G-codes for Integrated Care Models

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Introduction

Philosophers, scientists, and healers have struggled for thousands of years to understand the relationship between the mind and the body. Traditionally, people have felt that there is something "more" to humans than their physical body – a mind, a soul, consciousness, or a spirit of some kind. However, biological sciences seem to provide evidence that what we experience as "mind" may be, in fact, a complex component of our physical brain. This "mind-brain problem" has significant implications for our modern health care system, where treatment of the mind is often separated from treatment of the body. In particular, this separation of treatment systems and cultures has created new problems for health care delivery in the United States.

In the United States, treatment of mental health has been complex and controversial. The twentieth century saw a dramatic shift in conceptualization of mental illness from a moral flaw or permanent disability into a biological problem that can be treated with medications. At the same time, the psychoanalytic school showed clear benefits of the "talking cure" and a variety of psychotherapy techniques were developed. These two traditions come together in our current mental health specialty system which includes psychiatrists, psychologists, licensed counselors, psychiatric nurses, social workers, and other types of providers. In theory, primary care providers would refer out their patients with mental health and substance abuse concerns to a skilled specialty behavioral health system.

However, despite the wide array of treatments and providers, the majority of mental illness continues to be treated in the primary care setting. Part of the reason for this phenomena is the shortage of psychiatrists in the United States – to serve the 7% of the population that needs specialty care, it is estimated that we need 25 employed full-time psychiatrists per 100,000 people (Konrad TR et al, 2009). The US currently (2016) has a total of 24,820 psychiatrists; North Carolina only has 13 employed psychiatrists per 100,000 people (Bureau of Labor Statistics). So in NC, primary care is the de facto mental health treatment system in part because we only have 50% of the psychiatrists needed to treat the population.

The treatment of depression illustrates the demands placed on primary care to treat mental illness. In 2010, 20% of <u>all</u> visits to primary care physicians were for mental health issues (2010 National Ambulatory Medical Care Survey). 80% of antidepressant prescriptions are from non-psychiatrist providers (Mark TL et al 2009), and antidepressants were prescribed in almost 10% of <u>all</u> patient visits to primary care providers (Mojtabai and Olfson, 2011). Primary care providers are often ill-equipped to manage depression since they receive little training in residency and limited comfort level with diagnosing and treating depression, but nonetheless prescribe antidepressants frequently. For example, between 1996 and 2007, the proportion of primary care visits at which antidepressants were prescribed with no psychiatric diagnosis increased from 59.5% to 72.7% (Mojtabal and Olfson, 2011). Primary care providers have mixed feelings about treating mental health issues like depression; this is nicely described in a narrative New Yorker article written by a primary care physician (Koven S, 2013).

The current system fails depressed patients for a number of reasons. If they are able to get a referral into the specialty system for mental health, they quickly find that their mind is separated from their body. They find themselves in an uncomfortable specialty system designed for treatment of severe and persistent mental illness, like schizophrenia. They may suffer stigma and embarrassment from having to go to a "clinic" for "crazy people". They find that the culture of behavioral health is very different from that of primary care and that the two cultures do not communicate well. For those that do not have access to specialty care or refuse to go, their mind remains attached to their body but their providers do not have the skills to provide them with high quality depression care. In the primary care setting, depressed patients often "fall between the cracks" of the system and have substandard treatment of depression.

The mind-body separation in health care can be seen clearly in "carve-out" systems of care, where patients experience entirely different systems of care delivery and payment for their physical health and mental health. There are several states who have adapted carve-out Medicaid models, including North Carolina. In NC, Medicaid patients with mental health and substance abuse diagnoses are treated in primary care through Medicaid. However, patient care in the mental health specialty system is managed through a utilization agent (LME/MCO). The LME/MCOs rely on organizations with ties to local government structures (former county-based area programs to provide services. One benefit of this carve-out system was to achieve cost-predictability; however this system has not achieved statewide consistency in service level or significant integration of behavioral health and physical health (Richard D, 2017).

The quadruple aim of health care reform is a way to understand the shortfalls of our current system and to implement meaningful change. Integrated care is a term that is being used widely to describe programs to re-attach the mind to the body and provide high-quality whole-person care. The literature strongly supports evidence-based integrated care models as a way to address the quadruple aim of health care reform. Here are some examples:

Decreased cost:

In California, patients working with an integrated behavioral health consultant in an integrated primary care setting decreased their ER utilization by 13% (Clarke et al, 2016).

Increased quality of care:

The evidence-based Collaborative Care Model in primary care was more effective in reducing depression symptoms and only marginally more expensive than usual care when implemented in an integrated health care environment (Wright et al, 2016).

