

## NEW YORK STATE MEDICAID COLLABORATIVE CARE PROVIDER CERTIFICATION

Items Contained in this Packet:

1. Terms of Participation
  - includes introductory billing guidance and pay-for-performance standards
2. Appendix 1 – State Approved Registries
3. Four (4) Part Provider Application:
  - ✓ Site Applicant Demographics
  - ✓ Medical Director Attestation
  - ✓ CEO Letter of Support (addressed to Lloyd Sederer, MD, OMH Medical Director)

Completed applications should be sent to [NYSCollaborativeCare@omh.ny.gov](mailto:NYSCollaborativeCare@omh.ny.gov), along with a letter of support from the applying organization's CEO or executive director.

Questions should be directed to the same email address.

## TERMS FOR PROVIDERS PARTICIPATING IN NYS MEDICAID COLLABORATIVE CARE DEPRESSION PROGRAM

If you are a primary care provider seeking supplemental monthly case rate Medicaid payment for Collaborative Care please see these terms.

Article 28 of the Public Health Law allows primary care practices to deliver Collaborative Care health services to patients with certain behavioral health diagnoses. Prior approval from the Commissioner of the Department of Health and the Commissioner of the Office of Mental Health, or their designees, must be obtained. Submit your application to the Commissioner of the Office of Mental Health, in the format described below.

**Eligibility Criteria:** A Primary Care clinic must deliver the following essential elements of Collaborative Care:

- **Trained Behavioral Health Care Managers** in the primary care setting who oversee and provide mental health care support; screening; patient engagement, education and follow-up; ongoing patient contact; monitoring of adherence with psychotropic medications; mental health and substance disorder referrals; brief interventions appropriate for primary care settings; and related activities. Some acceptable individuals for this role are: LCSW, LMSW, BSW with appropriate supervision, LMHC, LMFT, RN with behavioral health training (for job description see: <http://aims.uw.edu/collaborative-care/team-structure/care-manager> )
- **Designated Psychiatric Consultant** who provide caseload-focused consultation at least weekly with the Depression Care Managers or primary care providers on patients, for those not responding to care. Psychiatrist, or Psych NP with Psychiatrist backup, can provide caseload supervision remotely (e.g. by phone or video) but must have access to the patient care registry.
- **Use of a state-approved *patient care registry*\*** for ongoing performance monitoring that includes the delivery of services; patient responses through routine use of the relevant screening tool; and ongoing performance improvement. \*see Appendix 1 for details
- **Trained primary care providers** in screening and providing evidence-based, stepped care for certain behavioral health diagnoses.

Additional factors considered in determining who will receive this supplemental payment include:

1. Past performance delivering Collaborative Care
2. Capacity to scale up Collaborative Care

### Billing NYS Medicaid for Collaborative Care

Payment for Collaborative Care services will only be made for patients that meet diagnostic criteria for behavioral health conditions approved by OMH; Patients' scores are actively tracked in a registry; and who receive evidence-based BH care in a primary care setting by primary care providers, where trained Behavioral Health Care Managers (BHCM) are in place and actively providing services; and where a designated consulting psychiatrist regularly reviews, with either the primary care provider or the BHCM, the needs of all patients under care who are not improving and makes recommendations for changes in treatment as needed.

NOTE: The Behavioral Health Care Managers may provide evidence-based treatments such as brief, structured psychotherapies or work with other mental health providers when such treatment is indicated and within the scope of their training and licensure. If Behavioral Health Care Managers provide psychotherapeutic treatment, they will require the clinical licensure/certifications to do so (e.g., Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, Licensed Master Social Worker, Certified Counselor, Licensed Psychologist, Licensed Registered Nurse, or Nurse Practitioner; BSW can provide these services when under supervision of a Masters Social Worker). If BH care managers perform all functions except the delivery of psychotherapeutic treatment, they can be a paraprofessional (e.g., Bachelor's or Associate level Counselor, Mental Health Aide, Behavioral Health Aide, Medical Assistant, Vocational Nurse, or Nursing Assistant). If the BHCM is not licensed, there must be a process in place to provide therapy to patients that need it, ideally without having to refer all of these patients out.

