



Population Health Advisor

Evaluating Reimbursement Models for Integrated Behavioral Health Programs

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Population Health Advisor

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Overview of Project and Research Methodology

Introduction and Purpose



This research brief provides original research on commercial payer practices for reimbursing integrated behavioral health in the primary care setting.

Case studies profiled in this report highlight important considerations for identifying billable services across commercial payers, target populations and eligibility criteria, and reimbursement models and covered services.

Project in Brief



1. **The Case for Integrated Care:** Brief overview of the case for improved behavioral health services along with discussion on reimbursement models and payer activity supporting integrated care
2. **Profiles of Integrated Behavioral Health Models:** Describes five organizations' integrated behavioral health programs, with particular emphasis on pathways for enhancing the sustainability of the model

Interview Methodology



The Population Health Advisor team conducted a literature review of integrated behavioral health programs, and subsequently identified and interviewed stakeholders from organizations with behavioral health programs evaluating processes to enhance financial sustainability.

Research contacts were selected to represent a spectrum of integrated behavioral health models operating with minimal or short-term support from grant funding.



The Case for Integrated Care

Behavioral Health Co-Morbidities Complicate Care, Increase Cost

The impact of behavioral health in the United States is significant, both in terms of the financial cost of associated health outcomes and in the quality of life implications for patients requiring these services. Behavioral health conditions are highly prevalent, with results from the most recent National Health and Nutrition Examination Survey (NHANES) indicating that over one in five individuals reports depressive symptoms. Furthermore, among those with severe depression, over a third of individuals receive no mental health treatment.

Under the current status quo, the cost impact of ineffective treatment of comorbid behavioral health conditions has been attributed to an estimated \$350 billion spent annually on unnecessary medical and surgical services.¹ Behavioral health consequently represents an important and promising opportunity for many health care providers to enhance care, improve quality outcomes, and lower costs.

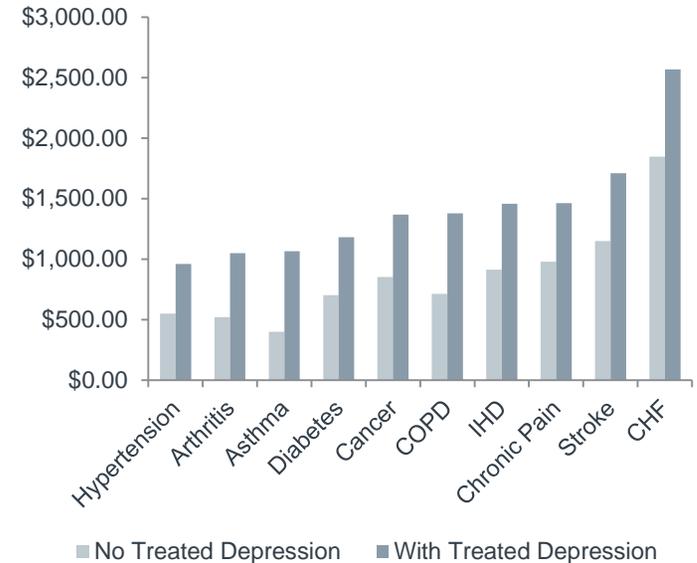
Expected Comorbid Depression Prevalence¹

2005-2006

Chronic Medical Condition	Comorbid Depression Prevalence
Hypertension	23%
Arthritis	25%
Asthma	45%
Diabetes	25%
Cancer	30%
COPD ²	30%
IHD ³	35%
Chronic Pain	50%
Stroke	40%
CHF ⁴	35%

Health Care Costs for Patients with Comorbid Depression¹

Per Member Per Month
2005-2006



Behavioral Health Co-Morbidities

29%

Adults with a medical condition and a co-morbid behavioral health condition⁵

38%

Dual-eligibles with a physical and mental health condition⁶

1) Milliman Research Report (July 2008).
 2) Chronic obstructive pulmonary disease.
 3) Ischaemic heart disease.
 4) Congestive heart failure.
 5) Goodell, Druss, & Walker (February 2011).
 6) Kasper, et al. (July 2010).

Sources: Goodell S, Druss BG, and Walker ER. "Mental Disorders and Medical Comorbidity," *RWJF*, February 2011; Kasper C. et al. "Chronic Disease and Co-Morbidity Among Dual Eligibles," *KFF*, July 2010; Shim RS, Baltrus P, Ye J & Rust G, "Prevalence, treatment, and control of depressive symptoms in the United States: Results from the NHANES, 2005-2008" *Journal of the American Board of Family Medicine*, January 2011, 24(1): 33-38; Melek S, Norris D, "Chronic conditions and comorbid psychological disorders," *Milliman Research Report*, July, 2008, available at: <http://www.milliman.com/insight/research/health/pdfs/Chronic-conditions-and-comorbid-psychological-disorders/>; Population Health Advisor interviews and analysis.

New Care Models Promote Integrated Behavioral-Primary Care Management

The traditional approach for managing patients with concurrent medical and behavioral conditions is often hindered by a lack of patient adherence to referrals. Moreover, two thirds of primary care providers report that their patients lack access to effective mental health services.¹

Coordinated care models have been developed to increase behavioral health access and treatment rates. Multiple frameworks exist for describing the levels of primary care-behavioral health collaboration.

In an integrated model, behavioral health staff serve as part of a collaborative care team of both medical and behavioral health care providers. These collaborative care teams use standardized screenings, unified treatment plans, actionable screening results, protocol-based care processes, and robust information sharing to improve patient-centered care delivery.

Levels of Behavioral Health Integration into Primary Care

	1	2	3	4	5
Doherty, McDaniel, Baird (1995)	Minimal collaboration <ul style="list-style-type: none"> Separate systems Separate facilities Rare communication Little appreciation of each others, role, culture 	Basic collaboration from a distance <ul style="list-style-type: none"> Separate systems Separate facilities Periodic communication driven by specific patient issues Limited understanding of each others role, culture 	Basic collaboration on-site <ul style="list-style-type: none"> Separate systems Same facilities Regular communication, occasional in-person consultations Some appreciation of each others role, culture 	Close collaboration in partly integrated system <ul style="list-style-type: none"> Some shared systems Same facilities Regular in-person consultations, coordinated treatment plans Basic appreciation of each others role, culture 	Close collaboration in fully integrated system <ul style="list-style-type: none"> Shared systems Same facilities Regular in-person, collaborative care team meetings In-depth appreciation of each others role, culture
Seaburn, Lorenz, Gunn, Gawinski, Mauksch (1996)	Parallel delivery: Clear division of labor	Informal consultation: BH professional helps physician	Formal consultation: Typical consulting specialist relationship	Co-provision of care: Patient care is shared, some joint patients visits	Collaborative networking: Team includes other specialists, community resources
Blount (2003)	Coordinated: <ul style="list-style-type: none"> Routine screening in primary care Referral relationship; routine exchange of information Brief, algorithm-driven behavioral health interventions delivered in primary care Connections made to community resources 		Co-located: <ul style="list-style-type: none"> Same facility Referral processes, enhanced informal communication due to proximity Consultations between providers Increase in level and quality of behavioral health services 		Integrated: <ul style="list-style-type: none"> Same or separate facilities One medical-behavioral health treatment plan Protocol-driven team-based care Database to track care of screened patients

Sources: Collins C. et al., "Evolving Models of Behavioral Health Integration in Primary Care," Milbank Memorial Fund, 2010; Wang PS, et al., "Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication" *Arch Gen Psychiatry*, 2005, 62:629-40; Cunningham P, "Beyond parity: Primary care physicians' perspectives on access to mental health care," *Health Affairs*, May 2009, 28(3):490-501; Population Health Advisor interviews and analysis.

