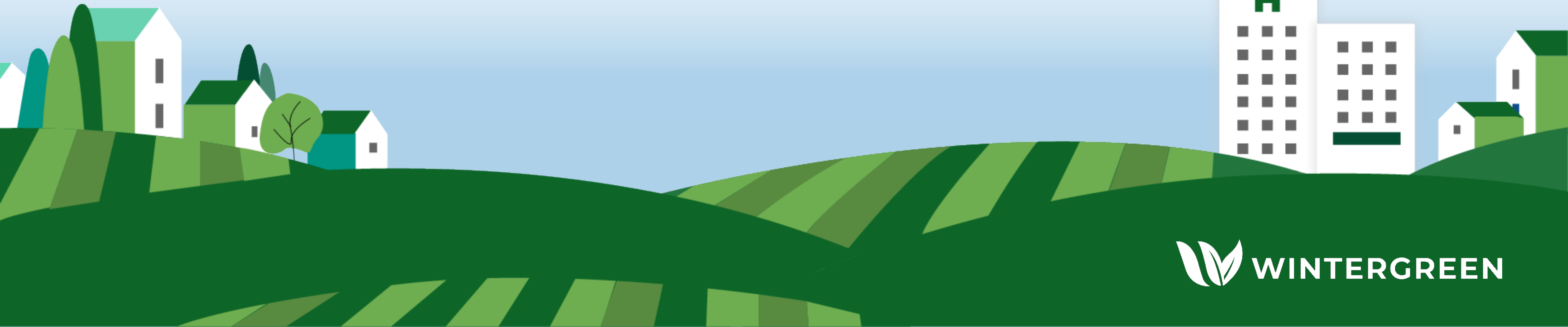
Behavioral Health

Leveraging RHCs to Expand an Essential Service

May 23, 2023



Overview

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Objectives

- The benefits of integrated behavioral health and primary care services in an RHC
- The different types of behavioral health services that can be provided in a primary care setting
- Functional aspects of integrated BH services: coding, clinical, and structural considerations
- Examples of integrated behavioral health services in RHCs and clinical settings
- Reimbursement issues
- Financial Implications

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Operational Considerations

Context

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- **Rural residents:**
  - Face longstanding access barriers to MH services – limited services and long travel distances
  - Rely more heavily on primary care providers (PCPs) to meet their BH needs than do urban residents

- **Behavioral health is a “core” RHC service and RHCs:**
  - Enhanced Medicare reimbursement for services provided by doctoral-level clinical psychologists (CPs) and licensed clinical social workers (LCSWs)
  - Medicaid reimbursement for additional masters-trained MH clinicians such as licensed professional counselors (LPCs)
    - As of January 1, 2024, LPCs and MFTs will be able to enroll and bill as a Medicare provider

- **COVID-19 Pandemic has increased willingness of patients to seek BH and wellness services**

Benefits of BH Services in an RHC

- **RHC BH services make good clinical sense**
  - Many BH conditions can be treated appropriately in a primary care setting
  - Medication and therapy produces the best clinical results
  - Meets patients’ needs and reduces stigma
  - Problems are not limited to MH/SUDs, includes many other health and safety problems
  - Many patients treated for medical issues also have MH and SU issues that complicate their treatment
  - MH/SU has serious economic consequences
  - Every RHC treats patients with BH issues regardless of whether it offers organized BH services

Benefits of BH Services in an RHC

- **RHC BH services make good financial sense**
  - Increases patient/visit volume, expands the range of treatment services, expands revenue and profitability
  - Under Medicare and Medicaid, BH services are paid at the all-inclusive rate (AIR)

- **Supports population health management**
  - A common priority in community health needs assessments
  - Improves patient outcomes
  - Supports chronic care management
  - Improves compliance with medical treatments

Understanding BH Care in an RHC

- **RHCs are primary care providers**
  - Can provide primary medical and primary BH care
  - Leverages skills of medical providers and BH specialists
  - Appropriate for depression, anxiety, adjustment disorders, PTSD, substance use disorders, etc.