Billing shall be on a monthly basis. To bill for services for a Medicaid patient receiving Collaborative Care, the primary care provider and/or Behavioral Health Care Managers must:

- Enter the patient into a state-approved *registry* based on an initial diagnosis of the PCP and completion of an initial assessment and treatment plan by the Behavioral Health Care Manager
- Have a minimum of one clinical contact with the patient and a completed symptom scale (e.g. GAD-7, PHQ-9) every 30 days; [A "clinical contact" is defined as a contact in which monitoring may occur and treatment is delivered with corroborating documentation in the patient chart. This includes individual or group psychotherapy visits and telephonic engagement as long as treatment is delivered.]
- Have seen the patient face-to-face with a licensed provider for at least 15 minutes at least once during the most recent three months (90 days); this may be their PCP, Licensed BHCM or other licensed professional staff.
- Keep a record of all patient contacts; and
- Consult for one hour or more per week, depending on case load, with a designated consulting psychiatrist regarding patients in the registry, including all patients who are not improving in terms of their symptom scores. This psychiatrist cannot bill Medicaid for the Collaborative Care consultation work unless they perform in-person evaluations and consultation services.



After a patient scores positive on the screening tool, is diagnosed with a Behavioral Health condition by a primary care provider, has an initial assessment and treatment plan done by the Behavioral Health Care Manager, and has been entered into the approved registry, billing for Collaborative Care may begin.

The initial monthly payment for this service shall be \$150 for Article 28 clinics and \$112.50 for Private Practitioners. This amount shall be subject to periodic adjustment by NYS.

For Article 28 practices, twenty-five percent of each monthly payment shall be withheld by the state. This “retainage” shall be paid to the provider retroactively after the patient has completed at least three months of Collaborative Care based on attestation that the provider has complied with all aspects described above, as well as all applicable billing and programmatic guidelines AND approval has been granted by NYS or its designee. Please note, the retainage does not apply to IPA practices due to their unique billing processes. To qualify for the retainage, the patient must have been enrolled in the Collaborative Care program for a minimum of 3 months of treatment and in addition to being in full compliance with the terms of this program, the provider must document in the patient record that one of the following outcomes was achieved:

- Demonstrable clinical improvement, as defined by:
  1. A drop in the relevant symptom score to below ‘positive’ level; for PHQ-9 and GAD-7, this is below 10
  2. Or a 50% decrease in the symptom score from the level of the original score
- In cases where there was no demonstrable clinical improvement, there must be documentation in the medical record of one of the following:
  1. Psychiatric consultation (defined here as review of the case by the designated collaborative care psychiatrist with either the care manager or primary care provider) and a recommendation for treatment change by the psychiatric consultant
  2. Change in treatment (e.g., change in medication\*, change in psychotherapy type or frequency, or completed referral to more intensive specialty mental health treatment).  
*\*Please note, change in dosage may constitute a change in medication only if the dose change does not represent a titration up to treatment dose, but a true modification of the patient’s course. In order to capture this, we will limit the window for change in dose to between 6 weeks and 12 weeks after starting treatment.*

A patient is limited to 12 months of Collaborative Care treatment. The 12 months do not have to be consecutive. However, with prior approval from the Office of Mental Health’s Medical Director, or designee, an additional 12 months is permitted at two-thirds of the monthly rate of the initial 12 months if the treatment team demonstrates the need for ongoing depression care management. The retainage rules above also apply to the second 12 month period.

**Billing Start Date:** Certified providers in compliance with all requirements described herein will be given an approval date after which they can begin billing. Services for a given month will be billed on the first of the next month, i.e. January 2018 services would then be billed in February 1, 2018; and so forth, such

that all services delivered are billed during the subsequent month. Claims must be submitted within 90 days of the date of service to avoid timely filing denial. **Sites will be notified when they are approved and eligible to bill.** The Collaborative Care program will be subject to audit by a designated NYS entity. In cases where the provider has failed to comply with all clinical and reporting requirements, rates codes will be inactivated and payments will be recovered.

