

Addressing Barriers to Integration: Successful Reimbursement Strategies for Behavioral Health Providers in Primary Care

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The Gap Between Demand and Reimbursement for Behavioral Services in Primary Care

- *Despite a demonstrated need for behavioral health providers in primary care, there is a gap between the **principle** of providing behavioral health in primary care and **payment***
- *A key component of the Accountable Care Act (ACA) is reform of reimbursement to support behavioral interventions for chronic health conditions*
- *The **idea** of reimbursement reform has not led to significant **actual** reform in payment*
- *Clear consensus that administrative issues such as billing as the central barrier to service integration*

Learning Objectives

- Identify administrative barriers to successful reimbursement of behavioral health services in primary care
- Review current strategies for service reimbursement under a fee for service model
- Identify opportunities for new models of reimbursement based on the Accountable Care Act and anticipated Accountable Care Organization (ACO) model

One Caveat...

- Substantial variation right now
 - State to state
 - Plan to plan
- The Affordable Care Act is ushering in a new era of reimbursement...
 - If it continues to exist!
 - And if it does, we can only hypothesize about how this will play out

Limitations of the PCP as Behavioral Care Provider

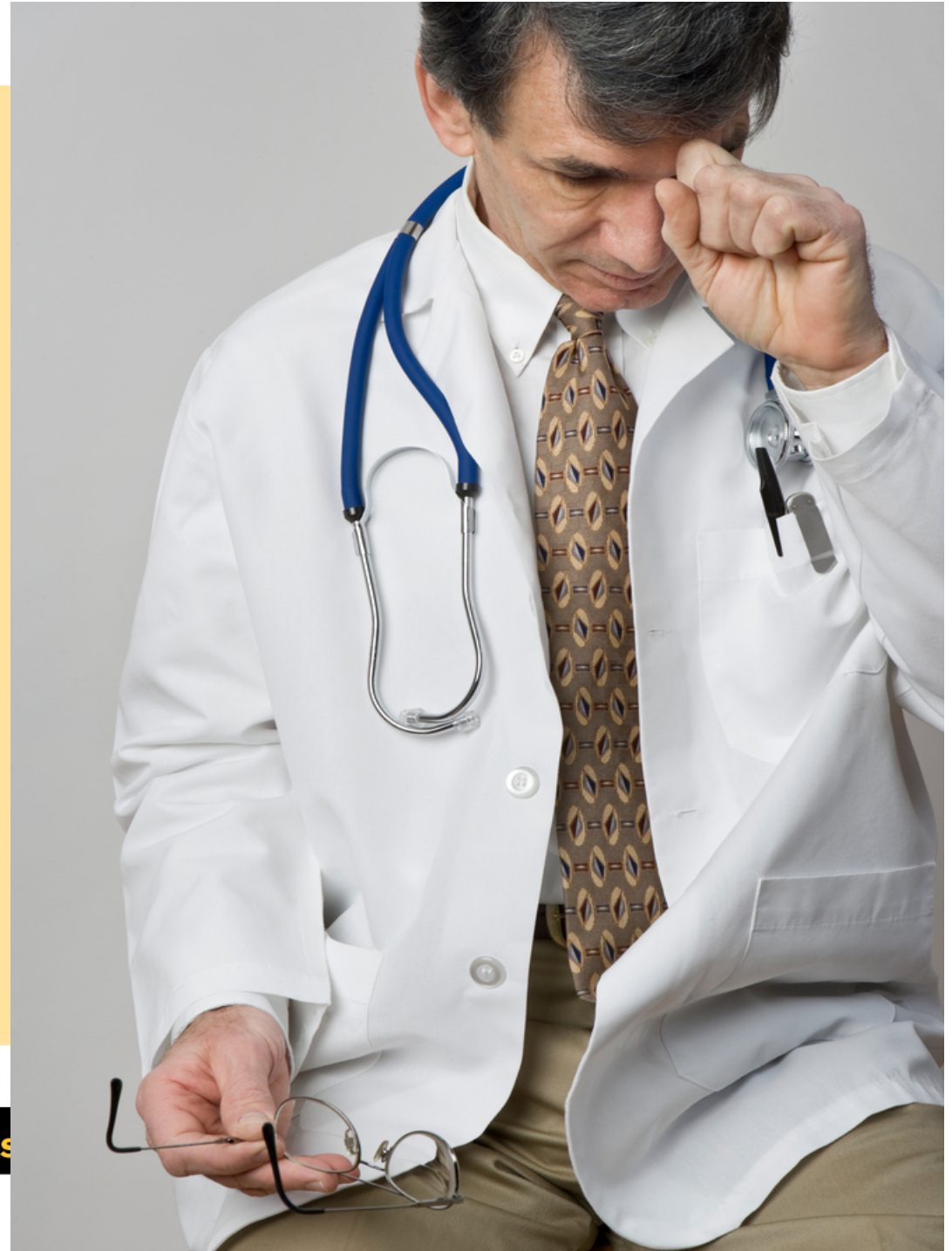
Time

Training

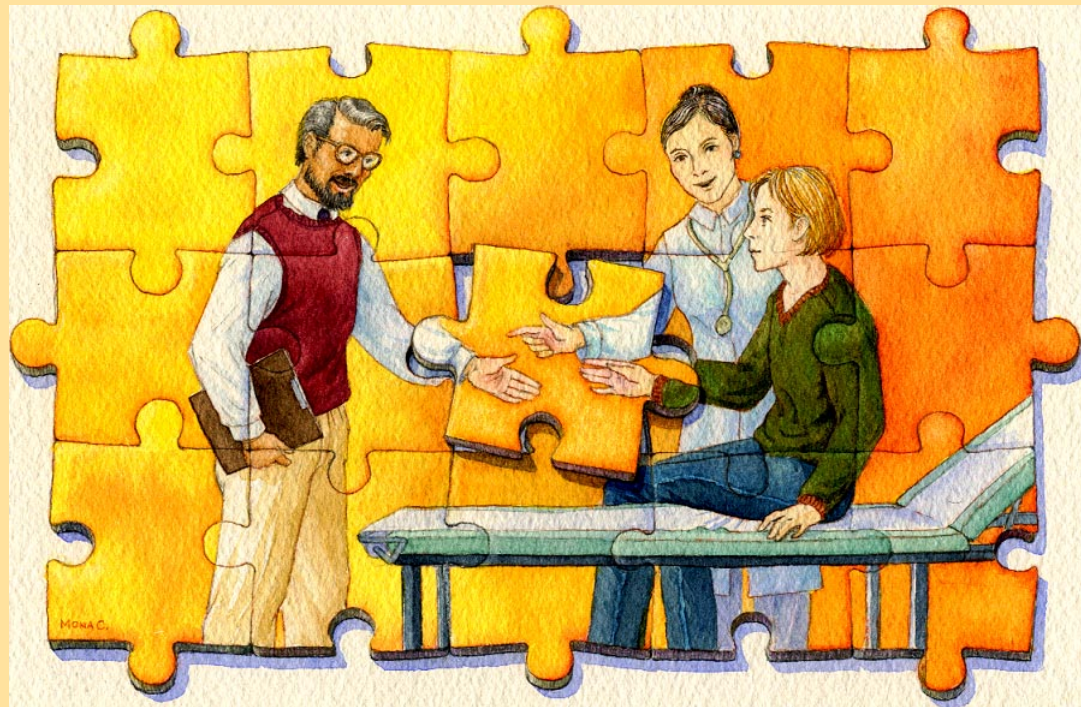
Referral to Specialty Behavioral Health

Medication as first (and often only) line of treatment

Reimbursement



The Solutions



Barriers to Reimbursement (Farrel, 2010)

- Covering the uninsured patient
- Medicaid does not always reimburse for services
- Restrictions on same-day services
- Service pre-authorization needed by some insurance companies
- Specific codes not being recognized or reimbursed
- Psychologists being denied for paneling by insurance companies due to too many providers in the area.
- Psychologists being denied for paneling by insurance companies due to not being licensed long enough

