Children and Youth Behavioral Health Work Group – Behavioral Health Integration (BHI) Subgroup

August 29, 2023

Glossary of Terms

AHRQ: (national) Agency for Healthcare Research and Quality

BHI: Behavioral Health Integration

CHW: Community Health Worker

HCA: Washington State Health Care Authority

Meeting Topics

- Sheryl Morelli, MD, MS presented on care coordination to support behavioral, socio-emotional health and social determinants of health.
  See page 5 for meeting slide deck
- Group discussion on the presented information and prioritizing recommendations to pursue.
- Discussion of submission timeline led by Behavioral Health Catalyst

Proposed Recommendation

Recommendation	Description
Screening Reimbursement & Behavioral Health Integration	Consider proposing that the Legislature fund community health workers and staff fulfilling similar functions to do activities of care coordination for behavioral health and social determinants in primary care, using the following funding mechanisms: 1. Fully fund screening in primary care for behavioral health issues so that when a child (or parent of an infant) screens positive for a behavioral, social or financial need, community health workers or similar roles can ensure appropriate referrals to services and can follow up to ensure that services were obtained and effective. 2. Direct the Health Care Authority to adopt General Behavioral Health Integration code 99484 and to adequately fund reimbursement for services billed under that code, including by community health workers or similar non-licensed team members.

Discussion Summary

1. *Care Coordination to Support Behavioral and Socio-Emotional Health* presentation by Sheryl Morelli, MD, FAAP

a. Following the AHRQ guidelines, care coordination is defined as deliberately organizing patient care activities and sharing information among all the participants concerned with a patient's care to achieve safer and more effective care.
b. Importance of care coordination in WA State
    i. Youth mental health crisis:
        1. About 25% of pediatric patients seen in primary care experience a chronic mental health condition, with only one in five of those going on to receive treatment.
        2. About 43% of these children have care coordination needs with almost half of these needs going unmet.
            a. *These statistics are from 2015. The subgroup would be interested in a study of current conditions.
    ii. Care Coordination
        1. Lowers health care costs
        2. Improves outcomes for vulnerable children
        3. Helps connect and address care, responding to needs identified through screenings
        4. Improves care in out-patient settings and during high-risk care transitions
c. Current state of the pediatric screening and care coordination funding on Medicaid:
    i. Thanks to a decision package the HCA submitted, in the 2023 state legislative session the legislature increased funding for pediatric screenings (cpt 96110, 96127, 96160, 96161) effective January 2024.
    ii. Beginning January 2024, reimbursement for developmental screenings (96110) will cover 100% of the cost to: screen a patient, interpret the screen, refer and ensure needed services are received for children who screen in need. .
    iii. However, reimbursement for behavioral and social determinants screenings (cpt 96127, 96160, 96161) still falls short of covering the costs to screen, interpret, refer, and ensure services for those who screen in need, as follows:
        1. Post partum depression screens are funded at 65% of cost
        2. Behavioral health screens are funded at 51% of cost
        3. Social determinants screens are funded at 35% of cost
    iv. Recommendation would build upon the HCA and legislature's 2023 efforts to increase Medicaid pediatric screening reimbursement to full coverage forpost-partum depression, behavioral health, and social determinants of health screenings.
d. Behavioral Health Integration models
    i. BHI code 99484
    ii. Includes care management services and planning for behavioral health conditions, including systematic assessments, and monitoring, care plan revision for patients not progressing or whose status changes, facilitating and

coordinating treatments, continuous relationships with the beneficiary and collaborative, integrated relationships with the rest of the care team.

iii. These models rely on continuity of care with a designated member of the care team, not including administrative or clerical staff time, who may or may not be a professional who meets all the requirements to independently deliver and report services and may include a behavioral health care manager or psychiatric consultant if it is best fit.

e. Transitional Care Management
    i. Care codes 99495 and 99496
    ii. Care management and coordination services for patients whose psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an in-patient hospital setting, partial hospital to community setting.
    iii. Post-discharge requires a face-to-face visit and initial patient contact within 7 or 14 days (about 2 weeks).
    iv. This service is not designated for patients discharged from the emergency department.
    v. Transitional care management also includes non-face-to-face services administered by clinical staff that includes communicating with the patient and the agencies/community service providers they utilize, educating the patient and their support team, assessing, and supporting treatment adherence, identifying available community and health resources, and helping the patient and family access needed care and services.

