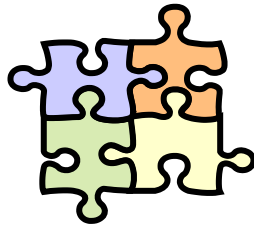


The Business Case for Behavioral Health Care



$$\mathbf{S+I+T \leq X+P+R}$$

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The Business Case for the Integration of Behavioral Health and Primary Care

A central tenet of the Patient Centered Medical Home (PCMH) Model is *holistic* and *comprehensive* primary care. Primary care providers have always known that behavioral health is a major public health issue and a primary or co-morbid diagnosis of many of the patients seen by the primary care team. The literature suggests that the incidence of depression as a comorbidity with chronic disease ranges from 24% to 40% in a normalized population. Health Centers that have implemented universal screening of their chronically ill patients are finding the incidence as high as 70%. Unfortunately, reimbursement for behavioral health related conditions has been fragmented and structural barriers (such as regulatory guidelines precluding billing for a behavioral visit on the same day as a primary care visit when providers use the same provider number) have resulted in a lack of integration of behavioral health services and primary care. This monograph addresses the business case for integration of behavioral health and provides guidance on how to evaluate this business case at an individual Health Center.

Behavioral Health Services Integrated in Primary Care

A fully integrated behavioral health model includes resources for a number of services required by those with mental health conditions:

- universal screening for behavioral health issues (including substance and alcohol abuse, depression and other mental health conditions);
- self-management support and brief interventions by a behaviorist;
- treatment of the behavioral health condition by the care team; and
- appropriate referral for treatment to a psychologist or psychiatrist, as warranted.

As you know there are several models for integration of behavioral health and primary care. One model is a fully integrated staff working as a multi-disciplinary care team. A colocation of behavioral health providers and primary care providers working for the same organization can facilitate warm handoffs and facilitate access. Integration can also be achieved through a purposively designed co-location model where staffs from partnering organizations collaborate in the care of individuals. Variations of these are being pursued in this collaborative.

For patients with severe behavioral health conditions where the patient is being seen frequently in a behavioral health setting the behavioral health organization may serve as the individual's health home, working with a primary care team to address issues of physical health and prevention for a particular patient. A third approach is use of tele-health services supporting the primary care team. The major challenge faced by most primary care organizations working to integrate behavioral health in the PCMH is finding the resources required to provide universal screening and a basic level of intervention. Attention to the business case can help mitigate this challenge.

The Business Case Equation for BH Integration: $S+I+T \leq X+ P+ R$.

The basic business case formula for any service is that cost must be less than revenue. For behavioral health integration this translates to the following: Cost of Screening (S) + Cost of Intervention Services (I) + Transition Costs (T) must be less than or equal to Screening Reimbursement (X) + Productivity Gains (P) + Reimbursement for Treatment (R). This formula is summarized as:

$$S+I+T \leq X+P+R$$

Each element is reviewed below:

Screening (S): A variety of screening approaches have been implemented across the country. A model promoted by Dr. Richard Brown (University of Wisconsin) retains bachelor level graduates at a salary range in the mid \$20,000's to conduct universal screening for substance and drug abuse. In other settings, screening is built into pre-visit work flows with clerical staff and/or medical assistants helping patients with screening tools. Calculate your costs for screening services by multiplying how much time is needed to screen each patient, the number of patients that need screening, and the salary of the staff doing the screening.

Example: 5 minutes for each screening and data entry, 1000 patients screened, screened by someone making \$25,000 per year equals \$1447 (assuming 1800 hours worked per year and fringe rate of 25%).

Where possible, try to build screening into existing work flows without devoting additional staff time to the process. An example might be to ask patients to complete a screening tool such as a PHQ-2 in the waiting room or as part of existing self-management support interventions.