In Washington State, Medicaid children received fewer antipsychotics (58% in children and 52% in teenagers) after implementation of psychiatric consultation program (Barclay RP et al, 2017).

Improved patient experience:

Integration led to improved patient experiences (Balasubramanian BA et al, 2017).

In Sweden, patients reported minimized symptoms and high degree of satisfaction in an evidence-based integrated care model called Primary Care Behavioral Health – PCBH (Angantyr et al, 2015).

Improved provider experience:

Over 75% of primary care providers who worked with behavioral health consultants in their practice found the BHC services helpful, and providers who interacted more with BHCs were more comfortable discussing and effectively treating behavioral health issues with patients (Torrence et al, 2014).

North Carolina has long recognized the problems with the current system and documented efforts to develop integrated care programs go back to the 1980s with the Community Oriented Primary Care (COPC) programs (Nutting and Connor, 1984). In recent years, integrated care programs have focused on co-location programs where a behavioral health provider (often a social worker or psychologist) is physically located in the same space as a primary care practice. These programs have tended to be grant-sponsored or funded through an affiliated academic center. While these programs have served a critical step towards integrated care, they have disappointed on several levels. Co-location without integration leads to a strange situation of physical proximity where the mind is still detached from the body. Grant-funded projects do not require the type of business case planning that is needed to ensure fiscal sustainability. Most programs do not measure health outcomes and it is difficult to know what is working and what is not working. Return on investment appears lackluster.

North Carolina is now faced with an opportunity to re-attach the mind to the body as the state has applied for a federal waiver to innovate its Medicaid program. Implementation of evidence-based models for integrated care in the primary care setting can achieve the quadruple aim of health care reform. Innovative policy and value-based payment models can be used to encourage and support primary care practices who wish to implement evidence-based models of integration. Solid business case planning with a demonstrated return on investment (ROI) is within our reach for sustainable high-quality integrated care programs. The state has a strong network of independent primary care practices who see the majority of the state's Medicaid patients. These practices need technical assistance to ensure fidelity to an evidence-based integrated care model. By moving away from grant-funded variability to evidence-based models with a strong return on investment we can sustain and grow our integrated care efforts and thus re-attach the mind to the body.

The purpose of this document is to introduce a new way that North Carolina Medicaid can encourage, support, and grow integrated care in the primary care setting. "G-codes" are a set of billing codes with prescribed requirements which were specifically designed to support the Collaborative Care Model – an evidence-based, integrated care model for treating depression in the primary care setting. These codes have already been activated for use in Medicare patients, and they are a critical first step to supporting integrated care for Medicaid populations. We will first review and compare 3 evidence-based models of integrated care. We will then discuss the

"G-codes" in more detail and why they are important to successful integration models. Finally, we will discuss ways in which we envision Community Care of North Carolina (CCNC) providing the technical assistance needed to translate evidence-based models to our primary care providers.

Description of CCNC evidence-based models

Collaborative Care Model (IMPACT)

- *"vertical"* model which focuses on one condition or disease state (most often depression)
- adds embedded care manager to the PCP team
- adds a psychiatric consultant to the PCP team (can be remote)
- uses an algorithm and registry to facilitate a proactive, population health, "treat-to-target" strategy
- strong evidence base, estimated return on investment (ROI) of 6:1 (Milliman report, 2014)
- most evidence for depression, also emerging for anxiety, PTSD, comorbid medical conditions (diabetes and cancer)
- best supported by the American Psychiatric Association (APA)

Primary Care Behavioral Health Model (PCBH)

- *"horizontal"* model which targets entire PCP population
- adds embedded behavioral health specialist to the PCP team
- hallmarks include health behaviors, preventative care, brief therapeutic interventions, referral to BH specialty
- high PCP provider satisfaction
- good evidence base, estimated savings of $100 annually per patient in the PCP population (Reiss-Brennan et al. 2016)
- best supported by Collaborative Family Healthcare Association (CFHA)

Screening, Brief Intervention, and Referral to Treatment Model (SBIRT)

- *"vertical"* model which focuses on high-risk alcohol and drug use
- does not require additional embedded staff
- uses a highly-defined screening and brief intervention protocol to define and manage high-risk alcohol and drug use, referral to treatment if substance use disorder identified
- strong evidence base, estimated ROI of 5:1 (Solberg et al., 2008)
- best supported by federal Substance Abuse and Mental Health Services-Health Resources and Services Administration (SAMHSA-HRSA)

