Creating Sustainable Care Management Programs

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Statewide Healthcare Innovation Plan

SHIP PCMH Learning Collaborative

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PCMH TRANSFORMATION TEAM

PCMH Standards and Competencies

- Care Management (CM) and Support
  - Identifying and monitoring patients for CM
  - Risk Stratification (credit)
  - Person-centered care plans
  - Self-management plans (credit)
- Care Coordination and Transitions
  - Identifying patients with unplanned hospitalization/Emergency Department (ED) visits
  - Post hospitalization and ED visit follow up
  - Sharing of clinical information with admitting hospitals and ED
  - Behavioral Health (BH) referral tracking (credit)
  - Behavioral Health Integration (BHI) (credit)

PCMH Standards and Competencies
(Continued)

- Knowing and Managing Your Patients
  - BH screenings and assessments using standardized tools (credit)
- Team-based Care
  - BH Care Manager (credit)

Care Management Program

Care Management Program

Access

Time

Technology

Care Management/Care Coordination (CM/CC) Elements of Best Practice

Evidence-based Elements:

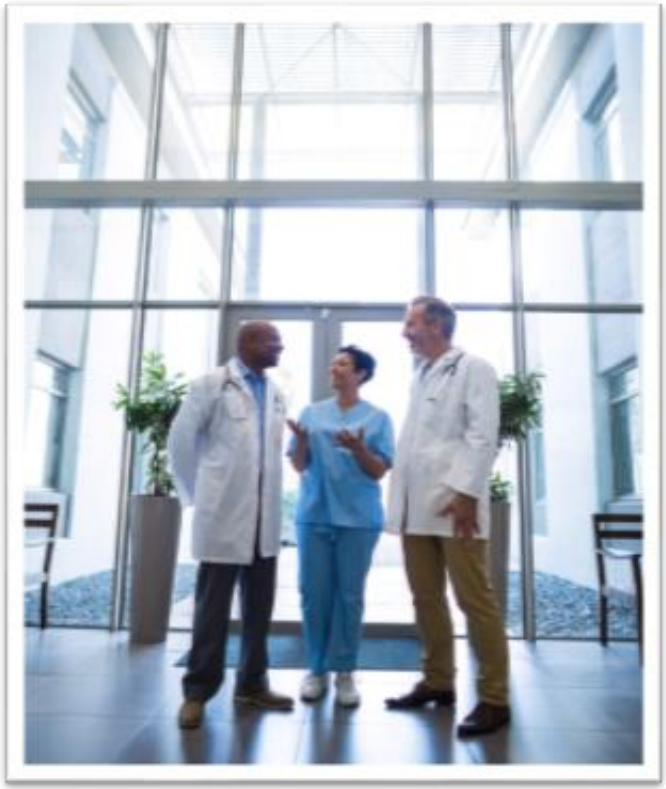
- Risk Stratification
- Care Managers (CMs) can be in the primary care practice or at least connected to the team and patient record
- Face-to-face interactions with CMs and their patients on a regular basis

CM/CC Elements of Best Practice *(Continued)*

- Health Information Technology (HIT) to support clinical team and interact with patients
- Strong linked culture between BH and physical health
- Medication management emphasis
- Comprehensive, planned, and evidence-based transitions of care programs involving multi-disciplinary teams
- Recognition of health social determinants impact, and not solely using clinical health assessments
- Efficient use of “right staff” at top of their license
- Planned team approach

What Services Do We Have Trouble Billing in Fee-For-Service (FFS)?

- Brief interventions
- Stress/no diagnosis
- Huddles
- Hallway conversations/consultations
- Warm hand-offs
- Curbside consultations with psychiatric consultants
- Phone calls to patients
- Repeating rating scales
- Interdisciplinary team meetings
- Registry management



Medicare Payment for CCM, TCM, and CoCM

- Medicare is now paying for traditionally non-covered services known to: improve patient outcomes and care experience; lower cost; and add to the care team's satisfaction.
  - Chronic Care Management (CCM)
  - Transitional Care Management (TCM)
  - Collaborative Care Model (CoCM)
- A way to retain and grow Medicare
- A first step along the continuum of risk-based reimbursement
- In some states, Medicaid accepts and pays these codes as well

