

## NEW YORK STATE MEDICAID COLLABORATIVE CARE PROVIDER CERTIFICATION PACKET

### Items Contained in this Packet:

1. RFA Cover Letter
2. Terms of Participation
  - includes billing guidance and pay-for-performance standards
3. Appendix 1 – State Approved Registries
4. Appendix 2 – Reporting Requirements
5. Four (4) Part Provider Application:
  - ✓ Site Applicant Demographics
  - ✓ AIMS Center Principles of Integrated Behavioral Healthcare Baseline Checklist (This separate attachment to be filled out by the Clinic Medical Director is an important self-assessment for you to complete to understand your baseline and what will need to be done)
  - ✓ Medical Director Attestation
  - ✓ CEO Letter of Support

Please note: Completed applications should be sent to [NYSCollaborativeCare@omh.ny.gov](mailto:NYSCollaborativeCare@omh.ny.gov) by Friday, December 12<sup>th</sup>, 2014, along with a letter of support from the applying organization's CEO or executive director.

Questions should be directed to the same email address.



November 10<sup>th</sup>, 2014

Dear Colleague,

I write to invite you to apply for certification to participate in the ongoing New York State Medicaid Collaborative Care Depression Program. We are seeking a limited number of clinics to join a now over two year project that involved 19 academic medical centers throughout NYS.

We now have the capacity to extend this project beyond its Federal grant through a supplemental Medicaid payment. Providers will be eligible to bill a monthly case rate for a specified form of Collaborative Care for depression services provided to Medicaid recipients, including those covered by fee-for-service AND managed care Medicaid.

Applications are due Friday, December 12th, 2014.

We anticipate that approved providers will be able to bill beginning December 1st, 2014 - for services begun the prior month and continuing thereafter.

NYS is very pleased to offer this significant opportunity to sustain the implementation of Collaborative Care in New York State as both public and private health care payers transition from fee-for-service to value-based purchasing. Jointly lead by the Office of Mental Health and Department of Health, New York has overseen the largest state implementation of Collaborative Care for depression as part of the State Department of Health Hospital Medical Home Demonstration Project; this federally funded grant ends this December.

For you as a clinical provider to be eligible to participate in this supplemental payment program for Collaborative Care, you must demonstrate specified elements of Collaborative Care including depression care manager(s), primary care provider delivery of services, and caseload consultant psychiatrist(s) adequately trained to the model; and a depression care registry or functional equivalent for tracking measurement-based care and driving delivery of this evidenced-based model of care.

Not all eligible providers will be certified. Preference will be given to providers with a record of delivering high fidelity Collaborative Care/IMPACT/Team Care for depression, namely the effective detection and treatment of depression in the primary care setting. Additional consideration will be given to those providers whose organizations have demonstrated a commitment to scale this evidence-based model of care.

See the accompanying application for details.

**COMPLETED APPLICATIONS SHOULD BE EMAILED NO LATER THAN FRIDAY, DECEMBER 12th, 2014 TO: [NYSCollaborativeCare@omh.ny.gov](mailto:NYSCollaborativeCare@omh.ny.gov)**

Questions can be sent 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 for Depression please see these terms.

Article 28 of the Public Health Law allows primary care practices to deliver Collaborative Care health services to patients with a diagnosis of depression. 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:** An Article 28 clinic must deliver the following essential elements of Depression Collaborative Care:

- **Trained Depression Care Managers** in the primary care setting who oversee and provide mental health care support; depression 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. (for job description see: <http://aims.uw.edu/collaborative-care/team-structure/care-manager> )
- **Designated Psychiatrist(s)** 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. Psychiatrists 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 PHQ-2/9; and ongoing performance improvement.
- **Trained primary care providers** in screening and providing evidence-based, stepped care for depression.

\*see Appendix 1 for details

**Please Note:** Applicants who have not participated in the NYS Collaborative Care Initiative (CCI) Grant are required to complete an online LMS Collaborative Care basic training curriculum available in mid-late January 2015. OMH or its designee will track use of this training tool. CCI applicants are also encouraged to utilize this tool to orient new staff.