- **Not appropriate for patients too acutely ill for treatment in an outpatient setting**
  - Individuals with serious and persistent mental illness or severe emotional disorders requiring long term inpatient care
  - Not appropriate sites for intensive outpatient programs or community mental health center programs

- **Coordination - support and recovery services**

Issues to Keep in Mind

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- **BH and PC providers speak different coding languages**
  - PC: ICD-10 coding system
  - BH: Diagnostic and Statistical Manual of Mental Disorders

- **BH and PC providers diagnose differently**
  - BH: diagnose with greater specificity after multiple encounters and testing
  - PC: diagnose with less specificity based on current symptoms

- **Integrated care involves two components**
  - Direct BH services and are typically reimbursable
  - Integrative services (e.g., warm-hand offs, hallway and office consults which are not typically reimbursable
  - Must balance the two

Issues to Keep in Mind

- **Allowable providers and 3rd-party payers**
  - Medicare limited to psychiatrists, physicians, physician assistants (Pas), nurse practitioners (NPs), advanced practice nurses (APNs), LCSWs, and CPs
    - As of January 1, 2024, LPCs and MFTs will be able to bill Medicare Part B and reimbursement for approved services in accordance with Medicare reimbursement rates
  - Medicaid includes these providers and other state-licensed providers, based on state policies
  - Commercial payers vary in types of providers allowed
  - May require enrollment in different provider panels
  - Managed care tools to manage utilizations and costs
  - Mental health parity laws – prohibit differential financial requirements or treatment restrictions on BH

Provider & Practice Barriers

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- **Provider alignment and engagement**
  - Differing practice styles
  - Differing practice cultures and languages
  - Selecting integration model based on practice context
  - Difficulty matching provider skills with patient needs
  - Management and supervision of behavioral health staff
  - Tension between direct patient care services and integrative services
  - Differing coding and billing systems
  - Heavy reliance on physician services
  - Provider resistance

Regulatory, Licensure, and Economic Barriers

- **Regulatory, licensure, and scope of practice**
  - Primarily licensure and scope of practice vary by states
  - Governs types of services that can provided and the extent to which clinicians can practice independently
  - Difficulty in arranging for clinical supervision
  - Licensure/scope of practice regs limit pool of providers

- **Economic**
  - High “no-show” rates, relatively low patient volumes, high salary costs, and low rates of insurance coverage
  - Administrative/access restrictions by third party payers
  - Coverage of provider types and services vary by payer type

Reimbursement and Patient Barriers

- **Reimbursement**
  - High rates of uninsurance and underinsurance (increases self pay and out-of-pocket costs
  - Low reimbursement rates/variations in methods of payment
  - High deductibles and co-pays
  - Coverage of provider types and services vary by payer type
  - Administrative and access restrictions imposed by MBHOs

- **Patient**
  - Stigma
  - Impact of high deductibles and co-payments on utilization

Recruitment and Retention Barriers

- **Recruitment and Retention**
  - Limited supply of specialty behavioral health providers
  - Licensure and scope of practice regs, payer policies further divide pool
  - Retention issues include inability to specialize, professional isolation, and boundary issues in small communities
  - Recruiting local behavioral health providers only rearranges existing resources and does not expand capacity unless replacement providers from outside the community are hired

Behavioral Health Services

- **Target population – the general population of primary care patients including persons with chronic diseases, high users of primary care services, etc.**

- **Types of Services**
  - Brief intake followed by short series of visits
  - Traditional MH and SU services
  - Patient education in self-management skills
  - Referral to community resources
  - Referral in acute and emergency care situations
  - Behavioral management of chronic and physical health conditions
  - Behavioral chronic care management

Behavioral Health Services and Codes

- **Evaluation and management codes**
  - Office visits, nursing home visits, outpatient, consults
  - Limited to physicians, physician assistants (PAs), nurse practitioners (NPs), advanced practice nurses (APNs)

