIMARY CARE TEAM = primary care provider + care manager

- Working in collaboration with psychiatric consultant (i.e. psychiatrist)
- Directed by primary care team AND includes structured case management
- Includes regular assessments of clinical status using validated tools and continuous modification of treatment
Collaborative Care Model (CoCM)

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Barriers and Challenges

- **Financial**
  - How to support traditionally non-billable services key to integration efforts
  - Payment systems that discourage engaging complex patients that are more difficult to manage

- **Regulatory**
  - Licensing (e.g. challenges in implementing integration with current and new licensure opportunities)
  - Telemedicine restrictions (not just a rural issue; issues of different rules for different payers)

- **Workforce challenges**
  - Gaps in workforce
  - Challenges with BH specialist referrals: lack of providers, capacity, and coverage
  - Challenges of role definition in integrated models

- **Information exchange between providers**
  - Difficulty getting follow-up information after referral to BH specialist
Medicare Part B pays for physician services based on the Medicare PFS, which lists the more than 7,400 unique covered services and their payment rates.

Physicians’ services include the following:

- Office visits
- Surgical procedures
- Anesthesia services
- A range of diagnostic and therapeutic services

Mental health services that may be covered:
- Psychotherapy
- Psychoanalysis
- Pharmacologic management
- Electroconvulsive therapy
- Diagnostic and neuropsychological tests
- Hypnotherapy, biofeedback, activity therapy
- Depression screening
Physician services are furnished in all settings including:

- Physician offices
- Hospitals
- Ambulatory Surgical Centers
- Skilled Nursing Facilities and other post-acute care settings
- Hospices
- Outpatient facilities
- Beneficiaries’ homes
Medicare PFS

Eligible Professionals:

• Physicians (MD, DO, particularly psychiatrists)
• Clinical psychologists (CP)
• Clinical social workers (CSW)
• Clinical nurse specialists (CNS)
• Nurse practitioners (NP)
• Physician assistants (PA)
• Certified nurse-midwives (CNM) and
• Independently practicing psychologists (IPP)
Payment rates for an individual service are based on the following components as shown in the Medicare PFS payment rates formula:

1. Relative Value Units (RVUs);
   - Work RVU;
   - Practice Expense (PE) RVU; and
   - Malpractice (MP) RVU;
2. Conversion Factor (CF); and
3. Geographic Practice Cost Indices (GPCIs).
Medicare Does Pay For

• Two Visits on the same day
• Incident to visits
• Behavioral health provider health centers
• Depression Screenings
• Form Completion
Increased Payments
Care Management Services

• Make separate payments using new codes to pay primary care practices that use interprofessional care management resources to treat patients with behavioral health conditions.

• Make separate payments for codes describing CCM for patients with greater complexity.

• Make several changes to reduce administrative burden associated with the CCM codes to remove potential barriers to furnishing and billing for these important services.
New Codes for 2017

These codes parallel the CPT codes that are being created to report these services.
Rules for Using G-Codes

- Patient has diagnosed disorder that requires behavioral health assessment
- Establishing, implementing or monitoring a care plan
- Provision of brief interventions
- Dx may be pre-existing or made by practitioner
Rules for Using G-Codes

✓ Services are reported by treating physician or QHP and include the service of the treating physician or QHP

✓ Episode of care begins when behavioral health care manager engages in the care of the patient under appropriate supervision

✓ Ends when
  ✓ Targeted treatment goals attained
  ✓ Failure to attain targeted treatment goals and are referred
  ✓ Lack of continued engagement with no psychiatric collaborative care management

✓ A new episode of care begins after 6 month break
Rules for Using G-Codes

✓ Treating physician/QHP directs the behavioral healthcare manager and continues to oversee the care (prescribing, referrals)

✓ Medically necessary E/M and other services may be reported separately by physician, QHP or other practitioners during the same calendar month

✓ Time spend by the PCP/QHP on activities reported separately cannot be include in G code
Rules for Using G-Codes

Behavioral Healthcare Manager

✓ Member of the PCP/QHP’s clinical staff with formal education or specialized training in behavioral health (social work, nursing, psychology)
✓ Provides care management, assessment, administers rating scales, develops care plan, provides brief interventions, ongoing collaboration
✓ May or may not be an independent Medicare provider (if so they can use those CPT codes)
✓ Services face-to-face and non face-to-face
✓ Expect the care manager to be on site
GPPP1

Initial psychiatric collaborative care management, first 70 mins 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 healthcare professional

REQUIRED ELEMENTS

• Outreach and engagement in treatment directed by the treating physician or another qualified health care professional
• Initial assessment of the patient including administration of validated rating scales, with the development of an ITP
• Review by the psychiatric consultant with modification of the plan if recommended
• Entering patient in a registry and tracking patient follow up and progress using the registry
• Provision of brief interventions using EBP such as behavioral activation, motivational interviewing, and other focused treatment strategies
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

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 healthcare professional and any other treating MH providers
- Additional review of progress and recommendation for changes in treatment, as indicated, including medication, base on recommendations of psychiatric consultant
- Provision of brief interventions using EBP
- Monitoring 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
GPPP3

Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral care management activities, in consultation with a psychiatric consultant and directed by the treating physician or other qualified healthcare professional.

