Moving Financing for BH Services in New Hampshire Forward

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NH ranked last in New England in BH claim payments/capita (Medicare+Medicaid+Commercial, 2012)

State	N.E. Rank	
ME	$	490
CT	$	458
RI	$	421
VT	$	370
MA	$	365
NH	$	352

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Rhode%20Island%20FINAL%20Behavioral%20Health%20Spending%20Report%202015-06-11%20(submitted).pdf

http://kff.org/other/state-indicator/smha-expenditures-per-capita/?currentTimeframe=1&selectedRows=%7B%22nested%22:%7B%22all%22:%7B%7D%7D,%22wrapups%22:%

http://www.governing.com/gov-data/state-census-population-migration-births-deaths-estimates.html

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/2012_Section13.pdf#Table13.3

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/Downloads/2012_Section2.pdf#Table2.7

http://kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

BH Underfunded

- The NH BH system has been underfunded by private and public payers
- Result is inadequate capacity and access
- Consistent with findings from CMS
- Medicaid expansion and SIM grant should help move things in the right direction
- Coordinated/supporting

Higher payment can help but not a guarantee

- Can make NH a more attractive place for BH professionals to practice
- Can fund innovative programs, including integrated PH/BH
- Payment alone does not guarantee better programs and outcomes
- Payment increases alone increase cost sharing and so have a negative incentive for patients

Developed a payment model focused on depression in primary care

- Commercial market is a key to sufficient funding for BH and BH integration, but also could be used in Medicaid
- Large evidence base for managing depression in primary care
- BH workers likely to manage other conditions as well but many are co-occurring (anxiety and depression, SUD and depression)
- Allows focus on basic financial “hydraulics” to demonstrate mutual financial feasibility

General Summary of “Collaborative Care” Model for Depression

- PCP uses evidence-based practice standard tool for measuring severity, response to treatment, and remission
- Systematic method is used for tracking and reminding patients at appropriate intervals about PCP visits and adherence
- Care manager (psych nurse, LCSW, etc.) uses tracking system and makes frequent contacts with patients for education, self-management support, and monitoring for required responses to support remission and avoid relapse
- In addition to care manager on PH team, frequent communication between PCP and psychiatry consult

Synthesizing the requirements for successful incentives

1. Population-based payment in some form
   - Global payment (long run), or
   - PCMH management fee with population cost incentives (next step)
2. Measure outcomes and make payment dependent in part on outcomes
3. Use VBID to provide incentive for patient compliance

Criteria for Success of Payment Model

- Savings to carriers >= extra payments for intervention
- Extra payments to providers >= cost of intervention
- Outcomes improved

Practice-level costs of model

Example Per-Patient Time Requirements	
Initial History	2
Education	1
8 sessions psychotherapy (referred)	-
Weekly supervision by PCP/Psych	1
Phone/In person	4
Relapse prevention plan	2
Total hours per patient	10
Implications for Per-Staff Patient Load	
Hours available (net admin/PTO/training)	1,740
# patients annually	**178**
Time period = 1 year per patient	
Fully loaded salary	**$85,000**

Net savings to carrier

	NH Commercial Population 18 -64	
	Epidemiological Data	**NH Provider Example**
Management Fee PMPM	**$8.13**	**$5.42**
# Patients per panel		
Implied Panel Size	872	1,307
Prevalence	20.5%	13.7%
# Patients Seen	178	178
Average medical costs avoided year one		
Per Patient per Year	$500	$600
Per Panel per Year	$89,231	$107,077
PMPM	$8.53	$6.83
Net savings (cost) PMPM	**$0.40**	**$1.41**
Average medical costs avoided over multiple years (annualized)		
Per Patient per Year	$1,000	$1,200
Per Panel per Year	$178,462	$214,154
PMPM	$17.06	$13.65
Net savings (cost) PMPM	**$8.94**	**$8.23**

Is the model feasible?

