Welcome!

Please add your name, organization and role in the chat

Behavioral Health Integration (BHI) Financing

Cal-IN Peer Group Meeting

California Quality Collaborative

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Connecting today

Today, we'll:

Bring visibility to work that has been done to understand the landscape of current BHI financing

Brainstorm opportunities for in working together to solve some of the challenges

Connect with behavioral health integrated leaders in California

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Advancing the quality and efficiency of the outpatient health care delivery system by creating scalable, measurable improvement.

Launched in 2007, CQC is a **multi-stakeholder quality improvement program** of the Purchaser Business Group on Health. Core funding comes from health plans sharing a delivery system.

Identifies and spreads best practices across outpatient delivery system in California

Trains 2,000 individuals from 250 organizations each year

CQC's track record includes **20% relative improvement** in clinical outcomes and **10:1 ROI**

Sponsors

Connecting Today

In the chat or off mute, please share your biggest challenge with BHI Financing

(e.g., coding, billing, credentialing, reimbursement)

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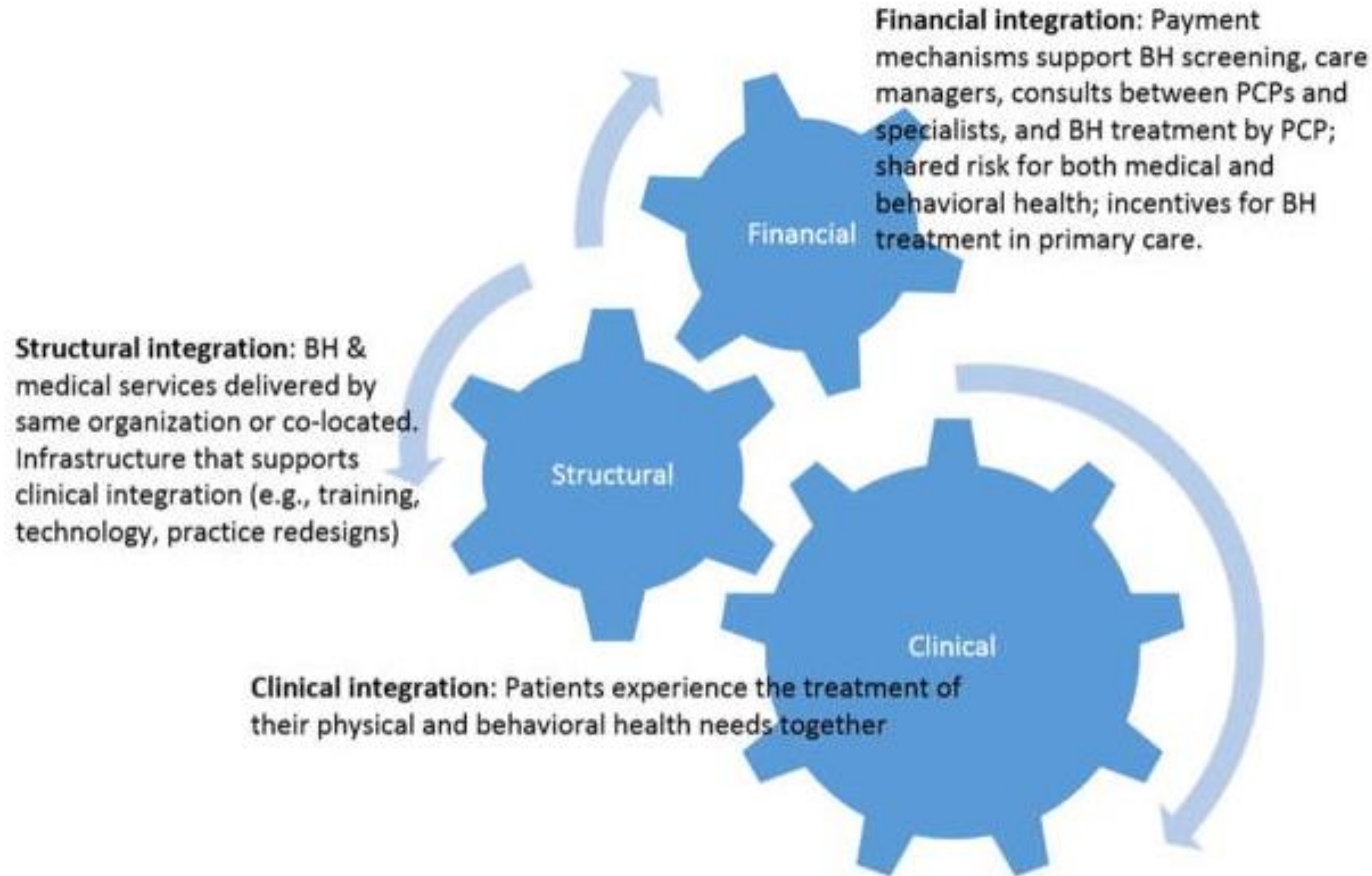
Behavioral Health Integration in California

