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

 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED

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

 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED

Data in Action

HWASUN GARIN

CITIZENS HEALTH INITIATIVE

 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED

Plan – Do – **STUDY** – Act

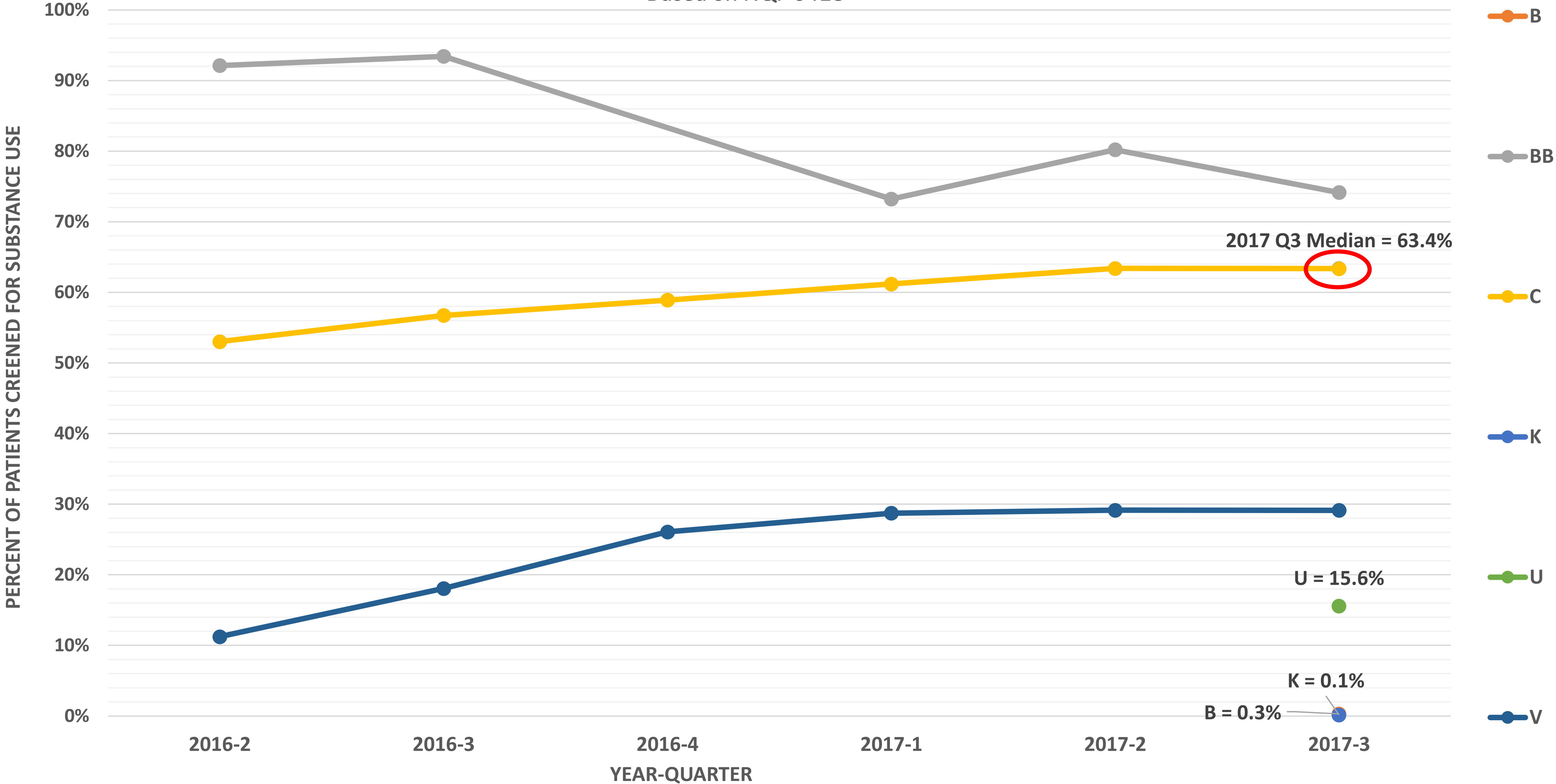
Studying our ACTION

New measures:

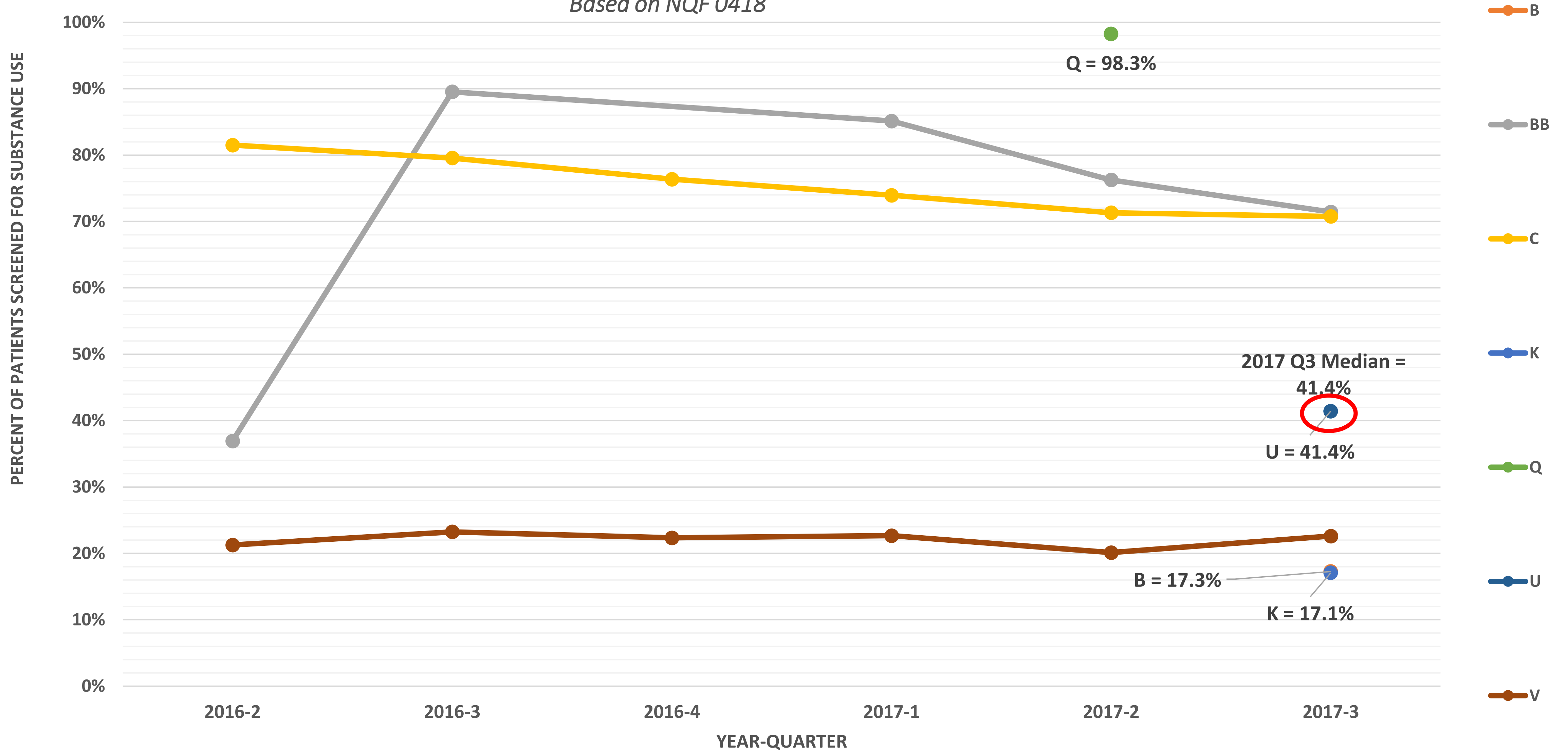
- Depression Screening + Follow-Up
  Alignment with NQF 0418

