

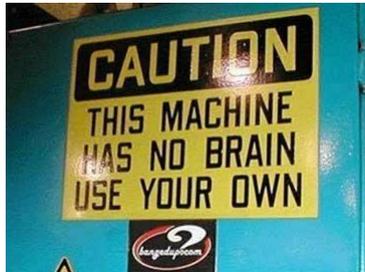


## Get Paid: Sustaining Integrated Health Care Through Correct Coding

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National Council for Behavioral Health

## Overview

1. Healthcare 2014: A Grand Experiment
2. Trends in IH Financing
3. Developing Your Business Plan using Bundled Rates
4. Update on New Billing Codes for IH
5. Billing and Coding for Success
6. Questions/Discussions



The ideal model is focused on the four key elements of health care reform: access, care coordination, health information technology, and payment reform.

1. Reduce the preferences for procedural services.
2. Use value (quality per unit of cost) rather than cost of delivery as a key metric in payment design.
3. Reduce the emphasis on volume.
4. Reimburse payment for teams and information technology.

Source: March 2011 Meeting Report; Better to Best: Value-Driving Elements of the PCMH & ACO  
[http://www.pcpcc.net/sites/default/files/media/better\\_best\\_guide\\_full\\_2011.pdf](http://www.pcpcc.net/sites/default/files/media/better_best_guide_full_2011.pdf)

5. Reimburse practices' encounters beyond the face-to-face visit.
6. Pay for services provided by all team members.
7. Risk-adjust reward payments to support practices caring for complex or needy patients.
8. Balance incentives between over- and underutilization. This is done through use of a blended payment mechanism so practices are not rewarded solely for cost containment.
9. Ensure coordinated, patient-centered care.

Source: March 2011 Meeting Report; Better to Best: Value-Driving Elements of the PCMH & ACO  
[http://www.pcpsc.net/sites/default/files/media/better\\_best\\_guide\\_full\\_2011.pdf](http://www.pcpsc.net/sites/default/files/media/better_best_guide_full_2011.pdf)

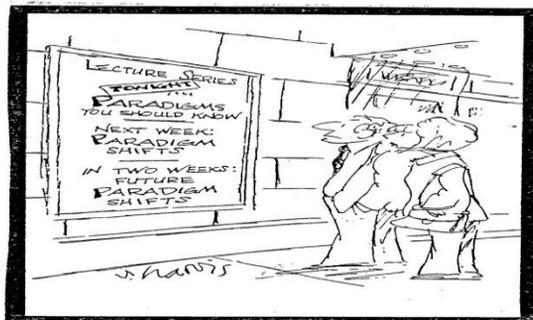
BH is attractive to investors b/c:

- Growing Market: National expenditures on BH are expected to reach \$239 billion in 2014, up from \$121 billion in 2003 ( 7% compounding growth rate).
- Favorable Legislation: Includes ACA, Parity, Carve-in approaches, & states moving to Managed Medicaid.
- Diverse Payer Mix: Mcare, Third Party, Mcaid (most risky)
- Attractive Financing Model: Compared to general acute care hospitals margins=mid-teens, inpatient behavioral healthcare margins = 20-40% for acute hospitalization & 15-25% for residential treatment w/ maintenance at 2% of revenue.
- Niche Markets: BH with untapped "Downsize fitness" business models.

*Private equity investors accounting for roughly 30% of overall activity during 2010 & 2011. (Source: Jon Hill; Triple-Tree.com)*

“CMS reports Pioneer ACOs achieved lower cost growth (3%) for their 669,000 beneficiaries than the growth observed (8%) for similar beneficiaries in fee-for-service during the same period.”

Source: Taking Stock Of Initial Year One  
Results For Pioneer ACOs.  
Health Affairs Blog, 7/25/13



**While this cartoon is true insofar as we’re learning  
as we go in healthcare...the basic paradigm of  
“value based care” is not going to change  
because...**