1) Cunningham P (May 2009).

Integrated Behavioral Health Programs Increase Access and Improve Outcomes

Evidence-based, integrated behavioral health interventions have demonstrated cost-effective improvements in clinical outcomes among patients with depression, anxiety, and substance abuse comorbidities.

In a large randomized controlled trial examining the effectiveness of the integrated behavioral health model across eighteen primary care clinics from eight health organizations in five states, the IMPACT intervention demonstrated significant reduction in depressive symptoms for patients participating in collaborative care relative to usual care. Patients participating in the IMPACT intervention additionally reported significantly higher rates of depression treatment, better satisfaction with depression care, lower depression severity, less functional impairment, and greater quality of life.¹

Despite these promising results, widespread adoption of the integrated behavioral health model has yet to gain traction on a larger, national scale due to various operational, cultural, and financial impediments.

Key Program Design Elements of IMPACT

1 Standardized Patient Assessment



Behavioral health specialist conducts the initial visit with patient, reviews educational materials, and discusses the patient's treatment preferences

2 Protocol-Based Treatment Plan



The behavioral health specialist works with the patient and his/her regular primary care provider to establish a treatment plan informed by IMPACT's treatment algorithm (primary care provider makes final treatment choices)

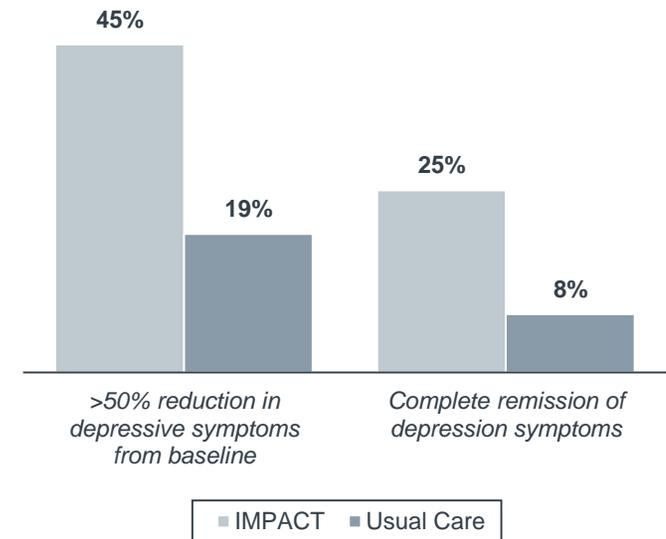
3 Routine Care Team Meetings



During weekly team meetings, the supervising psychiatrist, behavioral health specialist and primary care physician discuss new cases and cases requiring treatment plan adjustments

IMPACT Clinical Outcomes at 12-Month Follow-up¹

n=1,801



Financial Outcomes of IMPACT Model

\$533

Estimated mean cost per intervention patient for 12-month period²

\$1.88

Average per member per month (PMPM) program cost²

\$3,363

Average four-year savings in total health care costs per IMPACT participant²

\$6.50

Return on investment per dollar spent, IMPACT years 1-4.³

1) Unützer (2002).
2) Unützer (2010).
3) Unützer (May 2013).

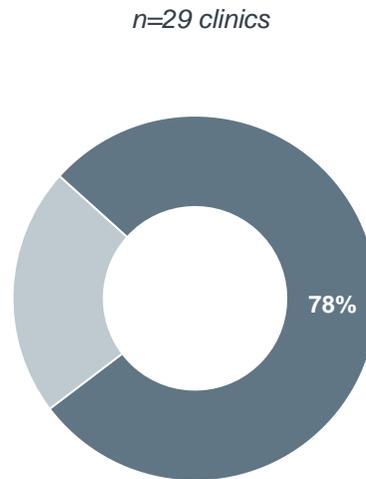
Sources: Unützer J, et al. "Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial." *JAMA*, 2002, 288(22):2836-2845; Unützer J. "Financing integrated mental health care." *AIMS*, 2010, accessed July 24, available at: <http://impact-uw.org/training/onlinetraining.html>; Unützer J, et al., "The collaborative care model: An approach for integrating physical and mental health care in Medicaid health homes." *Health Home IRC*, May 2013, available at: <http://www.medicaid.gov/>; Population Health Advisor interviews and analysis.

Financial Sustainability Is a Common Hurdle to Adoption of the Integrated Model

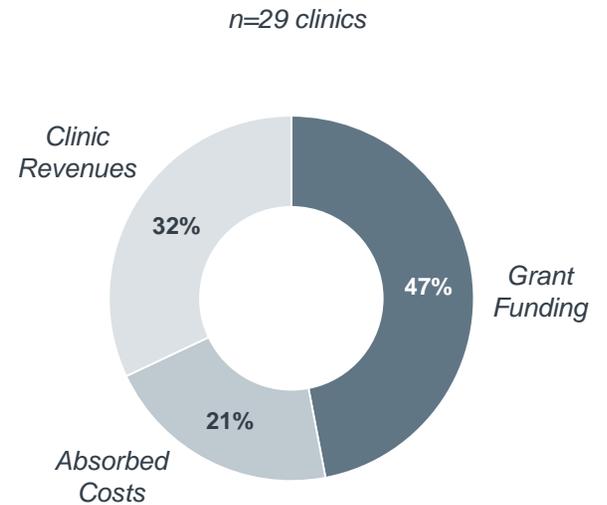
Limitations in the behavioral health policy framework and both private and public reimbursement structures have significantly hindered the implementation of effective behavioral health services nationwide. In particular, low reimbursement rates for behavioral health services and misaligned incentives under fee-for-service payment models have slowed coverage of integrated behavioral health among private payers.

As such, the overwhelming majority of integrated care models is grant-funded or applied within systems that predominantly use risk-based or capitated payment models. A 2011 survey sponsored by the Colorado Health Foundation found that among surveyed clinics using an integrated behavioral health model, 78% of respondents rely on grant funding. Furthermore, over half of the responding clinics identified insufficient grant funding as a substantial obstacle to the financial sustainability of their programs.

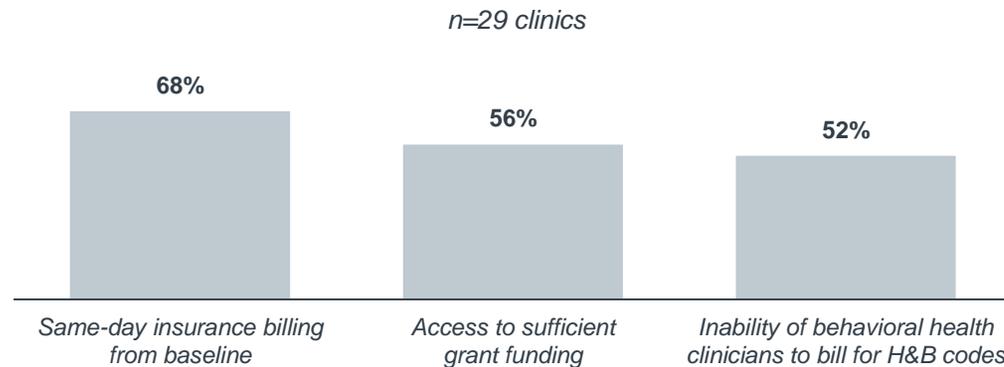
Percentage of Clinics Receiving Grant Funding for Collaborative Care Costs¹



Breakdown of Funding Sources for Integrated Behavioral Health Programs¹



Largest Obstacles to Better Financial Sustainability for Collaborative Care¹



Sources: Talen M, Burke Valeras A, *Integrated Behavioral Health in Primary Care*. Springer Publications (2013), accessed July 15, 2014, available at: <http://www.springer.com/psychology/health+and+behavior/book/978-1-4614-6888-2>; Population Health Advisor interviews and analysis.

