AHCCCS Targeted Investments Program

Adult B Quality Improvement Collaborative

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TIP Year 5: Session #1
October 14, 2020

ASU College of Health Solutions
Arizona State University

AHCCCS Arizona Health Care Cost Containment System | Targeted Investments

ASU College of Health Solutions
Arizona State University
Center for Health Information and Research

Disclosures

Tasneem Doctor is VP Behavioral Health at Equality Health

Agenda

TIME	TOPIC	PRESENTER
11:30 AM – 11:35 AM	Overview • Agenda	Kailey Love
11:35 AM – 12:00 PM	Collaborative Care Model • Overview • Billing Codes	Tasneem Doctor, Ed.D Stephanie Furniss, PhD
12:00 PM – 12:20 PM	Collaborative Care Model: Use Case	Velda Rose Medical Center
12:20 PM – 12:55 PM	Discussion & Q&A	All
12:55 PM – 1:00 PM	Next Steps	Kailey Love

TIP Year 5

QIC Attendance:

- There will be a total of 10 virtual quality improvement collaboratives (QICs) during TIP Year 5, which begins October 2020.
  - Two of these will occur in what remains of 2020—October and November.
  - There will be no QICs in December 2020.
  - The remaining 8 QICs will be scheduled in 2021.
  - Attendance requirements will stay the same for TIP Year 5

Continuing Education Units:

- Continuing Education Units (CEUs) for the virtual quality improvement collaboratives (QIC) will be awarded on an annual basis following the last QIC session of the calendar year.
  - For 2020, TIP participants can receive up to 12 CEU (1.5 per virtual QIC session) and will be awarded following the last virtual QIC session in November 2020.
  - For 2021, participants will have the opportunity to earn up to 12 CEUs (1.5 per virtual QIC session).

Learning Objectives

1. Describe the components of the Collaborative Care Model.
2. Analyze the role of Collaborative Care Model in healthcare integration and value-based care.
3. Identify opportunities for incorporating the Collaborative Care Model in a Primary Care and Behavioral Health practice.

Behavioral Health Integration

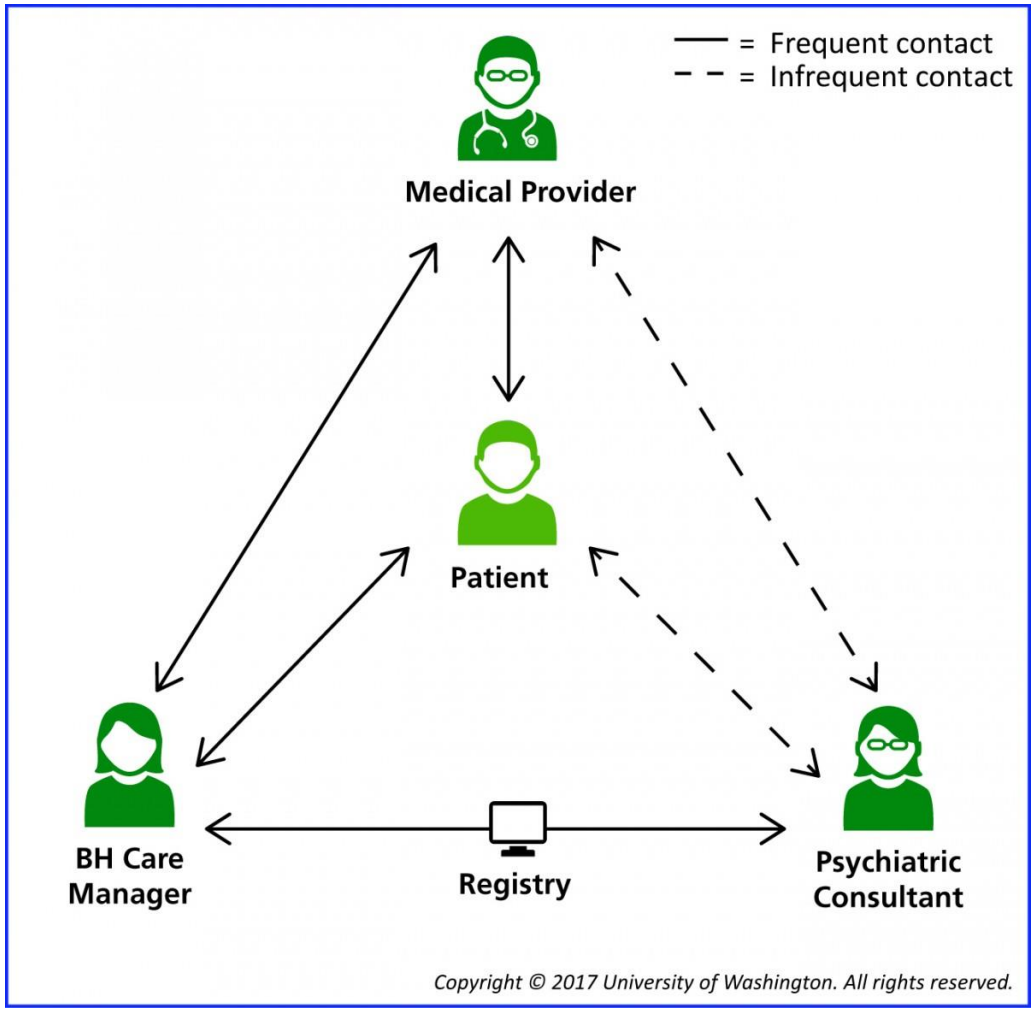
- 10% of patient visits are BH related
- Patients referred to BH often do not follow through
- Typically 30-60 days to see a psychiatric provider
- Collaborative Care Model (CoCM) reduces these barrier