## Healthcare is too expensive.

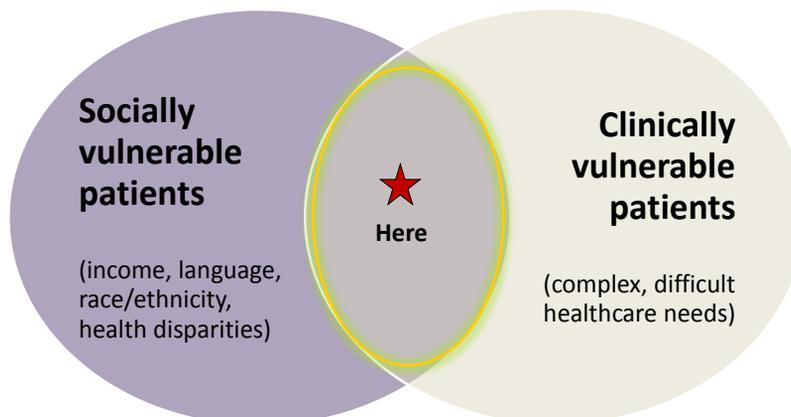


- ▶ Health care waste exceeds the 2009 budget for the Department of Defense by more than \$100 billion.
- ▶ Amounts to more than 1.5 times the nation's total infrastructure investment in 2004, including roads, railroads, aviation, drinking water, telecommunications, and other structures.
- ▶ If redirected the funds could provide health insurance coverage (employer/employee cost) for more than 150 million workers.
- ▶ And the total projected waste could pay the salaries of all of the nation's first response personnel, including firefighters, police officers, and emergency medical technicians, for more than 12 years.
- ▶ The current design of healthcare can not be sustained...

Source: IOM (Institute of Medicine), 2012. *Best care at lower cost: The path to continuously learning health care in America.* Washington, DC: The National Academies Press.

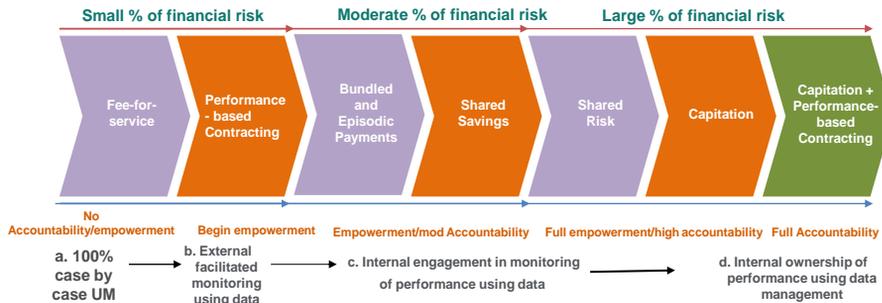
## Good News... Behavioral Healthcare is A Major Player:

[www.TheNationalCouncil.org](http://www.TheNationalCouncil.org)



Source: *Health Affairs*: VA Lewis, et al. "The Promise and Peril of Accountable Care for Vulnerable Populations: A Framework for Overcoming Obstacles." 2012.

**Provider Compensation Continuum**  
(Level of Financial Risk)



Source: Rhonda J Robinson Beale, M.D.  
Optum Chief Medical Officer, External Affairs

**Defining Our Terms**

- **Fee For Service:** Provide a service receive a payment.
- **Bundled Rate/Payment:** Often used as general term to describe a variety of payment methods (e.g., capitation, case rate, episode of care, etc.).
- **Case Rate:** A single payment per pt. served.
- **Episode of Care:** Payment for the care of pt. defined by specific healthcare need & associated set of services provided over an interval of time.

- HHS is required to establish a 5 year, voluntary pilot bundling program beginning in 2013.
- The program is to include 10 conditions representing a mix of chronic, acute, surgical, & medical conditions.
- The payment “bundles” will include care provided 3 days prior to admission thru 30 days post d/c & whatever range of acute & post-acute services the HHS secretary deems appropriate.



- Designing episode of care rates for Pts with Multiple Chronic Conditions is very difficult\*.
- Services that require a high degree of care coordination across many providers make calculating episode of care rates very difficult\*.
- Conditions with evidence-based treatment guidelines with clear treat to target metrics that can be achieved in 60-90 days are easier to establish episode of care rates\*.
- While you may be thinking why bother...it's important that you experiment with developing your bundled rate business plan!

*\*Source: AHA Research Synthesis Report: Bundled Payment (2010)*

1. The Value Proposition: What will your agency provide to Consumers, Families, Community Members, Health Network Partners, & Payers?
2. What are the Start-up Costs? How will it be funded?
3. What is the Model for Linking Outcome Data to Cost (i.e., episode of care logic)?
4. How are Operating Costs (i.e., fix & variable costs) met by a sustainable service model constructed from episodes of care that can be collapsed into a case rate?
5. How is the episode of care logic mapped to the service array and embedded in the team work flows?

