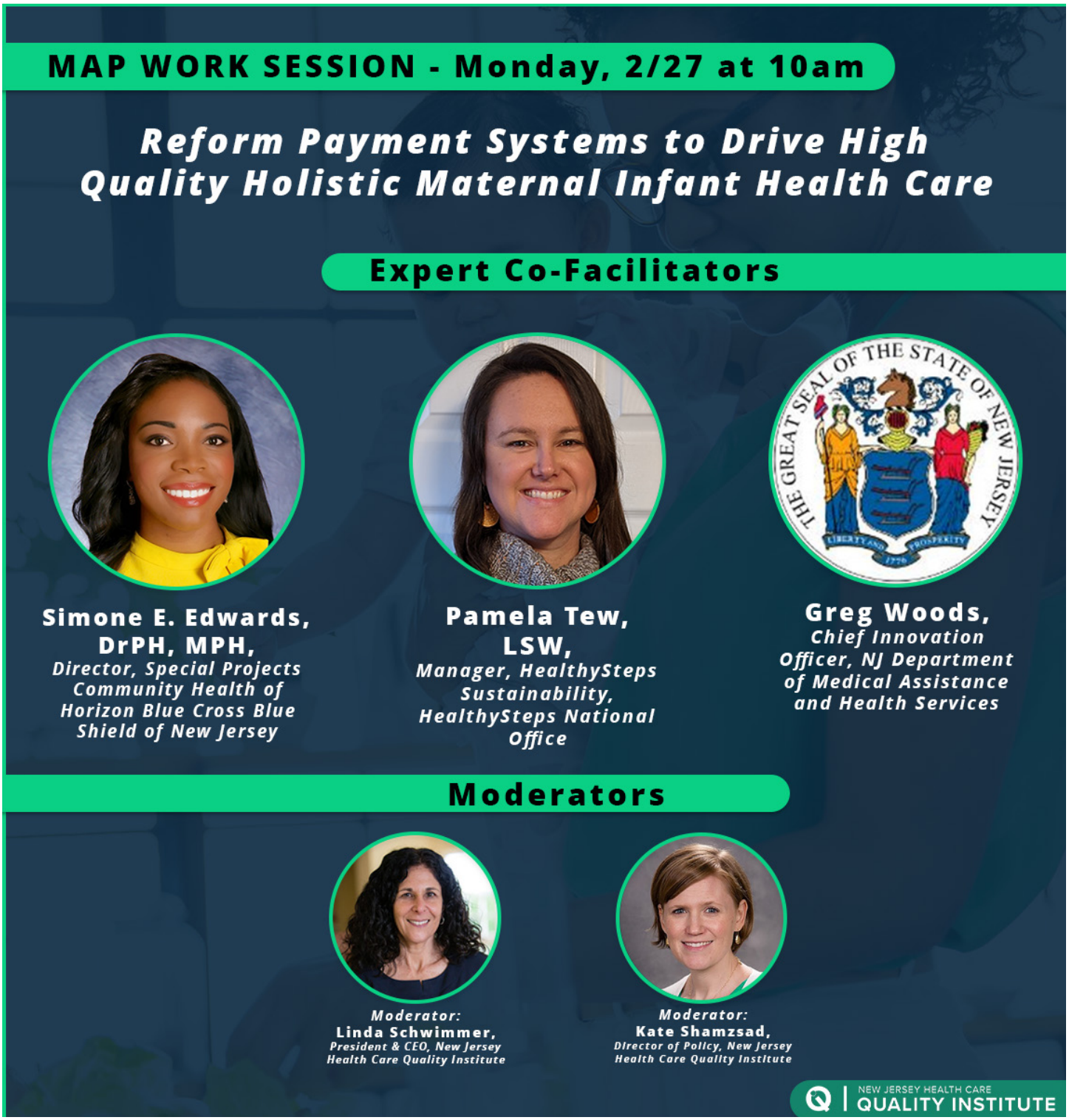
MAP to Action

Resources: Payment



View Recording of This Session: https://youtu.be/b83xNdgmKj8

Table of Contents

Financing Opportunities to Support Integrated Behavioral Health Promotion and Prevention Services

HealthySteps National Office Policy and Finance Team

To ensure positive health and development of young children, the child-caregiver relationship and the caregiver's well-being must be a focus of primary care interventions during early childhood. Evidence-based dyadic models, such as HealthySteps (HS), have shown effectiveness in employing this two-generation lens to mitigate the effects of trauma and adverse childhood experiences, address social determinants of health, and support behavioral health (BH) prevention and connection to needed treatment through team-based integrated pediatric primary care.

