



Financing Suicide Prevention in Health Care Systems

Best Practices and Recommendations

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Financing Suicide Prevention in Health Care Systems: Best Practices and Recommendations

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Executive Summary

The United States is facing a suicide epidemic that directly affects more than 44,000 individuals and families each year.¹ Effective services and treatment are available to prevent suicide; however, providers face financial barriers to implementing suicide prevention services.

The National Council for Behavioral Health and the Suicide Prevention Resource Center, at Education Development Center, have collected quantitative and qualitative data from providers and subject matter experts to assess best practices, challenges, and opportunities related to financing suicide prevention services.² The data informs practice and policy recommendations for health care systems and policymakers to improve access to effective suicide prevention services nationwide.

Findings from this data reveal that organizations delivering suicide prevention services use a diverse array of funding streams to fund individual components, leaning on different payer sources (Medicaid, Medicare, commercial insurance, state and federal grants, and philanthropy, among others) to support provision of individual services. Findings also demonstrate that while each service component had a funding stream to support it, there were stark differences among providers regarding the ability to individually finance a comprehensive array of suicide prevention services, and many reported that their funders do not support reimbursement for specific services.

Together, these findings suggest opportunities at the provider and policy levels to enhance access to critically necessary suicide prevention services through different financing strategies.

To address the financial barriers affecting the delivery of comprehensive suicide prevention services, providers can improve reimbursement opportunities by taking the following actions:

- Ensure workflows are aligned to maximize the use of existing and sometimes underutilized procedure codes
- Diversify funding streams
- Seek contracts with payers that specifically include suicide prevention services
- Become actively involved in state-level decision-making on delivery systems and payment policies

Policymakers can increase funding for suicide prevention by taking these steps:

- Expand Medicaid services to include Health Homes and Certified Community Behavioral Health Clinics
- Require managed care organizations, by way of state contracts, to ensure provision of the array of services

¹ Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2017). Web-based injury statistics query and reporting system (WISQARS). Retrieved from www.cdc.gov/injury/wisqars

² These data include 161 responses to a survey conducted in 2016 with a convenience sample.

- Fund staff awareness and gatekeeper training³
- Fund clinical training in suicide care
- Expand presumptive eligibility criteria to include risk of suicide

With quality practices and a strategic approach to reimbursement for providing effective suicide prevention care, health systems and policymakers can positively impact the lives of countless individuals at risk for suicide.

³ For more information on training options appropriate for clinical and non-clinical staff see the Suicide Care Training Options resource available at: <http://zerosuicide.sprc.org/resources/suicide-care-training-options>

Introduction

Suicide is a preventable occurrence that affects individuals across all races and genders and has been steadily increasing since 2000 (Stone et al., 2017).

- **2000–2015:** The overall suicide rate increased by 28 percent, while the suicide rate among individuals aged 34 to 64 years rose by 35 percent. Within this age group, the suicide rate of women increased by 53 percent, and the suicide rate of men increased by 29 percent (Stone et al., 2017).
- **2003–2008:** The suicide rate for veterans and other military personnel nearly doubled (Stone et al., 2017).
- **2015:** More than 44,000 individuals in the United States died by suicide, making it the 10th leading cause of death. For individuals 15 to 34 years of age, suicide was the second leading cause of death and the third leading cause of death among youth aged 10 to 14 years (Centers for Disease Control and Prevention [CDC], 2017).

In addition to the immense toll that suicide has on families and communities, the burden on society and across health systems is also significant. The annual cost of deaths by suicide in 2013, including medical costs and loss of work, was \$50.8 billion, representing nearly a quarter of all costs associated with injury-related deaths (Florence et al., 2015). The mean medical and work-loss cost per suicide was \$1.2 million. In Indiana alone, the cost of suicide was estimated to be an average of \$1,184,944 per suicide death in 2010 (Goodpaster, 2015).

Over the last decade, research has emerged that supports the use of programs with evidence of effectiveness for the prevention, identification, and treatment of suicidal behaviors (Table 1).

Table 1. Examples of programs with evidence of effectiveness

Name	Definition
Collaborative Assessment and Management of Suicidality (CAMS)	CAMS is a philosophy of clinical care and a therapeutic framework in which the patient and provider work together to assess suicide risk and manage treatment. The Suicide Status Form (SSF) guides assessment and treatment and is developed collaboratively between the patient and provider throughout the course of therapy. ⁴
Cognitive Therapy for Suicide Prevention (CT-SP)	CT-SP is a cognitive-behavioral psychotherapy designed to treat patients who have thoughts of suicide or who have made a suicide attempt. CT-SP teaches patients to use alternative ways of thinking and behaving during suicidal crises. ⁵
Dialectical Behavioral Therapy (DBT)	DBT provides clients with new skills to manage painful emotions and decrease conflict in relationships. DBT specifically focuses on providing therapeutic skills in four key areas: (1) mindfulness, (2) distress tolerance, (3) emotion regulation, and (4) interpersonal effectiveness. ⁶

⁴ CAMS Care. (2018). About Cams. Retrieved from <https://cams-care.com/about-cams/>
⁵ Uniformed Services University. (2019). Cognitive therapy for suicidal patients (CT-SP). Retrieved from <https://deploymentpsych.org/treatments/Cognitive-Therapy-for-Suicidal-Patients-CT-SP>
⁶ Behavioral Tech. (n.d.). *What is dialectical behavioral therapy (DBT)?* Retrieved from <https://behavioraltech.org/resources/faqs/dialectical-behavior-therapy-dbt/>

Additionally, health care systems have begun to employ the Zero Suicide framework (zerosuicide.com) to address suicide care. The Zero Suicide framework is defined by a system wide, organizational commitment to safer suicide care in health and behavioral health care systems. Using evidence-based tools, systematic practices, training, and embedded workflows, Zero Suicide fills the gaps that patients at risk for suicide often fall through. However, despite the effective use of this framework, gaps in funding for the array of components necessary for safer suicide care are repeatedly cited as a barrier.

To better understand these financing challenges, as well as the opportunities and best practices available to the field, the National Council for Behavioral Health (National Council) and the Suicide Prevention Research Center (SPRC), at Educational Development Center (EDC), collected quantitative and qualitative data from a survey of provider organizations, key informant interviews, and subject matter experts (SMEs) on (1) how behavioral health organizations currently finance suicide prevention care activities (listed in Table 2), (2) strategies being used to improve financial support, and (3) the potential steps that providers and policymakers can take to improve the financial viability of such programs.

Table 2. Care components⁷ included in the provider survey

Financing Care Components
1. Screening for suicide risk
2. Suicide risk assessment and/or risk formulation
3. Safety planning
4. Lethal means counseling
5. Evidence-based treatments
6. Warm handoff and rapid follow-up and referrals
7. Follow-up contacts
8. Peer-based services
9. 24-hour mobile crisis team
10. Crisis contact services
11. Crisis respite services

⁷ Throughout this paper, we will use the term *care components* when addressing suicide prevention care activities.

Section 1: Survey Results for Financing Suicide Prevention Care

Qualitative and quantitative data were collected in 2016 via an electronic survey of 161 community behavioral health organizations and key informant interviews of representatives from those behavioral health organizations and policy experts. Data collected included (1) the types of suicide prevention care services being offered by the organizations, (2) the financing mechanisms and resources utilized to support those services, and (3) the financial barriers to providing suicide prevention care services.

Sources of Funding for Suicide Prevention Activities

Survey results showed that, at an aggregate level, and except for crisis respite services, providers successfully leveraged every named funding source to support every care component. See Table 3 for a list of funding sources included in the survey. Across the board, Medicaid was the number one source of funding for each care component.

Table 3. Funding sources included in the survey

Funding Source	Brief Description
Medicaid	A public health insurance program funded by both federal and state governments and administered by states. This program primarily serves low-income individuals and families and individuals with disabilities. Eligibility requirements and scope of services vary by state (Centers for Medicare and Medicaid Services, 2017b).
Medicare	A public health insurance program funded and administered by the federal government. This program primarily serves older adults and individuals with disabilities. Unlike Medicaid, Medicare benefits do not vary by state; however, some Medicare plans (Medicare Advantage) are offered through commercial insurance, and the benefits within those plans can vary (Centers for Medicare and Medicaid Services, 2017a).
Military Funding (TRICARE)	Insurance for individuals who are serving or who have served in the military and their family members.
Private or Commercial Insurance	Private and commercial insurance plans are commonly provided to individuals through employer plans, through the Affordable Care Act's Marketplace, or through other private insurance providers. Benefits in these plans vary by plan and are subjected to state and federal regulations.
State Behavioral Health Agency Funding	Funds distributed by state agencies using local state and county funds or funds from federal mental health or substance use block grants.
Self-Pay	Clients pay for the services that they receive without the assistance of public or private health insurance.
Grants	Funds received from foundations; research organizations; and federal, state, or county funders.