1. Must define an episode of care including dx, services bundle, and episode duration.
2. Using historical data calculate your cost to provide the episode.
3. Determine how a bundled payment would be divided across staff and overhead costs.
4. Design policy, procedures, & training so staff can deliver services efficiently and effectively (i.e., use of EBP and treat to target).

Choose Condition Parameters: High Blood Pressure (BP)

Define Population: Dx, Screening/Assessment Scores

Collect Available Service & Claims Data: Analyze Clusters

Define Services: BP Screening at intake/quarterly; Care Coord./Referral & Coordination w/ Primary Care

Episode Length of Time: 9 months from dx to BP within normal target parameters

Calculate Cost: Average cost to treat this episode of care?

[Total Cost divided by (Number of Patient Days in an Episode x Number of Patients)] times 365

Total Cost for High BP Care Coord: \$50,000

- Number of Patient Days in an Episode: 180
- Number of Patients: 100/year
- Case Rate Per Member Per Day \$3; PMP Month \$84; PMP Year \$1014

Source: R. Manderscheid; Intro. to Case Rates & Capitation Rates

Choose Condition Parameters: Acute Bipolar Disorder

Define Population: Dx BPAD, Screening/Assessment Scores,

Collect Available Service & Claims Data: Analyze Clusters

Define Services: EBP/Medication Management, EBP/Family Psycho-education Services, Crisis Services, Moderate or High Intensity Care Team Management

Episode Length of Time: 10-18 months from start of episode (i.e., d/c from inpt.) to recovery/stabilization (i.e., d/c to medication only care)

Calculate Cost: Average cost to treat this episode of care?

[Total Cost divided by (Number of Patient Days in an Episode x Number of Patients)] times 365

Total Cost for Acute Psychosis: \$100,000

- Number of Patient Days in an Episode: 300
- Number of Patients: 100/year
- Case Rate Per Member Per Day \$3; PMP Month \$101; PMP Year \$1216

Source: R. Manderscheid; Intro. to Case Rates & Capitation Rates

## Overlapping Episodes

- Illness episodes rarely occur independently (i.e., pt w/ BPAD may also have High BP).
- Services such as care management, medication reviews, etc. are able to address more than one illness episode simultaneously.
- Level of care parameters provide a logical way of clustering low and high cost/need pts.

## Simple Bundling Logic Model

Condition	Level of Service	Service Bundle	Length of Care	Target Parameters
	Low Intensity Not Eligible			DLA 20 Target Willingness to take Medication
Adult Dx Bipolar Affective Disorder	Moderate Intensity Care Management Team	Medication Services  Care Management	Moderate Intensity 9-12 Months	Appt Kept Rate Hospitalizations ED or Crisis Use
Qualify for Mod or High Intensity Services	High Intensity Care Management Team	Family Psychoeducation  Crisis Services	High Intensity 12 -18 Months	Employment Housing Status

Given the risks involved in making “Global Budgets” the ACA provides insurers loss controls:

- Risk Corridors protection from administrative overhead losses (2014-2016)
- Reinsurance Mechanisms protection against losses from individual sick pts (2014-2016)
- Risk Adjustment protection against losses from populations of sick pts (Indefinitely)

- Per MH Parity & Addiction Equity Act of 2008 a health plan/insurer cannot impose financial requirements or tx limitations on BH benefits that are more restrictive than the predominant treatment limitations/financial requirements applied to all covered medical & surgical benefits.
- Furthermore, a health plan/insurer is not allowed to impose separate tx limitations [or cost sharing requirements] that are applicable only with respect to the BH benefits.

- Essential benefits include mental health and substance use treatment
- MH and SUD must be offered at parity with medical/surgical benefits

This means...