2. Group Discussion
    a. There is a desire for more information on parity with commercial insurance & deductibles in screenings. The subgroup would like to consider advocacy avenues on this point. Follow-up conversation needs to occur with the Office of the Insurance Commissioner.
    b. Based on family, patient and provider feedback, there is a need for building trust in the context of care. The subgroup would like to see a dedicated effort to develop educational and racial, ethnic, and cultural congruence in the screening process, and expanding screenings to be more family centered.
        i. Community Health Workers (CHWs) can bridge some of that trust and the chasm of disconnect between the backgrounds of patients and families and those of practitioners.
        ii. There is growing concern with form-induced trauma and providers asking sensitive questions without the proper follow-up and wraparound services.
    c. HCA (Health Care Authority) offered to provide additional information on the history and origins of the 2023 decision package and is open to receiving feedback on the billing guide.
    d. Intentionality around non-duplication of services. There is a need for a bridging role between clinicians and CHWs and co-location of behavioral health professions, whether embedded or outside the clinical setting.

e. The group would also like to explore expanding telehealth options to increase accessibility.
f. While funding Transitional Care Management codes would provide important support for children and teens post inpatient psychiatric hospitalization, these codes would also be "opened up" for transitional care for all enrollees post hospitalization for physical reasons as well. The scale and cost of this would be significant yet the children and teens for whom it would help post psychiatric hospitalization are quite small. The group prefers advocating for care coordination that will reach larger populations of children. Pursuing these codes requires more research and development. Not to be pursued this session.

Next Steps

- Finalize recommendations to be submitted in the 2024 session.
- Build out recommendation package for presentation at the September 22nd working group meeting.

Care Coordination to Support Behavioral and Social-Emotional Health

CYBHWG: BHI Subgroup
August 29, 2023

Sheryl Morelli, MD, FAAP
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Agenda

- Define Care Coordination
- Present Three Options for Funding Care Coordination
- Discuss Options
- Summarize Feedback and Agree on Next Steps

Care Coordination

AHRQ Definition: Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

https://www.ahrq.gov/ncepcr/care/coordination.html

Care Coordination for Mental Health and Social Needs

Mental health crisis for children and teens

- ~ 25% pediatric patients seen in primary care experience a chronic mental health condition; one in five receive treatment
- ~ 43% of children with mental health conditions have care coordination needs; almost half of these needs go unmet

Care coordination

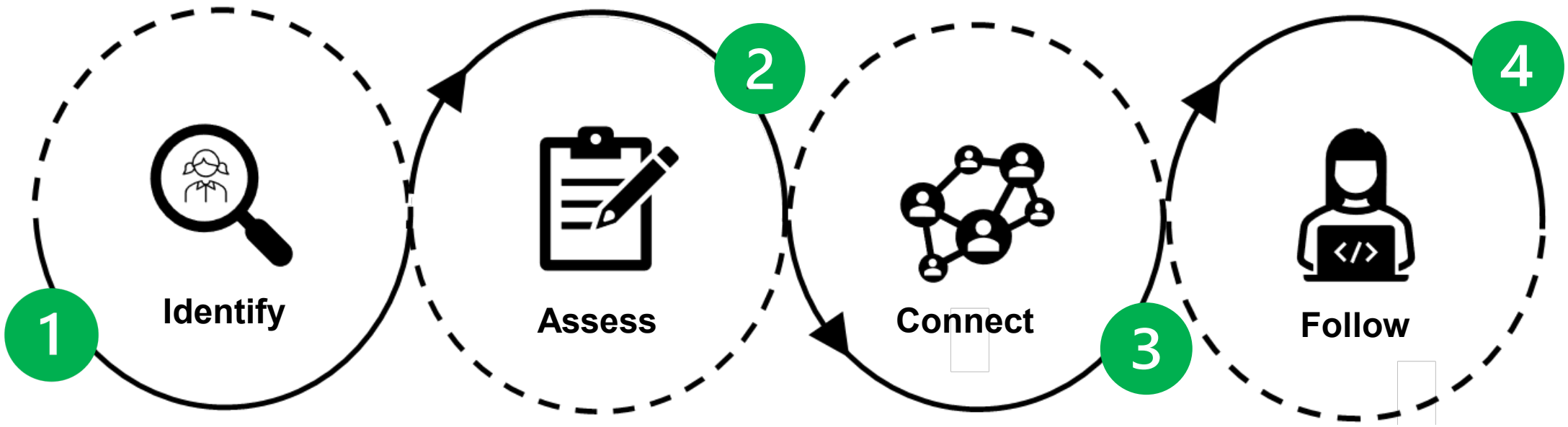
- Lowers health care costs
- Improves outcomes for vulnerable children
- Helps connect and address care for needs identified in population-level (universal) screening
- Improves care for kids with diagnosable mental health conditions in outpatient settings and during high-risk care transitions

