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STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

March 28, 2017

TO: The Honorable Senator Jill N. Tokuda, Chair
Senate Committee on Ways and Means

FROM: Pankaj Bhanot, Director

SUBJECT: **HB 1272 HD 1 SD 1- RELATING TO IMPROVING ACCESS TO PSYCHIATRIC CARE FOR MEDICAID PATIENTS**

Hearing: March 28, 2017, 1:30 p.m.
Conference Room 211, State Capitol

DEPARTMENT'S POSITION: The Department of Human Services (DHS) offers comments.

PURPOSE: The purpose of the bill is to specify that coverage for telehealth under the State's Medicaid managed care and fee-for-service programs includes psychiatric services provided through a coordinated care manager who is present in a primary care provider's office through telehealth.

DHS is in agreement that continued improvements in the provision of behavioral health care, including psychiatric services, are needed, and that the collaborative care model is one such model that has been successful elsewhere in the country. Although the bill is making changes to the telehealth statutes related to Medicaid, it in essence is adding a new benefit or service, the collaborative care model, to be covered by Medicaid. However, at this point, the collaborative care model is not implemented in Hawaii for the Medicaid population, although it is being piloted by a major health insurer for its Medicare population.

There are several specific aspects of the collaborative care model that are not available or are not covered that this bill does not address. For example, the telehealth

psychiatric consultations specified in the bill are not generally allowed under the definition of telehealth that the federal Medicaid agency, Centers for Medicaid and CHIP Services, includes. Additionally, the bill presumes that there would be behavioral health care managers located in provider's offices, which today there are not.

Finally, the "coordinated care manager" would be providing case management services for a much broader population than what our current Medicaid program authorizes, and thus, those services would not be available by telehealth or any other mode of service delivery.

For these reasons, Med-QUEST would need additional time to: request permission via the 1115 waiver from the federal regulating agency, Centers for Medicare and Medicaid Services (CMCS), to implement a new benefit or service than what is currently covered; to broaden to additional providers to provide the new service or benefits; and to expand to allow reimbursements for telehealth for the specific type of provider to provider consultations envisioned using the collaborative care model. Unlike the other telehealth provisions, it is not clear that CMCS would permit reimbursement for the provider to provider psychiatric consultations. Without the permissions, reimbursements would be comprised of state general funds only. Med-QUEST would request an appropriation if unable to obtain CMCS permission.

Finally, analysis would be needed regarding the overall costs versus savings to implement this new collaborative care model in order to determine if an additional appropriation would be needed even if CMCS allowed coverage. For these reasons, we respectfully suggest that the pilot project be completed, perhaps with an inclusion of a sunset provision, so that we can learn how to implement such a program here on a broader scale, and understand the relative costs and potential savings, before mandating coverage under Medicaid.

Thank you for the opportunity to testify on this bill.

THE QUEEN'S HEALTH SYSTEMS

To: The Honorable Jill N. Tokuda, Chair
The Honorable Donovan M. Dela Cruz, Vice Chair
Members, Committee on Ways and Means

From: Paula Yoshioka, Senior Vice President, The Queen's Health Systems
Date: March 24, 2017
Hrg: Senate Committee on Ways and Means Hearing; Tuesday, March 28, 2017 at 1:30PM in Room 211

Re: **Support Intent of HB 1272, HD1, SD1, Relating to Improving Access to Psychiatric Care for Medicaid Patients**

My name is Paula Yoshioka, and I am a Senior Vice President at The Queen's Health Systems (QHS). QHS would like to express our **support** for the intent of HB 1272, HD1, SD1, Relating to Improving Access to Psychiatric Care for Medicaid Patients. This bill specifies that coverage for telehealth under the State's Medicaid managed care and fee-for-service programs includes psychiatric services provided through a behavioral health care manager who is present in a primary health care provider's office through telehealth.

The Queen's Clinically Integrated Physician Network (QCIPN) is working with our psychiatrist colleagues to develop a mental health integration (MHI) model for our primary care physicians (PCPs) to improve the care of patients with behavioral health needs using the Collaborative Care model initially developed at the University of Washington. The Centers for Medicare and Medicaid (CMS) developed billing codes to allow PCP's to get reimbursement for adopting this model of care for Medicare fee-for-service patients in their practice. This bill uses the new Medicare billing structure as a basis for Medicaid reimbursement in the Collaborative Care model.

While QHS supports the intent of the bill, we understand that the Department of Human Services (DHS) has a raised a few concerns in their testimony. We understand that they require some additional time to request permission via the 1115 waiver from CMS and that analysis is needed regarding costs. QHS would be supportive of a pilot project, as suggested by DHS, to understand the relative costs and potential savings.

Thank you for your time and attention to this important issue.

An Independent Licensee of the Blue Cross and Blue Shield Association

March 28, 2017

The Honorable Jill Tokuda, Chair
The Honorable Donovan M. Dela Cruz, Vice Chair
Senate Committee on Ways and Means

Re: HB1272, HD1, SD1 – Relating to Improving Access to Psychiatric Care for Medicaid Patients

Dear Chair Tokuda, Vice Chair Dela Cruz, and Committee Members:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 1272, HD1, SD1 which would specify that coverage for telehealth under the State's Medicaid managed care and fee-for-service programs includes psychiatric services provided through a coordinated care manager who is present in a primary health care provider's office through telehealth. HMSA offers the following comments on HB 1272, HD1, SD1.

HB 1272, HD1, SD1 seeks to comport with federal CMS guidelines, as referenced in Section 1 of the bill. The CMS psychiatric collaborative care model typically is administered by a primary care team consisting of a primary care provider (PCP) and a behavioral health care manager, working in collaboration with a psychiatric consultant, such as a psychiatrist. Care is directed by the primary care team, and the psychiatric consultant provides regular consultations. The corresponding codes incorporate the services of all members of the collaborative care team as incident-to services of the PCP.

We appreciate the previous Committees' adoption of proposed amendments to address some of our concerns. However, in Section 2 we have concerns with the inclusion of "licensed counselor" in the definition of "behavioral health care manager." It is unclear who the "licensed counselor" would include and whether DCCA would have licensing control/oversight over this group.

Thank you for allowing us to provide testimony on HB1272, HD1, SD1.

