Integrated Care:
A Briefing Guide for Pediatric Providers in Washington

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WCAAP
The Washington Chapter of the AMERICAN ACADEMY OF PEDIATRICS

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The pediatric community has a long history recognizing and treating both general medical and behavioral health conditions and providing comprehensive whole child care. Pediatric providers work every day to address the needs of children with special health care needs, including children with developmental delays, behavioral health disorders, socio-economic, educational barriers and more. The American Academy of Pediatrics (AAP) introduced the term "medical home" to describe primary care that is accessible, family-centered, coordinated, comprehensive, continuous, compassionate and culturally effective" in 1967. Today, the rest of the medical community has come to embrace this concept, and continues to evolve and build upon this model as the foundation for providing whole person care through primary care medical homes.

While the pediatric community was a pioneer in recognizing the need to address the whole child, the financing and payment to support these efforts has lagged; as a result many pediatric providers face a number of barriers to transform their practices to provide integrated care and build a sustainable infrastructure to support the work in an ongoing fashion. Two new opportunities in Washington are available to pediatric providers that could assist with this transformation and provide the ongoing resources to support sustainable integrated care for children in a variety of pediatric settings including Washington's Medicaid Transformation through the Regional Accountable Communities of Health (ACHs) and the availability of new billing codes for use of the Collaborative Care Model (CoCM) for behavioral health. Much of the focus in these opportunities has been focused on adults; this briefing guide explores ideal approaches for providing integrated care for children, existing mechanisms to support them, and describes how these new resources could support broader system transformation and sustainability of these approaches within the pediatric community.

What is Washington's Medicaid Transformation?

Washington has embarked on an effort to reform and redesign its health care delivery system through the Healthier Washington Initiative. Healthier Washington has three key goals:

- Building healthier communities through a collaborative regional approach through the establishment of Accountable Communities of Health;
- Meeting whole person needs through integrating physical and behavioral health needs; and
- Improving how services are paid for by rewarding quality over quantity through value-based payment.

To help facilitate this work, Washington has secured a Medicaid waiver from the Centers for Medicare and Medicaid Services (CMS). The agreement with CMS requires that Washington achieve improvements on a number of health measures in exchange for the dollars and flexibility to redesign its Medicaid delivery system. It is important to understand that this is not *new money*; rather, these are funds that would have otherwise been expended without the expected savings from making these system reforms to improve outcomes and reduce costs.

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The structure that has been established to implement and oversee much of the Medicaid Transformation are the regional Accountable Communities of Health (ACHs). There are nine ACHs across the state- see the map below for information about each of these.

ACHs are regional bodies that bring together community members and organizations across sectors to work on shared regional health priorities. The organizations participating in the ACHs across the state are wide-ranging in scope since the focus is on improving overall health and a collective understanding that overall health is determined by much more than what happens in the doctor's office. Therefore, the ACHs include representatives from community based organizations, public health, criminal justice and education. In addition to these partners, the ACHs include representatives from the health care delivery system such as hospitals, federally qualified health centers, behavioral health providers and provider groups. For more information about each of the ACHs please go https://www.hca.wa.gov/assets/program/ach-contact-list.pdf.

Medicaid Transformation Toolkit Integrated Care Models

To achieve delivery system transformation through the ACHs, the Health Care Authority developed a toolkit of projects aimed at the outcome metrics the state is expected to achieve in exchange for the upfront dollars from the federal government. Toolkit projects fall into three domains: health and community systems capacity building, care delivery redesign, and prevention and health promotion.

ACH Regions Map

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Project 2A "Bi-Directional Integration of Physical and Behavioral Health" is a required project for ACH's in the area of Care Delivery Redesign and is an important opportunity to help support integrated care for pediatric patients in primary care settings. The Bi-Directional Integrated Care project has two components, 1) providing behavioral health care in a primary care setting and 2) providing primary care in a behavioral health setting.