1) 2011 Survey by Colorado Health Foundation.

Making the Case for an Integrated Behavioral Health Model

While the business case for an integrated behavioral health model is strongest in managing populations covered through at-risk contracts, even under fee-for-service, providers have an incentive to promote improved behavioral health treatment for Medicaid and uninsured patients to reduce the low-value downstream services such as avoidable medical admissions or readmissions.

For providers with at-risk populations like contracts, there is additional incentive given the integrated care models have been shown to reduce overall medical costs through improved prescription management, decreased ED visits, and fewer hospitalizations.

With careful consideration of practice, patient, and provider characteristics, anticipated program costs, and available revenue streams, program planners may be able to model and generate return on investment from integrated behavioral health services.

Critical Components of an Integrated Behavioral Health Pro Forma

Core Assumptions



Details on practice operations, including information on patient demographics, prevalence of behavioral health conditions, and volume and type of services offered

Costs



Breakdown of program costs, including infrastructure/space requirements, behavioral staff salary, training, and dedicated time to quality improvement among care team members

Revenue



Financial returns, including reimbursement for screenings, interventions, and treatment, productivity gains, increased patient utilization, and reductions in avoidable hospital admissions or readmissions

Pro Forma Components	Sample Metrics	SAMHSA Sample Inputs ¹
Core Assumptions	Panel size	1500
	Encounters	4200
	Payer mix	40% Medicaid, 12% Medicare, 8% commercial, 40% sliding fee scale
	Average reimbursement per visit	\$135
	Behaviorist hourly rate/base salary	\$39.06/\$65,000 (+25% benefits)
Costs	Intervention	\$40,625.00 (salary resource)
	Transition costs	\$1,843.20 (salary resource)
Revenue	Screening reimbursement	\$55,248.48
	Gains in productivity	\$33,264.00
	Reimbursement for screen and treatment	\$8,714.76



\$48,279

Net anticipated annual profit generated from SAMHSA's "Behavioral Health Pro Forma Model"¹



See Appendix for complete sample pro forma from SAMHSA

1) SAMHSA (September 2013).

Sources: SAMHSA "Business Case for Behavioral Health Pro Forma Model" (September 2013), accessed July 21, 2014, available at: www.integration.samhsa.gov; Population Health Advisor interviews and analysis.



Profiles of Integrated Behavioral Health Models

Profiled Integrated Behavioral Health Organizations and Programs

Organization	Organization/Program Description	Payment Model	Staffing Model
1. Maine Behavioral Healthcare	MaineHealth is a six-hospital not-for-profit health system based in Portland, Maine; Maine Behavioral Healthcare, a subsidiary of MaineHealth, operates the Mental Health Integration Program, offering operational and administrative support to behavioral health clinicians participating in the integrated care model across select MaineHealth primary care practices	Fee-for-service	Maine Behavioral Healthcare employs 26 behavioral health clinicians working at 40 system-owned practices. The majority of behavioral health specialists are licensed clinical social workers (LCSWs) working at designated primary care practices for a total of 20 hours, three days per week.
2. Aetna Integrated Primary Care Behavioral Health Program	Specialized behavioral health program offered by national commercial insurance provider; program maintains targeted support for depression, anxiety, substance abuse, stress, and medical psychiatric conditions	Fee-for-service plus enhanced reimbursement	Aetna provides enhanced reimbursements directly to behavioral health providers for the first three patient sessions administered in the primary care setting.
3. Washington State Mental Health Integration Program (MHIP)	Administered by the Community Health Plan of Washington with funding from the State of Washington; provides integrated medical and mental health services in the primary care setting across over 100 community health clinics and 30 community mental health centers statewide	Pay-for-performance	Integrated services are provided by a team comprised of a primary care practitioner, a care coordinator, and a consulting psychiatrist. Each care coordinator receives weekly caseload consultation with a psychiatrist to review cases and develop a recommended treatment plan.
4. Depression Improvement Across Minnesota Offering a New Direction (DIAMOND)	Collaboration between six non-profit health plans, the Minnesota Department of Human Resources, and the Institute for Clinical Systems Improvement across multiple practice sites to evaluate primary care practice redesign through the application of a flat, monthly payment for integrated behavioral health care	Flat monthly rate for bundled set of services	Each certified practice is required to have a dedicated care manager onsite. In a practice of 12 to 15 physicians, each care manager's caseload is approximately 80 to 120 patients. Fifteen psychiatrists have contracts with the participating medical groups to provide weekly consulting services to the care managers.
5. Sustaining Healthcare Across Integrated Primary Care Efforts (SHAPE)	Three-year study conducted by the Collaborative Family Healthcare Association, Rocky Mountain Health Plans, UC Denver Department of Family Medicine, and the Colorado Health Foundation piloting six integrated care model primary care practices to examine the effect of global payments	Risk-adjusted prospective global payments with quality incentive threshold	Practice dependent; primary care providers may partner with behavioral health organizations in the community or contract directly with behavioral health providers to offer co-located care.

Source: Population Health Advisor interviews and analysis.

Key Insights on Securing Reimbursement for Integrated Behavioral Health

Insight #1

Clarify reimbursement practices across payer network to optimize billing policies

- Prepare for managing complex billing processes across public and private payers; support practice by providing tools that outline reimbursement requirements for licensing/credentialing, pre-authorization, and coding policies across various payer contracts
- Form or participate in a multi-stakeholder learning collaborative to encourage joint problem solving for shared challenges and disseminate best practices across integrated primary care network

Insight #2

Determine baseline reimbursement targets to achieve “breakeven” point

- In determining budget allocations, include consideration of service revenues, deductions for non-billable services, and operating expenses (staffing, infrastructure, management and supervision) to model anticipated program cost/savings
- Consider importance of dedicated administrative staff support, especially in initial years of development

Insight #3

Discuss with commercial payers opportunities for support beyond direct FFS reimbursement

- In discussions with commercial insurers, address alternate payment mechanisms like global payments, pay-for-performance, or enhanced care coordination fees to more closely align incentive structure with practice outcomes
- Collaborate with payers on additional support services they may be able to provide; for example, depression screening tools, staff/patient/employer education materials, etc.

Insight #4

Assess downstream cost-savings to demonstrate long-term value of integrated model

- In ongoing performance monitoring, incorporate impact of cost-savings attributable to potential medication cost reductions, avoidable admissions, and avoidable ED utilization

Source: Population Health Advisor interviews and analysis.