Current vs proposed billing mechanisms in Medicaid

	CURRENT			PROPOSED****		
model	action	code*	payer	action	code***	payer
PCBH	warm hand-off	-	-	warm hand-off		
	meeting #1	90832	MCO	meeting #1		
	meeting #2	90832	MCO	meeting #2	G0507	
	meeting #3	90832	MCO	meeting #3		DMA
	hand-off	-	-	hand-off		
	health behavior**	96150	DMA	health behavior	G0507	
	health behavior**	96151	DMA	health behavior		
Collab Care (IMPACT)	screen	96127	DMA	screen	96127	DMA
	warm hand-off	-	-	warm hand-off		
	meeting #1	90832	MCO	meeting #1		
	registry	-	-	registry		
	psychiatry consult	-	-	psychiatry consult	G0502	DMA
	phone call	-	-	phone call		
	phone call	-	-	phone call		
	discuss with PCP	-	-	discuss with PCP		
	registry	-	-	registry		
SBIRT	screen AND	99408	DMA	screen AND	99408	DMA
	brief intervention	"	-	brief intervention	"	-
	referral	-	-	referral	-	-

NOTES:

*most commonly used codes, variable depending on site, time, etc.

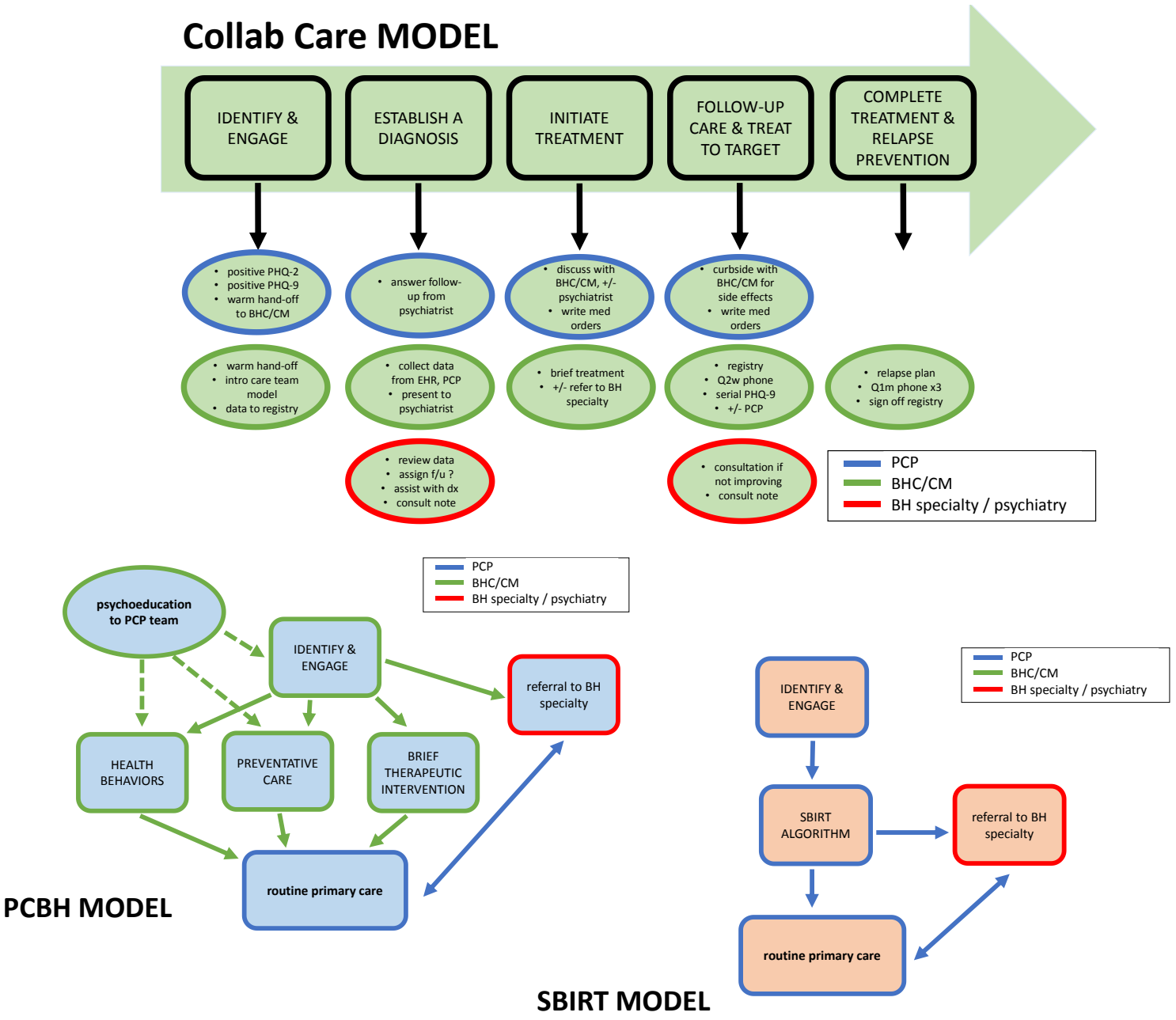
** must be billed incident-to PCP

*** G0502 is for first month, G0503 for subsequent months, G0507 is a monthly code

- Of note, "the behavioral health care manager may or may not be a professional who meets all the requirements to independently furnish and report services to Medicare"
- If eligible to individually furnish and report services, the BHC may report separate services in the same calendar month. These could include: psychiatric evaluation (90791-2), psychotherapy (90832-8), psychotherapy for crisis (90839-40), multiple family group psychotherapy (90849), group psychotherapy (90853), smoking and tobacco use cessation counseling (99406-7), alcohol or substance abuse structured screening and brief intervention (99408-9). Time spent by the BHC on activities for services reported separately may not be included in the services reported using time applied to the GPPP1, GPPP2, GPPP3, and GPPPX codes.

- CMS expects an Initiating Visit prior to billing for the G0502-0507 codes. This visit is required for new patients and for those who have not been seen within a year of commencement of integrated behavioral health services. This visit will include the PCP establishing a relationship with the patient, assessing the patient prior to referral, and obtaining broad beneficiary consent to consult with specialists that can be verbally obtained but must be documented in the medical record.
- patients will be billed a Medicare co-pay as applicable under their Medicare plan
- FQHCs are not eligible to bill these codes

Comparison of CCNC evidence-based models



CCNC position statement on integrated care G-codes

Clinical Need in North Carolina

CCNC has historically focused on helping primary care practices improve the quality of care and lowering costs for Medicaid recipients. We believe that diagnosis and treatment of mild to moderate behavioral health (BH) conditions does and should occur in the primary medical home (PCMH). Treatment for this population is already happening in primary care; for example primary care providers prescribe 79% of antidepressant medications and see 60% of people being treated for depression in the US (Barkil-Oteo A, 2013). Unfortunately, most primary care providers have had very limited training in treatment for mental illness and behavioral health, and treatment for this population is suboptimal.

