Sustaining Collaborative Care with Incentives and Reporting

Dorian Gittleman, MPH
How to sustain Collaborative Care

• Payment Incentives
• Consolidation of Reporting and CQI Activities
• Effective Data Use
• Staff Training and Empowerment
Value Based Payments

There is heavy overlap between the different incentivizing programs! Both commercial and public insurance programs value the same tools!

- NY Medicaid/DSRIP Value Based Payments (VBPs)
- Healthcare Effectiveness Data and Information Set (HEDIS) Quality Assurance Reporting Requirements (QARR)
- New York Patient Centered Medical Home (PCMH)
- Medicare Access and CHIP Reauthorization Act (MIPS) Merit Based Incentive Payment System (MIPS)
Consolidate Data Reporting and CQI Activities

• Can you consolidate reporting? Are multiple people running the same report to meet different requirements? Can one person run one report and disseminate out?

• Are multiple reports related? Can you use them to build a better picture of patient care? Is one report superfluous?

• Seeing the relationship between reports will help you build better CQI activities and workflows. There should be a dynamic relationship between data and activity.

• The fewer reports you run, the more time you have to improve the reports.
Use Data Effectively

• Collect Accurate Data – assure that the reports reflect information entered into EHR by provider
• Collect Data that reflects what is actually happening – Are staff actually doing a PHQ with every patient? Is there a warm handoff?
• Create Reports that will be meaningful to staff
  • What are staff doing well/badly?
  • How can they improve?
  • Aim to demonstrate cause and effect
• Effectively disseminating findings
  • Sharing information as a part of patient care, to improve patient care
  • Sharing findings to demonstrate that it works and that it’s important because it’s improving patient care.
Designing the Process with Data Collection and Incentives in Mind

- **Screening**
  - Data Collection Point: PHQ 2/9 Screenings
  - Other Screenings: GAD-7, Alcohol/Substance Use (SBIRT)
  - Incentives: PCMH, HEDIS, MIPS, VBP

- **PCP Encounter**
  - Data Point: Acute Anti-depressant Medication Management
  - Data Point: Medication Reconciliation
  - Potential: Documentation of Risk Stratification
  - Incentives: HEDIS/QARR, VBP

- **Handoff to DCC**
  - Data Point: Enrollment in Collaborative Care
  - Data Point: Shared Treatment Plan

- **Follow Up**
  - Data Point: Patient Follow Up
  - Data Point: Follow Up Plan in Patient File
  - Data Point: Closing the Loop

- **Remission/Treatment Plan**
  - Data Point: Med Management Continuation Phase
  - Data Point: Repeat PHQ Screening
  - Data Point: Change in Treatment Plan
  - Data Point: Psychiatric Consultation
  - Incentives: HEDIS/QARR, VBP, PCMH, MIPS
Conclusions

• Measures and incentives are constantly changing. Value Based Payments are a work in progress.
• CQI and Data Reporting should remain patient and provider experience focused, even in the face of state requirements.
• There should be a clear plan for data dissemination to ALL involved staff.
• Incentives programs have heavy overlap, so health programs should not miss out.
• Data is a tool to help you improve your practice. If that’s not what’s happening, sit down with your staff to find out what’s missing or inaccurate.
Collaborative Care: Best Practices for Billing and Financial Sustainability

Virna Little, PSYD, LCSW-R, SAP
Initial Review

- Site – Article 28, 31, FQHC, etc. plays a large role in reimbursements and sustainability planning
- Staffing – Types of licensure impacts billing codes, services, and reimbursements directly
- Payers – Variations in billing collaborative care across payers
Reimbursement Across the Board!

- Medicaid and Medicare reimburse case rates for collaborative care
- Third party payers are reimbursing Medicare codes (let us know if you don’t get paid)
<table>
<thead>
<tr>
<th>Payer Spreadsheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Title</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>BSW</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Licensed Counselor</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
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<tr>
<td></td>
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<tr>
<td>Psychiatric NP</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Psychiatric PA</td>
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<td></td>
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<tr>
<td>RN</td>
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</tbody>
</table>
Workflows and Sustainability

- Often need to be modified based on sustainability plan or efforts
- Workflows can also be used not just for clinical services but for points in a process like prior authorizations or access initiatives
Coding

- Code for tracking and billing
- Optimize use of screening codes keeping in mind special populations such as prenatal
- Code case conferences such as psychiatric consultation
## BHI Coding Summary

