TIPS FOR FINANCIAL SUSTAINABILITY IN INTEGRATED BEHAVIORAL HEALTH

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Table of Contents

Introduction **3**

Support from Rocky Mountain Health Plans (RMHP) 3

Tools for Business Development **4**

Calculating a Business Case 4

Creating a Pro Forma 4

Direct Sources of Revenue **6**

Assessment and Psychotherapy Codes 6

Health and Behavior Codes 7

Screening, Assessment, and Brief Intervention Codes 9

Collaborative Care Model (CoCM) Codes 12

Grant Funding 13

Indirect Forms of Funding **14**

Return on Investment 14

Cost Savings 14

Value-based Payments 14

Action Planning Checklist **15**

References **16**

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Introduction

Working towards financial sustainability for integrated behavioral health (IBH) in primary care is an evolving, complex process. This requires effective use of staff time based upon licensure and credentialing, appropriate documentation, strategic budgeting, and periodically re-visiting your practice's vision of providing comprehensive care. In this guide, we provide a brief overview of key considerations for developing a business case for integrated behavioral health, as well as direct and indirect sources of funding that practices can use to support behavioral health integration. Although there are various types of professionals that are important parts of integrated care teams (e.g. pharmacists, care coordinators, care managers), this guide will focus on key aspects of funding integrated behavioral health services delivered by a licensed behavioral health provider, such as a licensed professional counselor (LPC), licensed psychologist, licensed clinical social worker (LCSW), or licensed marriage and family therapist (LMFT).

A report by the **Colorado Health Foundation (2012)** listed 11 potential fund sources for integrated care, such as:

- Community fundraising
- Grant funding
- Self-pay/sliding-fee-scale
- Billing through current procedural terminology (CPT) codes for behavioral health services
- Billing through CPT codes for medical services
- Billing through CPT codes for health and behavior (H&B) codes
- Billing through screening codes
- Internal restructuring of funds
- Capitation arrangements
- Payment arrangements with managed care organizations
- Joint use of funds with another organization

The RMHP Practice Transformation Team does not specifically endorse any of these methods for funding integrated behavioral health services, nor are the lists of codes intended to be all-inclusive of those that could be used to support viability of integrated behavioral health in primary care. Not all codes mentioned in this guide may be in your practice's contracts with RMHP or other payers. Our aim is that practices use this guide to engage in informed discussions with their billing staff and payers to determine billing practices that are appropriate for their site type and staffing arrangements. Since reimbursement information can become outdated quickly, we strongly recommend you consult payers' billing manuals for the most up-to-date and complete information. Before billing any of these codes, it is essential that you research available resources and consult with your practice's coding experts to determine the best, most appropriate code and the documentation required for reimbursement.

Support from Rocky Mountain Health Plans (RMHP)

RMHP's Practice Transformation Team is here to help. The team includes Quality Improvement Advisors (QIAs), Clinical Informaticists (CIs), and an Integrated Behavioral Health Advisor (IBHA) who have expertise in helping practices use data and workflow analyses to leverage meaningful change that impacts patients, families, providers, and staff members and supports high-quality, patient-centered care. Although we are not experts in billing and coding, our team helps coach practices through changing workflows and utilizing data to support financial sustainability for integrated behavioral health.

For more information, contact your assigned QIA, CI, or IBHA. To connect with Practice Transformation for the first time, email **practice.transformation3@rmhp.org**.

RMHP's Provider Relations representatives are also an excellent resource for specific questions about claims and billing issues. For more information, contact your regional representative, or you can call RMHP's Provider Relations Line at 970-244-7798 or 888-286-3113.