State Medicaid agencies are finding innovative ways to support dyadic integrated pediatric primary care models by utilizing new billing codes, allowing flexibilities in how codes are used, and exploring the use of alternative payment models to support team-based care. Additionally, the Centers for Medicare and Medicaid Services recently released an Informational Bulletin to provide guidance to states on the provision of high-quality behavioral health services to children and youth, which includes the following recommendations:

- Foster an environment for preventive health care by **not requiring a behavioral health diagnosis for the provision of EPSDT behavioral health services**. States can determine medical necessity for children and youth without a diagnosed behavioral health condition.
- Increase access to behavioral health screenings by **covering behavioral health screenings in primary care**.
- **Utilize age-appropriate diagnostic criteria for young children**, such as the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-5). Age-appropriate diagnostic criteria help practitioners more accurately identify diagnoses in young children who do not have language skills or exhibit the same symptoms as older children and adults.
- Expand provider capacity by **utilizing a provider network with a range of different qualifications** that can best meet the disparate needs of children and youth. Licensed professionals, such as psychiatrists, other physicians, psychologists, social workers, and nurses can complement peer support specialists with lived experience, case managers, and community health workers to provide direct services and/or linkages to needed health care and community resources.
- **Increased integration of behavioral health and primary care** can help ensure that individuals with a behavioral health condition are identified earlier and connected with appropriate treatment sooner.
- Reimburse pediatricians and other primary care practitioners for behavioral health services, even in advance of a formal behavioral health diagnosis, via:
    - **Utilization of non-specific codes**;
    - Reimbursement for treatment of more complex individuals (e.g., intensive care management codes and longer office visits);
    - **Reimbursement of care coordination**, including linkages of beneficiaries with needed behavioral health specialists;
    - **Removal of prohibitions on same-day billing** for behavioral health and primary care; and
    - **Reimbursement parity** for the same billing codes across primary care and behavioral health clinicians.

Below are HealthySteps National Office recommendations and examples of how states can reimburse and provide funding for prevention-oriented integrated services through Medicaid. There are variations in state Medicaid programs that will impact decision making on the best approach for financing prevention-oriented behavioral health services in each state. For more information, reach out to Senior Director of Growth and Sustainability, Jennifer Tracey, jtracey@zerotothree.org.

Recommended Prevention-Oriented Payment Innovations

Recommendation/Examples	Relevant Codes (if applicable)	Code Definition/Context of Service
Reimburse for universal screenings including developmental, autism, behavioral, maternal depression, and social drivers of health (SDOH) – incenting health care providers to complete universal screenings for young children and caregivers.	Developmental – 96110 Autism – 96110 with a modifier Behavioral – 96127 Maternal depression – negative screen (G8510) and positive screen (G8431) Maternal depression rendered during a well-child visit and/or SDOH – 96161 (caregiver focused) and 96160 (patient focused)	Allows reimbursement for universal screenings, reflecting the recommended baseline American Academy of Pediatrics' Bright Futures Periodicity Schedule. Also allows additional preventive screens beyond the Bright Futures schedule based on medical necessity and provider clinical judgement.
Open Medicaid billing opportunities for prevention-oriented dyadic services that are delivered in primary care. **Example:** California	BH Preventive education services – H0025 H1011 – Family assessment by licensed BH professional H2027 – Psychoeducational service, per 15 minutes T1027 – Family training and counseling for child development, per 15 minutes	Allows codes to be billed by behavioral health providers for the provision of dyadic services.
Allow individual and family psychotherapy to be billed under infants and toddlers (when a concrete mental health or behavioral health diagnosis is not present) for the provision of dyadic services in a pediatric primary care setting. **Examples:** California Massachusetts	Psychotherapy 90832-90847	Allows individual and family psychotherapy to be billed with Z65.9 (problem related to unspecified psychosocial circumstances) to cover a variety of SDOH codes. This can provide families with necessary preventive therapy services to address dyadic concerns before they require more costly interventions.
Provide an enhanced rate to primary care providers for universal evidence- and team-based enhanced primary care services for young children (0-3) to address key prevention/early intervention goals	Preventive education services recommendation - H0025	Allows a state to identify a relevant billing code for preventive education/early intervention services for all E/M visits[1], that is not otherwise widely used, to identify a clinic and/or provider delivering a universal, evidence based and

[1] Sick and well-child visits billed by the primary care provider.