Evidence-based integrated care models guide PCMHs through specific workflows and provide appropriate support for treatment of low acuity BH issues. These models improve provider satisfaction (Torrence et al 2014) and improve health outcomes (Wright et al. 2016). Higher acuity BH issues are better served within the specialty behavioral health system, currently managed by LME/MCO organizations in North Carolina. The American Psychiatric Association (APA) is in agreement. In their position statement on psychiatry and primary care across the lifespan in 2010, they state "Access to and payment for clinically appropriate services provided by psychiatrists should be included as an essential feature in medical/health home initiatives". Locally, the North Carolina Psychiatric Association (NCPA) has endorsed the APA position.

Past models of integrated care in North Carolina have often relied on the "co-location" model of care where a BH provider is in the same physical location as the PCMH but is not integrated into the model of care. Few PCMHs have demonstrated high level of fidelity to evidence-based models of integrated care. Low fidelity has weakened the efficacy and the return on investment (ROI) seen in evidence-based models of integration. Typically a co-located BH provider will focus on patients in crisis or with the highest acuity, leaving up to 90% of the PCMH population without behavioral interventions.

This experience is not limited to North Carolina: in fact, multiple professional entities at the national level have identified a clear need for integrated care approach in primary care. In the July 2015 Federal Register, the Department of Health and Human Services outlined the need for new codes to facilitate and offer compensation for evidence-based integrated care models (pages 46200-46205). Importantly they note "We believe the focus of the health care system has shifted to delivery system reforms, such as patient-centered medical homes, clinical practice improvement, and increased investment in primary and comprehensive care management/coordination services for chronic and other conditions. This shift requires centralized management of patient needs and extensive care coordination among practitioners and providers (often on a non-face-to-face basis across an extended period of time). In contrast, the current CPT code set is designed with an overall orientation to pay for discrete services and procedural care as opposed to ongoing primary care, care management, and cognitive

services….We recognize that the current set of E/M codes limits Medicare's ability under the PFS (Physician Fee Schedule) to appropriately recognize the relative resource costs of primary care, care management/coordination…"

As a result, the Centers for Medicare and Medicaid Services (CMS) has proposed a temporary set of CPT "G-codes" (G0502-4, G0507) to start paying for evidence-based integrated care models. The G-codes were designed to reduce obstacles to implementation and sustainability of integrated care, as well as to improve outcomes by encouraging higher level of model fidelity. Medicare expects to replace the temporary codes as early as 2018 based on data and feedback from their use in 2017.

The American Psychiatric Association (APA) has strongly supported these new codes and offered recommendations for their expansion in their public letter to CMS in September 2016:

1) We recommend that CMS finalize its proposal to establish coverage of the Collaborative Care Model for any diagnosed behavioral health condition through the creation of and coverage for G-codes that parallel the recently approved CPT codes that describe psychiatric collaborative care management services consistent with the CoCM. (Collaborative Care Model).