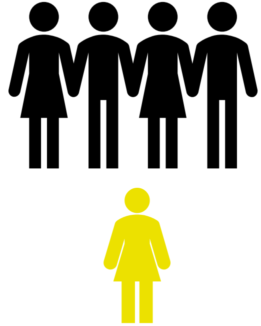
Financing Landscape

Integration: Clinical, Structural & Financial



Source: The Role of Health Plans in Supporting Behavioral Health Integration. Adm Policy Ment Health. 2017 Nov;44(6):967-977.

Integrated Care | Two Models, Two Payment Structures

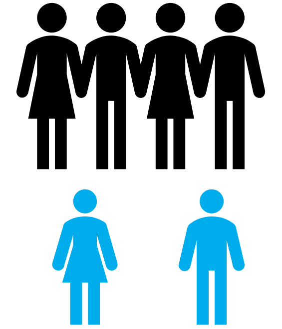


Primary Care Behavioral Health Model

- Available for primary care population for any behaviorally influenced concern
- Adds licensed behavioral health professional as behavioral health consultant
- Often billed under behavioral health benefits, directly by BH provider

Collaborative Care Model

- Targets specific population (mild-to- moderate depression) using registry and PHQ-9 and psychotropic medication
- Adds psychiatric consultant and behavioral health care manager
- Often billed under medical benefits, "incident to" PCP



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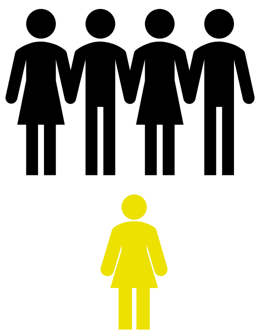
Learn more:

- CQC BHI Implementation Snapshot: Selecting an Integration Model
- CQC Webinar: BHI Concepts & Models (6/13/23)

BHI Payment | Two Common Pathways

Primary Care Behavioral Health model



Primary Care Practice

- Implements and bills for PCBH model
- Behavioral Health Provider bills FFS

Health Plan

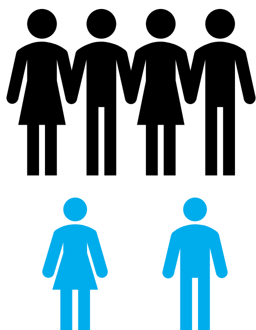
- Carves Out BH

Direct billing

MBHO

- Credentials BH Provider
- Pays BHI Claims

Collaborative Care Model



Primary Care Provider

- Behavioral Health Care Manager bills "incident to" Primary Care Provider (PCP)

Health Plan 1 (FFS)

- Credentials PCP
- Pays BHI Claims

Health Plan 2 (Capitated)