Psychiatric Collaborative Care Model (CoCM)

- An approach to BHI developed at the University of Washington and shown to be effective in randomized controlled trials
- Enhances primary care with addition of two key services:
    1. Care management/therapeutic support for patients receiving behavioral health treatment
    2. Psychiatric inter-specialty consultation for the primary care team
- Services provided by a team of primary care and behavioral health specialists who each have well-defined roles

5 Core Principles

1. Patient-Centered Team Care
2. Population-Based Care
3. Measurement-Based Treatment to Target
4. Evidence-Based Care
5. Accountable Care



Citation: https://aims.uw.edu/collaborative-care/team-structure

Service Components

- **Initial assessment** by the primary care team (billing practitioner and behavioral health care manager)
- **Care planning** by the primary care team, jointly with the beneficiary, with care plan revision for patients whose condition is not improving adequately. Treatment may include pharmacotherapy, psychotherapy, and/or other indicated treatments
- Behavioral health care manager performs **proactive, systematic follow-up** using validated rating scales and a registry
- **Regular case load review** with psychiatric consultant

Citation: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

Why PCP's love Psychiatric Collaborative Care

- **Established Evidence Base-** CoCM has a robust evidence base of over 80 randomized controlled trials and has been shown to be the best approach to treating depression in many populations and settings.
- **Better Medical Outcomes-** CoCM is linked to better medical outcomes for patients with diabetes, cardiovascular disease, cancer, and chronic arthritis.
- **Help with Challenging Patient Cases-** Many challenging cases likely have patients with untreated or undertreated behavioral health conditions. Behavioral health providers do the follow-up and intervention tasks that a busy PCP doesn't have time to do but make a big difference for patients.
- **Faster Improvement-** A 2016 retrospective study at Mayo Clinic found that the time to depression remission was 86 days in a CoCM program while in usual care it was 614 days.
- **It Takes a Team-** CoCM has a population-based treatment to target approach utilizing a psychiatric consultant. Only 30-50% of patient have a full response to the first treatment (psychiatric medication). 50-70% require one adjustment which is why the psychiatric consultant is so crucial.

