NH Behavioral Health Integration Learning Collaborative

Webinar Integrating SUD Screening & Treatment:
A Collaborative Care Approach to Practice and Payment

January 10th 2018
12:00 pm – 1:00 pm
Agenda

- Welcome
- Data Driven Action: Substance Use Disorder Screening – Hwasun Garin
- NH Roadmap for Medicaid Payment Development – Lucy Hodder, JD
- Building Sustainable Behavioral Health Integration – Anna Ratzliff, MD, PhD
- Next Steps
Data in Action

HWASUN GARIN

CITIZENS HEALTH INITIATIVE
Plan – Do – STUDY – Act

Studying our ACTION

New measures:

• Depression Screening + Follow-Up Alignment with NQF 0418

• SUD Screening + Follow-Up Based on NQF 0418, with guidance and review by Accountable Care Learning Network Clinical Committee
PTN: Adult Depression Screening & Follow Up

Based on NQF 0418

PERCENT OF PATIENTS WHO RECEIVED FOLLOW UP IF POSITIVE FOR DEPRESSION

AF = 17.1%

Median = 10.0%

YEAR-QUARTER

PTN: Adolescent Depression Screening & Follow Up

Based on NQF 0418

PERCENT OF PATIENTS WHO RECEIVED FOLLOW UP IF POSITIVE FOR DEPRESSION

YEAR-QUARTER


2017 Q3 Median = 8.6%

AS = 2.9%

PTN: Adolescent Depression Screening & Follow Up

Based on NQF 0418
MEDICAID APM ROADMAP
JANUARY 10, 2018

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Professor, UNH School of Law
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Jo Porter
Director IHPP
Jo.Porter@unh.edu
Pathway to alternative payments
State Medicaid Roadmap
.... 2018
“This initiative will provide a short term federal investment, such that by the end of the demonstration the behavioral health infrastructure will be supported through the state's managed care delivery system using alternative payment methodologies, without the need for demonstration authority.” January 5, 2016 Letter of Approval from Andy Slavitt, Acting Administrator, CMS for NH’s DSRIP waiver.

“The Medicaid service delivery plan should address what approaches service delivery providers will use to reimburse providers to encourage practices consistent with IDN objectives and metrics, including how the state will plan and implement a goal of 50 percent of Medicaid provider payments to providers using Alternative Payment Methodologies.” STC 33
Roadmap: APM Strategy

• Leverages APM strategies used across all payers.

• Supports new innovative strategies that meet IDN metrics/measures and impact the behavioral health needs and infrastructure of the state.

• Relies on a population health framework for APMs (HCP-LAN).

• Plans for APMs that encourage providers to care for high need beneficiaries by achieving metrics and measures that ensure good care through sustainable payment models in the best interest of beneficiaries and Medicaid program.

• Establishes a goal of moving at least 50% of Medicaid payments to APMs by 2020 and relying on stakeholder engagement to inform the process.

• IDN experience will help shape which APMs are implemented, and the related financial and operational components of the selected APMs.
APM Models can include:

- Primary Care Incentive Models:
  - Integrated behavioral health
  - Chronic and high need patient care, management and coordination
- Integrated behavioral health models across the spectrum of behavioral health needs
- Acute and chronic bundled rates
- Global capitation arrangements/accountable care for entire populations or special needs
- Network incentive pool methods based on regional DSRIP measures/successes
Learning and Action Network (LAN): Alternative Payment Model Framework

**Category 1**
Fee for Service – No Link to Quality & Value

**Category 2**
Fee for Service – Link to Quality & Value

**Category 3**
APMs Built on Fee-for-Service Architecture

**Category 4**
Population-Based Payment

- **A** Foundational Payments for Infrastructure & Operations
- **B** Pay for Reporting
- **C** Rewards for Performance
- **D** Rewards and Penalties for Performance
- **A** APMs with Upside Gainsharing
- **B** APMs with Upside Gainsharing/Downside Risk
- **A** Condition-Specific Population-Based Payment
- **B** Comprehensive Population-Based Payment

Process

• The state is meeting with managed care plans to review current APM models that support the state’s population health goals.

• The state is seeking input from stakeholders to develop payment methods that can help support the state’s behavioral health infrastructure needs consistent with the IDN metrics and supporting the DSRIP goals of:
  • improved behavioral health integration,
  • care coordination transitions and
  • prevention, treatment and recovery.

