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

Urgent Memo

To: All Clinicians

From: Bruce A. Maloof

Date: December 12, 2012

Re: Please pay very close attention to the items below

A very happy holiday season to each of you!

Below you will find several very important changes that we are preparing for, and they all have the same rapidly approaching deadline imposed on us by outside bodies—namely January 1, 2013. I am referring to the CPT Code changes, the Physician Quality Reporting System (PQRS), and a new authorization year. It is important that you carefully read and follow the information provided below about these matters as each will directly affect the processing of your claims.

Under the section on the critical new items, you will also find information about a new contract that will provide a very interesting opportunity for those of you who are interested in doing some work with patient groups in a day hospital/partial hospitalization program.

The last section of the memo is a summary of developments pursuant to the new State healthcare reform act that went into effect this past summer.

Before examining the three issues I want to summarize some on-going items to be sure that you are aware of them and can tend to them as they may be applicable to you.

I apologize for the length of this memo, but in spite of the fact that I just sent one out in October so much is happening that you need to know about, I felt I could

not sacrifice information for the sake of brevity. Please be patient with its length and read the material carefully.

Thank you.

Important Ongoing Items

- Please remember to send in copies of your renewed licenses and malpractice insurance plans. Those of you who are LICSWs may have opted for the new plan being offered by NASW, do not forget to notify us of this change and send in a copy of the new plan facesheet.

- 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.

- As the new year begins, authorizations for patients that you received in 2012 will be vacated even if you have not used the total number of visits that had been authorized. The only exception to this is Tufts whose authorizations may carryover to 2013 as long as the active date range for the authorization is still in effect. As has been the case for the past two years BC/BS of MA will automatically authorize 12 visits, Beacon is 8, and Magellan, Aetna, UBH and Cigna do not require authorizations for routine services. Tricare requires a new authorization for those in active duty status with a referral from their PCP, however their dependents get the first 8 visits automatically.

Critical New Business

- I know from conversations with some of you during the interview process that there is some interest in running groups. I have negotiated a contract with a very large clinic that operates groups for

patients in a partial hospitalization/day hospital program who were recently discharged from a hospital stay. These groups are run in about seven different locations, and each group session includes an average of 6 to 8 patients and they run for two hours. There is NO responsibility for these patients outside of the group session, and the clinic expects that the notes will be generated during the sessions themselves. If you would like to explore this further, please write or call me directly.

- The Current Procedural Terminology (CPT) Codes have changed and all providers and insurers are required to comply with these changes effective January 1, 2013. There will be no delays in the implementation of these changes as had been hoped. Most of the changes affect psychiatrists, but a few will affect non-prescribers. A summary of these changes prepared by the National Council for Community Behavioral Healthcare will have been faxed to you by the time you read this memo, and will be posted on our Downloadable Forms section of our website before year-end. Keep this summary for your reference until you are completely at ease with the changes.

  If you bill for a service that you provided in 2012, you will use the old Codes. But any service that you provide in 2013 must be billed using the new Codes.

  If you are interested in getting any training in the use of the new Codes you will find that Massachusetts Medical Society and NASW are offering courses, and UBH has an on-line tutorial, and we will probably soon see that other sponsors will come forward as well.

- 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, clinicians 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**.** There will be more on this as the time for implementation approaches. If you have been watching its developments who will realize that there are a few significant changes, but the new edition is certainly not going to be the *de novo* effort some wanted it to be. Watch for CEU events offered by national training organizations.

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

Much of the information below was included in the previous provider memo, however, much more has begun to be implemented, and the pace that the Governor's Office had originally hoped for is now being realized.

The other important development is that I have been appointed to the Task Force created by the legislation that is charged with the responsibility of deciding how behavioral healthcare should be integrated with medicine, and how it should fit under the new Global Payment model.

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 services (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. Finally, as mentioned above, I have recently been approved by the Commisioner of Mental Health to be a member of the Task Force that will decide how mental health is to be integrated with primary medicine. 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.