- Credentials PCP
- Pays for CoCM codes as part of capitated rate

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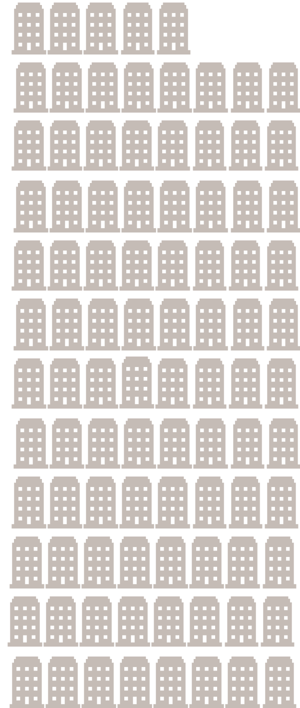
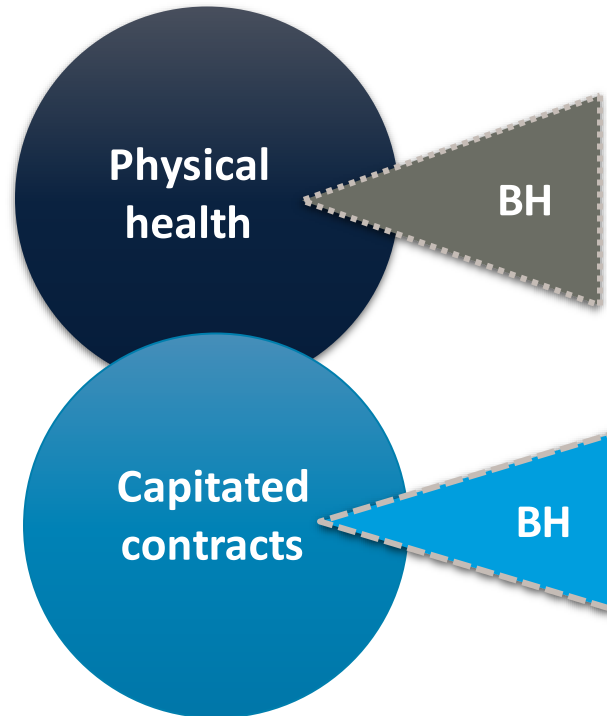
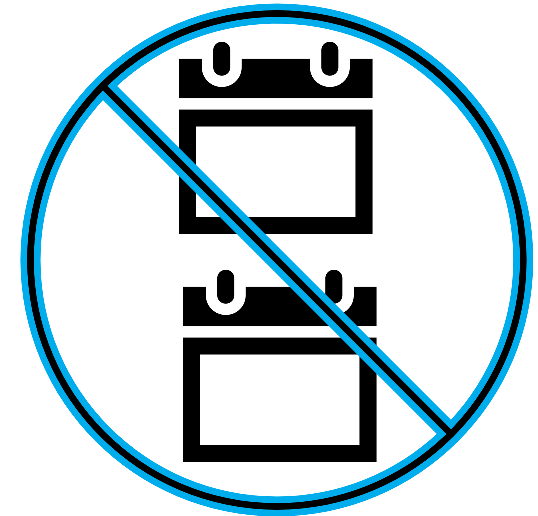
Learn more: Slide 33

California's Context for BHI Payment







93 different payers (health plans and delegated provider organizations)

Two (often overlapping) **carve-outs**

- Mental health benefits
- Capitated arrangements

Same day billing prohibited for medical and behavioral visit for FQHCs

Sources: California Health Care Foundation. [California Health Insurers and Enrollment]() – 2023 Edition
"[Weaving Together Mental and Physical Health Care Outside the Safety Net](),” CQC (May 2020)

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BHI & Industry Landscape (2024 and beyond)

Regulatory Oversight
- CA: Department of Managed Health Care BH health plan investigations
- CA: SB 1320 of 2024: Requires commercial plans to pay for BHI
- CMS: Mental Health Parity regulations released (September 2024)

Quality Measurement
- CA: Depression Screening and follow-up measure reporting
  - IHA AMP testing (first year reporting commercial); 2025: likely P4P
  - Medi-Cal Accountability Set reporting; 2025: likely P4P

Cost
- CA: Office of Health Care Affordability to set statewide spending target for 2025 (not for enforcement)
  - 2025: set 2026 target (for enforcement in 2028)

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Findings: BHI Financing Interviews

CQC 2024 Project
Sustainable BHI Financing in Commercial Settings

Objective: work across California to identify, synthesize and communicate successful practices to ensure sustainable payment for behavioral health integration (BHI) into primary care for **commercial settings**

Conducted 11 interviews to date

4 Providers

3 Health Plans

1 Managed Behavioral Health Organization

1 Health Plan/MBHO

1 IPA

1 Provider vendor

18 organizations outreached

60-minute semi structured calls

Focused on BHI payment in commercial setting

Areas covered:

Contracting

Credentialing

Claims

Strategic Planning / Sustainability

Opportunities for Improvement & Alignment

Stakeholder Meeting

Brought together 8 organizations to discuss report findings and brainstorm opportunities for collective action

Publication

Issue Brief forthcoming Q4 2024

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High-Level Findings: Providers

- **BHI billing success is possible**
  - Most payment for BHI reported to be facilitated in fee-for-service, rather than in capitated, arrangements
- BHI billing success **only after many months working with individual health plans to troubleshoot and problem-solve claim rejections and denials**
- Providers reported **finding the right contact** at the health plans able to answer questions regarding behavioral health integration "**extremely challenging"**
- **Credentialing process ranges from 3 to 6 months** from initial application to credentialed for BH providers
- **Confusion as to who the "final decision maker"** regarding operational and clinical issues that had compliance and billing implications
  - Statewide example: California's State Health Information Guidance (SHIG)
- **Would value a strategic partner in plans** to support development and sustainability of BHI

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Claims and Billing Support
Sample Patient Insurance Card

Health Plan

Member: SUBSCRIBER SMITH
Member ID: 123456789 Group Number: 98765

Dependents
SPOUSE SMITH
CHILD1 SMITH
CHILD2 SMITH
CHILD3 SMITH

Customer Literal Name Line 1
Customer Literal Name Line 2

Payer ID 87726

Copays:
Office: $20 ER: $300
UrgCare: $75 Spec: $30

Rx Bin:
Rx PCN:
Rx Grp:

	DED IND/FAM	OOPM IND/FAM
INN:	$99999/$99999	$99999/$99999
OON:	$99999/$99999	$99999/$99999

0501

Printed: 09/13/23

This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the websites or call.
For Members: 888-888-8888

For Providers:
Medical Claims

Pharmacy Claims:
For Pharmacis...

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High-Level Findings: Plans

- Several plans **expressed support for behavioral health integration**
  - Some plans have made recent organizational changes regarding behavioral health administrative and operational leads, and were **re-structuring internally**
  - Plans are in different phases of their BHI strategy & described how they were **thinking expansively during the planning process**
- Most plans were **unaware of which providers in their network provide integrated care**
- Plans had plans or made early inroads into **administrative simplification**
  - Examples included streamlining billing platforms and aligning credentialing processes
- There is a desire from plans to **connect and collaborate with other plans**, and discuss and hear what other plans are doing this area to possibly adopt and sustain methods to reduce administrative complexity for providers

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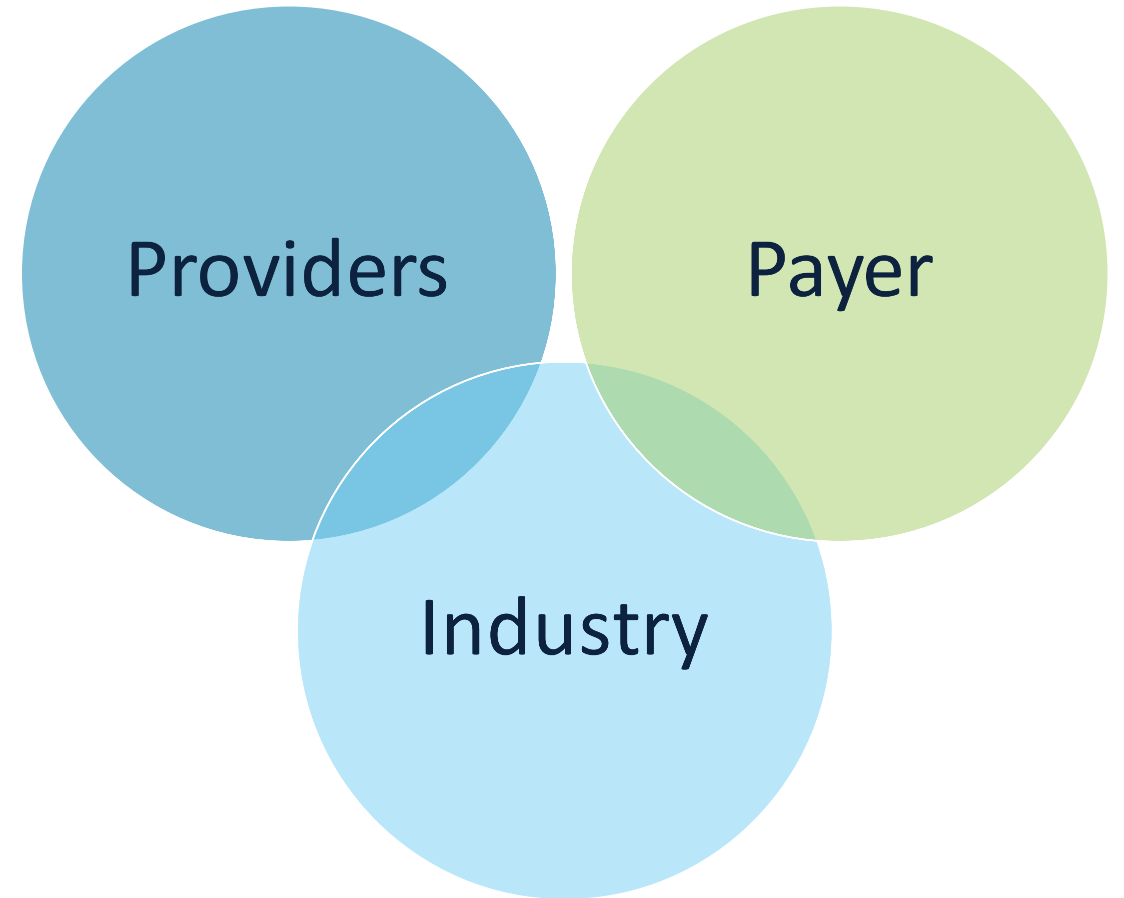
Recommendations
Providers, Payers, Industry