Sincerely,

Mark K. Oto
Director, Government Relations

To: Senator Jill N. Tokuda, Chair, Senator Donovan M. Dela Cruz, Vice Chair, and members of the Senate Committee on Ways and Means

From: Julienne O. Aulwes, M.D., Chair, Task Force on Improved Access to Psychiatric Care, Hawaii Psychiatric Medical Association

Hearing Date: March 28, 2017
Hearing Time: 1:30pm

Re: HB1272 HD1 SD1

RELATING TO IMPROVING ACCESS TO PSYCHIATRIC CARE FOR MEDICAID PATIENTS

Position: SUPPORT

Dear Chairperson Tokuda, Vice Chairperson Dela Cruz, and members of the Senate Committee on Ways and Means:

Please vote YES on HB1272 HD1 SD1.

Thank you for the opportunity to testify on behalf of the Hawaii Psychiatric Medical Association (HPMA) in Strong Support of this measure, HB1272, which seeks to provide a means by which patients with psychiatric difficulties, particularly in underserved rural areas, will have improved access to psychiatric care.

Such patients can have difficulty gaining access to the expertise of a psychiatrist, especially if they are on Medicare or Med-QUEST. HB1272 seeks to alleviate this access problem by supporting psychiatric consultation to family physicians and their patients with psychiatric difficulties through the Collaborative Care Model: a method of psychiatric care delivery shown to 1) improve access, 2) improve outcomes, 3) improve satisfaction, and 4) reduce costs.

Medicare began covering the Collaborative Care Model with new payment codes on January 2, 2017, but Hawaii Medicaid does not. This is because Hawaii Medicaid will only cover physician to patient contact, but Collaborative Care requires psychiatrist to family physician or to behavioral care manager contact. It does not typically involve direct contact between the consulting psychiatrist and the patient.

The purpose of HB1272 is to specify that Hawaii's Medicaid managed care programs, which currently do not cover Collaborative Care, will cover Collaborative Care, specifically, psychiatric services including consultation provided to a coordinated behavioral health care manager and/or a primary care provider through telehealth, in the same way that Medicare began covering these services on January 2, 2017.

Background:

Collaborative Care Model (CoCM)
The Collaborative Care Model is a specific type of integrated care that improves access to evidence-based mental health care for patients in the primary care setting. Over 80 evidence-based studies show that by treating patients with mild to moderate psychiatric conditions right in

their family doctor's office (rather than sending the patient to a psychiatrist's office somewhere else) by employing a behavioral health care manager there, and contracting with an off-site psychiatric consultant, Collaborative Care results in better medical as well as psychiatric care. It has been shown to achieve the Institute for Healthcare Improvement's Triple Aim: improving the individual experience of care, improving the health of populations, and reducing the per capita costs of care for populations by up to $600-1000/patient/year. Instead of a psychiatrist taking care of only three or four patients in a morning, the Collaborative Care Model allows a psychiatrist to oversee the care of 10-15 patients in the same amount of time. The outcome data is so good that Medicare started paying for Collaborative Care on January 2, 2017. But it is not covered by Medicaid. What we need is for Medicaid to cover the same service that Medicare started paying for, because so many of our neighbor island residents are not on Medicare but rather on Medicaid. That's why we worked with the legislature on HB1272, with companion SB1155 to accomplish this, which should move Hawaii healthcare in the direction of better medical (including psychiatric) care for our entire population at less cost.

The behavioral health care manager is typically a nurse, social worker, licensed counselor, or psychologist, who coordinates the overall effort of the group and ensures effective communication among team members and provides psychotherapy when that is part of the treatment plan. The behavioral health care manager is responsible for coordinating and supporting mental health care within the clinic and for coordinating referrals to clinically indicated services outside the clinic. Primary care practices track and reach out to patients who are not improving and the psychiatric consultant provides caseload-focused consultation, not just ad-hoc advice. They get feedback on their patients' behavioral health problems within days versus months. The psychiatric consultant reviews all patients who are not improving and then makes treatment recommendations, typically providing consultation on 10-20 patients in a half day as opposed to 3-4 patients in the same amount of time if the psychiatrist were in a co-located or traditional consultation role or even in the same building. As of January 2017, there are reimbursement codes through Medicare that provide compensation for this model of care in Hawaii. But our Medicaid patients here in Hawaii need Collaborative Care too.

Since *Sine Die* of the legislature, the Hawaii Psychiatric Medical Association (HPMA) working with the Hawaii Medical Association (HMA) and the American Psychiatric Association (APA) has:

- created a Task Force on Improved Access to Psychiatric Care with physician representatives on each island of the state to support the development of the collaborative care model in Hawaii including pilot projects
- attended the Hawaii Health Workforce Summit to assess the behavioral health needs of the state and promote the collaborative care model
- provided a free webinar to the public regarding the collaborative care model, 20 participants dialed in
- been working with the Queen's Clinically Integrated Physician Network in launching the collaborative care model in their physician network
- been working with the East Hawaii Independent Physicians Association in planning and implementing the collaborative care model for their member physicians
- met with the Hawaii Primary Care Association in discussion about how to implement the collaborative care model in their Federally Qualified Health Centers
- been working with the Molokai Community Health Center in setting up collaborative care services along with tele-behavioral health services to their child and adolescent population

- reached out to Hana Health Clinic for a psychiatric needs assessment to lay the groundwork for implementing the collaborative care model in that community
- supported the Ka'u Rural Health Community Association in their procurement of a telehealth kiosk which will provide clinical services free of charge to that community and attended their 19th annual rural health conference
- met with Ka'u Rural Health Clinic introducing the collaborative care model
- met with HMSA (Hawaii Medical Service Association) to discuss best practice methods to roll out the collaborative care model including providing behavioral health care managers for their members so collaborative care can be accessible to all, including their HMSA QUEST patients
- trained ten psychiatrists in Hawaii in the collaborative care model who are ready to partner with primary care providers
- reached out to Castle Health Group to provide information on the collaborative care model
- reached out to the Waianae Coast Comprehensive Health Center to provide information on the collaborative care model

HPMA, in conjunction with the Hawaii Medical Association (HMA), looks forward to working with you to improve access to psychiatric care through Collaborative Care to our Medicaid populations wherever they may reside to:

1) Improve medical outcomes
2) Improve satisfaction
3) Save money ($600-$1000 per patient per year)

Collaborative Care is already covered by Medicare. It is in varied stages of implementation in Hawaii, including The Queen's Clinically Integrated Physician Network. We need to encourage expanding its implementation by providing support to clinical practices caring for Medicaid patients throughout the state.

Please vote YES on HB1272 HD1 SD1. Thank you for the opportunity to testify.