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Tools for Business Development

There are some key factors for your practice to consider when developing a business case for integrated behavioral health (IBH) in primary care. **Corso, Hunter, Dahl, Kallenberg, and Manson (2016)** described five important steps in a business development strategy. Their book includes more detail, but the general process is as follows:

1. Identify your health care institution site licensure and whether it legally allows you to offer integrated care services.
2. Classify your site type (e.g. Federally Qualified Health Center [FQHC], Rural Health Center [RHC], hospital, physician-owned practice, system-owned practice) and how it impacts regulations and metrics related to integrated care.
3. Explore your payer mix and their investment in behavioral health care since that will dictate key aspects of your program (e.g. services, provider types, billing codes, documentation).
4. Determine accepted behavioral health provider license type(s) that fit with your site licensure, type, and payer mix. Adjust training, documentation, and metrics to fit accordingly. For more information on this, review **RMHP's guide to hiring and onboarding a behavioral health provider**.
5. Identify service delivery and available coding you can use for the services and providers you plan to include. Build a pro forma related to billing and cost savings for program monitoring. Create auditing tools to ensure your interventions and documentation meet criteria.

The above steps provide you the initial foundation for using tools such as calculating a business case and building a pro forma.

Calculating a Business Case

In order to assess the financial viability of a new part of your integrated behavioral health program (e.g. introducing a screening for depression or alcohol misuse), it is wise to assess the costs and benefits of this process before implementing it. The **SAMHSA-HRSA Center for Integrated Health Solutions (2013)** detailed a business case formula that can be adapted for a wide array of processes relevant to integrated care such as introducing brief behavioral health interventions or adding a new type of screening.

The formula is as follows:

Cost of Screening (S) + Cost of Intervention (I) + Transition Costs (T) < Screening Reimbursement (X) + Productivity Gains (P) + Reimbursement for Treatment (R)

$$S + I + P < X + P + R$$

See **Corso and colleagues (2016)** for sample case studies.

Creating a Pro Forma

A pro forma is a method of calculating current or projected costs and expected revenue to support program accountability and financial sustainability. Building a pro forma involves identifying your practice's payer mix, reimbursement rates, expected program costs, and needed revenue generation. You can compare your pro forma to profit/loss projections, balance sheets, and overall revenue generation. It is important to note that a pro forma for each behavioral health provider in your practice may be different, based upon their licensure and credentialing status with various payers **(Corso et al., 2016)**.

A sample of information you will need to research before starting your pro forma includes:

- How many behavioral health visits your BHP(s) will conduct each year
- An estimate of how many behavioral health visits will be reimbursed
- Estimated reimbursement per psychotherapy code and number of visits reimbursed
- Estimated reimbursement per screening, brief intervention, and referral to treatment (SBIRT) code and number of visits reimbursed
- Estimated reimbursement per health and behavior (H&B) code and number of visits reimbursed

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- Indirect revenue such as cost offset from medical providers seeing extra patients per day (conservative estimates include 2 additional medical encounters/day)
- Grant funding revenue
- Salary of your BHP
- Benefits of your BHP
- Additional expenses such as funds for CEUs, laptop, etc.
- Coding and billing expense

Excellent examples of templates for pro formas can be found in **Corso et al. (2016)**, and you can also download an Excel version of another sample from **CSI Solutions**.

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Direct Sources of Revenue

Current fee-for-service arrangements are often not, on their own, a wholly sustainable method for seeking financial sustainability for integrated behavioral health services in primary care. This is largely due to the fact that there are many activities that primary care BHPs engage in that are not reimbursed in fee-for-service systems, such as consulting with other team members on complex patients **(Serrano, 2019)**. Also, keep in mind that not all codes are included in contracts with payers, so read your contracts carefully and consult payer representatives with any questions you might have.

As your practice prepares for more value-based payment systems, consider fee-for-service payments as a bridging strategy. Also keep in mind that there are limitations such as only licensed clinical social workers (LCSWs) and licensed psychologists being able to directly bill Medicare for behavioral health services; at this time, licensed marriage and family therapists (LMFTs) and licensed professional counselors (LPCs) are not qualified providers with Medicare. The following section includes general groups of codes that help generate revenue for integrated behavioral health services in primary care.