Barriers Continued (Farrel, 2010)

- Extensive paperwork for minimal reimbursement
- Reimbursement rate a small portion of full rate of service
- Lack of understanding of insurance and legal reimbursement requirements by agency administration
- Primary care agencies reluctant to pursue reimbursement due to feared liability if it is not done the “correct” way
- Local Medicaid system wants primary care to only use their specialty behavioral health services for eligible patients for all services
- Lack of insurance benefits for IBHS in primary care
- Difficulty communicating with payers

Defining Integration

- Lots of variation in what integrated care looks like:(Collins et al., 2010):
- **Collaborative Care:** behavioral health working with primary care
 - Coordinated
- **Integrated Care:** behavioral health working in primary care
 - Co-located
 - Fully Integrated

Part One: Fee For Service (FFS)

The Historical Context

- 1978: The Healthcare Common Procedure Coding System (HCPCS) was developed
- 1996: HIPAA passes
- 2002: Health & Behavior Codes developed

Psychotherapy Codes

- 90801-90808, 90862, 99241-99245
 - Developed for use by mental health and physician providers
- Most commonly used in co-located practices
 - Can be used in integrated practices, often need to bill for shorter services
- Do not comprehensively address the nature of services provided by BHPs

Health and Behavior Codes (H&B)

(Casciani, 2012)

- Used to modify the psychological, behavioral, emotional, cognitive, or social factors that affect or interfere with physical functioning or to improve health:
 - Health risk factors
 - E.g. the COPD patient who continues to smoke
 - Negative attitudes towards recovery
 - Non-adherence to medical treatment
 - E.g. misuse of prescription medication for chronic pain
 - Inability to cope with or manage symptoms of illness
 - Family disagreements in care plan
- May **ONLY** be used with medical dx (not psychiatric)
 - Psychological factors are influencing the course of the medical disorder

Differences between Psychotherapy and H&B Codes (Casciani, 2012)

