



Healthy Blue

# Integration of Collaborative Care Model

*2022.11 LA RHC Conference*

*2022.10.18: Prepared by Yvette DeLaune*

# Barriers Becoming Opportunities



**Provider “Listening Sessions”** teach us that gaps in collaboration and communication exist between BH and primary care along with an opportunity to reward providers for addressing identified barriers to care such as health equity, health disparity, rural care, behavioral health care...

**23%\* of Louisianans live with chronic conditions as compared to 1 in 6 for USA....**

- *\*LDH [CCPA-Louisiana-State-of-Chronic-Disease \(chroniccarealliance.org\)](http://www.chroniccarealliance.org)*

## **Complexity of healthcare system**

- Impacts whole-person health outcomes
- Is a greater challenge for members with concurrent diagnoses
- **56% of HBL members seeking assistance with SDOH** request help with healthcare
  - **Medications, referrals - often due to health literacy - NOT the typical food, housing, transportation**

**SOLUTION:** Development of Integrated Collaborative Care Model which is categorized as a Pay for Performance Incentive Program focused upon biopsychosocial holistic care.

- **ICCM encourages health delivery re-design by incenting holistic community care processes and workflow changes necessary for better outcomes, while involving health delivery partners throughout our members' communities.**



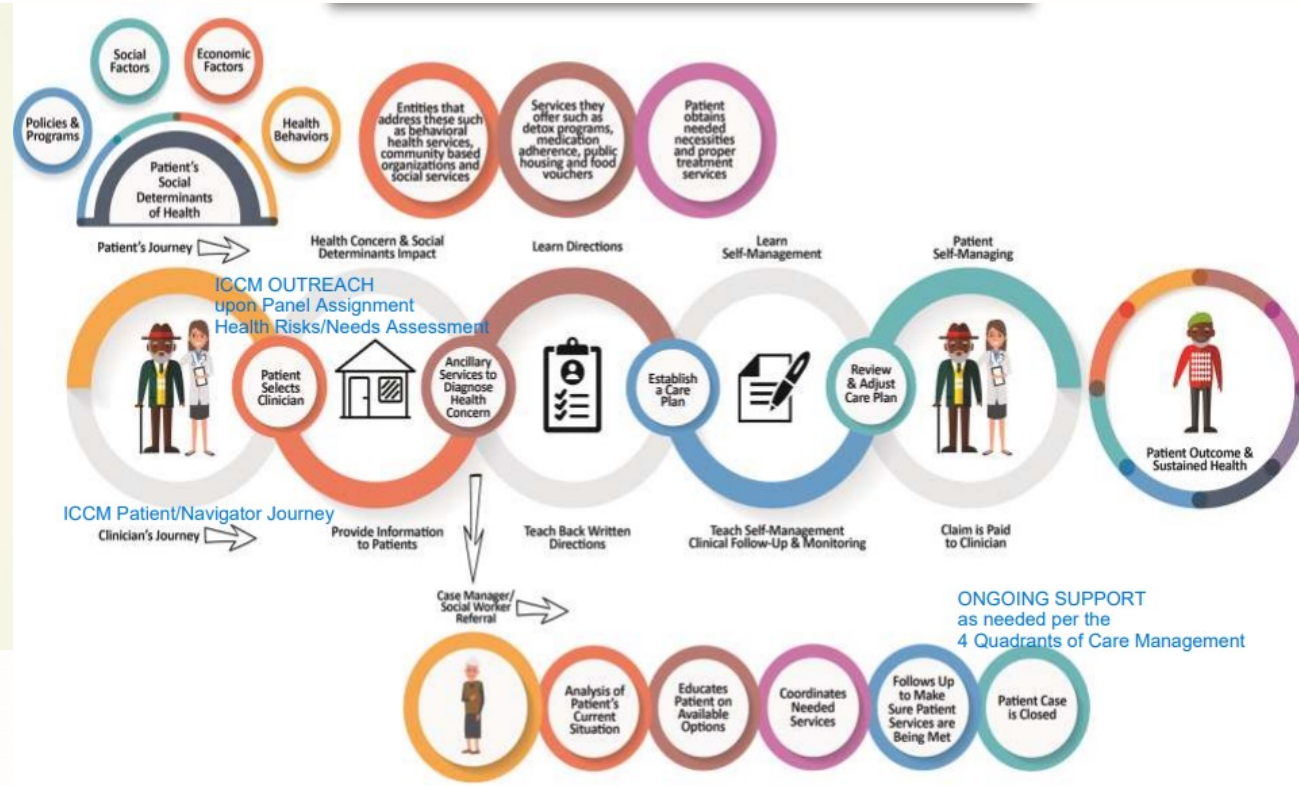


# OUR MISSION:

ICCM seeks to simplify our Members' navigation of our Healthcare Communities, *particularly those needing it most, while striving to improve their biopsychosocial outcomes.*