**NOTE: SBIRT Billing** - When appropriate, billing for SBIRT services delivered may also occur, using existing fee-for-service or managed care payment methods. This payment would be in addition to that paid for Collaborative Care.

## APPENDIX 1: State-Approved Depression Care Registry\*

Effective management of common behavioral health conditions requires the ability to track clinical outcomes for populations of patients and to support systematic changes in treatment for patients who are not improving as expected. This measurement-based, treatment-to-target approach is one of the core principles of Collaborative Care and is essential in ensuring stated goals are being met. It requires a systematic method of tracking information on all patients being treated for behavioral health conditions, like anxiety or depression. How it is done is much less important than that it is done.

Registries must be able to support the following functions:

- ✓ Track clinical outcomes and progress at the individual patient and caseload levels.
- ✓ Track population-based outcomes.
- ✓ Prompt treatment to target by summarizing patient's improvement and challenges in an easily understandable way, such as charts.
- ✓ Facilitate efficient case review, allowing providers, including the psychiatric consultant, to prioritize patients who need to be evaluated for changes in treatment or who are new to the caseload.
- ✓ Able to extract the relevant data for the required quarterly reporting to NYS OMH.
- ✓ Able to supply de-identified reports to outside auditors to demonstrate regulatory compliance, intensity of clinical contacts, staffing ratios, and outcomes.

Sites use a variety of programs to perform these functions.

- Many clinics begin their Collaborative Care programs using a spreadsheet as a registry.
- The AIMS Center offers a Patient Tracking Spreadsheet Template for providers to use.
- The AIMS Caseload Tracker is a cloud-based, HIPAA compliant registry that was introduced in 2017. This simple registry is useful for integrated care sites when the psychiatric consultant has direct access to the EHR.
- The AIMS Center offers an online, HIPAA compliant Care Management Tracking System (CMTS) that is particularly useful for healthcare organizations using multiple EHRs and diverse primary care practices. NYS OMH has designed a build that address all reporting criteria. If you are interested in using CMTS, please contact [NYSCollaborativeCare@omh.ny.gov](mailto:NYSCollaborativeCare@omh.ny.gov) for information on access to this version.
- Some organizations have customized registry builds for their EHR or in a care management software system.

For more information on registry requirements and the various options, see <https://aims.uw.edu/sites/default/files/CollaborativeCareRegistryRequirements.pdf>



**NYS COLLABORATIVE CARE MEDICAID PROGRAM CERTIFICATION:  
PROVIDER APPLICATION**

Please provide all the information requested below. Organizations seeking certification for multiple sites must complete a separate application for *each* site, patient volume, and readiness data. Groups of sites that share leadership and process may only submit one workflow and one letter of support for all.

Incomplete applications will not be processed.

Complete applications should be sent to [NYSCollaborativeCare@omh.ny.gov](mailto:NYSCollaborativeCare@omh.ny.gov)

**Name of point of contact for this application:**

**Email:**

**Phone:**

**Name of Practice:**

**Physical Address:**

**Zip code + 4:**

**Mailing Address (if different from above):**

**Facility License Type: (FQHC / Article 28 / Private Practitioner) \_\_\_\_\_**

**Clinic Medicaid ID #\*:**

**and Locator Code:**

**Clinic NPI:**

*\*For private practitioners, you will also need to submit names, Medicaid IDs, and NPIs for each individual physician.*

**Clinic Director (if applicable):**

**Medical Director:**

**Name of current BH Care Manager(s) with associated NYS license:**

**Current BH Care Manager FTE:**

**Planned staffing FTE:**

**How many Primary Care Providers (MD/DO, NP, PA) are at this site? \_\_\_\_\_**

**Total annual patient volume at your site:**

**Number of patients currently receiving collaborative care at your site, If any:**

**Anticipated maximum number of patients enrolled in collaborative care program at any given time:**



**Current Collaborative Care Registry:** \_\_\_\_\_

In its current form, can it perform the following functions? (check all that apply):

