

Adding Value in a Transformed Pediatric Health Care System: Beyond Fee for Service

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Healthcare reform: Changes in Payment

- Emphasis on quality
 - Payment for Services
 - Patient Improvement
 - Patient and Family Satisfaction
- Emphasis on outcome
 - Utilization
 - Reduced hospitalizations
 - Medication adherence
- De-Emphasis on services provided
 - Fee-for-Service (FFS)



Fee for Service: Inevitable Decline

“That’s one of our goals – to get rid of fee for service”

Adam Boehler, CMMI Director, Senior Advisor on Value Based Care for HHS. November 29, 2018

“Fee for service will break the system” December 3, 2018

Former Gov. Beshear - Kentucky.

“I want fee for service volume based payment to die. I want to kill it as fast as possible” October 22, 2018

Patrick Conway, CMMI Director 2013-2016

President & CEO Blue Cross of North Carolina

Payment Models



Payment Models

Some are still focused on Category 1 FFS

Most have moved on to Categories 2 & 3

Payment for quality and outcome

Shared Savings and Risk

Few have moved on to Category 4 – Population pay

Still based on a Fee for Service Platform but with substantial extra payment available.

Models Integrated Care CMS Recognizes in CPC +

Key Features of PCBH and CoCM

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graph TD; A[Key Features of PCBH and CoCM] --> B[Primary Care Behaviorist Model]; A --> C[Care Management for Patients With Mental Health Conditions Model];
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Primary Care Behaviorist Model

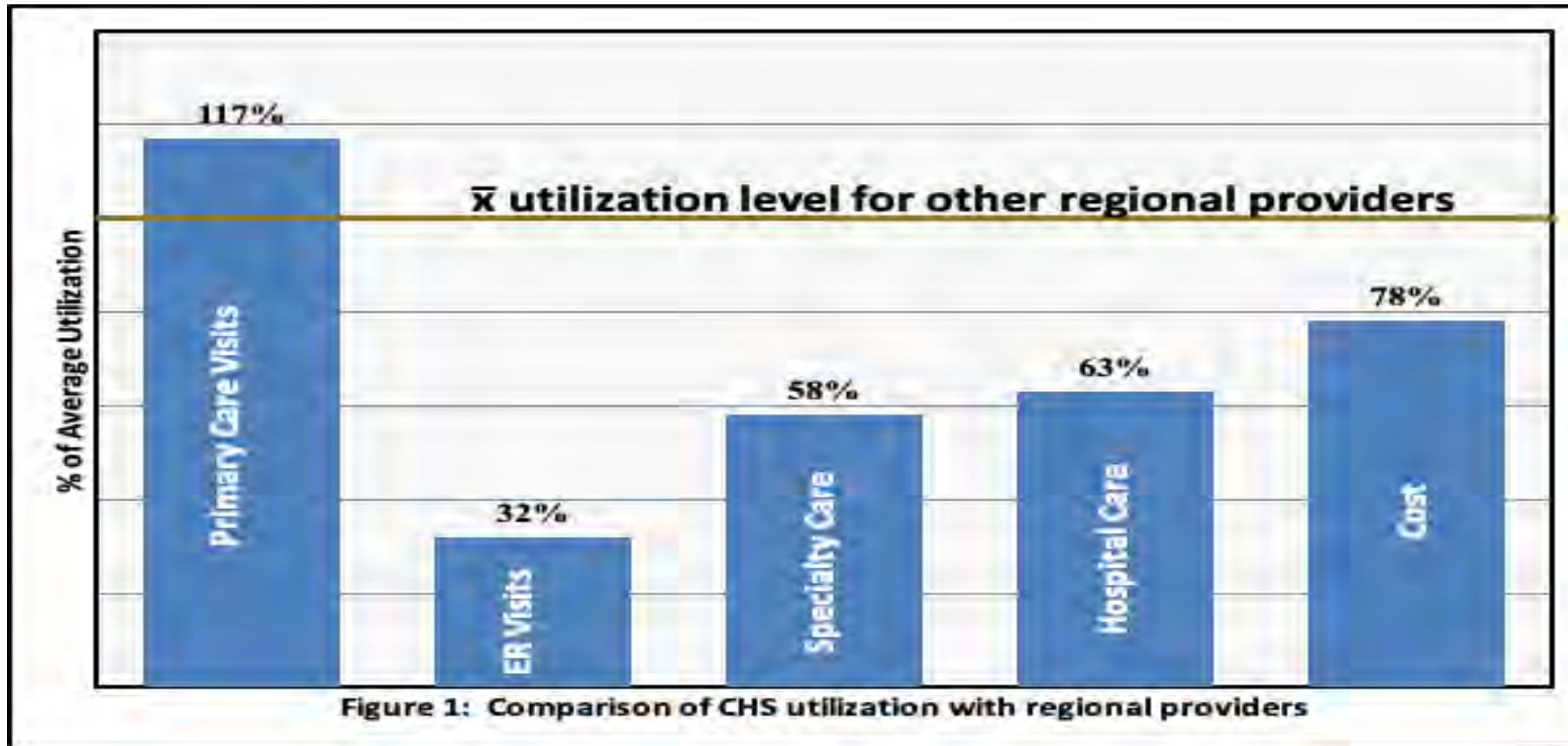
- Co-located and integrated behavioral health specialist (Primary Care Behaviorist)
- Evidence-based screening with diagnosis by practitioner
- Warm hand-offs to behaviorist
- Evidence-based behavioral treatments customized for primary care
- Treatment duration ≤ 6 sessions (time-limited therapy)