Proposal 1: Increase screening rates on Apple Health to allow for completion of assessment, referrals and follow-up generated from positive universal screenings (cpt: 96127, 96160, 96161) ~ $6-7 million per year

Proposal 2: Allow and fund for Apple Health Behavioral Health Integration cpt 99484 ~ $1-2 million per year (for pediatric population)

Proposal 3: Allow and fund for Apple Health Transitional Care Management cpt 99495, 99496

Screening and Care Coordination Process



100% Screened | 10-15% Assess, Connect and Follow

Universal Screening	Indicated Evaluation	Individualized Connection	Comprehensive Follow-Up
• Postpartum depression • Social, emotional, behavioral	• Assess • Determine acuity	• Refer to services • Assist in connection	• Track referrals • Monitor and reassess

Screening and Care Coordination Cost

	Cost per screen	2024 Reimbursement per screen*	% Total cost reimbursement*	Total Increased Cost *(If kids come for well-care at national Medicaid HEDIS rates, 75th percentile)*
DEV	$8.00	$12.20	100%	$0
PPD	$9.32	$6.10	65%	$195,392
BH	$11.32	$5.82	51%	$2,243,362
SDoH	$9.88	$3.50	35%	$4,659,179

* Washington State 2023-2025 Operating Budget includes funding 100% increase in screening reimbursement effective January 1, 2024

Behavioral Health Integration

WHAT:

- Services delivered using **BHI models** of care other than Collaborative Care
- Care management services for behavioral health conditions
- Behavioral health care planning, including:
  - Systematic assessment and monitoring
  - Care plan revision for patients not progressing or whose status changes
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, or psychiatric consultation
- Continuous relationship with the beneficiary and a collaborative, integrated relationship with the rest of the care team

WHO:

- Continuity of care with a designated member of the care team
- May or may not be a professional who meets all the requirements to independently deliver and report services
- Does not include administrative or clerical staff time
- May include (but not required to include) a behavioral health care manager or psychiatric consultant

Behavioral Health Integration Services Booklet (cms.gov)

Behavioral Health Integration

99484: Care Management Services for Behavioral Health Conditions Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month, with the following required elements:

- Initial assessment or follow-up monitoring, including using applicable validated rating scales
- Behavioral health care planning about behavioral or psychiatric health problems, including revision for patients not progressing or whose status changes
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, or psychiatric consultation
- Continuity of care with an appointed member of the care team

Behavioral Health Integration Services Booklet

Transitional Care Management

WHAT

- Care management and coordination services for patients whose psychosocial problems require moderate or high complexity medical decision-making during transitions in care from an inpatient hospital setting, partial hospital to community setting
- Post-discharge requires a face-to-face visit, initial patient contact, within specified timeframes (7 or 14 days)
- Not for patients discharged from the emergency department

WHO

Face-to-Face Services and *Supervise auxiliary personnel* (including clinical staff):

- Physicians (any specialty) and Non-physician practitioners: Certified nurse-midwives (CNMs), Clinical nurse specialists (CNSs), Nurse practitioners (NPs) and Physician assistants (PAs)

Non-Face-to-Face Services: Clinical staff under your direction

- Communicate with the patient and agencies and community service providers the patient uses
- Educate the patient, family, guardian, or caregiver to support self-management, independent living, and activities of daily living
- Assess and support treatment adherence, including medication management
- Identify available community and health resources
- Help the patient and family access needed care and services

Transitional Care Management

99495 - Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision-making (MDM) of at least moderate complexity during the service period; Face-to-face visit, within 14 calendar days of discharge

99496 Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; Medical decision-making of high complexity during the service period; face-to-face visit, within 7 calendar days of discharge.

