Collaborative Care Financing and Sustainment

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Learning Objectives

- Name the core financing requirements to implement a Collaborative Care Model (CoCM) program

- List the CoCM CPT codes and core billing requirements

- Discuss common CoCM sustainability strategies

Collaborative Care Costs
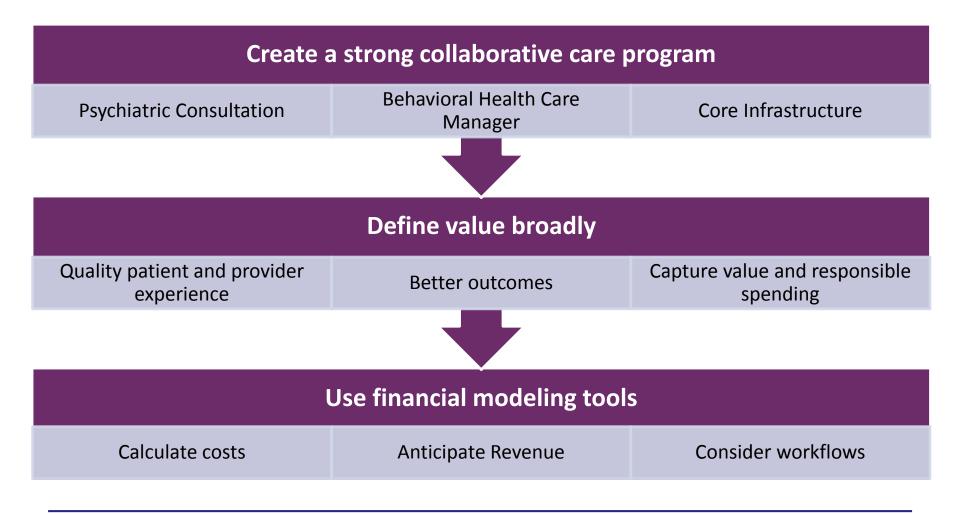
Initial Costs of Practice Change:

- 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)

Financing for Collaborative Care

Create a strong collaborative care program		
Psychiatric Consultation	Behavioral Health Care Manager	Core Infrastructure

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Define value broadly		
Quality patient and provider experience	Better outcomes	Capture value and responsible spending

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Use financial modeling tools		
Calculate costs	Anticipate Revenue	Consider workflows

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CPT Codes for CoCM/BHI

CPT® Code	Description	2020 Rate
99492	CoCM – first 70 mins in first month	$156.99
99493	CoCM – first 60 mins in any subsequent months	$126.31
99494	CoCM – up to two additional 30 mins in any month (billed with 99492 or 99493)	$63.88
G2214	**NEW!** 30 minutes in any month, billed alone	
99484	BHI services - 20 mins per month	$48.00

- 50% + 1 rule applies to these codes
- CPT® codes above cannot be applied to FQHC-RHC billing
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

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FQHC/RHC HCPCS Codes

G-Code	Description	2020 rates
G0512	**Psychiatric CoCM – min. 60 mins/month**	**$141.83**
G0511	**General Care Management Services – min. of 20 mins/month**	**$66.77**

- G0511 incorporates General BHI services (99484) and old Chronic Care Management (99490 and 99487)
- G0512 is specific to CoCM services (99492 and 99493) – no add on code

CoCM Billing Requirements

Key Components

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

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

- Regular (typically weekly) systematic psychiatric caseload reviews and consultation by a psychiatric consultant.

Additional Considerations

- Count the **BH Care Manager time**

- **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 (valuation includes psychiatrist activity). Contracts 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 psychiatric providers can also bill additional codes for therapy etc.

Finance Office Hours

FINANCE

Hosted in collaboration with the **American Psychiatric Association** ↗, these sessions address questions on billing, financial sustainability, and our **Financial Modeling Workbook**.

When

- First Wednesday of every month at **9:00-10:00 am Pacific Time**.
- See the calendar below for 2021 dates.

How to Join

- **Join URL:** https://zoom.us/j/95007236406 ↗
- **Phone Number:** Find the Zoom number for your state here https://zoom.us/u/aboC3R0F0P ↗
- **Meeting ID:** 950 0723 6406 #

http://aims.uw.edu/what-we-do/aims-office-hours

AIMS Center Phases of Implementation

COLLABORATIVE CARE: A step-by-step guide to implementing the core model

Lay the foundation	Plan for Clinical Practice Change	Build your Clinical Skills	Launch your Care	Nurture your Care
Collaborative Care is a new way of doing medicine and requires an openness to creating a new vision that everyone supports.	Time to clearly define care team roles, create a patient-centered workflow, and decide how to track patient treatment and outcomes	Effective Collaborative Care creates a team in which all of the providers work together using evidence-based treatments.	Is your team is in place? Are they ready to use evidence-based interventions appropriate for primary care? Are all systems go? Time to launch!	Now is the time to see the results of your efforts as well as to think about ways to improve it.