Procedure Codes Used to Support Reimbursement

In addition to funding sources, the survey asked respondents to identify specific procedure codes that they used to secure reimbursement for each suicide prevention care component. Federal law requires that, with few exceptions, insurers use a common set of procedure codes to report health care services. While payers can set policies around the use of such codes (e.g., whether to cover the service at all, reimbursement rates, eligible rendering providers, frequency of use), definitions are supposed to hold constant for the underlying service. Procedure codes that were included in the survey are outlined in Table 4, along with their short definitions. In addition, survey respondents could indicate that they paid for their service via capitated payments (which is generally a single payment for a combination of services), block grants, or “other.” Since many procedure codes overlap in their underlying service (e.g., 90791 for a diagnostic evaluation can include use of a screening tool, and G8431 is a code specifically for depression screening), survey respondents could indicate the use of multiple codes for a single care component.

Several procedure codes included in the survey were newly created in the last several years and had varying uptake at the payer and provider levels, such as psychotherapy for crisis, transitional care management, and chronic care management services. These procedure codes are described in more detail in Section 2: Practice Implications, along with additional codes that were not available at the time of the survey.

Table 4. Procedure codes included in the survey

CPT or HCPCS Code	Definition
90791	Psychiatric diagnostic evaluation (without medical services)
90792	Psychiatric diagnostic evaluation (with medical services)
99201-99215	Office or other outpatient visit for the evaluation of a new or established patient
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month ⁸
G8932	Suicide risk assessed at the initial evaluation
G8431	Screening for depression is documented as being positive, and a follow-up plan is documented
G8510	Screening for clinical depression is documented as being negative, and a follow-up plan is not required
90832, 34, 37	Individual psychotherapy 30, 45, and 60 minutes
90839	Psychotherapy for crisis, for first 60 minutes + crisis code add-on for each additional 30 minutes

⁸ Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2016). *Chronic care management services*. Retrieved from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf>

CPT or HCPCS Code	Definition
99495	Transitional care management services with moderate medical decision complexity (face-to-face within 7–14 days of discharge) ⁹
99496	Transitional care management services with high medical decision complexity (face-to-face within 7 days of discharge) ¹⁰
S9484	Crisis intervention mental health services, per hour
S9485	Crisis intervention mental health services, per diem

Source: Centers for Medicare and Medicaid Services (n.d.)

Table 5 shows the procedure codes reported by providers when billing for specific care components, and three conclusions can be drawn from the results shown in the table.

Conclusion 1: The *availability* of procedure codes is not a primary concern for the financing of suicide care prevention activities. Every care component had two or more accompanying procedure code(s). While both payer reimbursement policies and providers’ capacity to deliver the underlying service impacted the ability to legitimately bill for a service, the existence (or non-existence) of procedure codes themselves did not appear to be a primary concern.

Conclusion 2: Many of the codes that providers are using for suicide prevention activities are already in use for other behavioral health services. For instance, 90832 and other psychotherapy codes are being used to support reporting of certain evidence-based practices (EBPs). While this survey does not try to answer the question of whether every EBP has an accompanying billing code, the survey does show that codes representing general behavioral health services can also support activities that are specific to suicide prevention.

Conclusion 3: The survey results show that the sequencing or workflow of health care services matters when it comes to successful revenue capture. Procedure codes such as 90791 and 90792, which represent comprehensive psychiatric evaluations (without and with medical services, respectively), cannot be reported for some of the single components of suicide prevention that were named in the survey; for example, 90791 and 90792 could not be used for screening services alone. However, when screening services are *paired with* an assessment, history, treatment plan, etc., then the provider can successfully capture revenue for an encounter that includes a screening. Many survey respondents indicated that their staff did not know how to bill for services, which is essential to being able to successfully sequence services in a way that is both clinically effective and compliant with billing policy.

⁹ Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2016, December). *Transitional care management services*. Retrieved from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf>

¹⁰ Department of Health and Human Services, Centers for Medicare and Medicaid Services. (2016, December). *Transitional care management services*. Retrieved from <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf>

Table 5. Current Procedural Terminology (CPT) codes reported by survey respondents for specific suicide prevention activities

CPT or HCPCS Code	Components of Suicide Prevention Care										
	Screening	Suicide risk assessment	Safety planning	Lethal means counseling	Evidence-based treatments	Warm handoffs	Follow-up contacts	Peer-based services	24-hour mobile crisis	Crisis contact	Crisis respite care
90791 Psychiatric diagnostic evaluation (without medical services)	x	x	x	x				x			
90792 Psychiatric diagnostic evaluation (with medical services)	x	x	x	x				x			
99201-99215 Office or other outpatient visit for the evaluation of a new patient	x		x			x					
99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month						x	x				
G8932 Suicide risk assessed at the initial evaluation	x	x						x			
G8431 Screening for depression is documented as being positive and a follow-up plan is documented	x	x							x		
G8510 Screening for clinical depression is documented as negative, follow-up plan not required	x	x							x		
90832, 34, 37 Individual psychotherapy 30, 45, and 60 minutes								x	x		
90839 Psychotherapy for crisis, for first 60 minutes + crisis code add-on for each additional 30 minutes		x	x	x		x	x	x			
99495 Transitional care management services with moderate medical decision complexity (face-to-face within 7 – 14 days of discharge)						x	x				
99496 Transitional care management services with high medical decision complexity (face-to-face within 7 days of discharge)						x	x				
S9484 Crisis intervention mental health services, per hour											x
S9485 Crisis intervention mental health services, per diem											x

During key informant interviews, participants named several methods they used for overcoming billing challenges. These are offered as suggestions for practitioners, clinic managers, integrated care project directors, and billing/coding staff:

- Understand state-based rules and regulations regarding same-day billing, scope of practice laws, supervised billing, etc. The SAMHSA-HRSA Center for Integrated Health Solutions maintains state-level billing sheets that are one resource for understanding available procedure codes.¹¹
- Establish a director of reimbursement position to oversee all billing to ensure it is done accurately and appropriately for all payers as well as to identify opportunities to maximize reimbursement and ease the burden on providers.
- Maximize health information technology, including electronic health records (EHRs), to ease the documentation and billing burden on individual providers.
- Understand provider credential and licensure requirements to inform hiring practices. This includes understanding reimbursement rates and treatment limitations to accurately conduct a cost-benefit analysis.

Obtaining and Diversifying Funding

In addition to utilizing procedure codes for reimbursement, organizations are using other funding sources to overcome barriers to financing suicide prevention services. Key informant interviews revealed practices that some organizations have used to address limited funding availability:

- Identifying and implementing reimbursable evidence-based practices.
- Advocating for the inclusion of more services into insurance programs, such as Medicaid, to address long-term sustainability issues. Some organizations reported challenges with long-term funding sustainability given the time-limited nature of grant funding. Through participation on state-led coalitions and workgroups, one organization was advocating for greater inclusion of suicide prevention services within the state's Medicaid Waiver.
- Seeking grant funding that can offer flexibility for training and services, which are otherwise non-reimbursable, and allow the organization to provide a wider range of services to clients.
- Obtaining "train the trainer" funding from local, state, and federal partners to train organizational staff and community partners can help sustain training efforts.
- Negotiating a strategic number of train-the-trainer events to minimize provider time away from direct services to clients (which decreases revenue).
- Ensuring individuals with lived experience with suicide crisis (suicide loss survivors, suicide attempt survivors, and family members), and suicide prevention providers have an active voice in informing funding, policy decision-making, and state-led suicide prevention activities. For example, individuals with lived experience can share first-hand

¹¹ The SAMHSA-HRSA Center for Integrated Health Solutions state billing and finance sheets can be found at <https://www.integration.samhsa.gov/resource/billing-financial-worksheets>.

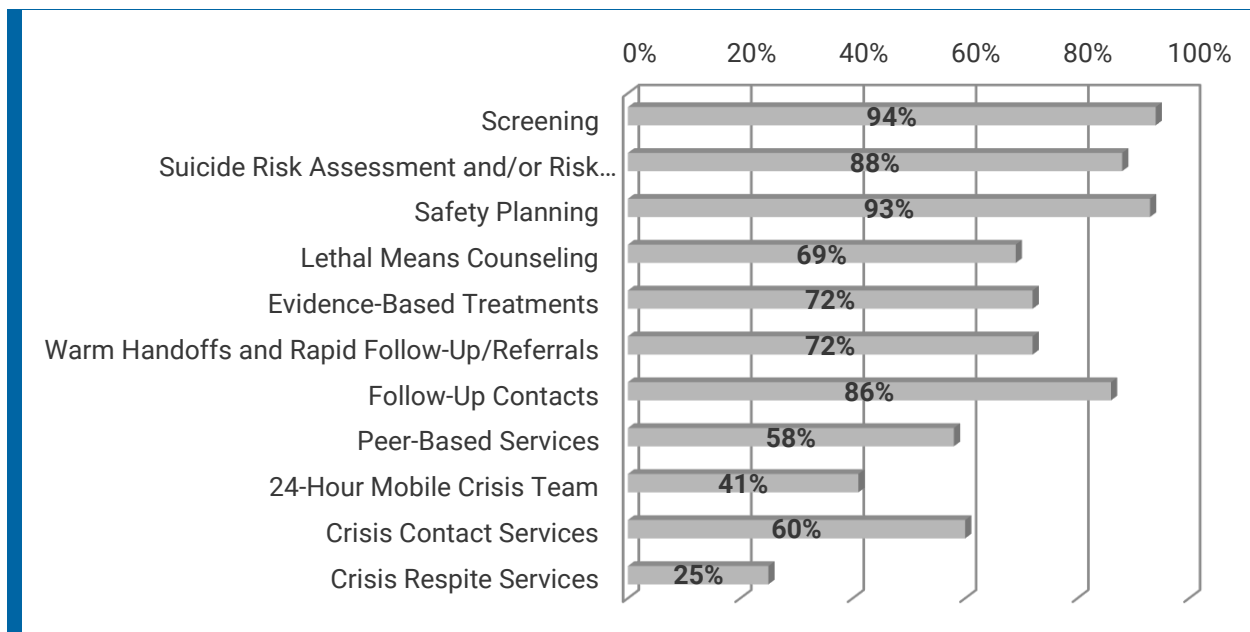
experiences with the current health care system and the need for recommended strategies, improvements, and supports for suicide prevention.