Sources: University of Washington AIMS Center; Psychosomatic Medicine, 2014; Family Community Health , 2015; Psychiatric Services, 2015

Benefits of Psychiatric Collaborative Care

- **2- 3** times increase in PMPM cost for comorbid mental health conditions. Effective integration reducing this number by **9 to 17%** with savings of 38 to 68 billion annually (Milliman)
- The **IMPACT** study suggested that up to $6.50 are saved in health care costs for every dollar spent on collaborative care, a return on investment of 6:1.
- Avg of $600 annual savings per member (over 80 clinical trials)
- **TEAMCare** study: PQH 9, HbA1c, Systolic BP, LDL all improved for patients receiving CoCM
- Lower cost than specialty BH care- caps on Utilization
- 70-80% of members won't accept referrals. Typical PCP tx with meds only= 19% Efficacy
- 24-72 hour access to psychiatric care vs 30 days
- Increased PCP satisfaction- No credentialing/contracting required
- Endorsed by APA, CMS and all Major Health Plan Partners

Source: http://aims.uw.edu/resource-library/long-term-cost-effects-collaborative-care-late-life-depression
http://us.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf

Billing Overview

- PCP is billing provider
- PCP collaborates with BH team members
- Covered by all major health plans
- Service billable by the PCP to all major health plans under current contract

CoCM Codes

BHI code	BH Care Manager or Clinical Staff Threshold Time	Assumed Billing Practitioner Time
CoCM First Month (99492)	70 minutes per calendar month	30 minutes
CoCM Subsequent Months* (99493)	60 minutes per calendar month	26 minutes
Add-On CoCM (Any month) (99494)	Each additional 30 minutes per calendar month	13 minutes

* CoCM is furnished monthly for an episode of care that ends when targeted treatment goals are met or there is failure to attain targeted treatment goals culminating in referral for direct psychiatric care, or there is a break in episode (no CoCM for 6 consecutive months).

Citation: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

What about CPT 99484?

- Not a CoCM code and not included in TIP however this code is an essential component of integration
  - Allows provider to monitor progress of members seeing BH specialist
- Used to bill services furnished using other BHI models of care “that include systematic assessment and monitoring using validated clinical rating scales (where applicable), behavioral health care planning (with care plan revision for patients whose condition is not improving), facilitation and coordination of behavioral health treatment, and a continuous relationship with a designated member of the care team.” [NEJM Press et al 2018]
- “Services billed under this code may be provided directly by the primary care clinician and do not necessarily have to be furnished by a designated behavioral health care manager or involve a psychiatric consultant” [NEJM Press et al 2018]

CoCM codes & FUH 7/30-day

Psychiatric Collaborative Care Model (CoCM) is an approach to behavioral health integration recognized by CMS. An AHCCCS Committee in consultation with CHiR established how the CoCM services (i.e., codes 99492, 99493 and 99494) will be recognized in the TI Program.

- *PCP measure evaluation (i.e., 7/30-day follow up after hospitalization for mental illness measures):* CoCM codes will count as a qualified visit for numerator.
- *PCP attribution:* CoCM codes will not be included among E&M codes or other qualifying visit in PCP attribution process.
- *BH measure evaluation & attribution (i.e., 7/30-day follow up after hospitalization for mental illness measures):* In post-discharge period, CoCM codes will count as a qualified visit for numerator. In period prior to hospitalization (i.e., 90 days prior), CoCM codes will qualify the BH provider in denominator.

Peer Presenter: Discussion Questions

1. When and how did you implement the Collaborative Care Model?
2. What have been your experiences with the Collaborative Care Model?
    a. How has the Collaborative Care Model helped your practice?
    b. How has the Collaborative Care Model helped improve the experience for your members and outcomes?
    c. What were major difficulties you encountered during implementation of the Collaborative Care Model and in providing these services?
3. How has the Collaborative Care Model improved the integration of primary care and behavioral health?

