CODING FOR BEHAVIORAL HEALTH SERVICES: EVALUATION AND MANAGEMENT CPT CODE ADOPTION
Changes to Medicare billing codes affecting provision of psychiatric services went into effect January 1, 2013. Medicaid and private payers have also been adapting coding policy to these new requirements, however, implementation of changes to the American Medical Association-maintained current procedural terminology (CPT) codes for Evaluation and Management (E/M) services has been inconsistent. This brief explains the effects of the codes and looks at how two states are dealing with the new requirements.

The stakes are high for equity in Medicaid provider reimbursement. In July 2014, the General Accounting Office (GAO) issued a report indicating that payments to physicians for E/M services under Medicaid were 27-65% lower than those received from private insurance, prior to increases required by the Health Care and Education Reconciliation Act (HCERA) in 2010. In addition, Medicaid managed care payments to physicians for such services typically were 12% higher than Medicaid fee-for-service. The report further emphasized the variation in payment across states and types of E/M services.

The National Council for Behavioral Health has invested extensive resources in educating members and other stakeholders about the required changes and best implementation practices. In June 2014, the National Council undertook a survey to determine the status of code adoption and identify related advocacy efforts by its members. The survey found that:

- Adoption of the E/M codes and interactive complexity code has been variable.
- Medicaid programs may not require that the same codes be used by managed care providers, creating the potential for coding compliance errors.
- Rate setting for E/M services typically varies between fee-for-service (FFS) and managed care providers—except in Massachusetts, where a law sets Medicaid FFS rates as the floor for managed care plans.

The American Psychiatric Association says that, in general, there has been a smooth transition to code adoption. However, implementation of the code for interactive complexity has not been universal, and in some states, rate differentials exist between E/M services provided by psychiatrists and those provided by primary care providers. Further, CMS has not required rate parity and state insurance commissioners are not enforcing such requirements among private health plans. APA is pursuing legal action in Connecticut, and monitoring the issue in Florida, Massachusetts, and Pennsylvania. APA representatives point to New York as a “good standard” for code implementation and reimbursement within health networks.

2. See New York State Office of Mental Health briefing to providers on December 12, 2013 at http://www.omh.ny.gov/omhweb/clinic_restructuring/2012-12-13cpt.pdf
In an ongoing effort to highlight the issue and encourage member action, the National Council profiled actions taken by the Association for Behavioral Healthcare (ABH) in Massachusetts and the Community Behavioral Health Association of Maryland. Their experiences underscore the importance of advocacy for E/M code adoption and offer strategic lessons for fellow National Council members.

Massachusetts – It’s About Access

Vic DiGravio, President and CEO of the Association for Behavioral Healthcare (ABH), emphasizes that ABH has long advocated for improved reimbursement policy for outpatient providers to ensure access to services. When the new CPT codes became available, two issues arose that drove ABH's work:

- Beacon Health Strategies (a major payer) implemented the new E/M codes, but weighted the rates for the top tiers of complexity—essentially under-cutting rates for the lower, less complex codes; and
- Fee-for-service (FFS) and managed care payers in the state did not consistently use all five levels of E/M codes, creating a compliance issue for providers and raising concern about negative audits.

ABH approached MassHealth (Medicaid) about the issues and learned that the agency was working on related issues at a measured pace. DiGravio says ABH sought to accelerate a solution and encountered some resistance within the agency and the executive office. Ultimately, ABH sought and successfully passed budget amendment language3 that:

- Requires all payer entities under MassHealth to adopt all CPT E/M codes;
- Sets a rate floor—behavioral health providers are paid at the same rate as medical surgical services in non-facility settings;
- Requires adjustment to managed care capitation rates to reflect changes to behavioral health services payments; and,
- Requires any Medicaid integrated care organization, managed care entity or behavioral health carve-out entity to pay, at a minimum, the MassHealth rates for all CPT E/M codes.

DiGravio notes that ABH was the primary driver of these provisions and used substantial political capital, including provider relationships with key legislators, and engaging a former senator on the Board of an ABH member organization to communicate with the former Capitol Hill colleagues. The Medicaid agency officially opposed the language, thus requiring legislative leadership to lobby Governor Deval Patrick to sign the provisions as proposed. DiGravio noted that ABH’s compliance arguments were important, but explaining the economic impact on providers was critical to their success. A key element of this economic platform was a 2013 member survey that quantified the breadth and scope of financial losses since 2010 and demonstrated the crisis experienced by outpatient service providers.

Despite legislative success, implementation of the law has been slow due to issues with the implementation of the Affordable Care Act and the requisite emergency rulemaking that made requirements of the law retroactive to January 1, 2014. DiGravio and colleagues are not concerned that the requirements are under threat, but note that delays by MassHealth and managed care organizations require advocates to maintain pressure for implementation of the law.