- ...Most members of the safety net will have coverage, including mental health and substance use disorders

- Providing behavioral health services in primary care – Primary Behavioral Health
- Providing primary care services in behavioral health settings

- One agency does it all
  - Federally Qualified Health Center hires psychiatrist(s), social workers and/or psychologists
  - Community Behavioral Health Organization hires primary care provider(s)
- Public Agencies Partner
  - FQHC, Public Hospitals, Rural Health Center and public mental health and addictions providers
- Private Agencies Partner
  - Private hospitals, private behavioral health organizations partner
- Public/Private Partnerships
  - A mixture of public and private agencies

## Effectively Billing Integrated Healthcare

- Provider Registration & NPI Numbers
- Proper Fee Schedule Setup
- Correct Forms
- Steps in the Billing Process
- Coding Overview
- Generating Bills
- Accounts Receivable
- HIT System to Manage it All



- Ensure you collect all PIN numbers for each provider
  - NPI
  - Medicare
  - Medicaid
  - 3<sup>rd</sup> Party Insurance
- HIT system should manage each PIN
  - By Provider
  - Effective and Expiration Dates
  - Associated with Payers



## National Provider Identification Numbers (NPI)

- 10 digit number
- To apply for your NPI online, visit:
- <https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions>
- For information:  
<https://www.cms.gov/nationalprovidentstand/>

## Fee Schedule Setup

- Setup your standard procedure codes and rates
  - CPT Codes and HCPCS Codes
- Ensure the HIT system can crosswalk standard codes to Medicaid and 3<sup>rd</sup> party payer required codes
- Verify that your HIT system can track expected payment amounts

CPT® Code	Description	2009 In-Office Fee**	2009 Facility Fee**
90801	Psych diag. Interview	\$152.92	\$128.04
90806	45-50 min. psychotherapy	\$93.54	\$87.10
96101	Psych test by psychologist	\$84.40	\$84.04
96102	psych test by tech.	\$51.21	\$22.72
96116	Neurobehav. Status exam	\$95.58	\$90.53
96118	Neuropsych test by psych	\$108.20	\$88.36
96119	Neuropsych test by tech.	\$74.80	\$31.02
96150	Health/Behav. Assessmt.	\$22.72	\$22.36
96152	Health/Behav. Intervent.	\$20.92	\$20.56

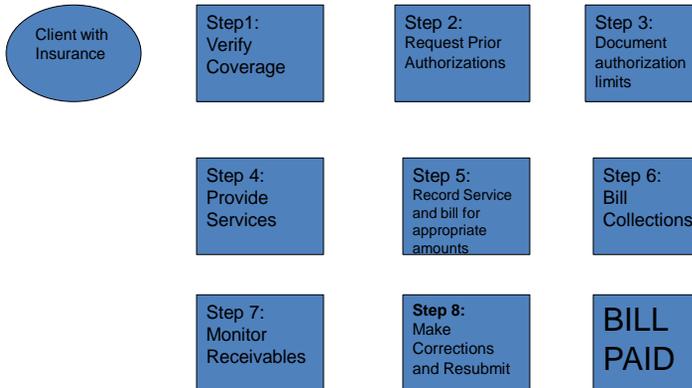
## Get standard billing forms

- Paper Forms
  - CMS 1500/HCFA 1500 – Outpatient Services
  - UB-04 for Institutional Claims
- Electronic Claim Formats
  - 837 Professional 5010
  - 837 Institutional 5010
- Ensure the HIT can process EDI response files
  - 997 – Acknowledgment file
  - 835 – Electronic Remittance Advice
  - 277 – Claim Status Response

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ISA*00*                *00*                *ZZ*133052274
GS*HC*133052274*363692630*20010815*1826*000000001
ST*837*3456
BHT*0019*00*244579*19981015*1023*CH
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## Steps to a Good Billing Process (NIATx – 2011)



## Step 1: Verify Coverage

### Description

- Make a copy of the insurance card at time of service
- Contact company to verify coverage



### HIT Support(s)

- Store a scanned copy of the card in the HIT system
- Real-time lookup of eligibility
- Show insurance verification on the calendar or reception window
- Setup a Reminder call process or service

## Step 2: Request prior authorization

### Description

- If prior authorization is required get
  - Format from Company
  - Complete Form
  - Transmit per company rules
  - Secure prior authorization

### HIT Supports

- Setup Insurance Policy
- Configure required prior authorizations by payer
- Track the status of the request at a client level

## Step 3: Document Authorization Limits

### Description

- When authorization is received:
  - Document the limit
  - Let provider and consumer know