- Designating a member of the organization’s executive leadership team as a champion for suicide prevention. For example, one organization benefited from the fact that an executive leader was also the designated suicide prevention officer/director. This helped to instill suicide prevention values throughout the organization as well as keep suicide prevention at the forefront of conversations regarding funding and resource allocation.
- Including suicide prevention-related measures and outcomes as part of the performance measurement in their service contracts. For example, one organization successfully advocated for the inclusion of suicide prevention measures within their system’s Meaningful Use program for EHR adoption.

Care Components

Figure 1 shows the percentage of respondent organizations providing care components. At 94 percent, the most common care component provided by surveyed organizations was screening. Approximately 60 percent of those that provided screening reported that they received Medicaid reimbursement, and approximately 40 percent reported that they received private or commercial insurance reimbursement. The least common component provided is crisis respite services (25 percent): 89 percent reported that they received Medicaid reimbursement, and 36 percent reported that they received private or commercial insurance reimbursement.

Figure 1. Percentage of respondent organizations providing care components



Barriers to Implementation

Financial barriers to implementing suicide prevention services impact providers and individuals at risk of suicide in several ways, for example:

- If organizations do not receive funding or reimbursement for service delivery, they must provide services at a loss to the organization. Without sustainable funding, organizations cannot continue to offer suicide prevention support.
- Inadequate reimbursement rates delay access to care and result in long waiting lists for individuals seeking care.

Table 6 shows the percentage of organizations that reported *very significant* or *moderately significant* barriers to implementing each of the care components. Percentages are calculated based on the number of organizations that responded to each question; therefore, the total number of applicable respondents varies. Because organizations were permitted to select more than one barrier for each question, the total percent for each question could exceed 100.

Table 6. Percentage of respondent organizations reporting *very significant* or *moderately significant* barriers to providing care components

Care Component	Staff do not have correct licensure/credentialing to be reimbursed	Staff are not trained to deliver the service	We do not know how to bill for the service	Not funded by our payers to provide the service
Screening	8%	6%	10%	19%
Assessments	8%	6%	9%	12%
Safety planning	5%	8%	8%	14%
Lethal means counseling	7%	16%	10%	17%
Evidence-based treatments	9%	16%	6%	16%
Warm handoffs/referrals	9%	13%	16%	25%
Follow-up contacts	8%	9%	19%	29%
Peer-based services	19%	15%	11%	30%
24-hour mobile crisis team	10%	17%	19%	34%
Crisis contact services	10%	14%	22%	35%
Crisis respite	17%	19%	22%	40%

As demonstrated in Table 6, the category “Not funded by our payers” was identified as the most significant barrier in *all* care component categories. Nearly a fifth of the organizations reported that credentialing was a *moderate* or *very significant* barrier for providing peer-based services. Staff training as a barrier is most significant for the crisis respite, 24-hour mobile crisis team, evidence-based treatments, and lethal means counseling components. Training can be costly to organizations, both for the cost of training and unbilled staff time. Inadequate billing workflows and improper use of documentation for reimbursement were reported as *moderate* or *very significant* barriers by over 10 percent of organizations in nine care component categories.

Medicaid, private or commercial insurance, self-pay, state behavioral health agency funds, military funding, public grants, and other philanthropic sources are all used to support suicide prevention services. Among participating organizations, Medicaid financing was the most common funding source for all care components. The least common funding source identified was TRICARE.

Section 2: Practice Implications

Survey results demonstrated that every care component surveyed had a successful billing strategy. However, the success at an individual provider level was greatly influenced by the technical knowledge of the providers regarding billing and coding, payer policy, and staff training. The following section outlines practice recommendations for health care systems that are informed by survey results, key informant interviews, subject matter experts (SMEs), and state and federal policies that influence reimbursement for suicide prevention care activities.

Billing and Workflow Redesign

As discussed in Section 1, the survey results showed that many suicide prevention care services are reimbursable within the guidelines for other commonly used procedure codes. For example, when implementing cognitive behavioral therapy (CBT), several care components are included in the scope of services: (1) suicide screening, (2) suicide risk assessment, (3) safety planning, and (4) evidence-based treatment. Using procedure codes 90832 (individual psychotherapy 30 minutes), 90834 (individual psychotherapy 45 minutes), and 90837 (individual psychotherapy 60 minutes) when implementing CBT will ensure reimbursement for services that include suicide prevention care.

One approach to capturing suicide prevention services in the coding process is to work with the organization's billing office to maximize billing opportunities. Following are suggestions of ways that billing offices and providers can collaborate:

- Review billing contracts:
 - Ensure that either the codes are included or the scope of service encompasses suicide prevention services
 - Ensure that the scope of services is reflected in the contract to include types of clinicians and other professionals providing services, at what frequency, and for which types of clients (both for insurance coverage and diagnosis)
 - Negotiate which specific provider credentials are minimally required to deliver services under respective procedure codes
- Evaluate and implement procedure codes introduced in recent years, such as the following:
 - Transitional care management
 - Complex and chronic care management
 - Psychotherapy for crisis
 - Collaborative care

Note: Service requirements for these procedure codes are further described later in this section.

- Ensure that service providers are utilizing the range of appropriate procedure codes
- Ensure that providers are appropriately and accurately utilizing extender codes to provide additional reimbursement based on the length or difficulty of a service provided

- Utilize supervised billing, where available, which allows for staff who are being supervised by licensed and credentialed professionals to bill under their supervisor’s license
- Engage in state-based advocacy and work groups related to procedure codes and reimbursement

Another way in which clinical and billing office staff can collaborate is by conducting a workflow analysis of billing and coding processes that optimize opportunities to capture billable services and increase revenue. Codes can be billed more effectively when a workflow is in place. For example, organizations can develop a workflow sequence to include codes 90791 and 90792, which include multiple components of suicide prevention care. Table 7 presents several tools that can assist with (1) the implementation of a practice improvement process, (2) the examination of outdated strategies, and (3) the creation of more effective, streamlined, and sustainable workflows across an organization.

Table 7. Examples of practice improvement tools

Examples of Practice Improvement Tools¹²	
Swim Lanes/Cross-Functional Flowcharts	Swim Lanes can be used to analyze several types of processes, from simple to complex. This tool is especially useful with workflows that involve many people or groups and multiple steps in the process. It visually breaks down a process and exposes inefficiencies.
Value Stream Mapping	The aim of Value Stream Mapping is to improve the whole workflow and not to just optimize one part of it. It allows a team to easily see the flow of work and information in a way that exposes the waste that is inherent in the process. It creates a common vision for the team members connected to the value stream in both the current and future states. It provides a foundation to build a process that is based on the client/patient perspective.
Solutions and Criteria Matrix	The purpose of the Solutions and Criteria Matrix is to identify the best solution from the ideas that were brainstormed. Solutions are judged against the criteria set by the managed care organization/payer and the provider organization.

Leveraging Recently Introduced Procedure Codes and Services

In the last several years, multiple new procedure codes have been introduced that support many of the care components for suicide prevention described in this paper. Payer adoption of these codes has been variable, but providers should be aware of them to identify whether they

¹² Institute for Healthcare Improvement. (2018). *Quality improvement essentials toolkit*. Retrieved from <http://www.ihl.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx>

represent a funding stream to support suicide prevention care components for their own patients. Many of these procedure codes were included in the survey, but some have been introduced since the survey was designed.

Transitional Care Management Services

In 2013, the Centers for Medicare and Medicaid Services (CMS) established a benefit policy for beneficiaries enrolled in fee-for-service Medicare that provides reimbursement for transitional care management (TCM) services for the intensive, 30-day service period post-discharge from an inpatient hospital setting (as defined in Figure 2; Centers for Medicare and Medicaid Services, 2016). Well suited for the supportive services, coordination, and timely follow-up that is necessary post-discharge from a psychiatric facility, TCM services under Medicare must include the following:

1. An interactive contact with the client (or caregiver, as appropriate) within two business days following the client's discharge to a community setting; contacts may be by phone, email, or face-to-face
2. Non-face-to-face services, such as obtaining and reviewing discharge information, providing education to the client or family members, establishing referrals for community services, and interacting with other health professionals
3. A face-to-face visit within either 7 or 14 days of discharge, depending on the degree of medical complexity

Only one health care professional may bill for TCM services, and TCM services cannot be reported at the same time as chronic care management services.