Care Management for Patients With Mental Health Conditions Model

- Co-located and integrated care manager with behavioral health training
- Evidence-based screening with diagnosis by practitioner
- Decision support for complex mental health needs provided by practitioner or psychiatric consult
- Algorithm-based, stepped care with proactive patient follow-up and monitoring
- Treatment duration 3-12 months

Cherokee Primary Care Behaviorist with Adults

- Cherokee 70,000 patients, high needs
- Overall 28% reduction in total costs
- ER decrease 68%, Primary care increase 117%



Psychiatry Care Management in Adults: Collaborative Care Lower costs in three studies

Studies



Results

\$896 lower total health care cost over 24 months, \$448 PMPY for subgroup ¹

\$3,363 lower total health care cost over 48 months. \$840 PMPY for subgroup, resulting in a **return of \$6.50 for every \$1 spent**²

\$594 saved per person over 24 months, \$297 PMPY ³

1. Katon et al., Diabetes Care. 2006;29:265-270.

2. Unützer et al., American Journal of Managed Care 2008;14:95-100.

3. Katon et al. Arch Gen Psych, 2012;69:506-514

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Implementation Costs, California Medicaid Estimates:

High needs population of 200,000 patients with 15% diagnosed with MDD.

For AIMS/CCM model, hires of 200 RN & 50 FTE Psychiatrists

For Primary Care Psychology model, hires of 20 Psychologists & 5 FTE Psychiatrists.

	AIMS Collaborative Care Model	Primary Care Psychology
Training & Start Up	78,901	34,725
Ongoing Screening	313,524	313,524
Staff & Overhead	51,048,318	4,951,751
Total	51,440,743	5,300,000
PMPM	20.43	2.21

Why Psychologists in Pediatrics

1. High level of expertise is needed for the imbedded behavioral health clinicians in pediatrics. (German & Briggs, 2017) Expertise needed in evaluation of attention & learning problems, affective problems and developmental delay from birth to 18. High level of diagnostic complexity in many patients.
2. Skills need to consult with education system and review school based psychological and educational evaluations.
3. First line treatment for anxiety and depression is psychotherapy. Expertise is needed in evidence based treatment for disruptive behavior, attention problems and mood disorders.
4. Few medications are FDA approved for children other than stimulants and a few anti-depressants. There is a very restricted formulary.

er All Sources of Revenue

1. CPT Codes for Mental Health Services
2. CPT Codes for Health & Behavior Services
 - Masters level providers can bill Wisconsin Medicaid.
 - Masters level providers cannot bill Medicare.
3. Quality Goals: Screening by primary care provider
 - Assist PCP in their billing for screening. Behavior & development
4. Collaborative Care Payment codes
 - these are part B Medicare-20% co-pay required
5. Increased Primary Care efficiency
6. Shared Savings

Psychologist Billing CPT Codes

- Health & Behavior Codes – physical diagnosis
 - Diagnostic interviews*
 - Individual interventions based on duration*
 - Family therapy with or without patient present.*
 - Group therapy*
 - Mental Health Codes – patients with MH diagnoses
 - Diagnostic interview
 - Individual intervention codes based on duration.
 - Family therapy with or without patient present
 - Group therapy.
 - Psychological testing (e.g. capacity competence).*
- *Psychologist only codes under Medicare.