- SUD Screening + Follow-Up
  Based on NQF 0418, with guidance and review by Accountable Care Learning Network Clinical Committee

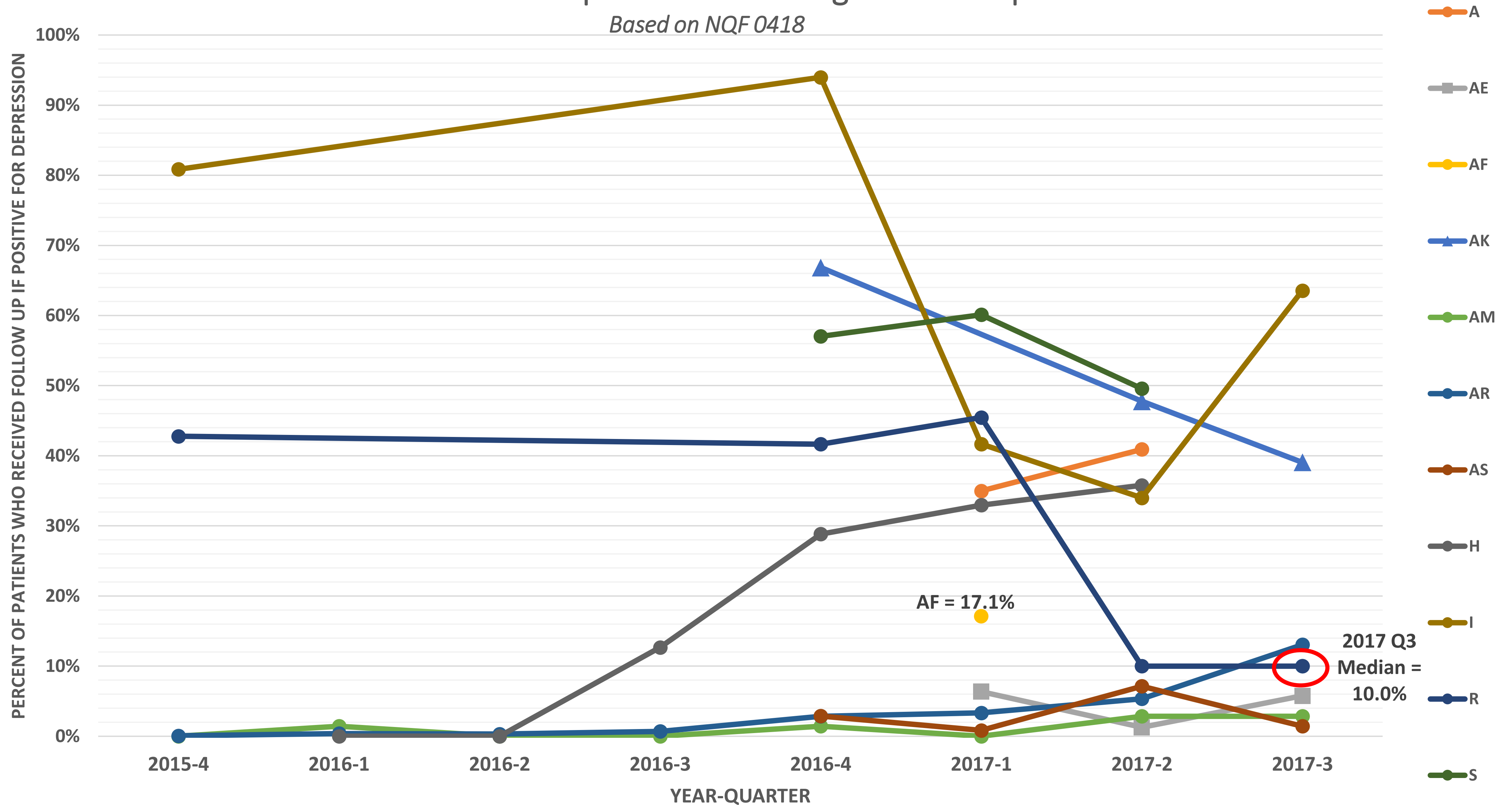
© 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED



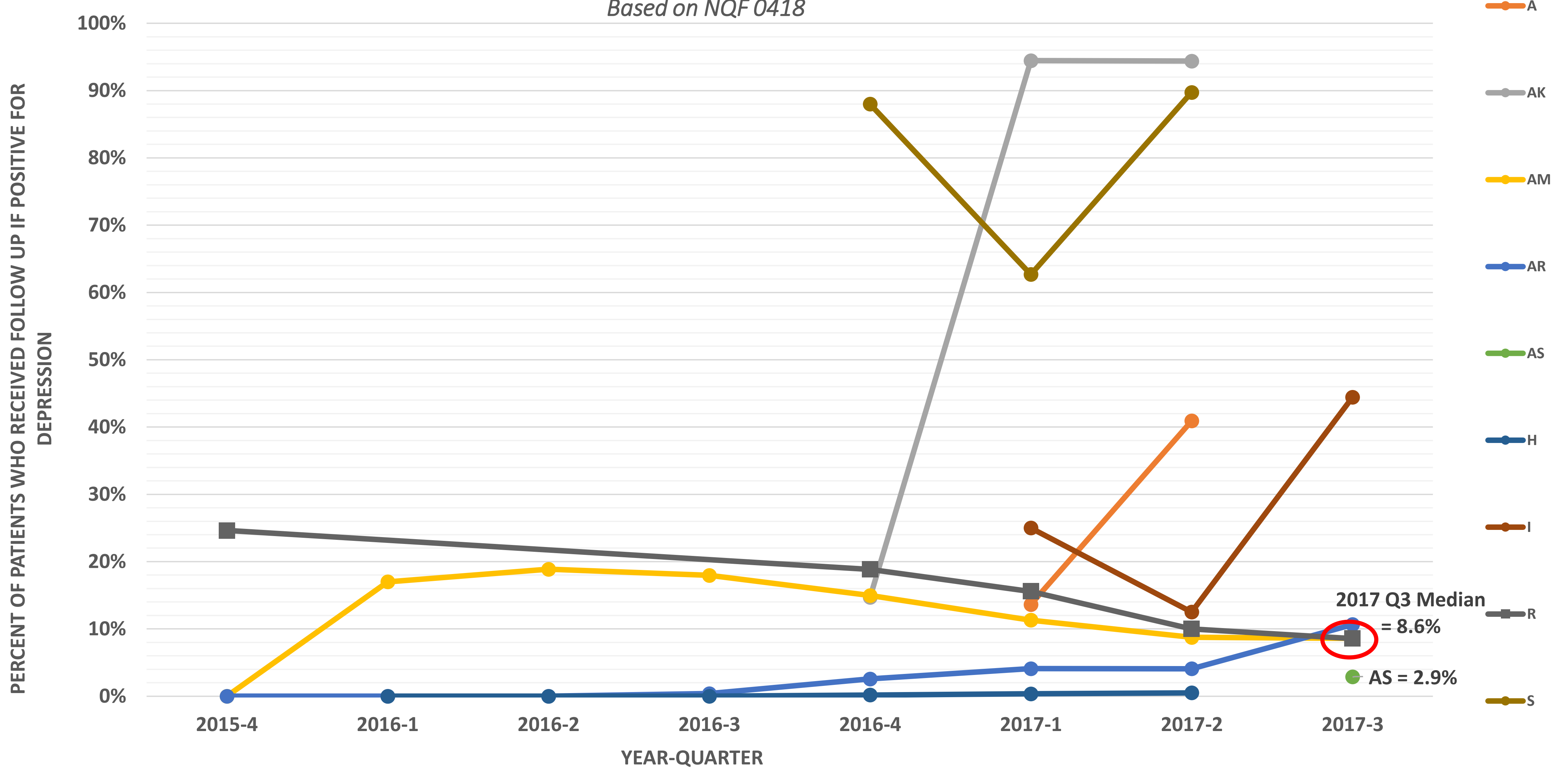
 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED



BHI: Adolescent Substance Use, Screening Only
Based on NQF 0418
PERCENT OF PATIENTS SCREENED FOR SUBSTANCE USE
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Q = 98.3%
2017 Q3 Median = 41.4%
U = 41.4%
B = 17.3%
K = 17.1%
2016-2
2016-3
2016-4
2017-1
2017-2
2017-3
YEAR-QUARTER
B
BB
C
K
Q
U
V



 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED



 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED

MEDICAID APM ROADMAP
JANUARY 10, 2018

Lucy C. Hodder
Director, Health Law and Policy Programs (IHPP)
Professor, UNH School of Law
Lucy.Hodder@unh.edu
Jo Porter
Director IHPP
Jo.Porter@unh.edu

© 2017 University of New Hampshire. All rights reserved.

Pathway to alternative payments State Medicaid Roadmap …. 2018

New Hampshire’s DSRIP Promise to CMS

STC Language

“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.

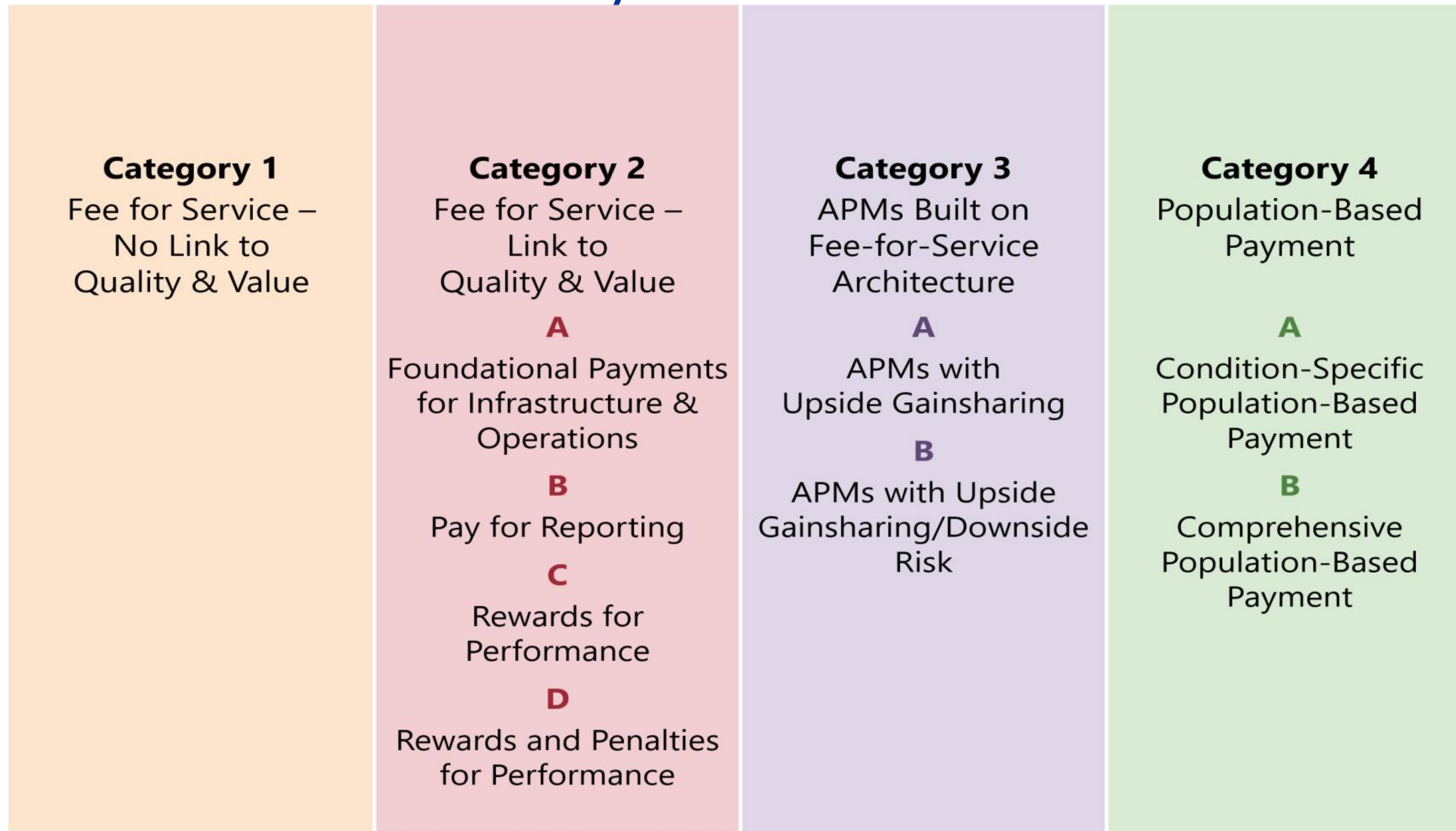
- IDN experience will help shape which APMs are implemented, and the related financial and operational components of the selected APMs.

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

© 2017 University of New Hampshire. All rights reserved.

Learning and Action Network (LAN): Alternative Payment Model Framework



https://hcp-lan.org/workproducts/apm-whitepaper.pdf

© 2017 University of New Hampshire. All rights reserved.

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.