• APM strategies will be flexible in order to reflect the multi-year goals of the reform plan.
NH Timeline

• **1115 DSRIP Waiver goal**: 50% Medicaid provider payments in contractual APMs by 2020

• **MCO Contracts**: Planned DHHS re-procurement of MCO contracts for 1/1/19 for 7/1/19 “go live”

• **NH Political Questions**:
  • Medicaid expansion reauthorization?
  • Continuation of Premium Assistance Program?

• **Meanwhile**: Medicare and commercials continue on towards payment reform
Medicaid Provider Payments, by MCO, FFS, and Other: FY2016

Distribution of Provider Payments, MCO and FFS
(TOTAL: $465.5M)

Source: Base data from Milliman’s SFY2018 Capitation Rate Development for Medicaid Care Management Program
Provider Payments by Service Category, FY2016

PAYMENTS BY SERVICE CATEGORY, FY 2016

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Center</td>
<td>16%</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>25%</td>
</tr>
<tr>
<td>Professional/Other State Plan</td>
<td>31%</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>17%</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>12%</td>
</tr>
</tbody>
</table>

Source: Base data from Milliman’s *SFY2018 Capitation Rate Development for Medicaid Care Management Program*
What Does this Mean for Providers?

• Providers have a voice in APM model options
  • What flexibility do you need to better serve your patient population?
  • What are your key infrastructure needs?
  • How will you show a return on investment?
  • Where will the money come from?
  • Who are your key partners?
• APMs that succeed will be those that build on models that work
• For more information on the approved Roadmap, see DSRIP Alternative Payment Models Roadmap for Year 2 and Year 3 (CY 2018)
Building Sustainable Behavioral Health Integration

Anna Ratzliff, MD, PhD
Associate Professor
University of Washington
TCPI National Faculty
Disclosures:

• Anna Ratzliff, MD, PhD
  – **Grant/Research Support**: Supported from contracts and grants to the AIMS Center at the University of Washington including support from Washington State and CMMI.
  – **Allergan**: Spouse employed in last 12 months
  – **Royalties**: Wiley - *Integrated Care: Integrated Care: Creating Effective Mental and Primary Health Care Teams* (Paid to UW Department of Psychiatry and Behavioral Sciences)
Polling Question

What is your top priority in creating an integrated behavioral health program in your organization? Pick ONE top priority.

• Quality of Care – 3 Responses
  – Patients consistently receive appropriate effective treatment; both brief behavioral intervention and supported medication management are available, population-level impact

• Care Coordination Capacity: Critical to patient-centered care efforts; PCMH accreditation; relevance to chronic care and transitional care services, increasing skills for team-based care

• Patient Experience – 2 Responses
  – Improved satisfaction, improved access, decreased stigma, improved communication between multiple providers

• Patient Outcomes – 2 Responses
  – Improved quality process measures, improved quality of life, improved return to work (absenteeism), decreased impact on productivity (presenteeism)

• Mental Health Care Access – 1 Response
  – Improved access and access times, ability to leverage access to psychiatric provider time

• Health Care Savings – 1 Response
  – Treating depression shown to result in a $6:1 return on investment; patients with comorbid mental and physical health conditions cost two to three times more than patients with physical health conditions alone

• Provider Experience
  – Reduced isolation, increased support/improved access to specialty consultation, improved satisfaction rate, case-based learning, opportunity to work on a team, reduced burnout and turnover of staff

• Maximizing Funding Opportunities
  – Mental health as a target for accountable care organization (ACO) shared savings target, value-based payments, and new payment opportunity with Medicare behavioral health integration/collaborative care codes (CoCM); Develop your billing skills for codes that cover integrated care; maximize staffing models and workflows to increase revenue from CPT billing
Objectives

By the end of this presentation you should be able to:

• Discuss sustainability of your integration plan.
• List financing strategies for behavioral health integration.
• Apply a strategy to assess practice impact of sustaining CoCM using APA-AIMS Center financial modeling workbook.
Why behavioral health integration?