Chronic Care Management Services

In 2015, new procedure codes for chronic care management services were introduced and then adopted by CMS for Medicare beneficiaries to reflect establishing, implementing, revising, or monitoring care plans for patients who have chronic health conditions, such as depression (Centers for Medicare

Figure 2. Transitional care management services under Original Medicare

Eligibility: To Original Medicare beneficiaries for 30 days post discharge from one of the following inpatient hospital settings:

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care hospital
- Skilled nursing facility
- Inpatient rehabilitation facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center (as defined by Medicare)

Procedure codes: 99495 (for moderate medical decision-making with a face-to-face visit within 14 days of discharge) and 99496 (for high medical decision complexity with a face-to-face visit within seven days of discharge); telehealth services may substitute for face-to-face services where it aligns with existing Medicare telehealth policy.

See the Transitional Care Management Services [fact sheet](#) for additional service requirements, such as eligible providers and supervision requirements.

and Medicaid Services, 2016). Additional client eligibility requirements are described in Figure 3. Chronic care management services are a monthly payment and may be reported following at least 20 minutes of clinical staff time spent developing and updating care plans, coordinating referrals and care with other providers, following-up post-discharge from an emergency department or hospitalization, and other services.

As reflected in the survey results, providers can use this code to support warm handoffs and follow-up contacts. Clients must provide written consent for the provision of the service, and no more than one provider may bill for chronic care management services. For clients who require more intensive services (i.e., more than 20 minutes per month), providers may instead report *complex* chronic care management services. This level of care services is for clients requiring medical decision-making of moderate or high complexity, and clinical staff care management time of at least 60 minutes. See Figure 3 for the short definitions of chronic care management services and complex chronic care management services and for resources detailing the additional requirements for these services.

General Behavioral Health Integration Services

Newly introduced in 2018, and often described alongside the more structured Collaborative Care Model (CoCM), the general behavioral health integration procedure code 99484 is a monthly care management procedure code that can be used for providing services to clients with mental, behavioral, or psychiatric conditions (including substance use disorders). These services include initial assessment, evaluation and monitoring, care planning in collaboration with the primary care team, facilitation and coordination of behavioral health treatment, and

Figure 3. Chronic care management service procedure codes

Eligibility: Patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

99490: Chronic care management services, at least 20 minutes of clinical staff time, per calendar month.

99487: Complex chronic care management services for clients requiring moderate or high complexity medical decision-making and 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. Use +99489 for each additional 30 minutes of clinical staff time.

See the Chronic Care Management [fact sheet](#) for additional service requirements, such as eligible providers and supervision requirements.

ongoing follow-up. The procedure code also reflects treatment by a billing practitioner, both physician and non-physician, as long as certain care components are in place. See Figure 4 for the short definition of general behavioral health integration services and for resources detailing the additional requirements for these services.

Collaborative Care Services

Effective in 2017, CMS began covering CoCM as a monthly reimbursable service for fee-for-service Medicare beneficiaries. Participating providers can be reimbursed for delivery of care management services for patients receiving behavioral health treatment and regular psychiatric inter-specialty consultation to primary care teams.

Care team members include the following:

- Treating (billing) practitioner: Physician and/or non-physician practitioner
- Behavioral health care manager: A designated individual with formal education or specialized training in behavioral health, working under the direction of the billing practitioner
- Psychiatric consultant: A medical professional trained in psychiatry and qualified to prescribe a full range of medications
- Beneficiary: The client receiving services

Medicare codes support reimbursement for many of the services regularly provided through the CoCM of integrated care (Advancing Integrated Mental Health Solutions Center, 2017). The services include initial assessment, care planning, treatment, and systematic follow-ups. Additionally, a case load review between the primary care team and the psychiatric consultant should take place at least weekly (Centers for Medicare and Medicaid Services, 2018). These codes provide Medicare payments for services provided by primary care providers for patients participating in a collaborative care program or receiving integrated behavioral health services. See Figure 5 for additional information.

Staff Training

Patient access to evidence-based suicide prevention care can be increased by developing a qualified workforce (Goodpaster, 2015). Behavioral health staff (clinical and administrative) should be trained in the organization's clinical workflow for suicide prevention and the billing practices relevant to those suicide prevention services. Following are the credentialing and training competencies to consider when hiring and retaining qualified staff:

Figure 4. General behavioral health integration services

Eligibility: Patients with any mental, behavioral health, or psychiatric condition, including substance use disorders, being treated by the billing practitioner that warrants behavioral health integration. Diagnosis or diagnoses could be pre-existing or made by the billing practitioner.

99484: Behavioral health integration services, other than collaborative care services, per calendar month

See the General Behavioral Health Integration [fact sheet](#) for additional service requirements, such as eligible providers and supervision requirements

- Training those staff members who influence clinical and administrative workflow development to understand the basics of procedure code requirements and payer policies.
- Ensuring that the workforce serving individuals at-risk for suicide are appropriately trained in pre-intervention, intervention, and post-intervention.
- Requiring that staff members receive, or have received, training or certification in EBPs for which the organization is seeking reimbursement.

Figure 5. Psychiatric collaborative care services

Eligible conditions: Any mental, behavioral health, or psychiatric condition being treated by the billing practitioners, including substance use disorders that, in the clinical judgment of the billing practitioners, warrants behavioral health integration services.

Procedure codes: 99492 (first month), 99493 (subsequent months), +99494 (each additional 30 minutes per calendar month)

See the Billing Psychiatric Collaborative Care Management Codes [FAQ sheet](#) for additional service requirements, such as eligible providers and supervision requirements.

Section 3: Policy Implications

In addition to supporting creative and effective ways to finance suicide prevention care by encouraging practice and systems changes, policymakers can directly influence the funding for and financial sustainability of suicide prevention care. Prior to seeking legislative support for policy changes, key state and organizational leadership should collaborate to identify the goals for suicide prevention initiatives within and across health care systems and the funding needed to achieve those goals. This will help policymakers create conditions under which providers can adopt and implement best-known practices.

Few states report that legislative funding has been a reliable source of financial support for suicide prevention, including comprehensive clinical care (Centers for Disease Control and Prevention, 2008). The following programs and recommendations can help increase funding for suicide prevention care.

Certified Community Behavioral Health Clinics

The Certified Community Behavioral Health Clinics (CCBHC) initiative is a new program within Medicaid, established in 2014 by legislation based on the Excellence in Mental Health Act (National Council for Behavioral Health 2017b). CCBHC-covered services include most of the suicide prevention components provided in an outpatient setting,¹³ including those that have generally proven to be challenging to fund—as reflected in survey results. Examples include care coordination and crisis intervention services.

CCBHCs are mandated to provide 24-hour crisis care and are required by the state to provide a core set of evidence-based services. In most states, these services include motivational interviewing, cognitive-behavioral therapy, and depression screening. According to a poll by the National Council (2017a), 63 percent of respondents reported that their CCBHC had implemented either Zero Suicide or another kind of suicide prevention program. CCBHCs also provide care coordination across the spectrum of health services, including physical and behavioral health and other social services. See Figure 6 for a list of CCBHC-required services. While authorized and funded

Figure 6. CCBHC required services

1. 24/7 crisis care, including mobile crisis response
2. Screening, assessment, and diagnosis, including risk assessment
3. Person- and family-centered treatment planning
4. Direct provision of outpatient mental health and substance use services
5. Outpatient primary care screening and monitoring of key health indicators and health risk
6. Targeted case management
7. Psychiatric rehabilitation services
8. Peer support and counselor services and family supports
9. Intensive, community-based health care for members of the armed forces and veterans

¹³ More information on the CCBHC initiative is available at <https://www.thenationalcouncil.org/topics/certified-community-behavioral-health-clinics/>

through Medicaid, CCBHCs are required to serve all who seek help.

Like Federally Qualified Health Centers (FQHCs), CCBHCs are paid through a Prospective Payment System (PPS) that accounts for the anticipated costs for delivering services and is, therefore, a more stable funding source for providers. The PPS rate includes Medicaid-allowable training and IT costs, as well as a range of non-face-to-face activities involved in suicide prevention.

Depending on the individual state, CCBHCs are also eligible for quality measure bonus payments. All states that elect to include quality measure bonuses are required to account for certain measures highly relevant to suicide prevention, including follow-up after hospitalization and suicide risk assessment.

CCBHCs were authorized as part of a two-year, eight-state demonstration program. The states currently participating are Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania. As of this writing, legislation is being considered in Congress that would expand the number of states that can participate as well as extend the timeline for the demonstration program. Additionally, some states not currently participating in the demonstration program are exploring waivers and other avenues to implement CCBHCs, irrespective of the demonstration program. Policymakers invested in ensuring a strong safety net for behavioral health services might consider supporting a CCBHC model in their own state.