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

1. Past performance delivering Collaborative Care for depression
2. Capacity to scale up Collaborative Care for depression (and other conditions)

**Billing for Collaborative Care for Depression** - Payment for Collaborative Care services will only be made for patients with an initial PHQ-9 score greater than or equal to 10 and who then are diagnosed with depression; whose PHQ-9 scores are actively tracked in a registry; and who receive evidence-based depression care in a primary care setting by primary care providers, where trained Depression Care Managers are in place and actively providing services; and where a designated consulting psychiatrist regularly reviews, with either the primary care provider or the depression care manager, the needs of all patients under care who are not improving and makes recommendations for changes in treatment as needed.

NOTE: The Depression Care Manager 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 Depression 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). If depression 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).

Billing shall be on a monthly basis. To bill for services to a patient receiving Collaborative Care, the primary care provider and/or depression care managers must:

- Enter the patient into a state-approved *registry* based on an initial PHQ-9 score greater than or equal to 10, a confirming diagnosis of depression, and completion of an initial assessment and treatment plan by the Depression Care Manager
- have a minimum of one clinical contact with the patient and a completed symptom scale (the 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 for at least 15 minutes at least once during the most recent three months (90 days);
- 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 depression scores. This psychiatrist cannot bill Medicaid for the Collaborative Care consultation work unless they perform in-person evaluations and consultation services.

With state approval, the patient registry may be within the provider's information systems, but must be available for inspection and audit by the Office of Mental Health, or its designee. A patient diagnosed with depression and enrolled in the program must be evaluated using the PHQ-9 at a minimum of a monthly basis (and each month the score must be entered into the approved registry).

After a patient scores greater than or equal to 10 on the PHQ-9 screening tool, is diagnosed with depression by a primary care provider, has an initial assessment and treatment plan done by the depression care manager, and has been entered into the approved registry, billing for Collaborative Care may begin on the first day of the following month.

The initial monthly payment for this service shall be \$150. This amount shall be subject to periodic adjustment by NYS.

Twenty-five percent of each monthly payment shall be withheld by the state. This retainage shall be paid to the provider every six months 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. 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 PHQ-9 score of at least 5 points from baseline and a total score below 10
  2. Or a 50% decrease in the PHQ-9 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).

A patient is limited to 12 months of Collaborative Care treatment. 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.

**Program Start Date:** November 1, 2014 is the first allowable date of service for this program.

**Billing Start Date:** Certified providers in compliance with all requirements described herein can commence billing for November 2014 services beginning on December 1, 2014; December services would then be billed in January 2015; and so forth, such that all services delivered are billed during the subsequent month.

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 Depression Collaborative Care.

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

\*Registries are distinct from Electronic Medical Records (EMRs). The central function of a care registry is to track and manage caseloads and to facilitate the delivery of evidence-based care for specific medical or behavioral health conditions, in this case depression. Most EMRs are not designed to do this. While some EMRs may have some caseload query functionality, they typically lack the clinical decision support features that facilitate the delivery of evidence-based clinical care. In some cases, this functionality can be built into the EMR but this usually takes a significant investment of both time and money.

At present only the following Depression Care Registries are State-Approved:

1. Care Management Tracking System (CMTS)
  - a. [http://c4c.uwc4c.com/express\\_license\\_technologies/care-management-tracking-software](http://c4c.uwc4c.com/express_license_technologies/care-management-tracking-software)
2. EPIC Depression Care Registry
3. Other registries are permissible as long as they perform central patient care registry functions:
  - ✓ Ability to track and manage caseloads toward evidence-based care delivery – a core registry design feature
  - ✓ Supports treatment to target (PHQ-9) and caseload review for depression 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, such as screening rate, # enrolled, intensity of clinical contacts, including psychiatrist consultation, staffing ratios, and response to treatment for the population served
  - ✓ Able to supply de-identified reports to outside auditors to demonstrate regulatory compliance, intensity of clinical contacts, staffing ratios, and outcomes (SEE APPENDIX 2 FOR REPORTING DETAILS)

Note: At least until September 2015, NYS is making the Collaborative Care Initiative CMTS registry available to NYS collaborative care providers, even those who did not participate in the original grant at no charge upon completion of the associated Software Users Agreement (SUA). Contact Ashley Heald at the University of Washington AIMS Center - [Aheald@uw.edu](mailto:Aheald@uw.edu) for additional information.