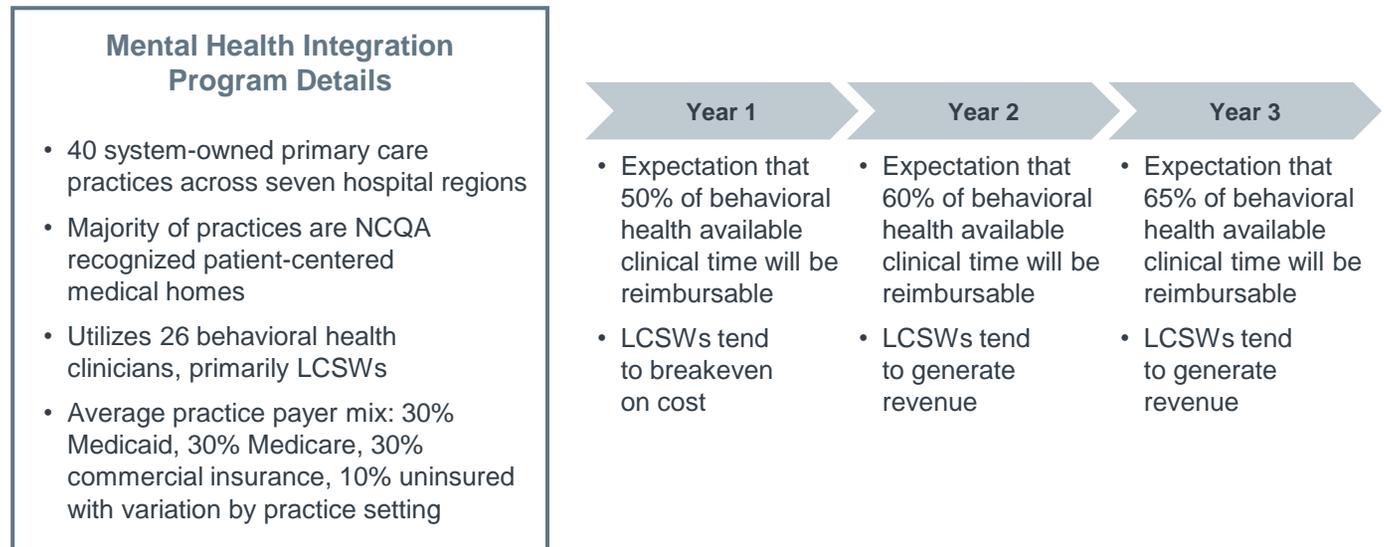
Maine Behavioral Healthcare Clarifies Billing Protocols and Performance Targets

When it first launched in 2006, Maine Behavioral Healthcare's (MBH) Mental Health Integration program relied on grant funding as well as support from MaineHealth to pilot the integrated model across 20 primary care practices. Starting in 2011, MBH has brought this pilot to scale across 40 primary care sites in seven different hospital regions, and established a three year transition plan to achieve gradual sustainability.

The hospital systems within MaineHealth, the parent organization of MBH, fund the "Mental Health Integration Program" by paying for behavioral health staff salary plus a management fee that supports the program's administrative costs.

The health system goal is that participating primary care practices will achieve breakeven targets through reimbursable services.

Overview of Maine Behavioral Healthcare



Case in Brief: Maine Behavioral Healthcare (MBH)

- Maine Behavioral Healthcare is an integrated network of mental health providers and a subsidiary of MaineHealth, a not-for profit six-hospital health system based in Portland, Maine
- In 2006, MBH received a grant to work with 20 primary care practices and their local mental health agencies to support integrated behavioral health services
- In 2011, MBH began its transition toward a self-sustaining model, expanding to 40 hospital-owned practices across MaineHealth's hospital regions

Source: Population Health Advisor interviews and analysis.

Learning Collaborative Facilitates Operations and Best Practice Sharing

In addition to setting performance expectations across the primary care network, MBH staff meet with each of the participating practices to guide information sharing and operations development for the integrated model. MBH staff have used learning collaboratives as well as monthly clinical and operational meetings in each hospital region to determine best practices and share tactics for addressing common challenges across providers.

Through these meetings, MBH has found that behavioral health clinicians benefit from working at least 20 hours per week with a minimum of 3 days co-located within each designated practice. Practices also report that consistent co-location helps generate higher patient referral volumes by encouraging good relationships between behavioral health specialists, primary care physicians, and their care teams.

MBH also offers resources on proper coding protocols to participating providers to facilitate effective billing practices. For example, the MBH Reimbursement Grid identifies which payers cover each of the possible billing codes for integrated behavioral health services.

MBH Reimbursement Grid

Funding, Licensing and Regulation Grid														
Information for the State of Maine - Updated October 2013														
Commercial and State Funders		MaineCare (Maine Medicaid)				Commercial				Commercial and State Funders				
E&M		Health & Behavior				Health & Behavior				Psychiatric Services - Commercial or MaineCare				
										MaineCare Section 65- (Transition codes into H codes)				
95201-95205	New Pt	MD/MP/PA	96150	Assessment	LCSW/LCPC/PHD	96150	Assessment	LCSW/LCPC/PHD	90791	Initial Psych Assess	LCSW, LCPC, LMFT/PhD	90791	Initial Psych Assess	LCSW, LCPC, PHD
95212-95215	Established Pt	MD/MP/PA	96151	Re-assessment	LCSW/LCPC/PHD	96151	Re-assessment	LCSW/LCPC/PHD	90791	Initial Psych Assess	LCSW, LCPC, LMFT/PhD	90791	Initial Psych Assess	LCSW, LCPC, PHD
90933, 90936, 90938	Add-on Psychotherapy codes	MD/MP/PA	96152	Ind Intervention	LCSW/LCPC/PHD	96152	Ind Intervention	LCSW/LCPC/PHD	90822, 90834, 90837	Psychotherapy with or without Pt	LCSW, LCPC, LMFT/PhD	90832, 90834, 90837	Psychotherapy Tx with or without Initial Psych Assess	LCSW, LCPC, PHD
30792	Initial Psych Assessment	MD/MP/PA	96153	Grp Intervention	LCSW/LCPC/PHD	96153	Grp Intervention	LCSW/LCPC/PHD	90846-90847	Initial Psych Assess	LCSW, LCPC, LMFT/PhD	90846-90847	Tx with or without Initial Psych Assess	MD/MP/PA, Psych MD, NP, PA
98371-98373	Phone Consults	MD/MP/PA, Medicaid only, Mass	96154	Family Interv	LCSW/LCPC/PHD	96154	Family Interv	LCSW/LCPC/PHD	90792	Initial Psych Assess	LCSW, LCPC, LMFT/PhD	90792	Initial Psych Assess	Psych MD, NP, PA
95242	Admin and Interpretation of Health Risk Assessment Instrument	MD/MP/PA												
95443	Telephone eval and management service	MD/MP/PA												
	Hospital License													
	Private MH Practice License													
	Primary Care Office - Physician Practice													
	Initial Health Clinic													
	FGHC													
	FGHC Look-alike													

Regular Clinical and Operational Meetings Tackle Shared Challenges

“As we grow, it is helpful to have the meetings... A lot of times our role in those meetings is just to facilitate getting the good information from one provider to the other. If you're going to have a quick growing program, those regional meetings are the way to do it.”

Mary Jean Mork, LCSW
Program Director
Maine Behavioral Healthcare

An electronic version of the MBH reimbursement “Funding, Licensing and Regulation Grid” is available upon request.

See Appendix for additional information.