Sincerely,

Julienne O. Aulwes, M.D.
Chair, Task Force on Improved Access to Psychiatric Care
Hawaii Psychiatric Medical Association

From: mailinglist@capitol.hawaii.gov
Sent: Monday, March 27, 2017 10:20 PM
To: WAM Testimony
Cc: oliveiraj009@gmail.com
Subject: Submitted testimony for HB1272 on Mar 28, 2017 13:30PM

HB1272
Submitted on: 3/27/2017
Testimony for WAM on Mar 28, 2017 13:30PM in Conference Room 211

Submitted By	Organization	Testifier Position	Present at Hearing
Jill	Hawaii Psychological Association	Comments Only	No

Comments: COMMITTEE ON WAYS AND MEANS Senator Jill N. Tokuda, Chair Senator Donovan M. Dela Cruz, Vice Chair Tuesday, March 28, 2017, 1:30 pm, Room 211 The Hawai'i Psychological Association has long recognized the significant barriers to accessing psychiatric services in our state. We would like to submit comments for HB 1272 HD1 SD1 that seeks to improve access to psychiatric services for Medicaid patients. HB 1272 HD 1 SD 1 has undergone revisions that have mostly served to improve the clarity in the bill language. However, SD 1 removes an important definition that was added in HD 1, namely for that of “psychiatric consultation services.” This definition was removed in SD 1 and the line stating “…provided that the psychiatric consultant shall be a licensed psychiatrist in the State” appeared. It is our opinion that both are necessary and helpful in clarifying roles and functions of the collaborative care team, thus, the full definition of “psychiatric consultation services” should be added again to the bill language. While this legislation will hopefully help to increase psychiatric consultation services, it should be viewed as one approach and not the only approach given the widespread shortage of psychiatrists both locally and nationally. Having said this, it would be helpful to have a report completed after a specified time period to see the potential impact of this collaborative care model approach. Additionally, other measures being brought forth in the 2017 legislature focus on a similar intent (SB384 SD2 HD1) while recognizing the need to increase the workforce that can provide access to psychotropic medication rather than spread thin an already limited pool of psychiatrists. Respectfully submitted, Jill Oliveira Gray, Ph.D. HPA, Legislative Action Committee

AMERICAN PSYCHIATRIC ASSOCIATION

Medical leadership for mind, brain and body.

COORDINATING MENTAL HEALTH CARE WITH PSYCHIATRISTS IN HI

November 1, 2016

OBJECTIVES

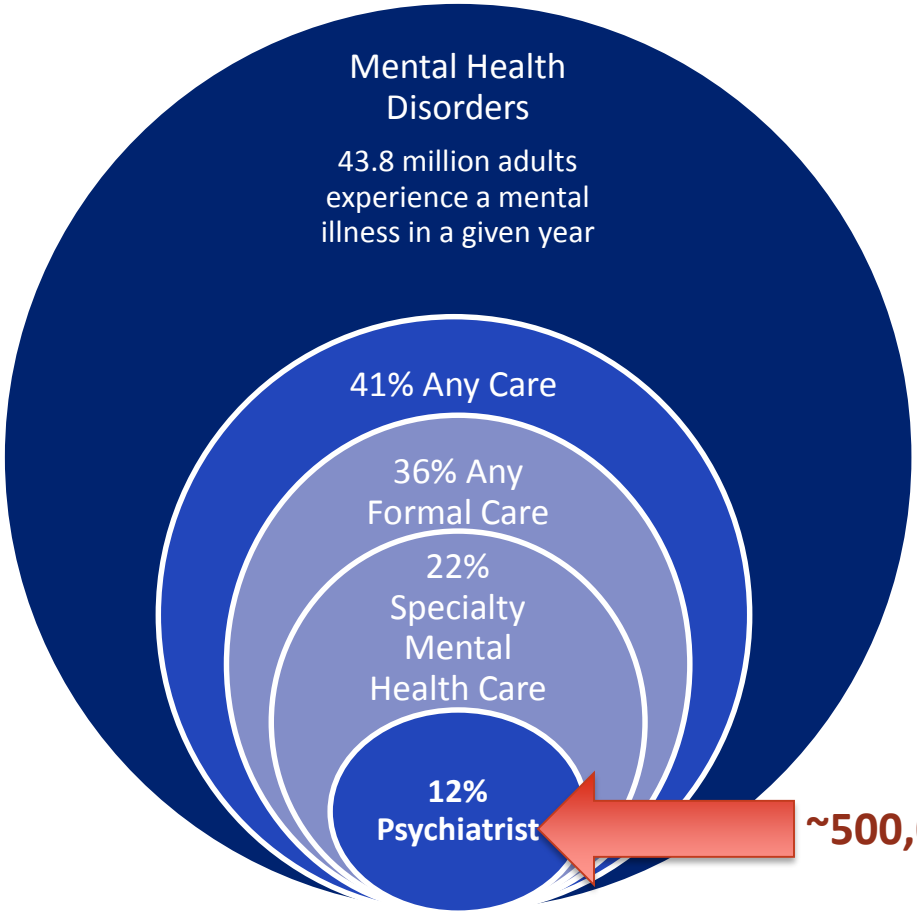
AMERICAN PSYCHIATRIC ASSOCIATION

- Primary care practices will learn about the Collaborative Care Model as a solution for increased access, better patient outcomes, and reduced costs.

- Primary care practices will learn about how to get started in Collaborative Care and connected with a trained psychiatric consultant.

TREATMENT FOR MENTAL HEALTH DISORDERS

AMERICAN PSYCHIATRIC ASSOCIATION



~500,000 see a psychiatrist

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. Arch Gen Psychiatry, 62(6), 629-640.

Any Mental Illness (AMI) Among Adults. (n.d.). Retrieved October 23, 2015, from http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml.

LINKING BEHAVIORAL HEALTH AND HEALTH

AMERICAN PSYCHIATRIC ASSOCIATION

Behavioral Health

Psychiatric disorders cause:

- 25% of all disability worldwide*
- 3x diabetes, 10x heart disease, 40x cancer
- In the US, one suicide every 14 minutes

Health Behaviors

- Unhealthy behaviors are major drivers of health care costs
- Behavior determines ≈ 50 % of all mortality and morbidity
- 40 – 50% struggle with treatment adherence
- Employers struggle with absenteeism and presenteeism

*C. Murray, GBD Study, *Lancet* 2012

BEHAVIORAL HEALTH IS A CHALLENGE FOR PCP PRACTICES

AMERICAN PSYCHIATRIC ASSOCIATION

- Mental illness is commonly treated in primary care: 43–60% of treatment for mental illness occurs in primary care and 17–22% in specialty mental health settings

- More than half of practices (62%) reported using electronic, standardized depression screening and monitoring;

- Among the practices, 54% used evidence-based health behavior protocols for mental health and substance use conditions.