<table>
<thead>
<tr>
<th>BHI Code</th>
<th>Behavioral Health Care Manager or Clinical Staff Threshold Time</th>
<th>Activities Include:</th>
</tr>
</thead>
</table>
| CoCM First Month (G0502) (CPT 99492) | First 70 minutes per calendar month | • Initial Assessment  
• Outreach/engagement  
• Entering patients in registry  
• Psychiatric consultation  
• Brief intervention |
| CoCM Subsequent Months (G0503) (CPT 99493) | 60 minutes per calendar month | • Tracking + Follow-up  
• Caseload Review  
• Collaboration of care team  
• Brief intervention  
• Ongoing screening/monitoring  
• Relapse Prevention Planning |
| Add-on CoCM (Any month) (G0504) (CPT 99494) | Each additional 30 minutes per calendar month | • Same as Above |
| General BHI (G0507) (CPT 99484) | At least 20 minutes per calendar month | • Assessment + Follow-up  
• Treatment/care planning  
• Facilitating and coordinating treatment  
• Continuity of care |
Warm Hand-offs

- To bill or not to bill........
- Workflows that support billing (empty slots, hand-offs for billable payers)
- What do I code if I do bill?
- How do I measure abstract revenue for doing hand-offs?
- What is an effective hand-off?
- Who to use for hand-offs (non billable)

WARM HAND-OFFS ARE CRITICAL FOR INTEGRATED CARE; WARM HAND-OFF MANGEMENT IS A KEY ELEMENT FOR SUSTAINABILITY REVIEW OF SAME DAY SERVICES REIMBURSEMENT
Common Billing Codes for Therapy

- 90791 - Diagnostic Evaluation/Intake
- 90832 - Psychotherapy, 30 minutes
- 90834 - Psychotherapy, 45 minutes
- 90837 - Psychotherapy, 60 minutes
- 90839 - Psychotherapy for crisis
- 90853 - Group Psychotherapy
- 90846 - Family/Couples Psychotherapy w/o Pt
- 90847 - Family/Couples Psychotherapy w/Pt
Common Billing Codes for Psychiatry

- 90792 - Psychiatric Evaluation
- 99212 - Medication Management
- 99213 - Medication Management
- 99214 - Medication Management

- Use above E&M Codes and then add on a therapy code if needed
NYS Medicaid Maternal Depression Screening Guidelines

• **Billing Guidance**
  • If maternal depression screening is provided postpartum by the maternal healthcare provider, the service can be reimbursed in addition to the E&M visit. Effective September 1, 2016 for FFS and November 1, 2016 for MMC, providers should bill for this service using CPT code G8431 in conjunction with the “HD” modifier for a positive depression screen of the mother and G8510 in conjunction with the “HD” modifier when the screening returns a negative result. These two new “G” series codes replace CPT code 99420 (The Administration and Interpretation of Health Risk Assessment Instrument - Health Hazard Appraisal) currently being used for maternal depression screening. Upon the effective date outlined above, the CPT code 99420 will no longer be active in the Medicaid billing system.
  • If maternal depression screening is performed on the same day as the infant's primary care visit (E&M) by the infant's healthcare provider, one claim can be submitted for both services using the appropriate “G” series code (G8431/G8510) with the HD modifier under the infant's Medicaid identification number. Alternatively, providers may bill this service separately under the mother’s Medicaid identification number.
## Coding and Diagnosis Information

### Procedure Codes and Descriptors

Use the following Healthcare Common Procedure Coding System (HCPCS) code to report screening for depression in adults.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Code Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0444</td>
<td>Annual depression screening, 15 minutes</td>
</tr>
</tbody>
</table>
# Screening Codes