- Recommendations for facilitating payment for behavioral health integration

- Opportunities and Action Steps in areas of:
  - Contracting
  - Credentialing
  - Billing/Claims
  - Strategy



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Key Recommendations
Providers

▶ Opportunity ❑ Action Step	Providers	Plans	Industry
Contracting ❑ Integrated administrators: connect regularly with internal business team (e.g., payer strategy, managed care, value-based teams) to ensure that integrated program needs and outcomes are incorporated into contracting strategy and can represent behavioral health integrated programs accurately when negotiating	◆		
Credentialing ❑ Credential providers with all medical and behavioral health plans (medical and MBHO) to ensure coverage for more patients' insurance	◆		
Billing ❑ Providers should bill for the services that they are providing to be able to identify what denials/rejections come through and get credit for clinical care already being provided (e.g., for example, depression screening has a discrete code)	◆		
Strategy ❑ Providers and plans need to partner to better develop complementary strategies to improve behavioral health access and quality, including integrated BH in primary care	◆	◆	

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Key Recommendations
Plans: Individual Action

▶ Opportunity ❑ Action Step	Providers	Plans	Industry
Billing ❑ Aggregate information in a "Health Plan BHI Implementation Guide," that includes billing codes accepted, documentation required and costs expected based on claims		◆	
❑ Provide a specific role (with contact information) for technical issues and escalation in the event of claims rejected or denied		◆	
Credentialing ❑ Monitor average credentialing time cycle for BH, identify roadblocks and brainstorm solutions to ensure compliance with the 60-day cycle required by California law (Health & Safety Code § 1374.197)		◆	
Strategy ❑ Understand which providers are providing integrated services by running reports based on CPT claims and/or surveying providers for interest and/or planning for BHI		◆	

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Key Recommendations
Plans: Collective Action

▶ Opportunity ❑ Action Step	Providers	Plans	Industry
Contracting ❑ Plans that "carve out" behavioral health should maintain oversight as well as regular collaboration with their MBHO partners that includes reviewing BHI visit and access data		◆	
Strategy - Providers and plans need to partner to better develop complementary strategies to improve behavioral health access and quality, including integrated BH in primary care ❑ Plans: share information with provider organizations to help them model if BHI is a financially sound investment (e.g., codes accepted, expected payment) ❑ Providers: use plan information to model out BHI implementation costs and expected revenue based on their payer mix and product lines	◆	◆	
Plans can champion BHI as part of their BH access and quality strategy ❑ Reduce the administrative burden for BHI, including: waiving co-pays for BH visits; making BHI visits a preventive service; eliminating patient prior-authorization requirements for BHI		◆	