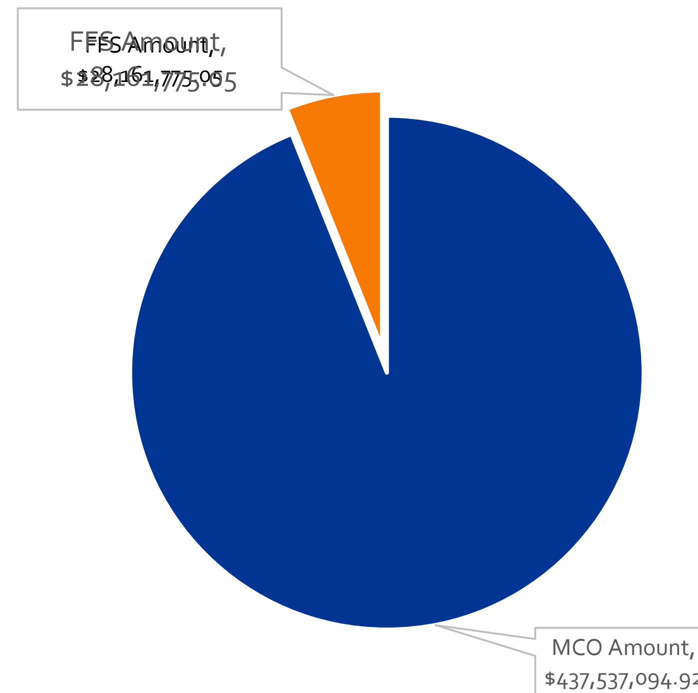
© 2017 University of New Hampshire. All rights reserved.

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

© 2017 University of New Hampshire. All rights reserved.

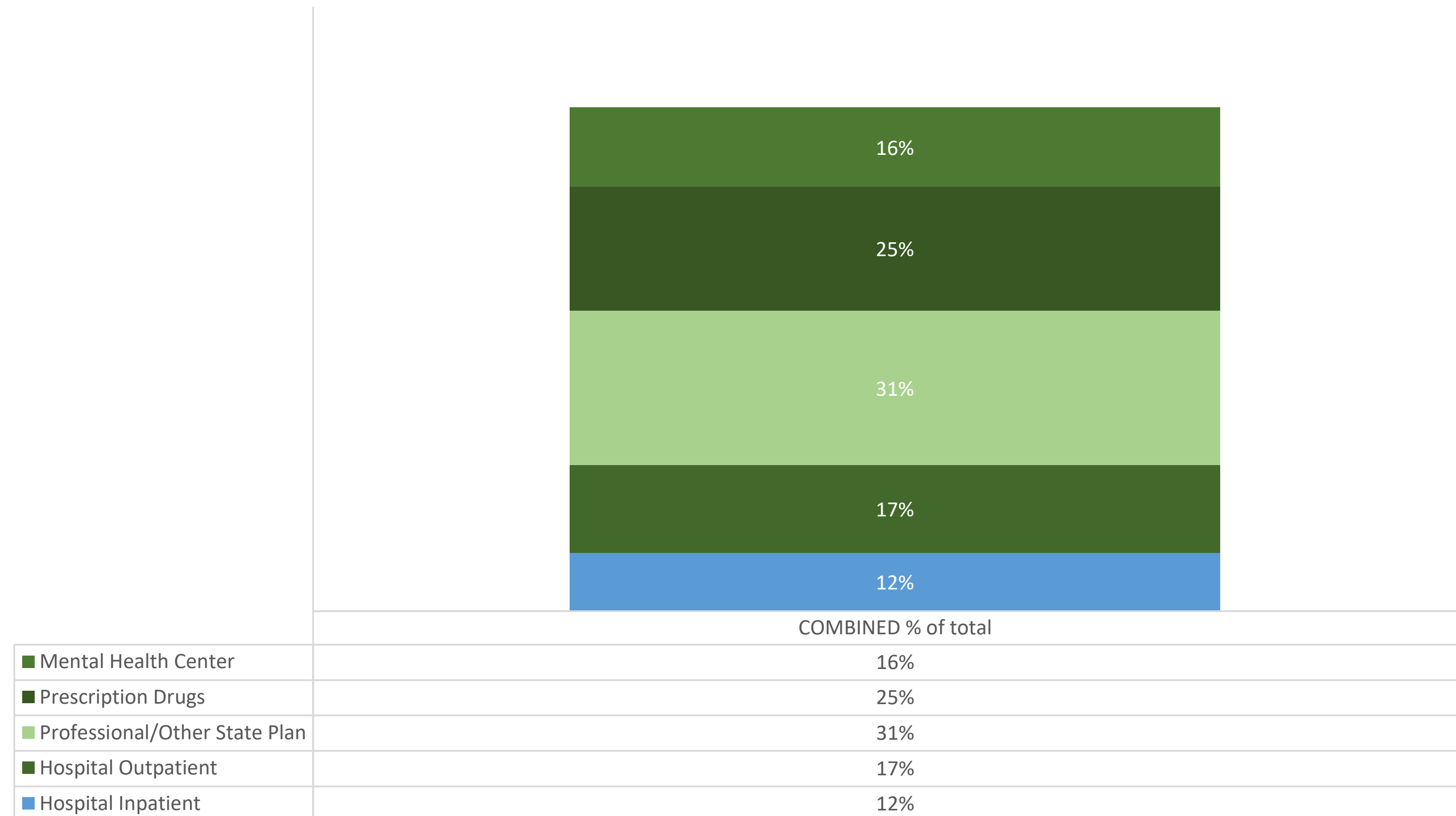
Medicaid Provider Payments, by MCO, FFS, and Other: FY2016



Source: Base data from Milliman's *SFY2018 Capitation Rate Development for Medicaid Care Management Program*

© 2017 University of New Hampshire. All rights reserved.

Provider Payments by Service Category, FY2016



	COMBINED % of total
Mental Health Center	16%
Prescription Drugs	25%
Professional/Other State Plan	31%
Hospital Outpatient	17%
Hospital Inpatient	12%

Source: Base data from Milliman's *SFY2018 Capitation Rate Development for Medicaid Care Management Program*

© 2017 University of New Hampshire. All rights reserved.

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

© 2017 University of New Hampshire. All rights reserved.

- For more information on the approved Roadmap, see DSRIP Alternative Payment Models Roadmap for Year 2 and Year 3 (CY 2018)
- https://www.dhhs.nh.gov/section-1115-waiver/documents/dsrip-apm-roadmap.pdf

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Building Sustainable Behavioral Health Integration

Anna Ratzliff, MD, PhD

Associate Professor

University of Washington

TCPI National Faculty

Copyright © 2017 University of Washington

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)

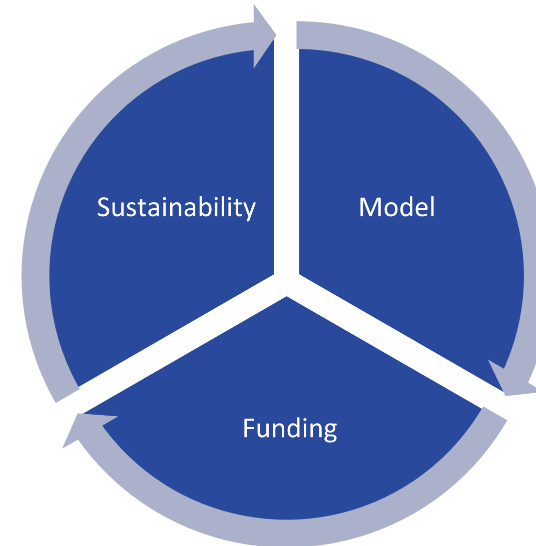
Copyright © 2017 University of Washington

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

Copyright © 2017 University of Washington

Objectives



Integrated Behavioral Health

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.