- Use GPPP3 in conjunction with GPPP1 and GPPP2
- List EP separately in addition to code for primary procedure
Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other QHP, per calendar month

• Expect this to be refined over time

• Reflects preference for beneficiary-centered treatment rather than adherence to a specific model

• Reflects a broader application of integrations not otherwise adequately reflected under the PFS
## Medicare PFS Payment Rates

### Enhanced Payment Proposed for Primary Care, Care Management, and Patient-Centered Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Short Description</th>
<th>Medicare Allowances</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2016</td>
<td>2017</td>
</tr>
<tr>
<td>99354</td>
<td>Prolonged E/M Outpatient</td>
<td>$ 100.97</td>
<td>$ 130.94</td>
</tr>
<tr>
<td>99355</td>
<td>Prolonged E/M Outpatient add-on</td>
<td>$ 98.10</td>
<td>$ 98.74</td>
</tr>
<tr>
<td>99356</td>
<td>Prolonged service inpatient</td>
<td>$ 92.73</td>
<td>$ 93.02</td>
</tr>
<tr>
<td>99357</td>
<td>Prolonged service inpatient add-on</td>
<td>$ 92.02</td>
<td>$ 92.66</td>
</tr>
<tr>
<td>99358</td>
<td>Prolonged service non face-to-face</td>
<td>$ -</td>
<td>$ 113.41</td>
</tr>
<tr>
<td>99359</td>
<td>Prolonged service non face-to-face add-on</td>
<td>$ -</td>
<td>$ 54.38</td>
</tr>
<tr>
<td>99487</td>
<td>Complex Chronic Care Management without patient visit</td>
<td>$ -</td>
<td>$ 92.66</td>
</tr>
<tr>
<td>99489</td>
<td>Complex Chronic Care Management additional 30 minutes</td>
<td>$ -</td>
<td>$ 46.87</td>
</tr>
<tr>
<td>GDDD1</td>
<td>Intensive service during E/M for mobility-related impairments</td>
<td>n/a</td>
<td>$ 44.36</td>
</tr>
<tr>
<td>GPPP1</td>
<td>Initial psychiatric care management</td>
<td>n/a</td>
<td>$ 135.95</td>
</tr>
<tr>
<td>GPPP2</td>
<td>Subsequent psychiatric care management</td>
<td>n/a</td>
<td>$ 119.85</td>
</tr>
<tr>
<td>GPPP3</td>
<td>Initial/Subsequent psychiatric care management</td>
<td>n/a</td>
<td>$ 59.74</td>
</tr>
<tr>
<td>GPPP6</td>
<td>Assessment for cognitive impairment</td>
<td>n/a</td>
<td>$ 217.51</td>
</tr>
<tr>
<td>GPPP7</td>
<td>Assessment for Chronic Care Management care plan</td>
<td>n/a</td>
<td>$ 63.68</td>
</tr>
<tr>
<td>GPPPX</td>
<td>Behavioral health care month</td>
<td>n/a</td>
<td>$ 44.00</td>
</tr>
</tbody>
</table>
# PCMH standards

1. **Additional emphasis on team-based care**
   - **New element = Team-Based Care**
     - Highlights patient as part of team, including QI

2. **Care management focused on high-risk patients**
   - **Use evidence-based decision support**
   - **Identify patients who may benefit from care management and self-care support:**
     - Social determinants of health
     - Behavioral health
     - High cost/utilization
     - Poorly controlled or complex conditions
PCMH Standards (cont.)

3. More focused, sustained Quality Improvement (QI) on patient experience, utilization, clinical quality
   – Annual QI activities; reports must show the practice re-measures at least annually
   – Renewing practices will benefit from streamlined requirements, but must demonstrate re-measurement from at least two prior years

4. Further Integration of Behavioral Health.
   – Show capability to treat unhealthy behaviors, mental health or substance abuse
   – Communicate services related to behavioral health
   – Refer to behavioral health providers
Primary Care → Behavioral Care

Characteristics: frequent medical hospitalizations; 2 or more medical conditions; dually diagnosed with substance use disorder; resistant to psychiatric follow-up; inconsistent with medical appointments.