- PCP practices were less likely to have procedures for referrals, communication, and patient scheduling for responding to MH/SU services than for other medical subspecialties
  - (50% compared with 73% for cardiology and 69% for endocrinology).

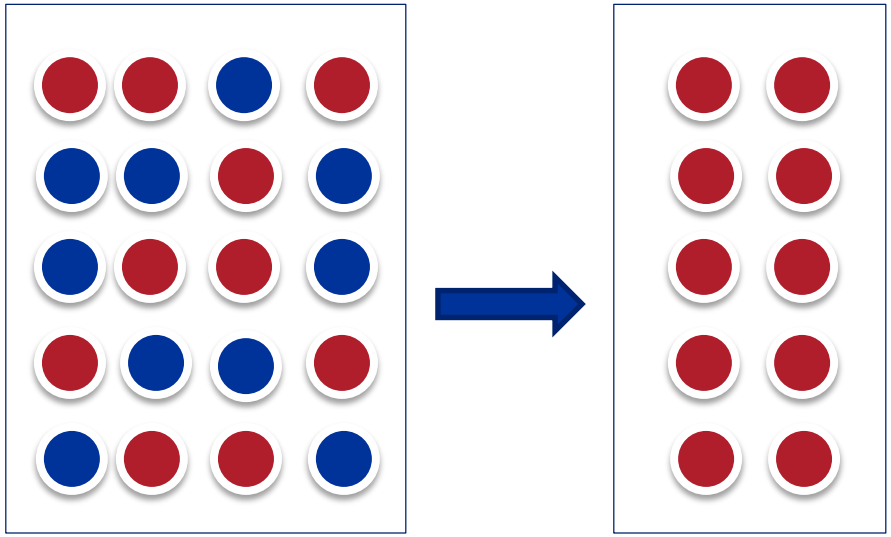
- Practices reported that **lack of reimbursement, time, separation of MH and health systems and sufficient knowledge** were obstacles to providing care

NCQA, 2014

WHY NOT JUST REFER?
PATIENT FACTORS

AMERICAN PSYCHIATRIC ASSOCIATION

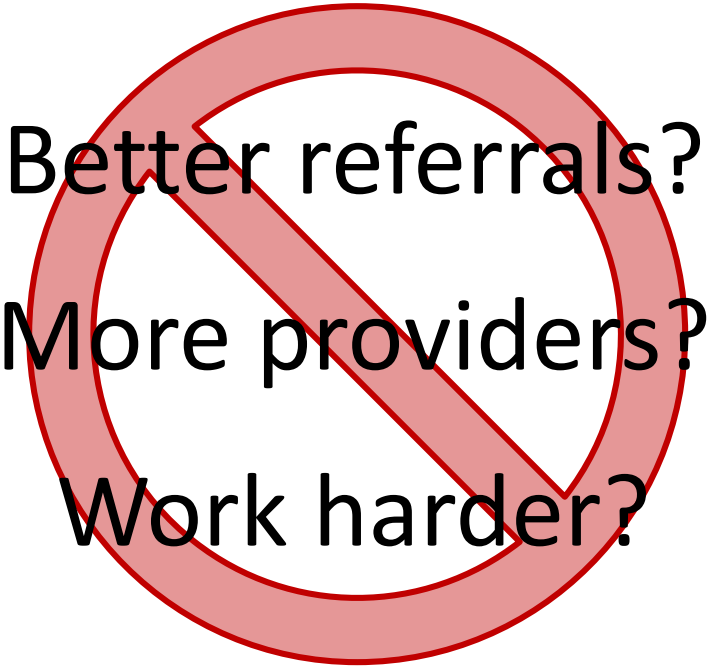
- **Half of those referred do not follow through.**



- **Mean # of visits = 2**

Grembowski, Martin et al., 2002
Simon, Ding et al., 2012

HOW DO WE CLOSE THE GAP?



Working smarter = Integrated care

INTEGRATED CARE OFFERS A SOLUTION

AMERICAN PSYCHIATRIC ASSOCIATION

- **Improves access for patients**
  - Nearby primary care clinic
  - More timely appointments
  - Less stigmatizing
  - Lower out-of-pocket costs

- **Increases capacity of mental health providers**
  - Consultation
  - Collaboration
  - Leverages scarce mental health resources

INTEGRATION EFFORTS

AMERICAN PSYCHIATRIC ASSOCIATION

Most models of integrated care are <u>not evidence based</u>

Collaborative Care

- Estimated 5-10% reduction of healthcare expenditures
- Potential annual savings of $26-48 billion
- **More cost-effective**
  - ⑩ **ROI $6.50: 1**

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THE COLLABORATIVE CARE MODEL (CCM)

COLLABORATIVE CARE PRINCIPLES: GOOD FOR ***ANY*** PRACTICE

AMERICAN PSYCHIATRIC ASSOCIATION

Population-Based Care

Measurement-Based Treatment to Target

Patient-Centered Collaboration

Evidence-Based Care

Accountable Care

Principles: © University of Washington

COLLABORATIVE CARE: THE IMPACT STUDY

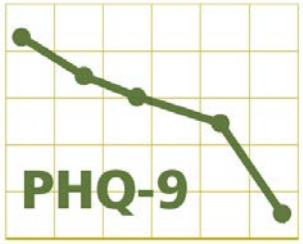
AMERICAN PSYCHIATRIC ASSOCIATION

Prepared, Pro-active Practice Team

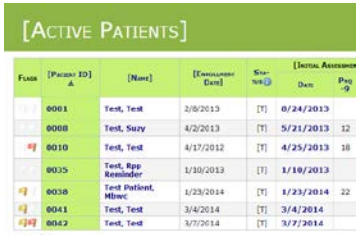
Effective Collaboration

Informed, Active Patient

Practice Support



Outcome Measures



Population Registry

Problem Solving Treatment (PST)
Behavioral Activation (BA)
Motivational Interviewing (MI)
Medications