Intervention (I): The cost of intervention is dependent on a determination of what level of professional training is required as part of your integration model. The following example illustrates the business case model. A bachelor trained social worker or behavioral health counselor works as a behaviorist embedded in the care team. The behaviorist provides self-management support, uses motivational interviewing skills and/or coping skills to support behavior change, and may provide a limited number of separately scheduled consultations to address more complex challenges. In states where reimbursement is available, the payers (e.g. state Medicaid) may determine a minimum level of education/licensure requirement in order to receive reimbursement (e.g. a Master's degree or license).

Once again, the business case requires that the cost be computed for the resources used to provide same day intervention services for your population of patients. Multiply salary (including fringe) by time needed for each intervention by patient volume. See the Hale Health Center Case Study below for an example.

Transition Costs (T): Moving to an integrated model does have transition costs associated with staff training, adapting electronic medical record systems, and adapting to the new work flows. These transition costs usually are expended over the first six months of the implementation period. Training

costs can be calculated by estimating time needed for training, the cost of materials and faculty, and the decrease in revenue due to clinical time lost to training. An estimate of the cost of adapting your electronic medical record for any templates or modifications may also be required.

Reimbursement for Screening (X): Reimbursement for screening has been patchwork and inconsistent across the health care environment. Medicare now reimburses for SBIRT screening while the availability of Medicaid reimbursement varies widely. Indiana, Wisconsin and Missouri have been more progressive, with Missouri offering a significant per member per month reimbursement for Medicaid members with a serious mental illness under the Health Home Program. Private payers are increasingly expecting screening to be accommodated by any per member per month reimbursement made for PCMH services. In order to assess the business case the reimbursement climate must be validated by the individual organization.

Gains in Productivity (P): A hidden source of funding is the re-captured cost of lost productivity associated with behavioral health conditions being presented during a primary care visit. A planned ten minute visit can easily turn into a forty five minute encounter as a result of trying to manage anxiety or depression during the visit. Increasingly, reports from the field reflect that integration of behavioral health has resulted in dramatic increases in workflow productivity of the primary care team. One of the best examples is South Central Foundation in Alaska which has seen a dramatic reduction in global costs by increasing their throughput with fewer primary care resources.

To estimate potential productivity gains and translate them into incremental revenue, the best approach is direct observation on a sampling basis. Observe a random sample of patients or all patients for one physician over the period of a few days. Observers should measure the amount of time needed for patient counseling and support that could have been handled by a behavioral health professional if one were available on site. Extrapolate for your population how much time could have been saved out of a given day's panel. Divide that time by the standard visit time you plan for visits (e.g. 15 or 20 minute slots). Then multiply that number by your average reimbursement rate (e.g. \$135 per visit). This yields the potential for increased revenue. Although it is unlikely you will be able to capture 100% of behavioral health time as reimbursable visits, an adjustment factor can be applied that meets a reasonableness test.

Reimbursement for Interventions (R): Reimbursement for interventions has also been patchwork and inconsistent across the health care environment. Increasingly, payers are reimbursing for behavioral health services. The reimbursement might be in the form of direct payment for a behavioral health visit or could be included under an additional per member per month fee on top of fee-for service revenue for serving as a Patient Centered Medical Home. Health Centers need to do their own homework for each payer.

Calculating Your Business Case

The previous section defined the core variables of the business case that a Health Center can influence. Each organization can use these ideas to model its own business case and determine which variables it can influence within its own reimbursement environment.

As a starting point, centers should review of one care team (a microsystem) and explore the results from that review. Once a single care team has been modeled, a decision can be made as to whether this care team is representative of the whole practice. Consideration should be given to evaluating practice sites differently as their respective cost models may vary by location. The analysis should start by estimating the cost side of the equation (S, I and T), and then move to the revenue side of the equation (X, P and R).

Sample Case Study: Hale Health Center

Let's assume Hale Health Center decides to model Dr. Reims' panel. They decide to observe 100% of Dr. Reims' patient visits for two days. They will determine the burden of illness and also test the workflows necessary to complete screenings and interventions. As a result of their observation they find that 65% of Dr. Reims' patients had at least one behavioral health issue that warranted intervention. The observation also revealed that 42% of the Dr. Reims' patient visits required more time than the standard appointment interval of 15 minutes. Of these patients, the average time added was 11 minutes. In 80% of the cases where additional time was needed, the extra time was due to behavioral health related issues that could have been handled by another internal resource. Among patients needing more time, 40% were covered by Medicaid, 12% by Medicare, 6% by commercial insurance (primarily BCBS); and the remainder were billed using a sliding fee scale. The evidence base suggests 23% of patients that complete an SBIRT screen will be identified as needing an intervention.