Healthcare's complex chaos without ICCM Whole-Health Navigation versus integrated and organized Whole-Health Care with ICCM Navigation





# ICCM Combines 2 Statistical Clinical Models

AIMS Integration of Care + Harold P. Freeman Navigation

ICCM model improves outcomes and saves costs

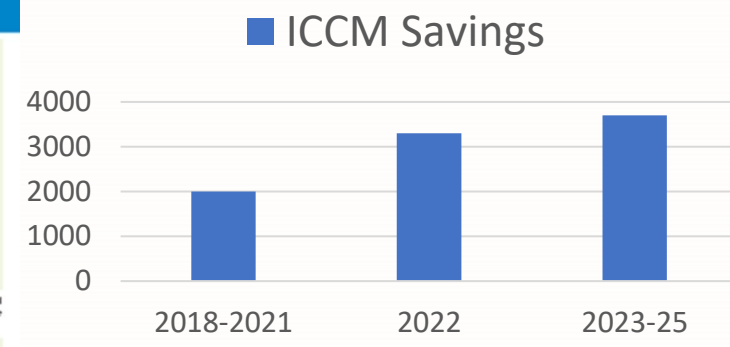
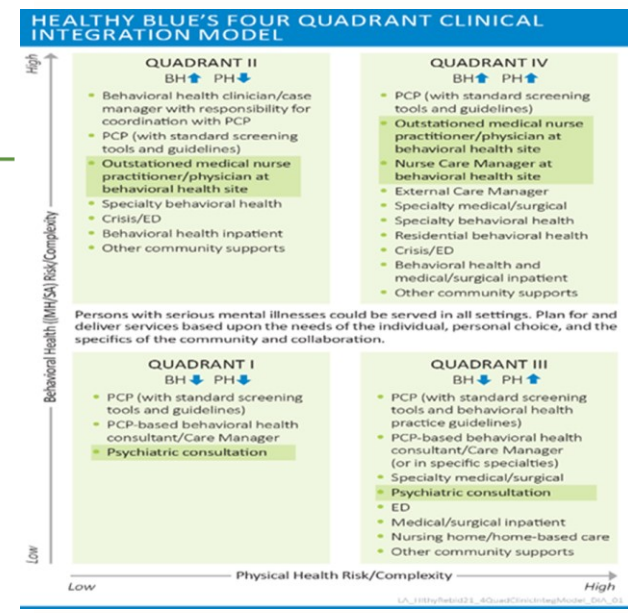


## BUILDING THE BUSINESS CASE FOR TEAM-BASED INTEGRATED CARE

Numerous trials and studies have demonstrated that the collaborative care model and other proven integration strategies are cost effective and can lead to significant savings in healthcare costs.

The **IMPACT** (Improving Mood and Promoting Access to Collaborative Treatment) model showed a savings of \$3,365 per patient (n = 272) over patients receiving usual primary care over a four-year period, even though the intervention ended after one year.

Patients participating in the IMPACT trial of depression collaborative care for older adults had lower mean total health care costs than patients who received usual care over the four year period. The IMPACT study suggested that up to \$6 are saved in long term health care costs for patients for every dollar spent on collaborative care, a return on investment of 6:1.