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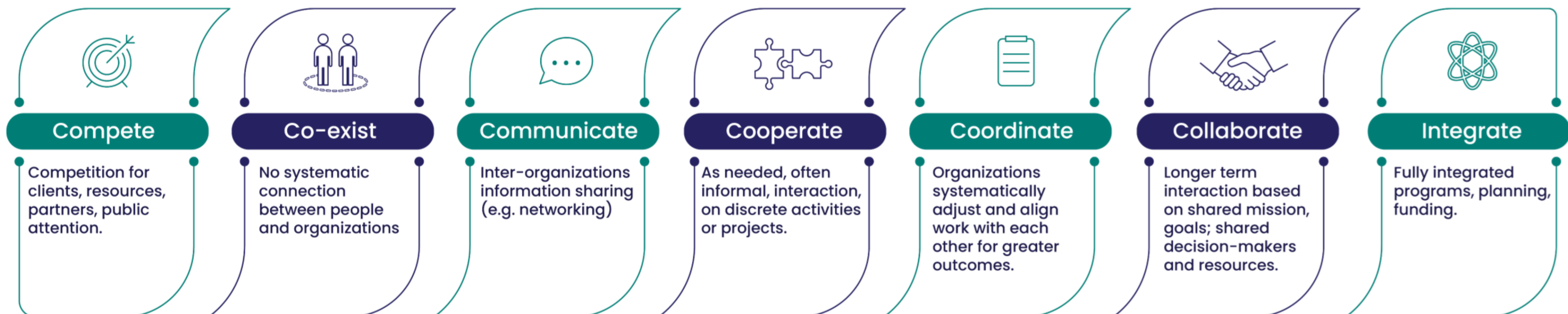
Discussion and Q&A

How Might We?

- Internal work: policies, procedures, allocation/funding, workgroups, training
- **Communicate:** share successful practices / approaches / tools
- **Cooperate:** offer feedback, improvements on projects
- **Coordinate:** align on approaches to implementation
- **Collaborate**: contracting, partnerships



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Discussion Questions

1. What **questions/feedback** do you have on the findings and recommendations (for providers, plans or both)?
2. How might we work collectively, as a group to implement **provider recommendations?**
3. How might we work with **other stakeholders** (e.g. plans)?
4. How could regulatory action (e.g., SB 1320 of 2024) support collective action?

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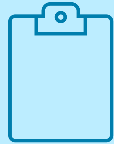
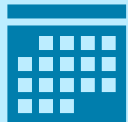
Next Steps



October: Final issue brief released



October: Presentation at CFHA Conference

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COLLABORATIVE
FAMILY HEALTHCARE
ASSOCIATION

Cal-IN Peer Group

Cal-IN Group
Upcoming Meetings

- **Upcoming Meetings**
  - October 25: Table lunch discussion @ CFHA Conference in San Antonio
    - Discussion topics: CA challenges, Cal-IN Value Prop?
  - Wed. December 4, 12-1 – BHI Training & Development
    - **Who would like to present?**
  - 2025
    - Quarterly meetings
    - In person?
- **Discussion topics requested by group:**
  - ✓ Sustainability, billing, maybe a breakout room for FQHCs
  - ✓ Advocacy for changing laws to remove barriers to integration
  - CalAIM, ECM, Value Based Payment
  - Integrated healthcare in different settings, job possibilities, research/grant opportunities
  - Pediatric Collaborative Care
  - Progress and barriers to progress- what worked well and what were struggles

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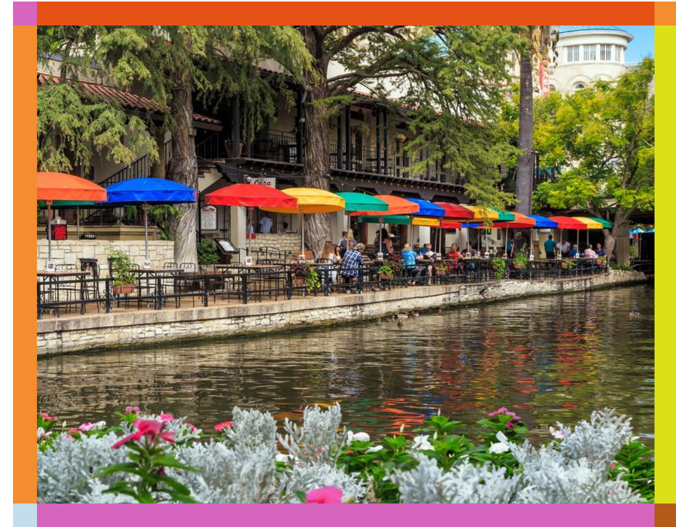
2024 CFHA CONFERENCE