Transitional Care Management Services (cms.gov)

Appendix

Data:

Washington State Office of Financial Management

2020 Washington Census Data

Child < 19

Total: 1,885,556

Age	Total	Medicaid
0-4	449,128	197,616
5-9	481,674	211,937
10-14	486,751	214,170
15-19	465,069	204,630

ofm_pop_age_sex_postcensal_2010_2020_s.xlsx (live.com)

Healthier Washington

2020 Medicaid Enrollment

Child < 19

Total Medicaid: 824,038

Workbook: MedicaidExplorer (wa.gov)

824,038/1,882,622 = 44% child < 19 Medicaid

Salaries:

Social Work (SW)	$48,000-53,000/year
Behavioral Health (BH)	$60,000-95,000/year
Medical Assistant (MA)	$38,400-$42,240/year
Care Coordinator (CC)	$28,000-$38,400/year

Estimated cost for population level documenting, tracking and reporting for all screening and care coordination ~ $1.50-2.00 per member per month (includes paying for tools/technology used to support this work and paying for medical director, behavioral health director and clinic administrator time to design, implement and assess the reports) NOT included in this financial model.

Coding Preventive Care.pdf (aap.org)

Developmental Reporting (aap.org)

Appendix

Evidence-Based Recommendations:

Developmental nationally 10-15% positive screening

Promoting Optimal Development: Identifying Infants and Young Children With Developmental Disorders Through Developmental Surveillance and Screening | Pediatrics | American Academy of Pediatrics (aap.org)

Universal Mental Health and Developmental Screening in the Medical Home: Screening Rates and Prevalence of Abnormal Results | Pediatrics | American Academy of Pediatrics (aap.org)

Preventive Care/Periodicity Schedule (aap.org)

Postpartum Depression nationally 11-18% positive screening increasing to 25% in low-income populations

Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice | Pediatrics | American Academy of Pediatrics (aap.org)

Integrating Postpartum Depression Screening in Your Practice in 4 Steps (aap.org)

Behavioral/social/emotional Health nationally 10-20 % positive screening

Promoting Optimal Development: Screening for Behavioral and Emotional Problems | Pediatrics | American Academy of Pediatrics (aap.org)

Screening Tools: Pediatric Mental Health Minute Series (aap.org)

Universal Mental Health and Developmental Screening in the Medical Home: Screening Rates and PPreventive Care/Periodicity Schedule (aap.org)

revalence of Abnormal Results | Pediatrics | American Academy of Pediatrics (aap.org)

Social Determinants of Health (SDoH) nationally 12% positive screening up to 25% in low income populations

Screening Children for Social Determinants of Health: A Systematic Review | Pediatrics | American Academy of Pediatrics (aap.org)

Screening for Social Determinants of Health Among Children and Families Living in Poverty: A Guide for Clinicians - PMC (nih.gov)

SHD Fact Sheet FINAL.pdf (aap.org)

Appendix

EPSDT Well-Child Checkups

EPSDT requires a periodic well-child checkup with the client's primary care provider (PCP). HCA's expectations for the recommended frequency of checkups align with the American Academy for Pediatrics (AAP) Bright Futures Periodicity Schedule, including:

Infancy					
1st week	1 month	2 months	4 months	6 months	9 months

Early Childhood						
12 months	15 months	18 months	24 months	30 months	3 years	4 years

Middle Childhood and Adolescence
One checkup every calendar year for ages 5 through 20 years

Note: Children in foster care may receive additional EPSDT well-child checkups. See EPSDT Well-Child Checkups and Foster Care for more information.

Condition	CPT® Code	Additional information
Developmental Screening	96110	A structured developmental screen is required for ages 9 – 11 months, 18 months and 30 months
Autism Screening	96110	A structured autism screen is required at ages 18 months and 24 months.
Depression Screening	96160 96127	HCA covers one structured depression screening every year for children ages 12 and older. If more frequent screening is needed, providers can submit a limitation extension (LE) request to HCA. See What is a Limitation Extension (LE).
Caregiver and Parent Depression Screening	96161	Caregivers of infants ages 12 months and younger must be screened for depression. Submit claims using the infant's ProviderOne client ID. When billing for a fee-for-service (FFS) client, use EPA # 870001424*.
General Behavioral Health Screening Tools	96160 96127	
Tobacco, Alcohol, and Drug Screening	96160 96127	

[Legislatively funded managed care rate increase overview (wa.gov)]