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Abbreviation</th>
<th>CPT code</th>
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</thead>
<tbody>
<tr>
<td>Ages and Stages Questionnaire - Third Edition</td>
<td>ASQ</td>
<td>96110</td>
</tr>
<tr>
<td>Ages and Stages Questionnaire: Social-Emotional</td>
<td>ASQ:SE</td>
<td>96127</td>
</tr>
<tr>
<td>Australian Scale for Asperger’s Syndrome</td>
<td>ASAS</td>
<td>96127</td>
</tr>
<tr>
<td>Beck Youth Inventories - Second Edition</td>
<td>BYI-II</td>
<td>96127</td>
</tr>
<tr>
<td>Behavior Assessment Scale for Children - Second Edition</td>
<td>BASC-2</td>
<td>96127</td>
</tr>
<tr>
<td>Behavioral Rating Inventory of Executive Function</td>
<td>BRIEF</td>
<td>96127</td>
</tr>
<tr>
<td>Brigance Screens II</td>
<td>(No Abbreviation)</td>
<td>96127</td>
</tr>
<tr>
<td>Brief Infant and Toddler Social Emotional Assessment</td>
<td>BITSEA</td>
<td>96127</td>
</tr>
<tr>
<td>Connor's Rating Scale</td>
<td>(No Abbreviation)</td>
<td>96127</td>
</tr>
<tr>
<td>Denver II</td>
<td>(No Abbreviation)</td>
<td>96110</td>
</tr>
<tr>
<td>Kutcher Adolescent Depression Scale</td>
<td>(No Abbreviation)</td>
<td>96127</td>
</tr>
<tr>
<td>Modified Checklist for Autism in Toddlers</td>
<td>M-CHAT</td>
<td>96110</td>
</tr>
<tr>
<td>Patient Health Questionnaire</td>
<td>PHQ-2 or PHQ-9</td>
<td>96127</td>
</tr>
<tr>
<td>Parents' Evaluation of Developmental Status</td>
<td>PEDS</td>
<td>96110</td>
</tr>
<tr>
<td>Pediatric Symptom Checklist</td>
<td>PSC</td>
<td>96127</td>
</tr>
<tr>
<td>Pediatric Symptom Checklist - Youth Report</td>
<td>Y-PSC</td>
<td>96127</td>
</tr>
<tr>
<td>Screen for Child Anxiety Related Disorders</td>
<td>SCARED</td>
<td>96127</td>
</tr>
<tr>
<td>Strength and Difficulties Questionnaire</td>
<td>SDQ</td>
<td>96127</td>
</tr>
<tr>
<td>Substance Abuse and Alcohol Abuse Screening</td>
<td>CRAFFT</td>
<td>96127</td>
</tr>
<tr>
<td>Vanderbilt Rating Scales</td>
<td>(No Abbreviation)</td>
<td>96127</td>
</tr>
</tbody>
</table>
Service Optimization

• Transitions of Care
• Chronic Care Management
• Collaborative Care

PRACTICES OFTEN DON’T KNOW THEY CAN USE ALL OF THESE WITH INDIVIDUAL PATIENTS;

Medicare patients can be enrolled in all
Scheduling

- Largest barrier for sustainability in many organizations
- Case Finding
- Gap - full schedules and open slots
- Not training front desk (how to cancel, pre-appointment)
- Shadow scheduling
- Scheduling out by clinicians
- Not incorporating open access
Development of Dashboards

UNUSED TEMPLATE HOURS
Unused Template hours indicate patient care session time where no appointments were scheduled.

The Director of Practice Operations is responsible for filling completely all providers’ patient care sessions and continue the downward trend in reducing unused template hours at a rate of 35%.

Actions include: Assessing template strategies through the use of appropriate same day appointment holds based on historical demands, reducing no show rates and predicting no show “hot spotting” to correlate with the same day holds.

Total Payments

Visit projections through 2014 demonstrate a continued rate of 20% decrease in the template unused hours with the introduction of efficiency reports, a 35% decrease in 2015 due to interventions mentioned above is expected.

Total payment projections demonstrate an average reimbursement of $127.33 per visit (actual rate, year to date at Hyde Park). Projections include bad debt assuming 2015 uncollected visit rates remain the same as the first half of 2014.

WHAT DO YOU NEED TO KNOW AND WHEN DO YOU NEED TO KNOW IT
Denial Management

Best Practices
• Know your timely filing limits
• Work denials immediately
• Identify trends
• Document
• Timely filing

• Let us know about denials ASAP !!!
### Core Assumptions:

