DEFINING PRIMARY CARE AND BEHAVIORAL HEALTH EXPENDITURES

Public Listening Session

February 12, 2020

CENTER FOR HEALTH INFORMATION AND ANALYSIS

CHIA.

Agenda

- Discuss objectives of supplemental data collection
- Outline proposed specifications
- Review next steps
- Solicit public feedback and respond to questions

Objectives

- Enable measurement of behavioral health and primary care expenditures
- Specify detailed service categories using standard codes that appear on medical and prescription drug claims
- Leverage existing data specifications as much as possible to minimize burden on data submitters
- Support future initiatives and policies related to primary care and behavioral health

Proposed Specifications: Overview

- Data submitters will be asked to categorize expenses into mutually-exclusive, hierarchal categories
- Data will be classified based on a combination of **provider types** and **service types**, based on defined code sets provided by CHIA
- Population will be Massachusetts resident-members for whom the data submitter provides primary, medical insurance
  - Consistent with current Total Medical Expense (TME) requirements
- Expenditures will reflect allowed amounts – separately identifying the amount paid by the insurer as well as any member cost-sharing

Proposed Specifications: Overview

Expenses will be reported by the following mutually-exclusive subcategories:

Behavioral Health (BH)	Primary Care (PC)	All Other Services
▪ BH Inpatient Facility	▪ PC Office Type Visits	▪ Other Medical
▪ BH Inpatient Professional	▪ PC Home/Nursing Facility Visits	▪ Other Prescription Drugs
▪ BH ED/Observation Facility	▪ PC Preventive Visits	▪ Other Non-Claims*
▪ BH ED/Observation Professional	▪ PC Other Visits	
▪ BH Outpatient Facility	▪ PC Immunizations & Injections	
▪ BH Outpatient Professional	▪ PC Obstetric Visits	
▪ BH Prescription Drugs	▪ PC Non-Claims*	
▪ BH Non-Claims*		

*Non-claims based expenditures will be further broken out into additional categories – see slide 14 for detailed information.

Proposed Specifications: Overview

- **Behavioral health** service expenses classified based on combinations of:
  - ICD-10-CM Principal Diagnosis Code
  - Current Procedure Terminology (CPT) / Healthcare Common Procedure Coding System (HCPCS) codes
  - Place of Service (POS) Codes
  - Revenue Codes
  - National Drug Codes (NDC)
  - Provider Types

- **Primary care** expenses will be classified based on combinations of CPT/HCPCS codes and Provider Types

- **Non-claims expenses** will be more generally defined, and reliant on payer-provider contractual definitions

*Services paid on capitation should *not* be reported using fee-for-service equivalents; rather, these payments will be reported in the non-claims capitation category.

Proposed Specifications: Behavioral Health

Service Types

1. **Behavioral Health Inpatient** (Facility): All payments made to acute and non-acute facilities for facility claims in an inpatient setting, with a behavioral health principal diagnosis.

2. **Behavioral Health Inpatient** (Professional): All payments made for professional services in an inpatient setting, for claims with a behavioral health principal diagnosis.

3. **Behavioral Health Emergency Department / Observation** (Facility): All payments made for emergency or observation services in an acute or non-acute facility for facility claims with a behavioral health principal diagnosis.

4. **Behavioral Health Emergency Department / Observation** (Professional): All payments made for professional services when delivered by a behavioral health provider, in an emergency department or observation setting, for claims with a behavioral health principal diagnosis.

Proposed Specifications: Behavioral Health

Service Types

5. **Behavioral Health Outpatient** (Facility):
   a) All payments for BH-specific facility outpatient services, including intensive outpatient services and other diversionary care and residential treatment, with a behavioral health principal diagnosis, delivered by any provider type.

   b) All payments for facility outpatient face-to-face and telehealth services, including evaluation and management and integrated behavioral health primary care services, excluding ancillaries, with a behavioral health principal diagnosis, when delivered by a behavioral health provider.

6. **Behavioral Health Outpatient** (Professional):
   a) All payments for BH-specific professional outpatient services, including intensive outpatient services and other diversionary care and residential treatment, with a behavioral health principal diagnosis, delivered by any provider type.

   b) All payments for professional outpatient services, including evaluation and management and integrated behavioral health primary care, in combination with a behavioral health principal diagnosis and specified list of procedure codes, when delivered by a behavioral health provider.

Proposed Specifications: Behavioral Health

Service Types

7. **Prescription Drugs: Behavioral Health:** All payments made for prescription drugs prescribed to address behavioral health needs, based on a specified set of National Drug Codes (NDC)

    - Note that Medication Assisted Treatment (MAT) codes H0020 and H0033 should be included in the behavioral health outpatient category, *not* in prescription drugs.