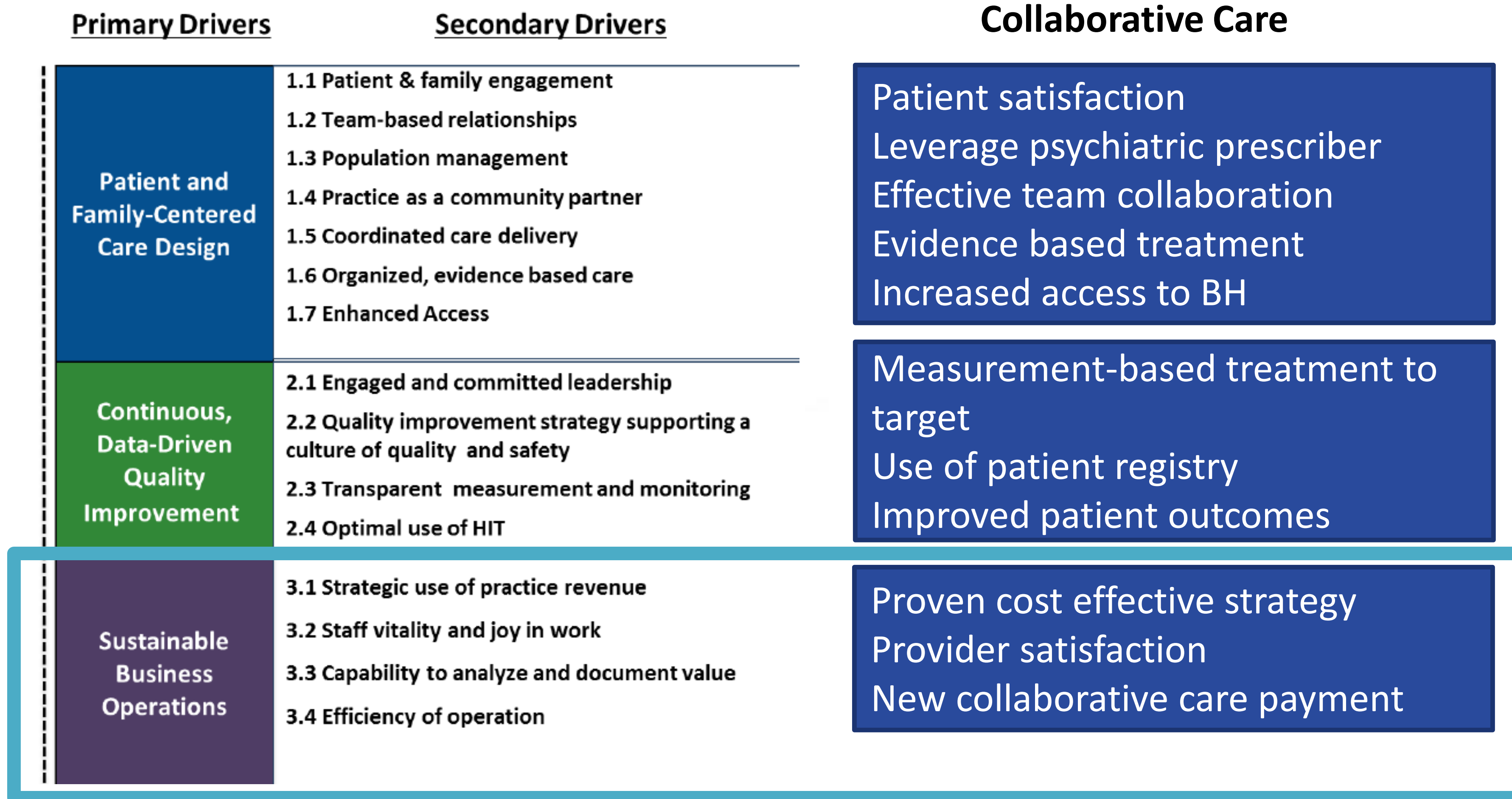
Copyright © 2017 University of Washington

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

Copyright © 2017 University of Washington

Collaborative Care Aligned with TCPI Goals



Copyright © 2017 University of Washington

- 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

Used with permission from the AIMS Center

Copyright © 2017 University of Washington

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**

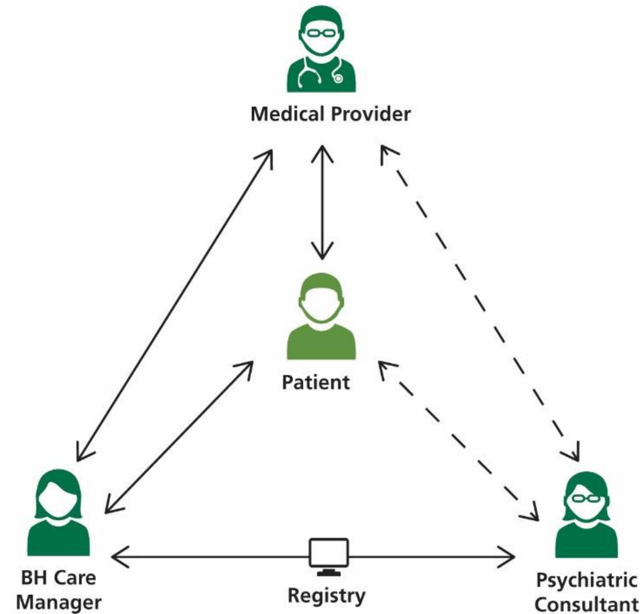
- **Value-based payments and pay for performance contracting with health plans**

Used with permission from the AIMS Center

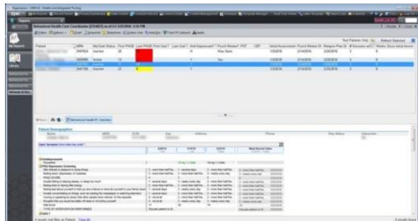
Copyright © 2017 University of Washington

Collaborative Care Model (CoCM)

Primary care patient-centered team-based care



Systematic case review with psychiatric consultant (focus on patients not improved)



Registry to track population

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

Active treatment with evidence-based approaches

Validated outcome measures tracked over time

Copyright © 2017 University of Washington

HOW WELL DOES IT WORK WITH OTHER DISORDERS?

AMERICAN PSYCHIATRIC ASSOCIATION

Evidence Base Established	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	• ADHD • Bipolar Disorder

© 2016 American Psychiatric Association. All rights reserved.