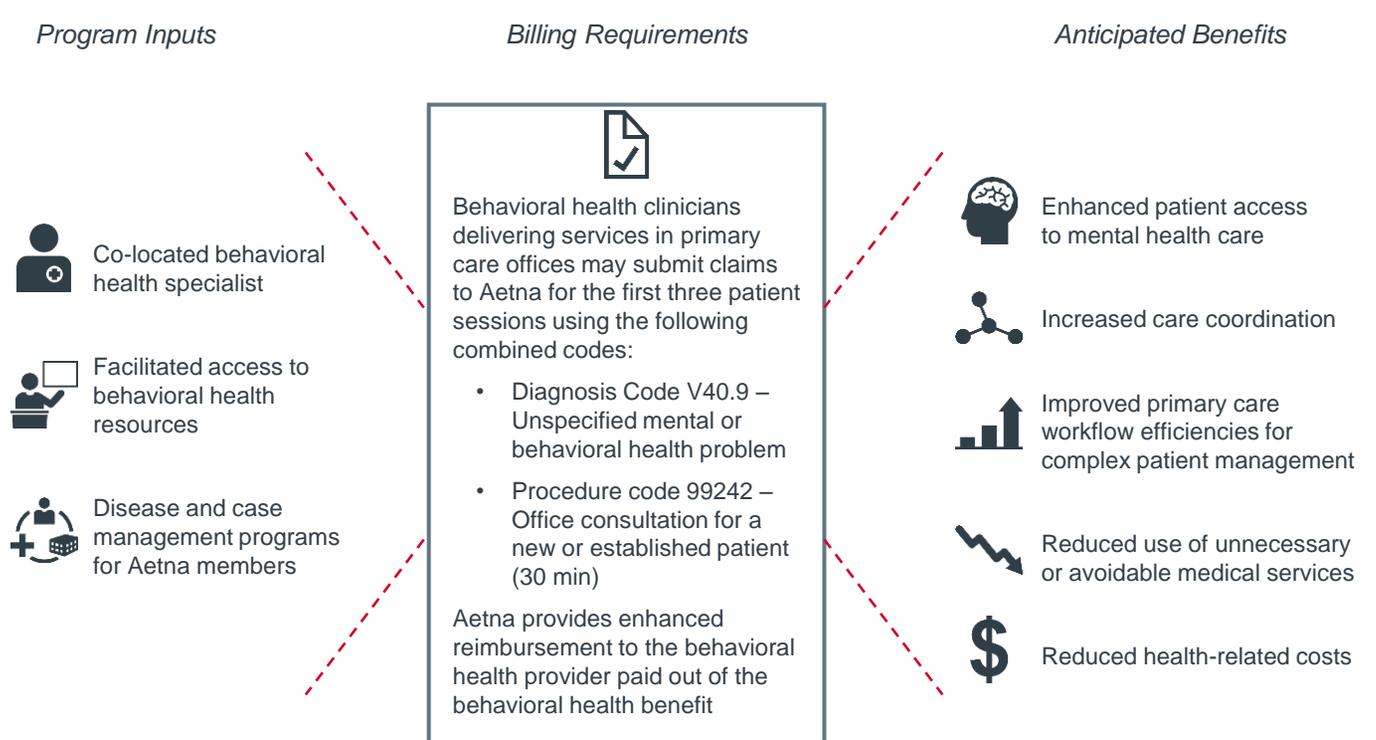
1) Reproduced with permission from author.

Sources: Mork, MJ, “Reimbursement Tracking Sheet: Mental Health Integration” (Oct 2011), accessed July 10, 2014, available at: <http://bh.org/uploads/file/ReimbursementTrackingSheet-blank.pdf>; Population Health Advisor interviews and analysis.

Aetna Model Provides Enhanced Reimbursement for Integrated Care

After launching a successful pilot across seven family care practices in 2010, Aetna, a national health insurance provider, has continued to support the integrated behavioral health model under a fee-for-service payment structure. Participating behavioral health specialists bill Aetna directly for services rendered within the primary care setting under a combined diagnosis and procedure code (V40.9 & 99242, respectively). This combined code offers a higher reimbursement rate for behavioral health services performed in the primary care setting compared to the fees behavioral health specialists would otherwise receive for care administered within their own practice.

The behavioral health providers may be reimbursed for a maximum of three sessions per patient, after which patients requiring ongoing support are referred to external specialists. To support participating primary care practices, Aetna provides standardized and validated screening tools, reimbursement and change assistance, and facilitated discussions/matching with regional behavioral health consultants. The primary care practices are responsible for covering program start-up costs including program leadership, training, and operational workflow changes.



 **Case in Brief: Aetna¹ Integrated Primary Care Behavioral Health Program**

- National health insurance provider covering nearly 18 million medical members with commercial, Medicare, and Medicaid products
- The Integrated Primary Care Behavioral Health program includes co-location of a behavioral health clinician to address behavioral health/wellness, facilitated access to behavioral health services, and disease and case management programs for Aetna members
- Program provides enhanced reimbursement fees to behavioral health providers for services administered in the primary care setting

1) Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies (Aetna).

Sources: Population Health Advisor interviews and analysis.

Aetna Considers Operational, Cultural Criteria in Identifying Practice Sites

Practices participating in Aetna Integrated Primary Care Behavioral Health Program tend to achieve the best results when they satisfy a specific set of operational and cultural characteristics.

First, members of the primary care team must demonstrate engagement in the integrated behavioral health model. In general, practices benefit from the inclusion of two program champions representing both primary care and behavioral health.

Second, the primary care practice needs to be large enough to sustain a sufficient volume of Aetna referrals to a behavioral health provider, as well as the infrastructure to absorb the start-up costs. The practice must also have access to psychiatric support for patients in crisis. Finally, the practice must have a plan to accommodate reimbursement from other payers to ensure sustainability over time.

Operational Criteria



Practice Size

- High patient volumes and demonstrated need for integrated behavioral health services
- High prevalence of Aetna members in patient population
- Ability to fund start-up costs (e.g., training, leadership support, dedicated space)



Advanced Psychiatric Support

- Reliable access to external behavioral health resources and specialist services to accommodate patients in crisis



Multi-Payer Reimbursement Plan

- Formal assessment of practice costs and business case for offering integrated behavioral health services
- Plans for sustaining integrated behavioral health services for non-Aetna patients

Cultural Criteria



Care Team Awareness and Interest

- Understanding of integrated behavioral health model among clinical and administrative staff
- Training on how to manage information sharing processes between physical and behavioral health providers (e.g., privacy protections, scheduling considerations)



Engagement of Program Champions

- Commitment from at least one medical and one behavioral health leader to oversee on-the-ground implementation
- Dedicated/protected time for program champions to organize and manage integrated workflows, quality improvement processes

Source: Population Health Advisor interviews and analysis.

MHIP Builds Extensive Community Network with University Faculty Support

The Washington State Mental Health Integration Program (MHIP) provides medical and integrated behavioral health services for safety-net patients at over 100 community health clinics and 30 community mental health centers in the Seattle-Tacoma area.

MHIP uses a collaborative care model in which the primary care provider, a care coordinator, and a consulting psychiatrist or behavioral health specialist are assigned to each of the primary care-based teams. Care coordinators and the consulting psychiatrist meet weekly to review cases and develop joint treatment plans. Patients requiring more intensive services are referred to a partnering community mental health center for additional treatment.

The MHIP program also receives informational and technical assistance from University of Washington's Advancing Integrated Mental Health Solutions (AIMS) Center. Expert faculty from the AIMS Center provide a web-based tracking system to support ongoing performance monitoring and quality improvement. Additionally, the AIMS Center hosts in-person training workshops for care coordinators and monthly webinars.