Steps to Implementation

- Identify targeted patients
  - Medicare patients with two or more chronic conditions
  - Medicare patients at moderate or high risk who have been discharged from hospital
  - Medicare patients with behavioral health conditions
- Gain verbal consent to engage
  - Document consent
- Understanding responsibility for co-pay
- Patient engagement techniques

Practice Capabilities - CCM

1. Use a certified Electronic Health Record (EHR) for specified purposes.
2. Maintain a comprehensive electronic care plan.
3. Ensure access to care.
4. Facilitate transitions of care.
5. Coordinate care.

Care Coordination/Management

- 20+ minutes of non-face-to-face CM services:
  - Reconciling medication and overseeing self-management of meds
  - Ensuring receipt of all recommended preventive services
  - Monitoring the patient's condition (physical, mental, social)

Care Coordination/Management *(Continued)*

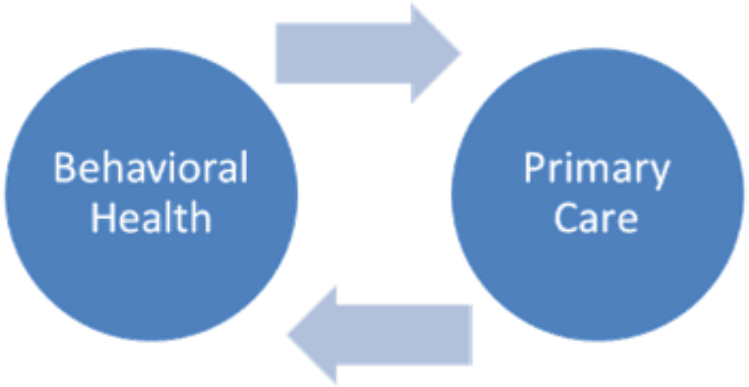
- 20+ minutes of non-face-to-face CM services – ADDITIONAL types of services could include:
  - Education and addressing questions from the patient and family
  - Arrangement and coordination of community resources needed
  - Communication and coordination with the patient's other providers

Practice Capabilities - TCM

- Follow-up after admission
- Provide 30-day post-discharge TCM services (cannot bill for TCM and CCM during same month)
- Coordinate referrals to other clinicians
- Share information electronically with other clinicians, as appropriate
- Coordinate with home- and community-based clinical service providers to meet patients psychosocial needs/functional deficits

Behavioral Health (BH) Integration

- Identify strong linkages between behavioral and somatic health cultures.
- Emphasize making primary care providers (PCPs) aware of danger signals and need for referrals to Behavioral Health (BH) specialists.
- Encourage BH providers to ensure their patients are getting proper treatment for physical conditions prevalent in individuals with serious mental illness.



Idaho's Mental Health Burden

- **21.62 %**of persons age 18+ experience mental illness.
- **4.98%** experienced serious mental illness (SMI) in the past year, averaged from 2012 and 2014.
- **7.62%** of people age 18+ experienced a major depressive episode (MDE).
- **15.93%** of persons ages 12 to 17 reported past MDE.
- **SUICIDE** is the SECOND leading cause of death in Idaho for residents 15-24 years old, 25-34 years old, and 35-44 years old.

Source: SAMHSA's 2015-2016 National Survey on Drug Use and Health
https://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2016/NSDUHsaePercents2016.pdf
Leading Cause of Death data retrieved from Idaho Vital Statistics: Mortality 2016 produced by the Division of Public Health.
https://healthandwelfare.idaho.gov/Portals/0/Health/Statistics/2016-Reports/2016_Mortality.pdf

PCMH Behavioral Health Terms

Collaborative Care:

- Often used interchangeably with the term *integrated care*
- It's how we interact with other disciplines
- It's sometimes used as shorthand for the Collaborative Care Model

Models of Integrated Care

1. Coordinated:

- Screen patients for BH problems
- Coordinate approaches with PCP and BH specialists in separate facilities
- Work together through phone and/or email or provide an online service to provide BH advice to PCP