Medicare BHI/CoCM Codes

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

Copyright © 2017 University of Washington

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.**

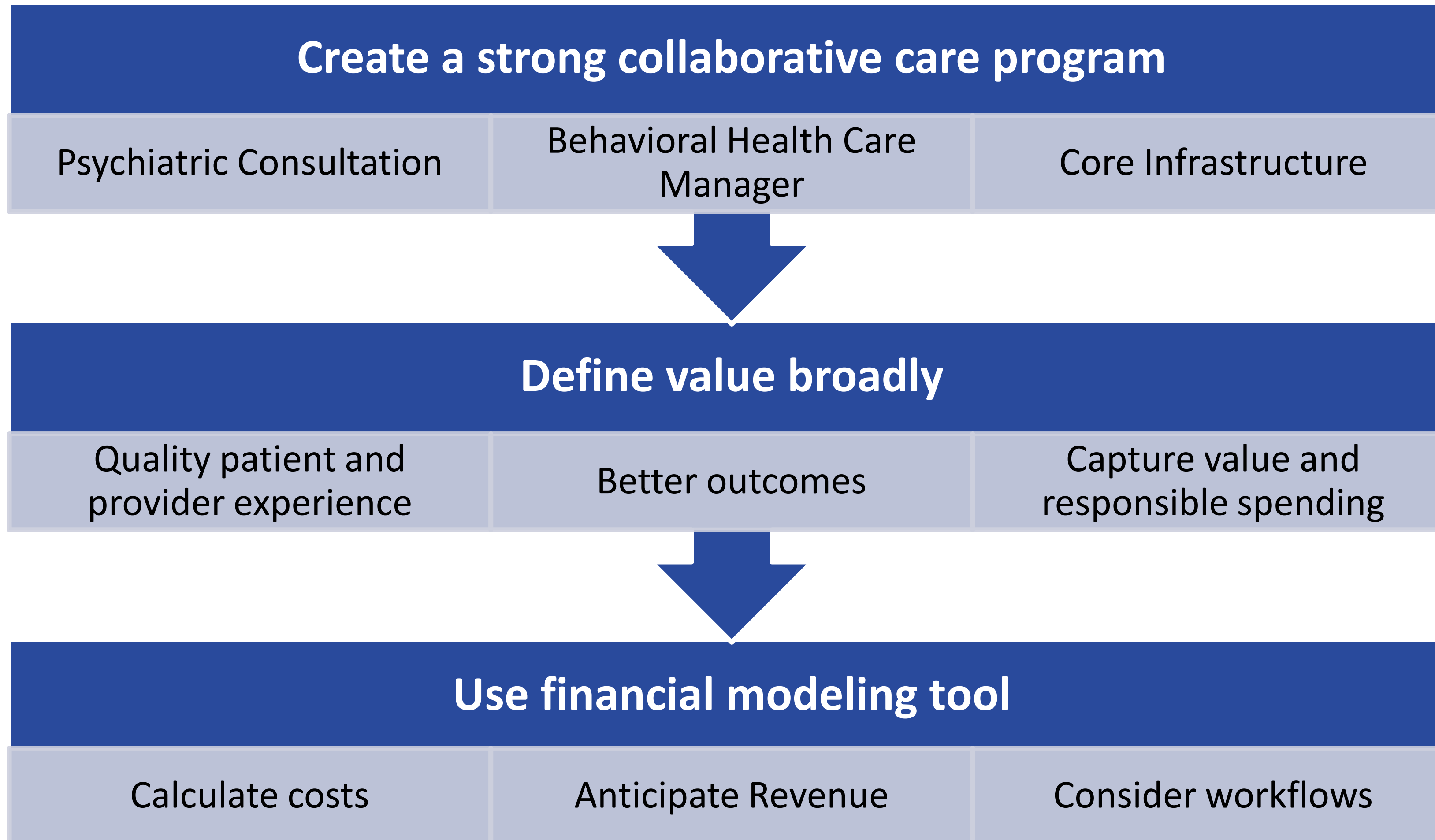
Copyright © 2017 University of Washington

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.

Copyright © 2017 University of Washington

Building a Sustainable Program



Copyright © 2017 University of Washington

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)

Used with permission from the AIMS Center

Copyright © 2017 University of Washington

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.

Copyright © 2017 University of Washington

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?

Copyright © 2017 University of Washington

- 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?

Copyright © 2017 University of Washington

Financial Modeling Workbook

Tab 1: Disclaimer

AMERICAN PSYCHIATRIC ASSOCIATION

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

THIS FINANCIAL MODELING WORKBOOK ("WORKBOOK") IS AN ESTIMATION TOOL PROVIDED WITHOUT COST AND FOR YOUR CONVENIENCE THAT SHOULD ONLY BE USED FOR INFORMATIONAL PURPOSES. THE INFORMATION GENERATED BY THE WORKBOOK IS RELIANT ON USER INPUT DATA AND THE WORKBOOK'S ACCURACY IS DEPENDENT ON THE DATA PROVIDED BY THE END USER. NEITHER THE UNIVERSITY OF WASHINGTON ("UW") NOR THE AMERICAN PSYCHIATRIC ASSOCIATION ("APA") SHALL BE LIABLE IN ANY WAY FOR ANY DIRECT, INDIRECT, CONSEQUENTIAL, OR PUNITIVE DAMAGES, LOST PROFITS, TECHNICAL ISSUES, OR OTHER DAMAGES, REGARDLESS OF FORESEEABILITY, THAT ARISE OUT OF OR RELATE TO THE USE OF THE WORKBOOK. USERS OF THE WORKBOOK HEREBY RELEASE UW, UW SCHOOL OF MEDICINE, APA AND THEIR OFFICERS, AGENTS, EMPLOYEES, REPRESENTATIVES, FACULTY, AND STUDENTS FROM ALL CLAIMS ARISING OUT OF OR RELATING TO THE WORKBOOK.

THE WORKBOOK IS PROVIDED "AS-IS" AND NEITHER APA NOR UW MAKE ANY WARRANTIES, EXPRESS OR IMPLIED, INCLUDING WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, NON-INFRINGEMENT AND INTERFERENCE RELATING TO THE WORKBOOK AND HEREBY DISCLAIMS ALL SUCH WARRANTIES AS TO ANY MATTER WHATSOEVER.

As Agreed:

Used with permission from the AIMS Center

Copyright © 2017 University of Washington

Financial Modeling Workbook

Tab 2: Staffing

AMERICAN PSYCHIATRIC ASSOCIATION
AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Workbook Template Updated 05/25/2017

Staffing and Service Delivery

Input	= User-entered value
Calculation	= Calculated field (not editable)
Benchmark	= Suggested benchmark (editable)
Linked Information	= Information copied from another cell

STAFFING

	FTE	Total Hours per Week	Suggested Hours per Week (Based on 40:3 ratio)
Hours per week per 1.0 FTE at your organization	40		
Team Member	**FTE**	**Total Hours per Week**	**Suggested Hours per Week (Based on 40:3 ratio)**
Care Manager	1.00	40.0	
Psychiatric Consultant	0.10	4.0	*3.0*

WEEKLY TIME AND EFFORT ALLOCATION AND SERVICE UNIT GENERATION: CARE MANAGER

Total Care Manager Hours per Week	40.0
	Percentage (%)

Details of staffing

- Weeks for 1.0 FTE
- Care manager FTE
- Psychiatric consultant FTE

Copyright © 2017 University of Washington

Financial Modeling Workbook

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

WEEKLY TIME AND EFFORT ALLOCATION AND SERVICE UNIT GENERATION: CARE MANAGER

Total Care Manager Hours per Week: 40.0

Row	Care Management Service Category	Percentage (%) of Total Hours per Week	Hours per Week	Service Units Generated	Hours per Service Unit	
19	*Reimbursable Direct Care Services*					
20	Direct Treatment: Assessment Visit	10.0%	4.00	4	1.00	
21	Direct Treatment: Ongoing Visits	51.3%	20.50	41	0.50	
22	Group Treatment	3.75%	1.50	6	0.25	
23	***Subtotal:** Reimbursable Direct Care Services*	65.0%	26.00	51		
24	*Non-Reimbursable Direct Care Services*					
25	Warm Connection (Non-Billable)	7.5%	3.00	15	0.20	Avg. length of warm connection
26	Care Management Telephonic Services	7.5%	3.00	15	0.20	Avg. length of phone calls
27	***Subtotal:** Non-Reimbursable Direct Care Services*	15.0%	6.00			
28	*Indirect Care Coordination and Administrative Tasks*					
29	Charting	5.0%	2.00			
30	Registry Management	3.0%	1.20			
31	Psychiatric Consultation	2.5%	1.00			
32	Team Communication	4.5%	1.80			
33	Other (Clinical Supervision, Staff Meetings, Training, etc.)	5.0%	2.00			
34	***Subtotal:** Indirect Care Coordination and Administrative Tasks*	20.0%	8.00			
36	Unassigned Time [Target = 0%]	✔ 0.0%	(Green checkmark indicates value is at target)			