Select Resources from the AIMS Center Implementation Guide



IMAGE CREDIT: AIMS CENTER, UNIVERSITY OF WASHINGTON

Organizational Readiness Worksheet

- Checklist for self-assessment of an organization's adherence to seven core components of the integrated behavioral health model: 1) Patient identification; 2) care team engagement, 3) evidence-based treatment; 4) systematic follow-up and treatment adjustment; 5) communication and care coordination; 6) systematic psychiatric case review; and, 7) program oversight and quality improvement

Team Building Tool

- Breaks down team-building process into five steps and provides a team member self assessment, a task summary by team member, and a change plan summary to support an effective shared workflow for primary care and behavioral health staff

Care Team Training Module

- Webinar training by expert faculty from the University of Washington on key components of the collaborative care model including the use of behavioral health measures, patient engagement tactics, care management processes, tracking and monitoring, and relapse prevention



Case in Brief: Washington State Mental Health Integration Program

- Integrated behavioral health program launched in 2007 across 29 community health clinics, and expanded in 2010 to over 100 community health clinics and 30 community health centers statewide
- Funding provided by the State of Washington; program administration supported by Public Health-Seattle & King County and the Community Health Plan of Washington (CHPW), a non-profit managed care plan
- Eligible patients include low-income adults covered by the State of Washington's Disability Lifeline Program, veterans and their families, the uninsured, low-income mothers and their children, and low-income older adults

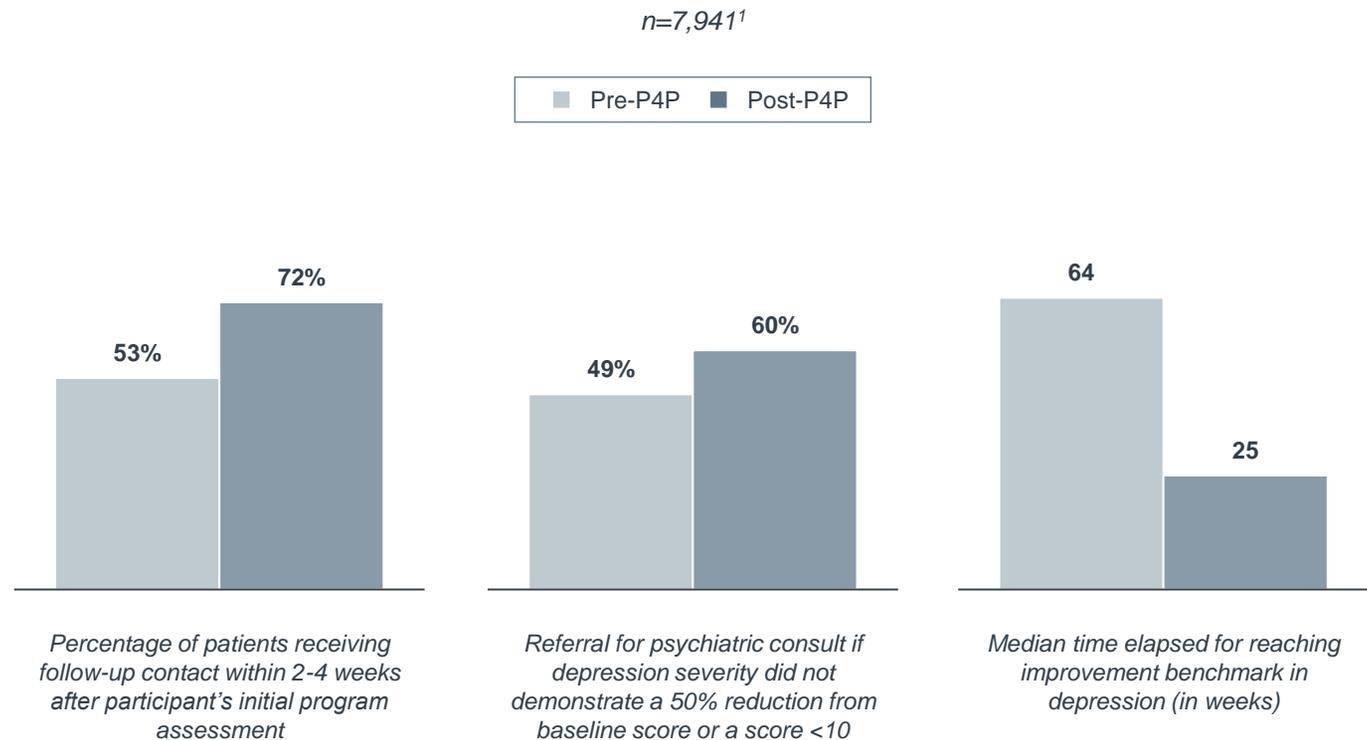
Sources: Unützer J et al. "Quality Improvement with Pay-for-Performance Incentives in Integrated Behavioral Health Care," *Am J Public Health*, April 2012:e1-e5.; AIMS Center, "Integrated Behavioral Health Team Building Process," accessed July 14, 2014, available at: <http://uaimhs.org/tools/index.html>; Population Health Advisor interviews and analysis.

Pay-for-Performance Thresholds Promote Adherence to Quality Indicators

To address substantial variation in quality and outcomes across participating clinics, MHIP program sponsors instituted a pay-for-performance (P4P) incentive effective January 1, 2009. In the P4P model, program sponsors tied 25% of the annual program funding to process metrics and quality indicators, including timely patient follow-up, referrals to psychiatric consultation for appropriate patients, and medication tracking. Participating providers monitored these quality indicators through the AIMS web-based clinical tracking system.

In comparing patients participating in MHIP after the introduction of P4P incentives in 2009 relative to patients participating in the model prior to the performance incentives, program sponsors found that patients in the P4P model were 1.73 times more likely to achieve either a 50% or greater reduction in reported symptom severity from baseline or a PHQ-9 score less than 10. These results indicate that tracking and making payments contingent on quality indicators may significantly improve the effectiveness of integrated behavioral health care.

Impact of P4P Model on MHIP Performance Outcomes



1) Sample size: n=1,637 (pre-P4P); n=6,304 (post-P4P).

Sources: Unützer J et al. "Quality Improvement with Pay-for-Performance Incentives in Integrated Behavioral Health Care." *Am J Public Health*, April 2012:e1-e5; Population Health Advisor interviews and analysis.

Behavioral Health, Care Management Reimbursed Under Single Billing Code

The Institute for Clinical Systems Improvement (ICSI) created the “Depression Improvement Across Minnesota Offering a New Direction” (DIAMOND) program to explore reimbursement redesign for integrated behavioral health across a broad group of collaborating stakeholders.

Under the DIAMOND model, participating practices receive a flat monthly rate for bundled integrated behavioral health services. ICSI staff work directly with participating practices to assist with training, workflow planning processes, and DIAMOND certification. As part of this process, ICSI assesses organizational readiness and, for eligible practices, offers a learning collaborative series of in-person meetings, conference calls, and care manager training.

DIAMOND-certified practices use a standardized care delivery model to provide a core bundle of services. These practices then apply a single billing code to receive a flat monthly fee for each patient enrolled in the program. This code covers initial and follow-up contact by the care manager, weekly consultations, and psychiatrist case reviews for up to 12 months. Each health plan independently negotiates payment to participating practices in compliance with antitrust laws.

DIAMOND Bundled Behavioral Health Services



Patient Assessment with Validated Instrument



Dedicated Care Manager



Evidence-Based, Stepped Treatment



Patient Registry to Track Progress



Psychiatric Consultation, Caseload Review



PCP Approval to Implement Psychiatrist Recommendations



Relapse Prevention Planning



Referral to More Intensive Services



Case in Brief: Institute for Clinical System’s Improvement and DIAMOND

- Institute for Clinical Systems Improvement (ICSI) is a non-profit organization that conducts best practice research for over 50 member medical groups and hospitals concentrated in the Minnesota area
- As of February 2013, ICSI’s DIAMOND program has been implemented across 68 primary care clinics and served over 9,700 patients

Sources: AHRQ, “Initiative features fixed monthly payments to primary care clinics for providing depression care bundle, allowing many patients to achieve good outcomes,” February 2014, accessed July 14, 2014, available at: <http://www.innovations.ahrq.gov/content.aspx?id=3838#3>; Population Health Advisor interviews and analysis.