Treatment Protocols

Psychiatric Consultation

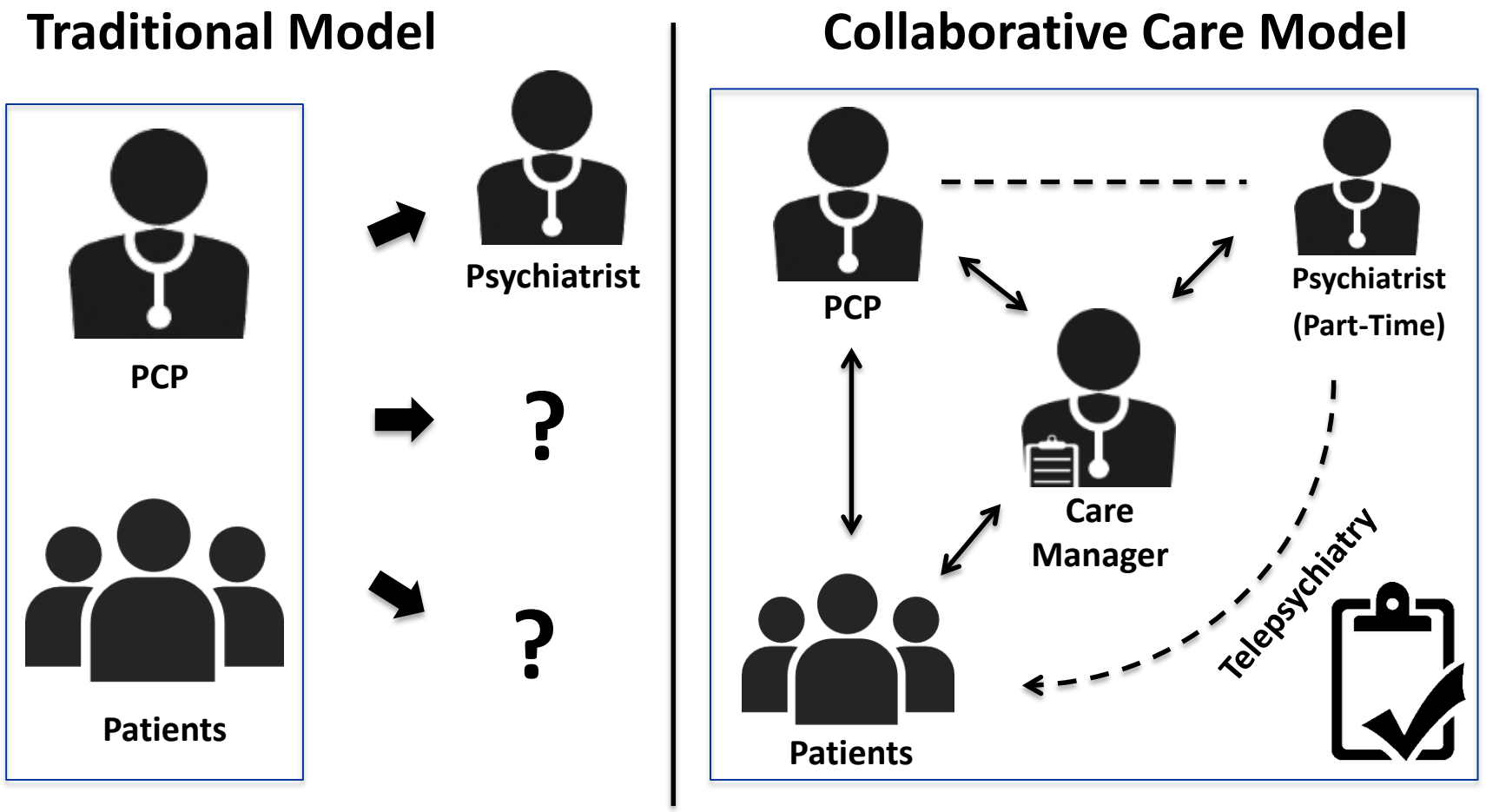
THE COLLABORATIVE CARE MODEL

AMERICAN PSYCHIATRIC ASSOCIATION

Caseload-focused psychiatric consultation supported by a BHP or care manager

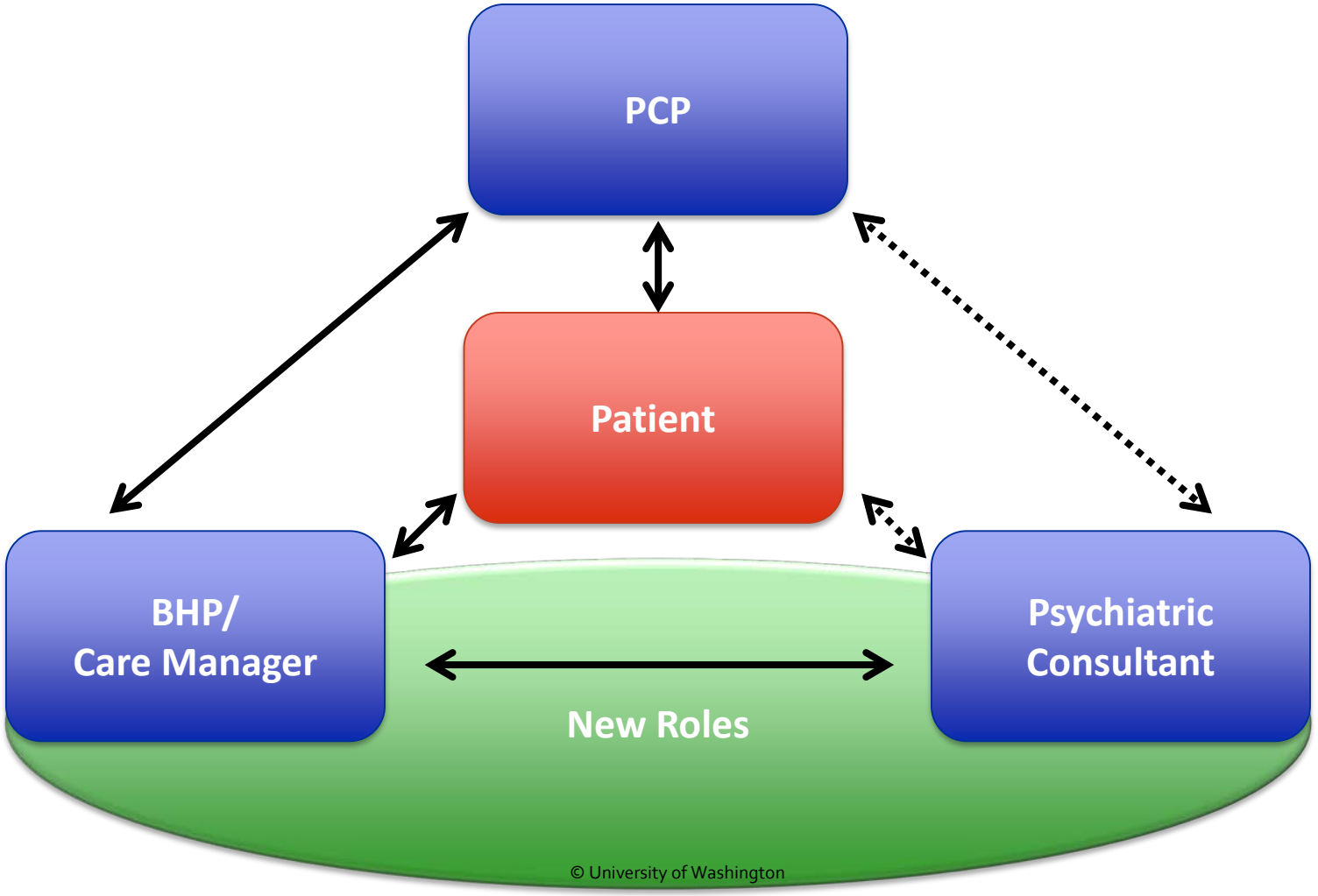
Better access	PCPs get input on their patients' behavioral health problems within days/weeks versus months
	Focuses in-person visits on the most challenging patients
Regular Communication	Psychiatrist has regular (weekly) meetings with a BHP/care manager
	Reviews all patients who are not improving and makes treatment recommendations
More patients covered by one psychiatrist	Psychiatrist provides input on 10 – 20 patients in a half day as opposed to 3-4 patients
Shaping over time	Multiple brief consultations More opportunity to 'correct the course' if patients are not improving