2) We recommend an increase in the proposed payment amount, valuing the work of the psychiatric consultant no less than that of the primary care physician. After extensive discussions with experts in the CoCM, we have concluded that the proposed values assigned to the GPPP1, GPPP2, and GPPP3 do not adequately reflect the work of the psychiatric consultant and would result in values that are not sufficient to sustain the model.

3) We support the creation of GPPPX, "care management services for behavioral health conditions." However, we recommend that CMS provide further clarification regarding the proposed code and we believe the creation of an add-on-code would be premature.

4) We recommend that the CMS adopt appropriate requirements for GPPP1, GPPP2, and GPPP3 that reflect the prescribed elements of the CoCM model; delineate practitioner's eligibility, supervision requirements, patient eligibility, patient agreement requirements, and the scope or required elements of GPPX services; and avoid applying unduly restrictive requirements for all four codes.

5) We recommend that CMS allow the behavioral health care manager (BHCM) to work off-site, under the general supervision of the treating physician or other qualified health professional (QHP), consistent with the evidence base for the CoCM and similar to current requirements for care managers for chronic care management (CCM) services.

6) We recommend that CMS finalize its proposal to require an initial visit prior to the initiation of these services. Specifically, CMS should finalize its proposal to allow the same types of service which serve as the initiating visit for chronic care management (CCM) services also be allowed for the behavioral health integration codes (GPPP1, GPPP2, GPPP#, and GPPPX).

7) We recommend that CMS finalize its proposal to establish a beneficiary general consent standard for BHI services.

8) We recommend moving ahead with coverage of GPPP1, GPPP2, and GPPP3 with any cost-sharing that is currently required; while simultaneously urging CMS to establish a Centers for Medicare and Medicaid Innovation (CMMI) demonstration project to assess the impact of requiring cost-sharing for CoCM services on beneficiary participation.

9) We recommend that CMS provide separate payment for psychiatric collaborative care management services furnished in PHCs and FQHCs.

ROI

At CCNC, we strongly believe that **all** payers (Medicare, Medicaid, commercial) should adopt payment for the new G-codes in 2017. Providing payment for the G-codes would stack the deck in favor of integration and create financial and logistic incentives for PCMHs to implement evidence-based, sustainable models of integration. Funding the G-codes would also benefit payers, as high fidelity integrated care models have a 6:1 return on investment.

Specifically, the 2014 Milliman report has estimated total annual value opportunity through integration of mental health/substance abuse and medical conditions: $162 billion in the commercial market, $31 billion in the Medicare market, and $100 billion in the Medicaid market. This estimate comes from literature review finding an estimated 5-10% savings of total healthcare expenditures for patients with behavioral conditions through effective integration of behavioral healthcare with medical care.

It is important to note that the ROI for integrated care is *most pronounced for treatment of medical issues, **not** for treatment of behavioral health issues*. Cost savings comes from improved utilization of the medical system by patients with co-morbid medical and mental health issues. For North Carolina Medicaid recipients, this finding strengthens the case that coding and billing for integrated care should be through the medical system, not the carve-out specialty BH system.

Role of CCNC

We believe that CCNC serves a valuable role in promoting efficient and effective use of the new G-codes in integrated care models. CCNC has a strong infrastructure within primary medical homes across North Carolina and has been working under the federal Practice Transformation Network (PTN) collaboration to develop a technical assistance model to PTN participants across the state. As part of the PTN platform, the CCNC behavioral health team is working with 84 practices to provide structured, practical, and time-efficient technical assistance around understanding, implementing, and sustaining integrated care in the primary care medical home.

We plan to continue development and refinement of a robust integrated care technical assistance program for integrated care across the state. Specifically, CCNC helps practices with:

1) Understanding evidence-based models of integration
2) Assessment of readiness for integration and progress towards integration goals
3) Quality improvement support that understands the “big picture” of how integrated care fits with the practice’s goals
4) Quality improvement support to ensure integrated care model fidelity
5) Help recruiting, matching, training, and supporting psychiatrists to collaborative care models

6) Help recruiting, matching, training, and supporting behavioral health providers (BHC) to PCBH models
7) Help with implementation and use of registries for collaborative care models to support a population health approach
8) Education and support from network BH teams around local resources for behavioral health specialty
9) Coordination of efforts with third-party utilization managers (like the Medicaid LME-MCO companies)
10) Ability and willingness to collaborate with the North Carolina's professional associations – NCPA, NC Psychological Association, NC Association of Social Workers, NC Board of Licensed Professional Counselors, etc.