Health Homes

Health Homes were established by the Patient Protection and Affordable Care Act (ACA section 2703) to provide care coordination services to meet the whole health needs of Medicaid beneficiaries with chronic health conditions. Health Home services are available in states that have selected this Medicaid State Plan benefit for Medicaid beneficiaries who have a serious mental illness (such as major depression), two chronic conditions as defined by the state Medicaid agency, or one chronic health condition and are at risk for a second one. Health Home care coordination systems are meant to help integrate and coordinate primary, acute, behavioral, and long-term care services and to also address social support needs.

While Health Home services do not include underlying *treatment* services, such as diagnosis, psychotherapy, and mobile crisis, they do encompass many of the *ancillary* care components for suicide prevention that have been proven more difficult for securing reimbursement, such as screening, planning, follow-up contacts, warm handoffs in referrals, and crisis contact. See Figure 7 for a list of required Health Home services. Payment is usually a bundled per-member-per-month (PMPM) that is designed and set by the state Medicaid agency (Nardone & Paradise, 2014).

Figure 7. Medicaid Health Home required services

1. Care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referral to community services

Recommendations for Medicaid Changes

Health care systems, providers, individuals with lived experience with suicide crisis (suicide loss survivors, suicide attempt survivors, and family members), and suicide prevention practitioners can all participate in supporting state-level Medicaid changes that improve suicide prevention care; for example:

- Adopt the Medicare chronic care management and transitional care management codes.
- Establish presumptive eligibility to include individuals at risk of suicide for at least 60 days, similar to the presumptive eligibility applied by states to women who are pregnant or have certain life-threatening conditions to increase client access to critical services and treatments. The following states have elected to provide presumptive eligibility: California, Colorado, Connecticut, Illinois, Indiana, Iowa, Kansas, Massachusetts, Michigan, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon, Tennessee, West Virginia, and Wisconsin.
- Ensure state Medicaid managed care contracts include coverage of all suicide prevention service components, including crisis services and care coordination.
- Include performance measures and offer pay-for-performance incentives related to warm handoffs, referrals, and follow-up contacts.

Recommended State Legislation for Mental Health Services

- Require suicide awareness or gatekeeper training for staff who work across state mental health and addiction departments or services.
- Train first responders to provide appropriate crisis services and referrals to mental health services for individuals and families when there is a suicide crisis.
- Support state legislation that mandates training for health and behavioral health care professionals in suicide assessment, treatment, and management.¹⁴
- Support state legislation that provides tuition reimbursement and other incentives for professional education or training in suicide prevention care.
- Collaborate with state-level partners through coalitions and work groups to advocate for the inclusion of suicide prevention services as reimbursable services. For example, in Michigan, providers participated in a state-led work group to advocate for resolutions regarding issues related to billing, including available codes and restrictions on same-day billing (Michigan Association for Suicide Prevention, 2012).

¹⁴ More information on states that have adopted legislation requiring training for health and behavioral health care professionals is available at http://afsp.org/wp-content/uploads/2018/02/AFSP_Health-Professional-Issue-Brief-2-5-18.pdf.

Conclusion

The purpose of this paper is to provide information to guide providers and policymakers toward taking action steps to effectively finance and improve accessibility to suicide prevention services. The recommendations identified by SMEs and the data collected from a range of health care systems in this paper offer successful strategies for financing and implementing suicide prevention care. Providers can maximize reimbursement opportunities, diversify funding streams, ensure compliance with state-based rules and regulations, participate in alternative payment models, and become actively engaged in state-level decision-making on a range of finance-related issues. Policymakers can take steps to increase funding for suicide prevention by mandating the availability of crisis services in managed care contracting, adopting collaborative care and complex care codes, expanding presumptive eligibility criteria to include risk of suicide, and funding mental health first-aid training. Preventing suicide is possible, and financing suicide prevention services is a critical component that requires the joint efforts of providers to advocate for and policymakers to sustain and create legislation for funding.

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Appendix A



Funding Sources to Support Suicide Prevention Services

The National Council for Behavioral Health (National Council) and EDC's Suicide Prevention Resource Center (SPRC) collected quantitative and qualitative data through the *Financing Suicide Prevention Survey* in 2016 to better understand the challenges, best practices, and opportunities related to financing suicide prevention services. The results of the survey, published in a technical report, were used to inform practice and policy recommendations.

The National Council received 623 responses to the electronic survey. Of those, 161 were used in the analysis. Four hundred sixty-two surveys were excluded from analysis due to incomplete answers (n = 193), not meeting survey respondent requirements (n = 256), and duplicate responses from the same organization (n = 13).

The organizational respondents represented community mental health organizations (n = 120), integrated primary care settings (n = 20), and psychiatric inpatient settings (n = 11). The professionals completing the survey on behalf of his or her organization represented the positions of clinical administrator (31%), chief executive officer (13%), direct care provider (13%), quality/compliance administrator (7%), billing administrator (3%), chief operating officer (2%), and other position (30%). Individuals who responded that their title was "other" represented a range of positions, including advocate, counselor supervisor, peer specialist, grants manager, division director, clinical supervisor, chief financial officer, education specialist, program director, care coordinator, suicide prevention director, integrated care case manager, and contract manager.

Respondent organizations reported on the financing mechanisms they use to support suicide prevention care components. Organizations could choose more than one funding source for each care component. The financing sources included Medicaid, private or commercial insurance, self-pay, state behavioral health agency funds, military funding, or other sources. Medicaid financing was the most common funding source for all 11 care components. The least common funding source for all 11 components was military funding.

Medicaid

Medicaid was the most common funding source for all 11 care components; however, the percentage of organizations that reported it as a finance source varied by care component. For example, 90 percent of respondent organizations reported they receive Medicaid funding for their 24-hour mobile crisis team, but only 44 percent of respondent organizations reported they receive Medicaid funding for warm handoffs/rapid follow-ups. Please note that not all respondent organizations provided all 11 care components; therefore, the percentages represent only those organizations that reported offering specific care components. Table 1 illustrates the percentage of organizations that reported Medicaid as a financing source for care components.

Table 1. Percentage of organizations reporting Medicaid as a funding source, by care component

Care Component	Percentage of Organizations Using Medicaid Financing
24-hour mobile crisis team	90%
Crisis respite	89%
Safety planning	86%
Suicide risk assessment/risk formulation	83%
Evidence-based treatments	80%
Follow-up contacts	78%
Crisis contact	77%
Peer-based services	75%
Suicide screening	59%
Lethal means counseling	55%
Warm handoffs/rapid follow-ups	44%

Private or Commercial Insurance

Private or commercial insurance was noted as a funding source for all 11 care components, but it was not as frequently used as Medicaid. Private or commercial insurance was most frequently cited as a funding source for evidence-based treatments (57% of respondent organizations). Only 22 percent of the organizations cited private or commercial insurance as a payor source for warm handoffs/rapid follow-ups. Table 2 illustrates the range in the organizations' use of private or commercial insurance for each care component.

Table 2. Percentage of organizations reporting private or commercial insurance as a funding source, by care component

Care Component	Percentage of Organizations Using Private and Commercial Insurance
Evidence-based treatments	57%
Suicide risk assessment/risk formulation	55%
Safety planning	54%
24-hour mobile crisis team	50%
Peer-based services	44%
Suicide screening	41%
Crisis contact	37%
Lethal means counseling	36%
Crisis respite	36%
Follow-up contacts	31%
Warm handoffs/rapid follow-ups	22%

Medicare

Medicare was reported as a funding source for all 11 care component categories. Medicare was most commonly cited as a payment mechanism for suicide risk assessment/risk formulation (55% of respondent organizations) and least commonly cited as a funder of crisis respite (18%). Table 3 shows the range of respondents reporting Medicare financing for each care component.

Table 3. Percentage of organizations reporting Medicare as funding source, by care component

Care Component	Percentage of Organizations Using Medicare Financing
Suicide risk assessment/risk formulation	55%
Evidence-based treatments	53%
Safety planning	50%
24-hour mobile crisis team	38%
Suicide screening	35%
Lethal means counseling	35%
Follow-up contacts	24%
Crisis contact	23%
Warm handoffs/ rapid follow-ups	21%
Peer-based services	21%
Crisis respite	18%

Self-Pay

Self-pay was also identified as a funding source for all 11 core components. The range of organizations reporting self-pay as a funding mechanism by core component is shown in Table 4.

Table 4. Percentage of organizations reporting self-pay as a funding source, by care component

Care Component	Percentage of Organizations Using Self-Pay as Financing Mechanism
Evidence-based treatments	48%
Suicide risk assessment/risk formulation	47%
Safety planning	47%
24-hour mobile crisis team	36%
Follow-up contacts	31%
Lethal means counseling	29%
Suicide screening	27%

Care Component	Percentage of Organizations Using Self-Pay as Financing Mechanism
Crisis contact	23%
Peer-based services	19%
Crisis respite	18%
Warm handoffs/rapid follow-ups	15%

State Behavioral Health Agency Funding

State behavioral health agency funding was also identified as a funding source by organizations for all 11 categories. The range of organizations reporting state behavioral health agency funding as financing mechanism by care component is illustrated in Table 5.