- Mental health is part of overall health
- Treat mental health disorders where the patient is / feels most comfortable receiving care
  - Established doctor-patient relationship is an important foundation of trust
  - Less stigma
  - Better coordination with medical care
- Critical for transformation and TCPI goals
Collaborative Care Aligned with TCPI Goals

<table>
<thead>
<tr>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
<th>Collaborative Care</th>
</tr>
</thead>
</table>
| Patient and Family-Centered Care Design | 1.1 Patient & family engagement  
1.2 Team-based relationships  
1.3 Population management  
1.4 Practice as a community partner  
1.5 Coordinated care delivery  
1.6 Organized, evidence based care  
1.7 Enhanced Access | Patient satisfaction  
Leverage psychiatric prescriber  
Effective team collaboration  
Evidence based treatment  
Increased access to BH |
| Continuous, Data-Driven Quality Improvement | 2.1 Engaged and committed leadership  
2.2 Quality improvement strategy supporting a culture of quality and safety  
2.3 Transparent measurement and monitoring  
2.4 Optimal use of HIT | Measurement-based treatment to target  
Use of patient registry  
Improved patient outcomes |
| Sustainable Business Operations | 3.1 Strategic use of practice revenue  
3.2 Staff vitality and joy in work  
3.3 Capability to analyze and document value  
3.4 Efficiency of operation | Proven cost effective strategy  
Provider satisfaction  
New collaborative care payment |
Sustainability: Define Value of Behavioral Health Integration Broadly

- Mental Health Care Access
- Improved Patient Experience
- Improved Provider Experience
- Improved Primary Care Provider Productivity
- High Quality of Care
- Improved Patient Outcomes
- New Funding Opportunities

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Primary Funding Mechanisms

• Traditional CPT Codes
  – Psychiatry, Psychotherapy, Health and Behavior, Screening, SBIRT
  – All require specific credentialing, licensure, and setting *(varies by service and insurance)*

• Bundled Payment Models
  – CMS Behavioral Health Integration codes

• Value-based payments and pay for performance contracting with health plans

*Used with permission from the AIMS Center*
Collaborative Care Model (CoCM)

- Primary care patient-centered team-based care
- Registry to track population
- Active treatment with evidence-based approaches
- Systematic case review with psychiatric consultant (focus on patients not improved)
- Validated outcome measures tracked over time

Problem Solving Treatment (PST)
Behavioral Activation (BA)
Motivational Interviewing (MI)
Medications

PHQ-9
### HOW WELL DOES IT WORK WITH OTHER DISORDERS?

<table>
<thead>
<tr>
<th>Evidence Base Established</th>
<th>Emerging Evidence</th>
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<tbody>
<tr>
<td>- Depression</td>
<td>• ADHD</td>
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<tr>
<td>- Adolescent Depression</td>
<td>- Bipolar Disorder</td>
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<tr>
<td>- Depression, Diabetes, and Heart Disease</td>
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<td>- Depression and Cancer</td>
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<td>- Depression in Women’s Health Care</td>
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<td>- Anxiety</td>
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<td>- Post Traumatic Stress Disorder</td>
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<td>- Chronic Pain</td>
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<td>- Dementia</td>
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<tr>
<td>- Substance Use Disorders</td>
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</table>

Emerging Evidence:
- Depression
  - Adolescent Depression
  - Depression, Diabetes, and Heart Disease
  - Depression and Cancer
  - Depression in Women’s Health Care
- Anxiety
- Post Traumatic Stress Disorder
- Chronic Pain
- Dementia
- Substance Use Disorders
# Medicare BHI/CoCM Codes

<table>
<thead>
<tr>
<th>2018 Code</th>
<th>2017 Code</th>
<th>Description</th>
<th>2017 Rate</th>
<th>2018 Rate</th>
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<tr>
<td>99492</td>
<td>G0502</td>
<td>CoCM - first 70 min in first month</td>
<td>$142.84</td>
<td>$161.28</td>
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<tr>
<td>99493</td>
<td>G0503</td>
<td>CoCM - first 60 min in any subsequent months</td>
<td>$126.33</td>
<td>$128.88</td>
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<tr>
<td>99494</td>
<td>G0504</td>
<td>CoCM - each additional 30 min in any month (used in conjunction with 99492 or 99493)</td>
<td>$66.04</td>
<td>$66.60</td>
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<tr>
<td>99484</td>
<td>G0507</td>
<td>Other BH services - 20 min per month</td>
<td>$47.73</td>
<td>$48.60</td>
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<tr>
<td></td>
<td></td>
<td>For FQHC and RHC Only</td>
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<tr>
<td>G0511</td>
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<td>CCM – General Care Management</td>
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<td>$61.37</td>
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<tr>
<td>G0512</td>
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<td>CoCM: Psychiatric Collaborative Care Model</td>
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<td>$134.58</td>
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</tbody>
</table>
3 Key Elements

