POLICY BRIEF

Examining the Use of Psychiatric Collaborative Care Management (CoCM) and Behavioral Health Integration Codes at Federally Qualified Health Centers

Project Team

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Background

Integrating behavioral healthcare into routine physical healthcare practices, particularly primary care clinics, is widely considered an evidenced-informed model of care. The value of integrated behavioral health (IBH) in improving outcomes and reducing costs through increased access to behavioral health (BH) screening, assessment, and treatment has been shown repeatedly across a spectrum of common and costly BH problems, including depression and anxiety (Archer et al., 2012; Asarnow et al., 2015). Although IBH continues to expand, health systems and policy makers at the state and federal level have been stymied in how best to finance this model of care. Much of the early adoption of IBH has been supported through innovation and research grants (Carlo et al., 2018). Health systems have expanded IBH by hiring additional BH staff in the hopes that the model would lead to overall cost-savings along with improved patient health and well-being outcomes (Carlo et al., 2019). To support the continued growth of IBH, the Center for Medicare and Medicaid Services (CMS) released the Psychiatric Collaborative Care Management (CoCM) and Behavioral Health Integration (BHI) codes in fiscal year 2017. Similarly, CMS released CoCM and BHI G-codes for federally qualified health centers (FQHCs) to bill for behavioral health integration. (See CMS Medicare Learning Network Fact Sheet for Behavioral Health Integration Services for details). The codes are intended to pay for the systematic screening and assessment of BH symptoms using standardized tools, continued monitoring of BH needs, care planning by an interprofessional team, facilitation and coordination of BH treatment, and ongoing support to manage BH problems (CMS, 2019).

The uptake of CoCM and BHI codes has been slow and the underuse is documented in the literature (Brown et al., 2021). Yet, financing is critical to the continued expansion of IBH. Further, secured financing will support a growing investment in the BH workforce that is being trained to specifically work in IBH settings (Kepley &Streeter, 2018). This mixed-method study aims to provide clarity on the implementation of IBH in FQHCs and the use of CoCM/BHI codes, as well as identify barriers to utilizing these codes and IBH models.

Methods

This mixed-methods design involved a two-pronged data collection strategy. First, a survey was electronically sent to FQHCs' administrators to determine if billing codes were used. Next, follow-up interviews were conducted to learn about their experiences with implementing IBH and any barriers encountered, particularly in financing. An electronic survey (via Qualtrics) was developed and disseminated (October to December 2020) to a convenience sample of FQHC administrators identified using HRSA's "find a health center" website. FQHC administrators were contacted by email and phone to participate in the study. Study recruitment was also included in a monthly HRSA newsletter for FQHCs. Respondents who completed the online survey were asked to participate in a follow-up interview; those who were willing were later contacted for qualitative interviews. A semi-structured interview guide was developed for in-depth interviews which were recorded via Zoom (February to April 2021). A $25 incentive was offered for participating in the quantitative survey and $50 for in-depth interviews. Quantitative data were analyzed using descriptive analysis in Stata

16. Qualitative data collected from the interviews were first cleaned, transcribed, and checked for accuracy. Two independent reviewers used thematic coding to read, comment, create, and identify salient themes.

Key Findings

A total of 52 administrators from 11 states completed the online survey. A sub-sample of 46 (88.5% of total) who indicated the FQHC organization had implemented IBH were retained for the current study (see Table 1 for description of included FQHCs). Few reported use of CoCM or BHI codes. Only six (13%) FQHCs reported CoCM code usage and only eight (17.4%) reported BHI codes were used. Lack of use was, in part, due to administrators being unaware of the codes; 72% reported lack of knowledge on the availability of the CoCM codes and 70% reported they were unaware of BHI codes. Further, some FQHC administrators were uninformed about the potential to use codes in addition to the billed prospective payment system (PPS) visit, MH screening codes, and individual psychotherapy codes. Other reported barriers to using these codes included workflow issues, staffing problems, and inadequate reimbursement for the cost of the services (see Table 2). For those not using CoCM or BHI codes to pay for IBH, most said the services were supported through grants (n=20), other CMS codes (n=12), general operating funds (n=4), and existing psychotherapy and MH screening codes (n=4).

Table 1: Survey Sample Description (n=46)

State	N (46)	100%
Arizona	1	2.2%
California	12	26.1%
Kansas	10	21.7%
Kentucky	1	2.2%
Montana	1	2.3%
New York	4	8.7%
Pennsylvania	8	17.4%
South Carolina	3	6.5%
Texas	4	8.7%
West Virginia	2	4.6%
Number of clinics sites		
1 clinic	8	17.4%
2 to 4 clinics	13	28.3%
5 to 9 clinics	15	32.6%
10 or more clinics	10	21.7%

Table 2: Barriers to Collaborative Care Management and Behavioral Health Integration Code Use

Barriers	CoCM (n=15)	BHI (n=16)
Patient cost sharing	4 (26.7%)	3 (18.8%)
Inadequate reimbursement for IBH services	5 (33.3%)	4 (25.0%)
Workflow barriers	6 (40.0%)	4 (25.0%)
Lack of infrastructure to implement model	1 (6.7%)	1 (6.3%)
Code is not available for all patients who need services	2 (13.3%)	4 (25.0%)
Staffing barriers	6 (40.0%)	5 (31.3%)