Table 5. Percentage of organizations reporting state behavioral health agency funding as a source, by care component

Care Component	Percentage of Organizations Using State Behavioral Health Agency Funding as Financing Mechanism
Evidence-based treatments	37%
Safety planning	33%
Suicide risk assessment/risk formulation	31%
24-hour mobile crisis team	29%
Lethal means counseling	29%
Suicide screening	23%
Crisis respite	18%
Crisis contact	17%
Follow-up contacts	14%
Peer-based services	13%
Warm handoffs/rapid follow-ups	9%

Military Funding

Respondents reported military funding as a financing mechanism for 10 of the 11 care components. No organizations reported using military funding for crisis respite services. Furthermore, the percentage of organizations that reported using military funding as a financing mechanism across all categories was 15 percent or below. Table 6 illustrates the range of use in military funding to support care components.

Table 6. Percentage of organizations reporting military funding as a source, by care component

Care Component	Percentage of Organizations Using State Military Funding as Financing Mechanism
Suicide risk assessment/risk formulation	15%
Safety planning	15%
Lethal means counseling	11%
Suicide screening	10%
Follow-up contacts	10%
24-hour mobile crisis team	10%
Crisis contact	9%
Evidence-based treatments	7%
Warm handoffs/rapid follow-ups	7%
Peer-based services	3%
Crisis respite	0%

Other Financing

Organizations also reported that they used other types of financing for all 11 care component categories. The survey results do not identify what types of financing mechanisms fall under the other category. The range of other financing sources used by organizations for suicide prevention care components is shown in Table 7.

Table 7. Percentage of organizations reporting other funding sources, by care component

Care Component	Percentage of Organizations Using Other Funding As Financing Mechanism
Evidence-based treatments	22%
Suicide risk assessment/risk formulation	17%
Suicide screening	16%
Safety planning	15%
Follow-up contacts	14%
Lethal means counseling	13%
Peer-based services	12%
24-hour mobile crisis teams	12%
Crisis contact	11%
Crisis respite	11%
Warm handoffs/rapid follow-ups	8%

Appendix B



Financing Suicide Prevention in Health Care Systems: Best Practices and Recommendations

The four tools linked below are key components of the *Financing Suicide Prevention in Health Care Systems: Best Practices and Recommendations* resource package. These tools are designed to be used as quick references and to provide guidance to health care systems in optimizing opportunities to capture billable services.

Identify Patients at Risk for Suicide: Tips for Supporting Depression Screening

<http://zerosuicide.sprc.org/resources/depression-screening-table-financing>

Safer Suicide Care Billing Tip Sheet

<http://zerosuicide.sprc.org/resources/billing-codes-table-financing>

Suicide Care Pathway Coding for Primary and Behavioral Health Care

<http://zerosuicide.sprc.org/resources/integrated-care-pathway-financing>

Suicide Care Pathway Coding for Primary Care

<http://zerosuicide.sprc.org/resources/primary-care-pathway-financing>

Collaborative Care Medicare Program: Reimbursement Opportunity for Primary Care Practices Caring for Patients at Risk for Suicide

Introduction

A number of innovative and evolving strategies for treating behavioral health conditions, such as suicide risk and depression, within primary care have come to fruition in recent years, including the Zero Suicide initiative and the Collaborative Care Model (CoCM). The Zero Suicide initiative is “based on the realization that suicidal individuals often fall through the cracks in a sometimes fragmented and distracted health care system (Zero Suicide, 2018).” The CoCM is an evidence-based model of care that treats mental health conditions that require systematic follow-up due to their persistent nature, such as depression and anxiety (Advancing Integrated Mental Health Solutions Center, 2018). CoCM has become an important method for providing more comprehensive care for patients at risk for suicide in primary care settings. In the CoCM model, a primary care team provides care coordination and psychiatric consultation to the patient in order to reduce symptoms of depression and anxiety. The model affords for and reimburses care coordination and telephonic work that is often critical for patients at risk for suicide but not reimbursed through other mechanisms. CoCM is now a benefit for Medicare beneficiaries, many commercial insurance members, and Medicaid recipients in select states, such as New York.

Using CoCM for Patients at Risk for Suicide

Depression is the illness most commonly associated with suicide, and it is a significant risk factor for suicide. Screening for depression can help identify patients who are at risk for suicide, and a large proportion of patients who are identified with risk for suicide may have depression. Consequently, it is critical to develop a suicide care pathway that includes systematic procedures for screening for depression and suicide, conducting suicide risk assessment, and ensuring follow-up care. Primary care settings can help support suicide care pathways by leveraging CoCM.

CoCM allows for reimbursement of services being addressed by the treating provider, and the CoCM payment structure can be used to reimburse for services provided to those patients who are on a suicide care pathway. The billing codes, listed in Table 2, are included in the Center for Medicare and Medicaid Services Physician Fee Schedule of 2018 (Centers for Medicare and Medicaid Services, 2018).

Additionally the CoCM codes can be billed by providers who are not recognized by Medicare and some commercial plans, such as licensed professional counselors, licensed marriage and family therapists, licensed mental health counselors, and psychiatric registered nurses. This is

because these codes are billed under the primary care provider and not the mental health professional. Consistent with Medicare fee schedules, there may be adjustments in rates for mid-level providers, such as nurse practitioners or physician assistants, or for geographic regions.

Tables 1 and 2 list the Medicare billing codes and rates for non-federally qualified health centers (FQHC) and rural health center (RHC) primary care providers. They are the codes for all providers for billing commercial plans.

Table 1. Medicare Billing Codes and Rates for Non-FQHCs and RHCs

CPT	Description	Payment/Pt (Non-Facilities) Primary Care Settings	Payment/Pt (Fac) Hospitals and Facilities
99492	Initial psych care mgmt, 70 min/month - CoCM	\$162.18	\$90.46
99493	Subsequent psych care mgmt, 60 min/month - CoCM	\$129.38	\$81.81
99494	Initial/subsequent psych care mgmt, additional 30 min CoCM	\$67.03	\$43.97
99484	Care mgmt. services, min 20 min – General BHI Services	\$48.65	\$32.80

**Please note actual payment rates may vary. Check with your billing/finance department.*

Source: Advancing Integrated Mental Health Solutions Center, 2019b

Table 2. Medicare Billing Codes and Time Details for Non-FQHCs and RHCs

BHI CODE	BEHAVIORAL HEALTH CARE MANAGER OR CLINICAL STAFF THRESHOLD TIME	ASSUMED BILLING PRACTITIONER TIME
CoCM First Month (99492)	70 minutes per calendar month	30 min
CoCM Subsequent Months** (99493)	60 minutes per calendar month	26 min
Add-On CoCM (Any month) (99494)	Each additional 30 minutes per calendar month	13 min
General BHI (99484)	At least 20 minutes per calendar month	15 min
BHI Initiating Visit (AWV, IPPE, TCM or other qualifying E/M)	N/A	Usual work for the visit code

Source: Centers for Medicare and Medicaid Services, 2018

Table 3 lists the codes for federally qualified health centers and rural health centers to use to bill Medicare.

Table 3. Medicare Billing Codes for FQHCs and RHCs

Code	Description	Payment
G0511	General Care Management Services - Minimum 20 min/month	\$67.03
G0512	Psychiatric CoCM - Minimum 70 min initial month and 60 min subsequent months	\$145.96

**Please note actual payment rates may vary. Check with your billing/finance department.*

Source: Advancing Integrated Mental Health Solutions Center, 2019a

Conclusion

Using CoCM and its billing codes can complement the work already being done to treat patients on a suicide care pathway in a primary care setting. This allows for improved treatment of the patient, better clinical outcomes, and reimbursement that fosters the continual growth of the practice. Additionally, the treat-to-target approach and the registry requirement central to CoCM enable primary care organizations to better track their population of patients who are at risk for suicide and patients' clinical outcomes.

It is advisable to review the number of patients on your pathway who have depression or anxiety and identify those who have a payer plan that would reimburse for CoCM (e.g., Medicare, Medicare Advantage Plan, many commercial payers, and Medicaid in select states). For many organizations, a significant number of the patients on their pathways would benefit from the coordination provided by CoCM, and the organization would be able to recognize additional revenue.

Supplemental Information

Care Team Members

- Treating (Billing) practitioner – A physician and/or a non-physician practitioner (physician assistant, nurse practitioner, clinical nurse specialist or certified nurse midwife). These are typically primary care but may be another specialty.
- Beneficiary – The beneficiary is a member of the care team.
- Clinical staff – The services (service components are listed below) may be provided in full by the billing practitioner. Alternatively, the billing practitioner may use qualified clinical staff to provide certain services using a team-based approach. These clinical staff may include a designated behavioral health care manager or psychiatric consultant, although they are not required.

