Get Paid: Sustaining Integrated Health Care Through Correct Coding

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Overview

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
Vision for Financing Healthcare

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-Driven Elements of the PCMH & ACO
Vision for Financing Healthcare

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.

Source: March 2011 Meeting Report; Better to Best: Value-Driving Elements of the PCMH & ACO

Trend: Movement to Invest in BH

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…


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

Provider Compensation Continuum
(Level of Financial Risk)

- Small % of financial risk
  - Fee-for-service
  - Performance-based Contracting

- Moderate % of financial risk
  - Bundled and Episodic Payments
  - Shared Savings

- Large % of financial risk
  - Shared Risk
  - Capitation
  - Capitation + Performance-based Contracting

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.

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

- 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.

A Few Caveats…

- 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!

New Business Model for Integration Must Include Answers to:

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?

Building the Episode of Care

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).
Physical Health Example

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 Coor./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?

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

Total Cost for High BP Care Coor: $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
Behavioral Health Example

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 Psychoeducation 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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Level of Service</th>
<th>Service Bundle</th>
<th>Length of Care</th>
<th>Target Parameters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Dx Bipolar Affective Disorder</td>
<td>Low Intensity Not Eligible</td>
<td>Medication Services</td>
<td>Moderate Intensity 9-12 Months</td>
<td>DLA 20 Target</td>
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<tr>
<td></td>
<td></td>
<td>Care Management</td>
<td></td>
<td>Willingness to take Medication</td>
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<tr>
<td>Qualify for Mod or High Intensity Services</td>
<td>Moderate Intensity Care Management Team</td>
<td>Family Psychoeducation</td>
<td>High Intensity 12-18 Months</td>
<td>Appt Kept Refe</td>
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<td></td>
<td></td>
<td>Crisis Services</td>
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<td>Hospitalizations</td>
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<td>ED or Crisis Use</td>
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<td></td>
<td>Employment</td>
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<td>Housing Status</td>
</tr>
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</table>
Risk Estimation

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)

Parity’s Role in Rate Setting

• 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.
National Context for Including BH in the Health Home in the Affordable Care Act

- 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

Bi-Directional Integration

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

- 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
Core Elements of Good Billing Practice

- 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

Provider Registration

- Ensure you collect all PIN numbers for each provider
  - NPI
  - Medicare
  - Medicaid
  - 3rd 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:
- For information: [https://www.cms.gov/nationalproviderstand/](https://www.cms.gov/nationalproviderstand/)

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 3rd party payer required codes
- Verify that your HIT system can track expected payment amounts

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
<th>2009 In-Office Fees</th>
<th>2009 Facility Fees</th>
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<tbody>
<tr>
<td>90802</td>
<td>Psychotherapy Interviewing</td>
<td>$92.54</td>
<td>$185.10</td>
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<tr>
<td>90804</td>
<td>50-10 min. psychotherapy</td>
<td>$92.54</td>
<td>$185.10</td>
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<tr>
<td>90805</td>
<td>Psych test by psych tech</td>
<td>$51.13</td>
<td>$27.72</td>
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<tr>
<td>90818</td>
<td>Neurobehav. Status assess</td>
<td>$95.29</td>
<td>$190.56</td>
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<tr>
<td>90819</td>
<td>Neuropsych test by psych</td>
<td>$105.20</td>
<td>$130.80</td>
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<td>96136</td>
<td>Health/Behav. Intervent.</td>
<td>$71.72</td>
<td>$133.46</td>
</tr>
<tr>
<td>96152</td>
<td>Health/Behav. Intervent.</td>
<td>$70.92</td>
<td>$130.56</td>
</tr>
</tbody>
</table>
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

Steps to a Good Billing Process (NIATx – 2011)

1. Client with Insurance
   - Step 1: Verify Coverage
   - Step 4: Provide Services
   - Step 7: Monitor Receivables
2. Step 2: Request Prior Authorizations
3. Step 3: Document authorization limits
4. Step 5: Record Service and bill for appropriate amounts
5. Step 6: Bill Collections
   - BILL PAID
6. Step 8: Make Corrections and Resubmit
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