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APPENDIX A - Terminology

APA – American Psychiatric Association

BH – Behavioral Health

BHCM – Behavioral Health Care Manager

BHI – Behavioral Health Integration

CCM – Chronic Care Management

CCNC – Community Care of North Carolina

CMMI – Centers for Medicare and Medicaid Services Innovation

CMS – Centers for Medicare and Medicaid Services

CoCM – Collaborative Care Model

CPT – Current Procedural Terminology

FQHC – Federally Qualified Health Center

HEDIS – Healthcare Effectiveness Data and Information Set

IMPACT – Improving Mood—Promoting Access to Collaborative Treatment

LME-MCO – Local Management Entity-Managed Care Organization

NCPA – North Carolina Psychiatric Association

PCBH – Primary Care Behavioral Health Model

PTN – Practice Transformation Network

QHP – Qualified Health Professional

RHC – Rural Health Clinic

ROI – Return on Investment

RVU – Relative Value Unit

SAN – Support and Alignment Network

SBIRT – Screening, Brief Intervention, Referral to Treatment

APPENDIX B – FAQs on G-codes for Integrated Care

***Q**: What exactly is being billed with the G-codes?*
A: The G-code is billing for the Behavioral Health Care Manager (BH CM) time, there is the assumption that there will be additional time spent by the PCP and the psychiatric consultant.

***Q**: Can a practice bill the G-codes to all insurance payers?*
A: NO, currently (June 2017) G-codes can be billed to Medicare only. It is expected that Medicaid and commercial payers will adapt the G-codes in the near future.

***Q:** Does the patient pay the Medicare co-pay when the G-codes are billed?*
A: YES if patient is Medicare only, NO if patient is dual eligible Medicaid/Medicare.

***Q:** Is a visit with the PCP required to start billing the G-codes?*
A: YES, there must be an initiating visit with the PCP in the year prior to the G-code billing.

***Q:** Are ongoing E/M visits with the PCP required monthly?*
A: NO, just the initial visit.

***Q:** Does the PCP have to be physically present on site at all times?*
A: NO – the billing is "incident to", under "general supervision", which means that the PCP is not required to be on site at all times, but available by phone.

***Q:** Does the BH CM have to be physically present on site at all times?*
A: The BH CM is required to be "available to provide services face-to-face" with the patient, although not required to provide face-to-face services, just to be available.

***Q:** What kind of consent is required from the patient to bill the G-codes?*
A: Advance consent is required, both consent to participate in the Collaborative Care treatment (including consultation with psychiatrist) and informing the patient that cost-sharing applies. This may be VERBAL but must be documented in the medical record.

***Q:** What if the BH CM doesn't reach threshold for time spent during the month on the patient in Collaborative Care?*
A: The "General BHI code" (G0507) which does not require the psychiatric consultant or use of registry, but pays less, can be used for months when the BH CM time does not reach threshold.

