Connecting the Dots in your Commercial Contracts

Introduction

This chapter will take everything we have discussed throughout the curriculum thus far, and apply it to adding behavioral health services to your commercial contracts, as it is appropriate. We will review the process as a whole and break it down into steps when it comes to working with your commercial payers.

Key Takeaways

I. Understand that behavioral health policies are different for each payer
II. Know your own capacity when adding behavioral health services
III. Know some key questions you can ask your payer representatives

Section 1.0 – Analyze your payer mix

1.1 - Once you have determined that your practice has the capacity, as well as the patient need, to integrate behavioral health into the range of services offered, the first place to start before adding behavioral health services to your contracts will be to analyze your payer mix. Your payer mix is the breakdown of the various insurances that you accept in your office and the plans/products within each insurance. Analyze your payer mix to understand which payers send the most volume to your practice. This will give you an idea of which patients you see the most, so you can begin to prioritize for your contract negotiations. You can pull this information straight from your EHR system to analyze volume within your practice.

Example:

Payer A = 35% of practice volume

Payer B = 15% of practice volume

Payer C = 20% of practice volume

Payer D = 30% of practice volume

You will want to focus on Payer A to start with because this is where most of your patients are coming from. By prioritizing and negotiating with Payer A first, you will see a greater impact on your overall reimbursement because you see these patients the most.

Keep in mind Anthem Blue Cross Blue Shield and UnitedHealthcare are two of the largest payers in the Colorado market.

1.2 - It is important to analyze your payers, and those respective patient populations, individually because each payer does things differently. Each payer has different plans and products, different policies and procedures, and even different rates and reimbursement structures. When it comes to behavioral health, keep in mind that some of the payers may have a narrow network for behavioral health, while other payers may have benefits through HMO and

PPO products. These are some important things to keep in mind when analyzing your payer mix and working with your payer representatives.

It is important to verify benefits and eligibility prior to scheduling new patients. This will help you identify out of network plans and provide better services to your patients. If you realize you are out of network for a specific plan or product, if possible, you can then refer those patients to a participating provider, or recommend that they visit their insurance plan's patient portal to find an in-network provider in the area.

Section 2.0 – Understand your contracts

2.1 - Now that you have analyzed your payer mix and identified your priority targets for contracting, you will need to review and understand each of those contracts. Considering that each payer has different policies, each contract will be structured differently (we will provide a more in-depth overview of contract structures in Chapter 6). The key things to pay attention to, especially for behavioral health services, will be the reimbursement methodology and contracted rates. Is your contract strictly fee for service, or are you participating in an alternative payment model (APM)? Are you receiving any incentive payments as part of your commercial agreement? These are things to consider as you look to add, or expand, behavioral health services in your agreement to better understand how you will be paid.

2.2 - Coding is an important part of understanding your contracts and reimbursement. Since each health plan is different, they may cover different codes or they may have certain requirements when submitting claims. This focus on coding plays a huge role when adding additional services to your contracts because you need to know what codes to use and how to bill correctly. A good place to start if you do not know the codes for behavioral health would be with the Centers for Medicare and Medicaid Services (CMS). CMS sets the standard in the insurance market, and the commercial payers tend to follow suit. You can visit the CMS website to do your research on those behavioral health codes and what services are covered. We have included a list of "Care Management" codes in the worksheet for this chapter to get you started.

Keep in mind that some behavioral health codes may have specific required elements. One of the easiest things to miss is documented patient consent for these services.

Section 3.0 – Strategize using practice information

3.1 - Adding behavioral health providers for these new services may impact the capacity for your practice overall, not just on the behavioral health side. There are a lot of things to consider, including practice space, provider time, additional costs, training, scheduling, etc. Adding new services is not something to be taken lightly, so you need to prepare for these changes accordingly. One very important piece of your strategy should relate back to the behavioral health codes and how you are tracking this information. It is not enough to just provide these services. You must be able to track this information and then analyze your data. This step will help you understand your own practice, so you can strategize for contract negotiations. As we have said before, understanding your data is almost as important as having it.

3.2 - Use your own practice data and information to analyze the cost of adding these services as it applies to space and personnel costs in your practice. You can look at how many patients you are currently seeing for behavioral health, or predict how many patients you may see in the future, to determine the workload for a new behavioral health provider. When you have an understanding of how many patients you can see (your capacity), that will help you determine how much space you may need to fulfill this demand. Scheduling is another important piece. Do you have enough staff to handle this workload in your office? All of this should be considered part of your strategy as you think about adding, or expanding, behavioral health service in your practice.

Your strategy is the set of choices you use to achieve your overall goal, while the tactics are the specific actions used when applying those strategic choices. As you think both strategically and tactically, you need to consider each health plan and their products.

Section 4.0 – Have the conversation with your payers

4.1 - Now that you have analyzed your payer mix, reviewed your contracts, and put together your strategy, you are ready to have a conversation with your payers about behavioral health services in your practice. Whether you are already providing these services and looking to renegotiate your contract, or if you are adding new service lines to your practice, these steps in sections 1-3 will help you prepare, so you can successfully convey your needs to the health plans. Again, it is important that you understand your own practice information to have an effective conversation. Behavioral health services are important to the members (your patients) and health plans alike, so you should be paid accordingly to provide these services. Make sure you focus on that point when having a conversation with your payer representatives.