Collaborative Care Model (CoCM)

Andrea Durand, DBH, LCSW

Maddie Timonte-Practice Administrator

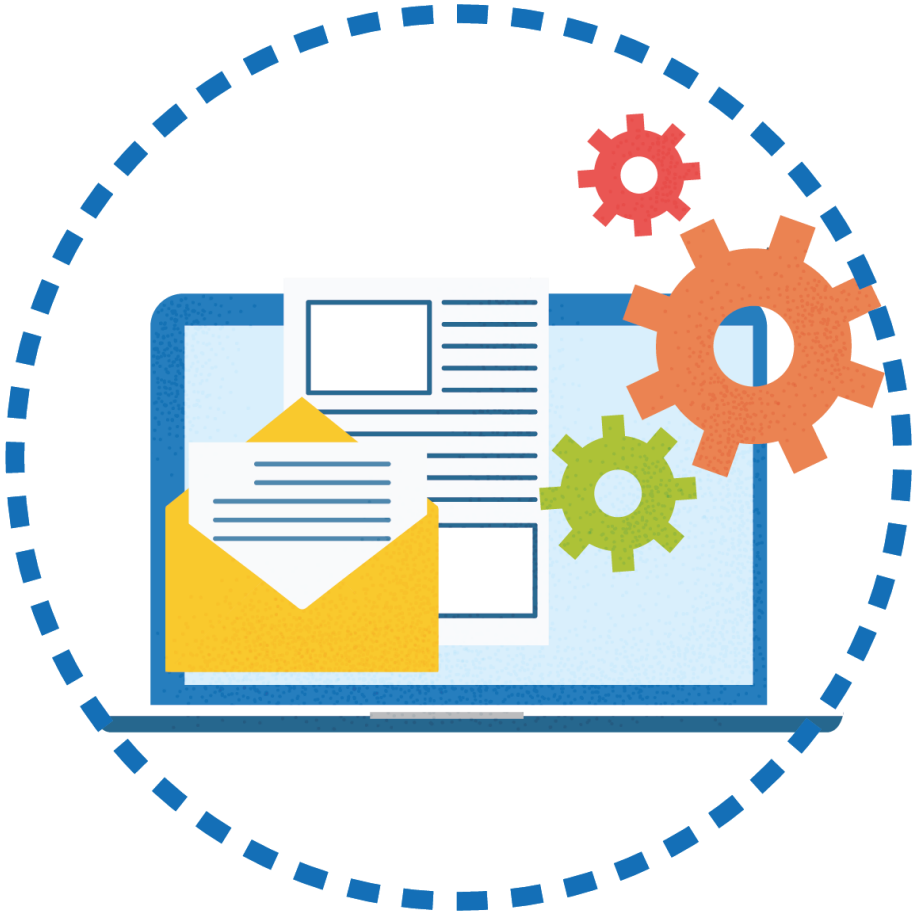
CoCM Implementation Timeline

2017 committed to BH Integration by signing up for the AHCCCS TI Program

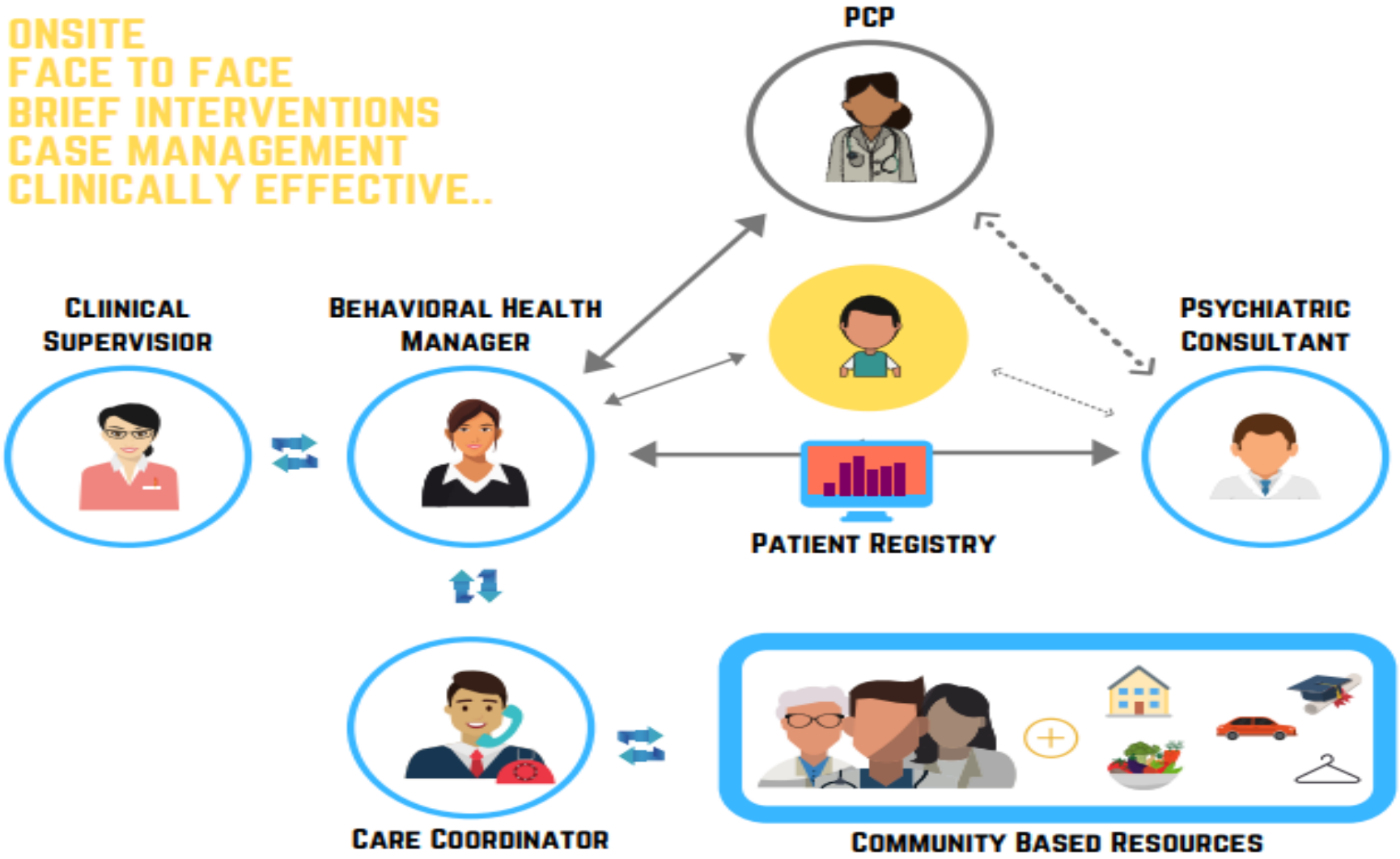
January 2018 Most Commerical and Medicaid MCO's implemented CoCM codes

July 2018 Partnered with evolvedMD to implement the CoCM model for Integration

August 2018 Hired first onsite Behavioral Health Manager



Additional Support to CoCM Model



Psychiatric Collaborative Care: Patient Management

Patient Management

- Ongoing Patient Monitoring Using Validated Scales to Screen for BH/MH conditions
- Conduct Evidenced Based Psychotherapy Interventions
- Follow up Based Visits based on patient need and established care plan, 1-3x per month
- Weekly patient panel review w/ Psychiatric Consultant
- Connect Patient with Community Based Resources
- Refer patients to extension programs (diabetes and depression, chronic pain and long term opiate use)

Examples of Conditions Managed

- General Behavioral Health Conditions such as Depression, Anxiety, PTSD, Grief
- Addictive Disorders, Smoking Cessation, Lifestyle Changes (sleep, exercise)
- ADHD, Cognitive Impairment (MMSE)
- Bipolar Dx, Borderline personality Dx, Schizophrenia (Mild-Moderate acuity)
- Any Behavioral Health concern can be routed through the program