TRADITIONAL MODEL VS. COLLABORATIVE CARE MODEL

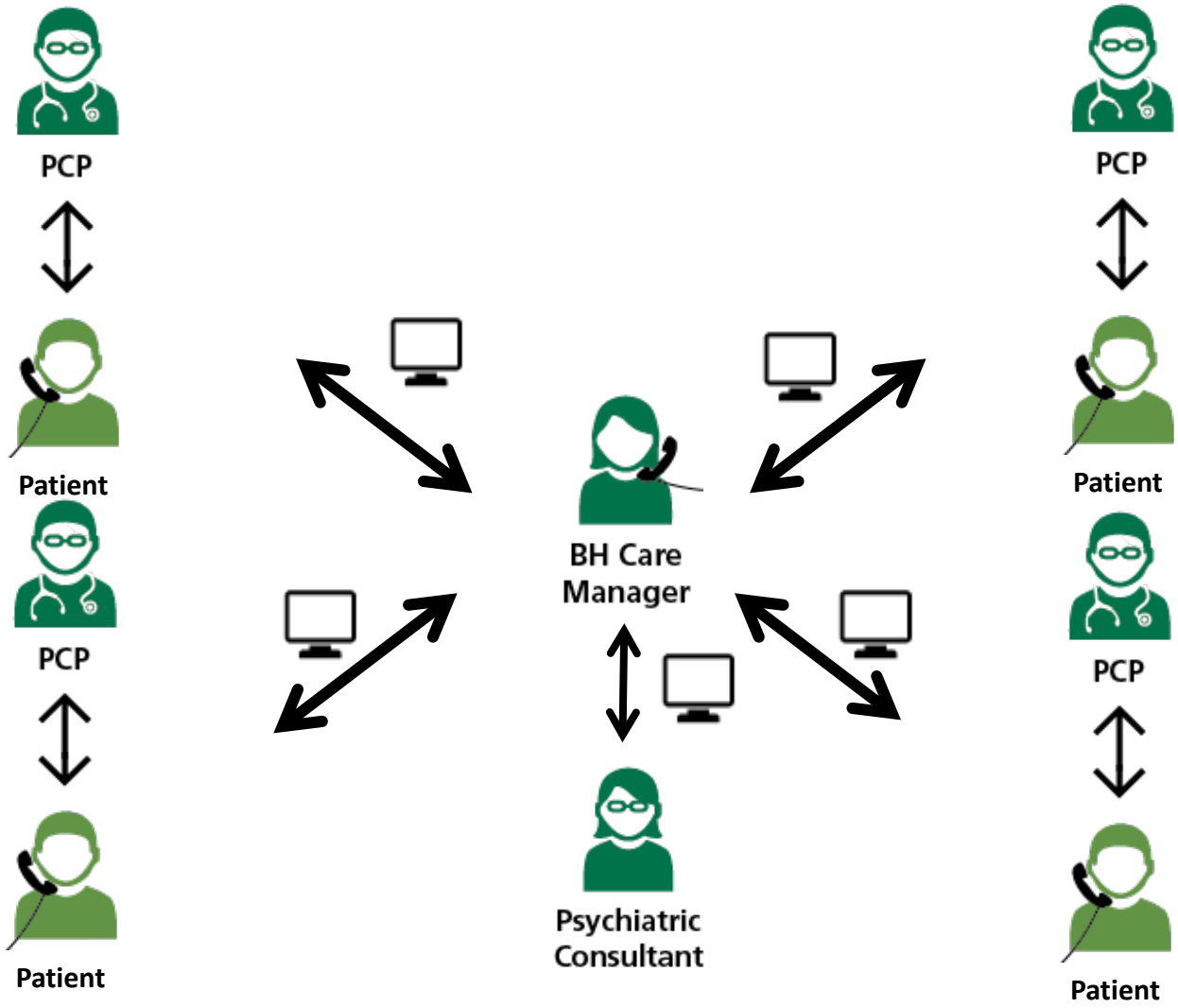


PRINCIPLE: **PATIENT-CENTERED COLLABORATION**

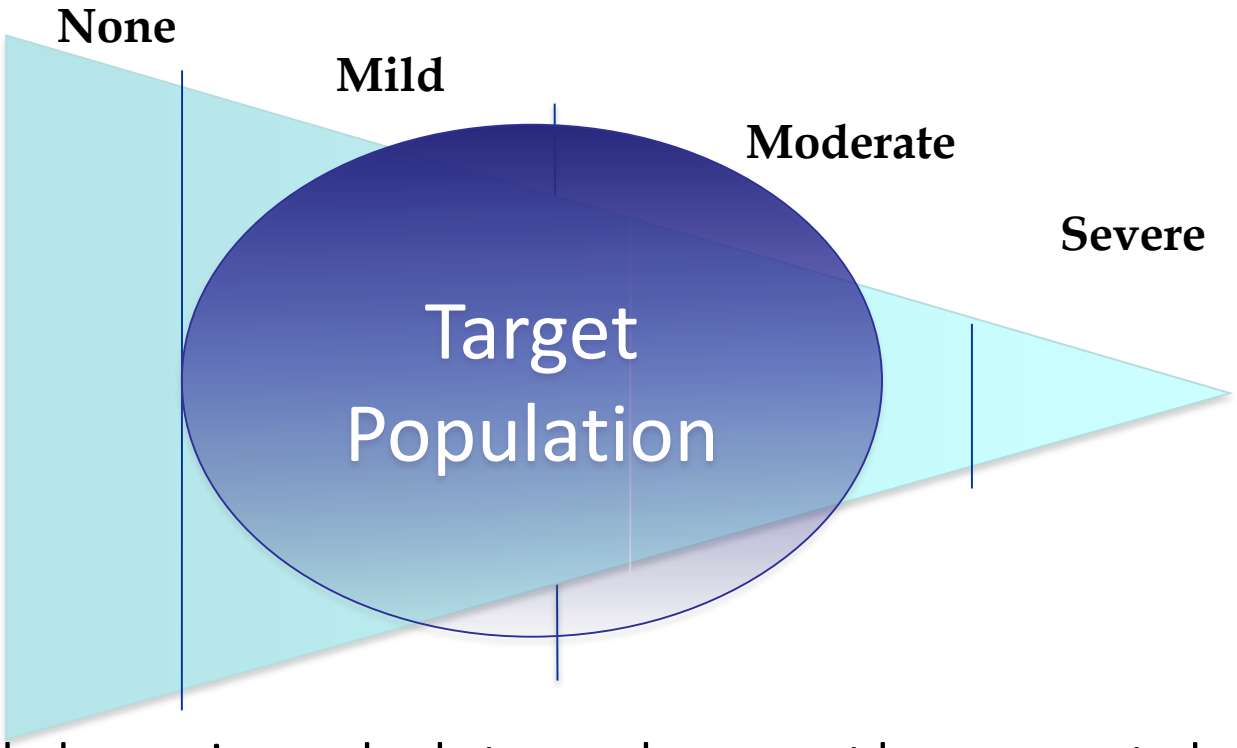
AMERICAN PSYCHIATRIC ASSOCIATION



CENTRALIZED CARE MANGER SUPPORTING MULTIPLE SMALL PRACTICES



"SWEET" SPOT FOR THE COLLABORATIVE CARE MODEL



- Issues with depression and substance abuse must be pre-empted, rather than treated once advanced.
- Goal is to detect early and apply early interventions to prevent from getting more severe

POPULATION-BASED CARE

AMERICAN PSYCHIATRIC ASSOCIATION

Caseload Overview

			Treatment Status				PHQ-9				GAD-7				Psychiatric Consultation	
			! Indicates that the most recent contact was over 2 months (60 days) ago				✓ Indicates that the last available PHQ-9 score is at target (less than 5 or 50% decrease from initial score) ! Indicates that the last available PHQ-9 score is more than 30 days old				✓ Indicates that the last available GAD-7 score is at target (less than 10 or 50% decrease from initial score) ! Indicates that the last available GAD-7 score is more than 30 days old					