Note: BHI=Behavioral Health Integration; CoCM=Collaborative Care Management; IBH=Integrated Behavioral Health

Nine in-depth interviews with FQHC administrators from six states were conducted: California (n=3), Kansas (n=2), Arizona (n=1), New York (n=1), Pennsylvania (n=1), and West Virginia (n=1). Only two of the in-depth interviewees reported the FQHC used the CoCM/BHI codes. One FQHC was connected to the AIMS center to establish CoCM workflow, yet continued to struggle with the implementation and documentation of CoCM services. Because of these barriers, as well as staff shortages, the FQHC discontinued CoCM in most of the clinic sites which made it even more challenging for it to be a fiscally-sustainable model. Another FQHC that

used CoCM/BHI codes reported they were purposeful in trying to find sources to pay for IBH services and stated: "*We are very large, very entrepreneurial, and if there's a way to get paid for a service that helps people, we figure it out."* However, there were complications in expanding BHI code use into all of the clinics*: "It is very difficult to make it work and not even from a reimbursement perspective it's just difficult to find the humans and the whole team that can understand it and really make it successful*."

For those that had not implemented the CoCM/BHI codes, there was a general sense that the reimbursement practices were *"…not self-sustaining."* However, because of the desire to provide quality care, FQHCs found ways to cover associated costs. To support the IBH model, FQHCs reported relying on: 1) Revenue from individual psychotherapy; 2) Funds from the general operating budget gathered from PPS and other sources; 3) Grant and foundational support; and 4) An intern or trainee's time to deliver care. For example, one participant described how individual psychotherapy pays for IBH team: "*We basically eat the cost for [IBH]—we consider it part of our treatment. So we bill for psychotherapy and then all of those other things are just auxiliary services we provide."*

Many FQHCs presented a tension between providing intensive BH psychotherapy and brief, solution-focused IBH. BH provider time was reimbursed through either the PPS or billing CPT psychotherapy codes and was considered a consistent source of revenue which was greatly needed. However, because of the need to bill psychotherapy, the BH clinicians were not regularly available to do pieces of IBH including screening, assessments, coordination, and warm-handoffs. For example, one said: "…*again with cost involved we can't just set up a therapist or a social worker upstairs in an office and wait for the possibility that maybe somebody might want us to come in."* In addition to needing to earn revenue to pay for BH clinicians time, FQHCs prioritized individual BH treatment because there were no other available sources to provide care. One person stated *"theoretically we're supposed to be a brief solution focused model. And if they need more they would be sent to a community provider who could provide more like weekly long term services. But the reality is most of our clients are Spanish speaking, and there aren't enough Spanish speaking providers…so we are the people that would need to be providing those services."* Because of the need to bill for psychotherapy, FQHCs were mindful to only hire licensed clinical social workers (LCSWs) or psychologists, the only types of BH providers who can independently bill CMS and private insurers. This further complicated the staffing issues since it limited the types of BH providers FQHCs could employ.

The complexity of finding ways to pay for IBH along with the priority to provide individual psychotherapy kept FQHCs from having the time, energy, and resources to create systems that enabled the organization to bill for CoCM/BHI. In addition, the added cost to build workflows and payment systems were seen as too cumbersome and best summarized by one respondent who stated: *"…it becomes a cost benefit analysis of how much additional money does it bring in for us to deploy these codes for these 15 minute chunks of time we use here and there. And if it takes an IT person making $100,000 a year, 100 person hours to convince people to utilize these [codes] and we end up making less than that by utilizing these, at a certain point we just kind of go 'It's not worth it.'"*

Conclusions & Policy Implications

Findings from this study suggest FQHCs are working-hard to meet the needs of the communities they serve, including addressing BH conditions in the context of areas that have significant shortages of BH treatment and high psychosocial needs. All FQHC administrators acknowledged the need for BH integration and the value of the model to improve care. However, because of the conflicting demands of providing care in underserved communities to safety net populations (including addressing the Covid-19 pandemic), many clinics have difficulty shifting time and resources to set up workflows, staffing patterns, and payment systems to properly support CoCM/BHI billing. Most FQHCs are implementing a model that straddles between co-located BH psychotherapy and IBH teams deploying CoCM. Unfortunately, because of the lack of fidelity to the model, FQHCs are not billing for care management though most are doing pieces of CoCM/BHI and paying for it through grants and general operating funds. Additionally, some FQHCs appear to be unaware of the availability of the codes or that the services provided could meet the criteria for CoCM or BHI codes. Findings from this study suggest FQHCs could benefit from financial and logistical support on the front end to build the infrastructure (e.g., workflows, easy EHR documentation systems, consistent staffing, time for collaboration) to deploy and bill for CoCM/BHI, as well as technical assistance on the ability to use CMS

CoCM and BHI G codes for IBH services already delivered in the clinics.

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