Rhode Island Office of the Health Insurance Commissioner

Integrated Behavioral Health Work Group

Final Report

August 7, 2019

I. Introduction

In 2018, the Legislature added new powers and duties to the Office of the Health Insurance Commissioner's (OHIC) charge focused on working with other state agencies and insurers to improve the integration of physical, mental health, and unhealthy substance use care in the primary care setting, herein referred to as "behavioral health integration." OHIC has made a priority of working with insurers and other stakeholders to improve access to integrated behavioral health services. As a first step, OHIC sought to understand what administrative barriers existed to providing integrated behavioral health in the primary care setting. In May and June of 2018, Bailit Health interviewed individuals from six organizations selected by OHIC to identify any such administrative barriers. As a result of these interviews, and Bailit Health's review of the Care Transformation Collaborative of Rhode Island's (CTC-RI) evaluation of its Integrated Behavioral Health Pilot program, we identified the following administrative barriers to behavioral health integration:

a. Patients are required to pay two co-payments on the same day for behavioral health services delivered in an integrated primary care setting;
b. There is variation in billing and coding policies for integrated services, causing confusion among practices and inconsistencies in what services are reimbursable; and
c. There is variation in payer credentialing of provider practices in an integrated environment.

In its 2019 Care Transformation Plan, OHIC established the Integrated Behavioral Health Work Group (Work Group) to identify potential solutions to the aforementioned barriers. This report provides a summary of the Work Group meetings, recommendations made by the Work Group, and a brief discussion of topics that were unaddressed in the scope of this Work Group's charge that could be considered in the future.

The Work Group met four times between February and June 2019. Each meeting was well attended by between 40 and 50 people. (See Appendix A for a list of attendees). Among the people attending were representatives of integrated and non-integrated primary care practices, behavioral health providers practicing in integrated and non-integrated settings, hospital-based systems, community health centers, health insurers, and consumer organizations. Also attending were state staff representing OHIC, the State Innovation Model (SIM) grant program, the Executive Office of Health and Human Services (EOHHS), RI Medicaid, the Department of Health, and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). Each meeting was jointly facilitated by Bailit Health and OHIC Principal Policy Associate, Marea Tumber.

In between meetings, OHIC and Bailit Health interviewed three primary care practices and administered a survey to insurers. Data from the primary care practices and insurers was sought to help quantify the administrative barriers being discussed, and to identify payer policies and practices related to the issues of focus. Findings from these information gathering efforts were used to support Work Group discussions.

II. Summary of Work Group Proceedings and Recommendations

The following is a summary of the discussions and, where applicable, the resulting recommendations, organized by administrative barrier. The recommendations that are included in this report were developed by the Work Group and discussed over the course of the four meetings.[1] The Work Group was facilitated using a consensus-based approach, where each member had the opportunity participate in the discussion, offer suggestions, review proposed recommendations in advance of each meeting, and discuss them during the meeting. While these recommendations represent the consensus of the Work Group, they do not necessarily represent the individual opinions of any Work Group member or organization.[2]

A. Patients being charged two copayments for services received in an integrated primary care practice on the same day.

The barrier, as reported to OHIC, was that some patients had refused warm hand-offs[3] to, or a brief intervention by, behavioral health providers if they occurred on the same day as a primary care visit because it would trigger a copayment. In some instances, this would be the second copayment for a patient for what might be perceived as a continuation of the care the patient had been receiving at the primary care practice.

Information received from the insurers showed that one payer did waive (or reduce) copayments for primary care visits to practices that were certified Patient Centered Medical Homes (PCMHs) and for practices that documented evidence of practicing the Collaborative Care Model.[4] However, no insurer waived copayments for behavioral health services that occurred on the same day and in the same location as a primary care service; copayments were applied consistent with the member benefit. Data received from the insurers suggested that a small percentage (i.e., 2–6%) of patients had had a primary care visit and a behavioral health visit on the same day. The Work Group felt the insurers' estimates were accurate but noted that the rates of members with two visits on the same day were low because: a) patients may reject services when there is a second copayment, and b) some practices did not bill for the co-located behavioral health service to prevent the copayment from being billed to the patient. Finally, primary care practices interviewed in March 2019 did not report receiving patient complaints about copayments for an integrated behavioral health visit. The

[1] The recommendations in this report apply only to commercial insurance products in fully insured lines of business, and not self-insured lines of business. These recommendations may not apply to all high deductible health plans (HDHPs).
[2] After the final meeting, BCBSRI expressed concerns in writing to OHIC about the recommendations.
[3] A warm hand-off is a technique used by primary care practices to personally introduce a patient to a behavioral health provider.
[4] According to CMS, the Collaborative Care Model refers to "a model of behavioral health integration that enhances "usual" primary care by adding two key services: care management support for patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose conditions are not improving."