Medicaid in the state provides reimbursement for SBIRT at \$30.93 for G0396 if a physician does the screening and \$26.29 if done by an ancillary provider. Medicare reimburses \$29.42 for an SBIRT screening and \$57.69 for a screening and intervention.

Hale Health Center assumes that the screening will be built into the front end work flow in the clinic when patients register and no additional staffing will be added to do the screening. The provider will review the screen as part of the exam and bill accordingly. However, the health center does intend to add a licensed behavioral health professional at an assigned full loaded salary of \$81,250. That resource would be shared between two primary care panels and would handle the intervention part of the visit. The business case per primary care panel would be as follows:

Panel Size= 1500

Annual Encounters= 4200

S= No salary cost for SBIRT screening

I= Allocated salary of \$40,625 for the behaviorist (half the total cost allocated to each panel)

T=Transition costs estimated at 16 hours of total training time for the care team comprised of primary care provider, nurse, and medical assistant. Salary costs are estimated at \$72/hr. for a primary care provider; \$27.60/hr. for a nurse and \$15.60/hr. for an MA. The total staff time investment would be \$1843.20. They also assumed they would lose revenue of \$6480 assuming 3 visits an hour at an average \$135 reimbursement per visit. So T= \$8323.20

Cost then is assumed at \$40,625 + \$8323.20 = \$48,948.20

On the revenue side Hale Health Center models the following:

X= SBIRT reimbursement from Medicaid (4200 encounters x 40% =1680 x \$24.00=\$40,320). From Medicare it would be (4200 x 12%=504 x \$29.62= \$14,928.48). Assumes no reimbursement from commercial payers or sliding fee scale. X=\$55,248.48.

P= Gains in productivity are calculated based on the number of minutes of primary care provider time that would be freed up and potentially available for another billable visit. If we assume 4200 encounters and all are screened and 16% will receive an intervention that would result in 672 encounters where a portion of time could be diverted from the provider. A reasonable assumption would be that the majority of these patients are the same ones who are requiring additional time as part of their Primary Care visit. To be conservative, assume half are candidates for a warm hand-off that saves PCP time. We know from the field sampling Hale Health Center did that the average amount of extra time burden on the PCP was 11 minutes. That would translate into 246 potential patient slots (336 x 11 / 15). If one assumes a reimbursement rate of \$135 per PCP visit that would translate to \$33,264 of new revenue opportunity.

R= New revenue would be based on the number of SBIRT screens that would be reimbursed for the intervention by the behaviorist working as part of the care team. So we can take our Medicare and Medicaid SBIRT screens (504+ 1680=2184) and assume 16% result in a brief intervention (349) and then apply the reimbursement rate for an intervention versus a screen. That would translate to 168 x \$24.00+ 81 x \$29.62 = \$8,714.76.

Revenue from integrating screening and intervention would be estimated at \$97,227.24

The net business case then would be \$97,227.24 - \$48,948.20= \$48,279.04 potential above the costs.

This is a hypothetical model and there are obvious flaws and a certain degree of margin for error. For example, it assumes you can capture revenue for all the time redirected from the PCP. The model also does not capture revenue for independent visits by the behaviorists that could be billed and captured. The model does not factor in revenues from tele-health and that would need to be added to the model if reimbursement from payers is available. The model also does not factor in the opportunity gain in revenue from a per member per month fee for care management in patient center medical home environments.

If Medicaid did not reimburse for SBIRT or intervention, then the net in this example would only be \$1206.01. However, it is still break-even based on Medicare revenue and gains in productivity.