- Ability to track and manage caseloads toward evidence-based care delivery – a core registry design feature
- Supports treatment to target and caseload review for BH care manager with psychiatrist consultation for those not improving
- Supplies reports to program managers and clinical leadership to monitor progress toward goals, including processes of care, quality of care and patient outcomes metrics
- Able to supply de-identified reports to outside auditors to demonstrate regulatory compliance, intensity of service, staffing ratios, process measures, such as screening, diagnose and enrollment rates, and clinical outcomes

**Staffing:**

In order to participate in the Collaborative Care Learning Network, proper staffing is required. Please provide the contact information for the team members listed in this table. For more information, see the Team Roles Flyer for definitions of each role.

Role	Name	Degree/ licensure	Email address	Telephone Number
Program Lead				
BH Care Manager				
PCP Champion				
Psychiatric Consultant				
Billing & Data Lead				

The BH Care Manager should have training in one or more of the following psychotherapy interventions. Please indicate in which skills they have been trained:

- True Behavioral Activation
- Problem Solving Therapy
- Cognitive Behavioral Therapy
- Interpersonal Therapy

The BH Care Manager should devote at least .5 FTE to the role. A CM may be shared between sites, but sharing 1.0 FTE between more than two sites is not recommended. If the CM is not available for a minimum amount of time, hand-offs are not consistent, and the CM becomes distant from the Primary Care team. This impact both provider and patient engagement. If the CM is not available every day, there should be a formal process to supplement the hand-off and for the CM to follow up in a timely manner.

Find a CM job description and details on the recommended type of candidate on the AIMS website:

<https://aims.uw.edu/resource-library/care-manager-role-and-job-description>





### Case Review:

A key component of Collaborative Care is the weekly, 1-hour systematic case review of patients who are not improving between the care manager and the psychiatric consultant. Please enter the set day and time each week your care manager and psychiatric consultant will meet, whether this will occur in person or over the phone, and whether the consultant has access to your clinic's EHR and/or registry.

Note, even if you do not believe you have significant caseload to warrant a full hour each week, it is recommended that you continue to meet for one hour. This reserves the time in case needs change later on, but also allows the CM to ask questions of the psychiatric consultant that they may not otherwise have the opportunity to, such as guidance on pharmacology.

Case Review:

### Workflow:

Please submit your Collaborative Care workflow along with this application. In addition to the basic Collaborative Care workflow elements, the reviewers will also be looking for the following processes to be addressed:

- Consistent administration of BH Screening tools (75% or more), review, and recording of scores
- Ability to do a live warm connection (warm handoff) between PCP and care manager some or most of the time and plan for when this is not possible
- Communication plan in place for getting PC recommendations to the PCP and monitoring the PCP's response

**VIOLATIONS SUBJECT TO PENALTY:** Clinics participating in the Collaborative Care described above must comply with the terms and standards set forth by NYS DOH and OMH and are subject to audit. Reimbursement is contingent on full compliance therein. Clinics found to be in violation of standards will be subject to financial penalty.

**CLINIC MEDICAL DIRECTOR ATTESTATION:** I, [clinic medical director], understand the terms and standards for participation for the NYS Medicaid Collaborative Care Program and attest that [practice name] meets all specified eligibility requirements, including currently having in place all the required service elements for delivering Collaborative Care (e.g. state-approved patient care registry, outside caseload consultant psychiatrist(s), Behavioral Health Care Manager(s), and primary care providers trained to deliver Collaborative Care for depression). Furthermore, I understand full compliance with the terms and standards above is required for reimbursement; and that failure to comply may result in financial penalty.

Name:

Title:

Signature: \_\_\_\_\_

Date:

\*\*Please attach to this application:

1. Letter of support from the Executive Leadership of your organization or health system demonstrating support for this implementation and commitment to the standards.

**Incomplete Applications will not be reviewed**