### HIT Supports

- Track Authorization Life Cycle
  - Prior Authorization #
  - Total Units Authorized
  - Units Used
  - Units Available
  - Effective Date
  - Expiration Date
  - Provide Reminders of Expiration

## Step 4: Provide Service

### Description

- Make sure you have NPI
- Use correctly credentialed staff to provide service
- Make sure service provided is what is/was authorized

### HIT Support

- Manage schedule with a calendar
  - Provide warnings if invalid staff are scheduled for service
- Use dashboard to trigger required documentation and validations
  - Make Tx Plan readily available
  - Quick links to chart

## Step 5: Record Service and Bill

### Description

- Insure progress note form conform with insurance requirements
- Amount, Scope, Duration
- Concurrent Documentation
- Signed

### HIT Support

- Link the clinical documentation to the billing information
  - It should all be a part of the signature process
- HIT should provide edits and validations
  - Service Requires Auth
  - Duplicate Service
  - Overlapping Service

## HIT Billing Best Practices

- Calculate rates based on degree/credentials of clinician
- Generate Claims in batches
  - Electronic is preferable in all cases (837 P & I)
  - Paper Claims where required (CMS-1500 & UB-04 5010)
  - Custom invoices for grants and special programs (Paper, Excel, etc)
- Waterfall Billing
  - Medicare Crossover
  - Secondary Billing
  - 1<sup>st</sup> Party Billing
- Collect Client Payments at time of service
  - Determine Co-Pays

## Step 6: Collections: Bill status

### Description

- Check on bill status every 30 days with insurer
  - Paid
  - Denied
  - No response

### HIT Support

- Where Electronic process 835 and 277 files
  - Electronic Remittance Advice
  - Provides detail claim status
- Create A/R Aging Reports

**Total A/R Aging**  
Age ( 0 - 365 )  
Patient(s): All  
Billing Provider(s): All  
Financial Center(s): All

Payer/Plan/ Patient Name	Patient ID	Account Type	Superbill ID	CPT/ICD Code	Date of Service	Original Charges	0 - 30	30 - 60	60 - 90	90 - 180	180 +	Balance
Strom, Suzanne	19	Main	202	87880, 99214	05/21/2010	\$140.00	\$0.00	\$0.00	\$0.00	\$0.00	\$160.00	\$140.00
Clayton, Sara	13	Main	132	99203, 99214	05/21/2010	\$235.00	\$0.00	\$0.00	\$0.00	\$0.00	(\$10.00)	(\$10.00)
Clayton, David	18	Main	211	87880, 99214	06/14/2010	\$140.00	\$0.00	\$0.00	\$0.00	\$0.00	\$15.00	\$15.00
Clayton, Sara	7	Main	145	99214, 99214	03/01/2010	\$140.00	\$0.00	\$0.00	\$0.00	\$0.00	(\$10.00)	(\$10.00)
Clayton, Sara	7	Main	148	99214, 99214	03/05/2010	\$140.00	\$0.00	\$0.00	\$0.00	\$0.00	\$10.00	\$10.00

## Step 7: Monitor Receivables

### Description

- Occurs when bill is not paid
- Follow up on status ongoing
- Write off uncollectables



### HIT Support

- Process Remittance Advice Information
  - Use 835 to electronically update
  - Post all transaction to clients
- Generate Secondary Bills
  - Track payment from primary
- Setup to receive EFTs

## Step 8: Make Corrections and Resubmit

### Description

- If error is on agency end, correct and resubmit bill
- And initiate Steps 6 & 7 until paid or denied

### HIT Support

- Track client level errors
- Allow option to Rebill
  - Billing Rate issue
  - Coding Issue
  - Authorization Missing
  - Missing documentation
- Track claim through all stages of billing through payment

## Desirable Qualities in HIT Billing Systems

- Dashboards to track billings and receivables
- Integrated Practice Management and EHR
  - Clinical Documentation tied to Billing
    - Determine/Suggest code based on clinical information
  - Appointment Scheduler linked to Forms
- Manage Client Insurance Policies
  - Track policy priorities
  - Manage self-pay and co-pays
- Managed Spend-Down information

## HIT Claims Management Needs

- Claims Management
  - Batch Processing
  - Electronic EDI Claims Processing - 837
  - Electronic Remittance Processing – 835
  - Secondary Billing
  - Medicare Crossover
  - Client Statements
- Client Collections Management
  - Track client collection status
  - Allow online payments