4.2 - A big part of this conversation is asking questions. If you do not understand some of the aspects related to behavioral health, ask your payer representative. These individuals can help you understand the billing and coding requirements, as well as, the payment and reimbursement structures related to your contracts. We discussed communication in Chapter 4, and we suggest that you refer back to the "Commercial Payer Contact List" to review your payer representatives for each of the payers. Bring your questions to these individuals to make sure your contract is set up correctly, and you are being reimbursed appropriately. The worksheet for this chapter has more information on some of the questions you can ask to ensure your behavioral health services are included, and you are being paid appropriately.

Plan to hear "No" when negotiating, but treat this as a request for more information. Change your approach and work on different options, but do not be discouraged.

Please fill out the survey included in the link below. Tell us what you think!

Survey Link: https://www.surveymonkey.com/r/9QR6SPV

Chapter 5 Worksheets

There are two worksheets for Chapter 5.

1) This worksheet includes two lists of questions. The first list is a series of questions for you to ask yourself about your own practice. This will help you better understand your practice's capacity to add behavioral health services. The second list is a series of questions that you can ask your provider representatives when working on your contracts. This will help you start the conversation to make sure everything is in order.

2) This worksheet is more of a resource for your practice with information on the "Care Management" codes that you can use for behavioral health services in the primary care setting. This worksheet is two pages, and it includes a list with some of the required elements, a list of the Care Management codes with descriptions, and some additional considerations for you. This will help you better understand some of the coding requirements that will play a role in your contracts.

Remember: Every payer does things differently. You will need to verify that the various commercial payers accept these codes to cover the services in your practice.

****Worksheets attached on next page.***

Worksheet 1: Behavioral Health Questions

When communicating with the commercial payers, it is important to ask the right questions. This worksheet has a series of questions for you to ask yourself as you are strategizing for contract negotiations, and this will help you understand your own practice needs before you get started. There is also a series of questions you can ask your payer representatives when having those conversations about behavioral health services in your contracts.

Questions to ask yourself:

1. What is my internal capacity to provide behavioral health services?
    a. Does my practice have enough space?
    b. Does my practice have enough staff?
    c. Does my practice have enough providers? If not, does my practice have the capacity and funding to add a new behavioral health provider?
2. What is the associated cost for me to provide these services?
    - *You want to be sure you are being paid based on your costs.*
3. Per CMS, what codes can be used for behavioral health services in the PCP setting?
    - *Use this link as a helpful resource from CMS.*
    - *See the next worksheet for more information on codes.*
4. Do I understand the requirements for tracking behavioral health services?
    - *Make sure you have a system in place to track behavioral health services.*
    - *See the next worksheet for more information on codes*
5. How many patients am I currently seeing, or how many patients do I predict I will see?
    - *Understanding your volume will help you better manage these patients.*
6. Out of my payer mix, which of these payers cover behavioral health services?
    - *Understand your payer mix. If you do not know which payers cover these services, you can ask your payer representatives. Refer back to Chapter 4 for Payer Contacts.*

Questions to ask the Payers:

1. Does [*health plan*] cover behavioral health services?
2. Does [*health plan*] have an ancillary network for behavioral health services?
3. Of [*health plan's*] products, which have behavioral health as a covered benefit?
    a. Are there any out of network benefits for members?
4. What provider types are covered to render behavioral health services?
    a. What are the credentialing requirements for these provider types?
5. What codes do you cover for behavioral health services?
    a. What are the reporting requirements for these codes?
6. What is the reimbursement for these codes and services?
    a. What is the reimbursement structure for these services?

Worksheet 2: Behavioral Health Codes in the Primary Care Setting

The codes listed below are for Care Management services rendered in the primary care setting. The information below was produced by RT Welter & Associates and has been pulled from the Centers for Medicare and Medicaid Services (CMS). These codes can be found in both the 2019 Medicare Fee Schedule and 2019 Resource-based Relative Value Scale (RBRVS).

Required Elements for Care Management codes:

- Obtained patient consent
- Collaboration between care providers
- Coordination by BH Provider or Care Manager
- Tracking and updating registry with current care plan
- Participation in weekly caseload review with psychiatric consultant

Care Management code series:

Care Management

- **99484**
  - 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, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.

Collaborative Care Management

- **99492 - Initial**
  - Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the

psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
    - The required elements include outreach and engagement; initial patient assessment that involves the administration of a validated rating scale; development of an individual patient care plan; psychiatric consultant review and modifications, as needed; input of patient data into a registry and tracking of patient progress and follow up; and provision of brief interventions using evidence-based techniques.

- **99493 - Subsequent**
    - Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.
    - The required elements include tracking patient follow-up and progress via registry; weekly caseload participation with a psychiatric consultant; working together and coordinating with the qualified clinician on a regular basis; additional ongoing review of the patient's progress and recommendations for treatment changes, including medications with the psychiatric consultant; provision of brief interventions with the use of evidence-based techniques; monitoring patient outcomes using validated rating scales; and relapse prevention planning. Episodes of care begin when the patient is first directed to the behavioral health care manager and ends when the treatment goals have been reached, the goals were not reached and the patient was referred to another provider for ongoing treatment, or no psychiatric collaborative care management was provided for a period of six consecutive months. These codes do not differentiate between new or established patient status.

- **99494 – Add on**
    - Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)
    - Reported for each additional 30 minutes of initial or subsequent care in a calendar month.

Additional Considerations:

- SBIRT Services
- Cessation Services
- Risk Assessments
- Other Screenings

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