Assessment & Psychotherapy Codes

Assessment and psychotherapy codes are appropriate when the primary diagnosis is related to a mental health condition or a substance use disorder. Treatment interventions could include improving adherence to treatment regimens, managing symptoms, increasing engagement in health-promoting behaviors, and reducing risky behaviors **(Corso et al., 2016)**

Code	Description	Covered by RMHP Medicaid	Covered by RMHP Medicare	Covered by RMHP Commerical	Covered by RMHP Medicare	Resource Links
90791*	Initial assessment	✓	✓	✓	✓	Medicaid • **Short-Term Behavioral Health Services in Primary Care** • **Colorado Medicaid Uniform Coding Standards** • **Colorado Medicaid Outpatient Behavioral Health Billing and Policy Manual** Medicare • **Outpatient Psychiatry and Psychology Services** • **Telehealth Services** General • **Basic Coding for Integrated Behavioral Health** • **Telemedicine Modifiers and Psychotherapy Code Clarification** • **CPT Coding in Psychiatry**
90832*	Psychotherapy – 30 minutes	✓	✓	✓	✓	
90834*	Psychotherapy – 45 minutes	✓	✓	✓	✓	
90837*	Psychotherapy – 60 minutes	✓	✓	✓	✓	
90846*	Family psychotherapy without patient present – 50 minutes	✓	✓	✓	✓	
90847* ^	Family psychotherapy with patient present – 50 minutes	✓	✓	✓	✓	

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Code	Description	Covered by RMHP Medicaid	Covered by RMHP Medicare	Covered by RMHP Commerical	Covered by RMHP Medicare	Resource Links
90785	Interactive complexity (add-on)	✓	✓	✓	✓	General • **Interactive Complexity Guidelines**
90853	Group psychotherapy	✓	✓	✓	✓	Medicaid • **Colorado Medicaid Outpatient Behavioral Health Billing and Policy Manual** • **Colorado Medicaid Uniform Coding Standards** Medicare • **Outpatient Psychiatry and Psychology Services**

**Covered in 6 visits with short term behavioral health in primary care by Colorado Medicaid*

^ Requires prior authorization after 12th session, except for a temporary waiver through 5/31/20 to accommodate COVID-19 management

Key recommendations:

- Review **RMHP's RAE Behavioral Health Provider Manual** for requirements for treatment plans for patients with Medicaid coverage and other details.
- Ensure that you are documenting start and stop times to justify time-based codes.
- Ensure you are adding the 'HE' modifier to any behavioral health code for Colorado Medicaid members submitted to RMHP. This modifier is used in primary care, as well as other settings.
- Assign a staff member (usually front desk or billing staff) to check in with provider portals (e.g. **HCPF's Provider Web Portal** for Colorado Medicaid) for payers to check benefits and eligibility.

Health and Behavior Codes

Health behavior assessment and intervention (HBAI) codes are used when the primary diagnosis is a medical condition (e.g. diabetes, hypertension, obesity). Prior to January 2020, these were called Health and Behavior (H&B) codes, and you can review a crosswalk of the changes on the American Psychological Association's website. Like psychotherapy codes, treatment interventions could include improving adherence to treatment regimens, managing symptoms, increasing engagement in health-promoting behaviors, and reducing risky behaviors (Corso et al., 2016). At this time, H&B codes are not covered by Colorado Medicaid, but they are reimbursed by credentialed providers with Medicare and some commercial payers.

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Code	Description	Covered by Medicaid	Covered by Medicare	Covered by RMHP Commercial	Covered by RMHP CHP+	Resource Links
96156	Initial assessment	✓ (physical health benefit for Prime only)	✓	✓	✓	General • **2020 Changes to H&B Codes**
96158	Individual intervention - first 30 minutes	✓ (physical health benefit for Prime only)	✓	✓	✓	
96159	Individual intervention – 15 minute add-on code beyond first 30 minutes	✓ (physical health benefit for Prime only)	✓	✓	✓	
96164	Group intervention – each 30 minutes	✓ (physical health benefit for Prime only)	✓	✓	✓	
96165	Group intervention – each 15 minutes add-on code beyond first 30 minutes	✓ (physical health benefit for Prime only)	✓	✓	✓	
96167	Family with patient present intervention - first 30 minutes	✓ (physical health benefit for Prime only)	✓	✓	✓	
96168	Family with patient present intervention - 15 minute add-on code beyond first 30 minutes	✓ (physical health benefit for Prime only)	✓	✓	✓	
96170	Family without patient present intervention - first 30 minutes	✓ (physical health benefit for Prime only)	✓	✓	✓	
96171	Family without patient present intervention - 15 minute add-on code beyond first 30 minutes	✓ (physical health benefit for Prime only)	✓	✓	✓	

Key recommendations:

- H&B codes and psychotherapy codes cannot be billed in the same visit.
- Ensure the referring physician has documented the need for this assessment **(Corso et al., 2016)**.
- Document the length of assessment and date **(Corso et al., 2016)**.