Service Components

- Initial assessment
 - Initiating visit (if required, separately billed)
 - Administration of applicable validated rating scale(s)
- Systematic assessment and monitoring using applicable validated clinical rating scales

- Care planning by the primary care team jointly with the beneficiary, with care plan revision for patients whose condition is not improving
- Facilitation and coordination of behavioral health treatment
- Continuous relationship with a designated member of the care team

Eligible Conditions

Any mental health, behavioral health, or psychiatric condition being treated by the billing practitioner, including substance use disorders, that, in the clinical judgment of the billing practitioner, warrants behavioral health integration services is eligible. The diagnosis or diagnoses could be either pre-existing or made by the billing practitioner, and they may be refined over time.

Full Code Descriptors

The following code descriptors are excerpted from the Medical Learning Network fact sheet *Behavioral Health Integration Services* (Center for Medicare and Medicaid Services, 2018):

99492 – Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- Outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional
- Initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan
- Review by the psychiatric consultant with modifications of the plan if recommended
- Entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant
- Provision of brief interventions using evidence-based techniques, such as behavioral activation, motivational interviewing, and other focused treatment strategies

99493 – Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- Tracking patient follow-up and progress using the registry, with appropriate documentation
- Participation in weekly caseload consultation with the psychiatric consultant

- Ongoing collaboration with and coordination of the patient’s mental health care with the treating physician or other qualified health care professional and any other treating mental health providers
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant
- Provision of brief interventions using evidence-based techniques, such as behavioral activation, motivational interviewing, and other focused treatment strategies
- Monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment

99494 – Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (list separately in addition to code for primary procedure)

99484 – Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month, with the following required elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team

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Behavioral Health Integration Medicare Program: Reimbursement Opportunity for Patients at Risk for Suicide

Introduction

Medicare has released codes that support care coordination and supportive services for patients in primary care with behavioral health needs, such as suicide risk. Effective in 2017 for primary care providers and in 2018 for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). Additionally, these codes can now be used by the following:

- Licensed behavioral health providers, who were previously not able to produce revenue when providing care for the Medicare and, sometimes, commercial population
- Licensed mental health clinicians
- Licensed marriage and family counselors
- Licensed professional counselors
- Psychiatric registered nurses

These codes support the provision of care coordination through the Collaborative Care Model (CoCM), as well as a separate payment for behavioral health integration (BHI) services that fall outside of the CoCM benefit. (CoCM predominantly focuses on depression and anxiety.)

CoCM is an evidence-based model of integrated care that treats common mental health conditions requiring systematic follow-up due to their persistent nature, such as depression and anxiety. The payment structure for BHI services may be used for patients with any behavioral health condition being addressed by the treating provider, including substance use disorders (Advancing Integrated Mental Health Solutions Center, 2019a). Between the BHI and CoCM codes most patients at risk for suicide and on an organization's suicide care pathway will fall clinically into one of the two categories. Medicare is the primary payer of these codes, along with many commercial plans and, in some states, Medicaid.

Unfortunately, the general BHI code has not been released for use in FQHCs or RHCs at this time.

Using the Behavioral Health Integration Codes for Patients at Risk for Suicide

The BHI codes and payment structure discussed above can provide an opportunity for primary care providers to subsidize additional support for patients in their care who are at risk for suicide. These codes can also be used to support the telephonic follow-up and care coordination services that many organizations provide as part of their care for patients at risk for suicide.

These billing codes can be found in the Center for Medicare and Medicaid Services Physician Fee Schedule of 2018 (Centers for Medicare and Medicaid Services, 2018). The Collaborative Care Codes for primary care settings and FQHCs and RHCs are included below. Mental health organizations are not eligible to use or bill with these codes. It is recommended to review the requirements for CoCM and the general BHI codes before billing.

Table 1. Codes for Medicare payments for BHI services in primary care settings (non-FQHCs and RHCs)

CPT	Description	Payment/Pt (Non-Facilities) Primary Care Settings	Payment/Pt (Fac) Hospitals and Facilities
99492	Initial psych care mgmt, 70 min/month - CoCM	\$162.18	\$90.46
99493	Subsequent psych care mgmt, 60 min/month - CoCM	\$129.38	\$81.81
99494	Initial/subsequent psych care mgmt, additional 30 min CoCM	\$67.03	\$43.97
99484	Care mgmt. services, min 20 min – General BHI Services	\$48.65	\$32.80

**Please note actual payment rates may vary. Check with your billing/finance department.*

Source: Advancing Integrated Mental Health Solutions Center, 2019b

Table 2. Codes for Medicare payments for BHI services in FQHCs and RHCs

Code	Description	Payment
G0511	General Care Management Services - Minimum 20 min/month	\$67.03
G0512	Psychiatric CoCM - Minimum 70 min initial month and 60 min subsequent months	\$145.96

**Please note actual payment rates may vary. Check with your billing/finance department.*

Source: Advancing Integrated Mental Health Solutions Center, 2019a

Conclusion

Using the CoCM and the general BHI codes can complement the work already being done to treat patients on a suicide care pathway. Even if these codes are not recognized by your state Medicaid, the ability to get reimbursement from Medicare and commercial payers could add significant revenue to support care for patients at risk for suicide. Overall, this allows for improved treatment of patients, better clinical outcomes, and reimbursement.

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Transitions of Care Coordination: Reimbursement Opportunity for Patients at Risk for Suicide

“Transitional care is defined as a broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another.” (Naylor et al., 2011)

Introduction

Research demonstrates that the first 30 days after discharge is a particularly vulnerable time for patients, particularly those at risk for suicide (Knesper, 2010). Care transitions (e.g., change in level of care, change of location, discharge) are vulnerable points in care that can increase unnecessary health service utilization (e.g., repeat hospitalizations) and can expose patients to lapses in care quality and safety (Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2011). Also, it is during transitions that mistakes commonly occur (e.g., medication discrepancies, unmet community needs). In 2009, approximately 20 percent of Medicare beneficiaries discharged from hospitals were re-hospitalized within 30 days (Naylor et al., 2011). Thirteen percent experienced three or more provider transfers within a 30-day period. The movement of patients between hospital discharge, community, and back again accounts for approximately \$15 billion in Medicare spending annually (Naylor et al., 2011). In 2010, solutions aimed at improving integration and continuity of care for patients who are chronically ill or who need moderate to complex care (including those who are at risk for suicide) were developed to interrupt patterns of unnecessary health service utilization and to address the negative effects of lapses in care on care quality and costs (Naylor et al., 2011). These solutions comprise what we know today as *transitional care*.

Managing transitions through proper care coordination and effective management can improve outcomes for individuals transitioning from medical and psychiatric hospitalizations. One model for improving transitions is Transition Care Management. Many organizations currently have individuals such as case managers, coordinators, engagement specialists, or peers who are charged with following up with patients identified as at risk for suicide during hospitalization and following discharge. If an organization does not employ these individuals it is often left to the individual or the receiving clinician to coordinate care. Many organizations are not aware that these efforts and services for suicide-related hospitalizations are reimbursable by some payers, the most significant being Medicare. If an organization is not currently coordinating care for those individuals whom they know are hospitalized, they are likely being encouraged to do so as part of payer, state, organizational, or regulatory efforts.

The implementation of a transitions of care protocol that meets billing criteria will provide a consistent process for staff, much needed support for patients, and reimbursement opportunities for the organization. Many organizations have found that even a few billable

transitions of care visits a week can help support the coordination services they have been supporting out of organizational or grant dollars.

Background

Transition Care Management (TCM) helps a beneficiary who has medical and/or psychological problems that require moderate or high complexity medical decision-making transition back to a community setting (their home, domicile, a rest home, or an assisted-living environment) without gaps in service. It is limited to only particular kinds of discharges from inpatient hospital settings such as the following (Centers for Medicare and Medicaid Services, 2016):

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Long-term care hospital
- Skilled nursing facility
- Inpatient rehabilitation facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a community mental health center

As a part of the TCM service model, the TCM facilitator is responsible for making an interactive contact, completing non-face-to-face services (such as reviewing discharge information, reviewing the need for follow-up services, establishing referrals for the beneficiary, and assisting in scheduling), and completing a face-to-face visit within the 30 days immediately following the beneficiary's discharge from one of the settings mentioned above (American College of Physicians, 2017).

As of 2013, the Medicare Physician Fee Schedule included TCM codes allowing for the reimbursement of the non-face-to-face care provided when a patient transitions from an acute care setting back into the community (American College of Physicians, 2017). The two Current Procedural Terminology (CPT) codes for reimbursement follow (Centers for Medicare and Medicaid Services, 2016):

1. **CPT Code 99495** covers communication with the patient or caregiver within two business days of discharge. This can be done by phone, email, or in person. It involves medical decision-making of at least moderate complexity and a face-to-face visit within 14 days of discharge. The location of the visit is not specified. The work RVU is 2.11.
2. **CPT Code 99496** covers communication with the patient or caregiver within two business days of discharge. This can be done by phone, e-mail, or in person. It involves medical decision-making of high complexity and a face-to-face visit within seven days of discharge. The location of the visit is not specified. The work RVU is 3.05.