WEEKLY TIME AND EFFORT ALLOCATION AND SERVICE UNIT GENERATION: PSYCHIATRIC CONSULTANT

Total Psychiatric Consultant Hours per Week: 4.0

Row	Psychiatric Consultant Service Category	Percentage (%) of Total Hours per Week	Hours per Week	Service Units Generated	Hours Per Service Unit
42	*Indirect Care and Administrative Tasks*				
43	Registry Management	10.0%	0.40		
44	Psychiatric Consultation	25.0%	1.00		

Disclaimer | Staffing and Service Delivery | Net Financial Impact | Monthly CoCM Case Rate

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

Copyright © 2017 University of Washington

Financial Modeling Workbook

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

AMERICAN PSYCHIATRIC ASSOCIATION
AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Workbook Template Updated 05/25/2017

Staffing and Service Delivery

Key	Meaning
Input	= User-entered value
Calculation	= Calculated field (not editable)
Benchmark	= Suggested benchmark (editable)
Linked Information	= Information copied from another cell

ANNUALIZED REIMBURSABLE DIRECT CARE SERVICES

Working Weeks Per Year: 47

Annualized Reimbursable Direct Care Service Units	Direct Treatment: Assessment	Direct Treatment: Ongoing	Group Treatment	Total Service Units
Care Manager	188	1,927	282	2,397
Psychiatric Consultant	75	19		94
Total: Annualized Reimbursable Direct Care Service Units	263	1,946	282	2,491

CASELOAD AND MONTHLY CASE VOLUME

Item	Value	Per 1.0 FTE
Average Weeks Elapsed Between First and Last Direct Care Service Avg. number of weeks per episode of care	25.0	
Average Count of Direct Care Service Units Provided Avg. number of contacts per episode of care	12.0	
Single Point in Time Caseload Capacity Number of individuals feasible to have on the caseload at any point in time across all Care Managers	96	96
Projected Annual Caseload Capacity Number of unique individuals feasible to serve over one year across all Care Managers	200	
Projected Average Monthly Caseload Turnover Number of cases opened and closed each month, based on above estimate of number of individuals possible to serve over one year	17	
Projected Number of Patients Served per Calendar Month Potential number of patients served over one month who might be eligible for monthly case rate reimbursement	113	
Projected Annualized Monthly Case Rate Potential Number of times a monthly case rate could potentially be billed in one year--before accounting for payer mix.	1,352	

Disclaimer | Staffing and Service Delivery | Net Financial Impact | Monthly CoCM Case Rate

Used with permission from the AIMS Center

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

Copyright © 2017 University of Washington

Financial Modeling Workbook

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

AMERICAN PSYCHIATRIC ASSOCIATION

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Workbook Template Updated 05/25/2017

Net Financial Impact

Input	= User-entered value
Calculation	= Calculated field (not editable)
Linked Information	= Information copied from another cell

PAYER MIX

Payer	% of Patients per Payer	% of Patients per Payer Eligible for Monthly Case Rate	Adjusted % of Patients Eligible for Monthly Case Rate
medicaid	33.0%	100%	33.0%
medicare	33.0%	100%	33.0%
commercial	33.0%	0%	0.0%
self pay	1.0%	0%	0.0%

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

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

REIMBURSEMENT: ANNUALIZED MONTHLY CASE RATE

Potential patient/months for billing case rate **1,352**

Payer	Monthly Case Rate Name	Monthly Reimbursement per Case	Adjusted % of Patients Eligible for Monthly Case Rate	Of Patients Eligible for Case Rate, % of Patients Also Eligible for Individual Services	Annualized Count of Cases Eligible for Monthly Case Rate	Annualized Reimbursement per Monthly Case Rate
medicare	Medicare CoCM	$ 134.58	33%	0%	446	$ 60,051.05
medicaid	WA Medicaid CoCM	$ 134.58	33%	0%	446	$ 60,051.05

To add rows: 1) Unprotect sheet 2) Insert rows above the last row with data 3) Copy formula in columns E, G, and H 4) Protect sheet

Disclaimer | Staffing and Service Delivery | Net Financial Impact | Monthly CoCM Case Rate

Payer Mix

- CoCM codes
- Other value-based payments
- Direct care revenue

Used with permission from the AIMS Center

Copyright © 2017 University of Washington

Financial Modeling Workbook

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

AMERICAN PSYCHIATRIC ASSOCIATION

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Workbook Template Updated 05/25/2017

Net Financial Impact

Input	= User-entered value
Calculation	= Calculated field (not editable)
Linked Information	= Information copied from another cell

REIMBURSEMENT: ANNUALIZED BILLABLE INDIVIDUAL SERVICES

Reimbursable Direct Care Service Units 2,491

		Care Manager			Psychiatric Consultant		
Payer	**% of Patients per Payer Eligible for Monthly Service Billing**	**Direct Treatment: Assessment Avg. Payment**	**Direct Treatment: Ongoing Avg. Payment**	**Group Treatment Avg. Payment**	**Direct Treatment: Assessment Avg. Payment**	**Direct Treatment: Ongoing Avg. Payment**	
commercial	33.0%	$ 106.00	$ 75.00	$ 40.00	$ 175.00	$ 105.00	
medicaid	0.0%	$ 90.00	$ 65.00	$ 35.00	$ 150.00	$ 95.00	
self pay	1.0%	$ 190.00	$ 125.00	$ 50.00	$ 200.00	$ 150.00	
To add rows: 1) Unprotect sheet 2) Insert rows above the last row with data 3) Copy formula in column C 4) Protect sheet							
Weighted Average per Service Unit		$ 108.47	$ 76.47	$ 40.29	$ 175.74	$ 106.32	
Annualized Service Units		188	1,927	282	75	19	**Across All Individual**
Billable Individual Service Units		64	655	96	26	6	**Service Categories:**
Subtotal: *Annualized Billable Individual Services Reimbursement*		**$ 6,933.44**	**$ 50,102.00**	**$ 3,863.40**	**$ 4,493.20**	**$ 679.62**	**$ 66,071.66**

TOTAL REIMBURSEMENT

Total Reimbursement:

Monthly Case Rate Reimbursement + Billable Individual Services Reimbursement

Monthly Case Rate Reimbursement		*Billable Individual Services Reimbursement*		
$ 120,102.09	+	**$ 66,071.66**	=	**$ 186,173.75**

TOTAL COST

Annual Salary per **Fringe Benefits**

Disclaimer | Staffing and Service Delivery | Net Financial Impact | Monthly CoCM Case Rate

Used with permission from the AIMS Center

Copyright © 2017 University of Washington

Financial Modeling Workbook

Tab 3: Net Financial Impact – Summary of Financial Model and Net Impact

AMERICAN PSYCHIATRIC ASSOCIATION

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Workbook Template Updated 05/25/2017

