The Practice Sentry, LLC
Behavioral Solutions, P.C.

Urgent Memo

To: All Clinicians

From: Bruce A. Maloof

Date: October 8, 2012

Re: Please pay very close attention to the items below

I hope that you all had a great summer! From the point of view of changes it has been a very quiet time. Internally, the biggest emphasis has been on growing the number of licensed affiliates in the practice. Thanks to all of you who have referred colleagues! (1) Even now there are only a few changes internally to make you aware of. They will be found below under **Important Business.** (2) The second section will give you a summary of some upcoming changes that were summarized by NASW in a recent correspondence from them (two of the three items apply to all licensed clinicians). (3) Finally, there has been a real quake in the healthcare environment with the passage this summer of another Massachusetts healthcare reform bill. I have tried to provide you with a digest of the most important features affecting private practice. In sum these changes are, as anticipated earlier this year, all very favorable to large group practices. However, it does mean that there will be organizational changes that will be necessary to take full advantage of this opportunity.

The most immediate concerns are in the **Important Business** section, so please be sure to read these right away. While the rest can be delayed, they are nevertheless time-sensitive and I urge you to read them soon.

Important Business

- For most of you, the month of October is the time during which you must renew your licenses and malpractice insurance policies. Please send your updated licenses and insurance plans to Gail as soon as you get them.

- CPT codes will be changed. Effective January 1, 2013 the new CPT codes must be used for all billing. They are not expected to change much for non-prescribers, but we will let you know the changes as soon as the final cross-walk between current codes and new codes are finalized and promulgated by the AMA.

- **Effective immediately, please send your TRFs for your Blue Cross/Blue Shield patients directly to Janet via fax (781-221-3183) or e-mail (janetknight2@verizon.net). We will submit them to BC/BS on your behalf—this will enable us to track these requests to make sure that the insurer responds to these in a timely fashion.**

- We are approaching that time of the year when an increasing number of patients have or will soon max-out their benefit limits. Remember that the benefit limit varies considerably from plan to plan. If there is an annual benefit limit that information was supplied to you for each patient at the time the referral was made to you by Gail. Just refer back to the material she faxed to you at the time. The benefit limit is separate from medical necessity—patients can still meet the requirements of medical necessity, and yet their claims can be rejected for being outside of the benefit limit.

- From time to time we notice that some of you have forgotten your passwords and follow our web site prompts about getting new ones issued. Please discontinue that practice. Simply contact Paula or myself and we will remind you of your password. If you wish to change it to something that is more memorable for you, that's fine. Just let us know what you want it to be. As the Administrator for the web site I have to be able to work easily with our web hosting agent to reconstruct the site in the event it crashes, and it is a nightmare to do that if I do not have a record of the active password for each member, i.e., therapist. If you have already changed your password, please send that information along to me or Paula via e-mail or voice mail at your earliest convenience.

Excerpt from NASW Communication (much will effect other licensees)

The following was excerpted directly from a communication from NASW but bullets one and three apply to all licensed clinicians regardless of discipline.

"Clinical social workers should prepare for three major practice changes which will significantly impact the way in which clinical social workers practice and seek reimbursement for mental health services they perform. Occurring in 2013, the changes are in the areas of coding, diagnosing, and measurement and include the following:

- **The psychiatric Current Procedural Terminology (CPT) codes are expected to change January 1, 2013**. Clinical social workers use CPT codes to identify services/procedures performed when seeking reimbursement. Changes will include replacement of the current outpatient individual, interactive, and residential care CPT psychotherapy codes. As information is disseminated about the new codes, NASW will inform its members of the new codes, and develop training and technical assistance to assist its members in adapting to the new coding changes.

- **The Centers for Medicare and Medicaid Services (CMS) has announced the Physician Quality Reporting System (PQRS) will subject clinical social workers and other health care professionals who are Medicare providers to a 1.5 percent penalty fee in 2015 if they do not use measures when performing services to Medicare patients during the year of 2013.** PQRS is a program promoting the reporting of measures to determine quality services. To avoid this penalty in 2015, clinical social workers must begin using clinical measures developed by PQRS in 2013. A list of measures and instructions on how to use measures with Medicare patients is available online at the PQRS Web site at the following link: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqrs

- **The fifth edition of the *Diagnostic Statistical Manual of Mental Health Disorders (*DSM-5) is expected to be released in May 2013**. The DSM is a classification of mental health disorders commonly used by clinical social workers when conducting a diagnostic assessment. Clinical social workers may find changes which include new, deleted, or expanded diagnostic criteria and coding for mental health diagnoses. NASW will provide additional information about the DSM-5 as it becomes available and assist members in transitioning to the DSM-5 through trainings and technical assistance."

A Front Row Seat to Healthcare Reform—Very, Very Important Developments

It has been a while since I distributed a Provider Memo because operationally our world of behavioral healthcare has been pretty quiet. **That is all about to change**. At the end of this legislative session the new Massachusetts Health Care Reform Act passed without much opposition. Generally, members of the legislature have been softened to negotiation by the abysmal economics of healthcare. Two words often came up in my discussion with legislative aides, and members of the Governor's Commission that developed the substantive spine of the new act to describe the economics of the current healthcare climate. They were "grim" and "catastrophic."