Recommendation/Examples	Relevant Codes (if applicable)	Code Definition/Context of Service
Example: Maryland	Alternative: H0024 H2027 90887	team-based behavioral health pediatric primary care model. This streamlined approach: • Encourages access to preventive services for young children and their families • Eases administrative burden on clinics and state Medicaid Supports employment of both licensed and non-licensed behavioral and mental health providers to provide services
Clarify time rules for the Family Therapy benefit to align it with national guidelines and allow for practical use in a primary care setting (i.e., the total duration of the session is 26 minutes or more).	Family Psychotherapy 90846-90847	Allow providers to bill for family psychotherapy services based on national guidelines, specifying the adoption of the CPT time rule for the billing of psychotherapy sessions per the American Psychological Association.
Allow licensed behavioral health providers (ideally extended to non-licensed staff as well) to bill for case management and other supports associated with promotion and prevention services. **Example:** California	Case management, 15 min, T1016 H2015 - Comprehensive community support services, per 15 minutes 99484	Encourages providers to use a dyadic care (caregiver-child dyad) approach to successful service linkages that support a families' overall well-being.
Reimburse providers for behavioral health well-child visits. **Examples** Colorado Delaware Massachusetts	H1011 - Family assessment by licensed behavioral health professional	Provides an opportunity for behavioral health providers to assess the needs of all children and prevent the development of behavioral health disorders needing more costly interventions later in life.
Allow billing for physical health and behavioral health visits on the same day in Federally Qualified Health Centers (FQHCs). **Examples:** Related CMS Fact Sheet New Jersey		Same-day billing exclusions prevent FQHCs from being reimbursed for integrated care.
Reimburse for services delivered by Community Health Workers. **Example** California	98960-98962 – Self-management education and training, face-to-face, 30 minutes	Community Health Workers are critical partners in delivering high-quality integrated care and can help alleviate issues related to behavioral health workforce shortages.

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NEW JERSEY LEAD & MANAGER,
HEALTHYSTEPS SUSTAINABILITY

HealthySteps®

PEDIATRIC CARE • SUPPORTING • PARENTING
A Program of ZERO TO THREE

What is HealthySteps?

An evidence-based, interdisciplinary pediatric primary care program that promotes nurturing parenting and healthy development for babies and toddlers, particularly in areas where there have been persistent inequities for families of color or with low incomes.

HealthySteps Specialists are integrated into the pediatric team to provide short-term behavior/development consultation and referrals, intensive services when needed, and support practice screening efforts.

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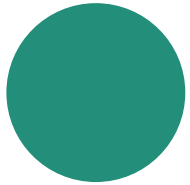
Tiers of Service Delivery

TIER 3

COMPREHENSIVE SERVICES

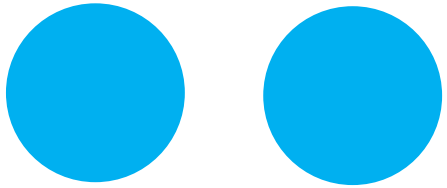
FAMILIES MOST AT RISK



TIER 2

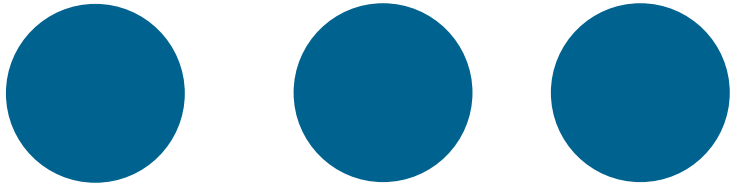
SHORT-TERM SUPPORT

MILD CONCERNS



TIER 1

UNIVERSAL SERVICES



SERVICES INCLUDE

Ongoing, preventive team-based well-child visits

Child development & behavior consults
Care coordination & systems navigation
Positive parenting guidance & information
Early learning resources

Child developmental, social-emotional & behavioral screenings

Screening for family needs
- MATERNAL DEPRESSION
- OTHER RISK FACTORS
- SOCIAL DETERMINANTS OF HEALTH

Family support line
- PHONE, TEXT, EMAIL, ONLINE PORTAL

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HealthySteps Advances Health Equity