***Q:** Does the consulting psychiatrist have to be part of the PCP practice?*
A: NO

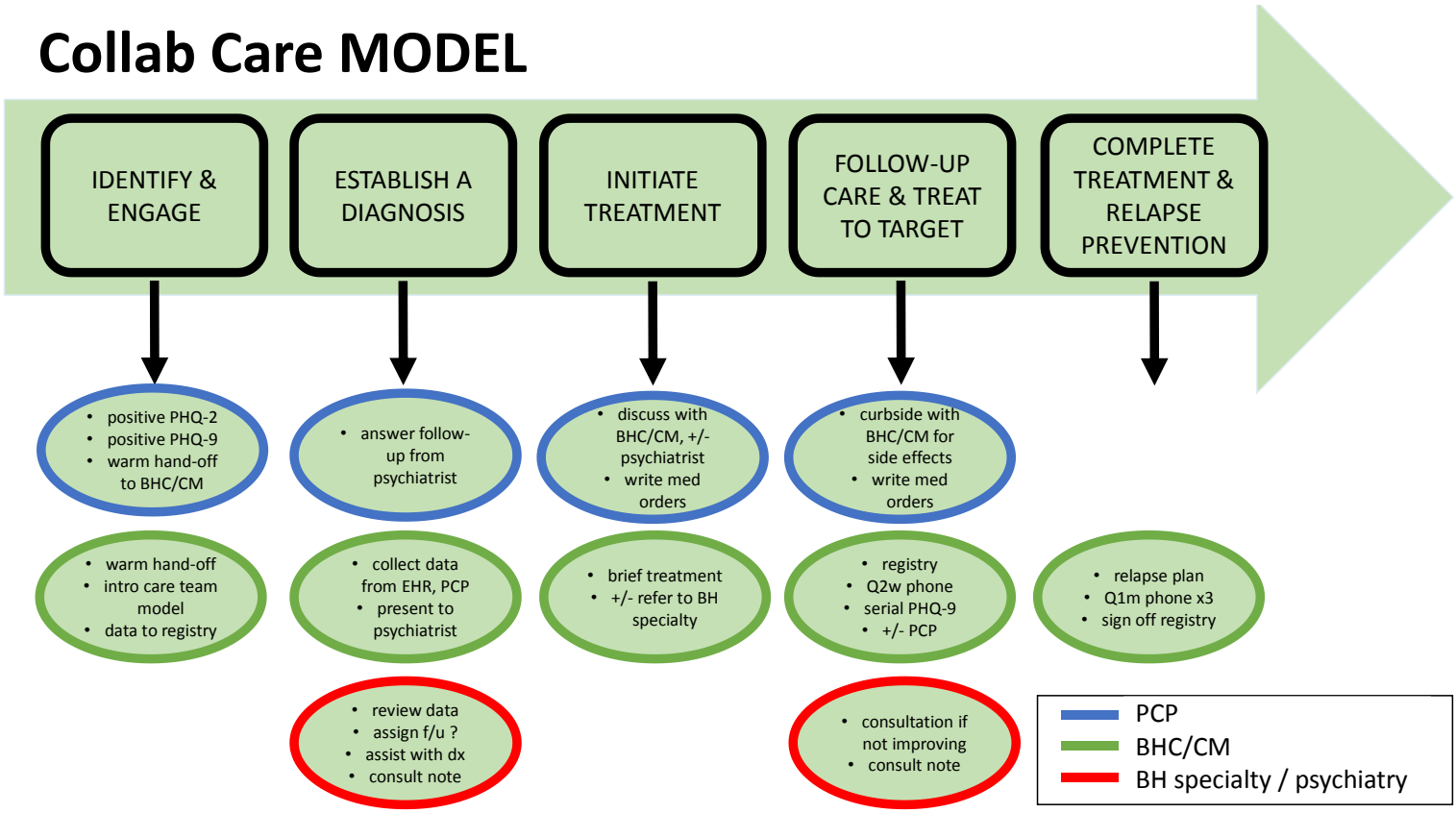
***Q:** Does the consulting psychiatrist have to be participating in Medicare?*
A: NO