1. Active treatment and care management using established protocols for an identified patient population;

2. Use of a patient tracking tool to promote regular, proactive outcome monitoring and treatment-to-target using validated and quantifiable clinical rating scales; and

3. Regular (typically weekly) systematic psychiatric caseload reviews and consultation by a psychiatric consultant, working in collaboration with the behavioral health care manager and primary care team. These primarily focus on patients who are new to the caseload or not showing expected clinical improvement.
Medicare CoCM Codes

• Payment goes to the PCP who bills the service
• Billed on a per patient basis for those that have met the established time thresholds
• The psychiatrist does not bill separately.
  – contract with the PCP practice
• The patient must provide general consent for the service and they will have a co-pay
• Interaction does not have to be face-to-face
• Care manager and psychiatrists can also bill additional codes for therapy etc.
Building a Sustainable Program

Create a strong collaborative care program

| Psychiatric Consultation | Behavioral Health Care Manager | Core Infrastructure |

Define value broadly

| Quality patient and provider experience | Better outcomes | Capture value and responsible spending |

Use financial modeling tool

| Calculate costs | Anticipate Revenue | Consider workflows |
Financing: Costs of Behavioral Health Integration

Initial Costs of Practice Change:

• provider and administrator time to plan for change
• care team training costs and time/workforce development
• development of registry
• workflow planning, billing optimization

Ongoing Care Delivery Costs:

• care manager time
• psychiatric consultant time
• administration time and overhead (including continuous quality improvement efforts)

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Using the Workbook as a Team

• The workbook asks for information that may “live” with various people in your organization.
  – Finance
  – HR/Staffing
  – Operations
  – BH Program Management

• Use all your resources to gather the most accurate information.
Payer Mix

• Which payers does your organization or BH services get reimbursement from?
• Does the payer reimburse for all credentials, i.e. social workers vs. counselors?
• What is the average reimbursement for specific services from each payer?
• Which payers pay a case rate, and which pay only for individual services?
Task Allocations and Visit Statistics

• How do your care managers and psychiatric consultants spend their time each week?

• What kind of visits do they have?

• What is the average length of a treatment episode, and the average number of visits during that episode?

• How many weeks in the year do your staff work – not counting holidays, sick and vacation?
Financial Modeling Workbook

Tab 1: Disclaimer

As Agreed:

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As Agreed:

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# Financial Modeling Workbook

## Tab 2: Staffing

<table>
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<th>A</th>
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<td><strong>AMERICAN PSYCHIATRIC ASSOCIATION</strong></td>
<td><strong>AIMS CENTER</strong></td>
<td><strong>University of Washington</strong></td>
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<td><strong>Workbook Template Updated 05/25/2017</strong></td>
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<td><strong>Staffing and Service Delivery</strong></td>
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<td>10</td>
<td><strong>Hours per week per 1.0 FTE at your organization</strong></td>
<td>40</td>
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<tr>
<td>11</td>
<td><strong>Team Member</strong></td>
<td><strong>FTE</strong></td>
<td><strong>Total Hours per Week</strong></td>
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<tr>
<td>12</td>
<td>Care Manager</td>
<td>1.00</td>
<td>40.0</td>
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<tr>
<td>13</td>
<td>Psychiatric Consultant</td>
<td>0.10</td>
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<td>15</td>
<td><strong>WEEKLY TIME AND EFFORT ALLOCATION AND SERVICE UNIT GENERATION: CARE MANAGER</strong></td>
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<td>16</td>
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<td>17</td>
<td>Total Care Manager Hours per Week</td>
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<td>40.0</td>
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<td>17</td>
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</tbody>
</table>

**Details of staffing**
- Weeks for 1.0 FTE
- Care manager FTE
- Psychiatric consultant FTE
# Financial Modeling Workbook