Work Group thought this was because the behavioral health provider may be more likely to field such complaints, and again reiterated that some practices may not bill for the behavioral health visit in order to reduce the financial burden to the patient.

The Work Group considered three possible options to ameliorate this issue: (1) require no copayment for behavioral health visits on the same day and in the same location as a primary care visit; (2) require no copayment for behavioral health visits on the same day as a primary care visit, regardless of location; and (3) require insurers to apply a lower or no copayment for practices that obtain external recognition for behavioral health integration.

To help deliberate these three options, and in particular option (3), the Work Group received a briefing on the NCQA Behavioral Health Distinction Program, which was at the time the only known external recognition program for behavioral health integration. Nelly Burdette and Denise Andrade from Providence Community Health Center described the requirements of the NCQA Behavioral Health Distinction program and the efforts they undertook to achieve the honor. The Work Group weighed the benefits vs. burdens of applying for and working toward the NCQA Behavioral Health Distinction Program noting that its requirements may be too steep for many primary care practices in Rhode Island.

As a result of the Work Group's deliberation, the following recommendation was made:

Recommendation: Payers should eliminate copayments for patients who have a behavioral health visit with a qualified in-network behavioral health provider on the same day and in the same location as a primary care visit at a qualifying primary care practice. The Work Group felt this recommendation would remove the financial burden faced by patients receiving integrated behavioral health services on the same day as a primary care visit, and a barrier to integrated care. The suggested implementation steps identified by the Work Group seek to make an immediate impact on patients receiving care from integrated practices, while also incentivizing more practices to work toward NCQA Behavioral Health Distinction Program recognition and achieve evidence-based models of integration.

Suggested Implementation Process:

1. Payers would need to develop a code modifier or another process that when implemented by practices is as consistent as possible across payers and approved by OHIC. A code modifier or other such process is to be used by behavioral health providers in designated (see step #2) primary care practices to indicate that a qualified visit is occurring on the same day and in the same location as a primary care visit. No copayments should be applied to these services.
2. To identify which behavioral health providers are designated to waive copayments for qualified behavioral health visits, OHIC should add a limited set of questions regarding behavioral health integration to the existing OHIC annual PCMH survey. OHIC would then communicate to the payers which practices are eligible to have their co-located behavioral health providers waive

copayments for qualified behavioral health visits.[5] During 2019[6] and annually thereafter, such questions should include:

a. Has the practice received the NCQA Behavioral Health Distinction, or is the practice receiving facilitated assistance from a formal program designed to assist primary care practices in achieving the NCQA Behavioral Health Distinction?[7] *If yes, practice is eligible. Practices may only be designated eligible by virtue of receiving facilitated assistance for up to three years in order to encourage practices to work toward NCQA Behavioral Health Distinction.*
b. Does the practice currently, or did the practice participate in and successfully complete the CTC Integration Behavioral Health Program? *If yes, practice is eligible. Practices may only be designated eligible through this option for up to three years in order to encourage practices to work toward NCQA Behavioral Health Distinction.*
c. If option (a) or (b) are not applicable, has the practice completed a behavioral health integration self-assessment tool and developed an action plan for improving its level of integration? Self-assessment tools include, but are not limited to: Organizational Assessment Toolkit for Primary and Behavioral Health Care Integration, the PCBH Implementation Kit, and the Maine Health Access Foundation Site Self-Assessment. *If the practice has submitted an attestation indicating it has completed an assessment and developed an action plan, then the practice is eligible. Practices may only be designated eligible through this option for up to three years in order to encourage practices to work toward NCQA Behavioral Health Distinction. Practices must attest to having made demonstrable progress towards achieving NCQA Behavioral Health Distinction in their year 2 and 3 attestations, if applicable.*

Practices deemed eligible would have the behavioral health provider's copayment waived for their patients for same day/same location services starting January 1, 2021, or January 1 of the calendar year following their successful qualification of the above options. Practices may not qualify for waived copayments for qualified behavioral health visits that occur on the same day and in the same location using options (b) or (c) for more than three years in either option, or in total.

