Remaining Questions from 2/1/18 Webinar

Q: Can you speak about the lack of reimbursement for BH in primary care and regulatory restrictions, especially as it relates to staffing restrictions?
There are certain regulations in place that direct what type of services can be provided and reimbursed in certain settings. Two of the issues that have come up around the co-location of primary care and BH in DSRIP projects are the shared space requirements CMS has when BH services are co-located with Article 28 services. The restrictions on the ability for Social Workers to bill in Article 28 Primary Care settings has also created some barriers. Note: These barriers do not apply to Collaborative Care.

There is an FAQ on Integrated Billing here:
http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/2016-01_integrated_care_faqs.htm

Integration Billing Matrix:

http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/2016-03-18_billing_matrix.pdf

Q: This is used for depression and anxiety. Does this model work for people with schizophrenia? PTSD?
This model is designed to be used for conditions that are appropriate for treatment in primary care, with brief interventions and psychopharmacology management by the PCP. There is evidence to support the use of the model to treat Depression, Anxiety, PTSD and ADHD, but diagnoses of SMI such as schizophrenia would probably not be the best fit for the Collaborative Care approach.

Q: Could you explain the "threshold to behavioral health"? Isn't there parity in healthcare?
A licensed or certified outpatient provider may add primary care, mental health and/or substance use disorder services under a single license or certification without any additional licenses or certifications, as long as the service to be added does not exceed the applicable Licensure Threshold.

Licensure Thresholds are not currently applicable for substance use disorder services; OASAS certification is required if a clinic licensed by DOH or OMH wishes to provide any substance use disorder services.

A clinic site licensed by DOH pursuant to PHL Article 28 must also be licensed by OMH if it provides more than 10,000 annual mental health visits, or if more than 30 percent of its annual visits are for mental health services. The policy is the lowest of 30%/10,000 visits.
A clinic site licensed by OMH pursuant to MHL Article 31 or certified pursuant to MHL Article 32 must also be licensed by DOH if more than 5 percent of its visits are for medical services or any visits are for dental services.

There are waivers in place that sites participating in DSRIP may apply for to increase these thresholds as part of DSRIP projects.

Q: Out of the 100 practices, how many are in a rural setting?
About 15% of our current CCMP practices are in rural settings. The original grant program which led to the creation of the CCMP was based on Academic Medical Centers, most of which are located in larger

metropolitan areas in the state, so our original cohort of sites were based in these settings. A higher percentage of sites that have joined the program more recently are from rural areas.

Q: Is this approach more appropriate for an urban setting or could it be beneficial for a rural community?
It can be very beneficial to rural providers since they may have greater access issues than urban practices if they are relying on referring their patients out to specialists. The Collaborative Care model allows for virtual interactions so this potentially expands access beyond a geographic area.

Q: We're an outpatient mental health clinic. We typically don't have clients see both the psychiatrist and the clinician on the same day, primarily because the blended rate for seeing both is much lower than seeing them on separate days. If we brought in a PCP into our practice, would the reimbursement rate also be that lower blended rate, or would we be able to bill separately for each service?
If you bill APGs, when two E&Ms are provided to a member on the same date of service, both codes may receive full payment.

Q: As a person with mental health illness, this kind of care sounds great, but I would get disheartend having to see that many people and might feel like I am getting handed off. Is there any way to decrease the amount of people needed to be seen?
That is one of the great things about this model, it's very seamless, and minimizes the number of people involved in your care. The only two providers that the patient interacts with are their Primary Care Provider, who they already have a relationship with, and the BH Care Manager who is in the same office, part of the primary care team. This streamlines the process as opposed to "usual" care where you need to find a BH Specialist in another practice, transfer records back and forth, and potentially need to see a Psychiatric provider to prescribe medication.

Q: How does this avoid the need for site licensing (i.e. OMH OASAS satellite) or professional credentialing/licensing?
Collaborative Care services are primary care services and are billed by the primary care practice, so there is no need for licensing under OMH or OASAS. Since they are billed by primary care as a monthly case rate, the BH professional is not billing themselves, so the practice is not restricted by only those that can bill for services (SWs and LMHCs cannot bill under most circumstances in Article 28 Primary Care practices).

Q: In our DSRIP integration efforts, we are using a model where BH clinics set up a satellite location in the PCP office. How much is this model being used across the state? The direct supervisor for the BH staff is an LCSW with a psychiatrist available prn...the psychiatrist is expected to offer consultation on a regular basis to the physician
We are definitely seeing this model being used across the state, but it is often hindered by having to get a satellite license. This differs from Collaborative Care, as well, because the BH staff is providing traditional care, just in a co-located setting, rather than being integrated as part of the Primary Care team.

Q: I appreciate the information on the utilization of peers in this model, however can you clarify on whether it can be billed?
Currently, the only way to bill Medicaid for these services in NYS is through HCBS.

Q: How does billing work if services provided on the same day within an integrated practice? If patient seen primary and then is handed off to BHCM who might then provide some intervention?
In Collaborative Care, services are not billed by unit, but a monthly rate is paid that incorporates all of the services provided to the patient. If a patient is given a warm handoff to a BH specialist, the BH services would not be billed for, and in most cases, would not be billable in primary care anyway.

Q: If the patient has medicare does the Behavioral Health component have to be provided by a LCSW or does this model negate those Medicare regulations?
The behavioral health care manager has formal education or specialized training in behavioral health, which could include a range of disciplines including social work, nursing, and psychology, but need not be licensed to bill traditional psychotherapy codes.
More details on Medicare billing can be found here:
https://aims.uw.edu/sites/default/files/CMS_FinalRule_BHI_CheatSheet.pdf