- **Psychotherapy and substance use codes**
  - Patient, family, group psychotherapy, crisis, psychoanalysis
  - Initial diagnostic evaluation
  - Medication management
  - Medication assisted treatment
  - Can be used by physicians, PAs, NPs, APNs, CPs, LCSWs, and other practice types (based on scope of practice regulations and payer rules)

Behavioral Health Services and Codes

- **Health behavior Assessment Services codes**
  - Procedures to identify psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment or management of physical health problems
  - Focus is not on BH but on the biopsychosocial factors important to physical health problems and treatments
  - Can be used by physicians, PAs, NPs, APNs, CPs, LCSWs, and other practice types (based on scope of practice regulations and payer rules)

Behavioral Health Services and Codes

- **BH integration (BHI) and care management**
  - Psychiatric Collaborative Care Model (CoCM)
    - Medicare pays physicians and non-physician practitioners supplying BHI services using the to patients during a calendar month
    - COCM team includes a Behavioral Health Care Manager, a Psychiatric Consultant, and a Treating (Billing) Practitioner
  - Behavioral health integration (BHI)
    - Medicare also pays for BHI services using models other than CoCM
    - BHI team includes a treating (billing) practitioner and other clinical staff with a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team
    - May (or may not) be a professional who meets all the requirements to independently deliver and report services to Medicare
    - May include a BH care manager or psychiatric consultant

Behavioral Health Services and Codes

- **Telehealth**
  - RHCs can provide telecommunications for mental health visits using audio-video and audio-only technology
    - Audio-only allowed in situations when patient can't access or does not consent to audio-video technology
  - Billable BH services that are billable face-to-face including:
    - Assessments and screening, diagnostic evaluation; individual and family psychotherapy; psychoanalysis; group psychotherapy; psychological/neurobehavioral testing; crisis intervention; psychological evaluation; health behavior assessment and intervention (individual, family and group); developmental screening; adaptive behavior assessment and treatment; therapeutic interventions; smoking and tobacco use counseling; screening, brief intervention, and referral to treatment; and opioid use disorder treatment
  - Can be used by the same staff as face-to-face

Clinic Examples

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- **Weeks Medical Center (New Hampshire)**
  - Provides integrated ambulatory/outpatient services through its four RHCs in northern New Hampshire
  - Staff includes two licensed clinical MH counselors, licensed alcohol and drug counselors, licensed independent clinical social worker (LICSW), psychiatric nurse practitioners, and psychiatrists
  - Also provide services at the North Country Serenity Center in Littleton and the Doorway, an SU treatment program at Androscoggin Valley Hospital in Berlin
  - Services at Weeks' RHCs include SU and MH counseling, medically driven recovery plans, and care coordination
  - MAT services are provided at Lancaster and Whitefield sites

Clinic Examples

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- **Sacopee Valley Health Center (Maine)**
  - FQHC in operation since 1976 with a long-term commitment to providing BH services
  - Traditional BH (MH and Substance use) counseling services
  - Integrated primary care (behavioral health and assessment) services (since 2005) targeting the behavioral health needs of patients with chronic health problems such as diabetes, hypertension, obesity, fibromyalgia, etc.
  - Behavioral Health Consultant works with patient and medical provider to design strategies to help them reach goals for a healthier lifestyle
  - Service billed using diagnosis for physical health condition

Financial Considerations

Financial Considerations

- Revenue Optimization Opportunities
  - With declining reimbursements and the drive toward an integrated model, organizations must evaluate additional opportunities to improve financial performance
    - This holds particularly true due to the change in the change in the reimbursement model brought forth by the Consolidated Appropriations Act of 2021.