***Q**: Can FQHCs bill the G-codes?*
A: NO, since they have other billing mechanisms for behavioral health care.

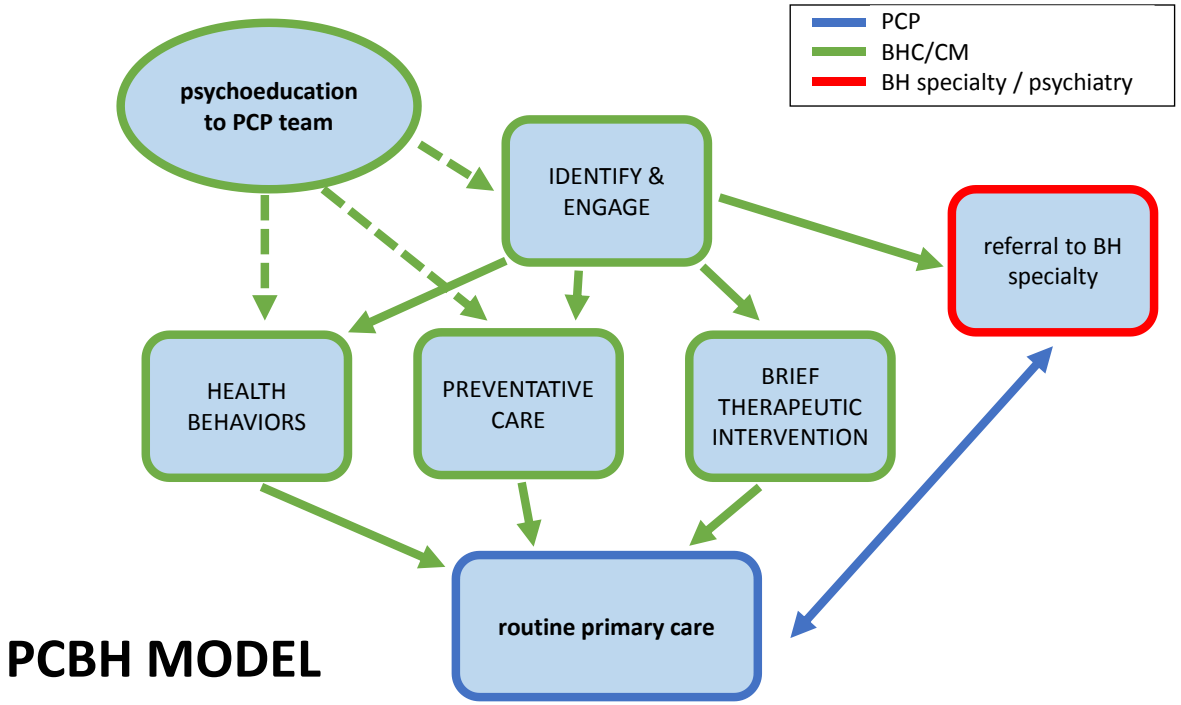
APPENDIX C – Code Definitions

- **G0502 - Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional**
    - **Outreach to and engagement in treatment of a patient** directed by the treating physician or other qualified health care professional;
    - **Initial assessment** of the patient
    - **Review by the psychiatric consultant** with modifications of the plan if recommended
    - Entering patient in a **registry and tracking** patient follow-up and progress using the registry, and participation in weekly caseload consultation with the psychiatric consultant
    - **Provision of brief interventions** using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
    - Payment will be $142.84 in primary care settings; **$136.41** in NC
- **G0503 - Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional**
    - **Tracking** patient follow-up and progress **using the registry**
    - Participation in **weekly caseload consultation** with the psychiatric consultant
    - Ongoing collaboration with and **coordination of the patient's mental health care** with the treating physician or other qualified health care professional and any other treating mental health providers
    - Additional **review of progress and recommendations for changes in treatment**, as indicated, including medications, based on recommendations provided by the psychiatric consultant
    - Provision of **brief interventions** using evidence-based techniques
    - **Monitoring of patient outcomes** using validated rating scales
    - **Relapse prevention planning** with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment
    - Payment will be $126.33 in primary care settings; **$120.89** in NC
- **G0507 – Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month.**
    - Payment will be $47.73 in primary care settings; **$45.66** in NC

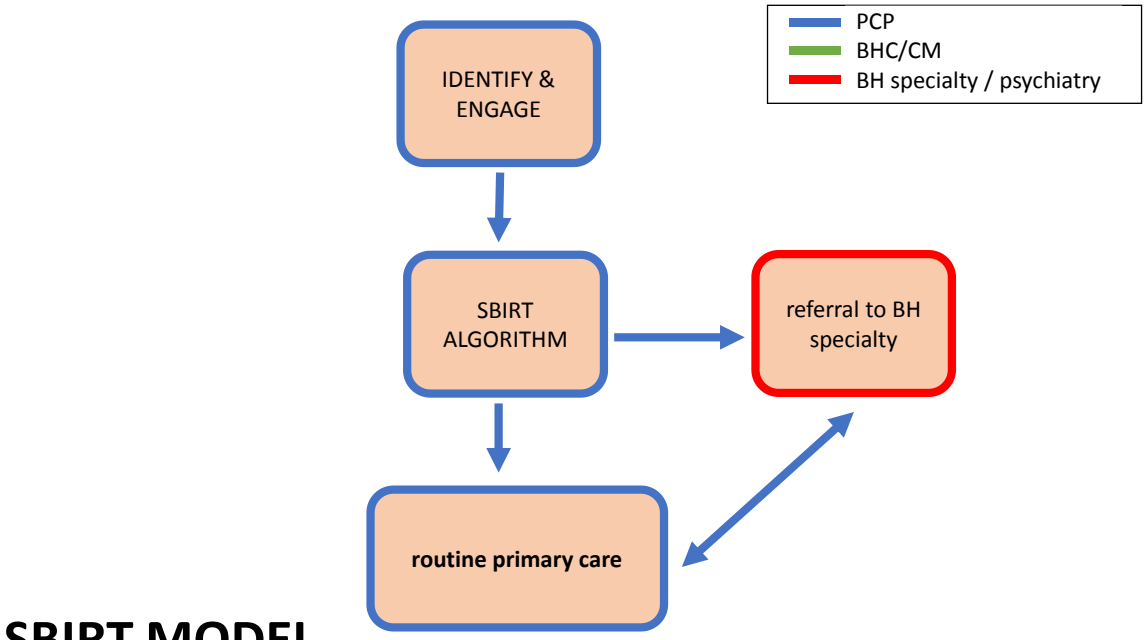
APPENDIX D – Schematic for Collaborative Care Model



APPENDIX E – Schematic for Primary Care Behavioral Health Model



APPENDIX F – Schematics for Screening, Brief Intervention, Referral to Treatment Model



SBIRT MODEL

Please note that "SBIRT ALGORITHM" is a placeholder for one of multiple SBIRT workflows. Some workflows focus on alcohol, others on illegal drug use. A practice would choose which workflow works best for their needs and staffing resources. Multiple SBIRT guides and workflows can be found on the SAMSHA website:

http://www.integration.samhsa.gov/clinical-practice/sbirt