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- Refrain from duplicative health assessments, and document changes in medical or mental status (not mental health) with clear precipitating event & rationale warranting re-assessment (Corso et al., 2016).
- Specify goals and expected duration of treatment, along with biopsychosocial factors influencing medical condition and clear connection between intervention and improvement in disease management (Corso et al., 2016).

Screening, Assessment, and Brief Intervention Codes

Below you will find a list of various screenings that address behavioral health factors for both children and adults, as well as brief interventions to follow based on the result of the screening.

Code	Description	Covered by RMHP Medicaid	Covered by RMHP Medicare	Covered by RMHP Commercial	Covered by RMHP CHP+	Resource Links
G8431	Depression screening (positive result)	✓		✓	✓	Medicaid • Depression Tool Kit Medicare • Update on Depression Screening General • CCHAP Summary of Behavioral Health Screenings – Pediatrics
G8510	Depression screening (negative result)	✓		✓	✓	
G0444	Depression screening		✓	✓	✓	
G0447	Behavorial counseling for obesity - individual (15 minutes)		✓	✓	✓	Medicaid • Intensive Behavioral Therapy for Obesity
G0473	Behavorial counseling for obesity -					
96110	Childhood developmental screening	✓ (physical health benefit for Prime only)		✓	✓	General • Getting Paid for Screening and Assessment Services • 96127 Usage and Guidance • Developmental, Behavioral, and Emotional Coding Fact Sheet for Pediatricians • CCHAP Summary of Behavioral Health
G0451	Childhood developmental screening	✓ (physical health benefit for Prime only)				
96127	Brief behavioral assessment (initial and follow-up)	✓	✓	✓	✓	
96160	Health risk assessment (patient)	✓	✓	✓	✓	
96161	Health risk assessment (caregiver)		✓	✓	✓	

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Code	Description	Covered by RMHP Medicaid	Covered by RMHP Medicare	Covered by RMHP Commercial	Covered by RMHP CHP+	Resource Links
99401	Preventive medicine counseling or risk factor reduction intervention – individual (15 minutes)	✓		✓	✓	Medicaid • What Providers Need to Know about Smoking Cessation Benefit General • Coding for Preventive Visits • Coding for Tobacco Cessation Counseling
99402	Preventive medicine counseling or risk factor reduction intervention – individual (30 minutes)	✓		✓	✓	
99403	Preventive medicine counseling or risk factor reduction intervention – individual (45 minutes)	✓		✓	✓	
99404	Preventive medicine counseling or risk factor reduction intervention – individual (60 minutes)	✓		✓	✓	
99411	Preventive medicine counseling or risk factor reduction intervention – group (30 minutes)	✓		✓	✓	
99412	Preventive medicine counseling or risk factor reduction intervention – group (60 minutes)	✓		✓	✓	Medicaid • What Providers Need to Know about Smoking Cessation Benefit General • Coding for Preventive Visits • Coding for Tobacco Cessation Counseling
99406	Smoking and tobacco use cessation counseling visit (3-10 minutes)	✓	✓	✓	✓	
99407	Smoking and tobacco use cessation counseling visit (>10 minutes)	✓	✓	✓	✓	

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Code	Description	Covered by RMHP Medicaid	Covered by RMHP Medicare	Covered by RMHP Commercial	Covered by RMHP CHP+	Resource Links
99408	SBIRT (positive result) – alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services (15-30 minutes)	✓		✓	✓	Medicaid • **SBIRT Billing Manual** Medicare • **SBIRT Services** General • **Reimbursement for SBIRT**
99409	SBIRT (positive result) – alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services (>30 minutes)	✓		✓	✓	
H0049	SBIRT (negative result) – alcohol and/or substance (other than tobacco) abuse structured screening	✓				
G2011	SBIRT (positive result) – alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services (5-14 minutes)		✓	✓	✓	
G0396	SBIRT (positive result) – alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services (15-30 minutes)		✓	✓	✓	
G0397	SBIRT (positive result) – alcohol and/or substance (other than tobacco) abuse structured screening and brief intervention services (>30 minutes)		✓	✓	✓	

Key recommendations for successful billing:

- Know which types of encounters are acceptable for which codes. For example, 96127 is only reimbursable for visits with a medical provider for Medicaid since it is not a RAE-covered benefit, but Medicare will reimburse the code for medical and behavioral health providers.