- The following some of the opportunities are available to Rural Health Clinics (RHC) to improve reimbursements and financial performance when those practices meet the appropriate eligibility / regulatory requirements:
  1. Integrate behavioral health providers (CP and LCSW) into the RHC to leverage alternative reimbursement methodologies
     - Although Medicare reimburses CPs and LCSWs, explore which designations are allowed through Medicaid reimbursement
  2. The acquisition of independent behavioral health practices for integration into the RHC
  3. The addition of tele-behavioral health services within the RHC
     - The CY22 Physician Fee Schedule Final Rule made permanent the ability to provide distant site mental health visits using interactive, real-time telecommunications technology as of January 1, 2023
  4. Explore the addition of care management services (BHI, CoCM, etc.) to patient outcomes and revenue

RHC Reimbursement Methodology

- On April 1, 2021, the RHC reimbursement methodology went through a material change due to the "*Consolidated Appropriations Act, 2021 (CAA)*" which changed the reimbursement methodology for Rural Health Clinics (RHC) starting on April 1, 2021
  - Starting on April 1, 2021, all new RHCs established after December 31, 2020, regardless of whether they are independent, owned and operated by a hospital with fewer than 50 beds, or owned and operated by a hospital with greater than 50 beds, shall be reimbursed based on reasonable cost with an upper payment limit (UPL) set at the following rates:
    - In 2021, after March 31, at $100 per visit;
    - In 2022, at $113 per visit;
    - In 2023, at $126 per visit;
    - In 2024, at $139 per visit;
    - In 2025, at $152 per visit;
    - In 2026, at $165 per visit;
    - In 2027, at $178 per visit;
    - In 2028, at $190 per visit;
    - In subsequent years, the rate will increase based on the Medicare Economic Index (MEI) for primary care services
  - RHCs owned and operated by a hospital with fewer than 50 beds and established on or before December 31, 2020, will use their 2020 rate to establish a clinic-specific grandfathered UPL that will then be increased each year based on the MEI

Medicare Economic Index (MEI)

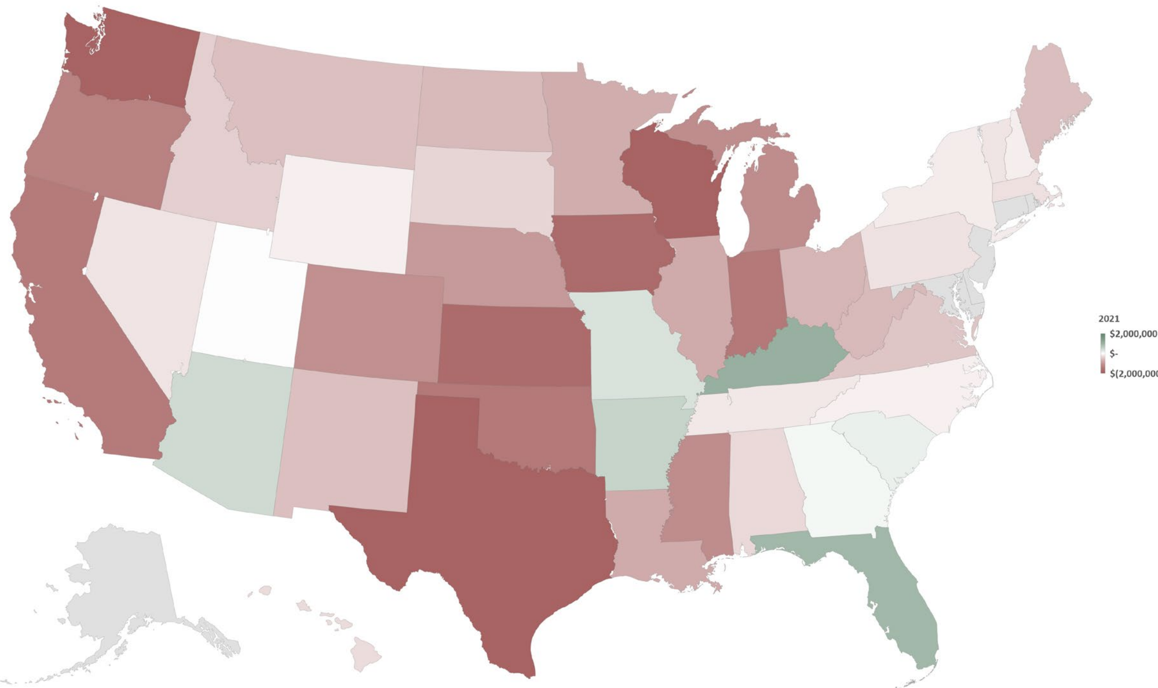
- The Medicare Economic Index (MEI) was developed in 1975 and is the baseline for each year's payment update calculation
  - The following table presents the MEI from 2014 through 2023