## Tab 2: Staffing and Service Delivery for Care Manager & Psych Consultant

### Details of BH care manager effort
- Direct care
- Warm connections
- Telephone services
- Charting
- Care management
- Psychiatric consultation

### Details of psychiatric consultant effort
- Indirect psychiatric consultation
- Registry/Charting
- Direct care

<table>
<thead>
<tr>
<th>Core Management Service Category</th>
<th>Percentage (%) of Total Hours per Week</th>
<th>Hours per Week</th>
<th>Service Units Generated</th>
<th>Hours per Service Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursable Direct Core Services</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Treatment: Assessment Visit</td>
<td>10.0%</td>
<td>4.00</td>
<td>4</td>
<td>1.00</td>
</tr>
<tr>
<td>Direct Treatment: Receiving Visits</td>
<td>51.3%</td>
<td>20.50</td>
<td>41</td>
<td>0.50</td>
</tr>
<tr>
<td>Group Treatment</td>
<td>2.75%</td>
<td>1.50</td>
<td>6</td>
<td>0.25</td>
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<tr>
<td>Subtotal: Reimbursable Direct Core Services</td>
<td>65.0%</td>
<td>26.00</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Non-Reimbursable Direct Core Services</td>
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<td></td>
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<tr>
<td>Warm Connection (Non-Billable)</td>
<td>7.5%</td>
<td>3.00</td>
<td>15</td>
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<tr>
<td>Care Management: Telephone Services</td>
<td>7.5%</td>
<td>3.00</td>
<td>15</td>
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<tr>
<td>Subtotal: Non-Reimbursable Direct Core Services</td>
<td>15.0%</td>
<td>6.00</td>
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</tr>
<tr>
<td>Indirect Core Coordination and Administrative Tasks</td>
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<td></td>
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</tr>
<tr>
<td>Charting</td>
<td>5.0%</td>
<td>2.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registry Management</td>
<td>5.0%</td>
<td>1.20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric Consultation</td>
<td>5.0%</td>
<td>1.00</td>
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<tr>
<td>Team Communication</td>
<td>4.5%</td>
<td>1.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Clinical Supervision, Staff Meetings, Training, etc.)</td>
<td>5.0%</td>
<td>2.00</td>
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<tr>
<td>Subtotal: Indirect Core Coordination and Administrative Tasks</td>
<td></td>
<td>20.0%</td>
<td>8.00</td>
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<table>
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<tr>
<th>Indirect Core and Administrative Tasks</th>
<th>Percentage (%) of Total Hours per Week</th>
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<th>Service Units Generated</th>
<th>Hours per Service Unit</th>
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<tbody>
<tr>
<td>Registry Management</td>
<td>10.0%</td>
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<tr>
<td>Psychiatric Consultation</td>
<td>10.0%</td>
<td>1.00</td>
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</table>

### Weekly Time and Effort Allocation and Service Unit Generation: Care Manager

### Weekly Time and Effort Allocation and Service Unit Generation: Psychiatric Consultant
# Financial Modeling Workbook

## Tab 2: Staffing And Service Delivery for Care Manager and Psych Consultant

### Summary of available care
- Direct Care
- Caseload details
  - Length of episode
  - Caseload capacity
  - Eligibility for case rate

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<thead>
<tr>
<th>A</th>
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<tbody>
<tr>
<td><strong>ANNUALIZED REIMBURSABLE DIRECT CARE SERVICES</strong></td>
<td></td>
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<td>Working Weeks Per Year</td>
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<td></td>
<td></td>
<td>47</td>
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<tr>
<td>Annual Reimbursable Direct Care Service Hours</td>
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<tr>
<td>Direct Treatment:</td>
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<tr>
<td>Assessment</td>
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<tr>
<td>Direct Treatment:</td>
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<td>Discharge</td>
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<td>Group Treatment</td>
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<tr>
<td>Total Service Units</td>
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</tr>
</tbody>
</table>

### Average Weeks Elapsed Between 1st and Last Direct Care Service

- Avg number of weeks per episode of care

### Average Count of Direct Care Service Units Performed

- Avg number of contacts per episode of care

### Single Point in Time Caseload Capacity

- Number of individuals dependent on the caseload at any point in time across all Caseload Managers