The two evidence-based models or strategies for ACHs offered in the Medicaid Transformation Toolkit for providing behavioral health in a primary care setting include the Collaborative Care Model (CoCM) and the Bree Collaborative's Behavioral Health Integration Report and Recommendations. Both of these models/strategies include the following key principles for providing behavioral health in a primary care setting:

- **Team-Based and Person-Centered:** Primary care and behavioral health providers collaborate effectively using shared care plans;
- **Evidence-Based:** Uses therapeutic interventions proven to work in the primary care setting, psychopharmacologic treatments are according to guidelines and standards;
- **Population-Based and Data-Driven:** A defined group of patients or clients is tracked in a registry so that no one "falls through the cracks";
- **Measurement-Based Treatment to Target:** Treatment goals clearly defined and tracked for every patient. Treatments are actively changed until clinical goals are achieved.

The ACH Toolkit Projects include three stages of work: a "Planning" phase (2018), an "Implementation" Phase (2019) and a "Scale and Sustain" Phase (2020-21). If ACHs are successful (evident by achieving project implementation milestone and health outcome metrics) they will be able to generate funding for their region to invest as the ACH determines.

As part of this transformation, ACHs are expected to address how the projects will help the region transition to value-based payment (paying for outcomes), how the projects will address workforce challenges and how/what IT support and systems are needed to support the projects. ACHs are expected to design a project portfolio that addresses their specific regional health needs and transforms the delivery system. Each ACH must submit a project application to the Health Care Authority on **November 16, 2017 with these goals in mind.**

Depending on the strength of its application, ACHs will receive Health Care Authority approval to move forward with their project portfolios and access to financing to **support planning activities in 2018.** This initial infusion of dollars is to support planning related activities and will be earned by the ACH meeting planning milestones; future resources will be tied to project implementation milestones and achievement of outcome metrics. ACHs have yet to determine how resources will be allocated to their communities to support successful projects, but it is clear that "partnering providers" will need support from the ACH to ensure their success by meeting outcome metrics. Examples of what this support could look like include technical assistance on practice transformation, training and investments in Health Information Technology such as patient registries, etc.

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Why Pediatricians Should Consider Becoming a "Partnering Provider" of the ACHs

For the purposes of the project application due in 2017, ACHs are expected to submit a preliminary list of "partnering providers" interested in implementing project(s). However, it is important to note, this preliminary list and is not binding or definitive at this stage; rather it is in 2018, during the official "Planning" year when binding letters and formal commitments will be made between the ACHs and their "partnering providers".

Pediatric providers have much to offer in ensuring the success of the ACHs. ACHs must show improvement on a number of clinical outcome metrics for the overall Medicaid population; children account for 830,000 of the 1.8 million enrolled in Apple Health (Medicaid). As noted earlier, while ACHs are submitting project applications to the Health Care Authority in November 2017, ACHs will be embarking on more specific planning activities in early 2018 and this is an ideal time for pediatric providers to engage in this work and consider becoming a "partnering provider" in their ACH.

From Transformation to Sustainability: Existing and New Opportunities to Support Integrated Care

While engaging as a partnering provider in the ACHs may help pediatric providers secure resources to address the short-term challenges with practice transformation such as assessment, training and IT that stand in the way of providing integrated care for children, there is still an important question about long-term sustainability of doing this work. We discuss in more detail ways in which pediatric providers could leverage existing financial resources to support integration and outline a significant new opportunity that will soon be available to providers serving Medicaid that can also help to address this challenge.

Financial sustainability continues to be a difficult goal to reach. There are numerous approaches however that will lead to a greater chance of obtaining reimbursement for services using existing codes. These include:

1. **Bill for everything you can:** By using licensed therapists (LPC, LCSW, PhD, etc.) a brief session with a child that includes the necessary components to meet a diagnostic assessment (90791) or psychotherapy (90832, etc.) can be billed (see chart below). With the current rates offered by the Washington State Health Care Authority (HCA), advocacy to increase to a reasonable rate is paramount to sustainability. Through Senate Bill 5779, the Governor has instructed the HCA to evaluate the rates for several behavioral health codes and WCAAP is working closely with HCA to inform this process.