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Collaborative Care Models Codes

The Collaborative Care Model (CoCM) enhances “usual” primary care by adding several key services to the primary care team: care management support for patients receiving behavioral health treatment and regular interaction between the prescribing provider and a consulting psychiatric provider. CoCM includes a team of three individuals: the behavioral health care manager, the psychiatric consultant, and the treating practitioner (usually a primary care provider). This model is especially useful for patients with more complex needs who are not improving and could use multidisciplinary collaboration to help improve wellbeing and functioning.

At this time, CoCM codes are not covered by Colorado Medicaid, but they are reimbursed by Medicare and some commercial payers. The American Psychiatric Association (2019) provided a list of payers who accept CoCM codes, as of June 2019.

Code	Description	Covered by RMHP Medicaid	Covered by RMHP Medicare	Covered by RMHP Commerical	Covered by RMHP CPC+	Resource Links
99492	Behavioral health care manager duties –first 70 minutes in first month **FQHCs and RHCs not eligible*		✓			Medicare • Cheat Sheet on Medicare Payments for IBH • Cheat Sheet on Medicare Payments for IBH in FQHCs and RHCs • Behavioral Health Integration Services General • Getting Paid in the Collaborative Care Model
99493	Behavioral health care manager duties – first 60 minutes in subsequent months **FQHCs and RHCs not eligible*		✓			
99494	Behavioral health care manager duties – additional 30 minutes **FQHCs and RHCs not eligible*		✓			
99484	General care management services – 20 minutes **FQHCs and RHCs not eligible*		✓			
G0511	Care management services – 20 minutes **FQHCs and RHCs only*		✓			
G0512	Behavioral health care manager duties – first 70 minutes in first months and first 60 minutes in subsequent months **FQHCs and RHCs only*		✓			

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Grant Funding

Although not sustainable long-term, grant funding can be an important way to get integrated behavioral health services up and running in a clinic as your practice becomes more proficient with billing for IBH services in primary care. Due to increased opportunities for billing for behavioral health services, many funding agencies have moved away from simply funding salaries for licensed behavioral health providers. However, there are still opportunities to help fund infrastructure and resources needed for specific projects related to integration (e.g. group visits for a specific condition, enhancing access through telebehavioral health, etc.).

Some foundations to consider reviewing for applicable requests for proposals (RFPs) include:

- Colorado Health Foundation
- Denver Foundation
- Caring for Colorado
- Western Colorado Community Foundation
- Tri County Health Network
- Your local public health department
- Health Resources and Services Administration (HRSA)
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- Robert Wood Johnson Foundation (RWJF)

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Indirect Forms of Funding

As healthcare continues to move towards alternative payment models beyond fee-for-service reimbursement, there are many opportunities to help ensure the financial viability of your integrated behavioral health program.

Return on Investment

There are multiple ways to calculate return on investment (ROI) in healthcare, and building your pro forma is a good start. **Corso et al. (2016)** provided one equation for calculating ROI:

$$\text{Percent of ROI} = \frac{\text{gain from program} - \text{cost of program}}{\text{cost of program}} \times 100$$

In addition to creating a return on investment by billing for BHPs' time delivering interventions, there are also cost offsets related to PCP time and reimbursement. For example, **Gouge, Polaha, Rogers, and Harden (2016)** found that on days when a behavioral health provider was present in clinic, medical providers spent an average of 2 minutes fewer with each patient, saw 42% more patients, and collected $1142 more revenue, compared to days when a behavioral health provider was not present in the same pediatric clinic. This demonstrates a significant return on investment with provider time and cost with behavioral health integration into primary care. Another example of a return on investment includes medical providers who may be able to increase their panel size – and any associated global payment strategies – when they practice as part of an integrated care team that includes dedicated behavioral health and care management staff.