\$2,000 PMPY      ~\$3,300 PMPY      >\$3,700 PMPY

PMPY = Per Member Per Year Savings

- [Building the Business Case for Team-Based Integrated Care | University of Washington AIMS Center \(uw.edu\)](https://uw.edu)
- [Transformacion Para Salud: A Patient Navigation Model for Chronic Disease Self-management | OJIN: The Online Journal of Issues in Nursing \(nursingworld.org\)](https://nursingworld.org)
- <https://hpfreemanpni.org/>





# ICCM: Reliable Results

*Risk Stratification determines Workflow - Workflow produces results...*

## ICCM 2022 Claims-based Incentive Codes & Rates Go-LIVE:

- January – September 2022: 5,282 distinct members assessed for SDoH
- January – September 2022: >7,000 claims for 4,701 distinct members

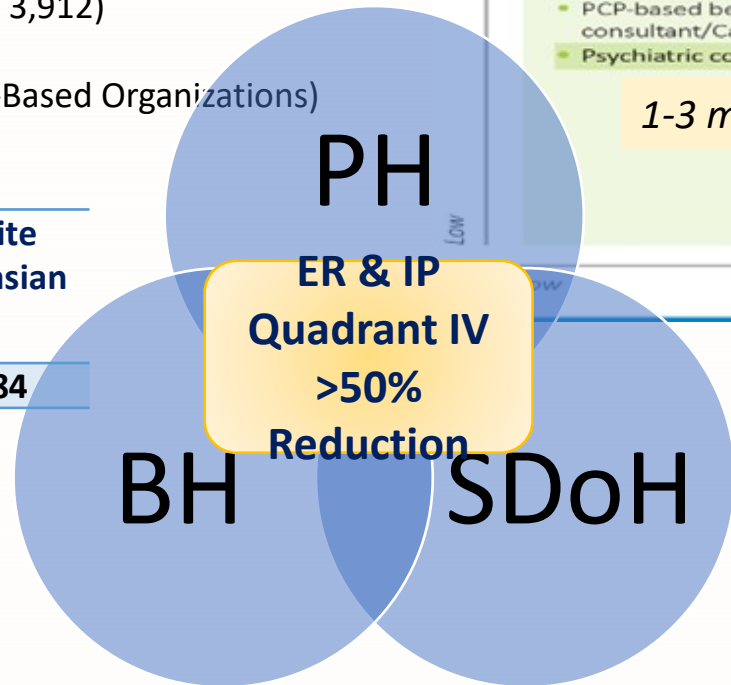
## ICCM 2021 Year-End Results involving 16 Provider Groups:

- 52% reduction in avoidable ER visits for those positive with SDoH
- 57% reduction in avoidable inpatient admissions, positive with SDoH
- 59% increase in member SDoH assessments vs prior year (2,461 vs 3,912)
- 134% increase in SDoH referrals vs prior year (1,718 vs 4,021)
- 234% increase in Got Help (SDoH needs addressed by Community-Based Organizations) vs prior year (505 vs 1,685)

Members "Got Help" Jan – July 2022	Ethnicity Not Provided or Blank	Black	Ethnicities (including Black, excluding White)	White Caucasian
3057	170	1392	1703	1184

## Year over Year, since 2018:

- 17% reduction in ER visits
- 8% reduction in inpatient visits
- \$2000 Per Member Per Year Cost of Care Savings
- Consistent Improvements with HEDIS



# ICCM as a Rural Health Solution in 2023

*To address vulnerable populations in rural and remote areas*



- Go-Live in 2023, Healthy Blue is aggregating rural health clinic providers with smaller patient panels (*providers with fewer than 500 members*) with the BH specialized care management group, **Target Health Care Management**
- In rural parishes of greatest need - ***Avoyelles, Concordia, East Carroll, Madison, Natchitoches, Sabine, Tensas, Webster, West Carroll, and Winn***
  - **40 RHCs to start with >3,300 members**
- Customized version of ICCM that encourages an increase in the ***diversity of participating VBP providers*** and helps address access to care, health equity, and geographic disparities involving member outcomes...

# Claims-based Incentive Table

FOR: Target Care RHCs, BH, Facilities, LGEs, Pediatricians, Specialists, etc.



ICCM Navigation Code & Rate	Requires Z-Code: *Z-Codes are reimbursed either at \$10 or \$0 and is dependent upon CMS bi-annual Z-Code updates.	<b>Non-FQHC/RHCs - Physician/Professional Description</b> <i>BH, Facilities, LGEs, Pediatricians, Specialists, Traditional PCPs, etc.</i>  <b>Purpose:</b> <i>“WARM TRANSFERS” involved in community care coordination</i>
<b>98960</b> <b>\$108</b> <b>Per Service</b>	<b>+ Z-Code*</b> <b>(\$10 or \$0)</b>	Peer Navigation Services – all provider types, not just primary care, whether licensed or unlicensed, using the MHR definition (regarding education requirements) for “unlicensed” – Community Navigation / Peer Navigation per service - All provider types and facilities like PCPs, FQHCs/RHCs, LGEs, pediatricians, specialists, BH and facilities