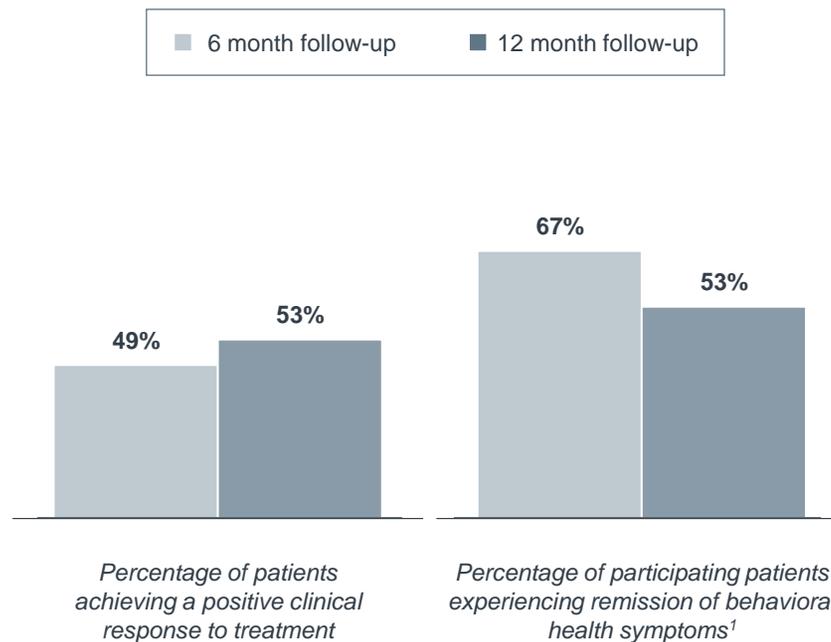
Single Practice Budget Strengthens Care Processes, Improves Patient Outcomes

As part of the DIAMOND program, certified clinics submit performance data on various process and outcome measures to ICSI on a monthly basis. Data sets are shared among participating providers to promote transparency and identify best practices. Since its initial launch in 2008, the DIAMOND program has demonstrated successful treatment responses and high levels of provider satisfaction.

DIAMOND-certified practices report positive clinical responses from their patients and elevated remission rates. Primary care physicians also report improvements in clinic culture, enhanced care continuity and coordination, and stronger linkages with external behavioral health providers.

Following the program's early successes, the program model has been spread to numerous health care organizations across Minnesota, Michigan, and Hawaii. In 2012, ICSI and nine other medical groups received a CMS Innovation Award to apply a similar integrated model in eight states to improve depression services for patients with comorbid conditions, including diabetes and heart disease.

Impact of DIAMOND Program on Patient Clinical Outcomes



1) Not including patients who also achieved clinical remission.

DIAMOND Planning and Development Process

- ❑ Formed a steering committee including representatives from physician groups, health plans, state health agencies, and the patient community
- ❑ Conducted literature review of existing collaborative care models and incorporated evidence-based best practices
- ❑ Recruited health care plans with high market penetration among targeted primary care practices
- ❑ Designed reimbursement model that addresses anticipated patient demand, start-up costs, and health plan liability
- ❑ Phased project in five waves over a 2.5-year period, with new set of clinics receiving certification every 6 months
- ❑ Currently expanding model across new practice sites with additional focus on high cost comorbidities

Sources: AHRQ, "Initiative features fixed monthly payments to primary care clinics for providing depression care bundle, allowing many patients to achieve good outcomes," February 2014, accessed July 14, 2014, available at: <http://www.innovations.ahrq.gov/content.aspx?id=3838#3>; Population Health Advisor interviews and analysis.

SHAPE Supports Integrated Care Through Global Payments

Sustaining Integrated Healthcare Across Primary Care Efforts (SHAPE) is a three-year collaborative initiative evaluating the application of a global budget model for integrated behavioral health. The aims of the study are: 1) to determine if global payment methods can sustainably support the integrated behavioral health model; 2) to assess the clinical and financial impact of different payment models; and, 3) to inform policy through the real-world application of a global payment methodology.

At present, the global payments are applied exclusively to integrated behavioral health services, although payers have expressed interest in encompassing all primary care services in future iterations.

SHAPE's global budget allocates payments based on each practice's cost, panel size, panel complexity, and program design. Additionally, the model introduces shared risk through quality targets, as well as incentive opportunities for quality improvement for certain patient health outcomes.

In short, the SHAPE program uniquely applies a risk-adjusted, non-volume, non-encounter based payment model to support comprehensive, patient-centered primary care.

Considerations in Global Payment Designations



Cost

Behavioral health providers are compensated directly by the practice based on the clinical and population health interventions performed

Panel Size

Larger practices serving a higher volume of patients may require additional services and patient support systems



Panel Complexity

Payments are "risk-adjusted" to accommodate the needs of patients with complex conditions and circumstances

Program Design

Payments are contingent on practice adherence to evidence-based standards and ongoing quality improvement



Case in Brief: Sustaining Integrated Healthcare Across Primary Care Efforts (SHAPE)

- Three-year pilot program across six sites in Western Colorado examining the application of global payments as sustainable financial structure for integrated behavioral health services
- Developed in 2012 as a collaboration between Rocky Mountain Health Plans (RMHP), UC Denver Department of Family Medicine, the Colorado Health Foundation, and the Collaborative Family Healthcare Association
- Actuarial modeling will be used to evaluate the program's financial and clinical impact for patients, providers, and the community

Sources: "SHAPE Policy Brief," accessed July 8, 2014, available at: <http://sustainingintegratedcare.net/wp-content/uploads/2013/04/SHAPE-policy-brief.pdf>; Population Health Advisor interviews and analysis.

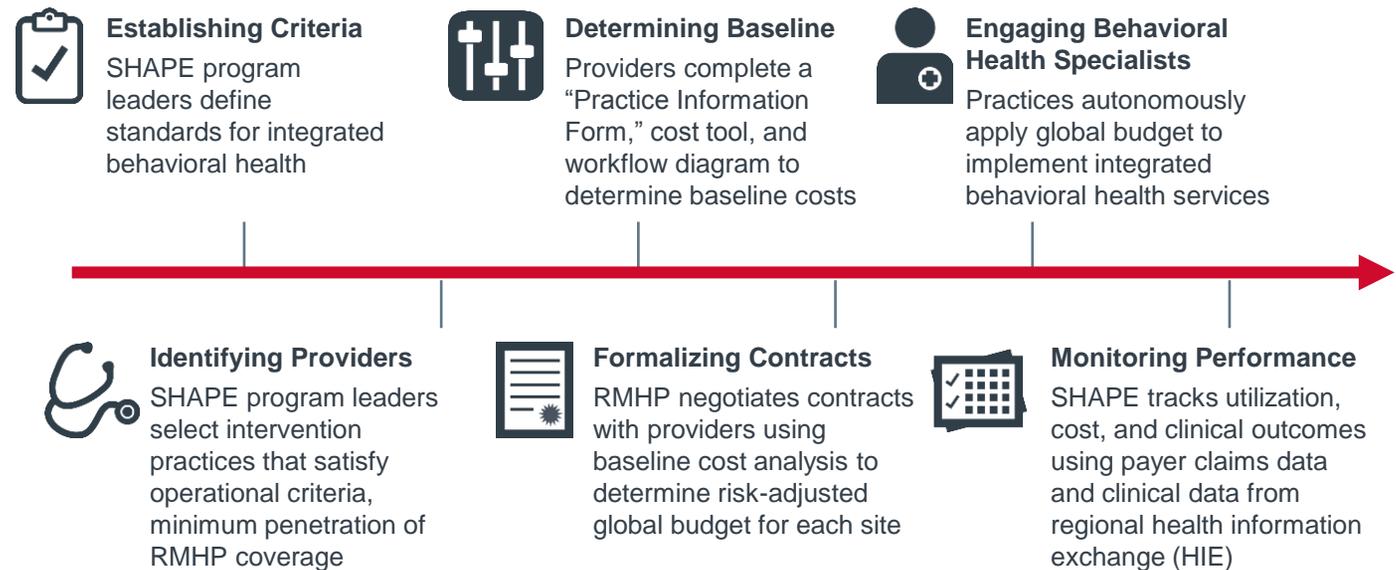
Program Assesses Operational Costs, but Practices Function Autonomously

SHAPE is currently in place at six integrated behavioral health practice sites. Three practices serve as the intervention group receiving the new global payments, and the remaining three practices serve as the control group, operating under existing payment structures. SHAPE program managers selected the intervention practices based on their adoption of the integrated behavioral model, as well as a high prevalence of RMHP patients.