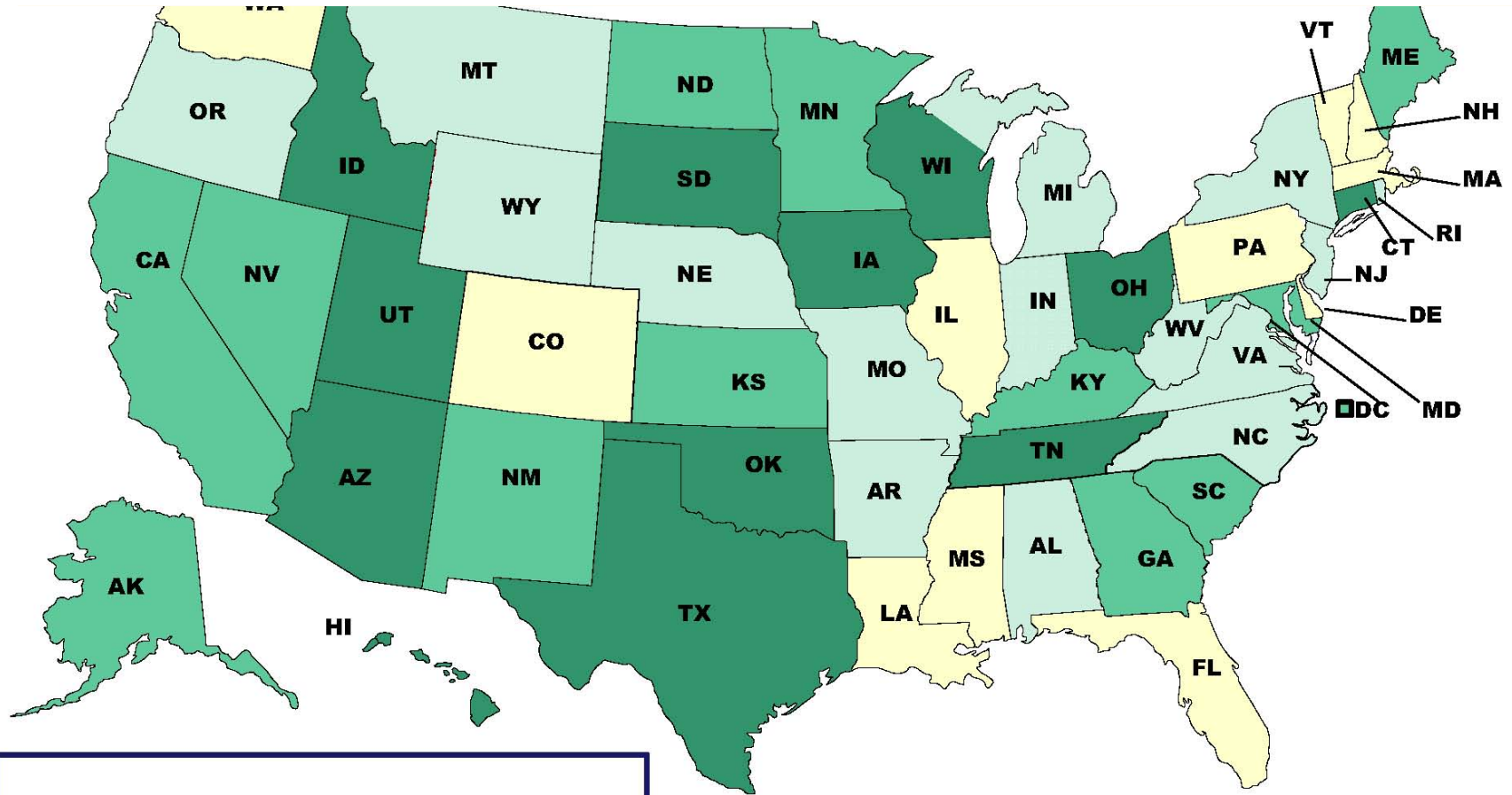
	Psychotherapy	H&B
Diagnosis	Mental illness and behavioral disturbance	Physical illness or injury
Primary Focus	Affective relief, insight, decision making, resolve emotional condition	Psychological factors that affect or interfere with physical functioning and recovery
Goal	Alleviate emotional disturbance, change behavior, growth	Improve health and well being
Collaboration	Emphasis on privacy and confidentiality	Encourages collaboration and co-treatment with PC team





Pitfalls of H&B

- Variation in reimbursement (more in a moment)
- “Infinite loop” of reimbursement rejection (Bruns, 2009)
 - Mental health insurance companies won’t reimburse for medical diagnosis
 - Medical insurance companies won’t reimburse provider type

Step-By-Step Guide to Reimbursement of H&B Codes (Bruns, 2009):

http://www.healthpsych.com/tools/resolving_h_and_b_problems.pdf



	Entire HBAI Series turned on*
	Part of HBAI Series turned on*
	HBAI Series not turned on
	No information

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Evaluation/Management (E&M Codes)