30 YEARS OF INTEGRATION: INNOVATING IN THE PURSUIT OF HEALING

SAN ANTONIO, TX

CELEBRATING
30 YEARS OF INTEGRATION



October 24th - 26th
Grand Hyatt
San Antonio River Walk

Registration Open!
https://www.integratedcareconference.com/

Open Discussion / Sharing

- Burning questions?
- Needs?
- Resources?

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Thank you!

- Cal-IN Collaboration Space
  - Basecamp
- Peer Group Roster [link]
  - Opt-in document; link will be posted on Basecamp
  - Members can add: name, org, email, how long integrated, your strengths, what you want to talk about
- Upcoming Cal-IN Meetings
  - October 24 or 25: Table @ CFHA Conference in San Antonio
  - Wed. December 4, 12-1 – Topic TBD

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Appendix

California: Navigating the Carve Out(s) for BHI

#1

Carve-out Scenario #1: Physical and behavioral health insurance carve-out

- Health insurance companies often delegate or "carve out" responsibility for mental health benefits to an internal or external MBHO
- That entity develops its own provider network and has its own processes for claims, utilization management, and care coordination

#2

Carve-out Scenario #2: Capitated contracts that exclude behavioral health

- Division of financial responsibility (DOFR) excludes behavioral health, with health plan retaining responsibility rather than delegating it to the provider groups
- PCPs in delegated groups have to develop workflows with each payer's MBHO

*Other carve out scenarios exist, including those specific to Medi-Cal and specialty mental health care.

Source: "Weaving Together Mental and Physical Health Care Outside the Safety Net," CQC (May 2020)

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Learn more: Slide 27

California Commercial Health Plans & Managed Behavioral Health Organizations

Health Plan

Medical Coverage
- Routine Well-being Visit
- Specialty Medical Care
- Speech/Occupational/Physical Therapy
- Emergency & Hospital

BH Carve Out

Managed Behavioral Health Organization (MBHO)

Behavioral Health
- Outpatient, Intensive Outpatient, Partial Hospitalization, and Inpatient Behavioral Health services
  - Mental Health
  - Substance Use Disorder
  - Neurological and Developmental Disorder

Health Plans	Managed Behavioral Health Organizations (MBHOs)
Aetna	Aetna
Anthem/Elevance	Carelon
Blue Shield of California (commercial)	Magellan
Cigna	Evernorth
Health Net	MHN (in-house)
United Healthcare of California	Optum Health
Western Health Advantage	Optum Health

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Financing: Billing/Coding

<table>
<tr><th></th><th>Collaborative Care Model (CoCM)</th><th>Primary Care Behavioral Health (PCBH)</th></tr>
<tr><td>Overview</td><td>

Billed incident to Primary Care Treating Provider
Billed under medical benefit (Cost Sharing)
Typical episode of care 3-9 months
Requires Primary Medical Provider, Behavioral Health Care Manager, and Psychiatric provider
CoCM specific CPT codes

99492 – Initial month of service
99493 – Subsequent months of service
99494 – add-on codes
G0512* - FQHC, initial and subsequent
General Behavioral Health Code (<20 min)

99484
G0511 *FQHC

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Billed Directly by Behavioral Health Provider
Billed under the patient’s Behavioral Health Benefit (Cost Sharing)
Typically, 1-6 visits per presenting problem
Assessment CPT Code
90791 – not time based
Traditional Psychotherapy CPT Codes

90832 – 30 min
90834 – 45 min
90837 – 60 min

Health and Behavior Codes

96156- Assessment
96158- Intervention, individual
96164- Intervention, group

General Behavioral Health code (<20 min)

99484
G0511 *FQHC

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