Uptake of Medicare Behavioral Health Integration Billing Codes in 2017 and 2018

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INTRODUCTION

Reimbursement models have not historically supported the integration of mental health services into primary care.¹ In January 2017, the Centers for Medicare & Medicaid Services introduced fee-for-service (FFS) Medicare Part B billing codes for Psychiatric Collaborative Care Management (CoCM) and General Behavioral Health Integration (BHI).² CoCM enhances primary care through the addition of behavioral health care managers and psychiatric consultation whereas BHI supports various integration models and staffing configurations. Qualitative research has identified barriers to using the CoCM codes and a recent study based on a random sample of Medicare beneficiaries found that 0.1% of those with behavioral health conditions received services through either type of code in 2017 and 2018.³ We expanded on that study to examine the uptake of these codes among a different group of beneficiaries—those with behavioral health conditions attributed to primary care practices, as those with primary care providers are most likely to benefit from these codes. We also examined whether the types of diagnoses and providers differed between CoCM and BHI claims, and if claims were concentrated within practices and states.

METHODS

We conducted these analyses using data from the Comprehensive Primary Care Plus (CPC+) evaluation, which requires practices to integrate behavioral health care and allows them to use these billing codes among others. We analyzed calendar year 2017–2018 Medicare FFS data that included 7.2 million beneficiaries located in 38 states and DC who were attributed to either the 2888 primary care practices that began CPC+ in 2017 or the 6921 comparison primary care practices. (Peikes et al. (2019) describe patient attribution methods, which used a 2-year lookback period).⁴ Among these beneficiaries, 2.1 million (22% of

CPC+ beneficiaries and 22% of comparison beneficiaries) had a behavioral health condition (mental health or substance use) defined as any claim with a primary behavioral health diagnosis or 1 inpatient or 2 outpatient/ambulatory claims with any behavioral health diagnosis during each analytic year. We conducted descriptive analyses of CoCM and BHI claims among beneficiaries with behavioral health conditions.

RESULTS

Uptake. From 2017 to 2018, the number of CoCM and BHI claims and the proportion of beneficiaries represented by those claims increased but were less than 0.1% in both years (Table 1). Given the small number of claims using these codes and because CPC+ practices had not yet fully implemented integration during our analytic period, we did not compare CPC+ and comparison practices.

Conditions. Almost all CoCM claims had a primary mental health diagnosis; major depressive disorder and anxiety disorder were most common. In contrast, 31% of BHI claims had a non-behavioral health primary diagnosis and the primary behavioral health diagnoses were more diverse. Hypertension, diabetes/metabolic disorders, and heart/vascular disease were common conditions among beneficiaries with CoCM or BHI claims.

Providers. Internal medicine physicians most commonly submitted CoCM claims whereas family physicians most commonly submitted BHI claims. Specialists, including psychiatrists, submitted few claims. The number of providers with claims increased from 2017 to 2018 but claims were concentrated in a small group of practices and states in both years. For example, in 2018, 384 providers submitted CoCM claims; 40% of these providers were affiliated with 25 practices, which together accounted for 70% of CoCM claims. Likewise, in 2018, 325 providers submitted BHI claims; 21% were affiliated with 20 practices that together accounted for 78% of BHI claims.

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Table 1 Behavioral Health Integration Claims, Beneficiaries, and Providers

	CoCM*		General BHI†	
	2017	2018	2017	2018
All CPC+ and comparison group beneficiaries	6,075,589		6,745,744	
All CPC+ and comparison beneficiaries with behavioral health conditions	1,357,411		1,538,018	
Number of claims submitted using code(s)‡	341	2372	636	3547
Beneficiaries with behavioral health conditions represented by claims using code(s)	158 (0.01%)	914 (0.06%)	293 (0.02%)	1234 (0.08%)
Primary diagnosis on claim				
Major depressive disorder	220 (65%)	1220 (51%)	175 (28%)	787 (22%)
Anxiety disorder	97 (28%)	808 (34%)	125 (20%)	675 (19%)
Other behavioral health§	13 (4%)	217 (9%)	154 (24%)	955 (27%)
Non-behavioral health	11 (3%)	127 (5%)	182 (29%)	1130 (32%)
Comorbid conditions of beneficiaries¶				
Hypertension	103 (65%)	620 (68%)	215 (73%)	917 (74%)
Diabetes and/or metabolic disorders	52 (33%)	311 (34%)	107 (37%)	453 (37%)
Chronic obstructive pulmonary disease	32 (20%)	154 (17%)	57 (19%)	262 (21%)
Heart disease and/or vascular disease	53 (34%)	329 (36%)	131 (45%)	585 (47%)
Number of providers that submitted claim	68	384	79	325
Billing provider on claim				
Internal medicine	215 (63%)	1066 (45%)	86 (14%)	563 (16%)
Family practice	91 (27%)	778 (33%)	414 (65%)	1678 (47%)
General practitioner	3 (0.9%)	11 (0.5%)	0 (0%)	26 (0.7%)
Nurse practitioner	26 (8%)	196 (8%)	39 (6%)	606 (17%)
Physician assistant	1 (0.3%)	50 (2%)	15 (2%)	146 (4%)
Psychiatrist	4 (1%)	16 (0.7%)	57 (9%)	216 (6%)
Social worker	0 (0%)	76 (3%)	7 (1%)	21 (0.6%)
Other	1 (0.3%)	180 (8%)	18 (3%)	291 (7%)
States with the most claims				
State 1	WA (39%)	NC (16%)	PA (53%)	PA (28%)
State 2	NC (16%)	WA (11%)	CO (12%)	SC (18%)
State 3	AR (15%)	AR (10%)	WI (7%)	CO (16%)
State 4	WI (8%)	MI (7%)	FL (7%)	OH (9%)
State 5	NV (5%)	NY (6%)	OH (6%)	NY (4%)
Proportion of claims represented by top 5 states	83%	50%	85%	75%
Number of states with at least one claim	14	28	18	34