### Projected Annual Caseload Capacity

- Number of unique individuals expected to serve across one or more access to Care Managers

### Projected Average Monthly Caseload

- Number of clients served and/or treated each month

### Projected Number of Patients Served per Calendar Month

- Potential number of patients treated over one month who might be eligible for monthly case rate reimbursement

### Projected Annualized Monthly Case Rate Potential

- Number of times a monthly case rate could potentially be billed in a one-year period:

---

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# Financial Modeling Workbook

**Tab 3: Net Financial Impact – Payer Mix and Case Rate**

## Payer Mix
- CoCM codes
- Other value-based payments
- Direct care revenue

### Net Financial Impact

#### Payer Mix

<table>
<thead>
<tr>
<th>Payer</th>
<th>% of Patients per Payer</th>
<th>% of Patients Eligible for Monthly Case Rate</th>
<th>Adjusted % of Patients Eligible for Monthly Case Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>13.0%</td>
<td>100%</td>
<td>13.0%</td>
</tr>
<tr>
<td>Medicare</td>
<td>33.0%</td>
<td>100%</td>
<td>33.0%</td>
</tr>
<tr>
<td>Commercial</td>
<td>33.0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Self Pay</td>
<td>1.0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

To add rows: 1) Unprotect sheet 2) Insert rows above the last row with data 3) Copy formula in column F 4) Protect sheet

No Payer Assigned [Target = 0%] 0.0% [Green checkmark indicates value is at target]

### Reimbursement: Annualized Monthly Case Rate

<table>
<thead>
<tr>
<th>Payer</th>
<th>Monthly Case Rate Name</th>
<th>Monthly Reimbursement per Case</th>
<th>Adjusted % of Patients Eligible for Monthly Case Rate</th>
<th>Of Patients Eligible for Case Rate, % of Patients Also Eligible for Individual Services</th>
<th>Annualized Count of Cases Eligible for Monthly Case Rate</th>
<th>Annualized Reimbursement per Monthly Case Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>Medicare CoCM</td>
<td>$3,345</td>
<td>13%</td>
<td>0%</td>
<td>446</td>
<td>$60,051.05</td>
</tr>
<tr>
<td>Medicaid</td>
<td>WA Medicaid CoCM</td>
<td>$3,345</td>
<td>13%</td>
<td>0%</td>
<td>446</td>
<td>$60,051.05</td>
</tr>
</tbody>
</table>

Used with permission from the AIMS Center
# Financial Modeling Workbook

**Tab 3: Net Financial Impact – Reimbursement Annualized Billable Individual Services**

![Image of financial modeling workbook](image_url)

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**Used with permission from the AIMS Center**
Financial Modeling Workbook


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Resources to Help Plan a Sustainable Model

- Defining value for your model of integrated care
- Guidance on planning behavioral health staffing
- Financing strategies on the way to VBP:
  - aims.uw.edu/collaborative-care/financing-strategies-collaborative-care
- Financial Modeling Workbook Download:
  - aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook
AIMS/APA-SAN FMW Office Hours

• Next *virtual* drop-in:
  – January 10, 2018
  – 12noon Eastern

• Join details on AIMS Center Website: [aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook](http://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook)
## Sustainability Strategies for Primary Care in Mental Health Settings

<table>
<thead>
<tr>
<th>Build a primary care site in your mental health center</th>
<th>Partner with a primary care site</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Need to see BOTH mental health center and general primary care</td>
<td>• Need strong system to share information and coordinate care</td>
</tr>
<tr>
<td>• Providers need to build comfort with mental health center patient adaptations</td>
<td>• Role for patient navigator coordinator</td>
</tr>
<tr>
<td></td>
<td>• Stratify patients and track total costs of care</td>
</tr>
</tbody>
</table>
Leaving in Action

Which of the following actions would you like to take?