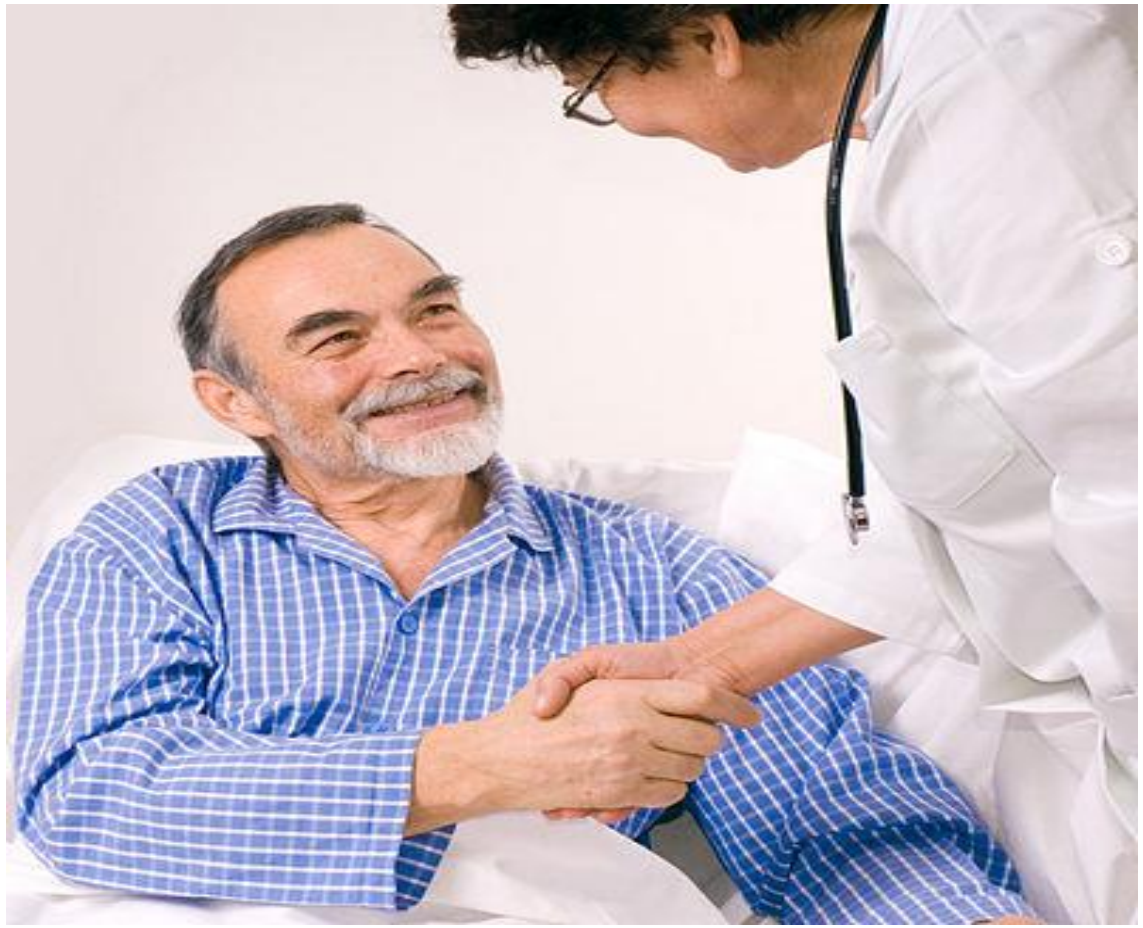
evolvedMD

How has the CoCM model helped our practice?

- Provided our PCP's with much needed support for high risk patients
- Educated PCP's with a better understanding of BH services and psychotropic medication use
- Decreased liability for physicians prescribing opioids or any psychotropic medication since they are evaluated by the BHM
- Increased access to VBS
- Increased revenue with expanded services

How has the CoCM improved experience for members and patient outcomes?