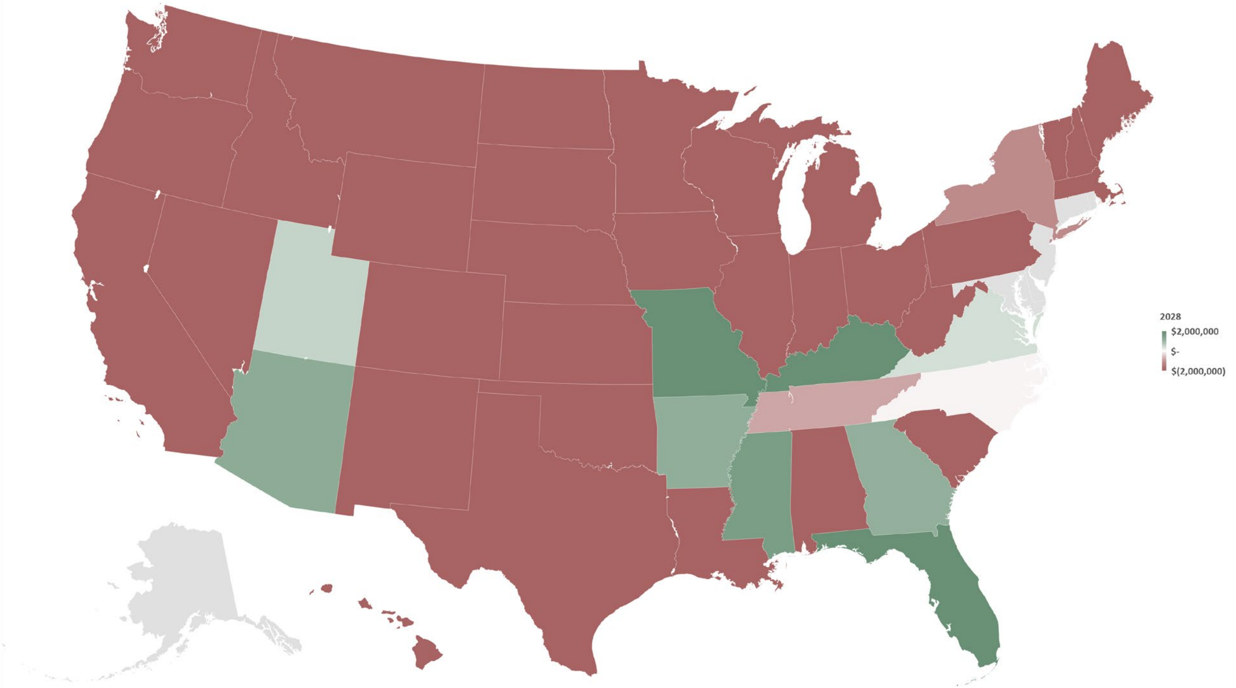
Medicare Economic Index [1]	CY14	CY15 [2]	CY16 [3]	CY17	CY18	CY19	CY20	CY21	CY22	CY23	AVERAGE
Market Basket Update	0.8	0.8	1.1	1.2	1.4	1.5	1.9	1.4	2.1	3.8	1.6

1. Physician payments were updated annually based on the MEI starting in 1992
   - The Medicare Economic Index has always included a productivity adjustment
2. The Medicare Access and CHIP Reauthorization Act of 2015,ended use of the SGR and replaced with defined annual update factors from 2015 through 2025. https://www.congress.gov/bill/114th-congress/house-bill/2/text
3. The MEI market basket was used to update FQHC PPS payments in CY 2016

Projected RHC Reimbursement Impact

- **Projected RHC Reimbursement Impact**
  - The following map reflects the impact of the new reimbursement methodology on each state





Data Source: December 2022 Medicare Cost Report release for hospital and RHC fiscal year 2021; and December 2022 CMS Provider of Services (POS) data file.