<table>
<thead>
<tr>
<th>Panel size</th>
<th>1500</th>
<th>Average Visit Scheduled Time</th>
<th>15 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounters</td>
<td>4200</td>
<td>Estimated time saved by diverting</td>
<td>11 minutes</td>
</tr>
<tr>
<td>Payer Mix</td>
<td></td>
<td>to a behaviorist</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td>40%</td>
<td>Average visits per hour</td>
<td>3</td>
</tr>
<tr>
<td>Medicare</td>
<td>12%</td>
<td>Transition training time</td>
<td>16 hours</td>
</tr>
<tr>
<td>Commercial</td>
<td>8%</td>
<td>SBIRT screenings that triage for intervention</td>
<td>16%</td>
</tr>
<tr>
<td>Sliding fee scale</td>
<td>40%</td>
<td>Projected proportion that could be diverted to Behaviorist</td>
<td>50%</td>
</tr>
<tr>
<td>Average Reimbursement per visit</td>
<td>$135</td>
<td>Slots created as a result of integration model</td>
<td>246.4</td>
</tr>
<tr>
<td>Medicare SBIRT Reimbursement</td>
<td></td>
<td>Estimated Medicare SBIRT Screens</td>
<td>504</td>
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<tr>
<td>G0396</td>
<td>$29.62</td>
<td>Estimated Medicaid SBIRT Screens</td>
<td>1680</td>
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<tr>
<td>G0397</td>
<td>$57.69</td>
<td>Estimated Medicare Screen &amp; Intervention</td>
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<tr>
<td>Medicaid SBIRT Reimb H0049</td>
<td></td>
<td>Estimated Medicaid Screen &amp; Intervention</td>
<td>268.8</td>
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<tr>
<td>H0049</td>
<td>$24.00</td>
<td>Medicare encounters</td>
<td>504</td>
</tr>
<tr>
<td>H0050</td>
<td>$48.00</td>
<td>Medicaid encounters</td>
<td>1680</td>
</tr>
<tr>
<td>Provider Hourly Rate</td>
<td>$72.00</td>
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<tr>
<td>RN Hourly Rate</td>
<td>$27.60</td>
<td></td>
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<tr>
<td>Medical Assistant Hourly Rate</td>
<td>$15.60</td>
<td></td>
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</tr>
<tr>
<td>Behaviorist Hourly Rate</td>
<td>$39.06</td>
<td>$81,250</td>
<td>$65,000 Base salary</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2080 Hours worked a year</td>
<td></td>
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</table>

### Costs

<table>
<thead>
<tr>
<th></th>
<th>Screening</th>
<th>Time</th>
<th>Lost Revenue</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>S S</td>
<td>$40,625.00</td>
<td></td>
<td></td>
<td>$40,625.00</td>
</tr>
<tr>
<td>I I</td>
<td>$1,843.20</td>
<td>16</td>
<td>$6,480</td>
<td>$8,323.20</td>
</tr>
</tbody>
</table>

**Subtotal** $48,948.20

### Revenue

<table>
<thead>
<tr>
<th></th>
<th>Screening Reimbursement</th>
<th>$55,248.48</th>
<th>$55,248.48</th>
</tr>
</thead>
<tbody>
<tr>
<td>P P</td>
<td>Gains in Productivity</td>
<td>$33,264.00</td>
<td>$33,264.00</td>
</tr>
<tr>
<td>R R</td>
<td>Reimbursement for Screen and Treatment</td>
<td>$8,714.76</td>
<td>$8,714.76</td>
</tr>
</tbody>
</table>

**$97,227.24**

### Net Business Case

$48,279.04
Questions/Thoughts

vlittle@sph.cuny.org

Sometimes the best thing you can do is not think not wonder not imagine not obsess just breathe and have faith that everything will work out for the best.

DespicableMeMinions.org
NYS Collaborative Care Medicaid Program

Amy Jones-Renaud, MPH
Director, Primary Care Behavioral Health Integration
NYS Office of Mental Health
NYS Collaborative Care Medicaid Program

- 2013-2014, NYS DOH Medical Home Grant Program established CC programs in academic medical centers

- To sustain the progress, OMH launched the Medicaid program in 2015
  - More than 100 sites currently participating
  - Value based reimbursement
  - Address regulatory and reimbursement barriers
Collaborative Care services are not reimbursable under most current financing mechanisms

- PCP coordination time
- BHCM (SW, LMHC, or other) care management and brief intervention, phone and group time
- Psychiatric Consultation, not face-to-face with patient
- Data entry and registry management
Monthly Case Rate Reimbursement Methodology

- Designed a Medicaid Monthly Case Rate
  - Carve out, not Managed Care
  - Value Based
  - Bundled services
- $150 per patient per month
  - 75% up front, 25% quality retainage
NYS CCMP Case Rate

- For meeting the monthly engagement requirements, providers get 75% of the payment, $112.50.
- After three months of enrollment, if the patient has received one of the following, the practice can receive the 25% Retainage withhold retroactively, and can receive the 25% for each additional month they continue to meet criteria. *
  - Patient has met clinical improvement criteria (PHQ9 50% dec. or <10)
  - Documented change to Treatment Plan
  - Documented case review by Psychiatric Consultant

*Non- Article 28 clinics do not receive Retainage
Billing Requirements

To Bill the Medicaid Case Rate each month,

✓ Have a Documented clinical contact that month
✓ PHQ-9 that month
✓ Seen face-to-face by a licensed provider within the last 90 days
Reimbursement

- $112.50 Per Patient Per Month for maintaining engagement
- With 60 patient caseload, $6,750 per month
- $81,000 per year from CCMP Billing

*Can carry caseloads larger than 60*

*Does not include billing for screening, SBIRT, or other billable services that may be part of CC*

AIMS Center Financial Modeling Workbook:
https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook
Questions?

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