Lay the foundation
- √ Develop an understanding of the Collaborative Care approach, including its history and guiding principles.
- √ Develop strong advocacy for Collaborative Care within organizational leadership and among the clinical team.
- √ Create a unified vision for Collaborative Care for your organization with respect to your overall mission and quality improvement efforts.
- √ Assess the difference between your organization's current care model compared to a Collaborative Care model.

Plan for Clinical Practice Change
- √ Identify all Collaborative Care team members and organize them for training.
- √ Develop a clinical flowchart and detailed action plan for the care team.
- √ Identify a population-based tracking system for your organization.
- √ Plan for funding, space, human resource, and other administrative needs.
- √ Plan to merge Collaborative Care monitoring and reporting outcomes into an existing quality improvement plan.

Build your Clinical Skills
- √ Describe Collaborative Care's key tasks, including patient engagement and identification, treatment initiation, outcome tracking, treatment adjustment and relapse prevention.
- √ Develop a qualified and prepared care team, equipped with the functional knowledge necessary for a successful Collaborative Care implementation.
- √ Develop skills in psycho-therapy treatment that are evidence-based and appropriate for primary care (e.g. Problem Solving Treatment, Behavioral Activation, etc)

Launch your Care
- √ Implement a patient engagement plan
- √ Manage the enrollment and tracking of patients in a registry
- √ Develop a care team monitoring plan to ensure effective collaborations
- √ Develop clinical skills to help patients from the beginning to the end of their treatment, including a relapse prevention plan

Nurture your Care
- √ Implement the care team monitoring plan to ensure effective team collaborations
- √ Update your program vision and workflow
- √ Implement advanced training and support where necessary

Continuous Quality Improvement

http://aims.uw.edu/

New York Five Year Sustainability: Quantitative Results

Clinic Sustained	Clinic Opted-Out
• Care Manager: 1.0 FTE	• Care Manager: 0.5 FTE
• Number of Patients/FTE: 137	• Number of Patients/FTE: 58
• Improvement Rate: 46%	• Improvement Rate: 7.5%

Moise N et al. Sustainability of collaborative care management for depression in primary care settings with academic affiliations across New York State. *Implement Sci.* 2018.

New York Five Year Sustainability: Qualitative Results

Facilitators ↑

- •- Strong patient engagement
- •- Strong screening/referral workflow
- •- Adequate personnel/ BH care manager
- •- Ongoing Training
- •- Effective use of IT/Registry
- •- Aligned leadership
- •- Leveraged funding sources
- •- Accountability (audit and feedback)

- Inadequate time/ personnel
- Poor patient engagement
- Poor provider engagement
- Competing initiatives
- Challenges with workflow/screening
- Lack of funding

Barriers ↓

Moise N et al. Sustainability of collaborative care management for depression in primary care settings with academic affiliations across New York State. *Implement Sci.* 2018.

Integrated Care Training Program

Collaborating to Heal Addiction and Mental Health in Primary Care
Research Project Manager: Lori Ferro, MHA, PMP | Research Study Coordinator: Danielle Bohonos, MPH

John Fortney, PHD

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Anna Ratzliff, MD, PHD

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What We Want to Learn

CHAMP is based on a series of 3 questions

1. Does systematic screening for OUD help us identify more people with OUD?

2. Is Collaborative Care (CoCM) for OUD and MHD more effective for patients with co-occurring disorders than CoCM for MHD only?

3. What kind of sustainment support helps maintain high quality CoCM for co-occurring disorders?

Identifying Targets for Sustainment Intervention

- ## Financial Sustainment
  - SIF Project included sustainment planning continued to deliver CoCM at on year (AIMS Center Experience)

- ## Staff Turnover
  - Clinics struggling when champions left (AIMS Center Experience)
  - Full time care manager more likely to sustain (Moise)

- ## Address Fidelity Drift
  - Clinics with better outcomes more likely to sustain (Moise)

Summative Evaluation:
What kind of sustainment support is needed for high quality CoCM for co-occurring disorders?

- Stratified by cohort, CHAMP clinics randomized to
  - Low-intensity strategy: internal facilitation
  - High-intensity strategy: internal facilitation AND external facilitation

Implementation Strategy	Barrier Targeted	Mechanism(s) of Action	Proximal Outcome Measure	Distal Outcome Measure
Produce a report documenting current financing and billing practices	Lack of revenue	Creating revenue streams for CHAMP encounters	Proportion of CHAMP encounters billed, denied, and paid	Adoption Reach
Develop a formal training plan to manage staff turnover	Staff turnover	Cover CHAMP roles with existing staff transferring knowledge to new staff	All CHAMP roles adequately staffed and trained	Adoption Reach Effectiveness
Develop a systematic audit and feedback system and quality improvement skills	Fidelity drift	Monitoring drift and correcting course over time	Drift detect and corrected	Fidelity Effectiveness

QUESTIONS?

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