- At least some studies show savings well in excess of break-even, which would magnify net savings to payers
- Some payers already implement programs like this because they demonstrate savings – more effective with warm handoff
- Measurement of provider fidelity to model designed to pay savings only when achieved
- Strong evidence for work day productivity as sales pitch to employers
- Value of depression free days for members
- Requires providers to follow principles of model

Incorporating outcome measures into payment model

- First year requires process measure standards met for supplemental component of PCMH management fee
- Second year outcome standards must be met to earn payment (standards may increase over time)
- Third year adds penalties for well-below standard performance (supplemental management fee is negative)

ACO risk sharing can work in conjunction but not without payment model

- Full risk (e.g., global capitation) for providers would make this an issue solely for providers – make the investment and realize all the return
- Risk sharing without a payment model management fee leaves the investment to the provider but only earns them part of the return
- Not financially feasible unless investment and return considered from both payer and provider perspective

Simple Example

- PHBH costs $100,000 and returns $110,000 in savings on services overall
- Provider invests money in program for hiring, etc.
- Receives return through combination of management fee and shared savings
- Payer invests management fee and receives their share of savings

Only scenarios with positive return are feasible in the long run

	Provider Investment	Provider Return	Provider Net	Payer Investment	Payer Return	Payer Net
FFS	$ 100,000	$ -	$ (100,000)	$ -	$ 110,000	$ 110,000
Global capitation	$ 100,000	$ 110,000	$ 10,000	$ -	$ -	$ -
ACO with 25% upside	$ 100,000	$ 27,500	$ (72,500)	$ -	$ 82,500	$ 82,500
BH fee increase w/ outcomes	$ -	$ -	$ -	$ 100,000	$ 110,000	$ 10,000
BH fee increase w/o outcomes	$ -	$ -	$ -	$ 100,000	$ -	$ (100,000)
Payment model	$ 100,000	$ 100,000	$ -	$ 100,000	$ 110,000	$ 10,000
Mixed ACO/payment model	$ 100,000	$ 102,500	$ 2,500	$ 102,500	$ 110,000	$ 7,500

Agenda for future development

- Expand payment model to include other BH conditions including anxiety and SUD
- Survey and analyze BH reimbursement rates and staffing costs in detail for New Hampshire providers
- Model financial impacts of reimbursement and reimbursement model changes on providers

Current State: Substance Use + SBIRT*

NH Health Protection Program Substance Use Disorder Service Benefit (only for NH HPP beneficiaries NOT traditional Medicaid)[1]

Description	Code	Charge
Screening		
Screening by Behavioral Health practitioners[2]	H0049	$65.01
S•BI•RT 15-30 minutes	99408	$37.33
S•BI•RT >30 minutes	99409	$71.64
Individual Counseling	H0004	
30 minutes	U1	$65.01
45 minutes	U2	$86.18
60 minutes	U3	$112.96
Family Counseling		
Without patient present	H0047-HS	$104.58
With patient present	H0047-HR	$107.79
Group Counseling		
	H0005	$26.59[3]

Additional Notes:

- Code G0442 is an annual benefit so at least 11 months must pass between services.
- Both screening and counseling services have time elements of 15 minutes, so documentation should include duration of visit as well as screening or counseling notes.
- Counseling for alcohol misuse must be based on the Five As (Assess, Advise, Agree, Assist, and Arrange), so be sure your documentation reflects this.
- The alcohol screening and counseling services are payable with another visit on the same day (e.g., office visit for other problems), except for the Initial Preventive Physical Exam ("Welcome to Medicare" physical).
- Medicare allows payment for both G0442 and G0443 on the same date (except in rural health clinics and FQHCs), but will not pay for more than one G0443 service on the same date.
- These services are not subject to deductible or co-insurance.

Reference Sheet: Private Insurance Billing and Code Sheet

Type of Visit	CPT Codes	Patient Status	Additional Notes
Preventive	*99401 – 99404 & 99420*		
Evaluation & Management (E & M)	*99201 – 99205*	New Patients	CPT Up Coding: Providers who devote more than half of a visit counseling a patient about their alcohol or drug use may use the E & M codes for office and other outpatient services (99210-99215), with appropriate documentation of services provided in the clinical record.[4]
	99211 – 99215	Established Patients	

Major Carrier #1: 44 NH SBIRT billings/year

Major Carrier #2: 75 NH SBIRT billings/year

*Screening, Brief Intervention, Referral to Treatment

Source: Center for Excellence, JSI/Community Health Institute, http://www.sbirtnh.org/