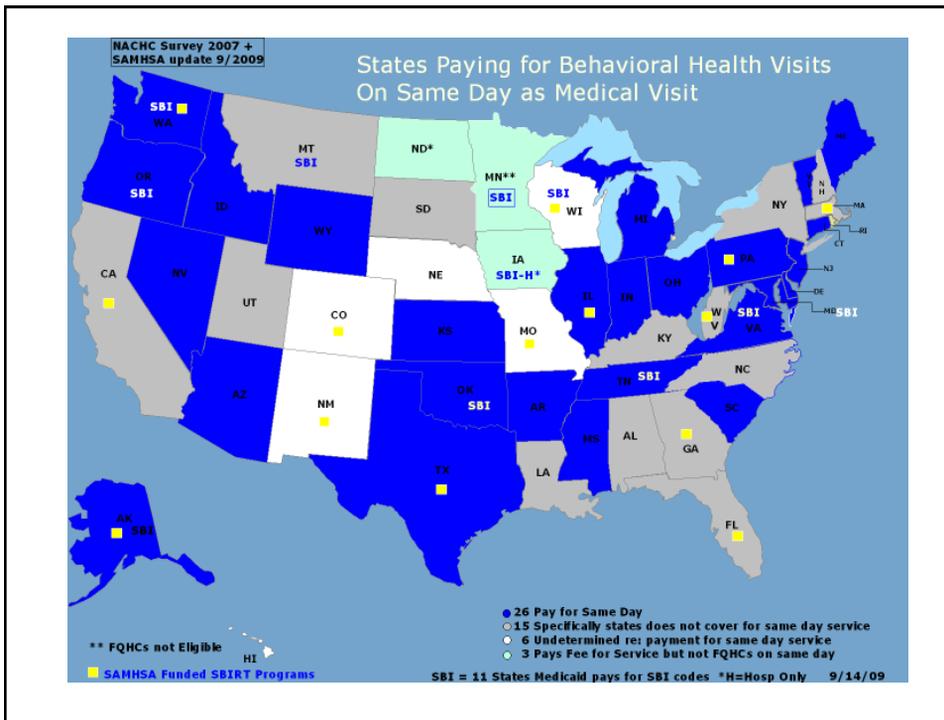
## HIT Interfaces and Maintenance

- System Interfaces
  - General Ledger System
    - Ensure GL Account mapping can be setup in the system
  - HR System
  - Claims Clearing House
- Administrative Maintenance
  - All HIPAA required Auditing and Security
  - Updated standard coding
    - ICD-9 and ICD-10
    - HCPCS
    - Medications and Drug Allergies
    - EDI formats including 5010

- The NIATx Third Party Billing Guide, Second Edition, University of Wisconsin – Madison (2011)

- Two Services in One Day
- 96000 Series of Codes
- SBIRT
- Obesity Counseling
- Tobacco Cessation

- ▶ Myth: The federal government prohibits this or Medicaid won't pay for this!
- ▶ Reality: This is a state by state Medicaid issue, not a federal rule or
- ▶ Federal Citations:
  - Medicare will cover a physical health and mental health visit same day/same provider – CFR Title 42 Volume 2, Part 405. Section 405.2463
  - Medicaid rules vary by state



Currently billable in states where it has been negotiated

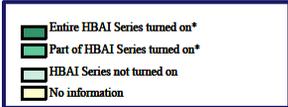
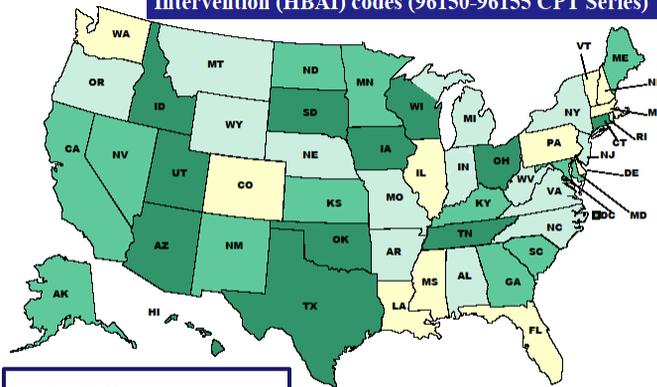
Two providers bill for the services they provide on the same day – Contractual Business Model