Net Financial Impact

Legend	
Input	= User-entered value
Calculation	= Calculated field (not editable)
Linked Information	= Information copied from another cell

TOTAL REIMBURSEMENT

	Monthly Case Rate Reimbursement		Billable Individual Services Reimbursement		
Total Reimbursement: *Monthly Case Rate Reimbursement + Billable Individual Services Reimbursement*	$ 120,102.09	+	$ 66,071.66	=	$ 186,173.75

TOTAL COST

Personnel	Annual Salary per 1.0 FTE	FTE	Salary Cost Per FTE	Fringe Benefits % of Salary	Fringe Benefits Cost	Personnel Subtotal
Care Manager	$ 60,000.00	1.00	$ 60,000.00	30.0%	$ 18,000.00	$ 78,000.00
Psychiatric Consultant	$ 250,000.00	0.10	$ 25,000.00	30.0%	$ 7,500.00	$ 32,500.00
Subtotal: *Personnel Cost*						$ 110,500.00
Organizational Overhead				*Percentage:*	30.0%	$ 33,150.00
Total Cost: *Personnel + Overhead*						$ 143,650.00

NET IMPACT

	Total Reimbursement		Total Cost		
Net Impact: *Total Reimbursement - Total Cost*	$ 186,173.75	-	$ 143,650.00	=	$ 42,523.75

Disclaimer | Staffing and Service Delivery | Net Financial Impact | Monthly CoCM Case Rate

Used with permission from the AIMS Center

Copyright © 2017 University of Washington

- **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**

Copyright © 2017 University of Washington

- **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**

Copyright © 2017 University of Washington

Build a primary care site in your mental health center

- Need to see BOTH mental health center and general primary care
- Providers need to build comfort with mental health center patient adaptations

Partner with a primary care site

- Need strong system to share information and coordinate care
- Role for patient navigator coordinator
- Stratify patients and track total costs of care

Copyright © 2017 University of Washington

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**

Copyright © 2017 University of Washington

Next Steps

 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED

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)

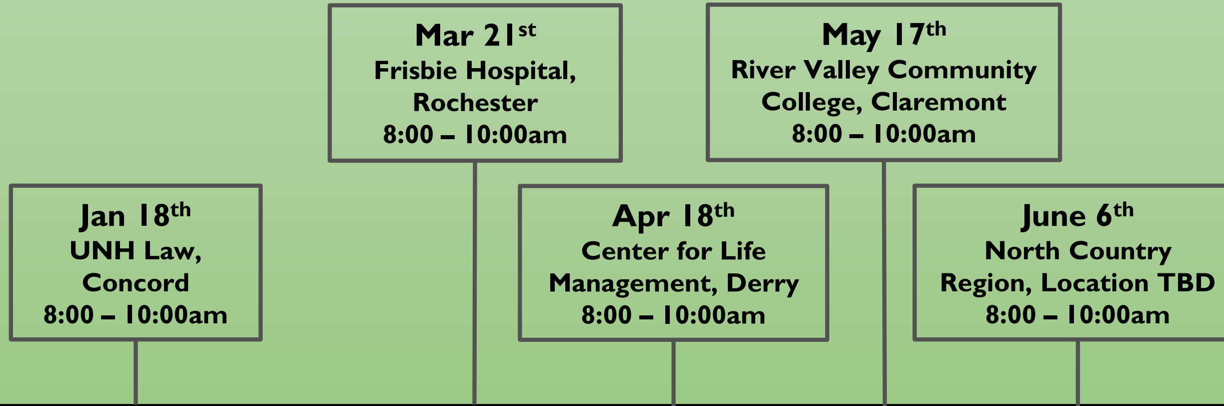
- Payer A: 20 Claims (12 month period ending 8/31/2017)

Collaborative Care Codes effective 1/1/2018

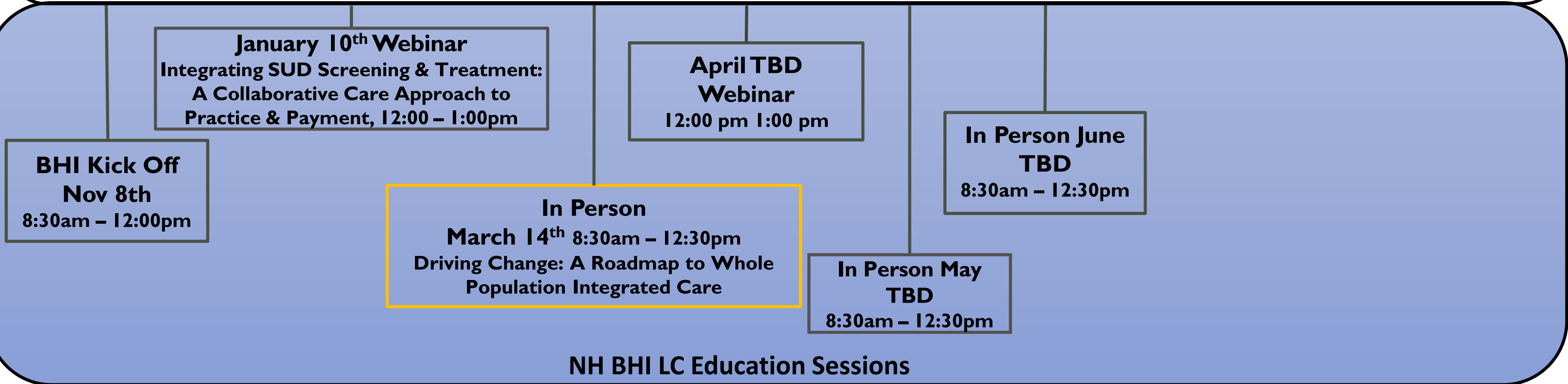
- Anthem: 99492 – 99494, 99484
- Harvard Pilgrim Health Plan: 99492 – 99494
- Cigna: Piloting 99492 – 99494 with medical groups in collaborative relationships

 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED

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



2017 Nov Dec Jan Feb Mar Apr May Jun July Aug Sept 2018



 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED

Announcements

NNE ECHO (Expanding Connectivity for Health Outcomes) Collaborative

Kick off – January 25th

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

Now Recruiting!

Learn More: Marguerite Corvini 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

Academic Partners

Manchester Community College
Plymouth State University
Rivier University
University of New Hampshire
Antioch University

 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED

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

 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED

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

 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED

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

 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED

Staff Contacts

Jeanne Ryer	jeanne.ryer@unh.edu	Lucy Hodder	lucy.hodder@unh.edu
Annie Averill	annie.averill@unh.edu	Matt Humer	matthew.humer@unh.edu
Stephanie Cameron	stephanie.cameron@unh.edu	Sally Minkow	sally.minkow@unh.edu
Katherine Cox	katherine.cox@unh.edu	Molly O'Neil	molly.oneil@unh.edu
Marcy Doyle	marcy.doyle@unh.edu	Janet Thomas	janet.thomas@unh.edu
Hwasun Garin	hwasun.garin@unh.edu	Holly Tutko	holly.tutko@unh.edu

 © 2018 UNIVERSITY OF NEW HAMPSHIRE ALL RIGHTS RESERVED