Transitional care is meant to complement the work that already exists through primary care, care coordination, discharge planning, suicide risk care, and/or case management. The major hallmarks of transitional care include the focus on highly vulnerable patients and their movement through critical transitions in care and in health care settings, with particular focus on the time-sensitive nature of services, an emphasis on educating patients and family to address root causes of poor outcomes, and to avoid preventable re-hospitalizations (Naylor et al., 2011).

Reimbursement for Transitions of Care Services

Medicare’s payment allowance for transition of care services differ geographically and by payer. Additionally, the Medicare allowance is contingent on the conversion factor during the time frame in which claims are paid. The reimbursement rates for 2017 are listed in Table 1.

Table 1. 2017 reimbursement rates, non-facility and facility settings

Code	Reimbursement-Based on Setting	
	Non-facility Setting	Facility Setting
99495	Reimbursement is around \$165.45. Example: A physician’s office.	Corresponding allowance is about \$112.
99496	Reimbursement is around \$233.99.	Reimbursement is around \$162.

Source: American Academy of Family Physicians, 2017

These codes are added to the code that the provider would use for the visit. For example, a psychiatrist seeing a patient for a transitions of care visit might code the visit a 99213 EM code and then add the 99496 CPT code, both billed under that same prescriber. The care coordination services leading up to the visit, while documented in the patient’s record, are not directly reimbursable and are considered included in the transitions of care rate added to the prescriber visit. While Medicare is the primary payer for these codes, some commercial plans do recognize and reimburse for them.

Many organizations report that they do not have a high number of Medicare or commercial patients who fit the criteria for transitions of care services. However using these codes for just one visit a week would generate over \$7,000.00 a year in additional revenue, which could contribute to support staff salary.

“Just by putting a formal transitions of care process in place to capture the work we were doing for our patients we knew were hospitalized was a game changer—even though we had only 15% Medicare patients it helped us with all of our patients and generated thousands of dollars in revenue.”

Administrator, New York

Documentation Guidelines for Transitions of Care Services

At a minimum, the following must be documented in the patient’s medical record:

- Date the patient was discharged
- Date health care professional made an interactive contact with the patient and/or caregiver
- Date health care professional provided the face-to-face visit
- Complexity of the medical decision-making (moderate or high)

Only one health care professional may report transitional care services per patient during the transitional care time frame (Centers for Medicare and Medicaid Services, 2016). Bloink and Adler (2013) advise documenting any initial contact with the patient prior to the face-to-face visit. Recommendations for documentation are provided in Figures 1 and 2 below:

Figure 1. Documentation guidance for initial contact with patient¹⁵

INITIAL TRANSITIONAL CARE CONTACT

Patient name: _____

Date of contact: ____/____/____

Sources of information:

- Patient, family member, or caregiver
(Name: _____)
- Hospital discharge summary
- Hospital fax
- List of recent hospitalizations or ED visits
- Other _____

Discharged from: _____
on ____/____/____

Diagnosis/problem: _____

Medication changes: Yes No

Medication list updated: Yes No

Needs referral or lab: Yes No

Needs follow-up appointment:

- Within seven days of discharge (highly complex visit).
- Within 14 days of discharge (moderately complex visit).

Appointment made for ____/____/____
with _____

Additional information needed and requested:

- Yes: _____
- No

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Figure 2. Documentation guidance for face-to-face visit¹⁶

FACE-TO-FACE TRANSITIONAL CARE VISIT DOCUMENTATION

For use in plan section of visit note.

Medication reconciliation:

- Medication list updated
- New medication list given to patient/family/caregiver

Referrals:

- None needed
- Referrals made to: _____

Community resources identified for patient/family:

- None needed
- Home health agency
- Assisted living
- Hospice
- Support group
- Education program: _____

Durable medical equipment ordered:

- None needed
- DME ordered: _____

Additional communication delivered or planned:

- Family/caregiver: _____
- Specialists: _____
- Other: _____

Patient education:

Topics discussed: _____

Handouts given: _____

Initial transitional care contact was made on
____/____/____ (see separate note)

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“We learned that some of the documentation required could be done by others on the team before I saw the patient. This was really helpful in completing these visits.”

Psychiatrist, New York

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Operationalizing Transitions of Care

Staff of all disciplines, licensed and unlicensed, are able to provide some of the core components of transitions of care, such as speaking with collaterals such as family members, scheduling appointments, and communicating with patients to coordinate follow-up services and remove barriers that would prevent follow-up care. Many organizations have been under the impression that only registered nurses could provide these services for reimbursement. This was true when the codes were originally created, but it is no longer the case. As noted above:

- The codes are added to the code that the provider would use for the visit – A psychiatrist seeing a patient for a transitions of care visit might code the visit a 99213 EM code and then add the 99496 CPT code, both billed under that prescriber.
- The care coordination services leading up to the visit, while documented in the patients record, are not directly reimbursable and are considered included in transitions of care rate added to the prescriber visit.

Patients do not need to consent for transitional or coordination services, and it is appropriate and compliant for two HIPPA-protected organizations to coordinate a transition of care from inpatient to the community. Organizations often struggle with how to identify patients who present for a transitions of care visit so they can complete the required documentation. This is often done electronically with a “note” next to the patient’s name in the provider’s schedule.

“I put a note in the schedule so that everyone can see it and then I also send a note to the provider and nurse on the day the patient is coming in so that everyone is aware.”

Care Coordinator, Montana

Conclusion

As mentioned previously, some providers and practitioners are providing transitional care without reimbursement, while others may not engage in transitional care management due to a lack of reimbursement. These codes can help provide some of the support and coordination that patients at risk for suicide need in order to have the services and continuity they need to be safe. Identifying patients who are hospitalized and coordinating follow-up transitions of care visits have the potential to support patients and organizations simultaneously.

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Chronic Care Management: An Opportunity to Support Suicide Care Pathway Activities

Introduction

While we most commonly associate depression with suicide, a number of other chronic illnesses have been shown to increase the risk of suicide. In one study, Orlando Health found that 17 health conditions were associated with a higher risk of suicide, including asthma, back pain, brain injury, cancer, congestive heart failure, diabetes, epilepsy, HIV/AIDS, heart disease, high blood pressure, migraine, and Parkinson's disease (Robinson, 2017). The study also indicated that having more than one chronic condition may increase suicide risk. Based on these findings, we can see a strong correlation between chronic illness and the risk of suicide, and this correlation should inform primary care practice.

When organizations place patients on a suicide care pathway, they often struggle in obtaining reimbursements for the care coordination components and thereby making the pathway level of care sustainable. One option for supporting reimbursement for care coordination is to document any chronic illnesses that patients who are being assessed for risk of suicide may have. It is likely that many patients at risk of suicide will have more than one chronic illness present, which may make the patients eligible for Chronic Care Management Services.

Background of Chronic Care Management

Chronic Care Management (CCM) is recognized by the Centers for Medicare and Medicaid Services (CMS) as a critical component of primary care that contributes to better health and care for individuals. Medicare pays separately for CCM services furnished to Medicare patients with multiple chronic conditions (Centers for Medicare and Medicaid Services, 2016). According to the CPT 99490 billing codes, CCM services may be provided by physicians, certified nurse midwives, clinical nurse specialists, nurse practitioners, and physician assistants. The services consist of at least 20 minutes of clinical staff time directed by one of these providers, per calendar month, with the following requirements (Centers for Medicare and Medicaid Services, 2016):

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored

Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer’s disease and related dementia,
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Cardiovascular disease
- Chronic obstructive pulmonary disease
- Depression
- Diabetes (both Type 1 and Type 2)
- Hypertension
- Infectious diseases such as HIV/AIDS

The reimbursement for CCM is paid on a monthly case rate at an average of 46.00 per patient per month. While this is not a high reimbursement rate, when it is multiplied over a patient population, it can support some care coordination staff and/or pathway activities. Medicare is the primary payer of CCM services, although it is anticipated that commercial payers will soon follow.

Benefits of CCM for Patients at Risk of Suicide

While providers may already be using CCM for some of their patients, many do not think to apply them to patients with a risk of suicide. CCM benefits both your patient and your practice in a number of ways. Patients at risk for suicide will benefit from having a comprehensive care plan to keep them on track in treatment, provide them with the support necessary between visits, provide improved care coordination, and give them a deeper sense of connection. Your practice will benefit by decreasing hospitalization and emergency department visits, by receiving payment specifically in support of using the CCM approach that will help sustain your practice and ongoing work, and by providing you with additional resources to help your practice serve more patients in need (Centers for Medicare and Medicaid Services, 2018).

The take-home message is that chronic health conditions don’t just have physical implications, they affect the overall quality of life of many patients – and this in turn can affect them mentally and emotionally (Robinson, 2017). By coordinating the care of patients at risk of suicide with chronic care management services using the CCM codes, organizations not only provide improved, more holistic care for their patients at risk of suicide, but they also can increase both direct (reimbursement for CCM) and abstract (reduced hospitalizations) revenue.

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