Ensures More Frequent Screenings, Creates More Opportunities for Prevention

Provides Age-Appropriate Nutritional Guidance

Strengthens Early Social-Emotional Development

Connects Families to Early Intervention Services

Helps Mothers Find Success with Breastfeeding

Ensures Timely Screenings and Referrals for Autism

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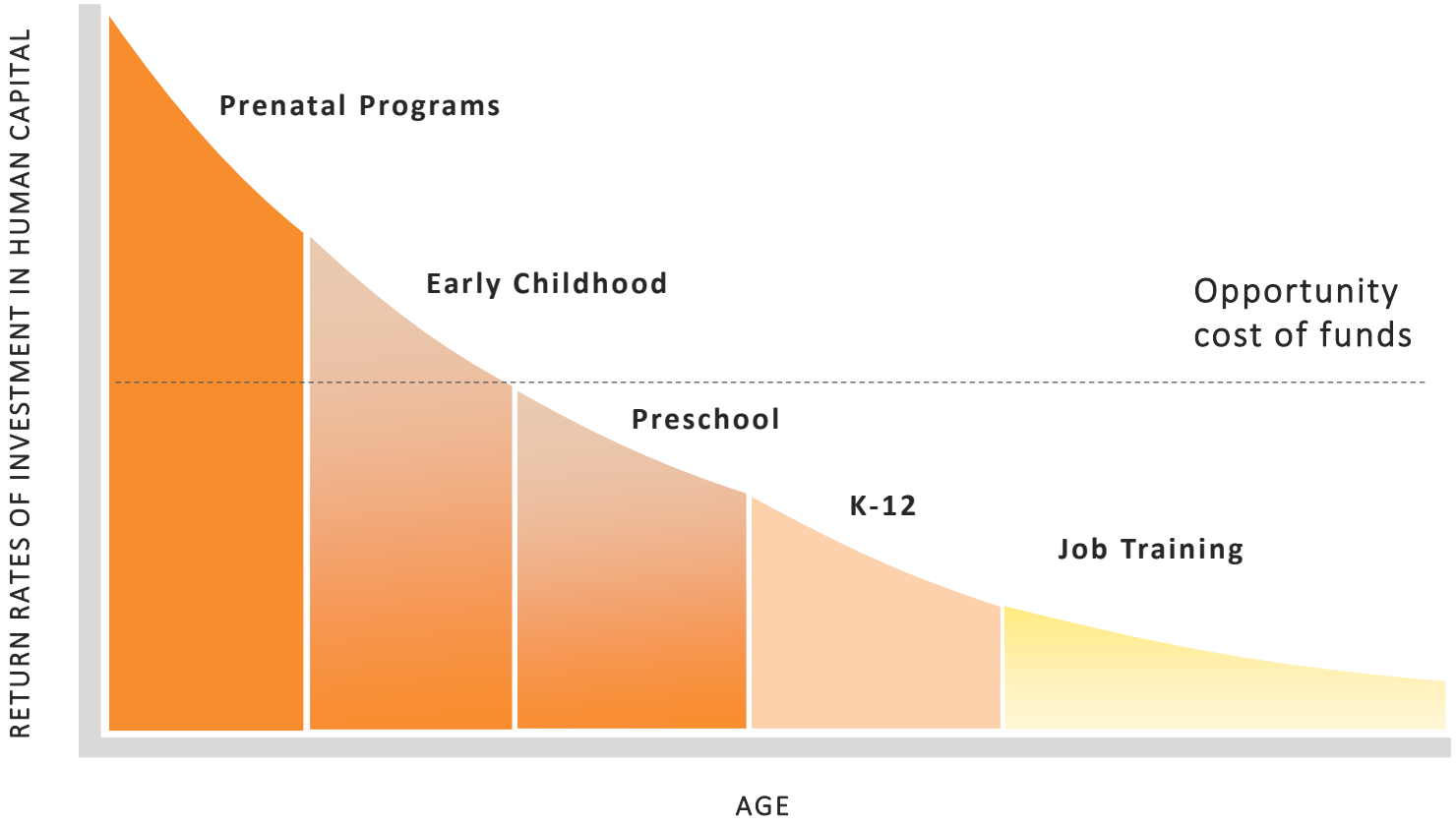
Early Investments, Greatest Gains

Rates Of Return To Human Capital Investment



Adapted from Heckman, J., "Return on Investment in Birth-to-Three Early Childhood Development Programs", September 6, 2018.

Benefits of Early Investment

INCREASES IN

- Children's cognitive and social-emotional development
- Educational performance and graduation rates
- Parental involvement
- Job training and earnings

REDUCTION IN

- Juvenile and adult crimes
- Cases of abuse and neglect
- Intimate partner violence
- Welfare dependency
- Special education

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Short-Term Medicaid Cost Savings

CHILD-FOCUSED INTERVENTIONS

- Oral health
- Asthma*
- Appropriate use of care for ambulatory sensitive conditions
- Flu vaccine

ADULT-FOCUSED INTERVENTIONS

- Breastfeeding
- Postpartum maternal depression
- Intimate partner violence
- Healthy birth spacing
- Smoking cessation