• Define organizational priorities
• Explore direct services payment for current behavioral health integration
• Learn more about CoCM codes
• Explore sustainability for primary care in mental health settings
Next Steps
Payer Updates

SBIRT Code Claims

• Payer A: 118 claims – 12 months ending 6/30/2017
• Payer B: 33 Claims - 11/1/16-10/31/17

Health & Behavioral Code Claims (96150-96154)

• Payer A: 20 Claims (12 month period ending 8/31/2017)

Collaborative Care Codes effective 1/1/2018

• Anthem: 99492 – 99494, 99484
• Harvard Pilgrim Health Plan: 99492 – 99494
• Cigna: Piloting 99492 – 99494 with medical groups in collaborative relationships
Upcoming Behavioral Health Integration Learning Collaborative and Northern New England Practice Transformation Network Events

**NNE-PTN 2 Hour Quality Improvement Sessions Around NH**

- **Mar 21st**
  - Frisbie Hospital, Rochester
  - 8:00 – 10:00am
- **May 17th**
  - River Valley Community College, Claremont
  - 8:00 – 10:00am
- **Jan 18th**
  - UNH Law, Concord
  - 8:00 – 10:00am
- **Apr 18th**
  - Center for Life Management, Derry
  - 8:00 – 10:00am
- **June 6th**
  - North Country Region, Location TBD
  - 8:00 – 10:00am

**Upcoming Behavioral Health Integration Learning Collaborative and Northern New England Practice Transformation Network Events**

- **January 10th Webinar**
  - Integrating SUD Screening & Treatment: A Collaborative Care Approach to Practice & Payment, 12:00 – 1:00pm
- **April TBD**
  - Webinar
  - 12:00 pm – 1:00 pm
- **In Person May TBD**
  - 8:30am – 12:30pm
- **In Person June TBD**
  - 8:30am – 12:30pm
- **In Person March 14th**
  - 8:30am – 12:30pm
  - Driving Change: A Roadmap to Whole Population Integrated Care

**NH BHI LC Education Sessions**

- **BHI Kick Off**
  - Nov 8th
  - 8:30am – 12:00pm
Announcements

**NNE ECHO (Expanding Connectivity for Health Outcomes) Collaborative**

Kick off – January 25\(^{th}\)

*Continuity of Care for Substance Use and Exposure During the Perinatal Period*

*Now Recruiting!*

**Learn More:** Marguerite Corvini [Marguerite.Corvini@unh.edu](mailto:Marguerite.Corvini@unh.edu)

**Behavioral Health Workforce Education and Training Program (HRSA Grant)**

Recruiting clinical sites for integrated behavioral health for a range of disciplines

**Learn More:** Kerrin Edelman [Kerrin.edelman@unh.edu](mailto:Kerrin.edelman@unh.edu)

**Academic Partners**

- Manchester Community College
- Plymouth State University
- Rivier University
- University of New Hampshire
- Antioch University
THANK YOU!

Please fill out the CME Evaluation to receive credit for your participation!

https://www.surveymonkey.com/r/eval_2018_BHI_Webinar_1-10-18
Appendix

AIMS Center, Cheat Sheet on Medicare Payments for Behavioral Health Integration Services,
https://aims.uw.edu/resource-library/cms-collaborative-care-payment-cheat-sheet

AIMS Center, Basic Coding for Integrated Behavioral Health Care,
https://aims.uw.edu/resource-library/basic-coding-integrated-behavioral-health-care

Past Presentations:

Behavioral Health Integration Landscape: Payment and Policy:
https://unh.box.com/s/z2j797wqxzmy3n4s6nu7g9rei61wirk7
CME Disclosures

The following individuals have responded that they have nothing to disclose:

Planner: Katherine Cox, MSW, Research Associate, NH Citizens Health Initiative

Planner: Frederick Kelsey, MD, FACP, past Medical Director, Mid State Health Center

Planner: Annie Averill, BA, Research Associate, NH Citizens Health Initiative

Planner: Stephanie Cameron, MPH, Research Associate, NH Citizens Health Initiative

Planner: Laura Remick, MEd, CHES, Education and Workforce Coordinator, North Country Health Consortium

Planner: Diana Gibbs, BA, CPS, Program Director, North Country Health Consortium

Planner: Jill Gregoire, RN, MSN, Lead Nurse Reviewer, North Country Health Consortium

Planner: Mitch Sullivan, MD, Lead CME Physician Reviewer, Coos Family Health Services

Presenter: Lucy Hodder, JD, Director, Health Law and Policy, Prof of Law, University of New Hampshire, IHPP

Presenter: Hwasun Garin, BA, Project Director, University of New Hampshire, IHPP
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</tr>
</thead>
<tbody>
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