See **Corso and colleagues (2016)** for a deeper dive on return on investment strategies and specific calculations.

Cost Savings

There is ample data to show that it is more expensive to provide care for patients with comorbid mental and physical health conditions than patients with only a physical health condition; for example, the additional cost of a mental health diagnosis associated with a heart condition was over $2000 (US Dept of Health and Human Services, 2002). Providing effective behavioral health care, in addition to excellent medical care, can save money for patients and families, reduces costs for the healthcare system, and help your practice work towards value-based payments.

Another example of cost savings comes from a practice who noticed a high rate of no-shows during patients' first appointments with an onsite part-time psychiatrist. The psychiatrist's time was billed at a rate around $150/hour, so that no show left a substantial gap in potential revenue. This practice elected to have patients first meet with a licensed mental health provider (whose time was billed around $40/hour) for their intake to ensure patients were adequately motivated for treatment, instead, so if the patient no-showed, this would be less of a financial loss.

Value-Based Payments

Based upon contracting and desire to pursue innovation, your practice's opportunities for value-based payments are unique and vary between payers. In general, practices who are committed to financial sustainability for IBH look for ways in which their behavioral health providers (BHPs) can help contribute to high-quality work that is reimbursed beyond fee-for-service, such as value-based payments. For this reason, it is important that behavioral health providers' job descriptions reflect the nature of team-based work, not just individual clinical work.

Behavioral health providers can help your practice work towards various metrics that could be eligible for value-based payments with RMHP through RAE key performance indicators (KPIs) and Medicaid Prime shared savings. Ideas include:

- Tracking behavioral health outcomes that your practice can attest to in RAE verification processes;
- Engaging in Plan, Do, Study, Act (PDSA) cycles to improve clinical quality measures (CQMs) such as depression screening, diabetes control, hypertension control, and smoking cessation counseling; and
- Intervening with patients who have frequent emergency department (ED) ED utilization and hospital stays to reduce avoidable visits.

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Action Planning Checklist

- ☐ Consider asking for support from RMHP's Practice Transformation Team **(practice.transformation3@rmhp.org)** through our incentivized practice transformation programs or flexible, free consultative services options. You can choose from support from an Integrated Behavioral Health Advisor, a Clinical Informaticist, and/or a Quality Improvement Advisor.

- ☐ Create a team who will work on evaluating your business strategy to support IBH and make adjustments to the program as needed. It is essential to include staff with business expertise (office managers, billing and coding staff, scheduling staff, etc.), as well as those with clinical expertise (e.g. medical and behavioral health providers). Begin by creating or reviewing a pro forma for each behavioral health provider's position so you can establish a baseline and goals.

  Key questions to ask:

  - Where does our program stand at baseline in terms of costs and revenue associated with integrated behavioral health? What are our goals to ensure financial sustainability?
  - How would additional financial sustainability impact our patients and families? Our community? Our providers and staff?
  - Where are our most valuable opportunities for fee-for-service reimbursement? How much do we need to expand revenue in this area? What changes (e.g. scheduling, physical space, staffing, workflow) need to be put in place to make this happen?
  - Where are our most valuable opportunities for return on investment? What is our desired return on investment? What changes (e.g. scheduling, physical space, staffing, workflow) need to be put in place to make this happen?
  - Where are our most valuable opportunities for cost savings? How much do we need to improve in this area? What changes (e.g. scheduling, physical space, staffing, workflow) need to be put in place to make this happen?
  - Consider whether there are any grants you would like to apply for to support a new part of your integrated behavioral health.

- ☐ Consider whether there are any grants you would like to apply for to support a new part of your integrated behavioral health.
- ☐ Review additional resources as needed. A few ideas include:
  - **American Psychological Association (APA)'s tutorial on CPT and diagnostic codes**
  - **Collaborative Family Healthcare Association (CFHA)'s FAQ on funding for primary care behavioral health (PCBH)**
  - **Integrated Behavioral Health Partners (IBHP)'s page on billing, reimbursement, and financing**

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