Proposed Specifications: Behavioral Health

Provider Types

- Physician: addiction specialist
- Physician: psychiatrist
- Community Mental Health Center
- Counselor (including LMHC and LADC)
- Early Intervention Agency
- Licensed Social Worker
- Local Education Agency
- Marriage and Family Therapist
- Peer Recovery Specialist
- Nurse Practitioner: psychiatric
- Psychiatric Rehabilitation Practitioners
- Psychologist
- Registered Behavior Technician
- Single Specialty Group (specializing in behavioral health services)

Proposed Specifications: Primary Care

Service Types

1. **Office Type Visits:** All payments made for professional evaluation and management services, delivered in an office or other outpatient setting, including telehealth.

2. **Home/Nursing Facility Visits:** All payments made for professional evaluation and management services, delivered in the home, rest home, or nursing facility.

3. **Preventive Visits:** All payments made for professional preventive medicine services, including exams, screenings, and counseling.

4. **Other Primary Care Visits:** All payments made for professional services, including initial Medicare enrollment visit, annual wellness visits, and chronic disease care.

5. **Immunizations and Injections:** All payments made for the professional administration of injections, infusions, and vaccinations.

6. **Obstetric Visits:** All payments made for the professional components of routine obstetric care, as well as OB/GYN evaluation and management services.

Proposed Specifications: Primary Care

Provider Types

- Physician: family medicine
- Physician: internal medicine
- Physician: general practice
- Physician: pediatrics
- Physician: adolescent medicine
- Physician: general internal medicine
- Physician: geriatric medicine
- Physician: obstetrics and gynecology*
- Physician: preventive medicine
- Certified clinical nurse specialist
- Federally Qualified Health Center
- Community Health Center
- Homeopathic medicine
- Naturopathic medicine
- Nurse Practitioner: adult health
- Nurse Practitioner: family medicine
- Nurse Practitioner: gerontology
- Nurse Practitioner: pediatrics
- Nurse Practitioner: primary care
- Nurse Practitioner: women's health
- Nurse Practitioner: obstetrics and gynecology*
- Nurse, non-practitioner
- Physician's assistant
- Physician's assistant, medical
- Primary Care Clinic
- Rural Health Clinic

*Expenses for services delivered by these practitioner types should only be reported as primary care when the **Obstetric Visit** CPT codes are present on the claim.

Proposed Specifications: All Other Services

Service Types

1. **All Other Services:** Medical Expenses
2. **All Other Services:** Prescription Drug Expenses

Proposed Specifications: Non-Claims

These non-claims categories will be further subcategorized into Behavioral Health, Primary Care, and All Other:

1. **Incentive Programs**: All payments made to providers for achievement in specific pre-defined goals for quality, cost reduction, or infrastructure development.

2. **Capitation**: All payments made to providers not on the basis of claims. Amounts reported as capitation should not include any incentives or performance bonuses.

3. **Risk Settlements**: All payments made to providers as a reconciliation of payments made. Amounts reported as Risk Settlement should not include any incentive or performance bonuses.

4. **Care Management**: All payments made to providers for providing care management, utilization review, discharge planning, and other care management programs.

5. **Other Non-Claims**: All other payments made pursuant to the payer's contract with a provider that were not made on the basis of a claim for medical services and that cannot be properly classified elsewhere.

Next Steps

- Slides and detailed proposal document posted to CHIA's website
- Feedback can be submitted through **Friday, February 28, 2020** via email to chia.transparency@state.ma.us
- CHIA will consolidate and summarize feedback in a written document that will be available on CHIA's website
- Final specifications will be issued in March 2020
- CHIA proposes data submissions to be submitted in May 2020, as part of the regular TME/APM filing

Discussion

- Are there other services, activities, or provider types not mentioned here that should also be considered behavioral health and primary care?
- CHIA is proposing to supply standard code sets; do you have additional internal classifications for primary care and behavioral health not listed in this proposal?
- Should CHIA consider adding prescription drugs considered preventive services under the Affordable Care Act to the primary care specification?
- Can data submitters separate physician and other provider types within the professional categories?
- Can non-claims based payments be divided by behavioral health and primary care?
- How much lead time would data submitters expect to need to report this data to CHIA?

Appendix: Code Sets

Behavioral Health Prescription Drugs

- See attached NDC List

Appendix: Code Sets

Behavioral Health Diagnosis Codes

ICD-10 Code	Description	Notes and Exclusions
F01 - F09	Organic, including symptomatic, mental disorders	
F10 – F16. 99	Mental and behavioral disorders due to psychoactive substance use	Excluding F17
F18 - F19.99	Inhalant Related Disorders	
F20 - F29	Schizophrenia and Delusional disorders	
F30 - F39	Mood disorders	Excluding F38
F40 - F48	Neurotic, stress-related, somatoform disorders	
F50 - F59	Behavioral syndromes	Excluding F54
F60 -F69	Disorders of adult personality and behavior	Excluding F61 and F62
F80-F89	Disorders of psychological development	Excluding F83
F90-F98	Behavioral and emotional disorders with childhood/adolescent onset	Excluding F92
F99	Mental disorder, not otherwise specified	