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FREQUENTLY USED LOW-ACUITY BEHAVIORAL HEALTH SERVICE PROCEDURE CODES (EXISTING)			
Code	**Definition**	**HCA Allowable**	**Example of MCO Payment***
90791	Diagnostic Evaluation without Medical Services	$37.34	$29.87
90792	Diagnostic Evaluation with Medical Services	$77.47	$61.98
90832	Psychotherapy-30 minutes	$33.61	$26.89
90833	Psychotherapy-30 min with Office Visit (Same Day)	$38.79	$31.03
90834	Psychotherapy-45 minutes	$44.62	$35.70
90836	Psychotherapy-45 min with Office (Same Day)	$48.95	$39.16
90837	Psychotherapy-60 minutes	$67.02	$53.62
90838	Psychotherapy-60 min with Office (Same Day)	$64.51	$51.61
90853	Group Psychotherapy	$13.44	
90846	Family Psychotherapy (w/o patient)	$53.96	$43.17
90847	Family Psychotherapy (with patient)	$62.23	

**WCAAP members were asked to share information about rates paid to them by Medicaid MCOs, these are examples of what some MCOs pay for these codes.*

There is also concern these rates are not reaching the level of parity required by law and this should be pointed out to the payers.

2. **Consider the complexity of an integrated visit and bill appropriately.** If a BHP is working in the exam room with a patient and parent, more time and effort is occurring in this visit and should be billed for appropriately. This could include something like the behavioral health provider providing anticipatory guidance with a parent, working using motivational interviewing around a health condition, or addressing an acute stressor. A typical 99212 could potentially be billed as a 99231 or 99214 if CPT coding requirements (for time and/or complexity) are met.

3. **Improved efficiency could lead to seeing a few more patients.** If a pediatrician has a BHP helping during the sessions, they allow the provider to move on to the next exam room or can enter the exam room first and get started with a behavioral health problem that will likely slow the pediatrician and get behind schedule. It has been suggested a PCP could see 1.7 more patients with a BHP assisting them. These additional visits would provide more revenue to pay for the BHP time.

New Billing Codes for the Collaborative Care Model (CoCM)

In addition to leveraging the existing opportunities above, another new financing mechanism will soon be available to providers, including pediatric providers

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serving Medicaid beneficiaries beginning in 2018. In 2016, CMS announced a commitment to providing a reimbursement solution to encourage implementation of the Collaborative Care Model (CoCM) by announcing the creation of three new codes for the distinct services in this model. The new codes will be in the 2018 Physician Fee Schedule but due to a sense of urgency to make this available sooner, CMS-designed temporary codes that have been available since January 2017. These codes are currently being used for Medicare patients **and the Washington State Health Care Authority has approved their use for Medicaid (Apple Health) beginning in January 2018 (the first state in the nation to do this!)** These codes support the time spent by the behavioral health care manager and psychiatric consultant providing care non-billable care activities (see Appendix A).

Collaborative Care is different from simply co-locating a therapist or psychiatric provider in a medical clinic and having him or her see patients who may be presenting with a behavioral health concern. Instead, a population health approach is implemented utilizing validated screening tools to identify problems, tracking response to treatment with a data management tool called a registry and weekly reviews with a psychiatrist. The registry is used to make sure kids and their parents not actively participating in treatment get follow-up, and allows the team to see who is and is not improving over time. Evidence-based brief interventions proven to work in the primary care setting are used instead of traditional longer- term psychotherapy. This could include behavioral activation, problem solving therapy, distress tolerance skills, cognitive behavioral techniques, and motivational interviewing. If someone is not improving, they are easily identified through review of the registry, and during the weekly review with a child psychiatric consultant (MD/DO or child psychiatric NP or PA) additional recommendations for treatment changes can be suggested and relayed to the pediatrician.

