Get the Balance Right (Part 1):

A step-wise guide to navigating the business case considerations for integrating behavioral health services into primary care

PBGH California Quality Collaborative

This guide is a California-focused outline of process steps and planning considerations for building a financially sustainable program of integrated behavioral health services in primary care (BHI).

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Introduction

The Collaborative Care Model, in its entirety or in a modified form, is held as the ideal. The Purchaser Business Group on Health's California Quality Collaborative (CQC) guided its development as part of the Behavioral Health Integration Improvement Collaborative Curriculum, which contains curated expert resources and guided learning activities in a seven-stage guide to support organizations implementing BHI. We recommend this guide to be used in combination with these other resources:

1. "Get the Balance Right, Part 2," a CQC report from interviews with two California experts who have led their organizations to successful integrated programs,

2. "Financial Modeling Workbook" for the Collaborative Care Model, a program planning and budgeting spreadsheet from the University of Washington AIMS Center and the American Psychiatric Association.

Why present multiple resources as a set? When CQC began working on the creation of the Behavioral Health Integration Curriculum, we quickly discovered the Financial Modeling Workbook from the AIMS Center. This spreadsheet tool answered many of the support needs of California provider organizations identified by CQC, in the promotion of the Collaborative Care Model (CoCM) and planning for its use. The Workbook is not intended to be comprehensive of all needs, however. For one thing, it requires the use of the CoCM with its specific care team roles (the most novel of which is a psychiatrist serving as a consultant to primary care providers), instead of any other staffing and care delivery model. Additionally, the Workbook does not address the new opportunities and concerns of provider organizations, including care delivery trends that accelerated during the COVID-19 pandemic.

Three questions seek to capture these recent trends:

- **Treatment modality:** What is the ideal mix of in-person visits and virtual care by phone or video call? Until very recently, the assumption for integrated primary care-behavioral health care was that in-person care by a co-located integrated care team was the ideal. The natural experiments in visit types during the COVID-19 pandemic showed the benefits for patients and clinicians of a mixed model with both in-person care and virtual care. As of publication time in late 2021, primary care leaders and program managers are taking these lessons into account. They are also figuring out how to keep integrated care team members connected when some or most team members are not onsite together every day.

- **In-house or external clinicians:** What is the ideal mix of in-house behavioral health clinicians and external clinician partners? External clinicians (who work for contracted behavioral health vendors or community partners) are a great option for some provider organizations, particularly when an integrated care program is small and growing. These decisions can make the difference between a financially sustainable program of integrated behavioral health, and no program.
- **Funding beyond per-member-per-month and fee-for-service:** Will alternative payment models soon make it possible to build a sustainable integrated care team to deliver an effective continuum of integrated services? How can a provider organization prepare for these long-anticipated changes? The Financial Modeling Workbook uses the service codes that allow for CoCM billing (the three CPT codes for specific services by minutes of service, and the new G-code). Other payment options such as value-based payment are not included.

These three questions also guided our interviews with California experts for the report "Get the Balance Right, Part 2." Find more insights there.

This guide includes three sections:

A six-step process for understanding available reimbursement, potential program size, and staffing, either on your own, through the use of the Financial Modeling Workbook, or both in a parallel comparative process

Appendix A: Advice from operational experts on when and how to use the AIMS Center Financial Modeling Workbook

Appendix B: Types of payments that may be available to fund behavioral health services in primary care

Step 1:

Decide whether to use the AIMS Center Financial Modeling Workbook, or your own program planning calculations or both.

1. **Consider the intended purpose of the Workbook compared to your program design goals and opportunities for payment.** The Workbook supports the use of the Collaborative Care Model, in which the most novel care team role is the psychiatrist consultant to primary care providers. The Workbook captures payment tied to CoCM CPT codes and the new CoCM HCPCS G-code. If this is a current goal for your efforts, or if you would like to find out how this model would work for you, it is worth spending time with the Workbook.

2. **Read the expert recommendations for when and how to use the Financial Modeling Workbook, in Appendix A below.** The two experts interviewed by CQC about their work implementing integrated behavioral health programs tested the Workbook and have valuable advice.

3. **If you decide to use the Workbook, either to learn more about CoCM or to help you manage a CoCM program, review its three tabs and their data fields.**

- Find the Worksheet (Excel) here: https://aims.uw.edu/collaborative-care/financing-strategies/financial-modeling-workbook

- Find the guide to its use here: https://aims.uw.edu/sites/default/files/Using%20the%20FM%20Workbook.pdf

4. **Decide whether to use the Workbook as your main program planning resource, or to use your own financial modeling process, or both.** You may choose to use both in a parallel planning process, to learn whether CoCM care is a better model for your organization. Steps 2 through 6 below apply to any of these three planning scenarios.