The codes that would be eligible to have no copayment are the most commonly used codes for behavioral health services integrated into the primary care setting identified by CTC. They are listed in the table below.

CPT Categories	**CPT Code Range**
Behavioral Health	90791-90792, 90832-90837, 90839-90840, 90846,

[5] When a practice becomes eligible for same-day, same-location copayments to be waived, the behavioral health provider delivering the service is eligible regardless of whether the behavioral health provider is contracted or employed by or with the primary care practice.
[6] Practice data collected in the fall of 2019 will inform insurer plan design administration for the year starting January 1, 2021.
[7] A formal program consists of a structured training or support program for primary care providers and/or behavioral health providers with a pre-defined curriculum and technical assistance and designed to systematically build the skills within the practice with a goal of pursuing and attaining NCQA Behavioral Health Distinction.

	90847, 90849, 90853, 90863
Psychiatric Collaborative Care Management and Behavioral Health Care Management	99492-99494, 99484
SBIRT	99408-99409
HABI Codes	96150-96155

B. Variation in billing and coding policies for integrated services, causing confusion among practices and inconsistencies in what services are reimbursable.

Variation in billing and coding for integrated behavioral health services constitutes a wide category of topics. The specific issues the Work Group focused on in this category were related to a) the reimbursement of Health and Behavior Intervention (HABI) codes; b) concerns about certain screening codes triggering patient obligations to pay out-of-pocket costs; and c) reimbursement for warm hand-offs. A summary of each these topics and their recommendations appears separately below.

a) HABI codes: HABI codes (96150-96154) are used for services that identify and manage the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems. These codes are used to reimburse behavioral health providers for providing behavioral health intervention techniques to help a patient manage a medical condition. For example, these codes could support a behavioral health provider in teaching coping skills to a group of patients with diabetes, or to use behavioral health techniques to support a patient newly diagnosed with a chronic medical condition. These codes are not designed to treat behavioral health conditions as the primary diagnosis. Information collected for this Work Group showed that there was variation in use of the HABI codes among integrated primary care practices, and variation in HABI code payer reimbursement policies.

   All four commercial insurers participating in OHIC survey indicated that they reimburse for the HABI services. However, their reimbursement policies varied. For example, one payer would not allow these codes to be used if the patient had a behavioral health condition, whereas others would. Additionally, one payer required a primary care visit to make a referral to a behavioral health provider for services covered by these codes. Finally, data from the All-Payer Claims Database (APCD) pulled by OHIC showed that one payer did not pay claims (though also did not deny claims) for these codes. The Work Group noted that the variation in payer policy was problematic and agreed on the following recommendation.

   Recommendation: Payers should adopt policies for Health and Behavior Assessment/Intervention (HABI) codes that are no more restrictive than current CMS' Coding Guidelines for HABI codes.

b) Out-of-pocket costs for behavioral health screening:

Primary care practices interviewed in March 2019 reported receiving complaints from patients with "surprise," however low-dollar, coinsurance payments for behavioral health screenings conducted in the primary care setting. Work Group members noted that preventive services should be covered with no cost sharing requirements under the federal requirements. Specifically, Section 2713 of the Patient Protection and Affordable Care Act (ACA) requires insurers offering group or individual coverage to provide coverage for and not impose any cost sharing requirements for certain preventive health services, including developmental and behavioral health services, such as alcohol misuse screening and counseling, autism screening, developmental screenings, and surveillance, psychosocial / behavioral assessment and depression screening.[8,9] OHIC never received the specifics of these complaints to identify the exact origin of the issue, particularly whether the complaints were from patients with non-commercial plans or commercial plans that were not subject to the ACA requirements (e.g., self-insured employer plans or grandfathered plans).