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score	% Change in GAD-7 Score	Date of Last GAD-7 Score	Flag	Most Recent Psychiatric Consultant Note
View	Active	Susan Test	9/5/2015	2/23/2016	10	26	22	14	-36%	2/23/2016	18	17	-6%	! 1/23/2016	Flag for discussion & safety risk	1/27/2016
View	Active	Albert Smith	8/13/2015	! 12/2/2015	7	29	18	17	-6%	! 12/2/2015	14	10	-29%	! 12/2/2015	Flag for discussion	
View	Active	Joe Smith	11/30/2015	2/28/2016	6	14	14	10	-29%	2/28/2016	10	✓ 6	-40%	2/28/2016	Flag for discussion	2/26/2016
View	Active	Bob Dolittle	1/5/2016	3/1/2016	3	9	21	19	-10%	3/1/2016	12	10	-17%	3/1/2016	Flag as safety risk	2/18/2016
View	Active	Nancy Fake	2/4/2016	2/4/2016	0	4	.	No Score			.	No Score				
View	RP	John Doe	9/15/2015	3/6/2016	10	25	20	✓ 2	✓ -90%	3/6/2016	14	✓ 3	✓ -79%	3/6/2016		2/20/2016

FREE UW AIMS Excel® Registry (https://aims.uw.edu/resource-library/patient-tracking-spreadsheet-example-data)

Allows proactive engagement (“no one falls through the cracks”) and treatment adjustment!