## APPENDIX 2: Reporting Requirements

The following outcome and process measures are required to be reported to OMH or its designee on a quarterly basis for participation in the Medicaid Collaborative Care Depression Program:

1. **Improvement Rate** – Number (#) and proportion (%) of patients in treatment for 90 days or greater who demonstrated clinically significant improvement either by:
  - a. a 50% reduction from baseline PHQ-9
  - b. or a drop from baseline PHQ-9 of at least 5 points and to less than 10  
(2015 Target Rate ≥50%)
2. **Consultation Rate** – among those in treatment for 90 days or greater who did not improve, number (#) and proportion (%) who received a psychiatric consultation as defined above  
(2015 Target Rate ≥75%)
3. **Change in Treatment Rate** – among those in treatment for 90 days or greater who did not improve, number (#) and proportion (%) where a change in treatment was initiated and documented in the patient record  
(2015 Target Rate ≥75%)
4. **Depression Screening Rate** - Number (#) and proportion (%) of unique adult patients/year who received a PHQ 2 or PHQ 9  
(2015 Target Rate ≥75%)
5. **Enrollment Rate** - Number (#) and proportion (%) screening positive for depression and meeting diagnostic criteria for depression who are enrolled in the Collaborate Care Depression Program (Note enrollment commences upon completion of a baseline PHQ-9 score  $\geq 10$ , a confirmatory diagnosis of depression, and an initial assessment and treatment plan by the Depression Care Manager. The patient is entered into the depression care registry at this time.)
6. **Engagement Rate** – Number (#) and proportion (%) of those enrolled in treatment for 90 days or more who received at least one clinical contact and one PHQ-9 every 30 days for the most recent 90 day period – i.e. those in treatment for 90 days or more who are eligible for the monthly case rate over the most recent 90 day period
7. **Active Patients** – Number (#) of patients receiving active (i.e. those receiving acute or maintenance phase treatment; excludes relapse prevention and discharged patients) and mean (average) PHQ-9 score of patients in active care
8. **Staffing** – Depression Care Manager FTEs dedicated to chronic physical and behavioral health management

**Please Note:** State Approved Registries capture all of the above data. Additional reporting guidance will be provided upon certification. Although the PHQ-9 for depression is the scale used for treatment to target in this program, other valid measures in parallel as clinically indicated are encouraged (e.g. GAD-7 for anxiety or PCL for posttraumatic stress disorder).





**Current Depression Care Registry:**CMTS If Other, please specify the name of your registry:

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

- Ability to track and manage depression caseloads toward evidence-based care delivery – a core registry design feature
- Supports treatment to target and caseload review for depression 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

**\*\*Before the applicant Medical Director signs the attestation below, he or she must fill out a baseline survey entitled “Patient-Centered Integrated Behavioral Health Care Principles and Tasks” from the AIMS Center with respect to your primary care depression care program and attach it to this application. This separate attachment is an important self-assessment for you to complete to understand your baseline and what will need to be done**

**VIOLATIONS SUBJECT TO PENALTY:** Clinics participating in the Collaborative Care for depression 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 for Depression Program and attest that Article 28 Clinic [clinic name] meets all specified eligibility requirements, including currently having in place all the required service elements for delivering Collaborative Care for depression (e.g. state-approved patient care registry, outside caseload consultant psychiatrist(s), Depression Care Manager(s), and primary care providers trained to deliver Collaborative Care for depression). I have completed the “Patient-Centered Integrated Behavioral Health Care Principles and Tasks”, include it in this application, and attest that my answers accurately reflect the above clinic’s readiness for delivering 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 CEO of your organization or health system.
2. A completed copy of “Patient-Centered Integrated Behavioral Health Care Principles and Tasks” survey from the AIMS Center

**Incomplete Applications will not be reviewed**