Core Set of Child Quality Measures Medicaid

Primary Care Access and Preventive Care		
0024	NCQA	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents (WCC-CH)
0033	NCQA	Chlamydia Screening in Women Ages 16–20 (CHL-CH)
0038	NCQA	Childhood Immunization Status (CIS-CH)
0418/0418e	CMS	Screening for Depression and Follow-Up Plan: Ages 12–17 (CDF-CH)*
1392	NCQA	Well-Child Visits in the First 15 Months of Life (W15-CH)
1407	NCQA	Immunizations for Adolescents (IMA-CH)
1448**	OHSU	Developmental Screening in the First Three Years of Life (DEV-CH)
1516	NCQA	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH)
NA	NCQA	Adolescent Well-Care Visits (AWC-CH)
NA	NCQA	Children and Adolescents' Access to Primary Care Practitioners (CAP-CH)

Core Set of Child Quality Measures Medicaid

Care of Acute and Chronic Conditions		
1800***	NCQA	Asthma Medication Ratio: Ages 5–18 (AMR-CH)*
NA	NCQA	Ambulatory Care: Emergency Department (ED) Visits (AMB-CH)

Behavioral Health Care		
0108	NCQA	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
0576	NCQA	Follow-Up After Hospitalization for Mental Illness: Ages 6–20 (FUH-CH)
2801	NCQA	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)
NA	NCQA	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC-CH)

Meeting Quality Goals in Pediatrics

Meeting Developmental Screening Goals for a Pediatric Practice, Nemours Pediatric example:

Choose screener - PEDS

Imbed within EPIC - Toggle

Build into workflow –by office staff.

Pediatrics bills for screener - 96110

Establish disposition with 0-3 program.

Meeting Quality Goals in Pediatrics

Meeting Developmental Screening Goals for a Pediatric Practice, 2017
data from Nemours Pediatrics, MM Lines:

10 Offices: 84.3 % eligible, 4647 screened

5.0 % screened to CDW; 8.6% screened referred.

\$151,612 billed; \$59,719 collected – \$90,000 pace for year.

For the families: Early Screen, Early Service

For the office, meet both quality bonus goal & enhanced fee for services revenue, likely reduced total cost of care for patients.

Meeting Other Behavioral Health Goals

- Screening & Treatment of Depression in Adolescents
 - Addressing Smoking and Tobacco Use in Adolescents
 - Follow up treatment for patient diagnosed with ADHD
 - Follow up in a timely fashion after Psychiatric Discharge.
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- Screening benefits patients, generates FFS revenue and generates quality goal revenue.

Meeting Shared Savings Goals #3: Areas where Psychologist Consultation has had an impact: ED visits & Follow up for ADHD.

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High Cost Patients: Develop Effective Programs

Rank	Condition	2013 Spending (US\$ in Billions)	2013 Spending per Child (US\$ in Thousands)	2013 Spending per GDP, %	2013 Spending, %			
					Ambulatory Care	Inpatient Care	Retail Pharmaceuticals	Age <1 y
	All conditions	233.5	2.78	1.42	38.6	30.4	7.8	21.6
1	Well-newborn	27.9	6.49 ^a	0.17	0	100	0	100
2	ADHD	20.6	0.24	0.13	63.9	0.7	35.4	0
3	Well-dental (eg, general examination and cleaning, x-rays, and orthodontia)	18.2	0.22	0.11	NA	NA	NA	0
4	Asthma	9.0	0.11	0.05	35.6	7.7	47.1	0
5	Oral disorders (eg, oral surgery and caries, including fillings, crowns, extraction, and dentures)	8.7	0.10	0.05	0.8	2.1	0.2	0
6	Well-child	8.5	0.10	0.05	100	0	0	39.0
7	Upper respiratory tract infections	8.4	0.10	0.05	71.0	4.0	2.1	15.3
8	Other long-term respiratory diseases (eg, sleep apnea, allergic rhinitis, and chronic sinusitis)	8.1	0.10	0.05	76.8	2.7	16.3	0
9	Skin and subcutaneous diseases (eg, cellulitis, sebaceous cyst, acne, and eczema)	8.0	0.10	0.05	60.3	9.3	20.9	2.4
10	Exposure to mechanical forces (eg, falling object, striking other object, cuts, and being crushed)	7.8	0.09	0.05	40.5	4.0	0.4	0.9

Psychology Adding Value: Patient Panels

- #2 ADHD – Develop integrated care protocol to meet AAP guidelines
 - Screen and evaluation – including home and school checklist data
 - Parenting intervention
 - Stimulant medicine
 - School consultation
- #4 Asthma – Develop integrated care protocol to meet AAP guidelines
 - Asthma action plan.
 - Parenting intervention.
 - Assess social obstacles to care.