Annual Savings to Medicaid

163% AVERAGE ANNUAL ROI

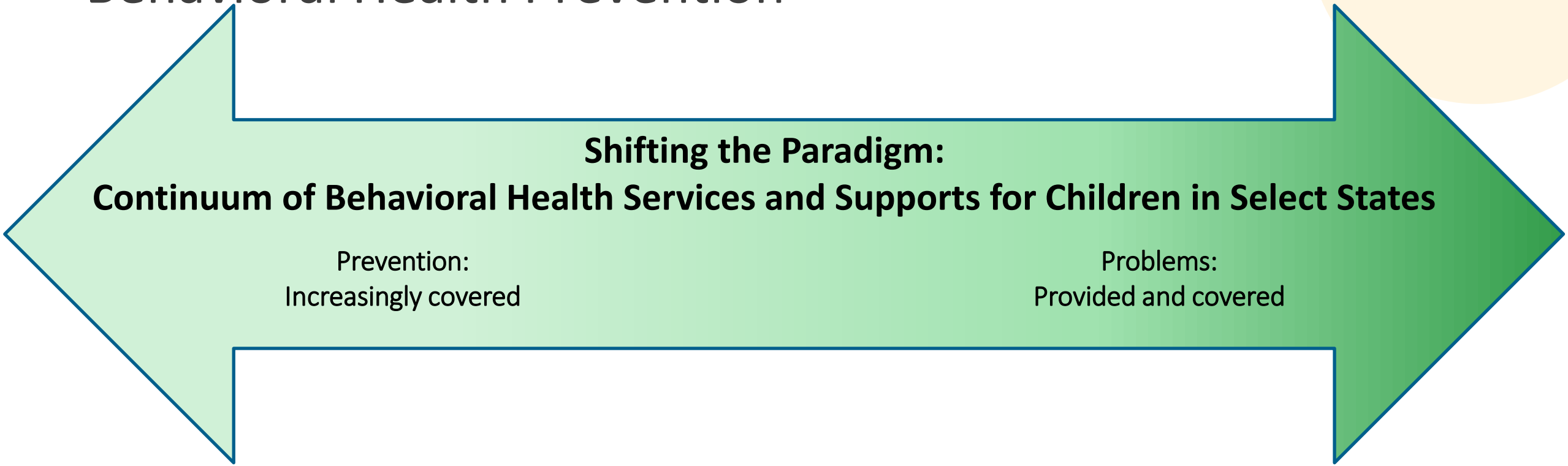
Includes analyses at state, health system, and site levels with both well-established and new sites, leveraging the HealthySteps cost savings model developed by Manatt Health.

For every $1 invested in HealthySteps, an estimated $2.63 in savings is realized by state Medicaid agencies each year.

*Asthma is a *recently* added cost savings intervention and therefore is not captured in the 163% annual ROI calculation.

HealthySteps A Program of ZERO TO THREE

For the First Time Ever, States are Beginning to Pay for Behavioral Health Prevention



The HealthySteps National Office is helping payers design new preventive behavioral health benefits that help young children AND their caregivers at the same time

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The Road to Scaling HealthySteps in NJ

SECURING PHILANTHROPIC SUPPORT TO BRING HEALTHYSTEPS TO NJ

✓ Secured funding to support:

- Finance training and implementation at initial sites
- National Office and local partner sustainability activities
- Hackensack research on impact of HealthySteps

WE ARE HERE

IDENTIFYING SUSTAINABLE FUNDING

✓ Engaging relevant community partners and potential payers to explore partnership opportunities

✓ Development of recommendations submitted to NJ Medicaid

✓ Public investment in growing the HealthySteps footprint

✓ Identification of HealthySteps Champions within state government

SCALING THE MODEL ACROSS NJ

❑ Ongoing access to sustainable financing

❑ Financial support for new site implementation

❑ Ongoing partnership with state agencies and payers to integrate model into existing service delivery systems

❑ Setting a new standard for pediatric primary care in NJ

HealthySteps A Program of ZERO TO THREE

Maryland Enhanced Payment to Support HealthySteps

Payment Model

- $15 enhanced payment paid through Medicaid MCOs for every E/M visit (well child and sick visits) for all children age birth through three – regardless of HS Specialist participation in the visit
- The E/M service is coded with H0025

Practice Eligibility

- The HealthySteps National Office provides an annual letter to the State Medicaid agency identifying HS sites on track to or meeting model fidelity
- The State Medicaid agency created a service category for HealthySteps in the provider enrollment system to differentiate HS sites for payment eligibility. The practice selects the service category in the provider enrollment system and uploads the letter from the National Office.
- Promotes workforce equity and covers HS costs

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HealthySteps Alignment with California's Dyadic Benefit

