Making it Work Today: 
Prompter Perspectives on Financing Integration

Moderator: Judith Steinberg, MD, MPH
Deputy Chief Medical Officer, Commonwealth Medicine
University of Massachusetts Medical School
The Challenge

We Are Ahead of our Time

We recognize the value of integrating behavioral and physical health care

But...

Incentives are not aligned.

There are major systemic barriers.

How do we make it work?
Objectives

• Understand how providers of different types have implemented and are financing integrated care models

• Key questions to be addressed:
  • Design of the integration program
  • How integrated clinicians are credentialed
  • What services are provided and how these services are reimbursed
  • Overall financial performance and sustainability of the program
  • How challenges related to reimbursement are being approached
Panelists

• Glenn Focht, MD
  • Chief Medical Officer, Pediatric Physicians’ Organization at Children’s
• Mark Alexakos, MD
  • Chief Behavioral Health Officer, Lynn Community Health Center
• Scott Early, MD
  • Chief Medical Officer, Lynn Community Health Center
• Katherine Moss, PhD
  • Director of Healthcare and Community Integration, Behavioral Health Network
<table>
<thead>
<tr>
<th>2007 Original</th>
<th>2014 Integrating Behavioral Health</th>
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<tbody>
<tr>
<td>Personal physician</td>
<td>Home of the team</td>
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<tr>
<td>Whole person orientation</td>
<td>Requires BH service as part of care</td>
</tr>
<tr>
<td>Care coordinated</td>
<td>Shared problem and medication lists</td>
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<tr>
<td>Quality and safety</td>
<td>Requires BH on team</td>
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<tr>
<td>Enhanced access</td>
<td>Includes BH for patient, family and provider</td>
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<tr>
<td>Appropriate payment</td>
<td>Funding pooled and flexible</td>
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- [http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/jointprinc_05_17.pdf](http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/demonstrations/jointprinc_05_17.pdf)
- *Ann Fam Med* 2014; 183-185; Joint Principles from AAFP, ABFM, STFM
- Slide adapted from Sandy Blount
Models of Integrated Care: A Continuum

Continuum of Payment Methods: Moving to Value-Based Payments

- Fee for Service (FFS)
- FFS and care management fee
- Bundled payments
- Global Payments
Incentivizing Value

• Pay for Performance
  • Clinical quality
  • Efficiency
  • Patient Experience

• Shared Savings
  • With quality gates and/or quality performance modifiers
Discussion
Bringing Integrated Behavioral Health to the Pediatric Patient Centered Medical Home: A Review of the PPOC/Boston Children’s Hospital Behavioral Health Initiative and Its Fiscal Sustainability

May 12, 2015

Glenn Focht, MD, Chief Medical Officer, PPOC
Jonas Bromberg, PsyD, Program Manager, Behavioral Health, PPOC
1. Overview of Clinical Model of Integration

2. Fiscal Strategies and Tensions Inherent in Behavioral Health Integration

3. Summary/Wrap Up/Questions
Who is the PPOC?

- 280+ providers
- 80+ unique private practices
- Affiliated with Boston Children’s Hospital
The BHI Program implementation is:

• An innovative model of BH
• Creates sustainable capacity to deliver integrated, evidence-based behavioral health services in the pediatric medical home to children with needs for
  • Prevention/resilience building
  • Treatment of low to moderate intensity behavioral health illnesses in pediatric primary care settings
  • Care coordination for all with a focus on those with identified behavioral health needs
• Leverages Patient-Centered Medical Home functions/Medical Home Care Coordination
The BHI program addresses four foundational clinical issues that create and support a more capable medical home team

• Delivering education and skills training to improve PCP competence in behavioral health care
• Integrating expert, co-located BH providers into the medical home team
• Providing just-in-time, case-focused, longitudinal support of a pediatric psychiatrist
• Working to form behavioral health neighborhoods
**Integrated Care Model - Depression**