Meeting Efficiency Goals in Primary Care

Pediatrics: Gouge N, Polaha J, Rogers R, Harden A. (2016)

- On days when an integrated behavioral health consultant (BHC)
 - was present, medical providers spent 2 fewer minutes on average
 - for every patient seen in comparison to days when the consultant
 - was not available.
- On days when an integrated BHC was available, medical
 - providers saw 42% more patients than they did on days when
 - no consultant was available.
- The practice generated \$1142 more in revenue on days with BHC
 - integration as compared with non-BHC days.

Collaborative Care Payment Codes

Payment for General Behavioral Health Integration Services

CMS provides a separate payment for behavioral health integration services that are delivered outside of the CoCM benefit. A behavioral health care manager with formal or specialized education is not required. CMS rules allow “clinical staff” to provide these services using the same definition as applied under the Chronic Care Management benefit.

99484 (formerly G0507) – Care management services for behavioral health conditions - At least 20 minutes of clinical staff time per calendar month. Must include:

- Initial assessment or follow-up monitoring, including use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

99484	Care mgmt. services, min 20 min – General BHI Services	\$48.60	\$32.76
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Shared Savings for One Practice

- Jacksonville Florida Practice – 20,000 patients, 4 offices, 50% Medicaid.
- 23 primary care providers and 2 psychologists.
- Co-located psychologist in 2015, added post doctoral fellow late 2016.
- Data are from calendar year 2017 on quality goals and shared savings revenue. Met 9/10 goals
- Net savings returned to practice \$60 PMPY
- Presented at CMS/CMMI Innovation meeting on November 10, 2018

Our Community Impact



Patient Diversity



- White
- Minority



Table 5. Angel Kids Pediatrics Population Based Performance 2017

Performance Domain	Measurement	Number of Patients Eligible	2017 Population Targets by Payer	2017 Performance	Level of Success*
Chronic Disease Management					
ADHD	% Follow up: Initiation Phase	388	51.83%	71%	19.17%
ADHD	% Follow up: Maintenance Phase	388	63.77%	85%	21.23%
Asthma	% Using Appropriate Medications	790	47.43%	83.19%	35.76%
Children & Adolescent Preventive					
Well visits for Children/Adolescents	% with Visit Completed	15,392	59.72%	54%	-5.72%
Body Mass Index for Children/Adolescents	% with Test given	8,341	80.54%	99.52%	18.98%
Nutrition Counseling	% with Counseling performed	8,338	76.64%	96.83%	20.19%
Physical Activity Counseling	% with Counseling performed	8,338	67.64%	88.56%	20.92%
Blood Lead Screen	% with Test given	2982	65%	74.17%	9.17%
Health Resource Utilization (Avoid unnecessary use)					
Appropriate URI Treatment/Children	% Avoid med	4,168	93.54%	94.10%	.56%
Generic Prescribing	% w Generics prescribed	29,007	80%	84.79%	4.79%

Our Success in Value-Based Programs

Angel Kids Pediatrics Performance Based Payment Programs In 2017				
Payment Source	Type of Patient Population Needing Care	Number of Patients Under Care	The Performance Resulting in Additional Payment	Additional Dollars Awarded
Sunshine: P4P Program	Medicaid	5115	HEDIS metrics defined in P4P agreement	\$49,168
Sunshine: Shared Savings	Medicaid	5115	Actual HBR: 66% Goal HBR: 83%	\$1,159,669
BCBS	Members with Chronic Disease	478	Care management of patients with chronic diseases	\$35,850
Total				\$1,244,687

Reviewing Revenue

- New Payment Models: Help meet goals for Quality Payment.
 - Both payment for quality and shared savings
 - Develop billing of developmental (96110) or behavioral screens (96127)
 - This generates additional revenue.
- Makes Primary care provider more efficient – see more patients.
 - Likely reduces stress on PCP.
- PCP bills for Collaborative care code 99484

You have increased revenue, improved efficiency, in addition, factor in your fee for service billing.

Partnering with Primary Care to Achieve Quality & Value & Shared Savings.

- Assist the Practice to meet required quality of care goals
 - Developmental screening
 - Depression Screening
- Assist the Practice to meet outcome goals.
 - ADHD treatment goals.
 - Asthma treatment goals.
 - Total cost of care including ED visits
- Making the Primary Care office more efficient
 - Psychologist sees labor and time intensive patients.
- PCP billing for 99484 Code- Unspecified collaborative care
- Then bill using Mental Health or H& B codes
 - for assessment and therapy services provided.

Germán, M., Rinke, M. L., Gurney, B. A., Gross, R. S., Bloomfield, D. E., Haliczner, L. A., ... & Briggs, R. D. (2017). Comparing two models of integrated behavioral health programs in pediatric primary care. *Child and Adolescent Psychiatric Clinics*, 26(4), 815-828.