<table>
<thead>
<tr>
<th>Description</th>
<th>HIT Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Insure progress note form conform with insurance requirements</td>
<td>• Link the clinical documentation to the billing information</td>
</tr>
<tr>
<td>• Amount, Scope, Duration</td>
<td>• It should all be a part of the signature process</td>
</tr>
<tr>
<td>• Concurrent Documentation</td>
<td>• HIT should provide edits and validations</td>
</tr>
<tr>
<td>• Signed</td>
<td>• Service Requires Auth</td>
</tr>
<tr>
<td></td>
<td>• Duplicate Service</td>
</tr>
<tr>
<td></td>
<td>• Overlapping Service</td>
</tr>
</tbody>
</table>

## 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
  - 1st 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

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

Contact: Communications@TheNationalCouncil.org
202.684.7457
Resource


Billing Opportunities

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

- 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
Two Services in one Day

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

The 96000 Series

• 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
The 96000 Series Codes

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)
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

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<th>Commercial Insurance</th>
<th>Medicare</th>
<th>Medicaid</th>
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<tr>
<td>CPT 99408</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</td>
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<td>CPT 99409</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes</td>
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<td>G0396</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</td>
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<td>G0397</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes</td>
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<td>H0049</td>
<td>Alcohol and/or drug screening</td>
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<tr>
<td>H0050</td>
<td>Alcohol and/or drug service, brief intervention, per 15 minutes</td>
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<tr>
<td></td>
<td>$48.00</td>
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</table>
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

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
Status of Health Home Statewide Work

- 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

<table>
<thead>
<tr>
<th>State</th>
<th>Population</th>
<th>Providers</th>
<th>Enrollment</th>
<th>Payment</th>
<th>Geog. Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idaho</td>
<td>SPMI or SED; Diabetes or Asthma; D/A and at risk for another chronic condition</td>
<td>Current Healthy Connections Providers</td>
<td>Self referred or referred by provider; opt out</td>
<td>PMPM for comprehensive care mgmt services</td>
<td>Statewide</td>
</tr>
<tr>
<td>Iowa</td>
<td>Two chronic conditions or one and at risk for another; includes hypertension</td>
<td>All primary care and CMHCs</td>
<td>Opt in at providers office</td>
<td>PMPM with performance based payment in 2013</td>
<td>Statewide</td>
</tr>
<tr>
<td>Missouri</td>
<td>SPMI only and MH or SA plus one chronic condition; MH/SA + tobacco</td>
<td>CMHCs</td>
<td>Auto-assigned with opt out</td>
<td>PMPM</td>
<td>Statewide</td>
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<td>Missouri</td>
<td>Physical Health</td>
<td>Primary care</td>
<td>Auto-assigned with opt out</td>
<td>PMPM</td>
<td>Statewide</td>
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<tr>
<td>New York</td>
<td>SMI, Chronic Medical and BH conditions</td>
<td>Any providers meeting criteria</td>
<td>Auto-enroll with opt out</td>
<td>PMPM based on regions, case mix</td>
<td>Statewide</td>
</tr>
<tr>
<td>State</td>
<td>Provider</td>
<td>Geog Area</td>
<td>Population</td>
<td>Payment</td>
<td>Payment Methodology</td>
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<td>----------------------------------------------------------</td>
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<tr>
<td>North Carolina</td>
<td>Medical Homes</td>
<td>Statewide</td>
<td>Two chronic medical conditions or one and at risk for another</td>
<td>Voluntary through Community Care North Carolina</td>
<td>Tiered PMPM with add on payments for specialized support</td>
</tr>
<tr>
<td>Ohio</td>
<td>CBHCs</td>
<td>Targeted to 5 counties – statewide year 2</td>
<td>SPMI and SED</td>
<td>Opt out</td>
<td>PMPM</td>
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<tr>
<td>Oregon</td>
<td>PCPCH at Tier 1, 2 or 3 or PCPs meeting state criteria</td>
<td>Statewide</td>
<td>Statute based plus Hep C, HIV/AIDS, kidney disease and cancer</td>
<td>Opt out</td>
<td>PMPM based on Tier</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>CEDARR Family Centers</td>
<td>Statewide</td>
<td>SMI or SED; two chronic conditions; or one and at risk of another; specific conditions</td>
<td>Voluntary</td>
<td>Alternate payment methodology</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>7 CMHO and 2 smaller mhp</td>
<td>Statewide</td>
<td>SPMI</td>
<td>Auto-assigned with opt out</td>
<td>Case rate</td>
</tr>
</tbody>
</table>

Excellence in MH Act

- 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.
Thank You!

Questions/Discussion

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Resources

American Hospital Association: Issue Brief Mowing 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