Meet Kendrick

- Kendrick was referred to treatment in February. He had been hospitalized on medical units 14 times in the past year, with each stay being lengthy.
- When he was not hospitalized, Kendrick, he was homeless.
- He refused to go to homeless shelters.
- He also was using K2 on a regular basis. In addition to his diagnoses of major depression, bipolar disorder, and polysubstance dependence, he has comorbid medical conditions of diabetes, hypertension, glaucoma, kidney failure, and congestive heart failure.
- He received dialysis 3 times per week.
- He was assigned to an Assertive Community Treatment team, and had a housing voucher from another ACT team that was trying to ready an apartment for him.
- The treatment team met him on the medical unit and had to gain the confidence of the medical team, which had worked with Kendrick many times.
- After one week, the team had secured short-term, 24-hour housing from a community agency that was able to provide safety and semi medical oversight, as well as nutritious meals.
Behavioral Care → Primary Care

Characteristics: patients have usually had 1 previous psychiatric admission; lives with family or friends; dually diagnosed; in their mid- to late-30s.

Meet Tonya

- Tonya admitted herself to the hospital because she was paranoid and experiencing suicidal ideation.
- She is 47, has a history of trauma, and was hospitalized ten years ago because her paranoia had prompted her to be aggressive.
- She dropped out of service at another agency because they required her to come to their office on her own, and her paranoia prevented her from being able to do so.
- Tonya self-medicated with crack cocaine, marijuana, K2, and alcohol, all readily available in front of her apartment building. She has hypertension and COPD, and is non-compliant with her medications because she does not like to go to the doctor for check-ups.
- Tonya was on the inpatient unit for five days, and started on a regimen of antipsychotics and antidepressants/SSRIs, which she responded to quickly.
- The hospital scheduled her to see a psychiatrist at her previous agency, but when she there for her appointment they refused to see her because she had been discharged due to lack of engagement.
Considerations for Sustainability

✓ Staffing
✓ Productivity/Volume
✓ Direct Revenue
✓ Indirect Revenue
✓ Coding
✓ Contracting
✓ Optimization (concurrent doc)
✓ Back end-denials,
✓ Dashboard development
✓ Even if you have a grant......
Staffing

✓ Billing varies greatly with staffing

✓ What is the licensing of the staff you are hiring or who will be working on this project?

✓ Billing varies greatly by state

✓ Do your billing and reimbursement homework BEFORE you hire your staff

✓ Do you have staff now you can’t afford to keep when the grant goes - unlicensed, Licensed Mental Health Clinician (LMHC)

✓ Do you know how to figure out how much a staff person costs you?
Defining Efficiency Benchmarks

FISCAL PERFORMANCE INDICATORS —

Necessary Data Points:

✓ Revenues
✓ Expenses
✓ Count of visits
✓ Average Reimbursement rate per visit
✓ What do you need/want to know and when?
What payers does your organization or BH services get reimbursement from

Make a grid to review each payers each service and each provider

Review guidelines for each payers- are services part of the contract or do they need to be added

Does the payer reimburse for all credentials, i.e. social workers vs. counselors

Special payer programs-like depression
Workflows Often Equal $$\text{$$$$}$$

• There are many different workflows
• Workflows can vary by location or provider
• Not set in stone

• Why do I need to do my reimbursement work before I figure out my workflows?
• Why do workflows matter?
• Example-Medicare, hand off to open slots
Please select the description that best describes your site’s workflow as it is performed at least 70% of the time:

a) Patients are only identified when they present with BH symptoms (no systematic screening performed)

b) Systematic screening, including a follow-up assessment, of target population (e.g. patients with diabetes, CAD) is performed

c) Systematic screening of all patients performed with diagnostic confirmation by trained clinician as indicated

d) Population stratification or analysis as a component of both outreach and screening with follow-up which is routinely followed by assessment and engagement
You Can’t Get Paid......

- If you don’t see enough patients
- Know the ratios
- Productivity needs to support sustainability
Lessons Learned for BH integration in Primary care

• Screening: Patient self report is superior to interview administered = **technology** (patient portal, IVR, apps?)

• Treatment: Early follow-up after initial assessment, treatment changes when appropriate, and behavioral activation are priority factors = **technology** (tracking registry)

• Substance Use – needs further exploration and standardization, i.e. what are the key ingredients to SBIRT, for whom, and for what conditions?

• Support Patient choice in treatment

• Small and independent practices will need shared resources
References


http://www.cms.gov/Medicare/Medicare-Fee-forService-Payment/PhysicianFeeSched/PFS-FederalRegulation-Notices.html


https://www.federalregister.gov/public-inspection

https://www.uhfny.org/publications/881131
Questions???