Step 2:

Establish the types of reimbursement available for behavioral health services, and the amounts.

List all payments available for behavioral health services in the primary care practice.

1. **For each payer, list each type of funding for behavioral health care and the service or diagnosis it pays for: any behavioral health care, any mental illness, any behavioral health condition, or specific conditions.** You can find a list of different types of payment in Appendix B.

2. **Research payment for any required behavioral health services, where payment responsibility is not clear.** For some California practices, it is unclear where responsibility for payment lies for some services. Even where a payer is requesting or requiring data from primary care practices on behavioral health services, you may want to confirm that this reporting will generate payment. You may want to refer to the Division of Financial Responsibility between your provider organization and each payer's coverage product, to confirm the services required and the reimbursement amounts.

3. **If you are using the Financial Modeling Workbook, direct services data will go in the "Net Financial Impact" tab of the spreadsheet.**

Step 3:

Capture any additional funding available, if any, in addition to those listed in the previous step.

1. **List any additional funding your organization currently receives or could receive within the next 12 months. (These additional funding sources are not accounted for in the CoCM Financial Modeling Workbook.)**
   - Grants or other external investments for integrated care or care for specific mental health or substance use conditions.
   - Pay for performance, e.g., for meeting benchmarks for depression screenings or treat-to-target for depression.
   - Down-side risk from a value-based payment arrangement where your organization could lose funding for low performance.
2. **If you are using a contract organization to deliver behavioral health services, or are considering such an arrangement, add any estimated income from that business relationship.** Some arrangements include the arrangement for partial payment to remain at the provider organization for program overhead, instead of all the funding from payers being passed through to the contracted entity.

Step 4:

Consider the number of patients you could serve with these funding sources, either through the calculations in the AIMS Center Financial Modeling Workbook, or your own budget analysis process.

1. **From the services-supply side. Learn how many patients your potential number of CoCM team members could serve.** The Financial Modeling Workbook has a "Staffing and Service Delivery" tab that supports supply-side capacity planning. It generates the number of patients you could serve in the Collaborative Care Model in a financially sustainable way, given the staffing a practice could achieve through billable CoCM services.
2. **From the services-demand side. Learn what staffing you would need to serve the number of patients in your primary care practice who could use behavioral health services at that level of care.** If you are using your own financial modeling process, see Appendix A below for the suggestion to do demand-side modeling, using the number of patients who would benefit from integrated behavioral health services.

Step 5:

Establish costs for your preferred care model, for both visit modality (in-person/virtual) and staffing mix (in-house/external).

Consider these two workforce issues and how choices in those two categories could impact BHI financial sustainability. See the "Get the Balance Right, Part 2" interviews report for pros and cons of in-person and virtual care, for care quality and patient experience as well as financial considerations.

1. **If funding varies between in-person and virtual care, consider the ideal mix of in-person and virtual behavioral health visits for program sustainability.** Use the number of patients that you would like to serve in your program's next phase of growth, up to the full number of eligible patients if you are ready to go to full scale at one clinical site or more than one site. Example: For 100 patients, estimate reimbursement for 12 sessions with the initial visit in person followed by every following visit by video or phone. (In summer 2021, the COVID-19 public health emergency was extended through the end of 2022. This extends the period of equal payment for phone and video visits relative to in-person visits for that time period, providing a reprieve for many organizations for the financial considerations of the ideal mix of these different types of visits.)

    - Cost variables for virtual care, where the clinician is not in the office, include the cost of computers and other work-from-home equipment like ergonomic chairs, and perhaps ongoing costs if the organization pays for clinicians' internet access.

    - Cost variables for in-person care include the cost of office space and office computers and other equipment.

2. **If you use, or would like to use, an external provider to deliver some level of behavioral health services, determine those costs.**

    - For external providers, will it be a contractual relationship for paid services, or through a referral relationship (no payment exchanged) with an independent agency in the community, like a local SUD treatment program?

    - Consider whether to mix staffing models by behavioral health service, across screening, assessment, pharmacotherapy, psychotherapy, care management? Examples: 1) Based on patients' preferences, offer both in-person psychotherapy with in-house clinicians and teletherapy through a vendor to another group of patients. 2) Hire a vendor to complete patient screenings to establish behavioral health needs, then in-house clinicians engage to assess, diagnose, and engage in care where appropriate.

    - If you are using the Financial Modeling Workbook and want to model non-salaried contractor staff (e.g., use of an external psychiatric consultant), enter zero in the "Fringe benefits % of salary" field under "Net Financial Impact" tab.

