NATIONAL COUNCIL for Mental Wellbeing

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INTEGRATED CARE FINANCING SERIES

PRIMER

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Background

The integrated care movement emphasizes the importance of holistic health care that curates prevention and treatment services for physical health, mental health and substance use disorders in a coordinated patient-centered manner. The movement has served as both a participant and accelerant in advocating for policy transformations that have yielded tangible benefits to society. Prominent examples include mental health parity as part of health insurance benefits, mandatory coverage of substance use treatment services as part of essential health benefits, and the United States Prevention Service Task Force emphasizing the need for behavioral health screening, including mental health and substance use screening. While these policy advances create a framework for promoting integrated care, maximizing access to actual services rests on the ability of provider organizations to implement sustainable financing strategies that increase access to services for patients.

The National Council for Mental Wellbeing's integrated care financing series equips provider organizations with tactical considerations to optimize financing strategies for six service modules and consolidates billing codes and other key information from the modules into the excel-based decisions support tool (DST):

1. Medication for opioid use disorder (MOUD)
2. Screening
3. Care coordination
4. Metabolic monitoring
5. Treatment for tobacco use disorder
6. Health-related social needs (HRSN)

The modules are designed to be used in tandem or independently and can be paired with the Integrated Care Decision Support Tool to estimate potential revenue based on the unique staffing mix of each organization.

Application and Limitations

The national health care financing landscape is complex and variable, often informed by local factors, such as state policy decisions, allocation of categorical grant-based funding, health insurance coverage and payer priorities. The Integrated Care Financing series—consisting of the six integrated care service modules and DST—primarily focus on fee-for-service (FFS) financing considerations. Despite this FFS lens, the insights that follow apply universally to organization settings that are financed through alternative payment mechanisms such as cost-based, prospective and value-based payment arrangements, acknowledging that FFS costing considerations are often the financial benchmark to structure alternative payment mechanisms. In short, the information in this primer is as specific as possible, while acknowledging variations in local payment and delivery landscapes and operational diversity across organization settings.

Guidance on adapting this information to your local landscape is highlighted throughout this brief in the Implementation Considerations subsections.

Please note that the decision support tool does not assess enrollment, licensing and credentialing. This tool is accurate as of its publication date (May 2024).

Decision Support Tool Overview

The decision support tool module provides organizations with the opportunity to estimate potential revenue based on specific codes, identify provider disciplines permitted to bill specific codes and provide additional context salient to the utilization of respective codes. The tool is in Microsoft Excel format and can be sorted and manipulated to provide organization-specific insight. Table 1 defines each column in the tool's "Billing Codes" worksheet.

Table 1. Decision Support Tool Explanation

COLUMN	TITLE	DEFINITION
C	**General Category**	A general categorization of the type of service, generally based on service categories as outlined in the Current Procedural Terminology (CPT®) 2024 codebook.
D	**Brief Description**	Brief descriptor of services.
E	**Billing Code**	The specific billing code that applies to a service.
F	**Medicaid**	An assessment on whether the service code is typically covered by Medicaid. Note: State Medicaid rules can vary greatly. Please confirm applicable billing codes with state Medicaid agencies and/or managed care plans.
G	**Medicare**	An assessment of whether the service code is typically covered by Medicare.

COLUMN	TITLE	DEFINITION
H	**Third Party/Commercial**	An assessment of whether the service code is typically covered by a third party or commercial insurer.
I	**Eligible Provider**	A list of the provider or practitioner types that are typically able to deliver services associated with a given code.
J	**Medicare 2024 Rate (Min)**	The relative minimum Medicare reimbursement rate for calendar year 2024, which is based on Medicare Locality 13 (state of Arkansas).
K	**Medicare 2024 Rate (Max)**	The relative maximum Medicare reimbursement rate for calendar year 2024, which is based on Medicare Locality 9 (Santa Clara, California).
L	**Medicare 2024 Rate (Mid)**	The estimated average Medicare payment rate, which is based on the average of the minimum (Column J) and maximum (Column K) payment rates.
M	**Estimated Medicaid Rate (if billable)**	An estimated Medicaid rate based on approximately what a given state Medicaid agency tends to pay relative to Medicare in that state[i]. Note: Differences in Medicaid rules vary greatly; please confirm applicable billing codes within state Medicaid agencies and/or managed care plans.
N	**Estimated Commercial Rate (if billable)**	An estimated commercial payer rate based on what private insurers tend to pay for services relative to Medicare.
O-AB	**Professional Discipline Coverage**	The professional disciplines allowed to provide and/or bill for specific service codes in Medicare.
AC	**Documentation**	Documents or services required to bill the service code in Medicare.
AD	**Time Requirements**	The amount of time required to be spent by a provider (if applicable) for the service to be valid and reimbursable.
AE	**Comments**	Additional considerations relevant to use of the code.

[i] The estimated Medicaid payment in the DST is based on the Medicaid-to-Medicare fee index, which measures each state's physician fees relative to Medicare fees in each state. KFF. (2024). Medicaid-to-Medicare Fee Index. Retrieved from: https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Coding Considerations

In an FFS environment, coding is the foundation for seeking reimbursement for specific services. Organizations are encouraged to examine their state's model Medicaid contract, payer contracts and the Medicare fee schedule to determine the extent to which they are permitted to seek reimbursement under specific codes. The most common categories of codes include:

- **International Classification of Disease, 10th Revision (ICD-10) Codes.** Diagnostic codes that capture a condition, injury or social driver of health. These codes explain why a patient is seeking care and explain to payers the reasons for the services that have or will be rendered. ICD-10 codes are alphanumeric and contain a decimal point. The characters prior to the decimal point are the disease category. The characters following the decimal point are the disease subcategory. For example, ICD-10 code F11.21 refers to a patient living with opioid use disorder (F11) that is in remission (21).
- **Current Procedural Terminology (CPT) Codes.** Generally used by private payers and managed care organizations to indicate services rendered. CPT codes are owned and maintained by the American Medical Association and are structured as five-digit numeric codes. For example, 99205 is used for the evaluation and management of a new patient. CPT codes can be modified using a two-digit number to further explain a procedure or service.
- **Healthcare Common Procedure Coding System (HCPCS) Codes.** Maintained by the Centers for Medicare and Medicaid Services (CMS), these codes are used to explain services rendered in Medicare. Like CPT codes, HCPCS codes may also be accompanied by a two-digit modifier.

While the modules will primarily focus on FFS billing and reimbursement opportunities, they will also address (where applicable) considerations salient to value-based payment and service delivery models inherently bundled from a reimbursement perspective. For example, the Care Coordination module addresses the Psychiatric Collaborative Care Services Model, which includes sequence of services and corresponding codes that are required to seek reimbursement.

Closing

This brief is part of a series that aims to ease the implementation of evidence-based integrated care interventions across a range of organization settings. It serves as complement to the Integrated Care Financing Decision Support Tool, which provides billing, reimbursement and aggregate financial modeling insights to support implementation. Please contact the Center of Excellence for Integrated Health Solutions through their website if you have any questions or concerns.

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