- Improved treatment outcomes
  - Decreased depression and anxiety scores
  - Decreased hospital re-admission
  - Decreased risk of opioid abuse
  - Increased chronic pain functioning
  - Increased # of patients with controlled A1c
- Eliminates many barriers to treatment such as
  - Insurance, prior- authorization, decreased co-pays
  - Wait times
  - PCP and BH visits same day
  - Provider notes in one place
  - Evaluated for SDOH needs, connected to community resources



What were the major barriers you encountered during implementation of the CoCM?

- Getting support staff used to screening every patient for depression and anxiety at every visit
- Getting providers comfortable with referring to the program
- Making sure the amount of onsite resource is appropriate for the clinic need
- Making sure BHM has personality characteristics and skill set for primary care setting
- Consistent re-education for staff is key

How has the CoCM improved the integration of primary care and behavioral health?

- Allows for the incorporation of a psychiatric consultant so most patients don't have to be referred out for medications
- Allows for BH to be onsite with shared resources and shared staffing which significantly improves communication
- Eliminates need for credentialing BHM with insurance companies and dealing with prior auths
- Allows for extension programs that incorporate both BH and Physical health

Q&A

- Please insert any questions in the Q&A box

Next Steps

- Next Steps
  - Post-Event Survey: 2 Parts
    - Feedback Questions for TIP Year 5 QIC
    - Continuing Education Evaluation
  - Continuing Education
    - For 2020, TIP participants can receive up to 12 CEU (1.5 per virtual QIC session) and will be awarded following the last virtual QIC session in November 2020.
    - For 2021, participants will have the opportunity to earn up to 12 CEUs (1.5 per virtual QIC session) and will be awarded following the last virtual QIC session in 2021

- Questions or concerns?
  - Please contact ASU QIC team at TIPQIC@asu.edu if questions or concerns regarding performance data

Thank you!

TIPQIC@asu.edu

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Appendix

Implementation / Tools

- AIMS Center website
  - Building the business case
  - Financing Strategies
  - Job Descriptions
  - Care Manager Essentials
  - Implementation Guide
  - AIMS Caseload Tracker
  - And more!

Resources

- CMS and Medicare Learning Network. Behavioral Health Integration Services. Updated 5/2019.
- CMS. Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services. Updated 4/17/2018.
- University of Washington AIMS Center. Collaborative Care.
  - They also have an online Resource Library
- American Psychiatric Association and Academy of Psychosomatic Medicine. Dissemination of Integrated Care Within Adult Primary Care Settings: The Collaborative Care Model. 2016.
- American Psychiatric Association. FAQs for billing the Psychiatric Collaborative Care Management (CoCM) codes (99492, 99493, 99494, and G0512 in FQHCs/RHCs) and General Behavioral Health Intervention (BHI) code (99484, and G0511 in FQHCs/RHCs). Updated 6/2019.

Typical Care Vs Collaborative Care

Typical Care

- Little impact on physical health
- 20% members receive BH care
- Difficult to scale
- 19% efficacy PCP meds only
- 30-day average access to psychiatric services
- Limited outcomes