In the end, organizations need to play with their own variables and change its own assumptions to understand the business case. As a result, sensitivity testing can be done for the individual health center environment.

Influencing Payers

Homework must be done first

A challenge many FQHCs face is that the reimbursement environment has yet to embrace reimbursement for Behavioral Health services in primary care. The challenge then is to influence payers to make changes in their reimbursement models. In any dialogue with payers it is critical that homework be done in advance that includes:

1. Develop a complete understanding of the reimbursement environment. What is currently reimbursed and what is not? What previous efforts to get reimbursement changed have been put forth and why did they fail? Are there any initiatives underway with key stakeholders such as the Primary Care Association, Foundations, or state based Behavioral Health organizations?
2. Understand who the health center's patients are for the respective payer. Run a report by payer from the practice management system to identify that panel of patients the center supports. Know the health center's annual billings for that payer.
3. Understand the payer's population of patients cared for by the center and its burden of illness. Consider a sample SBIRT screening for those patients in order to be able to present credible data on the opportunity for those patients.
4. Develop a model of what the potential impact would be on the payer's future medical costs if these patients were treated in an integrated primary care setting. . Model the potential savings that might accrue due to avoided ER visits, hospitalizations, and other health service utilization by addressing the behavioral health challenges.
5. Understand how the payer is currently addressing behavioral health issues. For example, do they have a carve-out contract for Behavioral Health Services?

Collaborating for Increased Leverage

There is always strength in numbers. Where possible, work with the state Primary Care Association and other primary care colleagues to influence the environment. As experience tells us, changing reimbursement is not an overnight effort. It requires a variety of forces from different vantage points. Explore what collective effort can be made to influence the environment. That might include educating key stakeholders such as the Insurance Commissioner; state Secretary of Health; the Governor's staff; and Board Members of payers. Explore what opportunities there are to influence reimbursement through federal initiatives such as the Medicaid 2703 program for Health Homes for people with chronic diseases, or a multi-payer demonstration.

Approaching Payers

A health center's first approach to any payer should be as the medical home for the members cared for by the center. Ask the payers for a summary of the claims data for these patients so a better understanding can be gained about how the payer dollar is being spent for the patients. Payer data can provide frequency of hospitalizations, emergency room visits and medication expenditures. In addition, payers often have additional data that can be helpful in a health center's analysis of potential medical cost savings. This might include risk stratification data, information about patients enrolled in disease management programs, or data on episodes of care.

Do your homework on the impact of behavioral of health conditions on the utilization of health care. A good source for some of this information is <http://www.promoteacceptance.samhsa.gov/10by10/publications/depressionCosts.aspx>.

The provider relations staff may be the best place to start with a payer or the center's medical director can speak to the payer's medical director. The goal is to communicate a sincere interest in better understanding how to manage a payer's members in an integrated way in order to influence their health status, outcomes, experience of care, and costs. In order to do this, data is needed. Persistence may be essential as it may require multiple attempts to obtain data from payer sources. However, any information that can be obtained will be useful as part of the homework in making the business case.

At the right time, the payers should be approached with an offer as well as a request. The offer should include the quantification of what the health center is bringing to the table by better managing the care of their members by integrating behavioral health. The request should be to explore the possibility of a pilot or demonstration for enhanced reimbursement for behavioral health screening and intervention. It is unlikely that a blanket change to reimbursement can occur overnight, but the right business case and pitch may secure a small scale demonstration that could lead to larger scale changes in the future.

Resources on Behavioral Health for FQHCs

The following resources should be helpful to clarify reimbursement questions.

1. https://www.nachc.com/client/Reimbursement%20for%20Behavioral%20Health%20Services_MentalHealthSA_PPSReport-%20Final%20Nov%202010.pdf
2. <http://bphc.hrsa.gov/policiesregulations/policies/pdfs/pin200405.pdf>
3. <http://www.samhsa.gov/prevention/sbirt/coding.aspx>
4. http://www.samhsa.gov/samhsanewsletter/Volume_17_Number_6/SBIRT.aspx
5. <http://www.integration.samhsa.gov/financing>