Key: PCP = Primary Care Physician   BHC = Behavioral Health Clinician   * denotes junctions for potential care coordination

**Level 1 Goals:**
- Increase detection of BH issues
- Increase PCPs ability to provide guided self-help and support
- Increase prevention and resilience building opportunities

**Level 2 Goal:**
- Improve access to rapid diagnostic and evaluation services, and patient engagement

**Level 3 Goals:**
- Improve access to BH treatment services
- Increase integration with primary medical care

**Level 4 Goals:**
- Improve access to community-based BH services
- Improve coordination of care; especially following a psychiatric hospitalization

**Use of Evidence-Based Stepped Care Protocols**

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**Integrating Care: From Evidence to Operations**

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Revenue Cycle Realities

1. Training is essential
   • Clinicians, billing, referral management

2. Contracts are **not** standard and vary significantly in allowable/paid CPT codes

3. Managing no show rates is important
   • Open/unfilled appointments can be avoided and mitigated with some work
Revenue Cycle Realities

4. Use of behavior and wellness codes is a path to disappointment
5. Capture available structured screening fees and care coordination
6. Learn and share learning from each denial
7. Call out and manage the tension between billable and non-billable high value work
8. Offload clerical activities to others in practice
9. Leverage your medical home core functions
Long term sustainability

- FFS across CHICO-contracted payors, and MBHP
- Potential PMPM in MassHealth new payment reform
- Cost avoidance in risk contracts (TME)
- Other funding sources are being pursued
Summary/Wrap Up/Questions
APPENDIX 1: Operations Support Facilitating Behavioral Health Integration

BHI Operations Support

- Space
- Practice Orientation
- BH Neighbors
- EHR Documentation
- Revenue Cycle Management
- Clinician Hiring
- Practice-specific needs
- EHR integration and privacy
- Credentialing and Contracting

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APPENDIX 2: Operational Support

Thirteen Buckets of Work

1. Hiring the right Behavioral Health Provider
2. Internal marketing plan
3. Orientation for your practice
4. Orientation to the BHI Program
5. Care coordination plan
6. Plan for clinical supervision and quality
7. Integrated EHR/data management plan
8. Patient and family engagement
9. Confidentiality and privacy
10. Space plan
11. Billing and revenue cycle
12. Plan for telemedicine and remote learning
13. Integrating community and local behavioral health resources

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Primary Care and Behavioral Health Integration at the Lynn Community Health Center

Mark Alexakos MD, MPP
Chief Behavioral Health Officer

Scott Early, MD
Chief Medical Officer
Lynn Community Health Center

We are an FQHC that serves a diverse population in Lynn. We have over 45,000 patients who receive primary care and behavioral health services. The health center has over 500 employees and almost an equal number of primary care and behavioral health providers.
Strategic Plan

- Developmental Process
- Integration Incorporated
- Senior Management Training
Team Development

- Champions/Leaders Identified
- Team-Based Meeting Times
- Team-Based Champions Meeting
- Cross-Team Learning Environment
What Teams are Working On

• Co-Location
• Warm Hand Offs
• Universal Care Plans
• Universal Screening
• Population Management
• Co-Management of Disease
Integration at LCHC

- Collaborative Care (99%)
- Co-Location (90%)
- Unified Care (75%)
- Disease Management (25%)
- Team-Based Care (20%)
- System of Care

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Financial Nuts and Bolts
Is Integration Really Different?