Pediatric providers can work with the local chapter of the American Psychiatric Association (APA) which has list of psychiatrists who have been trained in this model (see below), the local chapter of the American Association of Child and Adolescent Psychiatrists (ACAP), and the Partnership Access Line (PAL) program to find psychiatrists with some expertise (or willingness to be trained or read reference sources including two text books on Integrated Care- see below). The model includes regular measurement of progress to identify when adjustments are needed including referral to behavioral health specialty care. Using this stepped care approach, Collaborative Care can judiciously use scarce resources (such as child psychiatric expertise) to provide effective treatment. In this model, the PCP receives the payment (billed monthly under their NPI number) and then hires or contracts with the behavioral care manager and child psychiatric consultant.

Many of the tasks listed above do not include face-to-face evaluation of patients or are very time limited and therefore are not billable. The new codes from CMS provide a monthly bundled payment to cover the cost of staff who are providing outreach, provision of brief interventions, monitoring of outcomes using

validated scales, registry maintenance and data entry, child psychiatric caseload review and other care management duties (see Appendix A). It is important for health care systems and clinics to understand these codes and the required tasks and how this differs from simple co-location of behavioral health services.

An Ideal Model for Children- Adapting the Collaborative Care Model (CoCM)

Many pediatric clinics are most likely already providing some level of behavioral health for children in their clinics- whether it is screening, regularly utilizing PAL to access a consulting child psychiatrist, coordinating care with local behavioral health agencies, or forging a more formal relationship with a behavioral health agency through the **Pediatric-Transforming Practice Clinical Initiative (P-TPCI) Provider Toolkit.** However, overall practice transformation continues to elude many because of the barriers previously noted in the literature including time, training and teamwork and the lack of resources needed to initially overcome these barriers in the short-term as well as a sustainable business model for the long-term.

An ideal blended model of pediatric integrated care would combine the key tasks of the collaborative care model (CoCM) for specific diagnoses (for example, depression, anxiety, ADHD) with other interventions provided by a behavioral health provider (BHP) to assist pediatricians with acute stressors, participatory guidance, coordinating referrals to specialty behavioral health organizations, working with parents and other tasks that may be different from the typical adult focused integrated care setting. This model could be achieved in different ways depending on the practice size, location, workforce capacity and other factors. Examples of these adaptations are offered below.

- **Rural small practices:** Rural practices face a number of barriers to implementing integrated care as they may have limited resources for implementation and hiring, a smaller patient population that may not warrant hiring their own staff, limited professional workforce in their area who may have the skills to do this work. However, practices could still follow some of the key tasks of effective integrated care such as measurement-based care (repeat PHQA or Vanderbilt for example) and tracking a portion of their panel regularly to identify kids that are not improving. These practices could also utilize the remote services of the PAL program to provide curbside consultation not only for acute needs but also upon review of their registries to get input on treatment adjustments that could lead to improvement in symptoms. Clinics could also consider utilizing not only remote child psychiatric services but also remote BHP services with e-hand-offs in their offices. If both psychiatric consultation, measurement-based care and registry implementation and review are implemented, these sites may be eligible to bill the new CoCM codes as well. One of these codes (G0507) could be billed for some of these services if no psychiatric consultation is available (see Appendix 1). They could also bill for the teletherapy sessions. Assistance through the Regional Telehealth Resource Center (UW Telepsychiatry program run by Mark Duncan, MD),

or through vetting of the 30-50 telepsychiatry vendor businesses would be options. These practices could also continue to foster close relationships and agreements with local behavioral health providers to maintain a good referral network (and feedback once referred).