*HCPCS codes G0502, G0503, and G0504 in 2017; replaced with CPT codes 99492–99494 in 2018. The national non-facility physician professional service price for these codes in 2018 was \$161.28, \$128.88, and \$66.60, respectively. These codes may only be used for services furnished using CoCM, which enhances usual primary care through the delivery of care management support for patients receiving behavioral health treatment and regular psychiatric consultation. The CoCM model must include the treating (billing) practitioner (typically a primary care provider but can be another specialty), a behavioral health care manager with formal education or specialized training in behavioral health, and a psychiatric consultant (medical professional trained in psychiatry and qualified to prescribe psychiatric medications)

†HCPCS code G0507 in 2017; replaced with CPT code 99484 in 2018. The national non-facility physician professional service price for this code in 2018 was \$48.60. This code may be used for services furnished using BHI models of care other than CoCM. General BHI services require a treating (billing) practitioner (typically a primary care provider but can be another specialty) and may involve other clinical staff but do not require a behavioral health care manager or psychiatric consultant. General BHI services can be entirely delivered by the treating (billing) practitioner

‡Although these analyses were not intended to compare the uptake of the billing codes between CPC+ and comparison group practices, for the purposes of understanding the generalizability of the findings, 20% (n = 63) of CoCM claims and 20% (n = 131) of BHI claims were submitted for CPC+ beneficiaries in 2017. In 2018, 44% (n = 1047) of CoCM claims and 29% (n = 1030) of BHI claims were submitted for CPC+ beneficiaries. In sum, most claims for CoCM and BHI services were not submitted for CPC+ beneficiaries

§Across both years, among CoCM claims with other behavioral health primary diagnoses, the most common primary diagnoses included unspecified dementia (38%), specific personality disorders (16%), and mood disorders due to a known psychological condition (10%). Across both years, among BHI claims with other behavioral health primary diagnoses, the most common primary diagnoses included unspecified dementia (58%), unspecified psychosis (7%), mood disorders due to a known psychological condition (7%), insomnia (6%), and vascular dementia (5%)

||Across both years, among CoCM claims with a non-behavioral health primary diagnoses, the most common primary diagnoses included Alzheimer's/dementia/other cognitive impairment (20%), hypertension (13%), and diabetes and other metabolic disorders (7%). Across both years, among BHI claims with a non-behavioral health primary diagnosis, the most common primary diagnoses included hypertension (29%), diabetes and other metabolic disorders (19%), and musculoskeletal system and connective tissue diseases (11%)

¶Based on the availability of data used for this analysis, the presence of comorbid conditions was defined somewhat differently for each condition. Diabetes/metabolic disorders, chronic obstructive pulmonary disease, and heart disease (congestive heart failure and vascular disease) were defined using Hierarchical Condition Category (HCC) scores whereas hypertension was defined using Chronic Condition Warehouse (CCW) algorithm. Both HCC and CCW scores are based on claims from the calendar year prior to the analytic year. The denominator for the percentages is the number of beneficiaries with behavioral health conditions represented by the claims

DISCUSSION

Consistent with another recent study, we found infrequent use of these codes even among beneficiaries with a primary care provider.⁵ Adoption of the codes

increased over time but has been somewhat lower than other care management codes introduced by CMS.⁶ While our findings are not generalizable to all primary care practices nationally, the claims using these codes

were concentrated in a small group of practices and states, some of which have integration initiatives. However, we cannot link our findings to specific initiatives. BHI claims were more common than CoCM claims and were submitted for a wider range of conditions, likely reflecting the greater flexibility of this code. As CMS plans to refine the future use of these codes, research could identify the features of integration models reimbursed through the BHI code and investigate if payment rates cover the costs of care management services to inform potential changes.²

Jonathan D. Brown, PhD, MHS¹
 Carol Urato, MA¹
 Precious Ogbuefi, MSPH¹

¹Mathematica,
 Washington, DC 20002, USA

Corresponding Author: Jonathan D. Brown, PhD, MHS;
 Mathematica, Washington, DC 20002, USA
 (e-mail: jbrown@mathematica-mpr.com).

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Compliance with Ethical Standards:

Conflict of Interest: The authors declare that they do not have a conflict of interest.

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