Maryland – Capitalizing on a Technicality

Community Behavioral Health Association of Maryland (CBH) Executive Director Herb Cromwell says the issues around coding changes and increased reimbursement for primary care providers came to his attention at a briefing of the multi-stakeholder Medicaid Advisory Committee. He noted that the state originally intended to only elevate rates for primary care, but the state’s Medicaid Management Information System (MMIS) is not able to differentiate between primary and specialty providers, so specialty providers are included as well. Cromwell noted that the state has not implemented the interactive CPT codes to date, due to complexity and the state’s concern about increased costs. They have found implementation to be relatively smooth, given that the state uses Value Options as the Administrative Services Organization (ASO) for centralized claims processing. The state medical society was a primary advocate for implementing the increase, which took effect July 1, 2013. Cromwell noted that while his organization sought retroactive implementation to January 1, 2013, the required appropriation was not approved.

Cromwell and his policy director, Lori Doyle, are particularly concerned with sustaining rates for E/M service provision. The primary care rate increase to the Medicare allowable rate is borne 100% by federal dollars until January 1, 2015, when the usual 50/50 state-federal match for Maryland resumes. Meanwhile, rate increases for specialty providers have been subject to the state’s FMAP share (50%). This required FY 2014 state appropriations of $8 million. A recent state budget impact assessment noted that the general fund burden for FY 2015 is $16 million, and advocates met with Governor Martin O’Malley to emphasize the need to include appropriations to retain the increase for both primary and specialty care through the second half of FY 2015.

While gaining Medicare rates for such services was a significant increase for Maryland providers, Cromwell and Doyle agree that the future is unclear. For example, CMS adjusts Medicare allowable rates for E/M codes each January and in 2014, rate adjustments reduced psychiatry rates by 4%, resulting in required payback of fees by several Maryland providers.

While he believes there is a “safe harbor” for rate parity due to the MMIS situation, Cromwell says that future funding to maintain the increase is unclear. Continued partnership with the state medical society to monitor the situation and advocate for sustained rate increases will be essential, he says.

### PROFIT/LOSS

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>PERCENTAGE OF ORGANIZATIONS REPORTING A LOSS FOR OUTPATIENT SERVICES</th>
<th>AVERAGE LOSS</th>
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<tr>
<td>2010</td>
<td>75%</td>
<td>$430,000</td>
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<tr>
<td>2011</td>
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<tr>
<td>2012</td>
<td>84%</td>
<td>$390,000</td>
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Figure 1 ABH Member Survey Results

### LOSS AS COMPARED TO OVERALL ANNUAL OUTPATIENT COSTS

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>AVERAGE LOSS*</th>
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<tbody>
<tr>
<td>2010</td>
<td>20%</td>
</tr>
<tr>
<td>2011</td>
<td>19%</td>
</tr>
<tr>
<td>2012</td>
<td>25%</td>
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Figure 2 ABH Member Survey Showing Average Loss
Strategies to Consider

Both executives emphasized that advocacy for E/M code adoption and parity in rates requires thoughtful preparation. Here are a few lessons from their experience:

- **Focus on the Compelling Argument**—It can be perceived as arcane to focus on opening billing codes as an imperative policy issue. Frame E/M coding and reimbursement as an access to services issue first.

- **Keep it Simple**—Stay away from coding jargon and focus on the network adequacy and access perspectives.

- **Weigh Benefits of E/M Code Adoption**—Training and compliance for the new coding system is significant, and advocates with experience emphasize that ensuring E/M rates are at Medicare allowable rates is essential. This is made more challenging by the return to the usual state-federal matching rate for Medicaid beginning January 1, 2015 for both primary and specialty providers.

- **Link to a Bigger Health Care Reform Goal**—For example, if integration of behavioral health and primary care is a key priority or trend in your state, then ensuring reliable outpatient behavioral health services is vital in the service mix.

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**Rationale for Action**

- Medicaid programs are state-run and therefore may not universally adopt use of all CPT E/M codes.

- Medicaid and commercial payers establish rates for reimbursing providers independent of Medicare. This may result in variability in rates and also between primary care and psychiatric specialty providers.

- Variability in coding and rates within a state raises compliance issues for providers, in addition to affecting their financial status.

- Access to the codes and parity in reimbursement for psychiatric professionals is integral to network adequacy and access to outpatient behavioral health issues.

- Advocacy in this area offers opportunities to bring stakeholder groups across specialties together.

- Advocacy in this area offers opportunities to showcase best practices in provider structure and business management and to showcase value of behavioral health providers.

- Medicaid payment policy changes annually, so an opportunity exists to effect change to scope of codes and rates, where disparities are identified.

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*In Massachusetts, the Association for Behavioral Healthcare emphasized that disparities in coding and reimbursement further stressed a struggling outpatient system, which jeopardizes successful implementation of Chapter 224, a cost containment act that prioritized integration as a mechanism of health care system efficiency.*
Gather Data—Use member survey data and economic information about service changes over time to clarify the impact of changes in coding and reimbursement on providers’ ability to provide outpatient services.

Use “Grasstops” Relationships — Identify and use members and current and former legislators to target developing support with core political decision makers. In Massachusetts, the focus was legislative leadership and the Ways & Means Committees, for example.

Retain and Use a Great Contract Lobbyist—Get them to “move the ball down the field” between key meetings with state decision makers.

Monitor the Impact—Follow implementation with special attention to provider experience with denials and reduced reimbursements. Document disparities and impact to share with policy makers and use as the basis for ongoing advocacy.

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