.....limited effect but it's a start

Models of Integrated Care *(Continued)*

2. Co-located:

- The PCP and BH specialists work in same facility and together to varying degrees
- Referrals are provided back and forth
- Specialists may have patient huddles and send each other information about shared patient
- Co-location does not naturally promote full sharing and integration of systems

Models of Integrated Care *(Continued)*

3. Integrated:

- BH specialists within PCP facility and system
- Team approach to co-management
- Integrated care plan
- One EHR
- One billing system

The Collaborative Care Model

Informed Activated Patient

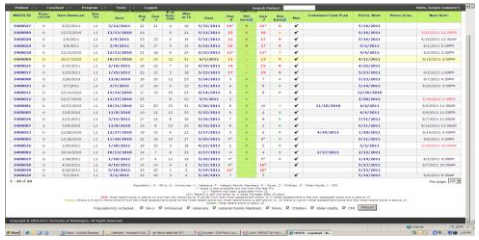
Effective Collaboration

PRACTICE SUPPORT

PCP supported by Care Manager

Measurement-based Treat to Target

Psychiatric Consultation



Caseload-focused Registry review

Training

https://aims.uw.edu

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New Medicare Codes for CoCM Require Attention to Detail

99492 (Initial month, CoCM) - $161

99493 (Subsequent month, CoCM) - $129

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

} Billed once a month by the PCP

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
- GCCC2 – proposed new code for FQHCs $135/month starting January 1, 2017

Medicare Code 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 and engage
  - Initial assessment and treatment plan
  - Review with psychiatric consultant
  - Enter and track in registry
  - Ongoing brief interventions such as motivational interviewing and behavioral activation

Medicare Code 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:**
  - Track and follow up
  - Weekly caseload review with psychiatric consultant
  - Monitoring of patient outcomes in registry and using validated tools for re-measurement
  - Ongoing coordination with all patient's health care providers
  - Relapse prevention

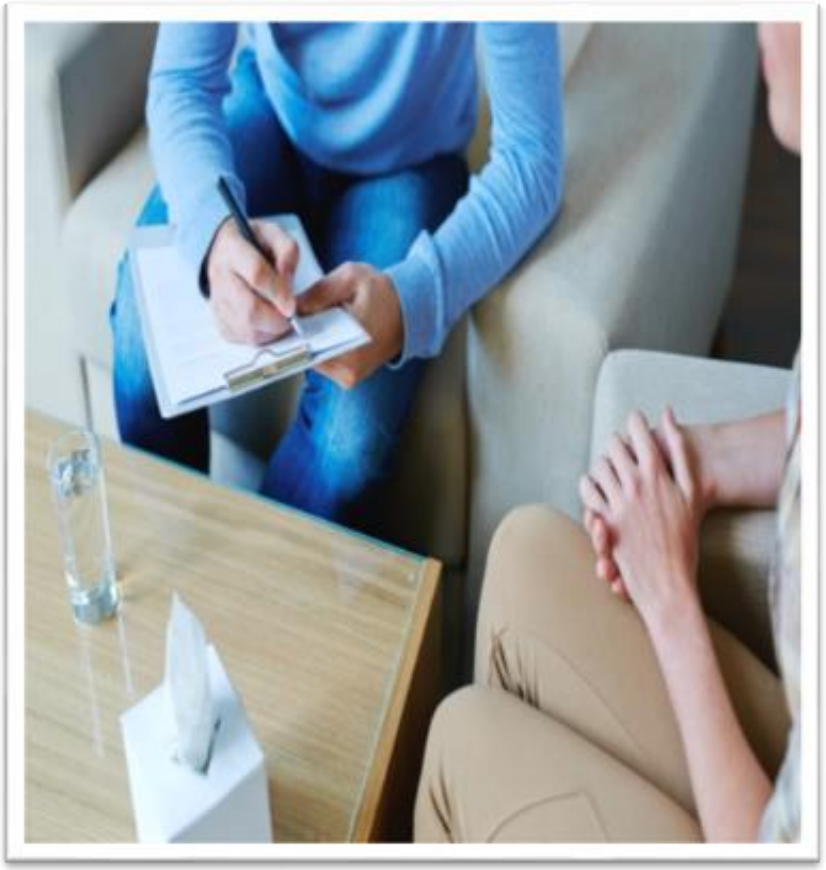
Medicare Code 99494

- **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**

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.
    - Those who have not been seen within a year of commencement of Behavioral Health Integrated services.
  - This visit will include:
    - The treating provider establishing a relationship with the patient.
    - Assessing the patient prior to referral.
    - Obtaining broad beneficiary consent to consult with specialists. who 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.