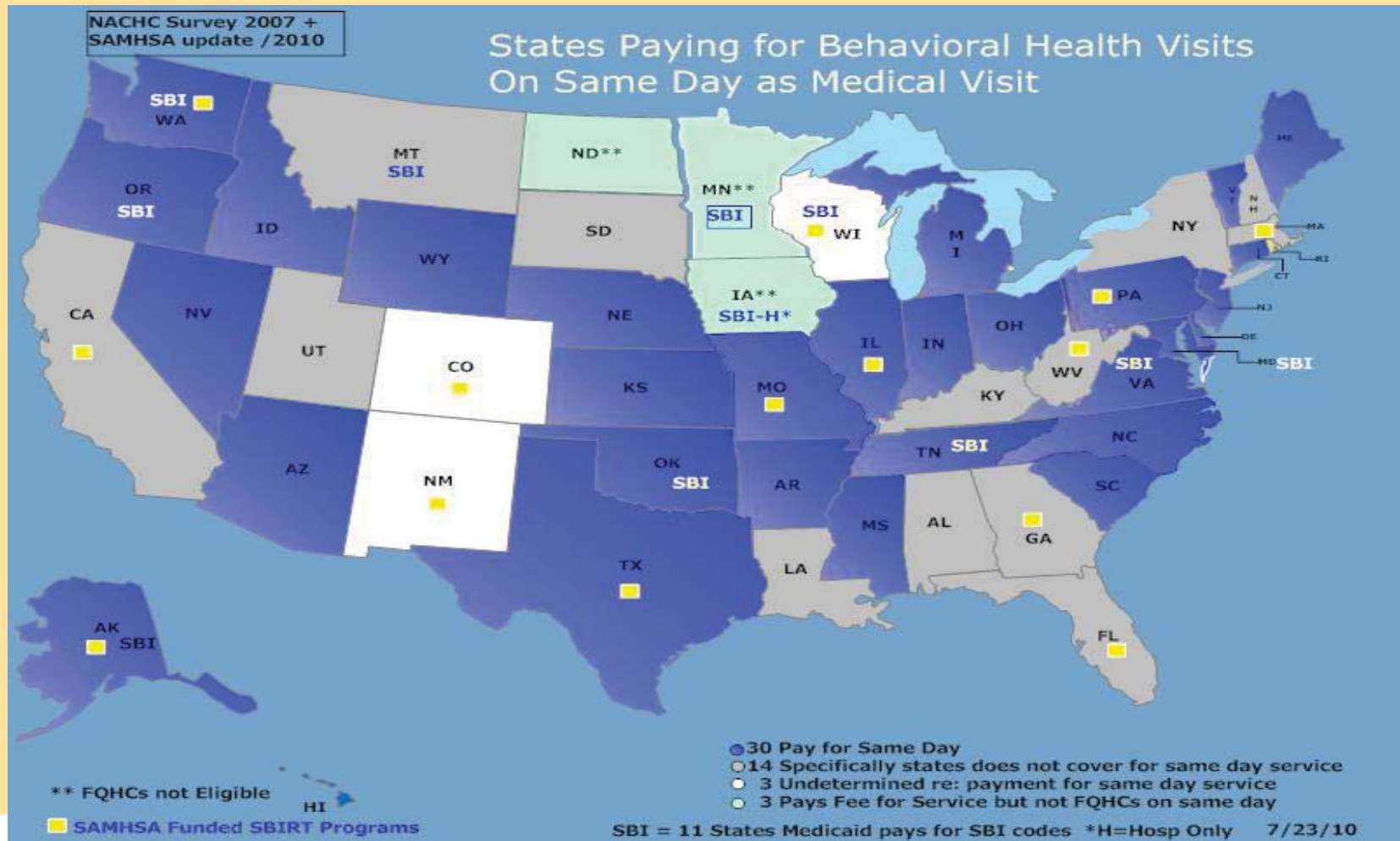
- For use by physicians and primary care extenders only
 - Physician assistants, nurse practitioners, clinical nurse specialists
 - Not for use by psychologists & social workers
- Intended for use for services that are unique to medical management
 - Laboratory results, medication management, medical diagnosis evaluations, etc.

(SAMHSA, 2008)

Substance Use Codes

- Substance use screening codes (99408 and 99409) currently intended for use by physicians
 - Used in tandem with E/M codes
 - Require minimum time commitment that most PCPs don't meet with SU screening

Additional Concerns...



Solutions Worth Attempting:

- Advocate for use of H & B codes on the state and local level
- Develop integration-specific codes on the state level
- Follow the VA example:
 - Create a system in which mental health funds are transferred into the physical health budget and provide payment for services under a single budget (blended or braided system)
- Provide administrative template for procedural aspects of billing

<http://www.integration.samhsa.gov/financing/billing-tools>

Conclusions

- Psychiatric codes appear to be most commonly used codes to obtain reimbursement
- Increased emphasis should be placed on expanding the acceptability of using H&B codes
- Fully integrated services have more options for reimbursement than co-located ones
 - Also greater reimbursement potential due to increased number of patients seen

PART TWO: ACO's – Brave New World or End of Times?!