# Claims-based Incentive Table

FOR: FQHCs



Encounter Code	ICCM Codes & Rates	FQHC / RHC Description
	*Z-Codes are reimbursed either at \$10 or \$0 and is dependent upon CMS bi-annual Z-Code updates.	NOTE: The ICCM FQHC/RHC set of codes should be used in conjunction with a Medical (T1015) or BH (H2020) Encounter Code. The ICCM FQHC/RHC codes shall pay at the following rates, however, T1015 or H2020 encounter codes shall pay at zero.
<b>T1015 or H2020</b>  <b>\$0</b>	<b>G0511 (per month)</b> <b>\$48.60</b> + <b>Z- Code*</b> <b>(\$10 or \$0)</b>	FQHC/RHC: Care Management services, General BH Integration (BHI) Services - minimum 20 min/month, primary care, FQHCs/RHCs
<b>T1015 or H2020</b>  <b>\$0</b>	<b>G0512 (per month)</b> <b>\$128.88</b> + <b>Z-Code*</b> <b>(\$10 or \$0)</b>	FQHC/RHC: Psych Collaborative care mgmt. - 60 min/month – CoCM, primary care, FQHCs/RHCs
<b>T1015 or H2020</b>  <b>\$0</b>	<b>98960 (per service)</b> <b>\$108.00</b> + <b>Z-Code*</b> <b>(\$10 or \$0)</b>	FQHC/RHC Peer Navigation Services - all FQHC/RHC provider types, whether licensed or unlicensed, using the LDH issued MHR definition for “unlicensed”; clinical supervision and documentation of Health Education are required. - Community Navigation / Peer Navigation per Service - All provider types and facilities like PCPs, FQHCs/RHCs, LGEs, pediatricians, specialists, BH and facilities



# ICCM Navigation Functions

Requirements to bill 98960 at \$108 + Z-code



Encounter Checklist	+ Z-Code	HEDIS Checklist	SDoH Screener \$20 8 per yr max	4 Quadrant Risk Stratification for Case Management Assignment	ACE, GAD, CAGE, SBIRT, Etc	Discharge Checklist	ER Survey	Treatment Plan & Health Record	New 2023: HRA \$20
Every Encounter	Every Encounter for \$108 Enhanced Rate	Every Encounter	First encounter, then as needed, Scale 1-10	First encounter, then as needed	As needed	After discharge, every stay	Every ER Visit	Every Encounter	+Z55.9 First, then each 6 months

# 2023: Birthing-Newborn Advocacy Go-LIVE

*Maternal & Newborn Z-Codes will pay at \$10 – Selected FQHC/RHCs*

[2021/2022 Newborn ICD-10-CM Codes \(icd10data.com\)](https://www.icd10data.com)

[Z Codes and Reproductive Services Challenge - Coding Guidelines - Medical Coding Buff](#)

<https://open.bu.edu/handle/2144/41455> (Model produces 16% CoC Savings, PMPY)



**Newborn ICD-10-CM Codes:** The following 41 ICD-10-CM codes are intended for newborns and/or neonates of age 0 years as each code is clinically and virtually impossible to be applicable to patients of any age greater than this.