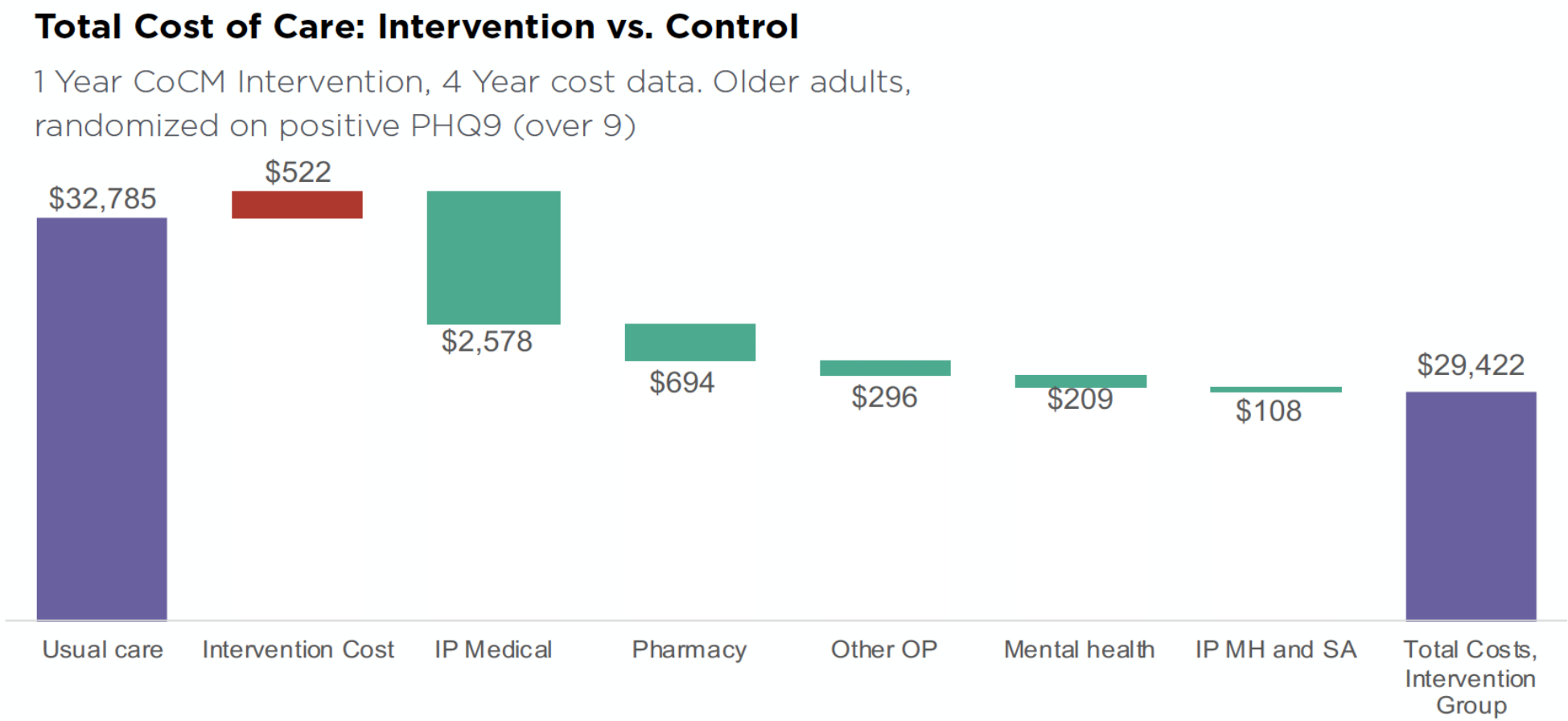
Collaborative Care

- Improvement in LDL, SBP and HbA1c (TEAMCare)
- >60% members receive BH care
- Easy to scale with telehealth/remote services
- 51% efficacy with CoCM
- Same day appointments/consults
- Over 80 randomized clinical trials (Endorsed by CMS and all major health plans)

IMPACT Study

- The IMPACT study was the first large randomized controlled trial of treatment for depression
- Demonstrated that collaborative care more than doubled the effectiveness of depression treatment for older adults in primary care settings.
- Collaborative care more than doubled the effectiveness of depression treatment for older adults in primary care settings.
- At 12 months, about half of the patients receiving collaborative care reported at least a 50 percent reduction in depressive symptoms, compared with only 19 percent of those in usual care.
- Savings of $3,365 per patient (n = 272) over patients receiving usual primary care over a four-year period, even though the intervention ended after one year.

IMPACT COST DATA: 4 YEAR SAVINGS ACROSS CATEGORIES



1. Source: https://pubmed.ncbi.nlm.nih.gov/18269305/

Notes:

a. Other outpatient incl: outpatient primary care and specialty medical and surgical visits, PT/OT, urgent care, ED care, & other outpatient services

b. Data now 15 years old – all values likely higher due to inflation. Study used Medicare data, so commercial/Medicaid experience may reflect smaller cost avoidance unless targeting high risk patients