OHIC surveyed the four commercial insurers to identify their coverage and reimbursement policy, and did find variation in reimbursement policy, specifically related to limits on the number of screenings allowed to be administered per year, and in one payer's case, the limitation of a universal screening code to the pediatric population. For example, one payer does not allow the most commonly used screening code (96127) to be used for adults. Another payer limits the number of times screening, brief intervention and referral to treatment (SBIRT) can be performed with a patient each year. In addition to the ACA requirements, the Work Group wanted to support the practice of universal screening of patients for common behavioral health conditions found in the primary care setting (e.g., depression, anxiety, unhealthy substance use), because of the value and importance of screening, and reduce the administrative burden of varying billing policies. Furthermore, screening for certain conditions is a requirement of Medicaid's Accountable Entities (AE) Program and screening measures for depression, early childhood development and for unhealthy alcohol and drug use are included in the OHIC Aligned Measure Sets.

Some Work Group members, however, did express concern that a recommendation should only follow evidence-based practices for screening. However, there is currently a lack of clear evidence for the frequency of screening for many conditions. According to the United Stated Preventive Services Task Force (USPSTF), for example, "a pragmatic approach in the absence of data [regarding evidence for how frequently to screen for depression] might include screening all adults who have not been screened previously and using clinical judgement in consideration of risk factors, comorbid conditions, and life events to determine if additional screening of high-risk patients is warranted.[10] As a result of the Work Group's deliberation, they made the following recommendation.

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[8] The Patient Protection and Affordable Care Act, Sec 2713, Coverage of Preventive Services.

[9] Kaiser Family Foundation. "Preventive Services Covered by Private Health Plans under the Affordable Care Act." August 4, 2015.

[10] U.S. Preventive Services Task Force. Depression in Adults: Screening. January 2016. https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1?ds=1&s=depression

Recommendation: Payers should remove limits on coverage and eliminate out-of-pocket costs to patients for the most common preventive behavioral health screenings[11] for the most common behavioral health conditions in primary care, so long as the behavioral health screen is clinically appropriate and administered by an individual under their scope of practice and who is eligible to bill payers for their services.

c) Reimbursement for warm hand-off: A warm hand-off is a technique used by primary care practices to personally introduce a patient to a behavioral health provider. Based on the interviews conducted before and during this Work Group's deliberations, it was clear that there was variation in how practices perform warm hand-offs. For example, some behavioral health providers delivered brief interventions after being introduced to the patient, while others were simply performing the introduction. Even though it was described as a "warm hand-off," the issue for the interviewees who discussed this topic was more about reimbursement for the immediately occurring brief intervention than the actual warm hand-off. That is, because some practices chose not to bill for brief interventions (which are reimbursable events) so as to not trigger a patient's copayment liability, they were concerned about lost revenue. However, because the Work Group had made a recommendation to eliminate copayments for qualified behavioral health services that occur on the same day and in the same location as a primary care practice, the Work Group felt that concerns related to "warm hand-offs" had been alleviated. Therefore, no additional recommendation for this topic was made.

C. Variation in payer credentialing of provider practices in an integrated environment

The interviews conducted in the summer of 2018 yielded concerns about the timeliness with which commercial payers were credentialing various members of an integrated care team (e.g., social workers, mental health counselors, or clinical psychologists) and about the payer's network of individuals being closed, therefore preventing additional individuals from being credentialed. OHIC asked each of the four commercial insurers to report the average credentialing time from completed application to approval for licensed social workers, psychologists and other therapy providers. Each of the payers reported meeting the 45-day statutorily mandated turn-around-time and accepting new providers into their network. OHIC did not seek to verify this information through an audit or other investigative means. OHIC instead informed the Work Group members of how to make official complaints to OHIC for instances when practices feel payers are not meeting the statutorily mandated timeframe.

III. Topics for Future Discussion

The Integrated Behavioral Health Work Group had a narrowly defined charge to consider specific administrative barriers. There was additional discussion during the Work Group meetings about

[11] Suggested codes include 96110 (screening of developmental disorders and autism); 96127 (generic screening code for depression, anxiety, ADHD, substance use and eating disorders); 96160 (substance use screening); 96161 (code for postpartum depression screening); 99408 and 99409 (SBIRT).

other important topics related to behavioral health integration that may be worthy of further discussion. They included the following:

a) Identifying Rhode Island's vision for integrated primary care. Frequently during the meetings some Work Group members asked for a better understanding of what the State's vision for integrated primary care is and how can OHIC, its partnering agencies, insurers, providers, and other stakeholders work together to achieve that vision. Some Work Group members felt it was more important to identify a vision for how integration should be achieved and promoted on an overall basis than to address specific administrative barriers.

b) Parity of behavioral health care. Some Work Group members expressed concerns that, overall, there was a lack of parity between behavioral health services and medical health services, which included concerns about whether, and if so which, behavioral health services should be considered preventive medicine.

c) Medicaid reimbursement. Work Group members expressed concerns that Medicaid does not have aligned reimbursement policies with commercial insurers for integrated behavioral health services. Work Group members noted that Medicaid does not reimburse for HABI codes, but that doing so would improve access to integrated services for Medicaid beneficiaries. Further work to identify the challenges and opportunities to align Medicaid reimbursement policies to support integrated behavioral health could be a positive next step in improving integration in the primary care setting.