Case Study: Provider Integration

- **Overview**
  - 25-bed, not-for-profit Critical Access Hospital (CAH) that services approximately 15,000 residents
    - Hospital operates the following primary and behavioral health clinics:
      - Primary Care Clinic designated as a Provider-Based Rural Health Clinic (PB-RHC)
      - Behavioral Health Clinic designated as a Free-Standing Health Clinic (FSHC)
        - Provider was a single LCSW
  - Wintergreen compared the net impact on reimbursements under the following scenarios:
    - Scenario #1: Reimbursements received as a PB-RHC and FSHC under the CAH
    - Scenario #2: Reimbursements received as an integrated PB-RHC (primary and behavioral) under the CAH
      - Net impact factors post Consolidated Appropriations Act of 2021

Case Study: Provider Integration

- **Financial Impact**
  - The following table shows the net financial impact of integrating the behavioral health provider into the RHC:

Summary Data	Scenario #1 Separate	Scenario #2 Intergrated	Variance
Free-Standing Health Clinic			
Medicare / Medicaid Average	$ 75.64	$ -	$ (75.64)
Annual Visits	641	-	(641)
Reimbursements Received	$ 48,485	$ -	$ (48,485)
Provider-Based Rural Health Clinic			
Medicare / Medicaid Average	$ 197.24	$ 191.65	$ (5.59)
Annual Visits	4,769	5,410	641
Reimbursements Received	$ 940,638	$ 1,036,827	$ 96,189
Critical Access Hospital			
Medicare / Medicaid Reimbursement	$ 9,967,243	$ 9,956,219	$ (11,024)
340B Revenue	367,241	367,241	-
Reimbursements Received	$ 10,334,484	$ 10,323,460	$ (11,024)
Integrated Benefit			**$ 36,680**

Case Study: Practice Acquisition

- **Overview**
  - A multi-hospital system that provides services to over 150,000 residents throughout multiple counties
    - Hospitals include, but not limited to:
      - A 23-bed Critical Access Hospital
      - A 75-bed short-term acute care facility
    - The system entered into an agreement and acquired a multi-provider behavioral health practice for alignment under one of the CAHs RHCs
      - Practice included two Clinical Psychologist
  - Wintergreen compared the net impact on reimbursements under the following scenarios:
    - Scenario #1: Reimbursements received for the CAH PB-RHC and the independent FSHC
    - Scenario #2: Reimbursements received as an integrated PB-RHC (primary and behavioral) under the CAH if the practice were acquired and included as a part of the RHC
      - Net impact factors post Consolidated Appropriations Act of 2021

Data Source: December 2021 Medicare Cost Report release for hospital and RHC fiscal year 2020; and December 2021 CMI Provider of Services (POS) data file.

Case Study: Practice Acquisition

- **Financial Impact**
  - The following table shows the net financial impact on reimbursements of acquiring and integrating the behavioral health practice into the RHC:

Summary Data	Scenario #1 Separate	Scenario #2 Acquired	Variance
Independent Free-Standing Health Clinic			
Medicare / Medicaid Average	$ 81.67	$ -	$ (81.67)
Annual Visits	1,752	-	(1,752)
Reimbursements Received	$ 143,086	$ -	$ (143,086)
Provider-Based Rural Health Clinic			
Medicare / Medicaid Average	$ 162.85	$ 159.23	$ (3.62)
Annual Visits	12,391	14,143	1,752
Reimbursements Received	$ 2,017,874	$ 2,251,990	$ 234,116
Critical Access Hospital			
Medicare / Medicaid Reimbursement	$ 14,643,281	$ 14,609,081	$ (34,200)
340B Revenue	367,241	367,241	-
Reimbursements Received	$ 15,010,522	$ 14,976,322	$ (34,200)
Acquired Benefit			**$ 56,830**

Data Source: December 2021 Medicare Cost Report release for hospital and RHC fiscal year 2020; and December 2021 CMI Provider of Services (POS) data file.

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