Appendix: Code Sets

Behavioral Health Inpatient Service Types

Measure Category	Specifications
Inpatient Facility	Report allowed amounts across all claims lines when a Facility claim has one or more of the following Revenue codes: (100-219; 1000-1002) with a behavioral health principal diagnosis
Inpatient Professional	Report allowed amounts across all medical claim lines for Professional claims with the following Place of Service codes (21, 31, 32, 34, 51, 55, 56, 61) with a behavioral health principal diagnosis

Appendix: Code Sets

Behavioral Health ED / Observation Service Types

Measure Category	Specifications
Emergency Department / Observation Facility	Report all allowed amounts across all claim lines for Facility claims with one or more of the following Revenue codes: (450-452; 456, 459; 760 - 762; 769; 981) with a behavioral health principal diagnosis
Emergency Department / Observation Professional	Report allowed amounts for only those claim lines on which a Professional claim has CPT codes in (99217-99220) or (99281-99285) with a behavioral health provider and with a behavioral health principal diagnosis

Appendix: Code Sets

Behavioral Health Outpatient Service Types

Measure Category	Specifications
Outpatient Professional	Report allowed amounts for only those claim lines on which a Professional claim has: POS codes in (02, 03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 57, 71, 72) *and*, CPT/HCPCS Codes in (97530, 97535, 97110-97112; 97803; 98966-98969; 99201-99205; 99211-99215; 99221-99223; 99231-99233; 99238-99239; 99241-99245; 99251-99255; 99291; 99341-99350; 99441-99444; 99483; 99510; 99381-99387; 99391-99397; 99534; 99401-99404; 99408-99409; 99411-99412; 99420; 98960-98962; 99078; G0463; G9012; T1006; T1012; T1015) with a behavioral health provider and with a behavioral health principal diagnosis ***Or,*** POS codes in (03, 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 57, 71, 72) *and*, CPT/HCPCS codes (90785;90791, 90792; 90832-90834, 90836, 90837, 90838, 90839, 90840, 90845, 90847, 90849, 90853, 90867, 90868, 90869, 90870, 90875, 90876, 96101-96105, 96110, 96111, 96112, 96113, 96116, 96118-96119; 96120; 96121, 96125, 96127, 96130-96133, 96136-96139; 96146; 96150-96155; 96484, 99494; G0396, G0397, H0049, H0050; G0155, G0176, G0177, G0409, G0410, G0411, G0442, G0443, G0451, H0001, H0002, H0004, H0005, H0007, H0011-H0018, H0020, H0022, H0031-H0040, H0047; H0049; H0050, H2000, H2001, H2010-H2020, H2035, H2036, S0109, S0201, S9475, S9480, S9484, S9485) with a behavioral health principal diagnosis

Appendix: Code Sets

Behavioral Health Outpatient Service Types

Measure Category	Specifications
Outpatient Facility	Report allowed amounts across all claim lines when a Facility claim has: Revenue codes in (510, 513, 515, 516, 517, 519, 520, 521, 522, 523, 526, 527, 528, 529, 982, 983) with a behavioral health provider and with a behavioral health principal diagnosis Or, Revenue codes in (900, 901, 902, 903, 904, 905, 906, 907, 911, 912, 913, 914, 915, 916, 917, 918, 919, 944, 945) and with a behavioral health principal diagnosis

Appendix: Code Sets

Primary Care Service Types

Measure Category	Specifications
Office Type Visits	Report allowed amounts only for claim lines for Professional claims with CPT codes in (98966; 98967; 98968; 98969; 99201-99205; 99211-99215; 99241-99245)
Home/Nursing Facility Visits	Report allowed amounts only for claim lines for Professional claims with CPT codes in (99339-99340; 99324-99328; 99334-99337; 99304-99310, 99315-99316; 99318; 99341-99345; 99347-99350; 99354-99355; 99358; 99359)
Preventive Visits	Report allowed amounts only for claim lines for Professional claims with CPT codes in (99381-99385; 99386-99387; 99391-99395; 99396-99397; 99401-99404; 99406-99409; 99411-99412; 99420; 99429; 99442; 99444; 99495-99496)
Medicare Visits	Report allowed amounts only for claim lines for Professional claims with HCPCS codes in (G0008-G0009; G0402; G0438-G0439; G0444; G0463; G0502-G0507; T1015; 99487; 99489; 99490; G0506)
Immunizations and Injections	Report allowed amounts only for claim lines for Professional claims with CPT codes in (90460-90461; 90471-90474; 90649; 90670; 90658; 90686; 90688; 90715; 90732; 90736; 96372)
Obstetric Visits	Report allowed amounts only for claim lines for Professional claims with CPT codes in (59400; 59610; 59618; 99460-99465)