Accountable Care Organization ACO defined

- ACO outlined in Patient Protection and Affordable Care Act (ACA) of 2010 “an organization of health care providers that agrees to be accountable for the quality, cost and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it”
- Examples
 - Physicians, group practices
 - Physician networks
 - Partnerships or joint ventures between hospitals and physicians
 - Hospitals employing physicians
- Think beyond patients to *populations*
- Accountability for *performance* and *cost*

IHI “Triple Aim”

1. Improve population health
2. Enhance patient experience (access, quality)
3. Reduce or control costs

- Increase preventive care
- Promote early intervention
- Improve coordination of care
- Expand the use of evidence-based care
- Decrease overuse and underuse of services
- Reduce error rates

Value-Based Purchasing

- Fee for service (FFS) headed towards extinction?
- Replace FFS with *case rate or capitation* with a pay for performance component
- CMS members are assigned to ACO
- ACO is responsible for direct provision of and referral/coordination of care
- 3-layer funding
 - Case Rate
 - FFS
 - Bonus incentive

How do you fit into the ACO?

- Integration into ACO Primary Care Medical Home (PCMH)
- High performing, recovery and wellness-oriented BH specialty providers
- And in each case, will need to learn to operate with the reform rules for
 - Payment
 - Incentives
 - EHR
 - Outcomes data

How can you prepare for ACO's? The PCMH "Neighbor"

- ACO will partner with specialty MH/SA care with a "neighbor" provider to provide:
 - Pre-consultation exchange ("curbside comment")
 - Formal consultation
 - Co-management
 - Transfer to specialty care
- Formal service agreement or compact
- Defines core clinical data
- Shared financial incentives

Behavioral Health ACO/PCMH Resources

- Patient-Centered Primary Care Collaborative
www.pcpcc.net
- National Council for Community Behavioral Healthcare
www.thenationalcouncil.org
- Collaborative Family Healthcare Association
www.cfha.net
- National Alliance of Professional Psychology Providers
www.nappp.org
- The Care Continuum Alliance
<http://www.carecontinuum.org>

Download: *Achieving Accountable Care: Essential Population Health Management Tools for ACOs*

PART THREE: Meeting Market Demand

What are the criteria by which ACO leaders will decide on who provides integrated behavioral health services?

- Outcomes!
 - CMS Quality Metrics
 - Behavioral Health specific metrics
- Electronic Health Record compatibility
 - Ability to interface with ACO EHR critical
- Shared Incentives
 - **How can we contribute to achieving ACO-level incentives?**

Population Risk Factor Metrics

CMS Quality Measures for ACO's

1. Patient/Care Giver Experience
2. Care Coordination
3. Patient Safety
4. Preventive Health
5. At-Risk Population/Frail Elderly

CMS Measures for use in establishing quality performance standards that ACO's must meet for shared savings

- Care Coordination/Patient Safety
 - Risk-standardized, all condition readmission
 - Ambulatory sensitive conditions admission: COPD
 - Ambulatory sensitive conditions admission: CHF
 - Percent of PCP's who successfully qualify for EHR
 - Medication reconciliation: reconciliation after discharge from inpatient facility
 - Screening for fall risk

CMS Measures for use in establishing quality performance standards that ACO's must meet for shared savings

- Better health for *populations*
 - Preventive health influenza immunization
 - Preventive health pneumococcal vaccination
 - **Preventive health adult weight screening and follow-up**
 - **Preventive health tobacco use assessment and tobacco cessation**
 - **Preventive health depression screening**
 - Preventive health colorectal cancer screening
 - Preventive health mammography screening
 - **Preventive health proportion of adults 18+ who had their blood pressure measured within the preceding 2 years**

CMS Measures for use in establishing quality performance standards that ACO's must meet for shared savings

