DEFINING PRIMARY CARE AND BEHAVIORAL HEALTH EXPENDITURES

Public Listening Session
February 12, 2020
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.
Expenses will be reported by the following *mutually-exclusive* subcategories:

<table>
<thead>
<tr>
<th>Behavioral Health (BH)</th>
<th>Primary Care (PC)</th>
<th>All Other Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>BH Inpatient Facility</td>
<td>PC Office Type Visits</td>
<td>Other Medical</td>
</tr>
<tr>
<td>BH Inpatient Professional</td>
<td>PC Home/Nursing Facility Visits</td>
<td>Other Prescription Drugs</td>
</tr>
<tr>
<td>BH ED/Observation Facility</td>
<td>PC Preventive Visits</td>
<td>Other Non-Claims*</td>
</tr>
<tr>
<td>BH ED/Observation Professional</td>
<td>PC Other Visits</td>
<td></td>
</tr>
<tr>
<td>BH Outpatient Facility</td>
<td>PC Immunizations &amp; Injections</td>
<td></td>
</tr>
<tr>
<td>BH Outpatient Professional</td>
<td>PC Obstetric Visits</td>
<td></td>
</tr>
<tr>
<td>BH Prescription Drugs</td>
<td>PC Non-Claims*</td>
<td></td>
</tr>
<tr>
<td>BH Non-Claims*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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
  - 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.
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
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
## Behavioral Health Diagnosis Codes

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

## Behavioral Health Inpatient Service Types

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Facility</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Inpatient Professional</strong></td>
<td>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</td>
</tr>
</tbody>
</table>
## Appendix: Code Sets

### Behavioral Health ED / Observation Service Types

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Department / Observation Facility</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Emergency Department / Observation Professional</strong></td>
<td>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</td>
</tr>
</tbody>
</table>
### Behavioral Health Outpatient Service Types

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>Report allowed amounts for only those claim lines on which a Professional claim has:</td>
</tr>
<tr>
<td></td>
<td>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) \textit{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</td>
</tr>
<tr>
<td>Professional</td>
<td>\textit{Or},</td>
</tr>
<tr>
<td></td>
<td>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) \textit{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</td>
</tr>
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## Behavioral Health Outpatient Service Types

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</thead>
</table>
| 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

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office Type Visits</strong></td>
<td>Report allowed amounts only for claim lines for Professional claims with CPT codes in (98966; 98967; 98968; 99201-99205; 99211-99215; 99241-99245)</td>
</tr>
<tr>
<td><strong>Home/Nursing Facility Visits</strong></td>
<td>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)</td>
</tr>
<tr>
<td><strong>Preventive Visits</strong></td>
<td>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)</td>
</tr>
<tr>
<td><strong>Medicare Visits</strong></td>
<td>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)</td>
</tr>
<tr>
<td><strong>Immunizations and Injections</strong></td>
<td>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)</td>
</tr>
<tr>
<td><strong>Obstetric Visits</strong></td>
<td>Report allowed amounts only for claim lines for Professional claims with CPT codes in (59400; 59610; 59618; 99460-99465)</td>
</tr>
</tbody>
</table>