SERVICES INCLUDE

TIER 3

COMPREHENSIVE SERVICES

FAMILIES MOST AT RISK

Dyadic Behavioral Health Well-Child Visits (H1011)

- Ongoing, preventive team-based well-child visits

TIER 2

SHORT-TERM SUPPORT

MILD CONCERNS

Comprehensive Community Supports (H2015)
Family Training & Counseling for Child Development (T1027)
Psychoeducational Services (H2027)
Psychotherapy when risk factors present (Dx code Z65.9)*

- Child development & behavior consults
- Care coordination & systems navigation
- Positive parenting guidance & information
- Early learning resources

TIER 1

UNIVERSAL SERVICES

FFS reimbursement for screenings on top of well child visit payment (i.e., Developmental, ACES, Substance Misuse, Depression)

- Child developmental, social-emotional & behavioral screenings
- Screening for family needs
  - -MATERNAL DEPRESSION
  - -OTHER RISK FACTORS
  - -SOCIAL DETERMINANTS OF HEALTH
- Child development support line
  - -PHONE, TEXT, EMAIL, ONLINE PORTAL

*MA and NY also allow this flexibility

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NEW JERSEY
DEPARTMENT
OF HUMAN SERVICES

Maternity Action Plan: Payment Reform

February 27, 2023

Gregory Woods

Chief Innovation Officer, Division of
Medical Assistance and Health Services

Perinatal Episode of Care Pilot Overview

- The Perinatal Episode of Care (PEOC) pilot program is a voluntary model focused on NJ FamilyCare (Medicaid and CHIP) members enrolled in managed care plans.
- The goal of the PEOC Pilot is to improve quality and lower the cost of maternal and infant care in New Jersey.
- The PEOC program launched in New Jersey in April 2022.
- Currently, 16 providers are participating, collectively providing care for over 10,000 NJ FamilyCare births a year – approximately a third of total NJ FamilyCare births.

Perinatal Episode of Care Payment Model

- The PEOC's payment model is based on provider performance on quality and cost of care.
  - Quality Metrics include the four stages of the perinatal period:
    - Prenatal
    - Delivery
    - Postpartum
    - Neonatal phase
  - Cost of care includes spending related to maternity care across all providers and is based on Medicaid claims data
    - Spend includes a risk adjustment for patient clinical factors that affect the cost of delivery.

Performance Period 1 Payment Measure Quality Metrics
1. Prenatal Depression Screening
2. Gestational Diabetes Screening
3. Vaginal Delivery for Low-Risk Births
4. Postpartum Clinical Visit within 3 Weeks
5. Neonatal Visit within 5 Days

Perinatal Episode of Care Incentive Payments

Episode Incentive	Quality Requirement (Threshold)	Spend Requirement (Benchmark)	Other Requirements
Shared Savings Payment	Pass “minimum” thresholds for all five (5) payment metrics	Reduce average risk-adjusted episode spend by more then 3% relative to the individual provider’s historical performance	Episode minimum volume of more than fifteen (15) valid episodes
High Performer Bonus	Pass “minimum” thresholds for all five (5) payment metrics and “commendable” thresholds for at least two (2) payment metrics	Have lower average risk-adjusted episode spend than statewide peer median	Episode minimum volume of more than fifteen (15) valid episodes
Substance Use Disorder (SUD) Participation Incentive	None	None	Episode minimum volume of more than fifteen (15) valid episodes Serve the highest percentage (top 20% of all providers) of patients with an SUD diagnosis

Perinatal Episode of Care: Participants' Roles

Role of the **Participating Provider**:

- Provide high quality care
- Coordinate across the spectrum of care
- Bridge connections to essential resources
- Provide education and support to alleviate disparities

All NJ FamilyCare MCOs are required to participate:

- Aetna Better Health of NJ
- Amerigroup NJ Inc
- Horizon NJ Health
- United Healthcare
- WellCare

MCOs are responsible for making incentive payments to participating providers.

Perinatal Episode of Care Program: Next Steps

- Tweak program requirements in subsequent years, based on initial experience
  - The Perinatal Episode of Care is a 3-year pilot. Additional providers have the option to join the program in subsequent years.
- Evaluate the effectiveness of PEOC in improving quality and reducing cost of maternity and infant care, per a legislative mandate.
  - Evaluation expected to take place after conclusion of initial 3-year pilot period.