- At Risk Population
 - **Diabetes**
 - Hemoglobin A1c Control (< 8%)
 - LDL (< 100)
 - BP (<140/90)
 - Tobacco non-use
 - Aspirin use
 - A1c Poor control (>9%)
 - **Hypertension**
 - BP control
 - **Ischemic vascular disease**
 - Complete lipid profile and LDL control < 100 gm/dl
 - Use of aspirin

continued

CMS Measures for use in establishing quality performance standards that ACO's must meet for shared savings

- At Risk Population
 - Ischemic Vascular Disease (IVD): use of aspirin or o/antithrombotic
 - Heart Failure: Beta-blocker therapy for left ventricular systolic dysfunction
 - Coronary Artery Disease:
 - Drug therapy for lowering LDL-C
 - ACE Inhibitor or ARB therapy for patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction

Pay for Performance Incentive Programs

- Driven by CMS
- Provider types: Hospitals, Physician practices, Physician Group Practices, Individual Physicians
- Quality Measures
 - HEDIS measures, American Quality Alliance (AQA)
- Incentive Strategies
 - Pay for Performance
 - Bonus for high performers
 - Physician share of savings
 - Public reporting

P4P in Behavioral Health

- Measures used: HEDIS and Depression (PHQ-9)
- Evidence of training (e.g., Motivational Interviewing, DBT)
- Incentives: Increased reimbursement for either specific services or overall increase in fee schedule
 - Lump sum annual payments based on results
 - Fee based on number of patients screened
 - Withhold of fees later paid back
- In Behavioral Health Incentives *small* to date

P4P in Behavioral Health

- Barriers
 - Lack of consensus on behavioral health measures
 - Administrative burden using measures (forms, faxing, etc.)
 - BH providers unwilling to collect data
 - Concerns about validity of measures
 - Concerns about provider profiling
- Recommendations
 - Incorporate outcomes management system
 - Use feasible measures
 - Achieve buy-in from multiple stakeholders

Core Behavioral and Psychosocial Data Elements for the Electronic Health Record

Recommended data elements

- Anxiety and depression
- Eating patterns
- Physical activity
- Quality of life
- Risky drinking
- Sleep quality
- Stress
- Substance use
- Tobacco use
- Patient goals
- Medication-taking behavior
- Health literacy
- Demographics

Specific Recommendations

- Anxiety and Depression
 - PHQ-4
 - If +, then PHQ-8 or 9 and GAD-7
- Risky drinking
 - Single question screener: How many times in the past year have you had more than X drinks in a day (where X is 5 for men, 4 for women, >1 is positive)
 - If +, then AUDIT
- Substance use
 - Single question screener: How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?
 - If +, then DAST-10 or ASSIST

Specific Recommendations

- Stress
 - Distress thermometer (UK National Health Service)
- Quality of life
 - Population health measures
 - SF-8
 - DUKE
 - WHO-QOL Bref
- Sleep quality
 - 2-question screener to assess apnea, insomnia, and sleep inadequacy
 - Do you snore or has anyone told you that you snore
 - In the past 7 days, I was sleepy during the daytime
 - Never, rarely, sometimes, often, always

Performance Metrics: Cost

Reference: *Patient-centered medical home performance metrics for employers*

<http://www.pcpcc.net>

“cost data should be viewed by employers **as a consequence of healthcare utilization**, which is a consequence of population health” p. 8

Utilization/cost

- Common examples for ACOs
 - PCP visits
 - ED visits
 - Hospital days
 - Prescribed medications
- Based on data from ACO
- BH examples
 - Visits
 - Average length of stay
 - Population-health program metrics
 - Patients targeted, enrolled, engaged, completion

Pulling It All Together

- Key measures in CMS = **biometrics**
- Add Behavioral health specific measures
- Target behavioral interventions that will improve ACO metrics
 - Depression screening
 - Improved disease as evidenced by improved biometrics
- **RECOMMENDATIONS**
 - Develop integrated behavioral care programs
 - Stress management
 - Disease self-management
 - Integrate outcomes management
 - ACO measures
 - Behavioral health specific measures

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Thank you! Questions??