Step 6:

Compare costs to expected income, in the Financial Modeling Workbook or in your own calculations or both.

If the numbers do not balance, opportunities to make it work include scaling up or down the number of patients served, the visit modality (if there is a significant cost or reimbursement difference), and the staffing model (in-house or a contracted or community partner).

APPENDIX A

Advice on the AIMS Center Financial Modeling Workbook

CQC asked the two experts whose behavioral health integration successes are covered in the "Get the Balance Right, Part 2" report, to test the AIMS Center Financial Modeling Workbook for its application at California practices. Here is a summary of their advice:

- **Understand the Collaborative Care Model and its standard staff team.** https://aims.uw.edu/collaborative-care For example, you need to know what "behavioral health care manager" means in CoCM in order to make use of the Workbook, and to decide how CoCM fits with your integration plans.
- **Plan first for one clinical site.** The numbers required to fill in the workbook are much easier to get for a single clinical site, and the modeling is easiest to understand initially with that focus. It becomes complicated when trying to use the workbook to plan a care model and its budget across multiple sites with those many staff positions, a range of FTEs per staff position and individual, and so forth.
- **Use the workbook as part of a team planning effort, instead of asking one person to fill out all of the many data fields.** A good team for this activity includes a billing person, a financial analyst, and a program manager. "Do your research and then come together to use the workbook," as one of the expert advisers said.
- **The workbook is easier to fill in, if you are already doing some level of integrated behavioral health services.** The workbook is easier to use if you have your own data on staffing levels, visit volumes, reimbursement rates and other variables to fill in. To use it prospectively to plan a new program, an organization could ask payers that will reimburse for CoCM codes to provide these rates, and then use that data to consider staffing levels and other numbers needed to use the Workbook.

- **Consider your organization's recoupment rate from payers.** "What percentage do you get back from what you send? How good is your Accounts Receivable team? You may only get back 50% of all the billing you send to your payers." Include that percentage in your budget modelling, so your numbers are realistic and you avoid an inflated budget.
- **Use clinical time for your billable staff when you enter data into the Workbook.** Total working hours for staff who bill for services will give you an inflated idea about program capacity and productivity. You may want to look at retrospective data on productivity, no-show rates, and/or time allocated in schedules for patient visits versus meetings and administrative time.
- **Consider doing your own modeling from the demand side, for another perspective in addition to the Workbook's calculations which use care team (supply side) numbers.** "When we first were doing an analysis of the Collaborative Care Model and its potential for chronic health conditions, our starting point was the number of individuals who were eligible for the services, versus how much staff time we had."
- **Plan for the use of the CoCM CPT codes as you determine your total eligible patient population.** The new CoCM CPT codes require a minimum number of minutes of contact time per month. You may want to estimate the proportion of your total eligible population of patients who are likely to utilize the CPT-determined amount of care, to understand potential likely billing volume per month through each CPT code in the Workbook.
- **Discuss and document any lost revenue that may result from switching from billable individual services to the CoCM's psychiatric consultant role where that clinician does not interact directly with patients.**
- **Consider any negative impact on reimbursement of churn in eligibility for behavioral health services in your patient population.** If there is a regular gap in coverage in your patient population, decrease your estimate of the dollars you can expect in reimbursement. The flow out of eligibility could be based on patient acuity and a switch to the serious mental illness (SMI) level of care from your primary care site's behavioral health services, or on your organization's closing an episode of care due to sporadic contact with a patient.

APPENDIX B

Types of payments that may be available to fund behavioral health services in primary care

- Fee for Service (FFS)
  - Time-based care interactions, using the CoCM codes approved by Medicare, Medi-Cal and most commercial health plans (CPT codes 99484, 99492, 99493) or other codes used by a payer (e.g., psychotherapy)
  - For FQHCs and Rural Health Clinics, time-based care interactions using the 2021 HCPCS G-code G2214, for "Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of BH care manager activities, in consultation with a psychiatric consultant, and directed by treating physician or other qualified health care professional"
  - Other codes for care services for behavioral health conditions, e.g., billing codes for initiation of Medications for Addiction Treatment (MAT). Consider these services: Screening, Assessment, Pharmacotherapy, Psychotherapy, Care management.
- For Federally Qualified Health Centers: PPS rate, wrap-around payments as applicable
- Pay for performance measures related to screening or improvement for any of the four conditions
- Per member per month (PMPM) for patients with complex needs or other funds attached to specific patient populations (e.g., complex care, homeless patients for safety net practices)
- Incentives, grants or pilot funding (and the timeframe and expiration dates for these funding sources)

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