Behavioral Health Provider bills for BH service under their provider number

Primary Care bills for their services under their provider number

- Approved CPT Codes for use with Medicare right now
- Some states are using them now for Medicaid
- State Medicaid programs need to “turn on the codes” for use
- Behavioral Health Services “Ancillary to” a physical health diagnosis
  - Diabetes
  - COPD
  - Chronic Pain

**States use of Medicaid's Health and Behavior Assessment/  
Intervention (HBAI) codes (96150-96155 CPT Series)**



**NATIONAL COUNCIL**  
FOR COMMUNITY BEHAVIORAL HEALTHCARE

**NATIONAL COUNCIL**  
FOR BEHAVIORAL HEALTH  
MENTAL HEALTH FIRST AID

## The 96000 Series Codes

[www.TheNationalCouncil.org](http://www.TheNationalCouncil.org)

### Health and Behavior Assessment/Intervention (96150-96155)

Health and Behavior Assessment procedures are used to identify the psychological, behavioral, emotional, cognitive and social factors important to the prevention, treatment or management of physical health problems.

96150 – Initial Health and Behavior Assessment – each 15 minutes face-to-face with patient

96151 – Re-assessment – 15 minutes

96152 – Health and Behavior Intervention – each 15 minutes face-to-face with patient

96153 – Group (2 or more patients)

96154 – Family (with patient present)

96155 – Family (without patient present)

**NATIONAL COUNCIL FOR BEHAVIORAL HEALTH**

Contact: [Communications@TheNationalCouncil.org](mailto:Communications@TheNationalCouncil.org)

202.684.7457

## Intervention, Referral for Treatment (SBIRT)

[www.TheNationalCouncil.org](http://www.TheNationalCouncil.org)

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur.

**Screening** quickly assesses the severity of substance use and identifies the appropriate level of treatment.

**Brief intervention** focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.

**Referral to treatment** provides those identified as needing more extensive treatment with access to specialty care.

A key aspect of SBIRT is the integration and coordination of screening and treatment components into a system of services. This system links a community's specialized treatment programs with a network of early intervention and referral activities that are conducted in medical and social service settings.

## SBIRT Billing Codes

<b>Commercial Insurance</b>	<b>CPT 99408</b>	<b>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</b>	<b>\$33.41</b>
	CPT 99409	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	\$65.51
<b>Medicare</b>	G0396	Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes	\$29.42
	G0397	Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes	\$57.69
<b>Medicaid</b>	H0049	Alcohol and/or drug screening	\$24.00
	H0050	Alcohol and/or drug service, brief intervention, per 15 minutes	\$48.00

## Obesity Billing Codes

- 22 IBT Sessions in 12 month period
- G0447 - Face to Face behavioral health counseling for obesity
- With ICD 9 – V85.30 – V85.45
- Ancillary to a primary care doctor
- <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo>