Care Manager Qualifications



Centers for Medicare and Medicaid Services (CMS) states that the behavioral health care manager:

- Must have formal education or specialized training in behavioral health.
- May have training in one or more of a range of disciplines, including: social work, nursing, and psychology.
- Does NOT need to be licensed to bill traditional psychotherapy codes for Medicare.

Time Stamping – Per Month

- Minutes spent talking to patient (in person or phone)
- Minutes spent talking to the Primary Care Physician (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
- Be sure to document all time
- After break of 15 minutes (between 60 and 75 minutes) start the clock for 99494 (30 minutes) and again and again if needed

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.
- Time spent by the BHCM on activities for services reported separately may NOT be included in the services reported using time applied to codes 99492, 99493, and 99494.
  - 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 Behavioral Health Integrated Services

- **Code 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.

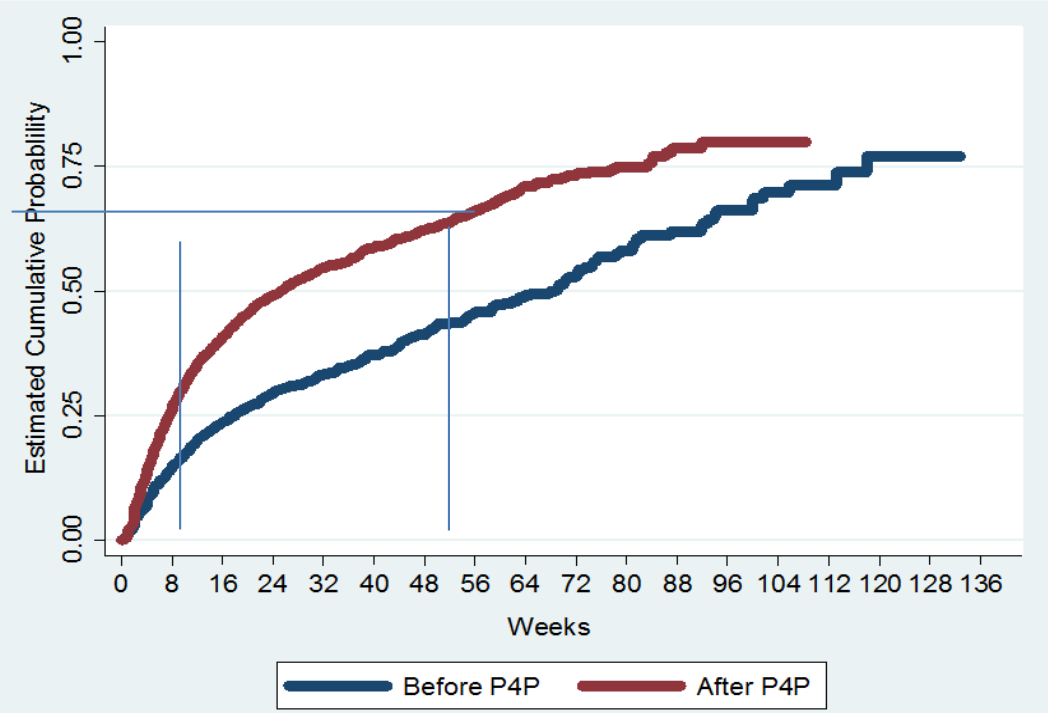
Medicare Code 99484 *(Continued)*

- Code 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.

Pay-for-Performance (P4P) Successfully Incents Improvements

American Psychiatric Association found that when P4P arrangements were in place, median time to depression treatment response was reduced by half.

- Cut median time to depression response in half



Source: Unützer et al., 2012

Questions/Answers/Discussion

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