Quality Maternal Infant Health Outcomes

As part of Nurture NJ initiative, Medicaid engages in various projects targeted to drive high quality outcomes in the Maternal Infant Health space, including:

- NJ Family Care
  - Cover All Kids
  - 12 Months Postpartum Coverage
  - Integrated Care for Kids (InCK)
  - Perinatal Episode of Care Pilot
  - Doula Learning Collaborative
  - Increased Reimbursement Rate for Maternity Care
- QIP-NJ
  - Maternal Learning Collaborative

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Division of Medical Assistance and Health Services

MAP to Action: Payment Session
Breakout Room Summary
February 27, 2023

Theme 1: Payment Reform: Paying for Quality- Measuring impact of payment pilots and building long-term engagement; Support payment for quality outcomes and better care across payer lines of business	**Theme 2: Enhancing payment models for integrated care services through embedded behavioral and developmentally-supportive services- the HealthySteps model as an example.**
What messages/ideas/information from the presentations resonated with you?	
• Focused on clarifying questions about the two models presented. Horizon's episodes of care started in 2014. Originally had Medicaid population, but now that the state has a Medicaid EOC program, all 5 MCOs use that model for patients covered by Medicaid.	• There is opportunity for HS sustainability. Return on investment is producing near immediatecost savings on physical health side. Will need the Medicaid MCOs to be partners to do the scaling? Enhanced payment is a baby step towards carving these benefits and operationalizing it in a low risk way. • The 1115 waiver identified the need to begin the mental health carve in process but did not identify a timeline, at least in the draft.
In your own work/industry/sector, are you engaged in a project or pilot that relates to this work? If not, where do you see potential to engage in the projects or priorities we're discussing today?	

• Potential: Co-design research with PhD candidates at Rutgers? We could think about strategies to put together this data. Look at big data and the individual experience through focus groups. Lots of interest and potentially funding for this topic.
• One challenge is there isn't a lot of REaL data which makes tracking disparities much harder, but need to do this.
• Medicaid EOC model's requirement for each provider to have a health equity action plan is a good opportunity to compare which plans were more success and why and to share lessons learned, results.
• Strategies that work for one practice may not work for the next;
• Value in convening the providers and payers in the models. Sharing best practices and challenges with the models is still useful. The goal is to understand what they want to do, what they hope to get out of it, and which approach works best. Informal collaboration and part of formal evaluation.
• Important to make sure that the providers, patients, MCOs in the model are aware of the newer iniatives and options that have been implemented through Nurture NJ such as the PRA and Connecting NJ changes.
• Community health workers and other newer team members also provide an avenue to address disparities
  ○ CHW program is part of Neighbors in Health that supports commercial and
	• To what extent are HS models and similar models incorporating doulas and CHWs?
	  ○ Centering Healthcare Institute has a call for doulas, CHWs, and providers for their new community partner pilot
	• Enhanced payment can allow practices to invest in other models as well. It's a flexible payment model that allows for innovation.
	• Centering, Reach Out and Read, just to name a few, provide higher quality of care to patients and families.
	• In the Maryland HealthySteps payment model, only Medicaid can bill the enhanced payment. Service delivery does not change, however, as every child can get HS services, even without reimbursement from another payer.
	• How might flexible philanthropic funding be used to encourage or expand testing of these types of models that help expand or advance the payment reform and outcomes we're looking for?
	  ○ Money to support IT systems and infrastructure to support these alternative models, should they be introduced
	  ○ Paying for staff to be in these conversations like the one we're having today, and to do advocacy work. Money can also go towards lobbying to raise awareness of sustainability and expansion opportunities.

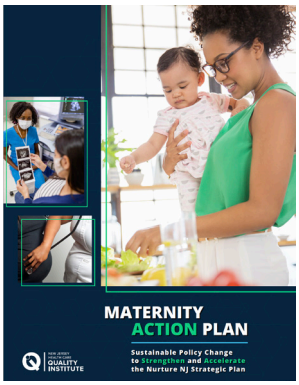
Medicaid lines of business. Not directly linked with episodes of care program right now. Looking at zip code level which areas need more participating providers. CHWs come into play there. That is part of Horizon's discussions for the future. Identifying successes and using that information to recruit new providers. o Most of the Medicaid EOC providers have a hospital affiliation. Some large independent practices. 1 or 2 single site. A site needs to have enough volume to make it worth the effort to participate. Medicaid is looking to have smaller providers participate. The EOC has good geographic representation, but looking more specifically at areas we might be missing. o Medicaid is hopeful that its 1115 waiver can foster some more innovation re CHWs.	
How would we collectively measure success for some of these ideas or projects? What are the near-term impacts? What does success look like a few years down the road?	
• Expanding the types of providers that can provide services and breaking down barriers to receiving integrated services. Broaden interdisciplinary approach. • Having a better understanding of effective strategies for different populations. • Important to look at outcomes. Look at them based on race and ethnicity. Improve infrastructure around data. • Informal and ongoing evaluation of success. Measures on quality and cost. It takes some time before you can see the data. Claims are 60 days after birth. EOC Program started in April 2022. We are now starting to look at data. Every quarter we will assess. We meet with providers every month to hear questions and concerns. Qualitative evaluation. Academic style quantitative evaluation later. Looking at impact on providers before and after the model. Any evaluation given the time has been made more difficult because of Covid. Performance metrics won't be changed during a year. From one year to the next we may look at them. But we would like to maintain consistency. If a measure gets topped out, we may look to change them. From year 1 to year 2 changes will be evolutionary. • HealthyPeople 2030 goal- Given our providers opportunities for shared savings. Member engagement and experience is important. Providers are reporting that members are more	• Return on investment- HS seeing a significant change in just 1 year of implementation in New Jersey. • We need to look at screening, screening rates; the need for accountability for follow-up connections to care. • Community-centered models – getting resources and having appropriately trained staff to engage family members in a safe, culturally congruent way. It can be hard for people to admit that they are struggling, even in a physician's office. Consider using CHWs in this space.