- **Larger practices/more urban setting:** These practices are in a better position to take advantage of access to a behavioral health workforce that could be onsite and there to assist. There could also be back-up from the PAL as well as consideration in hiring part-time psychiatric provider consultation for curbside consultations and periodic registry reviews. Technology solutions such as remote BHP are also an option here. These additions to the team along with measurement-based care, registry implementation and psychiatric review would help these sites offset the cost, at least in some populations with a definitive diagnosis.

- **Variations between 1 and 2 and use of technology solutions:** All sites need to assess their local resources and determine what their needs may be taking into account technology solutions may be an avenue to pursue.

***There are companies entering the market that can provide for all of these services (therapy, care management, psychiatric consultation, registry) from remote locations that would charge a percent of the reimbursement for the CoCM code (for example) to deliver all of these services.*

Training

Specific training in the Collaborative Care Model for clinic staff (medical and behavioral health providers) will be crucial to meet reimbursement and audit standards, regardless of how a practice chooses to adapt the model. This training could be provided by P-TCPI and by the American Psychiatric Association either in person or via online modules currently available for all primary care providers (not just pediatricians) at:

https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/get-trained.

Washington Chapter AAP is working with APA to arrange two trainings in 2017-2018. Visit https://wcaap.org/events to learn more or contact admin@wcaap.org

Additional training could also be requested as part of project planning for ACHs.

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Measuring Success

Whichever path pediatric providers may take to practice transformation and sustainability for providing integrated care, it will be important to measure performance. As noted earlier, ACHs are expected to perform on a number of outcome metrics in order to earn money to support transformation work in the region- engaging as a "partnering provider" of your ACH would mostly likely include access to and support for monitoring and achieving these measures. However, these metrics will be measured at a population level. Providers must have metrics that they can more easily collect and monitor that align with in-clinic operations and follow the basic tenet of measurement-based care in practice. A recent Kennedy Forum supplement provides a list of the measurement tools most commonly used in pediatric primary care. Below are some examples of potential measures that could be utilized- these measures closely align with the Collaborative Care Model, but could be used in other models of integration that meet the needs of the specific practice.

Measuring Success for Integration in the Pediatric Setting: Possible Metrics

PROCESS METRICS
Key tasks that can lead to positive outcomes

- Percent screened for condition (PHQ9) for depression, GAD7 for anxiety, AUDIT for alcohol use, etc.
- Percent who had at least 2 contacts with care manager/ BHP in the last month.
- Percent who are not improving with a documented psychiatric case review and recommendations for treatment adjustment
- Percent with psychiatric consultation that had a treatment change
- Percent not improving in primary care referred to specialty behavioral healthcare

OUTCOME MEASURES
Demonstrate the care delivered was successful

- Percent of caseload with 50% reduction in clinical outcome measure (ex. PHQ-9)
- Percent of caseload that reached remission (ex<5 for PHQ9 for depression, remission in depression symptoms at 6 and 12 months as measured by the PHQ-9; NQF quality measures #0711 and 0717)
- Percent of caseload that achieve a 5 point or greater reduction in PHQ9 score (set target %)

POPULATION HEALTH MEASURES (ACH)

- Reduction in psychiatric hospital utilization
- Reduction in ER utilization
- Reduction in hospital admissions

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Recommendations/ Next Steps

There are clearly a number of opportunities for pediatric providers to strengthen and support the important work they do meet the whole child daily. Realizing these opportunities will require commitment at the individual provider level to take advantage of these existing and new opportunities to support the work. It will also require support from our ACHs and leveraging other key resources and partners to ensure that children are not left behind in the work to transform our health care delivery system. Below are some critical next steps to move this work forward:

Providers

- Engage with ACHs to become a partnering provider and advocate for the resources you will need to transform your practice to help the ACH and the state meet its required outcomes
- Learn about the models and how they could benefit your practice to provide the ideal model of integrated care for children
- Utilize existing supports to best meet the behavioral health needs of your patient population through the Partnership Access Line and the P-TCPI
- Take advantage of existing financial resources to pay for what you are already doing to provide integrated care
- Learn about the new Collaborative Care Model (CoCM) codes that become available in 2018 to support providing integrated care
- Collect and monitor how these resources support you to provide more integrated care and identify gaps where funding is not sufficient to support the need

P-TCPI/ACH

- Arrange and support training for teams (PCPs, behavioral health provider, psychiatric consultant, etc.)
- Financial support for registry development
- Connection and support for telemental health – telepsychiatry (including consultation only and "tele-teaming"), teletherapy
- Training for billing and coding behavioral health visits in primary care
- Training in implementation – workflows, EMR, measurement tools, etc.
- Support for psychopharmacology for pediatric providers, Project ECHO Child Psych

Advocacy

- Work with other organizations to support initiatives such as reimbursement, policy changes, etc.
- Work to ensure SB 5779 results in fair reimbursement for typical behavioral health visits in primary care

[i] University of Washington AIMS Center webinar for the Washington State Hospital Association

[ii] HCA data

[iii] Hilt R, Sarvet B. Child and Adolescent Psychiatry in Integrated Settings; in Integrated Care: Working at the Interface of Primary Care and Behavioral Health. L Raney editor, American Psychiatric Publishing, Washington, DC 2015 Sheppard C, Keenan C, Roessler, K, Reese J. The Primary Care Provider; in Integrated Care: A Guide for Effective Implementation. L Raney editor, American Psychiatric Publishing, Washington, DC 2017

This briefing guide was prepared by Lori Raney, MD & Liz Arjun, MPH, MSW at Health Management Associates in September, 2017.

Appendix A: Detailed Description of the "G" Codes and Requirements (When Formally Implemented in 2018 they Will Begin with "99XXX")

HCPCS Code	Long Description	CY 2016 Work RVU	Proposed CY 2017 Work RVU	Final CY 2017 Work RVU	Rate
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, with the following required elements: • 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, including administration of validated rating scales, with the development of an individualized treatment plan; • 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, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and • provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.	NEW	1.59	1.70	$142.84 (non-facility) $90.08 (facility)

Appendix A: Detailed Description of the "G" Codes and Requirements (When Formally Implemented in 2018 they Will Begin with "99XXX")

continued

HCPCS Code	Long Description	CY 2016 Work RVU	Proposed CY 2017 Work RVU	Final CY 2017 Work RVU	Rate
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, with the following required elements: • Tracking patient follow-up and progress using the registry, with appropriate documentation; • 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 such as behavioral activation, motivational interviewing, and other focused treatment strategies; • Monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.	NEW	1.42	1.53	$126.33 (non facility) $81.11 (facility)
G0504	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a 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 (List separately in addition to code for primary procedure). (Use G0504 in conjunction with G0503 and G0502).	NEW	0.71	0.82	$66.04 (non facility) $43.43 (facility)

Appendix A: Detailed Description of the "G" Codes and Requirements (When Formally Implemented in 2018 they Will Begin with "99XXX")

continued

HCPCS Code	Long Description	CY 2016 Work RVU	Proposed CY 2017 Work RVU	Final CY 2017 Work RVU	Rate
G0507	**Payment for Other Models of Integrated Behavioral Health Services 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. G0507 can only be reported by a treating provider (PCP) and cannot be independently billed. For G0507, a behavioral health care manager with formal or specialized education is not required. CMS rules allow "clinical staff" to provide G0507 services using the same definition of "clinical staff" as applied under the Chronic Care Management benefit. behavioral health model: 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. G0507 can only be reported by a treating provider and cannot be independently billed. For G0507, a behavioral health care manager with formal or specialized education is not required. CMS rules allow "clinical staff" to provide G0507 services using the same definition of "clinical staff" as applied under the Chronic Care Management benefit.	NEW			$47.73