IV. Conclusion

Integrated behavioral health care is just one important way to improve the quality of care, patient satisfaction, and overall costs of the Rhode Island health care system. This Work Group, established by OHIC, sought to make thoughtful recommendations to relieve some administrative barriers integrated primary care practices and their patients experience. If implemented, these recommendations would be an important step forward in supporting patients who would benefit from accessing behavioral health services in primary care. Further steps should be considered by OHIC, its state partners, and stakeholders to continue to expand access to and availability of integrated primary care practices.

Appendix A: Work Group Participants[12]

Name	Organization
Almeida, Cristina	Optum
Anderson, Kelly	Regis
Andrade, Denise	PCHC
Arruda, Bob	QBH
Bailey, Emily	Tufts Health Plan
Beretta, John	Tufts Health Plan
Bliss, Gary	Prospect CharterCare
Bruce, Susan	Optum
Burdette, Nelly	PCHC/CTC-RI
Cabral, Linda	CTC-RI
Campbell, Melissa	RI Health Center Association
Campbell, Susanne	CTC-RI
Cantor, Liz	CTC-RI
Cerbo, Louis	BHDDH
Chase, Kathleen	Gateway
Clyne, Ailis	RI DOH
Daly, Brian	BHDDH
David, Kristin	RIPCPC
DeCarvalho, Sarah	RIPCPC
Detoy, Steven	Rhode Island Medical Society
DiChristofero, Scott	Lifespan
Durac, Shamus	RIPIN
Feder, Ruth	BHDDH
Galek, Stan	Quality Behavioral Health
Glucksman, Rich	BCBSRI
Glickman, Jill	SIM
Hardy, Jamie	Associates in Primary Care Medicine
Harvey, Matt	Integra
Healey, Jennifer	CCHP
Hunter, Catherine	BHDDH
Hurwitz, Deb	CTC-RI
Jenkins, Brenda	Healthcentric Advisors
Jurczyk, Carol	Blackstone Valley Community Health Center
Kerzer, Martin	Associates in Primary Care Medicine
King, Olivia	BHDDH
Kushnir, Kathy	BHDDH
Lawrence, Melody	EOHHS
Lindberg, Susan	DCYF
Lichtenstein, Michael	Integrated Health Partners
Lavoie, Ray	Blackstone Valley Community Health Center
Mavyn, Drift	APCM

[12] Participants listed attended one or more meetings and signed the attendance sheet. In some cases, misspellings or incorrect names are a result of unclear handwriting.

McCollum, Erin	BHDDH
Morales, Debbie	EOHHS
McGookin, Ed	Coastal Medical
McClaine, Liz	NHPRI
Nacci, Stephanie	OSCU
Okolowitez, Kelsey	Blackstone Valley Community Health Center
Plante, Wendy	Lifespan
Pardus, Sandy	Blackstone Valley Community Health Center
Parker, Victoria	PACE
Philbrick, Isak	Optum Behavioral Health
Phillips, Wendy	ESRI
Richards, Tinisha	UnitedHealthcare
Rosenberg, Marti	SIM/OHIC
Ryan, Kelsey	Coastal Medical
Ray, Corinna	Blackstone Valley Community Health Center
Russ, Cooney	Healthcentric Advisors
Ross, Elizabeth	Tufts Health Plan
Scott, Cindy	Integra
Steinmetz, Gregory	Associates in Primary Care Medicine
Stanton, Laura	Lifespan
Storti, Susan	The Leadership Council
Tassoni, John	SUMHLC
Thompson, Sarah	Coastal Medical
Vandine, Jennifer	BHDDH
Viveiros, Maria	UnitedHealthcare
Welte, Jill	Coastal Medical
Yeracaris, Pano	CTC-RI