A lot of hope and expectation are invested in the new Act, and it is the first "reform" in Massachusetts that calls for more than incremental changes in the way care is delivered and paid for. Here are some of the major changes that are called for and the timetable is being discussed in the context of Governor Patrick's sentiment that we need these provisions now.

- Perhaps the biggest changes are (1) the growing need for providers to contract with ACOs (see below) rather than with insurance companies, and (2) the fading use of fee-for-service in favor of global payments to reimburse all healthcare services. The short definition of a "global payment" is a single payment to a service provider who then has the responsibility to deliver all care to a designated population of patients. If the provider does that for less than what was paid, it gets to keep the extra as "profit". If it fails to, it will incur losses, as the services must still be provided. Service providers will probably seek to be indemnified by what is referred to as "stop-loss" insurance, which will cover losses beyond a certain dollar amount (to be sure premiums will be expensive).

- Global payments are not so new. They made a brief appearance in the '80s as "capitated contracts". These generally failed for a host of reasons leaving everyone in the lurch. This time around there are a number of provisions and safeguards intended to reduce those risks. Several years ago SAMSHA developed guidelines for ACOs (Accountable Care Organizations). These ACOs may also take the form of what is referred to as Medical Homes. These are the organizations that will be the recipients of the Global Payments. In order to be eligible as an ACO, these service providers will have to be large enough (minimum of 5000 active patients) to amortize the risk of a global payment over the entire population they serve. (There are several other requirements to qualify as well.) Some insurance companies are actually way ahead of the curve. BC/BS of MA, for example, has been using a contract model known as AQC with well over half of its medical practices for several years. This is one of the reasons that nearly every seemingly independent physician is actually an affiliate of a much larger practice. It is and increasingly will become the norm in order for physicians to practice.

- The second biggest change is the expectation that primary care physician practices must integrate behavioral healthcare services in their comprehensive service model. Some will actually hire behavioral healthcare specialists to work within their practices (already happening), others will contract out for these service

(already happening) and others may use a hybridization of these two models. Conversations with Medical Homes and AQCs that are already in existence indicate that they will be looking to contract with large behavioral health group practices because of the efficiency of scale, relative ease of accessibility, the ability of groups to respond more easily to legislative requirements, especially information systems (more on information systems below), and the shear impossibility of finding enough physical space in a practice to house enough behavioral care specialists with a broad enough range of expertise.

- A third mandated change is the coordination of care. It is the expectation that ACOs and their contracted affiliates will coordinate patient care, at a minimum by means of interoperable information systems, i.e., systems that can "talk to each other" and in which individual service providers have access to patient record entries of other providers in the system (subject to some ethical and confidentiality guidelines).

- A fourth expectation (already in place in AQCs) is the use of outcome measures. There will be a real push by insurers to require that practices meet not only certain standards of care vis a vis procedures, but that practices demonstrate that they produce acceptable levels of outcome.

- A fifth development that is expected is the growing use of behavioral healthcare paraprofessionals. This is not legislatively mandated, but insurance in collaboration with their contracted service providers, is expecting this because providers and insurers alike see that the highest users of behavioral healthcare services need a lot of case management services that are beyond the scope of the telephonic services insurers now offer and are needed *in vivo.* These are services that are not economically provided by licensed clinicians, most clinicians are poorly trained in case management, and most clinicians do not want to operate as case managers. The impetus behind this is the blurring line between public and private outpatient services. Private outpatient practices wind up with larger numbers of severely and chronically decompensated patients. These patients can use up to 900% more behavioral healthcare dollars than the general population. They are also very difficult to keep in treatment and to keep them compliant with treatment. When they leave or fail to comply with behavioral healthcare treatment they have many more psychiatric hospitalizations and also unnecessarily burden primary care physicians.

- Information systems are seen as a necessary component of better quality and less expensive care. They are a SAMSHA requirement to qualify as an ACO. Since there are dozens of information systems, the only acceptable ones will be those that are interoperable. The Practice Sentry, LLC is working with an information systems contractor to incorporate such a system as we prepare ourselves for contracting with ACOs and Medical Homes. It is unlikely that solo practitioners will invest in EMRs (electronic medical records) that meet both CMS (Medicare) and SAMSHA requirements because of the cost of these systems, but if some of you elect to do so, remember (1) CMS endorsed, and (2) meets standards of interoperability.

- There will be three different oversight bodies called for in the new legislation. These are intended to protect consumers, and represent major healthcare constituents (including professional associations such as NASW, MPA, etc).

A great deal more policy and procedural changes can be expected as the new legislation is operationalized. I currently Co-Chair the HMO/Managed Care Commission, and am a member of the Professional Advisory Councils of both Blue Cross/Blue Shield of Massachusetts and Tufts Health Plan, and have pretty good access to some of the members of the Governor's Health Care Reform Commission, and some legislators. Consequently, as a practice we should have plenty of "heads-up" to prepare for the changes that will keep us competitive in a very new environment.