EVIDENCE BASE

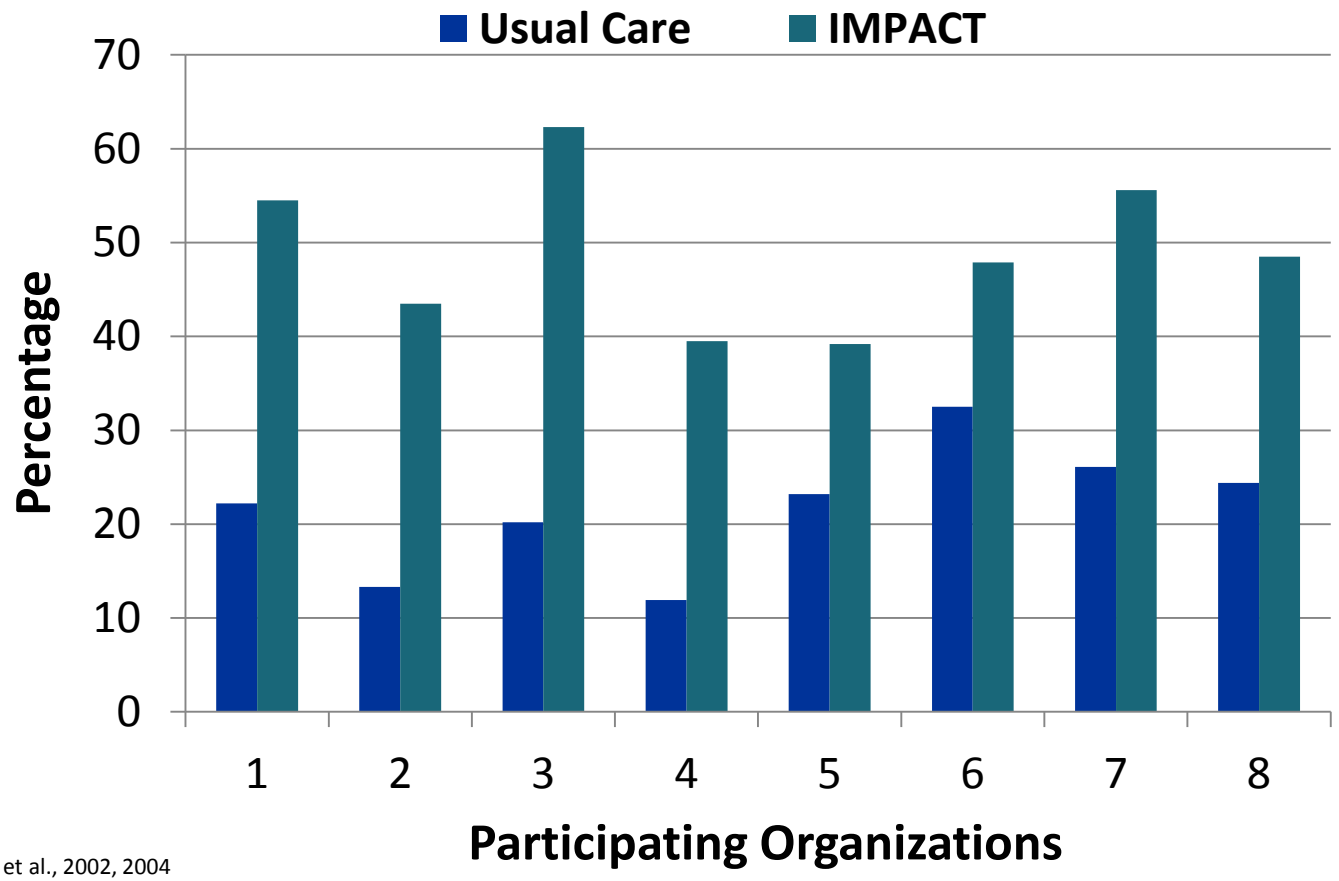
AMERICAN PSYCHIATRIC ASSOCIATION

- **79 randomized controlled trials**
  - 24,308 enrolled patients
- **Compared to usual care (screening, referral etc.)**
  - ↑ Response and remission rates
  - ↑ Quality of life
  - ↑ Patient satisfaction
  - ↓ Costs over the long run
- **Results are consistent across populations**
  - Stages of life
    - Adolescents → Adults → Older Adults
  - Minorities
  - Diagnoses
    - Depression, Anxiety, SUD
- **Effective integration has the potential to save $26.3-$48.3 billion in overall healthcare spending**
  - Melek, S., D.T. Norris, and J. Paulus, Economic Impact of Integrated Medical-Behavioral Healthcare. Milliman, 2014.

TWICE AS MANY PEOPLE IMPROVE

AMERICAN PSYCHIATRIC ASSOCIATION

50 % or greater improvement in depression at 12 months



Unützer et al., 2002, 2004

IMPACT

IMPACT: SUMMARY

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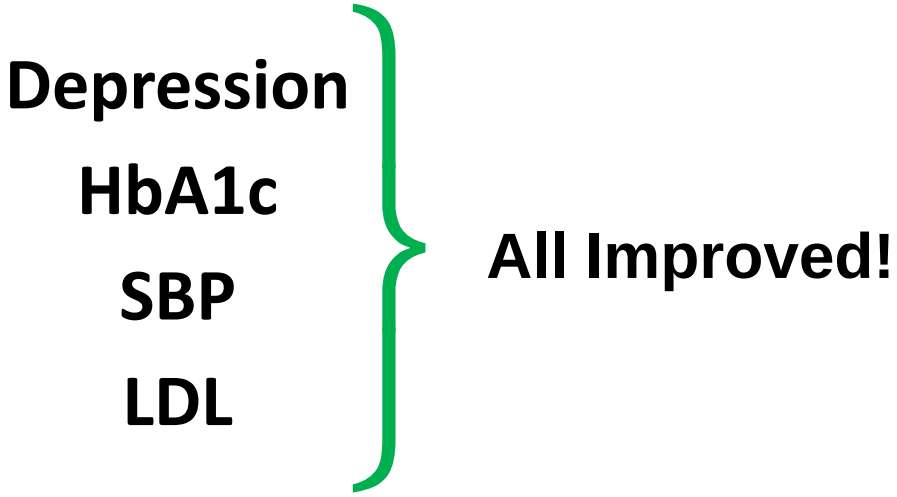
1) **Improved Outcomes**
   - **Less depression**
   - **Less physical pain**
   - **Better functioning**
   - **Higher quality of life**
2) **Greater patient and provider satisfaction**
3) **More cost-effective (ROI $6.50: 1)**

"I got my life back"

THE TRIPLE AIM

IMPACT

TEAMCARE OUTCOMES



COST SAVINGS: $600 - $1,100 per patient

PCP: ”WHY AM I DOING THIS?”

AMERICAN PSYCHIATRIC ASSOCIATION

- These patients are already your patients.
- They are not going away.
- We can help with clinic workflow, shorten long appointments, limit struggles over controlled substances, respond to questions... We have your back!
- Can help with chronic disease outcomes, IMPROVE YOUR METRICS!

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PAYMENT

COLLABORATIVE CARE IS NOW REIMBURSABLE

AMERICAN PSYCHIATRIC ASSOCIATION

Key Elements of the codes:

1. Active treatment and care management using established protocols for an identified patient population;

2. Use of a **patient tracking tool** to promote regular, proactive **outcome monitoring** and treatment-to-target using validated and quantifiable clinical rating scales; and

3. **Regular (typically weekly) systematic psychiatric caseload reviews and consultation by a psychiatric consultant, working in collaboration with the behavioral health care manager and primary care team**. These primarily focus on patients who are new to the caseload or not showing expected clinical improvement.

CCM CODES

- **Payment** goes to the **PCP** who bills the service
- Billed on a per patient basis for those that have met the established time thresholds
- The psychiatrist **does not bill** separately.
  - contract with the PCP practice
- The patient must provide **general consent** for the service and they will have a **co-pay**
- Interaction does not have to be face-to-face
- Care manager and psychiatrists can also bill additional codes for therapy etc.

NEW MEDICARE CODES

AMERICAN PSYCHIATRIC ASSOCIATION

**Includes the payment for the time and effort of all three members of the team - the PCP, the BHCM and the consulting psychiatrist*

- G0502: Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manger activities (billable at 36 minutes)

- G0503: Subsequent psychiatric collaborative care management, first 60 minutes in subsequent calendar month of behavioral health care manager activities (billable at 31 minutes)

- G0504: Initial or subsequent psych collaborative care management - each additional 30 min

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TRAINING FOR PRIMARY CARE PHYSICIANS & PSYCHIATRISTS

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- ✓**Psychiatrists**
- ✓**Joint PCP and Psychiatrist**

On line training Modules

- ✓**PCP**
- ✓**Psychiatrists**

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Submitted By	Organization	Testifier Position	Present at Hearing
Kaulana Dameg	Individual	Support	No

Comments:

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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