Regulatory Modernization Initiative

Integrated Primary Care and Behavioral Health Workgroup Meeting

Thursday August 17, 2017 10:30 a.m. – 3:00 p.m.

MINUTES

- Welcome and Opening Remarks: Dan Sheppard
- Meeting Objectives and Introduction of Workgroup Members: Dr. John Rugge
- State Agency Overview of Current Integrated Care Models: Jennifer Treacy (DOH), Keith McCarthy (OMH), Trisha Schell-Guy (OASAS)
    - 2008 Licensure Threshold
    - DSRIP 3.a.i Threshold
    - Integrated Outpatient Services (IOS)
    - Barriers
- Success and Limitations of Service Integration under Current Models:
    - Dr. David Flomenhaft (IOS Provider, Mercy Medical Center)
        - Great for patients ("no wrong door") do not have to move patients to another clinic as substance abuse comes under control
        - Barriers
            - Sustaining primary care services financially
                - Billing for physical medicine services on behavioral health claim inflexible
                - Limitations in preventative medicine coding in OMH guidelines (no Medicare reimbursement)
                - Unable to support full primary care services
            - Physical plant standards (e.g. clean and soiled linen rooms)
            - Professional change in traditional ways of providing care (e.g. tele psychiatry)
            - Reporting requirements (OASAS Federal Block Grant requirements)
            - Workforce (LMHCs not yet recognized by CMS)
    - David Shippee (DSRIP 3.a.i Provider Whitney Young Health Center)
        - Barriers
            - Scale matters to sustain services (expertise, volume)
            - Mobile Article 28 (not a long term solution but for the short term solves billing and ability to start offering services)
            - IT/Medical Records (Each provider having access to a patient's medical record in order to be able to coordinate care)
            - Billing
                - Confusion of payers with different types of billing FFS, APGs and new codes

    - Timeliness of reimbursement (Invest in order to provide services without seeing returns for some time)
- Licensure Expansion for Comprehensive Services Approaches: Ann Monroe
- Input and Comments main topics:
    - Billing/Reimbursement
        - Incentivize care integration
        - Better identification of total cost of care (where costs are saved, where spending increased)
        - Services within scope of practice should be billable
        - Inability for certain practitioners to bill in certain settings (e.g. Licensed Mental Health Counselors in Article 28)
        - More flexible billing (e.g. able to add physical medicine diagnosis on claim when treating behavioral health disorder)
    - Workforce/Staffing
        - Scope of practice (e.g. NP/PA regulations)
        - Reduction in unnecessary paperwork (e.g. Treatment Plan)
        - Resident physician supervision requirements
    - Care Transitions
        - Health Home
        - Medical Reconciliation, Care coordination
        - Social Determinants of Health Services (housing, transportation, education, etc.)
        - Flexibility in PCP assignment/designation
        - Promote/require provision of services
    - Oversight (joint surveillance/licensure)
        - Article 16 clinics
        - Simplification of application process and surveillance
        - Physical Plant Requirements
        - Allowance of services in other settings (e.g. Syringe Exchange Programs, Day Rehab, OMH/OASAS Inpatient Settings)
    - Information Technology (EMR, telehealth)
        - Record Sharing (especially for MH and SUD)
        - Geographic barriers in Tele psychiatry
- Licensure Expansion for Comprehensive Services
    - It is more difficult to add primary care to behavioral health settings
    - Suggestions from meeting are on attached table