- [Z00.110](#) Health examination for newborn under 8 days old
- [Z00.111](#) Health examination for newborn 8 to 28 days old
- [Z05.0](#) Observation and evaluation of newborn for suspected cardiac condition ruled out
- [Z05.1](#) Observation and evaluation of newborn for suspected infectious condition ruled out
- [Z05.2](#) Observation and evaluation of newborn for suspected neurological condition ruled out
- [Z05.3](#) Observation and evaluation of newborn for suspected respiratory condition ruled out
- [Z05.41](#) Observation and evaluation of newborn for suspected genetic condition ruled out
- [Z05.42](#) Observation and evaluation of newborn for suspected metabolic condition ruled out
- [Z05.43](#) Observation and evaluation of newborn for suspected immunologic condition ruled out
- [Z05.5](#) Observation and evaluation of newborn for suspected gastrointestinal condition ruled out
- [Z05.6](#) Observation and evaluation of newborn for suspected genitourinary condition ruled out
- [Z05.71](#) Observation and evaluation of newborn for suspected skin and subcutaneous tissue condition ruled out
- [Z05.72](#) Observation and evaluation of newborn for suspected musculoskeletal condition ruled out
- [Z05.73](#) Observation and evaluation of newborn for suspected connective tissue condition ruled out
- [Z05.8](#) Observation and evaluation of newborn for other specified suspected condition ruled out
- [Z05.9](#) Observation and evaluation of newborn for unspecified suspected condition ruled out
- [Z38.00](#) Single liveborn infant, delivered vaginally
- [Z38.01](#) Single liveborn infant, delivered by cesarean
- [Z38.1](#) Single liveborn infant, born outside hospital
- [Z38.2](#) Single liveborn infant, unspecified as to place of birth
- [Z38.30](#) Twin liveborn infant, delivered vaginally
- [Z38.31](#) Twin liveborn infant, delivered by cesarean
- [Z38.4](#) Twin liveborn infant, born outside hospital
- [Z38.5](#) Twin liveborn infant, unspecified as to place of birth
- [Z38.61](#) Triplet liveborn infant, delivered vaginally
- [Z38.62](#) Triplet liveborn infant, delivered by cesarean
- [Z38.63](#) Quadruplet liveborn infant, delivered vaginally
- [Z38.64](#) Quadruplet liveborn infant, delivered by cesarean
- [Z38.65](#) Quintuplet liveborn infant, delivered vaginally
- [Z38.66](#) Quintuplet liveborn infant, delivered by cesarean
- [Z38.68](#) Other multiple liveborn infant, delivered vaginally
- [Z38.69](#) Other multiple liveborn infant, delivered by cesarean
- [Z38.7](#) Other multiple liveborn infant, born outside hospital
- [Z38.8](#) Other multiple liveborn infant, unspecified as to place of birth

**Reproductive services Z-Codes** are found in the section called Persons Encountering Health Services in Circumstances Related to Reproduction (Z30-Z39):

- Z30, Encounter for contraceptive management
- Z31, Encounter for procreative management
- Z32, Encounter for pregnancy test and childbirth and childcare instruction
- Z33, Pregnant state
- Z34, Encounter for supervision of normal pregnancy
- Z36, Encounter for antenatal screening of mother
- Z37, Outcome of delivery
- Z38, Liveborn infants according to place of birth and type of delivery
- Z39, Encounter for maternal postpartum care and examination
- Z3A, Weeks of gestation

# ICCM HEDIS Set

Within our Integrated Collaborative Care Model (ICCM), for a selection of providers, **HEDIS measures are being incented by ethnicity progressively across all percentiles.**



## ICCM Composite Set of Incented Measures

(Percentile Targets set per Provider Population)

FUH: Follow-Up After Hospitalization for Mental Illness — 7

FUH: Follow-Up After Hospitalization for Mental Illness — 30 Day

FUM: Follow-Up After Emergency Department Visit for Mental Illness — 7 Day

FUM: Follow-Up After Emergency Department Visit for Mental Illness — 30 Day

FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence — 7 Day

FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence — 30 Day

SMD: Diabetes Monitoring for People With Diabetes and Schizophrenia

SMC: Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia

CDC

- 140/90
- Eye Exam
- A1c Test
- A1c Control <8%
- Poor A1c Control >9%

SSD: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications

SAA: Adherence to Antipsychotic Medications for Individuals With Schizophrenia

APM: Metabolic Monitoring for Children and Adolescents on Antipsychotics

IET: Initiation of AOD Treatment: Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis.

IET: Engagement of AOD Treatment: Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit.

POD Total: Pharmacotherapy for Opioid Use Disorder

**NEW 2023** - PPC1: Pre

**NEW 2023** - PPC2: Post

**NEW 2023** – Health Equity Measures



Healthy Blue



# ICCM 2023 Health Equity Incentives

FOR: Selected FQHCs/RHCs in 2023



Each Percentile = \$.05 Value but with a PMPM max overall value and a payout ceiling		Percentiles					
		25th	33*	50	66*	75	90
HEDIS PMPM (All Ethnicities)	HEDIS Report	\$0.05	\$0.10	\$0.15	\$0.20	\$0.25	\$0.30
<b>By Ethnic Disparity</b>	HEDIS Report	\$0.05	\$0.10	\$0.15	\$0.20	\$0.25	\$0.30

# Integrated Collaborative Care Team



## HBL ICCM Program Management Team:

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