educated and in tune to their health with the information they've been receiving. As it relates to disparities, take a strategic approach that providers in certain areas with large disparities are engaged in our episodes program. Making them aware of it and getting them engaged to see better outcomes in those zip codes. Mitigating barriers to disparities.	
If you or your organization has held back or hesitated in engaging in new projects or pilots, what has held you back (resources, financial impact, connection and support from other organizations and partners, uncertainty about where to start, etc.)?	

• Ongoing training (that is part of a consistent training module) and readily available tools for providers on episode of care
  ○ Horizon has an episodes of care team that work with the providers in the commercial program. When you first enter the program, you are given a run down and then participate in monthly meetings. Educational materials available. We continually educate providers.
• Having support to be part of a successful alternative payment model
	• As someone not in the payment reform space, how can we integrate these conversations into our day-to-day since it does not directly involve payment?
	  ○ What is the change **you** want to see? Start with families and look at the services they receive. How is payment involved? There is often a disconnect. Consider doing the following: site visit with a legislator, following bills that are pending on the legislative side, have a meeting with local payers and state.
	  ○ Research existing policies and understand how they impact families.
	• For providers, time and resources are challenges. Time restraints and heavy workloads make it difficult for providers to effectively educate patients. However, making a relationship with the patient can create the behavior change you want to see in them. Plus, the financial benefit is on the physician so they should saddle up and get the work done. There is benefit on many fronts.
	  ○ Not everything is well-measured as an outcome. Talk to individuals about what they want to see in terms of their plans.

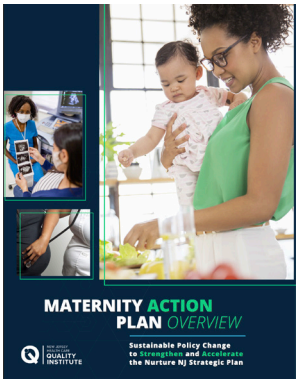
MAP to Action

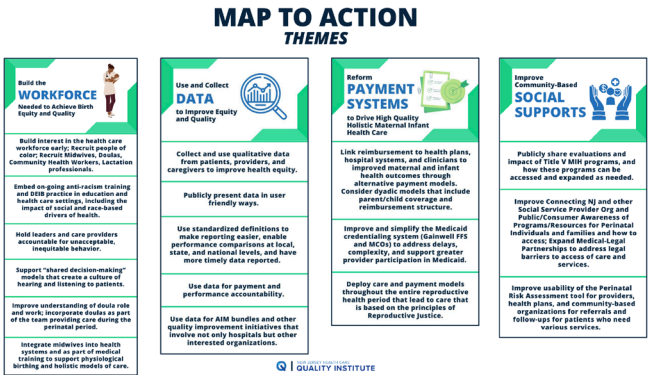
Additional Resources: Payment



Maternity Action Plan: https://njhcqi.info/MAP4NJ

MAP Executive Summaries: https://www.njhcqi.org/wp-content/uploads/2023/02/MAP_Summaries_ALL_2023_v2.pdf





Key Themes - ***These are the main concepts that rose to the top throughout the MAP to Action Series*:** https://www.njhcqi.org/wp-content/uploads/2023/06/MAP-to-Action-Themes-State-suggestions.pdf

Connection Guide - ***Use this tool to guide continued collaboration—to share ideas, nurture relationships, and build a coalition*:** https://www.njhcqi.org/wp-content/uploads/2023/04/Connection-Guide.pdf