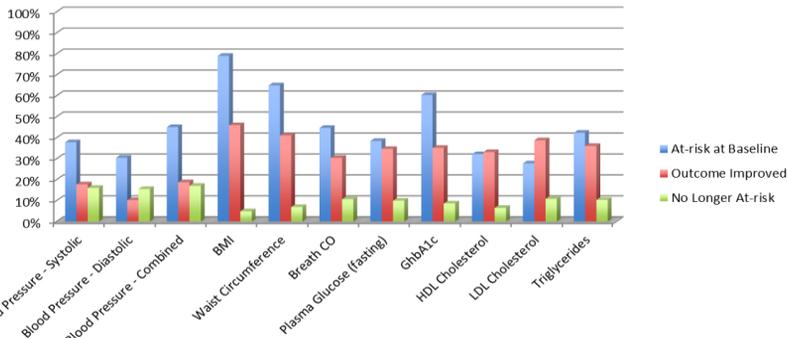
## Tobacco Cessation Billing

- Search Tobacco Cessation + CMS Billing

## Successes

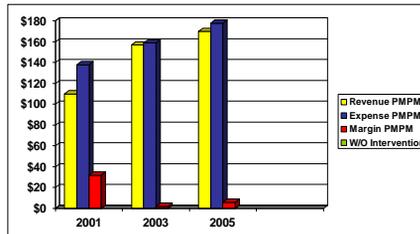
# PBHCI Grantee Data

**Change in Section H Indicators from Baseline to Most Recent Recording - Oct 11, 2012**



# Washtenaw County, MI

**Impact on Costs**



## Missouri Data

Base Period (CY2006)	\$1,556
Expected Trend	16.67%
Expected Trend with no Intervention	\$1,815.81
Actual PMPM in Performance Period (FY2007)	\$1,504.34
Gross PMPM Cost Savings	\$311.47
Lives	6,757
Gross Program Savings	\$25,254,928
Vendor Fees	\$1,301,560
Net Program Savings	\$23,953,368
NET PMPM Program Savings	\$295.41
Net Program Savings/(Cost) as percentage of Expected PMPM	16.3%

## Consumer Outcomes - Missouri

- Independent Living increased by 33%
- Vocational Activity increased by 44%
- Legal Involvement decreased by 68%
- Psychiatric Hospitalization decreased by 52%
- Illegal Substance use decreased by 52%
- IN ADDITION- Study shows CMHCs services substantially decrease overall medical cost

- ▶ 8 State's Plans have been approved:
  - ▶ Missouri (2) – Behavioral Health and Primary Care
  - ▶ Rhode Island (2) – adults and children with SMI
  - ▶ New York – chronic behavioral and physical health
  - ▶ Oregon
  - ▶ North Carolina
  - ▶ Iowa
  - ▶ Idaho
- ▶ 15 States with Planning Grants:
  - ▶ Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Maine, Michigan, Nevada, New Jersey, New Mexico, North Carolina, Washington, West Virginia, and Wisconsin

State	Population	Providers	Enrollment	Payment	Geog. Area
Idaho	SPMI or SED; Diabetes or Asthma; D/A and at risk for another chronic condition	Current Healthy Connections Providers	Self referred or referred by provider; opt out	PMPM for comprehensive care mgmt services	Statewide
Iowa	Two chronic conditions or one and at risk for another; includes hypertension	All primary care and CMHCs	Opt in at providers office	PMPM with performance based payment in 2013	Statewide
Missouri	SPMI only and MH or SA plus one chronic condition; MH/SA + tobacco	CMHCs	Auto-assigned with opt out	PMPM	Statewide
Missouri	Physical Health	Primary care	Auto-assigned with opt out	PMPM	Statewide
New York	SMI, Chronic Medical and BH conditions	Any providers meeting criteria	Auto-enroll with opt out	PMPM based on regions, case mix	Statewide

State	Population	Provider	Enrollment	Payment	Geog Area
North Carolina	Two chronic medical conditions or one and at risk for another	Medical Homes	Voluntary through Community Care North Carolina	Tiered PMPM with add on payments for specialized support	Statewide
Ohio	SPMI and SED	CBHCs	Opt out	PMPM	Targeted to 5 counties – statewide year 2
Oregon	Statute based plus Hep C, HIV/AIDS, kidney disease and cancer	PCPCH at Tier 1, 2 or 3 or PCPs meeting state criteria	Opt out	PMPM based on Tier	Statewide
Rhode Island	SMI or SED; two chronic conditions; or one and at risk of another; specific conditions	CEDARR Family Centers	Voluntary	Alternate payment methodology	Statewide
Rhode Island	SPMI	7 CMHO and 2 smaller mhp	Auto- assigned with opt out	Case rate	Statewide

Contact: Communications@TheNationalCouncil.org  
202.684.7457

## Excellence in MH Act

[www.TheNationalCouncil.org](http://www.TheNationalCouncil.org)

- Est. a new federal definition/criteria for “Certified Community Behavioral Health Clinics” (CBHC).
- Provides for a 2-year, 8-state pilot project in which orgs that meet CBHC criteria will be eligible for a Medicaid state based PPS rate.
- The ultimate goal: improved access to comprehensive mental health and addiction treatment services.

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## Questions/Discussion

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## American Hospital Association: Issue Brief Moving Towards Bundled Payment

<http://www.aha.org/content/13/13jan-bundlingissbrief.pdf>

## CMS Bundled Payments for Care Improvement: Learning & Resources Area

<http://innovation.cms.gov/initiatives/Bundled-Payments/learning-area.html>