Participating primary care practices have autonomy to determine their own staffing model, resource allocation, and quality/cost improvement processes. However, in the initial stages, SHAPE staff provided technical assistance to help clarify best practices for integrated behavioral health. Resources included workflow tools and metrics to facilitate tracking capabilities.

To enhance access and eliminate potential complications resulting from payer-specific interventions, integrated behavioral health services are offered to appropriate patients, regardless of their payer status. The SHAPE project is consistent with RMHP's Medicaid pilot under the state's Accountable Care Collaborative, enabling RMHPs to incorporate both public and private plans into their global budgeting process.

Overview of Major Program Milestones and Process Steps



Sources: Gaipa M, Pathy V & Edie S, "Paying for Integrated Primary Care and Behavioral Health" CIVHC (Sept 2013), available at: http://civhc.org/getmedia/df4707ef-3a8a-41d9-9418-cf6686db23db/Paying-for-Integrated-Primary-Care-and-Behavioral-Health_9.2013.aspx; Population Health Advisor interviews and analysis.



Appendix

- SAMHSA's "Business Case for Behavioral Health Pro Forma Model"
- Maine Behavioral Healthcare's "Funding, Licensing and Regulation Grid"

SAMHSA's Business Case for Behavioral Health Pro Forma Model

Core Assumptions			
Panel size	1500	Average Visit Scheduled Time	15 minutes
Encounters	4200	Estimated time saved by diverting to a behaviorist	11 minutes
Payer Mix	Medicaid	40%	Average visits per hour
	Medicare	12%	3
	Commercial	8%	Transition training time
	Sliding fee scale	40%	16 hours
Average Reimbursement per visit	\$135	SBIRT screenings that triage for intervention	16%
Medicare SBIRT Reimbursement		Projected proportion that could be diverted to behaviorist	50%
G0396	\$29.62	Slots created as a result of integration model	246.4
G0397	\$57.69	Estimated Medicare SBIRT Screens	504
Medicaid SBIRT Reimbursement		Estimated Medicaid SBIRT Screens	1680
H0049	\$24.00	Estimated Medicare Screen & Intervention	80.64
H0050	\$48.00	Estimated Medicaid Screen & Intervention	268.8
Provider Costs			
Provider Hourly Rate	\$72.00		
RN Hourly Rate	\$27.60		
MA Hourly Rate	\$15.60		
Behaviorist Hourly Rate	\$39.06	(Total Salary = \$81,250; Base Salary = \$65,000; Hours worked /year = 2,080; Benefits = 25%)	
Costs		Salary Resource	Lost Revenue
Screening		\$ 40,625.00	
Intervention		\$ 1,843.20	\$6,480 (16 hours)
Transition Costs			Subtotal
			\$48,948.20
Revenue			
Screening Reimbursement		\$ 55,248.48	\$55,248.48
Gains in Productivity		\$33,264.00	\$33,264
Reimbursement for Screen and Treatment		\$ 8,714.76	\$8,714.76
			Subtotal
			\$97,227.24
Net Business Case			\$ 48,279.04

Source: Substance Abuse and Mental Health Services Administration, available at: [©2014 The Advisory Board Company](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CB0QFjAA&url=http%3A%2F%2Fwww.integration.samhsa.gov%2FBusiness_Case_for_BH_Integration.xlsx&ei=kg3pU4m2E9P8yQSKoYHQQAQ&usq=AFQjCNHnIroTCZqik55RN80QirZIaEcmxQ&sig2=swfHArV65CJumEo3bOb2ig&bvm=bv.72676100,d.aWw; Population Health Advisor interviews and analysis.</p>
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Maine Behavioral Healthcare’s “Funding, Licensing and Regulation Grid”

Commercial and State Funders			MaineCare (Maine Medicaid)			Commercial			Commercial and State Funders					
E&M			Health & Behavior			Health & Behavior			Psychiatric Services - Commercial or MaineCare					
									MaineCare Section 65- (Translate codes into H codes)		Commercial or MaineCare Section 90 or Section 45			
99201-99205	New Pt	MD/NP/PA	96150	Assessment	LCSW/LCPC/PhD	96150	Assessment	LCSW/LCPC/PhD		Initial Psych Assess	/LCSW, LCPC, LMFT/PhD	90791	Initial Psych Assess	LCSW, LCPC, PhD,
99212-99215	Established Pt	MD/NP/PA	96151	Re-assessment	LCSW/LCPC/PhD	96151	Re-assessment	LCSW/LCPC/PhD	90832, 90834, 90837	Psychotherapy	Psych MD /LCSW, LCPC, LMFT/PhD	90832, 90834, 90837	Psychotherapy	LCSW, LCPC, PhD,
90833, 90836, 90838 +	Add-on Psychotherapy codes	MD/NP/PA	96152	Ind Intervention	LCSW/LCPC/PhD	96152	Ind Intervention	LCSW/LCPC/PhD	90846-90847	Family Tx with or without Pt	/LCSW, LCPC, LMFT/PhD	90846-90847	Family Tx with or without Pt	MD/NP/PA
90792	Initial Psych Assessment	MD/NP/PA	96153	Grp Intervention	LCSW/LCPC/PhD	96153	Grp Intervention	LCSW/LCPC/PhD	90792	Initial Psych Assess	Psych MD, NP, PA	90792	Initial Psych Assess	Psych MD, NP, PA
			96154	Family Intervention	LCSW/LCPC/PhD	96154	Family Intervention	LCSW/LCPC/PhD						
99371-99373	Phone Consults	Minn - Physician, Medicaid only. Mass for children												
99242	Admin and Interpretation of Health Risk Assessment Instrument	Aetna - in Physician practice												
99443	Telephone eval and management service	Aetna - in Physician practice and for Psychiatry												
Hospital License						Hospital License			Mental Health License		Private MH Practice License			
						Private MH Practice License			Private MH Practice License		Primary Care Office - Physician Practice			
Primary Care Office - Physician Practice						Primary Care Office - Physician Practice								
Rural Health Clinic			Rural Health Clinic			Rural Health Clinic			**Rural Health Clinic		**Rural Health Clinic			
FQHC			FQHC			FQHC			**FQHC		**FQHC			
FQHC Look-alike			FQHC Look-alike			FQHC Look-alike			**FQHC Look-alike		**FQHC Look-alike			

 For an electronic version of the MBH reimbursement “Funding, Licensing and Regulation Grid” please contact your Dedicated Advisor.

1) Section 90 allows for reimbursement for LCPC's, LMSW's and LCSW's
 2) **FQHC's and RHC's bill under Section 31 and Section 103, respectively, in MaineCare, not 65 or 90.
 3) This document represents the best information we have at the time and continues to evolve as coding changes and becomes clearer. Always consult with your organization's billing/coding experts.
 4) Developed by Mary Jean Mork, Neil Kosen, Girard Robinson and MaineHealth Funding and Licensing workgroup - based on information available. Contact morkm@mmc.org

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