• Primarily FFS model (90% FFS/10% Grant)
• Bill Warm Handoffs
• Second Visit is an Intake/Bill for Psychotherapy
• Productivity Expectations Standard
• Schedule and Referral Management
• Authorization Management
• Denial Management
How Model Impacts Finances

3 FTE Therapists per Primary Care Team

Means:

✓ More Patients Seen Long Term On Team
✓ Fewer Unbilled Consults per Therapist
✓ More Availability for PCPs and Patients

Integrated Therapist Performance 2015:
-4 exceeding, 2 meeting, 4 below
Ways to Lose Money

• Health Behavior Codes Not Universally Covered (99150-99155) (G codes)

• Problems with Primary Diagnosis:
  – Tobacco Cessation
  – Primary Insomnia
  – Obesity
  – V codes

• Lack of Administrative Infrastructure
Behavioral Health Network

Implementing Behavioral Health in Primary Care - Perspectives from a Community Behavioral Health Agency

Katherine M. Moss, Ph.D.
Director- Healthcare and Community Integration
BHN at a Glance

- Private, non-profit community-based agency
- Full spectrum of MH, SUD, and ID/DD services
- Serving all 4 Western Mass. counties
- 1400 employees
- Annual revenue of approximately $65M
Integration Model and Staffing

- **Partnership** with Primary Care Practices (FQHCs, Hospital-owned community health centers, large group practices, small group practices)

- Integrated behavioral health staff **hired and credentialed by BHN**.

- BHN provides behavioral health **supervision** and direct **connection** to comprehensive community BH services.
Funding

- Grant/contract funding or third party behavioral health billing
- Standard BH insurance billing
- Care management not financially supported. (utilize insurance plan care managers, CSP)
Degree of Integration

Co-located

Min. consult

Warm hand-off

Full Integration

Funding type

A. Third party
B. 3rd pty, Minimal subsidy
C. Partner Subsidy, 3rd pty
D. Grant, Partner Subsidy, 3rd pty

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Second Annual Statewide Forum on Integration
## Program - By the Numbers

<table>
<thead>
<tr>
<th>Site-type</th>
<th>Site-#</th>
<th>Funding type</th>
<th>FTE of IBH</th>
<th>Warm hand-off per month</th>
<th>Scheduled visits per month</th>
<th>Show rates for scheduled visit</th>
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<tbody>
<tr>
<td>FQHC</td>
<td>1</td>
<td>D</td>
<td>2.5</td>
<td>99</td>
<td>106</td>
<td>62%</td>
</tr>
<tr>
<td>Hospital community health center</td>
<td>4</td>
<td>B-C</td>
<td>2.5</td>
<td>118</td>
<td>190</td>
<td>46%</td>
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<tr>
<td>Large group practice</td>
<td>2</td>
<td>A</td>
<td>1.5</td>
<td>10</td>
<td>16</td>
<td>51%</td>
</tr>
<tr>
<td>Small group practice</td>
<td>3</td>
<td>A</td>
<td>1</td>
<td>10</td>
<td>16</td>
<td>58%</td>
</tr>
</tbody>
</table>
Successful Implementation Requirements -
Financial implications

- **Highly trained clinicians**: Requires higher salary than standard grade
- **Low show rates**: Requires lower productivity = lower revenue
- **Close partnerships**: Requires more administrative time to build and maintain partnerships
- **New models**: Requires more administrative time to build, modify and gather data.
- **Financial implications**: decreased revenue, increased expense. Not sustainable without contract/ grants or funding restructuring.
Challenges

• Limited tool box of service options with third party billing (outpatient therapy-individual and family therapy, case consult)

• Care management a key component and not an integrated system (plan-based, no provider-based)

• Identified patients are disproportionally at lower stage of motivation for behavioral health engagement. Leads to lower show rates.
Strategies:

- Low show rates
  - Marketing material
  - Provider training on introducing services
  - Emphasizing one touch interventions
  - IBH training on motivational interviewing, etc.
  - Management tool: reports of show rates by site, by clinician, by day. Next phase: by diagnosis, by treatment type; and patient satisfaction.
Financial Summary

• Within a fee for service model, increased costs and high no-show rates render integrated BH health financially unsustainable without some form of subsidy.

• Some health centers have chosen to hire their own staff – subsidizing BH. This provides some on-site services but potentially has fewer connections to care in the community BH system.

• Fully functional integrated BH support has been successful with financial support from grants, or when health centers have used their financial resources to support integrating our BH system into their practices.